COWDEN
2016 Celebrating our 20 Year Anniversary

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COWDEN TIMES

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Cowden News

President/CEO Elliot Dinkin Quoted in HealthcareDIVE Newsletter on the New DOL Overtime Rule

The Department of Labor's (DOL) final overtime rule, announced two weeks ago, raises the salary threshold to qualify for overtime from $23,660 to $47,476, affecting 4.2 million Americans. The salary threshold was last raised in 2004, and the recent ruling marks the first time overtime eligibility has been raised so drastically. Another first is the rule's provision to automatically update the threshold every three years, so employers will need to adopt a solid financial plan to accommodate these overtime changes.

Click here for full article

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Elliot Dinkin Quoted in Employee Benefit Advisor (EBA) on Microsoft/LinkedIn Acquisition

Microsoft's agreement to buy LinkedIn may help the software developer boost its HR technology presence while making the social network even more valuable to recruiters and other HR professionals, according to benefit professionals.

Microsoft, on Monday, announced the $26.2 billion planned purchase, which would be one of the largest-ever technology-industry deals. The software giant, in announcing the move, outlined a vision in which a person's LinkedIn profile resides at the middle of other pieces of their work life, connecting with Windows, Outlook, Skype, Office productivity tools such as Excel and PowerPoint, and other Microsoft products. Read more here

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Brad Rigby Quoted in the Post Gazette on Teamster Pensions Spared by the PBGC for the Time Being

Late in 2014, Congress quietly approved a scheme to prevent the insolvency of the federal program backing the pension benefits of about 10 million Americans.

The unprecedented idea was to permit distressed multiemployer pension plans backed by the Pension Benefit Guaranty Corp. to reduce pension benefits. That would put the plans on sounder footing and make them less likely to seek help from the PBGC, which faced a $42 billion deficit at the time. Since then, the PBGC's multiemployer plan deficit has grown to $52 billion.

Now the first pension plan to propose slashing benefits — the plan many say the legislation was designed for — has been prevented from doing that. Read the full

article here.

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Cowden Associates, Inc. Launches New Client-Focused Technology Solutions

Pittsburgh-based Cowden Associates, Inc., (“Cowden”) the leading independent actuarial, compensation and employee benefits consulting firm in the tri-state region has launched new Zywave client-focused technology solutions.

On May 17, 2016, Cowden announced the launch of new client-focused solutions through Zywave that enhances our ability to deliver best in class client-focused solutions and agency efficiency.
Cowden made the decision to invest in the Zywave’s solutions to enhance our client service delivery model. The introduction of the new technology means that Cowden will deliver:

- MyWave Connect – Client content that assists in solving real business problems
- Plan Doc Builder – Trusted ERISA materials to meet client needs

“We understand that our clients rely on us for more than just traditional services offered by most consultants,” said Lesa M. Votovich, vice president of health and benefits of Cowden. “As an organization, we began researching how we could deliver more information, more effective communication, and more impactful solutions to our clients. The introduction of this new technology into our agency practice is another innovative way for us to meet our clients’ needs and enhance the value of the consulting relationship.”

“Cowden has already begun using these new tools in an effort to drive immediate

results for our clients," said Elliot N. Dinkin, president/CEO of Cowden. "We are wholly committed to our clients and to delivering on our promise to provide meaningful value. Our investment in this new technology solidifies our vision to enhance our clients' continued ability to receive communication, compliance updates, loss management and stewardship reports to guide them in aligning their business objectives."

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Bob Crnjarich to Speak at the ISCEBS's 35th Annual Symposium

De-Risking Your Defined Benefit Pension Plan

Derisking is an important tool for effective management of defined benefit pension plans; however, they may take different forms. Employers may choose to retain all assets and liabilities by aligning a portion of the plan assets to a portion of the liability,or entirely eliminate the volatility, interest rate and longevity risk by transferring the assets to another party. They may also consider a lump-sum window. Defined benefit plans should be managed like a separate line of business with budgets, forecasts and a strategic plan. Ultimately, the plan is a use of cash and creates volatile liability and often causes negative consequences at the worst times in business cycles.

Takeaways

- Impact on benefit design, cost, risk management, cash flow, taxes, competitiveness and labor management
- Evaluation of investment strategies; impact of potential accounting

changes; and development of funding policies
- Considerations and examples for controlling costs/liability management

Speaker: **Robert Crnjarich,** Vice President, Retirement and Actuarial Services, Cowden Associates, Pittsburgh, Pennsylvania

Learn more about the ISCEBS Symposium here!

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Elliot Dinkin Featured in Healthcare Council of Western PA Briefing

Elliot Dinkin, president and chief executive officers of Cowden Associates, discussed how healthcare organizations can prepare for the implementation of the new overtime rule and estimate the impact of the rule. Learn more!

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Industry News

Shrinking Pension Plan Participation and PBGC Reportable Events

Are you administering a frozen defined benefit pension plan? If so, the number of plan participants who are actively employed will inevitably shrink as time passes. The Pension Benefit Guaranty Corporation (PBGC) requires that you monitor this active participant reduction and report the decrease if it meets certain criteria. This so-called “Active Participant Reduction” under PBGC regulation

section 4043 has been a reportable event for many years, but the PBGC implemented new reporting rules effective January 1, 2016.

The PBGC modified the rules to:

- Distinguish between reductions caused by single cause events and normal attrition.
- Craft waivers of the filing requirements so that plans that pose a low risk to the PBGC insurance system can avoid reporting.
- Provide longer periods to file after the event has occurred in some cases.
- Require electronic reporting.

The PBGC defines an **active participant** as one who performs work in the plan sponsor's controlled group and receives compensation for it, though special rules may apply. Some of these special situations include paid or unpaid leave, layoffs lasting less than 30 days, and regularly recurring employment reductions that happen annually or more frequently.

Active participant reduction monitoring involves three steps:

- Testing for a reduction event
- Determining the reduction category
- Identifying any filing waivers

Reduction Event Testing

A reduction event occurs if the number of active participants falls below (a) 75% of the number at the beginning of the prior plan year OR (b) 80% of the number at the beginning of the current plan year.

As an example, consider the Shrinking Pension Plan's active participant count as shown below. Midway through 2015, the Plan purchased annuities for certain

retired and terminated vested participants. This caused the total participant count to decline substantially, while the active count only declined by a handful of participants. As will be seen later, total participant counts have a bearing on whether reporting requirements may be waived.

	2016 Plan Year Event Check		**2017 Plan Year Event Check**	
Plan Year Beginning	**1/1/2015**	**1/1/2016**	**1/1/2016**	**1/1/2017**
Total Participants	108	60	60	60
Active Count	19	15	15	13
a) 75% of Count	14.25	n/a	11.25	n/a
b) 80% of Count	n/a	12	n/a	10.4
Greater of (a) and (b), rounded up	15		12	

Assume 2 active participants actually retire during 2016 and enter pay status. There would be a 2016 reportable event, and the active count declines to 13 by year end. Only two active participants leaving during 2017 would trigger an event for the 2017 plan year.If the active count falls below 15 during the 2016 plan year, a reportable event occurs. Only one active plan participant’s departure triggers an event for the 2016 plan year.

