

Tech Flex

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SENATE FINANCE COMMITTEE ISSUES HEALTH CARE REFORM BILL

As reported in the July [\[LINK\]](#), August [\[LINK\]](#) and September [\[LINK\]](#) 2009 Tech Flex, a number of legislative actions have taken place in the United States House and Senate in relation to health care reform. On October 13, 2009, the Senate Finance Committee passed out of committee its health care reform proposal titled “America’s Healthy Future Act of 2009.”

Previously, the House passed out of committee three proposals for health care reform and with the recent Senate Finance Committee action; the Senate now has two versions. The House and Senate will now need to individually reconcile its versions until one proposal is sent for consideration by the full membership of each legislative body. Once a bill is passed in both chambers, the House and Senate versions will need to be reconciled into a single bill that must be passed by both the House and Senate. Once this process has been completed, the single bill must be signed by President Obama in order to enact into law.

Below is a brief summary of some highlights contained in the Senate Finance Committee proposal. For information in relation to the other four bills under consideration, please see the July, August and September 2009 versions of Tech utilizing the links provided above.

Selected provisions of the America’s Healthy Future Act of 2009 as summarized by Senator Baucus (D-MT) in a press release dated October 13, 2009.

Individual Market Reforms: Effective in the year 2013, insurers of medical coverage would no longer be allowed to limit coverage based on pre-existing conditions. Consequently, insurance companies would be required to issue coverage to all individuals regardless of health status. However, limited variation in premium rates would be permitted for tobacco use, age, and family composition.

Health Insurance Exchanges: Creation of state-based web portals, or “exchanges” that would direct consumers seeking to purchase coverage in the individual market to all the health plan options available in their zip code. The exchanges would offer standardized health insurance enrollment applications, a standard format companies would use to present their insurance plans, and standardized marketing materials. The exchanges would have a call center for customer support.

Preserving Employer-Sponsored Retiree Coverage: Provide assistance to employers struggling with rising health care costs to continue to provide health care benefits to retirees without increasing premiums. The policy would add \$5 billion to create a reinsurance program to provide assistance to employer-sponsored retiree coverage.

Out-of-Pocket Limits: Plans would have out-of-pocket limits no greater than \$5,950 for an individual and \$11,900 for a family (which is the out-of-pocket limit for Health Savings Accounts (HSAs) in 2010).

Personal Responsibility: Create a personal responsibility requirement for health care coverage, with exceptions provided for religious conscience (as defined in Medicare) and undocumented individuals. Individuals who fail to meet the requirement are subject to a penalty. The penalty phases in over a four-year period beginning in 2014, when the penalty is \$200 per adult, rising to \$400 in 2015, \$600 in 2016 and \$750 in 2017.

Responsibility for Employers: The proposal would not require employers to offer health insurance. However, effective July 1, 2013, all employers with more than 50 employees who do not offer coverage will have to reimburse the government for each full-time employee (defined as those working 30 or more hours a week) receiving a health care affordability tax credit in the exchange equal to the average national exchange credit and subsidy up to a cap of \$400 per total number of employees (whether they are receiving a tax credit and subsidy or not).

Providing an Annual Wellness Visit: Provide Medicare beneficiaries with a free visit to their primary care provider every year to create and update a personalized prevention plan designed to address health risks and chronic health problems and to develop a schedule for regular recommended preventive screenings.

High Cost Insurance Excise Tax: Beginning in 2013, a nondeductible excise tax of 40 percent would be levied on insurance companies and plan administrators for any health insurance plan that is above the threshold of \$8,000 for single coverage and \$21,000 for family coverage. 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. The tax would apply to self-insured plans and plans sold in the group market, but not to plans sold in the individual market. The threshold would be indexed for inflation by an amount equal to CPI-U (Consumer Price Index for All Urban Consumers) plus one percentage point.

Transparency in Employer W-2 Reporting of the Value of Health Benefits: This provision would require employers to disclose the value of the benefit provided by employers for

each employee's health insurance coverage on the employee's annual Form W-2. The policy would be effective beginning in 2010.

Limit Health FSA Contributions: This provision would limit the amount of contributions to health Flexible Spending Accounts (health FSAs) to \$2,500 per year, beginning in 2011.

Standardize the Definition of Qualified Medical Expenses: Beginning in 2010, this provision would conform the definition of qualified medical expenses for Health Savings Accounts (HSAs), health FSAs, and Health Reimbursement Arrangements (HRAs) to the definition used for the itemized deduction. An exception to this rule would allow amounts paid for over-the-counter medicines with prescriptions to continue to qualify as medical expenses.

