Fact Sheet

U.S. Department of Labor
Employee Benefits Security Administration
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MEWA Enforcement

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 that do not fall within their desirable risk category.

MEWAs generally operate in one of two ways. Employers forward money to the MEWA (often including employee contributions) which is used either to pay premiums for a health insurance policy or to pay for benefits directly from the MEWA. It is the latter arrangement that more often causes problems. The MEWA organizers may not have conducted a prudent analysis to determine the amount of contributions needed in order to fully pay claims.

Although MEWAs can be provided through legitimate organizations, they are sometimes marketed using attractive but actuarially unsound premium structures that generate large administrative fees for the promoters. These high fees are often paid before any claims are paid, leaving insufficient funds available to pay for the benefits promised by the promoters. In addition, certain promoters will set up arrangements that 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 the Employee Retirement Income Security Act (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 ERISA against MEWA operators to the extent a MEWA is an ERISA plan or is holding plan assets. State insurance laws that set standards requiring specified levels of reserves or contributions are applicable to MEWAs even if they also are covered by ERISA.

Recent Final Regulations and Criminal Statutes

The Patient Protection and Affordable Care Act (Affordable Care Act) added section 521 to ERISA to authorize the Secretary of Labor to issue a cease and desist order, ex parte, when it appears that the alleged conduct of a MEWA is fraudulent, creates an immediate danger to the public safety or welfare, or is causing or can be reasonably expected to cause significant, imminent, and irreparable public injury. The Secretary may also seek a summary seizure order when it appears that a MEWA is in a financially hazardous condition. Systematic failures to pay benefit claims or the diversion of premiums for personal use are common examples of these types of conduct. Before this change, stopping the activities of an abusive arrangement immediately and freezing its assets required a court-issued temporary restraining order and preliminary injunction. With this new authority, the Secretary may take steps to protect plan participants and small employers much earlier in the

process, before all of the assets have been exhausted. On March 1, 2013, final rules were published in the Federal Register to facilitate implementation of this new enforcement authority provided to the Secretary.

The Health Insurance Portability and Accountability Act of 1996 added section 101(g) to ERISA to provide the Secretary with the authority to require, by regulation, annual reporting by MEWAs that are not ERISA-covered plans. The Affordable Care Act amended section 101(g) to require that such MEWAs register with the Department of Labor prior to operating in a state. On March 1, 2013, the Department published final rules in the Federal Register implementing the changes made by the Affordable Care Act.

While reporting requirements for MEWAs have been in place since 1999, the Department often did not find out about insolvent or fraudulent MEWAs until significant harm had occurred to employers and participants. This new registration enhances the existing reporting rules to require all MEWAs as well as certain other entities that offer or provide health benefits to the employees of two or more employers to register with the Department via the Form M-1. These changes also require MEWAs that are ERISA plans which are subject to the Form M-1 filing requirements to file a Form 5500 Annual Report, regardless of plan size. By requiring MEWAs to register with the Department before operating in a State, this rule enhances the State and Federal governments' joint mission to prevent and take enforcement action against fraudulent and abusive MEWAs and limit the losses suffered by American workers, their families, and businesses in instances when abusive MEWAs become insolvent and fail to reimburse medical claims.

The Affordable Care Act also added a new criminal provision, section 519, to ERISA, which imposes criminal penalties for knowing false statements or representations made to abet the marketing or sale of a health plan arrangement to any employee organization, beneficiary, or employer. Section 519 provides EBSA with a powerful tool to combat fraudulent promotions of MEWAs in the private health care market.

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.

Recent Civil Litigation Cases

W.I.N. Association (WIN) - The Department filed a complaint on February 22, 2011 against the W.I.N. Association, Michael Ray Bianchi, President, and the W.I.N. Association Health Plan for the failure to make payments on health care claims, excessive fees, and the non-disclosure of fees to the employers. The complaint was filed in the U.S. District Court, Southern District of Texas, Houston Division. The Department's suit alleged that Michael Bianchi withdrew funds from the Plan with no justification that such expenditures were associated with reasonable and necessary expenses for the Plan's administration and management. The suit also alleged that Bianchi and W.I.N. mismanaged Plan assets causing the Plan to incur unpaid health claims, failed to prudently operate the Plan, and failed to properly segregate Plan assets and corporate funds. The Department's investigation found at least $198,000 in unpaid claims to be outstanding.

