CHCF Issue Brief

MARCH 2021

by Emma Hoo
Purchaser Business Group on Health

California Policy Perspectives on Association Health Plans

Association health plans (AHPs) are insurance arrangements that allow small businesses, associations, and self-employed workers to organize together to purchase health care coverage, potentially obtaining lower-priced coverage by spreading risk and negotiating on behalf of a larger set of enrollees. Recent federal regulatory changes have expanded the definition of AHPs to reduce the requirements and conditions under which such entities could form, while also bypassing the coverage requirements specified in the Affordable Care Act (ACA). In response, many states have issued regulations that seek to mitigate the effects that AHPs could have on other insurance products and to reinforce the consumer protections that the ACA requires.

This brief examines these developments and the current market for AHPs in California, including a related expansion of less-regulated professional employment organization (PEO) insurance products. Interviews with current market participants and observers suggest a potential need for additional oversight of both AHPs and PEOs. Absent such oversight, the spread of coverage products not fully compliant with the consumer protections codified by the ACA may lead to adverse risk selection and undermine the functioning of individual and small group markets both within and outside the Covered California health insurance exchange.

Background and Legislative History

Under federal law, AHPs are a type of multiemployer welfare arrangement (MEWA) established or maintained to provide insurance coverage for medical, surgical, hospital care, or other benefits in the event of sickness.[1] The National Association of Insurance Commissioners (NAIC) holds that states have regulatory authority over both fully insured and self-funded MEWAs, with the ability to regulate, among other things, the terms of the insurance contract, the rates the insurer charges, and the sales practices and personnel used by the insurer.[2] AHPs are often fully insured because state insurance laws may establish reserve requirements for self-funded MEWAs.

AHPs have long been offered and regulated in the state of California. In 1992, State Assembly Bill 1672 set forth requirements for small group reform that applied to AHPs, including criteria for guaranteed issue, standard rating rules, defined risk corridors, specific age bands, and the number of geographic regions for the small group insurance market (see sidebar on page 2).[3] In effect, AB 1672 created a pre-ACA small group insurance exchange, with products that included the Health Insurance Plan of California and its successor, PacAdvantage, along with several AHPs that included sole proprietors who would have otherwise been eligible for individual market products only.

While AB 1672 did not set insurance rates, it did require health plans to establish a standard premium rate, around which they could assign a "risk adjustment factor" that would price small groups up to 10% above or below the standard rate. However, plans were not required to price products of a similar benefit design at the same level inside and outside the exchange, which contributed to a higher-risk mix inside the exchange over time. A key lesson learned was that purchasing pools cannot be required to follow more stringent rules in the marketplace, or they will be adversely selected against.[4]

In 2010, the Affordable Care Act changed the rating rules and benefit coverage requirements in the individual and small group markets, and led to the establishment of the California Health Benefit Exchange, later named Covered California. Through Covered California, individuals and employees of participating small businesses can enroll in subsidized and unsubsidized health coverage. The

California Definition (AB 1672)

"Guaranteed association" means a nonprofit organization composed of a group of individuals or employers who associate based solely on participation in a specified profession or industry, accepting for membership any individual or employer meeting its membership criteria that:

- Includes one or more small employers as defined in subparagraph (A) of paragraph (1) of subdivision (q)
- Does not condition membership directly or indirectly on the health or claims history of any person
- Uses membership dues solely for and in consideration of the membership and membership benefits, except that the amount of the dues shall not depend on whether the member applies for or purchases insurance offered by the association
- Is organized and maintained in good faith for purposes unrelated to insurance
- Has been in active existence on January 1, 1992, and for at least five years prior to that date
- Has been offering health insurance to its members for at least five years prior to January 1, 1992
- Has a constitution and bylaws, or other analogous governing documents that provide for election of the governing board of the association by its members
- Offers any purchased benefit plan design to all individual members and employer members in this state
- Includes any member choosing to enroll in the benefit plan design offered to the association provided that the member has agreed to make the required premium payments
- Covers at least 1,000 persons with the carrier with which it contracts

