

SECTION 125 PLANS FOR INDIVIDUAL INSURANCE AND HIPAA'S GROUP INSURANCE PROVISIONS

Amy B. Monahan, J.D.¹

Mark A. Hall, J.D.²

October 2008

Several states have either passed or proposed legislation requiring employers to offer their employees the ability to pay for health insurance on a pre-tax basis through a “cafeteria” (or “premium-only” or “flexible spending”) plan under section 125 of the tax code (a “section 125 plan”). Prior to these initiatives, many employers voluntarily established section 125 plans for this purpose. Recently, some authorities have raised a serious concern about the legality of this arrangement under the federal Health Insurance Portability and Accountability Act of 1996 (“HIPAA”).³ Specifically, they maintain that, under the tax code, section 125 plans cannot be used to purchase medically-underwritten individual insurance because doing so would violate HIPAA’s non-discrimination provisions for group plans.

This issue 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.

BACKGROUND

HIPAA prohibits group health plans from discriminating against individuals based on health status. These non-discrimination provisions apply both to eligibility to enroll in a group health plan and to premium contributions, and are contained 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, using section 125 plans to pay health insurance premiums 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.

For employers that do not currently offer health care coverage, if the combination of a section 125 plan and individually-purchased health insurance is considered a group health plan, the arrangement would be subject to HIPAA’s non-discrimination requirements.

¹ Visiting Associate Professor, University of Minnesota Law School and Associate Professor, University of Missouri School of Law.

² Fred D. and Elizabeth L. Turnage Professor of Law and Public Health, Wake Forest University. This policy brief was funded by a grant from the Robert Wood Johnson Foundation’s State Health Access Reform Evaluation program, but this support does not imply endorsement of the views expressed here.

³ See, e.g., Patricia A. Butler, J.D., Legal Issues in State Requirements that Employers Offer Cafeteria (Section 125) Plans (Oct. 2008), available at www.chcf.org/publications/.

Because the health insurance policies would be individually purchased, and subject in most states to individual medical underwriting and risk rating, both eligibility for coverage and premiums charged for the individual policies could differ based on health status, in violation of HIPAA.

Resolving this issue is complicated by the fact that HIPAA's non-discrimination provisions are codified both in ERISA and the tax code, which use different definitions of "group health plan." Rulings under ERISA have clarified that individual insurance policies purchased through a section 125 plan do not constitute group health plans as long as the employer does not contribute to the premium and does not otherwise sponsor or promote the insurance. Therefore, this brief will primarily focus on the same issue under the tax code.

KEY STATUTORY PROVISIONS

The crux of the issue under the tax code is this: in order for funds placed in a section 125 plan to not be taxed to the employee, the tax code considers these funds as belonging to the employer, so they never become employee income subject to taxation. (More technically speaking, section 125 funds are excluded from income because they are used to purchase qualified employee benefits under section 106.)⁴ The tax code defines group health plan as a plan "*of, or contributed to by, an employer.*" 26 U.S.C. 5000(b)(1). Even though section 125 funds are perceived as coming from employees' wages (for instance, employees' pay stubs show them as payroll deductions and employees contribute to them through "salary reduction agreements"), tax code regulations technically declare them to be the employer's. Thus, using a section 125 plan to pay for insurance might be viewed as automatically triggering HIPAA's requirements for employer-sponsored group insurance, even when used only to pay for insurance that is issued and state-regulated as purely individual insurance.

If an employee's election to forgo salary in order to pay for health insurance premiums through a section 125 plan automatically makes the health insurance plan "*of, or contributed to by, an employer,*" then employees could not pay health insurance premiums on a pre-tax basis without having such coverage meet HIPAA's requirements for group health coverage (which include guarantee issue, limits on pre-existing exclusion periods, and prohibition of individual risk-rating). There are no regulations, nor any cases, directly interpreting the tax code's definition of group health insurance for purposes of HIPAA.⁵ However, at least one Treasury Department official (in the Office

⁴ Section 106 provides "[e]xcept as otherwise provided in this section, gross income of an employee does not include *employer-provided coverage* under an accident or health plan." According to proposed Treasury Regulations, when an employee makes an election to pay for health insurance coverage under a section 125 plan, it is considered an election to forgo salary in return for an *employer* contribution toward the benefit. Prop. Reg. §1.125-1(r)(2). As a result, the section 106 requirement that the coverage be *employer-provided* is satisfied.

