McDermott Will & Emery

SPECIAL REPORT

FUNDING EMPLOYER-SPONSORED GROUP HEALTH COVERAGE: THE GROUP CAPTIVE SOLUTION

November 2023

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For more information, please contact your regular McDermott lawyer, or:

ALDEN J. BIANCHI
COUNSEL

abianchi@mwe.com
Tel +1 617 535 4152

LISA M. KADERABEK
PARTNER

lkaderabek@mwe.com
Tel +1 312 984 7649

TEAL N. TRUJILLO
ASSOCIATE

ttrujillo@mwe.com
Tel +1 312 984 6910

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INTRODUCTION

Employer-sponsored health insurance covers almost 159 million non-elderly US workers and their dependents,[1] and employees and jobseekers alike view group health coverage as the single most important non-cash job-related benefit.[2] The enactment of the Affordable Care Act (ACA) in 2010 led to a sharp increase in employers self-funding their group health plans, with the market tripling in size in the decade that followed.[3] Large employers (*e.g.*, with more than 500 employees) can, and for the most part do, self-fund their group medical coverage in a relatively efficient manner. Self-funding gives these groups transparency and a measure of control over plan design and operation. But because self-funding relies on the law of large numbers for its efficacy, it does not work well, or at all, for smaller employers. The latter must usually look to commercial group health insurance. For groups of 50 employees or less, this usually means the small group markets, which tend to be opaque and expensive.

As overall, year-over-year spending on healthcare in the United States continues to outpace growth in real gross domestic product by wide margins, employers of all sizes continue to seek to make group health insurance coverage available to their employees at a reasonable cost. Group captive-funded medical stop-loss insurance offers a way for smaller employers (ranging, typically, from 50 to 500 or more employees) to obtain the full benefit of self-funding. Employers seeking to adopt these arrangements must, however, navigate a host of complex federal and state laws and regulations. Principally, these include the Employee Retirement Income Security Act (ERISA), the Internal Revenue Code (the Code), and the insurance laws of the various states in which they operate.

This *Special Report* explains what group medical stop-loss captives are and how they are structured and regulated. It opens with a description of group captive structures and how group captives differ from other captive funding plans, programs and arrangements. It also includes a discussion of the criteria that an employer might apply to determine whether a group captive solution is appropriate. Then, it offers an overview of the applicable laws, regulations and other considerations that guide group captive formation, maintenance and operation. Finally, the report concludes with some practical recommendations for employers that either currently participate in, or are considering signing on to, a group captive arrangement.

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[1] *KKF Employer Health Benefits Survey*. Oct. 27, 2022, available at: https://www.kff.org/health-costs/report/2022-employer-health-benefits-survey/.
[2] "12 Employee Benefits and Perks for Your Hiring and Retention Plan," Robert Half Talent Solutions, available at: https://www.roberthalf.com/blog/compensation-and-benefits/10-top-perks-and-benefits-that-win-employees-over.
[3] Phillip C. Giles, CEBS, *Medical Stop-Loss Captives: A Comprehensive Overview*, MSL Captive Solutions, Inc.

OVERVIEW

Captive insurance is not new. In is most basic form, a "captive" is a subsidiary of an operating company formed to manage one (or more) particular risks, *e.g.*, workers' compensation, product liability, medical and other professional malpractice, etc. The operating company/parent retains the cost of covering the risk through the captive insurance company instead of paying premiums to a third-party insurer for commercial insurance.[4] As insurance companies, captives may offer the tax advantages accorded insurance products under the Code. Not all captive structures need or even intend to benefit from the available tax leverage, however.

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 operating company/parent and in some instances its affiliates. Single-parent captives may offer certain tax and risk-management advantages. Historically, single-parent captives insured property and casualty risks and workers' compensation, but they have more recently been pressed into service to cover employee welfare plan risks.[5] Where the covered risk involves ERISA-covered welfare benefits, such as group medical benefits, the ERISA prohibited transaction rules become a factor. These arrangements typically require an exemption from the US Department of Labor (DOL).

Single-parent captives seek to leverage the tax rules governing insurance. Captives may be taxed as insurance companies owned by for-profit entities, which are ordinarily allowed a deduction for increases to reserves. The operating company that owns a single-parent captive may be able to deduct premiums paid to the captive as ordinary and necessary business expenses under Code §162. The captive thereupon includes the premiums in income, but it may take a deduction to the extent that the premium increases its reserves. In the absence of the captive structure, no deduction for reserves is allowed.

Group captive arrangements are different. In contrast to a single-parent captive, a group 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. While single-parent captives are owned by a parent/operating company or are part of a group of companies or other entities under common control, group captives (or, sometimes, cells with an existing sponsored captive structure) are often rented. Under a fronting arrangement, the captive cell acts as a reinsurer rather than a direct insurer.

