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Employer Cafeteria Plans: States' Legal and Policy Issues

Prepared for

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by

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I. About Cafeteria Plans

STATE HEALTH POLICYMAKERS INTERESTED IN EXPANDING access to uninsured working populations have begun to consider requiring employers to offer employment-based “cafeteria” (Section 125) plans. Such plans allow employees to use pre-tax funds to pay for their share of employer-sponsored coverage or (subject to certain caveats) buy their own coverage in the individual insurance market. The substantial tax subsidies available through these plans can reduce the effective cost of insurance for uninsured employees, such as part-time workers not eligible for a firm’s plan or those in firms not offering coverage.

This report outlines the legal requirements employers must meet to establish and maintain cafeteria plans, with particular focus on those involving health insurance purchased solely by employees (without employer contributions). It also discusses other federal laws affecting these plans. It is important for state health policymakers to understand these legal issues, because some federal laws may affect whether and how states can require employers to offer Section 125 plans. Furthermore, if state policymakers are aware of the responsibilities imposed on employers by federal law, they may be able to help employers comply with both state and federal requirements.

Because Section 125 plans are “group health plans” under the Internal Revenue Code, it appears they are subject to both employer notice provisions under COBRA and employer and insurer nondiscrimination and benefit design requirements under HIPAA. But because the definition of employer group health coverage is different under ERISA than under the federal tax code, as long as employers do not endorse or promote specific individually purchased health insurance policies, these policies should not be subject to ERISA. Nor should a state requirement that employers offer Section 125 plans be preempted by ERISA.

Cafeteria Plan Requirements

Section 125 of the Internal Revenue Code allows health coverage (and other similar qualified benefits) to be excluded from employee income even though the employee can choose whether to elect a payroll deduction for this coverage or retain the cash wages. Without Section 125, the employee would be deemed to have

“constructively received” income and then “spent it” on health coverage. The amount spent on coverage would have been taxed as income and only a limited deduction (for amounts exceeding 7.5 percent of adjusted gross income) would have been available for the premium cost.

In August 2007, the Internal Revenue Service (IRS) issued a set of proposed regulations outlining requirements for Section 125 plans.¹ These regulations restate and clarify prior IRS policy and incorporate references to health savings accounts (HSAs) and other recent statutory changes applicable to cafeteria plans. The rules provide that health coverage can be offered under Section 125 for employee-paid premiums of an employer-sponsored group plan, disease- or accident-specific policies, contributions to an HSA, reimbursement for medical expenses (but not insurance premiums) under a “flexible spending account,” payment of COBRA premiums for employees not eligible for the employer’s plan, or reimbursement to the individual employee for individually owned health insurance policies as long as the employer assures that the insurance is currently in force and is being paid by the employee.^{2,3} If health insurance is the only benefit, the cafeteria plan may be called a “premium-only plan,” “premium conversion plan” or a “premium reimbursement account,” and often is referred to as a POP.⁴ The proposed rule includes three ways that employers can substantiate that the payroll withholding pays for individually purchased health insurance.⁵ Even when insurance is purchased only with the employee’s wages, the IRS considers such payment to be an “employer contribution” for purposes of Section 125 so as to bring it within the Internal Revenue Code section 106 requirement of “employer-provided” health coverage that is excludable from income.⁶

Employers must establish a Section 125 plan in a written document that lists the specific benefits that can be paid for via payroll deductions as an alternative to cash wages, and outlines eligibility policies (only employees may participate), procedures

for employee elections, maximum amount of elective contributions, and the plan year.^{7,8} An election to pay for qualified benefits under a cafeteria plan is irrevocable for a year except in the case of status changes, such as the number of work hours, marriage, birth, adoption, or a dependent aging out of the employee’s coverage.⁹ Failure to follow the plan’s terms invalidates the plan and results in tax liabilities for the employer and its employees.¹⁰

Self-employed people, partners, or certain shareholders of Subchapter S corporations are not employees and therefore cannot be participants in Section 125 plans. Employees may pay for covered benefits for their dependents, but the dependents themselves are not plan participants who can elect or purchase benefits. Former employees who are treated as employees may be able to buy benefits through a Section 125 plan, but the plan cannot be established or maintained predominantly for their benefit.

Nondiscrimination Provisions

Consistent with the tax code and provisions of federal pension law, the proposed regulations also prescribe standards for nondiscrimination in cafeteria plan benefits on behalf of “highly compensated individuals” and “key employees.”¹¹ (Self-insured employer medical plans offered outside a cafeteria plan, which are not our focus here, are subject to somewhat different nondiscrimination rules under section 105(h) of the tax code.)¹² If the plan discriminates in favor of either of these groups, it remains a qualified cafeteria plan, but the employees will be taxed on the value of the excess benefits (and employers may be subject to additional employment [FICA] taxes). The discussion below focuses on cafeteria plans allowing salary reduction without a direct employer contribution to health coverage; Appendix A includes examples of how the nondiscrimination rules apply and calculations for how to assess their impact.

Highly Compensated Employees

With respect to highly paid employees as defined in tax code Section 125, the law provides that lower

paid employees must have a similar opportunity to become eligible for the plan and have access to similar benefits and employer contributions.¹³ Following are some rules that apply:

- **Eligibility.** If all employees (including part-timers) are eligible for the cafeteria plan, it meets the eligibility test.¹⁴ (Some exclusions are allowed as well as the opportunity to create “reasonable classifications” of employees.)¹⁵ If not, the plan may still meet this test if the ratio of lower compensated to highly compensated employees eligible for the plan meets IRS standards.¹⁶
- **Contributions.** If employers make contributions (for example, to health insurance premiums), they must be offered at the same level for similarly situated highly compensated and lower paid workers, and highly compensated employees must not use them disproportionately.^{17,18}
- **Benefits.** Actual utilization of cafeteria plan benefits cannot favor highly compensated employees. Both groups of employees must have the same opportunity to elect benefits under the plan, and highly compensated employees must not disproportionately elect to take them.¹⁹

Cafeteria plans allowing salary reduction (with no employer contributions) to pay for premiums of an employer-sponsored plan or to buy individual insurance products must pass this benefits test. Whether the plan is discriminatory will depend on how many employees are in each group, their aggregate compensation, which employees choose to buy coverage, and what coverage they buy. If lower paid employees spend proportionally less than highly compensated ones (because they have public subsidies or buy cheaper products) the plan could pass this test as long as the aggregate salary-reduction amounts of highly compensated employees as a percentage of their aggregate compensation does not exceed the aggregate salary-reduction amount for the other employees as a percentage of their aggregate compensation.

- **Safe harbors.** The proposed regulations provide a simplified, alternative way for specified types of Section 125 plans to comply with the nondiscrimination rules, which the regulation calls a “safe harbor.” The safe harbor applies to: (1) plans offering health benefits; and (2) premium-only plans. The health coverage safe harbor provision appears, however, unlikely to apply to salary-reduction plans.²⁰ It provides that a POP will be deemed to meet the nondiscrimination benefits/utilization test if the plan meets the eligibility test noted above—that is, if a high enough proportion of employees are eligible for the same amount of salary reduction, even if some do not elect to use it.²¹ This safe harbor applies to salary-reduction premium-only plans where the employer sponsors a health plan, but it is not clear whether it applies to POPs where employees can “salary-reduce” (set aside pre-tax income) only to buy individual health insurance products. The final regulations, likely to be published by the end of 2008, reportedly will clarify this ambiguity.

Key Employees

The amount of tax-advantaged benefits that goes to key employees cannot exceed 25 percent of the aggregate tax-advantaged benefits among all who elect salary reduction in a cafeteria plan. Consequently, depending on the actual premium levels paid for individual insurance by key employees compared to other employees, firms with “too many” key employees relative to total employees (most likely small firms) may be unable to provide tax-advantaged benefits to key employees.²² The nondiscrimination test examines all benefits from both actual employer contributions and individual employee salary-reduction elections. The proposed regulations provide the same POP safe harbor as for highly compensated employees.²³ While this safe harbor applies to salary reductions used to pay premiums for employer-sponsored plans, it remains unclear whether it applies to salary reductions with which employees can buy individual health insurance products.

