Testimony of W. Wyatt Bosworth
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Before the Committee on Insurance & Real Estate
Hartford, Connecticut
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Testifying in Support of:

House Bill 6710: AAC Association Health Plans

My name is Wyatt Bosworth and I am assistant counsel for CBIA, the Connecticut Business & Industry Association. CBIA is Connecticut's largest business organization, with thousands of member companies, small and large, representing a diverse range of industries from across the state. Ninety-five percent of our member companies are small businesses, with less than 100 employees. Thank you for the opportunity to testify in **support** of **HB 6710: AAC Association Health Plans.**

Every day, small businesses are struggling to attract and retain workers following the turmoil from the COVID-19 pandemic and the historic workforce shortage that has left more than 100,000 unfilled positions in the state. One of the only tools small employers have that can boost workforce and productivity is the ability to offer comprehensive benefit packages that include affordable and comprehensive health insurance plans. Unfortunately, due to market conditions, the small group market is becoming more consolidated and less affordable every year.

Just last fall, the Connecticut Insurance Department approved a wide-range of premium increases in the on-exchange and off-exchange small group markets. Insurance carriers had requested an average increase of 14.8% which was reduced by 47% by regulators resulting in an average increase of 7.9%.[1] According to a survey issued by Beckers's Healthcare in 2022, ninety-five percent of small business owners said they have seen the cost of health insurance increase over the past four years, and 56 percent estimate the yearly increase of their

[1] Health Insurance Rates for 2023, Connecticut Insurance Department, (Sept. 2, 2022) https://www.catalog.state.ct.us/cid/portalApps/HCfiling2023.aspx.

healthcare costs is 10 percent or higher.[2] In Connecticut, between 2016 and 2021, the average annual single premium per enrolled employee for employer-based health insurance rose 17.9%.[3]

As a result of these increases as well as increases in the past, small employers are increasingly shifting away from the small group market to self-funded and level-funded products in order to control costs while maintaining competitive benefit plans. According to the Kaiser Family Foundation's 2022 Employer Health Benefits Survey, thirty-five percent of covered workers in small firms (3-199 workers) are in a level-funded plan.[4] Recent state data for Connecticut from KFF also showed a 30% increase in small employers (2-50 workers) moving to self-funded and level-funded products between 2019 and 2022.[5] CBIA estimates the share of small employers in self-funded and level-funded products today is around 30%.

The bill before you today represents a coming-to-terms with the fact that the small group market is becoming increasingly unattractive for small employers every year and that current self-funded products don't work for every small employer. For example, the Commonwealth Fund notes that good candidates for self-funding will have (1) a good track record of low-to-normal annual medical claims; (2) strong cash flow; (3) more than 35 workers; and (4) a strong interest in actively managing their own health benefits or a consultant who can help do so.[6]

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[2] *41% of small businesses have increased prices due to rising health insurance costs, Becker's Healthcare (Oct. 27, 2022)* *https://www.beckerspayer.com/payer/41-of-small-businesses-have-increased-prices-due-to-rising-health-insurance-costs.html#:~:text=Ninety%2Dfive%20percent%20of%20small,is%2010%20percent%20or%20higher*.

[3] State Health Facts, KFF (2023) https://www.kff.org/other/state-indicator/single-coverage/?activeTab=graph¤tTimeframe=0&startTimeframe=8&selectedDistributions=employee-contribution--employer-contribution--total-annual-premium&selectedRows=%7B%22states%22:%7B%22connecticut%22:%7B%7D%7D%7D&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D.

[4] *2022 Employer Health Benefits Survey*, KFF (Oct. 27, 2022) https://www.kff.org/report-section/ehbs-2022-section-10-plan-funding/.

[5] *See Share of Private-Sector Enrollees Enrolled in Self-Insured Plans*, KFF (2022) https://www.kff.org/other/state-indicator/share-of-private-sector-enrollees-enrolled-in-self-insured-plans-2018/?activeTab=graph¤tTimeframe=0&startTimeframe=9&selectedDistributions=firms-with-fewer-than-50-employees&selectedRows=%7B%22states%22:%7B%22connecticut%22:%7B%7D%7D%7D&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D (2019: 14.5 vs. 2020: 19.3%; data from 2022 is forthcoming).

[6] *Can Smaller Firms Self Fund? Surprise - Many Already Are*, The Commonwealth Fund https://www.commonwealthfund.org/publications/newsletter-article/can-smaller-firms-self-fund-surprise-many-already-are.

HB 6710 will provide small employers with relief by allowing the trade and industry associations they are members of to aggregate groups and purchase existing ACA-compliant large group fully-insured and self-funded products.

Option 1: ACA-Compliant, Fully-Insured Large Group Health Insurance

Under Section 3, trade associations with fifty or more employer members that have been maintained in good faith for not less than five years for purposes other than obtaining or providing insurance will be able to aggregate their membership and purchase a fully-insured, large group, ACA-compliant plan from an insurance carrier. Additionally, the bill is compliant with updated federal Department of Labor rules that require fully-insured association plans to meet the definition of "bona fide association".[7] This requirement ensures that only trade associations that have a commonality of interest amongst membership (i.e. membership is homogenous) can access this market.

By allowing associations to aggregate their employer-members and become "one large employer", small employers can enjoy the same benefits large employers enjoy in this fully insured large group market.

First, the banding together of small employers will allow the group to negotiate directly with the insurance company to design a plan that meets its needs. Today, small employers simply take what they can get in the small group with limited to no buying power. Second, due to this scale, the association can push to incorporate digital health programs and value based insurance design which have been proven to improve employees outcomes and drive down premiums over time. Third, small employers would maintain the right and ability to approve or veto health plan decisions or activities that relate to formation, design, modification, and termination of the health plan. These rights include modifications to plan premiums and benefits. This is because the DOL requires bona fide associations and its health plans to be controlled by the employers belonging to the association. Simply put, this is an essential regulatory tactic to discourage fraud and put small employers in the driver seat of their health plan. Fourth, large group products have a medical loss ratio

[7] *Applications of Individual and Group Market Requirements under Title XXVII of the Public Health Service Act when Insurance Coverage Is Sold to, or through, Associations*, Gary Cohen, Centers for Medicare & Medicaid Services (Sept. 1, 2011) https://www.cms.gov/cciio/resources/files/downloads/association_coverage_9_1_2011.pdf.

requirement of 85% compared to 80% in the small group market. This means large group plans are more affordable for the same benefits since a smaller portion of premiums can be spent on profit, marketing and administrative costs.

Contrary to what critics will say, large group, fully-insured AHPs are not an "end-run around" the ACA. In fact, it's quite the opposite. AHPs offer more robust coverage at a lower price compared to small group plans. Similar to many large employer products today, AHPs across the country voluntarily cover all ten of the ACA's Essential Health Benefits (EHBs). Additionally, AHPs offer broader health care provider networks relative to many existing ACA small group plans and are priced at an actuarially fair premium for both young and old participants. This premium encourages young and healthy employers to enroll in coverage which in turn benefits older and less healthy small employers by increasing the size of the risk pool.