Group-health captives are often managed by a non-risk-bearing "program manager," which may be a benefits consultant, managing general underwriter, or other sponsor, organizer or promoter. The program manager provides, bundles or otherwise facilitates access to the various products and services required for captive-program maintenance and operation. These services include claims processing and adjudication, actuarial services, banking services, captive management, pharmacy benefits management, compliance and other, related services.

A principal advantage of a group captive is the ability to distribute, annually, dividends that result from a favorable claims experience. In contrast to single-parent captives, group captives do not seek to build large reserves.

In a sponsored group cell captive arrangement, a commercial stop-loss carrier underwrites the employee

[4] For an excellent discussion of the principles underlying captive insurance, see Patricia Born, William T. Hold, *A Comprehensive Evaluation of the Member-Owned Group Captive Option*, published by The National Alliance Program in Risk Management and Insurance College of Business, Florida State University, April 2021.

[5] DOL, Prohibited Transaction Exemption 2000–48. 65 Fed. Reg., p. 60452 (Oct. 11, 2000) (granting individual prohibited transaction exemption to Columbia Energy Group for long-term disability coverage).

health stop-loss risk in the first instance, and then transfers or "cedes" a portion of the risk under an "insurance treaty" to the captive cell owned by the participating employer. The commercial carrier is sometimes referred to as the "fronting" or "ceding" carrier, and the resulting stop-loss coverage is sometimes referred to as a "fronting" arrangement. Access to the commercial carrier's paper is important with respect to licensing. Captive insurers are rarely licensed to transact insurance in each state in which the policyholder or insured risks are located. Under a fronting arrangement, the licensed commercial carrier is the primary underwriter of the risk. Fronting is not free, of course. There is administrative overhead and a risk charge that is passed on to the group captive and absorbed by participating employers.

Group captives are owned by a group of unrelated member companies, and they are formed to insure the member-owners. Group captives are variously classified as heterogeneous or homogeneous. Heterogeneous programs are made up of employers in disparate industries, while homogeneous programs comprise employers in a single industry. In general, heterogeneous captives have a more diverse risk profile, which requires these groups to be larger than their homogeneous counterparts. It is common for program managers to establish multiple captives along industry lines for this very reason. Irrespective of the type of group, promoters also seek to recruit groups with good claims experience, thereby hedging claims volatility and reducing overall plan expenses, all with the goal of making available dividends to members each year (usually after a one-to-two-year lag).

Certain questionable captive employee benefit arrangements have caught the attention of federal and state regulators. These include:

- **Low attachment points:** A stop-loss insurer might offer insurance policies with attachment points set so low that the insurer assumes most of the employer's claims risk. For example, the attachment point could be set at $5,000 per employee, or $100,000 for a small group. While a plan might purport to be self-funded under these circumstances, the arrangement functions much more like a fully insured, high-deductible health plan. The group captives that are the subject of this *Special Report* do not take this approach.
- **Micro-captives/abusive tax shelters:** A micro-captive arrangement is one in which a taxpayer endeavors to reduce aggregate taxable income using a combination of an insurance contract and a captive insurance company. The taxpayer claims deductions for insurance premiums, and the captive insurance company elects to be taxed only on investment income, thereby excluding payments it directly or indirectly receives under the contracts from its taxable income. The IRS in Notice 2016-66 said that the way these contracts are interpreted, administered and applied is inconsistent with arm's-length transactions and sound business practices. The group captives that are the subject of this *Special Report* do seek this sort of tax leverage.
- **Fully insured arrangements that include reinsurance:** IRS Revenue Ruling 2014-15 describes and sanctions use of a captive to reinsure fully insured health benefits. The ruling describes an arrangement in which an employer makes contributions to a funded welfare trust to provide health benefits to certain retirees and their dependents. The trust then purchases insurance from a commercial carrier, which cedes a portion of the risk to a captive 100% owned by the employer. Thus, this arrangement is like a group captive, except that it is fully insured. It is also worth noting that the employer was required, as one of the conditions for approval of the arrangement, to obtain a prohibited transaction exemption from the DOL. The group captives that are the subject of this *Special Report* do not take this approach.

GROUP CAPTIVE STRUCTURE AND ADMINISTRATION

In a sponsored employee benefit group captive structure, each participating employer establishes its own self-funded group health plan. Plan design features and specific and aggregate attachment points for medical stop-loss coverage may (and often do) vary from employer-to-employer based on their unique preferences and appetite for risk. Each participating employer is also usually free to choose its own third-party administrator (TPA) and provider network, although, as a practical matter, participating employers often choose from among the options recommended by the program manager. Participating employers often purchase the commercial layer of stop-loss coverage from the same licensed carrier.

