COWDEN
2016 Celebrating our 20 Year Anniversary

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COWDEN TIMES

Inside This Issue

Cowden News

Understanding the Cost of Health Care in Retirement

Many employers today provide access to planning tools and financial advisers to assist employees in maximizing their retirement wealth to provide for a comfortable post-work lifestyle.

These tools and services are absolutely necessary for employees. However, there are other major factors that are often overlooked, namely:

- Out-of-pocket health-care costs and migrating through the complicated world of Medicare.
- Optimization of Social Security in order to maximize benefits.

Without a thorough understanding of these issues, there could be a devastating impact on retirement wealth.

Health-care costs can have a significant impact on when you take retirement and apply for Medicare. That being said, individuals must remember that Medicare does not cover dental, hearing, vision, podiatry and long-term (custodial) care.

For example, a 65-year-old Ohio couple retiring today and living to age 90 can expect to pay almost $475,000 in health-related costs throughout retirement. This is a healthy couple with no supplemental coverage earning the minimum before income penalties are levied and residing in a state that represents the national average for health-care costs. Now, back up one decade and that couple is 55. When they retire in 10 years, they can expect to pay more than $800,000 for the same coverage.

Decisions will need to be made whether an individual will apply for original Medicare (Parts A and B or Parts A, B and D) or choose to pay for a Medicare

Advantage Plan or even a MediGap policy. There are significant differences in plan design and doctor access when choosing a Medicare Advantage Plan.

Premiums for Medicare Parts B and D can be affected by an income means test, with higher incomes equaling higher premiums. (Higher income is representative of Social Security, pensions, wages,401(k)s, annuities, capital gains, dividends, municipal bonds and rental income.) These premiums are also subject to state of residency with rates fluctuating drastically among states.

Table 1 Projected Health-Care Costs for 55-Year-Old Couple Planning to Retire at 65

	Basic Medicare Coverage	New State, Higher Income, MediGap
Age	55 (retiring at 65)	
State of Residency	MA	FL
Income	Under $170,000	$170,000-$214,000
Health	Tom (Type 2 Diabetes) Nancy (Healthy)	
Life Expectancy	Tom (77) Nancy (90)	
Coverage	Medicare A, B, and D	A,B,D + MediGap
Total Cost	**$464,800**	**$734,985**

Employees need to be cognizant of their planned retirement age versus full-retirement age (FRA) and how waiting a few years can increase their retirement wealth.

It is very difficult for employees and spouses to determine when to retire and what methods of filing for Social Security should be utilized to maximize their benefits. And, it becomes much more complicated for married couples.

Individuals who choose to retire before FRA will see a reduction in their Social Security benefits. For example, those retiring at age 62 will see a 25% reduction in

their Social Security benefits. Meanwhile, those who retire at age 70 will see a 32% increase in their benefits.

Table 2 Monthly Payments Based on Age Beginning Social Security

Age	62	63	64	65	66	67	68	69
Monthly Benefit Paid	$1,200	$1,280	$1,387	$1,493	$1,600	$1,728	$1,856	$1,984
% of PIA Paid	75.0%	80.0%	86.7%	93.3%	100%	108%	116%	124%

Additionally, employees need to understand life expectancy and how that can impact their retirement planning. The average life expectancy is 78.6 years for women and 76.3 years for men. These figures can vary greatly depending upon health conditions.

Cowden Associates Inc. offers the Retirement Comprehensive Cast service developed to provide missing elements of financial planning and aid employers in equipping employees with the tools and services necessary to maximize their retirement lifestyle.

About the Author

Elliot N. Dinkin is president/CEO of Cowden Associates Inc.

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Cowden Associates Participated in the 2016 Pittsburgh MS Walk

On April 17, 2016, Cowden Associates participated in the 2016 Multiple Sclerosis (MS) Walk in Downtown Pittsburgh. The team consisted of five employees and seven friends. A total amount of $2,165 was raised to donate to the charity.

Cowden Associates would like to thank all those who generously made a donation!

