Employment-Based Health Coverage and Health Reform: Selected Legal Considerations

Jennifer Staman
Legislative Attorney

Edward C. Liu
Legislative Attorney

June 12, 2009

Congressional Research Service
7-5700
www.crs.gov
R40635

CRS Report for Congress
Prepared for Members and Committees of Congress

Summary

It is estimated that nearly 170 million individuals have employer-based health coverage. As part of a comprehensive health care reform effort, there has been support (including from the Obama Administration) in enacting comprehensive health insurance reform that retains the employer-based system. This report presents selected legal considerations inherent in amending two of the primary federal laws governing employer-sponsored health care: the Employee Retirement Income Security Act (ERISA) and the Internal Revenue Code (IRC).

ERISA may be a key part of the health reform discussion in two main ways. The first way is if Congress desires to amend the employer-based system, for example, to require financing or benefits for group health plans as provided by employers. If a national proposal were to require employers to provide or contribute to the payment of health benefits or to provide specific benefits as part of group health plans, ERISA could be a vehicle for this type of proposal. Second, if Congress were to amend the role of states in regulating employment-based health benefits, ERISA's express preemption provision, § 514, would likely be implicated. Section 514 of ERISA is commonly seen as a barrier for states in enacting health reform that affects the employer-based system. This report provides an overview of ERISA preemption and analyzes some of the current issues dealing with the extent to which ERISA can preempt state health reform efforts, as well as issues that may be considered in a national health reform effort.

While the current tax treatment of employer-provided health insurance is not technically an obstacle to health reform, various health reform proposals have included amendments to these tax provisions. The value of employer-provided health insurance is generally not subject to income or payroll taxes. This effectively results in the subsidization of employer-provided health insurance by the federal government. Some have argued that this subsidization is partly responsible for increasing costs of health insurance, as it gives participants an inaccurate sense of the true cost of their health care and leads to increased utilization of health care resources. Therefore, some have proposed reducing or eliminating this exclusion in order to provide individuals with a more accurate economic picture of their health care choices, while simultaneously raising federal revenue to pay for other aspects of health care reform. This report discusses the legal framework underlying the current tax treatment of employer-provided health care.

Contents

The Employee Retirement Income Security Act (ERISA) ... 1
Overview of ERISA Preemption ... 4
ERISA Preemption and Health Reform ... 7
ERISA and Current State Health Reform Efforts ... 7
ERISA and National Health Reform Efforts ... 9
Federal Tax Treatment for Employer-Provided Health Care Insurance ... 11
Employer Paid Health Insurance Premiums ... 12
Premium Conversion ... 12
Employment and Unemployment Taxes ... 13
Incentives for Employees to Elect Employer-provided Health Insurance ... 14
Incentives for Employers to Offer Health Insurance ... 15

Contacts

Author Contact Information ... 15

It has been estimated that nearly 170 million individuals, or approximately 64% of the non-elderly population, have employer-based health coverage in the United States.[1] While under federal law, employers are not required to provide coverage to employees, many do so voluntarily.[2] Employment-based insurance has several strengths, including risk pools that are not formed on the basis of health status, ease of acquisition by workers, and tax subsidies that exceed those for individual market insurance.[3] In addition, employers may have greater negotiating power with an insurance company than does an individual consumer.[4] On the other hand, plans chosen by employers may not meet individual workers' needs, and changing jobs may require obtaining both new insurance and new doctors. Nevertheless, given that employers are a large source of financing for health coverage in the United States, whether employment-based insurance should be strengthened, weakened, or kept the same is likely to be evaluated by Congress. If Congress chooses to amend the employer-based system as part of a federal health reform effort, it is possible that two primary federal laws governing employer-based coverage, Employee Retirement Income Security Act and the Internal Revenue Code, may be the vehicle for making changes. [5] This report provides an analysis of selected legal considerations in amending these two federal laws.[6]

The Employee Retirement Income Security Act (ERISA)

The Employee Retirement Income Security Act (ERISA)[7] provides a comprehensive federal scheme for the regulation of private sector employee benefit plans.[8] While ERISA does not require an employer to provide employee benefits, it does mandate compliance with its provisions if such benefits are offered. Enacted in 1974, the act sought to eliminate the conflicting and

[1] See CRS Report 96-891, *Health Insurance Coverage: Characteristics of the Insured and Uninsured Populations in 2007*, by Chris L. Peterson and April Grady.

[2] It should be noted that employers may provide health benefits pursuant to a collective bargaining agreement. This report does not discuss possible implications that the presence of an agreement may have on amending employer-based health coverage.

[3] For more information on the advantages or disadvantages of an employer-based system, see CRS Report R40517, *Health Care Reform: An Introduction*, by Bob Lyke.

[4] Joint Committee on Taxation, Background Materials for Senate Committee on Finance Roundtable on Health Care Financing, JCX-27-09 (May 8, 2009).

[5] It is important to note that ERISA is not the only federal law that governs health coverage. In general, while ERISA covers private-sector employee benefit plans and health insurance issuers providing group health coverage, it does not cover governmental plans, church plans, or plans with less than 2 participants. The Public Health Service Act covers both group health plans, health insurance issuers providing group health coverage, and coverage in the individual market, including some governmental plans. The Internal Revenue Code covers group health plans, including church plans, but does not cover health insurers. The requirements of the PHSA may apply to church plans if the plan provides coverage through a health insurer.

[6] One predominant concern that Congress will likely address in enacting major health reform legislation is how to improve health care quality. While employers may play a role in attempting to improve health care quality for employees and beneficiaries (e.g., by creating a wellness program), issues of health care quality will not be discussed in this report.

[7] P.L. 93-406, 88 Stat. 829 (Sept. 2, 1974).

[8] For a general discussion of ERISA's requirements, see CRS Report RL34443, *Summary of the Employee Retirement Income Security Act (ERISA)*, by Patrick Purcell and Jennifer Staman.

inconsistent regulation of employee benefit plans by various state laws.[9] Such laws were believed by some to be inadequate in protecting the interests of plan participants and beneficiaries.[10]

While ERISA was enacted primarily to regulate pension plans, ERISA also regulates welfare benefit plans[11] offered by an employer to provide medical, surgical, and other health benefits.[12] ERISA applies to health benefit coverage offered through health insurance or other arrangements (e.g., self-funded plans).[13] Health plans, like other welfare benefit plans governed by ERISA, must comply with certain standards, including plan fiduciary standards and reporting and disclosure requirements. However, while ERISA provides extensive regulation of pension plans, its regulation of health and other welfare benefit plans is less detailed. For example, unlike its regulation of pension plans, ERISA does not include vesting requirements for welfare benefit plans, under which a benefit becomes non-forfeitable.[14] In addition, ERISA requires pension plans to meet extensive funding requirements, but these requirements do not apply to health and other welfare benefit plans. Thus, if an employer with a self-funded plan were to go bankrupt, there is little federal protection for employee medical claims.

