McDermott Will & Emery

SPECIAL REPORT

EXAMINING GROUP HEALTH COVERAGE ALTERNATIVES FOR SMALL EMPLOYERS

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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 equivalent 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 a 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, but the leverage approach requires transparency.

Over the past two decades, the small-group market has experienced a steady and long-term 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 as a fringe benefit, compared to 30% in 2023.[2] Large-group underwriting for these "smaller" large groups tends to be opaque, leaving employers with little or no control over plan costs. Both groups have increasingly sought out alternatives.

For small employers,[3] there are, broadly speaking, three commonly encountered alternative 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 or level-funded; and individual 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 group 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.

health reimbursement arrangements (ICHRAs). In practice, these approaches 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.
- 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 their own individual, self-funded group health plan.
- Establishment of an ICHRA, which provide access to individual market insurance coverage.

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 together into a single, large group for underwriting purposes. In practice, however, the approach poses daunting challenges that have 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, the AHP 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 relatively 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. The former, 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 less 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 is less settled. Level-funding products are both appropriate for, and routinely marketed to, small groups.

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 generally pays less, sometimes significantly less, than someone older.

This *Special Report* examines and explains these options available to, and the obstacles routinely encountered by, small employers as they seek to make affordable health insurance coverage available to 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.

THE STATUTORY AND REGULATORY BACKGROUND

THE 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 specifically 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 federal as well as 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).

THE INTERNAL REVENUE CODE

The generous tax treatment of group health plan coverage is generally well understood, although its ubiquitousness masks the complexity of the 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 purposes of this paper, this common understanding is perfectly serviceable.

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, and 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 a series of reporting and disclosure requirements that include a requirement to memorialize the terms of the plan 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 short, 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 – that is, fully insured or self-insured. Plans that fail to file may be subject to penalties of up to $1,942 per day for 2024. Unlike Forms 5500, for which the DOL maintains a formal late filing program, there is no equivalent program for late filers of the 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 (*i.e.*, 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.

THE PUBLIC HEALTH SERVICE 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 greatly expand the scope of federal regulation over private health insurance coverage by establishing numerous market reforms largely 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 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 where ownership must be attributed to certain individuals due to their relationships (*e.g.*, family, grantors of a trust, 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

[5] Treas. Reg. §1.414(c)-2(b).
[6] Treas. Reg. §1.414(c)-2(c).
[7] Treas. Reg. §1.414(c)-2(d).

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 to 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) 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, in which the DOL 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 provision of ERISA 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 might not be under common control for purposes of the ERISA rules governing MEWAs but at the same time be considered

[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] 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] MEWA Guide, p. 21.
[13] Code § 4980H(c)(2)(C)(i).

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 that there are two, fundamentally distinct types of MEWA: one that is a welfare benefit plan and another that is some other 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 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 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 the regulation of MEWAs with a far greater level of detail than is required for purpose of this paper. 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.

[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."

[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.

- A plan MEWA is a MEWA that is itself a welfare plan, *e.g.*, a plan maintained by a bona fide group of employers that is governed by its employer-members. For example, a health plan maintained by the association may qualify as a plan MEWA.
- A non-plan MEWA is a MEWA that 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 the 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 the MEWA is not directly governed by ERISA, those who operate or manage the 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 law regulation.

STATE REGULATION OF MEWAS

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

[17] *See, e.g.,* 1992 GAO report entitled, "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 over $123 million in unpaid claims and that more than 600 MEWAs failed to comply with State insurance laws).

"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, HHS, nor the various state regulators seem to care.[20] Instead, all interested parties appear to be willing to take the word of state insurance departments.

Group health plan design options available to small employer groups are constrained in ways that are not always intuitively obvious under both federal – principally, though not exclusively, the ACA – and state law. The ACA divides the health insurance market into segments consisting of the individual market, the small group market, and the large group market, each of which is regulated differently. In the vast majority of states, "small group" means no more than 50 employees, while large group is anything more than that.[21] These rules play a part in the regulation of AHPs for three reasons: (i) subject to a narrow but important exception discussed below, it is not possible to combine a number of small groups to make a large group; (ii) small groups must be underwritten based on community rate(s) established under state law; and (iii) self-employed individuals can only be covered by individual market products.

