Health & Retirement Services of Illinois
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OUR NEWS LETTER

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HEALTH SAVINGS ACCOUNT FAMILY CONTRIBUTION LIMIT CHANGE FOR 2018

The Internal Revenue Service (IRS) recently announced that **the maximum contribution to a health savings account (HSA) for family coverage under a high-deductible health plan has reverted to $6,900 for 2018**

Rev. Proc. 2018-27

SECTION 1. PURPOSE

This revenue procedure modifies the annual limitation on deductions for contributions to Health Savings Accounts (HSAs) allowed for individuals with family coverage under a high deductible health plan (HDHP) for calendar year 2018 announced in Revenue Procedure 2018-18, 2018-10 I.R.B. 392. For 2018, taxpayers may treat $6,900 as the annual limitation on the deduction for an individual with family coverage under an HDHP pursuant to section 223(b)(2)(B) of the Internal Revenue Code. This revenue procedure makes no other changes to Rev. Proc. 2018-18.

SECTION 2. BACKGROUND

On May 4, 2017, the Department of the Treasury (Treasury Department) and the Internal Revenue Service (IRS) released Revenue Procedure 2017-37, 2017-21 I.R.B. 1252, which provided the 2018 inflation adjusted amounts for HSAs as determined under section 223. Under Rev. Proc. 2017-37, the annual limitation on deductions under section 223(b)(2)(B) for an individual with family coverage under an HDHP was $6,900.

Subsequently, statutory amendments by “An Act to Provide for Reconciliation Pursuant to Titles II and V of the Concurrent Resolution on the Budget for Fiscal Year 2018” (the Act), Pub. L. 115–97, 131 Stat. 2504, enacted December 22, 2017, modified the inflation adjustments for certain provisions of the Internal Revenue Code, including the inflation adjustments under section 223. On March 2, 2018, the Treasury Department and the IRS released Rev. Proc. 2018-18, which superseded Rev.Proc.2017-37, to reflect the statutory amendments to the inflation adjustments under the Act. Under section 4 of Rev. Proc. 2018-18, the annual limitation on deductions under section 223(b)(2)(B) for an individual with family coverage under an HDHP was $6,850 for 2018 a $50 reduction from the limitation announced in Rev.

Proc. 2017-37. Rev. Proc. 2018-18 did not change any other annual limitation or any other requirement under section 223 for calendar year 2018. In response to Rev. Proc. 2018-18, stakeholders informed the Treasury Department and the IRS that implementing the $50 reduction to the limitation on deductions for individuals with family coverage would impose numerous unanticipated administrative and financial burdens. Specifically,

stakeholders noted that some individuals with family coverage under an HDHP made the maximum HSA contribution for the 2018 calendar year before the issuance of Rev. Proc. 2018-18 reducing the deduction limitation, and that many other individuals made annual salary reduction elections for HSA contributions through their employers' cafeteria plans based on the $6,900 limit for an individual with family coverage under an HDHP. Further, stakeholders informed the Treasury Department and the IRS that the costs of modifying the various systems to reflect the reduced maximum, as well as the costs associated with distributing a $50 excess contribution (and earnings), would be significantly greater than any tax benefit associated with an unreduced HSA contribution (and in some instances may exceed $50). Some stakeholders also pointed to section 223(g)(1), which requires annual inflation adjustments for HSAs to be published by June 1 of the preceding calendar year, as another indication that a current year change would be unduly burdensome.

In response to these concerns, the Treasury Department and the IRS have determined that it is in the best interest of sound and efficient tax administration to allow taxpayers to treat the $6,900 annual limitation originally published in Rev. Proc. 2017-37 as the 2018 inflation adjusted limitation on HSA contributions for eligible individuals with family coverage under an HDHP.

SECTION 3. PROCEDURE

For calendar year 2018, taxpayers may treat $6,900 as the annual limitation on deductions under section 223(b)(2)(B) for an individual with family coverage under an HDHP.

An individual who receives a distribution from an HSA of an excess contribution (with earnings) based on the $6,850 deduction limit published in Rev.Proc.2018-18 may repay the distribution to the HSA and treat the distribution as the result of a mistake of fact due to reasonable cause under Q&A-37 of Notice 2004-50, 2004-2 C.B. 196.