ACA phased in other insurance market requirements, including:

- Penalties for individuals who did not have coverage and employers who did not offer it
- A minimum set of essential health benefits
- No preexisting condition exclusions
- No annual or lifetime coverage limits
- Rating restrictions that reduced the permissible ratio of premiums across age bands

For example, age-rated bands established that premiums for the oldest group, 60- to 64-year-olds, cannot exceed three times those of younger adults. While this policy resulted in lower premiums for people age 60 to 64, it also meant higher premiums for younger people. As a consequence, the three-to-one ratio encouraged creation of AHPs that market to younger people because a product covering a younger demographic would cost less per person than one offered through Covered California or directly from carriers. Concerns over the potential for AHPs to destabilize the risk mix in the small group market in turn spawned new legislation and regulations at the state level with considerable variability in the oversight of AHPs.[5]

Meanwhile, efforts to unwind key provisions of the ACA manifested in a variety of ways. In 2018, the US Department of Labor (DOL) finalized a new regulation for AHPs that made it easier for small employers to organize for the purpose of accessing health insurance typically available only to large groups. Previously, the DOL allowed those with a shared industry or business interest to be treated as a single employer and avoid certain plan restrictions applicable to small employers. The "shared industry or business interest" requirement made it attractive for groups in life sciences, education, and technology to aggregate for the purpose of obtaining health insurance as a large group. Such groups would have more favorable rates based on demographics and direct underwriting than if they accessed insurance through the small group market that was community-rated.

The new rule also allowed for the formation of associations among small groups with a "commonality of interest" — such as geographic colocation — to purchase health insurance collectively. Working owners without direct employees were also permitted to participate in these type of AHPs. In the past, self-employed workers such as independent contractors were not permitted to participate in ERISA (Employee Retirement Income Security Act) plans that were underwritten as group coverage. The AHP rule allowed sole proprietors and small employers to more easily organize to form AHPs and buy health care coverage in the large group market. The rule expanded the circumstances under which an AHP could be considered a single employer, relaxed the standards for forming an AHP, and treated sole proprietors as both employers and "employees" so they can qualify as small employers.[6]

These changes were very controversial. Diverse stakeholders including regulators, health plans, health policy advocates, and consumer organizations weighed in actively in 722 comment letters on the new regulation, Definition of Employer – Small Health Plans RIN 1210-AB85.[7] Many cited the troubled history of fraud, rate insufficiency, and instability among MEWAs.[8] Others voiced concerns about the destabilizing effect of "skinny" health plans designed to cherry-pick favorable risk while putting consumers at risk for coverage gaps and limitations on benefits that were previously defined as essential health benefits under the ACA.

Opponents of the DOL rule argued that such plans would create adverse selection by driving higher-risk individuals into the state or federal health insurance marketplace options, increasing costs and ultimately undermining the stability of those risk pools. Premiums for the small group market are determined by a community rating methodology whereby the claims experience across the small group segment is pooled to determine health insurance premiums and annual rate increases.[9] Opponents of the rule argued that an AHP could bypass the community rating process by qualifying as a large group that is rated separately based on its own claims experience, much as a large business or government entity would operate.

Meanwhile, proponents of the DOL rule argued that AHPs promote competition in increasingly consolidated insurance markets and provide more affordable options in the face of ever-escalating and unaffordable health insurance premiums. By allowing a more restrictive benefit design, such plans could also be attractive to small groups with a lower-risk profile. Such groups could design products that do not cover the essential health benefits as required for individual and small group plans under the ACA but instead comply with less stringent ERISA consumer protections. In so doing, new products could be designed with a lower actuarial value — that is, offering less protection to the consumer, and therefore be lower cost — than plan designs fully compliant with the ACA.

Recent AHP Regulation in California and Other States

In response to the new DOL rule, the California legislature passed Senate Bill 1375 in 2018 to protect the state's individual and small group markets from potential adverse selection by specifying that the status of each distinct member of an association shall determine whether that member's association coverage is individual, small group, or large group health coverage.[10] For example, if an AHP includes 10 individuals or working owners/proprietors, three small businesses, and one large employer, the individuals would then be subject to the individual market products and rates, the small businesses would have access to the small group products, and the large employer would be underwritten based on demographics, service industry code, and claims history.

