

# BenAlert

**BENEFIT TRENDS AND LEGISLATIVE UPDATES**

FEBRUARY 2009



**HOWITT**  
Benefit Services

Howitt Benefit Services is pleased to provide you with periodic updates on benefit trends and legislative updates. As part of our valuable services, we want to ensure that you are in compliance and well-informed of the ongoing changes in our industry.

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## **Healthy San Francisco Update**

### **2008 Annual Reporting Form Due April 30, 2009**

As you know, the Health Care Security Ordinance (Healthy San Francisco) requires for-profit employers with 20 or more employees (and nonprofits with 50 or more employees) to spend a minimum amount on health care for covered employees and to report on these expenditures annually. On January 15, 2009, San Francisco's Office of Labor Standards Enforcement (OLSE) released an updated Annual Reporting Form (ARF) to be completed by covered employers by April 30, 2009. Attached are the Annual Reporting Form Instructions and Form.

Covered employers have the choice of completing the online PDF (see above) or the ARF mailed to them by OLSE. The online ARF must include the employer's Business Account Number, Ownership Name, and Mailing Address or face possible penalties and other corrective action.

### **Eligible Employees Change**

As of January 1, 2009, employees need only to work 8 hours per week in San Francisco to be eligible for Healthy San Francisco benefits upon completion of 90 calendar days of employment.

DEPARTMENT OF ADMINISTRATIVE SERVICES  
**OFFICE OF LABOR STANDARDS ENFORCEMENT**  
DONNA LEVITT, MANAGER



## INSTRUCTIONS FOR THE HCSO ANNUAL REPORTING FORM

The Health Care Security Ordinance (HCSO) requires for-profit employers with 20 or more employees (and nonprofits with 50 or more employees) to spend a minimum amount (set by law) on health care for Covered Employees and to report on these expenditures annually, using the Annual Reporting Form (ARF). The HCSO is enforced by the Office of Labor Standards Enforcement (OLSE).

**Employers with fewer than 20 employees are not covered by the HCSO and should not return the ARF.**

For more information on the HCSO and the Annual Reporting Form go to [www.sfgov.org/olse/hcso](http://www.sfgov.org/olse/hcso).

### GENERAL INSTRUCTIONS

This year’s Annual Reporting Form (ARF) is available from our website as a “fillable PDF,” allowing employers to open the document, type in their answers, then print, sign, and return the form. The form is also mailed to employers. **Employers that download and return the ARF from our website do not need to complete or return the ARF received by mail.**

The data you provide on the ARF will be electronically scanned. To ensure accuracy in the scanning process, we encourage you to type your answers, by either opening the PDF from our website and filling in your responses using the computer, or using a typewriter. If you must write in your answers, please use **black** ink, stay inside the boxes provided for your responses, and print your numbers similar to these:

**1 2 3 4 5 6 7 8 9 0**

**Confidentiality of Data Provided:** Data collected from the ARFs may be released publicly in aggregate form; however, this office will treat individual data as confidential to the extent provided by law.

**Annual Reporting with Quarterly Breakdowns:** The ARF must be submitted only once per year; however, your answers for most of the lines on this form should be broken down for each quarterly period. Quarter 1 includes the period from January through March of 2008; quarter 2, from April through June of 2008; quarter 3, from July through September of 2008; and quarter 4, from October through December of 2008. Generally, a quarter consists of 13 weeks.

**Reporting Deadline:** To avoid penalties and other corrective action, Covered Employers must return the ARF by April 30, 2009. Please do not return the form to our City Hall address; instead, please mail it to Post Office Box 7378, San Francisco, CA 94120-7378, as indicated at the top of the ARF and the purple return envelope provided in your mailing.

## LINE-BY-LINE INSTRUCTIONS

**Business Account or Certificate Number:** Every registered San Francisco business ownership has a unique six-digit business account or certificate number, which should be pre-printed on your form. (For more information regarding business registration, please visit [www.sfgov.org/BusinessRegistration](http://www.sfgov.org/BusinessRegistration) or call Taxpayer Assistance at 415-554-4400.)

- If your business account number does not appear on your form, be sure to type or print it in the space provided.

**For Businesses in the Same “Control Group”:** Only one ARF shall be filed for all entities within the same “controlled group of corporations” (as defined for purposes of income tax filing). Please fill the circle in completely (● rather than x or √) if you are filing this form on behalf of several entities in the same “control group,” and enclose the blank ARFs for the other entities in the same envelope.

