COWDEN
2016 Celebrating our 20 Year Anniversary

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COWDEN TIMES

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Cowden News

Elliot Dinkin to Speak at the Pittsburgh Total Rewards Association's Fall Conference

On September 21, President and CEO, Elliot Dinkin will be speaking at the Pittsburgh Total Rewards Association's Fall Conference. Elliot will be speaking on "Fine Tuning the Impact of Pay or Play." For more information about the Pittsburgh Total Rewards Association, please click here.

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Bob Crnjarich to Speak at the 2016 ISCEBS Symposium

On September 19, Bob Crnjarich, Vice President, Retirement and Actuarial Services will be speaking at the 2016 ISCEBS Symposium in Baltimore, MD. Bob's presentation is entitled "De-Risking Your Defined Benefit Pension Plan." For more information on the ISCEBS 2016 Symposium, please click here.

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The ACA and the Individual Shared Responsibility Requirement, Including an Update on Proposed Regulations Issued on July 8, 2016

General Information

The individual responsibility requirement (also known as the individual mandate) became effective for most people as of January 1, 2014. Under the individual mandate, most people residing in the U.S. are required to have minimum essential

coverage or they must pay a penalty. Many individuals will be eligible for financial assistance through premium tax credits (also known as premium subsidies) to help them purchase coverage if they buy coverage through the health insurance Marketplace (also known as the Exchange).

Employers are not required to educate employees about their individual responsibilities under the Patient Protection and Affordable Care Act (ACA). This Advisor simply provides information that employers may find helpful to know.

For 2014, the penalty for an adult was the greater of $95 or 1 percent of household income above the tax filing threshold. For 2015, the penalty was the greater of $325 and 2 percent of income above the tax filing threshold. For 2016, the penalty is the greater of $695 and 2.5 percent of income above the tax filing threshold.

The penalty for a child under age 18 is 50 percent of the adult penalty. The maximum penalty per family is three times the individual penalty. The penalty is calculated and paid as part of the employee's federal income tax filing.

Minimum Essential Coverage

A person must have "minimum essential coverage" to avoid a penalty. Minimum essential coverage is basic medical coverage and may be provided through an employer, Medicare, Medicaid, CHIP, TRICARE, some VA programs, or an individual policy (through or outside the Marketplace). Acceptable employer coverage includes both insured and self-funded PPO, HMO, HDHP and fee-for-service plans, as well as grandfathered coverage, COBRA, retiree medical, and health reimbursement arrangements (HRAs). It does not matter whether the coverage is provided directly by the employer or through another party, such as a multiemployer plan, a collectively bargained plan, a PEO, or a staffing agency.

Exempt Individuals

While most people must obtain coverage or pay penalties, individuals will not be penalized if they do not obtain coverage and:

- They do not have access to affordable coverage (cost exceeds 8 percent of modified adjusted gross household income)
- Their household income is below the tax filing threshold
- They meet hardship criteria (such as recent bankruptcy, homelessness, unreimbursed expenses from natural disasters)
- Their period without coverage is less than three consecutive months
- They live outside the U.S. long enough to qualify for the foreign earned income exclusion
- They reside in a U.S. territory for at least 183 days during the year
- They are a member of a Native American Tribe
- They belong to a religious group that objects to having insurance, including Medicare and Social Security, on religious grounds (e.g., Amish)
- They belong to a health sharing ministry that has been in existence since 1999
- They are incarcerated (unless awaiting trial or sentencing)
- They are illegal aliens

If the person has access to employer-provided coverage as either the employee or an eligible dependent, affordability of the employer-provided coverage is the only factor considered for purposes of the individual mandate.

