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Section 125 Plans in the Post-reform Environment: Issues for Individual Insurance

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INTRODUCTION

Prior to the enactment of the Patient Protection and Affordable Care Act ("PPACA"), many public policymakers were interested in encouraging employers to take advantage of existing federal tax laws in order to make health insurance more affordable for employees. For instance, several states passed laws requiring or encouraging employers who did not offer group health coverage to establish a cafeteria plan pursuant to section 125 of the tax code in order to allow employees to purchase individual health insurance on a pre-tax basis. The tax savings that result from using a section 125 plan to pay for health premiums are substantial; the employee does not have to pay federal income or payroll taxes on such amounts, and generally escapes state income taxation as well.

While section 125 plans appeared to be a viable way to make health insurance more affordable, there was concern that these state laws would inadvertently cause employers to violate the non-discrimination requirements of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA")[i]. PPACA, however, will fundamentally change how individual health insurance is offered and paid for. Therefore, its passage calls for re-examination of whether individual insurance can be paid on a pre-tax basis through a cafeteria plan.

BACKGROUND

HIPAA prohibits group health plans from discriminating against individuals based on health status with respect to premiums, eligibility, and benefits. These non-discrimination provisions are codified in both the Employee Retirement Income Security Act of 1974 ("ERISA") and the federal income tax code. Employers who currently offer their employees a group health plan must already comply with HIPAA's non-discrimination requirements. For these employers, allowing employees to pay health insurance premiums through section 125 plans does not create any concerns with HIPAA compliance. Rather, the concern centers on employers who do not currently offer a group health plan to employees.

The specific concern is whether the use of a section 125 plan in and of itself invokes HIPAA's group health plan provisions. If the use of a section 125 plan creates a group health plan, then the individual health insurance policies that are funded through the section 125 plan would be subject to the nondiscrimination requirements of HIPAA. Because the health insurance policies would be individually purchased, and in most states subject to individual medical underwriting or risk rating, both eligibility for coverage and individual premiums could differ based on health status, thus violating HIPAA.

The definition of "group health plan" is therefore critical. Complicating matters is the fact that HIPAA's non-discrimination requirements are included in both ERISA and the tax code, and both statutes use different definitions of this key term. As has been detailed elsewhere, using a section 125 plan to pay for individual health insurance, without any other employer involvement or contribution, does not create a group health plan for purposes of ERISA.[ii] The cause of the legal uncertainty is the tax code definition of "group health plan." The tax code defines a group health plan as a plan "of, or contributed to by, an employer."[iii] On its face, this definition does not appear to lead to an outcome any different than that under ERISA. However, the tax code treats employee elections to contribute to section 125 plans as elections to forgo salary in return for the offered benefits. This foregone salary is then used by the employer to pay for the elected benefits, and is treated as the employer's money for tax purposes. The open question is whether the use of section 125 plans creates an employer contribution to health insurance, which in turn creates a group health plan for HIPAA purposes.

Given this legal uncertainty, many insurers and benefits advisors backed away from using section 125 plans to pay for individual health insurance, except in the few states that bar medical underwriting for individual insurance. [iv] Therefore, most states that passed laws encouraging such arrangements saw relatively little activity. In addition, with federal health reform legislation pending, many states and market participants chose a wait and see approach in this area. The sections below analyze PPACA's likely effects on using section 125 plans to pay for individual health insurance.

KEY PROVISIONS OF PPACA

PPACA in many ways will change how health insurance is priced, purchased, and paid for in this country. Among other things, PPACA imposes guaranteed issue requirements on all insurers, substantially limits the ability of insurers to vary premiums, establishes state-based exchanges for the purchase of individual and small group insurance, and provides substantial tax credits to subsidize the cost of health insurance for low and moderate income individuals. Despite these reforms, affordability concerns are likely to remain for those individuals not eligible for premium tax credits and for whom subsidized employer coverage is unavailable. As a result, interest in expanding the use of section 125 plans to pay for individual health insurance will remain.

PPACA amends section 125 of the tax code to provide that insurance purchased through a state exchange may not be funded through a cafeteria plan unless the employee's employer is eligible to participate in the exchange and elects to make group coverage available to employees through the exchange.[v,vi] In other words, individual health insurance offered through a state exchange may not be purchased on a pre-tax basis through a cafeteria plan.

Regardless of where or how insurance is purchased, PPACA substantially reduces the possible discrimination that individuals can face with respect to health insurance eligibility and premiums. Beginning in 2014, individual and small group health insurance premiums may vary only based on age, family size, geographic area, and tobacco use.[vii] In addition, all health insurance issuers in the individual and group markets must accept every individual and employer that applies for coverage.[viii]

LEGAL ANALYSIS

PPACA's amendment of section 125 makes it clear that cafeteria plans may not be used to allow individual health insurance to be purchased on a pre-tax basis when such purchases are made through state-based exchanges. However, it leaves open the question of whether cafeteria plans may be used to purchase individual insurance outside of an exchange.[ix]

As a matter of statutory interpretation, the fact that PPACA amended section 125 of the tax code to prohibit the use of cafeteria plans to fund individual, exchange-based coverage suggests that purchases of individual insurance policies may otherwise be permitted through a cafeteria plan. If it was impermissible to pay for such individual policies through a cafeteria plan, there would be no need to amend section 125 for individual, exchange-based policies. Further, the fact that Congress chose to amend section 125 only for exchange-based policies and did not, for example, simply state that individual health insurance policies were not eligible benefits under a cafeteria plan or that health insurance coverage that was not part of a group health plan was not a qualified benefit, suggests that cafeteria plans can be used for non-exchange-based individual policies. Of course, even if section 125 permits the purchase of non-exchange-based individual policies, HIPAA may still be violated by utilizing such arrangements.

