



QUALITY ▪ INTEGRITY ▪ LONGEVITY

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From The Desk of the Editor

I am completing my editorial review and finalizing my comments to this quarter's newsletter on Halloween night while I keep my ear tuned for little voices calling Trick or Treat. And it strikes me I have been doing the same thing all quarter - listening and watching for some measure of "trick or treat."

For example, in August, the Federal Trade Commission (FTC) guidance clarified that benefits administrators (FBMC) and possibly plan administrators (employers) offering a debit card associated with tax-favored accounts were bound by the Red Flags Rule (pg 5) effective 11/1/2009 - **Trick**. Then on October 30th (just 2 days short of the deadline) at the request of Members of Congress, the FTC delayed enforcement of the Rule until June 1, 2010 - **Treat**.

Health care reform in general has vacillated between a **trick or treat** depending upon the day, the debate, the "debater", the spin of the media reporting it, and the reader's own perspective (pg 7). I do not envy Congress the difficult decisions they must make and I am only cautiously optimistic in the final outcome.

A **treat** would be GINA's resulting consumer confidence in genetic testing to "help researchers get a better handle on the genetic basis of diseases" as HHS Secretary Kathleen Sebelius predicts. However, GINA has the potential to drive up the cost of premiums due to adverse selection concerns - **Trick** (pg 2).

Revenue Procedure 2009-50 was published last week, giving taxpayers an overview of the 2010 cost-of-living adjustments (pg 12). Although we do not include Social Security benefits in our charts, it is worth noting that there won't be a cost-of-living adjustment this year for SS beneficiaries.

As we head into 2010 let me extend our best wishes for the holiday season and a sincere hope that you successfully weather what remains of the economic storms.

Regards,
Trish Neely

Genetic Information Post GINA Is it ever OK to Collect?

Trish Neely, CFCI

The answer is yes; however, it is important to understand the nuances. The following is our review of the Interim Final Rules (74 FR 51664, 10/7/09) for GINA. A full text of the Rules is available on the Web at www.dol.gov/ebsa.

Understanding Congressional intent behind the

Act. Congress was concerned about the vast number of individuals denied coverage under a group or individual health plan due to genetic information; or if not denied then unable to **afford** the coverage available. Congress was also aware that needed research was being thwarted because individuals feared adverse employment-related or health coverage-related consequences associated with having genetic testing or participating in research studies.

With this background, legislation was introduced and the Act signed into law in 2008. GINA (the Genetic Information Nondiscrimination Act) assures that genetic information is not used adversely in determining health care coverages. It does this by eliminating or minimizing access to “genetic information” by employers, health plans and insurers. While GINA does not mandate any specific benefits for health care services related to genetic tests, diseases, conditions, or genetic services, GINA **does** establish rules that prohibit discrimination based upon genetic information. Plans cannot: 1) increase the group premium based on genetic information; 2) request or require a genetic test; and 3) request, require, or purchase genetic information prior to or in connection with enrollment or any time for underwriting purposes. Virtually all group and individual health plans and disease management programs are touched by GINA. On October 1, 2009 the IRS, DOL and HHS jointly published **Interim Final Rules** (74 FR 51664) applicable to GINA which provide clarification and additional guidance to the original legislation.

New Interim Final Rules clarify provisions. The Interim Final Rules (Rules) confirm that plans and issuers are only prohibited from collecting the **genetic information** for either 1) **underwriting purposes** or 2) prior to, **or** in connection with, **enrollment**. Because of the Act’s new broad definition of “genetic information” and “underwriting purposes” it is really important that plans pay close attention to the types of data collected, when it is collected, and the reason for the collection to assure compliance.