Since the enactment of ERISA, Congress has taken certain steps to regulate the nature and content of group health plans more comprehensively.[15] These requirements, found in Part 6 and Part 7 of Title I of ERISA, only apply to group health plans and health insurance issuers offering group health coverage. [16] For example, the Consolidated Omnibus Budget Reconciliation Act of

---

[9] According to a statement made by one of ERISA's sponsors, Representative Dent, "I wish to make note of what is to many the crowning achievement of this legislation, the reservation to Federal authority the sole power to regulate the field of employee benefit plans. …[W]e round out the protection afforded participants by eliminating the threat of conflicting and inconsistent State and local regulation." 120 Cong. Rec. 29197 (1974).

[10] See, e.g., *id.* See also generally, James A. Wooten, *A Legislative and Political History of ERISA Preemption, Parts 1-3, Journal of Pension Benefits*, Vols. 14-15, (2006-2008).

[11] ERISA considers a number of non-pension benefit programs offered by an employer to be "employee welfare benefit plans." For example, health plans, life insurance plans, and plans that provide dependent care assistance, educational assistance, or legal assistance can all be deemed welfare benefit plans. See 29 U.S.C. § 1002(1).

[12] See Phyllis C. Borzi, *Symposium: On the Cusp: Insight and Perspectives on health Reform: Part II: Private and Public health Coverage: How Should They Change?: There's Private and then There's "Private": ERISA, Its Impact, and Options for Reform*, 36 J.L. Med. & Ethics, 660 (Winter 2008), for a discussion of the reasoning behind the disparity between regulation of pension and welfare benefit plans under ERISA.

[13] Under self-funded (or self-insured) plans, instead of using health insurance (i.e., where an employer pays a premium to an insurer to cover the claims of plan participants) an employer acts as the insurer itself and pays the health care claims of the plan participants. While self-insured plans may use an insurance company or other third party to administer the plan, the employer bears the risk associated with offering health benefits. See Employee Benefits Research Institute, Capping the Tax Exclusion for Employment-Based Health Coverage: Implications for Employers and Workers, January 2009, available at http://www.ebri.org/publications/ib/index.cfm?fa=ibDisp&content_id=4159.

[14] However, it should be noted that in the context of retiree health benefits, some courts have found that under certain circumstances, when an employer has made a promise to provide health benefits for an employee's lifetime or other length of time, the health benefits have been found to vest. For a discussion of this issue, see James P. Baker, Andy Kramer, Evan Miller, and Steve Sacher, *Retiree Medical Litigation's Dirty Little Secret-"Location, Location, Location!"* 22 Benefits Law Journal 26 (2009).

[15] For additional information on the regulation of health benefits under ERISA, see CRS Report RS22643, *Regulation of Health Benefits Under ERISA: An Outline*, by Jennifer Staman.

[16] It should be noted that insurance matters are primarily regulated at the state, rather than the federal, level. Congress explicitly recognized the role of the states in the regulation of insurance with the passage of the McCarran-Ferguson Act of 1945. This law was passed in response to the Supreme Court's ruling in *United States v. South-Eastern Underwriters*, 322 U.S. 533 (1944), in which the Court affirmed the federal government's right to regulate the competitive practices of insurers under the Commerce Clause of the United States Constitution. The intent of the McCarran-Ferguson Act was to grant states the explicit authority to regulate insurance in light of the *South- Eastern*
(continued...)

1985 (COBRA) amended ERISA and the IRC to require the sponsor of a group health plan to provide an option of temporarily continuing health care coverage for plan participants and beneficiaries under certain circumstances.[17] The Health Insurance Portability and Accountability Act of 1996 (HIPAA) created additional health plan coverage requirements under ERISA and other federal laws, including limitations on an exclusion period for an individual's preexisting condition.[18] HIPAA also prohibits a health plan from requiring an individual to pay a higher premium or contribution than another "similarly situated" participant, based on certain health-related factors, such as medical history or disability.[19] Further, ERISA also contains provisions that do not require employers to provide specific benefits, but regulates these benefits if such coverage is offered. For example, health plans that choose to provide mental health benefits must provide a certain amount of parity between medical/surgical benefits and mental health benefits offered, and plans that provide hospital coverage in connection with the birth of a child must allow for certain minimum hospital stay requirements for these mothers following childbirth.[20] In addition, ERISA requires group health plans providing mastectomy coverage to cover prosthetic devices and reconstructive surgery.[21] Congress also recently enacted Michelle's Law,[22] which amended ERISA and other laws to require group health plans and health insurance issuers that provide coverage for dependents to retain as dependents on the health plan, college-age students who are required to take a medically necessary leave of absence from school.[23] While some commentators may argue that ERISA's regulation of health plans is sufficient in scope and should not be expanded (so that employers are not discouraged from providing health benefits to employees), others have pointed to a lack of regulation in this area.[24]

ERISA may be a key part of the health reform discussion in two main ways. The first way is if Congress desires to amend the employer-based system, for example, to require financing or benefits for group health plans as provided by employers.[25] If a national proposal were to require employers to provide or contribute to the payment of health benefits or to provide specific

---

(...continued)

Underwriters decision. Section 2(a) of the act states: The business of insurance, and every person engaged therein, shall be subject to the laws of the several States which relate to the regulation or taxation of such business. 15 U.S.C. § 1012(a). However, under the act, Congress also reserved to itself the right to enact federal statutes that "specifically" relate to "the business of insurance." 15 U.S.C. § 1012(b). Parts 6 and 7 of ERISA are examples of where Congress has exercised this right.

[17] P.L. 99-272, tit. X, 100 Stat. 327 (1985). For additional information on COBRA, see CRS Report R40142, *Health Insurance Continuation Coverage Under COBRA*, by Janet Kinzer. It also should be noted that COBRA amended the Public Health Service Act to that requires coverage for certain state and local government employees (if the state receives funds under the act). See 42 U.S.C. § 300bb-1 et. seq.