California's Department of Managed Health Care (DMHC) issued additional regulations to health plans to limit the expansion of AHPs.[11] Beginning July 1, 2020, all association health plans must cease renewing existing large group contracts that include small employers. DMHC subsequently issued a second All Plan Letter (APL 20-031) to extend the AHP phase-out period to February 28, 2021, in response to the COVID-19 state of emergency.[12]

Although the future of the federal AHP rule is unclear, California law still takes precedent insofar as the Department of Labor has not changed states' authority to regulate MEWAs, including AHPs. The NAIC notes that while the DOL requested comments on potential MEWA exemptions from state regulation, the preamble to the final AHP rule indicated that the DOL views this exemption authority as "a potential future mechanism for preempting state insurance laws that go too far in regulating non-fully-insured AHPs in ways that interfere with the important policy goals advanced by this final rule."[13] Many states have acted swiftly to implement oversight of AHPs and to provide consumer protections, as summarized in Table 1.[14]

Table 1. Beyond the Federal Minimum Standards: Key Approaches States Are Taking to Regulate AHPs Under the New Pathway

POLICY OPTION	DESCRIPTION	STATES		OBJECTIVE
		FULLY INSURED AHPS	SELF-FUNDED AHPS	
Prohibit new AHPs.	New AHPs are entirely prohibited, or are prohibited from forming under the easier-to-satisfy standards of the new rule.	None	California, Washington	Reduce risk of AHP fraud and insolvency.
Require associations to satisfy additional standards before they may market health coverage.	Require that an association be formed for a purpose other than offering insurance, or be in existence for a minimum number of years, before it may market coverage.	Indiana, Iowa, Kansas, Maryland, New York, Pennsylvania, Vermont	Indiana, Iowa, Kansas, Maryland, Michigan, New York, Pennsylvania	Reduce risk of AHP fraud and insolvency.
Maintain the "look through" approach.	For purposes of determining whether association coverage is part of the individual, small group, or large group market — and therefore, which insurance rules apply to it — regulators "look through" the association and focus on its underlying members, classifying coverage based on the size of each member. That is, coverage sold through an association to individuals is part of the individual market risk pool and must comply with individual market standards, while coverage sold to small businesses is part of the small group market risk pool and must comply with small group market standards.	California, Connecticut, Kansas, Maryland, New York, Pennsylvania	Connecticut, Maryland, New York, Pennsylvania	Maintain a level regulatory playing field. Coverage sold to individuals and small businesses must follow the same rules, whether or not purchased through an association.
Do not classify a sole proprietor as a "group" for purposes of AHP enrollment.	Sole proprietors must use the traditional individual insurance market to obtain coverage and cannot qualify as a "small employer group" to join an employer-based AHP.	California, Connecticut, Kansas, New York, Pennsylvania	Connecticut, New York, Pennsylvania	Maintain a level regulatory playing field. Coverage sold to individuals must follow the same rules, whether or not purchased through an association.
Require self-funded AHPs to meet commercial licensure requirements.	AHP must satisfy the same licensure and financial standards as commercial insurers.	—	Alabama, Connecticut, Louisiana, Maryland, New York, Pennsylvania	Reduce risk of AHP fraud and insolvency.

Source: Kevin Lucia, Justin Giovannelli, and Sabrina Corlette, "In the Wake of New Association Health Plan Standards, States Are Exercising Authority to Protect Consumers, Providers, and Markets," *Commonwealth Foundation Blog*, November 27, 2018.

Furthermore, 11 states (including California) and the District of Columbia sued the Department of Labor, and a federal court struck down much of the federal AHP rule. The Department of Labor appealed in April 2019, and that case is still pending. The amicus briefs and court testimony document the concerns about risk segmentation in the small group market, potential for fraud and unfunded MEWAs, and the need for consumer protections.[15] The Biden administration could issue new guidance, or there could be a court decision that affects the AHP rule.

