

## OCTOBER 28, 2010 EMPLOYEE BENEFITS UPDATE WEBINAR

### QUESTIONS AND ANSWERS

#### **QUESTION: Has "full-time employee" been defined by number of hours worked, etc.?**

The Health Care Reform Act uses the concept "full-time employee" in a couple of limited circumstances, most notably as to the determination of the amount of penalty incurred by an employer who does not fully comply with the employer mandate requirements that become effective in 2014. The Health Care Reform Act does **not** establish a federal definition of "full-time employee" for purposes of determining eligibility for coverage under a group health plan or policy sponsored by an employer. Those determinations are made under the terms of the group plan or policy itself as well as the provisions of applicable state law.

Beginning in 2014, "large" employers, those with at least 50 "full-time employees," which do not offer *affordable* insurance and who have at least one employee receiving coverage through a state exchange, must pay a monthly penalty. The amount of the penalty is equal to the number of "full-time employees" (minus 30 employees) multiplied by \$2,000. Employers who do not offer any coverage and who have at least one employee receiving coverage through an exchange will be subject to a higher penalty – \$3,000 per employee. For purposes of the penalty provision, PPACA states that the term "full-time employee" means an employee who works at least 30 hours on average per week. (This definition of "full-time employee" also applies to IRS reporting requirements that become effective in 2014 regarding the free choice voucher program.)

Also in 2014, PPACA requires an employer with more than 200 "full-time employees" to provide automatic enrollment for new full-time employees into the employer's group health plan. This provision actually amends the Fair Labor Standards Act, which does not define the term "full-time employee." We will have to wait until regulations are issued to determine how "full-time employee" will be defined for automatic enrollment purposes.

#### **QUESTION: As to the definition of "full-time" employee, does PPACA specify the duration of the 30-hr/week threshold? This would impact businesses with seasonal employees or those with peak seasons where hours increase based on need, then fall below 30 hours/week during certain times.**

The Health Care Reform Act states that seasonal workers are disregarded in determining FTEs and average annual wages unless the seasonal worker works for the employer on more than 120 days during the tax year.

The Act gives a tax credit to certain small employers that provide health care coverage to their employees, effective with tax years beginning in 2010. To be eligible for the credit:

1. An employer must have fewer than 25 "full-time equivalent employees" ("FTE") for the tax year;
2. The average annual wages of the employees for the year must be less than \$50,000 per FTE; and
3. The employer must at least 50% of the total premium cost for the health care coverage.

The full credit is available to employers with 10 or fewer FTEs and average annual wages of less than \$25,000.

The number of FTEs is determined by dividing (i) the total hours for which the employer pays wages to employees during the year (but not more than 2,080 hours for any employee) by 2,080. The result is rounded to the next lowest whole number. Because the limitation on the number of employees is based on FTEs, an employer with 25 or more employees could qualify for the credit if some its employees work part-time.

A sole proprietor, a partner in a partnership, a shareholder owning more than 2% of an S corporation, and any owner of more than 4% of other businesses are not considered employees for purposes of the credit. Thus, the wages or hours of these business owners and partners are not counted in determining either the number of FTEs or the amount of average annual wages. Premiums paid on behalf of business owners and partners are not counted in determining the amount of the credit. Certain family members are also excluded from the calculation.

**QUESTION: Doesn't Ohio law state that a "full-time employee" is one that works 25 hours per week?**

Ohio Revised Code Chapter 3924 regulates the contents of health insurers' policies that provide health care insurance to the small employer market (i.e., employers with 2 to 50 employees) in Ohio. Under this Chapter, each health insurance product that a carrier extends to the small employer market must make coverage available to all employees of an employer who regularly work at least 25 hours per week. This means that health insurance products offered in the small employer market in Ohio cannot exclude from coverage anyone working 25 or more hours per week.

ORC Chapter 3924 does not directly require "small employers" to provide health insurance coverage for any employee who works 25 or more hours per week. The Chapter regulates the insurance industry and not employers. However, according to the Ohio Department of Insurance interpretation, ORC Chapter 3924 does require a small employer who purchases one of the health care policies that is subject to this rule to provide health care coverage to any employee who works a normal work week of 25 or more hours, but may exclude temporary or substitute employees, and seasonal employees who work only part of the calendar year.

As long as a small employer in Ohio is providing group health insurance through a product that is subject to Chapter 3924, employees who work 25 or more hours per week must be eligible for coverage (with the exception for temporary or seasonal employees). If a small employer (2 to 50 employees) is self-funded for group health care purposes or purchases a product that is not subject to Chapter 3924, the employer would have more leeway to define the terms of eligibility.