[18] P.L. 104-191, 110 Stat. 1936 (1996).

[19] 29 U.S.C. § 1182(a)(1)(A)-(H).

[20] 29 U.S.C. § 1185a; 29 U.S.C. § 1185.

[21] 29 U.S.C. § 1185b.

[22] P.L. 110-381, §2(a)(1), 122 Stat. 4081 (Oct. 9, 2008).

[23] 29 U.S.C. § 1185c.

[24] See, e.g., The ERISA Industry Committee Health Policy Issue Brief, Successful Employer-Provided Health Plans Depend On Nationally Uniform Standards (Oct. 15, 2007), cf. Rebecca A.D. O'Reilly, *Is ERISA Ready for a New Generation of State Health Care Reform? Preemption, Innovation, and Expanding Access to Health Care Coverage*, 8 U. Pa. J. Lab. & Emp. L. 387 (Winter 2006) ("The scope of ERISA preemption in the context of health and welfare plans is particularly significant because … unlike ERISA's expansive regulation of pension plans, it provides relatively little substantive regulation of health plans. The result is that health plans governed by ERISA can be structured to go largely unregulated." citations omitted.)

[25] *Id.*

benefits as part of group health plans, ERISA could be a vehicle for this type of proposal. Second, if Congress were to amend the role of states in regulating employment-based health benefits, ERISA's express preemption provision, § 514, would likely be implicated. Section 514 of ERISA is commonly seen as a barrier for states in enacting health reform that affects the employer-based system.[26] This report will provide an overview of ERISA preemption and analyze some of the current issues dealing with the extent to which ERISA can preempt state health reform efforts, as well as issues that may considered in a national health reform effort.

Overview of ERISA Preemption

In an effort to protect employee benefit plans and participants, Congress, through ERISA, federalized regulation of plan administration "to minimize the administrative and financial burden of complying with conflicting directives among States or between States and the Federal Government"[27] This goal is carried out through a critical feature of ERISA: its preemption of state laws.[28] According to the Supreme Court, Congress provided for ERISA preemption in order to "avoid a multiplicity of regulation in order to permit the nationally uniform administration of employee benefit plans."[29] The question of whether ERISA preempts state law has, at times, been complex and controversial. The provisions at issue in the preemption debate are (1) § 514, ERISA's express preemption section, under which ERISA may supersede state law, and (2) § 502(a), which limits claims that may be brought and remedies a plaintiff may recover under ERISA, and may preempt a state law cause of action.[30] Section 514 will be the focus of this report.

ERISA § 514 preempts "any and all State laws insofar as they may now or hereafter relate to any employee benefit plan.... "[31] The U.S. Supreme Court has interpreted this language as applying to any state law that "has a connection with or reference to such a plan."[32] In conjunction with these

---

[26] See generally, e.g., Peter D. Jacobson, The Role of ERISA Preemption in Health Reform: Opportunities and Limits, Legal Solutions in Health Reform, available at http://www.rwjf.org/pr/product.jsp?id=39410; Wendy Parmet, Regulation and Federalism: Legal Impediments to State Health Care Reform, 19 Am. J. L. and Med. 121(1993).

[27] Ingersoll-Rand Co. v. McClendon, 498 U.S. 133, 142 (1990).

[28] The preemption doctrine derives from the Supremacy Clause of the Constitution, which establishes that the laws of the United States "shall be the supreme Law of the Land; and the Judges in every State shall be bound thereby, any Thing in the Constitution or Laws of any State to the Contrary notwithstanding." U.S. Const., art. VI, cl. 2. In general, federal preemption occurs when a validly enacted federal law supersedes an inconsistent state law. For a discussion of preemption doctrine, see Constitution of the United States of America, Analysis and Interpretation, Congressional Research Service, pp. 257-278.

[29] Travelers, 514 U.S. at 657.

[30] Section 502(a) of ERISA (29 U.S.C. § 1132) creates a civil enforcement scheme that allows a participant or beneficiary of a plan to bring a civil action for various reasons, including "to recover benefits due to him under the terms of the plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan." If a plaintiff seeks to bring a state law claim is "within the scope" of § 502(a), the state law claim can be preempted. While the remedial provisions of ERISA may come into play in a federal health reform effort, this report will only address preemption under § 514. For more information on preemption under § 502 of ERISA, see CRS Report 98-286, *ERISA's Impact on Medical Malpractice and Negligence Claims Against Managed Care Plans*, by Jon O. Shimabukuro.

[31] 29 U.S.C. § 1144(a). "State law" includes "[a]ll laws, decisions, rules, regulations, or other State actions have the effect of law of any State. A law of the United States, applicable only to the District of Columbia, shall be treated as a State law rather than a law of the United States." 29 U.S.C. § 1144(c)(1).

[32] See Shaw v. Delta Air Lines, Inc., 463 U.S. 85, 97 (1982).

two factors articulated by the Supreme Court, a court's preemption analysis typically examines whether a state law interferes with the ERISA's goal of uniform national standards.[33]

The Supreme Court has explained that to determine whether a state law has a "connection with" an ERISA plan, a court must consider the objectives of ERISA as a guide to the scope of the statute that Congress understood would survive, as well as the nature of the effect of the state law on ERISA plans.[34] State laws that attempt to regulate plan benefits or the administration, operation, or structure of the plan may be seen as having an improper connection with an ERISA plan. For example, in *Shaw v. Delta Airlines*, [35] a New York law which required plans to provide pregnancy-related benefits was found preempted because it burdened the administration of employee benefit plans.[36] Similarly, in *Egelhoff v. Egelhoff,* the Washington law at issue provided that the designation of a spouse as the beneficiary of a non-probate asset (e.g., a pension plan) would be revoked automatically upon divorce. In determining that the Washington law had an impermissible connection with ERISA plans because it interfered with nationally uniform plan administration, the Court explained that one of the principal goals of ERISA is to enable employers to establish a uniform administrative scheme that provides standard procedures for the processing of claims and disbursement of benefits. The Court maintained that uniformity is impossible if plans are subject to different legal obligations in different states.

