McDermott Will & Emery

SPECIAL REPORT

EXAMINING GROUP HEALTH COVERAGE ALTERNATIVES FOR SMALL EMPLOYERS

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SPECIAL REPORT

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INTRODUCTION

Small employers seeking to offer robust major medical coverage to employees and their dependents face daunting price and transparency hurdles. Employers with 50 or fewer full-time employees, so-called "small groups,"[1] have historically been relegated to state small-group markets, which are underwritten based on a carrier's collective claims experience in the state. Employers with more than 50 employees but fewer than, say, 100 to 150 employees face similar challenges. Large groups are underwritten as one group, usually on a consolidated basis, with all employees charged an equal amount. While this typically represents an improvement when contrasted with small-group, community rating, this commercial, fully insured approach generally lacks transparency.

Over the past two decades, the small-group market has experienced a steady decline, owing principally to a combination of rapidly rising costs and a near, if not total, lack of transparency. In 2002, approximately 47% of small employers offered health insurance, compared to 30% in 2023.[2] Large group underwriting for "smaller" large groups tends to be opaque, leaving employers with little leverage upon renewal. Both groups have increasingly sought out alternatives.

For small employers,[3] there are three commonly encountered approaches that have gained traction in the marketplace. These include pooling of groups under association-style arrangements; individual self-funded plans, which may be captive, level-funded, or reference-based priced; and individual coverage health reimbursement arrangements (ICHRAs). These approaches combine to present small employers with the following options:

- The separate purchase of commercial group health insurance from a licensed insurer/carrier, which means group market coverage.

[1] The Public Health Service Act establishes separate underwriting rules for "small groups," which in most states refers to businesses with 50 or fewer full-time equivalent employees; but in four states, small-group plans are sold to businesses with up to 100 employees, although this will drop to three states when Colorado changes its definition of small groups starting in 2026.
[2] M. Meiselbach, J. Abraham, Understanding The Long-Term Decline Of The Small-Group Health Insurance Market, Health Affairs (Jan. 17, 2025). Available at: https://www.healthaffairs.org/content/forefront/understanding-long-term-decline-small-group-health-insurance-market.
[3] We use the term "small employer" to include small groups and employers that, although technically large groups, for insurance underwriting purposes are of a size that prevents them from obtaining the transparency ordinarily available in the large-group insurance underwriting process.

- The purchase of fully insured group health coverage that is underwritten as a single, large group under an arrangement that may or may not be offered by or purchased through a professional employer organization (PEO).
- A group captive medical stop-loss structure in which the stop-loss coverage is separated into tranches, with a portion of the risk being laid off to captive cells owned or "rented" (under a so-called "fronting arrangement") by each separate small employer.
- Separate "level-funded" plans, under which the employer establishes and maintains its own individual, self-funded group health plan.
- Establishment of an ICHRA, which provides access to individual market insurance coverage.
- In certain limited instances (*e.g.*, physician practice management groups), so-called "mirror plans" that pool risk at the stop-loss level in a manner similar to group captive medical stop-loss but dispense with the captive layer.
- Separate, self-funded plans that pay benefits based on a reference price (e.g., a multiple of the Medicare fee schedule)
- Minimum essential coverage (MEC), MEC+, and fixed-indemnity plans

The first bullet above is simply the baseline against which the remaining options are compared.

As reflected in the second bullet, pooling allows small employers to band to together to gain access to the sorts of economies of scale that are routinely available to large employers. An obvious approach to the problem has been around for decades, and it is deceptively simple: allow a number of small groups to combine into a single, large group for underwriting purposes. In practice, however, the approach poses daunting challenges that have long perplexed Congress and state policymakers and regulators alike. For federal regulatory purposes, group health plans that cover employers of two or more unrelated employers are referred to as multiple employer welfare arrangements (MEWAs). More colloquially, they are also variously referred to as multiple employer plans

(MEPs) or association health plans (AHPs).[4] In an ideal world, AHPs could be self-funded, which under current law (for reasons explained at length below) is either not possible or structurally and administratively difficult, depending on the state(s) in which the arrangement proposes to operate. Fully insured AHPs are easier to establish and maintain.

In contrast to the pooling approach, group medical stop-loss captives and level-funding each involve the establishment of individual, self-funded group health plans. Group medical stop-loss captives have been around for some time, and their regulatory status is, if not well settled, at least generally agreed on. These arrangements are generally inappropriate for groups with fewer than 50 to 100 covered lives. Level-funding, in contrast, is a relative newcomer. While level-funded plans are, in some respects, indistinguishable from other self-funded plans, the particulars of their regulation are less settled. Level-funding products are both appropriate for, and routinely marketed to, small groups. The "relative newcomer" category also includes reference-based pricing (RBP) arrangements, which differ from typical self-funded arrangements in one import respect relating to reimbursements.

ICHRAs merely offer access to individual market coverage under what has been described as a "defined contribution" approach. While the idea is attractive to many employers, the concept has not gained as much traction as anticipated. At bottom, the problem is cost, particularly in large, urban environments. Also, because ICHRAs rely on individual market coverage, the rates charged to employees and dependents vary based on age and smoker status. A younger person pays less, sometimes significantly less, than someone older.

This *Special Report* examines the options available to small employers – and the obstacles they routinely encounter – as they seek to make affordable health insurance coverage available to their employees and their families.

[4] There are some technical differences among these terms. An AHP is usually understood as a MEWA that covers employers that have some common bond, the nature of which has some important regulatory consequences.

STATUTORY AND REGULATORY BACKGROUND

REGULATION OF GROUP HEALTH INSURANCE

Historically, health insurance was regulated at the state, rather than the federal, level. The McCarran-Ferguson Act, which was passed in 1945, expressly recognized the role of the states in the regulation of insurance, although Congress reserved the right to enact federal statutes that relate to "the business of insurance." Consistent with this right, Congress has passed legislation that regulates insurance in particular instances. As a result, the rules governing the establishment and maintenance of group health coverage require compliance with both federal and state laws.

Federal law regulates private health insurance principally under three separate laws: the Internal Revenue Code (Code), the Employee Retirement Income Security Act (ERISA), and the Public Health Service Act (PHS Act).