AHPs in California: Current Landscape and Evolving Products

Current Landscape

Regardless of recent federal and state legislation and litigation over AHPs, reviews of DMHC filings and interviews conducted for this brief suggest they remain an enduring and evolving component of California's health insurance coverage landscape. As of 2019, approximately 83 MEWAs, representing 151,000 enrollees, reported their enrollment data to state regulators. Commonly represented industries included agriculture, construction, education, food services, publishing and print organizations, real estate, and restaurant workers. A number of these organizations are represented by a single educational labor trust, professional employment organizations, industry-centric trusts, and brokerage firms. Some of these organizations operate as a voluntary employee beneficiary association, or VEBA (voluntary employees' beneficiary association) trust. It should be noted that some industries, particularly construction, organize as AHPs to improve purchasing power for worker compensation coverage, which can be more costly than medical insurance plans.

Of the membership reported to DMHC, approximately 49,500 are enrolled in HMO products, 1,700 in POS (point of service) products, and 99,500 in PPO (preferred provider organization) products. The vast majority of MEWAs are underwritten by Anthem Blue Cross, with a limited number spread across additional carriers, as shown in Table 2. Table 3 shows the distribution by industry types.

A review of benefit design information available on public websites revealed a range of benefit designs, with PPO products reflecting a wide range of deductible levels. Among the publicly available benefit summaries, there did not appear to be significant adoption of non-ACA-compliant benefit designs.

However, the lack of transparency requirements for benefit designs offered through AHPs can place consumers at risk in selecting health plans that may have unexpected benefit exclusions or which are otherwise not compliant in offering the essential health benefits required by the ACA. Additionally, there are national organizations with endorsed relationships with franchise-based entities in California, but which appear not to report enrollment data to DMHC.

Table 2. MEWA Volume, by Carrier as Reported to DMHC

Aetna Health of California	4
Blue Cross of California (Anthem Blue Cross)	60
California Physicians' Service (Blue Shield of California)	6
Health Net of California	6
Kaiser Foundation Health Plan	3
Sistemas Medicos Nacionales	1
Western Health Advantage	3

Table 3. MEWA Volume, by Industry Type

Agricultural	4
Arts/Entertainment	3
Construction	6
Education	26
Insurance Agents / Real Estate	8
Law	1
Miscellaneous	9
PEO (tech, life sciences, general)	11
Printing	3
Restaurant/Brewery	9
Technology	3

Interviews conducted for this brief suggest that AHPs in California typically offer two to four benefit designs with different point-of-service cost-sharing levels that vary with employee and family insurance premium contributions. An illustrative example includes "the Producers' Health Benefits Plan" underwritten by Anthem Blue Cross, which offers the following four products:

- **Modified Classic HMO** with a $10 primary care copay, $30 specialty care, and $250 inpatient copay per admission, with no out-of-network coverage
- **Modified Classic PPO** with a $30 primary care / specialty copay, 20% co-insurance for other services, $500 individual / $1,000 family deductible, with higher cost sharing for out-of-network providers
- **Modified Classic Premier PPO** with a $25 primary care copay, 20% co-insurance for other services including inpatient, and $500 individual / $1,000 family deductible, with higher cost sharing for out-of-network providers
- **Custom Anthem PPO HSA** with a $2,700 single, $2,800 per member, or $5,400 per family deductible, 20% co-insurance for other services, and 50% for select services such as durable medical equipment

Other associations such as the California Association of Realtors (C.A.R.) offer a broader array of plans. Within Kaiser, C.A.R. Insurance Products offers three Bronze plans, five Silver plans including an HSA-qualified high deductible health plan, four Gold plans and two Platinum plans. Its Anthem PPO offerings include seven Bronze plans, six Silver plans, four Gold plans, two Platinum plans; its Anthem HMO coverage products include two Silver and two Gold options. The Restaurant Industry Health and Welfare Trust Fund offers five Kaiser options, including HMO plans with deductibles, and eight Anthem product coverages with varying provider network options.