⁵ As discussed below, the same definition of "group health plan" is used for other purposes, such as the Medicare Secondary Payer rules and the COBRA continuation coverage rules, and there are interpreting

of Tax Policy) has recently agreed with this interpretation, in informal, nonbinding, and unwritten remarks.⁶

CONTRARY AUTHORITY

Proposed Section 125 Regulations

Despite the apparent consistency of this interpretation of the tax code, there are several reasonable arguments why using a section 125 plan to pay for individual insurance might not trigger HIPAA's group insurance requirements.⁷ First, such an interpretation would appear to be inconsistent with proposed regulations under section 125. Following previous Treasury Department policy, proposed regulations permit section 125 plans to be used to pay "employees' substantiated individual health insurance premiums" ... Prop. Reg. § 1.125-1(m), 72 Fed. Reg. 43953 (Aug. 6, 2007). Logically, if paying for individual insurance through a section 125 plan automatically converted the insurance to a group plan under the Code's definition, then it would be contradictory to say that section 125 plans may be used to purchase individual insurance. Recognizing or allowing the possibility of employee-paid individual insurance seems to suggest that using a section 125 plan does not automatically convert insurance to a group plan. However, these regulations are only proposed. Finalization is not expected until the end of 2008 or early 2009, and the draft regulations may change in the meantime.

COBRA

A second argument against this reading of the tax code is that this same definition of group health insurance appears in COBRA's continuation of coverage provisions (which allow workers to remain in a group plan for a period of time after leaving employment). It is not sensible to apply COBRA to purely individual insurance purchased through a 125 plan because the purpose of COBRA is to permit an employee to remain with an employer group plan after leaving employment. Workers who lose employment do not lose eligibility for their individual insurance, for the very reason that it is not actually group insurance. Employees lose only the ability to pay for the insurance through an

cases and regulations in both of those contexts, but those interpretations do not directly govern HIPAA's non-discrimination provisions.

⁶ See Butler, *supra* note 3; Employee Benefits Institute of America Manual, 3rd Quarter 2008 supplement, p. 329, note 224.

⁷ In addition to these arguments, HIPAA's legislative history does not support the position that its group insurance provisions should apply to employees who choose their own individual policies. For example, with respect to the prohibition on exclusions based on health status, the conference committee report states, "[T]his provision is meant to prohibit insurers or employers from excluding employees in a group from coverage or charging them higher premiums based on their health status or other related factors that could lead to higher health costs. This does not mean that an entire group cannot be charged more. But it does preclude health plans from singling out individuals in the group for higher premiums or dropping them from coverage altogether." <http://www.house.gov/jct/x-29-99.htm> The fair implication appears to be a concern with either (1) insurance products issued on the group market or (2) self-insured plans that cover a group of employees. Neither of these situations is present where individual employees shop on the individual market for health insurance and merely pays such premiums through a section 125 plan.

employer's section 125 plan, but COBRA generally cannot restore that ability since the individual is no longer receiving a salary that can be allocated to a section 125 plan.⁸

Therefore, it is largely nonsensical to apply COBRA's "*of, or contributed to by, an employer*" language to this situation. Nor is this required by COBRA's regulations. The regulations are not entirely clear on this point because they confusingly say that they apply to "one or more individual insurance policies in any arrangement [maintained by an employer] that involves the provision of health care to two or more employees" § 54.4980B-2. But this proviso appears directed to types of insurance policies that effectively are the same as employer-sponsored group insurance, even when they are not technically regulated or issued as such. The COBRA regulations do not say that they apply to *any* type of individual insurance, nor do they say that an employee who purchases what undeniably is true individual insurance automatically converts the policy to an employer group plan simply by paying for it through a section 125 plan. (Instead, they say only that insurance that is otherwise a group plan does not lose its group status simply because employees elect it through a section 125 plan.)