II. Employer Responsibilities Under COBRA, HIPAA, and ERISA

IN ADDITION TO STANDARDS FOR ESTABLISHING AND maintaining a Section 125 plan, state policymakers should be familiar with other federal law responsibilities associated with cafeteria plans. This section discusses three applicable federal laws. COBRA prescribes certain employee notice requirements, and HIPAA prohibits discrimination on the basis of health status in health insurance eligibility and worker contributions.²⁴ ERISA, the federal employee benefits law, applies to plans sponsored by employers contributing to or “endorsing” noncontributory health coverage. If an employer offers a cafeteria plan through which employees can buy individual insurance coverage with pre-tax dollars, it is possible to avoid such an arrangement being characterized as an ERISA plan, as discussed below. But even policies offered through a non-ERISA cafeteria plan are likely to be subject to other federal laws, such as COBRA and HIPAA.

COBRA

The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) provides that employers with 20 or more employees offering health coverage must allow employees and their dependents who experience a “qualifying event” to continue in the group health plan for 18, 29, or 36 months by paying the full premium (plus up to 2 percent for administrative costs).²⁵ Qualifying events include the employee’s death, termination from employment, Medicare eligibility, reduction in work hours, divorce from the employment group spouse, dependents exceeding the dependent-eligible age, or the employer’s bankruptcy. Employers must provide notice about COBRA continuation when employees become eligible for the workplace coverage and give notice to the plan administrator if the employee dies, is terminated, changes work hours, or becomes eligible for Medicare. Employees must inform employers of divorce or dependents exceeding the age of covered dependency. The plan administrator must notify beneficiaries of these events (within 60 days of their occurrence) and of their right to continuation coverage through the health coverage group. Failure to provide the notice or the continuation coverage opportunity results in tax code penalties on the employer and the plan administrator. The IRS can impose financial penalties on employers for COBRA violations.²⁶

As interpreted by the IRS, the definition of “group health plan” under COBRA is broader than what is commonly considered group health insurance.²⁷ COBRA regulations define a group health plan as not only one offered through a group insurance policy “contributed to (directly or indirectly) by an employer” but also one offered through a Section 125 cafeteria plan and “one or more individual insurance policies in any arrangement that involves the provision of health care to two or more employees.”²⁸ Because the IRS considers even salary-reduction cafeteria plans to involve employer contributions (in order to comply with tax code Section 106 regarding excluding employer-provided health coverage from taxable income), reading this regulation in its entirety, it seems likely that Section 125 plans are subject to COBRA continuation and notice provisions.²⁹

As a practical matter, in the case of individually purchased health insurance, the value of COBRA would be that: (1) employees with access to a Section 125 plan can use severance pay (but not pension benefits) to purchase health coverage with pre-tax funds from their former employers; and (2) employees with COBRA coverage from a former employer can pay that premium under the cafeteria plan of a new employer while waiting to become eligible for coverage through the new employer.³⁰ The main objective of the required COBRA notice would be to remind the employee that coverage after leaving the workplace would not be purchased through a Section 125 plan and so would not have salary-reduction tax advantages.

HIPAA

Federal Requirements

The federal Health Insurance Portability and Accountability Act (HIPAA) imposes various standards on group health plans and health insurers. It defines acceptable pre-existing condition exclusion (pre-ex) periods, prohibits discrimination in coverage eligibility and worker-paid premiums on the basis

of health status, and prescribes special enrollment periods.³¹

Pre-ex periods. Using the same definition of group health plan as COBRA, HIPAA requires group health plans with two or more employees to include pre-ex periods no longer than 12 months for conditions diagnosed or treated within no more than the previous six months.³² Pre-ex periods can be satisfied by coverage under another health plan, a state high-risk pool, Medicare, or Medicaid as long as there has been no break in such coverage of 63 or more days.³³ Group health plans also must allow employees and dependents to enroll if they lose other coverage (whose existence was the reason they declined to enroll in the group) and if an employee has new dependents resulting from marriage, birth, or adoption.³⁴

Nondiscrimination. HIPAA also prohibits private sector group health plans with two or more employees from discriminating regarding eligibility on the basis of health status, physical or mental medical condition, claims experience, health care receipt, medical history, genetic information, evidence of insurability, or disability.³⁵ Nor can group health plans require employees to pay higher premiums (relative to similarly situated individuals) on the basis of this medical or health status information. The law and regulations allow group health plans to provide premium discounts and reduced cost-sharing for health promotion and disease prevention program participation.³⁶

Portability and accessibility. HIPAA requires all products in the individual market to be renewable regardless of claims experience or health status, and requires insurers to allow people leaving workplace group coverage to enroll in an individual product without regard to their health status.³⁷ The tax code permits states to use “alternative mechanisms” for guaranteed access to a choice of individual products without pre-ex periods.³⁸ Other than a ceiling on high-risk pool premiums, there is no federal law

limit on premiums that insurers may charge, and these products are often very expensive.

HIPAA Implications for State Health Policy

HIPAA's definition of a group health plan is identical to that under COBRA, and the IRS interprets the COBRA definition to include health coverage that is purchased by individuals through a Section 125 plan. Consequently, 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, and therefore that HIPAA's group health plan standards would apply.³⁹

Because the IRS interprets its regulations to classify health insurance purchased by employees in the individual market through a cafeteria plan to be group health plans, those plans should be subject to the HIPAA standards discussed above. To comply with the tax law, employers would want to be sure that insurers selling individual plans to their employees meet these standards. Individual insurers currently must meet federal guaranteed renewability requirements and many states limit pre-ex periods in their overall individual health insurance markets, but not necessarily consistent with HIPAA standards. For example, in 2001, only 15 states had pre-ex periods and coverage provisions at least as stringent as those under HIPAA.⁴⁰ Furthermore, only a few states require insurers to issue policies in the individual market without regard to health status or prohibit premium variation due to health status or claims experience. It is therefore possible that the IRS would impose penalties on employers whose employees' individual health insurance products purchased through cafeteria plans did not meet HIPAA standards. To assist employers to comply with HIPAA and minimize uncertainty for employers and insurers:

- States could revise their individual health insurance regulations to conform to HIPAA group health plan standards. (Massachusetts

effectively did so in its reform law by merging its individual and small group insurance markets.)

- States could offer employees whose employers are subject to a cafeteria plan mandate the option to purchase individual insurance through a state-sponsored purchasing pool. The states could establish regulatory standards for pool-participating insurers consistent with HIPAA group health plan standards (in terms of pre-ex periods, special enrollment periods, eligibility, and premium nondiscrimination).

A state law (for example, requiring employers to offer "premium-only" cafeteria plans) that might cause employers or health insurers to violate federal law (if the state's individual insurance market does not conform to federal HIPAA standards) could be subject to a legal challenge on preemption grounds. HIPAA contains provisions that specifically authorize certain state laws to be more stringent than federal law and generally allows state laws that do not prevent the application of federal law.^{41,42} This latter standard represents the constitutional principle of federalism under the United States Constitution: State and federal laws can coexist as long as the state law does not make compliance with federal law impossible.⁴³ This "conflict" preemption standard is much less sweeping than that under ERISA's statutory preemption clause; nevertheless, it still might be advanced to challenge a state law requiring employers to offer cafeteria plans for pre-tax purchase of individual health insurance on the ground that the state law directly conflicts with HIPAA unless state insurance standards or other provisions protect consumers to the same extent as the federal law.