A properly structured and administered group captive arrangement holds out the prospect of a policy dividend in years in which the sponsored employee benefit program has good claims experience. Under a traditional stop-loss program, the benefit of good claims experience accrues to the carrier and the carrier's shareholders. In group captives, however, the dividends are returned to participating employer owners. The prospect of dividends encourages both the captive program organizer and participating employers to adopt and operate their plans efficiently and to take steps to reduce claims.

A captive is a licensed, regulated entity that must qualify within its domicile jurisdiction as an insurance company (captive license laws are less onerous than commercial insurance license laws). Like any business, a captive sponsor or platform owner enters into a transaction to earn a profit and retain the important ability to manage the operating company's risks. Once profitable, dividends are available with the approval of the department of insurance for payment to owners. In such a group captive arrangement, the ceding carrier takes responsibility for payment of claims that exceed the risk retained by the employer. It then transfers a portion of the risk to the employer/sponsor's captive. The arrangement is analogous to the securitization of mortgage loans, in that the excess risk (that is, the risk over and above the anticipated claims and any additional retained risk) is carved up into tranches by agreement or treaty.

Under the insurance treaty, the captive cell is responsible for the tranche immediately above the employer/sponsor's retained risk, up to a pre-set amount. The specific attachment point is a specified dollar amount for each employee, *e.g.*, $50,000 per claim. The captive's layer of risk would start there and rise to, say, $500,000, with the commercial stop-loss carrier being responsible for the portion of a claim that exceeds $500,000. Aggregate stop-loss coverage limits an employer's total liability, which its expressed as some percentage (*e.g.*, 25%) above actuarially anticipated claims. Individual claims that exceed the specific deductible do not accumulate toward the aggregate limit (lest they be double counted). The captive tranche might pay between 125% and 500% of aggregate annual claims; claims that exceed these amounts are the responsibility of the commercial stop-loss carrier.

Two approaches to structuring an employee benefit medical stop-loss captive are allowed in the current market. Under the first approach, the group captive consists of a series of fronted captive cells that are sponsored by the commercial carrier from which the stop-loss coverage is purchased in the manner described above. Under the second approach, the group captive is separately maintained and subscribed to under an enabling state captive law. In one common approach, each employer/member selects the level of its retained risk, which informs the level of the premium paid. The employer/member then pays a premium, a portion of which is allocated to the captive's risk pool. If there are underwriting profits in the risk pool that exceed claims in a year, the excess is

returned to the employer/members *pro rata*, based on premiums and without regard to the employer/member's individual experience. Going forward, each employer/member's experience informs the following year's premiums. This is, of course, no different than what happens under a traditional self-funded plan, the sponsor of which procures stop loss-coverage.

GROUP CAPTIVES AS "SINGLE-EMPLOYER" PLANS AND THE MEWA ISSUE

Critical to the successful operation of any type of group captives is a healthy respect for where risk is shared and where it is not. Risk must not be shared at the level of the underlying group health plan (sometimes referred to as the "ERISA plan") which, in the case of a group captive arrangement, must be a single-employer plan. It is for this reason (and as explained in greater detail below) that group captives cannot be used to provide coverage to associations. To do so would subject the arrangement to the full weight of state insurance regulation, which is anathema to successful group captive structure. Rather, in a properly structured group captive arrangement, it is stop-loss risk that is pooled—and, even then, only up to a point. In addition, the stop-loss insurance must cover the employer, not the plan, and the underlying assets of the ERISA plan must be accounted for, routed and applied properly.

THE UNDERLYING ERISA PLAN

Self-funded employer group health plans are, and are regulated as, "employee welfare benefit plans" as that term is defined and described in ERISA § 3(1). When these plans are established or maintained by a private-sector employer, the plans are subject to ERISA, which—in the case of a group captive—is a good thing. ERISA preempts "any and all State laws insofar as they may now or hereafter relate to any employee benefit plan." This places self-funded plans beyond the reach of state insurance regulators.

There are two important exceptions to ERISA's broad preemption of state law. The ERISA saving clause provides that "nothing in this title shall be construed to exempt or relieve any person from any law of any State which regulates *insurance*, banking, or securities." (Italics added for emphasis). There is also the "deemer" clause, which prevents state regulators from deeming a self-funded plan to be an insurance company.

In practice, this means that a sponsor of one of these types of group captive arrangements must be either a single employer or a group of employers that are treated as a single employer for purposes of the rules set out in the Code governing corporations and other entities under common control. Under these rules, a group of corporations or other entities that is connected through ownership or control is treated as a single employer.

There are three principal types of controlled groups:

- **Parent-subsidiary controlled groups**: This type of controlled group involves a parent corporation and one or more subsidiary corporations in which the parent owns at least 80% of the stock.
- **Brother-sister controlled groups:** A brother-sister controlled group consists of two or more corporations with each corporation owned by the same group of five or fewer individuals, estates or trusts where specified ownership requirements are satisfied.
- **Affiliated-service groups:** Affiliated-service groups are groups of companies that are connected via a commonly owned management service organization. A common example is a group of independent medical practices that jointly own a scheduling company that provides scheduling services to separate medical practices.