- For the employee, coverage is unaffordable (so no penalty applies for failure to have coverage) if the cost of single coverage is more than 8 percent of household income
- For a dependent, coverage is unaffordable (so no penalty applies for failure to have coverage) if the cost of the least expensive employer-provided dependent coverage is more than 8 percent of household income
- If the employee and spouse both have access to coverage through their own employer, the cost for each person’s coverage is based on the cost of their own single coverage, but the totals are then combined to see if the

total cost exceeds 8 percent of household income

This means that there will be situations in which the employee has to pay a penalty, but family members do not. It also means that a while a low-income person could choose not to purchase coverage (and pay no penalty), he or she also has the option to purchase through the Marketplace and receive a premium subsidy.

An individual who is exempt from the individual mandate because he or she does not have affordable coverage available also has the option to purchase catastrophic coverage. Premium subsidies are not available for catastrophic coverage.

If the person does not have access to employer (or other non-Marketplace) coverage, the measure of unaffordability is the person's premium after the premium subsidy is applied to the lowest cost bronze plan available through the Marketplace.

Eligibility for Premium Subsidies

To help lower-income people meet the requirement to have insurance, a premium subsidy will be available to a person who:

- Purchases coverage through a public Marketplace; and
- Has a household modified adjusted gross income between 100 percent or 133 percent (depending on the person's state) and 400 percent of Federal Poverty Level (FPL); and
- Is not eligible for minimum essential medical coverage through a government program such as Medicare, Medicaid, or CHIP; and
- Is not eligible for employer-provided coverage that both is minimum value (is expected to cover at least 60 percent of claims) and affordable (the cost of single coverage is not more than 9.5 percent of household income; this means that dependents are not eligible for a premium subsidy if the cost of

employee-only coverage is affordable and they are eligible for the employer-provided coverage, even if the cost of family coverage exceeds 9.5 percent of income).

Additional requirements to be eligible for the premium subsidy are that the person:

- Is a U.S. citizen, national or alien lawfully present in the U.S. (e.g., on a visa)
- Is not eligible to be claimed as another person's tax dependent
- Files a tax return (if married, a joint return must be filed)
- Does not have employer-provided minimum essential coverage, including an HRA with a balance (regardless of whether it is affordable and minimum value)

The amount of available premium subsidy depends on the person's household income. The percentage of income a person will be expected to pay for coverage ranges from 2 percent for someone whose income is 100 percent to 133 percent of FPL to 9.5 percent for someone whose income is 300 percent to 400 percent of FPL. Basically, the Marketplace will look at how much a specific silver (70 percent value) plan costs in the Marketplace and determine how much of that cost the person should pay based on their income. The person will directly pay his or her share to the insurer and the government will pay the rest directly to the insurer.

The government payment of the premium subsidies is considered an advance tax credit, so when the person files his or her federal income tax return after the end of the year there will be a true-up using IRS Form 8962, and the employee will pay extra tax (to a maximum) or get money back if the monthly subsidies/credits were too large or too small.

Individuals with incomes below 250 percent of FPL will also be eligible for help with deductibles, coinsurance and co-pays.

A person who applies for a premium subsidy will be required to provide information

about coverage available through sources other than the Marketplace as part of the application process. If the person says that coverage is available through the person's employer (or his or her spouse's employer), the Marketplace will contact the employer to verify that the employee's information is accurate. Employers will be encouraged, but not required, to respond to these verification requests. Income will be verified through tax filings. Equifax will be used to obtain current income information if that is needed. The IRS has the right to audit both the employer and individual.

Note: The ACA defines "affordability" differently based on the situation. Affordability for purposes of the individual responsibility requirement is based on 8 percent of household income; affordability for purposes of the premium subsidy is based on 9.5 percent of household income; and affordability for purposes of the employer shared responsibility requirement is based on 9.5 percent of the employee's safe harbor income for self-only coverage.

The IRS has issued an FAQ about the individual mandate: Questions and Answers on the Individual Shared Responsibility Provision

A Fact Sheet is also available: The Individual Shared Responsibility Provision

Noteworthy Numbers and Other Details

For 2015, the tax filing threshold is $10,300 if filing single (under 65) and $20,600 if married and filing jointly (both spouses under 65).