GINA has broad definitions. **Genetic Information** under GINA refers to information about an individual’s genetic tests, the genetic tests of family members of the individual, and the manifestation of a disease or disorder in the individual’s family members. **Family members** mean the individual’s dependents under the group health plan and any first, second, third or fourth-degree relative. It is intended that the term be broadly interpreted to provide the maximum protection against discrimination. **Underwriting purposes** is defined as including rules for a determination of eligibility, computation of premium or contribution, and application of preexisting condition exclusions. Underwriting also includes those activities related to rating and pricing and includes changing deductibles or other cost-sharing mechanisms, providing discounts, rebates, payments in kind or other premium differential mechanisms in return for activities such as participating in a wellness program.

When is it ok to collect and use? Although GINA generally prohibits plans and issuers from requiring individuals or their family members to undergo a genetic test, the prohibition relates to discrimination practices. There are some valid reasons to request and require. For example, when the appropriateness of certain courses of treatment depends on the patient’s genetic makeup, the health care professional may request genetic information, and a treatment plan and payment may be conditioned on the outcome of a genetic test. In accordance with HIPAA,

only the minimum necessary information may be collected to determine medical appropriateness.

Congress has already established the need for research and a health plan or issuer is permitted to request that a participant or beneficiary undergo a genetic test for research purposes. Any such request must be in writing and must indicate that participation is voluntary and noncompliance will have no impact on future eligibility, premium, or coverages. Genetic information collected prior to or in connection with enrollment is OK when it is incidental to the collection of other information and is not used for underwriting. However, the exception does not apply unless the collection explicitly states that genetic information should not be provided in answer to any questions. GINA interprets genetic information to include any family medical history.

A final and important note to this section is that the prohibition of adjusting premiums based on genetic information does not limit the ability of the plan to increase the premium amount for a group based on the manifestation of a disease or disorder of an individual enrolled in the plan. In other words experience-based premium adjustments are ok.

What is the impact upon disease management and wellness

programs? Underwriting purposes includes providing discounts, rebates, payments in kind or other premium differential mechanisms in return for activities such as completing a health risk assessment or participating in a wellness program. This is how GINA significantly impacts disease management or wellness programs. Under no circumstances may an “assessment” request family medical information or individual health information (i.e. genetic information) **prior to enrollment** (prior to the effective date) in the plan. **No rewards or penalties** may be offered in conjunction with an assessment that asks for genetic information—even if the request is made **after enrollment** has occurred.

You have two options to keep your programs in compliance. Your wellness or disease management plan can as part of a health risk assessment, collect and use genetic information post enrollment **AS LONG AS** there is no financial incentive or penalty related to the assessment’s completion. This is true even if any **reward** you may give is not based on the outcome of the assessment. The collection of the genetic information binds you to GINA rules.

Alternatively don’t collect ANY genetic information (remember how broad is the definition of genetic information) and you may keep your **rewards** program in place.

A note regarding penalties. In combination with the new penalties for violations of the HIPAA Privacy Rule, as provided for by the American Recovery and Reinvestment Act (ARRA), a use or disclosure of genetic information in violation of the HIPAA Privacy Rule could result in a fine of \$100 to \$50,000 or more for each violation.

A note for public employers with self-funded plans. Section 2721(b)(2)(D) of the PHS Act precludes any exemption election by a self-funded non-Federal governmental plan sponsor from GINA’s requirements.

GINA & HIPAA: GINA builds on existing protections found in the Health Insurance Portability and Accountability Act of 1996 (HIPAA). HIPAA portability provisions prohibit a group health plan or insurance issuer from imposing a preexisting condition exclusion based solely on genetic information. (69 FR 78720 – 12/30/04)

HIPAA nondiscrimination provisions prohibit a group health plan or insurance issuer from discriminating against an individual in eligibility, benefits, or premiums based on genetic information of the individual or his/her dependent. (71 FR 75014 – 12/13/06)

Genetic information is health information. Section 105, Title I of GINA revises the HIPAA privacy regulations definition to conform to GINA's definition of **genetic information**. This new definition clarifies that genetic information is health information under the rule and prohibits the use or disclosure of genetic information for underwriting purposes. This also means that a myriad of other HIPAA rules apply, including minimum necessary collection rules (when genetic information is collected in accordance with GINA). Title II of GINA prohibits discrimination in employment based on genetic information.

