

Quarterly Review

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From the Desk of the Editor

A New Look

FBMC turns thirty this year. In three decades we have experienced, and in many cases helped shape, a multitude of changes in the benefits industry: from defined benefit to defined contribution plans; from indemnity to managed care, to consumer-directed health care; the introduction of Cafeteria Plans, FSAs, MSAs, QTBs, HRAs, HSAs; the dreaded Section 89 (long-since repealed); the reimburse-ability of OTCs; and the acceptance by Treasury of the debit card as an alternative mode of reimbursement.

For the majority of our history we have kept our clients and friends informed of new developments in the benefits arena through our *Quarterly Review* newsletter. And as long as the "Feds" and the States continue to mandate reforms, enact laws, issue rulings, offer guidance, and the like we will continue to keep you abreast of the news (frankly, given the criteria, I don't see us stopping any time soon!)

With this issue we are changing the *Quarterly Review's* format and content. We will continue to provide detailed information about the action, be it a new proposed regulation, an enacted law, a ruling or opinion; however, we will focus more on how the "event" is likely to impact, or has impacted employers and plan sponsors rather than merely reporting facts and leaving the reader to interpret. We will also share insights from conferences or direct conversations with Treasury, IRS, Congressional, and other officials whose rulings impact our programs.

In some editions we will offer suggestions or make recommendations for your input or approval and then publish your feed back in subsequent Newsletters (de-identified of course!).

All in all, our goal is to make the newsletter more responsive to your needs and make it an interesting read. Your continued feedback is welcomed and encouraged.

This is my first issue as editor; I look forward with much enthusiasm (and with much help from the expertise of my contributing-author colleagues), to the challenge.

Trish Neely

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About our New Editor

2005 is Trish Neely's 18th year with FBMC. She has held 12 different posts with us on the journey from Training Specialist to Chief Compliance Officer. As Senior Vice President of FBMC's Standards and Practices Division, she oversees all corporate legal, regulatory and compliance activities, corporate best business practices and the corporate training and development programs. In addition to Chief Compliance Officer, she is also FBMC's Privacy Officer responsible for HIPAA compliance.

Understanding the various rules associated with flexible benefit plans and tax-favored accounts began as a job requirement but has long since become a passion. *"I enjoy the challenge of making sense of the often conflicting rulings we have to interpret. There are hundreds of rulings and regulations and sometimes it seems like just as many agencies issuing them. Too often the "federal" right hand doesn't know what the left is doing or the resulting impact."*

On the challenges of working in a highly regulated industry: *"My staff and I have a tough job: we want to keep in step with prevailing tax law to protect our clients and customers, but at times that means appearing to be at odds with those we are protecting. It's not always black and white and we are constantly testing our assumptions and interpretations with the industry and our peers. We look for ways to say "yes"."*

To be invited to testify before Treasury and IRS officials before they issued the now famous debit-card ruling is a *"career highlight"* she offers, *"it also recognized FBMC's solid reputation in the field – we were honored."*

Trish is active in the Employers Counsel on Flexible Compensation (ECFC) and received their designation of Certified in Flexible Compensation (CFC) in 2003. She is also a member of IAPP (International Association of Privacy Officers). She has been invited to speak at several industry conferences on the topic of tax favored accounts.

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A Perspective from the Hill

Robert McKnight, Senator; Senior VP

With the federal deficits reaching record breaking levels, and the Congress pushing back on the President's budget recommendations, pressure is mounting for changes in the tax code. Senator Grassley (R, Iowa) appears to be the lead proponent to keeping all options on the table, including the recently surfaced proposal to eliminate all or a part of exclusion of Social Security and Medicare taxes on "Cafeteria Benefit Plans." The proposal first surfaced a few months ago from a Joint Tax Committee of the Congress. The fiscal impact of that elimination could be in the \$200 billion range per year. Even the employer deduction for health care coverage is on the table, but at this point does not appear to enjoy widespread support. It appears the IRS will not go along with a repeal of "use it or lose it" for Federal Spending Accounts because it might dampen the interest for the Administration's favorite, high deductible Health Savings Accounts and Consumer Driven Health Care. The President's Social Security proposal is only fanning the flames and the angry constituents range from AARP to organized labor to chambers of commerce, to liberals and conservatives alike.