Penalty for Use of HSA Funds for Non-qualified Medical Expenses: Increase the additional tax for HSA withdrawals prior to age 65 that are not used for qualified medical expenses from 10 percent to 20 percent, beginning in 2011.

Increase the Threshold for Claiming the Itemized Deduction for Medical Expenses: This provision increases the threshold for claiming the itemized deduction for medical expenses from 7.5 percent to 10 percent of adjusted gross income beginning in 2013. 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. As noted previously, all health care reform legislation is proposed at this time. ADP will continue to monitor and provide information in future Tech Flex editions.

For a copy of the America's Healthy Future Act of 2009, please click on the link below:

http://finance.senate.gov/sitepages/leg/LEG%202009/100209_Americas_Healthy_Future_Act_AMENDED.pdf

GENETIC INFORMATION NONDISCRIMINATION ACT REGULATIONS RELEASED

It was reported in the June 2008 Tech Flex [\[LINK\]](#) that on May 21, 2008, the Genetic Information Nondiscrimination Act (GINA) was signed into law by President Bush. GINA establishes a national, uniform, basic standard to protect individuals from discrimination in health care and employment practices based on genetic information. In addition, GINA generally eliminates, with limited exceptions, access to "genetic information" by

health plans, health insurers and employers. GINA consists of two parts: (1) genetic nondiscrimination in relation to health insurance; and (2) employment discrimination based on genetic information. The provisions related to health insurance were effective for plan years beginning on or after May 8, 2009. The provisions related to employment nondiscrimination are effective as of November 8, 2009.

On October 7, 2009, the Internal Revenue Service (IRS), Department of Labor (DOL) and Health and Human Services (HHS) jointly released interim final regulations in relation to the GINA non-discrimination requirements. These rules implement the GINA group and individual market provisions, which generally parallel one another. The term "genetic information" in the regulations includes family medical history.

The interim final rules apply to group health plans for plan years beginning on or after December 7, 2009. Consequently for calendar-year plans, the effective date is January 1, 2010. The individual market must comply with the rules beginning December 7, 2009.

Below is a sampling of the GINA interim final regulation provisions:

Underwriting: Under the interim final regulations, the prohibition against collection of genetic information for underwriting purposes is interpreted to include rules for eligibility for benefits and the computation of premium or contribution amounts. As a result, wellness programs will violate GINA if they provide rewards (e.g. reduced deductibles, discounts, additional benefits, or rebates) for completing health risk assessments that request genetic information. Examples in the rules illustrate that questions in a health risk assessment about family medical history violate GINA if they may result in an individual becoming eligible for a disease-management program, because determining eligibility for the disease-management program is considered an underwriting purpose.

Medically Appropriate Determinations: In relation to determining whether a benefit is medically appropriate, plans and insurers may only use the minimum necessary amount of genetic information without violating the prohibition on using genetic information for underwriting.

Collecting Information Prior to or in Connection With Enrollment: Group health plans and insurers are prohibited from collecting genetic information prior to or in connection with enrollment, regardless of whether the information is used for underwriting. An example provided in the interim final regulations shows a health risk assessment that includes questions about family medical history and that is completed prior to enrollment

results in a GINA violation, even where no incentive is provided to the participant for the completion of the assessment.

For a copy of the GINA final interim regulations, please click on the link provided below:

<http://edocket.access.gpo.gov/2009/pdf/E9-22504.pdf>

FORM FOR REPORTING SECURITY BREACHES RELEASED

In the September 2009 Tech Flex [\[LINK\]](#) it was reported that August 24, 2009, the Department of Health and Human Services (HHS) released the final interim security breach regulations with an effective date of September 23, 2009. The HHS Office for Civil Rights (OCR) posted the instructions for the reporting of breaches of unsecured PHI on its website. In addition, an online form has also been provided for covered entities to use to meet its HHS reporting obligation.

For a copy of the instructions and form, please click on the link provided below:

<http://www.hhs.gov/ocr/privacy/hipaa/administrative/breachnotificationrule/brinstruction.html>

Background

As a way of brief background, The American Recovery and Reinvestment Act of 2009 (ARRA) enacted on February 17, 2009, mandated significant modifications to the privacy and security requirements imposed on health plans, business associates, and other vendors of personal health records under the Health Insurance Portability and Accountability Act (HIPAA).

It is important to note that the HHS has stated in formal guidance that it realizes that it will take covered entities and business associates time to implement the processes and procedures necessary to meet the new requirement and will not impose sanctions for failure to provide the required notifications for breaches discovered prior to February 22, 2010.

One of the provisions of the interim final regulations was that a covered entity must report to the HHS instances of unsecured protected health information (PHI) security breaches based on the following rules.

