LINDSTROM INSURANCE
EMPLOYEE BENEFITS • LIFE AND DISABILITY INSURANCE
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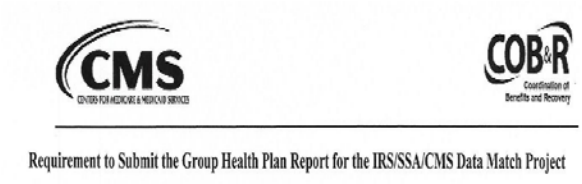
Spring, 2017

Updated Maximums for 2017

Below are important benefit and contribution limits for 2017:

	2016	2017
Contribution Maximums:		
401(k) & 403 (b)	$18,000	$18,000
Catch Up Amount	$ 6,000	$ 6,000
SIMPLE Plans	$12,500	$12,500
SIMPLE Catch Up	$ 3,000	$ 3,000
Social Security & Medicare:		
Social Security Tax	6.2%	6.2%
Social Security Taxable Wage Base	$118,500	$127,200
Medicare Tax	1.45%	1.45%
Compensation Limits:		
Qualified Retirement Plans	$230,000	$245,000
Defined Benefit Retirement Plans	$210,000	$215,000
Defined Contribution Plans (max cont)	$53,000	$ 54,000
Highly Compensated Employee Threshold	$120,000	$120,000
Key Employee Officer Threshold	$170,000	$175,000

	2016	2017
Flexible Spending Accounts (FSA)& Dependent Care Maximum:		
Maximum Credit	$ 2,550	$ 2,600
Maximum Election	$ 5,000	$ 5,000
(Married does not double this Dependent Care max)		
Transportation Reimbursement Plan:		
Mo. Parking Limit	$255	$255
Mo. Mass Transit/ Carpool Limit	$255	$255
Mo. Bicycle Limit	$ 20	$ 20
Long Term Care:		
Maximum LTC premiums deducted as "medical care":		
Thru age 40	$ 390	$ 410
Age 41 – 50	$ 730	$ 770
Age 51 – 60	$1,460	$1,530
Age 61 – 70	$3,900	$4,090
Age 70+	$4,870	$5,110
HSA		
Contribution Maximums:		
Single	$ 3,350	$ 3,400
Family	$ 6,750	$ 6,750
Catch Up	$ 1,000	$ 1,000
Out of Pocket Maximums (excluding premiums)		
Single	$ 6,550	$ 6,550
Family	$13,100	$13,100
Deductible Minimums		
Single	$ 1,300	$ 1,300
Family	$ 2,600	$ 2,600



IRS/SSA/CMS Data Match Letters, Round 2 or 3. Don't Ignore These!!

Some of our small group clients are receiving Data Match letters or follow up letters. This is not junk mail or a scam, but a real IRS letter that requires a response. Here's the info again, from last summer's newsletter, just to be sure we're clear:

The Centers for Medicare and Medicaid Services, the Social Security Administration, and the Internal Revenue Service are working together and it may cost you money. The project is about Medicare Secondary Payer rules. If you receive a letter, DO NOT IGNORE IT.

Letters are going out pursuant to the 2007 Medicare Modernization Act, including higher recovery through CMS's coordination of benefits program, targeting employers where group insurance is primary and Medicare is secondary. (These are generally groups with 20 or more employees (all employees, not just full time, and including groups counted together under common ownership).

While there are fines for encouraging or enticing an employee to take Medicare instead of remaining on the group insurance ($5,000 per situation), the bigger hit is the bill for claims that Medicare has paid as primary versus what they should have paid as secondary.

The three government bureaucracies are looking for instances where an employee (or the dependent of an employee) is enrolled in Medicare and is also the employee of a group. They're running reports to see where someone's social security number is showing up both on the income tax withholding list for an employer and also on the Medicare rolls, hence the term "data match".

If you receive one of these letters, you have a 30-day deadline to respond. There are three different stages to the process that we know about. First, you must set up an account with the data match program.

Once that's complete, there's a 1-2 day wait so the account can connect with the data match questionnaire. The second stage will involve requests for information about health plan information back to 2011, including carrier info, group ID, RxPCN numbers and such, as well as questions about particular employees.

The third stage will be additional information requests involving those Medicare eligible employees who waived the group coverage. This is where your paper trail will be important. You'll want to be able to document that the employee requested to leave the group plan on their own or was not eligible based on the hours worked, etc.

If you have questions about how to handle an employee's request to leave the group plan upon Medicare eligibility, please give us a call!

Moving to a New Carrier?