1. Internal Revenue Code

The generous tax treatment of group health plan coverage is generally well understood, although its ubiquity sometimes masks the complexity of these otherwise familiar rules. The common understanding is that premiums and benefits in the group health plan setting are "tax free" (*i.e.*, the employer gets a deduction for premiums, or premium equivalents in the case of self-insured plans); neither employee nor employer premiums are taxed to the employee; and amounts paid or reimbursed for healthcare are excluded from income. For the purposes of this report, this common understanding is perfectly serviceable.

2. ERISA

ERISA regulates employee benefit plans maintained by private-sector employers. The term "employee benefit plan" includes pension plans and welfare plans, and the term "welfare plan" includes employment-based group health plans. ERISA's principal purpose is to protect employees and their beneficiaries. Notably, ERISA does not require employers to offer plans; it merely sets the standards for employers that choose to do so. These include fiduciary standards, as well as information disclosure and reporting requirements. There are also protections relating to the application and handling of the "plan assets." Unlike the Code and the PHS Act (discussed next), ERISA authorizes plan participants and other individuals to bring various civil actions against group health plans and health insurance issuers.

Where welfare benefits are concerned, ERISA imposes reporting and disclosure requirements that include a requirement to memorialize the terms in a written plan document, the material terms of which must be communicated in a summary plan description (SPD) in language that employees can understand. Plans that provide medical benefits must also provide a summary of benefits and coverage (SBC), which is a high-level summary of the medical coverage available under the plan. Rounding out the core ERISA protections are the ERISA fiduciary standards.

ERISA's basic reporting requirement is the Form 5500 annual report, which must be filed by welfare and pension plans alike. The administrators of MEWAs that provide medical benefits must also file Form M-1 with the US Department of Labor (DOL) within 30 days of the date on which the MEWA is established and annually by March 1 of each year. If an administrator is not designated, the plan sponsor is the administrator for this purpose. This filing requirement applies regardless of plan size or type of MEWA funding (*i.e.*, fully insured, or self-funded). Plans that fail to file may be subject to penalties of up to $$1,992 per day for 2025. Unlike Form 5500, for which the DOL maintains a

formal late filing program, there is no equivalent program for late filers of Form M-1. Nevertheless, the DOL appears willing to accept late-filed M-1s.

Certain MEWAs are exempt from the Form M-1 filing requirement, including:

- MEWAs that provide coverage that consists solely of excepted benefits such as limited scope dental or vision benefits.
- MEWAs that provide coverage to employees of two or more trades or businesses that share a common ownership interest of at least 25% at any time during the plan year.
- MEWAs that provide coverage to employees of two or more employers due to a change in control of the businesses (*e.g.*, merger or acquisition) that occurs for a reason other than avoiding the Form M-1 filing and is temporary in nature.
- MEWAs that provide coverage to persons, excluding spouses and dependents, who are not employees or former employees of the plan sponsor, such as nonemployee members of the board of directors or independent contractors, and the number of these individuals does not exceed 1% of the total number of employees or former employees covered under the arrangement.

The exception for MEWAs that provide coverage to employees of two or more trades or businesses that share a common ownership interest of at least 25%, which is discussed below, is both relevant and sometimes misunderstood.

3. PHS Act

The PHS Act applies to health insurance issuers (*i.e.*, licensed health insurers/carriers) in the group and individual markets and to self-insured, nonfederal governmental group plans. With respect to the regulation and oversight of carriers, the PHS Act maintains an approach deferential to state governments, giving states the option to be the primary enforcers of the federal private health insurance requirements. However, if the secretary of the US Department of Health and Human Services (HHS) determines that a state has failed to "substantially enforce" PHS Act requirements with respect to health insurance issuers in the state, the secretary must enforce the relevant federal provisions.

The Patient Protection and Affordable Care Act (ACA) amended the PHS Act to expand the scope of federal regulation over private health insurance coverage by establishing a series of market reforms designed to expand access to private health insurance. These reforms include a required extension of dependent coverage, if such coverage is offered, up to age 26; a ban on lifetime and certain annual benefit limits; coverage of certain essential health benefits; a prohibition on health insurance rescissions (except under limited circumstances); and coverage of preventive health services without cost sharing. In addition, the ACA prohibits plans and insurers in both the individual and group markets from excluding coverage based on an individual's preexisting health conditions and generally requires all group health plans and insurers to offer coverage on a guaranteed issue basis (*i.e.*, accept every applicant for coverage). These reforms were also incorporated by reference into ERISA and the Code. As a result, they apply to group health plans maintained by private-sector employers, to government and church plans, and to the policies of health insurance in the individual and group markets.

CONTROLLED GROUPS/AFFILIATED SERVICE GROUPS

The controlled group and affiliated service group rules determine whether two or more employers are treated as a single employer. These rules have a significant impact on which employees can participate in employee benefit plans.

There are three primary ways in which employers can compose a controlled group:

- Parent-Subsidiary Controlled Group: A parent-subsidiary controlled group exists if the common parent corporation owns 80% or more of the total combined voting power of all classes of stock entitled to the vote of another entity, the subsidiary.[5]
- Brother-Sister Controlled Group: A brother-sister controlled group exists where five or fewer persons who are individuals, estates, or trusts own, directly or indirectly, 80% or more of the total combined voting power of all classes of stock entitled to the vote of each corporation *and* where the same five or fewer individuals, estates, or trusts, in the aggregate, own more than 50% of that stock, taking into account the stock ownership only to the extent that the level of ownership interest is identical with respect to each corporation.[6] Identical ownership means the least percentage owned by a person in the entities being tested. For example, if person X owns 25% of entity A and 50% of entity B, person X's "identical" ownership is 25%.
- Combined Controlled Group: A combined controlled group is a combination of both a parent-subsidiary controlled group and a brother-sister controlled group among three or more entities. A combined controlled group exists if each corporation is a member of either a parent-subsidiary controlled group or a brother-sister controlled group *and* at least one of the corporations is the common parent of the parent-subsidiary controlled group and is a member of a brother-sister controlled group.[7]

To further complicate an already dense set of tests, there are very technical rules regarding situations in which certain shares are excluded or disregarded and in which ownership must be attributed to certain individuals due to their relationships (*e.g.*, family, grantors of a trust, or shareholders).