On March 31, 2011, the Department obtained a Consent Judgment and Order against W.I.N. Association, LLC, Bianchi, and the W.I.N. Association Health Plan. The Consent Judgment and Order confirmed that the defendants violated ERISA from April 2006 through April 2008, when they failed to pay approximately $341,215 in health care claims and withdrew approximately $238,383 without authorization from the Plan. Additionally, the Consent Judgment and Order permanently enjoined the defendants from violating ERISA or from acting as fiduciaries, and authorized the Secretary to bring a collection action for the Plan losses of $579,597 if defendants are found to have assets to effect restitution.

Castleton Group Health Plan - On January 4, 2010 the Department filed a District Court action against the Castleton Group, as well as Suzanne Clifton, the Castleton Group's owner and President, for failure to fund accounts maintained for the purpose of paying promised benefits. The Department filed a corresponding Bankruptcy Adversary Proceeding against Suzanne Clifton on January 5, 2010. The Department filed its action in the U.S. District Court, Eastern District of North Carolina.

The Castleton Group ceased operations and filed for Chapter 7 bankruptcy protection in December 2007. Suzanne Clifton subsequently filed for personal bankruptcy. The Department's suit alleged that the Castleton Group had failed to forward employee and employer contributions to the third party administrator, thereby underfunding benefits owed to participants. The amount not remitted to the Plan was estimated to be at least $247,000.

The Department filed a Consent Judgment that was approved by the District Court on January 19, 2011, and the remaining settlement actions were taken, including: payment of insurance proceeds, distribution of $45,000 to the 401(k) Plan in the Castleton Group bankruptcy and subsequent reduction of the Plan's Proof of Claim; payment of $84,000 to the 401(k) Plan Special Counsel and subsequent withdrawal of application for fees; withdrawal of the 401(k) Plan Successor Trustee's Proof of Claim in the Clifton bankruptcy; recognition of a priority claim of $66,705 on behalf of the Health Plan in the Castleton Group bankruptcy; and forwarding of the insurance proceeds to an independent fiduciary, in the amount of $265,000 for deposit and distribution.

Mutual Employees Benefit Trust - The U.S. Department of Labor obtained a final consent order in 2010 that permanently bars Leonard Slutsky and Sharlene Slutsky from control over or serving in positions of responsibility to employee benefit plans governed by the Employee Retirement Income Security Act, except as outlined in the court order.

The defendants were sued by the department in 2001 for allegedly engaging in numerous violations of ERISA with regard to the Huntington, N.Y-based Mutual Employees Benefit Trust. MEBT was a multiple employer welfare arrangement that provided health and other welfare benefits to 1,912 participants in the Long Island and New York City areas.

Leonard Slutsky allegedly acted as a fiduciary to the MEBT plan. His wife, Sharlene Slutsky, was the owner and president of MEBT's third party administrator. The Department's lawsuit alleged that they and other MEBT trustees diverted MEBT's assets to sham labor unions and corporations. The trustees were ordered to make restitution under a separate consent judgment.

The final consent order, entered in the U.S. District Court for the Eastern District of New York, also prohibits the Slutskys from providing or rendering to any employee benefit plan services of any kind, except in very limited circumstances, and from selling, leasing or otherwise transferring for a fee any interest in any property to any employee benefit plan.

Contractors and Merchants Association (CMA) and Small and Independent Business Associates, Inc. (SIBA) – The Department sued a purported employer association, a health fund trustee, and the fund's consultant over alleged imprudent management of the Manufacturing and Industrial Workers Benefit Fund (MIWU) of Bryan, Texas. The defendants' actions allegedly resulted in more than $3.4 million in unpaid health claims affecting participants in Arizona, California, Florida, Georgia, Illinois, Texas and other states.

According to the lawsuit, Raymond Palombo, Mitchel Coneley, Leonard Steinberg, Contractors and Merchants Association, and the Small and Independent Business Associates Inc. (SIBA) violated ERISA by causing the insolvency of the MIWU health fund and by their failure to hold the fund assets in trust. The defendants permitted Palombo to transfer the health claim liabilities of members of his alleged sham employer association,

CMA, to the MIWU fund. Palombo allegedly diverted plan assets to benefit him, the defendants and others, improperly set contribution rates for 880 participants of CMA, enrolled ineligible individuals in the health fund, and failed to properly fund the plan.

