



# Issue Brief

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## MEWAs: The Threat of Plan Insolvency and Other Challenges

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Congress and some state policymakers are considering legislation to promote the growth of association health plans and other types of “multiple employer welfare arrangements” (MEWAs) as a way to expand access to affordable health insurance coverage. These plans band together self-employed people, small businesses, and, in some cases, larger businesses to purchase insurance—all seeking to save money and maximize affordability of coverage by using their leverage as a large group to negotiate lower premiums. Some try to lower their costs by self-insuring and by pooling administrative functions.

MEWAs, however, have a long history marred by financial instability and even fraud. Due to licensing requirements that are often less stringent than those imposed on traditional insurers, they are at far greater risk of becoming insolvent when claims suddenly or unexpectedly exceed their ability to pay them. As thousands of Americans have found out, insolvency means that medical bills go unpaid, spelling financial ruin for many who are stuck with huge expenses. Meanwhile, doctors and hospitals are forced to contend with ways to finance uncompensated care; some pass these costs along to insured patients in the form of higher fees, which in turn can drive up already high insurance premiums.

In June 2003, the U.S. House of Representatives passed H.R. 660, which would establish new federal licensing requirements for health coverage offered by professional and trade associations and would exempt association health plans from existing state consumer protections. Similar legislation (S. 545) is pending in the Senate. In addition, President Bush reiterated his support for these plans in his 2004 State of the Union

address,<sup>1</sup> and some state policymakers are seeking to encourage their growth as an alternative to traditional insurance coverage.

This issue brief seeks to provide guidance to federal and state lawmakers who are considering legislation to allow self-insured, group-purchasing arrangements. We examine the experiences of three states that have developed helpful regulatory oversight strategies for preventing insolvencies as well as laws that seek to protect consumers covered by such plans. With a combined 36 years of experience regulating these insurance arrangements, California, Michigan, and Oklahoma can offer lessons to federal and state policymakers. Standards for self-insured MEWAs in these states are similar to those in other states that have specific licensing for MEWAs. California, however, has the highest surplus requirement for self-insured MEWAs. In Michigan and Oklahoma, state regulators have been particularly aggressive in their oversight. The findings presented here are based on interviews with regulators, legal research, and analysis of statutes and rules applicable to MEWAs. (*Authors' Note:* MEWA is defined broadly here as an arrangement providing health benefits to two or more employers or self-employed individuals, including plans offered by professional, trade, and other associations.)

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## **THE GROWING FREQUENCY OF MEWA INSOLVENCIES**

MEWAs seek to improve access to health insurance for small businesses and self-employed individuals. When purchasing coverage from an insurance company or health maintenance organization (HMO), they seek to negotiate rates lower than what are available to individual small businesses and individuals who buy directly from insurers. In some cases, associations choose to self-insure health benefits by collecting premiums for a trust fund established to pay medical claims, instead of paying an insurance company or HMO to provide benefits. Through economies of scale, they seek to provide coverage at lower premiums than are otherwise available.<sup>2</sup>

Many states have tried to stem the rising cost of health coverage by promoting the growth of self-insured health plans offered by professional and trade associations. They have done this by minimizing the cost of doing business. Although some 20 states have special licensing laws for self-insured MEWAs, these standards are often less stringent than those for traditional insurers.<sup>3</sup> MEWAs are exempt from state taxes on premiums and from assessments that fund state safety net pro-

grams, such as guaranty funds, which pay claims when an insurer becomes insolvent.

Insolvencies by self-insured MEWAs have left thousands of Americans with millions of dollars in unpaid medical bills. Recently, this serious problem worsened due to double-digit increases in health costs. In 2001, Sunkist Growers, Inc., a licensed MEWA in California covering 23,000 people, became insolvent. Sunkist collected over \$30 million in premiums (\$8 million most recently) and, according to news reports, now owes around \$11 million for medical claims.<sup>4</sup> When New Jersey's Coalition of Automotive Retailers, a longstanding MEWA that covered 20,000 people, became insolvent in 2002, it had \$15 million in outstanding medical bills.<sup>5</sup> The Indiana Construction Industry Trust, in operation since the 1960s and fully insured until 1999, also became insolvent in 2002. The trust insured approximately 790 employers and 14 association groups covering over 22,000 employees and their dependents. It now has less than \$1 million in assets and more than \$20 million in unpaid claims.<sup>6</sup>

The safety net for consumers covered by self-insured MEWAs is not as strong as the one protecting consumers with traditional insurance (Table 1). When an insurance company becomes

**Table 1. Consumer Protections for Insurers and MEWAs in California, Michigan, and Oklahoma**

Consumer Protections	Insurers	MEWAs
Solvency Standards	Yes	Yes, weaker*
Guaranty Associations/Funds	Yes	No
Receiverships	Yes	Yes**

\* Standards applicable to MEWAs are less stringent than those applicable to traditional insurance companies.