Under normal circumstances the leadership of the House and Senate can quell firestorms like this, but the leadership in both chambers is currently imperiled: Senator Frist (R, TN.) is constrained by his anticipated bid for the Presidency in 2008 in the Senate, while the House Whip Tom DeLay (R, Texas) is under siege from serious allegations of ethical breaches. Senator Frist has raised the possibility of changing the Senate rules authorizing the filibuster option, which really remains the Democrat's only viable tactic to influence the outcome.

It is not a time for the faint of heart in Washington.

Reconsidering Use it or lose it

Julia Hylton, Manager Tax Favored Accounts (TFA) – Claims
Trish Neely, CFC

The IRS is still contemplating this issue despite the fact that last year Treasury officials opined that the IRS did not have the authority to revoke

the rule. A creative solution is to modify the rule by permitting a limited \$500 health flexible spending account rollover. The rollover might be within the plan, into a health savings account (HSA) or into a 401(k). Some of you have voiced a concern – is this a blessing or a curse?

We pulled out a study that we prepared in 2003 and thought you might be interested in some of the results. The data sample we selected is a good cross-section in terms of employer size, % of forfeitures and dollar amount. Since many of our clients use participant forfeitures to offset the risk of the availability rule, we wanted to assess the impact of a "rollover" upon our clients.

Historically for our clients, the ER risk due to uniform coverage is more than offset with plan forfeitures. Chart I is indicative of this fact.

Chart I

Client	MFSA customers	% who forfeited	Amount forfeited <i>ER gain</i>	Negative balances <i>ER risk</i>
Large	6,400	13%	171,000	47,000
Small	200	20%	8,000	1,500
Medium	1,400	25%	86,000	9,000
Medium	2,100	26%	36,000	28,000
Med – ER contribution	1,200	38%	67,000	6,300
Large – ER contribution	6,400	49%	315,000	4,600

When we applied a \$500 rollover to the same sample (Chart II), larger employers, or plans with higher participation were more likely to continue to offset the risk with forfeitures.

Chart II

The same table if the \$500 rollover had been in effect. The amounts highlighted represent instances where the gain did not offset the risk to the employer.

Client	MFSA customers	% who forfeited	Amount forfeited <i>ER gain</i>	Negative balances <i>ER risk</i>
Large	6,400	1.5%	55,000	47,000
Small	200	2%	1,100	1,500
Medium	1,400	3%	28,000	9,000
Medium	2,100	.6%	11,000	28,000
Med – ER contribution	1,200	2%	9,000	6,300
Large – ER contribution	6,400	2%	15,000	4,600

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Certainly a factor to consider that this data does not measure is the increase in participation that is likely with the fear of forfeiting removed – this expected increase in participation may offset the risk even for small ERs.

The other variable is the increased employee satisfaction with the program. Given that our average participant forfeiture is \$150, there can be no doubt our average participant will benefit.

WFTRA – Is it safe yet to come out?

Trish Neely, CFC, Chief Compliance Officer
Tina Bischoff, CFC, Compliance Officer

Congress enacts, the rest of us react. The Working Families Tax Relief Act (WFTRA) was passed last fall. The IRS followed with clarifications and a few teleconferences; FBMC issued the first Benefits Alert to Clients in December following our discussions with the IRS; and followed the Alert with a lengthy article in the December *Quarterly Review* – all in preparation for a 1/1/05 effective date. Whatever happened to that time honored tradition of providing a period of transition before a law goes into effect?

As one might have expected the 1/1/05 effective date for WFTRA came and went with a series of anxious sighs nationwide. However, more concerning is that February and March have also passed with an extended sense of anxiety. Many employers are still puzzled about what they must do with their health plans, and their dependent care assistance programs. Treasury and IRS officials have been issuing further rulings to address some of the complications when trying to apply the definition to a myriad of governing statutes.