If your group will be moving to a new carrier for Medical or Dental coverage, please stop any automatic payments the month before you plan to switch.

We always ask for letters to your old insurance company to cancel coverage when we're certain coverage is approved with the new carrier, but we have no idea if you've made arrangements for automatic bank drafts or other automatic payments. Refunds can take months to arrive in your office!

F.S.A. / H.S.A./ Voluntary Plan Incompatibility

In order to enjoy a Federally "Tax Deductible" contribution to a Health Savings Account (H.S.A.), your sole health coverage must be through a qualified High Deductible Health Plan (HDHP). You cannot be covered by one H.S.A. qualified plan AND a conventional HMO or PPO, for example, and still contribute to your H.S.A. Everyone knows that, right?

Participation in a Flexible Spending Account (FSA) that allows pre-tax contributions, which can later be used for unreimbursed medical expenses, can void your eligibility to contribute to an H.S.A. If the FSA is limited, for "dental only", for example, you may be just fine.

In addition to the FSA issue, if you or your employees have purchased voluntary plans, such as those offered by Colonial Life, Standard, Transamerica, or AFLAC, there are proposed regulations that could cause some difficulties.

Specifically, Hospital Indemnity, Critical Illness and disease-specific products that do not provide a flat per-day benefit or a flat benefit per a defined time period may become noncompliant this year. For example, if a policy provides a benefit of $50 for an office visit, various surgical procedures at different amounts per procedure, and prescription drugs at $20 per prescription, this policy will not comply with the proposed regulations, and could cause the employee's contribution to the Health Savings Account to be disallowed.

Our best advice is to direct employees to their tax professional to determine if their voluntary plan will preclude them from making a contribution to their H.S.A.

For more information on H.S.A.s, see IRS Publication 969.

Additions and Terminations

Please remember that "new hires" are considered eligible when they've worked the requisite number of hours (usually 30 hours/week) for the eligibility waiting period (typically 30 or 60 days, but this varies by plan). Coverage generally starts the first of the following month.

Carriers have absolutely no sense of humor or inclination to be merciful if a deadline is missed. Late enrollees may be required to wait until your next open enrollment period to be added to the plan.

Newly eligible dependents must be added to the plan(s) within 30 days of the wedding, within 30 days of the adoption or birth.

If an employee reduces their hours, quits, you need to fire them, etc., there is generally a form to submit to notify the insurance carrier that coverage should end. Again, if you have enrollment online, the termination may also be processed electronically. Please call us if you need clarification on any of this.

New Benefits Person? Not Sure About Procedures? We Want To Help!

We're noticing some of our group clients have hired new employees who are handling benefits administration. Please let us know when you have a new person in this position!

We've developed a short training program and Carol will be happy to meet with your new office manager or benefits administrator to review the "Care and Feeding" of your benefit plans and privacy rules to avoid future problems and make things go more smoothly.

We're also happy to review procedures with your current benefits person and make sure you have the correct, up to date forms for your current plan(s). We'll bring you an electronic copy of the forms, review eligibility waiting periods, benefits offered, the employer contribution, etc., and generally want you to be comfortable with this important aspect of your business.

Vicki Melendy walks for the Live Like Coco Foundation

While Vicki continues to train for long distance walking events, her fundraising efforts are now being directed to the Live Like Coco Foundation. "Team Coco" supports several local charities focusing on causes such as literacy, health, nature, theater and children's concerns. Examples of the charities are the Homeless Garden Project, Birthday Books From Coco (which distributes books to children), Jacob's Heart (which supports families of children stricken with cancer), and The Teen Kitchen Project which brings teens into the kitchen and teaches them how to cook delicious and nutritious meals.

If you would like to support Team Coco, please donate at LiveLikeCoco.com or send a check payable to the Live Like Coco Foundation to our office, Lindstrom Insurance, P.O. Box 4026, Felton, CA 95018. Thank you so much for your support.

MLR (Minimum Loss Ratio) Season Again

Insurance carriers have been sending letters and making announcements about determining the number of employees you had during 2016. Please respond to these promptly….it may be a questionnaire or a link to a website where you enter information.

The purpose of this exercise is to distribute refunds required under this portion of the Affordable Care Act. For most of our clients, the law mandates that insurance companies spend 80% of the health insurance premiums received to pay claims. If they have a good year, and claims are lower than this figure, the "extra" premiums collected must be refunded to those who paid the cost of the insurance.

The first step is to determine the size (number of employees) in each covered group. If any of the plans your employees selected qualify for a refund, you'll be receiving a letter and a check later this year. Call us with questions.