Today, small employers with a less healthy risk profile have two options for group insurance: (1) enroll in the small group market where premiums increase drastically every year; or (2) join the 30% of other small employers who enroll in self-funded and level-funded products. Unfortunately, due to the lack of scale for many small employers, level-funded products are not realistic given their small size, tight finances and risk profile. That small employer can only enroll in the small group market; a market which is becoming *less* healthy due to healthy groups migrating to level-funded products and *more* expensive due to increased carrier consolidation and restrictive plan requirements. Even small employers with a decent risk profile who enroll in level-funded products can see massive premium renewals if a few bad claims spoil the group's experience for the prior year. It's *only* when these groups can combine with healthier groups in a large group product where economies of scale can be achieved and risk can be better spread out that truly valuable coverage can be attained.

Option 2: CID Regulated Self-Funded Multiple Employer Welfare Arrangements (MEWAs)

Recognizing the size and scale that state chambers of commerce possess in terms of small-employer membership, a number of states, including Virginia last year, paved the way for significantly large associations to band their members together to offer a self-funded health benefit plan, and be subject to rigorous financial

and solvency oversight by the respective state's Department of Insurance as well as the Federal Department of Labor. Sections 1 and 2 of the bill would add Connecticut to this growing list.

While Connecticut has shared-jurisdiction over MEWAs with the Department of Labor, amendments to ERISA in 1983 gives policy makers near-unlimited authority to not only set up a regulatory scheme for MEWAs, but set requirements for plan design, benefits and trust governance as well.[8]

Under section 2, an association that is licensed by the CID and meets the requirements set out in regulation regarding licensing, financial condition and actuarial standards, solvency and insolvency, transparency and reporting, and filings would be able to offer thousands of its members a self-funded option that only the largest employers and state benefit plans in the country can offer.

Beyond CID licensing and oversight, these self-funded plans would be required to offer comprehensive benefits and ensure rigorous solvency and capital requirements. Section 2 requires these plans to cover Essential Health Benefits and state mandates, meet a minimum actuarial value of sixty percent (the ACA minimum for employers with 51 or more employees), and not discriminate against individuals on the basis of preexisting conditions. Moreover, the plan would be required to create and maintain a trust controlled by its employer-members, purchase and maintain stop loss insurance, purchase and maintain commercially reasonable fiduciary liability insurance, purchase and maintain a bond in an amount approved by the CID Commissioner, and follow generally accepted fiduciary standards.

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[8] *See* MEWAs under the Employee Retirement Income Security Act: A Guide to Federal and State Regulation, U.S. Dep't of Labor at page 5 https://www.dol.gov/sites/dolgov/files/ebsa/about-ebsa/our-activities/resource-center/publications/mewa-under-erisa-a-guide-to-federal-and-state-regulation.pdf ("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, discussed in detail later in this booklet, States are now free to regulate MEWAs whether or not the MEWA may also be an ERISA-covered employee welfare benefit plan."); *see also* ERISA Section 514(b)(6)(A)(ii) ("[I]n the case of any other employee welfare benefit plan which is a multiple employer welfare arrangement, in addition to this title, any law of any State which regulates insurance may apply to the extent not inconsistent with the preceding sections of this title").

Section 2 also closely mirrors a bill that passed on a bipartisan basis in Virginia earlier last year.[9] The bill, and the regulations issued by the Commonwealth's State Corporation Commission (the regulatory agency analogous to the CID), would allow the Virginia Chamber of Commerce and its tens of thousands of members to come together and self-fund a health benefit plan. The Virginia Chamber is currently working to set up the plan and comply with rigorous VA regulations regarding capital, surplus and solvency requirements. For example, the regulations issued by the VA SEC require the VA Chamber to (1) establish a minimum net worth of $4 million that will grow proportionally to the increase in size of the plan; (2) post a security deposit with the Treasurer between $50,000 and $500,000; (3) obtain guarantees or standby letters of credit as prescribed;l and (4) show that it has secured terminal excess insurance to cover claims in the event of insolvency because the MEWA would not participate in the state's Guarantee Association. The regulations also require the MEWA to file annual financial statements,[10] additional reports throughout the plan year[11], and be subject to audits by the VA SEC as often as the SEC deems necessary[12].

Many other states, including Georgia, Ohio, Missouri, Maine and Washington also allow heterogenous organizations (i.e. chambers of commerce) to offer Non-Plan self-funded MEWAs with rigorous licensing,

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[9] 2022 VA Session, SB 195 Group health benefit plans; sponsoring associations, formations of benefits consortium, definitions (2022) https://lis.virginia.gov/cgi-bin/legp604.exe?221+sum+SB195.

[10] 14VAC5-415-50(A), Annual statement, additional reports, and examinations (Each self-funded MEWA shall file an annual statement . . . with the Commissioner annually by March 1. The statement shall be verified by at least two principal officers and shall cover the preceding calendar year.").

[11] 14VAC5-415-50(B), Annual statement, additional reports, and examinations ("In addition to the annual statement, the Commission may require a licensed self-funded MEWA to file additional reports . . . exhibits or statements considered necessary to secure complete information concerning the condition, solvency, experience, transactions or affairs of the self-funded MEWA.").

[12] 14VAC5-415-50(C), Annual statement, additional reports, and examinations ("The Commission shall examine the affairs of each self-funded MEWA and its members . . . as often as the Bureau deems necessary. The self-funded MEWA may be required to pay the Commission the expenses incurred by it in making an examination authorized under this section.").

oversight and capital and reserve requirements.[13] All are Third Party Administered by reputable national health insurance carriers.

In Connecticut, this self-funded MEWA can be a real game changer for small employers. With large industry groups like the Nonprofit Alliance and CBIA having hundreds and thousands of employer-members, aggregating their respective employees would allow these associations to implement transformational plan designs that can improve patient outcomes, incentivize healthy lifestyles, and keep healthcare costs down.

Perhaps most importantly, the scale of a self-funded MEWA provides a small employer the power and voice of an Active Purchaser through their Association. This allows the Association and its participating small employers to influence benefits and services focused on better outcomes and lower cost through incorporation of value-based plan designs (VBID), price transparency tools, pharmacy savings, wellness incentives, centers of excellence strategies, and more. These tools exist today yet are infrequently deployed in the small group market as small employers lack the voice and scale to effectively incorporate and leverage them as a large employer can.

The state employee plan utilizes degrees of VBID through their Centers of Excellence and wellness incentives under the Health Enhancement Program. Research by the CDC shows that VBID significantly increases treatment and medication adherence, particularly for chronic disease, leading to improved outcomes without additional costs.[14]

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[13] *See* MEWAs under the Employee Retirement Income Security Act: A Guide to Federal and State Regulation, U.S. Dep't of Labor at page 8 https://www.dol.gov/sites/dolgov/files/ebsa/about-ebsa/our-activities/resource-center/publications/mewa-under-erisa-a-guide-to-federal-and-state-regulation.pdf ("Where no bona fide group or association of employers exists, the benefit program sponsored by the group or association would not itself constitute an ERISA-covered welfare plan; however, the Department would view each of the employer-members that utilizes the group or association benefit program to provide welfare benefits to its employees as having established separate, single-employer welfare benefit plans subject to ERISA. In effect, the arrangement sponsored by the group or association, under such circumstances, be viewed merely as a vehicle for funding the provision of benefits (like an insurance company) to a number of individual ERISA-covered plans."); *see also* (April 2022) Refer to the document attached titled "Other States — Self-Funded MEWA Statutes."