A discussion of the affiliated service group rules is beyond the scope of this work. In practice, these rules rarely arise in the group captive context, with two notable exceptions: arrangements covering portfolio companies of a private equity fund or family office; and "friendly medical professional corporation," or "friendly PC," management arrangements (typically, a venture-backed professional corporation that manages physician-owned professional corporations' non-clinical assets and employs administrative staff).[6]

MULTIPLE EMPLOYER WELFARE ARRANGEMENTS (MEWAs)

In 1983, ERISA was amended to expand the ability of the states to regulate plans that cover unrelated employers. In particular, the then-newly added ERISA § 514(b)(6) provides that an employee welfare benefit plan that is a "multiple employer welfare arrangement" may be subject to at least some state insurance laws. The MEWA rules regulate the status of entities that act like insurers but nonetheless claim, due to ERISA's deemer clause, to be plans exempt from any state insurance regulation.

MEWAs are subject to some or all state insurance laws, depending on whether the MEWA is "fully insured." If a MEWA is fully insured, it may be subject to state insurance laws that provide "standards, requiring the maintenance of specified levels of reserves and specified levels of contributions, which any such plan, or any trust established under such a plan, must meet in order to be considered under such law able to pay benefits in full when due." A self-funded MEWA, in contrast, is subject to any state insurance law to the extent such law is not inconsistent with ERISA.[7]

MEWAs can be further subdivided into "plan" and "non-plan" MEWAs. The former, 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. The latter, 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." While this distinction is important in the context of plans that are designed as MEWAs, it is not relevant in the case of most employee benefit group captives. To function properly as such, a group captive must *not* be a MEWA. Since group captives form a part of a self-funded group health plan, a group captive arrangement that is also a MEWA is subject to state law. This means that, in most states, a group captive would be either treated as an unlicensed insurance company or otherwise run afoul of a specifically applicable state law governing self-funded MEWAs.

MEWAs are commonly encountered in the context of industry or trade associations. These can include "association health plans," *i.e.*, plans that cover entities in the same industry, or they can be groups that cover disparate types of employers. While the nature of the group is important in some circumstances, they are all problematic, as the following examples illustrate:

- **Example 1:** National Widget Manufacturer Trade Association has only employers with common-law employees as members. The sponsor of a group captive program strikes a deal with the association to provide a modest discount to individual (single-employer) groups that fit the sponsor's client profile. This is fine. The trade association here is merely a marketing channel. Each end-user client is a single employer, the retained risk of which is not shared.

[6] *See* DOL Information Letter 05-24-2004 (May 24, 2004) (holding that affiliated service group status does not, in and of itself, support the conclusion that a group of trades and businesses is a single employer because affiliated service group status may be based on an interest of less than 25%). While a group of friendly medical PCs might be a single employer for tax purposes, a group health plan covering the group is not a single employer plan for ERISA purposes unless there is at least 25% common control.

[7] ERISA § 514(b)(6)(A)(ii).

- **Example 2:** Consider the same facts as Example 1, except that the claims-underwriting experience of all the covered groups is combined.[8] This is a MEWA. It could also be an unlicensed insurance company for state-law purposes.
- **Example 3:** Consider the same facts as Example 1, except that the association also includes self-employed individuals, all of whom are free to join the captive. Under the ACA rules governing market segmentation, self-employed individuals may only be covered in the individual market. The arrangement does not get the benefit of any ERISA preemption because it does not cover *employees*.[9] (ERISA is, after all the *Employee* Retirement Income Security Act (italics added for emphasis).)

In sum, for an employee benefit group captive arrangement to work as advertised, it must be treated as a series or collection of individual, single-employer group health plans. Stop-loss coverage, which is in the nature of property and casualty insurance, must insure the employer/sponsor.[10] Because the pooling of risk does not occur in connection with the providing 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 central importance, for which there is support,[11] although not in all states.[12]

A MEWA may be either an "employee welfare benefit plan" or an "arrangement." Employee benefit group captive arrangements start from the premise that each participating employer establishes its own, individual plan. But because neither the statute nor any implementing regulations define the term "arrangement" for MEWA purposes, any understanding, program or scheme that results in the provision of ERISA-covered welfare benefits (which of course include medical coverage) to the employees of two or more employers could be deemed to be an arrangement. If a program manager provides a standardized bundle of captive-related administrative products and services to several, unrelated participating employers, might that rise to the level of an arrangement that would result in a MEWA? The DOL says that it does not. The department considered this question in Advisory Opinion 2017-01A, in which it held that a "program of services that facilitates the efficient establishment and operation of employee benefit plans by employer-members" does not create an employee welfare plan.

