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Newsletter for Commercial Businesses

IN THIS ISSUE:

Tax reform and employee benefits – what to know now

As you have probably heard by now, the recently enacted Tax Cuts and Jobs Act (the Tax Reform Act) made significant changes to the Internal Revenue Code. With regard to executive compensation, the Tax Reform Act made widely publicized changes impacting public companies and nonprofit entities. The new law also made changes affecting employer-provided retirement, welfare, and fringe benefits.

Nearly all employers, including publicly held, private, and nonprofit, need to understand what is required by the new rules. To get started, here is our list of the Top Three Things to Know Now.

1. Public Company Executive Compensation Rules Have Changed.

Code Section 162(m) imposes a $1 million deduction limit on most compensation payments made by a publicly traded employer to its covered employees in a particular fiscal year. Publicly traded employers generally spend a lot of time ensuring compliance with this rule, especially ensuring that a significant portion of the compensation paid

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Mike's Notes

Important 2018 Compliance Information All employers should know

As a part of our commitment to our clients, we will continue to share updates regarding the Affordable Care Act and changes to the health insurance industry as they occur. We have produced and published a 20 minute video regarding the a few recent announcements - including:

- 6055 & 6056 updates
- Individual Mandate Repeal
- H.S.A. Funding

Visit http://wi.st/2DXluK6 for samples and details.

20 min could save your company $1000's in fines. Call us today and we will walk you through it, 1-800-362-2809.

We have also included important information regarding CMS reporting in the newsletter and on our website at www.abm360solutions.com

We are happy to introduce 360 solutions a new a la carte platform providing various services: :

Introducing ABM 360

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to covered employees qualifies as "performance-based compensation." That is because, before the Tax Reform Act, performance-based compensation was excluded from the $1 million calculation and thus was fully deductible no matter the amount. The Tax Reform Act has made three significant changes for compensation paid for fiscal years that begin January 1, 2018, or later:

· Changing the definition of "covered employee" – A "covered employee" will now be anyone who has ever been the CEO, CFO or one of the three most highly compensated officers, starting with the fiscal years beginning after December 31, 2016. Thus, the new rule is essentially "once a covered employee, always a covered employee."

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· Eliminating the exception for performance-based compensation – Performance-based compensation is no longer exempt from the $1 million deduction limit. Thus, all performance-based compensation, including performance share units, stock options and annual bonuses, will now be subject to the $1 million deduction limitation, unless grandfathered (as explained below).
· Expansion of entities subject to Code Section 162(m) – Application of the rule is no longer limited to corporations that issue a class of common equity securities required to be registered under Section 12 of the Securities Exchange Act. The rule now also covers entities required to file pursuant to Section 15(d) of the Securities Exchange Act.

Note, however, that the changes described above do not apply to remuneration paid pursuant to a "grandfathered" arrangement, which is defined as a written binding contract that was in effect on November 2, 2017, and has not been modified in any material respect on or after such date.

More detail on these rules is discussed in the newsletter published by our Executive Compensation team and will be covered in an upcoming webinar

2. There are Big Changes to Executive Compensation Rules Applicable to Nonprofit Entities.

As a result of the Tax Reform Act, recruiting and retaining executive talent will be more costly for nonprofit entities. Specifically, beginning in 2018, nonprofit entities will be subject to limitations (and penalties) similar to those faced by publicly held companies under Code Section 162(m) and Code Section 280G:

· An annual 21 percent excise tax will be imposed on a nonprofit employer with respect to current and vested deferred compensation in excess of $1 million paid to the entity's five highest paid employees (covered employees). As with the new rules under Code Section 162(m), once an employee is treated as a covered employee for this purpose, he or she will remain in the covered group – "once a covered employee, always a covered employee."
· In addition, a 21 percent employer excise tax will apply if a nonprofit employer pays "parachute payments," which generally refer to payments that are triggered by a covered employee's separation from employment and exceed three times the employee's average compensation over the most recent five years. Note, however, that the excise tax itself will be imposed with respect to compensation that exceeds one times the employee's five-year average compensation (similar to Code Section 280G).