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Cowden Associates Exceeds Goal on WQED-FM Challenge

On April 12, 2016, Cowden Associates participated in the WQED-FM Challenge. Participation included snippets throughout the 8:00 a.m. – 9:00 a.m. hour from Elliot Dinkin, president of Cowden Associates.

We are pleased to announce that we were able to exceed our goal! If you were unable to listen in, you can access the full interview with Elliot Dinkin here.

Cowden Associates would like to thank all those who generously made a pledge or donation!

WQED changes lives by creating and sharing outstanding public media that educates, entertains, and inspires. It is the parent company of WQED-TV (PBS); WQED Create; WQED WORLD; WQED Showcase; Classical WQED-FM 89.3/Pittsburgh; Classical WQEJ-FM 89.7/Johnstown; the Pittsburgh Concert Channel at WQED-HD2 (89.3-2FM) and www.wqedfm.org; local and national television and radio productions; WQED Interactive (www.wqed.org) and iQ: smartmedia, WQED's Educational initiative (www.wqed.org/edu).

Cowden Associates, Inc. would like to thank you in advance for your support.

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Industry News

PBGC Issues Final 4010 Reporting Rule

On March 22, 2016, the PBGC published a final rule amending prior regulations related to Annual Financial and Actuarial Information Reporting, often referred to as 4010 reporting. The final rule has made some significant changes to prior reporting rules, and extends the reporting requirement to more plans where organizations have at least 500 participants in defined benefit plans.

Reporting is generally required on a controlled group basis if:

1. There is any defined benefit plan with a Funding Target Attainment Percentage (FTAP) less than 80%, and
2. Total underfunding of greater than $15 million in the aggregate for all defined benefit plans in the controlled group.

Under prior rules, the 80% test was performed without reflecting pension funding stabilization legislation, and the $15 million aggregate test was performed using interest rates modified by stabilization.

Under the revised rules, the 80% FTAP test remains unchanged, but the $15 million aggregate underfunding test will be required to use interest rates that do not reflect pension funding stabilization. At present, and in near future, there is a large spread between these two sets of interest rates, and the new $15 million test will be much harder to pass for sponsors of larger plans since the interest rates without stabilization are much lower.

In addition, the PBGC has provided a waiver for small controlled groups such that 4010 reporting will not be required if the count of defined benefit plan participants in the controlled group is under 500, regardless of the amount of underfunding.

These final rules go into effect for information years (generally, a controlled group's fiscal year) beginning after December 31, 2015, meaning the earliest deadline any group would be required to report under the new rules is April 17, 2017.

4010 reporting requirements are significant and can be costly and time consuming for both sponsors and their advisors, and unfortunately, the reporting provides no benefit to the sponsor. Sponsors of plans where 4010 reporting is required may wish to work with their actuary or other plan advisors to determine whether or not there are additional contribution scenarios that may be worth examining to avoid the reporting requirement. This may also include participant reduction strategies such as lump sum windows or annuity purchases for plans in controlled groups close to the 500 participant threshold.

For more information please contact:

David Weaver, FSA, EA, MAAA

Senior Consultant and Actuary

Ph: 412-394-9992; Email: davidw@cowdenassociates.com

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Unbreaking the Bank: 3 Tax-Exempt Benefits to Boost Employee Satisfaction

With tax season currently in full swing, many employers likely have exemptions on the brain. In addition to the numerous tax considerations, employers may also be considering ways in which to improve their benefits and compensation packages - particularly with the ever-competitive job market. Acquiring and retaining good talent is very important to the success of a business, but turning the organization inside-out financially in order to create adequate rewards is not the way to achieve this.

Because it can be seemingly difficult to discover this delicate balance of quality benefits and cost efficiency, consider these three great tax-exempt benefits that could potentially make great additions to any organization:

Health Savings Account (HSA): HSAs have been around since 2003 and were put in place so that individuals who fell under high-deductible insurance plans could have a way to set aside tax-free money from their paychecks in order to put towards any medical expenses. According to a study performed in 2013, ten years after rolling out the program, over 10 million HSA accounts had been created in the U.S. - and 70% of them were opened from 2011 on. So clearly, the attraction to this benefit is there, and for employers looking to implement this program within their own benefits package, it's a win-win situation. Employer contributions to Health Savings Accounts are tax free (up to the qualified limit) and provides cost savings for the company by offering its employees more control over their healthcare.

