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Employer-Sponsored Health Insurance Coverage Part II: Regulatory Issues

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THE ISSUES: Employer-based health insurance is the foundation of the health care system in the United States, and employers continue to play a significant part in providing health care coverage to Americans under the age of 65. During the past two years, trends in employer-sponsored health coverage show a pattern of escalating premium costs and coverage erosion. In an effort to offer and maintain worker coverage, employers of all sizes have sought ways to bring down these costs. Self-insurance and group purchasing arrangements have become increasingly popular options in states across the country, including New Jersey.

In regulating the business of health insurance and health coverage, state policymakers and regulators are confronted with the fact that self-insured plans are regulated by federal law – the Employee Retirement Income Security Act (ERISA) of 1974 – that supersedes state laws which have traditionally governed the insurance business. How do state policymakers, charged with the administrative and regulatory authority for health care:

- bring about comprehensive health care reform in New Jersey in light of the role of ERISA and its implications regarding employer self-insured plans?
- deal with incidents of liability cases involving denial or changing coverage of certain benefits because self-insured plans are not subject to state benefits mandates?
- address the insolvency of self-insured plans that leave policyholders with terminated coverage or unpaid claims?

INTRODUCTION

In discussing the pros and cons of our current employer-based health care system, health policy analysts Jack Meyer and Sharon Silow-Carroll point out that “the system lacks cost discipline, as clearly manifested by both the recent surge in premiums and the long-term trend in inflation-adjusted health care spending” (*Health Affairs, Web Exclusive*, August 27, 2003). The employer-based system is also challenged by a regulatory “Moebius strip” that lacks standardization and on which state and federal laws move in and out of relationship to each other, one superseding the other under different cases and circumstances. Administrative practices and challenges to laws trigger court cases in order to define jurisdiction and regulatory authority. In the absence of an overall national health insurance regulatory framework, blueprints for health care reform designed by state policymakers are circumscribed by the parameters of these federal and state laws and regulations.

In the present system, employers can provide their employees with health coverage through a single employer health benefits plan or through a multiple employer health benefits plan. Both single-employer and multiple-employer arrangements can be either fully-insured or self-funded. These distinctions are relevant in determining the state and federal laws that apply to a particular health plan. As state governments work to bring comprehensive health care reform to their own states, they face many health care coverage issues, not the least of which is the role of ERISA and its implications regarding employer self-insured plans and group purchasing arrangements.





ERISA – WHAT IS IT AND WHY DOES IT MATTER?

The federal Employee Retirement Income Security Act of 1974 (ERISA) regulates private sector pension and retirement plans. It is the culmination of several pieces of legislation that were concerned with the labor and tax aspects of employee benefit plans and it was enacted to remedy fraud and mismanagement in private-sector employer pension plans. However, it applies to other types of employee benefit plans, including health coverage offered through insurance or otherwise.

Although ERISA primarily regulates private pension plans, it includes a critical section – Section 514 – with the following provisions that limit the ability of states to regulate employer-based health insurance (National Conference of State Legislatures, 2001):

- ERISA provides preemption, meaning that all state laws “relating to” employer benefit plans (including health plans) sponsored by private-sector employers or unions are preempted under the federal law. States cannot dictate how an employer handles its benefits.
- The savings clause, however, preserves a state’s right to continue to regulate the insurance business and insurance companies. Therefore, although a state is not allowed to tell an employer what insurance it must buy, it can tell insurance companies what they are allowed to sell, how to sell it, and to whom.
- The deemer clause says that states may not treat self-insured employer plans as insurance in order to regulate their activities. Further, self-insured plans can’t be required to comply with state mandated benefits laws.

