

MEMORANDUM

To: Tom Coleman, SFECA Executive Manager
Re: Affordable Care Act Compliance Requirements
Date: July 1, 2011

The Affordable Care Act of 2010 (the "ACA") generally describes several pieces of health care reform legislation passed into law in early 2010 that substantially changed the delivery of health care in the United States. Although full implementation of the ACA does not occur until January 1, 2014, or later, some of its provisions have already become effective and others will become effective before 2014. This memorandum briefly discusses several ACA provisions that are most likely to effect your members before full implementation in 2014.

1. Coverage of Adult Children. Among the first changes under the ACA to take effect was the requirement to cover adult children of participants up to the age of 26 on a tax-free basis regardless of the child's marital and tax dependent status. This change, for the most part, was likely implemented by your members' health insurer and probably contributed to a premium increase upon contract renewal. There was, for a time, both confusion and annoyance at the inability of the California state legislature to pass legislation quickly conforming the unfavorable state income tax treatment for imputed income on coverage for non-dependent adult children with the favorable federal rule. But, in April 2011 California passed conforming legislation on a retroactive basis that eliminated any imputed taxable income for the coverage of an adult child for 2010 and later years.

2. Elimination of Annual and Lifetime Benefit Limits. Another recent change that group insurers implemented is the elimination of annual and lifetime benefit restrictions. Your member group plans probably contained relatively high annual and lifetime limits that would be unlikely to apply to the average employee. So, many employers probably barely noticed this change in the company group policy. Some employers in relatively low wage industries, however, sponsor plans with very low annual limits (e.g., \$10,000) known as "mini-med" plans. The federal government has been granting many of these plans waivers that allow the plan to maintain the low annual limits until 2014 when the ACA becomes more fully implemented. Without the waivers, most of these mini-med plans would be terminated by their employers. These waivers, widely reported in the national press, are not likely to be available or necessary to members' plans that already had relatively high limits.

3. Small Business Tax Credit. Effective beginning in 2010, small employers that offer their employees health insurance coverage may be entitled to a tax credit of up to 35% of employer contributions toward the coverage. An employer is eligible for the credit only if it employs less than 25 full-time equivalent employees (FTEs) with an average annual wage less than \$50,000. When determining an employer's eligibility for the credit, self-employed individuals, shareholders and family members of shareholders are generally excluded from consideration. Collectively bargained employees, however, are counted. Probably few of your member contractors (if any) would qualify for this credit, given high Bay Area wage levels.

4. Nondiscrimination Rules for Fully Insured Plans. Before the ACA, employers could provide tax-free insured health care for its employees on a basis that discriminated in favor of highly compensated employees. For example, the employer could exclude from participation lower paid employees while offering a rich plan of tax-free insured benefits for its highly paid employees. For many years, this type of discrimination has not been allowed for health benefits that the employer *self-insured* (which is more common for larger employers), but no nondiscrimination rule existed for insured benefits. The ACA changed that, and now requires insured health benefits to be tested for discrimination against lower paid employees in a manner similar to the test that applies to self-insured benefits. This new rule

was to take effect for plan years beginning after September 23, 2010, but the IRS has delayed its implementation until it can issue new regulations that describe how the testing is to be conducted. So, if an employer provides discriminatory health insurance benefits, it does not need to change its plan just yet. But, that employer should watch for new regulations to be issued by the IRS, probably sometime in 2012.

5. Simple Cafeteria Plans. Some small employers do not sponsor cafeteria plans because applicable nondiscrimination tests often prevent key employees from receiving tax benefits under the plan. Beginning in 2011, small employers (generally, those with fewer than 100 employees) may sponsor a "simple" cafeteria plan that is treated as meeting the nondiscrimination requirements that otherwise might prevent highly paid key employees from receiving tax benefits under the plan. The price to the employer of avoiding the nondiscrimination tests is an employer contribution to benefits of at least 2% of compensation (or a 6% match alternative) to nonhighly paid employees. Bargained employees are excluded for purposes of the simple cafeteria plan. If an employer does not make a cafeteria plan available because of nondiscrimination testing, it may want to consider a simple cafeteria plan.

6. Over-the-Counter Drugs. Effective January 1, 2011, over-the-counter drugs may no longer be reimbursed by an employer health plan (including cafeteria plan flexible spending accounts) unless the drug is prescribed by a physician (regardless of whether a prescription is necessary to obtain the drug). Similarly, a health savings account (HSA) may no longer reimburse non-prescribed OTC drugs after 2010. Under IRS transition guidance, cafeteria plans could have been amended anytime before July 1, 2011, to conform to this new rule, provided the amendment was retroactive to January 1, 2011.

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