Breaches involving 500 or more individuals – Where the unsecured PHI of 500 or more individuals is breached in a single incident in a State or jurisdiction, a covered entity must notify the HHS “without reasonable delay” but not later than 60 days from the discovery of the breach.

Breaches involving less than 500 individuals - For breaches of unsecured PHI involving less than 500 individuals, a covered entity must keep a log “or other documentation” of the breaches. Within 60 days after the end of each calendar year, the covered entity must provide notice to the HHS in relation to the breaches which occurred during the preceding calendar year.

For both circumstances it was stated that breaches must be reported to the HHS “in the manner specified on the HHS web site.”

TRANSPORTATION LIMITS FOR 2010 RELEASED

On October 15, 2009, the Internal Revenue Service (IRS) announced, via Rev. Proc. 2009-50, the 2010 limits in relation to transportation benefits. The combined transit pass/vanpooling limit will remain at the 2009 level of \$230 per month. The qualified parking limit will also remain at the same 2009 monthly limit of \$230 month.

The IRS stated the following on page 14 of Rev. Proc. 2009 – 50:

.12 Qualified Transportation Fringe. For taxable years beginning in 2010, the monthly limitation under § 132(f)(2)(A), regarding the aggregate fringe benefit exclusion amount for transportation in a commuter highway vehicle and any transit pass, and under § 132(f)(2)(B), regarding the fringe benefit exclusion amount for qualified parking, is \$230.

For a copy of Rev. Proc. 2008-66, please click on the link below:

<http://www.irs.gov/pub/irs-drop/rp-09-50.pdf>

NEW YORK PROVIDES GUIDANCE ON DEPENDENT AGE RULES

Information regarding the extension of dependent age requirements for insured health policies was provided in the September 2009 Tech Flex [[LINK](#)]. Under the new rules,

commercial insurers that provide group health coverage are required to offer a coverage option to participants that allows unmarried children through age 29 to be covered under a parent's group health insurance policy regardless of financial dependence.

Specifically, unmarried adult children can maintain their health coverage through age 29, provided they are not eligible for other employer-sponsored coverage or social insurance. Employers are not required to pay premiums for adult children who elect this coverage. However, insurers must at least offer employers an option to purchase coverage that includes adult children as dependents in family policies through age 29. The law is effective for insured policies and contracts issued or renewed on or after September 1, 2009 meaning that calendar year plans will need to comply as of January 1, 2010.

On September 30, 2009, the New York Department of Insurance via Circular Letter 22 (2009), released guidance on the state's new dependent age mandate. This release provides guidance on the different options that employers and employees may use for complying with the law. Also addressed in Circular Letter 22 are the rules surrounding eligibility, coverage, rating and notices, as well as the interaction of the dependent age mandate with the provisions of the Consolidated Omnibus Budget Reconciliation Act (COBRA).

For a copy of Circular Letter 22, please click on the link provided below.

http://www.ins.state.ny.us/circltr/2009/cl2009_22.htm

NO CHANGE TO SOCIAL SECURITY WAGE BASE IN 2010

The Social Security Administration (SSA) announced on Thursday, October 15, 2009, that the 2010 social security wage base will be \$106,800, unchanged from 2009. As in prior years, there is no limit to the wages subject to the Medicare tax; therefore all covered wages are still subject to the 1.45% tax.

The Federal Insurance Contributions Act (FICA) tax rate, which is the combined social security tax rate of 6.2% and the Medicare tax rate of 1.45%, remains at 7.65% for 2010. The maximum social security tax employees and employers will each pay in 2010 is \$6,621.60. This is unchanged from the 2009 maximum.

The social security wage base for self-employed individuals in 2010 will also be \$106,800. There is no limit on covered self-employment income that will be subject to

the Medicare tax. The self-employment tax rate remains 15.3% (combined social security tax rate of 12.4% and Medicare tax rate of 2.9%). In 2010, the maximum social security tax for a self-employed individual will be \$13,243.20. This is unchanged from the 2009 maximum.

FICA coverage threshold unchanged for domestic, election workers.

The threshold for coverage under social security and Medicare for domestic employees will be \$1,700 in 2010, unchanged from 2009; the coverage threshold for election workers will be \$1,500 in 2010, also unchanged from 2009.

For a copy of the SSA Announcement, please click on the link provided below:

<http://www.ssa.gov/pressoffice/pr/2010cola-pr.htm>

2010 PENSION CONTRIBUTION LIMITS UNCHANGED

On October 15, 2009, the Internal Revenue Service (IRS) announced cost-of-living adjustments applicable to dollar limitations for pension plans and other items for Tax Year 2010.

Section 415 of the Internal Revenue Code provides for dollar limitations on benefits and contributions under qualified retirement plans. It also requires that the Commissioner annually adjust these limits for cost-of-living increases.