The only health plans that states can fully regulate are individual plans and state and local government plans. States share jurisdiction with the federal government over employees in insured health plans where coverage is purchased from an insurance company. However, self-insured plans (which can be managed by insurance companies) are regulated by the federal government only:

ERISA Regulatory Jurisdiction by Type of Plan

Type of Plan	State	Federal
Individual coverage, state and local government	X	
Insurance policy, “insured plan”	X	
Employer policy, “self-insured plan”		X
Employer-purchased insurance	X	X

Source: National Conference of State Legislatures, January 2001

Because the preemption provisions of ERISA are not especially clear, the courts have been interpreting them ever since the law was enacted. For two decades, the U.S. Supreme Court took an open view of ERISA state law preemption, overturning state laws that had almost any impact on or referred to the benefits, structure or administration of a private sector employer health plan. However, in 1995, the Supreme Court upheld New York’s hospital rate-setting law that imposed surcharges on hospital bills paid by insurers other than Blue Cross. The law increased costs for ERISA health plans buying coverage from these insurers. The Court upheld the New York surcharges on the ground that they would have, at most, an indirect economic effect on an employer-sponsored plan’s choices about which insurer to offer. It held that the law was not preempted because it would not compel plan administrators to structure benefits in any particular way or limit a plan’s ability to design uniform benefit packages or administrative practices across the country (National Conference of State Legislatures, 2001).





While the Supreme Court's decision in this groundbreaking case and several others that followed permit state laws that indirectly affect employer-sponsored health coverage in various ways, ERISA still prohibits state attempts to mandate that employers offer health insurance and other state laws directed explicitly at employer-sponsored health plans. For example, the federal courts held that ERISA preempted Hawaii's 1973 employer health insurance mandate, later authorized by Congress (National Conference of State Legislatures, 2001). To date, there have not been any notable advances that allow states more flexibility around ERISA.¹

EXPANDING OR MAINTAINING COVERAGE IN TIMES OF ESCALATING COSTS: SELF-INSURANCE AND GROUP PURCHASING ARRANGEMENTS

On September 9, 2003, the Kaiser Family Foundation and Health Research and Educational Trust (HRET) released findings from their 2003 *Annual Employer Health Benefits Survey*. The *Survey* is conducted among over 2,800 randomly selected public and private firms ranging in size from three to more than 300,000 employees. Selected critical findings include:

- The costs of private health insurance increased 13.9 percent in 2003 (the largest increase since 1990)
- 2003 marked the third consecutive year of double-digit increases
- Emerging trend – employers are not dropping coverage but most are passing on higher costs to their employees
- Since 2000, the amount of the average annual premium employees pay for family coverage has increased almost 50 percent, from \$1,619 to \$2,412
- On average, employers are paying 73 percent of the premium for a family health insurance policy and employees are paying 27 percent

In efforts to continue to offer and maintain health insurance coverage to employees, while containing costs, employers throughout states are using several models in order to purchase and provide health insurance. Two common strategies are self-insured plans and group purchasing arrangements.

Self-insured Plans

Self-insurance, also known as self-funding, refers to the process by which an employer assumes all or part of the risks of insurance coverage. Instead of paying premiums to an insurance company, an employer puts money directly into a plan, which then pays for the covered benefits when claims are incurred. There are distinct fiscal responsibilities involved with self-insurance, and significant differences exist between purchased (or fully insured) and self-insured health plans due to ERISA. ERISA exempts self-insured plans from providing state-mandated benefits and from paying premium taxes because the employers offering them are not considered to be in the business of insurance, with the exception of Hawaii as indicated previously (Park, 2000).

Because of its opportunity for cost savings and flexibility in designing a health plan, self-insurance became an increasingly popular means of providing health benefits to employees in the 1980s. Recent studies report that the prevalence of self-insurance peaked in the mid-1990s but has reversed its course because of managed care expansion (Copeland and Pierron, 1998; Fubini and Antonelli, 1997; Liston and Patterson, 1996; Marquis and Long, 1999; Wojcik, 1998).

In 2000, 30.3 percent of all New Jersey private-sector establishments offered health insurance that self-insured at least one plan. That percentage is a notable increase from 1999, when only 20 percent of such





establishments self-insured (Medical Expenditure Panel Survey from Agency for Healthcare Research and Quality, www.meps.ahrq.gov).