Commuting benefits: In addition to health care coverage, another commonality between most employees, regardless of the company, is that they need to commute to work. Because of this, a pre-tax commuter benefit built into employees' compensation packages is a great way for employers to increase the appeal of those packages without breaking the bank. In fact, according to the ARRA, commuter benefits fall under the Qualified Transportation Fringe Benefits - which means that payroll taxes do not apply. Employees can reserve portions from their paychecks before tax, and up to $255 per month is counted as tax exclusion. These reserves can go towards public transportation passes, commuter vehicle maintenance, or even parking benefits.

Educational assistance: Given the astonishing rise in cost of higher education, employers who can manage to offer educational assistance (otherwise known as Tuition Assistance programs) to their employees are sure to dramatically improve their benefits package. Not only will a good portion of staff likely be interested (one survey found that of 53% of employees believed that additional education would be valuable to their jobs), but it also makes for a good investment in the organization as a whole. By providing employees the opportunity to develop skills and grow professionally, those gained skills will then be added back into the business. Additionally (and here's the monetary incentive bit), up to $5,250 of that educational assistance is tax-exempt.

Again, employee satisfaction is key to a company's success if it hopes to retain quality talent. In fact, companies with around 9 actively engaged employees to every 1 disengaged employee experience approximately 147% increase in earned profit shares. With this in mind, there are certainly ways to avoid crippling an organization's finances to help achieve this engagement through benefits packages - and there are certainly many more beyond this brief list.

For more information on how Cowden Associates can strengthen your own benefits plan, contact us today to learn more!

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IRS Reporting: Now What?

Applicable large employers and self-funded employers of all sizes have now completed the first round of required IRS reporting under the Patient Protection and Affordable Care Act (ACA). The ACA requires individuals to have health insurance, while applicable large employers (ALEs) are required to offer health benefits to their full-time employees. In order for the IRS to verify that:

1. Individuals have the required minimum essential coverage;
2. Individuals who request premium tax credits are entitled to them; and
3. ALEs are meeting their shared responsibility (play or pay) obligations;

employers with 50 or more full-time or full-time equivalent employees and insurers were required to report on the health coverage they offered. Similarly, insurers and employers with less than 50 full-time employees but that have a self-funded plan also have reporting obligations. All of this reporting is done on IRS Forms 1094-B, 1095-B, 1094-C and 1095-C.

Now that the first set of forms have been completed, many employers are wondering what the next steps are. Employers that did not fulfill all of their obligations under the employer shared responsibility provision (play or pay) might owe a penalty to the IRS. A penalty will be owed in regard to the 2015 plan year if:

- The employer does not offer health coverage or offers coverage to fewer than 70 percent of its full-time employees and the dependents of those employees, and at least one of the full-time employees receives a premium tax credit to help pay for coverage on a Marketplace; or
- The employer offers health coverage to all or at least 70 percent of its full-time employees, but at least one full-time employee receives a premium tax

credit to help pay for coverage on a Marketplace, which may occur because the employer did not offer coverage to that employee or because the coverage the employer offered that employee was either unaffordable to the employee or did not provide minimum value.

As of March 2016, the only information from the IRS on the payment of these penalties is as follows:

The IRS will adopt procedures that ensure employers receive certification that one or more employees have received a premium tax credit. The IRS will contact employers to inform them of their potential liability and provide them an opportunity to respond before any liability is assessed or notice and demand for payment is made. The contact for a given calendar year will not occur until after the due date for employees to file individual tax returns for that year claiming premium tax credits and after the due date for applicable large employers to file the information returns identifying their full-time employees and describing the coverage that was offered, if any.