[14] *Issue Brief - Understanding Value-Based Insurance Design*, CDC - Div. Of Community Health (June 2015) https://www.cdc.gov/nccdphp/dch/pdfs/value_based_ins_design.pdf.

Associations with small employers, who are ultimately paying the claims and administrative fees themselves, have an incentive to keep costs low, promote valuable outcomes, and drive efficiencies in the healthcare system; all of which is lacking in the small group fully-insured market today. For patients with chronic disease and high healthcare costs, this is a powerful tool to lower the overall risk to the pool.

Critics claim that self-funded MEWA plans, including its ability to medically underwrite, will leave many who have chronic conditions with higher healthcare costs and without stable access to the plan. ***This is false.*** First, section two requires the self-funded MEWA plans to cover Essential Health Benefits *and* state benefit mandates. Second, these plans will allow higher cost individuals and employers to *benefit* from a plan design that spreads risk across tens of thousands of lives. In today's current market, higher cost small employers cannot be underwritten in the small group level funded market because of their small size relative to their expensive claims. As a result, these small employers are paying for more expensive, less benefit rich programs in the fully-insured market which is increasingly becoming *more* risky. Third, and most importantly, medical underwriting is a key rating factor, among many other factors, that the vast majority of employer-sponsored health plans utilize today. In fact, municipalities utilize medical underwriting when rated as blocks in the private self-funded market, *and* when combined-rated in the Partnership Plan with the State Employee Plan today. In the FY-22 Annual Partnership Plan Report, the Office of the Comptroller noted the benefit of group medical writing to not only high-cost groups, but the pool at-large:

> "Creating premium tiers would allow the Partnership Plan to better attract and retain lower risk groups because they would get a relatively lower premium rate than available today. In addition, it would allow the Partnership Plan to collect more in premiums when the membership, on average, is more costly than the State Plan. This is because a higher percentage of the participating groups would fall into the higher cost premium tier, increasing the premium amount collected and keeping premiums in line with total projected claims costs."[15]

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[15] *Report on the Status of the Connecticut Partnership Plan - FY22*, Office of the State Comptroller (Jan. 2023) https://www.osc.ct.gov/docs/Partnership_Report_F22%20F.

Critics also make the claim that allowing heterogenous associations (like CBIA or the Nonprofit Alliance) runs afoul of standing DOL regulations requiring trade associations to have commonality amongst members to qualify for association health plans. ***This is also false.*** The memorandum attached to this testimony, as well as recent guidance put out by the U.S. DOL's Employee Benefits Security Administration, speaks for itself. For example, the US DOL unequivocally recognizes the ability for heterogeneous trade associations to offer self-funded benefit arrangements. In the DOL's *Guide to Federal and State Regulation,* revised in April 2022, the agency states:

> "Where no bona fide group or association of employers exists, the benefit program sponsored by the group or association would not itself constitute an ERISA-covered welfare plan; however, the Department would view each of the employer-members that utilizes the group or association benefit program to provide welfare benefits to its employees as having established separate, single employer welfare benefit plans subject to ERISA. In effect, the arrangement sponsored by the group or association would, under such circumstances, be viewed merely as a vehicle for funding the provision of benefits (like an insurance company) to a number of individual ERISA-covered plans."[16]

The Trump Rule issued in 2018, which was subsequently overturned by a federal court, did one thing and one thing only: it expanded the definition of "bona fide association" for fully insured plans. The current DOL rule, as evidenced by the DOL's guidance on MEWAs, has no bearing on a "non-bona fide trade association" from establishing a plan to service small employers who would be treated as separate and individual ERISA-covered welfare benefit plans. The only functional difference between a "Plan MEWA" (i.e. a self-funded arrangement offered by a bona fide trade association) and a "Non-Plan MEWA (i.e. a self-funded arrangement offered by a non-bona fide trade association) is *who* is responsible for filing required forms with the EBSA.

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[16] *See MEWAs under the Employee Retirement Income Security Act: A Guide to Federal and State Regulation,* U.S. Dep't of Labor at page 8 https://www.dol.gov/sites/dolgov/files/ebsa/about-ebsa/our-activities/resource-center/publications/mewa-under-erisa-a-guide-to-federal-and-state-regulation.pdf.

ERISA's requirement prohibiting states from adopting any rule that is inconsistent with the provisions of Title I (i.e. fiduciary standards; plans to establish a grievance and appeals process for participants; the right for participants to sue for benefits and breaches of fiduciary duty; and the provision of certain plan information to plan participants) applies to *both* Plan and Non-Plan MEWAs. This is highlighted again by the DOL's recent guidance on MEWAs revised in 2022:

> "Under current law, a MEWA that constitutes an ERISA-covered plan is required to comply with the provisions of Title I of ERISA applicable to employee welfare benefit plans, in addition to any State insurance laws that may be applicable to the MEWA. *If a MEWA is determined not to be an ERISA-covered plan, the persons who operate or manage the MEWA may nonetheless be subject to ERISA's fiduciary responsibility provisions if such persons are responsible for, or exercise control over, the assets of ERISA-covered plans. In both situations, the Department of Labor would have concurrent jurisdiction with the State(s) over the MEWA."*
> (emphasis added)[17]

The third and final argument advanced by critics appears to insinuate that these large self-funded MEWAs are virtually free to impose whatever restrictions or requirements on plan design they desire. Plan and Non-Plan MEWAs are group health plans for purposes of Federal law. Like any other group health plan, they are subject to what is generally referred to as the ACA insurance market reforms or simply "market reforms." These are the rules set out in Title XXVII of the Public Health Service Act (PHS Act) and Title I of the ACA. They are also incorporated by reference into ERISA and the Internal Revenue Code.

These market reforms include the ACA's rating reforms as well as the medical loss ratio, rate review, and risk adjustment programs, in the case of fully insured plans. While these rules don't apply to self-funded plans, other ACA market reforms do. These include, among others, dependent coverage for adult children up to age 26, coverage of preventive health services without cost-sharing (grandfathered plans are exempt), a bar on

[17] *Id*. at page 5.

discrimination based on health status, no rescissions of coverage, except in the case of fraud, intentional misrepresentation of material fact or non-payment of premiums, no lifetime or annual dollar limits on essential health benefits, improved internal claims and appeals process and minimum requirements for external review (grandfathered plans are exempt), no waiting periods exceeding 90 days, no pre-existing condition exclusions for any enrollees, no discrimination against participants who participate in clinical trials (grandfathered plans are exempt), and maximum out-of-pocket expenses for covered essential health benefits cannot exceed specified amounts (grandfathered plans are exempt).