For 2016, the Federal Poverty Level (FPL) in the 48 contiguous states is $11,880 for a household size of one and $24,300 for a household of four. It is $14,840/$30,380 in Alaska and $13,670/$27,950 in Hawaii.

The subsidy is based on the following table (a sliding scale applies in a linear manner, rounded to the nearest one-hundredth of one percent between the minimum and maximum percentage).

Applicable Percentage

Household income as a percent of FPL	Minimum	Maximum
Up to 133%	2.0	2.0
133% – 150%	3.0	4.0
150% – 200%	4.0	6.3
200% – 250%	6.3	8.05
250% – 300%	8.05	9.5
300% – 400%	9.5	9.5

The applicable percentage multiplied by the person's household income determines the person's required share of premiums for the second least expensive silver plan in the Marketplace.

Household income generally includes the income of all individuals in the tax household (e.g., the income of employed children is considered unless the child files his or her own tax return).

Proposed Regulations

On July 8, 2016, the Department of the Treasury issued proposed regulations relating to the health insurance premium tax credit (premium tax credit) and the individual shared responsibility provision.

The proposed regulations affect:

- Individuals who enroll in qualified health plans through the health insurance exchanges and claim the premium tax credit;
- The exchanges that make qualified health plans available to individuals and employers;
- Individuals who are eligible for employer-sponsored health coverage; and
- Individuals who seek to claim an exemption from the individual shared responsibility provision because of unaffordable coverage.

The regulations are proposed to apply for taxable years beginning after December

31, 2016, unless otherwise indicated. Taxpayers may rely on certain provisions of the proposed regulations for taxable years ending after December 31, 2013. Rules related to the benchmark plan are proposed to apply for taxable years beginning after December 31, 2018.

Although employers are not directly affected by the rules governing the premium tax credit, these proposed regulations may indirectly affect employers through the employer shared responsibility provisions and the related information reporting provisions.

How the Proposed Regulations Affect Individuals

The proposed regulations aim to reduce the likelihood that individuals who recklessly or intentionally provide inaccurate information to an Exchange will benefit from an Exchange determination, specifically the determination that the taxpayer's household income will be between 100 percent and 400 percent of the applicable FPL for the year, or the determination that the taxpayer or a member of the taxpayer's family is not eligible for certain government-sponsored programs.

The proposed regulations provide that, where these determinations are made, a taxpayer will not be treated as an applicable taxpayer or a taxpayer may be treated as eligible for coverage under the government-sponsored program if the taxpayer provided incorrect information to the Exchange with intentional or reckless disregard for the facts. Essentially, individuals who intentionally or recklessly disregard the facts will be unable to benefit from the regulations that do not require a repayment of advance credit payments (for taxpayers who experience an unforeseen decline in income, or for taxpayers with household income within the range for eligibility for certain government-sponsored programs.)

The proposed regulations provide that the Nonappropriated Fund Health Benefits Program offered by the Department of Defense is treated as an eligible employer-sponsored plan for purposes of determining if an individual is eligible for minimum essential coverage.

Employer Sponsored Plan Considerations

The proposed regulations clarify that, if an individual declined to enroll in employer-sponsored coverage for a plan year and did not have the opportunity to enroll in that coverage for one or more succeeding plan years, the individual is treated as ineligible for that coverage for the succeeding plan year or years for which there is no enrollment opportunity.

The proposed regulations also clarify that an individual is considered eligible for coverage under an eligible employer-sponsored plan only if that plan is minimum essential coverage; further, an individual enrolled or offered a plan consisting solely of excepted benefits is not denied the premium tax credit because of that excepted benefits offer or coverage.