The MIWU health fund became financially insolvent in 2005 due to the transfer of CMA members to the fund. At the time of the improper actions, Palombo was the president and sole shareholder of CMA, and Steinberg was the president of SIBA and provided consulting services to the MIWU health fund through SIBA. Coneley was the fund's trustee.

The amended complaint, filed July 2, 2008 in the U.S. District Court for the Northern District of Georgia in Atlanta, sought to have the defendants restore to the fund all losses with interest, undo all prohibited transactions, offset any claims for benefits against the MIWU fund, and permanently bar the defendants from serving in a fiduciary capacity to any ERISA-covered plan in the future. In related Department litigation, the court appointed an independent fiduciary to pay health claims of affected participants and beneficiaries and to manage the more than $1.9 million in fund assets recovered by the Department and collected by the independent fiduciary as of May 2008.

The Department's Motion for Default Judgment was granted by the Court against four of five defendants. The June 9, 2009 Judgment enjoined the defendants from serving as fiduciaries or service providers, or having control over the assets of any ERISA covered employee welfare benefit plan. The Court concluded that defendants CMA, Coneley, Steinberg, and SIBA had breached their fiduciary duties under ERISA when the defendants failed to establish a reserve or a funding policy to ensure that the MIWU Fund could meet its financial obligations, neglected to perform any underwriting activities and failed to discharge their duties under the terms and requirements of the documents and instruments establishing the MIWU Fund. The defendants were further found to have engaged in self-dealing for their part in assisting Palombo in diverting MIWU Fund assets to CMA and others, and for assisting in schemes to allow the enrollment of ineligible participants, all of which personally benefited Palombo. The Court also found that Steinberg, as the consultant to the MIWU Fund, was a knowing participant who enabled Coneley to breach his fiduciary duties by assisting Coneley with transferring 880 participants into the MIWU Fund with unpaid health claims that could not be financially supported by the Fund. The motion against Palombo was initially dismissed without prejudice due to his Chapter 7 bankruptcy filing. The Department's motion that the ERISA claims be exempt from the Palombo bankruptcy stay was granted, however, on July 15, 2009, allowing the civil prosecution of Palombo to proceed.

On October 8, 2009, the U.S. District Court for the Northern District of Georgia permanently enjoined Palombo from serving directly or indirectly as a fiduciary or service provider to ERISA covered plans. The District Court found that Palombo was liable for multiple violations of ERISA for his part in the MIWU fund's insolvency. Palombo must post a copy of the District Court Order on his website. The Order binds anyone who has notice of it and works in concert with Palombo. On October 26, 2009, the District Court granted the Secretary's Motion for Entry of Judgment Awarding Monetary Relief in the amount of $2.9 million.

On December 8, 2008, the Department filed an adversary complaint against Palombo's filing for Chapter 7 bankruptcy protection, to determine the non-dischargeability of any monetary judgment that the District Court might award against Palombo. On December 29, 2010, the Bankruptcy Court ruled in favor of both of the Department's two motions: 1) that Palombo was a functional fiduciary with respect to the assets of the Manufacturing and Industrial Workers Benefit Fund (MIWU Fund); and had breached his fiduciary duties committing an act of defalcation, and 2) the issues decided in an earlier District Court action (default judgment) were precluded from being re-litigated in the Bankruptcy Court. As a result of the ruling on the first motion, Palombo's request in bankruptcy to discharge his debt of $2,958,681 for unpaid health claims to the MIWU Fund was denied.

On March 23, 2011, the Bankruptcy Court issued an order approving the Department's Motion for Summary Judgment. The Bankruptcy Court held that issues decided in the second Default Judgment were precluded from being re-litigated in the Bankruptcy Court action, that the District Court's findings supported a finding of defalcation against Palombo, and that Palombo was barred from re-litigating facts and issues already adjudicated. As a result, the Bankruptcy Court refused to discharge Palombo's $2,958,681 debt to the MIWU Fund.