While certain exceptions could apply, the Tax Reform Act's new changes may put nonprofit entities at a disadvantage vis-à-vis for-profit companies when recruiting and retaining top talent.

More detail on the new excise tax, along with other Tax Reform Act changes that will affect nonprofit employers, will be covered in an upcoming webinar on January 17 (Register Here).

3. The Changes to Retirement, Welfare, and Fringe Benefit Rules Are Less Significant Than Expected.

Although there was a lot of press coverage about potential changes impacting employer-provided retirement, welfare, and fringe benefits, the reality is that the final version of the law did not make any sweeping changes in this area. For example, there will not be a mandatory "Rothification" of retirement plan contributions, dependent care flexible spending accounts will not be eliminated, and the employer shared responsibility provisions under the Affordable Care Act (ACA) are still in effect.

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Notwithstanding that this was much ado about (almost) nothing, nearly all employers, including public, private, and nonprofit, should note that the following changes were made

· Individuals now have more time to make loan offset deposits to IRAs and eligible retirement plans;
· Certain retirement plan withdrawals received in connection with a qualifying 2016 disaster are eligible for additional relief;
· The ACA's individual mandate is effectively eliminated; and
· There are new limitations on the tax treatment of certain employee fringe benefits.

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ERISA class action settlements reach almost $1 billion

Class action lawsuit settlements skyrocketed this past year, with a record $2.72 billion paid by employers for litigation that pertained to employment discrimination, wage hours, ERISA statutory and government enforcement cases, according to Seyfarth Shaw's Workplace Class Action Litigation Report for 2018.

Of the $2.7 billion in total settlements, $927.8 million came from ERISA cases. From the 1,408 cases evaluated, Seyfarth Shaw has identified key trends within the past ERISA cases that employers need to watch for in 2018.

There were two primary trends in ERISA class action litigation in 2017. The first was the U.S. Supreme Court issued a significant decision relating to the parameters of what is known as the church plan exemption to ERISA.

ERISA generally requires private companies' defined benefit pension plans to satisfy funding rules. Typically, the plan must be at least 80% funded to avoid special penalties and limitations.

These rules do not apply to state or local governments or churches. In 1980, Congress added language to pull certain church-affiliated organizations into the definition of "church" for funding purposes.

In the Advocate Health Care Network v. Stapleton case on June, 5 2017, the Supreme Court's ruling determined that pension plans that otherwise meet the definition of a church plan under ERISA can qualify for the exemption without being established by a church.

The decision was the culmination of a wave of ERISA class actions brought by employees of religiously affiliated non-profit hospitals who asserted that the employers improperly claimed their pension plans were ERISA-exempt church plans.

Although the decision settled one of the major questions in church plan litigation, a second wave of

The secret of a good sermon is to have a good beginning and a good ending; and to have the two as close together as possible
-George Burns

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these cases may be starting as the plaintiffs' action bar attempts to challenge the religious bona fides of these principal purpose organizations.

The second trend in ERISA class action litigation for 2017 was the plaintiffs' class action bar filed an influx of new 401(k) and 403(b) fee and investment lawsuits against various employers, with a particular concentration on institutions of higher education.

The university ERISA lawsuits challenge the design model of their 403(b) retirement plans, and the payment of allegedly excessive fees for record-keeping and administrative services. Many of these cases remain active and rulings are expected throughout 2018. Corporate counsel can also expect to see further litigation regarding the reasonableness of 401(k) and 403(b) plan fees and expenses in the numerous class action lawsuits pending around the country on these issues.

Potential confusion:
Courts are likely to continue to grapple with the complicated and intertwined issues related to who has standing to bring claims under ERISA and when those claims accrue.