IRS Revenue Ruling 2004-79 negated the income requirement on health plans since this was not Congress' intent; however, there are remaining trouble spots for health plans within a flexible benefit-type arrangement. It also left unanswered the question of disabled adult dependents that have income of \$3,200 or more and no longer qualify as a dependent under Code Section 129 even if the individual provides over half of the individual's support.

State laws which govern the definition of

“dependent” are an additional complication for pre-tax health plans since Cafeteria Plans are governed by federal tax rules and WFTRA changed those rules in some unintended ways.

FBMC was not immune. As an employer and plan sponsor of a flexible benefits plan we scrambled in January to advise our employees of the new definitions. (This information is available on our Web site: www.fbmc-benefits.com.) Since the IRS permits self-certification, we told our employees that as long as their dependents **pre-WFTRA** were still their dependents **post-WFTRA**, no action was needed. But if a dependent included on their health plan(s) or their DCAP plan did not meet the new definitions they needed to complete a new enrollment form. They didn't need to prove dependent status – that's what self-certification means.

As the employer and plan sponsor our obligation was to notify, educate, permit a new election, and a retroactive change. (By the way, the IRS deemed this an acceptable change and a retroactive change even for flexible benefit plans where the plan year had already begun.)

We made the difficult decision and informed our employees that if one dependent met our health plan definition but did not meet the WFTRA definition, the employee could drop the dependent and keep his/her premiums **pre-tax**. Or the employee could keep the dependent and his/her affected premiums would convert to **post-tax**.

And yes, we considered but decided against imputing income and allowing employees to keep all premiums pre-tax as long as our plans permitted coverage regardless of WFTRA dependent eligibility rules. This would have required on year-end W-2 statements, imputing the participant's income for the fair market value of the “premium” that was paid for the ineligible dependent. We had already established precedence with our Domestic Partner coverage and decided that we would remain consistent in our approach and treat the entire premium post-tax.

FBMC is communicating with voluntary benefit providers whose benefits are included in the flexible benefit plans of our Clients. We are encouraging them to **conform** the definition of dependent in their products to the WFTRA definition and secure State approval for the

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change now. We have sent plan document amendments to all of our clients to conform flexible spending arrangement definitions of dependent to the WFTRA definition.

We recommend that our Clients and their consultants, who have not already done so, review the definitions of dependent in their **health plans** and determine a course of action for employees whose dependent(s) no longer qualify for pre-tax premiums. If you are still pondering what to do and how to do it you are definitely not alone.

As for DCAP programs, at the recent ECFC Conference in Washington DC, Harry Beker went so far as to suggest a "wait and see" approach. A bill has been proposed by Congress to make a conforming amendment to Section 129 so that a qualifying individual under Section 129 is defined similarly as prior years. The bill will be retroactive to 1/1/05 – if the bill does not pass, IRS/Treasury will likely (per Harry) issue corrective relief at that time. Although the IRS is not bound by IRS officials' informal and "unofficial" comments, this is a reasonable approach by the IRS.

Congress' objective to create uniform definitions of dependent was initially welcomed – we have no doubt that the passage of time (and a few rulings, amendments or clarifications) will garner the Act and its sponsors the deserved accolades.

In the interim, and if you sponsor a flexible benefits plan, inclusive of the various tax-favored account arrangements, it is not too late to begin reviewing those definitions and taking appropriate action.

HIPAA: What's New?

Security Regulations

Kedra Baumgardner, AVP; Security Officer

The final security regulations were issued 2/20/03 by the Department of Health and Human Services (HHS) and are effective 4/20/2005 (small health plans have an additional year to comply). On March 25, 2005, CMS issued procedures for filing complaints for alleged violations of the Security Rule and other non-privacy portions of the administrative simplification provisions of HIPAA (OCR processes privacy complaints).