ERISA

The Employee Retirement Income Security Act of 1974 (ERISA), is relevant to state policy requiring employers to offer cafeteria plans. If a Section 125 plan (or each employee's individual health insurance policy purchased through it) is an ERISA plan, employers would be subject to standards under ERISA such as reports to the U.S. Department of

Labor (DOL), employee information disclosure, claims dispute appeals procedures, and fiduciary duties. ERISA plans also are subject to COBRA and HIPAA requirements. Furthermore, because ERISA preempts state laws that “relate to” employee benefit plans (by either “referring to” such plans or having an impermissible “connection with” them), it might preempt a state Section 125 plan mandate if cafeteria plans are characterized as ERISA plans.⁴⁴

Section 3(1) of ERISA defines an ERISA plan as a plan, fund, or program offering health and other qualifying benefits that is “established or maintained by an employer or employee organization, or both.”⁴⁵ A 1996 Advisory Opinion by the DOL supports an argument that a Section 125 plan under which employee-paid health insurance premiums are deducted from payroll is not itself an ERISA plan.⁴⁶ In that situation, an employer had established an ERISA health plan offering three options for which the employer paid part of the premium (indemnity coverage and HMOs), as well as a Section 125 plan under which employees could pay their portion of the premiums from before-tax wages. In its Advisory Opinion, the DOL stated that a Section 125 plan itself is not an ERISA plan because its function is to provide a method of paying premiums in a tax-favored manner, but that advantage is not a “benefit” within the meaning of ERISA.⁴⁷ This opinion is very helpful to overcome an ERISA preemption challenge to a state law requiring employers to establish Section 125 plans through which to shelter employee premiums. Not surprisingly, this issue has not arisen in any reported court cases, but courts do give deference to agency interpretation of the statutes they administer.⁴⁸

In developing their requirement that employers offer cafeteria plans, policymakers in Massachusetts conferred with DOL officials and were told that a cafeteria plan mandated by state law would be exempt from being considered an employer-sponsored plan under DOL regulations.⁴⁹ The DOL has not provided written policy on this issue or any further guidance to states.

Individually Purchased Coverage and ERISA

Despite the DOL Advisory Opinion, opponents of a state Section 125 plan mandate may argue that health coverage purchased from the individual market through a Section 125 plan becomes an ERISA plan and therefore that ERISA would preempt the state Section 125 plan requirement (and also require employers to comply with ERISA reporting, disclosure, and fiduciary standards).⁵⁰ Opponents would base such an argument on several cases that hold that insurance purchased individually through Section 125 plans (along with other factors) is an ERISA plan in cases seeking damages for insurers’ failing to pay claims. Some of these cases cite the DOL regulation defining what constitutes an ERISA plan and providing a “safe harbor” for plans with minimal employer involvement. Therefore, it is useful to consider how to bring state law and employer conduct within the regulation’s “safe harbor.” The case law can be examined for guidance about how to avoid having individually purchased health coverage characterized as ERISA plans.

The DOL “safe harbor” regulation provides that the terms “employee welfare benefit plan” and “welfare plan” shall not include a group or group-type insurance program offered by an insurer to employees or members of an employee organization, under which:

- No contributions are made by an employer or employee organization;
- Participation in the program is completely voluntary for employees or members;
- The sole functions of the employer or employee organization with respect to the program are, without endorsing the program, to permit the insurer to publicize the program to employees or members, to collect premiums through payroll deductions or dues check offs and to remit them to the insurer; and
- The employer or employee organization receives no consideration in the form of cash or otherwise

in connection with the program, other than reasonable compensation, excluding any profit, for administrative services actually rendered in connection with payroll deductions or dues checkoffs.^{51,52,53,54}

A state law that requires employers to establish Section 125 plans in order to exclude from income employee premiums for coverage purchased individually (either in the open market or through a public pool) should meet at least three of the “safe harbor” criteria: (1) the requirement would not involve employer contributions; (2) employee participation in the payroll deduction program would be voluntary; and (3) the employer would not be compensated beyond (possibly) administrative payroll deduction costs.⁵⁵ The one criterion that might present problems is the prohibition on employers “endorsing” the benefit program. A few federal courts have held that listing a benefit option in the Section 125 plan, among other factors, constituted endorsement.

The DOL has applied its “safe harbor” regulation in advisory opinions. For example, it determined that an employer did endorse life insurance, disability insurance, and group legal insurance plans available for employees to purchase individually because the employer had input on their design and structure, encouraged members to participate, and included its logo on plan materials. DOL stated that endorsement occurs when the employer or employee organization “expresses to its employees or members any positive, normative judgment regarding the program” including “activities that would lead an employee or member reasonably to conclude that the program is part of a benefit arrangement established or maintained by the employer or employee organization.”⁵⁶ It should be possible to avoid that type of employer endorsement of health coverage options that employees might choose to purchase in the individual market or through a public pool. But the DOL has not issued any formal policy guidance on whether allowing an employee to purchase health coverage with pre-tax funds under a Section 125

plan turns that coverage itself into an ERISA plan without more active employer involvement.⁵⁷

Court Opinions

Several federal courts have held that insurance purchased through a Section 125 plan (along with other types of employer involvement with these plans) can be characterized as an ERISA plan for purposes of limiting remedies for failure to pay claims. (See Appendix B.) These cases and the DOL “safe harbor” regulation make clear that an employer “endorsement” that turns individually purchased insurance into an ERISA plan depends heavily on the facts and circumstances of each case. It is not a foregone conclusion that any coverage purchased by such a salary-reduction arrangement automatically becomes an ERISA plan.

The fact that some employer conduct might cause the DOL or a court (in a damages lawsuit involving the coverage) to characterize individually purchased coverage to be an ERISA plan should not undermine a state’s authority to require employers to create cafeteria plans. None of the court decisions holding individually purchased insurance to be an ERISA plan relies exclusively on its purchase through a Section 125 plan. All the cases involve additional types of active employer involvement in the design, creation, promotion, and/or administration of the insurance at issue. Courts found employer endorsement in cases involving:

- A single policy listed in the Section 125 plan booklet along with an employee responsible for administering it;
- A detailed description in its benefits handbook, employer promotion of the policy, the employer being the designated “group benefits policyholder” on the policy, and written endorsement by an officer; and
- An employer picking the insurer, deciding on key terms and amount of coverage, setting eligibility standards, and including the plan’s terms in its Section 125 summary plan description.^{58,59,60}

Inferring no endorsement from the absence of a Section 125 plan is a fairly weak argument. Cases noting this factor also found no other significant employer involvement in designing, creating, or administering the insurance in question.⁶¹ And merely providing to an insurer a list of employees is not endorsement.⁶²

Even if some employers might become involved with the administration of individually purchased insurance so that it could be characterized as an ERISA plan, the fact that employers do not need to do so provides a defense against a preemption challenge. As the Supreme Court has held in *California Division of Labor Standards Enforcement v. Dillingham Construction*, if an employer can comply with a state law by means other than through an ERISA plan, the state law does not “relate to” an ERISA plan and will not be preempted.⁶³

Another ERISA concern could arise if a state requirement that employers offer a Section 125 plan includes employers that already offer workplace health insurance (as can occur, for example, under the Massachusetts 2006 reform law), allowing employees to pay their ERISA plan premium share with pre-tax dollars. Because these employers already offer an ERISA plan, opponents may assert that this state requirement involves the administration of an employer’s existing ERISA plan and interferes with multi-state employers’ administration of nationally uniform plans.⁶⁴ It can be argued, however, that as long as the Section 125 plan itself is not an ERISA plan (under the DOL’s Advisory Opinion, which involved employees paying their share of an ERISA plan premium under a cafeteria plan), such a state requirement does not affect uniform national administration of ERISA plans. Regardless of what employers may perceive, not all programs that involve employee health insurance are ERISA plans. As discussed in section III, it is important to draft a cafeteria plan mandate so as to avoid “referring to” ERISA plans, which is one ground for preemption.

The 2007 4th Circuit Court of Appeals decision in *Retail Industry Leaders’ Association v. Fielder* should not affect analysis of whether ERISA preempts a state Section 125 plan requirement.⁶⁵ The court in *Fielder* held that ERISA preempts Maryland’s law requiring Wal-Mart to pay the state the difference between what it spent on employee health care and 8 percent of its Maryland payroll. The court based its decision on the law’s sponsors’ objectives to compel Wal-Mart to modify its extant ERISA plan and the law’s practical effect (that the employer would expand its plan rather than pay the difference to the state).⁶⁶ Because the court held the assessment to be a health coverage mandate (rather than a tax), it is consistent with previous Supreme Court precedent that ERISA preempts states from mandating employers to offer or change the terms of their ERISA plans. ERISA should not preempt a state requirement that employers establish Section 125 plans as long as a court agrees that a Section 125 plan is not an ERISA plan (by relying on the DOL policy and accepting the argument that allowing employees to purchase individual coverage through the 125 plan does not automatically turn the individual coverage into an ERISA plan so that the cafeteria plan requirement itself becomes an ERISA plan mandate).