Reduction Event Category

Under the new regulations two different scenarios exist:

- First, if active participants leave due to a **single cause** then the plan administrator and a contributing sponsor must file a notice with the PBGC within 30 days after they know or have reason to know that the reduction occurred, unless a waiver applies. The PBGC gives examples of such causes as plan sponsor reorganization, layoffs, shutting down an operation, early retirement incentives, and natural disasters. Waivers are discussed later in this article.
- Second, **normal attrition**, such as retirements and terminations initiated by the employee, may cause an active participant reduction. The regulations permit accumulation of these through the plan year end and an extended period of time to file. If attrition triggers an event, the plan administrator and contributing plan sponsor must report it no later than the premium filing due date for the following year if no waivers apply.

For the Shrinking Pension Plan, normal attrition during 2016 triggered an active participant reduction measured on December 31, 2016, so the event must be reported by October 15, 2017, the 2017 plan year premium filing due date.

Electronic reporting will be required under either scenario in accordance with the instructions posted on the PBGC website. Failure to file can result in fines of up to $1,100 per day for each day late, but the PBGC assesses much smaller amounts starting at $25 per day based on considerations such as how quickly notice violations are corrected and the size of the plan involved.

Available Waivers

The new regulations provide four possible waivers of active participant reduction filing requirements:

- The small plan waiver. This depends on the total participant count for paying the PBGC flat rate premium for the plan year before the year of the reportable event. The count must be 100 or fewer to obtain the waiver.

In the example, for the active participant reduction that occurs in the 2016 plan year, the relevant count is 108 for the 2015 premium filing. The Shrinking Pension Plan could take advantage of this waiver in 2017 and in future years, but not for 2016.

- The "well-funded" plan waiver. This requires that no variable rate premium (VRP) was owed for the plan year before the year of the event. If the Shrinking Pension Plan owed no variable rate premium for 2015, it could use this waiver for a 2016 event.
- The "public company" waiver. Public companies that file SEC Form 8-K in a timely manner obtain this waiver if they disclose the event in the filing, but under an item other than "Results of Operations and Financial Condition" or in financial statements under "Financial Statements and Exhibit".
- The "low default risk" waiver. To use this option, the contributing plan sponsor and its highest U.S. parent must meet PBGC criteria on a "financial information date". That date begins a "safe harbor period" that can extend up to thirteen months. If the reportable event takes place during a plan year when the plan is in the safe harbor period, reporting is waived.

The PBGC waives reporting for certain terminating plans and for multiemployer plans.

Other Considerations

A reportable event might also trigger notice obligations to lenders or possibly a default under credit and other agreements that the sponsor or members of its controlled group may have with lenders and other parties. Plan sponsors should review such agreements.

In addition to the Active Participant Reduction rules, soft frozen pension plans must also monitor compliance with IRS Code Section 401(a)(26) Minimum Participation rules, where the plan must cover the lesser of 50 employees, or 40% of the total

employee group.

Keep in mind that the Active Participant Reduction is not the only reportable event under regulations. Of the list below, the last seven may require advance reporting.

- Failure to make required minimum contributions
- Inability to pay benefits when due
- Distribution to a substantial owner
- Change in contributing sponsor or controlled group
- Liquidation of a controlled group member
- Extraordinary dividends or stock redemptions
- Transfers of benefit liabilities (except for lump sum payments or annuity purchases)
- Application for a minimum funding waiver
- Loan default
- Insolvency or similar settlements

Waiver requirements vary for these other reportable events.

Please contact Cowden Associates if you have any questions, know or suspect that a reportable event has occurred and need assistance filing with the PBGC, wish to investigate the applicability of the waivers, or are concerned about Minimum Participation rules.

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Piecing Together A Pension Plan: A Cowden Case Study

Pension plans have easily become one of the more complex and difficult components of a company's compensation strategy. As pension costs continue to rise across most industries, maintaining a company retirement plan can often grow into an enormous burden for a company's executives.

Cowden Associates, Inc. has experienced firsthand the challenges that arise from these increases to a pension plan. One particular client, a community hospital, confronted these issues while also dealing with reduced Medicare reimbursements. Additionally, the hospital calculated its cash flow projections, which led to the understanding that its contributions would continue to rise without an emphasis on investment returns.

The hospital, realizing that the cost of maintaining their pension plan would continue to grow and be unpredictable in the future, found themselves in quite the pickle. As they contemplated their various options, they turned to Cowden for support and advice.

Developing a Strategy

Once the Cowden consultants were tasked with the duty of relieving the hospital's financial stresses, they began to assess how to do just that, and still serve the plan's participants. First the consulting team collated an analysis of the hospital's resources and specific needs. After some lengthy research into various options, the team finally recommended that the hospital freeze the pension plan entirely, and replace it with a new retirement vehicle: a competitive 401(k) plan.

After the hospital accepted this proposal, the plan's participants were told that their accruals would be frozen in the pension plan. The Cowden consulting team filed for plan termination that ultimately resulted in an immediate receipt of a determination letter. They proceeded to purchase annuities for current retirees, while also beginning the implementation of their new strategy by searching for and interviewing 401(k) vendors. Once they secured a vendor, they started the

transition activities that were relative to the new 401(k) plan.

The Cowden Difference

Because 401(k) plans are virtually self-sustaining, Cowden's team knew that the hospital would eventually no longer need their actuarial services once the plan was in place. Despite this though, they still made the recommendation and implemented the strategy because they knew it was the client's best solution.

It is this principle of serving the best interests of their clientele that differentiates Cowden Associates from other firms. These ethics also motivate the team of Cowden professionals and weave integrity and passion throughout their various projects.

It is this type of example that inspires companies of all industries and sizes to contact Cowden for assistance in planning their compensation, health and benefits, and retirement strategies. In the end, the hospital terminated their pension plan and the active participants could receive lump sum distributions. These distributions, in conjunction with 401(k) contributions from both the hospital and its employees, created a competitive and current retirement package that worked for everyone.

If you're ready to seek assistance in your organization's plans, contact Cowden Associates today.

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ACA Advisor: FAQs about the Patient-Centered Outcomes/Comparative Effectiveness (PCORI) Fee

Q1: What plans does the PCORI fee apply to?

A1: All plans that provide medical coverage to employees owe this fee. Medical

coverage includes preferred provider (PPO) plans, health maintenance organization (HMO) plans, point-of-service (POS) plans, high deductible health plans (HDHPs), and health reimbursement arrangements (HRAs).

The fee does not apply to:

- Stand-alone dental and vision plans (stand-alone means these benefits are elected separately from medical, or the benefits are provided under separate insurance policies from the medical coverage)
- Life insurance
- Short- and long-term disability and accident insurance
- Long-term care
- Health flexible spending accounts (FSAs), as long as the employee also is offered medical coverage and any employer contribution is (in most cases) $500 or less
- Health savings accounts (HSAs)
- Hospital indemnity or specified illness coverage
- Employee assistance programs (EAPs) and wellness programs that do not provide significant medical care or treatment
- Stop-loss coverage

Q2: Does the fee apply to all medical plans?

