Fact Sheet on MEWA Enforcement

U.S. Department of Labor

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Background:

Multiple Employer Welfare Arrangements (MEWAs) provide health and welfare benefits to employees of two or more unrelated employers who are not parties to bona fide collective bargaining agreements. In concept, MEWAs are designed to give small employers access to low cost health coverage on terms similar to those available to large employers. For certain employers they represent the only available option for providing employees with health care because insurance companies often will not insure small employers who do not fall within their desirable risk category.

Although MEWAs can be provided through legitimate organizations, they are sometimes marketed using attractive but actuarially unsound premium structures which generate large administrative fees for the promoters. In addition, certain promoters will set up arrangements which they claim are established pursuant to a collective bargaining agreement and, therefore, are not MEWAs but legitimate benefit plans free from state insurance regulations. Often, however, these collective bargaining agreements are nothing more than shams designed to avoid state insurance regulation.

States and the federal government coordinate the regulation of MEWAs pursuant to a 1982 amendment to ERISA. This dual jurisdiction gives states primary responsibility for overseeing the financial soundness of MEWAs and the licensing of MEWA operators. The Department of Labor enforces the fiduciary provisions of the Employee Retirement Income Security Act (ERISA) against MEWA operators to the extent a MEWA is an ERISA plan or is holding plan assets. State insurance laws which set standards requiring specified levels of reserves or contributions are applicable to MEWAs even if they are also covered by ERISA.

While no comprehensive data exists on how many MEWAs there are, a 1992 General Accounting Office report estimated over 2.5 million participants and beneficiaries in 46 states were enrolled in MEWAs. However, in February 2000, the EBSA published the new Form M-1 Annual Report for Multiple Employer Welfare Arrangements (MEWAs) and certain Entities Claiming Exception (ECEs), which, over time, should establish a reliable database for the number of MEWAs operating across the country.

EBSA Enforcement Efforts:

The Department has devoted significant resources to investigating and litigating issues connected with abusive MEWAs created by unscrupulous promoters who sell the promise of inexpensive health benefit insurance, but default on their obligations. Particular emphasis has been put on identifying ongoing abusive and fraudulent MEWAs, and working to shut down such operations.

In further recognition of the importance of aggressive enforcement in the MEWA area, the Department affirmed MEWAs as one of the significant issues in its Enforcement Strategy Implementation Plan (ESIP) in the1990s. In EBSA's Strategic Enforcement Plan (StEP), EBSA has identified MEWAs as one of its longstanding national projects that it continues to aggressively pursue.

To date, the Department has:

- Initiated 637 civil and 117 criminal investigations affecting over 1.946 million participants and their beneficiaries and identifying monetary violations of over $143 million. There are currently 122 civil and 38 criminal investigations open.
- Filed 68 civil complaints.
- Indicted 98 individuals with 70 convictions.
- Published technical assistance materials, including a booklet explaining federal and state regulation of MEWAs.
- Issued numerous advisory opinions to assist state prosecutors and regulators to enforce state insurance laws against MEWAs.

?? Convicted individuals have been sentenced total prison terms of approximately 201 years. Most of these investigations have been jointly investigated with other agencies, including the Department's Division of Labor Racketeering, the FBI, the U. S. Postal Inspection Service, and the Internal Revenue Service's Criminal Investigative Division.

Recent Litigation Cases:

In April 2004, the Department obtained a consent decree appointing a temporary fiduciary for 45 days to manage the Paramount, Calif.-based International Union of Industrial and Independent Workers Benefit Fund and to conduct an accounting of the plan's finances and claims. The order also temporarily relieves the trustees and the union of their positions and duties as plan fiduciaries. Under the order, the court-appointed fiduciary will assume control of the fund for 45 days, continue to pay claims incurred by participants and report to the court on the fund's finances and claims.

In April 2004, The Department filed a lawsuit against the purported union, former plan administrator Oak Tree Administrators, its owner Cherille Shelp and current and former trustees Geoffrey J. Beltz, James Miller, David Wright, and Henry Solowiej.

The Department's suit alleges that the purported union is a MEWA that operates in Alpharetta, Ga., Plano, Texas, and Paramount, Calif. The purported union was part of a MEWA that marketed health benefits to employers in Texas, Georgia, Oklahoma, California and many other states. Several states, including Oklahoma and Georgia, have ordered the fund's operators to stop all insurance-related activities.

In its suit, the Department alleged that from July 2000 to June 2003, the defendants allegedly spent millions of dollars of fund assets on administrative expenses – including several hundred thousand dollars paid to the purported union and more than $1 million to marketers of the arrangement. The Department also alleged that the defendants delayed processing health claims, failed to operate the fund in an actuarially sound manner and paid excessive fees for services provided to the fund. In the court action, the Department seeks to restore losses to the fund and to appoint a permanent fiduciary to manage it.

In April 2004, the Department sued the former president of the Memphis-based International staff-leasing firm that operated a Multiple Employer Welfare Arrangement (MEWA) that left Staff Management Inc. for mismanagement of the Section 125 cafeteria health plan. ISM was a participants with as much as $535,000 in unpaid health claims.