Per the IRS Release:

“The limitations that are adjusted by reference to Section 415(d) will remain unchanged for 2010. This is because the cost-of-living index for the quarter ended September 30, 2009, is less than the cost-of-living index for the quarter ended September 30, 2008, and, following the procedures under the Social Security Act for adjusting benefit amounts, any decline in the applicable index cannot result in a reduced limitation.”

The 2010 limits remain the same as the 2009 limits:

Plan Maximum Contribution Limits	2009	2010
Section 401(k) Plan or SAR-SEP	\$16,500	\$16,500
Section 403(b) Plan	\$16,500	\$16,500
Section 408(p)(2)(A) SIMPLE Plan Contributions	\$11,500	\$11,500
Section 457(e)(15) Limit	\$16,500	\$16,500
Section 415 Limit for: Defined Contribution Plans	\$49,000	\$49,000
Defined Benefit Plans	\$195,000	\$195,000
Highly Compensated Employees: Section 414(q)	\$110,000	\$110,000
Key Employee Section 416(i)(1)(A)(i)	\$160,000	\$160,000
Control Employee Compensation: Section 1.61-21(f)(5)(i) fringe benefit	\$95,000	\$95,000
Section 1.61-21(f)(5)(iii)	\$195,000	\$195,000
Includible Compensation – Sec. 401(a)(17)	\$245,000	\$245,000
SEP Compensation	\$245,000	\$245,000
SEP Earnings Threshold	\$550	\$550
Limited Governmental Plans (pre 7/1/93)	\$360,000	\$360,000
Employee Stock Ownership Plan - Sec. 409	\$985,000	\$985,000
Max. to lengthen 5-year distribution	\$195,000	\$195,000

The dollar limitation under Section 414(v)(2)(B)(i) for catch-up contributions to an applicable employer plan other than a plan described in Section 401(k)(11) or Section 408(p) for individuals aged 50 or over remains unchanged at \$5,500. The dollar limitation under Section 414(v)(2)(B)(ii) for catch-up contributions to an applicable employer plan described in Section 401(k)(11) or Section 408(p) for individuals aged 50 or over remains unchanged at \$2,500.

For a copy of the IRS announcement, please click on the link provided below.

<http://www.irs.gov/newsroom/article/0,,id=214321,00.html>

NEW YORK ANNOUNCES MTA TAX FILING DUE DATE

New York announced that the first payment of the Metropolitan Commuter Transportation Mobility Tax (MTA) is **due by November 2, 2009**. Employers are required to file Form MTA-305 titled “Employer’s Quarterly Metropolitan Commuter Transportation Mobility Tax Return.”

As a way of background, the state of New York enacted the Metropolitan Commuter Transportation Mobility Tax (MCTMT). The MCTMT became effective March 1, 2009 for employers, January 1, 2009 for self employed individuals, and September 1, 2009 for public school districts located within the Metropolitan Commuter District. The purpose of this new tax is to fund the Metropolitan Transportation Authority (MTA) and applies to employers who are required to withhold New York State income tax from employee wages and whose payroll expense exceeds \$2,500 in any calendar quarter.

Below is a link to the New York Department of Taxation and Finance portal providing extensive guidance on the MCTMT as well as online filing and payment tools and frequently asked questions.

<http://www.tax.state.ny.us/sbc/mta.htm>

CALIFORNIA RELEASES NEW WITHHOLDING TABLES

Effective November 1, 2009 through December 31, 2009, California has instituted new tax withholding tables that reflect a 10% increase in personal income tax rates. In addition, the tax rate will increase from 6% to 6.6% for supplemental wages and to 10.23% from 9.23% for stock option and bonus payments paid on or after November 1, 2009.

Below is a copy of the new withholding tax tables:

http://www.edd.ca.gov/Payroll_Taxes/Rates_and_Withholding.htm

A link to a FAQ provided by California in relation to the new tax tables is provided below:

http://www.edd.ca.gov/Payroll_Taxes/FAQ_-_2009_PIT_Table.htm

WISCONSIN – MINNESOTA END INCOME RECIPROCITY AGREEMENT

As of January 1, 2010, Minnesota will terminate the income reciprocity agreement with Wisconsin. Consequently, residents of one state who work in the other state will be required to file returns and pay taxes for both states beginning in 2010. In addition, employers will be required to withhold taxes for the state in which services are performed and in some instances withhold taxes in relation to the employee's state of residence.

For information provided by Minnesota, please click on the link below:

http://www.taxes.state.mn.us/taxes/other_supporting_content/wi_reciprocity.shtml

For information provided by Wisconsin, please click on the link below:

<http://www.revenue.wi.gov/faqs/ise/mnrecipro.html>

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