If it is determined that an employer is liable for an Employer Shared Responsibility payment after the employer has responded to the initial IRS contact, the IRS will send a notice and demand for payment. That notice will instruct the employer on how to make the payment. Employers will not be required to include the employer shared responsibility payment on any tax return that they file.

Exchange Notification "Employer Notice Program"

The penalty is only triggered if an employee, who either was not offered coverage, or who was not offered affordable, minimum value, or minimum essential coverage, goes to the Exchange and gets a subsidy or "advance premium tax credit."

Although the IRS has not completely determined its system for penalty assessment, it does have a system to notify employers when one of their employees enrolls in Exchange coverage and is eligible to receive advance

payment of the premium tax credit. The Marketplace notice will identify the employee that is eligible for the tax credit, that this could trigger a penalty on the part of the employer, and that the employer may appeal the decision. Employers are strictly prohibited from retaliating against an employee for going to the Exchange or receiving a tax credit.

The IRS has a four-page Employer Appeal Request form, which must be submitted within 90 days of receipt of a Marketplace notice. The form asks for basic information about the employer, provides a place to identify a secondary contact, and asks for the employer to explain why they are appealing the determination that the employee is eligible for premium assistance.

Alternatively, the employer can send a letter requesting an appeal. An employer must submit an appeal with the following information:

- Business name
- Employer ID Number (EIN)
- Employer's primary contact name, phone number and address
- The reason for the appeal
- Information from the Marketplace notice received, including date and employee information

Employers must then mail the appeal request form and a copy of the Marketplace notice to:

Health Insurance Marketplace

Department of Health and Human Services

465 Industrial Blvd. London, KY 40750-0061

This appeal will not determine if the employer owes a fee, but could help prevent employees from erroneously obtaining an advance premium tax credit, which in

turn could provide the employer with information about whether or not it might owe a penalty. By preventing employees from incorrectly obtaining the advance premium tax credit, employers could lessen the chance of being asked to provide further information to the IRS to prove they met their obligations under the employer shared responsibility requirements.

Documentation

Employers should keep in mind that, in order to consider their offer of coverage affordable, they must meet the requirements of one of three affordability safe harbors. Affordability may be met under any of these criteria:

- The W-2 test, which requires that the employee's cost not exceed 9.5 percent (indexed) of the employee's income as reported in Box 1 of the W-2.
- The rate of pay method, which requires that the employee's cost not exceed 9.5 percent (indexed) of the lowest hourly rate paid to the employee, multiplied by 130 hours per month.
- The federal poverty line test, which requires that the employee's cost not exceed 9.5 percent (indexed) of federal poverty rate (or about $93/month for 2015).

In some rare instances an employer might meet the requirements of an affordability safe harbor, but based on unique factors in an employee's household, the employee will be eligible for premium assistance (a tax subsidy or an advance premium tax credit) because the coverage is not affordable in relation to their household income. This situation would not trigger a penalty for the employer, so long as it met the requirements of one of the three affordability safe harbors. As a best practice, employers should have documentation that their offer of coverage fulfilled the requirements of their chosen affordability safe harbor.

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Compliance Advisor: Same-Sex Marriage and Group Health Benefits

From 2013 to 2015, a series of Supreme Court cases and government updates have changed the landscape of the way employers must consider same-sex spouses in relation to employee benefits.

Most recently, in June 2015, the Supreme Court ruled in Obergefell v. Hodges ("Obergefell"), that the 14th Amendment requires a state to license a marriage between two people of the same sex, and to recognize a marriage between two people of the same sex when their marriage was lawfully licensed and performed out of state. Prior to the Supreme Court's decision in Obergefell, approximately two-thirds of states recognized same-sex marriage (whether performed within the state or another state or country that recognizes same-sex marriage).

In February 2015, the Department of Labor (DOL) issued an updated definition of "spouse" under the Family and Medical Leave Act (FMLA) to make compliance easier, and defined "spouse" as a husband or wife, which refers to a person "with whom an individual entered into marriage as defined or recognized by state law." The governing state law is that of the celebration state, or where the marriage took place. This definition was set to go into effect across the United States on March 27, 2015, but litigation in Texas, Arkansas, Louisiana, and Nebraska prevented the new rule from going into effect in those states immediately. After the ruling in Obergefell, which severely undermined the arguments of the objecting states, the injunction was dissolved.