\*\* In California, according to state regulators, the receivership law is vague about the Insurance Department's authority to takeover a licensed MEWA.

insolvent, consumers generally are not responsible for unpaid medical bills because a state guaranty fund will pay claims.<sup>7</sup> But MEWAs generally are excluded from participating in guaranty funds, and therefore do not have to pay the assessments required to finance them.<sup>8</sup> When a MEWA becomes insolvent, patients and, in some cases, employers, are responsible for unpaid medical bills.

Furthermore, some states' receivership laws—which allow the insurance department to take over financially failing insurance companies—either exclude MEWAs or are vague about the department's authority to assume control over one (for example, California).<sup>9</sup> Typically, the insurance department or an independent receiver liquidates an insolvent insurance company, uncovering assets in order to pay claims. A receiver may also negotiate with health care providers on behalf of patients to accept a reduced fee when the amount in assets is insufficient to cover 100 percent of the claims. This greatly benefits consumers who otherwise would be responsible for unpaid medical bills.

Absent a receivership, licensed, self-insured MEWAs can end up in bankruptcy court—a development that has significant implications for consumers. Unlike state receiverships, bankruptcy courts do not pay outstanding medical claims first; some creditors may be paid prior to patients and providers.

The effects of insolvency have been both serious and widespread. Individuals and families covered by self-insured MEWAs are left with unpaid medical bills and without health insurance; for some, this means financial ruin. Hospitals and doctors, meanwhile, face the burden of finding ways

to finance the uncompensated care or be stuck with it. Some of the cost of uncompensated care is shifted to insured patients in the form of higher fees, which in turn can lead to increases in insurance premiums.

The proposed federal legislation to encourage the growth of association health plans would exempt such plans from state regulation, thereby making it less expensive for them to offer health coverage. Although the legislation would establish solvency requirements, these would be less stringent than what states require for insurers. This means that self-insured, group purchasing arrangements that are subject to low federal solvency standards would be allowed to operate in the majority of states that currently prohibit such entities unless they are licensed as insurers. In some cases, the proposed standards would also be less stringent than the state standards currently applicable to self-insured MEWAs.

## CURRENT LAW GOVERNING MEWAs

Both states and the federal government currently regulate MEWAs, although this was not always the case.

### Evolution of Federal and State Regulation

When Congress federalized regulation of employee benefits by enacting the Employee Retirement Income Security Act of 1974 (ERISA), it severely restricted states' authority to regulate group purchasing arrangements. Under the original statute, states could not regulate group purchasing arrangements considered to be an "employee welfare benefit plan"—an ERISA plan.<sup>10</sup> The U.S. Department of Labor, rather, became responsible for regulating such arrangements. To determine if an arrangement was an ERISA plan, a state (and in many cases a court) had to apply a very technical and complex federal standard requiring a fact-intensive inquiry.

ERISA replaced state-based standards with minimal federal standards to encourage employers to provide medical benefits to their workers. The federal statute required ERISA health plans to

comply only with fiduciary standards and reporting and disclosure requirements, but did not require such plans to be licensed or to meet any solvency requirements.<sup>11</sup> Fewer regulatory requirements, some argued, would make it less costly for employers to provide their workers with health coverage.

This broad preemption of state law, however, had unintended consequences. When states tried to regulate group purchasing arrangements that were not subject to ERISA, those operating them successfully claimed ERISA exemption from state law.<sup>12</sup> The U.S. Department of Labor, meanwhile, claimed not to have authority over such arrangements because most were not ERISA plans.<sup>13</sup> Ambiguity about whether states have the authority to regulate group purchasing arrangements, minimal federal standards in ERISA, and limited federal oversight opened the door to insolvencies and, in some cases, fraud.