Both Options Will Benefit Small Employers

This bill gives small employers a voice. By clearing the way for trade and industry associations to aggregate their membership and become an active purchaser for health insurance, small employers will finally enjoy the same benefits that only large employers enjoy today. For smaller trade associations, their small employers will finally be able to negotiate and work directly with a health insurance carrier to design a plan that is not only affordable, but meets the direct needs of their employees. For trade and industry associations with significant scale, the allowance to offer a self-funded purchasing arrangement has the potential to move the needle in significantly bringing down healthcare costs while implementing plan features that place *value over volume*. These larger associations will be able to replicate many of the successful models that larger employers are working with today: value based insurance design, wellness incentives, administrative efficiencies, care navigations, centers of excellence, investments in primary care, and more. All of this while being rigorously subject to the Connecticut Insurance Department and federal rules. CBIA respectfully urges you to support HB 6710.

MEMORANDUM

Date: February 6, 2023

To: Jane Callanan, Esq., General Counsel, Connecticut Insurance Department

From: Alden J. Bianchi

Re: Regulation of Self-Funded, Non-Plan MEWAs by the State of Connecticut

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This memorandum is in response to a request made by Kenneth Comeau, President, and Wyatt Bosworth Assistant Counsel, of CBIA Service Corp. (CBIA). They have asked me to provide you with my views on the how the invalidation of a 2018 Department of Labor final regulation[1] (the "2018 AHP final rule") by the Federal District Court of the District of Columbia in *State of New York v. U.S. Department of Labor*[2] might limit the power of the State of Connecticut to adopt legislation enabling self-funded association-style Multiple Employer Welfare Arrangements (MEWAs). The headings set out in bold below, the text of which were provided to me by CBIA, represent variations on this question.

For the reasons explained below, I am of the view that the State of Connecticut has broad powers to enact rules governing self-funded, association-style MEWAs, irrespective of, and unaffected by, the invalidation of the 2018 AHP final rule.

The Regulation of Self-Funded Multiple Employer Welfare Arrangements under Federal and State Law

MEWAs that are sponsored by employer, trade, or industry groups are sometimes referred to colloquially as "association health plans" or AHPs. AHPs exist for the purpose of providing welfare benefits to employees of participating employers. (While MEWAs can provide all manner of welfare benefits, this memorandum concerns itself principally with medical benefits.) The term association health plan has no independent legal significance; all AHPs are MEWAs. This memorandum uses the terms interchangeably.

MEWAs themselves, as well as the group health plans of which they are composed, are subject to varying degrees of regulation under the Employee Retirement Income Security Act of 1974 (ERISA). They are subject to state law as well, also to varying degrees. As originally enacted, ERISA § 514(a) broadly preempted state laws that related to employee benefit plans, including those governing MEWAs.

[1] DOL Reg. § 2510.3-5 (Jun. 21, 2018).
[2] 2019 WL 1410370 (D. D.C. 2019).

From and after the enactment of ERISA, unscrupulous commercial MEWA operators sought, successfully in many instances, to use ERISA's broad preemption provisions as a shield. In response, ERISA was amended in the Multiple Employer Welfare Arrangement Act of 1983[3] to clarify and strengthen states' ability to regulate MEWAs. Under the post-1983 Federal regulatory scheme, there are two types of MEWAs:[4]

- *Plan MEWAs*. Plans that are "employee welfare benefit plans" as that term is defined by ERISA § 3(1); and

- *Non-Plan MEWAs*. Plans that qualify as any other arrangement "established or maintained for the purpose of offering or providing welfare plan benefits to the employees of two or more employers (including one or more self-employed individuals), or to their beneficiaries," subject to certain statutory exceptions for union and cooperative plans.

In either case, where the MEWA is self-funded, states have, because of the 1983 amendments to ERISA, a great deal of regulatory latitude.

ERISA's definition of "employer" is central to the regulation of AHPs. ERISA regulates "employee benefit plans," which include "employee welfare plans" and "employee pension plans." Because the term "employee welfare plan" includes "medical benefits," group health plans are employee welfare plans when they are maintained by an employer. The reference above to ''two or more employers'' means and refers to two or more *unrelated* employers, because ERISA treats trades or businesses under common control as a single employer.

ERISA § 3(1) defines the term, "employee welfare benefit plan" to include:

> [A]ny plan [ ] *established or maintained by an employer* [ ] to the extent that such plan [ ] was established or is maintained for the purpose of providing for its participants or their beneficiaries, through the purchase of insurance or otherwise, (A) medical, surgical, or hospital care or benefits, or benefits in the event of sickness, accident, disability, death [ ]
>
> (Emphasis added).

Thus, while a MEWA may provide group health benefits, it is an employee welfare benefit plan only if it is established or maintained by an employer. Conversely, a MEWA that is established or maintained by an entity that is not an employer is not itself an ERISA-regulated employee welfare benefit plan.

> **Example:** A MEWA established by a state dental society might qualify as a plan MEWA, but a MEWA established by a local Chamber of Commerce would be a non-plan MEWA. The difference is that, while dentists might qualify as a bona fide association of employers that can qualify as an employer for ERISA purposes, members of a Chamber of Commerce cannot.

Historically, the Department of Labor has interpreted the term bona fide association of employers narrowly, requiring that there be a strict commonality of interest (dentistry in my example) and that the arrangement be controlled by an employer (rather than a third-party administrator or a promoter).

[3], Pub. L. No. 97-473 (Jan. 14, 1983).
[4] ERISA § 3(40).

The MEWAs that are the subject of this memorandum are non-plan MEWAs that are self-funded, with respect to which state power is near absolute. That power is described in a seminal Department of Labor Advisory Opinion (Ad. Op. 90-18A) as follows:

> [T]he Department is of the opinion that [ ] in the case of a MEWA which is not fully insured [i.e., a self-funded MEWA], [ERISA] section 514(b)(6)(A) saves from ERISA preemption *any law of any state which regulates insurance to the extent such law is not inconsistent with the provisions of title I of ERISA*. [A] state law which regulates insurance would be inconsistent with the provisions of title I to the extent that compliance with such law would abolish or abridge an affirmative protection or safeguard otherwise available to plan participants and beneficiaries under title I of ERISA or conflict with any provision of title I of ERISA. For example, state insurance law which would require an ERISA-covered MEWA to make imprudent investments would be deemed to be "inconsistent" with the provisions of title I of ERISA because compliance with such a law would "conflict" with the fiduciary responsibility provisions of ERISA section 404, and, as such, would be preempted pursuant to the provisions of ERISA section 514(b)(6)(A)(ii).
>
> (Emphasis added; footnotes omitted).

It is technically possible for a state to pass a law applicable to non-plan MEWAs that is inconsistent with the provisions of Title I of ERISA, since by its terms ERISA does not regulate non-plan MEWAs. But ERISA does separately regulate the individual group health plans maintained by the non-plan MEWA's member employers. Such a law would, therefore, be preempted under ERISA § 514(a) rather than ERISA § 514(b)(6)(A). Either way, a state law that is inconsistent with the provisions of title I of ERISA is not enforceable against a self-funded MEWA.