An affiliated service group (ASG) is another species of controlled group, except that employers are aggregated because of joint activity or services rendered back and forth, in addition to common ownership. In 1983, the IRS released proposed regulations interpreting the ASG rules that have never been finalized. Under these rules and proposed regulations, there are three types of business combinations used to create an ASG:

- A-Organization (A-Org): The first type of ASG is a combination of a first service organization (FSO) and another service organization, the A-Org. An FSO can be a sole proprietorship, partnership, corporation, or any other type of entity, but it must be a "service organization." A business is automatically a service organization if it engages in certain fields provided for in the regulations (*e.g.*, health).[8] An A-Org is a service organization that is a partner or shareholder in the FSO and that regularly performs services for the FSO or is regularly associated with the FSO in performing services for third parties.[9] This is determined based on a facts-and-circumstances analysis, but one factor is the amount of income the A-Org receives for performing services for the FSO or third parties associated with the FSO.
- B-Organization (B-Org): The second type of ASG is a combination of an FSO and another organization, the B-Org. A B-Org is not required to be a service organization. An organization is a B-Org if it satisfies three tests: (i) a significant portion of the B-Org's business consists of performing services for the FSO, for an A-Org of that FSO, or for both; (ii) those services are of a type historically performed by employees in the service field of the FSO or the A-Org; and (iii)

[5] Treas. Reg. §1.414(c)-2(b).
[6] Treas. Reg. §1.414(c)-2(c).
[7] Treas. Reg. §1.414(c)-2(d).
[8] Prop. Treas. Reg. §1.414(m)-2(f).
[9] Code §414(m)(2)(A); Prop. Treas. Reg. §1.414(m)-2(b)(1).

10% or more of the interest in the B-Org is held, in the aggregate, by highly compensated employees of the FSO or of an A-Org of the FSO.

- Management Organization: The third type of ASG is a combination of an organization that performs management functions and the entity it services. The management organization's principal business must be performing management functions on a regular and continuing basis for the recipient organization.[10]

From time to time, we encounter the claim that otherwise unrelated employers should nevertheless be treated as a single employer because they share common management. For example, a private equity firm might provide management and back-office support to its portfolio companies in which it has only minority investments. In Information Letter 05-24-2004, the DOL examined this approach and expressed the view that trades or businesses with less than a 25% ownership interest are not under "common control" for purposes of determining MEWA status. The 25% threshold was not selected at random. Rather, it is grounded in the ERISA provision that permits the DOL to reduce the level of common ownership by regulation (which the DOL has never adopted) from the levels established by the Code for purposes of regulating MEWAs.[11] The DOL did, however, prescribe a 25% common ownership threshold in connection with the Form M-1 filing requirement. The DOL's purpose in lowering the common ownership requirement where MEWAs are concerned is to "remove impediments to the states' ability to regulate MEWAs and assure the financial soundness and timely payment of benefits under such arrangements."[12]

The tax rules governing management organization ASGs nevertheless remain relevant. The liability for assessable payments under Code § 4980H applies to applicable large employers (ALEs). For purposes of determining whether an employer is an ALE, all entities under common control are treated as a single employer. This includes entities treated as a single employer by virtue of qualifying as a management organization ASG.[13] Thus, a group that is not under common control for purposes of the ERISA rules governing MEWAs could, at the same time, be considered under common control for purposes of applying the ACA employer-shared responsibility rules.

MULTIPLE EMPLOYER WELFARE ARRANGEMENTS

Simply put, and with exceptions not here relevant,[14] a MEWA is a welfare plan that covers employees of two or more unrelated employers. ERISA §3(40) defines the term to mean.

> "[An] employee welfare benefit plan, or any other arrangement (other than an employee welfare benefit plan), which is established or maintained for the purpose of offering or providing [welfare benefits] to the employees of two or more employers (including one or more self-employed individuals), or to their beneficiaries…"

The reference in ERISA §3(40) to a "welfare benefit plan, or any other arrangement" has important consequences. Among other things, it means that there are two fundamentally distinct types of MEWA: one that is a welfare benefit plan and another that is an arrangement that is not a welfare benefit plan. Critically, a MEWA that is a welfare benefit plan is itself subject to regulation under ERISA, while a MEWA that is an arrangement that is not a welfare

[10] Code §414(m)(6)(A).
[11] ERISA § 3(40)(B). "[T]he determination of whether a trade or business is under "common control" with another trade or business shall be determined under regulations of the Secretary applying principles similar to the principles applied in determining whether employees of two or more trades or businesses are treated as employed by a single employer under section 4001(b) [29 U.S.C. §1301(b)], except that, for purposes of this paragraph, common control shall not be based on an interest of less than 25 percent."
[12] *Supra* note 16, at p. 21.
[13] Code § 4980H(c)(2)(C)(i).
[14] ERISA § 3(40) excludes from the definition of MEWA "any such plan or other arrangement which is established or maintained under or pursuant to one or more agreements which the Secretary finds to be collective bargaining agreements, by a rural electric cooperative, or by a rural telephone cooperative association."

benefit plan is not subject to regulation under ERISA, with certain exceptions discussed next.

Welfare benefit plans must be established by employers, which can include a "*bona fide group or association of employers* acting in the interest of its employer-members to provide benefits for their employees.[15] In order for a group or association to constitute an "employer," there must be a bona fide group or association of employers acting in the interest of its employer-members to provide benefits for their employees. No employer group exists, however, where several unrelated employers merely execute identically worded trust agreements or similar documents in the absence of any genuine organizational relationship between the employers. Similarly, where membership in a group or association is open to anyone engaged in a particular trade or profession regardless of their status as employers (*i.e.*, the group or association members include self-employed individuals) or where control of the group or association is not vested solely in employer-members, the group or association is not a bona fide group or association of employers for this purpose. To qualify as a bona fide group or association of employers, there must be commonality of interest among groups or associations' employer-members, and the members within the group must control the MEWA. The group or association must also have at least one other purpose that would make the association a viable entity, even in the absence of providing health coverage.

The DOL has published a comprehensive guide to MEWAs[16] that explains their regulation with a far greater level of detail than is required here. For purposes of this report, we need only focus on the two types of MEWAs described above, which are colloquially referred to as "plan" and "non-plan" MEWAs.

- A plan MEWA is itself a welfare plan (*e.g.*, a plan maintained by a bona fide group of employers that is governed by its employer-members). A health plan maintained by an association may qualify as a plan MEWA.
- A non-plan MEWA is not itself an employee welfare benefit plan (*e.g.*, an arrangement involving unaffiliated employers that are not affiliated with an entity that meets the definition of employer). This would include a MEWA maintained by a civic organization such as a chamber of commerce. This also describes most association-style arrangements that are sponsored by third-party organizations, such as consultants.