Responding to this situation, Congress amended ERISA to limit its preemptive effect on state law. As of 1983, states can, with almost no limitations, regulate MEWAs.<sup>14</sup>

### **Current Regulation of MEWAs**

While the 1983 amendments to ERISA also allow the U.S. Department of Labor to regulate MEWAs, most consumer protections are state-based, not federally based. States regulate both fully insured and self-insured MEWAs. States may require operators of fully insured arrangements to obtain a license. They can also require self-insured arrangements to be licensed as an insurer or specifically as a MEWA.<sup>15</sup>

State standards are more comprehensive than federal standards. State insurance laws include licensing, solvency, and benefit requirements; the enrollee's right to an external appeal when benefits are denied; and other consumer protections. Federal standards are generally limited to fiduciary obligations; disclosure and notice requirements regarding health services covered by the plan; and, more recently, a requirement to register with the U.S. Department of Labor.<sup>16</sup> ERISA does not require MEWAs to be licensed, and it contains no

federal solvency, external review, or other consumer protections similar to those generally found in state insurance law.

### **MEWA LAWS IN CALIFORNIA, MICHIGAN, AND OKLAHOMA**

Although some 20 states have regulations addressing insolvency, we focus on three states—California, Michigan, and Oklahoma—that have made special attempts to prevent insolvencies and provide additional consumer protections through regulation and oversight. Each requires self-insured MEWAs to be licensed and to meet specific solvency requirements. To be eligible for a license, a self-insured MEWA must meet the following criteria:

- be nonprofit;
- be established and maintained by a trade, industry, or professional association that has been in existence for a minimum period of time (five years in California and Oklahoma, two years in Michigan);
- offer benefits only to association members;
- be engaged in activities other than offering a health plan;
- have a board of trustees (who are participating employer members and/or employees) with complete fiscal control and oversight;
- have adequate management and staff to handle administration; and
- have a procedure for handling claims in the event of insolvency.

Additionally, California requires a self-insured MEWA to cover at least 2,000 employees and 50 paid employer members, while Michigan requires at least 200 employees and two employer members.

To help maintain solvency, states have surplus, reserve, stop-loss insurance, filing, and disclosure requirements (Table 2):

- The surplus is determined by a MEWA's assets minus its liabilities.

**Table 2. Solvency Standards for MEWAs**

<b>Solvency Laws</b>	<b>California</b>	<b>Michigan</b>	<b>Oklahoma</b>
<i>Surplus Requirements</i>	Maintain surplus of \$1 million in 2003 (\$4 million by 2007)	None	Maintain surplus of \$200,000 in cash or federally guaranteed obligations with less than five-year maturity
<i>Reserve Requirements</i>	Appropriate loss and loss adjustment reserves determined by sound actuarial principles	Maintain minimum cash reserves of not less than 25% of aggregate contributions in current fiscal year or not less than 35% of claims paid in preceding fiscal year, whichever is greater  (Cash reserves must be held as “restricted asset” in separate bank account that cannot be commingled with any of MEWA’s other funds)	Maintain reserves not less than greater of 20 percent of total contributions of preceding plan year or 20% of total estimated contributions for current plan year
<i>Stop-Loss Insurance</i>			
Specific	Specific attachment point not greater than 5% of annual expected claims	Amount must first be approved by commissioner – If policy has specific retention of no more than \$25,000, commissioner accepts policy as adequate – If higher specific retention requested, it must be approved by commissioner	Specific attachment point as annually indicated in actuarial opinion
Aggregate	Aggregate attachment point not greater than 125 percent of annual expected claims	If commissioner deems necessary on case-by-case basis; otherwise no requirement	Aggregate attachment point not greater than 125 percent of annual expected claims
Other Standards		Must be purchased through insurer authorized to do business in state	Must be purchased through insurer authorized to do business in state
<i>Filing Requirements</i>			
Annual	Audited financial statements	Audited financial statements	Audited financial statements Report certifying sufficient reserves Report of financial condition submitted to all employers
Quarterly	Unaudited financial statements Report certifying sufficient reserves and stop-loss insurance	Unaudited financial statements Report certifying sufficient reserves and stop-loss insurance	Commissioner may require quarterly reporting
MEWA in financially hazardous condition	Monthly	Monthly	Commissioner may require quarterly reporting
<i>Rate Filing Requirements</i>	Filed prior to use	Filed prior to use	Filed prior to use
<i>Disclosure Requirements to Employers and Employees</i>	Disclose state guaranty association does not protect enrollees in case of MEWA insolvency Disclose guaranty association does not pay for claims in case of MEWA insolvency	Disclose state guaranty association does not protect enrollees in case of MEWA insolvency Disclose enrollees may be liable for outstanding medical expenses	Disclose state guaranty association does not protect enrollees in case of MEWA insolvency
<i>Other Standards</i>	MEWAs that use TPAs must use licensed/authorized TPAs	MEWAs that use TPAs must use licensed/authorized TPAs	MEWAs that use TPAs must use licensed/authorized TPAs  Feasibility study made by qualified actuary showing MEWA would not, at any month’s end of the projection period, have less than 90% of reserves