A state law has a "reference to" an ERISA plan if it acts "immediately and exclusively" on ERISA plans or if the existence of such a plan is essential to the law's operations.[37] For example, in *Mackey v. Lanier Collection Agency & Service*,[38] the Court evaluated Georgia statutes which addressed the garnishment of funds from ERISA employee welfare benefit plans. The Court held that ERISA preempted the state statute that specifically exempted ERISA plans under state garnishment procedures. The Court declared that "any state law which singles out ERISA plans, by express reference, for special treatment is pre-empted."[39]

Despite § 514's wide scope, ERISA does not preempt every state action that affects an employee benefit plan.[40]As the Supreme Court has articulated, "[s]ome state actions may affect employee benefit plans in too tenuous, remote, or peripheral a manner to warrant a finding that the law 'relates to' the plan."[41] While the Court's early ERISA preemption decisions suggested that the application of ERISA's explicit preemption clause was virtually limitless, its decision in *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Insurance Co.* signaled a change in the Court's interpretation of § 514(a).[42] In *Travelers*, several commercial insurers challenged a state law that required them, but not Blue Cross and Blue Shield, to pay hospital surcharges. The

[33] As the Supreme Court has stated with regard to ERISA preemption, "[t]he purpose of Congress is the ultimate touchstone." Ingersoll-Rand Co. v. McClendon, 498 U.S. 133, 138 (1990), quoting Allis-Chalmers Corp. v. Lueck, 471 U.S. 202, 208, (1985).

[34] See California Div. of Lab. Standards Enforcement v. Dillingham Construction, 519 U.S. 316 (1997).

[35] 463 U.S. 85 (1983).

[36] In *Shaw*, which first articulated this test, the Court found that the law had both an impermissible connection and related to a plan.

[37]*Id.* at 325.

[38] 486 U.S. 825 (1988).

[39] *Id.* at 838, n. 12.

[40] Marram v. Kobrick Offshore Fund, Ltd, 2009 Mass. Super. LEXIS 85, (Jan. 30, 2009).

[41] Shaw, 463 U.S. at 100 n. 21.

[42] 514 U.S. 645 (1995).

commercial insurers argued that the law was preempted by ERISA because it "relate[d] to" employer-sponsored health insurance plans. In addressing the issue of ERISA's preemption clause, the Court first noted that there is a "presumption that Congress does not intend to supplant state law."[43] The Court then turned to whether Congress intended to preempt state law by looking to "the structure and purpose of the act."[44] The Court concluded that "nothing in the language of the act or the context of its passage indicates that Congress chose to displace general health care regulation, which historically has been a matter of local concern."[45] In other cases, the Court has similarly recognized the states' ability to regulate matters of health and safety, and has concluded that state laws of general applicability are not necessarily preempted by ERISA.[46] However, in spite of an arguable narrowing in the scope of § 514(a), this section still is considered to broadly preempt state law.[47]

Under § 514(b)(2)(A), a state law that relates to an ERISA plan may avoid preemption if it regulates insurance within the meaning of ERISA's "saving clause." This section "saves" from preemption "any law of any State which regulates insurance, banking, or securities."[48] Thus, the savings clause permits states to regulate health insurance without running afoul of ERISA's preemptive scheme, and states may therefore impose requirements on health insurers that are more comprehensive than the requirements set forth under ERISA.[49] However, under § 514(b)(2)(B) of ERISA, commonly referred to as the "deemer clause," a state law that "purport[s] to regulate insurance" cannot deem an employee benefit plan to be an insurance company for purposes of regulation.[50] In interpreting this provision, the Supreme Court has found that a self-insured health plan cannot be "deemed" an insured plan for the purpose of state regulation.[51]

Accordingly, a plan that provides health benefits through an insurance company can, in effect, be regulated by state insurance law, as well as by ERISA. On the other hand, a plan that is self-insured is only subject to ERISA's requirements, and is immune from state law. It is estimated that approximately 55% of workers with employment-based health coverage participate in self-insured plans.[52] Thus, by self-insuring an employer can avoid compliance with state requirements that may be more onerous or costly, and may be able to provide the same coverage to all

[43] *Id.* at 654.

[44] *Id.* at 655.

[45] *Id.* at 661.

[46] De Buono v. NYSA-ILSA Medical and Clinical Services Fund, 520 U.S. 806 (1997) (state tax on gross receipts of health care facilities not preempted by ERISA); California Div. of Labor Standards Enforcement v. Dillingham Constr., 519 U.S. 316 (1997) (California's prevailing wage law not preempted by ERISA).

[47] See Constitution of the United States of America, Analysis and Interpretation, Congressional Research Service, p. 262, stating that ERISA's preemption provision is "[p]erhaps the broadest preemption section ever enacted."

[48] 29 U.S.C. § 1144(b)(2)(A).

[49] Every state has adopted various standards for health insurance, including requirements for the prompt payment of claims, access to health insurance (e.g., a requirement to cover dependants under a policy up to a certain age), rating requirements that affect insurance premiums, and mandated benefit requirements (i.e., requirements for health insurers cover services provided by certain medical specialties or cover treatments for specific diseases). See Mila Kaufman and Karen Pollitz, Health Insurance Regulation by States and the Federal Government: A Review of Current Approaches and Proposals for Change, April 2006.

[50] 29 U.S.C. § 1144(b)(2)(B). See Metropolitan Life Ins. Co. v. Massachusetts, 471 U.S. 724, 733 (1984) (discussing ERISA's "saving clause" and "deemer clause").

[51] FMC v. Holliday, 498 U.S. 52 (1990).

[52] Kaiser Family Foundation and Health Research & Educational Trust, Employee Health Benefits, 2008 Annual Survey, Exhibit 10.1, http://ehbs.kff.org/pdf/7790.pdf.

employees, regardless of the state where the employee works or resides, which may have administrative advantages. However, it has been noted that leaving self-insured plans out of state regulation can lead to greater costs for states.[53]

ERISA Preemption and Health Reform

ERISA's preemptive scheme is important in examining possible roles that states might plan in regulating employment-based health benefits. ERISA preemption arises in the health reform debate in two primary contexts. First, in the absence of federal legislation, states and localities have undertaken certain efforts to improve health coverage for their residents, and questions have been raised about whether ERISA preempts these state laws. Second, if a federal health reform effort includes a larger role for the states in terms of employee benefit regulation, then ERISA's preemption provisions may need to be reviewed.