The Impact of the 2011 "Cohn Memo" on "Pathway 1"[5] MEWAs and the Bona Fide Association Exception on Self-Funded MEWAs.

Both at the Federal and state levels, the regulation of group health insurance is segmented among the individual, small group, and large group markets. In part because of the Affordable Care Act (ACA), large groups enjoy materially greater design and underwriting flexibility when compared to small employers and self-employed individuals. These market segmentation rules were summarized at length in a memorandum dated September 1, 2011, from Gary Cohen, the then CMS Acting Director, Office of Oversight, in which he articulated a broad, general "look through" rule and a narrow exception:

- Under the look-through rule, health insurance coverage provided through a trade or industry, chamber of commerce, or similar organization, is generally regulated under the same standards that apply to each member of the group. This rule disregards the group or association in determining whether coverage obtained by each participating individual or employer is individual, small group, or large group market coverage.

- Under the narrow exception, coverage sponsored by "bona fide" groups or associations is regulated as a single ERISA-covered plan.

[5] The reference to Pathway 1 is to the law in effect prior to the 2018 AHP final rule. Following the invalidation of the 2018 AHP rule, Pathway 1 merely refers to existing law on the subject of bona fide associations.

Importantly, the Federal look through rule and its exceptions apply only to fully insured plans. That this is the case is made explicit in footnote 2 of the Cohen memo, which states in relevant part, "[t]he requirements of Title XXVII of the PHS Act apply to individual and group health insurance coverage provided through MEWAs." Neither the Cohen memo, nor the look through rule, nor its exception, apply to self-funded arrangements. The look through rule is rather an *insurance* rating rule.

Self-funded plans, by definition, are their own rating group. (States could establish their own look-through rule for self-funded MEWAs, but that would be a matter of state, not Federal, law.) For purposes of the subject matter of this memorandum, the 2018 AHP final rule did one thing and one thing only: it expanded the narrow exception for bona fide associations described in the Cohen memorandum to encompass a larger number of associations. It did so by loosening of the criteria for what constituted a bone fide association of employers, such that more associations would not be bound by the look through rule - *all* in the context of fully insured plans. None of this has any impact on the ability of the State of Connecticut to establish a regulatory structure for self-funded AHPs. Because we are dealing here with self-funded MEWAs, the only restraint is that the state law must not be inconsistent with ERISA.

The Relevant Provisions of Federal Law (i.e., ACA, PHS, HIPAA, etc.) that Apply to Non-Plan MEWAs

Non-plan MEWAs are group health plans for purposes of Federal law. Like any other group health plan, they are subject to what is generally referred to as the ACA insurance market reforms or simply "market reforms." These are the rules set out in Title XXVII of the Public Health Service Act (PHS Act) and Title I of the ACA. They are also incorporated by reference into ERISA and the Internal Revenue Code.

These market reforms include the ACA's rating reforms as well as the medical loss ratio, rate review, and risk adjustment programs, in the case of fully insured plans. While these rules don't apply to self-funded plans, other ACA market reforms do. These include, among others, dependent coverage for adult children up to age 26, coverage of preventive health services without cost-sharing (grandfathered plans are exempt), a bar on discrimination based on health status, no rescissions of coverage, except in the case of fraud, intentional misrepresentation of material fact or non-payment of premiums, no lifetime or annual dollar limits on essential health benefits, improved internal claims and appeals process and minimum requirements for external review (grandfathered plans are exempt), no waiting periods exceeding 90 days, no pre-existing condition exclusions for any enrollees, no discrimination against participants who participate in clinical trials (grandfathered plans are exempt), and maximum out-of-pocket expenses for covered essential health benefits cannot exceed specified amounts (grandfathered plans are exempt).

Notably, group health plans that are part of a non-Plan MEWA are regulated at the level of the individual employer. The ACA bar on discrimination based on health status applies at the level of the individual employer member. states are free of course to impose a broad, non-discrimination standard on a self-funded, non-plan MEWA, since such a provision would not be inconsistent with ERISA. This approach was taken by the Department of Labor in the 2018 AHP rule, which barred separate underwriting employer-by-employer in a MEWA covered by the rule.

The State of Connecticut Is Free to Regulate MEWAs Other Than in Conflict with ERISA

Following the 1983 amendments to ERISA on the subject of MEWAs, the rules are clear: The State of Connecticut has broad powers to regulate MEWAs, subject only to the requirement that it not adopt any rule that is inconsistent with (or otherwise preempted by) the provisions of Title I of ERISA. The 2018 AHP rule did not change this standard. As a result, that the rule was subsequently overturned is of no consequence in this context. Similarly, nothing in any prior law, regulation, or other guidance (including the Cohn memo) modifies the rules that apply to self-funded arrangements, whether they be plan MEWAs or non-plan MEWAs.

This leaves only the qualifier that the state may not adopt any rule that is inconsistent with the provisions of Title I of ERISA. These provisions are largely formal. They include rules that, in the case of welfare plans, establish fiduciary standards for those who manage and control plan assets; requires plans to establish a grievance and appeals process for participants to get benefits from their plans; gives participants the right to sue for benefits and breaches of fiduciary duty; and require plans to provide participants with certain plan information. They are rules that pose few substantive burdens, and their only rating provisions are those incorporated into ERISA by the PHS Act.

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Virginia Self-Funded MEWA
Capital & Surplus Requirements

Background

CBIA spoke with Kenn Penn, a former VA Chamber executive and current consultant with Affinity Benefits Consulting LLC for the Chamber MEWA, regarding the recently released MEWA regulations and the Chamber's capital and reserve requirements. The following includes a top level summary of the requirements relayed by the consultant with statutory and regulatory language attached. The requirements include:

- Like all other domestic insurers in the Commonwealth, the MEWA must have a minimum net worth of $4 million (this increases as the MEWA grows)
- The MEWA must post a security deposit with the Treasurer between $50,000 and $500,000 (this is considered part of the $4 million)
- The MEWA must obtain guarantees or standby letters of credit as prescribed
- Because the MEWA does not participate in the state's Guarantee Association, the MEWA must show that it has secured "terminal excess insurance" to cover claims in the event of insolvency

Chapter 415 (Regulations)

- Capital requirement (Page 12):
  - **"The applicant's net worth which shall include minimum net worth in an amount at least equal to $4 million . . ."**
  - "A licensed self-funded MEWA shall have and maintain at all times the minimum net worth described [above] . . . "if the Commission finds that the minimum net worth of a self-funded MEWA is impaired, the Commission shall issue an order requiring the self-funded MEWA to eliminate the impairment within a period not exceeding 90 days"
- Protection against insolvency (Page 15)
  - "Each self-funded MEWA shall deposit and maintain acceptable securities with the State Treasurer in the amounts prescribed by Sec. 38.2-1045 of the Code of Virginia."
    - § 38.2-1045. Deposits required of insurers generally.