State Policy Responses

It might be more difficult to argue that employers are “endorsing” coverage their employees purchase via a Section 125 plan from a publicly authorized purchasing pool or exchange (rather than coverage purchased in the individual health insurance market) that offers multiple insurance products. DOL’s policy concern is that employees not be misled about whether benefits are available from employer-sponsored plans; but employees should be less likely to think that coverage under a public pool is sponsored by their employers. Consequently, it may be somewhat easier to defend a challenge to a Section 125 plan requirement if employees purchasing individual coverage are able to do so through a public or publicly authorized pool or exchange offering multiple insurance products.

Beyond listing the pool/exchange as an option in a Section 125 plan description, submitting employment information to the pool/exchange, and remitting premiums, such an arrangement would involve very little employer responsibility. The employer would have no control over coverage design, eligibility, administration, or claims processing for plans offered through a public pool. Even when employees purchase health coverage in the individual insurance market, however, it seems possible for employers to undertake very limited administrative responsibilities, particularly if employees can purchase any available coverage and the employer plays no role in identifying or promoting specific policies. To remove any doubt about whether the employer has assumed sponsorship (and address a possible DOL concern), a state could require employers to note explicitly that neither the cafeteria plan nor any policies individually purchased through it are ERISA plans.

Using a public or publicly sponsored purchasing pool or exchange has advantages beyond minimizing ERISA preemption concerns. For example, to comply with tax code Section 125 plan requirements, an employer must assure that the tax-sheltered income is being used for individually purchased health insurance. As provided under the IRS proposed cafeteria plan regulation, this could be accomplished by the employer writing checks to each insurer an employee chooses or requiring employees to verify they have paid their own premiums with the funds. More efficient for an employer would be to transfer these pre-tax employee funds to a purchasing pool or exchange through which employees can choose among multiple offerings, as Massachusetts has done through its independent state agency, the Health Connector. Such an arrangement provides the employer assurance required by the IRS while minimizing employer administrative responsibilities.

Employer Concerns

Due to ambiguity among agency policies and court opinions, employers may be concerned that

establishing a Section 125 plan through which employees can buy insurance in the private market or through a state pool subjects them to ERISA responsibilities. If such concerns were to become an issue in a state, they could undermine business support for a state cafeteria plan requirement. Because the options for coverage may vary and employers may choose to become more or less involved with promoting or administering them, it is not possible to be sure that coverage purchased through Section 125 plans could never be ERISA plans. But a state can help minimize potential business opposition by: (1) requiring statements that the policies are not employer-sponsored plans; (2) obtaining general guidance from the DOL; and (3) publicizing factors that courts hold to constitute employer plan endorsement.

Summary of Federal Law

The federal tax code allows employers to establish cafeteria plans under which employees can, with pre-tax dollars, pay their share of any employer-sponsored health coverage or buy health insurance in the individual market. If eligible for, or benefits under, these plans favor key employees or highly compensated employees, those employees lose tax advantages and employers may be subject to additional employment taxes. The tests for determining nondiscrimination are somewhat complex and may particularly challenge small firms. If cafeteria plans are not available for all employees, including part-timers, if any employer contributions favor key or highly compensated employees, and if highly paid employees are more likely to use benefits offered, the benefits to those employees may be subject to tax, although the plan and its tax advantages remain in force for other employees. To be consistent with other tax code provisions that exclude employer-provided coverage from employees' taxable income, the IRS considers that even individually purchased health coverage involves an employer contribution and therefore is a "group health plan." Because group health plans are subject to both COBRA continuation and HIPAA portability and accessibility standards, the IRS

could require employers (as well as other applicable plan administrators) to comply with COBRA and HIPAA. With respect to COBRA, this primarily means that employers with cafeteria plans must notify employees leaving work about their rights. The IRS has not explicitly stated that premium-only salary-reduction plans where employees purchase individual health insurance violate HIPAA's group health plan standards unless the individual policies satisfy its health status nondiscrimination rules and pre-ex period standards. But to the extent that states require employers to establish such cafeteria plans, it is appropriate to avoid a potential conflict of state and federal law and a preemption challenge by assuring that the individual insurance available to employees through cafeteria plans complies with federal group health plan standards on pre-ex periods, availability regardless of health status factors, and premium nondiscrimination.

ERISA's definition of an employee welfare benefit plan is different from that under the tax code. The DOL has taken the position, for example, that Section 125 plans themselves are not ERISA plans. Whether health insurance purchased individually by an employee (through a cafeteria plan or with post-tax dollars) is an ERISA plan depends on factors under the DOL "safe harbor" rule, primarily whether the employer has become involved in selecting, promoting, or administering an individually purchased policy or policies so as to create the impression that the coverage is an employer-sponsored plan. It is not possible for a state to control employer behavior so as to be sure that such individually purchased policies are never characterized as employer-sponsored, (implying both employer responsibilities under ERISA and the possibility of a preemption challenge). However, states can assist employers in avoiding this label while offering coverage mechanisms such as a public purchasing pool that can minimize the likelihood that employees believe individually purchased plans are employer-sponsored coverage under ERISA.

States should be able to argue that ERISA does not preempt a state law requiring employers to offer cafeteria plans for employees either to pay for their share of an employer-sponsored plan premium or to buy individual health insurance products (as under the Massachusetts 2006 reform law for firms of 11 or more full-time equivalent employees). As long as it is possible for employers to allow employees to buy individual health insurance through a cafeteria plan without "endorsing" it so that the individual coverage becomes an ERISA plan, a state cafeteria plan mandate would not require an employer to create ERISA plans. The case law on this point is inconsistent and does not involve state mandates. It would be very helpful for the Department of Labor to provide policy guidance to states on this issue. In the meantime, although states might face a legal challenge to their authority to mandate cafeteria plans, they have credible arguments to defend such laws as long as they are carefully drafted to avoid referring to ERISA plans.

III. State Policy Options

A NUMBER OF OPTIONS ARE AVAILABLE TO THOSE involved in state policy.

Drafting Considerations

- To minimize potential preemption problems under ERISA and the tax code, states should draft a cafeteria plan mandate very broadly, for example:

All employers (or those above a certain size) must offer the opportunity for employees to pay for health insurance by salary-reduction arrangements permitted under Section 125 of the Internal Revenue Code.

- State laws should avoid referring to ERISA (employer-sponsored) plans in drafting a cafeteria plan mandate.
- To minimize confusion about whether individual policies offered under cafeteria plans are employer-sponsored plans under ERISA, it would be useful to avoid terms such as “employer group,” “employer-sponsored,” “employer-created,” “employer-maintained,” or “group” plans. A more neutral description might be “plans available under a cafeteria plan.”
- To minimize concerns that a state law Section 125 mandate might be preempted by HIPAA or COBRA, the requirement could be drafted as applying to the extent it does not conflict with federal law.
- To assure that benefits under a Section 125 plan are traditional health coverage (rather than, for example, only cash payments in the case of “dread disease”), state laws requiring or offering incentives for employers to offer Section 125 plans can refer to those allowing employees to pay for “health insurance” or similar terms defined under state law as traditional health coverage benefits.

ERISA Concerns

- States could seek DOL clarification of its policy on how to avoid health insurance purchased individually through a salary-reduction cafeteria plan being characterized as an ERISA plan.

- States could assist employers to avoid endorsing plans through technical assistance, model written materials, and notices to enrollees in the state pool/exchange.