ERISA and Current State Health Reform Efforts

As discussed above, ERISA preemption may limit the types of health reform initiatives states may enact. For example, based on judicial precedent interpreting ERISA § 514, states cannot require employers to provide a minimum level of coverage or specific health benefits.[54] While states may regulate health insurance, they cannot impose regulation on self-insured plans. In addition, while states may have some flexibility to pass laws of general applicability in order to generate revenue to pay for health insurance for their constituents (e.g., a tax on all employers), it has been pointed out that there may be some downsides to this type of approach.[55] Despite these obstacles, and in response to an increasing number of uninsured individuals, the declining number of employers offering insurance to their employees, and the absence of federal action, states and localities have experimented with certain measures to address the problems of health care financing and access, and have sought ways to make employers pay for health coverage of their employees. One leading approach that states and localities have taken is "fair share laws" (also referred to as "pay or play" statutes), which generally require employers to choose between paying a certain amount toward health expenditures or coverage for their employees, or contributing to a state or locality to offset the cost of medical expenses for uninsured residents. Recently, questions have been raised as to whether § 514 of ERISA prevents the application of fair share laws.

Legal challenges to fair share laws enacted in Maryland and San Francisco have yielded varying conclusions. In 2006, Maryland enacted the Fair Share Health Care Fund Act, which would have

---

[53] See Mila Kofman, "Health Care Reform: Recommendations to Improve Coordination of Federal and State Initiatives," Testimony before the U.S. House of Representatives, Committee on Education and Labor Subcommittee on Health, Employment, Labor and Pensions, May 22, 2007 (discussing, among other things, that [w]hen small businesses with healthy workers self-insure, their claims are not pooled with others and coverage is more expensive in state-regulated products as fewer healthy people help pay for the sicker ones.") See also generally Russell Korobkin, *The Battle over Self-Insured Health Plans, or "One Good Loophole Deserves Another*," 5 Yale J. Health Pol'y L. & Ethics 89 (2005).

[54] See e.g., Shaw, footnote 32 supra; Standard Oil v. Agsalud, 633 F.2d 760 (9th Cir. 1980), aff'd. mem., 454 U.S. 801 (1981).

[55] See Borzi, footnote 12 supra (explaining that a proposal to tax all employers in a state in order to pay for health coverage could be inequitable, as it would affect both employers who offer coverage, as well as those who do not).

required for-profit employers with 10,000 or more employees in the state to either spend at least 8% of their total payroll costs on employee health insurance costs, or pay to the state the amount their spending fell short of that percentage.[56] Shortly after the Fair Share Act was enacted, a retail trade association that includes Wal-Mart as a member, challenged the measure on the grounds that it was preempted by ERISA. In *Retail Industry Leaders Association v. Fielder*,[57] the Fourth Circuit found the Maryland Fair Share Act was preempted because it effectively forced employers to restructure their employee health plans, and as such, interfered with ERISA's goal of providing uniform nationwide administration of these plans.[58] The *Fielder* court opined that just because an employer had the option not to spend money on health care for their employees, this option was not a "meaningful alternative" and did not protect the law from preemption.[59]

The City of San Francisco passed the San Francisco Health Care Security Ordinance, which requires covered employers to make minimum health care expenditures on behalf of covered employees.[60] The San Francisco Ordinance identifies various qualifying health care expenditures, including contributions to health savings accounts and payments to a third party for the purpose of providing health care services for covered employees. Covered employers may also satisfy the Ordinance's spending requirement by making payments directly to the city. Regulations that implement the Ordinance confirm that a covered employer has discretion with regard to the type of health care expenditure it chooses to make for its covered employees. In a case challenging the Ordinance, *Golden Gate Restaurant Ass'n v. City and County of San Francisco*, the Ninth Circuit upheld San Francisco's Act as not preempted by ERISA. [61] In its opinion, the Ninth Circuit refuted the argument that the Ordinance established an ERISA plan (and therefore, "related to" and ERISA plan) because of the administrative obligations imposed on employers by the Ordinance. The court found that the Ordinance only places minimal duties on employers, and does not bind plan administrators to a particular choice of rules for determining plan eligibility or entitlement to particular benefits. [62] The court further explained that the Ordinance does not require employers to structure their employee benefit plans in a particular manner or to provide specific benefits. The Ninth Circuit also distinguished *Fielder*, emphasizing that the Ordinance does not require employers to structure their employee health care plans to provide a certain level of benefits. In contrast, the court maintained, the Maryland Fair Share Act did not provide

[56] 2006 Md. Laws 1.

[57] 475 F.3d 180 (4th Cir. 2007).

[58] The Department of Labor, in an Amicus brief, had argued for this result. It was argued that "[b]y setting an aggregate amount (by percentage of payroll) affected employers must spend on employee health benefits, Maryland is taking away employers' fundamental authority over whether, and on what terms, to sponsor a plan, and potentially subjecting employers to the competing demands of a multiplicity of state and local regulatory schemes." Brief of the Secretary of Labor as Amicus Curiae, Supporting Plaintiff-Appellee and Requesting Affirmance, RILA v. Fielder, 475 F.3d 180 (4th Cir. 2007) (No. 06-1840, 06-1901).

[59] See also RILA v. Suffolk County, 497 F.Supp.2d 403, 407 (E.D.N.Y. 2007) (Suffolk County Act, which enacted fair share legislation, found to be preempted by ERISA under similar reasoning as *Fielder*).

[60] "Covered employers" are defined by the Ordinance as employers engaged in business within the city that have an average of at least 20 employees performing work for compensation during a quarter. The term also applies to nonprofit corporations with an average of at least 50 employees performing work for compensation during a quarter. A "covered employee" under the Ordinance is defined as any individual who works in the city and county of San Francisco, works at least 10 hours per week, has worked for his employer for at least 90 days, and is not excluded from coverage by other provisions of the Ordinance.

[61] 546 F.3d 639 (9th Cir. 2008).