The security standards are closely aligned with

the Privacy Regulations; importantly this means that although the standards require some modifications to safeguard electronic PHI, we (employers and the industry) can build upon the framework already constructed for the Privacy Regulations in order to comply with the Security Regulations.

The scope of the Security Rule is more limited than that of the Privacy Rule. The Privacy Rule applies to protected health information in any form, while the Security Rule only applies to electronic protected health information (EPHI). The Security Rule has standards, which are categorized as administrative, physical or technical safeguards. The standards include over forty implementation specifications, which are either required or addressable.

One of FBMC's first steps was to complete a risk assessment and analysis as required by the Security Rule. The assessment took into account not only items where EPHI is stored, but other general areas of security as well. Each item was evaluated in terms of its security risk, the impact a breach would have and the likelihood that a breach could occur. We found no major areas of concern. The analysis did provide us with a few items that we will research for future security improvements.

No system modifications were required in order for FBMC to be in compliance with the Security Rule. As a result of the steps taken to implement the Privacy Rule and our annual SAS70 reviews, we already had appropriate security measures in place for our applications and databases.

Probably the biggest requirement of the Security Rule is that entities must have written policies and procedures in place to address the specific security standards. While FBMC was already practicing most of the standards, not all were formally documented. Security policies and procedures have now been written, and are available to all employees via a public network folder.

Per the requirements, all employees have received security awareness training and all business associates have been sent an amendment to their Business Associate Agreement. The amendment contains wording specific to the requirements of the Security Rule. For those of you looking for a good security rule

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reference book, the HIPAA Security Compliance Guide published by Atlantic Information Services, Inc. (www.AISHealth.com) is a wealth of information. The HIPAA Security Toolkit by Strategic Management Systems, Inc. (www.strategicm.com) is a CD that includes policy and procedure templates, assessment tools and training presentations.

Privacy Regulations: Who Must Comply?

Trish Neely, CFC, Privacy Officer

Compliance dates for large and small health plans have come and gone, yet there continues to be debate amongst employers, attorneys, consultants and others over who must comply.

Although employers generally do not meet the HIPAA definition of covered entity, as plan sponsors of health plans which are "covered entities" there are recommended safeguards that fall as much in the realm of **best business practices** as HIPAA-mandated requirements.

At a minimum, an employer/plan sponsor should limit access to employee data that contains health information to the minimum necessary. Conduct a desk review of staff in payroll, benefits, and human resources to assure that procedures are in place to govern paperwork: correspondence, spreadsheets, reports, statements, etc. If it contains personally identifiable information and health information it should not be left unattended, either physically on a desk, or in any electronic medium.

Determine all intake points for receiving health information; look at how requests for information are received and responded to. How is information distributed? How is it archived and then destroyed? (Don't forget that HIPAA requires that PHI be maintained for six years.)

Email is always troublesome since it can be misrouted, and confidential information can be imbedded in several layers (the infamous email chain) and be forgotten when ten replies later it is distributed to twenty people – constituting a potential breach in privacy. (These are the things that Privacy Officers think about during the wee hours!).

Finally, don't forget to get your documents updated with the recommended HIPAA language:

Benefit materials, SPDs, Plan Documents; and

sign Business Associate Agreements with your vendors.

Fortunately, HIPAA does not require that we retrofit our offices, we just need to put reasonable measures in place. Once you have created your standards and practices, don't forget to inform your staff through ongoing training.

It's never too late to assure procedures are in place and documented, staff trained, and all documents appropriately updated.

NAIC Issues Model Regulations; New State Laws on the Horizon

Robert Dunn, CLU, Manager, Benefits Consulting

The National Association of Insurance Commissioners (NAIC) developed model legislation calling for broker compensation disclosures to insurers. Several states' insurance regulators and/or attorneys general are moving forward with initiatives to adopt the model rules in their states, including Connecticut, Illinois, Massachusetts, New York, New Jersey, and Pennsylvania.

Note: Pennsylvania's Insurance Commissioner Diane Koken chaired the NAIC Executive Task Force.