GINA is already in effect for some plans. GINA's group health plan related provisions are effective for plan years beginning on or after May 21, 2009 or January 1, 2010 for calendar year plans. We recommend a close review of health plans, in particular wellness and disease management plans. Also carefully review your new hire and open enrollment applications to assure they do not contain questions related to genetic information (or that could lead to genetic information).

The impact of GINA is uncertain. Will GINA live up to its "promise" to increase the total number of persons insured who might otherwise be excluded due to genetic testing? Or will adverse selection resulting from individuals with known health risks and insurer's inability to know and accurately assess such risk just drive premiums stratospheric and preclude enrollment due to cost. Will genetic testing be covered under individual and group health plans so that individuals participate in research that probes the genetic basis of disease to allow scientists to develop new medicines and treatments to control costs or will this whole effort fall flat because insurance plans would have to raise their premiums even more to cover the new tests and plan sponsors are not interested? Some interesting questions to ponder although premature given the infancy of GINA; but future topics of discussion we are sure.

A few of GINA's important definitions

Collect. Collect means to request, require, or purchase genetic information.

Family Member. Family member means the individual's dependents under the group health plan and **any** first, second, third or fourth-degree relative.

Genetic Information. Genetic Information under GINA refers to information about an individual's genetic tests, the genetic tests of family members of the individual, and the manifestation of a disease or disorder in the individual's family members. Genetic information also includes family medical history.

Manifestation. A disease, disorder, or pathological condition is **manifested** if it has been diagnosed or could reasonably be diagnosed by a health care professional with appropriate training and experience. It is not manifested if a diagnosis is based principally on genetic information.

Underwriting Purposes. Underwriting purposes is defined as including rules for a determination of eligibility, computation of premium or contribution, and application of preexisting condition exclusions. Underwriting also includes those activities related to rating and pricing and includes changing deductibles or other cost-sharing mechanisms, providing discounts, rebates, payments in kind or other premium differential mechanisms in return for activities such as participating in a wellness program.

Identity Theft: Raising Red Flags

Kedra Baumgardner



In 2003, the Fair and Accurate Credit Transactions Act (FACT Act) was signed into law to provide guidance and regulations regarding the detection, prevention and mitigation of identity theft. In 2007, a final rule commonly referred to as the Red Flags Rule was issued and its rules have been delayed to June 10, 2010 (from November 1, 2009). Under the Red Flags Rule, certain businesses and organizations must establish and implement a written Identity Theft Prevention Program. This article discusses FBMC's ITTP Program.

Identity theft has become a major issue in today's society. Not only does it disrupt the life of the victim, but it can cause significant losses for the businesses involved. In compliance with the FACT Act and in coordination with our electronic payment card partners, we have a solid Identity Theft Prevention Program in place and in compliance well in advance of the June 2010 deadline.

Why does FBMC need a Program? When the Act was initially reviewed it did not appear to apply to FBMC since our activities, even those associated with debit card management did not appear to meet the definition of **financial institution** or **creditor** as those terms were defined within the Act. However, with recent Federal Trade Commission guidance, and consultation with industry experts and our attorneys we have concluded that the definition of a financial institution which includes businesses that have accounts a customer can use to transfer money to a third party (i.e. FBMC electronic payment card), the rule does apply to us.

FBMC's Red Flags Rule Identity Theft Program. The program is designed to meet the FTC's four basic elements (see insert top right page) and is overseen by Trish Neely, our Chief Compliance Officer.

Mitigating factors keep risk low. FBMC's role as a benefits administrator rather than the card vendor or processor (this role is outsourced to excellent vendors and business partners) limits the situations in which FBMC would be exposed to potential red flags.

Examples. FBMC does not provide credit and does not use any type of credit reporting. Card issuance is tied directly to benefit selection. A customer who doesn't have an associated tax favored account cannot be issued a card.