In the health and welfare space, plan sponsors can expect some potential confusion if Congress and the Trump Administration continue to take up the repeal and replace of the ACA. Employers have spent years preparing for and then implementing the ACA. The potential changes again to health coverage may cause some complications among plan participants, which could lead to an increase in class action litigation if the participants remain unsure about their applicable coverage for various benefits.

Various network providers have challenged the reimbursement rates from insurers and plans, dragging both administrators and plans into numerous litigation matters. Given the uncertainty in the future of the ACA and the continuing disputes between insurers and out-of-network providers, it is anticipated that this variety of class action litigation will increase in 2018, according to Seyfarth Shaw's Workplace Class Action Litigation Report.

A fight in the courts is expected regarding the DOL's recently issued final regulations on disability plan administration. These regulations change the landscape for the handling of disability claims through the frequently offered long-term disability benefits. These regulations are apt to be challenged in the courts, given their sweeping and onerous changes. Insurers and plan sponsors need to watch the litigation and its potential results closely. If the regulations do go into effect, plan administrators will need to closely examine them to ensure compliance. Additionally, the implementation of these regulations could spur class action lawsuits and DOL enforcement actions if they are not handled appropriately on a plan basis. You or your company may want to consider Directors & Officerscoverage and Employment Practices Liability Insurance (EDLI) for protection.

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8 Things to Know About Telehealth for 2018

In 2017 we saw an evolution in how employees are seeking care.

Aligned with a recent National Business Group on Health study that indicates that 96% of large employers are now offering some level of telehealth benefits today, more and more employees were engaging with telehealth in 2017 and learning firsthand that they could receive quality care while saving time and money.

Consider that it was only four years earlier, in 2013, when the National Business Group on Health/Towers Watson survey of large employers showed just 23% of large employers implementing telehealth.

With this rate of change, it leaves many – including benefits brokers and employers – wondering what to expect in 2018. Read on, for eight predictions for virtual care delivery in 2018:

1. Telehealth grows up, and it's powerful.

While many are now familiar with the role telehealth for treating episodic needs like cold & flu and upper respiratory infections, in 2018 we will see expansion to a more comprehensive virtual care delivery platform that will grow in breadth to include a full spectrum of medical conditions, ranging from episodic needs, to behavioral health and chronic, complicated medical conditions like heart disease and cancer. Also expect expansive clinical services ranging from expert second opinions to the use of artificial intelligence and predictive analytics to proactively identify patients in need of intervention.

2. Payers raise expectations, unlocking the full value of virtual healthcare delivery.

It's no secret that today's healthcare system is focused on value. Payers in particular will be looking to maximize value from telehealth, seeking not just financial savings, but increased engagement and satisfaction, and improved health outcomes. Thanks to advancements in technology and in data and analytics, the value of virtual care delivery will accelerate in 2018.

3. Utilization takes center stage as digital health adoption approaches mainstream.

90% of adults under the age of 65 have smartphones today, and 2/3 of Americans either have or are open to using mobile health apps to manage their health. As more employees become aware of telehealth through innovative marketing strategies, mobile technology will drive engagement and utilization, especially as vendors focus on delivering patient-centric systems.

4. Virtual healthcare delivery tackles the largest cost drivers. Finally.

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Diagnosing and treating chronic conditions is expensive and eats up approximately 84% of health care dollars in the U.S. alone.

In 2018 virtual care delivery will address the rising impact of chronic and complex conditions through a combination of analytics that pinpoint care needs, cognitive computing to support accuracy of diagnosis and treatment planning, and virtual access to specialists on a hyper-personalized basis for patients.

5. Mental health is part of the conversation. Organizations take action.

Shortages of mental health providers will persist, and to address that need, telebehavioral health will grow in popularity. Employees who need care will not only be able to overcome geographical barriers, but also the stigma that has too often been attached to mental health.