Group Purchasing Arrangements

Group purchasing arrangements attempt to achieve cost savings by combining their purchasing power to negotiate rates lower than each could otherwise get from an insurance company or HMO. A group purchasing arrangement can perform a variety of functions, including negotiating rates and benefits with insurers, marketing their products, enrolling new members, performing billing functions and paying premiums. Self-insured group purchasing arrangements seek to reduce costs by operating more inexpensively than traditional insurers; for example, by eliminating insurance costs such as taxes on their premiums (Kofman, 2003).

As illustrated in Appendix I, group purchasing arrangements may differ from one another in their structure and operation. They can be:

- privately managed or run by a state agency;
- established only through state legislation, or formed by associations of employers and individuals without legislative action;
- fully insured or self-insured; or
- for-profit or not-for-profit.

Examples of group purchasing arrangements include multiple employer welfare arrangements (MEWAs) and association health plans (AHPs). AHPs allow individuals and groups to purchase health insurance through an association, such as the American Automobile Association. Currently, AHPs must meet insurance regulations in each state in which they operate.²

State policymakers must decide which state insurance laws will apply to coverage offered through group purchasing arrangements, although there are some limitations on state actions by ERISA. These decisions will affect consumers, the group purchasing arrangements, and insurers selling traditional health insurance policies. States can exempt any type of group purchasing arrangement from any or all insurance market regulations. An advantage to exempting group purchasing arrangements from state insurance laws is that such action encourages these arrangements to form and grow. However, exempting the arrangements also can have the consequence of weakening consumer protections.³ In addition, exempting group purchasing arrangements from rating rules can affect the price of coverage in the rest of the insured market. If a group purchasing arrangement can manipulate premiums to attract healthy people and deter the sick, the cost of coverage in traditional insurance markets will be higher⁴ (Kofman, 2003).

State Regulations and Group Purchasing Arrangements in New Jersey

Self-funded group purchasing arrangements are designed to save employers money by avoiding skyrocketing health insurance premiums. But as health care costs have soared over the past several years, the price of self-funded coverage also has increased. In the past three years, three self-funded MEWA plans have failed in New Jersey, leaving millions in unpaid medical claims, and another one currently is under investigation by the state Department of Banking and Insurance.

When insurance companies fail, New Jersey's insurance guarantee fund can cover unpaid claims. However, MEWAs aren't backed by the state fund. The recent plan failures led New Jersey to pass a law that mandates financial standards for MEWAs and places such plans under state regulation.⁵ P.L. 2001, c.352, the Self-Funded Multiple Welfare Arrangement Regulation Act, was approved on January 6, 2002 and became effective 90 days after enactment (N.J.S.A. 17B:27C-1 et seq.) The Act was intended to ensure the financial integrity of self-funded MEWAs through registration and reporting requirements, as well as sanctions for noncompliance.





Regulations implementing the Self-Funded Multiple Welfare Arrangement Act were issued by the state Department of Banking and Insurance in August 2003 (the regulations may be accessed at http://www.state.nj.us/dobi/proposed/pn03_316.pdf). The proposed rules, under N.J.A.C. 11:4-46, establish self-funded MEWA registration and reporting requirements. They also implement N.J.S.A. 17B:27A-49, a provision of the Small Employer Health Benefits Act, which requires carriers that issue health benefits plans in New Jersey to notify annually the Commissioner of the Department of Banking and Insurance of any health care coverage or benefits, stop-loss coverage, or administrative services only contracts they provide or enter into with a multiple employer arrangement that provides health care benefits to employees and their dependents in New Jersey.

A CLOSER LOOK AT HEALTH CARE COVERAGE MANDATES AND THE CHOICE TO SELF-INSURE

When measured by the number of state laws covering health insurance, state regulation of the health insurance environment is higher than it has ever been: between 1994 and 2002, over 1,000 state laws have been enacted and insurance industry analysts expect that the number of state-specific mandates – exceeding 1,800 in 2002 – will continue to grow (Conning Research and Consulting, *Health Care Regulation*, 2002). The topic of the appropriateness and benefits of mandates and their impact on the costs of health insurance is controversial among advocates and critics, and the need for reliable, nonpartisan and evidence-based research on coverage mandates is critical.