[62] *Id.* at 643-47.

meaningful alternatives to comply with the law. It is expected that the Golden Gate Restaurant Association will petition the Supreme Court for review of the case.[63]

The state of Massachusetts, which has received a great deal of attention for enacting comprehensive health care reform, maintains a fair share requirement as part of its health care reform package. Under the Massachusetts Act,[64] employers with more than 11 full-time equivalent employees that do not make a "fair and reasonable" contribution to a group health plan for their employees' health coverage must pay a "fair-share contribution" into a state trust fund in order to help cover costs of health care provided to uninsured Massachusetts residents "fair and reasonable" contribution to a group health plan for their employees' health coverage.[65] The Massachusetts law has not been challenged on preemption grounds, but if the Supreme Court were to review *Golden Gate Restaurant Association*, there could be implications for the Massachusetts law. For a more detailed discussion of fair share laws, ERISA preemption and an analysis of the Massachusetts statute, see CRS Report RL34637, *Legal Issues Relating to State Health Care Regulation: ERISA Preemption and Fair Share Laws*, by Jon O. Shimabukuro and Jennifer Staman.

ERISA and National Health Reform Efforts

ERISA may come into play in a national health reform effort in two primary ways. First, as mentioned above, Congress may choose to supplement the current federal regulation of health plans under ERISA. If Congress were to require employers to establish a health plan, provide specific health benefits, or provide financing of health benefits, ERISA may be a vehicle for carrying out these types of proposals. For example, Congress may choose to create additional requirements for group health plans under Parts 6 and 7 of Title I of ERISA (which includes include rules on health care continuation coverage (COBRA), limitations on exclusions from health care coverage based on preexisting conditions, and parity between medical/surgical benefits and mental health benefits.)[66] While some may be in favor of using ERISA as a tool for requiring employers to play a potentially larger role in the financing of health coverage for employees, others may argue that adding requirements may cause employers to cease to provide benefits (assuming a proposal retains the voluntary nature of these benefits) or impose burdensome costs on employers. It is also possible that Congress could legislate in this area without amending ERISA. Congress could repeal ERISA's provisions as they relate to group health plans and create a new federal law with entirely new requirements. However, if national health reform includes an expansion or contraction of private-sector employment-based health coverage, ERISA's current regulation of health benefits may need to be amended or repealed.

Second, ERISA preemption may be implicated in any federal health reform proposal that involves greater state regulation of employment-related health benefits. As discussed above, there are impediments to states' involvement in the regulation of employment-based health coverage. Thus,

[63] After the Ninth Circuit decision, Golden Gate Restaurant Association petitioned for a rehearing, which was denied. Golden Gate Rest. Ass'n v. City & County of San Francisco, 558 F.3d 1000 (9th Cir. 2009). Following the rehearing, Golden Gate Restaurant Association filed an emergency stay application with the Supreme Court, which was also denied. The association's petition to the Supreme Court for review is due on June 8, 2009.

[64] An Act Providing Access to Affordable, Quality, Accountable Health Care, Ch. 58 of the Acts of 2006, available at http://www.mass.gov/legis/laws/seslaw06/sl060058.htm.

[65] MASS. GEN. LAWS ch. 149, § 188 (2008).

[66] See footnotes 15 through 23 and accompanying text.

any federal proposal that may involve a role for the states in regulating employment-based health coverage, may need to take ERISA preemption into account. For example, there has been interest in implementing some type of health insurance exchange,[67] either on a national, state, or local level.[68] Among the other federal laws that may be amended in this type of proposal, ERISA could come into play in the insurance exchange context with respect to state laws that seek some way to compel an employer or employee benefit plan to participate in an exchange.[69]

Another area where ERISA preemption may need to be evaluated is under a federal proposal that allows for states to have some flexibility to enact their own reforms. If Congress, as part of a large scale health reform effort, desires to preserve Massachusetts' fair share requirements, or wants to clarify that fair share legislation such as the San Francisco Ordinance are acceptable under ERISA, or to allow states to enact other types of legislation that could, at least in theory, "relate to" employee benefit plans, amending ERISA's preemption provision may be considered. While some may argue that states should be allowed to be laboratories of experimentation[70] in figuring out what practices work and what practices do not in controlling costs and assuring access to health care, others may argue that, as was desired by many when ERISA was enacted,[71] there is a need for national uniformity in regulating health plans and that a patchwork of state regulation could be burdensome on employers.

Some commentators have suggested that a waiver of ERISA preemption may be an avenue to pursue for allowing states to enact health reform legislation while keeping national standards in place.[72] Congress has granted one waiver to the state of Hawaii. Under the Hawaii Prepaid Health Care Act of 1974, employers are required to provide health insurance to employees who work more than 20 hours per week, but may require employees to contribute up to 50% of the costs of

---

[67] A health insurance exchange generally entails a public or private entity that facilitates the purchase of health insurance by private individuals or small employers and consists of a range of plans. See Timothy Stolzfus Jost, Health Insurance Exchanges: Legal Issues, Legal Solutions in Health Reform, available at http://www.rwjf.org/coverage/product.jsp?id=38109&c=OTC-RSS&attr=PA.

[68] See, e.g., Description of Policy Options, Expanding Health Care Coverage: Proposals to Provide Affordable Coverage to All Americans, Senate Finance Committee (May 14, 2009), available at http://finance.senate.gov/sitepages/leg/LEG%202009/051109%20Health%20Care%20Description%20of%20Policy%20Options.pdf. For additional legal issues regarding a Health Insurance Exchange, see Stolzfus, footnote 66 at 11.

[69] *Id.*

[70] As constitutional expert Erwin Chemerensky has explained, the Supreme Court has often recognized the idea that there is a need to protect states rights so that states can serve as "laboratories for experimentation." Justice Brandeis first articulated this idea:

> To stay experimentation in things social and economic is a grave responsibility. Denial of the right to experiment might be fraught with serious consequences to the Nation. It is one of the happy incidents of the federal system that a single courageous State may, if its citizens choose, serve as a laboratory; and try novel social and economic experiments without risk to the rest of the country.

See Erwin Chemerinsky, David G. Trager Public Policy Symposium: Our New Federalism? National Authority And Local Autonomy In The War On Terror: Empowering States When It Matters: A Different Approach to Preemption*quoting New State Ice Co. v. Liebmann, 285 U.S. 262, 311 (1932) (Brandeis, J., dissenting).

[71] Indeed, legislative history indicates that a number of Members of Congress influential the passage of ERISA expressed the desire to preempt state regulation of employer-provided health care. See, e.g., remarks of Senator Javits, "the emergence of a comprehensive and pervasive Federal interest and the interests of uniformity with respect to interstate plans required ... the displacement of State action in the field of private employee benefits programs." 129 Cong. Rec. 29942 (Aug. 22, 1974).

