When employees without group health insurance buy individual coverage, they do so using after-tax income—costing them from 20% to 50% more than others pay for equivalent coverage. Prior to the passage of the Patient Protection and Affordable Care Act (PPACA), several states promoted a potential solution that would allow employees to buy individual insurance through tax-sheltered payroll deduction. This technical but creative approach would allow insurers to combine what is known as “list-billing” with a Section 125 “cafeteria plan.” However, these state-level reform attempts have failed to gain significant traction because state small-group reform laws and federal restrictions on medical underwriting cloud the legality of tax-sheltered list-billing. Several authorities have taken the position that insurance paid for through a cafeteria plan must meet the nondiscrimination requirements of the Health Insurance Portability and Accountability Act with respect to eligibility, premiums, and benefits. The recently enacted Patient Protection and Affordable Care Act addresses some of the legal uncertainty in this area, but much remains. For health reform to have its greatest effect, federal regulators must clarify whether individual health insurance can be purchased on a pre-tax basis through a cafeteria plan.

It is a conspicuous anomaly in the United States that premiums for most private health insurance are excluded from taxable income, but not for the fairly small percentage of people who buy individual coverage outside the workplace. This differential tax treatment effectively increases the cost of individual coverage 20% to 50% or more. The Patient Protection and Affordable Care Act of 2010 (PPACA) changes much about the way health insurance is bought and paid for, but this differential tax treatment remains. Nevertheless, making insurance more affordable is one of PPACA’s central aims and is critical to the success of its individual mandate.

One possible way for people with individual coverage to obtain the same tax benefits as employees is to pay for individual insurance through payroll deduction using a “cafeteria plan.” Authorized by Section 125 of the Internal Revenue Code, cafeteria plans permit employers to offer voluntary benefits on a pre-tax basis. Many of us are familiar with flexible spending accounts that reimburse out-of-pocket medical costs with pre-tax dollars. Section 125 plans also may be used to pay...
health insurance premiums. This is what allows employed individuals to pay their share of group premiums on a pre-tax basis.

Usually only larger employers offer cafeteria plans with a full menu of benefits, but Section 125 cafeteria plans can also be set up for a single purpose such as paying health insurance premiums. These “premium-only cafeteria plans” are relatively simple to create and administer. Therefore, they are fairly ubiquitous as an adjunct to employer-sponsored group health insurance. Less common is their use solely as a pre-tax mechanism to pay for individual insurance without employer contributions.

Prior to PPACA, several states sought to capitalize on the tax advantages of Section 125 plans by requiring or encouraging all employers to offer a cafeteria plan for the pre-tax payment of health insurance premiums, even if the employer did not sponsor a group health plan (Hall, Hager, and Orentlicher 2010). For reasons discussed later, these state efforts involved significant legal uncertainty. Specifically, there was concern that paying for health insurance through a cafeteria plan creates a “group health plan” for purposes of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Group health plans are prohibited under HIPAA from using health status to determine eligibility, premiums, or benefits. Therefore, it was legally unclear whether cafeteria plans could be used to fund medically underwritten health insurance without violating HIPAA.

PPACA will significantly change this landscape by offering another option for purchasing insurance—through government-supervised exchanges that provide public subsidies for low- and moderate-income individuals. PPACA states that Section 125 plans may not be used for individual insurance purchased through exchanges, but it is silent about individual insurance purchased outside an exchange. Working Americans whose employers do not offer insurance will continue to face substantial affordability problems, especially if they do not qualify for public subsidies. For them, the ability to pay premiums on a pre-tax basis may be a significant factor in whether they obtain insurance coverage. Therefore, this article explores the legal issues involved in paying for individual health insurance on a pre-tax basis, how PPACA will impact this area of the law, and what questions remain.

Methods
This analysis draws in part from 64 interviews conducted in the period 2008–2009 with regulators (12), insurers (11), agents and benefits advisers (22), employer groups (7), and benefits administrators (12). These sources were spread fairly uniformly (14 to 18 each) nationally and among three states with relevant laws—Indiana, Massachusetts, and Missouri. These states were selected because they were the first to adopt laws requiring or encouraging employers to establish Section 125 plans and because each takes a different legal approach (Table 1). Informants were selected for interviews based on their known or reported experience through a “snowball” process in which initial contacts in each category recommended others; leads were followed until reaching saturation—that is, until no major new information or points of view were encountered.