Recent Criminal Prosecutions of Corrupt MEWA Operators

United States v. Dwayne Samuels – On January 25, 2013, Dwayne Samuels was sentenced in the United States District Court for the Eastern District of New York to three years in prison, to be followed by three years' probation, and was ordered to make restitution of $250,000. In May 2012, Samuels had entered a guilty plea to one count of embezzlement in connection with a health care benefit program (18 U.S.C. § 669) and one count of conspiracy to commit bank fraud (18 U.S.C. § 1347).

Dwayne Samuels had been the president of Vanguard Asset Group, Inc., a health care benefit program that provided medical benefits to individuals and employee health plans. Beginning in 2001, Samuels embezzled premium payments that client plans paid to Vanguard. He also falsely represented to several client plans that Vanguard had availed itself of stop-loss insurance to cover large medical claims. Samuels was indicted in 2005 on the health fraud issues and was rearrested in 2011 on mortgage fraud charges.

The case was investigated by the EBSA New York Regional Office and the Office of the Inspector General of the U.S. Department of Labor. The case was prosecuted by the United States Attorney's Office, Eastern District of New York.

United States v. Gerald Rising, Jr. – On March 30, 2012, Gerald Rising, Jr. of Centennial, Colorado was sentenced in the United States District Court of Colorado to 66 months in federal prison and ordered to pay restitution totaling $3,500,000 to the victims of his crimes. The sentence followed Rising's guilty plea entered in October 2011 to several counts of mail fraud, embezzling plan funds, and money laundering.

The owner and operator of Rural Health Plans Initiative Administration Company (RHPI), Rising defrauded individuals, companies, and entities throughout the country of medical benefits purchased by self-funded health benefit plans. Rising promoted, sold, and administered the packaged medical plans to various private clients, including ERISA-covered health plans. As part of his scheme, Rising told his clients that he kept the majority of their plan contributions in a trust account to pay claims and to purchase stop-loss insurance. The stop-loss coverage, purportedly provided by large insurers such as Lloyd's of London and AIG, was said to cover any claims that exceeded $25,000. In fact, the stop-loss policies, while they existed, did not activate until claims reached approximately $125,000.

Rising also owned RHPI Captive Insurance Company, LTD (RHPIC), an off-shore corporation incorporated in Anguilla, British West Indies, that held custody over the residual fund contributions after the deduction of administrative fees from the premiums paid by employers. In 2008 and 2009, Rising increased his salary in order to siphon monies held by RHPIC. Starting in 2009, he kited checks between different bank accounts to create a false impression about financial health of his businesses. In 2010, Rising directed RHPI and RHPIC employees falsely to represent to plan beneficiaries and employers that health care claims were paid when they knew that was not the case. In addition, Rising directed his employees to send out falsified plan account balance sheets. Finally, in late 2010, Rising had them submit falsified invoices to clients indicating debts owed to RHPIC for health care claims.

EBSA's investigation was conducted by the Kansas City Regional Office and the IRS Criminal Investigation Division. The case was prosecuted by the United States Attorney's Office, District of Colorado.

United States v. William Madison Worthy – On March 22, 2012 William Madison Worthy was sentenced to 87 months imprisonment and 3 years' supervised release. Worthy had pleaded guilty in the United States District Court, District of South Carolina, Spartanburg Division to one count of a crime affecting the business of insurance in interstate commerce. Worthy diverted approximately $972,000 in insurance premiums, which caused the insurance plan to fail. His embezzlement, and the plan's consequent failure, left behind approximately $1.7 million in unpaid medical claims. As part of his plea agreement, Worthy agreed to make restitution for the insurance claims.

Worthy has been involved in various aspects of the insurance industry for years. Among his activities, he owned a third party administrator serving self-insured health insurance plans. Among his firm's clients was an entity named the "Church Plan," so-called because a majority of its members were employed by local churches. Some private employers that were not religiously-affiliated also participated in the Church Plan, making it subject to ERISA and therefore to oversight by EBSA.

The investigation was conducted by EBSA's Atlanta Regional Office and the FBI. The case was prosecuted by the United States Attorney's Office, District of South Carolina.