Mandates can be segregated into three categories:

- Benefit mandates – which prescribe the individual benefit offerings that must be included in all state-regulated products
- Provider mandates – which identify the medical practitioners that must be included in the provider panels offered to covered persons
- Administrative practice mandates – which define who must be covered under various plans, establish provider prompt payments requirements and provide the framework for provider contracting.

Under ERISA, self-insured plans are not required to comply with state mandated benefits laws. By not having to comply with state mandated benefits, employers can be flexible in designing their own benefit plan.

A concern often raised about insurance mandates is that they encourage firms to self-insure in order to avoid the mandates. To date, all research on the characteristics of employers that self-insure report that firm size (or its surrogate measure — the number of subscribers in the plan) is the strongest determinant of a company's inclination to self-insure (Acs, et al., 1996; Garfinkel, 1995; Jensen and Gabel, 1988; Jensen, Cotter, and Morrisey, 1995; McDonnell, et al., 1986). According to this research, state benefit mandates and premium tax rates have no significant roles in that determination.

According to the most recent New Jersey Business and Industry (NJBIA) survey, New Jersey employers are overwhelmed by the rapid rise in health insurance costs. The average cost of employee health benefits rose 15 percent in 2002 and over 35 percent in the past three years. In 2002, the average cost of insuring one employee rose to \$6,323, an increase of 15 percent from the year before (Biddle, 2003). NJBIA and other employer groups regularly challenge additional mandated benefits that are proposed by the state Legislature.

Although findings from some insurance industry and actuarial reports suggest that mandated benefits cause increases in the cost of insurance, there are an equal number of studies which indicate that exemp-





tion from mandates do not translate into large savings (Carroll, 2002). For example, one 2003 study of mandated benefits in New York state conducted by a private consulting group this past year, found that mandated benefits increase health insurance premiums by a net amount of almost 12.2 percent throughout the state. This percentage increase translates into an increase in single coverage of \$444.57 a year and in family premiums of \$1,066.37 per year (Novak, 2003). A 2000 study conducted by Yondorf & Associates found that when the cost of plans that included mandates was compared with those that excluded mandates, the cost difference decreased approximately 10 percent (Carroll, 2002).

In recognition of the problems created by mandated benefits, some states have legislated mandatory reviews of all proposed mandates before they can be considered by the Legislature. The National Conference of State Legislatures (NCSL) reports that since 2001, six states – California, Florida, Louisiana, North Dakota, North Carolina and South Carolina – enacted legislation to study the financial impact of assessing new coverage requirements and/or evaluating current coverage mandates. An additional 12 states have introduced similar bills. Both enacted laws and bill proposals incorporate the requirement that cost-benefit analyses accompany mandated health benefit proposals.

In New Jersey, S-2275 passed both houses of the Legislature and currently is on the Governor's desk. The legislation would establish the Mandated Health Benefits Advisory Commission whose responsibility would be to study the social, financial and medical impact of proposed mandated health benefits bills prior to consideration by either house of the Legislature and to provide comments and recommendations to the Legislature.

NCSL senior policy analyst Richard Cauchi observes that it is still too soon to tell if the revival of legislative fiscal review policies regarding mandates – which also occurred during the late 1980s with the increase in health care costs – “will be widespread or limited experiments” among state legislatures (Carroll, 2002). He points to a method currently being employed by legislators in Indiana by which they are trying to reach a policy consensus about mandates that would protect patients “but still leave health plans able to provide more affordable coverage” (ibid.).

CONCLUDING REMARKS

Although self-insurance offers attractive features to employers, many state governments see it as a major hindrance to their efforts in bringing health care reforms to their states. ERISA preemption has effectively deterred states from implementing health reforms because they could not enforce insurance mandates on self-insured plans (Butler and Polzer, 1996; Chirba-Martin and Brennan, 1994; GAO, 1995).