Non-plan MEWAs are not subject to all ERISA requirements, but employers providing coverage through a non-plan MEWA may be considered to have established individual employee welfare benefit plans that are governed by ERISA and must separately comply. Additionally, although MEWAs are not directly governed by ERISA, those who operate or manage a MEWA may nonetheless be subject to ERISA's fiduciary requirements if they are responsible for, or exercise control over, the assets of the individual plan. Either way, the DOL would have concurrent jurisdiction with the state(s) over the MEWA. There is therefore nothing to preclude the application of the same insurance laws that apply to any other insurer in the state, at least to the extent that the state law does not conflict with ERISA.

Plan MEWAs, particularly those that are fully insured, gain some important protections under ERISA from state regulation. States are constrained in their ability to regulate these entities under ERISA's broad preemption provisions. Non-plan MEWAs, in contrast, are generally subject to state regulation.

STATE REGULATION OF MEWAS

The premise and promise of MEWAs is that employees of unrelated small employers are permitted to be combined and covered under a single group

[15] ERISA § 3(5) (emphasis added).

[16] *MEWAs – Multiple Employer Welfare Arrangements under the Employee Retirement Income Security Act (ERISA): A Guide to Federal and State Regulation U.S. Department of Labor Employee Benefits Security Administration*, available at: 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.

health plan that is rated using just the experience of the group. This, say MEWA advocates, allows small groups to access economies of scale, thereby giving them purchasing parity with larger groups. In practice, this goal has proven to be elusive.

As a result of a 1983 amendment to ERISA, states have broad powers to regulate MEWAs, whether fully insured or self-insured – the former narrowly, the latter broadly. Many states either prohibit self-insured MEWAs outright or require them to comply with insurance carrier funding, reserve, and reporting obligations. Multistate MEWAs are, as a result, subject to a patchwork of state regulations that makes it difficult for them to operate nationally. Complicating matters, states also tend to be protective of their small-group markets and (rightly) view with suspicion *any* group health plan, product, or arrangement that may become unable to pay claims in the ordinary course. MEWAs have historically had less than a stellar track record on this score.[17] For these reasons and more, the maintenance of AHP group health plan coverage poses no shortage of challenges.

Self-insured plan MEWAs are subject to any state law that regulates insurance that is not inconsistent with ERISA. A state law is inconsistent with ERISA to the extent that compliance with such a law would abolish or abridge an affirmative protection or safeguard available under, or where the state law affirmatively conflicts with, ERISA. It is for this reason that self-insured MEWAs are treated as unlicensed insurance companies or must comply with MEWA laws that are similar to the standards imposed on licensed carriers.

Fully insured plan MEWAs are subject to state insurance regulation only insofar as the law requires the "maintenance of specified levels of reserves and specified levels of contributions that the plan must meet in order to satisfy its benefit payment obligations when they are due, and also provides for the enforcement of those standards."[18] This is usually understood to mean standards such as licensing, registration, certification, financial reporting, examination, and audit requirements. Given the fully insured status of these plans, the carrier already satisfies the applicable reserve, contribution, and other related requirements. Nevertheless, the MEWA sponsor is still responsible for compliance with all other state law requirements. Curiously, while the statute provides that a MEWA is fully insured only when the secretary of the DOL says it is,[19] neither the DOL, nor HHS, nor the various state regulators seem to care. Instead, all interested parties appear to be willing to take the word of state insurance departments.

ERISA generally confers on states the express authority to impose any state insurance law requirement on self-funded MEWAs. Many states have acted on this authority by enacting MEWA-specific laws, some more onerous than others. For example, some states outlaw self-insured MEWAs operating within the state, either explicitly or by treating the MEWA as an unlicensed insurance company. In other cases, a state might require MEWAs to receive a certification from the state's insurance regulator that generally involves compliance with various reserve requirements, and in some cases, state benefit mandates and/or premium rating requirements.

MARKET SEGMENTATION

The PHS Act has a long-standing rule governing federal market reforms that applies to health insurance coverage sold to or through associations. These rules establish a test for determining whether health insurance coverage offered through an association is considered group market coverage or individual market coverage. The test applies whether health insurance is offered to employees or individuals. The statutory framework was first established by the

[17] *See, e.g.,* 1992 GAO report titled, "Employee Benefits: States Need Labor's Help Regulating Multiple Employer Welfare Arrangements," GAO/HRD–92–40 (Mar. 1992) (reporting that between 1988 and 1991, MEWAs left at least 398,000 participants and beneficiaries with more than $123 million in unpaid claims and that more than 600 MEWAs failed to comply with state insurance laws).

[18] ERISA § 514(b)(6)(A)(i).

[19] *See, e.g.*, Department of Labor Ad. Op. 2005-20A (Aug. 5, 2005).

Health Insurance Portability and Accountability Act of 1996 (HIPAA) and was modified by the ACA.

For determining whether any particular insurance coverage is group (rather than individual) coverage within the meaning of title XXVII of the PHS Act, it is irrelevant whether there is an association involved and whether state law classifies association coverage as group coverage. The PHS Act controls that determination. "Individual market coverage" for this purpose is any health insurance coverage that is not offered in connection with a group health plan. Coverage issued through an association but not in connection with a group health plan is not group health insurance coverage. Coverage under a non-plan MEWA is not group insurance coverage for this purpose. It matters not that the same coverage may be categorized as a group market for state law purposes. The term "group market" refers to health insurance coverage offered in connection with a group health plan. The group market is divided into the small-group market and the large-group market, depending on the number of individuals employed by the employer. In the vast majority of states, a small group means no more than 50 employees, while a large group is anything more than that.[20]

As a result of the foregoing, the PHS Act's market segmentation rules, amended by the ACA, operate as follows:[21]

- Look Through Rule

  Where coverage is provided under non-plan MEWAs, the group health plan exists at the individual employer level and not at the association-of-employers level. In these situations, the size of each individual employer participating in the association determines whether that employer's coverage is subject to the small-group market or the large-group market rules. This is referred to as the "look through rule," since it requires looking through the association to the underlying, separate employers.

- Bona Fide Associations

  In the case of plan MEWAs, where the association of employers is treated as the "employer," the association coverage is considered a single group health plan. Here, the number of individuals employed by all of the employers participating in the association determines whether the coverage is subject to the small-group market or the large-group market rules.

