



# issue brief

## Group Purchasing Arrangements: Issues for States

by Mila Kofman

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In the wake of escalating health care costs, state and federal policymakers are increasingly interested in creating low-cost health insurance options to help small businesses buy coverage for their employees. One approach is group purchasing, an arrangement in which a group of small businesses and sometimes self-employed individuals combine resources to provide health benefits for their workers and themselves.<sup>1,2</sup>

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Group purchasing arrangements (GPAs) seek to achieve cost savings by combining their purchasing power to negotiate rates lower than each could otherwise get from an insurance company or HMO. Self-insured GPAs seek to reduce costs by operating more inexpensively than traditional insurers (by eliminating insurance costs such as taxes on their premiums, for example).

Policymakers in several states have introduced legislation to establish GPAs for small businesses. Earlier this year, H.R. 660 was introduced in the U.S. House of Representatives and S. 545 was introduced in the Senate. These bills seek to establish federally regulated association health plans (AHPs; these are one type of GPA). President George W. Bush has actively promoted similar proposals.<sup>3</sup>

Decisions about which state insurance laws should apply to GPAs and who should sponsor and manage them will have important consequences for consumers—both those covered through GPAs and those insured outside of such arrangements. In addressing these issues, policymakers will need to balance two potentially competing goals: to protect consumers and encourage the growth of GPAs, thus helping small employers offer insurance. This brief will highlight federal laws that affect states' authority to regulate GPAs.

### Types of GPAs

There are several types of GPAs, including employer alliances or health insurance purchasing coalitions (HIPCs), association health plans (AHPs), and multiple employer welfare arrangements (MEWAs). The differences in their goals and functions may mean that some GPAs provide a better opportunity than others for coverage expansion.

GPAs may differ from one another in their structure and operation, as illustrated in Table 1. They can be privately managed or run by a state agency, for example. Some GPAs can be established only through state legislation, while others are formed by associations of employers and individuals without legislative action. GPAs may elect to offer health coverage to small businesses, large employers, self-employed individuals, or any combination of these.<sup>4</sup> They may be fully insured (purchase health insurance from insurers) or self-insured (pay medical claims directly);<sup>5</sup> or for-profit or not-for-profit.<sup>6</sup>

Any GPA can perform a variety of functions, including negotiating rates and benefits with insurers, marketing their products, enrolling new members, performing billing functions and paying premiums, and assisting with claims disputes. Some GPAs do not negotiate rates or benefits, but rather endorse coverage offered by an insurer in exchange for a fee.<sup>7</sup>



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In a functional sense, self-insured GPAs operate like insurers. They set rates and design benefit options, perform underwriting, market products, enroll new employees and dependents, collect premiums, and process claims. In addition, self-insured groups must remain solvent by collecting adequate premiums and maintaining sufficient reserves to cover a revenue shortfall, a miscalculation, or an unexpected increase in the cost of benefits (e.g., for prescription drugs).

### Sponsorship of GPAs

Most GPAs are private entities that operate independently from insurance companies. In some cases, however, GPAs are affiliated with, controlled, or owned by the insurance companies from which the arrangement purchases health insurance. This could create a potential conflict of interest because the association is the purchaser and decision-maker on behalf of association members. This conflict of interest could be avoided by prohibiting insurers from owning or affiliating with a GPA, by requiring a diverse board of directors, or by creating a quasi-governmental GPA.

Policyholders can take several steps to promote independence among GPAs. They could prohibit them from being affiliated with insurers, for example, or establish conflict-of-interest rules that require decisions to be made in the best interest of their members. In addition, requiring that a GPA's board of directors or trustees be comprised of a broad range of stakeholders can also help to ensure that the interest of enrolled members and workers are considered in board decisions. For example, a board may include participating employers and their employees, consumers, providers, and others with relevant expertise.

Another strategy is to establish quasi-governmental purchasing pools, in which a state agency is responsible for managing a public-private arrangement. The state agency makes decisions about covered benefits, exclusions, limitations, and co-pays and coinsurance. It also negotiates premiums with insurers, handles marketing, and performs enrollment functions.

Examples of such public-private partnerships include the Healthcare Group of Arizona (HCGA), which included 3,859 employers and covered 11,985 people in 2002, and the New Mexico Health Insurance Alliance (NMHIA), a group of 1,036 employers providing benefits to more than 5,200 people.<sup>8</sup> Both programs are primarily financed through premiums and assessments on insurers. Neither was established to address conflicts of interest, but state policymakers in Arizona and New Mexico have sought to prevent such conflicts by empowering a state agency to make key decisions affecting premiums and coverage.