The first author conducted all interviews except for four conducted by the second author. Interviews were done in person or by phone, following a guide that covered each informant’s category; however, responses were open-ended and lines of questioning flexible. Interview notes were coded and entered into QSR NVivo for retrieval and systematic analysis. Relevant descriptive data, legal rulings, operating instructions, marketing materials, and other documents were collected and analyzed (primarily by the first

<table>
<thead>
<tr>
<th>State law approach</th>
<th>Examples</th>
</tr>
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<tbody>
<tr>
<td>Require employers (with exceptions)</td>
<td>Massachusetts, Minnesota</td>
</tr>
<tr>
<td>to set up Section 125 plans for</td>
<td></td>
</tr>
<tr>
<td>individual insurance</td>
<td></td>
</tr>
<tr>
<td>Provide employers tax credits for</td>
<td>Indiana, Minnesota</td>
</tr>
<tr>
<td>setting up Section 125 plans for</td>
<td></td>
</tr>
<tr>
<td>individual insurance</td>
<td></td>
</tr>
<tr>
<td>Allow insurers to sell individual</td>
<td>Kansas, Missouri</td>
</tr>
<tr>
<td>coverage through payroll</td>
<td></td>
</tr>
</tbody>
</table>

Table 1. Facilitating cafeteria plans for individual health insurance
author). Analysis used standard qualitative approaches (Shortell 1999), looking for consistency or variation across different perspectives, information sources, and states.

State Law and “List-Billing”

Small-group health insurance laws in many states could be interpreted as prohibiting the use of payroll deduction to pay for individual (nongroup) premiums. If so, state reforms aimed at protecting the small-employer insurance market may stand in the way of state reforms aimed at making individual insurance more affordable to employees through the use of Section 125 plans.

Adopted mainly in the early to mid-1990s, state-enacted small-group health insurance reforms require guaranteed issue and set limits on medical underwriting and health-risk rating practices. These laws apply to employer-sponsored groups (usually limited to groups with two to 50 full-time workers). Following the National Association of Insurance Commissioners (NAIC) model act, most states define employer sponsorship as health insurance for which any “portion of the premium or benefits is paid by or on behalf of [a] small employer,” or for which the employer reimburses any employee “whether through wage adjustments or otherwise ... for any portion of the premium.”

This definition guards the border between individual insurance, which is individually medically underwritten (in most states), and group insurance, which is not (for the most part). Without a firewall between these two distinct market segments, adverse selection could spread (Hall 2000). In 2014, after PPACA takes full effect, this boundary will have much less actuarial significance. Then, insurance in both market segments will have guaranteed issue and community rating under rules that allow only limited variation in rates for age, family size, and tobacco use. States at that point may choose to merge their small group and individual markets, as Massachusetts did as part of its comprehensive reforms in 2007.

Until then, however, employers whose workers have a lower risk profile than community-rated market averages may have an incentive in most states to drop group coverage in favor of assisting healthier workers with purchasing individual insurance. To avoid this, state law prevents employers from contributing to workers’ individual insurance premiums, or if they do, the insurance is recharacterized and regulated as group insurance. But, short of actually paying part of the premium, if an employer simply allows payroll deduction for insurance that is paid for entirely from employees’ wages, does this constitute employer sponsorship?

Views differ across states and among regulators, depending in part on variations in statutory wording. Prior to small-group laws adopted in the 1990s, when both the individual and small-group markets were medically underwritten, it was fairly commonplace to pay for individual insurance through payroll deduction. Like much else in the realm of insurance, this acquired a specialized name—list-billing—which denotes billing an employer (or its payroll firm) different amounts for each individual subscriber listed, rather than a single amount for a group. Following the major change in market rules enacted by the small-group reform laws, many states began to look askance at list-billing, seeing it as circumventing insurance reform laws (Employee Benefits Corporation 2008; Wieske 2006; Goodman 2006).