A. Except as otherwise provided in this title, before the Commission issues a license to transact the business of insurance in this Commonwealth to any insurer, that insurer shall deposit with the State Treasurer securities that (i) are legal investments under the laws of this Commonwealth for public sinking funds or for other public funds, (ii) are not in default as to principal or interest, **(iii) have a current market value of not less than $50,000 nor more than $500,000,** and (iv) are issued pursuant to a system of book-entry evidencing ownership interests of the securities with transfers of ownership interests effected on the records of a depository and its participants pursuant to rules and procedures established by the depository.

B. The Commission may require a reasonable amount of additional deposits in securities that meet the requirements of clauses (i), (ii) and (iv) of subsection A of this section, whenever the Commission determines that the insurer's financial

condition, method of operation, or manner of doing business is such that the Commission is not satisfied that it can meet its obligations to all policyholders..

§ 59.1-590. Conditions for a benefits consortium.

[...]

5. **The trust shall establish and maintain reserves** determined in accordance with sound actuarial principles and **in compliance with all financial and solvency requirements imposed upon domestic self-funded MEWAs**;

6. The trust shall purchase and maintain policies of specific, aggregate, and **terminal excess insurance** with retention levels determined in accordance with sound actuarial principles from insurers licensed to transact the business of insurance in the Commonwealth;

7. The trust shall secure **one or more guarantees or standby letters of credit** that:

a. Guarantee the payment of claims under the health benefit plan in an aggregate amount not less than the amount of the trust's annual aggregate excess insurance retention level **minus** (i) the annual premium assessments for the health benefit plans and (ii) the trust's net assets, which amount shall be the net of the trust's reasonable estimate of incurred but not reported claims; and

b. Have been issued by a qualified United States financial institution, as such term is used in subdivision 2 c of § 38.2-1316.4;

Other States - Self-Funded MEWA Statutes

(Permits Chamber-Sponsored Non-Plans Self-Funded MEWAs)

States	Licensing, Registration, or Certification Requirements	Eligibility Requirements	Financial Reporting Requirements	Financial/Reserve Requirements
Georgia The provisions of law governing MEWAs do not apply to fully-insured MEWAs. GA. CODE ANN. § 33-50-1. GA. CODE ANN. § 33-50-2 et seq.; GA. COMP. R. & REGS. § 120-2-50-.01 et seq.; GA. CODE ANN. § 33-27-1 (allowing the lives of a group of individuals to be insured under a	To transact business in Georgia, self-insured MEWAs must obtain a license issued by the Commissioner. GA. CODE ANN. § 33-50-2. The licensing requirement does not, however, apply to certain arrangements. For information on the certificate of authority, see GA. CODE ANN. §§ 33-50-3 (application, fees, premium taxes); 33-50-4 (filing of documents); 33-50-8 (examination); 33-50-9 (procedures for dissolution); 33-50-11 (revocation or suspension of license); see also GA. COMP. R. & REGS. §§ 120-2-50-.04 (filing requirements); 120-2-50-.07 (examination); 120-2-50-.12 (fees); 120-2-50-.14 (dissolution).	The Georgia statutes and regulations are both silent on what type of trade associations/chambers/employer groups of commerce can offer a licensed self-insured MEWA. We know that the Georgia Chamber of Commerce currently offers the "Georgia Chamber SMART Plan" which is a self-funded MEWA that is open to any small business employer with at least two employees and domiciled in Georgia. Eligible members must be members of the Georgia Chamber or a participating local chamber. Read more here. The MEWA application can be found here. The latest M-1 form can be found here.	Self-insured MEWAs are subject to reporting requirements. *Financial Statements.* Every self-insured MEWA must file financial statements with the Commissioner in accordance with the rules requiring such financial reports from insurers. GA. CODE ANN. § 33-50-5(f); GA. COMP. R. & REGS. § 120-2-18-.06. Additionally, by March 1 annually, self-insured MEWAs are required to file a signed and certified statement of its condition and affairs as of the preceding December 31. GA. COMP. R. & REGS. § 120-2-50-.13. *Actuarial Opinion.* Every self-insured MEWA must annually obtain an opinion from a qualified actuary as to the adequacy of its loss reserves. GA. CODE ANN. § 33-50-5(d). Annual Audit. Every self-insured MEWA must have an annual audit performed by an independent certified public accountant. GA. CODE ANN. §	*Surplus*. Self-insured MEWAs may not be licensed unless they possess and maintain a minimum surplus of at least $200,000. GA. CODE ANN. § 33-50-5(a); GA. COMP. R. & REGS. § 120-2-50-.10. Loss Reserves. Self-insured MEWAs must establish and maintain loss reserves in an amount deemed appropriate by the Commissioner (if in existence and operating in a sound manner for 3 years prior to July 1, 1991, then may maintain a reserve amount, which combined with surplus, will be 35% of claims paid by such plan in the immediate preceding year). GA. COMP. R. & REGS. § 120-2-50-.11. *Security Deposit.* Self-insured MEWAs must also maintain a $100,000 security deposit with the Commissioner in the form of securities eligible for the investment of capital funds of domestic insurers. GA. CODE ANN. § 33-50-5(c); GA. COMP. R. & REGS. § 120-2-50-.06. *Stop Loss Coverage.* A self-insured MEWA is required to obtain individual and aggregate excess stop loss coverage from an insurer authorized to transact insurance in Georgia. GA. CODE ANN. §

States	Licensing, Registration, or Certification Requirements	Eligibility Requirements	Financial Reporting Requirements	Financial/Reserve Requirements
policy issued to a legal entity providing a MEWA); GA. CODE ANN. § 33-30-1 (authorizing MEWAs to provide group accident and sickness insurance)			33-50-5(e).	33-50-5(g); GA. COMP. R. & REGS. § 120-2-50-.05.
Maine Specific to self-insured MEWAs. ME. REV. STAT. ANN. tit. 24-A, § 6602(2). ME. REV. STAT. ANN. tit. 24-A, § 6601 et seq.	MEWAs may not commence operations unless the arrangement is approved by the Superintendent. ME. REV. STAT. ANN. tit. 24-A, § 6602. For information on the registration, see ME. REV. STAT. ANN. tit. 24-A, §§ 6604 (filing requirements); 6606 (examination); 6608 (forms); 6610 (termination); 6613 (grounds for denial, suspension, or revocation); see also MEWA Application Requirements.	To meet the requirements for approval and to maintain a MEWA, the MEWA must: - Be a nonprofit. - (Generally) be established by a trade association, industry association, etc. that has been organized and maintained in good faith for a continuous period of 1 year for purposes other than that of obtaining or providing insurance. - Be operated pursuant to a trust agreement by a board of trustees that has complete fiscal control over the MEWA	MEWAs are subject to reporting requirements. *Annual Report.* Annually within 4 months of the end of the fiscal year, every MEWA must file a report with the Superintendent. The report must summarize the business activities of the MEWA for the immediately preceding year and must contain: - A financial statement of the MEWA. - An analysis of the adequacy of reserves and contributions or premiums charged based on a review of past and projected claims and expenses.	*Fund Balance.* Each MEWA must maintain a positive fund balance. ME. REV. STAT. ANN. tit. 24-A, § 6605. *Specific Excess Insurance.* Each MEWA must maintain specific excess insurance with a retention level determined in accordance with sound actuarial principles and approved by the Superintendent. ME. REV. STAT. ANN. tit. 24-A, § 6603(3). *Appropriate Loss Reserves.* Each MEWA must establish and maintain appropriate loss and loss expense reserves determined in accordance with sound actuarial principles. ME. REV. STAT. ANN. tit. 24-A, § 6603(4). *Note*. If the Superintendent determines