The Federal Trade Commission provides guidance for implementing an Identity Theft Prevention Program. An ITTP must contain four basic elements: identification, detection, action, and review.

FBMC's ITTP has 1) Policies and procedures to **identify** and then 2) **detect** the Red Flags of identity theft based upon our day to day activities; as well as 3) stated **actions** once a Red Flag is detected, and 4) a periodic **review** of the plan to address any new risks.

Important note regarding Tax-Favored Accounts. Recent FTC guidance expressly provides that an entity that offers employees an FSA with a debit card will be considered a financial institution.

What about HRAs, QTB, DCAPs? The recent ruling did not address these accounts; however, prudence dictates applying an ITTP to all tax-favored accounts where a card is in use.

Fact Act Definitions

Creditor. This is an entity that regularly provides goods or services first and later accepts payment, or any entity that regularly grants loans, extends credit or makes credit decisions.

Financial Institution. A financial institution is any bank, credit union, or savings and loan association or any other person, that directly or indirectly holds a transaction account belonging to a customer.

Covered Account. An account offered or maintained primarily for personal, family, or household purposes that involves multiple payments or transactions;

OR

An account **NOT** offered or maintained primarily for personal, family, or household purposes that involves multiple payments or transactions where there is a reasonably foreseeable risk of identity theft.

Electronic payment cards have relatively low-funded amounts (when compared to available credit lines on standard cards, i.e. American Express, VISA), beyond which the cards won't work.

The cards can only be used at health related merchants and use real-time substantiation, such as matching to prescription drug claim information and the inventory information approval system (IIAS), which authorizes payment only if the card is used for eligible health expenses.

All card transactions that are not subject to real-time substantiation are manually reviewed by a processor who identifies whether or not the transaction is for an appropriate and eligible expense.

Detection is a "collaboration". FBMC collaborates with its card vendors on best practice business rules related to detection since card transactions are passed to FBMC from those vendors. Just one example related to an address change (potential red flag) we have set up a rule to reject a card request when preceded by a non-validated address change within a specified number of days. Many of the auditing procedures in place prior to the Red Flags Program continue unchanged, including: reviewing reports regarding lost and stolen cards, reviewing forced post transactions, and ongoing audits of outstanding transactions.

Red flags identified and monitored. Any of the following activities are closely monitored and scrutinized as Red Flags:

- ✓ Notice from a customer, client, law enforcement official or someone else that an account has been opened or used fraudulently.
- ✓ A customer dispute regarding transactions.
- ✓ Notice that a card is activated but the customer says he/she did not activate the card.
- ✓ Card application that looks suspicious: like it's been altered, forged or torn up and reassembled.
- ✓ A person who can't provide authenticating information.
- ✓ Suspicious account activity, such as large unauthorized or unsubstantiated dollar transactions
- ✓ Notice from customer that he/she isn't receiving account statements.

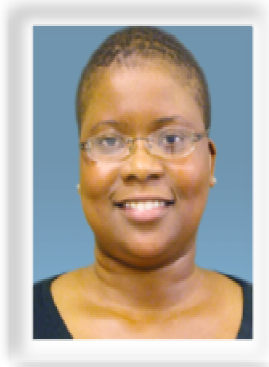
When a **Red Flag** is detected we respond depending on the facts of the situation. This may be as simple as Initiating a dispute process, closing an existing and reopening a new account all the way to involving law enforcement.

The FTC has extensive information on its website related to establishing a Program, who must comply etc. For additional information go to www.ftc.gov, or enter Red Flags into your search engine.

Health Care Reform

Muriel Etienne, CFC

For many of us, the frenzy surrounding health care reform is confusing. As I have listened to weekly conference calls with our industry organization ECFC (Employer's Council on Flexible Compensation) and have followed Congressional committee activities from their websites and through the news, I often find it hard to understand and grasp the complexities and the nuances. And if I (we) as benefits professionals have difficulty, imagine the general population; it is no wonder many are confused, frustrated, and tired of talking or reading about reform.