Interviewing many knowledgeable sources and reviewing the limited literature, the prevailing legal position on purchasing individual insurance through payroll deduction is widespread uncertainty and confusion. Few states have regulations that explicitly address whether list-billing violates small-group laws. Instead, many rely on what several people referred to as a “desk-drawer rule”—one that the regulator announces on occasion, perhaps during a field audit, but which is not officially promulgated. Others said that regulators use the “fear factor”—discouraging agents or insurers when they ask permission to list bill by “throwing back in [their] face” the risk of illegality, but not explicitly forbidding the practice. As one state regulator admitted, the issue has been debated, but there has been “no clear closure” to it.

Among states with articulated positions, there appear to be at least three distinct
stances. Some clearly permit list-billing, as long as the employer contributes nothing overtly and has not recently dropped coverage. Some states do not allow list-billing in any form for small employers, except perhaps for workers who are not eligible for group coverage (such as part-time employees or independent contractors). Still others take an intermediate approach, permitting list-billing for small employers unless it is done on a pre-tax basis through a cafeteria plan.

When done through a cafeteria plan, many states prohibit list-billing for small employers. Texas is one state that has such a prohibition. Following the original NAIC model statute, it defines a small employer plan as including any insurance whose premium is excluded from federal income tax as an employee benefit, and it notes that paying for insurance through a Section 125 plan has just this effect. Several sources characterized Texas as “very aggressive” in warning agents and insurers about the illegality of list-billing through a Section 125 plan (Hammonds and Stout 2008). Regulators in other states may hold similar views but are more “quiet” about their stance.

It is often difficult to classify where a state stands. In interviews for this study, answers about the practice and legality of list-billing varied depending on who was asked, how terms were understood, and what precisely was being contemplated. Of the four states we studied, only in Massachusetts did interviewees consistently say that list-billing was not done prior to the recent legislative change allowing it. In other states and nationally, insurers, agents, and benefits administrators gave contradictory responses, even within the same jurisdictions, and sometimes at the same company. At least one third-party administrator reported that many insurance companies will not allow list-billing through payroll deduction simply because they do not want to take the risk created by this legal uncertainty.

Interviews with experts resulted in similar responses, such as “there are two [opposing] views on that,” or “the short answer is yes [or no]; the longer answer is more complicated.” One employer who recently had attempted to set up a Section 125 list-billing arrangement complained that, after consulting with the company’s attorney, accountant, and insurance agent, she could get no definitive answer: “They instituted all these laws, but they don’t really explain various scenarios.” It should come as no surprise, then, that the National Association of Health Underwriters has called for legal clarification (Trautwein 2008).

Federal Law

Even in states where legislators and regulators have paved the way more clearly for employers to make Section 125 plans available for individual insurance, federal law complexities and uncertainties may keep such reforms from getting off the ground. Federal law has the monistic attribute of a single legal jurisdiction; nevertheless, it also has managed to fracture itself into a “tricky legal morass” (according to one national expert) that rivals state law in its complexity and uncertainty. At the federal level, HIPAA prohibits group health plans from discriminating on the basis of health status with respect to premiums, eligibility, or benefits. Due to the fragmentation of health insurance regulation across different laws and agencies, HIPAA’s non-discrimination provisions are located in two separate codifications: the Employee Retirement Income Security Act of 1974 (ERISA) and the Internal Revenue Code (Table 2).

Maddeningly, ERISA and the tax code have slightly different definitions of HIPAA’s key term “group health plan.” Moreover, each law is enforced by a different agency—the Labor Department and Treasury Department, respectively—in divergent statutory contexts. While the Labor and Treasury departments have agreed to ensure that HIPAA’s “shared provisions” are administered by both agencies “so as to have the same effect at all times,” this is not the current state of affairs, in part because these agencies have different regulatory responsibilities and goals.