States	Licensing, Registration, or Certification Requirements	Eligibility Requirements	Financial Reporting Requirements	Financial/Reserve Requirements
		and that is responsible for all operations of the MEWA. - (Generally) not be offered, advertised, or available to employers or other members of the public. - Be operated in accordance with sound actuarial principles. - Comply with the state's requirements governing continuity of health insurance coverage. - Comply with the state's requirements concerning continued coverage in the event of an employee being temporarily laid off or losing employment because of an injury/disease that the employee claims to be compensable under worker's compensation. - Not deny coverage to any otherwise eligible employer, employee, or dependent thereof on the basis of health status or claims	- A letter of qualification from a certifying accountant. ME. REV. STAT. ANN. tit. 24-A, § 6611(1)- (1-A). *Actuarial Report.* At least once every two years, each MEWA must have a report prepared by an actuary as to the actuarial soundness of the MEWA. ME. REV. STAT. ANN. tit. 24-A, § 6611(2).	that a MEWA has failed to establish or maintain the actuarially indicated level of funding as required, the Superintendent may require the MEWA to file a security deposit or surety bond. See ME. REV. STAT. ANN. tit. 24-A, § 6607.

States	Licensing, Registration, or Certification Requirements	Eligibility Requirements	Financial Reporting Requirements	Financial/Reserve Requirements
		experience. - Issue only health care benefit plans that comply with the state's law with regard to rating practices, coverage for late enrollees, and guaranteed renewal. ME. REV. STAT. ANN. tit. 24-A, § 6603(1). Additionally, to meet the requirements for approval and maintain a MEWA, an arrangement based on geographic association must: - Be established by an association with a principal office in a location within a 40-mile radius of the principal place of business of eligible employers. - Permit eligibility for an employer that has employed an average of 100 or fewer full-time employees during the preceding calendar year, for of whom are employed in Maine than in any other state.		

States	Licensing, Registration, or Certification Requirements	Eligibility Requirements	Financial Reporting Requirements	Financial/Reserve Requirements
		- Establish eligibility standards for membership in the association. - Meet the requirements listed above for all MEWAs. ME. REV. STAT. ANN. tit. 24-A, § 6603(1-A).		
Missouri Specific to plans or arrangements that are not fully-insured. MO. STAT. ANN. § 376.1000. MO. STAT. ANN. § 376.1000 et seq.; 20 MO. ADMIN. CODE § 200-14.100 et seq.	It is unlawful for any multiple employer self-insured health plan to transact business in Missouri without a certificate of authority issued by the Director. MO. STAT. ANN. § 376.1002; 20 MO. ADMIN. CODE § 200-14.100. For information on the certificate of authority, see MO. STAT. ANN. §§ 376.1005 (application); 376.1007 (filing requirements); 376.1015 (refusal to approve); 376.1022 (dissolution); see also 20 MO. ADMIN. CODE §§ 200-14.100 (application); 200-14.200 (renewal); 200-14.300 (employers who join the plan after the certificate of authority is granted); 200-14-400	The Missouri statutes and regulations are both silent on what type of trade associations/chambers/employer groups of commerce can offer a licensed self-insured MEWA. We know that the Missouri Chamber of Commerce currently offers the “” which is a self-funded MEWA that is open to any small business employer with at least two employees and domiciled in Missouri. Eligible members must be members of the Missouri Chamber or a participating local chamber. Read more here. The MEWA application can be found here. The latest M-1 form can be	Multiple employer self-insured health plans are subject to reporting requirements. *Annual Report.* Trustees, on behalf of the plan, are required to file an annual report by March 1 showing the condition and affairs of the plan as of the preceding calendar year. More frequent reports may be required at the direction of the Director. MO. STAT. ANN. § 376.1012(4).	*Reserves*. A plan must establish loss reserves for all incurred losses (both reported and unreported) and for unearned premiums. MO. STAT. ANN. § 376.1017(1). Surplus. A plan must establish a surplus account equal to the greater of the following: - For plans which do not yet have one fund year’s experience, three times estimated monthly premium - $600,000. MO. STAT. ANN. § 376.1017(2). *Excess Stop Loss Coverage.* A multiple employer self-insured health plan must maintain aggregate excess stop-loss coverage and individual excess stop-loss coverage provided by a Missouri-licensed insurer on a direct basis. Aggregate excess stop-loss coverage shall include provisions to cover incurred, unpaid claim liability in the event of plan termination. In addition, the plan shall have a

States	Licensing, Registration, or Certification Requirements	Eligibility Requirements	Financial Reporting Requirements	Financial/Reserve Requirements
	(dissolution).	found here.		participating employer's fund in an amount at least equal to the point at which the excess or stop-loss insurer shall assume 100% of additional liability. MO. STAT. ANN. § 376.1010
New Jersey Specific to self-insured MEWAs. N.J. STAT. ANN. § 17B:27C-2; N.J. ADMIN. CODE § 11:4-56.1.	Self-funded MEWAs are required to register annually with the Commissioner and pay a registration fee. N.J. STAT. ANN. § 17B:27C-4; N.J. ADMIN. CODE §§ 11:4-56.3, 11:4-56.4. For information on the certificate of registration, see N.J. STAT. ANN. §§ 17B:27C10 (revocation or suspension); 17B:27C-11 (rehabilitation, liquidation, conservation, or dissolution); see also N.J.ADMIN. CODE § 11:4-56.3 (application for registration).	Insurance Department regulations define "association" as: "a group of 100 or more persons organized and maintained in good faith for purposes other than that of obtaining insurance, in active existence for more than one year, having a constitution and by-laws that provide that: the association holds regular meetings not less than annually to further the purposes of the members, except for credit unions, the association collects dues or solicits contributions from members; and the members have voting privileges and representation on the governing board and committees. *See* N.J. ADMIN. CODE § 11:4-56.2.	Self-funded MEWAs are subject to reporting requirements. *Annual Report.* By May 15 annually (or 4 months and 15 days after the end of the self-funded MEWA's fiscal year), a self-funded MEWA must file: - Financial statements audited by a certified public accountant. - An actuarial opinion rendered by a qualified actuary. - A report of its RiskBased Capital as of the end of the immediately preceding calendar year. N.J. STAT. ANN. § 17B:27C6(a); N.J. ADMIN. CODE § 11:4-56.9(a), (c)-(f). *Quarterly Report.* Within 60 days after the end of each fiscal quarter, a self-funded MEWA must file: - Unaudited financial statements affirmed by	*Deposit Requirement.* A self-funded MEWA must deposit and continuously maintain with a licensed financial institution cash or securities with an admitted asset value of at least $200,000. N.J. STAT. ANN. § 17B:27C-5(a); N.J. ADMIN. CODE §§ 11:4- 56.3(e)(1), 11:4-56.8(e). *Cash Reserve Requirement.* A self-funded MEWA must maintain a cash reserve for loss in an amount established by a qualified actuary as being adequate to provide for all incurred losses, including unpaid claims. N.J. STAT. ANN. § 17B:27C-5(a); N.J. ADMIN. CODE § 11:4-56.8(f). *Stop-Loss Coverage.* A self-funded MEWA must maintain aggregate stop-loss coverage with a retention level of 125% of expected claims per year (including provisions to cover incurred, unpaid claims liability in the event of the termination or liquidation of the self-funded MEWA). A self-funded MEWA must also maintain specific stop-loss coverage with a

