TEVIS
INSURANCE SOLUTIONS

State Legislative Brief

Health Care Reform: Healthy San Francisco - 2011-1

As you know, the City and County of San Francisco (the City) requires most employers doing business within the City to make minimum expenditures toward the cost of health care services for their San Francisco employees. For details, please refer to www.sfgov.org/olse. The City's Ordinance requires that the covered employer pay a quarterly fee based on wages paid or to provide health care benefits to these employees. Some employers have established health care reimbursement accounts.

The City's Health Mandate Exemption

The Courts have held the City's Health Care Security Ordinance (HCSO) is not a group health plan and is not subject to the Employee Retirement Income Security Act (ERISA). The City has affirmed that it does not consider the HCSO itself as a health plan. As a result, it is not subject to the Patient Protection and Affordable Care Act or its related laws and regulations (PPACA). Accordingly, employers who pay the HCSO fees to the City have no PPACA obligations related to the HCSO. However, employers have set up self-funded health care reimbursement accounts (i.e. MERPs, HRA, 105(h) plans) which constitute health plans for purposes of the PPACA. The purpose of this Memorandum is to discuss the issues involved in that obligation.

Discussion

1. **Compliance with HCSO**. Many employers with employees working in San Francisco can satisfy the HCSO requirements by providing traditional medical benefits through conventional insurance policies or HMO contracts (e.g. Kaiser, Anthem Blue Cross, Blue Shield, etc.). However, employers whose San Francisco workforce includes individuals ineligible for traditional health care benefits (employees working less than 20 hours per week, for example) must either pay the City's fees or set up their own health care reimbursement mechanism on a self-funded basis.

> **Please note**: HCSO requirements will not apply to for-profit employers with less than 20 employees (total workforce regardless of job location) or non-profit organizations with less than 50 employed individuals. The HCSO also does not require benefits for employees working in San Francisco less than eight hours per week.

   The question becomes whether the type of plan established to achieve compliance with the HCSO is subject to the PPACA. The answer most often is that the plan will be subject to the PPACA.

2. **Will the Plan Avoid the PPACA by Qualifying as an "Excepted Benefit"**? Most likely not. To be an "Excepted Benefit" for purposes of the PPACA, it must meet specific criteria. The most common forms of "Excepted Benefits" are typically dental and/or vision plans which are offered with but not bundled with an underlying medical plan. It is worth noting that the PPACA rule here is the same rule used to determine "Excepted Benefit" status under the Health Insurance Portability and Accountability Act (HIPAA). To be considered an "Excepted Benefit", in the case of dental and vision benefits offered with

3. medical, the plan must provide dental and vision benefit on an unbundled basis. This means the participant can choose medical only or medical, dental (and/or vision) by making an additional contribution for the dental or vision coverage (Treasury Reg. ¶ 54.9831-1(c)(3)(ii)). Employer-sponsored plans established to satisfy the HCSO requirements which provide reimbursement for medical, dental or vision expenses, will be subject to PPACA since they are "bundled." If it truly is dental/vision only benefits, it will meet the definition of a health care expense as defined by HCSO regulations (Regulation Section 4.1(B)). And since it has no medical plan features, it will be exempt from PPACA, without regard to the "Excepted Benefit" provisions.
4. **Do the Plans Established for Compliance with HCSO meet the Independent, Non-coordinated Benefits Exclusion under PPACA?** PPACA rules will not apply to any group health plan which is offered to employees where the benefits are limited to "specific diseases, hospital indemnity ($100/day in ICU) or fixed indemnity plans" (Treasury Reg. ¶ 54.9831-1(c)(4)). These types of plans are those sold by AFLAC, Colonial, etc. I am not aware of any employers subject to the HCSO who have chosen to offer these to satisfy the HCSO obligation. It is not clear whether these would meet the health care expenditure requirements set forth in Section 14.1(b)(7).
5. **What about "Flexible Spending Accounts"**? These accounts are usually associated with cafeteria plans. Employers fund these accounts (FSAs) using employee contributions made through salary reduction or a combination of pre-tax contributions and employer "seed money." With the exception of the new statutory maximum of $2,500, effective in 2013, FSAs are not subject to PPACA. If the plan were to meet the definition of an FSA, then the employer would have no obligation to meet PPACA's annual limits provisions. To qualify as a Flexible Spending Account, the plan must have a limited benefit maximum not to exceed two times the employee's salary reduction amount plus $500. It also must be a supplement to another traditional group health plan. Since there is no underlying health plan available to the part-time workers covered under the health care reimbursement plan, it will not qualify as an FSA.
6. **What about Other Types of "Health Care Reimbursement Accounts"**? Many employers with part-time staff have elected to establish health care reimbursement accounts to meet the requirements of the HCSO. The employer makes money available to reimburse covered employees for medical expenses qualifying under IRC Section 213 up to a maximum benefit not to exceed the HCSO mandated expenditures. Unused balances role forward from quarter to quarter and become subject to COBRA pursuant to IRS Revenue Ruling 2002-41 and IRS Notice 2002-45. These plans will meet the HCSO compliance standard. Since they are health plans which to qualify as "Excepted", they also are subject to PPACA including the provision involving annual limits.

"HHS Waiver" an Option?

As we know, PPACA gives the Department of Health and Human Services (HHS) the authority to waive the annual limits provisions under PPACA which go into effect for plan years beginning on or after September 23, 2010 and before September 23, 2011 for health plans which, if required to meet the annual limits provision (annual limit must not be less than $750,000) would result in a significant increase in premiums or a significant decrease in access to coverage. The waiver process requires an employer to submit an application to HHS at least 30 days prior to the beginning of the HRA's plan year. This may present a problem for calendar year plans, absent a change in the plan year. To be successful, the application would need to indicate that because of the $750,000 minimum annual limit requirement, the employer would be forced to terminate the HRA and begin making contributions to the HCSO, thus decreasing access to benefits. Arguably, the employees living inside the City could access benefits only at City contracted facilities rather than from any provider and nonresident City workers would only be able to submit expenses to the City's fund for payment.

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In Summary

Employers subject to San Francisco's Health Care Security Ordinance should examine their plans established for purposes of satisfying the HCSO requirements and determine what they must do, if anything, to achieve compliance with PPACA.