Under ERISA, Department of Labor rulings and court decisions have clarified that individual insurance purchased through a Section 125 plan constitutes nongroup coverage as long as the employer does not contribute to the premium and does not otherwise endorse or promote the insurance.
Table 2. Legal issues raised by using Section 125 plans for individual insurance

<table>
<thead>
<tr>
<th>Source of law</th>
<th>Legal issues</th>
</tr>
</thead>
<tbody>
<tr>
<td>State small-group laws</td>
<td>Unclear whether “list-billing” is permitted; some states specifically prohibit list-billing done through a cafeteria plan</td>
</tr>
<tr>
<td>HIPAA</td>
<td>Prohibits discrimination based on health status for small group insurance; codified in both ERISA and the Internal Revenue Code</td>
</tr>
<tr>
<td>ERISA</td>
<td>Using a cafeteria plan to pay premiums does not necessarily create a group health plan</td>
</tr>
<tr>
<td>Internal Revenue Code</td>
<td>Treats cafeteria plan contributions as coming from employers rather than employees; therefore, using a cafeteria plan to fund the purchase of individual insurance may convert it to a group health plan</td>
</tr>
<tr>
<td>PPACA</td>
<td>Prohibits using cafeteria plans to pay for individual insurance purchased through the new exchanges; perhaps PPACA’s restrictions on medical underwriting will allow individual insurance outside an exchange to meet the nondiscrimination requirements of HIPAA and the tax code, but rating based on tobacco use creates some uncertainty</td>
</tr>
</tbody>
</table>

The details of this position are elaborated at great length in various legal memoranda. (Chollet et al. 2008; Stolzfus Jost 2009; Butler 2008; Schneider et al. 2007). In merciful brevity, they reason that if an employer does nothing more than facilitate payroll deduction, there is insufficient employer involvement to warrant ERISA jurisdiction. If ERISA does not apply, then neither would HIPAA’s non-discrimination provisions. Thus, the pre-tax purchase of individual insurance through cafeteria plans would be permitted.

Legal interpretation is different, or at least substantially unclear, under the Internal Revenue Code. The logic of the tax code is this: workers’ health insurance premiums are not counted as income if paid by the employer. Employees are free to pay their own premiums through after-tax payroll deduction, but if workers’ wages are run through a Section 125 plan, by definition they convert to implicit employer contributions. That is how the tax benefit is created: when workers forgo a portion of their wages to fund a cafeteria plan, they in effect give these funds back to the employer to pay for additional, voluntary fringe benefits. In everyday understanding, cafeteria plans are funded by workers and controlled by workers, as their own money. But according to Treasury regulations, these funds belong to employers (which is why they are not taxed to the employee).

“At a gut level, [treating individual insurance as employer-sponsored] doesn’t pass the laugh test,” said one national expert. Nevertheless, by syllogistic logic, insurance purchased through a Section 125 cafeteria plan is regarded as employer-funded insurance for tax purposes; therefore, it can trigger HIPAA group requirements contained in the tax code, even without any employer contribution. As one market participant observed, it does not make sense “to split legal hairs” this way, and others tend to agree. There are plausible legal arguments why this simple syllogism is not the only logical conclusion that can be drawn (Monahan and Hall 2009), but these arguments have “just fallen on deaf ears,” according to one benefits consultant. The Treasury Department has not written an official position in stone, but this is the legal interpretation that one or two key Treasury officials have indicated they personally hold (Employee Benefits Corporation 2008); other government officials have declined to issue contrary rulings or clarifications, despite many urgent requests.

Does the tax code technicality trump the more lenient ERISA position and rule the day? Most legal commentators are cautious. The leading treatise for legal practitioners warns ominously (in bold typeface): “Do Not Include Individual Health Policies Providing Major Medical Coverage Under a Cafeteria Plan—Difficulties Presented by HIPAA and Other Mandates Are Too Great” (Employee Benefits Institute of America 2008). Prominent health law analyst Patricia Butler concludes similarly that, “although there is no explicit IRS guidance on this issue, it
seems likely that the IRS will consider policies purchased through cafeteria plans under which employees buy individual coverage with pre-tax dollars to be "group health plans" for purposes of HIPAA ...." (Butler 2008). Elsewhere we have reasoned more suggestively that although there are "several reasonable legal arguments to support the position that HIPAA does not apply in this situation, ... 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" (Monahan and Hall 2009).