States	Licensing, Registration, or Certification Requirements	Eligibility Requirements	Financial Reporting Requirements	Financial/Reserve Requirements
			an appropriate officer or agent of the self-funded MEWA. - A report certifying that the self-funded MEWA maintains cash or liquid assets in a claim reserve account sufficient to meet the requirements under New Jersey law. N.J. STAT. ANN. § 17B:27C-6(b)-(c); N.J. ADMIN. CODE § 11:4-56.9(b), (h). *Proof of Stop-Loss Coverage*. A self-funded MEWA must file proof of the stop-loss coverage within 15 days of the renewal date of the stop-loss agreement. N.J. ADMIN. CODE § 11:4- 56.9(g). *Annual Loss Ratio Report.* A self-funded MEWA that provides benefits to small employers in New Jersey at any time during the preceding calendar year is required to file an annual loss ratio report of its small employer business. N.J. ADMIN. CODE § 11:4-56.6(d).	retention level determined annually by a qualified actuary based on sound actuarial principles. N.J. STAT. ANN. § 17B:27C-5(b); N.J. ADMIN. CODE §§ 11:4- 56.3(e)(3), 11:4-56.8(g). *Examinations*. The Commissioner may conduct an examination of the loss reserves of a self-funded MEWA. N.J. STAT. ANN. § 17B:27C-9; N.J. ADMIN. CODE § 11:4-56.10.
Ohio *Specific to MEWAs*	No person is permitted to establish, operate, or maintain a MEWA providing benefits through a group	The following groups that have been: - Organized and maintained in good	MEWAs operating group self-insurance programs are subject to reporting requirements.	*Minimum Surplus.* A MEWA operating a group self-insurance program must maintain a minimum surplus of not less than $500,000 or such higher amounts

States	Licensing, Registration, or Certification Requirements	Eligibility Requirements	Financial Reporting Requirements	Financial/Reserve Requirements
operating a group self-insurance plan. OHIO REV. CODE ANN. § 1739.02(C). *OHIO REV. CODE ANN. § 1739.01 et seq.*	self-insurance program in Ohio unless the MEWA has a valid certificate of authority from the Superintendent. OHIO REV. CODE ANN. § 1739.02(D). For information on the certificate of authority, *see* OHIO REV. CODE ANN. §§ 1739.03 (application); 1739.04 (issuance or refusal of certificate of authority); 1739.06 (required filings); 1739.07 (termination of membership); 1739.11 (determination of financial capacity).	faith - For a continuous period of 5 years or more - For purposes other than obtaining insurance… May establish, maintain, or operate a group self-insurance program under a MEWA that is chartered and created in Ohio: - A chamber of commerce - A trade association - An industry association - A professional association - A voluntary employee beneficiary association that is exempt from taxation by the IRS under section 501(c)(9) - A business league that is exempt from taxation by the IRS under section 501(c)(6) - Any other association that the superintendent of insurance may define by rule. . OHIO REV. CODE ANN. § 1739.02(A). Additionally, a MEWA that	*Annual Report.* Each MEWA operating a group self-insurance program must make and file (by March 31) an annual report of its affairs and operations during the last preceding calendar year. OHIO REV. CODE ANN. § 1739.09. *Annual Actuarial Certification.* Each MEWA operating a self-insurance program must file annually (by March 31) an actuarial certification. OHIO REV. CODE ANN. § 1739.141.	of surplus as the Superintendent may establish for the protection of members and their employees. OHIO REV. CODE ANN. § 1739.13. *Excess or Stop-Loss Insurance*. As a condition to the issuance and maintenance of a certificate of authority, a MEWA operating a group self-insurance program must purchase individual stop-loss insurance from insurers authorized to transact business in Ohio with a deductible retention of no more than 5% of the MEWA's annual aggregate premium up to $1 million and no more than 2.5% of the MEWA's annual aggregate premium above that amount. The MEWA must also purchase, as a condition to the issuance and maintenance of a certificate of authority, aggregate stop-loss insurance from insurers authorized to transact business in Ohio with a deductible retention of no more than 125% of its projected claims for the succeeding fiscal year. OHIO REV. CODE ANN. § 1739.12.

States	Licensing, Registration, or Certification Requirements	Eligibility Requirements	Financial Reporting Requirements	Financial/Reserve Requirements
		operates a group self-insurance program may be established only if any of the following apply: - The MEWA has and maintains a minimum enrollment of 300 employees of two or more employers - The MEWA has and maintains a minimum enrollment of 300 self-employed individuals - The MEWA has and maintains a minimum enrollment of 300 employees or self-employed individuals in any combination of the above. OHIO REV. CODE ANN. § 1739.05.		
Washington Specific to self-funded MEWAs. WASH. REV. CODE § 48.125.005 et seq.	A certificate of authority must be obtained before a self-funded MEWA is established. WASH. REV. CODE § 48.125.020.7 For information on the certificate of authority, see WASH. REV. CODE §§ 48.125.020-48.125.050,	The commissioner may not issue a certificate of authority to a self-funded multiple employer welfare arrangement unless the arrangement establishes to the satisfaction of the commissioner that the following requirements have been satisfied by the	*Annual Report.* Every self-funded MEWA must file a true statement of its financial condition, transactions, and affairs with the Commissioner. Additionally, every self-funded MEWA must file a copy of their Form 5500 together with all	*Surplus*. A self-funded MEWA must maintain a surplus equal to at least 10% of the next 12 months projected incurred claims or $2 million, whichever is greater. WASH. REV. CODE § 48.125.060.

States	Licensing, Registration, or Certification Requirements	Eligibility Requirements	Financial Reporting Requirements	Financial/Reserve Requirements
	48.125.080, 48.125.110.	arrangement: (1) The employers participating in the arrangement are members of a bona fide association; (2) The employers participating in the arrangement exercise control over the arrangement . . . WASH. REV. CODE § 48.125.030 “Bona fide association” defined as: an association of employers that has been in existence for a period of not less than ten years prior to sponsoring a self-funded multiple employer welfare arrangement, during which time the association has engaged in substantial activities relating to the common interests of member employers, and that continues to engage in substantial activities in addition to sponsoring an arrangement. However, an association that was formed and began sponsoring an arrangement prior to October 1, 1995, is not subject to the requirement that the association be in existence for ten years prior to sponsoring an arrangement. WASH. REV. CODE § 48.125.010	attachments. WASH. REV. CODE § 48.125.090.	