6. Health systems embrace telehealth (at scale).

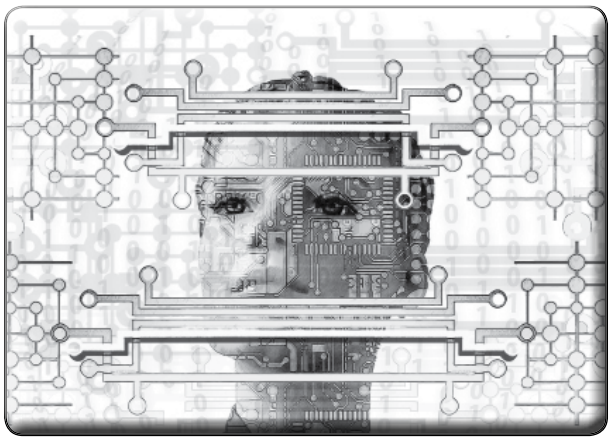
2017 was a momentum-building year for telehealth, as health systems increasingly added and expanded its use to deliver on their operational objectives. By December 2018, it is estimated that 76% of health systems will have implemented, or be in the midst of implementing, consumer telehealth to help reduce financial risks and provide more value to their patients .

7. Data security is front and center, as connected care accelerates.

Securing sensitive health data takes on new importance as consumers' devices increasingly become the conduit of health information. There will be an even greater need for strong third-party validation of a telehealth provides' ability to meet health care regulations and requirements for securing protected member and client health care information.

8. Artificial Intelligence + Medical Excellence = High-Quality Care.

The next big thing in healthcare is no doubt, artificial intelligence (AI). As AI helps guide decisions on care, the healthcare world in 2018 will increasingly need to remain focused on quality of the data that goes in and the experts that interpret what comes out.



Set to be a landmark year in virtual care delivery, 2018 will bring consumers a new level of value, access and quality. To get a glimpse of the magnitude of the reach of virtual care, consider that Teladoc has reported completing more than 5,000 virtual health visits in just one day – that is equal to the total number of patients seen in one day by the country's five largest hospital emergency departments combined. Employers evaluating their benefits spend will undoubtedly hear more about the virtual care boom and brokers who know what is coming will be best poised for the next evolution of telehealth coming their way.

Most commercial plans in the market include benefits for Telehealth. If you or your employees have questions regarding the Telehealth option, call us at 1-800-362-2809.

Medicare Premiums Increase for Many Retirees in 2018

Most of the Social Security cost-of-living adjustment will be used to pay for higher Medicare Part B premiums.

The standard Medicare Part B monthly premium will be $134 in 2018, the same amount as in 2017. But many retirees who have been paying less than the standard rate for the past several years will see a jump in their premiums. Here's a look at how much you can expect to pay for Medicare Part B premiums in 2018.

Held harmless. Medicare Part B payments are prevented by law from reducing Social Security payments by Social Security's "hold harmless" provision. Social Security recipients didn't get a cost-of-living adjustment in 2016 and only received a very low 0.3 percent cost-of-living adjustment in 2017, so they continued to pay premiums that were less than the standard rate charged to new enrollees and other people not protected by Social Security's "hold harmless" rule. Now that Social Security beneficiaries will receive a 2 percent cost-of-living adjustment in 2018, much or all of the gain may go toward Medicare Part B premiums. "Part B enrollees who were held harmless in 2016 and 2017 will see an increase in the monthly Part B premium from the roughly $109, on average, they paid in 2017," according to a statement from the Centers for Medicare and Medicaid Services.