[72] See, e.g., Jacobson, footnote 26 supra.

premiums or 1.5% of their salaries to health insurance, whichever is lower.[73] This mandate was challenged *Standard Oil Co. v. Agsalud*,[74] in which the Ninth Circuit found that the statute was preempted by ERISA.[75] After the Supreme Court affirmed the decision, in 1983 Congress exempted Hawaii's Act from ERISA preemption.[76] This type of waiver has been sought for other states, however, Congress has not granted them.[77] Case-by-case waivers may offer some state flexibility while maintaining some national uniformity. However, unless Congress articulates standards for acceptable state legislation and delegates the review process to an appropriate entity, Congress may have to umpire up to 50 separate disputes between employers and insurance companies arguing cost and uniformity against states arguing for local flexibility.

Federal Tax Treatment for Employer-Provided Health Care Insurance

In some ways, the cost of employer-provided health insurance is subsidized by the tax code. The tax burden of both employers and employees may be reduced when an employer provides health benefits to an employee. For example, the Joint Committee on Taxation recently estimated that limiting the size of this benefit to "the 75th percentile of health insurance premiums paid by or through employers" would increase federal revenues by $108.1 billion over the 2009-2013 period and by $452 billion over the 2009-2018 period.[78]

Although the preferential tax treatment of employer-provided health insurance does not technically provide a legal obstacle to legislative changes in health insurance coverage or delivery, some reform proposals have suggested repeal or modification of these provisions.[79] This

---

[73] See Haw. Rev. Stat. Ann. 393-13. Excluded from this list are emergency state employees, workers covered by collective bargaining agreements, independent contractors and part-time workers.

[74] 633 F.2d 760 (9th Cir. 1980), aff'd. mem., 454 U.S. 801 (1981).

[75] As the Supreme Court explained in *Fort Halifax Packing Co. v. Coyne*, 482 U.S. 1 (1987), the Hawaii law was struck down because of the obstacles it placed on the administration of ERISA health plans. As the Court explained :

> The Hawaii law was struck down, for it posed two types of problems. First, the employer in that case already had in place a health care plan governed by ERISA, which did not comply in all respects with the Hawaii Act. If the employer sought to achieve administrative efficiencies by integrating the Hawaii plan into its existing plan, different components of its single plan would be subject to different requirements. If it established a separate plan to administer the program directed by Hawaii, it would lose the benefits of maintaining a single administrative scheme. Second, if Hawaii could demand the operation of a particular benefit plan, so could other States, which would require that the employer coordinate perhaps dozens of programs. *Agsalud* thus illustrates that whether a State requires an existing plan to pay certain benefits, or whether it requires the establishment of a separate plan where none existed before, the problem is the same. Faced with the difficulty or impossibility of structuring administrative practices according to a set of uniform guidelines, an employer may decide to reduce benefits or simply not to pay them at all.
>
> Id. at 12-13 (citations omitted).

[76] 29 U.S.C. § 1144(b)(5).

[77] See, e.g., H.R. 3618, Universal Health Care for Oregonians Act of 1993, 103rd Congress, 1st Sess. (1993). See also 139 Cong. Rec. E3126 (daily ed. Nov. 24, 1993) (statement of Rep. Wyden) (explaining the necessity of obtaining an ERISA waiver for Oregon's health care reform legislation).

[78] CONGRESSIONAL BUDGET OFFICE, *Budget Option, Volume I: Health Care*, at 24 (Dec. 2008).

[79] For an analysis of the policy arguments surrounding the repeal or modification of these provisions, see CRS Report RL34767, *The Tax Exclusion for Employer-Provided Health Insurance: Policy Issues Regarding the Repeal Debate*, by Bob Lyke.

section of this report is intended to provide an overview of the operation of these provisions as they currently exist, as well as a general description of the effects they can have on one's income tax liability.

Employer Paid Health Insurance Premiums

Under § 106 of the IRC, gross income does not include amounts paid by an employer to provide health insurance for an employee.[80] As an example, consider an employee who earns a salary of $30,000, but also participates in a group health insurance plan offered through his employer that covers the medical expenses of himself and his family. The plan has annual premiums of $6,000, two-thirds of which are paid by the employer. The other third of the premiums is paid for through deductions from the employee's salary. In the absence of § 106, and assuming the employee has no other income, the employee would have $34,000 of gross income during a taxable year: the $30,000 he receives as salary plus the $4,000 contributed by his employer towards health insurance premiums. However, § 106 excludes the employer-provided premiums from gross income, leaving the employee with only the $30,000 in salary as gross income during the taxable year.

A similar tax benefit is provided for self-employed individuals under § 162(l) of the IRC.[81] Self-employed individuals cannot take advantage of § 106 to exclude the costs of health insurance because self-employed individuals do not qualify as "employees" as that term is generally used under the IRC. Therefore, § 162(l) permits a deduction equal to the cost of health insurance coverage for a self employed individual and her family. This deduction is not permitted if the self-employed individual is eligible for coverage offered by an employer of the individual or her spouse.[82]

Any amounts that are paid to individuals under a health insurance plan to reimburse the individual for medical costs[83] are also excluded from gross income.[84] For example, if an individual receives $1,000 worth of care through his employer-provided health insurance plan, the value of that care is not includable in his gross income.[85]

Premium Conversion

Section 106 only excludes amounts contributed by an employer. In contrast, amounts deducted from an employee's paycheck to pay for that employee's portion of employer-provided health insurance do not receive favorable tax treatment under § 106. However, many employers have established "premium conversion" programs in which an employee's contributions to health insurance premiums are converted into employer paid premiums that may be excluded under § 106.

---

[80] 26 U.S.C. § 106.

[81] 26 U.S.C. § 162(l). For more information, *see* CRS Report RL33311, *Federal Tax Treatment of Health Insurance Expenditures by the Self-Employed: Current Law and Issues for Congress*, by Gary Guenther.

[82] 26 U.S.C. § 162(l)(2)(B).

[83] Eligible medical costs are limited to those that also fall under 26 U.S.C. § 213 (providing a deduction for unreimbursed medical expenses).

[84] 26 U.S.C. § 105.

[85] This exclusion also applies to benefits paid from health insurance plans that are not provided by an employer.