It appears that the Congressional bills are headed for the floors of the respective chambers shortly (possibly as you read this article).

This article will briefly touch upon some of the provisions that have gained traction in both chambers and have a higher degree of inclusion in the final legislation. I have included possible effective dates where they are known. A discussion of individual and group market reforms is premature until the dust settles. We will wait and explore in detail in future issues.

Some of the key components of the Senate America's Healthy Future Act

2010 Transparency – Employers would be required to start disclosing the value of health coverage on employees' W-2 statements.

2010 Conform the definition of qualified medical expenses. This provision would require Health FSAs, Health Reimbursement Accounts, and Health Spending Accounts to use the same definition in the IRS Code for itemized deductions. The only addition is the inclusion of physician prescribed over-the-counter meds.

2011 Cafeteria Plan Changes. This provision creates a Simple Cafeteria Plan to ease the small employer's administrative burden of sponsoring a cafeteria plan. The provision exempts employers who make contributions for employees under a simple cafeteria plan from pension plan nondiscrimination requirements applicable to highly compensated and key employees.

Three principle goals of health care reform:

- It will provide more security and stability to those who have health insurance.
- It will provide insurance for those who don't.
- And it will slow the growth of health care costs for our families, our businesses, and our government.

Remarks to the joint session of Congress on healthcare by President Obama. 9/9/2009

America's Healthy Future Act cont.

2011 Penalty for use of HSA Funds for Non-qualified Medical Expenses. This provision increases the additional tax for HSA withdrawals prior to age 65 that are not used for qualified medical expenses from 10 percent to 20 percent.

2011 Health Flexible Spending Arrangements capped at \$2,500 annually.

2011 Elimination of deduction by Employer for Medicare Part D subsidy.

2013 Insurance Excise Tax. This provision would levy a **nondeductible** excise tax of 40 percent on insurance companies and plan administrators for any health insurance plan that is above the threshold of \$8,000 for singles and \$21,000 for family plans. The threshold would be \$1,850 higher for individual plans and \$5,000 for family plans for workers with high risk jobs or for retirees aged 55 and up. The tax would apply to the amount of the premium in excess of the threshold.

2013 Increase the Threshold for Claiming the Itemized Deduction for Medical Expenses – an increase in the threshold for claiming the itemized deduction for medical expenses from 7.5 percent to 10 percent. Individuals over the age of 65 would be able to claim the itemized deduction for medical expenses at 7.5 percent of adjusted gross income through 2016.

2013 Employer Mandate. This provision would not require employers to offer health insurance; however, those who don't (with greater than 50 EEs) will have to reimburse the government for each full-time employee receiving a health care affordability tax credit.

2013 Health Care affordability tax credits. Credits that will be made available on a sliding scale to offset the cost of insurance premiums

www.SaveMyFlexPlan.com

The Health FSA cap is expected to save billions of dollars and help fund the cost of reform. You can help raise the cap, eliminate the cap and/or suggest other funding alternatives to Congress through the website listed above. It is important to act now. The "Action Center" located on the right side of the web site contains a list of links that will take you to the various interactive tools available.

Some of the key components of the House Affordable Health Care for America Act

Distributions for medicine qualified only if for prescribed drug or insulin. (Senate has similar provision)

Cap on health flexible spending arrangements under cafeteria plans. This provision limits salary reduction contributions to \$2,500. (Similar to Senate but the House version is indexed to the consumer price index).

Increase in penalty for nonqualified distributions from health savings account. Increases the 10 percent penalty to 20 percent (Same as Senate).

Denial of deduction for Federal subsidies for prescription drug plans excluded from gross income Certain employers are eligible for Federal subsidies related to prescription drug benefits provided to retirees. This provision similar to the Senate would eliminate the ability of employers to deduct expenses for which they are subsidized.