The CMS estimates that 42 percent of Medicare Part B beneficiaries will see their Medicare premiums grow to $134 because the cost-of-living adjustment to their Social Security benefit will be greater than or equal to the amount that is necessary to increase their Medicare premium to the standard rate. "The majority of people who were protected by hold harmless will see a fairly significant increase in their premiums. That's because their Social Security cost-of-living adjustment is large enough to cover the Medicare increase," says Tricia Neuman, director of the Program on Medicare Policy at the Kaiser Family Foundation. "For some, it will take up the full income from their Social Security cost-of-living adjustment." However, CMS estimates that about 28 percent of Part B enrollees will continue to pay less than the full monthly premium of $134 because the increase in their Social Security benefit will not be large enough to cover the full Medicare Part B premium. "The hold harmless provision is designed to protect people so that the Part B premium doesn't result in a reduction in the Social Security check," Neuman says.

The standard rate. Retirees who newly enroll in Medicare in 2017 or 2018 pay the standard monthly premium of $134 per month. Those who signed up for Medicare without claiming Social Security benefits or who are directly billed for their Medicare Part B premium also pay the standard rate. Low-income retirees who are eligible for both Medicare and Medicaid generally have their premiums paid by state Medicaid agencies. Medicaid pays the standard premium on behalf of the qualifying beneficiary.

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High-income retirees. Retirees with high incomes are required to pay more for Medicare Part B. Those with an income that exceeds $85,000 as an individual or $170,000 for married couples have $53.50 added to their monthly rate for a total premium of $187.50. Seniors with retirement income between $107,000 and $133,500 ($214,000 to $267,000 for couples) must pay $267.90 per month for Medicare Part B in 2018, and monthly premiums further increase to $348.30 per month for retirees bringing in between $133,500 and $160,000 ($267,000 to $320,000 for couples). Wealthy retirees with incomes above $160,000 ($320,000 for couples) must pay $428.60 per month for Medicare Part B.

Late enrollees. You first become eligible to sign up for Medicare Part B during the months around your 65th birthday. If you sign up later, and you weren't covered by a group health insurance plan through your or a spouse's job while you delayed enrolling, you will be charged a 10 percent late enrollment penalty for each 12-month period you were eligible for Medicare Part B but delayed enrolling. For example, if your initial enrollment period ended on September 30, 2015, but you don't sign up for Medicare Part B until March 2018, your premiums will be 20 percent higher for the rest of your life due to two full years of delayed enrollment. In this case, the late enrollment penalty would increase the 2018 premium from $134 to $160.80 per month. "Some people miss their enrollment period, and unless they are covered by active employment, they will get a penalty," says Leslie Fried, senior director of the Center for Benefits Access at the National Council on Aging. "If you are five years late and you didn't have other insurance through active employment, then you could be hit with an additional 50 percent penalty."

Crystal Calaway

If you have any questions regarding Medicare for your employees, contact Crystal Calaway or Stevan DeLosSantos at 1-800-362-2809.

We have the ability to establish or recreate a Medicare Retirement plan for you and your employees that have access to Medicare Benefits. In most cases, we can establish plans that reduce your cost and provide your employees with greater benefits.

Stevan DeLosSantos

Meet Some of Our Group Health Experts

Michelle Vincent

Michelle has worked in the Employee Benefits Industry for several years handling enrollments for large employer groups. She is very detailed oriented with the "Can Do" attitude our clients expect from our organization.

Lily Moreno

Lily has worked for ABM for several years and has obtained her Group 1 license. She assist our Group Health department and is bilingual, speaking English and Spanish.

Medicare Part D Disclosures due by March 1, 2018 for Calendar Year Plans

Group health plan sponsors are required to complete an online disclosure form with the Centers for Medicare & Medicaid Services (CMS) on an annual basis and at other select times, indicating whether the plan's prescription drug coverage is creditable or non-creditable. This disclosure requirement applies when an employer-sponsored group health plan provides prescription drug coverage to individuals who are eligible for coverage under Medicare Part D.
The plan sponsor must complete the online disclosure within 60 days after the beginning of the plan year. For calendar year health plans, the deadline for the annual online disclosure is March 1.