Plan Creation and HIPAA/COBRA Concerns

- States could assist employers by providing model cafeteria plan materials and technical assistance on creating and maintaining the plans.
- States could provide model COBRA notices.
- States could evaluate their current individual insurance market standards for consistency with HIPAA.
- States could (with appropriate mechanisms to forestall adverse selection in place): (1) revise their individual insurance market standards to be consistent with HIPAA requirements for group health plans; or (2) condition insurer participation in state purchasing pools or exchanges on compliance with HIPAA group-health-plan requirements regarding pre-ex periods, special enrollment periods, and nondiscrimination regarding health status in coverage and premiums.⁶⁷
- Where state law requires insurers to offer coverage to family members who do not qualify as dependents for Section 125 purposes (such as domestic partners or children over age 19 who are not full-time students), states many want to provide information to employers about the need to provide separate payroll tax deductions for pre- and post-tax premium payments, as Massachusetts has done.⁶⁸

Use of State Purchasing Pools/ Exchanges

Public pools or exchanges that offer a choice of competing health plans provide the advantage of minimizing arguments that individually purchased health insurance is an employer-sponsored plan. This is because they are less likely to suggest to workers that employers are endorsing plans offered under the state pool, and it is easier for the pool itself to express the public nature of the pool and disclaim any employer sponsorship. In states whose individual insurance market regulations are not generally in compliance with HIPAA group health plan standards, another advantage to establishing a state purchasing pool is that the state could require insurers offering coverage through the pool (which could include all insurers in the individual market) to meet HIPAA-conforming pre-ex, special enrollment period, and health status eligibility and premium nondiscrimination requirements for group health plans. In this case, however, additional steps would have to be taken to forestall adverse selection that could, depending on the specific policy context, otherwise doom the pool.⁶⁹ The risk of adverse selection against a HIPAA-group-conforming public pool would be greatest in a state where insurance regulations allow full consideration of individual health status in setting premiums in the regular individual market and where the state plans no subsidies or requirements for insurance purchase other than access to Section 125 tax-sheltering of health insurance premiums.

Appendix A: Application of Cafeteria Plan Nondiscrimination Provisions

This appendix provides examples from the proposed cafeteria plan regulations illustrating their requirements as well as calculations to show how to apply the nondiscrimination tests regarding highly compensated employees (HCEs) or key employees (Keys).

Highly Compensated Employees

Nondiscrimination in eligibility. Unless all employees are eligible to participate in the cafeteria plan, eligibility must meet the nondiscrimination test specified in the pension nondiscrimination rules. This test requires calculating the “safe harbor percentage,” which is the ratio of the percentage of non-HCEs eligible for the plan to all non-HCEs, divided by the percentage of HCEs eligible for the plan to all HCEs. If this ratio is at least 50 percent, the plan meets the eligibility test. If it is less than 50 percent, the pension regulation permits a plan to pass the eligibility test with a lower percentage, which varies according to the proportion of non-HCEs in the overall workforce, according to a table in the pension nondiscrimination rules.⁷⁰ In other words, as the proportion of non-HCEs in the workplace increases (from 60 percent to 79 percent), the “safe harbor percentage” can decrease (from 50 percent to 36 percent). The “safe harbor percentage” is lower (making the test easier to satisfy) as the concentration of non-HCEs in the workplace increases.

Among the examples in the proposed cafeteria plan rules to illustrate the eligibility nondiscrimination test are:

- An employer has one employer-provided health plan, which costs employees \$10,000 per year for single coverage. All employees have the same opportunity to salary-reduce \$10,000 to buy this coverage. This Section 125 plan meets the eligibility test.⁷¹
- An employer has an employer-sponsored health plan for which non-HCEs can salary-reduce

\$10,000 to pay for coverage while HCEs can use up to \$8,000 of employer contributions to pay part of the premium and can salary-reduce \$2,000. This fails the eligibility test because it does not offer eligibility for comparable benefits.⁷²

- An employer offers two employer-sponsored plans: one available to only HCEs is a low deductible plan, and the other, available only to non-HCEs, is a high deductible plan with a lower premium. A cafeteria plan allowing for different salary-reduction amounts for these plans fails the test. And a cafeteria plan allowing the same salary-reduction amounts also fails because the allowable benefits are different for HCEs than for non-HCEs.⁷³

Nondiscrimination in employer contributions.

A plan must give similarly situated participants a uniform election with respect to employer contributions and the actual election with respect to employer contributions for qualified benefits through the plan must not be disproportionate by HCEs. Employer contributions are disproportionately used by HCEs if the aggregate contributions they use (as a percentage of their aggregate compensation) exceed the aggregate contributions used by non-HCEs (as a percentage of their aggregate compensation).

Nondiscrimination in benefits/utilization. The plan must give each similarly situated participant a uniform opportunity to elect cafeteria plan benefits and the actual election of benefits must not be disproportionate by HCEs. This is determined by comparing the amount of benefits used by HCEs as a percentage of their total compensation to the amount of benefits used by non-HCEs as a percentage of their total compensation. For example:

Assume a plan where all employees are eligible and under which employees can salary-reduce \$100 per month to pay health insurance premiums under an employer-sponsored plan, where HCEs each earn \$120,000/year and

non-HCEs earn \$30,000/year, and where 3 of 4 HCEs (75 percent) elect to salary-reduce the allowable amount while only 5 of 20 non-HCEs do so. The aggregate benefits elected by HCEs are \$3,600 (3 x \$1,200) and by non-HCEs are \$6,000 (5 x \$1,200). Aggregate compensation for all HCEs is \$480,000 (4 x \$120,000) and for non-HCEs is \$600,000 (20 x \$30,000). The amount of benefits elected as a percentage of total compensation is 0.75 percent for HCEs (\$3,600/\$480,000) and 1 percent for non-HCEs (\$6,000/\$600,000). In this case, the HCEs are not disproportionately electing to use the benefits (0.75 percent < 1 percent).

Key Employees

If all employees are eligible to participate in the cafeteria plan and two are Keys and four are non-Keys and all elect to participate for the same amount of benefits, all benefits are nontaxable.⁷⁴

If Keys receive in aggregate \$4,000 of benefits and non-Keys receive \$12,000, however, the plan provides 33 percent of the benefits to Keys and this exceeds the maximum 25 percent allowed by the rules.⁷⁵

Appendix B: ERISA “Endorsement” Cases

Several federal courts have held that insurance purchased through a Section 125 plan (along with other types of employer involvement with these plans) can be characterized as an ERISA plan for purposes of limiting remedies for failure to pay claims.⁷⁶ Because they may be cited to support an argument that ERISA preempts a state Section 125 plan requirement, the facts and decision in each case are outlined below, along with related cases regarding employer endorsement:

- In *Hrabe v. Paul Revere Life Insurance Company*, an employee who purchased disability coverage through his employer’s Section 125 plan sued the plan for nonpayment.⁷⁷ The district court held that listing the option to purchase disability insurance in the cafeteria plan’s Summary Plan Description “constitutes more than the mere publication of the disability policy. Instead, such listing of the disability policy is a direct endorsement of the disability policy.”⁷⁸ The court noted that listing implies this is a company-endorsed policy because it was the only disability policy available to employees on a pre-tax premium basis. The court also noted that the employer’s appointment of a staff member to administer the disability policy was another indicator the employer endorsed the plan.
- *Stoudemire v. Provident Life and Accident Insurance Co.* involved a suit against a disability carrier for failing to pay a claim.⁷⁹ The district court held ERISA preempted the damages suit because the coverage (though paid for only by employees through a 125 plan) was an ERISA plan since it was endorsed by the employer by actively maintaining and promoting it (e.g., a detailed description in its benefits handbook, employer promotion of the policy, the employer being the designated “group benefits policyholder” on the policy, and written endorsement by an officer).
- In *Butero v. Royal Maccabees Life Insurance Company*, an employee sued a life insurer for

failing to pay benefits.⁸⁰ The Court of Appeals held ERISA preempted the damages suit for two reasons. First, the employer’s active involvement (picking the insurer, deciding on key terms and amount of coverage, setting eligibility standards, and including the plan’s terms in its summary plan description for its Section 125 plan) took the program outside the DOL safe harbor. Second, it also fit the definition of an ERISA plan under the statute for similar reasons—the employer’s active involvement in creating and maintaining the insurance policy.

- In *Brown v. Paul Revere Life Insurance Company*, a damages suit against an insurer, the court held that a disability policy paid for individually by an employee on a pre-tax basis was an ERISA plan, so ERISA preempted the damages claim.⁸¹ The court held that an employer “contributed” to the premium because the employee paid less for the coverage than he would have by purchasing insurance individually: in addition to receiving a 15 percent premium discount by virtue of being employed, the court noted that the tax advantage also was available only because of the employment connection.⁸² This court’s position, however, is inconsistent with that of *Hrabe v. Paul Revere Life Insurance Company*, discussed above, which held that allowing individual employees to buy insurance through a Section 125 plans was not an employer premium contribution under the DOL “safe harbor” regulation.