For example, if an employee and his employer pay $100 and $200, respectively, toward health insurance for that employee, § 106 would only exclude the $200 provided by the employer from the employee's gross income. The employee would still be taxed on the $100 he contributes, as it constitutes part of his wages, even though it is likely deducted from his paycheck automatically. Under a premium conversion program, the employee's wages would be reduced by $100, but the employer would assume the $100 payment formerly contributed by the employee. For the employee, there is no difference in take home pay, but his overall tax liability decreases because the entire $300 premium is now paid by the employer, and is consequently excludable under § 106.

Premium conversion is made possible in part by § 125 of the IRC. [86] Under the doctrine of constructive receipt, if a taxpayer has a choice between a taxable benefit and a non-taxable benefit, he must include the value of the taxable benefit in gross income, even if he chooses the non-taxable benefit.[87] However, § 125 permits employees to choose between taxable and non-taxable benefits in a "cafeteria plan" without being forced to recognize the constructive receipt of income. Therefore, §125 allows employees to participate in a premium conversion program, essentially choosing between higher wages or employer paid premiums, without including the value of those premiums in gross income.[88]

Employment and Unemployment Taxes

Employer paid health insurance premiums similarly are not subject to employment tax liability.[89] Employees and employers both pay employment taxes on wages as defined under the Federal Insurance Contributions Act (FICA).[90] However, the statutory definition of wages excludes:

> the amount of any payment (including any amount paid by an employer for insurance or annuities, or into a fund, to provide for any such payment) made to, or on behalf of, an employee or any of his dependents under a plan or system established by an employer which makes provision for his employees generally (or for his employees generally and their dependents) or for a class or classes of his employees (or for a class or classes of his employees and their dependents), on account of ... medical or hospitalization expenses in connection with sickness or accident disability.[91]

Therefore, amounts paid by an employer to provide health insurance on behalf of an employee are not considered wages when calculating either employment tax liability of either employers or employees.

Employers are also required to pay unemployment taxes on all wages under the Federal Unemployment Tax Act (FUTA).[92] As with FICA, the act's definition of wages excludes employer paid health insurance premiums.[93]

---

[86] 26 U.S.C. § 125.

[87] Treas. Reg. § 1.451-2(a).

[88] Whether a premium conversion plan is offered to employees is subject to that employer's discretion. *See*, Rev. Rul. 2002-3.

[89] 26 U.S.C. § 3121(a)(2).

[90] 26 U.S.C. §§ 3101, 3111. The amounts collected from these taxes partially fund Medicare and Social Security.

[91] 26 U.S.C. § 3121(a)(2).

[92] 26 U.S.C. § 3301.

Incentives for Employees to Elect Employer-provided Health Insurance

The exclusion of health insurance premiums for employer-provided plans has a number of beneficial tax consequences for an employee's perspective. First, the taxpayer may benefit through a reduction in both his income and FICA tax liability.[94] Although a taxpayer who did not receive health benefits from his employer, but purchased health insurance independently, could deduct the cost of that insurance as an unreimbursed medical expense under § 213, that deduction would only be permitted to the extent that the taxpayers' total unreimbursed medical expenses exceeded 7.5% of his adjusted gross income. Taxpayers would also have to itemize their deductions in order to take advantage of § 213.[95]

Additionally, the operation of a number of other tax provisions may be affected by the reduction of a taxpayer's adjusted gross income (AGI). For example, a taxpayer that chooses to itemize her deductions is only permitted to take certain deductions to the extent that the aggregate amount of those deductions exceed 2% of her AGI.[96] Therefore, a reduction in AGI represents not only a reduction in taxable income directly, but also a reduction in the initial barrier to taking certain deductions. Other provisions also limit or reduce tax benefits to taxpayers above a certain AGI.[97] For individuals with AGI that is approaching that limit, whether employer paid health insurance premiums are included or excluded can affect whether these deductions or benefits can be claimed.

Excluding employer paid health insurance premiums from gross income also reduces an individual's earned income. Earned income is used primarily for determining the size of a taxpayer's earned income tax credit, if any. The statutory definition of earned income includes "wages, salaries, tips, and other employee compensation, but only if such amounts are includible in gross income for the taxable year." Therefore, because employer paid health insurance premiums are not includible in gross income, those amounts are similarly not includible in earned income. The effect of a reduction in earned income varies. The size of the earned income tax credit is directly proportional to earned income, up to a certain point. But, after earned income exceeds a statutorily defined "phaseout amount," the size of the credit gradually decreases. For individuals with earned income above the phaseout amount, reducing earned income can have the effect of increasing the size of the earned income credit.

(...continued)

[93] 26 U.S.C. § 3306(b)(2).

[94] The amount of the reduction in tax liability is governed by the taxpayer's marginal tax rate.

[95] 26 U.S.C. § 213(a).

[96] 26 U.S.C. § 67(a).

[97] *See*, *e.g.*, 26 U.S.C. § 24(b)(1) (phase out of child tax credit based on AGI); 26 U.S.C. § 25A(d) (phase out of Lifetime Learning Credit based on AGI); 26 U.S.C. § 213(a) (restricts deduction for unreimbursed medical expenses to aggregate amount in excess of 7.5% of AGI); 26 U.S.C. § 221(b)(2) (limiting deduction for interest on education loans based on AGI); 26 U.S.C. § 222(b) (amount of deduction for qualified tuition and related expenses dependant upon AGI).

Incentives for Employers to Offer Health Insurance

The exclusion of employer paid health insurance premiums also creates incentives for an employer to offer health benefits to its employees. Some of these are unrelated to an employer's income tax liability. For example, providing health benefits as compensation directly to employees results in lower tax liability for those employees than if the employer had simply raised their wages by the same amount. When comparing two jobs, an employee may find that a job with a lower salary plus health benefits results in a lower tax burden than a job with the same total compensation value paid entirely as salary. Therefore, an employer who provides health benefits may have a hiring advantage over other employers who offer higher nominal wages without health benefits.

Employers may also enjoy payroll tax deductions as a result of providing health benefits to employees. From an employer's perspective, the principal tax implication of providing health care to employees, instead of the comparable value in cash, is a reduction in the wage base of their employees. The reduction in wages means employer's tax burden, under FICA and FUTA, can be reduced by offering health insurance instead of increasing actual wages.

Author Contact Information

Jennifer Staman
Legislative Attorney
jstaman@crs.loc.gov, 7-2610

Edward C. Liu
Legislative Attorney
eliu@crs.loc.gov, 7-9166