A2: Yes it does. There are no exceptions for small employers. There are no exceptions for government, church or not-for-profit plans. Grandfathered plans owe this fee. Union plans must pay the fee on their covered members.

Q3: Who must pay this fee?

A3: The fee must be determined and paid by:

- The insurer for fully insured plans (although the fee likely will be passed on to the plan)

- The plan sponsor of self-funded plans, including HRAs
  – The plan's TPA may assist with the calculation, but the plan sponsor must file IRS Form 720 and pay the applicable fee
  – If multiple employers participate in the plan, each must file separately unless the plan document designates one as the plan sponsor

Q4: When is the PCORI fee due?

A4: The fee is due by July 31 of the year following the calendar year in which the plan/policy year ends.

The fee applies from 2012 to 2019, based on plan/policy years ending on or after October 1, 2012, and before October 1, 2019.

Click here to view charts

Q5: How much is the fee?

A5: The fee is $1.00 per covered life in the first year the fee is in effect. The fee is $2.00 per covered life in the second year. In the third through seventh years, the fee is $2.00, adjusted for medical inflation, per covered life. For plan years that end on or after October 1, 2014, and before October 1, 2015, the indexed fee is $2.08. For plan years that end on or after October 1, 2015, and before October 1, 2016, the indexed fee is $2.17.

The fee is based on covered lives (i.e., employees, retirees, and COBRA participants and covered spouses and children). If, however, the plan owes the fee for HRA or health FSA coverage, it only needs to count the employees/retirees/COBRA participants – covered dependents are not counted for HRAs or health FSAs. Employees and their dependents who are residing outside U.S. (based on the address on file with the employer) may be excluded.

Q6: What if the plan terminates?

A6: The fee is due for each plan year the plan was in effect.

Q7: What if a plan is new?

A7: The fee will be due for each year the plan is in effect. The rate for that plan year will apply (for example, if the first year is January 1, 2013 – December 31, 2013, the first fee will be $2.00 per covered life and will be due on July 31, 2014).

Q8: How is the fee calculated?

A8: Plan sponsors of self-funded benefits have several options to calculate the fee:

- Actual Count Method – Count the covered lives on each day of the plan year, and average the result.
- Snapshot Count Method – Determine the number of covered lives on the same day (plus or minus three days) of each quarter or month, and average the result.

Example: Acme has a calendar year plan, so this is its second year for the fee. Acme has chosen to measure on the first calendar day of each quarter. On January 1, 2013, it had 127 covered lives on its plan. On April 1, 2013, it had 130 covered lives. On July 1, 2013, it had 132 covered lives. On October 1, 2013, it had 128 covered lives. Acme will owe $258 on July 31, 2014 (127 + 130 +132 +128 = 517. Dividing by 4 gives an average of 129.25, which will be rounded down to 129 covered lives and multiplied by $2.00).

Example: Zest has a March 1 plan year so this is the first year the fee applies. Zest has chosen to measure on the first calendar day of each quarter. On April 1, 2013, it had 46 covered lives on its plan. On July 1, 2013, it had 50 covered lives. On October 1, 2013, it had 52 covered lives. On January 1, 2014, it had 48 covered lives. Acme will owe $49 on July 31, 2014 (46 + 50 + 52 + 48 = 196. Dividing by 4 gives an average of 49 covered lives; that is multiplied by $1.00).

- Snapshot Factor Method – Determine the number of covered employees/retirees/COBRA participants on the same day (plus or minus three days) of each quarter or month who have self-only coverage and the number who have other than self-only coverage. Multiply the number of employees/retirees/COBRA participants with other than self-only coverage by 2.35 to approximate the number of covered dependents (rather than actually counting them), and add that to the number of employees/retirees/COBRA participants with self-only coverage. Average the result.

Example: Blackstone has a calendar year plan. Blackstone has chosen to measure on the first workday of each month. Its covered employees are:

Jan. 1, 2013	50 (self-only) and 40 (other than self-only)
Feb. 1, 2013	50 (self-only) and 40 (other than self-only)
March 1, 2013	52 (self-only) and 42 (other than self-only)
April 1, 2013	53 (self-only) and 41 (other than self-only)
May 1, 2013	54 (self-only) and 40 (other than self-only)
June 3, 2013	53 (self-only) and 42 (other than self-only)
July 1, 2013	54 (self-only) and 42 (other than self-only)
Aug. 1, 2013	49 (self-only) and 40 (other than self-only)
Sept. 3, 2013	48 (self-only) and 41 (other than self-only)
Oct. 1, 2013	48 (self-only) and 40 (other than self-only)
Nov. 1, 2013	50 (self-only) and 40 (other than self-only)
Dec. 2, 2013	51 (self-only) and 43 (other than self-only)

For the year, Blackstone has a total of 612 self-only employee lives and 491 other than self-only employee lives. Blackstone will multiply the 491 by an assumed 2.35 dependents per employee, for total of 1,153.85 employee/dependent covered lives.

Add 612 and 1,153.85 for 1,765.85 total lives and divide by 12 for the average number of lives. Blackstone will owe $294 on July 31, 2014 (1,765.85 divided by 12 gives an average of 147.154, which will be rounded down to 147 covered lives and multiplied by $2.00 since this is Blackstone's second fee year).

- Form 5500 Method – Determine the number of participants at the beginning and end of the plan year as reported on Form 5500.
  – If dependents are covered, add the participant count for the start and the end of the plan year.

Example: Smith Bros. has a May 1 plan year. Smith's plan covers dependents. Smith's Form 5500 for the plan year May 1, 2012 – April 30, 2013, showed 131 participants at the beginning of the year and 137 participants at the end of the year. Smith will owe $268 on July 31, 2014 (131 + 137 = 268, multiplied by $1.00 since this is Smith's first fee year).
– If dependents are not covered, add the participant count for the start and the end of the plan year and average the result.
Example: Taylor Trucking has a March 1 plan year. Taylor's plan does not cover dependents. Taylor's Form 5500 for the plan year March 1, 2012 – February 28, 2013, showed 450 participants at the beginning of the year and 461 participants at the end of the year. Taylor will owe $456 on July 1, 2014 (450 + 461 = 911. Divide by 2, to get 455.5 and round up. Multiply the result by $1.00 since this is Taylor's first fee year).
– The Form 5500 must be filed by July 31 to use this option.

It is unclear how rounding should be handled if the fraction is 0.5 or higher. Clearly fractions of less than 0.5 can be rounded down.

Q9: May an employer change its calculation method?

A9: The same method must be used throughout a reporting year, but it may be

changed from year to year.

Q10: What if the employer sponsors multiple plans?

A10: If there are multiple self-funded plans (such as self-funded medical and HRA) with the same plan year, only one fee would apply to a covered life.

- For example, Z Corp. has a self-funded medical plan and a self-funded HRA that operate on a calendar year basis. The medical plan has 110 covered employees and 205 covered dependents. The same 110 employees are covered by the HRA. Z Corp. will owe $630 on July 31, 2014 [(110 + 205) x $2.00].