Using a negative inference, some courts have noted that the fact that disability or life insurance was purchased outside a Section 125 plan was one factor that helped to establish that employers did not endorse the insurance so as to turn it into an ERISA plan.

- In *Levett v. American Heritage Life Insurance Company*, employees sued for fraudulent inducement to buy disability coverage.⁸³ The court identified several factors to determine the

employer did not endorse the plan, including the fact that it had been designed and administered by the carrier and the carrier processed claims, in addition to being outside of a Section 125 plan.

- *Lott v. Metropolitan Life Insurance Company* involved a suit against a life insurance company for fraudulently inducing employees to buy coverage (outside of a 125 plan).⁸⁴ The court held that the employer's minimal involvement in allowing the insurer to advertise the plan did not constitute endorsement, but the court did not specifically mention as a factor in this holding that the coverage was outside a 125 plan.

In cases not specifically involving Section 125 plans, courts have identified types of conduct which do not constitute "endorsement" so as to create an ERISA plan.

- *Kerr v. United Teacher Associates Insurance Company* was a damages case against an insurer.⁸⁵ The federal district court held that an individual insurance policy purchased via a salary-reduction arrangement was not an ERISA plan.⁸⁶ The court stated "if an employer's only involvement in establishing or maintaining a plan is to allow an insurer to take premiums from employees' pay, this is not a sufficient basis to find that the program is an employee welfare benefits program for the purposes of ERISA."⁸⁷ The court also noted that the insurer was "one of a number of insurance companies that are permitted to offer optional insurance to employees of the Division of Corrections and receive payments for such insurance policies by way of payroll deductions from the employees' paychecks."⁸⁸ Finding that this offering met all the DOL's "safe harbor" criteria, the court held it was not an ERISA plan and allowed the suit to proceed in state court.
- *Johnson v. Watts Regulator Company* was a damages suit against an insurer.⁸⁹ The federal Court of Appeals held that a disability coverage policy purchased via payroll deduction was not an ERISA plan. (As in *Kerr*, the court did not indicate whether this plan was obtained

through a Section 125 plan or outside such a plan.) The court noted that the employer did not actively endorse the program but "merely advises employees of the availability of group insurance, accepts payroll deductions, passes them on to the insurer, and performs other ministerial tasks that assist the insurer in publicizing the program."⁹⁰ It also cited DOL Advisory Opinion No. 94-26A (1994), stating that endorsement occurs when an employee organization engages in activities "that would lead a member reasonably to conclude that the program is part of a benefit arrangement established or maintained by the employee organization." The court concluded that employer representations should be viewed in the light of whether employees would believe the plan was sponsored by the employer or made it appear to be part of the company's own benefit package. In this case, the employer made available to employees both enrollment forms and claims forms but was not involved in plan design or eligibility or claims investigation and determination. A cover letter indicating that the program was available but was voluntary for each employee did not constitute an endorsement ("endorsement of a program requires more than merely recommending it.")⁹¹ Similarly, in *Riggs v. Smith*, the district court held that an employer did not endorse a plan for which it sought price quotations at the request of employees, allowed insurers to present options to employees, and deducted premiums from employee wages.⁹²

- In *Zavora v. Paul Revere Life Insurance Company*, an insurance damages case, the 9th Circuit Court of Appeals held that minimal employer administrative activities (such as verifying employee eligibility to the insurer) does not constitute endorsement of an individually purchased insurance policy.⁹³ In this case, the employer's name was listed as plan administrator on the policy description. While this designation took the case out of the "safe harbor" regulation, the court held that there remained an issue of fact as to whether the employer created a plan and remanded the case to the lower court.⁹⁴

Endnotes

1. 72 Federal Register 43938–43968, August 6, 2007. Final regulations are expected to be issued effective January 2009, and taxpayers can rely on the proposed regulations until final rules are published.
2. For example, if a full-time employee becomes part-time or an employee with COBRA from one workplace moves to an employer with a cafeteria plan.
3. 26 C.F.R. section 1.125-1(m), 72 Federal Register at 43952–43953. This is consistent with long-standing IRS Policy, e.g., Revenue Ruling 61-146 (1961).
4. Premium-only plans (POP) are defined in 26 C.F.R. 1.125-1(a)(5), 72 Federal Register 43946, as those whose sole benefit is an election between salary and “payment of the employee share of the employer-provided accident and health insurance premium excludable from the employee’s gross income under section 106.” Because the IRS considers that premiums paid exclusively by an employee from pre-tax wages are “employer contributions” for purposes of the tax code (26 C.F.R. section 1.125-1(r)), it seems likely that cafeteria plans under which employees purchase individual health insurance products are POP.
5. The cafeteria plan can reimburse each employee directly for ‘substantiated’ health insurance premiums, issue to the employee a check payable to the insurer that the employee can remit to the insurer, or issue a check jointly payable to the employee and the insurer, 26 C.F.R. section 1.125-1(m)(2), 72 Federal Register 43952–3.
6. 26 C.F.R. section 1.125-1(r), 72 Federal Register 43955.
7. Presumably this could be a general statement of the types of individual coverage that can be offered rather than a list of all available insurance policies.
8. This can be a maximum dollar amount, a maximum percent of salary, or a method for determining the maximum amount.
9. 26 C.F.R. section 1.125-4.
10. For example, federal law regarding tax advantaged coverage of spouses is narrower than that allowed for same-gender domestic partners under some state laws and employer and insurer practices. And some states require insurers to cover dependent children beyond the age allowed for dependent health coverage under federal tax law (up to age 19, or 24 if a full-time student). Because payment for coverage of such spouses or dependents cannot be made with pre-tax funds under Section 125 plans, employers will have to provide separate payroll tax deductions for pre- and post-tax premium payments. Since including non-eligible spouses or dependents in a Section 125 plan can jeopardize the viability of the entire plan, states seeking to require or facilitate employer Section 125 plan offerings may want to provide information to employers on this issue.
11. Highly compensated individuals are those who are officers, 5 percent shareholders, or receive over \$100,000 in annual compensation (in 2007), and the spouses and dependents of any of these individuals. Key employees are officers paid more than \$145,000 (in 2007), 5 percent owners, or 1 percent owners whose annual pay is at least \$150,000.
12. The definition of highly compensated employees under IRC section 105(h) and the nondiscrimination tests differ from those under IRC Section 125. See 26 C.F.R. section 1.105-11(c)(2)(ii), incorporating by reference 26 C.F.R. section 1.410(b)–4(b).
13. There is an inconsistency in the statutory and regulatory language regarding whether both the contribution and benefits tests must be met—the statute seems to require only one or the other while the proposed regulations require compliance with both, EBIA *Cafeteria Plan Manual*, p. 1707 (1st quarter 2008).
14. The Section 125 plan regulations define employee to mean “current or [some] former employee” including common law and leased employees. The regulation does not exempt part-time workers from the eligibility test and they are not included in the definition of reasonable [bona fide business] classification” discussed below in endnote 15.