Surtax on high-income individuals. Unlike the Senate, the House does **not** include a tax on high-cost health plans. The main financing mechanism is a 5.4% surtax on high-income individuals defined as married couples with adjusted gross incomes exceeding \$1 million a year and individuals over \$500,000.

OCR Tracks HIPAA Privacy Complaints

Trish Neely, CFCI



Since the Privacy Rule went into effect in April 2003, over **46,973** complaints have been lodged with the Office of Civil Rights (OCR). This agency within the U. S. Department of Health and Human Services (HHS) is the arm that investigates complaints about failures to protect the privacy or security of health information. Of these complaints, 80% have been satisfactorily resolved – the remainder is pending. We thought you might be interested in a breakdown of some of the trends, including types of

complaints as well as the categories of top offenders. As a result of ARRA, OCR will likely add to the statistics the names of some offenders – more on this toward the end of the article.

The most common complaints investigated. The compliance issues investigated most, in order of frequency:

1. Impermissible uses and disclosures of protected health information (make sure your plan does not use PHI for underwriting purposes. See also article **Genetic Information Post GINA**;
2. Lack of safeguards of protected health information;
3. Lack of patient access to their protected health information (HIPAA determined that patients MUST have easy access to their medical records, including all physician notes);
4. Uses or disclosures of more than the minimum necessary protected health information; and
5. Lack of, or invalid authorizations for, uses and disclosures of protected health information.

The biggest offenders. Just looking at the top five categories, the greatest number of complaints originate as you might suspect where the most PHI is collected: doctors' offices, hospitals, drug stores, and outpatient facilities.

I do not find it at all surprising that health plans fall in at number four. The category includes health insurance issuers and group health plans and this is where the processing of premiums and claims occurs. As you will recall it is the health plan that often causes an employer (even one that provides fully insured health benefits) to be deemed a "covered entity" under HIPAA.

1. Private Practices
2. General Hospitals
3. Outpatient Facilities
4. Health Plans
5. Pharmacies

OCR Resolution breakdown:

- 4,680 complaints were resolved through investigation which resulted in a no violation finding;
- 9,318 were resolved through investigation which required changes in privacy practices and other corrective actions by the covered entities; and
- 26,964 were resolved through closure of cases not eligible for enforcement under the Privacy Rule.

Reminder: Effective September 23, 2009 covered entities must begin tracking and reporting privacy or security breaches to OCR.

What is a breach under HIPAA?

ARRA (HITECH) defines a breach as the unauthorized acquisition, access, use or disclosure of PHI which compromises the security, privacy or integrity of PHI maintained by or on behalf of a person.

A breach is **not** the unintentional acquisition by an employee or agent of the covered entity or business associate if such access was made in good faith and if such information is not further acquired, accessed, used or disclosed by such employee or agent.

Many of the “incidents” captured by administrators and plan sponsors to date do not meet the minimum criteria to be deemed a breach under the clarifying definition.

How OCR has resolved some of the complaints. Of the nearly 47,000 complaints received to date, 57% were not eligible for enforcement under the privacy rule. This would include complaints alleging a violation prior to April 2003; an alleged violation by an entity not covered by the Privacy Rule; or where the activity described is a circumstance in which the Rule permits a disclosure, such as to protect public health or to comply with law enforcement.

OCR has been far from draconian in its enforcement; even when the covered entity is determined to be out of compliance, OCR has provided a corrective action plan and encourages a voluntary compliance approach. However, if the covered entity does not take corrective action voluntarily, OCR has the authority to impose civil money penalties payable to the Department of the Treasury (not to the individual(s)).

How does ARRA (HITECH) alter the picture? Effective September 23, 2009 covered entities must begin tracking and reporting privacy or security breaches to OCR. As we mentioned in previous correspondence, under ARRA breaches affecting more than 500 individuals, require that some of the information provided on the form be made publicly available through posting on the HHS website and public media outlets within 60 days. ARRA requires that OCR provide an annual report to Congress regarding the number and nature of breaches that are reported each year and the actions taken to respond to such breaches.