United States v. Sean Alfortish and Mona Romero – On February 2, 2012 Sean Alfortish, former president of the Louisiana Horsemen's Benevolent & Protective Association (LHBPA), was sentenced to 46 months imprisonment and 3 years probation and Mona Romero, the LHBPA's former executive director was sentenced to thirteen months imprisonment and 3 years' probation after earlier pleading guilty separately to charges arising from their conspiracy to falsify the 2008 executive elections of the LHBPA. Romero and Alfortish had filed guilty pleas in the U.S. District Court, Eastern District of Louisiana, on July 11 and August 31, 2011, respectively. Romero pleaded guilty to several counts of conspiracy to commit mail fraud, wire fraud, and fraud involving personal identification documents. In his plea agreement, Alfortish similarly acknowledged charges of conspiracy to perpetrate mail, wire, and identification fraud. In addition, he admitted to conspiring to carry out fraud against the LHBPA's health care plan.

The HBPA is the official representative of horsemen of Louisiana. Under Louisiana law, commercial horse racing interests must make payments to the HBPA for the express purpose of providing medical and hospital benefits of jockeys and other personnel active in the industry. The state law dictated that no more than 30% of the funds paid for medical coverage could be used for administrative costs. Alfortish and Romero worked to keep administrative expenses below the 30% cap, but continued to charge the full percentage, applying the secret surplus to pay personal expenses and general expenses of the HBPA. Examples of such impermissible expenses included spa treatments, personal attire such as evening gowns, shoes, and diamond cufflinks, foreign travel, political consultants, travel to attend a fundraiser and the inauguration ceremony of a public official in California. In addition, the defendants paid to rig the 2008 election of HBPA officers out of the administrative account. Their theft of plan assets left the HBPA owing the Medical Benefit Trust over $800,000 in unpaid medical claims.

EBSA's Dallas Regional Office and the U.S. Postal Service Postal Inspector's Office together conducted the criminal investigation. The case was prosecuted by the United States Attorney's Office, Eastern District of Louisiana.

United States v. Michael L. Millman – On March 24, 2011, Michael L. Millman was sentenced by the U.S. District Court, District of Connecticut in New Haven to 63 months of imprisonment, followed by five years of supervised release, and was ordered to pay restitution of over $975,000 for stealing from a multiple

employer welfare arrangement. Millman had pleaded guilty in April 2010 to embezzlement from an employee benefit plan of more than $1 million, wire fraud, and bank fraud.

Millman had owned and managed the Nutmeg Benefit Group, LLC and the Nutmeg Welfare Benefit Plan and Trust. The Trust was a vehicle through which companies could provide their employees with life insurance and disability benefits. Millman stole from the Trust by failing to send insurance premiums to the appropriate insurance carrier, by taking loans from the value of participants' insurance policies and by diverting proceeds from policies that a plan participant had directed Millman to surrender and transfer to another insurance company. He also defrauded Essex Savings Bank, the former trustee of the Trust.

The case was prosecuted by the United States Attorney's Office for the District of Connecticut. It was investigated jointly by the Boston Regional Office and DOL Office of Inspector General.

United States v. Jonathan Hogge – On March 29, 2011, Jonathan Hogge, former owner of My Smart Benefits (MSB), was sentenced in Federal District Court in the Northern District of Indiana to 84 months in prison and two years of supervised release. The court ordered restitution of $254,425 to be paid to the victims with substantiated unpaid dental claims. Hogge had previously pleaded guilty to one count of conspiracy to commit theft or embezzlement from an employee benefit plan; nine counts of mail fraud, and one count of wire fraud.

Jonathan Hogge and Amy Wadas Hogge had co-owned MSB, a third party administrator serving self-funded direct reimbursement dental plans throughout the United States since February 2000. Jack Lait was the Vice President of Operation for MSB. Hogge closed MSB's doors in October 2003 after the company ran out of funds to pay claims and its employees' salaries. Hogge and Lait, along with other principals of MSB not charged, misrepresented to various insurance agents and employers that the direct reimbursement dental plan had a stop-loss component.

The case was a joint investigation of EBSA's Chicago Regional Office and the Office of the Inspector General of the U.S. Department of Labor. The case was prosecuted by the United States Attorney's Office, Northern District of Indiana.

This fact sheet has been developed by the U.S. Department of Labor, Employee Benefits Security Administration, Washington, DC 20210. It will be made available in alternate formats upon request: Voice phone: 202-693-8664; TTY: 202-501-3911. In addition, the information in this fact sheet constitutes a small entity compliance guide for purposes of the Small Business Regulatory Enforcement Fairness Act of 1996.