In June 2013, the Supreme Court ruled that the Defense of Marriage Act (DOMA), which provided that, for federal law purposes, marriage could only be between a man and a woman, was unconstitutional.

Implication for Employers

For individuals with a same-sex spouse (validly married in a state allowing same-sex marriage) who reside in a state that did not previously recognize same-sex marriage, the ruling in Obergefell likely triggered a change in status event for Section 125 plans. That is because, as of June 26, 2015, the individual was considered married under state law, whereas they were not the day before.

As a result of these changes, employers need to review the eligibility requirements in their group life and health plans, Section 125 plans, and health reimbursement arrangements. The Employee Retirement Income and Security Act (ERISA) requires employers to administer their plans according to the terms of the plan, which means that the plan's definition of a covered spouse is key. A plan that covers "spouses" or "lawful spouses" must offer coverage to same-sex spouses.

Opinions differ as to whether an employer may continue to write its self-funded plans to exclude same-sex spouses. To date there is only one court case that addresses this issue – in that case, the court held that a self-funded plan that specifically limited eligibility to opposite-sex spouses was not required to provide coverage to a same-sex spouse because ERISA does not prohibit discrimination based on sexual orientation. Roe v. Empire Blue Cross Blue Shield, No. 12–cv–04788 (NSR), 58 EBC 1077, 2014 WL 1760343 (S.D. N.Y. May 1, 2014). An employer that wishes to limit coverage under its Section 125, health reimbursement arrangement (HRA), or group health plan to opposite-sex spouses should:

- Verify that the plan and summary plan description are written to clearly limit eligibility to opposite sex spouses.
- Check their state and local laws to be sure that there is not a state or local law that prohibits discrimination based on sexual orientation.
- Recognize that there is a risk that this decision will be challenged by the Equal Employment Opportunity Commission or an employee.

However, self-funded plans that cover opposite sex spouses and do not cover

same-sex spouses have high exposure to individual lawsuits. Section 510 of ERISA prohibits discrimination against participants and beneficiaries for exercising rights under an ERISA plan, or for interfering with such rights. Lawsuits on the basis of violating an individual's civil rights are also a possibility.

Most practitioners agree that fully insured plans are required to cover same-sex spouses. Employers should contact their carrier to verify this approach.

The IRS has issued Frequently Asked Questions that employers and employees may find helpful. The questions and answers that relate to benefits begin with Question 10.

Tax Treatment

The DOL, the Department of Health and Human Services (HHS), and the Internal Revenue Service (IRS) have issued several notices that explain how same-sex spouses must be treated for purposes of Section 125 plans, including flexible spending accounts (FSAs) and health savings accounts (HSAs). Specifically,

- A new same-sex marriage is a change in status event that allows a mid-year change to pre-tax and health and dependent care FSA elections consistent with the marriage.
- Expenses of the new spouse or dependent child may be reimbursed from the FSA or HSA from the date of the marriage.
- As of the date of the marriage, imputed income for covering the new same-sex spouse (who may have been covered previously as a domestic partner) ends.

The regulatory agencies only recognize actual marriages of same-sex spouses. This means, for example, that if an employer chooses to offer coverage to those in a civil union or domestic partnership, it still must impute income on the value of the partner's benefit.

FMLA Administration

In February 2015, DOL updated its definition of “spouse” for the Family and Medical Leave Act (FMLA) to assist employers and employees with compliance. Prior to the change, the law of the state in which the employee lives when FMLA is requested would apply. This means that an employee who was legally married to a same-sex spouse but who moved to a state that does not recognize same-sex marriages was not entitled to FMLA to care for the same-sex spouse. (FMLA generally would be available in connection with caring for the same-sex spouse’s children – in all states – because FMLA is available to anyone helping to raise a child.)