How will FBMC assist its clients with reporting? Since HIPAA’s Privacy and Security requirements became effective we have been tracking and notifying our clients and customers of issues so our overall approach will not change, albeit with a much clearer understanding of what constitutes a breach. Since it appears that only the covered entity can submit the information to OCR on behalf of the plan, we will continue to conduct an investigation and provide the necessary details to our clients for purposes of reporting to OCR. The HHS website provides a fairly simple and straightforward form that can be completed and filed online.

The Office for Civil Rights (OCR) is the agency within the U. S. Department of Health and Human Services (HHS) that investigates complaints about failures to protect the privacy or security of health information. It does so under its authority to enforce the Privacy and Security Rules. A complaint must allege an activity that, if investigated and proven true, would violate the Privacy or Security Rule. OCR may refuse to investigate a complaint filed untimely. According to the regulations, a complaint must be filed within 180 days of when the person submitting the complaint knew or should have known about the alleged violation. However, if the facts indicate a compelling reason for the delay, OCR may waive this time limit. OCR may refer a complaint to the Department of Justice for investigation if a complaint describes an action that could be a violation of the criminal provision of HIPAA.

Fed Benefits for Domestic Partners

Trish Neely, CFCI

The Defense of Marriage Act (DOMA) was passed in 1996 and provides that marriage is between one man and one woman. Any employer with a Section 125 Cafeteria Plan who also offers benefits to domestic partners knows first hand the complexity of tax-favored vs. non tax-favored benefits for participants and their domestic partners, respectively. If the "partner" does not qualify as a dependent (qualified relative) of the participant under Code Section 152, the premium for the partner must be post-tax which creates some payroll contortions worthy of Houdini.

Thus it is with great interest that we have been watching and waiting to see how the Obama Administration tackles this thorny issue and importantly how it might result in changes to the Feds café plan (that will hopefully trickle down to all of us).

This past summer the President directed that benefits for federal employees and same-sex domestic partners be expanded. In response to the directive, on September 14, 2009 the federal Office of Personnel Management (OPM) issued proposed regulations that extend long-term care insurance eligibility to the same-sex domestic partners of federal employees. Currently, the Feds long-term care insurance (LTC) program extends eligibility to an employee's "qualified relative." The proposal would expand that term to include same-sex domestic partners in a committed relationship.

The regulations also include sick, funeral, and certain other types of leaves in connection with both same-sex or opposite-sex domestic partners. Interestingly this also expands the applicable definitions of "family member" and "immediate relative" to include domestic partners as well as certain other individuals, including grandparents and grandchildren. The eligibility requirements for domestic partners are similar to those provided for long-term care except that leave benefits may be used in connection with both same- and opposite-sex domestic partners; LTC applies only to same-sex partners (refer back to previous paragraph).

Although OPM proposals do not affect other employers, and although the OPM proposals do not mention or appear to address pre- or post-tax premiums, it is a challenge that Federal payroll administrators will face.

As it is a challenge many other employers already face, a change in federal law such that domestic partners in a committed relationship (same or opposite sex) would be covered for tax purposes would be a welcomed **Treat.**

OPM Definition of Committed

Relationship. The partners must be at least 18 years of age and each other's sole domestic partner; share a common residence and share responsibility for each other's financial obligations; not be married to anyone else; and not be related in a way that would prohibit marriage in their state of residence if they were of the opposite sex.

Note: If you are just introducing domestic partner benefits as part of your health & welfare plan and your premiums for such benefits are tax-favored through a \$125 Cafeteria Plan, a challenge you will face is that a domestic partner must qualify as a qualifying relative under the Code or the premiums (and any employer contribution) must be taxed.

The premium is the fair market value of the coverage and this portion is taxable regardless if the addition of the domestic partner results in a premium increase. For example, if the participant is already paying for family coverage, the fair market value becomes an imputed income amount to the participant and taxed accordingly.