If there are both fully insured and self-funded plans, a fee would apply to each plan unless the employee is only covered under one type of plan – the insurer would pay the fee on the insured coverage and the plan sponsor would pay the fee on the HRA.

- For example, Jay County has a fully insured medical plan and an integrated self-funded HRA. Both operate on a May 1 plan year. 130 employees and 212 dependents are covered by the medical plan and HRA. The insurer will pay a fee of $342 on the employees and dependents covered under the fully insured medical policy on July 31, 2014. Jay County will pay a fee of $130 on July 31, 2014 (because Jay owes the fee on the employees, but not the dependents, covered under the HRA).

Q11: How is the fee paid?

A11: The fee will be reported and paid on IRS Form 720 each July 31.

- Even though Form 720 is generally filed quarterly, the PCORI report and fee will just be filed once per year, at the end of the second quarter (unless the employer needs to file the form to report another tax).

- Even though government, church and not-for-profit plans don't generally file federal tax returns, they are required to file the Form 720.
- Only the relevant parts of the form need to be completed. The relevant parts are:
  – Identifying information at the beginning of the form
  – Part II, line 133 (self-funded plans complete the "Applicable self-insured plans" line; the "Specified health insurance policies" line will be completed by carriers for insured policies)
  – Part III, items 3 and 10
  – The signature section
  – The voucher form, if the form is mailed
- The form may be filed electronically or mailed to:
  Department of the Treasury
  Internal Revenue Service
  Cincinnati, OH 45999-0009

Q12: Is the fee tax-deductible?

A12: Yes, the fee is tax-deductible.

For more information, see:

- An IRS FAQ: Patient-Centered Outcomes Research Trust Fund Fee (IRC 4375, 4376 and 4377): Questions and Answers
- An IRS chart that shows which plans owe the fee: Application of the Patient-Centered Outcomes Research Trust Fund Fee to Common Types of Health Coverage or Arrangements
- IRS Form 720
- IRS Form 720 Instructions (see pages 8 – 9)
- PCORI regulation: Fees for the Patient-Centered Outcomes Research Trust Fund

- An IRS Information Page: Patient-Centered Outcomes Research Institute Fee

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Compliance Advisor: Final Rules Impose New Regulations on Wellness Programs under the ADA, GINA

In May 2016, the Equal Employment Opportunity Commission (EEOC) issued two final rules, one to amend regulations and provide guidance on implementing Title I of the Americans with Disabilities Act (ADA) as it relates to employer wellness programs, and one to amend the regulations implementing Title II of the Genetic Information Nondiscrimination Act (GINA) as they relate to employer wellness programs that are part of group health plans. Wellness programs are regulated by a plethora of federal regulations, and compliance with one set of regulations does not mean a wellness program is compliant with all regulations. Employers should use caution with plan design changes to ensure compliance across all regulations.

Both rules go into effect on July 18, 2016, and employers must comply as of the first date of the plan year beginning on or after January 1, 2017.

The EEOC's main concern is with an employer's use of disability-related inquires, primarily through health risk assessments (HRAs) and medical examinations, such as biometric screenings. Employers that offer or encourage employees to undergo HRAs or biometric screenings should be very careful to ensure they are complying with these new regulations. The EEOC is concerned that some incentives, offered in conjunction with HRAs or biometric screenings, will render a "voluntary" wellness program involuntary by virtue of the incentive.

These final rules apply to both wellness programs that are part of or are provided

by a group health plan; or by a health insurance issuer (carrier) offering group health insurance in conjunction with a group health plan; or wellness incentives that are offered as a benefit of employment by employers that do not sponsor a group health plan or group health insurance. Practically speaking, they apply to all wellness programs, regardless of their attachment to a fully insured or self-funded group health plan.

The final rules provide clarity to the meaning of a “voluntary” program, further rules on the calculation of the incentive limits, and further restrictions on smoking cessation wellness programs that include any sort of medical screening.

Neither the employee nor the employee’s spouse who is participating in a wellness program may earn a wellness program reward (or avoid a penalty) by submitting an attestation that they are under the treatment of a physician and that their physician is treating them for identified health risks. The EEOC has determined that this circumvents the “reasonable design” requirements of a wellness program.

The EEOC has already begun litigation against well-known employers with HRAs and biometric screening programs that do not meet the new requirements. Some federal courts have issued rulings in favor of the employers, and against the EEOC. The final rules acknowledge the rulings and state that the agency disagrees with the judicial decisions. Employers that wish to rely on the court rulings rather than federal guidance should only do so after discussion with their legal counsel.

History of Wellness Programs

Rules for wellness programs have been in effect since 2007, with additional rules that went into effect for the 2014 plan year under the Patient Protection and Affordable Care Act (ACA). Wellness programs are either “participatory” or “health-contingent.” A participatory program is one that either has no reward or penalty (such as providing free flu shots) or simply rewards participation (such as a

program that reimburses the cost of a membership to a fitness facility or the cost of a seminar on nutrition).

Health-contingent wellness programs are either classified as “activity only” or “outcome based.” Health-contingent wellness programs are programs that base incentives or requirements in any way on an employee’s health status. Health status includes things like body mass index (BMI), blood glucose level, blood pressure, cholesterol level, fitness level, regularity of exercise, and nicotine use.

A wellness program with health-contingent requirements must meet all of these basic requirements:

- Give employees a chance to qualify for the incentive at least once a year; and
- Cap the incentive at 30 percent of the total cost of employee-only coverage under the plan, including both the employee and employer contributions, with a 50 percent cap for tobacco cessation or reduction; and
- Be reasonably designed to promote health or prevent disease; and
- Provide that the full reward must be available to all similarly situated individuals with a “reasonable alternative” method of qualifying for the incentive for some individuals; and
- Describe the availability of the alternative method of qualifying for the incentive in written program materials.

Terminology

In the final rule, “group health plan” refers to both insured and self-insured group health plans. All of the changes relate to “employee health programs,” regardless of whether they are offered as part of or outside of a group health plan or group health insurance coverage. The term “incentives” includes financial and in-kind incentives for participation such as awards of time off, prizes, or other items of

value.

Final Rule – Americans with Disabilities Act

Title I of the ADA applies to employers with 15 or more employees, prohibits discrimination against people with disabilities, and requires equal opportunity in promotion and benefits, among other things. The final rule provides guidance on the extent to which employers may use incentives to encourage employees to participate in wellness programs that include disability-related inquires or medical examinations.

The ADA restricts employers from obtaining medical information from employees by generally prohibiting them from making disability-related inquiries or requiring medical examinations, with an exception for voluntary medical examinations for wellness programs.

Additionally, the ADA requires employers to provide reasonable accommodations (modifications or adjustments) to enable individuals with disabilities to have equal access to fringe benefits, such as general health and educational wellness programs, which are offered to individuals without disabilities. The EEOC has decided that allowing certain incentives related to a wellness program, while limiting them to prevent economic coercion that could make the program involuntary, is the best way to achieve the purposes of the wellness program provisions of both the ADA and HIPAA.