Accordingly, the portion of a distribution (including earnings) that an individual repays to an HSA by April 15, 2019, is not included in the individual's gross income under section223(f)(2) or subject to the 20 percent additional tax under section 223(f)(4), and the repayment is not subject to the excise tax on excess contributions under section4973(a)(5). Mistaken distributions that are repaid to an HSA are not required to be reported on Form 1099-SA or Form 8889 and are not required to be reported as additional HSA contributions. However, in accordance with Q&A-76 of Notice 2004-50, a trustee or custodian is not required to allow individuals to repay mistaken distributions.

Alternatively, an individual who receives a distribution from an HSA of an excess contribution (with earnings) based on the $6,850 deduction limit published in Rev.Proc.2018-18 and does not repay the distribution to the HSA may treat the distribution in accordance with section 223(f)(3), which describes the treatment of excess contributions returned before the due date of return. Thus, the excess contribution generally would not be included in gross income under section 223(f)(2) or subject to the 20 percent additional tax under section 223(f)(4), provided the distribution is received on or before the last day prescribed by law (including extensions of time) for filing the individual's 2018 tax return.

The tax treatment described in the preceding paragraph does not apply to distributions from an HSA that are attributable to employer contributions (pursuant to a cafeteria plan election or otherwise) if the employer does not include any portion of the contributions in the employee's wages because the employer treats $6,900 as the annual limitation on deductions under section223(b)(2)(B). In that case, unless the distribution from the HSA is used to pay qualified medical expenses, the distribution is includible in the employee's gross income under section 223(f)(2) and subject to the 20 percent additional tax under section 223(f)(4).

SECTION 4. EFFECT ON OTHER DOCUMENTS

This revenue procedure modifies and supersedes the second sentence of section 4 of Rev. Proc. 2018-18, which for calendar year 2018 addresses the annual limitation on deductions under section 223(b)(2)(B) for an individual with family coverage under an HDHP.

SECTION 5. EFFECTIVE DATE

This revenue procedure applies for calendar year 2018.

SECTION 6. DRAFTING INFORMATION

The principal author of this revenue procedure is Karen Levin of the Office of Associate Chief Counsel (Tax Exempt and Government Entities). For further information regarding this revenue procedure contact Karen Levin on (202) 317-5500

New Medicare cards are coming

Medicare is mailing new Medicare cards to all people with Medicare now.

10 things to know about your new Medicare card

1. Your new card will automatically come to you. You don't need to do anything as long as your address is up to date. If you need to update your address, visit your mySocial Security account.
2. Your new card will have a new Medicare Number that's unique to you, instead of your Social Security Number. This will help to protect your identity.
3. Your Medicare coverage and benefits will stay the same.
4. Mailing takes time. Your card may arrive at a different time than your friend's or neighbor's.
5. Your new card is paper, which is easier for many providers to use and copy.
6. Once you get your new Medicare card, destroy your old Medicare card and start using your new card right away.
7. If you're in a Medicare Advantage Plan (like an HMO or PPO), your Medicare Advantage Plan ID card is your main card for Medicare—you should still keep and use it whenever you need care. And, if you have a Medicare drug plan, be sure to keep that card as well. Even if you use one of these other cards, you also may be asked to show your new Medicare card, so keep it with you.
8. Doctors, other health care providers and facilities know it's coming and will ask for your new Medicare card when you need care, so carry it with you.
9. Only give your new Medicare Number to doctors, pharmacists, other health care providers, your insurers, or people you trust to work with Medicare on your behalf.
10. If you forget your new card, you, your doctor or other health care provider may be able to look up your Medicare Number online.

Watch out for scams

Medicare will never call you uninvited and ask you to give us personal or private information to get your new Medicare Number and card. Scam artists may try to get personal information (like your current Medicare Number) by contacting you about your new card. If someone asks you for your information, for money, or threatens to cancel your health benefits if you don't share your personal information, hang up and call us at 1-800-MEDICARE (1-800-633-4227). Learn more about the limited situations in which Medicare can call you.

How can I replace my Medicare card?

If your Medicare card is lost, stolen or damaged, you can ask Social Security for a new one.

- Your Medicare card will arrive in the mail in about 30 days.
- Social Security will mail your card to the address they have on file for you.
- If you need proof that you have Medicare sooner than 30 days, you can request a letter from Social Security. The letter will arrive in the mail in about 10 days.
- If you need proof immediately for your doctor or for a prescription, visit your local Social Security office.