ACTION STEPS
To determine if the CMS reporting requirement applies, employers should verify whether their group health plans cover any Medicare-eligible individuals at the start of each plan year.
Employers that are required to report to CMS should work with their advisors to determine whether their prescription drug coverage is creditable or non-creditable. They should also visit CMS' creditable coverage website, which includes links to the online disclosure form and related instructions.

Medicare Part D Disclosure to CMS
Group health plan sponsors are required to disclose to CMS whether their prescription drug coverage is creditable or non-creditable. This disclosure is required regardless of whether the health plan's coverage is primary or secondary to Medicare.

A group health plan's prescription drug coverage is considered creditable if its actuarial value equals or exceeds the actuarial value of the Medicare Part D prescription drug coverage. In general, this actuarial determination measures whether the expected amount of paid claims under the group health plan's prescription drug coverage is at least as much as the expected amount of paid claims under the Medicare Part D prescription drug benefit. The determination of creditable coverage does not require an attestation by a qualified actuary, except when the plan sponsor is electing the Retiree Drug Subsidy (RDS) for the group health plan.

If an employer's group health plan does not offer prescription drug benefits to any Medicare Part D eligible individuals (including active employees, disabled employees, COBRA participants, retirees, and their covered spouses and dependents) as of the beginning of the plan year, the group health plan is not required to submit the online disclosure form to CMS for that plan year.

Also, a plan sponsor who has been approved for the RDS is exempt from filing the CMS disclosure notice with respect to those qualified covered retirees for whom the sponsor is claiming the RDS.
Timing of Disclosures to CMS

The disclosure must be made to CMS on an annual basis and whenever any change occurs that affects whether the coverage is creditable. More specifically, the Medicare Part D disclosure notice

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must be provided within the following time frames:

- Within 60 days after the beginning date of the plan year for which the entity is providing the disclosure to CMS;
- Within 30 days after the termination of a plan's prescription drug coverage; and
- Within 30 days after any change in the plan's creditable coverage status.

Online Disclosure Method

Plan sponsors are required to use the online disclosure form on the CMS creditable coverage website. This is the sole method for compliance with the disclosure requirement, unless the entity does not have internet access.

The disclosure form lists the required data fields that must be completed in order to generate the disclosure notice to CMS, such as types of coverage, number of options offered, creditable coverage status, period covered by the disclosure notice, number of Part D-eligible individuals covered, date the creditable coverage disclosure notice is provided to Part D-eligible individuals, and change in creditable coverage status.

CMS has also provided instructions for detailed descriptions of these data fields and guidance on how to complete the form.

Disclosures to Individuals

In addition to the annual disclosure to CMS, group health plan sponsors must disclose to individuals who are eligible for Medicare Part D whether the plan's prescription drug coverage is creditable. At a minimum, creditable coverage disclosure notices must be provided to individuals at the following times:

1 Prior to the Medicare Part D annual coordinated election period—beginning Oct. 15 through Dec. 7 of each year
2 Prior to an individual's initial enrollment period for Part D
3 Prior to the effective date of coverage for any Medicare-eligible individual who joins the plan
4 Whenever prescription drug coverage ends or changes so that it is no longer creditable or becomes creditable
5 Upon a beneficiary's request

For online submittals, please visit CMS at http://go.cms.gov/YOWviX

If the creditable coverage disclosure notice is provided to all plan participants annually, before Oct. 15 of each year, items (1) and (2) above will be satisfied. "Prior to," as used above, means the individual must have been provided with the notice within the past 12 months. In addition to providing the notice each year before Oct. 15, plan sponsors should consider including the notice in plan enrollment materials provided to new hires.

CMS has provided model disclosure notices for plan sponsors to use when disclosing their creditable coverage status to Medicare beneficiaries.

For complete details and information call us at 1-800-362-2809 or visit http://bit.ly/2rSbL2M.

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" I would like you to know that Crystal is awesome and is so good at explaining all the insurances until I understood exactly what I wanted and needed. I'm so glad that I called her today and got my part F and D.
-Judy E.

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