The EEOC's final rule relating to the ADA focuses on reasonable design, the meaning of voluntary, the permitted incentives, and confidentiality requirements. The final rule defines a voluntary wellness program as one that:

1. Does not require employees to participate;
2. Does not deny coverage under any of its group health plans or particular benefits packages within a group health plan for non-participation; and
3. Does not take any adverse employment action or retaliate against, interfere with,

coerce, intimidate, or threaten employees within the meaning of Section 503 of the ADA.

Using a Wellness Program as a "Gatekeeper" for a More Comprehensive Group Health Plan

The second requirement of a voluntary wellness program prohibits the outright denial of access to a benefit available by virtue of employment. When an employer denies access to a health plan because the employee does not answer disability-related inquiries, e.g., HRAs, or undergo medical examinations, this is discrimination by virtue of requiring the employee to answer questions or undergo medical examinations that are not job-related and consistent with business necessity, and is not voluntary.

Practically speaking, this means employers cannot offer a "basic" group health plan and a more comprehensive group health plan, with the comprehensive health plan only being offered to employees who participate in the wellness program that involves an HRA or biometric screening. Similarly, lower deductibles or out-of-pocket costs cannot be offered only to individuals who participate in a group health plan that involves an HRA or biometric screening.

Incentives

The maximum allowable incentive (including in-kind incentives) for wellness programs that include HRAs or medical exams or for health-contingent programs that require participants to satisfy a standard related to a health factor may not exceed:

- 30 percent of the total cost of self-only coverage (including both the employee's and employer's contribution) where participation in a wellness program depends on enrollment in a particular health plan;
- 30 percent of the total cost of self-only coverage when the covered entity offers only one group health plan and participation in a wellness program is

offered to all employees regardless of whether they are enrolled in the plan;

- 30 percent of the total cost of the lowest cost self-only coverage under a major medical group health plan where the covered entity offers more than one group health plan but participation in the wellness program is offered to employees whether or not they are enrolled in a particular plan;
- 30 percent of the cost to a 40-year-old nonsmoker of the second-lowest-cost Silver Plan (available under the ACA) in the location that the employer identifies as its principal place of business, where the covered entity does not offer a group health plan or group health insurance coverage.

Smoking Cessation Limits

Generally wellness program rewards or penalties can be as much as 30 percent of the cost of coverage if the incentive is not related to tobacco usage. If there are multiple parts to the program (such as meeting certain BMI, blood pressure, cholesterol, and exercise targets), the maximum total reward or penalty for all parts of the program is 30 percent. However, the reward or penalty for not using tobacco can be up to 50 percent of the cost of coverage.

The final rule clarified that smoking cessation programs that ask employees whether they use tobacco, or whether or not they ceased using tobacco at the conclusion of a program, is not a program that includes disability-related inquires or medical exams.

However, tobacco or smoking cessation programs that include a medical exam or biometric screening that tests for the presence of nicotine or tobacco would be subject to the 30 percent limits, not the higher 50 percent limit. Calculation of the incentive limit follows four methods outlined above.

Reasonable Alternatives

Reasonable alternatives must be provided for employees for whom it is unreasonably difficult due to a medical condition to complete the disability-related

inquiry such as an HRA or biometric screening due to a medical condition. An example would be an individual who has a medical condition that makes a blood draw a risky procedure.

Notice Requirement

Furthermore, to be a voluntary program, employers must provide a notice that clearly explains what medical information will be obtained, who will receive that medical information, how the medical information will be used, the restrictions on its disclosure, and the methods the covered entity will employ to prevent improper disclosure of the medical information. The employer must also notify the employee whether it complies with privacy and security measures established by HIPAA. The information must be written so that the employee whose medical information is being obtained is reasonably likely to understand it.

The EEOC intends to publish a sample notice on its website that satisfies these requirements.

Use of Information

Under the final rule, a wellness program with a biometric screening or HRA requirement will not be able to show that it is reasonably designed to promote health if it merely claims that the collection of information is useful. Conversely, asking employees to complete an HRA in order to alert them to health risks they might have been unaware of would meet the standard of promoting health. Employers that use aggregated information from HRAs or biometric screening to design programs to meet the needs of their employee population (for example a program for individuals with diabetes or high blood pressure) would be sufficient. Collecting information without meaningful follow-up and advice is not sufficient. Employers must ensure that any wellness program involving medical screenings or HRAs is sufficient to promote health; any program that merely collects information should be avoided.

Confidentiality

Medical records developed in the course of wellness programs (and other voluntary health services generally) must be maintained in a confidential manner. Covered entities may not require employees to agree to the sale, exchange, sharing, transfer, or disclosure of information (except as required to carry out the wellness program) or to waive confidentiality in any way. If the wellness program is part of the group health plan, it is subject to HIPAA's privacy, security, and breach notification rules.

Individuals who handle medical information that is part of an employee health program should not be responsible for making decisions related to employment, such as hiring, termination, or discipline. If an employer uses a third-party vendor, it should be familiar with the vendor's privacy policies for ensuring the confidentiality of medical information. Employers that administer their own wellness programs need adequate firewalls in place to prevent unintended disclosure of information.

Safe Harbor

The ADA provides an insurance "safe harbor" that prohibits insurers or benefit plan administrators from establishing, sponsoring, observing or administering the terms of a bona fide benefit plan based on underwriting risks, classifying risks, or administering such risks that are based on or not inconsistent with state law. Essentially, the safe harbor permits insurers and employers to treat individuals differently based on disability, but only in certain justified situations according to accepted principles of risk classification. However, the EEOC notes that this safe harbor relates to underwriting and rate-making that was in place before the ADA and does not apply to the wellness programs that involve disability-related inquiries and medical examinations. The EEOC's position on the applicability (or lack thereof) of the safe harbor is contradictory to two federal court rulings. Risk-adverse employers should exercise caution and consult with legal counsel if they

are contemplating following the court rulings rather than the regulations.

Final Rule – GINA

Current wellness program rules provided by other federal agencies allow employers to extend the financial incentives of a wellness program to spouses and children of an employee, so long as the spouse and children are permitted to participate in the wellness program. GINA prohibits discrimination in insurance and employment on the basis of genetic information.

The statute and the EEOC's GINA regulations say that "genetic information" includes, among other things, information about the "manifestation of a disease or disorder in family members of an individual." Family members include certain blood relatives, like parents, grandparents, and children, but also include spouses and adopted children. This is because when Congress defined family members, it included two very specific provisions – one that covers blood relatives and a second that refers to "dependents" within the meaning of the Employee Retirement Income Security Act (ERISA). The section of ERISA referenced in GINA defines dependents to include spouses and adopted children.

When the EEOC issued its Proposed rule in April 2015 to integrate wellness program rules with Title I of the ADA, it expressly provided that financial incentives for wellness programs would be limited to employees only. That is because the current regulations at that time stated that a wellness program cannot require employees to provide genetic information as a condition of receiving incentives, including current or past health status of spouses and family members. This led to the interpretation that GINA prohibited employers from offering wellness program incentives to spouses who are asked to provide their current or past health information. The final rule intends to provide the parameters for an employer to lawfully offer wellness incentives to spouses. GINA's existing confidentiality protections of genetic information apply to the genetic information of all individuals

responding to a disability-related inquiry through a voluntary wellness program.