While some states categorically regulate health insurance coverage offered through associations as group coverage, this has no bearing on the applicable federal standards. The test for determining whether health insurance coverage offered through an association is group market coverage or individual market coverage is the same test that is applied to health insurance offered directly to employers or individuals.

PLAN DESIGN IMPLICATIONS

SEPARATE PURCHASE OF COMMERCIAL GROUP HEALTH INSURANCE

Under this option, small employers might separately purchase commercially available small- or large-group health insurance coverage, depending on the size of each group, from a licensed carrier. This option tends to be the most expensive.

[20] In California (Cal. Health & Safety Code § 1357(l)(1)), Colorado (before 2026) (Colo. Rev. Stat. § 10-16-102(61)(b)), New York (N.Y. Ins. Law §§ 3217-i, 3221, 4303; N.Y. Ins. Law § 4306-h), and Vermont (Vt. Stat. Ann. tit. 33, § 1804), "small group" means up to 100 employees.

[21] *See* CMS Insurance Standards Bulletin Transmittal No. 02-02, Application of Group and Individual Market Requirements Under Title XXVII of the Public Health Service (PHS) Act When Insurance Coverage is Sold To, or Through, Associations (Aug. 2002), available at: https://www.cms.gov/Regulations-and-Guidance/Health-Insurance-Reform/HealthInsReformforConsume/downloads/HIPAA-02-02.pdf; and CMS Insurance Standards Bulletin, Application of Individual and Group Market Requirements under Title XXVII of the Public Health Service Act when Insurance Coverage Is Sold to, or through, Associations (Sept. 1, 2011), available at: https://www.cms.gov/cciio/resources/files/downloads/association_coverage_9_1_2011.pdf.

POOLED PURCHASE OF COMMERCIAL GROUP HEALTH INSURANCE UNDERWRITTEN AS A SINGLE, LARGE GROUP, WHETHER OR NOT PURCHASED THROUGH A PROFESSIONAL EMPLOYER ORGANIZATION (PEO)

Any group health coverage plan, program, or arrangement that covers employees (and their dependents) of unrelated employers and is underwritten based on the collective experience of these groups is a MEWA. In most cases, this means a non-plan MEWA. Thus, each small employer is considered to have established individual employee welfare benefit plans that are subject to ERISA and must separately comply with ERISA's reporting, disclosure, fiduciary, and other requirements. Because states already regulate the carrier(s), states are generally less concerned about the separate regulation of the MEWA, although some states do impose reporting and other requirements on fully insured MEWAs.

Group health plan coverage provided by PEOs is usually made available under non-plan, fully insured MEWAs. Where this is the case, some care must be taken as to the routing of premium dollars. ERISA generally requires that plan assets be held in trust. Plan assets include participant contributions paid towards plan premiums (including salary deferrals made on a pre-tax basis through a Section 125 cafeteria plan, as well as COBRA or retiree plan premiums paid on an after-tax basis). The term also includes funds held in a separate account or trust for the purpose of paying plan benefits. Under a limited nonenforcement policy,[22] the DOL will not assert a violation of the trust requirements where participant contributions are forwarded to an insurer and/or made through a cafeteria plan, provided certain conditions are met. However, these exemptions require that participant contributions be forwarded to the insurer directly.

Routing premiums through a PEO or other service provider may cause the arrangement to lose the benefit of the non-enforcement policy, which applies only to participant contributions that continue to be held in the employer's general assets until paid over to the carrier. Failure to hold contributions in trust would constitute violations of the ERISA plan assets rules. While worrisome, the practice of routing employee premiums through a service provider nevertheless appears commonplace.

POOLED PURCHASE OF GROUP HEALTH INSURANCE UNDER A SELF-FUNDED ARRANGEMENT

The adoption of a self-insured group health plan covering employees of unrelated employers is possible but challenging. Such an arrangement is a MEWA, which states are free to regulate. The power to regulate MEWAs is provided under an exception[23] to preemption under ERISA's otherwise broad preemption rule[24] for any ERISA-covered employee welfare benefit plan that is a MEWA (*i.e.*, a plan MEWA). Under the exception, *any* law that regulates insurance of *any* state may apply to the extent it is not inconsistent with ERISA.[25] For example, states can enact a law that prohibits a self-insured association health plan from operating within the state altogether. California has such a law.[26] States can and have also imposed specific coverage and "premium rating" requirements on self-funded MEWAs and/or required that a self-insured MEWA must cover some or all of the benefits a small-group market plan must cover.

Nevertheless, difficult is not the same as impossible. Depending on the state(s) in which a plan MEWA seeks to operate, a self-insured plan MEWA could be

[22] DOL Technical Release 92-01.
[23] ERISA § 514(b)(6)(A).
[24] ERISA §514(a).
[25] DOL MEWA Guide, pp. 30, 31. Title I, as applied to welfare benefits plans includes ERISA reporting and disclosure requirements, fiduciary standards, and civil remedies. While a state law regulating insurance that requires a license or certificate of authority as a condition precedent to transacting insurance business would not in and of itself be inconsistent for this purpose, a state insurance law that would require an ERISA-covered plan to make imprudent investments would be inconsistent with the provisions of Title I.
[26] C.A. Code, H.S.C. 1357.500

established in a manner consistent with applicable state law.

GROUP MEDICAL STOP-LOSS CAPTIVES

The term "captive insurer" traditionally referred to a "single parent" captive, which is a subsidiary of an operating company/parent that insures the risks of the parent. Group captives are a more recent development, and as the name suggests, they allow for pooling at the level of stop-loss coverage. A group medical stop-loss captive is a legal entity owned by a group of unrelated companies, and it is formed to insure the risks of that group of unrelated member companies. There are least three basic group captive structures (fronted cells, direct writing, and quota share), but in each case, a plan's self-insured risk that sits on top of its retained risk is pooled to a greater or lesser extent.

Group medical stop-loss captives must have an authorized carrier issue an approved stop-loss policy to its member-owners. In most cases, captive insurance companies are treated as non-authorized insurers by the states. Since stop-loss insurance is regulated by states, most states will require that any entity acting as an insurance company must be duly licensed in the state. This would include at least each state in which group members are domiciled and, in many instances, each state in which covered employees reside.[27]

To avoid being classified as a MEWA, each small employer must establish a separate self-insured plan; each such plan must separately comply with ERISA; and each separate controlled group must separately comply with the ACA employer-shared responsibility requirements (including Forms 1095-B and 1095-C). Amounts paid for stop-loss coverage must not be treated as plan assets (*i.e.*, the stop-loss policy must be purchased by the sponsoring employer out of its own general assets and not with participant contributions).