Medicare's Secondary Payer Statute

The tax code's definition of group health plan is also referenced by Medicare's Secondary Payer statute. This has generated the only relevant appellate court interpretation of the "*of, or contributed to by, an employer*" statutory language. *Brooks v. Blue Cross & Blue Shield of Florida*, 116 F.3d 1364 (11th Cir. 1997) considered and rejected arguments similar to the ones being advanced here. It held that individual health insurance policies purchased through payroll deduction do not constitute a group health plan, despite the fact that Medicare regulations include "employee-pay-all plans":

The parties have expended considerable efforts in arguing whether or not the inclusion of "employee-pay-all" plans in the definition of "group health plan" in the regulations goes beyond the meaning of the statute. However, we need not address this question because we find that the basis upon which the Insurer Defendants' policies fall outside the statutory definition of "group health plan" is more fundamental. The Insurer Defendants were simply not providing group insurance or a "plan" of insurance to the Plaintiffs. The pleadings demonstrate that the Insurer Defendants issued *individual* policies of insurance to the Individual Plaintiffs...The Individual Plaintiffs applied separately for insurance with the Insurer Defendants and were issued independent Medigap insurance policies by the Insurer Defendants...Furthermore, the record is devoid of any indication that a group insurance policy, comprehensive policy, blanket policy, or other master plan of insurance ever issued to any of the Employer Plaintiffs by the Insurer Defendants. *Id.* at 1372-73.

⁸ It is possible to pay for COBRA premiums through a section 125 plan only where severance pay is being received, or where an election is made to pay for such premiums through funds placed in a section 125 plan prior to the final paycheck.

In rejecting more technical regulatory and statutory arguments, the court favored the more common sense view that individual insurance policies purchased by employees with no involvement on the part of an employer other than facilitating payroll deductions do not constitute a group health plan. Although this case did not address precisely the use of section 125 plans, it did address the definition of group health plan in the tax code and so it is highly relevant.

ERISA

Finally, if the HIPAA provisions in the tax code were interpreted to apply to individual policies purchased through section 125 plans, this would conflict with the fairly settled and court-tested interpretation of the same provisions under ERISA. HIPAA's group plan provisions are codified identically in both the tax code and ERISA. The only difference is that ERISA defines group health plan as one "*established or maintained* by an employer" (rather than "of, or contributed to by, an employer"). 29 U.S.C. §1002(1). The Department of Labor has issued an opinion letter stating that a premium-only section 125 plan is not, by itself, an employee welfare benefit plan governed by ERISA.⁹ In that ruling, the Department of Labor explained that "provision of this tax-favored treatment . . . is not the equivalent of the provision of a benefit It is therefore the position of the Department that the Pre-Tax Plan . . . does not constitute, in itself, a separate employee welfare benefit plan" under ERISA. Also, ERISA has a safe harbor regulation that declares that ERISA does not apply to arrangements where employers make no contributions to the purchase of group or group-type insurance but merely make such insurance available to employees should they voluntarily chose to enroll in such coverage. 29 C.F.R. § 2510-3-1(j).

Neither of these Department of Labor positions is totally conclusive of the possibility being explored here, but the primary cases in which courts have found individual health insurance policies to constitute an ERISA plan are special situations where employers pay the premiums and/or select the insurance, and the policies are part of a larger overall scheme to provide employees with health insurance.¹⁰ Where employees are left on their own to purchase individual health insurance policies, courts have found no ERISA group

⁹ DOL Op. Ltr. 96-12A (July 17, 1996), available at <http://www.dol.gov/ebsa/programs/ori/advisory96/96-12a.htm>.