Prohibition on Programs Involving Genetic Information of Children

The EEOC has determined that information about the manifestation of a disease or disorder in an employee's child can more easily lead to genetic discrimination against an employee than information about an employee's spouse. As a result, the final rule provides that no inducements are permitted in return for information about the manifestation of disease or disorder of an employee's children and makes no distinction between adult and minor children or between biological and adopted children. Practically speaking, the final rule prohibits employers from operating a wellness program that includes disability-related questions, such as HRAs or biometric screenings for children. The GINA rules do not apply to wellness programs that offer inducements for participation in an outcome-based program, such as attending a nutrition program or exercising for a certain amount of time every month.

Spouses

The final rule allows employers to offer limited inducements to obtain information about the "manifestation of a disease or disorder" (via a biometric screening, HRA, or medical examination) from a spouse of a covered employee, in certain situations. General rules about wellness programs continue to apply, including the requirement that the program be reasonably designed. Any wellness program with biometric screenings or HRAs must include follow-up information or advice to individual participants based on the results. The term "spouse" includes both opposite sex and same-sex spouses.

Again, the GINA rules do not apply to wellness programs that offer inducements for participation in an outcome-based program, such as attending a nutrition program or exercising for a certain amount of time every month.

When an employee and the employee's spouse are given the opportunity to enroll

in an employer sponsored wellness program, the inducement to each individual may not exceed 30 percent of the total cost of:

- Self-only coverage (including both the employee's and employer's contribution) where participation in a wellness program depends on enrollment in a particular health plan;
- Self-only coverage when the covered entity offers only one group health plan and participation in a wellness program is offered to all employees regardless of whether they are enrolled in the plan;
- The lowest cost self-only coverage under a major medical group health plan where the covered entity offers more than one group health plan but participation in the wellness program is offered to employees whether or not they are enrolled in a particular plan; or
- The cost to a 40-year-old nonsmoker of the second-lowest-cost Silver Plan (available under the ACA) in the location that the employer identifies as its principal place of business, where the covered entity does not offer a group health plan or group health insurance coverage.

Example: An employee is enrolled in a group health plan through the employer at a total cost (taking into account both employer and employee contributions toward the cost of coverage) of $14,000 for family coverage. The plan has a self-only option for a total cost of $6,000, and the employer provides the employee and spouse the option of participating in a wellness program if they participate in the plan. The employer may not offer more than $1,800 to the employee and $1,800 to the spouse. The 30 percent limit is based on the $6,000 cost of self-only coverage rather than the cost of family coverage.

Mirroring the final rule relating to wellness programs and the ADA, the final rule relating to GINA prohibits employers or covered entities from requiring employees to agree to the selling, exchanging, sharing, transferring, or disclosing of

information (except as required to carry out the wellness program) or waiving confidentiality in any way. Employers may not condition participation in any group health plan on the participation in a wellness program that makes disability related inquiries, this renders the program involuntary.

Reasonable alternatives must be provided for employees and spouses for whom it is unreasonably difficult due to a medical condition, to complete the HRA or biometric screening due to a medical condition. An example would be an individual who has a medical condition that makes a blood draw a risky procedure.

For more information, please contact: Lesa Votovich, Vice President Health and Benefits (412) 394-9308.

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ACA Advisor: Nondiscrimination Regulations Relating to Sex, Gender, Age, and More Finalized

On May 13, 2016, the Department of Health and Human Services (HHS) issued a final rule implementing Section 1557 of the Patient Protection and Affordable Care Act (ACA), which will take effect on July 18, 2016. If entities need to make changes to health insurance or group health plan benefit design as a result of this final rule, such provisions have an applicability date of the first day of the first plan year beginning on or after January 1, 2017.

ACA Section 1557 provides that individuals shall not be excluded from participation, denied the benefits of, or be subjected to discrimination under any health program or activity which receives federal financial assistance from HHS on the basis of race, color, national origin, sex, age, or disability. The rule applies to any program administered by HHS or any health program or activity administered

by an entity established under Title I of the ACA. These applicable entities are “covered entities” and include a broad array of providers, employers, and facilities. State-based Marketplaces are also covered entities, as are Federally-Facilitated Marketplaces.

The final regulations are aimed primarily at preventing discrimination by health care providers and insurers, as well as employee benefits programs of an employer that is principally or primarily engaged in providing or administering health services or health insurance coverage, or employers who receive federal financial assistance to fund their employee health benefit program or health services. Employee benefits programs include fully-insured and self-funded plans, employer-provided or sponsored wellness programs, employer-provided health clinics, and long-term care coverage provided or administered by an employer, group health plan, third party administrator, or health insurer.

Affected employers include:

- Hospitals
- Nursing homes
- Home health agencies
- Laboratories
- Community health centers
- Therapy service providers (physical, speech, etc.)
- Physicians’ groups
- Health insurers
- Ambulatory surgical centers
- End stage renal dialysis centers
- Health related schools receiving federal financial assistance through grant awards to support 40 health professional training programs

When determining if federal financial assistance is received through Medicaid

payments, meaningful use payments, or other payments a physician or physicians' group would not count Medicare Part B payments because these payments are not considered federal financial assistance. In the proposed rule, HHS estimated that most physicians will still be a covered entity because they accept federal financial assistance from other sources. The final rule includes the same estimate of physicians receiving federal financial assistance as in the proposed rule because almost all practicing physicians in the United States accept some form of federal reimbursement other than Medicare Part B. As a result, most physicians are reached by this rule.

Covered entities must take steps to notify beneficiaries, enrollees, applicants, or members of the public of their nondiscrimination obligations with respect to their health programs and activities. Covered entities are required to post notices stating that they do not discriminate on the grounds prohibited by Section 1557, and that they will provide free (and timely) aids and services to individuals with limited English proficiency and disabilities. These notices must be posted in conspicuous physical locations where the entity interacts with the public, in its significant public-facing publications, and on its website home page. In addition, covered entities that employ 15 or more persons must designate a responsible employee to coordinate the entity's compliance with the rule and adopt a grievance procedure.

Sex, Gender, and Sexual Orientation Discrimination

The final rule bans discrimination based on sex, gender, sexual orientation, and gender identity. Sex discrimination includes discrimination on the basis of pregnancy, false pregnancy, termination of pregnancy, or recovery from childbirth or related medical conditions.

The final rule prohibits discrimination faced by transgender individuals trying to access coverage of health services. The rule prohibits denying or limiting coverage, denying a claim, or imposing additional cost sharing on any health service due to the individual's sex assigned at birth, gender identity, or gender

otherwise recorded by the plan or issuer which is different from the one to which services are ordinarily or exclusively possible.