- Leave this circle blank if you are not filing on behalf of businesses in the same “control group.”

All members of a “controlled group of corporations” (as defined for purposes of income tax filing) are considered one employer under the Ordinance, and all employees of each entity must be counted to determine the size of the employer. Employees of businesses that are not incorporated are counted as working for one employer if the businesses are under common control. For purposes of this Ordinance, "under common control" means either (a) one person (individual, estate, or trust) has at least an 80 percent ownership interest in each of the businesses, or (b) two to five persons hold more than a 50 percent ownership interest in each of the businesses.

**Line A:** This question is to determine whether you are a Covered Employer.

- You must include all employees anywhere, including those working outside of the geographic boundaries of San Francisco, in this number.
- Owners who perform work for compensation for the business are considered employees and must be counted as such.
- For businesses employing a fluctuating number of employees during a quarter, please review Frequently Asked Question (“FAQ”) #14, available at [www.sfgov.org/olse/hcso](http://www.sfgov.org/olse/hcso).

If you are a for-profit business employing 20 or more employees per week or a nonprofit business employing 50 or more employees per week, you are a Covered Employer and must complete the rest of the ARF and return it by April 30, 2009 to Post Office Box 7378, San Francisco, CA 94120-7378.

*If you are not a Covered Employer, stop here, and do not return the form!*

**Lines B-E: Lines B-E should include only those employees who meet the definition of a Covered Employee under the HCSO.** Covered Employees are those who have been employed for at least 90 calendar days and, after completing this 90-calendar day eligibility period, have worked at least 10 or more hours per week in San Francisco in 2008.

For employees whose work hours fluctuate from week to week, please review FAQ #20, available at [www.sfgov.org/olse/hcso](http://www.sfgov.org/olse/hcso).

*If you had no Covered Employees in any quarter in 2008, enter zero, sign the form, and submit it to the OLSE by April 30, 2009.*

**Line B1:** Enter the number of Covered Employees (see criteria above). Do not include employees exempt from coverage under the HCSO; you will include those employees in Line B2. Exemption categories are explained in the instructions for Line B2 below.

**Line B2:** Enter the number of employees who meet the Covered Employee criteria above, but are exempt from coverage under the HCSO because they fall into one or more of the five categories of exempt employees. For more details, see FAQ #23 and/or Regulation 3.2, available at <http://www.sfgov.org/olse/hcso>.

**Line C:** Calculate and enter the total number of “hours paid” to all Covered Employees. Hours paid includes both hours worked and hours for which Covered Employees were entitled to be paid, such as paid time off, vacation, sick leave, and holidays, up to 172 hours per month or 516 hours per quarter per employee. (For full-time employees, you may enter 172 hours per month or 516 hours per quarter, rather than calculating actual hours paid.)

**Line D:** Enter the total amount of health care expenditures you made on behalf of Covered Employees in 2008 in whole dollars.

- Include all health care expenditures made on behalf of your Covered Employees, including dental and vision benefits, even if the total amount exceeds the minimum amount required under the Ordinance.
- Include health care expenditures made for dependents of your Covered Employees if you intend for those amounts to be counted towards the minimum health care expenditure required under the Ordinance. (For more information regarding dependent benefits, see Regulation 4.2(D), available at [www.sfgov.org/olse/hcso](http://www.sfgov.org/olse/hcso).)
- Do not include commas or cents.
- Do not include any health care contributions or expenditures made by employees.

Employers with self-insured plans (as defined in the instructions for Line E2) may use either the COBRA equivalent rate for the 2008 plan year (minus any administrative fees) or the actual expenditure amounts.

**Line E:** In each of the categories listed in this section, enter the number of Covered Employees for whom you provided the benefits listed. Count each Covered Employee only once per quarter. If you made more than one type of health care expenditure for a Covered Employee, count that employee in the category in which the largest or greatest dollar amount of spending was made.

**Line E1:** Enter the total number of Covered Employees whom you enrolled in group health insurance coverage. Include in this category any employees for whom you made contributions to a Taft-Hartley plan pursuant to a collective bargaining agreement or union contract.

**Line E2:** Enter the total number of Covered Employees enrolled in your self-insured group health plan.

A self-insured, or self-funded, group health plan is one in which the employer assumes the financial risk for providing health care benefits to its employees. Self-insured employers pay for their employees' health care expenses as they are incurred, rather than paying a fixed premium to an insurance carrier. Such employers must abide by federal laws governing self-insured or self-funded plans.

