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## The Use of Section 125 Plans for Individual Insurance Following the Enactment of Federal Health Reform

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### INTRODUCTION

Prior to the enactment of the Patient Protection and Affordable Care Act (the “ACA”), 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”)<sup>i</sup>. The ACA, 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.<sup>ii</sup> 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.”<sup>iii</sup> 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.<sup>iv</sup> 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 the ACA’s likely effects on using section 125 plans to pay for individual health insurance.

## KEY PROVISIONS OF THE ACA

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The ACA in many ways will change how health insurance is priced, purchased, and paid for in this country. Among other things, the ACA imposes guaranteed issue requirements on all insurers, substantially limits the ability of insurers to vary premiums, establishes 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.

The ACA amends section 125 of the tax code to provide that insurance purchased through a state or federal 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.<sup>v,vi</sup> In other words, individual health insurance offered through an ACA exchange may not be purchased on a pre-tax basis through a cafeteria plan.

Regardless of where or how insurance is purchased, the ACA 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.<sup>vii</sup> In addition, all health insurance issuers in the individual and group markets must accept every individual and employer that applies for coverage.<sup>viii</sup>

The ACA also requires that group health plans meet certain new standards, including covering certain preventive services in full and imposing no lifetime or annual limits on certain benefits.

## LEGAL ANALYSIS

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The ACA'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 ACA exchanges. However, it leaves open the question of whether cafeteria plans may be used to purchase individual insurance outside of an exchange.<sup>ix</sup>

As a matter of statutory interpretation, the fact that the ACA 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 would 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 could 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 ceased once the ACA's insurance market reforms took full effect in 2014. Because the ACA enacts guaranteed issue requirements, any concern with respect to discrimination in eligibility is removed. And the ACA'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.

The ACA, however, provides that its insurance pricing provisions are to be included in the tax code and that, in the event of a conflict between the ACA's provisions and current tax code provisions, the ACA shall control. Because the ACA 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, the ACA's provisions would control, and individual premiums could vary based on tobacco use without creating a non-discrimination problem. .

The ACA creates a new legal hurdle, however. It requires group health plans to meet certain standards, such as covering certain preventive services in full, and imposing no lifetime or annual limits on essential health benefits. In IRS Notice 2013-54, the IRS stated that, under its interpretation of relevant law, a group health plan is defined in such a way as to include not only insurance sponsored by employers, but also the establishment of a section 125 plan that is used to purchase individual insurance. As a group health plan, a section 125 plan would be required to comply with all of the ACA's group health plan requirements, including coverage of preventive services and the prohibition on certain types of annual and lifetime limits. The IRS guidance specifies that section 125 plans cannot look through to the health insurance that is purchased to show compliance with the ACA's requirements unless the health insurance is a traditional employer-sponsored group policy. As a result, individual insurance that is purchased through section 125 plans cannot be used to satisfy the group health plan requirements that apply to the section 125 plan. Thus, even if an individual who participates in an employer's section 125 plan has individual health insurance coverage that satisfies all of the ACA's requirements, the IRS would nevertheless consider the employer's section 125 plan to be non-compliant because it is not providing the required benefits directly. Employers that sponsor non-compliant group health plans face a \$100 per participant per day excise tax.

## CONCLUSIONS

Prior to the passage of the ACA, 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 the ACA precludes using section 125 plans for exchange-based individual insurance, it at first appeared to leave open the possibility of section 125 plan use outside of an exchange. The text of the ACA 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, the ACA's guaranteed issue requirements and substantial limitations on medical underwriting significantly reduce concerns regarding discrimination based on health status. However, the IRS identified a new legal barrier to using section 125 plans for individual insurance. Because section 125 plans themselves constitute "group health plans," it is the position of the IRS that unless a section 125 plan is used to purchase group rather than individual insurance, it fails to satisfy the ACA's group health plan requirements, thereby triggering a significant excise tax on the employer.

This report is a companion to the authors' January 2009 issue brief found at [http://www.shadac.org/files/shadac/publications/IssueBrief\\_HIPAA\\_2009Jan.pdf](http://www.shadac.org/files/shadac/publications/IssueBrief_HIPAA_2009Jan.pdf).

## NOTES

<sup>i</sup> 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](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/](http://www.chcf.org/publications/).

<sup>ii</sup> See Monahan & Hall, *supra* note 1.

<sup>iii</sup> I.R.C. section 5000(b)(1).

<sup>iv</sup> Mark A. Hall & Amy B. Monahan, *Paying for Individual Health Insurance through Tax-Sheltered Cafeteria Plans*, INQUIRY (forthcoming 2010).

<sup>v</sup> 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.

<sup>vi</sup> ACA § 1515.

<sup>vii</sup> ACA § 2701.

<sup>viii</sup> ACA § 2703.

<sup>ix</sup> Under the ACA, insurance companies are free to offer coverage outside of the ACA 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

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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

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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](http://www.statereformevaluation.org).

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