For example, a pelvic or prostate exam could not be denied based on a person's sex assigned at birth, gender identity, or recorded gender, if it was medically appropriate. Medically appropriate coverage could not be denied for a pelvic exam or ovarian cancer treatment for an individual who identifies as a transgender man, or is enrolled in a health plan as a man.

Furthermore, blanket exclusions for coverage of care associated with gender dysphoria or associated with gender transition is prohibited. Categorical or automatic exclusion of coverage for services related to gender transition are unlawful. Denials for these services would be discrimination if the denial results in discrimination against a transgender individual. These provisions do not require covered entities to cover any particular procedure or treatment for transition-related care; nor do they preclude neutral standards that govern the circumstances under which coverage will be offered.

The regulations do not prohibit single-sex toilets, locker rooms, or shower facilities so long as comparable facilities are provided regardless of sex. The final rule provides that sex-specific health programs are allowable only where the covered entity can demonstrate an exceedingly persuasive justification that the sex-specific program is substantially related to the achievement of an important health-related or scientific objective. While the rule does not require a provider that operates a gynecological practice to add or change the types of services offered in the practice, it prohibits the providers of health services from denying or limiting services based on an individual's sex, without a legitimate nondiscriminatory reason.

For example, if a hospital has specific protocols in place for domestic violence victims and only engages that protocol for women, the provider must revise its procedures to require that protocol for all domestic violence victims regardless of

sex.

The final rule does not resolve whether discrimination on the basis of an individual's sexual orientation status alone is a form of sex discrimination. The Office for Civil Rights (OCR) will evaluate complaints alleging sex discrimination based on sexual orientation status on a case-by-case basis to determine if they are the sort of discrimination that can be addressed under this rule.

Marketplace and Other Health Plans

A health insurance issuer seeking certification to participate in a Health Insurance Marketplace, or a state seeking approval to operate a State-based Marketplace, to which Section 1557 applies is required to submit an assurance that the health program or activity will operate in compliance with this rule.

Marketplaces must operate in a nondiscriminatory manner. Issuers that participate in the Marketplace cannot deny, cancel, limit, or refuse to issue or renew any policies that employ practices or benefit designs that discriminate on any of the protected bases.

An insurer that participates in a Marketplace would be subject to the nondiscrimination rules in the Marketplace, in its individual market business, in the group market, or when it serves as a third-party administrator for a self-insured plan.

Third-Party Administrators (TPAs)

The OCR will investigate a TPA when the alleged discrimination is in the administration of the plan. However, if the alleged discrimination is in benefit plan design, OCR will process the complaint against the employer or plan sponsor. If the OCR lacks jurisdiction over the employer, it will refer the matter to the Equal Employment Opportunity Commission (EEOC).

Discrimination against Persons with Limited English Proficiency (LEP) and

Disabilities

An individual with LEP is someone for whom English is not the primary language for communication, and who has a limited ability to read, speak, write, or understand English. The final rule increases assistance for individuals with LEP so that they can communicate with their health care providers and have meaningful access to health programs and activities.

Covered entities are required to post taglines in at least the top 15 non-English languages spoken in the state in which the entity is located or does business. These taglines will alert LEP individuals to the availability of free language assistance services and how these services can be obtained. The proposed rule provided a list of relevant factors to consider when determining if language obligations have been met; whereas, the only relevant factor listed in the final rule is whether a covered entity implemented an effective written language access plan.

Covered entities are required to provide effective communication and facility access for individuals with disabilities. Covered entities must provide access to auxiliary aids and services, including alternative formats and sign language interpreters, unless the entity can show undue burden or fundamental alteration. The final rule requires reasonable modifications where necessary to facilities and technology to provide equal access for individuals with disabilities.

Enforcement

The enforcement mechanisms under Title VI, Title IX, Section 504 of the Rehabilitation Act, and the Age Discrimination Act of 1975 apply for redress of violations of Section 1557, which include requiring covered entities to keep records and submit compliance reports to the OCR, conducting compliance reviews and complaint investigations, and providing technical assistance and guidance. If noncompliance cannot be corrected by informal means, enforcement mechanisms include suspension of, termination of, or refusal to grant federal financial

assistance.

Key Differences between the Proposed and Final Rule

While the final rule adopts the same structure and framework as the proposed rule, significant changes include the following.

- The final rule does not include any blanket religious exemptions; however, application of any requirement of the rule will not be required if it violates federal statutory protections for religious freedom and conscience.
- The final rule modifies the notice requirement to exclude publications and significant communications that are small in size from the requirement to post all of the content; instead, covered entities will be required to post a shorter nondiscrimination statement in such communications and publications.
- The final rule replaces the national threshold with a state-specific threshold requiring taglines in at least the top 15 non-English languages spoken by LEP populations in each state.
- The final rule provides that sex-specific health programs are allowable only where the covered entity can demonstrate an exceedingly persuasive justification that the sex-specific program is substantially related to the achievement of an important health-related or scientific objective.
- The final rule takes reasonable steps to provide meaningful access by requiring the Director of the OCR to evaluate, and give substantial weight to, the nature and importance of the health program or activity and the particular communication at issue to the individual with LEP, and take into account all other relevant factors, including whether the entity has developed and implemented an effective language access plan. The final rule deletes the specific list of illustrative factors in the proposed rule.

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Webinars

What Employers Need to Know About the Fair Labor Standards Act New Overtime Exemption Rule

After a long wait, the Department of Labor (DOL) released revisions to the white collar overtime exemption rules in the Fair Labor Standards Act (FLSA). Non-exempt, or "overtime eligible," workers in the United States are entitled to time-and-a-half pay for their hours worked after 40 hours in a week. The webinar will focus on the new standards for the "white collar" or "EAP" exemption that covers executive, administrative, professional, outside sales, and computer employees.

This webinar will:

- Review the FLSA overtime rules generally, and the employers (or enterprises) that they apply to
- Provide a brief overview of job-specific exemptions, such as switchboard operators
- Discuss the long-standing white collar or EAP exemption salary threshold, and how it will change in December 2016
- Provide insight on how the salary threshold is calculated, both in terms of the timing of paychecks, as well as the inclusion of commission or bonuses
- Discuss factors outside of the salary threshold that must also be considered when determining if an employee is exempt or not
- Discuss the duties tests that are looked at in addition to salary thresholds
- Provide best practices on reviewing current employee roles
- Discuss the potential conflict between the Affordable Care Act's rate of pay safe harbor for affordability (for applicable large employers) for employees who are moved from salary to hourly as the result of the new rules

This 60-minute beginner to intermediate level webinar will help employers understand the rules regarding aggregated groups and how they can impact benefit plans.

PRESENTER

Jennifer Sandberg, Partner, Atlanta GA – Fisher & Phillips, LLP

Employers, In-House Counsel, and Human Resource professionals view Jennifer as a trusted advisor providing solid business advice. Her advice is custom-tailored for employers with tens of thousands of employees or those with a mere handful of employees.

Jennifer delivers engaging and highly effective training for senior executives and managers on a diverse array of labor and employment topics. She conducts legal compliance audits of human resource functions, procedures and policies, and provides a triaged approach to audit findings.