Evolving Products

With the regulations and All Plan Letters issued by the DMHC, Blue Shield of California and Kaiser Foundation Health Plan indicate they no longer sell coverage for AHPs. Other health plans, however, maintain existing relationships or provide exemptions for these programs in their large group business. Additionally, some AHPs are organized out-of-state, but are offered through franchise businesses; it is unclear whether such entities are subject to California regulations. To extend their operations, some AHPs (or their broker of record) offered their membership early renewal packages as of October 2020 to extend coverage beyond the date specified in the DMHC's initial advisory, APL-19-024. Other workarounds are potentially more troubling.

Stakeholders interviewed for this study expressed significant concern about oversight of AHPs that elect to self-fund and thereby assert ERISA exemption. Several pointed to well-documented cases of AHPs that lacked sufficient capital or underbid their premium rates to attract membership, only to go bankrupt due to excess claims or unpredicted high-cost claimants.[16] One practice entails developing a competitive pricing structure, supported by reinsurance for high-cost claimants that can end up being inadequate for the volume of claims. Even though such an approach may provide near-term financial protection for an AHP, it is not sustainable if the reinsurance carriers refuse to underwrite future rating cycles.

A review of current California product offerings also suggests that brokers and associations have introduced other workarounds, such as the use of a wholly owned "captive insurer" to shield AHPs and their participants from premium fluctuations due to high-cost claimants. This takes place when a group of small employers pool their memberships to obtain a combined large group rate (i.e., self-funding) while separately contributing to a fund that provides a hedge against high-cost claimants. In such an arrangement, the association or risk-bearing entity may record a profit within that captive in a year with lower-than-expected claims volume or dollars; however, stakeholders noted that additional oversight of funding adequacy may be needed to ensure stability in an environment with higher-than-expected claims.

Key informants suggest captives may also be used to good effect. In some markets, the use of a captive could enable a group of small employers to come together and enter into direct-contracting relationships with select providers, implement targeted complex case management programs to manage population health and high-risk individuals while also adopting innovative benefit designs, such as reference pricing or centers of excellence, to steer members to higher-performing providers that the small groups would not otherwise have access to.[17] Gainsharing or risk sharing based on the captive's performance can also be established to assure equitable treatment of participants. To support financial stability of the pool, such a conglomeration of small businesses might purchase additional stop-loss insurance from a reinsurance carrier, which would further fragment the risk pool.

Several stakeholders have noted with concern the reinvention of AHPs as professional employment organizations (PEOs). The California market has seen a proliferation of PEOs that qualify to offer large group insurance. Some of the existing California AHP websites are now promoting additional services as PEOs, whereby a small business purchases payroll, ancillary or voluntary benefits, or other human resources services. Legally, small businesses entering into a PEO relationship assume a dual-employment relationship such that the PEO becomes the employer of record. As a result, the PEO may qualify as a large group for purchase of health insurance, workers' compensation, and other services. PEOs can be self-funded or fully insured, and the potential for fraud and abuse that was experienced among some AHPs can be an unintended consequence.

Some states regulate PEOs more strictly than California. As a result, PEOs in California can avoid many of the consumer-friendly ACA regulations, allowing them to operate multiple large group pools with different rating criteria; operate as fully insured, self-insured, or both; collect demographic information and an organizational health history questionnaire; and apply geographic rating factors, among other rating practices. As a result, a small group with individual employees who have preexisting conditions or with women in their child-bearing years is likely to experience a higher premium than a group without such history. While the PEO negotiates an average premium and total dollar amount with its contracting health plan(s), there is no limit to the number of rating tiers used for its clients, which in effect negates some of the consumer protections that the ACA was designed to provide.