The change in definition defines “spouse” as a husband or wife, which refers to a person “with whom an individual entered into marriage as defined or recognized under state law.” The governing state law is that of the “celebration state” or where the marriage took place. Residency of the employee or the state of the employer will no longer have any bearing on the definition of “spouse” for purposes of FMLA. This change means that the same criteria for determining whether an employee is legally married will apply to both benefits and FMLA eligibility determinations.

The updated regulations will allow an employee in a same-sex or common-law marriage to take FMLA leave to care for a child of his or her spouse, or take care of a parent’s same-sex or common-law spouse. For individuals married outside of the United States, the regulations will also apply to any marriages that were legal in the country in which they were performed, as long as the marriage could be legally entered into in at least one state.

Employers may request “reasonable” documentation of a family relationship, but the request cannot interfere with an employee’s rights, and the employer cannot dictate what documentation must be presented. A simple statement by the employee may be sufficient, although the employer may request that a statement be put in writing.

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Webinars

Special Delivery: Providing Participant Materials for Group Health Plans

Group health plans have a variety of requirements relating to materials and notices that must be provided to participants. These requirements come from different places -- the Department of Labor, ERISA, the Patient Protection and Affordable Care Act (ACA), and more. Employers must not only ensure that participants are provided certain information and notices, but must ensure the timing and delivery of the information is appropriate. This webinar will help employers understand the materials and notices they are obligated to provide, who they must give them to, how they should deliver them, and when they need to be provided.

This webinar will:

- Explain the basics of participant material and notice requirements, including the Mental Health Parity and Addiction Equity Act (MHPAEA) Criteria for Medically Necessary Determination Notice, Women's Health and Cancer Rights Act (WHCRA) notices, Summary Plan Descriptions, Summary of Benefits and Coverage notice of modification, Summary of Material Modifications, grandfathered plan disclosures, and annual notices
- Discuss the requirements of paper delivery and explain which notices may be provided electronically, and the difference in electronic delivery requirements for employees who use computers as part of their jobs and those who do not
- Provide best practices on electronic disclosure consent, recordkeeping for the consent forms, and frequency of obtaining consent forms

- Explain how different delivery methods may be used for different groups of plan participants
- Discuss when notices or materials should be sent to both the plan participant and their covered spouse or children separately
- Explain why the Michelle's Law Enrollment Notice is outdated, but should still be included in plan documents for the time being
- Discuss why placing notices in employer common areas or providing a kiosk for employees to use to access notices is not adequate
- Discuss which documents and notices must be provided upon request, and the amount of time an employer has to provide requested documents

This 90-minute beginner to intermediate level webinar will help employers understand the rules regarding aggregated groups and how they can impact benefit plans.

Presenter

Monique Warren, Principal - Jackson Lewis LLP Monique Warren counsels employers on employee benefits compliance and administrative matters, drafts plan documents and employee communication materials, and represents employers to government agencies. Her expertise includes health and welfare plans as well as retirement plans. She has extensive experience helping group health plan sponsors navigate COBRA, HIPAA, and other ERISA and Internal Revenue Code provisions. She also has extensive experience helping retirement plan sponsors comply with ERISA fiduciary requirements and the Code's qualification requirements and correcting plan errors under the Department of Labor and Internal Revenue Service voluntary correction programs.

Starts: Tuesday, May 10, 2016 - 2:00 p.m.

Time Zone: Eastern Daylight Time

Cost Factor: Originally $149; Free access code can be obtained by contacting Kathy Colbert, Cowden Associates, Inc., Marketing and Communications Coordinator via email: kathyc@cowdenassociates.com, or by telephone: 412-208-0482

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Meet Our Team

Our team consists of 25 employees; each newsletter we take time to highlight some of our employees. To see our leadership team click here; to see all employees please click here.

Mike Stevens
Analyst

Why I Enjoy My Job: I am constantly placed in positions that allow me to learn and grow in my career.

Something Interesting About Me: I have seen the Dave Matthews band live in concert 28 times.

Lori Turner
Administrative Assistant

Why I Enjoy My Job: I enjoy the work/life balance my job offers.

Something Interesting About Me: I enjoy knitting.