15. Employers need not include in the evaluation of eligibility discrimination in their Section 125 plans: employees in a collectively bargained plan, nonresident aliens, those using the cafeteria plan to pay for a COBRA continuation policy, or employees who have worked for the firm less than three years (or a shorter time, consistent with the cafeteria plan's eligibility waiting period). Additionally, consistent with pension nondiscrimination rules, a cafeteria plan will not be considered discriminatory if it benefits groups of employees who qualify under a "reasonable (bona fide business) classification" if the group of employees in the classification passes the "safe harbor" or "unsafe harbor" percentage test in the pension rules (see Appendix A). Reasonable classifications can include geographic areas, salaried vs. hourly compensation, or job categories. They do not explicitly include full-time vs. part-time status.
16. This ratio is the proportion of non-highly compensated employees eligible for the plan (as a percentage of all non-highly compensated employees) divided by the proportion of highly compensated employees eligible for the plan (as a percentage of all highly compensated employees). A ratio at or above 50 percent passes this test; if the ratio is below 50 percent, the plan must fall within the "safe harbor percentage" set out in the table in IRS regulation 26 C.F.R. section 1.410(b)-4(c)(iv). See Appendix A.
17. Contributions could differ by single vs. family coverage.
18. Employer contributions would be disproportionately used by highly compensated employees if the aggregate contributions used by them as a percentage of their aggregate compensation exceeds the aggregate employer contributions used by non-highly compensated employees as a percentage of their aggregate compensation.
19. Benefits are disproportionately used by highly compensated employees if the aggregate benefits used by them as a percentage of their aggregate compensation exceeds the aggregate benefits used by non-highly compensated employees as a percentage of their aggregate compensation.
20. A cafeteria plan providing health benefits is not discriminatory if all employees are eligible to elect coverage and if contributions on behalf of each participant equal 100 percent of the cost for the majority of similarly situated highly compensated employees – OR if 75 percent of the cost of the participant having the highest cost coverage and any additional contributions bear a uniform relationship to the employee's compensation, 26 C.F.R. section 1.125-7(e), 72 Federal Register 43967. Employer contributions can vary by single vs. family status or geographic location. The proposed regulations are not explicit about whether the safe harbor can apply to a salary-reduction plan under which employees only buy health insurance individually. Final regulations may clarify this point. Because the purpose of the nondiscrimination rules is not to advantage higher-paid employees compared to lower paid employees, the Employee Benefits Institute of America's Cafeteria Plan Manual (3d quarter 2007, p. 1714) indicates that employees' salary-reduction amounts would not be included in the safe harbor calculations, suggesting that a Section 125 plan that allows all employees to pay only for individually purchased insurance could not take advantage of the safe harbor and would have to meet the contribution and benefits nondiscrimination tests.
21. The safe harbor deems a POP plan to meet the benefits/utilization test if it satisfies the safe harbor percentage test for eligibility, discussed in Appendix A.
22. Such a situation is more likely to occur in very small firms, including Subchapter C corporations that happen to be very small. The effects on sole proprietorships, partnerships and Subchapter S corporations may be mitigated by the fact that their owners are not eligible to participate in the cafeteria plan at all and are therefore excluded from this calculation.
23. As under the eligibility test for highly compensated employees, this ratio is the proportion of non-key employees eligible for and electing the plan (as a percentage of all non-key employees) divided by the proportion of key employees eligible for the plan (as a percentage of all key employees). A ratio at or above 50 percent passes this test; if the ratio is below 50 percent, the plan must fall within the "safe harbor percentage" set out in the table in IRS regulation 26 C.F.R. section 1.410(b)-4(c)(iv).

24. Other federal employment laws prohibiting age discrimination, gender wage discrimination, and discrimination against pregnancy in employment or benefits may also affect employer-sponsored health coverage, e.g., the Age Discrimination in Employment Act, 29 U.S.C. 623, and the Equal Pay Act, 29 USC. 206(d).
25. 26 U.S.C. 4980B. COBRA amended ERISA (29 U.S.C. 1161), applying the continuation requirements to private sector-sponsored health plans. COBRA also amended the Public Health Services Act (42 U.S.C. 300bb-1 et seq.) so that it applies to state and local governmental plans and church plans, which are exempt from ERISA jurisdiction. The continuation periods are 18 months in the case of a job termination; 36 months in the case of an employee death or divorce or dependent child aging out of group eligibility, dependents of an employee who becomes Medicare eligible at age 65, or employer bankruptcy; and 29 months for employees qualifying for Medicare because of disability. 26 U.S.C. 4980(f).
26. 26 U.S.C. 4980B, 26 U.S.C. 5000.
27. The definition is set out in 26 U.S.C. 5000(b) (1): “The term ‘group health plan’ means a plan (including a self-insured plan) of, or contributed to by, an employer (including a self-employed person) or employee organization to provide health care (directly or otherwise) to the employees, former employees, the employer, others associated or formerly associated with the employer in a business relationship or their families.”
28. 26 C.F.R. section 54.4980B-2.
29. 26 C.F.R. section 1.125-1(r), 72 Federal Register 43955. See April 25, 2008 presentation at ECFC Annual Conference of Kevin Knopf, Attorney-Advisor, Office of Tax Policy of the Treasury Department, cited in EBIA *Cafeteria Plan Manual*, p.329 note 223 (3rd quarter 2008).
30. Note that for administrative simplicity, some employers might choose to offer—through a cafeteria plan to employees not yet eligible for the employer-sponsored plan—the opportunity to buy individual-only coverage from the same carrier(s) that administers the employer-sponsored plan. This approach could raise ERISA issues. Such an arrangement should not cause a state cafeteria plan mandate to be preempted, but it might impose ERISA reporting, disclosure, claims payment and fiduciary obligations on the employer regarding the individually purchased coverage. Because such employers already have ERISA plans that include these responsibilities, this might not be an issue for them, but it is one risk that states might want to point out to employers of not taking advantage of the existence of a state pool for these workers.
31. HIPAA also requires health insurers to issue products in the small group (2–50 employee) market without regard to health status (“guaranteed issue”) and renew products for small and large employer groups without regard to health status or claims experience.
32. 26 U.S.C. 5000, interpreted in regulations 26 C.F.R. section 54.4980B-2.
33. 26 U.S.C. 9801 defines coverage that meets these standards as “creditable coverage.”
34. *Id.*
35. 26 U.S.C. 9802.
36. 26 U.S.C. 9801(b)(2)(B), 26 C.F.R. section 54.9802-IT.
37. 42 U.S.C. sections 300gg-41–300gg-45. This accessibility provision applies to people who were enrolled in a private sector or government health plan for at least 18 months, exhausted any COBRA benefit to which they were entitled, and are not eligible for other group insurance, Medicare, or Medicaid. The law prohibits insurers in the individual market from declining to cover such individuals or imposing pre-existing exclusion periods. Besides guaranteed issue of all products in the individual market, insurers can offer to the entire individual market its two most popular products (by premium volume) or an actuarially valued lower and higher level policy meeting specific standards.

38. These alternatives can include laws conforming with the National Association of Insurance Commissioners (NAIC) model act on this topic, high-risk pools meeting NAIC model act standards, or other arrangements that incorporate risk spreading or risk adjustment mechanisms. The majority of states (30) meet this HIPAA standard through high-risk pools, while the remainder apply the federal guaranteed issue or two-product option, existing state reform laws that achieve the same purpose, or similar state standards. Laudicina, Susan, Joan Gardner and Angela Crawford. 2007. *State Legislative Health Care and Insurance Issues: 2007 Survey of Plans*. Washington, D.C.: Blue Cross and Blue Shield Association State Services Department Office of Policy and Representation.
39. This requirement applies group plan eligibility and premium health status nondiscrimination rules and does not implicate HIPAA's 'group to individual product' guaranteed issue requirement.
40. Laudicina, Susan, Betsy Losleben, Natasha Walker. 2001. *State Legislative Health Care and Insurance Issues*. Washington, D.C.: Blue Cross and Blue Shield Association State Services Department Office of Policy and Representation.
41. For example, states can shorten permitted insurance pre-ex periods, 29 U.S.C. 1191.
42. 42 U.S.C. 300gg-62 provides that the individual market insurance rules are not to be construed to preempt state regulations unless they "prevent the application of a requirement" of the federal law.
43. *Florida Lime and Avocado Growers, Inc. v. Paul*, 373 U.S. 132 (1963).
44. For a more detailed discussion of ERISA preemption of state health care initiatives, see Patricia A. Butler, *ERISA Implications for State Health Care Access Initiatives: Impact of the Maryland "Fair Share Act" Court Decision*, 2006 and *ERISA Preemption Manual for State Health Policymakers*, 2000, Washington D.C.: AcademyHealth and National Academy for State Health Policy (www.statecoverage.net and www.nashp.org).
45. 29 U.S.C. section 1002(1).
46. DOL Advisory Opinion 96-12A, July 17, 1996.
47. The Opinion notes, however, that the premium contributions constitute ERISA plan assets because they were contributed to the employer's ERISA health plan, and people exercising control over those assets are subject to ERISA fiduciary standards.
48. This issue has not arisen in any reported cases because the issue of what is an ERISA plan arises almost exclusively in cases where an employee is attempting to sue an insurer for damages (for failure to pay benefits), so even cases involving Section 125 plans challenge administration of the underlying health or disability benefit plan not the Section 125 plan itself.
49. This exemption, discussed more fully below, is found in regulations at 29 C.F.R. 2510.3-1(j).
50. See, e.g., Schiffbauer, William G. "ERISA Preempts Provisions of Massachusetts 'Pay or Play' Health Care Reform Law." *BNA Pension & Benefits Reporter* 33 (38):2315–2318, September 26, 2006.
51. 29 C.F.R. 2510.3-1(j).
52. In the preamble to this regulation, the DOL explained that it used the term "group-type insurance" because "many programs of the sort intended to be described by proposed section 2510.3-1(j) are not technically group insurance programs because no master contract is issued to an employer. In the insurance industry, these programs are sometimes characterized as 'group-type' programs" (40 Federal Register 34527, August 15, 1975).
53. In the preamble to its safe harbor regulation, DOL noted that the "requirement of employer neutrality is the key to the rationale for not treating such a program as an employee benefit plan, namely the absence of employer involvement" (40 Federal Register 34527, August 15, 1975).
54. All four criteria must be met to fall within the "safe harbor," *Johnson v. Watts Regulator Company*, 63 F. 3d 1129 (1st Circuit 1995). Courts have noted that a program might fail these tests and still be determined not to be an ERISA plan (e.g., *Johnson v. Watts Regulator Company*), though few courts further analyze a program that fails one of these tests. (As discussed in the text accompanying endnote 80, the court in *Butero v. Royal Maccabees Life Insurance Company*, 174 F. 3d 1207 (11th Circuit 1999) did so.)

