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**Georgetown University Study Finds Federal AHP Legislation Would
Lead to More Health Insurance Scams, Threaten the Health Coverage and
Financial Security of Millions of Americans**

*Georgetown University's Health Policy Institute Releases New Report on
Association Health Plans and Health Insurance Fraud*

WASHINGTON – Federal association health plans (AHPs), as proposed in legislation currently before Congress, would make the problem of health insurance scams in the United States much worse, according to a Georgetown University Health Policy Institute study released today at a briefing in Washington, D.C.

“The regulatory approach contemplated in the AHP legislation would leave many businesses and workers at the mercy of scam operators. The consequences are predictable: bankruptcy, delayed or foregone medical care, and loss of coverage for America’s businesses and workers,” study author Mila Kofman concludes in her report entitled, “Association Health Plans: Loss of State Oversight Means Regulatory Vacuum and More Fraud.” Kofman is an assistant research professor at Georgetown University and a national expert on health insurance scams.

In discussing the report’s findings at the press briefing, Kofman stated, “The AHP legislation is a license to steal.” Kofman went on to say that the new oversight strategy proposed in the legislation is based on “self-reported information and self-regulation” and that “crooks won’t be notifying the feds of lying, cheating, and stealing.”

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Since ERISA's enactment, there has been a long history of fraud related to multiple employer welfare arrangements, including AHPs. "The history of scams involving associations demonstrates that when the federal government has had sole oversight authority, fraud flourished with unscrupulous individuals leaving businesses and their workers without health insurance coverage and with millions of dollars in unpaid medical bills," Kofman writes in the report.

Between 2000 and 2002, this national problem affected more than 200,000 policyholders (number of people unknown) and left businesses and workers responsible for \$252 million in medical bills. States shut down 41 illegal operations selling coverage through phony and real associations, while the U.S. Department of Labor shut down three entities.

According to the report, the bill would prohibit states from shutting down health insurance scams and prohibit states from making it illegal to sell phony insurance to federal AHPs. Instead, the U.S. Department of Labor would be responsible for regulating this area. Kofman asserts in the report that this would create a "regulatory vacuum" and result in "the unintended consequence of widespread fraud threatening the financial security of millions of Americans."

States currently have the authority and resources to prevent, identify, and shut down fraudulent insurers, whereas, these same tools cannot be replicated at the federal level and would be lost under federal AHP legislation.

The study states that the reliance on self-reported information and self-regulation that would result if the AHP legislation is enacted "would make it almost impossible for the federal government to prevent conmen from obtaining a federal license." The report notes that the AHP proposal does not prohibit repeat offenders from becoming certified. The bill restricts federal courts' ability to order non-complying AHPs to shut down and creates a new vague preemption standard in ERISA, which would create new opportunities for criminals to hide behind. When found, criminals would use the expanded "ERISA shield" even when not covered by ERISA.

"Being federally certified is akin to a seal of good housekeeping," Kofman states in the report. "Criminals would use their federal certification to attract customers, taking advantage of unsuspecting businesses."

"The principal goal of insurance regulation is to protect consumers. It is in this critical area that federal AHP legislation fails so miserably," said Sandy Praeger, Kansas commissioner of insurance and secretary-treasurer of the National Association of Insurance Commissioners.

“Simply put, allowing federal AHPs to operate outside the authority of state regulators will expose consumers to more fraud and insurance scams. This is not just speculation but fact borne of years of experience with multiple employer welfare arrangements, association plans, out-of-state trusts and other schemes to avoid or limit state regulation.” Praeger participated in the briefing to release the report.

Several victims of health insurance scams put a face on the findings in the report. Janice Ramsey, who is self-employed, lost about \$21,000 in premiums and unpaid medical bills. Janice was one of 40,000 people covered by American Benefit Plans (ABP), an illegal arrangement that sold coverage through existing and phony professional associations. Janice bought ABP’s coverage through an existing association.

Jill and Brent Burgess had to file for bankruptcy and lost their small business as a result of a health insurance scam. They were covered by Vanguard Asset Group, an illegal arrangement whose operator in 2000 pled guilty to embezzling millions from a health plan and promised the U.S. Department of Labor not to do it again. The same year the operator pled guilty, the individual established a new illegal arrangement, in which the Burgess family enrolled. Both scams were shut down by the states.

To view the report and related materials from the press briefing, visit <http://hpi.georgetown.edu/ahp.html>.

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