

The Kinloch Link

Your Link to Employee Benefits News and Information

January 2011

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Compliance Link:

2011 Health and Welfare and Retirement Plan Limits

Maximum Annual HSA Contribution:
\$3,050 individual / \$6,150 family
Maximum Annual Out-of-Pocket for HDHP:
\$5,950 individual / \$11,900 family
Minimum Annual Deductible for HDHP:
\$1,200 individual / \$2,400 family
HSA Catch-up Contribution: \$1,000
Adoption Assistance Tax Credit: \$13,360
Qualified Transit & Commuter Expenses: \$230/month
Qualified Parking Expenses: \$230/month
Bicycle Commuter Benefit: \$20/month
401(k), 403(b) & 457 Deferrals: \$16,500
Retirement Catch-up Contribution: \$5,500
Highly Compensated Employee Threshold: \$110,000
Social Security Maximum Taxable Earnings: \$106,800

Extension of Employer Provided Tuition Assistance

Included in the recently passed Tax Relief, Unemployment Insurance Re-authorization, and Job Creation Act of 2010 is a two year extension, through 2012, of employer-provided tuition assistance. Up to \$5,250 a year in employer provided tuition assistance for undergraduate or graduate studies can be excluded from employee income per IRS Code Section 127.

Updated Debit Card Guidance

The IRS has issued updated guidance ([Notice 2011-5](#)) which allows individuals to continue to use their FSA or HRA debit card for over-the-counter medicines after January 15, 2011. In order to do so, a prescription must be presented to the pharmacist, an RX number must be assigned and the pharmacy or other vendor must keep a record of the prescription and purchase. The IRS has updated its [Q&A](#) on OTC medications to reflect the amendment.

Kinloch Consulting Group

Boston (617) 284-5250
Melville, NY (631) 773-6600

Genatt Associates, Inc.

New Hyde Park, NY (516) 869-8666



Medical Loss Ratio Regulations

The [interim final rule](#) on the Patient Protection and Affordable Care Act's (PPACA) Medical Loss Ratio (MLR) requirements was released by the Department of Health and Human Services (HHS) on November 22, 2010 and published in the Federal Register on December 1, 2010.

These requirements are among the latest efforts to bring transparency to the insurance marketplace and to ensure consumers receive the most value for their health insurance premium dollar. Although these rules apply to insurers, employers should be aware of the regulations as insurers could ask employers to distribute rebates to enrollees on their behalf.

The Rules

Effective January 1, 2011, health insurers in the individual and small group markets – under 50 enrollees – are required to spend 80 cents of every premium dollar on medical care and health care quality improvement, rather than executive salaries and bonuses, overhead, marketing and other administrative expenses. For those in the large group market – over 50 enrollees – the MLR is 85 cents of every premium dollar.

These rules apply to insured health plans only, self-insured plans are excluded. While the rules do apply to mini-med and expatriate international plans, an adjustment will be made to the MLR calculation for these plans for the 2011 reporting year.

Reporting Requirements

By June 1st of each year, starting in 2012, insurers must report how they spent their premium dollars for the prior calendar year. The following data must be reported for each state in which the insurance company does business: earned premiums, reimbursement for clinical services, spending on activities to improve quality and spending on all other non-claims costs (excluding federal and state taxes and fees). This data will be reported to HHS and posted on its website so that consumers can access information on how their premium dollars were spent.

Rebates

By August 1st of each year, beginning in 2012, insurance companies not meeting the MLR standard will be required to issue rebates either directly to enrollees or indirectly through the employer if the premium was paid by the employer on behalf of employees. The amount of rebate owed is the total premium paid (excluding taxes and other permissible adjustments) times the amount by which the actual MLR exceeded the MLR standard. Rebates must be issued in the form of a rebate check, credit/debit card reimbursement or a reduction in future premium. According to the [MLR fact sheet](#), an estimated 9 million Americans could be eligible for rebates and the average rebate per person could total \$164 in the individual market. Additionally, employers that paid a portion of premium on behalf of its employees may retain its proportionate share of the rebate.

As these are interim final rules, there is a 60-day comment period (through January 31, 2011) before the final rules are issued. Keep an eye on future issues of the Link for updates relating to the MLR requirement, as well as other aspects of PPACA. For additional information, please visit the HHS website (http://www.hhs.gov/ociio/regulations/medical_loss_ratio.html) or contact your Kinloch consultant.



For additional information on any of this month's topics, or for any other employee benefit questions, please contact your Kinloch consultant or local Kinloch office.

Non-Grandfathered Plans & Non-Discrimination Rules

New fully-insured plans and those that relinquish their grandfathered status under the Patient Protection and Affordable Care Act (PPACA), are not only facing plan design changes but also potential changes in the way benefits are provided to different employee classifications. PPACA implements new rules, modeled after existing non-discrimination rules in Internal Revenue Code Section 105(h), that prohibit more favorable treatment of highly compensated individuals with regard to plan eligibility and benefits.