Public-private partnerships have other advantages as well. By limiting an insurer's financial exposure in cases of enrollees with serious medical conditions, these arrangements encourage voluntary participation by insurers<sup>9</sup> more successfully than do purely private arrangements. For example, Arizona's program purchases a catastrophic reinsurance policy using state funding for claims exceeding \$100,000 and self-insures claims between \$20,000 and \$100,000. Insurers are only responsible for claims up to \$20,000.

Public-private partnerships also do not experience problems like insolvency and fraud, which sometimes plague private arrangements. For state policymakers, a potential drawback to public-private partnerships is that such arrangements may experience losses and thus run the risk that state funding may be necessary (e.g., assessments on insurers) in addition to premiums.

### Setting Standards for GPAs

State policymakers must decide which state insurance laws will apply to coverage offered through GPAs. These decisions will affect consumers, GPAs, and insurers selling traditional health insurance policies. There are some limitations on state actions by federal law.

#### Exemptions from State Law

States can exempt any type of GPA from any or all insurance market regulations. Some argue that subjecting GPAs to state regulations, such as restrictions on premiums and benefit mandates, makes health insurance

more expensive and therefore inhibits the growth of GPAs.

Indeed, a major advantage of exempting GPAs from state insurance laws is that doing so encourages these arrangements to form and grow.<sup>10</sup> For example, in Kentucky the number of people covered by AHPs nearly doubled within 90 days after the state enacted an exemption from its insurance reforms.<sup>11,12</sup>

Exempting GPAs from state laws can, however, have the undesired consequence of weakening consumer protections.<sup>13</sup> For example, one multi-state association sold coverage to Florida residents. Many of Florida's insurance laws do not apply to coverage sold through such arrangements, and the insurance department's authority to help consumers is limited. The insurer raised premiums up to 300 percent, targeting patients who had claims or a diagnosis of an illness—a practice that Florida law prohibits for traditional health insurance policies.<sup>14</sup> In response, Florida's legislature is reassessing exemptions from Florida's laws for multi-state associations.

Exempting GPAs from rating rules can also affect the price of coverage in the rest of the insured market. If GPAs can manipulate premiums to attract healthy people and deter the sick, the cost of coverage in traditional insurance markets will be higher.<sup>15</sup> The Congressional Budget Office, in evaluating a proposal to establish federally regulated AHPs, found that, through price manipulation, AHPs' ability to attract healthy people could lead to nationwide premium increases for 20 million people with traditional health insurance coverage.<sup>16</sup>

Market dynamics can be influenced even when exemptions are narrow, such as waiving benefit mandates. Small-business owners may be less likely to purchase a policy without certain benefits (e.g., prescription drug coverage) when they have employees who require those benefits. In the absence of benefit requirements, GPAs can design packages that discourage businesses with employees who have medical conditions from enrolling—which may lead to coverage in the traditional market becoming more expensive.

Table 1. Types of GPAs

Group Purchasing Arrangements	Health Insurance Purchasing Coalitions (HIPCs)/Employer Alliances	Association Health Plans (AHPs)	Multiple Employer Welfare Arrangements (MEWAs)
<b>Primary Purpose</b>	To buy or provide health insurance to small businesses and/or self-employed people.	To meet various business goals; these health plans are offered by professional and trade associations as one of many benefits to their members.	To provide health coverage to employees of two or more employers or self-employed individuals, according to federal law.  HIPCs, alliances, AHPs, and any other group purchasing arrangement may also be considered MEWAs for purposes of federal law.
<b>Eligibility Requirements</b>	Generally any employer may enroll as long as the employer meets size qualifications (i.e., employs 2–50 employees).	One must be a member of the association. Associations may restrict membership to a particular trade or industry, or may permit any employer or individual to join.	Varies depending on whether the arrangement is a HIPC, an AHP, or another type of GPA.
<b>State Legislation Needed</b>	Generally, authorizing statute is needed (especially in states prohibiting insurers from selling coverage to groups formed for the sole purpose of buying health insurance).  A HIPC that is considered a MEWA under federal law would also be subject to ERISA.	Generally, specific legislation is not required.  An AHP that is considered a MEWA under federal law would also be subject to ERISA.	Generally authorizing statute is not needed because MEWAs are defined by the federal Employee Retirement Income Security Act (ERISA) of 1974. States may also enact MEWA-specific standards (e.g., solvency requirements for self-funded MEWAs).
<b>Private/Public Arrangements</b>	These could be private arrangements or quasi-governmental pools managed by a state agency.	Private	Public or private
<b>Examples</b>	Healthcare Group of Arizona	California Society of Certified Public Accountants Group Insurance Trust	Healthcare Group of Arizona and the California Society of Certified Public Accountants Group Insurance Trust are considered MEWAs.