Nationally, there is tremendous variation in how states regulate PEOs, and there may be valuable lessons to be drawn from some of these approaches.[18]

- Some states, such as Maine, require small groups within PEOs to be insured through the state's small group market products.[19]
- In Connecticut, PEOs are required to register with the state with disclosure of information about ownership, client information (name, address, state Tax ID, state unemployment registration number), financial statements (including minimum working capital of $150,000), and itemization of group members.[20]
- Colorado law provides explicit definitions and scope of a PEO's relationship with its individual clients, requires initial certification and annual operational reporting.[21]
- Pennsylvania law defines PEO duties and agreements with respect to benefit plans, workers' compensation, and unemployment compensation insurance and requires a broad application with supporting documents.[22]

The NAIC ERISA Working Group has added guidance on the definition and role of states in oversight of PEOs, which ultimately depends on whether the PEO is a MEWA. If health coverage is fully insured, a state has the authority to regulate the carrier and establish standards if the PEO is a MEWA. Whether a self-funded benefit arrangement sponsored by a PEO is exempt from state regulation depends on whether the arrangement is an ERISA-covered single-employer plan or a MEWA: "Unlike a traditional employer, the PEO is being paid by its clients to provide this coverage, either as a separate line item or part of a global PEO service fee. Like an insurer, the PEO makes a profit or loss depending on whether the fees are sufficient to pay for the costs of the health plan, and the employer is dependent on the PEO's ability to pay all claims when due."[23]

Future State Regulatory Role

There are a number of options for policymakers interested in additional oversight of the market for AHPs and PEOs in California. For example, DMHC's efforts to oversee MEWA activity through a voluntary registration process could be augmented to limit exempting of AHPs to those established before 1992 and compliant with the definition established with the initial California small group reform legislation, AB 1672. Additional disclosure requirements with respect to ownership interests, benefit plan offerings, and enrollment distribution could serve to increase transparency of AHP operations and support consumer protection.

Beyond provisions to sunset AHPs and limiting exemptions that sustain existing AHPs, policymakers in California may learn from actions undertaken by other states to oversee PEOs and evolving AHP-based products. Based on the experience of other states, potential requirements could include:

- Registration of PEOs with disclosure of ownership, financial solvency, membership, and carrier relationships for health and welfare products, including fees and incentive payments
- Financial solvency requirements for stand-alone operations and self-funding
- Limitations on the total number of rate tiers within a PEO consistent with state law and/or disclosure of rating tiering structure, rating criteria, and age and demographic bands
- Definition of permissible claims history and pre-existing condition history in organization-level or individual-level health questionnaire
- Conditions for rating small groups outside the small group market
- Transparency requirements on benefit design offerings, including public access to benefit plan options in formats consistent with ACA-required benefit categories
- Disclosure of actuarial value and/or proximal alignment with defined platinum, gold, silver, and bronze metal classification depicting benefit coverage levels
- Requirements for stop-loss levels commensurate with AHP size
- Guidance on permissible use of captives and reinsurance

Pending Issues and Federal Policy

The Biden administration has already taken steps to bolster the ACA and counter recent efforts to limit subsidies and incentives to enroll in the federal marketplace and state exchanges. Policy changes could be implemented to reduce potential adverse risk selection issues for the small group market by reversing the expanded definition of AHPs or separately restricting short-term, limited-duration health plans. Additionally, although the US Court of Appeals for the District of Columbia Circuit heard oral arguments in State of *New York v. US Department of Labor*, in November 2019, review of the prior decision that invalidated the DOL rule has not been completed, and it is uncertain whether any court decision will fully address the regulation of AHPs.

Regardless of what happens in the executive, legislative, or judicial branches of the federal government in the next several years, the evolving nature of AHPs and PEOs in California necessitates a close look by state policymakers seeking to maintain the consumer protections established by the Affordable Care Act and to ensure the stability of individual and small group markets throughout the state.

About the Author

Emma Hoo directs value-purchasing, accountability and quality measurement initiatives at the **Purchaser Business Group on Health** (PBGH), including assessment of Accountable Care Organizations, adoption of common ACO quality and efficiency measures, and expanding use of patient-reported outcomes measures.

About the Foundation

The **California Health Care Foundation** is dedicated to advancing meaningful, measurable improvements in the way the health care delivery system provides care to the people of California, particularly those with low incomes and those whose needs are not well served by the status quo. We work to ensure that people have access to the care they need, when they need it, at a price they can afford.