Many states also assess taxes and fees on health plans to subsidize uncompensated care and medically high-risk pools. Due to increasing self-insurance, some states (Minnesota, Mississippi and Louisiana) have experienced decreasing pools of money available for the uninsured (Kenkel, 1991). As a result, various states have attempted to bypass self-insurance exemptions but without success. The state of New York had a major breakthrough in 1995 when the Supreme Court overturned the lower courts' decision and granted the state the right to impose a surcharge on commercial health plans, including the self-insured for hospital care.

Another concern with self-insurance stemming from the lack of regulation, as expressed by the National Association of Insurance Commissioners, is the possibility that employees covered under self-insured health plans are vulnerable to plan mismanagement, abuse and termination (GAO, 1995). Insurance companies also complain of unfair treatments, leading to uneven competition between self-insured and purchased plans (Butler and Polzer, 1996; Rublee, 1986).

In difficult economic times, group purchasing arrangements also are attractive because of the possibilities of reducing costs. However, the desire to expand coverage through group purchasing arrangements





must be balanced with the need to protect consumers who use these arrangements as well as those who still use traditional policies. Further, adequate protections against insolvency and scams must be ensured. State policymakers must address issues such as how to establish and promote group purchasing arrangements, who should sponsor such arrangements, and which state laws should apply to them (Kofman, 2003).

Recognizing these concerns and problems with self-insurance, there are attempts to amend ERISA or to pass federal regulations that will ameliorate some of the problems (Copeland and Pierron, 1998). The Health Insurance Portability and Accountability Act of 1996 is such an effort. However, the basic principles of ERISA are not expected to be easily amended as long as employers play key roles in the provision of health benefits in the U.S. Business leaders argue that ERISA promotes voluntary and more effective provision of health benefits to millions of Americans by allowing employers to manage costs and design health plans that fit their employees' needs (GAO, 1995). The outlook for the future for both the regulatory and cost aspects of employer-based health coverage appears to show little change from recent trends and practices. How will New Jersey – which has long been a state innovator in health insurance market reforms – and its policymakers stay the course in order to navigate through these challenging times?

ENDNOTES

¹ In 1983 ERISA amendments, Congress authorized Hawaii's law but noted in legislative history that this should not be seen as precedent for other similar state laws. Although there appears to be little congressional support for amending ERISA, H.R. 2979 (Tierney-MA), known as the "States Right to Innovate in Health Care Act of 2003," would waive ERISA preemption for state universal health care access demonstration programs. The bill was introduced on July 25, 2003 and referred to the Committee on Energy and Commerce. It was referred to the Subcommittee on Health on August 8, 2003. Reference is made to the National Academy for State Health Policy (www.nashp.org), which has produced several reports that address ERISA's impact on state health policy, including the [ERISA Preemption Primer and Manual for State Policymakers](#), its [2001 Update](#) and [Revisiting Pay or Play: How States Could Expand Employer-Based Coverage within ERISA Constraints](#).

² Legislation has been introduced in the current Congress to establish group purchasing arrangements for small businesses. H.R. 660 (Fletcher-KY) passed the U.S. House of Representatives and was received in the U.S. Senate where it was referred to the Committee on Health, Education, Labor and Pensions on June 20, 2003. S. 545 (Rockefeller-WV) was introduced on March 6, 2003 and was referred to the Committee on Veterans' Affairs. The bills seek to establish federally regulated association health plans by exempting such plans from state health insurance rating, benefit regulation, and solvency standards. The bills would place such plans under oversight by the U.S. Department of Labor rather than under state oversight. President George W. Bush also has actively promoted similar proposals (U.S. Department of Health and Human Services, February 2003 Press Release).

³ Terhune, C. "States Probe Health Policy Sales Promoted Through Associations." *The Wall Street Journal*. February 25, 2003. Terhune, C. "Insurer's Tactic: If You Get Sick, The Premium Rises." *The Wall Street Journal*, April 9, 2002.