Not all states are hostile to the group captives that cover unrelated employers. Some states recognize and separately regulate "association" group captives, usually from the same industry. These programs are MEWAs, and they must file DOL Form M-1 in connection with their formation, annually and when otherwise required.

[8] Labor Reg. §2510.3-5 (Jun. 21, 2018). This is the Trump-era rule making that made it possible for certain association-sponsored MEWAs that offer group health coverage (*e.g.*, a plan sponsored by a local chamber of commerce for its members) to be treated as a single "employer" for ERISA purposes. The rule was subsequently invalidated in *State of New York v. United States Department of Labor*, 2019 WL 1410370 (D. D.C. 2019).

[9] *But see*, Data Mktg. P'ship, LP v. United States Dep't of Lab., No. 20-11179, 2022 WL 3440652 (Fifth Cir. Aug. 17, 2022). Organizer, Data Marketing Partnership, offers a health insurance plan to individuals that download an app that tracks data usage. The claim is that covered individuals are all owners of a single business and that the plan is a single-employer group health plan under ERISA.

[10] *See* Centers for Medicare & Medicaid Services Memorandum (Sept. 1, 2011) (describing the "rare instances where the association is considered a single group health plan"); *See also* DOL Advisory Opinions 2005-20A (Dunkin' Donuts) and 2019-01A (Ace Hardware).

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

[12] *See* Regulation Under State Law (relating to the application of state law).

PROHIBITED TRANSACTIONS AND FIDUCIARY SELF-DEALING

What is sometimes referred to generically as the "ERISA-prohibited transaction rules" consists of two rules: one barring prohibited transactions and the other barring fiduciary self-dealing. These rules apply and must be navigated in the context of single-parent employee benefit captives, which usually requires an application to the DOL for an exemption. They are equally problematic in the group captive setting, which is why properly structured group captives are designed to avoid their application altogether.

Where employee benefit captives are concerned, the prohibited transaction rules tend to generate the most worry. Fiduciary self-dealing is less of a concern. For example, the latter may crop up in instances in which the captive organizer or its principals have some ownership rights in the dividend stream of a group captive and there is some involvement with the underlying plans; or where the captive organizer has discretion with respect to the timing or amount of its compensation or the ability to direct ancillary plan-related services to an affiliate. In these and other, similar circumstances, there is yet another reason to steer clear of plan assets altogether.

ERISA § 406(a)(1)(D) prohibits the "transfer to, or use by or for the benefit of, a party in interest, of any assets of the plan." For there to be a violation under this provision, there must be a transaction by a fiduciary, the transaction must involve assets of the plan, and the recipient of those assets must be a party in interest, which may or may not also be a fiduciary.

THE FIDUCIARY

Generally, any person or entity with authority to cause the plan to enter any insurance arrangement is a fiduciary. Employers in their capacity as sponsors and administrators of ERISA-covered group medical plans are both fiduciaries and parties in interest.[13] Entities that they own more than 50% of or to which they are entitled to more than 50% of the profits from are also parties in interest.[14]

Program managers are not usually fiduciaries or parties in interest unless, of course, they provide plan-level services. Where they do provide plan-level services, whether directly or through a majority-owned affiliate, they should be able to qualify for the "service provider" exemption under ERISA § 408(b)(2), which protects against prohibited transactions but not necessarily self-dealing by a fiduciary.[15] Program managers seeking the benefit of the service provider exemption should do so with care. The exemption is narrowly construed.

PLAN ASSETS

Participant contributions are always plan assets, but an insurance policy that is purchased with plan assets is not. What is not clear is whether the transaction between a direct insurer and any reinsurer would involve "assets of the plan." ERISA specifically provides that, where an insurer issues a guaranteed benefit policy to a plan, such as a group term-life policy, the assets of the plan include the policy, but not any assets of the insurer. In other words, the premium ceases to be plan assets once it has been received by the insurer. Therefore, when the insurer transfers assets to the reinsurer, it is transferring its own assets and not "plan assets." Notably, however, the DOL was unwilling to extend this rule to reinsurance provided by

[13] ERISA § 3(14)(C).
[14] ERISA § 3(14)(G).
[15] *But see*, Harley v. Minnesota Min. & Mfg. Co. (Eighth Cir. 2002) (holding that the ERISA service provider exemption extends to fiduciary self-dealing, at least to the extent of any reasonable compensation received by a fiduciary).

wholly owned captives or captive cells. According to the department [44 Fed. Reg. 46365, 46368]:

> "[I]t is the Department's view that if a plan purchases an insurance contract from a company that is unrelated to the employer pursuant to an agreement, arrangement or understanding, written or oral, under which it is expected that the unrelated company will subsequently reinsure all or part of the risk related to such insurance with an insurance company which is a party in interest of the plan, the purchase of the insurance contract would be a prohibited transaction."