How do I change my name or address?

Medicare uses the name and address you have on file with Social Security. To change your name and/or address, visit your online my Social Security account.

Note

Medicare is managed by the Centers for Medicare & Medicaid Services (CMS). Social Security works with CMS by enrolling people in Medicare.

STROKE AWARENESS

Do you know the warning signs of a stroke? May is Stroke Awareness Month, a perfect time to arm yourself with information to help prevent and detect a stroke—for both you and your loved ones.

Warning signs of a stroke include:

- Weakness in the face, arm, or leg
- Speech difficulty
- Vision loss
- Dizziness
- Brief loss of consciousness

Are you or a loved one at risk for a stroke? Watch our short video to **learn the risk factors for stroke** and see how Medicare can help.

Visit medicare.gov for further information

Is Rice Gluten-Free? Is Rice A Carb? The Answers To All Your Questions.

Kristen Aiken, May 16, 2018

If you type the phrase “is rice” into the Google search bar, it’ll fill in the rest of the question to indicate what the world is asking. In this case, the top two results are “is rice gluten-free?” and “is rice a carb?”

People just have no idea what rice is made of, which is a little shocking considering the amount of rice we eat.

In the 2017/2018 agricultural calendar alone, global consumption of rice topped 480,000 metric tons, so it’s probably a good idea to understand what exactly rice is and what it does to our bodies.

Is rice a carb?

Yes, rice is very much a carbohydrate. To be more precise, it’s a complex carb. To break it down even further, brown rice is an unrefined complex carb, and white rice is a refined complex carb.

Though we usually look down upon the unrefined things in life, unrefined carbs are actually a good thing when it comes to our health. The unrefined complex carbs found in brown rice require our bodies to do some work to digest them, which keeps us from having dramatic swings in our blood sugar and insulin levels. Because brown rice’s husk is intact, it contains tons of beneficial vitamins, nutrients and fiber (1.8 grams per serving) that can help lower cholesterol and reduce the risk of Type 2 diabetes.

White rice, on the other hand, is a refined complex carb, because the high-fiber parts of the grain have been removed by machinery. This makes the carbs easy for our bodies to digest, leading to unwanted sugar crashes. Compared with the 1.8 grams of fiber found in brown rice, white rice only contains has 0.4 grams of fiber.

Which has more carbs, brown or white rice?

In general, white rice has a higher number of total carbohydrates than brown rice. We’ve broken down popular types of rice below by grams of total carbohydrates per serving, but it’s important to keep in mind that nutritional info can vary by brand.

- Arborio rice (risotto rice): 45g carbs
- White basmati rice: 41g
- Brown basmati rice: 33g
- Long-grain white rice: 75g
- Long-grain brown rice: 35g
- White jasmine rice: 45g
- Brown jasmine rice: 22g
- Wild rice: 35g
- Japanese or sushi rice: 29g
- White short-grain rice: 53g
- Brown short-grain rice: 35g

Which has a higher glycemic index, brown or white rice?

A glycemic index, or GI, is a way of ranking carbohydrate-containing foods according to their immediate effects on blood sugar levels. Carbs with a low GI are more slowly digested, causing a slower rise in insulin levels. Foods with a high GI are quickly digested and make our insulin levels skyrocket.

A low GI is defined as 55 and under, intermediate is 56 to 69, and high is 70 and above.

Again, the GI varies by brand of rice, so shop around until you find a brand that suits you best. But here are a few examples that give a general sense of the numbers, according to GlycemicIndex.com:

- Long grain rice, white, Golden Crown brand: 76 (HIGH)
- Medium grain rice, white, Double Ram brand: 89 (HIGH)
- Brown rice (general): 66 (INTERMEDIATE)
- Japonica, short-grain brown rice: 62 (INTERMEDIATE)
- Japonica short-grain brown rice, pre-germinated: 54 (LOW)

Is rice gluten-free?

Yes, all rice is gluten-free in its natural state. Every type of white, brown and wild rice we've mentioned in this article is gluten-free, including sticky rice, which is also confusingly called glutinous rice. The term "glutinous" refers to the rice's stickiness, not its gluten content.

The only time your rice may not be gluten-free is when it's sold in packaging with a mix — such as a box of pilaf — that could've been mixed with glutinous ingredients. Always double check ingredient labels to be sure that what you are eating is truly gluten-free.