Sources: Cal Ins Code § 742.24 to § 742.34; MCLS § 500.7011 to § 500.7044; 36 Okl.St. Ann §633 to §639; Interviews with state insurance regulators from California (February 4, 2003), Michigan (January 30, 2003), and Oklahoma (January 31, 2003).

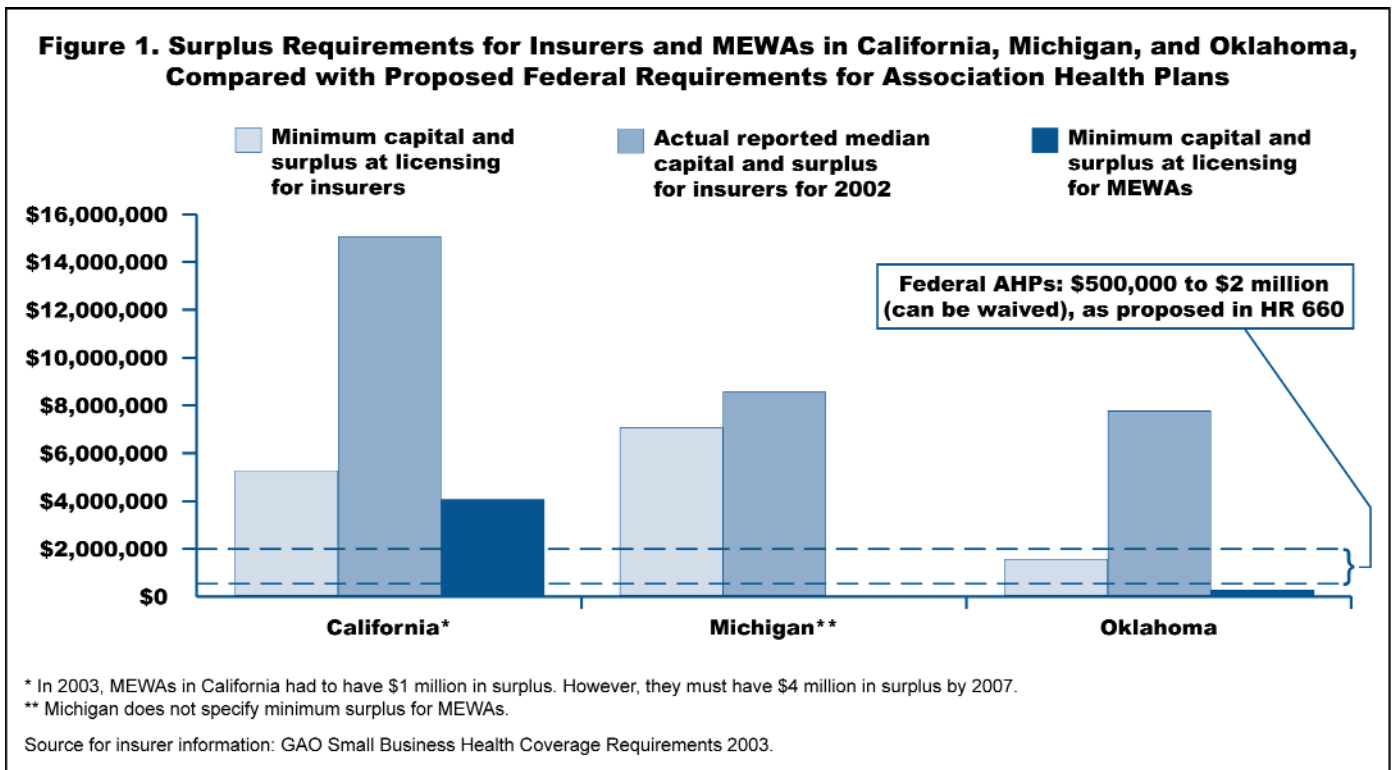
- The reserve is a MEWA’s liabilities for claims that have not been settled, including known claims that have not yet been paid, known claims that are not yet due, and incurred claims that have not been reported.
- Stop-loss coverage is insurance sold to self-insured health plans as protection against financial loss due to unexpected large claims or a high number of claims. The two types of stop-loss insurance are *specific* and *aggregate*. Specific stop-loss insurance protects the MEWA against unusually large claims by any one covered individual; it is triggered once the MEWA has paid claims equaling a certain dollar amount agreed upon in the stop-loss contract. Stop-loss insurance then reimburses the MEWA for the remaining covered expenses of the covered individual. Aggregate stop-loss insurance, which is triggered when the aggregate claims paid by the MEWA reach a certain level, protects the MEWA in case annual claims are underestimated.