PARTY IN INTEREST

For there to be a prohibited transaction, a "party in interest" must receive plan assets. Captive cells owned by their employer-sponsors, or cells within a rent-a-captive where the employer is entitled to more than 50% of the profits, would also be considered parties in interest.[16]

As a result of the application of the above-described rules, a group captive that traffics in plan assets would engage in a prohibited transaction absent an exemption. Group captives must therefore either fit within or obtain an individual exemption or find a way to avoid triggering a prohibited transaction in the first place. Thankfully, there is a relatively simple solution: Do not deal with any plan assets.

Group captives of the types discussed here provide stop-loss coverage. If the stop-loss policy is purchased by the employer and is intended to reimburse the employer, rather than the plan, it is not considered a plan asset. For a garden-variety self-funded plan (*i.e.*, not involving a group captive), whether the stop-loss policy is a plan asset is important only for reporting purposes. If the stop-loss policy is a plan asset, then it must be reported as such on a schedule to the plan's annual report (Form 5500). In the case of a group captive, the stakes are much higher, implicating both the ERISA-prohibited transaction rules and the treatment of MEWAs under state law.

THE ERISA TRUST REQUIREMENT

ERISA requires that plan assets be held in trust, subject to certain exceptions relating principally to fully insured arrangements. Employee contributions are always plan assets, as are employer contributions that are set aside from the employer's general assets. Thus, any self-funded plan that requires employee contributions (*i.e.*, most plans) would ordinarily be required to establish a trust. Recognizing that employee contributions tend to be applied to claims in short order, the DOL has adopted a non-enforcement policy,[17] under which the department will not assert a violation of the ERISA trust requirement where participant contributions are made under a cafeteria plan. Importantly, the department's non-enforcement policy does not mean that employee contributions are not plan assets. Rather, it means that the department will not enforce a violation of the trust requirement if the conditions of the department's policy are adhered to.

The ERISA trust requirement and the department's non-enforcement policy are critically important to the proper design and administration of group captive medical stop-loss arrangements. While some captive arrangements include individual trusts for each employer, most do not. Either way, compliance requires that amounts intended for the payment of claims and the administrative costs of the underlying ERISA plan not be routed through any third party (a violation of the trust requirement), commingled with the assets of other plans (thereby making the plan a MEWA and violating the exclusive-benefit rule) or

[16] Department positions set out in a preamble to a prohibited transaction class exemption do not have the force of law.

[17] Technical Release 92-01.

combined with stop-loss premiums (triggering a prohibited transaction).

Several issues merit additional attention:

- **Third-party routing:** As noted, the DOL's non-enforcement policy is narrow. It applies only to participant contributions in their capacity as plan assets. Done right, amounts intended for the payment of claims and the administrative costs (including employer and employee contributions) are deposited in an account in the name of the employer/plan sponsor, on which the plan's third-party administrator has drawing rights and from which the third-party administrator pays claims and other administrative costs.[18] If the account from which such amounts are paid is in the name of the third-party administrator and not in the name of the employer, then the trust requirement is violated. There is a good reason for this rule: If the third-party administrator becomes insolvent, benefit claims could go unpaid.
- **Commingled assets:** In the bullet point above, if the assets that are held in an account owned by a third-party administrator are commingled with the assets of other plans, then the assets of any one plan are available to cover the claims of other employers. Thus, the plan can be said to cover employees of two, unrelated employers. The result is a MEWA and a violation of the ERISA exclusive-benefit rule.
- **Prohibited transactions:** If a participating employer issues a single check to the captive organizer or the third-party administrator that covers amounts intended for the payment of claims, administrative costs and stop-loss premiums, then plan assets are involved, thereby implicating the prohibited transaction issues discussed in the Prohibited Transactions and Fiduciary Self-Dealing section, above.

As a practical matter, violations of all three of the above-listed items are not uncommon among medical stop-loss group captive programs. Nor are these problems described in the first two bullet points limited to group captives. Rather, they describe practices that are found in self-funded plans of all stripes.

PLACEMENT OF STOP-LOSS COVERAGE

In Advisory Opinion 92-02 (Jan. 17, 1992), the DOL determined that a stop-loss insurance policy purchased by an employer sponsoring a self-insured welfare benefit plan to which employees did not contribute would not be an asset of the plan if the following conditions were satisfied:

- The insurance proceeds from the policies are payable only to the plan sponsor, which is the named insured under the policy.
- 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.
- 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.
- 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.
- 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.

[18] See Placement of Stop-Loss Coverage, below.