⁴ The Congressional Budget Office, in evaluating a proposal to establish federally regulated AHPs, found that, through price manipulation, AHPs' ability to attract healthy people could lead to nationwide premium increases for 20 million people with traditional health insurance coverage (Congressional Budget Office, 2000).

⁵ Recognizing that it was both appropriate and necessary for states to be able to establish, apply and enforce state insurance laws with respect to MEWAs, the U.S. Congress amended ERISA in 1983, as part of P.L. 97-473, to provide an exception to ERISA's broad preemption provisions for the regulation of MEWAs under state insurance laws. Prior to 1983, if a MEWA was determined to be an ERISA-covered plan, state regulation of the arrangement would have been precluded by ERISA's preemption provisions. On the other hand, if the MEWA was not an ERISA covered plan, which was generally the case, ERISA's preemption provisions did not apply and states were free to regulate the entity in accordance with applicable state law. As a result of the 1983 MEWA amendments to ERISA, states are now free to regulate MEWAs whether or not the MEWA may also be an ERISA-covered employee welfare benefit plan (Ferrera, 2003).





REFERENCES

Acs, G., S.H. Long, M.S. Marquis, and P.F. Short. 1996. "Self-insured employer health plans: Prevalence, profile, provisions, and premiums." *Health Affairs* 15 (2): 266-78.

The American Legislative Exchange Council (ALEC) and The Council for Affordable Health Insurance (CAHI). 2003. "The State Legislators' Guide to Health Insurance Solutions and Glossary."

Biddle, Christopher. "NJBIA 2003 Health Benefits Survey." Report of the New Jersey Business and Industry Association, May 2003.

Butler, P., and K. Polzer. 1996. Private-sector health coverage: *Variation in consumer protections under ERISA and state law*. Washington, DC: National Health Policy Forum, The George Washington University.

Carroll, J. 2002. "Efforts to Kill Coverage Mandates Run Up Against Powerful Forces." "Legislation & Regulation." *Managed Care*.

Chirba-Martin, M.A., and T.A. Brennan. 1994. "The Critical role of ERISA in state health reform." *Health Affairs* 2 (spring): 142-56.

Congressional Budget Office, *Increasing Small Firm Health Insurance Coverage Through Association Health Plans and Healthmarts*, January 2000.

Conning Research and Consulting. 2002. *Health Care Regulation – A Gauntlet of Mandates*.

Copeland, C., and B. Pierron. 1998. *Implications of ERISA for health benefits and the number of self-funded ERISA plans*. Washington, DC: EBRI Issue Brief Number 198. Employee Benefits Research Institute.

Ferrera, Tess J., Esq., "PEO Health Plans – MEWAs or Not?" *NAPEO Legal Review*, June 2003, Vol. 1, Issue 5

Fubini, S., and V. Antonelli. 1997. "1997 Health Care Industry Outlook." *Healthcare Trends Report* 11 (1): 1-20.

Garfinkel, S.A. 1995. "Self-insuring employee health benefits." *Medical Care Research and Review* 52 (4): 475-91.

GAO. 1995. *Employer-based health plans: Issues, trends, and challenges posed by ERISA*. GAO/HEHS-95-167. Washington, DC.

Health Insurance Component Analytical Tool (MEPSnet/IC). December, 2002. Agency for Healthcare Research and Quality, Rockville, MD. <http://www.meps.ahrq.gov/mepsnet/IC/MEPSnetIC.asp>

Jensen, G.A., and J.R. Gabel. 1988. "The erosion of purchased health insurance." *Inquiry* 25: 328-43.

Jensen, G.A., K.D. Cotter, and M.A. Morrissey. 1995. "State insurance regulation and employers' decisions to self-insure." *Journal of Risk and Insurance* 62 (2): 185-213.

The Kaiser Family Foundation and Health Research and Educational Trust. 2003. *Annual Employer Health Benefits Survey*. <http://www.kff.org/content/2003/20030909a>.





Kenkel, P.J. 1991. "Growth in self-insurance puts squeeze on Minnesota risk pool." *Modern Healthcare*, 26 August, 30.