Prior to PPACA's changes, fully-insured plans were free to discriminate in favor of higher paid employees, most often taking the form of executive "carve-out" medical plans, a higher company subsidy of premium cost or a shorter waiting period for benefits. However, fully-insured plans subject to PPACA's new requirement that are found to be discriminatory in these ways could face steep excise tax penalties based on the individuals discriminated against. This is a significant difference from the self-insured rules where the penalty for discriminatory treatment is taxation to the highly compensated individuals – a much less onerous penalty for the employer.

The existing Section 105(h) rules are complex and often unclear. How analogous will the fully-insured rules be to the current self-insured rules? It's unknown – PPACA only indicates that "similar" rules will apply. Recognizing these difficulties, the IRS recently issued [Notice 2011-1](#), which delays the effective date of the new rules until after implementing regulations or other guidance has been issued. Comments on the Notice have been requested by March 11, 2011.

While we wait for more guidance, non-grandfathered, fully-insured plan can familiarize themselves with the existing regulations – briefly summarized below – but no further action is required. We will continue to report on new developments on this topic. Please contact your Kinloch consultant with additional questions.

Summary of Section 105(h) Non-Discrimination Tests

Who is a "Highly Compensated Individual" (HCI)? One of the 5 highest paid officers, OR a more than 10% shareholder, OR one of the highest paid 25% of all employees (certain employees can be excluded for purposes of the eligibility test – see below)

Test #1: Eligibility Test To pass this test, a plan must meet at least ONE of these requirements: (1) it benefits 70% of all non-excludable employees, OR (2) 70% of all non-excludable employees are eligible and 80% of eligibles benefit, OR (3) eligibility is based on a non-discriminatory classification. For #3, further subtests apply: 3(a) the classification must be "reasonable" and established under objective business criteria (e.g., salary/hourly, full-time/part-time, geographic or job type classification); AND 3(b) a "safe harbor" percentage is met when comparing HCIs and non-HCIs who benefit from the plan.

Excludable Employees, only if they are not eligible to participate in the plan: (1) those with < 3 years of service prior to the start of the plan year; (2) those < age 25 at the start of the plan year; (3) part-time or seasonal employees; (4) non-resident aliens; and (5) collectively bargained employees

Test #2: Benefits Test To pass this test, a plan must meet TWO requirements: (1) benefits provided to HCIs must also be provided to non-HCIs under the same terms and conditions; AND (2) maximum employer contributions must be uniform for HCIs and non-HCIs and not based on employee age, years of service or compensation.

Ask Kinloch – January Issue

Question: We are replacing our current medical program with an IRS qualified high deductible plan (HDHP) with a health savings account (HSA). The company will be making contributions to the HSA to help offset the increased deductible. Are there any rules we should be aware of when structuring our contributions?

Answer: Yes, an employer's contribution to employees' HSAs must satisfy the IRS's comparability rules (Code Sec. 4980G). In general, an employer must contribute the same dollar amount or percentage of the deductible to "comparable participating employees" which are defined as employees within the same category (full-time or part-time) and the same HDHP coverage level.

- For example, an employer who contributes \$500 to full-time employees enrolled in single coverage and \$1,000 to full-time employees enrolled in family coverage would satisfy the comparability rules. (The regulations provide additional guidelines for self plus one, plus two and plus three coverage levels.)

An employer can make a larger contribution to non-highly compensated employees and still satisfy the comparability rules provided that comparable participating employees receive the same contribution.

- For example, an employer who contributes \$1,000 to non-highly compensated employees enrolled in single coverage and \$500 to highly compensated employees enrolled in single coverage would satisfy the comparability rules.
- Expanding on the example above, if the employer contributes \$500 to non-highly compensated, management employees and \$1,000 to all other non-highly compensated employees, the comparability rules will not be satisfied.

Employers who fail to satisfy the comparability rules are subject to an excise tax equal to 35% of the aggregate amount of their HSA contributions for that calendar year.

When employer HSA contributions are made through a Section 125 plan the Section 125 nondiscrimination rules, not the comparability rules, apply.

The guidelines described above are not inclusive of every employer contribution scenario. When structuring your contributions it is important to consult with your HSA vendor, Kinloch consultant and legal counsel to ensure compliance with the applicable regulations.

Massachusetts Health Care Reform Reminders

Form MA 1099-HC

The 2010 Form MA 1099-HC must be provided on or before **January 31, 2011** to each MA resident plan participant for state tax filing purposes; a separate report must be filed electronically with the MA Department of Revenue (DOR). MA carriers will send and file the 1099-HC report with the DOR for insured plans and most will also fulfill this requirement for self-funded employers. More information can be found on the [DOR website](#).

Fair Share Contribution (FSC) Filing

All employers covered by the MA Health Reform Law are required to file for the 4th quarter of 2010 (and certify compliance for the first 3 quarters of 2010) no later than **February 15, 2011**. Employers who pass this FSC test will continue to file annually unless their circumstances change. Employers who fail this FSC test must file quarterly. Filing website: <https://fsc.dema.org/>

Kinloch Consulting Group does not provide legal advice. The information above is solely for general informational purposes and is not specific advice.