In addition, exemptions for GPAs create incentives for insurance companies to offer coverage only through such arrangements. Otherwise, they are at a competitive disadvantage. Selling traditional policies means complying with more regulations than does selling policies through GPAs. This means that consumers who want traditional insurance may have fewer options when insurers sell coverage only through GPAs.<sup>17</sup>

#### Federal Law

In some cases, exempting GPAs from state law may implicate federal enforcement of the 1996 Health Insurance Portability and Accountability Act (HIPAA), which is now

enforced by state insurance departments. HIPAA requires insurers to offer coverage to small businesses (2 to 50 employees), regardless of whether the insurance is purchased through a GPA or directly from carriers.<sup>18</sup> In addition, federal rules require insurers to accept everyone in an employer group regardless of medical history or existing health conditions and prohibit carriers from charging higher rates to employees with medical conditions. HIPAA portability rules also limit the use of preexisting condition exclusion periods. Finally, HIPAA-eligible individuals may also have guaranteed access rights in some circumstances.<sup>19</sup>

States have enacted their own laws to implement HIPAA. If a state exempts GPAs from state HIPAA requirements, then the Centers for Medicare and Medicaid Services (CMS) may elect to enforce federal HIPAA standards against insurers, and the state may lose its right to regulate insurers with respect to HIPAA requirements. HIPAA can also preempt such state-based exemptions if state law is less protective of consumers than HIPAA. Generally, however, federal law does not limit states that choose to exempt GPAs from laws not related to HIPAA, including premium rules and benefit requirements.

## Insolvency of Self-insured GPAs

Effective state oversight of GPAs is particularly important in light of a recent surge of problems with insolvency (See Table 2). Solvency and reserve requirements are less stringent for GPAs than for insurers in some states. State guaranty associations, which pay a significant portion of outstanding medical bills when an insurance company becomes insolvent, generally do not cover consumers in GPAs.

Thus, when a GPA becomes insolvent, consumers are responsible for unpaid medical bills. Consumers are further disadvantaged because, in some cases, federal bankruptcy courts rather than state receivers liquidate insolvent arrangements. State receivers generally provide more protection to covered individuals. Bankruptcy courts typically allow assets to be used to pay certain creditors before they are used to pay outstanding medical claims.

Although some GPAs have been self-insured for decades and remained solvent,<sup>20</sup> many others became bankrupt in the last 25 years, leaving thousands of people with millions of dollars in unpaid medical bills.

Unanticipated double-digit increases in health care costs and inadequate reserves may have contributed to recent insolvencies. In the last few years, several well-established self-insured groups became insolvent.

Insolvency presents a big challenge to policymakers. Establishing strong solvency and reserve requirements may mitigate the risk of future insolvencies. It has been argued, however, that such requirements may add to plan costs. This must be balanced against allowing self-insured GPAs to be under-capitalized, which has more serious conse-

quences than allowing insurance companies to be under-capitalized. Requiring that GPAs meet the same standards that are applicable to other insurers would help protect consumers. Ensuring that consumers have a strong safety net similar to guaranty associations will also help better protect those who rely on self-insured GPAs for their coverage. Hands-on oversight by state regulators can also help prevent insolvency through early detection of financial problems and required remedial actions.

### Federal Law

Both state insurance departments and the U.S. Department of Labor (DOL) pursuant to the Employee Retirement Income and Security Act (ERISA) of 1974 regulate GPAs (called MEWAs under ERISA).<sup>21</sup> ERISA does not establish federal solvency standards for self-insured arrangements and the U.S. Department of Labor does not have authority to establish such standards. Therefore, consumers look to states for solvency protection in self-insured GPAs.

States may regulate GPAs like insurers with few limitations by ERISA. However, this was not always the case. When Congress federalized regulation of employee benefits by enacting ERISA, it severely restricted states' authority to regulate GPAs. Unfortunately, broad preemption of state law had the unintended consequences of leading to widespread insolvencies and fraud. To address those problems, Congress amended ERISA in 1982 (effective in 1983) to limit its preemptive effect on state law in this area. As a result, both states and the federal government are now permitted to regulate MEWAs.<sup>22</sup>

The 1983 amendments have been interpreted to allow states to regulate self-insured MEWAs as licensed insurers as long as state laws are not inconsistent with ERISA. Some states have enacted MEWA laws, which, as evidenced by recent insolvencies, can sometimes be inadequate in protecting consumers against insolvency.