weaker than for traditional insurers. In fact, MEWA-specific standards were too low when legislation was initially enacted in the respective states. After a MEWA insolvency (or several in one state), legislators and regulators successfully worked to strengthen the laws. Prior to 2000, Oklahoma did not require MEWAs to maintain a minimum surplus, but the state’s new law requires a minimum surplus of \$200,000 in cash or federal bonds with less than a five-year maturity. In California, the insurance department successfully sought legislative changes to increase surplus requirements from \$1 million to \$4 million (phased in by 2007).

Although the proposed federal legislation to allow federally licensed association health plans would require a surplus of \$500,000 to \$2 million, such requirements would not apply when the U.S. Department of Labor chooses to waive these standards (Figure 1). The legislation would allow the Department to waive solvency requirements when a plan can demonstrate that its obligations would be met through security, guarantee, “hold harmless” arrangements, or plan sponsor’s assumption of risk (bonding, letter of credit, recourse and assessments

**Surplus Requirements**

Surplus and reserve requirements for MEWAs are



against participating employers, security, or other financial arrangements). For example, if a small business promises to contribute to a trust account when a plan does not collect enough to cover all claims, then such a promise could be a substitute for having the minimum \$500,000 in surplus. Allowing a plan to have no cash in surplus, however, increases the risk of insolvency. This is especially so because many small businesses may not have the financial resources to pay potentially hundreds of thousands of dollars to make up a shortfall, in addition to paying the premiums they would have paid.

### Stop-Loss Insurance

California, Michigan, and Oklahoma require MEWAs to purchase stop-loss insurance to protect against unexpectedly large claims or a high frequency of claims.<sup>17</sup> The amount in the stop-loss policy agreed upon by the MEWA and the stop-loss insurer is generally based on an estimate of the MEWA's expected claims. Because MEWAs are typically small entities compared with insurers, expected claims are often difficult to estimate with accuracy. For this reason, regulators believe that stop-loss "attachment points"—the dollar requirements at which stop-loss insurance is triggered for a specific individual—should be low to prevent a MEWA from exhausting its reserves and surplus.

While stop-loss insurance protects the MEWA when it miscalculates claims, it does not protect the consumer in a case of a MEWA insolvency.<sup>18</sup> Stop-loss insurance will pay only for the portion of medical claims that exceeds what the MEWA agreed to pay. If a MEWA's expected claims are \$1 million and its aggregate stop-loss coverage is set to begin once actual claims reach 110 percent of expected claims, then the MEWA is responsible for \$1.1 million. If a MEWA cannot pay this amount, then employers and patients ultimately become responsible for it.

The federal proposal would require that aggregate stop-loss coverage begin at 125 percent of expected claims (Table 3). However, this ceiling

**Table 3. High vs. Low Aggregate Stop-Loss Levels**

Expected Claims	Stop-Loss Set at 110 Percent	Stop-Loss Set at 125 Percent
\$1 million	MEWA will be responsible for the first \$1.1 million worth of claims before stop-loss policy is triggered	MEWA will be responsible for the first \$1.25 million worth of claims before stop-loss policy is triggered

can be raised when a MEWA has in reserve an amount that is higher than required—thereby exposing the plan to even greater financial risk. The legislation does not set a specific (or an individual) attachment point that would protect the plan from high claims an individual may incur.