At least one state, California, intends to adopt even broader reforms. The new rules and regulations will apply on a state by state basis; insurance brokerages with multi-state operations will likely develop standards that comply with the most stringent requirements of the states in which they operate. Thus, many are likely to model their rules on California's broader reforms.

The model legislation would implement new disclosure requirements designed to ensure consumers are provided the information necessary to understand the manner in which brokers are compensated for the sale of insurance products. The model amends the NAIC's current Producer Licensing Model Act.

Among the requirements contained in the model legislation, brokers would be required to disclose the amount of compensation from the insurer and the method for calculating the compensation, including any contingent commission. In those cases where contingent commission is not known, brokers would be required to provide a reasonable estimate of the amount and method for calculating

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such compensation. Producers who represent companies and do not receive compensation from customers would have a duty to disclose that relationship in certain circumstances.

The Florida Department of Financial Services has not yet released a press release regarding their opinion of the model legislation or response.

401(k) News:

Time to Return to the Basics

Peter F. Olsen Jr., NASD Registered Representative

As we look out upon the promise of 2005 and reflect on the year past, thoughts inevitably turn to those of a financial nature.

In all, 2004 was a banner year for U.S. economic growth in terms of Gross Domestic Product (GDP). Most estimates of the GDP for 2004 show

a growth rate of 4.5 percent. In 2005, most analysts predict we are likely to experience a slower growth rate of less than 3.5 percent in the GDP. The economic year 2004 was characterized by prosperity that was largely overshadowed by low consumer confidence. The economy would often overreact on the negative news reporting on geopolitical events, rising oil prices, terrorist threats, and a contentious presidential election.

The economy of 2005 is unique in the sense that despite these elements of uncertainty, companies remain remarkably healthy. Due to large-scale cut backs and serious belt tightening by a majority of domestic businesses, the economy is functioning at one of the highest productivity rates in the post World War II era. This means that many corporations are functioning with a healthy cash flow and high rates of profitability.

As investors, we look into our collective conscious and wonder, "What does this mean for a healthy portfolio?" No one can answer this question for sure, but there are some inferences we can draw from the current picture. There is a consensus among market analysts who are convinced that stocks (equities) will continue to outperform bonds (debt issues) in 2005. In such a climate, healthy companies seek to improve their long run position by reinvesting in technology, hiring more employees, and by paying dividends.

Market commentators believe this is a market of slow growth, where investors are bullish on large

companies with healthy balance sheets.

This market brings us all back to an idea that had been long lost amidst the swing profit dot-com days and recent corporate scandals. The idea that the market always grows steady in the long run has always been a cornerstone of the investment philosophy. In summary, 2005 should be viewed as a year to reevaluate and return to the basics. It is this sound principle that has been proven true for generations of investors. It is this principle alone that has defied world wars, economic depressions and political upheaval.

401(k) Plans add to Hardship Events

Holly Hance, Compliance Officer

The Department of the Treasury, on December 29, 2004, issued final regulations regarding hardship distributions. The final regulations add funeral expenses and repairs of damage to an

employee's principal residence as events that are deemed to be immediate and heavy financial needs. [Treas. Reg. § 1.401(k)-1(d) (3) (iii) (B)]

For a distribution of elective deferrals to qualify as a hardship distribution:

- the participant must have a hardship event, which is defined as an immediate and heavy financial need; and
- the distribution must be necessary to satisfy the hardship.

The following are currently deemed to be hardship events:

- (1) uninsured medical expenses of the participant, spouse, or dependents;
- (2) cost for purchase of a principal residence;
- (3) payment of tuition and related expenses for the next 12 months for post-secondary education for the participant, spouse, or dependents; and
- (4) payments to prevent eviction or foreclosure on a mortgage of the participant's principal residence.

The final regulations, which are generally effective beginning in 2006, have added the following hardship events:

- (5) payments for burial or funeral expenses for the participant's parent, spouse, or

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- (6) dependents; and
- (7) expenses for the repair of damage to the participant's principal residence that would qualify as a casualty deduction.