### Pending Federal Legislation

Since the early 1990s and, more recently, in the 108th Congress (H.R. 660 and S. 545), federal policymakers have sponsored bills to establish federal solvency standards for AHPs in an effort to federalize regulation of such arrangements. If enacted, states would lose their ability to apply state consumer protections to federally licensed AHPs. Consumer groups and other stakeholders have criticized these proposals for not adequately addressing the problem of insolvency and potentially making the problem worse by eliminating state authority and state-based consumer protections.<sup>23</sup>

### Fraud

Although many GPAs have played an important role in helping employers finance health benefits for their employees, such arrangements have also presented an opportunity for unscrupulous individuals to defraud employers and their workers by marketing non-existent health insurance through well-established associations or by establishing phony ones. In 2002, consumers in all 50 states and the District of Columbia were affected by health insurance scams.

Recently, the number and magnitude of AHP scams have increased to unprecedented levels. In 2001 and 2002, states and the federal gov-

**Table 2: Recent Examples of Self-insured GPA Insolvency**<sup>24</sup>

	Number of People Covered	Outstanding Medical Claims	Assets
Sunkist Growers, Inc.	23,000	\$11 million	less than \$1 million
New Jersey's Coalition of Automotive Retailers (established 1978)	20,000	\$16 million	less than \$2 million
Indiana Construction Industry Trust (established in 1960s)	22,000 individuals (790 employers & 14 association groups)	\$20 million	less than \$1 million

ernment shut down two nationwide entities that left more than 60,000 workers and their families without health insurance and an estimated \$40 million to \$65 million in unpaid medical bills. In January 2002, DOL reported having 76 civil and 14 criminal nationwide investigations.<sup>25</sup> Between 1988 and 1991, the last time there was a large number of scams, nearly 400,000 patients were left with medical bills exceeding \$123 million.<sup>26</sup>

New legislation to establish GPAs should include criminal penalties for promoters falsely claiming to be licensed or authorized as GPAs. Also, enforcement efforts can be strengthened with allocation of additional resources. This will help protect consumers against fraud.

### Conclusion

As states consider low-cost options to expand or maintain coverage in challenging economic times, pooled purchasing is attractive. Policymakers must balance their goal to expand coverage through GPAs with the need to protect consumers who rely on such arrangements as well as those who will remain covered by traditional policies. They must also ensure adequate protection against insolvency and scams. To do this, they will have to address issues such as how to establish and promote GPAs, who should sponsor such arrangements, and which state laws should apply to them. 🏠

### About the Author

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### Endnotes

1 For an extensive policy discussion, see Long, S. and S. Marquis, "Have Small-Group Health Insurance Purchasing Alliances Increased Coverage?" *Health Affairs*, Vol. 154, January/February 2001; Yegian J. et al., "The Health Insurance Plan of California: The First Five Years," *Health Affairs*, Vol. 158, September/October 2000; U.S. General Accounting Office, *Private Health Insurance: Cooperatives Offer Small Employers Plan Choice and Market Prices*, GAO/HEHS-00-49, March 2000; Curtis, E. et al., "Consumer-Choice Purchasing Pools: Past Tense, Future Perfect?" *Health Affairs*, Vol., 164, January/February 2001.

2 In addition to cost savings, GPAs may seek to provide coverage to a population that is not served well by insurers. For example, in California several GPAs serve agricultural workers, who otherwise would not be able to obtain health insurance.

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

4 The Connecticut Business and Industry Association's Health Connections is open only to small businesses, whereas the health plan offered by the Council of Smaller Enterprises, a division of Cleveland's Chamber of Commerce, is open to sole proprietors, small businesses, and mid-size businesses.

5 Self-insured arrangements deposit premiums into a trust fund, from which medical claims are paid instead of buying health insurance from insurers. Such arrangements also purchase stop-loss insurance, which pays medical claims after the GPA has paid a specified amount annually or per covered person.

6 See Institute for Health Policy Solutions, Chart: A Comparison of Consumer Choice Health Purchasing Groups, 1998 (on file with author).

7 Members may not have to pass medical underwriting as with traditional individual health insurance.

8 Georgetown University Institute for Health Care Research and Policy Database on State Coverage Initiatives (2002).

9 Colorado's Alliance, an employer purchasing coalition, recently ceased operations partly due to a lack of participation by insurers.