Legal Uncertainty in Action

This legal uncertainty has debilitated several states' attempts to reduce the cost of individual insurance using Section 125 plans (Hall, Hager, and Orentlicher 2010). Missouri is one example. Going further than any other state, a 2008 law permits employers to use Section 125 plans for medically underwritten nongroup coverage, even when the employer also pays part of the premium. State regulators, however, issued a bulletin warning (for good reason) that doing this might violate federal law, therefore delaying any implementation or enforcement until the federal conflict is resolved. One state official said lawmakers have been "screaming for" clarification from federal agencies, but have received no guidance, so the delay remains in place. This is "really frustrating," according to a leading employer representative in Missouri.

The legal clash has been more subdued in other states. Indiana's law provides a subsidy (via a $250 tax credit) for uninsured small employers who want to establish a cafeteria plan for health insurance. Sources there did not perceive any conflict with federal law, although few were even aware of the state law.

A 2009 Minnesota law calls on employers to establish Section 125 plans for both group and medically underwritten individual insurance and the state is making available small grants to help cover the start-up costs of establishing such plans. Presumably to avoid the unresolved legal issues, the law allows employers to "opt out" of the requirement to establish Section 125 plans by filling out a simple form. In addition, regulators instruct (on their website) that "employers are encouraged to contact an employee benefits expert or insurance broker" before complying. Not surprisingly, sources report little activity so far under this new law.

Massachusetts is the only state that has succeeded, at least legally. As part of its comprehensive reforms, Massachusetts augmented its individual mandate with a requirement that all employers with 11 or more full-time workers establish a Section 125 plan to reduce the effective cost of employees' contributions—both to individual and group insurance. Legal issues have not been a problem because individual insurance in Massachusetts is not medically underwritten. The state merged its individual and small-group markets, eliminating any distinction between how these products are offered and priced and therefore removing the primary reason to scrutinize the border between individuals and small groups.

In states with no special laws, a variety of reactions were observed to the background legal complexity. Some major insurers stopped doing list-billing following state or federal adoption of small-group reforms. A number of major insurers continue to offer list-billing, however, but only if this is not done through a Section 125 plan (and thus only if paid for with an after-tax payroll deduction). A lawyer with one local insurer explained that the company did not want to participate in an arrangement that would "bite the employer in the butt." A national employee benefits expert remarked that insurers also are "really leery of getting caught in the middle of the first big lawsuit," and said "it's only a matter of time until some lawyer brings a case" based, for instance, on an individual policy sold through list-billing without all the mandated benefits required for a group plan. (Imagine, for instance, a severe childbirth injury related to inadequate prenatal care because the mother's insurance lacked maternity benefits.)

Some insurers, however, are willing to accept the legal risk by using what is known
as a “premium reimbursement arrangement” (PRA). This approach differs from list-billing in that the premium is not paid through the workplace. Instead, the subscriber is billed at home and pays with a personal check. The subscriber receives favorable tax treatment by obtaining after-the-fact tax-free reimbursement for the premium from a Section 125 cafeteria plan at work upon documentation of the expense.

Even when insurers offer list-billing, legal risks make many insurance agents reluctant to recommend or sell this to employers, especially through a premium-only Section 125 plan. According to an Indiana agent, if there is an unresolved legal risk, then agents will “back away” unless they “get a clear green light” from regulators. “The last thing an agent wants is to be on the wrong side of [state insurance regulators],” the Indiana agent said. Several other agents noted that being neither an attorney nor CPA tax expert, they did not want to “test [their] E&O [professional liability] insurance” by trying out something risky.

Benefits advisers also are concerned about giving employers bad advice. An expert with one large, national benefits administrator recognized that some legal arguments support list-billing through cafeteria plans, but the expert still advises employers not to do this because “it’s just too hairy.” The risk of “anything really bad happening is probably pretty low,” the expert said, because if federal agencies started to enforce the interpretation described previously they probably would let employers correct any nonconforming arrangement without penalty. But, the adviser noted, “I won’t say that an employer; we’re a national [firm] and we don’t want any part of that.”