Subsequently, in Advisory Opinion 2015-02A, the department opined that a stop-loss policy purchased by a plan that included participant contributions would not be a plan asset if the following conditions were satisfied:

- Except for the use of participant contributions to partly fund medical benefits under the plan, the facts surrounding the purchase of the stop-loss policies satisfy the requirements of the 1992 ruling.
- With respect to the use of participant contributions to fund in part the benefits under the plan, the employer must put in place an accounting system that ensures that the payment of premiums for the stop-loss policy includes no employee contributions.
- The purchase of stop-loss insurance must not relieve the plan of its obligation to pay benefits to plan participants, and the stop-loss insurer has no obligation to pay claims of participants.
- The policies reimburse the plan sponsors only if the plan sponsors pay claims under the plans from their own assets so that the plan sponsors will never receive any reimbursement from the insurer for claim amounts paid with participant contributions.

The DOL elaborated on the accounting system in the second bullet point above (related to the need for an accounting system), noting:

> "Specifically, participant contributions are paid into the general account of [the employer] and recorded in a balance sheet. All health claims and other Plan expenses are paid from this [employer] general account. The plan sponsors will pay premiums for the policies, or any other stop-loss insurance, exclusively from a general account of [the employer]."

Despite the department's attempt at elaboration, its notion of what constitutes adequate accounting is less than clear, based solely on Ad. Op, 2015-02A. The following example should help clarify:

- Employer A hires a third-party administrator to manage its group health plan claims processing, adjudication, and other related tasks and services. The employer establishes an account at Bank X in the name of the employer, in which it deposits funds necessary to pay the plan's obligations. The plan's third-party administrator has drawing rights on the account that are limited to the payment of plan claims and other plan-related expenses. The employer issues a separate check from its general operating account to cover stop-loss premiums and other captive-related expenses.

The final Advisory Opinion bullet point set out above (relating to policies' reimbursements of plan sponsors) is also problematic for most group captives, since it would be unusual for plan sponsors to pay claims in full and await reimbursement from the captive or the stop-loss carrier. Carriers have responded to this conundrum by creating systems and processes that settle stop-loss claims in real time. These include simultaneous, specific stop-loss funding (a.k.a., advanced spec) and "aggregate-accommodation" products. Simultaneous or advance reimbursement allows the employer to submit claim amounts that exceed the specific deductible for reimbursement prior to paying the claim. This prevents large claims from negatively affecting an employer's cash flow. Similarly, the aggregate accommodation option limits monthly aggregate claims liability by funding amounts that exceed an accumulated monthly attachment point.

REGULATION UNDER STATE LAW

In the ERISA regulatory scheme, stop-loss coverage is insurance and is subject to regulation as such by the states by virtue of the ERISA saving clause. State regulation of stop-loss insurance typically takes one of three forms:[19]

- Setting minimum attachment points to ensure that stop-loss policies are only used for excess coverage and not as a replacement for health insurance (*e.g.*, as in the National Association of Insurance Commissioners (NAIC) Stop-Loss Insurance Model Act).
- Prohibiting stop-loss insurance for small groups, thus requiring small groups to have more funding available to self-insure (*e.g.*, Delaware and New York).
- Regulating stop-loss insurance as if it were health insurance, including setting minimum coverage requirements (*e.g.*, North Carolina).

REGULATING MINIMUM ATTACHMENT POINTS

The NAIC Stop-Loss Insurance Model Act establishes minimum attachment points and prohibits stop-loss policies from directly covering individual healthcare expenses. Under the act, an insurer may not issue a stop-loss policy with an attachment point (i) lower than $20,000 per individual, (ii) for groups of 50 or fewer, lower than the greater of $4,000 times the number of members, 120% of expected claims or $20,000, or (iii) for groups of 51 or more, lower than 110% of expected claims.

At least four states have enacted a version of the model act: Minnesota (Minn. Stat. §§ 60A.235 *et seq.*), New Hampshire (N.H. Rev. Stat. Ann. §§ 415-H:1 *et seq.*), Rhode Island (R.I. Gen. Laws §§ 27-8.2-1 *et seq.*) and Vermont (21-040 VT. Code R. § 024). While Minnesota, New Hampshire and Rhode Island each require a minimum individual attachment point of at least $20,000, Vermont requires it to be at least $28,700. Similarly, California SB 161 prohibits stop-loss insurers in California from issuing policies with specific deductibles below $40,000 to groups that have between one and 100 employees. Nor may aggregate attachment points be less than the greater of $5,000 times the total number of group members, 120% of expected claims or $40,000. Several other states have taken state action to regulate stop-loss insurance by enacting regulations or issuing administrative bulletins.

PROHIBITING STOP-LOSS INSURANCE FOR SMALL GROUPS

At least two states prohibit insurers from selling stop-loss policies to small groups. Delaware prohibits small-group health insurers from issuing stop-loss policies to employers with five or fewer employees, and it requires employers receiving stop-loss policies to have most of their employees employed in the state (Del. Code Ann. 18 § 7218). New York law prohibits the sale of all stop-loss policies to small employers (N.Y. Ins. Law §§ 3231 & 4317).