2010 COLAs

Holly Hance & Patrick Peters, CFC

On October 15, 2009, the IRS issued Revenue Procedure 2009-50, giving taxpayers an overview of the 2010 cost-of-living adjustments (COLAs) related to standard deductions and many other indexed adjustments (see tables below and next page). QTB increases to temporarily add parity are effective through 12/31/2010. Dependent Care Flexible Spending Arrangements (DFSAs) are not indexed and the standard caps (\$5,000, \$2,500, etc based upon circumstances) remain the same. However, other 2010 tax limits are relevant to determining when a DFSA is more beneficial than the Dependent Care Tax Credit, such as tax rate tables, personal exemption, and standard deduction. The entire document (Revenue Procedure 2009-50) is available at <http://www.irs.gov/pub/irs-drop/rp-09-50.pdf>

| INDIVIDUALS | | |
|-------------|----------|--|
| 2009 | 2010 | Tax Filing Status & Exemption |
| \$11,400 | \$11,400 | Married Individuals Filing Jointly and Qualifying Widow(er) |
| \$5700 | 5700 | Married Individuals Filing Separately |
| \$8350 | 8400 | Head of Household |
| \$5700 | 5700 | Single (unmarried individual other than HH and Qualifying Widow(er)) |
| \$3650 | 3650 | Personal Exemption (Phases out based on status and AGI) |

| RETIREMENT VEHICLES (§§ 401(K); 403(B); 457) | | |
|--|----------|--|
| 2009 | 2010 | Annual Limits |
| \$16,500 | \$16,500 | Elective Deferrals 401(k) & 403(b) <i>excludes adjustments & catch ups</i> |
| \$16,500 | \$16,500 | Limits for 457(b)(2) and 457(c)(1) <i>excludes catch ups</i> |
| \$5,500 | \$5,500 | Catch up Deferrals (401(k), 403(b), and 457 plans) |

| QUALIFIED TRANSPORTATION BENEFITS (§132) | | |
|--|--------|--|
| 2009 | 2010 | Transportation Costs |
| Monthly Contribution Limits | | |
| \$230* | \$230* | Commuter and Transit Pass (*temporary change per ARRA) |
| \$230 | \$230 | Qualified Parking |

2010 COLAs *continued.*

The following cost of living adjustments were originally reported in the July edition of this newsletter.

| HEALTH SAVINGS ACCOUNTS (HSAs) | | |
|--|----------|---------------------------------|
| 2009 | 2010 | Type of Coverage |
| Annual Contribution Limit | | |
| \$ 3,000 | \$ 3,050 | Self-only Coverage |
| \$ 5,950 | \$ 6,150 | Individual with Family Coverage |
| \$ 1,000 | \$ 1,000 | Catch up contribution |
| Annual HDHP Out-of-Pocket Expenses cannot exceed: | | |
| \$ 5,800 | \$ 5,950 | Self-only Coverage |
| \$11,600 | \$11,900 | Individual with Family Coverage |
| Annual HDHP Deductible cannot be less than: | | |
| \$ 1,150 | \$ 1,200 | Self-only Coverage |
| \$ 2,300 | \$ 2,400 | Individual with Family Coverage |

Quarterly Review Wins i-COMM Award

In September, Trish Neely, *QR* Editor and Desso Forman, Vice President of Marketing & Sales attended the Benefits Forum and Expo in Atlanta to receive Employee Benefit News magazine's prestigious award from Kelley Butler, Editor in Chief of *EBN*.

The newsletter was selected as the winner of the 2009 i-COMM Award for **Best Training Program** and will be featured in an upcoming issue of *Employee Benefit News* magazine.

Quarterly Review has been an integral feature of FBMC's services to clients, friends, and partners since 1990; FBMC uses the newsletter internally for employee education and training. Neely took over as lead writer and editor in chief in 2005. Forman's Marketing Team is responsible for recent aesthetic changes to the newsletter and for distribution.



Trish Neely and Desso Forman accepted the i-COMM Award on behalf of FBMC.



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