Bob Crnjarich
Vice President, Retirement and Actuarial Services

Why I Enjoy My Job: I enjoy my job because of the various clients I've gotten to know both professionally and personally over the years.

Something Interesting About Me: I'm a scratch golfer and had the pleasure to personally meet Arnold Palmer!

Amy Crouse
Senior Analyst

Why I Enjoy My Job: I feel empowered to grow and pursue my professional and personal goals.

Something Interesting About Me: I do not fit the mold of a stereotypical risk-adverse actuary. I jump out of airplanes, zip line through forests, rock climb up and repel down cliff faces, ride my own motorcycle, and travel to third world countries on mission trips.

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About Cowden

Cowden Associates, Inc. (Cowden) is recognized as a leading independent compensation, health and benefits, and retirement consulting firm regionally, nationally and internationally. Cowden was established in 1996, bringing together seasoned professionals to provide client-focused advice designed to produce superior and measurable results to businesses, regardless of size or industry. Client industries include: financial institutions, governmental entities, healthcare, manufacturing, not-for-profit, school districts and Taft Hartley.

Cowden's exceptional interactive approach is what sets us apart from similar consulting firms. To deliver a tailored resolution to your specific needs, we first identify the overall attributes exclusive to your organization. We build an understanding of your organization by asking questions, observing and listening. In this manner you are not merely receiving a pre-fabricated answer, but rather a

unique solution for your circumstances.

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What's Dinkin Thinkin?

Elliot Dinkin is equally comfortable whether he is in a courtroom providing testimony or in a CFO's office providing strategic counsel. The 25-year plus veteran of the actuarial, compensation and employee benefits field continues to make his mark.

Today, as President and CEO at Cowden Associates, Inc., Elliot provides leadership to position the company at the forefront of the industry. You can learn more about changes in actuarial, benefits, management, and compensation policies from his blog, "What's Dinkin Thinkin?" or on Twitter, @ElliotDofCowden.

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Cowden View

PBGC: The Noble Robin Hood Reports it Needs to Steal More from Your Pension

On March 31st the Pension Benefit Guaranty Corporation (“PBGC”) released text of its report to Congress where it said it would need to steal money from healthy pension plans so it could take care of dying plans. It promised that the only way that it could stay afloat is to stuff its bags of money even fuller, and at a greater

rate of stuffing. Maybe it didn't use those exact words, but I chose to read between the lines.

- "PBGC projects that current premiums ultimately will be inadequate to maintain benefit guarantee levels."
- "It is more likely than not that PBGC's multiemployer fund will be exhausted by 2025…"
- "…PBGC is at risk of not having the funds to continue to pay benefits beyond the next decade…."

We all know that Robin Hood and his merry men stalked Sherwood Forest stealing from the rich and giving to the poor. Unfortunately the analogy of the PBGC as Robin Hood falls short on two key items….1) in this case, Robin Hood isn't stealing from the rich. He's stealing from the pension of the hard-working middle class American, and 2) he's not giving to the poor; he's keeping it himself so he can dole it out to the poor in small amounts.

Before you jump to the side of the indefensible hapless quasi-government agency against the offense of the cruel actuary, make sure you understand the degree to which Robin Hood wants to steal from you, the "rich". Currently multiemployer pension plans pay an annual premium to PBGC of $27 per person, which already more than doubled from the 2014 premium rate of $12. When the Pension Protection Act (PPA) became effective in 2008 the rate was $9 per person. Despite the fact that the current $27 rate is already indexed to increase with inflation, PBGC wants more money from the "rich". PBGC hinted in their report that premiums may need to reach $208 per person.

Let's create a scenario that isn't too hard to imagine. For the sake of example, you are a decent sized pension plan with 2,000 participants. You are reasonably well funded, and by that I mean your actuary (who should be me - shameless plug) has told you that long-term you're expected to be able to pay all promised benefits. There are certainly risks and financial strains along the way as every plan

faces….maybe a flat year in the market or a temporary lull in work hours or strains on other fringe benefits would keep you from being able to allocate any contribution increase to the pension plan. Well-funded doesn't mean 100% funded or risk-free, but it does mean that you as a Board are managing things well under the guidance of your hired professionals. Projections are that you will be in the green zone for a long time to come (even if you're not there right now.)