The Impact of PPACA

PPACA does not provide conclusive resolution of these legal uncertainties. Nevertheless, PPACA changes the landscape of insurance purchase and regulation, and thus implicates both the policy rationales underlying state reform efforts and also some aspects of legal analysis regarding pre-tax premium payments.

Policy Impact

Despite PPACA’s subsidies and mandates, 23 million people will likely remain uninsured in 2019 (Foster 2010). As a result, states will remain concerned about making insurance more affordable, especially for people whose incomes exceed 400% of the federal poverty level and who are not covered by their employers. Moreover, most people who are currently uninsured must wait until 2014 to receive any premium subsidies, and efforts are needed to make coverage more affordable in the interim. Therefore, both before and after PPACA, affordability will remain a key concern, which pre-tax payment of individual premiums might address.

Other than loss of tax revenue, the only substantial policy concern about allowing Section 125 plans to be used to pay for individual insurance is the potential that lowering the cost of purchasing individual insurance might encourage more employers to drop sponsorship of group coverage. Employer crowd-out was a significant concern prior to Massachusetts’ reform, but it has not yet materialized, despite that state’s requirement that most employers adopt Section 125 plans for health insurance (Hall, Hager, and Orentlicher 2010). Employer drop-out is less likely under PPACA than under Massachusetts’ reform because PPACA’s “pay or play” penalties are substantially higher than those in Massachusetts. Additionally, even if a small number of employers drop group coverage, PPACA will provide a much more hospitable individual insurance market than currently exists—one that will have guaranteed issue and strict premium rating rules. Therefore, PPACA will eventually eliminate much of the current need to guard the border between the small-group and individual markets.

Legal Uncertainty

Allowing individual insurance to be paid on a pre-tax basis may be a good idea, but can it legally be done following PPACA? Among its many provisions, PPACA amends Section 125 of the tax code to provide that, when insurance is purchased through an exchange, a cafeteria plan may be used to pay the
premium only if offered by an exchange-eligible employer. An exchange-eligible employer is one that averages fewer than 100 full-time employees during the year (or 50 full-time employees, at the state’s election) and that chooses to make group coverage available to its employees through the exchange. As a result, cafeteria plans may not be used to pay for individual health insurance policies through an exchange.

However, this does not prevent the use of cafeteria plans to pay for individual insurance on a pre-tax basis outside the state-based exchanges. Small employers who do not have many employees eligible for tax credits might be interested in offering their employees a pre-tax method to pay for individual health insurance in order to make such coverage more affordable. PPACA is too new for legal clarity about this possibility, so we offer our own legal analysis here.

Beginning in 2014, PPACA will remove much of the legal uncertainty about using Section 125 plans for individual insurance because it will eliminate the most troubling aspect of individual insurance: medical underwriting. It is only because individual insurance in most states is not rated and sold like group insurance that using Section 125 plans in this way might be interpreted as violating HIPAA (as interpreted through the tax code). The new federal law, like the 2007 reform law in Massachusetts, eliminates most medical underwriting and requires insurance to be sold in the two market segments under essentially the same rules. Thus, it seems fairly clear that nationally, as in Massachusetts, Section 125 plans could be used for either type of insurance.

There is one problematic factor, however. PPACA allows individual insurance rates to vary (by up to 50%) based on tobacco use, and the Labor and Treasury departments have previously taken the position that this constitutes discrimination based on health status. Under existing regulations, the legality of using Section 125 plans to pay for individual insurance would remain questionable. However, the fact that insurers will be allowed to vary rates based on tobacco use does not mean they must do so. If they do not, then federal nondiscrimination rules would not be an issue. Moreover, because tobacco rating is specifically allowed by PPACA, and because PPACA declares that its premium pricing provisions supersede anything to the contrary in ERISA or the tax code, there is a reasonable argument that this last remaining form of medical underwriting would not violate these statutes’ nondiscrimination rules. While our interpretation might help employers feel more comfortable offering employees the option of purchasing individual health insurance with pre-tax income through a cafeteria plan, this is still not the authoritative ruling that most insurers, employers, and agents would like.