For a comprehensive treatment of group medical stop-loss captive arrangements, please see our *Special Report* titled "Funding Employer Sponsored Group Health Coverage: The Group Captive Solution."

Lastly, there is the matter of group size. Conventional wisdom holds that self-funding is appropriate for groups of, say, 300 to 500 covered lives. Some put this number lower than that. Group captives tend to place the threshold at 50 to 100 covered lives, and level-funded plans get down to as low as 10 (or even fewer) covered lives. These thresholds are established by actuarial science and sound underwriting practices with which we profess no familiarity or experience. For the purposes of this report, suffice it to say that the year-over-year predictability of costs relies on the law of large numbers. This law holds that, in the context of group health plans, the larger the number of lives independently exposed to loss, the greater the probability that the actual loss experience will equal the expected loss experience. In other words, the credibility of data increases with the size of the data pool, thereby increasing predictability as group size increases.

MIRROR PLANS

The reference to the establishment of mirror plans is generally confined to plans offered by physician practice management (PPM) arrangements. In a PPM structure, a management service organization or company (MSO), typically owned primarily by private equity investors, acquires substantially all of the non-clinical assets, and employs the non-clinical employees of a physician practice. The MSO will then enter into a business services agreement with the physician practice to provide all the necessary administrative and management services required to run the practice. The physicians and the clinical assets remain at the practice and can continue the practice of medicine without the burden of business administration. The physician owners of the practice may continue to own the practice along with what is referred to as "friendly physicians."

[27] *See* National Association of Benefits and Insurance Professionals (NABIP) Chart, "Stop-Loss Restrictions by State" (available at, https://nabip.org/media/8919/nabip-stop-loss-restrictions-by-state-chart-2023.pdf) for a state-by-state list of restrictions on stop-loss policies.

Under the mirror plan approach, the MSO and each unrelated physician practice establishes a separate self-insured plan, which may be similar or even identical to the self-insured plans adopted at the other entities. Each mirror plan must separately maintain the documents that are required under ERISA. Each mirror plan must also meet the relevant reporting requirements under ERISA and the Code. This includes a plan document, summary plan description, etc. Each mirror plan must also file its own Form 5500 and maintain its own set of HIPAA group health plan privacy and security policies and procedures. Certain requirements, such as compliance with the ACA employer-shared responsibly requirements (including Forms 1095-B and 1095-C), will apply to each individual, unrelated employer, or employer group.

The benefit of the mirror plan structure is that it affords the plans the opportunity to negotiate with third-party administrators and other vendors on more favorable terms, as the number of covered lives with all plans aggregated together is higher. For mirror plans to avoid being classified as a MEWA, and thereby avoid the application of unfavorable state law, care must be taken to ensure that amounts paid for stop-loss coverage are not treated as plan assets. Specifically, this requires that the stop-loss policy be purchased by the sponsoring employer out of its own general assets and not with participant contributions. Under applicable DOL guidance on the subject, the stop-loss policy will not be an asset of the plan if the facts surrounding the purchase of the stop-loss policy satisfy certain requirements[28] and if the employer puts in place an accounting system that ensures that the payment of premiums for the stop-loss policy includes no employee contributions. Also, the stop-loss policy must reimburse the plan sponsor only if the plan sponsor pays claims under the plans from its own assets so that the plan sponsor will never receive any reimbursement from the insurer for claim amounts paid with participant contributions. As a practical matter, this requires that each employer issue a separate check from its general operating account to cover stop-loss premiums.

Care must also be taken to ensure compliance with the ERISA trust requirement, which is described above in connection with fully insured arrangements. Typically, this would require the MSO and each physician practice to establish a separate bank account in the name of the employer, in which it deposits funds necessary to pay the plan's obligations. The plan's third-party administrator typically has drawing rights on the account that are limited to the payment of plan claims and other plan-related expenses.

For the mirror plan approach to work as advertised, it must qualify as a collection of individual, single-employer group health plans. Stop-loss coverage, which is similar to property and casualty insurance, must insure the employer/sponsor. Because the pooling of risk does not occur in connection with the provision of health insurance, there is no plan that covers employees of two or more unrelated employers (*i.e.*, there is no MEWA). The claim that stop-loss insurance is property and casualty insurance covering the employer, and not health insurance covering employees, is of crucial importance, for which there is support,[29] although not all states agree.

The pooling of stop-loss claims under the mirror plan approach is hardly foolproof. Typically, each unrelated employer in the mirror plan grouping purchases a separate stop-loss policy from the same carrier. Pooling is done, often informally, by the underwriter. In addition, if the group of employers includes smaller employers (*e.g.*, employers with fewer than 50 employees) the premiums of the larger employers in the group might subsidize participation by the smaller employers. These approaches are not permitted under some state laws governing issuance of stop-loss insurance.

[28] Advisory Opinion 92-02 requires that (i) the insurance proceeds from the policies are payable only to the plan sponsor, which is the named insured under the policy; (ii) the plan sponsor has all rights of ownership under the policy and the policy is subject to the claims of the creditors of the plan sponsor,;(iii) neither the plan nor any participant or beneficiary of the plan has any preferential claim against the policy or any beneficial interest in the policy; (iv) no representations are made to any participant or beneficiary of the plan that the policy will be used to pay benefits under the plan or that the policy in any way represents security for the payment of benefits; and (v) the benefits associated with the plan are not limited or governed in any way by the amount of stop-loss insurance proceeds received by the plan sponsor.

[29] Dept. of Lab. Ad. Op. 2015-02 (Oct. 19, 2015).

LEVEL-FUNDED ARRANGEMENTS

Level-funded plans are sometimes described as a hybrid between a fully insured health plan and a self-funded health plan. What distinguishes a level-funded plan from a traditional stop-loss program is that the employer pays a fixed annual sum paid monthly in an amount that covers claims, fixed costs, stop-loss premiums, and administrative expenses. Level-funded plans are usually marketed to employers with two to 50 employees (*i.e.*, employers whose only other option is the state small-group market), which makes them ideally suited to small physician groups and practices. From a regulatory perspective, a level-funded plan should qualify as a single-employer, self-insured plan that (except in the case of the largest employers) purchases its own stop-loss coverage. Like the group medical stop-loss approach, no MEWA is established.