The regulation was subsequently vacated by a US district court. The rule would have permitted third-party organizations, such as chambers of commerce, to sponsor AHPs underwritten as a single, large group. Under a much narrower, existing law standard, associations would be able to separately underwrite each participating small group. The premise and promise of AHPs is that employees of unrelated small employers could be permitted to be combined and covered under a single, group health plan that is rated using just the experience of the group. This, say AHP advocates, allows small groups to access "economies of scale," thereby giving them purchasing parity with larger groups.

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 the MEWA 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.

[18] ERISA § 514(b)(6)(A)(i).
[19] *See, e.g.*, Department of Labor Ad. Op. 2005-20A (Aug. 5, 2005).
[20] *See* DOL MEWA Guide, at p. 30 (explaining that a state's ability to regulate a plan does not depend on a DOL determination that the plan is fully insured).
[21] But 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.

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 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 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 it is also irrelevant whether state law classifies association coverage as group coverage for purposes of state insurance laws. 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 employees employed by the employer.

As a result of the foregoing, the PHS Act's market segmentation rules, amended by the ACA, operate as follows:[22]

The 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 employees 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

[22] *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/cciio/resources/files/downloads/hipaa_02_02_508.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.

the same test that is applied to health insurance offered directly to employers or individuals.

PLAN DESIGN IMPLICATIONS

THE 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 option.

THE 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,[23] 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. These exemptions require that participant contributions be forwarded to the insurer directly, however.

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. The 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.

[23] DOL Technical Release 92-01.

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

While possible, the adoption of a self-insured group health plan covering employees of unrelated employers is challenging. Such an arrangement is a MEWA, which states are free to regulate. The power to regulate MEWAs is provided under an exception[24] to preemption under ERISA's otherwise broad preemption rule[25] 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 not inconsistent with ERISA.[26] 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.[27] 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 (or states) in which a plan MEWA seeks to operate, a self-insured plan MEWA could be 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 that include 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 in each state in which covered employees reside.[28]

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 be purchased by the sponsoring employer out of its own, general assets and not with participant contributions).

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[24] ERISA § 514(b)(6)(A).
[25] ERISA §514(a).
[26] DOL MEWA Guide, pp. 30, 31. Title I, as applied to welfare benefits plana includes ERISA reporting and disclosure requirements, fiduciary standards, and civil remedies. While a state law regulating insurance which 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
[27] C.A. Code, H.S.C. 1357.500
[28] *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.

For a comprehensive treatment of group medical stop-loss captive arrangements, please see our *Special Report* entitled, "Funding Employer Sponsored Group Health Coverage: The Group Captive Solution," available at: https://www.mwe.com/pdf/funding-employer-sponsored-group-health-coverage-the-group-captive-solution/.

Lastly, there is the matter of the 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 expertise. For 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 leading to increasing predictability as group size increases.

LEVEL-FUNDED ARRANGEMENTS

Level-funded plans are sometimes described as a hybrid between a fully insured health plan and a fully self-insured 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 2 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 (other than 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.[29] Part of the problem is that 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 that 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.

ESTABLISHMENT OF ICHRAS

Rather than offer commercially available group coverage, small groups could instead offer ICHRAs.

[29] *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).

ICHRAs 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 coverage is either individual market coverage or small group coverage under the ACA Small Business Health Options Program (SHOP)[30], however.

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

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 states where the PEO 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 actually the sole common law employer of all of the individuals under the arrangement.[31] Most PEOs understand all this, and they file Form M-1s with the DOL each year.[32]

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 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.[33]

[30] *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).

[31] *See, e.g.*, DOL Advisory Opinion 93-29A (holding that a health benefit program offered by the employee leasing company constituted a MEWA).

[32] Form M-1s can be accessed at: https://www.askebsa.dol.gov/epds/.

[33] But see, Meghan McIntyre, *Feds crack down on Virginia realtor insurance law*, Virginia Mercury (October 11, 2023).

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 a PEO as a single employer for purposes of sponsoring welfare benefit plans for its worksite employees, thereby enabling the issuance of group health coverage on a large group basis.[34] 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 for licensing 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 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* deal with and endeavor to manage the shifting of risk, which is after all 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? And, 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?

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[34] *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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