In addition to enacting standards for the type of stop-loss coverage, both Michigan and Oklahoma require MEWAs to purchase such coverage from an insurer authorized to do business in their states. This requirement seeks to address the problem of off-shore and, in some cases, fly-by-night stop-loss insurers not paying claims.<sup>19</sup> The proposed federal legislation does not require stop-loss companies to be licensed in the United States.

### Filing Requirements

To help regulators monitor the financial condition of licensed MEWAs, all three states require MEWAs to file annual financial statements audited by a certified public accountant. Oklahoma also requires MEWAs to submit a report of its financial condition to employer members on a yearly basis. Additionally, plans in California and Michigan must file unaudited financial statements on a quarterly basis, including a report certifying that sufficient reserves are held. Major changes in assets and liabilities indicated in these quarterly reports help regulators to identify potential problems early.

To more closely monitor MEWAs' financial statements, California has designated an experienced financial examiner to review annual and quarterly reports filed by MEWAs. In some circumstances, an in-house actuary also reviews such statements. Michigan has an auditor to perform

onsite financial exams. In both states, if a MEWA is at risk for insolvency, the insurance department monitors it monthly and requires that it file monthly financial reports; Oklahoma requires plans that appear financially unstable to file quarterly financial reports.

To help ensure that premium rates are adequate to protect a MEWA against the risk of insolvency, these states also require MEWAs submit their rates for approval. In Oklahoma, a qualified actuary must certify that rates are adequate, nondiscriminatory, and appropriate for the classes of risks. In addition, a description of the rating methodology based on consistent and equitable actuarial principles must be filed with the insurance commissioner.

The proposed federal legislation would require that associated health plans file annual reports but would not require quarterly filings.<sup>20</sup> The annual report would have to include an actuarial opinion as to whether the contents reported are reasonably related to the experience of the plan and to reasonable expectations, as well as to whether they represent the best actuarial estimate of anticipated experience under the plan.<sup>21</sup> However, the bills do not require plans to provide federal regulators with information about premiums. As discussed, lack of such information may make it more difficult for federal regulators to detect potential problems. Furthermore, the proposed legislation would not require federal regulators to perform financial examinations; instead, it relies on plans' self-reported information. For example, a plan's board of trustees would have to inform the Department of Labor when the plan cannot meet the financial requirements in the statute. This lack of proactive regulatory oversight may place consumers enrolled in federally licensed associated health plans at higher risk for financial problems caused by plan insolvency than those individuals covered by more traditional insurance.

## **Disclosure Requirements**

Disclosure requirements provide consumers with information about the extent of their financial protection in the event of a plan's insolvency. They inform consumers about the type of coverage they are buying, allowing them to make an educated decision about their health insurance coverage options. To that end, licensed MEWAs in California, Michigan, and Oklahoma must disclose to their members that they do not participate in a guaranty association. Michigan requires an additional explanation that in the event the MEWA does not pay medical claims, covered individuals might ultimately be responsible for those expenses.

## **STATE OVERSIGHT STRATEGIES**

Given that the solvency standards for self-insured MEWAs are weaker than for traditional insurers, active and aggressive oversight by state regulators is critical for protecting consumers. State insurance regulators in California, Michigan, and Oklahoma have developed oversight strategies to protect consumers from MEWA insolvency. These include extensive prelicensing investigations and continuous, hands-on financial monitoring. And because even the most aggressive oversight cannot prevent MEWAs' insolvency—due to their thin financial cushion—regulators have also implemented strategies to mitigate the adverse impact on covered individuals when a MEWA does become insolvent.

## **Licensing**

Regulators in all three states conduct an extensive investigation of each entity that applies for licensing as a MEWA. Such investigations can include onsite visits by insurance department investigators, interviews, and requests for information in addition to that provided on the application. In effect, regulators assume the role of detectives, reviewing not only the stated purpose of the arrangement but also its actual operations and any underlying purpose inconsistent with the purpose stated in the application.