Flexible Benefit Plans:

IRS Permits Flexibility during Disasters

Jim Snyder, Senior VP, Client Services

FBMC proactively requested and received guidance from the Health and Welfare Branch of the IRS in the wake of six violent hurricanes that pummeled the Gulf Coast and Eastern Seaboard last year. The request for guidance dealt with how to handle enrollment, grace period, missing receipts and other thorny issues when a natural disaster strikes just as one plan year is ending and a new one beginning.

After extensive deliberation IRS officials authorized FBMC, as the benefit administrator, to take whatever actions reasonably necessary to meet the extenuating circumstances. To the extent that the actions went outside the general rules they were treated as administrative adjustments or changes and documented thoroughly and completely.

We and a few of the clients involved were more than a little concerned that the actions might have a negative impact upon new plan year implementation activities or might confuse customers. After closely monitoring data exchange activities related to payroll and eligibility as well as customer calls during the first quarter of 2005, it appears those concerns were unfounded. The communication and education campaign to notify customers of the special procedures went smoothly and customers were grateful for the special treatment.

For information to those of you who were not impacted by the hurricanes, the actions taken included:

- An extension of the open enrollment period
- A 30-day extension to incur expenses for the previous plan year

Some care providers were destroyed or out of commission for extended periods resulting in missed appointments, delayed procedures, etc.

- Permitting employees whose receipts were destroyed to sign an affidavit indicating so, along with an otherwise completed claim form for reimbursement.
- Permitting employees who were unable to incur day care expenses to receive a refund rather than forfeit funds in their accounts.

Several clients were closed for extensive periods of time and/or day care facilities were destroyed in the storms.

We also contacted all provider companies to assure no customer's coverage lapsed as a result of any delays in forwarding premium payments.

For additional information, contact your Account Manager or Trish Neely.

Mental Health Parity Extended

Carolyn Galliher, Director of Operations

President Bush signed into law a package of employee benefits-related provisions which included an extension of the Mental Health Parity Act through December 31, 2005. The MHPA amends ERISA to require that group health plans provide the same limits to medical benefits as they do to mental health benefits.

New Provisions to USERRA

Karen Gilliard, Manager Human Resources

The Veterans Benefits Improvement Act (VBIA) amends USERRA. Although the VBIA focuses primarily on improving housing, education, and other benefits for veterans, it also includes two provisions worth noting as they affect an employer's obligations under USERRA.

One new provision extends the USERRA health continuation requirement from 18 to 24 months for elections made on or after 12/10/04. The requirement applies to all employers regardless of size and to other health plans that might not otherwise be subject to COBRA. The other provision requires employers to provide employees a notice of their rights, benefits, and obligations under USERRA. This notice was to be posted or distributed by 3/10/05. A copy of the notice is available on the DOL website at:

<http://www.dol.gov/vets/programs/userra/poster.pdf>

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IRS Cost of Living Adjustments

Although the adjustments were issued last November and included in the previous *Quarterly Review* we continue to receive inquiries so we are repeating the info in table form this issue.

Cost of Living Adjustment Table

Item	2004 Amount	2005 Amount
SS Wage Base	\$87,900	\$90,000
Medicare Premium Part A Part B	\$343 \$66.60	\$375 \$78.20
Medicare Deductible Part A Part B	\$876 \$100	\$912 \$110
Definition of HCE for §§125 & 129 non-discrim testing	\$90,000	\$95,000
Compensation limits for officers and key employees under §§79 & 125	\$130,000	\$135,000
Qualified Transportation Benefit (QTB) parking maximum	\$195	\$200
QTB Transit and vanpooling	\$100	\$105
401(k) Plan maximum	\$13,000	\$14,000
401(k) catch-up contribution age ≥50	\$3,000	\$4,000
403(b) Contribution Limit	\$13,000	\$14,000
403(b) catch-up contribution age ≥50	\$3,000	\$4,000
403(b) 15-Year Rule	\$16,000	\$17,000
Mileage for medical care	\$.14/mile	\$.15/mile
HSA Maximum contributions Single Family	\$2,600 \$5,150	\$2,650 \$5,250
HSA Catch-up contribution age ≥55	\$500	\$600
HSA Minimum Deductible Single Family	≥\$1,000 ≥\$2,000	≥\$1,000 ≥\$2,000