That level-funded plans have high fixed costs, as some critics claim, has not staunched their rapid growth in market share.[30] Problematically, most level-funded products assume, when establishing their monthly premium equivalent amount, that the claims are being incurred at the maximum attachment point (*e.g.*, 110% of expected claims). These products also suffer from a lack of transparency, and the transition back to fully insured status can be costly: Obligations on termination may include forfeiture of any claims surplus or funding some period of run-out claims. Because a portion of a level-funded plan's costs are paid with employee contributions, which are always plan assets, any rebate paid to the plan sponsor as a result of a favorable claims experience must be shared with covered employees.

Level-funded plans are at heart self-insured plans. This means they are subject to all the compliance obligations (*e.g.*, the ERISA fiduciary standards and HIPAA privacy and security rules) with which all self-insured plans must comply.

REFERENCE-BASED PRICING

Reference-based pricing (RBP) is marketed as an alternative to traditional healthcare pricing under which reimbursement rates for medical services are based on an established benchmark – or "reference" rate – which is most commonly a percentage (*e.g.*, 125% or 150%) of the Centers for Medicare and Medicaid Services (CMS) Medicare rates. RBPs are generally self-funded. These plans are not currently all that commonplace, and they are accompanied by some controversy. Predictably, providers are opposed to these arrangements, as there is no opportunity to impose markups, arbitrary or otherwise. From the employer's perspective, however, these plans represent one of the few options available to push back against provider rates that are generally set at 200% to 300% of what Medicare charges and have been known to reach 600%.[31]

RBP arrangements have some downsides. Some providers and facilities will not accept these arrangements, although others are willing to negotiate. If a provider will not accept the RBP reimbursement rate, then it is likely that the employee will be balance billed. In the case of emergency services, if a claim is submitted to arbitration under the federal independent dispute resolution process, the plan will likely be required to pay the (higher) qualified payment amount and not the reference price. Arguably, this is merely a pricing issue, which could be baked into the RBP plan premium cost.

ESTABLISHMENT OF ICHRAS

Rather than offer commercially available group coverage, small groups could instead offer ICHRAs, which are billed as an alternative to offering a traditional group health plan. They are account-based health plans that allow employers to provide defined tax-free contributions to enable employees to purchase coverage from the state ACA marketplaces. The

[30] *See, e.g., Health Affairs, Administration Takes Action to Limit Junk Insurance* (July 10, 2023) (available at: https://www.healthaffairs.org/content/forefront/administration-takes-action-limit-junk-health-insurance).

[31] See, *e.g.*, Wade Symons, *Is it Time to Give Referenced Based Pricing Another Look*? Mercer, U.S. Health News, Jun. 13, 2019 (claiming a potential savings of 20%-40% on a company's overall medical spend.

coverage is either individual market coverage or small-group coverage under the ACA Small Business Health Options Program (SHOP)[32], however.

Whether coverage is purchased directly from carriers in the group health insurance market or indirectly though the state ACA marketplaces or SHOP, these coverage options tend to be the most expensive, which makes them the baseline against which other options (discussed below) are measured.

MEC, MEC+, AND FIXED-INDEMNITY PLANS

MEC Plans

The phrase "minimum essential coverage" was introduced by and is an integral part of the regulatory lexicon of the ACA's individual and employer-shared responsibility rules. Because the Tax Cuts and Jobs Act of 2017 reduced the penalties on individuals for failing to maintain minimum essential coverage, the requirement remains relevant only to the determination of penalties under the ACA's employer-shared responsibility rules. These are the rules that subject applicable large employers (*i.e.*, 50 or more full-time employees, including full-time equivalent employees, on average during the prior year) to tax penalties for failing to offer minimum essential coverage to at least 95% of their full-time employees.

The phase "MEC plan" has come to refer to a group health plan that provides the least amount of coverage necessary to satisfy the requirement to offer minimum essential coverage, thereby enabling applicable large employers to escape exposure under the "(a) penalty," which is one of the two levels of penalties imposed under Internal Revenue Code Sections 4980H(a) and (b). The so-called "(b) penalty" is imposed for failing to offer affordable major-medical coverage. The (a) penalty is imposed based on all of an applicable large employer's full-time employers, minus the first 30. The (b) penalty, on the other hand, is determined employee by employee and is imposed only where a full-time employee qualifies for a premium tax credit. Thus, the (a) penalty is considered to be far more onerous.

Coverage under a basic MEC plan is limited to wellness, preventative services, prescription discounts, and – in many if not most instances – telehealth services. Thus, for example, MEC plans do not cover emergency services. "Enhanced MEC plans" layer on coverage for primary and urgent care visits and discounted specialist and laboratory services, and lower copays. The highest-level MEC plans might also add coverage such as prescription coverage and lower copays. The latter two layers of MEC coverage are sometimes referred to as "MEC+" plans. The preventive services covered under MEC plans include cholesterol screening for adults of certain ages or at higher risk, colorectal cancer screening for adults aged 45 to 75, immunizations, and vaccinations. For women, preventive services also include screening during pregnancy for anemia, bacteriuria, syphilis, Rh incompatibility, and contraception. For children, covered services include vaccinations and autism screening at 18 and 24 months of age, as well as behavioral assessments for children from birth through age 17.

MEC plans are sometimes misleadingly billed as a type of health insurance that provides an affordable alternative to traditional major medical plans. Irrespective of how the coverage is described, MEC coverage falls far short of major medical coverage. Despite this sparse coverage, MEC plans are considered welfare plans for ERISA purposes, and they are regulated as such.

Hospital indemnity and other fixed-indemnity insurance

Hospital indemnity and other fixed-indemnity insurance, at least in its canonical form, is not health insurance. Rather, its primary purpose is to provide income replacement benefits. Benefits under this type of coverage are paid in a flat or "fixed" cash amount following the occurrence of a health-related event,

[32] See ACA, Pub. L. No. 111-148, §1311(b)(1) (2010). Preamble to PPACA; Establishment of Exchanges and Qualified Health Plans; Exchange Standards for Employers, 77 Fed. Reg. 18310 (Mar. 27, 2012).

such as a period of hospitalization or illness, subject to the terms of the contract. In addition, benefits are typically provided at a predetermined level, regardless of any actual healthcare costs incurred by a covered individual with respect to the qualifying event. Although a benefit payment may equal all or a portion of the cost of care related to an event, it is not necessarily designed to do so, and the benefit payment is made without regard to the amount of medical expense incurred.