Change in Individual's Status

The proposed regulations provide that, if an individual who is enrolled in a qualified health plan for which advance credit payments are made informs the Exchange that the individual is or will soon be eligible for other minimum essential coverage and that the advance credit payments should be discontinued, but the Exchange does not discontinue advance credit payments for the first calendar month after the individual notifies the Exchange, the individual is treated as eligible for the other minimum essential coverage no earlier than the first day of the second calendar month beginning after the first month the individual may enroll in the other minimum essential coverage. Similarly, if an individual is determined to be eligible for Medicaid or CHIP, but advance credit payments are not discontinued for the first calendar month after the eligibility determination, the individual is treated as eligible for Medicaid or CHIP no earlier than the first day of the second calendar month beginning after the determination. According to the proposed regulations, taxpayers may rely on these two rules for all taxable years beginning after December 31, 2013.

Partial Month Considerations

The proposed regulations provide that a taxpayer who is eligible for advance credit payments pursuant to an eligibility appeal for a member of the taxpayer's coverage family who, based on the appeals decision, retroactively enrolls in a qualified health plan, is considered to have met the requirement for enrollment in a qualified health plan for a month if the taxpayer pays the taxpayer's share of the premium for coverage under the plan for the month on or before the 120th day following the date of the appeals decision. According to the proposed regulations, taxpayers may rely on this rule for all taxable years beginning after December 31, 2013.

The proposed regulations clarify that, for purposes of the premium tax credit, the premium assistance amount for an individual who is not enrolled for an entire month is the same as for those whose qualified health plan is terminated before the last day of the month. As long as the individual was enrolled or is treated as enrolled as of the first day of the month, the premium assistance amount for a month is the lesser of the enrollment premium for the month (reduced by any amounts that were refunded), or the excess of the benchmark plan premium over the contribution amount for the month. According to the proposed regulations, taxpayers may rely on this rule for all taxable years beginning after December 31, 2013.

To ensure consistency with the rule above for calculation of premium assistance amounts for partial months of coverage, the proposed regulations provide that, if an individual is enrolled in a qualified health plan after the first day of the month, no value should be reported for the individual's enrollment premium or benchmark plan premium for that month. If an individual's coverage in a qualified health plan is terminated before the last day of a month, or an individual is enrolled in coverage after the first day of a month and the coverage is effective on the date of the individual's birth, adoption, or placement for adoption or foster care, or on the effective date of a court order, an Exchange must report the premium for the application benchmark plan for a full month of coverage (excluding the premium allocated to benefits in excess of essential health benefits.) Further, the Exchange

must report the enrollment premiums for the month (excluding the premium allocated to benefits in excess of essential health benefits), reduced by any amount that was refunded due to the plan's termination.

Other Considerations

The proposed regulations clarify that if advance credit payments are made for coverage of an individual for whom no taxpayer claims a personal exemption deduction, the taxpayer who attests to the Exchange to the intention to claim a personal exemption deduction for the individual – not the individual for whose coverage the advance credit payments were made – must file a tax return and reconcile the advance credit payments.

The proposed regulations also clarify that when multiple families enroll in a single qualified health plan and advance credit payments are made for the coverage, the enrollment premiums reported by the Exchange for each family is the family's allocable share of the enrollment premiums, which is based on the proportion of each family's applicable benchmark premium.

The proposed regulations also provide changes to benchmark plans that are proposed to apply for taxable years beginning after December 31, 2018.

Opt-Out Arrangements and an Employee's Required Contribution

The current regulations provide that, in determining whether employer-sponsored coverage is affordable to an employee, an employee's required contribution for the coverage includes the amount by which the employee's salary would be reduced to enroll in the coverage. The proposed regulations provide that if an employer makes an opt-out payment available to an employee, then the amount of the payment made under an unconditional opt-out arrangement increases the employee's required contribution.

Further, the proposed regulations clarify that an unconditional opt-out arrangement that is required under a collective bargaining agreement's terms in effect before

December 16, 2015, will be treated as having been adopted prior to December 16, 2015. The proposed regulations also clarify that employers participating in the collective bargaining agreement are not required to increase the amount of an employee's required contribution until the later of:

1. the beginning of the first plan year that begins after the expiration of the collection bargaining agreement that was in effect before December 16, 2015, (disregarding any extensions on or after December 16, 2015), or

2. the applicability date of these regulations with respect to sections 4980H and 6056.