If a section 125 plan creates a group health plan for purposes of HIPAA, under current law HIPAA's nondiscrimination requirements would be violated in the vast majority of states that allow medical underwriting in the individual insurance market. But, almost all forms of medical underwriting will cease once PPACA's insurance market reforms take full effect in 2014. Because PPACA enacts guaranteed issue requirements, any concern with respect to discrimination in eligibility is removed. And PPACA's restrictions on premium pricing substantially limit concerns with respect to premium discrimination. Beginning in 2014, the only "health status" on which premiums may vary is tobacco use. Still, because individual premiums could vary based on this one element of health status, HIPAA's non-discrimination requirements might remain a concern.

PPACA, however, provides that its insurance pricing provisions are to be included in the tax code and that, in the event of a conflict between PPACA's provisions and current tax code provisions, PPACA shall control. Because PPACA specifically provides that individual insurance premiums may vary based on one, and only one, health status — tobacco use — the current provisions that bar all forms of health status discrimination would appear to conflict. If this interpretation is correct, PPACA's provisions would control, and individual premiums could vary based on tobacco use without creating a non-discrimination problem. As a result, it may be that beginning in 2014 when PPACA's insurance pricing provisions take effect there will no longer be a legal impediment to using section 125 plans to pay for individual insurance policies purchased outside of state exchanges. Moreover, even if premium-rating based on tobacco use were to remain problematic, there appears to be no legal barrier to using section 125 plans for policies sold by insurers that opt not to use this particular rating element.

CONCLUSIONS

Prior to the passage of PPACA, the legal uncertainty surrounding the use of section 125 plans to pay for individual policies of health insurance prevented efforts to do so from getting off the ground. While the language of PPACA precludes using section 125 plans for exchange-based individual insurance, it leaves open the possibility of section 125 plan use outside of an exchange. PPACA provides fairly strong arguments that non-exchange-based individual insurance policies may be purchased through a section 125 plan, but it fails to state so explicitly. In addition, PPACA's guaranteed issue requirements and substantial limitations on medical underwriting significantly reduce concerns regarding discrimination based on health status. It is quite possible that once PPACA's insurance market reforms take effect in 2014, PPACA's provisions will trump HIPAA's non-discrimination rules, but this is not entirely clear from the statutory provisions. Pre-tax payment of premiums will likely remain a critical affordability issue following the implementation of PPACA. Therefore, federal regulators should give employers, insurers and public policy officials clear guidance that section 125 plans may be used for any type of comprehensive health insurance sold outside of exchanges.

This report is a companion to the authors' January 2009 issue brief analyzing the legality of states requiring that employers offer Section 125 Plans to their employees. The earlier brief explains the basis for this legal concern, and presents contrary legal arguments. It concludes that the current state of the law is unclear and is subject to change. The first brief can be found at http://www.shadac.org/files/shadac/publications/IssueBrief_HIPAA_2009Jan.pdf.

NOTES

[i] See Amy B. Monahan & Mark A. Hall, Section 125 Plans for Individual Insurance and HIPAA's Group Insurance Provisions, available at http://papers.ssrn.com/sol3/papers.cfm?abstract_id=1283780; Patricia A. Butler, Employer Cafeteria Plans: States' Legal and Policy Issues (Oct. 2008), available at www.chcf.org/publications/.
[ii] See Monahan & Hall, *supra* note 1.
[iii] I.R.C. section 5000(b)(1).
[iv] Mark A. Hall & Amy B. Monahan, *Paying for Individual Health Insurance through Tax-Sheltered Cafeteria Plans*, INQUIRY (forthcoming 2010).
[v] An employer is exchange-eligible if it averages fewer than 100 full-time employees during the year, or fewer than 50 full-time employees at the state's election.
[vi] PPACA § 1515.
[vii] PPACA § 2701.
[viii] PPACA § 2703.
[ix] Under PPACA, insurance companies are free to offer coverage outside of the state-based exchanges. However, individuals who are eligible for premium tax credits must purchase their coverage through an exchange in order to receive a tax credit.

ABOUT THE SHARE INITIATIVE

SHARE is a national program of the Robert Wood Johnson Foundation and is located at the University of Minnesota's State Health Access Data Assistance Center (SHADAC).

The SHARE project has the following key goals:

1. Coordinate evaluations of state reform efforts in a way that establishes a body of evidence to inform state and national policy makers on the mechanisms required for successful health reform.
2. Identify and address gaps in research on state health reform activities from a state and national policy perspective.
3. Disseminate findings in a manner that is meaningful and user-friendly for state and national policy makers, state agencies, and researchers alike.

To accomplish these goals, SHARE has funded 16 projects covering 29 states.

CONTACTING SHARE

The State Health Access Reform Evaluation (SHARE) is a Robert Wood Johnson Foundation (RWJF) program that aims to provide evidence to state policy makers on specific mechanisms that contribute to successful state health reform efforts. The program operates out of the State Health Access Data Assistance Center (SHADAC), an RWJF-funded research center in the Division of Health Policy and Management, School of Public Health, University of Minnesota. Information is available at www.statereformevaluation.org.

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