Fixed-indemnity arrangements are generally subject to ERISA. This means, among other things, that the plan must be set out in a written plan document, the material terms of which must be described in a summary plan description. There is a regulatory exception to this general rule for "voluntary" plans, which takes the form of a voluntary plan safe harbor. The safe harbor exemption requires that plan participation be voluntary and paid for entirely by the employee. It also requires that the employer neither contribute to, nor receive compensation in connection with, nor endorse the plan. (Since cafeteria plan contributions are treated for tax purposes as employer contributions, employee contributions must be after-tax to satisfy the safe harbor.)

Fixed-indemnity insurance is classified for federal tax and benefits purposes as an "excepted benefit," which is to say that they are not subject to the myriad requirements imposed on group health plans under the rules collectively and colloquially referred as the ACA's insurance market reforms. It is, therefore, important that products are designed to satisfy the requirements for excepted benefit status. To qualify as such, benefits meet each of the following conditions: (i) the benefits are provided under a separate policy, certificate, or contract of insurance; (ii) there must be no coordination between the provision of the benefits and an exclusion of benefits under any group health plan maintained by the same plan sponsor; and (iii) the benefits are paid in connection with an event without regard to whether benefits are provided with respect to the event under any group health plan maintained by the same plan sponsor. Under a 2023 proposed US Department of the Treasury regulation, the widespread practice of combining a MEC plan and a fixed-indemnity policy would no longer be permitted as a violation of the non-coordination rule (item (ii) above).

While employers sometimes express a desire to fit under the voluntary plan safe harbor, the requirement that the employer not "endorse" the plan is often challenging. Endorsement for this purpose includes designing or negotiating the plan terms, limiting coverage to select groups or classification of employees, or even assisting employees with claims. Although safe harbor protection might seem attractive, ERISA's limits on state law causes of action should make employers reconsider. ERISA coverage is often the better approach, despite some added compliance steps.

Neither MEC coverage nor fixed-indemnity insurance are health insurance in the traditional sense, which usually envisions something far more comprehensive. These products are better viewed as supplemental products that may have a place in a particular setting, industry, or sector. The challenge for employers – and the concern of the regulators – is that these products should not be confused with, or positioned as a substitute for, more robust group health insurance.

A WORD ABOUT PROFESSIONAL EMPLOYER ORGANIZATIONS

A PEO is, at its core, an employee leasing company that contracts typically with small employers to provide certain administrative functions, such as payroll, taxes, and employee benefits. PEOs often bill themselves as "full-service human resource outsourcing," and there is no doubt that they provide a valuable service. PEOs also routinely offer group health coverage from a licensed carrier under an insured group health plan. It is not sufficient for the carrier to be licensed in just the state of the PEO's domicile if licensure is required by the laws of one or more other states where the PEO's clients are located. Because the PEO and its clients are not (at least in the vast majority of cases) under common control, these plans are MEWAs, and any claim that the group health plans covering a PEO's clients is a single-

employer plan, and not a MEWA, is untenable. This claim has been rejected by the DOL, which has uniformly taken the position that a PEO cannot qualify as a single-employer plan under ERISA unless the PEO is the sole common law employer of all of the individuals under the arrangement.[33] Most PEOs understand all this, and they file Form M-1s with the DOL each year.[34]

Under the typical PEO structure, where the PEO client can come from disparate industries and businesses, there is rarely, if ever, a bona fide association of employer plans. PEO-sponsored MEWAs are therefore non-plan MEWAs over which states can exercise broad regulatory oversight. In practice, however, few states bother to do so for the simple reason that they can indirectly address any concerns about the MEWA through direct regulation of the carrier insurers involved. State laws that do regulate fully insured MEWAs are typically limited to such things as licensing, reporting, auditing, and other similar requirements to aid a state's oversight and funding.

The rules governing the rating of fully insured MEWAs are another matter entirely. Under the market segmentation rules described above, community rating is generally required in the small-group market on a uniform, nationwide basis. What constitutes a small group is determined under federal law, which includes the "look through rule." This means that, for rating purposes, each small employer is assessed separately rather than treating the arrangement as one large group. This requirement appears to be widely ignored by the HHS and state regulators alike.[35]

While states are free to define what constitutes employer status for purposes of state law, the status of a PEO as a MEWA is determined under federal law. A handful of states recognize PEOs as single employers for purposes of sponsoring welfare benefit plans for their worksite employees, thereby enabling the issuance of group health coverage on a large-group basis.[36] These laws are preempted by ERISA to the extent that they relate to any employee benefit plan, and contrary state laws are preempted by the ACA since they prevent the application of its market segmentation rules.

All of the issues described above relating to self-insured MEWAs generally apply with equal force to PEO-sponsored MEWAs. Some states have statutes allowing PEOs or employee leasing firms to self-insure health benefits or obtain a license allowing them to self-insure health benefits. The bar for self-insuring of MEWAs is high either way, but not impossibly so.

CONCLUSION

The challenge of delivering robust and affordable group health coverage implicates large policy questions that affect the way healthcare is paid for in the United States. All the approaches examined and explained in this *Special Report* address and endeavor to manage the shifting of risk, which is what insurance is all about. It is fair to ask, after the shells stop shuffling, where did the risk end up? As small groups seek access to affordable healthcare, the focus needs to be not only on price but also how risk is being apportioned. Is risk being transferred to a regulated entity? If so, who regulates the entity? Or might risk be unwittingly retained by a non-regulated purchaser where it ought to be borne by a regulated entity? Are there risks that the small groups do not adequately understand? And, perhaps of paramount importance, are employees at risk?

[33] *See, e.g.,* DOL Advisory Opinion 93-29A (holding that a health benefit program offered by the employee leasing company constituted a MEWA).
[34] Form M-1 can be accessed at: https://www.askebsa.dol.gov/epds/.
[35] But see, Meghan McIntyre, *Feds crack down on Virginia realtor insurance law Centers for Medicare and Medicaid Services threaten penalties following years of warnings*, Virginia Mercury (October 11, 2023).
[36] *See, e.g.*, N.Y. Labor Code § 922(5), L.A. Rev. Stat. § 22:22:1745, N.H. Rev. Stat. § 277-B:11, N.V. Rev. Stat. 611.460, and TN Code § 62-43-108.

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