Under this scenario, during 2016 the pension plan would take $54,000 of the money set aside to pay pension benefits and give it to the PBGC. (That may be more than you pay any of your hired professionals for their advice.) Since you're well-funded, there is strong likelihood that you will never collect on this insurance coverage. PBGC insurance coverage isn't like other insurance, say car insurance. With car insurance, over a long enough time frame you'll almost certainly have a claim of some amount. Maybe you've gone 10 years with a clean driving record, but there's always the chance that when you step into the car the next time it will result in the insurance company having to pay a benefit.

But PBGC coverage is different - you either never have a claim, or your plan has run out of money and PBGC is (almost) permanently giving you money to pay benefits. And while that might sound appealing, they only pay benefits at a fraction of the level of previously earned benefits. (For a member with 30 years of service the maximum benefit is just over $1,000 per month.)

So continuing this example, you are paying $54,000 this year, even though you'll almost certainly never need the coverage. If rates were increased to $208 as the PBGC hinted, then this total premium would be $416,000.

So you can see how "rich" Robin Hood thinks you are.

Now let me be clear…I see no reason to believe that the PBGC is wrong in their calculations. They are most likely correct in their projections, since the financial condition of several extremely large plans and the burden they would put on the multiemployer program is well documented. I do not question the math behind the

calculations, nor do I question the dire warning sirens screaming of catastrophe.

I do, however, question the solution. Why is the solution to take increasing amounts of money from plans that are highly unlikely to default on their pension promise? Why is the solution to increase the cost of running the plan, instead of providing more money to actually pay benefits? Would it be beneficial for a legislative change that makes the PBGC system for multi-employer plans be more like that for single employer plans?

The solutions posed by the PBGC in their report are nothing short of theft from the membership and employers who pay for benefits in these plans. Raiding otherwise healthy plans to shift money to failing plans will only accelerate the downward spiral of the entire defined benefit system.

Even healthy multiemployer plans face enormous struggles. Countless situations are straining a pension plan's financial security – longer life expectancies, volatile investment markets, construction projects put on hold reducing the hours of work available, increasing healthcare costs, and more. Apparently the PBGC wants the premium level to be part of this list too.

It's likely that many plans that are currently failing were once healthy plans and have found themselves in the "poor" category for the reasons just mentioned. This is by no means the fault of the Board who oversees those plans. In fact, any Board can make the best preparations for a plan to thrive long-term yet find themselves just a few short years later in the midst of funding difficulties. PBGC needs to foster an environment that gets these plans back to self-sustainability instead of only promoting methods that lead to insolvency. How can Robin Hood get everyone walking through Sherwood Forest to come out the other side "rich" without continuing to take more and more from those already "rich"?

We are not even 10 years into a complete overhaul of the funding rules that determine how well a multiemployer pension plan is funded. Certainly it has been a rocky 10 years due to many issues - namely 2008 market losses, a lackluster

rebound in the job market, and interest rates that seem to hit new record lows each month. But I don't believe that this new legislation has been yet given the chance to prove itself as a useful fix to the pension system's funding problems.

We are also still waiting to see how effective the 2014 legislative changes will be. While controversial in that they allow for the reduction of benefits already in payment, the new options Boards were given through this legislation may prove to be options that not only save the plan, but also save the PBGC.

What if a better response to this PBGC looming bankruptcy is to get more money into the failing plans instead of money into the insurance system that can't keep them afloat? What if there was a reward (financial incentive) for being a well-funded plan, instead of the current system that really just allows for the avoidance of pain and headache of being poorly funded?

I'm not pretending I have a solution to the PBGC's funding situation. But I do propose that the solution is NOT to bankrupt every other pension plan for the sake of the a few mammoth plans. Being Robin Hood will only make it so that there are no more pensions, and that's who Robin Hood apparently calls the "rich".

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