California's new Domestic Partner Law

Carolyn Galliher, Director of Operations
United Benefits Division

The California Domestic Partner Rights and Responsibilities Act (DPRRA) went into effect on January 1, 2005. The following article focuses on how the law impacts FBMC's self-funded medical plans.

The California statute is a Family Law statute and as such impacts all plan participants in the state. ERISA does not preempt this general public statute. If a Plan uses the generic term "spouse" in the Summary Plan Description, then the Family Law statute of the state applies. While the DPRRA requires that domestic partners be treated the same as spouses for most purposes under California law, it does not expand the coverage for domestic partners currently limited under the Federal Defense of Marriage Act or under the State DOMA enacted by many states, including California.

Under the new law, a domestic partnership is established when both persons file a Declaration of Domestic Partnership with the Secretary of State meeting the following requirements:

- Both persons have a common residence;
- Neither person is married to someone else or is a member of another domestic partnership;
- The two persons are not related by blood;
- Both are at least 18 years of age;
- Both are members of the same sex OR one or both of the persons meet the eligibility criteria under Title II of the Social Security Act for old-age insurance benefits. Persons of opposite sexes may not constitute a domestic partnership unless one or both are over age 62;
- Both persons are capable of consenting to the domestic partnership and share a common residence.

A domestic partnership may only be terminated by initiating a dissolution proceeding in the Superior Court and the filing of Notice of Termination of Domestic Partnership.

What should a Plan do?

It is advisable for an ERISA attorney to review your Summary Plan Description (as applicable) to

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ensure that the terms and conditions are clearly defined as the Plan intends. In general, if the Plan language includes the term "spouse" without limiting language that incorporates the federal language (between a man and a woman), it may become subject to the new state law. Regardless of the Plan's intention, it may be best to define "spouse" to alleviate any question.

Does this law include offering COBRA to domestic partners?

No, under the Federal Defense of Marriage Act, any federal benefits, such as COBRA, does not recognize domestic partners. The California Secretary of State website contains good information if you want to know more:

www.ss.ca.gov/dpregistry.

Regulatory Briefs

We are watching with interest

IRS Revisits Debit Card Ruling; Enhancements in Store

Kendall Hall, Card Services Manager

The IRS is looking at expanding the guidance found in RR 2003-43 to permit "automatic adjudication" of multiple co-pays. The current guidance requires that Mom and kids' expenses be swiped separately with the Card at point of sale to match the corresponding co-pay. Otherwise the transaction must be manually adjudicated and requires Mom to submit her receipt for the transaction. Automatic adjudication happens without the need for paperwork. FBMC and other card vendors have recommended that multiple co-pay transactions be available with just one swipe of the card and without the necessity for a receipt.

And in the category of Revenue Rulings we like . . .

IRS Revenue Rulings Address HRAs & HSAs

Patrick Peters, Manager, Product Development

On April 5th, 2005 the IRS issued Revenue Ruling 2005-24 in which it ruled that Health Reimbursement Arrangements (HRAs) will lose their tax-favored status if the HRA provided for cash distributions of unused amounts for any

purpose other than qualified medical expenses under §213. The HRA is disqualified under §105(b) if any person has the right to receive cash or any other taxable or non-taxable benefit under the arrangement. Additionally and more importantly, the ruling authorizes tax-free employer contributions of accumulated unused vacation and sick leave to an HRA upon an employee's retirement if certain conditions are met. This allowance benefits employers as they would save on the matching FICA **and** employees - they would permanently avoid all taxes on the transaction.