Conclusion

Our federalist constitutional regime of overlapping state and federal sovereignty creates never-ending opportunities for conflict, confusion, and consternation. This eternal truth is nowhere more evident than in health care policy and regulation. Leading instances are ERISA, HIPAA (both its privacy and its insurance provisions), and Medicaid, but others are less well known. This article has focused attention on one relatively overlooked area—the taxation of premiums that employees pay for individual health insurance—to draw lessons on how to better coordinate state and federal regulation under health care reform.

Although there is a shared desire to reduce the cost of insurance in order to expand coverage, individual employees who purchase their own insurance are the only ones who must do so with after-tax dollars. Despite this apparent inequity, it currently is not legally safe in most situations for employers to offer uninsured workers the substantial convenience and savings of purchasing individual insurance through a Section 125 cafeteria plan. The primary exception is those states where individual insurance is subject to guaranteed issue requirements and is not medically underwritten (and thus the insurance meets HIPAA’s group plan requirements).

Once PPACA’s provisions take full effect, much of this legal uncertainty should disappear, but without clear federal guidance some likely will remain. The simplest solution would be for Congress to eliminate the tax differential...
between employer-based and individually purchased health insurance. Then, we would have no need to bother with Section 125 plans. But simple solutions are elusive when it comes to health reform, and Congress cannot resolve all important legal and public policy issues.

Instead, some element of legal uncertainty is inevitable, leading to large elements of regulatory discretion. With these inevitabilities in mind, federal regulators should dutifully provide state officials and market participants the guidance they need.

Notes

Janice Lawlor provided helpful research assistance.

1 NAIC Small Employer Health Insurance Availability Act (1992), section 4.
2 Examples given by one insurer who focuses on this market include Colorado, Delaware, Idaho, Kentucky, Maryland, North Carolina, Oregon, Tennessee, Virginia, and Wisconsin. Another insurer placed only Connecticut and Florida in this category.
3 Others include Colorado, Idaho, and Oregon.
4 ERISA defines group health plan as one "established or maintained by an employer," whereas the tax code refers to plans "of, or contributed to by, an employer." 26 U.S.C. 5000(b)(1); 29 U.S.C. §1002(1).
6 This is so despite the fact that HIPAA anticipated and tried to avoid such problems in a provision entitled, “assuring coordination,” that requires the “Secretary of the Treasury, the Secretary of Health and Human Services, and the Secretary of Labor [to] ensure, through the execution of an interagency memorandum of understanding among such Secretaries, that regulations, rulings, and interpretations issued by such Secretaries relating to the same matter over which two or more such Secretaries have responsibility under this subtitle ... are administered so as to have the same effect at all times.” 42 USC 300gg-92 note.
8 The law reads as a mandate to employers, but there are no enforcement penalties, and employers are allowed simply to opt out of the mandate. See Minnesota Department of Commerce, Basic Facts About Minnesota’s Section 125 Plan Requirement for Employers, www.state.mn.us/portal/mn.jsp/common/content/include/contentitem.jsp?contentid=536917824.
9 Technical issues still exist under COBRA for coverage of workers at Massachusetts firms who live in other states, and for insurers that vary individual rates based on tobacco use.
10 Also, all the parties must sign what a source with one insurer called its “cover our butt form,” which states that the coverage does not meet group plan requirements and that the employer is not sponsoring the plan or contributing anything to the premium, directly or indirectly.
11 Some employee benefits advisers also recommend paying for individual insurance premiums using another tax haven, known as a health reimbursement account (HRA). It is not clear, though, why this would be any safer than a Section 125 cafeteria plan. HRA funds more explicitly belong to the employer and therefore are just as likely, or more likely, to characterize the insurance purchased as being employer sponsored.
12 This is similar to the method used for flexible spending accounts for medical expenses, which are another type of cafeteria plan.
13 While individuals who are eligible for premium tax credits must purchase their health insurance coverage through an exchange, individuals who are not eligible for premium tax credits face no such restrictions.
14 Treasury Regulation §§ 54.9802-1(c) and (f); Labor Regulation §§ 2590.702(c) and (f).

References