**QUESTION: If a self-funded calendar year plan, implements a (new) spousal carve-out to the plan, would this cause a loss of grandfathered status?**

The agencies (DOL, IRS and HHS) issued Interim Final Regulations June 14, 2010 regarding the grandfathering rules. Those Rules specify six events\* that will cause a loss of the grandfathering

exemption. Unless an event comes within the terms of one of these, grandfathering will not be lost. Implementing a spousal carve out to the plan's eligibility provisions does not fall within any of the six events. As a result, adding a spousal carve-out will not cause a loss of grandfathered status.

\*The six events that will cause a loss of grandfathered status are: 1. Change in insurers; 2. Elimination of benefits for a condition; 3. Increase in the plan's cost sharing requirement; 4. Increase in deductible or out-of-pocket maximum by more than medical inflation plus 15%; 5. Increase in copayments by more than greater of \$5 (adjusted for medical inflation) or medical inflation plus 15%; and 6. Decrease in employer contributions by more than 5% below the contribution rate in effect on March 23, 2010.

The agencies have sought comments to determine whether any additional events should be added, including substantial changes to plan design. Also, it is not yet clear whether termination of coverage for a group of people would cause a loss of grandfathered status. Some view the loss of coverage for a group as equivalent to the loss of all or substantially all of the benefits for a medical condition.

**QUESTION: As to the Small Employer Tax Credit under the Act, is the small employer premium payment of 50% for employee only or 50% of policy the employee has -- employee/spouse or family?**

The minimum amount that must be paid by the employer is 50% of single employee coverage. There is a transition rule for the 2010 credit. If the amount paid by the employer toward employee plus one or family coverage is at least the same, the credit is available for all categories. An employer only gets the credit on the premiums that meet the requirements.

**QUESTION: If a child under 19 is enrolled as a late enrollee and subject to a pre-existing condition limitation, does the pre-existing condition limitation go away after January 1 for a calendar year plan?**

The Affordable Care Act's prohibition on pre-existing condition exclusions and limitations for dependents under 19 years of age becomes effective January 1, 2011 for both grandfathered and nongrandfathered plans. As a result, a group health plan or policy can no longer enforce such a pre-existing condition exclusion or limitation on or after that date including any such provision that was contained in the plan or policy prior to January 1, 2011. In essence, the pre-existing condition exclusion or limitation simply goes away January 1, 2011.

**QUESTION: How many employees are considered to be a small company for Health Care Reform Act purposes?**

As noted in Q/A #\_\_, a "small employer" for purposes of the small employer tax credit is defined as an employer that has fewer than 25 full-time equivalent employees.

For most other provisions of PPACA, a "small employer" employs fewer than 50 full-time employees. Thus, the "small group market" refers to employers with fewer than 50 full-time employees.

## OHIO AND FEDERAL COVERAGE EXPANSION FOR OLDER AGE CHILDREN

Provision	Federal Law (Health Care Reform Act)	Ohio State Law (Ohio Revised Code 1751.14)
<b>Who is Eligible?</b>	<p>Child may be married or unmarried and must:</p> <ul style="list-style-type: none"> <li>a. Be the child of the covered employee as defined under the plan or policy;</li> <li>b. Have not yet reached 26<sup>th</sup> birthday;</li> <li>c. Not have their own employer coverage available if the parent is covered under a group health plan that was in existence on March 23, 2010 (grandfathered plan);</li> <li>d. No other eligibility requirements are permitted.</li> </ul>	<p>Child must be unmarried and:</p> <ul style="list-style-type: none"> <li>a. The natural child, stepchild or adopted child of the insured or covered employee;</li> <li>b. Have not yet reached 28<sup>th</sup> birthday;</li> <li>c. A resident of Ohio or a full-time student at an accredited public or private institution of higher education;</li> <li>d. Not employed by an employer that offers any health benefit plan under which the child is eligible for coverage; and</li> <li>e. Not eligible for coverage under Medicaid or Medicare.</li> </ul>
<b>Must the child be financially dependent on or live with the parent?</b>	No financial dependency or residential requirement with parent is permitted.	No financial dependency or residential requirement with parent is permitted.
<b>What type of coverage does the age expansion law apply to?</b>	Group health plans and insurance companies offering group or individual coverage that include coverage for dependents (includes self-funded ERISA plans).	<ul style="list-style-type: none"> <li>a. Group policies that include coverage for dependents including COBRA and state continuation coverage;</li> <li>b. Individual policies that include coverage for dependents including conversion, open enrollment basic and standard plans;</li> <li>c. Coverage issued by insurance companies, HMOs, MEWAs or governmental plans.</li> </ul>