**Line E3:** Enter the total number of Covered Employees enrolled in a health/medical reimbursement, spending, or savings account that was administered by a third-party vendor (e.g., Health Reimbursement Arrangement, Health Savings Account, Medical Flexible Spending Account, etc.)

**Line E3(a):** Enter the total dollar amount of funds that you made available to your Covered Employees listed in Line E3 over the entire plan year via a health/medical reimbursement, spending, or savings account administered by a third-party vendor. Enter the amount in whole dollars; *do not include commas or cents.*

**Line E3(b):** Enter the total dollar amount of funds that your Covered Employees listed in Line E3 were reimbursed during the plan year via a health/medical reimbursement, spending, or savings account administered by a third-party vendor. Enter the amount in whole dollars; *do not include commas or cents.*

**Line E4:** Enter the total number of Covered Employees for whom you provided direct reimbursement or made direct payments for health care expenses. This category includes any health spending accounts that were self-administered, in other words, the account was administered internally by the employer.

**Line E4(a):** Enter the total dollar amount of funds that you made available to your Covered Employees listed in Line E4 over the entire plan year via a self-administered health spending account. Enter the amount in whole dollars; *do not include commas or cents.*

**Line E4(b):** Enter the total dollar amount of funds that you paid out for your employees' health care during the plan year, through for example, reimbursements to your Covered Employees or direct payments to your employees' health care provider. Enter the amount in whole dollars; *do not include commas or cents.*

**Line E5:** Enter the total number of Covered Employees for whom you made payment for the City Option, which includes both *Healthy San Francisco* and the Medical Reimbursement Accounts administered by SHPS.

**Line E6:** If you made any other health care expenditures on behalf of your Covered Employees, enter the total number of Covered Employees for whom you made such expenses and describe how you made the expenditure in the space provided. If your explanation does not fit in the space provided, please provide your explanation on a separate page.

**Final Step:** Sign and date the form, then mail it to Post Office Box 7378, San Francisco, CA 94120-7378. To avoid penalties and other corrective action, return the ARF by April 30, 2009.

This notice is intended to provide general information and does not establish policy or offer legal advice regarding the Health Care Security Ordinance, Chapter 14 of the San Francisco Administrative Code. If you have any questions about your obligations under the ordinance, please visit [www.sfgov.org/olse/hcso](http://www.sfgov.org/olse/hcso), call (415) 554-7892, or email [HCSO@sfgov.org](mailto:HCSO@sfgov.org).

## Employer Expenditure Rate Changes

Beginning January 1, 2009, the health care expenditure rate for employers with 20 to 99 employees is \$1.23/hour; for employers with 100 or more employees, the rate is \$1.85/hour. Employers should begin using the 2009 rate to calculate the minimum expenditure for the first quarter of 2009 (which would include hours paid from January 1, 2009 through March 31, 2009).

Business Size	April 1, 2008	January 1, 2009
Large (100+ employees)	\$1.76/hour	\$1.85/hour
Medium (20-99 employees)	\$1.17/hour	\$1.23/hour
Small (1-19 employees)	Not covered	Not covered

## Annual Salary Exemption Change

Pursuant to Regulation 3.2(A)(1), an employee who is a manager, supervisor, or confidential employee and who earns at or above an annual salary limit is exempt from coverage under the Healthy San Francisco. OLSE has increased the annual salary exemption for 2009 to \$80,397 or \$38.65/hour from \$76,851 for 2008. Please review Regulation 3.2(A)(1) (see Page 8) for a detailed definition of a manager, supervisor, or confidential employee.

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**HEALTH CARE SECURITY ORDINANCE (HCSO) - MANDATORY ANNUAL REPORTING FOR 2008**

RETURN TO: SAN FRANCISCO OFFICE OF LABOR STANDARDS ENFORCEMENT

P.O. BOX 7378

San Francisco, CA 94120-7378

FOR ASSISTANCE: Refer to the enclosed instructions, visit  
http://www.sfgov.org/olse/hcso, or call (415) 554-7892

Business Account Number

**DELINQUENT AFTER April 30, 2009**

Covered Employers must complete all of the questions below. Failure to do so shall constitute a violation of § 14.3(b) of Chapter 14 of the SF Admin. Code. Violators shall be subject to penalties and other corrective action.