Kofman, Mila. State Coverage *Initiatives Issue Brief*: "Group Purchasing Arrangements: Issues for States," Vol. IV, No. 3, April 2003.

Liston, P., and M.P. Patterson. 1996 *Analysis of the number of workers covered by self-insured health plans under the Employee Retirement Income Security Act of 1974-1993 and 1995*. KPMG Peat Marwick Report to the Kaiser Family Foundation.

Marquis, M.S., and S.H. Long. 1999. "Recent trends in self-insured employer health plans." *Health Affairs* 18 (3): 161-67.

McDonnell, P., A. Guttenberg, L. Greenberg, and R.H. Arnett. 1986. "Self-insured health plans." *Health Care Financing Review* 8 (2): 1-16.

Meyer, J. A. and S. Silow-Carroll. "Building on the Job-Based Health Care System: What Would It Take?" *Health Affairs. Web Exclusive*. August 27, 2003. <http://www.healthaffairs.org/WebExclusives/2206Meyer.pdf>

National Conference of State Legislatures, Forum for State Health Policy Leadership, 2001. *Frequently Asked Questions...Insurance and Managed Care*.

Novak, D. "New York State Mandated Health Insurance Benefits." May 2003. NovaRest Consulting (www.NovaRest.com).

Park, Christina, H. "Prevalence of Employer Self-Insured Health Benefits: National and State Variation." Division of Health Care Statistics at the National Center for Health Statistics, Centers for Disease Control and Prevention. *Medical Care Research and Review*, Vol. 57 No. 3, (September 2000) 340-360.

Ruble, D.A. 1986. "Self-funded health benefit plans—trends, legal environment, and policy issues." *JAMA* 255 (6): 787-89.

U.S. Department of Health and Human Services, "Budget to Continue President's Initiatives for the Uninsured," *Press Release*, February 11, 2003; White House Press Office, Transcript: Bush Remarks on Health Care Reform, February 11, 2002.

Wojcik, J. 1998. "Self-insurance sees gains in health plan financing: More employers assume risk in HMOs, POS plans." *Business Insurance* 32:3.





APPENDIX 1

Types of Group Purchasing Arrangements

Group Purchasing Arrangement	Health Insurance Purchasing Coalitions (HIPCs)/Employer Alliances	Association Health Plans (AHPs)	Multiple Employer Welfare Arrangements (MEWAs)
Primary Purpose	To buy or provide health insurance to small businesses and/or self-employed people.	To meet various business goals: these health plans are offered by professional and trade associations.	To provide health coverage to employees of two or more employers or self-employed individuals; according to federal law. HIPCs, alliances, AHPs, and any other group purchasing arrangement may also be considered MEWAs for purposes of federal law.
Eligibility Requirements	Generally any employer may enroll as long as the employer meets size qualifications (i.e., employs 2-50 employees).	One must be a member of the association. Associations may restrict membership to a particular trade or industry, or may permit any employer or individual to join.	Varies depending on whether the arrangement is a HIPC, AHP, or another type of group purchasing arrangement.
State Legislation Needed	Generally, authorizing statute is needed (especially in states prohibiting insurers from selling coverage to groups formed for the sole purpose of buying health insurance). A HIPC that is considered a MEWA under federal law would also be subject to ERISA.	Generally, specific legislation is not required. An AHP that is considered a MEWA under federal law would also be subject to ERISA.	Generally, authorizing statute is not needed because MEWAs are defined by ERISA. States may also enact MEWA-specific standards (e.g., solvency requirements for self-funded MEWAs).
Private/Public Arrangements	These could be private arrangements or quasi-governmental pools managed by a state agency.	Private	Public or private
Examples	Healthcare Group of Arizona	California Society of Certified Public Accountants Group Insurance Trust	Healthcare Group of Arizona and the California Society of Certified Public Accountants Group Insurance Trust are considered MEWAs.

Source: Kofman, Mila. "Group Purchasing Arrangements: Issues for States," April 2003 Issue Brief for State Coverage Initiatives, an initiative of The Robert Wood Johnson Foundation.