The following week, April 13th, 2005, Revenue Ruling 2005-25 was issued. It confirms private conversations we have been having with IRS officials – but we wanted to see it in writing! This Ruling clears up the confusion on the definition of "family" coverage under §223, which defined "family" as any coverage other than "individual" coverage. An individual is now considered to be eligible to contribute to a Health Savings Account (HSA) **even if** his or her spouse has a non-qualifying health plan with "family" coverage, provided the spouse's coverage does not cover the individual. In addition, the ruling allows for two spouses to have different health plans (one being a HDHP), each with family coverage; spouse A with coverage for him/her and one child and no other coverage; spouse B with coverage for him/her plus one child; spouse **A** would be allowed to contribute the family maximum to the HSA. This is the best of both worlds because spouse **A** could contribute the maximum to the HSA and use those funds to pay for out-of-pocket expenses for the entire family.

FBMC to Implement Procedural Change re: Letters of Medical Need

Trish Neely, CFC, Chief Compliance Officer
Tina Bischoff, CFC, Compliance Officer

As we all know, complying with the various tax rules and other statutes that govern flexible benefit plans requires a lot of interpretation on the part of the plan sponsor and the administrator.

For this reason we constantly network with peers, subscribe to numerous interpretive services (EBIA is our favorite), and attend industry conferences where we pick each other's brains, including the IRS officials who graciously attend and answer our questions and "what ifs".

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From a quality standpoint in our Tax Favored Account – Claims area, we have been monitoring the volume and types of services that must be “pending” (set aside and not processed) waiting upon additional information from the customer. The original intent was to determine the type of additional information so that we could rewrite our communication materials. However, we spotted a trend that needed a review not just from a communication standpoint, but from a regulatory standpoint as well:

We were pending a high number of transactions waiting on a letter from the attending physician to confirm medical need in order to determine eligibility for payment.

As you know, we have always approached compliance interpretations two ways: First, what will the IRS or other governing agencies tolerate; and then, what is a defensible, **conservative** position as far as plan administration is concerned. This approach is extremely important to us; we want no client or customer to ever have a regulatory or tax consequence by adhering to our guidance or our plan management practices. We know that you chose us as your administrator based upon our reputation for monitoring and following the rules.

In terms of what is tolerated, there appears in recent years to be much leeway on both the timing and nature of dental expenses.

In terms of what is defensible and conservative in the way of plan management, we know that some employers may choose to administer the rules more conservatively and this is permitted - an employer may always be more restrictive. This protects against loss under uniform coverage and slows down funding requirements. For this reason, we offer a recommendation and then offer you an opportunity to consider and provide feedback.

Are there services where we can eliminate the need for the letter? We recommend there are.

In discussing this issue with outside counsel we recently learned that on the “cosmetic” vs. medically necessary front, the current state of the law is that expenses that “affect a function of the body” -- **even if also cosmetic**, are permissible without the need for validation from the attending doctor to their medical necessity. Informal IRS guidance has addressed this issue with

orthodontia and dental services. The rationale is this: since orthodontia, crowns and tooth capping, by their very nature affect jaw/chewing functions, they meet the Section 213 definition of medical care. Our outside counsel has some trepidation (as do we) regarding clearly cosmetic procedures such as bleaching and whitening or tooth veneers.

Change in Procedure 5/9/2005

Therefore, effective May 9, we will cease the requirement for a Letter of Medical need with orthodontia, crowns or tooth capping; we will continue to require a Letter with bleaching, whitening or tooth veneers.

If you wish to continue the requirement for the Letter as is current practice, please contact your Account Manager by phone or email.

Question of the Quarter

Do you have or are you considering offering an HRA or HSA in 2006 as part of a consumer driven health care strategy? Select the appropriate response below and click Submit to respond by email to tneely@fbmc-benefits.com. We will share the aggregated results in the next *Quarterly Review*.

Already have HRA or HSA
Don't have, but Considering
Not Considering

To respond by mail, please send your responses to:

Trish Neely, Chief Compliance Officer
PO Box 1878
Tallahassee, Florida 32302-1878

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