**FILL THIS CIRCLE IN COMPLETELY IF YOU ARE FILING THIS FORM ON BEHALF OF SEVERAL ENTITIES IN THE SAME "CONTROL GROUP."**

For each quarter, enter the following information:		1st Quarter: January to March 2008	2nd Quarter: April to June 2008	3rd Quarter: July to September 2008	4th Quarter: October to December 2008
A	<b>Number of Employees Employed per Week (anywhere):</b> <i>NOTE: Employers with 19 or fewer employees are NOT covered by the HCSO and should NOT complete or file this form.</i>	<input type="radio"/> 20-49 <input type="radio"/> 100-499 <input type="radio"/> 50-99 <input type="radio"/> 500+	<input type="radio"/> 20-49 <input type="radio"/> 100-499 <input type="radio"/> 50-99 <input type="radio"/> 500+	<input type="radio"/> 20-49 <input type="radio"/> 100-499 <input type="radio"/> 50-99 <input type="radio"/> 500+	<input type="radio"/> 20-49 <input type="radio"/> 100-499 <input type="radio"/> 50-99 <input type="radio"/> 500+
<b>IMPORTANT: The remaining questions refer only to those employees covered by the HCSO.</b>					
B1	<b>Total Number of "Covered Employees":</b> <i>Do not count employees exempt from coverage under this law; see instructions for more details.</i>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
B2	<b>Total Number of Employees Exempt From Coverage Under the HCSO,</b> <i>including those who have signed Voluntary Waivers</i>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
C	<b>Total Number of Hours Paid to All Covered Employees:</b> <i>Hours paid includes both hours worked and hours for which covered employees were entitled to be paid wages, such as paid vacation hours, paid time off, and paid sick leave hours, but not exceeding 172 hours/month or 516 hours/quarter.</i>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
D	<b>Total Amount of Health Care Expenditures Made for All Covered Employees</b> <i>(in whole dollars; do not include commas or cents)</i>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
E	<b>Breakdown of Health Care Expenditures Made by the Employer:</b> <i>Count each covered employee only once per quarter; if your business made more than one type of health care expenditure for an employee, count that employee in the category in which the largest health care expenditure was made.</i>				
E1	<b>Number of Covered Employees enrolled in group health insurance coverage</b>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
E2	<b>Number of Covered Employees enrolled in self-insured group health plan.</b> <i>Please review the instructions to determine if your plan meets the definition of a self-insured plan.</i>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
E3	<b>Number of Covered Employees enrolled in health/medical reimbursement, spending, or savings account administered by a third party vendor</b>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
E3(a)	<b>Total <u>annual</u> dollar amount of funds made available to Covered Employees for 2008 -- how much the employer made available via third-party health/medical reimbursement, spending, or savings accounts</b> <i>(in whole dollars; do not include commas or cents)</i>			\$ <input type="text"/>	
E3(b)	<b>Total <u>annual</u> dollar amount of reimbursements made to Covered Employees for 2008 -- how much employees were reimbursed via third-party health/medical reimbursement, spending, or savings accounts</b> <i>(in whole dollars; do not include commas or cents)</i>			\$ <input type="text"/>	
E4	<b>Number of Covered Employees for whom the employer provided direct reimbursement or made direct payments for health care expenses</b>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
E4(a)	<b>Total <u>annual</u> dollar amount of funds made available to Covered Employees for 2008 -- how much the employer made available for direct reimbursements or payments</b>			\$ <input type="text"/>	
E4(b)	<b>Total <u>annual</u> dollar amount of funds spent for Covered Employees for 2008 -- how much Covered Employees were reimbursed and/or how much was paid directly by the employer for Covered Employees' health care expenses</b> <i>(in whole dollars; do not include commas or cents)</i>			\$ <input type="text"/>	
E5	<b>Number of Covered Employees for whom payment was made for the City Option</b> <i>(includes both Healthy San Francisco and the City's Medical Reimbursement Account)</i>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
E6	<b>Other:</b> <i>(describe):</i>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

By submitting this report the above-named employer certifies the following: (1) that the information on this reporting form is correct; (2) that all compensable hours paid to the employees who performed work in the geographic boundaries of the City and County of San Francisco during the period covered by this report are reported herein; (3) that this report, whether or not signed in the space provided below, is being submitted by the employer or duly authorized representative of the employer. Under the laws of the State of California, I declare under penalty of perjury that I have read the foregoing and that it is true, correct, and complete to the best of my knowledge and belief.

3664

SIGN HERE \_\_\_\_\_

DATE \_\_\_\_\_, 2009