55. One court (in an insurance damages case) has held, however, that employee-paid disability insurance premiums were employer contributions because they were lower (due to the workplace connection) than if purchased individually and also because they were paid through a salary-reduction plan, which lowered their cost (*Brown v. Paul Revere Life Insurance Company*, 2002 U.S. District Lexis 8994, May 20, 2002). As discussed below, however, this case relied in part on an IRS COBRA regulation to interpret the meaning of an ERISA plan, which may be inappropriate because the IRS explicitly includes Section 125 plans as group health plans under COBRA and because ERISA's definition of an employer-sponsored plan differs from that under the tax code (including COBRA and HIPAA). Furthermore, the court's holding on this issue directly conflicts with one in *Hrabe v. Paul Revere Life Insurance Company*, 951 F. Supp. 997 (M.D. AL 1996), discussed in the text accompanying endnote 77, which cited a different IRS regulation. Finally, the facts in *Brown*, where a single disability policy was available to employees, distinguish it from the situation where employees would be able to choose among several health insurance plans in the private market or from a public pool.
56. DOL/PWBA Advisory Opinions 94-22A, 94-25A and 94-26A (July 11, 1994).
57. Keep in mind that the DOL issues advisory opinions based on requests involving specific facts, and apparently no employer has sought such advice in such a case.
58. *Hrabe v. Paul Revere Life Insurance Company*, 951 F. Supp. 997 (M.D. AL 1996).
59. *Stoudemire v. Provident Life and Accident Insurance Company*, 24 F. Supp. 2d 1252 (M.D. AL 1998).
60. *Butero v. Royal Maccabees Life Insurance Company*, 174 F. 3d 1207 (11th Circuit 1999).
61. *Levett v. American Heritage Life Insurance Company*, 971 F. Supp. 1399 (M.D. AL 1997); *Lott v. Metropolitan Life Insurance Company*, 849 F. Supp. 1451 (M.D. AL 1993).
62. *Zavora v. Paul Revere Life Insurance Company*, 145 F. 3d 1118 (9th Circuit 1998).
63. 519 U.S. 316 (1997).
64. See Schiffbauer, *supra* note 50.
65. 475 F. 3d 180 (4th Circuit 2007).
66. For a discussion of implications of the 4th Circuit's opinion for state health care access initiatives, see *ERISA Update: Federal Court of Appeals Agrees ERISA Preempts Maryland's "Fair Share Act"* February 22, 2007 (www.statecoverage.net and www.nashp.org).
67. "Voluntary" health insurance purchasing pools or exchanges are subject to adverse selection if they offer insurance on terms more favorable to the purchaser than the regular insurance market (e.g., guaranteed access, absence of health underwriting). This risk of adverse selection can be overcome if significant financial incentives (e.g., tax credits or other subsidies) are available only through the pool or if participation in the pool is mandatory. For a discussion of these issues, see Rick Curtis and Ed Neuschler, "What Health Insurance Pools Can and Can't Do," *Issue Brief [Insurance Markets]*, California HealthCare Foundation, November 2005.
68. Massachusetts Department of Revenue Technical Information Release 07-16, December 12, 2007 (www.mass.gov).
69. Curtis and Neuschler, *supra* note 67.
70. 26 C.F.R. section 1.410(b)-4(c)(iv).
71. Example 1 in proposed nondiscrimination rules, 26 C.F.R. section 1.125-7(b), 72 Federal Register 43966.
72. Example 2 in proposed nondiscrimination rules, 26 C.F.R. section 1.125-7(b), 72 Federal Register 43966.
73. Examples 3 and 4 in proposed nondiscrimination rules, 26 C.F.R. section 1.125-7(b), 72 Federal Register 43966.
74. Example 2(i) in proposed nondiscrimination rules, 26 C.F.R. section 1.125-7(d), 72 Federal Register 43966.
75. Example 2(ii) in proposed nondiscrimination rules, Example 2(i) in proposed nondiscrimination rules, 26 C.F.R. section 1.125-7(d), 72 Federal Register 43966.

76. ERISA allows plan participants to obtain only benefits wrongfully withheld and no other financial damages (such as lost wages, medical costs from treatment delays, or punitive damages) that would be available against insurers under state law.
77. 951 F. Supp. 997 (M.D. AL 1996).
78. 951 F. Supp. at 1003.
79. 24 F. Supp. 2d 1252 (M.D. AL 1998).
80. 174 F. 3d 1207 (11th Circuit 1999).
81. 2002 U.S. District Lexis 8994, May 20, 2002.
82. The safe harbor regulation prohibits employers from contributing to the premium. This case did not involve the issue of whether an employer “endorsed” the disability policy.
83. 971 F. Supp. 1399 (M.D. AL 1997).
84. 849 F. Supp. 1451 (M.D. AL 1993). The parties in this case conceded that a Section 125 plan (involving different benefits) was an ERISA plan so the court did not address that issue, but the case predates the DOL Advisory Opinion holding that a Section 125 plan was not an ERISA plan.
85. 313 F. Supp. 2d 617 (S.D. WV 2004).
86. The opinion does not indicate whether this salary-reduction arrangement was a Section 125 plan. Salary-reduction arrangements can occur outside cafeteria plans. Apparently the employer allowed employees to have premiums deducted from payroll for benefits from several insurers (suggesting the employer included a list of possible payees), but the opinion does not state whether this arrangement allowed premiums to be paid from pre-tax dollars.
87. 313 F. Supp. 2d at 619.
88. 313 F. Supp. 2d at 620.
89. 63 F. 3d 1129 (1st Circuit 1995).
90. 63 F. 3d. at 1134.
91. 63 F. 3d at 1136. In *Hansen v. Continental Insurance Company*, 990 F. 2d 871 (5th Cir. 1991), the Court of Appeals held that an employer endorsed an accidental injury policy (purchased voluntarily by employees with pre-tax dollars) by characterizing it as “our” group plan and encouraging employees to consider it and also by employing a staff member who accepted claims forms and passed them to the insurer.
92. 953 F. Supp. 389 (S.D. FL 1997).
93. 145 F. 3d 1118 (9th Circuit 1998).
94. In *Murdock v. UNUM Provident Corporation*, 265 F. Supp. 2d 39 (W.D. PA 2002), the court also remanded the case for trial on the issue of employer endorsement of a disability plan purchased through a Section 125 plan; the issue was not the existence of the 125 plan but whether employer selection of the plan as one of several available to employees constituted endorsement.



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