¹⁰ See, e.g., *Peterson v. American Life & Health Ins. Co.*, 48 F.3d 404 (9th Cir. 1995) (holding that an individual insurance policy was part of an ERISA plan where the employer "not only paid its partners' and employees' insurance premiums but also played an active role in the administration of the coverage, including choosing the insurance, adding and deleting employees and partners from various policies, contacting insurance companies for employees and partners, and distributing information relevant to the coverage"); *Heidelberg v. National Foundation Life Ins. Co.*, 2000 WL 1693635 (E.D. La. 2000) (holding that the employer's purchase of two individual health insurance policies constituted an ERISA plan where there was evidence of employer intent to provide health insurance coverage for its white-collar employees and testimony that, had it been economically feasible, the employer would have purchased a group policy rather than two individual policies); *Burrill v. Leco Corp.*, 1998 WL 34078144 (W.D. Mich. 1998) (holding that several individual insurance policies purchased by the employer constituted a group health plan for COBRA purposes where such plans were "an integral part of a broader scheme to provide health coverage to LECO employees.").

plan to exist.¹¹ The only case dealing directly with section 125 plan contributions and ERISA's safe harbor regulation is *Hrabe v. Paul Revere Life Ins. Co.*, 951 F. Supp. 997 (M.D. Ala. 1996). There the court specifically found that an employee's election to pay for benefits on a pre-tax basis through a section 125 plan does *not* establish that the employer has contributed to the purchase of the benefit, and therefore one of the safe harbor's requirements is not defeated.¹² Although another federal district court found that paying for benefits on a pre-tax basis voided the safe harbor, *Brown v. Paul Revere Life Ins. Co.*, 2002 WL 1019021 (E.D. Pa. 2002), that case can be distinguished because the employer paid the premiums out of bonuses that were allocated, but not yet paid, to the employees.

CONCLUSION

The tax code's treatment of section 125 funds as belonging to employers, even though they are withheld from employees' wages, complicates efforts to clarify the definition of group health plan under HIPAA. HIPAA's definition turns mainly on whether the employer pays for or sponsors the health insurance. This part of HIPAA is codified in two places. Under ERISA, it appears fairly well settled that merely allowing employees to pay for individual policies through a section 125 plan does not convert them to group health plans. Under the tax code, the very same question is in doubt, though, because clarifying rulings have not been issued, and informal guidance from one official reaches the opposite interpretation.

There are several reasonable legal arguments to support the position that HIPAA does not apply in this situation. However, until the Treasury Department resolves this issue, or until it is tested in the courts, it is not safe to assume that HIPAA's group insurance provisions do not apply to individual insurance purchased through a section 125 plan.

This legal uncertainty will complicate states' attempts to use section 125 plans to lower the costs of individual insurance, and may discourage employers from adopting or continuing this use of section 125 plans. However, this complication may also help to keep employers from dropping group insurance, or it may encourage some states to reform their non-group health insurance markets to offer protections similar to those in the group market. Further research is required to determine which of these possible public policy effects is likely to predominate.

¹¹ See, e.g., *New England Mut. Life Ins. Co. v. Baig*, 166 F. 3d 1 (1st Cir. 1999); *Strange v. Plaza Excavating, Inc.*, 2001 WL 114407 (N.D. Ill. 2001); *O'Brien v. Mutual of Omaha Ins. Co.*, 99 F. Supp.2d 744 (E.D. La. 1999).

¹² The court did find that the use of the cafeteria plan, together with other employer actions, constituted an employer endorsement of the plan, thereby causing the plan to fail another part of the safe harbor. See also *Stoudemire v. Provident Life and Accident Ins. Co.*, 24 F. Supp. 2d 1252 (M.D. Ala. 1998) (finding an ERISA plan where employer actively promoted and endorsed the policy that was purchased through a 125 plan); *Butero v. Royal Maccabees Life Ins. Co.*, 174 F.3d 1207 (11th Cir. 1999) (similar).