REGULATING STOP-LOSS INSURANCE AS HEALTH INSURANCE

North Carolina regulates stop-loss insurance by requiring minimum attachment points and the meeting of underwriting, rating and certain other standards typically associated with health insurance for policies

[19] See generally, Alex Reger and Kristen Miller, *State Regulation of Stop Loss Insurance*, Connecticut Office of Legislative Research, Sept. 27, 2019.

issued to small employers with fewer than 26 employees. These include guaranteed availability and renewability, required whole group coverage (*i.e.*, no individual underwriting) and a standard rating system for all small-employer group health plans (N.C. Gen. Stat. § 58–50–130 and North Carolina Department of Insurance Stop-Loss Insurance).

THE STOP-LOSS LAYER

The ACA transformed healthcare coverage and financing in the United States. At the center of the ACA are the "insurance market" reforms, which took the form of amendments to the Public Health Service Act that were also incorporated into ERISA and the Code. These reforms include the elimination of lifetime limits on coverage, restrictions on annual limits on coverage, a prohibition on rescinding coverage except in cases of fraud and the elimination of preexisting conditions, among others. These ACA requirements are imposed on group health plans and on *health insurance* issuers. Stop-loss coverage is, however, not health insurance.[20] It is, rather, property and casualty coverage, which protects the plan sponsor (and not the plan) against excess liability.

The ACA's ban on lifetime and annual limits poses a challenge to stop-loss carriers. Prior to the ACA, stop-loss polices routinely imposed lifetime limits, thereby permitting carriers to limit their exposure. Thus, stop-loss policies may still adopt these sorts of limits and more.

While stop-loss coverage should coordinate seamlessly with the terms of the underlying group health plan, this is not always the case. Some carriers impose lifetime limits to modulate their top-line exposure, and they sometimes identify specific individuals with large, ongoing medical conditions and exclude them from stop loss coverage (a practice referred to as "lasering"). For example, a policy's specific attachment point might be $100,000, but the attachment point for an individual participant with a rare or expensive medical condition might be set at $200,000. Since lasering is backward-looking, newly added members may not be lasered until renewal. The problem in either case, lifetime limits or lasers, is that the accompanying costs, when they arise, are borne by the employer/plan sponsor. "No laser" and "no new laser" contracts are available, but they come at a cost.

There are other ways to reduce an employer's exposure to catastrophic claims. Under what is referred to as a "rate-cap option," a carrier agrees to cap renewal increases at, say, 40%, irrespective of known risks and in return for negotiated premium increase.

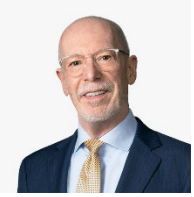
CONCLUSION

Employer-owned group captives that reinsure medical stop-loss insurance can be structured to rest on a solid regulatory foundation. To be ideally positioned to withstand challenge, employer-owned group captives need to establish insurance programs that follow the steps described above, including requiring employers to establish self-funded plans, select the various service providers for both the underlying plans and the stop-loss layers, and pay particular attention to the manner in which benefit claims and stop-loss coverage are procured and paid for. These requirements are set out in the ERISA Trust Requirement and Placement of Stop-Loss Coverage sections above.

Employer medical stop-loss group captives represent a viable and practical market solution. But it is a solution that requires plan sponsors, stop-loss carriers and captive organizers alike to pay attention to a host of rules that are complex and can at best be described as "challenging." Plan sponsors must exercise diligence when considering entering a group captive medical stop-loss insurance program and should do so with the advice of ERISA counsel.

[20] See Regulation Under State Law, above.

CONTRIBUTORS



ALDEN J. BIANCHI
COUNSEL

abianchi@mwe.com
Tel +1 617 535 4152

LISA M. KADERABEK
PARTNER

lkaderabek@mwe.com
Tel +1 312 984 7649

TEAL N. TRUJILLO
ASSOCIATE

ttrujillo@mwe.com
Tel +1 312 984 6910

The authors extend their thanks and appreciation to the following individuals and organizations who either assisted with or otherwise served as a resource (wittingly or otherwise) for this *Special Report*: David Shore, Employee Benefits Practice Leader, Borislow Insurance, was kind enough to review and offer comments on captive structure in the Group Captive Structure and Administration and the Stop-Loss Layer sections. Arthur Koritzinsky, Marsh Captive Solutions Group; Karin Landry, Managing Partner, Spring Consulting Group, an Alera Group Company; Michael (Mick) Rogers, Managing Partner and Founder, Axial Benefits Group; John Rutledge, Vice President, Assurance, a Marsh & McLennan Agency LLC Company; and Devin Taylor, General Counsel, Beyond Risk, helped us understand the practical issues involving group captives generally. Lastly, thanks to Alex Reger, Kristen Miller and the State of Connecticut Office of Legislative Research for their survey of applicable state laws, which we drew upon liberally in the Regulation Under State Law section.

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