She frequently speaks to numerous business associations and human resource groups on topics related to all areas of employment law, such as hiring and firing workers, disability accommodations, employee leaves, workplace investigations and wage-hour issues.

Jennifer was selected for inclusion in *The Legal 500* – Workplace

View Printable PDF

Starts: Tuesday, July 12, 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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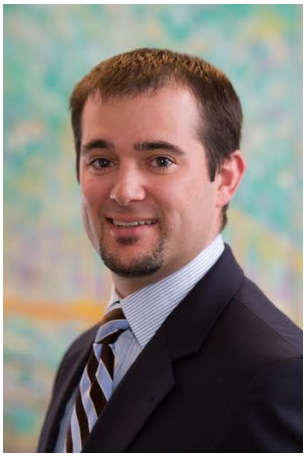
Meet Our Team

Our team consists of 27 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.



Brad Rigby
Director, Retirement and Actuarial Services

Why I Enjoy My Job: I enjoy my job because at the center of everything I am trying to turn clients into friends and make friends who become clients…(and this frequently happens on the golf course).

Something Interesting About Me: Actuarial work isn't the only thing that gives me the thrill of a lifetime– I've jumped out of a plane twice, gone skiing down steep mountains, tried swimming with a great white shark (only saw one), gone cliff diving, and eaten all sorts of weird food including live octopus.

Elliot Dinkin
President/CEO

Why I Enjoy My Job: There are two things that I really enjoy about what I do at Cowden Associates:
a. I have the opportunity to work with a variety of different people every day from our clients to our employees. Each of them brings a different perspective with a daily opportunity

to learn and be challenged.

b. Every day is different with activities ranging from: conducting external presentations/meetings, being part of internal planning and execution of projects, preparing and reviewing reports, engaging in marketing and sales activities, and meeting with prospects and centers of influence.

Something Interesting About Me: I play the piano and continue to take lessons.

Shane Parkhill
Analyst

Why I Enjoy My Job: As an Analyst at Cowden Associates, I enjoy the opportunity and support to grow professionally each and every day.

Something Interesting About Me: I play recreational inline hockey.

Todd Kordecki
Analyst

Why I Enjoy My Job: I enjoy solving problems with my coworkers to provide clients with useful information and analysis.

Something Interesting About Me: I play on a co-ed ice hockey team with my wife.

Jackie DePolo
Vice President, Health and Benefits

Why I Enjoy My Job: I enjoy working collaboratively with clients to achieve their goals.

Something Interesting About Me: I have a degree in Actuarial Sciences and am a “numbers geek” at heart.

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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

How to Avoid a DOL Audit

The term “audit” has a tendency to strike fear into the hearts of those who hear the word. Anyone with a hand in a company’s financial operations are aware that audits are used by the federal government to monitor and ensure that company is in compliance with applicable laws and regulations. Government audits examine past performance to ensure that funds have been properly administered in the appropriate manners.

Technically, any entity is at risk of being audited, but there are certain mistakes that organizations often make that put them at a higher likelihood for scrutiny. Companies hoping to avoid the dreaded threat of audit should ensure they are fulfilling the following requirements:

- **Submit reports to the DOL on time and accurately**. This includes things like filing Form 5500 reports, as well as 1095/1094s. Companies should also be submitting completed annual employee notifications (Medicare Part D, for instance, or Patient Protection and Affordable Care Act or HIPAA information).
- **Implement Summary Plan Descriptions (SPDs)**. Not only do SPDs help companies set standards for their employees, but they also ensure that they are compliant with ERISA, HIPAA, and the ACA regulations.
- **Develop a Summary of Material Modification (SMM)**. Whenever changes are made to a plan, federal regulations require that organizations create an SMM to document alterations or amendments – and also retain these documents for the future.
- **Retain necessary documents appropriately.** Items such as Section 125 Premium Only Plan and flexible spending accounts require that employers hold onto these documents and maintain their accuracy.

Following these few steps in remaining compliant and current are sure to help companies reduce their risk of receiving an audit. But amidst the intricacies of the DOL's requirements, it's certainly easy to lose track of which regulations organizations need to be concerned with. A company should avoid making a common mistake when it comes to filing paperwork, but should also not grow anxious about learning the subtleties of regulatory concerns. These details are important to know and understand, but there are experts who can help.

The experienced experts at Cowden Associates, Inc., for instance, can provide a

simple solution to staying compliant and decreasing the likelihood of getting audited. The team of professionals is well-versed and experienced fulfilling DOL regulations and is capable of assisting companies of all industries and sizes. Learn more today!

Please share your thoughts!

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Nondiscrimination Under the Affordable Care Act

On May 13, 2016, the Department of Health and Human Services (HHS) issued a final rule implementing Section 1557 of the Affordable Care Act (ACA). This rule prohibits discrimination based on race, color, national origin, sex, age, or disability in health programs and activities that receive Federal financial assistance from the HHS, that are run by HHS, or that are run by entities established by Title I of the ACA (that is, Health Insurance Marketplaces, both State and Federal).

Who Does This New Rule Affect?

This rule only covers entities that meet one of the following criteria:

1. They provide a health program or activity that receives at least part of its funding from the HHS.
2. They are a section of the HHS that provides health programs and activities directly.
3. They are an entity established under Title I of the ACA (i.e., a Health Insurance Marketplace).

Any business or program that falls into one of these categories must follow the nondiscrimination requirements set out by the new rule. They can’t exclude from

participation, deny benefits to, or subject to discrimination anyone based on the individual's race, color, national origin, sex, age, or disability.

The first category is the largest and includes hospitals, clinics, laboratories, and pharmacies, as long as they receive at least some money from the Federal government in the form of grants, loans, and other assistance. The rule does not cover Medicare B payments, however.

For most that fall under the rule, it goes into effect on July 18, 2016. An exception is made for insurance providers designing new plans, which must comply at the beginning of the plan year on or after January 1, 2017.

What Does This Mean For Employers?

Under the final rule, any entity applying for Federal assistance must submit an assurance that they comply with Section 1557. Also, they must notify employees and others who might be affected by the new rule and the kinds of discrimination it prohibits.

In addition, employers must train employees, including health care workers, administrators, and even pharmacists, in the new rule and the types of discrimination it covers. HHS estimates nearly 15 million health care workers and nearly 8 million other workers could require training under the new rule.

If your business is one of these covered entities, you should consider working with an advisor who understands the new ruling and can help you manage its impact on your organization.

What Does This Mean for Employees?

Obviously, if your employer is covered under the new rule, you will probably be scheduled for training in the prohibited forms of discrimination. This ensures that you can comply with the new rule and provide excellent service to your clients and customers.

More importantly, though, you will likely see a positive effect on your benefits program as insurance providers move to comply with the new rule. Coverage cannot be denied for reasons such as gender identity, age, disability, or even low English proficiency. It even covers intersectional discrimination that can affect some employees who fall into multiple protected groups.

This new rule cements the protections promised by the ACA since 2010 and ensures that everyone can receive the health care they need, regardless of who they are or how others see them.

Please share your thoughts!

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