<b>Provision</b>	<b>Federal Law (Health Care Reform Act)</b>	<b>Ohio State Law (Ohio Revised Code 1751.14)</b>
<b>What is the effective date of the coverage expansion?</b>	The first day of the first plan year that occurs on or after 9-23-2010 (i.e., 1-1-2011 for calendar year plans).	First policy renewal date on or after 7-1-2010 (i.e., 1-1-2011 for calendar year plans).
<b>How do the federal and state laws work together?</b>	Health plans and insurance policies that offer dependent coverage must make coverage available until a child reaches age 27.	Health plans and insurance policies must make coverage available until the child reaches age 28.
<b>When may an older age child enroll?</b>	Health plan or insurer must notify parent in writing of the opportunity to enroll a child and at least 30 days to actually enroll. Notice and opportunity to enroll may be provided during open enrollment. Coverage begins on the first day of the plan year even if the request for enrollment is made after the first day.	A parent may enroll the child during open enrollment, when the child reaches the federal limiting age of 27 or when the health plan or insurer is notified that the child has experienced a change in circumstances and has become newly eligible for coverage under state law.
<b>Are group health plans or insurance policies required to cover the children or spouses of older age children?</b>	No.	No.
<b>Must dental and vision plans be offered as well?</b>	These rules do not apply to stand alone dental or vision plans.	These rules do not apply to stand alone dental or vision plans.
<b>What is the difference between who pays for federal and state older age child coverage?</b>	The cost to the parent may not vary based upon the age of the child. Surcharges that apply only to older age children are not allowed.	For coverage between ages 26 and 28, the employer is not required to pay for any part of the cost.
<b>What coverage options are available to a covered older age child who reaches the federal limiting age of 27?</b>	The child may choose state coverage extension until age 28; elect COBRA continuation coverage (if eligible); or elect state conversion coverage.	NA
<b>What coverage options are available to a covered older age child who reaches the state limiting age of 28?</b>	NA	The child may elect COBRA continuation coverage (if eligible) or elect state conversion coverage.

**COST-OF-LIVING ADJUSTMENTS TO DOLLAR LIMITS  
UNDER EMPLOYEE BENEFIT PLANS<sup>1</sup>**

<b>ITEM</b>	<b>2011</b>	<b>2010</b>	<b>2009</b>
<b>401(k), 403(b), 457(b) salary deferrals</b>	\$16,500	\$16,500	\$16,500
<b>401(k), 403(b), 457(b) catch-up contribution</b>	\$5,500	\$5,500	\$5,500
<b>SEP maximum and minimum compensation</b>	\$245,000/\$550	\$245,000/\$550	\$245,000/\$550
<b>SIMPLE Plan deferrals</b>	\$11,500	\$11,500	\$11,500
<b>SIMPLE Plan catch-up contribution</b>	\$2,500	\$2,500	\$2,500
<b>Total contributions to defined contribution plan</b>	\$49,000	\$49,000	\$49,000
<b>Annual benefit under defined benefit plan</b>	\$195,000	\$195,000	\$195,000
<b>Maximum includible compensation</b>	\$245,000	\$245,000	\$245,000
<b>Highly compensated employee</b>	\$110,000	\$110,000	\$110,000
<b>Key employee-officer</b>	\$160,000	\$160,000	\$160,000

<sup>1</sup> Limits are subject to cost of living adjustments annually by the Internal Revenue Service. The IRS announced final 2011 figures on October 28, 2010, which are incorporated here.

<b>Health Savings Accounts<sup>2</sup></b>	<b>2011 Single Family</b>	<b>2010 Single Family</b>	<b>2009 Single Family</b>
<b>Maximum contributions</b>	\$3,050 \$6,150	\$3,050 \$6,150	\$3,000 \$5,950
<b>Minimum deductible</b>	\$1,200 \$2,400	\$1,200 \$2,400	\$1,150 \$2,300
<b>Maximum out-of-pocket</b>	\$5,950 \$11,900	\$5,950 \$11,900	\$5,800 \$11,600
<b>ITEM</b>	<b>2011</b>	<b>2010</b>	<b>2009</b>
<b>FICA taxable wage base</b>	\$106,800	\$106,800	\$106,800
	Social Security (6.2% tax rate)	Social Security (6.2% tax rate)	Social Security (6.2% tax rate)
	Medicare (1.45% tax rate), No Limit	Medicare (1.45% tax rate), No Limit	Medicare (1.45% tax rate), No Limit

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