Regulators in Oklahoma, for example, require applicants to submit a marketing plan to determine whether information in the application accurately reflects the true nature of the arrangement. In one instance, Oklahoma denied licensing to an arrangement because its application stated that coverage would only be available to small business members while its marketing plan indicated that insurance agents would sell coverage to individuals. In another Oklahoma case, an investigation revealed that an arrangement was set up by a company for no other purpose than to sell health insurance to consumers. The arrangement did not qualify for licensing because one criteria is that the arrangement must engage in activities other than selling health insurance. In California, an extensive precertification investigation resulted in the denial of licenses to five of 12 arrangements that applied for certification. According to the regulators, a high level of scrutiny has helped ensure that only qualified arrangements meeting all requirements receive a license.

### **Ongoing Oversight**

According to state regulators, hands-on monitoring is needed to detect financial problems early. Many MEWAs operate close to the margins; any miscalculation in premiums or claims can lead to insolvency, especially in light of the low surplus cushion. Small changes in the market—for example, higher prescription drug costs or changes in claims patterns—affect MEWAs more than traditional insurers. In Michigan, a MEWA became insolvent simply because of an unexpected claim related to neonatal twins. Frequent monitoring and hands-on oversight requires significant resources. Michigan, for example, assigns the equivalent of one full-time employee to regulate each self-insured MEWA.

### **Independent Financial Analysis**

In California, Michigan and Oklahoma, financial reports filed by a MEWA must be certified by a certified public accountant. Also, an actuary must certify that surplus and reserves are adequate to

meet a MEWA's liabilities. Some regulators believe, however, that actuarial certification is not always reliable, because actuaries base their analysis on the MEWA's own information, which may be incomplete or flawed. In addition to careful reviews of financial statements, Michigan conducts onsite financial exams.

### **Insolvency**

Because even the most aggressive oversight cannot prevent a MEWA's insolvency, states provide various forms of assistance to consumers in such cases. Michigan's insurance department has taken the following actions that have proved effective:

- Facilitated discussions with licensed insurance companies to cover employers.
- Negotiated with insurers to fully insure the MEWA. Because state regulations ensure the solvency of the insurance company, the MEWA is not at risk of financial failure.
- Negotiated with the professional and trade associations sponsoring the MEWA to make up for the financial short fall.
- Requested that the sponsoring association work out agreements with health care providers to accept reduced payment on outstanding claims and agree not to seek the remainder from patients.

These strategies assist employers in finding new coverage and reduce the amount of unpaid medical bills for which patients are responsible. The law did not require any of these actions; rather, these reflect the commitment and effectiveness of regulators.

### **IMPLICATIONS**

Insolvencies of self-insured associations present a significant challenge for state and federal policymakers. Although some of these associations have helped employers finance health benefits for their employees, many have become insolvent and left thousands of workers and employers with unpaid

medical bills and no coverage. This serious problem has recently worsened due to unanticipated double-digit increases in health care costs.

Policymakers have made a tradeoff. On one hand, weaker standards than the ones applicable to insurers may make the health insurance offered by associations less expensive; on the other hand, lower solvency requirements increase the risk of financial failure. Low surplus requirements, for example, may make it difficult to withstand fluctuations in health care costs. Raising premiums to make up for a shortfall may not be a realistic option, especially if less expensive traditional coverage is available to employers. The plans' small financial cushion, meanwhile, makes it more difficult to withstand problems stemming from mismanagement. Lack of guaranty funds means that employers and workers who rely on MEWAs are responsible for unpaid medical claims in the event of its insolvency.

The challenge is to strengthen solvency requirements and establish safety nets to protect employers and workers who rely on self-insured multiple employer arrangements. When regulators have the ability and the resources to act quickly—as well as the willingness to oversee these plans aggressively—the impact of an insolvency on employers and covered individuals can be minimized.

State and federal policymakers seeking to encourage new self-insured group purchasing arrangements must recognize that sacrificing solvency to save costs puts employers and workers at great risk. Even with strong solvency standards, hands-on regulatory oversight and a commitment to providing the necessary resources are essential to try to prevent insolvency.

## NOTES

<sup>1</sup> U.S. Department of Health and Human Services, “Budget to Continue President’s Initiatives for the Uninsured” (press release), Feb. 11, 2003.