Vermont becomes first state to allow imported drugs from Canada

By Rachel Roubein and Brooke Seipel - 05/16/18

Proponents of the law, which has been opposed by President Trump's health officials as well as pharmaceutical companies, believe it will help fight rising drug prices. It was widely supported in Vermont's Democratic-controlled state legislature.

The law must still be certified by the Department of Health and Human Services (HHS).

The move puts the state at odds with the Trump administration. HHS Secretary Alex Azar on Monday called the idea of importing drugs from another country a "gimmick."

Drug companies have also criticized such plans, with the lobbying group Pharmaceutical Research and Manufacturers of America (PhRMA) maintaining that "patient safety must be our top priority."

“Lawmakers cannot guarantee the authenticity and safety of prescription medicines when they bypass the FDA-approval process, and the Canadian government does not inspect or take responsibility for the legitimacy of prescription medicines shipped to the U.S.," PhRMA said in a statement.

"The burden of combating illicit drugs would fall on local law enforcement officials, who lack the capacity to inspect even a small percentage of increased counterfeit drugs, but who have witnessed their impact in communities across the state,” it added.

In the past, President Trump has supported drug importation from overseas, which was a plank of his health-care reform proposal as president-elect.

The Vermont law is built on model legislation from the National Academy for State Health Policy (NASHP). Eight states proposed similar legislation this year, but Vermont’s is the first to be signed into law.

Specifically, the law lets a wholesaler in the United States import drugs from a wholesaler in Canada. According to NASHP’s website, prescription drugs cost 30 percent less in Canada.

Several other states allow individuals to import drugs from other countries, but not wholesalers. Trish Riley, NASHP’s executive director, argues that requiring wholesalers to import the drugs is a key distinction that provides assurances the drugs coming into the state would be safe.

“Our model legislation assures safety and savings by buying drugs through the existing supply chain, so that all the checks and balances are in place to assure safety,” she said.

SEE IF YOU ARE ELIGIBLE FOR MEDICARE SAVINGS

If you're one of the many Americans who have difficulty paying for health care costs, there may be ways you can **save money on your Medicare premiums and other costs** even if you don't qualify for Medicaid.

Medicare has 4 programs that may be able to help with your health care costs:

1. Qualified Medicare Beneficiary (QMB) Program
2. Specified Low-Income Medicare Beneficiary (SLMB) Program
3. Qualifying Individual (QI) Program
4. Qualified Disabled and Working Individuals (QDWI) Program

To find out if you're eligible for savings through one of these programs, call your State Medicaid program, or visit Medicare.gov for more information.

CBO: ObamaCare premiums to rise 15 percent in 2019

By Rachel Roubein - 05/23/18

ObamaCare premiums are expected to rise an average of 15 percent next year, an increase largely due to the GOP's repeal of the law's individual mandate, according to a Congressional Budget Office (CBO) analysis released Wednesday.

The CBO estimates that gutting the requirement that Americans have health insurance or face a tax penalty will contribute to about a 10 percent rise in premiums for 2019, with insurers expected to see healthier people dropping out of the marketplaces, leaving sicker enrollees on the plans.

The nonpartisan agency attributed the rest of the expected increase to rising health-care costs and the lack of insurers receiving a key ObamaCare payment compensating them for subsidizing out-of-pocket costs for certain enrollees.

The price hikes don't affect the majority of people with ObamaCare plans, as lower-income Americans receive federal subsidies to help cover their insurance.

Political rhetoric surrounding ObamaCare premiums has escalated in recent weeks as several states have unveiled proposed rate hikes, including some by double digits.

Both parties are scrambling to blame the other for the expected increases, which won't be finalized until early fall — about a month before the November midterm elections.

Democrats argue the price hikes are the result of GOP efforts to sabotage ObamaCare, pointing to the repeal of the individual mandate in the tax bill that President Trump signed into law in December.

Republicans contend that Democrats were the ones who passed the health-care law in the first place, without any GOP support. They blame Democrats for the failure to pass a bill to shore up the ObamaCare exchanges, though Democrats protest that characterization of why the legislation wasn't able to become law.

CBO also projected that there will be 3 million more uninsured people between 2018 and 2019, largely due to the repeal of the individual mandate and higher premiums.

The agency estimated the ObamaCare marketplaces will be "stable in most areas of the country" over the next decade, yet that "stability may be fragile in some places."

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