CHCF informs policymakers and industry leaders, invests in ideas and innovations, and connects with changemakers to create a more responsive, patient-centered health care system.

Endnotes

1. *MEWAs — Multiple Employer Welfare Arrangements Under the Employee Retirement Income Security Act (ERISA): A Guide to Federal and State Regulation* (PDF), US Dept. of Labor (DOL), last revised August 2013.
2. *Health and Welfare Plans Under the Employee Retirement Income Security Act: Guidelines for State and Federal Regulation (draft)* (PDF), National Assn. of Insurance Commissioners (NAIC), November 1, 2018.
3. Cal. Ins. Code § 10755.
4. John Grgurina, *Purchasing Strategies to Increase Value and Access* (PDF), (presented at the State Coverage Initiatives national meeting, February 4, 2005).
5. *Association Health Plan Survey at Request of Washington State* (AUTOMATIC DOWNLOAD WORD DOC), NAIC, November 2010.
6. Sarah Ream (acting general counsel, California Dept. of Managed Health Care [DMHC]) to all health care service plans, All Plan Letter 19-024 (PDF), December 9, 2019.
7. "Definition of Employer Under Section 3(5) of ERISA-Association Health Plans," DOL, n.d.; David Jones (commissioner, California Dept. of Insurance) to Employee Benefits Security Administration (EBSA), comment letter (PDF), March 6, 2018; and Shelley Rouillard (director, DMHC) to EBSA, comment letter (PDF), March 5, 2018.
8. Mila Kofman, Eliza Bangit, and Kevin Lucia, *MEWAs: The Threat of Plan Insolvency and Other Challenges* (PDF), Commonwealth Fund, March 2004.
9. Kris Haltmeyer (vice president, Legislative & Regulatory Policy, Blue Cross Blue Shield Assn.) to Preston Rutledge (asst. secretary, DOL), comment letter (PDF), March 6, 2018.
10. S.B. 1375 (Cal. 2018).
11. Ream, All Plan Letter 19-024.
12. Sarah Ream (acting general counsel, DMHC) to all full-service health care service plans, All Plan Letter 20-031 (PDF), August 21, 2020.
13. *Health and Welfare Plans*, NAIC.
14. Kevin Lucia, Justin Giovannelli, and Sabrina Corlette, "In the Wake of New Association Health Plan Standards, States Are Exercising Authority to Protect Consumers, Providers, and Markets," *Commonwealth Foundation Blog*, November 27, 2018.
15. Mila Kofman, *Association Health Plans: Loss of State Oversight Means Regulatory Vacuum and More Fraud*, Georgetown University, Summer 2005.
16. Robert Pear, "Cheaper Health Plans Promoted by Trump Have a History of Fraud," *New York Times*, October 21, 2017; and Paige Winfield Cunningham, "The Health 202: Trump's Executive Order Has a History. And the Government Says It's Not All Great," *Washington Post*, October 12, 2017.

17. Robert McCollins (managing director, Employers' Advanced Cooperative on Healthcare) in discussion with author, January 13, 2021.
18. State-level resources reported at "PEO - Professional Employer Organizations Licensing by State," StaffMarket, n.d.; "Professional Employer Organization Licensing," Harbor Compliance, last reviewed December 7, 2016; and "Professional Employer Organizations (PEO) - Guide to State-Specific Requirements," NCCI.
19. Robert Wake (general counsel, Maine Bureau of Insurance), in discussion with author, December 17, 2020.
20. "Professional Employer Organizations (PEO)," Connecticut Dept. of Labor, n.d.; and PA 08-105—sHB 5113, Connecticut General Assembly, n.d.
21. CO Rev Stat § 8-70-114 (2016).
22. "Professional Employer Organization (PEO) Requirements," Pennsylvania Dept. of Labor & Industry, n.d.; and Professional Employer Organization Act of 2012, Penn. Pub. L. No. 946-102.
23. *Health and Welfare Plans*, NAIC.