<sup>2</sup> For a discussion about MEWAs and whether they have achieved their goals, see Stephen Long and

Susan Marquis, “Have Small-Group Health Insurance Purchasing Alliances Increased Coverage?,” *Health Affairs* 20 (Jan./Feb. 2001): 154; Jill Yegian, Thomas Buchmueller, Mark Smith, and Ann Monroe, “The Health Insurance Plan of California: The First Five Years,” *Health Affairs* 19 (Sept./Oct. 2000): 158; U.S. General Accounting Office, *Private Health Insurance: Cooperatives Offer Small Employers Plan Choice and Market Prices*, GAO/HEHS-00-49 (Mar. 2000); Richard Curtis, Edward Neuschler, and Rafe Forland, “Consumer-Choice Purchasing Pools: Past Tense, Future Perfect?,” *Health Affairs* 20 (Jan./Feb. 2001): 164; Mark A. Hall, Elliot K. Wicks, and Janice S. Lawlor, “HealthMarts, HIPCs, MEWAs, and AHPs: A Guide for the Perplexed,” *Health Affairs* 20 (Jan./Feb. 2001): 142.

- <sup>3</sup> Georgetown University research funded by Health Care Financing and Organization—Robert Wood Johnson Foundation. Findings forthcoming.
- <sup>4</sup> Dennis Pollock and Sanford Nax, “Sunkist Health Plan Sours,” *Fresno Bee*, Feb. 26, 2002, p.C1.
- <sup>5</sup> Beth Fitzgerald, “Car Dealers’ Health Insurance Trust Goes Under,” *Star-Ledger* (Newark, N.J.), Feb. 24, 2002.
- <sup>6</sup> E-mail from Sally McCarty, commissioner of the Indiana Insurance Department, to Mila Kofman, Sept. 18, 2002.
- <sup>7</sup> Not every state’s guaranty fund covers health maintenance organizations (HMOs). In many states, HMOs are required to have “hold harmless” clauses in their contracts with providers. This means that providers may not collect unpaid medical bills from covered individuals when the HMO does not pay.
- <sup>8</sup> See Cal. Ins. Code § 1067.02(b)(2)(E)(i), MCLS § 500.7704 (3)(d)(i), 36 Okl. St. Ann § 2025(B)(2)(d)(1).
- <sup>9</sup> Interviews with staff from the California Insurance Department, Feb. 4, 2003.
- <sup>10</sup> ERISA § 514(a), 29 U.S.C. §1144.
- <sup>11</sup> ERISA § 101-110, 404-413, 29 U.S.C. § 1021-1030, 1104-1113.
- <sup>12</sup> U.S. Department of Labor, Pension and Welfare Benefits Administration, *Multiple Employer Welfare Arrangements Under the Employee Retirement Income Security Act: A Guide to Federal and State Regulation* 1

(1992) (hereinafter *U.S. Department of Labor MEWA Guide*).

<sup>13</sup> Although there were no changes to the Department's jurisdictional authority, it now believes that it has broad authority to investigate arrangements that are not ERISA-covered plans when they handle ERISA plan assets, which occurs when employers covered by ERISA participate in the arrangement. See *U.S. Department of Labor MEWA Guide*, p.5.

<sup>14</sup> ERISA § 3(40), 29 U.S.C. § 1002.

<sup>15</sup> U.S. Department of Labor, Pension and Welfare Benefits Administration, AO 90-18A (1990) (letter to J.Scott Kyle, Texas State Board of Insurance).

<sup>16</sup> The registration requirement was enacted in 1996. In addition to these requirements, Health Insurance Portability and Accountability Act rules amended ERISA and therefore apply to MEWAs.

<sup>17</sup> Stop-loss insurance is not subject to the rules applicable to health insurance, including guaranteed renewability.

<sup>18</sup> Additionally, regulators suggested that one way to minimize the risk of insolvency is to require stop-loss insurance companies to perform an assessment on a MEWA's liabilities before they issue a policy. According to regulators, this is already a common practice in workers' compensation insurance. An independent review of the financial soundness of a MEWA could perhaps help reduce the risk of insolvency. Still, stop-loss insurance does not protect covered individuals when a MEWA is insolvent.

<sup>19</sup> Interview with Fred Nepple, General Counsel, Wisconsin Insurance Department (and Chair of the NAIC ERISA Working Group), February 18, 2004.

<sup>20</sup> See Small Business Health Fairness Act of 2003, H.R. 660, section 807(e).

<sup>21</sup> See Small Business Health Fairness Act of 2003, H.R. 660, section 807(f).

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