10 Insurers must comply with a broad range of state laws designed to protect consumers and in some cases stabilize the private market. States enacted major small group market reforms in the 1990s designed to improve access to coverage for small businesses by prohibiting or minimizing "cherry picking" (only selling coverage to healthy people) by insurers and to make coverage more secure.

11 Kentucky Department of Insurance, *Market Report on Health Insurance 1997*.

12 Even in Georgia, providing a narrow exemption for such coverage, it is estimated that there are over 1.5 million people covered by GPAs, while 300,000 are covered through the small group market, and 150,000 are covered by individual health insurance. Letter from Mila Kofman to National Association of Insurance Commissioners (NAIC), December 5, 2002 (summarizing preliminary results of a survey of state insurance regulators). Although there is no direct evidence showing a causal relationship between the exemption from state insurance standards and the number of people covered by association health plans, some believe that even narrowly tailored exemptions have contributed to more people being covered through associations.

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

14 See *Addison v. American Medical Security*, CL 00-01445AB (Fla. Cir. Ct. 5th circuit April 2002); Plaintiff's Eighth Amended Petition, Request for Class Certification and Jury Demand *Wendland v. Insurance of America Agency*, Nation Business Association, GN-00-3014 (Tx. D. Travis County March 6, 2002).

15 The insurance market works by using premiums from healthy individuals to subsidize individuals with serious medical conditions. If disproportionate numbers of healthy individuals leave the traditional insurance market, coverage becomes more expensive. GPAs that are exempt from rate reforms can impose a surcharge for providing coverage to people with medical conditions, thus encouraging them to obtain coverage in the traditional market. Moreover, by covering fewer such individuals, GPAs can charge lower prices, which may attract healthy individuals from the traditional insurance market. As a result, prices for traditional insurance could rise.

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

17 See NAIC Letter reference in endnote 12.

18 HIPAA provides an exemption to guaranteed issue requirements when an insurer sells coverage to a bona fide association. For a definition of a bona fide association, see Public Health Service Act title 27 § 2791(d)(3).

19 See Public Law 104-191 Title I amending ERISA, PHSA, and Internal Revenue Code.

20 For example, the United Agriculture Employee Welfare Benefit Plan and Trust (UAWBT) has been self-insuring health coverage for 20 years. UAWBT is a state-licensed MEWA covering nearly 500 employers with over 44,000 employees and dependents as of September 2001. California Department of Insurance, Report on Multiple Employer Welfare Arrangements (2001).

21 ERISA broadly defines MEWAs to include all types of arrangements offering health coverage to two or more employers or self-employed individuals. However, collectively bargained arrangements, rural electric cooperatives, and rural telephone cooperatives associations are not considered MEWAs and are therefore exempt from state laws. ERISA § 3(40).

22 See ERISA § 514(a); U.S. Department of Labor, Pension and Welfare Benefits Administration, AO 90-18A (1990) (letter to J. Scott Kyle, Texas State Board of Insurance).

23 For a detailed discussion, see Kofman, M. "Health Insurance Scams Promoted Through Associations: A Primer," *The Insurance Receiver*, Vol. 11, No. 3, September 2002.

24 "Sunkist Health Plan Sours," *Fresno Bee*, February 26, 2002, p. C1; "Car Dealers' Health Insurance Trust Goes Under," *Star Ledger*, February 24, 2002, p.5; E-mail from Sally McCarty, Insurance Commissioner, Indiana Insurance Department, to Mila Kofman (September 18, 2002).

25 Kofman, M. "Health Insurance Scams Promoted Through Associations: A Primer," *The Insurance Receiver*, Vol. 11, No. 3, pp. 10-12, September 2002.

26 U.S. General Accounting Office, *Employee Benefits: States Need Labor's Help Regulating Multiple Employer Welfare Arrangements*, GAO/HRD-92-40, at 2-3 (March 10, 1992).

## Sources of Interest

**Consumer-Choice Purchasing Pools:  
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**Report on Multiple Employer  
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**Barriers to Small-Group Purchasing  
Cooperatives: Purchasing Health  
Coverage for Small Employers**  
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[www.nashp.org/Files/GNL30\\_ERISA\\_Preemption\\_manual.pdf](http://www.nashp.org/Files/GNL30_ERISA_Preemption_manual.pdf)

**Revisiting Pay or Play: How States Could  
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**Increasing Small-Firm Health Insurance  
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Plans and Healthmarts**  
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**Healthcare Group of Arizona slides**  
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Institute for Health Care Research and Policy**  
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