The suit alleges that Don Starkey violated the Employee Retirement Income Security Act (ERISA) by failing to take reasonable action to ensure that the plan had adequate reserves to pay claims. The suit also alleges that he did not ensure that the plan was covered by stop loss insurance from May 1999, until it was terminated on Sept. 30, 2001.

The plan provided health benefits to approximately 94 participants under a re-insurance arrangement that was administered by American Heartland Health Administrators, Inc. until its insurer defaulted on benefit claims. In May 1999, Carolina Benefit Administrators was retained by Starkey to take over claims administration. From May 1999, until the plan was terminated, the plan operated without stop loss insurance and contribution rates created or approved by the defendant were not adequate to pay claims.

The suit seeks a court order to require that Starkey restore any losses with interest. In addition, the suit asks the court to appoint an independent fiduciary to administer the plan and permanently bar the defendant from serving any employee benefit plan governed by ERISA in the future.

On January 30, 2004, the Department sued the fiduciaries of Provider Medical Trust, a Tulsa-based Multiple Employer Welfare Arrangement (MEWA), for taking excessive fees and making misrepresentations that resulted in the participants incurring millions of dollars in medical bills while believing they had health plan coverage. Among the parties named in the lawsuit, is Johnson Benefit Administrators, LLC who controlled PMT and managed about 45 self-funded single employer group plans. It is no longer a going concern.

The suit seeks the removal and a permanent bar of the plan fiduciaries from serving any employee benefit plan governed by the Employee Retirement Income Security Act (ERISA), and asks that the fiduciaries provide an accounting of the excessive fee charges and that they make full restitution to the Plan.

Since Jan. 1, 1996, the defendants misrepresented the trust's solvency and caused the trust to pay excessive service fees to the plan administrator, which was owned by the fiduciaries. The fiduciaries also allegedly misrepresented the fund's solvency to meet state insurance solvency requirements and continued to market the trust without disclosing its true financial situation.

On September 10, 2003, a Federal Court in Nevada entered a default judgment requiring the principals of Employers Mutual LLC and affiliated companies to pay $7.3 in losses suffered by health plans operated by the corporation. Employers Mutual LLC is a multiple employer welfare arrangement (MEWA) that provided health benefits to more than 22,000 participants and beneficiaries in all 50 states. The Department's investigation disclosed numerous instances where monies were transferred from the MEWA to the MEWA's operators to pay excessive expenses rather than paying benefits for the participants. The investigation also disclosed that the amount of unpaid claims for the MEWA was approximately $27 million. On February 1, 2002, the Department obtained a preliminary injunction and order appointing an independent fiduciary to manage the Health Plan operated by Employers Mutual LLC and affiliated associations. In February 2003, default judgments were filed against the principal defendants.

On November 15, 2001, the Department filed a lawsuit against the trustees, corporations and principals affiliated with Mutual Employees Benefit Trust (MEBT) for diverting more than $2.2 million in assets of their health and welfare plan to benefit sham labor unions and corporations. MEBT is a MEWA that has provided group health and other benefits to as many as 1,912 participants. The relief requested required the defendants to restore all diverted assets and losses with interest and be removed from their position as fiduciaries. The Department also asked the Court to appoint an independent fiduciary to manage the plan. On May 4, 2002, the Court appointed an independent fiduciary to manage the plan, and barred the four plan trustees, the plan's third party administrator, its employer associations and several principals involved from serving as fiduciaries to the plan. On September 13, 2003, the Department obtained a partial consent decree which required that the owners of MEBT restore $1.7 million to the Plan.

On October 28, 2003, the Department sued executives of TRG Marketing, LLC for failing to prudently manage the firm's health plan, resulting in up to $17.5 million in unpaid health claims owed to plan participants nationwide. The suit alleges TRG's executives also diverted health plan assets to pay personal expenses for themselves and family members.

The defendants failed to charge adequate premiums, and did not establish appropriate underwriting procedures to ensure sufficient assets were available to pay benefits. The defendants also diverted money targeted to pay health benefits for personal enrichment, including paying for European family vacations, personal lines of credit, charitable contributions, brokerage commission and corporate distribution to themselves and spouses.

The suit, seeks payment of all health claims filed by participants and beneficiaries and also asks that the defendants be removed from their positions with the plan and permanently barred from serving as fiduciaries to any ERISA-covered plan.

TRG Marketing was a Nevada limited liability company. The TRG plan was a multiple employer welfare arrangement (MEWA) designed to protect participants and their dependents by providing reimbursement for catastrophic health expenses. When terminated in November 2001, the TRG plan had approximately 11,000 participants nationwide.

On July 12, 2001, the Department obtained a temporary restraining order freezing the assets of U.S. Alliance, Inc. and related companies. U.S. Alliance and Alliance Administrators operated numerous membership associations that marketed plans to employers on the East Coast. The employers paid contributions to purchase benefits provided by the various association plans. The health plan sponsored by U.S. Alliance resulted in more than $2.8 of unpaid medical claims for at least 1,500 participants. Plan officials and corporate executives diverted over one million dollars of plan assets for their personal use. The order also appoints an independent fiduciary to manage the Plan. A preliminary injunction was subsequently issued which continued the appointment of the independent fiduciary and froze the defendant's assets. The Department obtained a final consent judgment on May 16, 2003, holding that the health plan administrators of U.S. Alliance are liable to pay up to $2.8 million from future income for the unpaid medical claims.