This proposed regulation applies to any successor employer adopting the opt-out arrangement before the expiration of the collective bargaining agreement in effect before December 16, 2015 (disregarding any extensions on or after December 16, 2015).

The proposed regulations create a different rule for conditional opt-out arrangements. Amounts made available under conditional opt-out arrangements are disregarded in determining the required contribution if the arrangement satisfies certain conditions (eligible opt-out arrangement). If the arrangement does not satisfy the following conditions, then the amounts are taken into account in determining the employee's required contribution.

An eligible opt-out arrangement is an arrangement under which the employee's right to receive the opt-out payment is conditioned on:

1. The employee declining to enroll in the employer-sponsored coverage;

2. The employee providing reasonable evidence that the employee and the employee's expected tax family have or will have minimum essential coverage (other than coverage in the individual market, whether or not obtained through the Marketplace) during the period of coverage to which the opt-out arrangement applies; and

3. The employer having no knowledge or no reason to know that the employee or any other member of the employee's expected tax family does not have or will not have the required alternative coverage.

Reasonable evidence of alternative coverage includes the employee's attestation that the employee and all other members of the employee's expected tax family have or will have minimum essential coverage (other than coverage in the individual market, whether or not obtained through the Marketplace) or other reasonable coverage. Evidence of coverage must be provided at least every plan year to which the eligible opt-out arrangement applies.

As a best practice, employers should consider phasing out their use of opt-out arrangements because it appears that government agencies are continuing to limit the permissible use of opt-out arrangements. Employers who continue to use opt-out arrangements should consult with their legal counsel to ensure that their arrangements comply with current regulations.

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

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Bob Crnjarich Wins the 2016 Diamond Run Golf Men's Club Championship

Bob Crnjarich, Vice President of Retirement and Actuarial Services, won the 2016 Diamond Run Golf Club Men's Club Championship. The tournament ran from August 27-28. Diamond Run Golf Club is located in Sewickley, PA and was designed by PGA legend, Gary Player. Congratulations, Bob!

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Industry News

Reprieve on 2017 Mortality Table Change

The IRS has delayed, for at least one more year, its anticipated overhaul of the mortality tables used for minimum funding and lump sum distributions for defined benefit plans. Notice 2016-50 was released on September 2, extending the current methodology for setting the mortality tables through the 2017 plan year.

The Notice states that the IRS expects that new tables **"will apply beginning in 2018."** The Service will issue proposed regulations revising the base mortality rates and projection factors and solicit comments on the changes prior to implementation. The revised tables are expected to increase liabilities for minimum funding purposes and increase lump sum distribution amounts, but now not until 2018. Estimates are that funding liabilities and lump sums could both rise between 3% and 8% once these new tables become effective.

Because of this Notice, plan sponsors may wish to consider offering another round of lump sum windows to terminated vested participants in 2017. However, the savings from one more year of "lower-cost mortality" will be more than offset by lower interest rates, if a rebound doesn't occur in the next 3 months. Current lump sum rates are down roughly 80 basis points from November 2015 (the lookback month for many calendar year plans offering lump sums).

Click here for a copy of Notice 2016-50.

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What the New Mortality Table Release Means for Taft-Hartley Pension Plans

Earlier this week the IRS released a notice delaying for at least one more year the implementation of an overhaul of the mortality tables used in the actuarial valuation and lump sum determinations of defined benefit plans. While the notice specifically addresses single employer plans, for Taft-Hartley pension funds this should also

come as a small bit of good news.

Multiemployer plans (including Taft-Hartley Funds) are still valued using the actuary's discretion for the best estimate of life expectancy of the plan participants. However the frequent discussions about increasing life expectancy have led to more concern about how funding levels in multiemployer plans would be affected. Specifically, the concerns center around the risk that Congress or the IRS may mandate the use of the more recent mortality tables in multiemployer plans as they are currently mandated for single employer plans. Depending on the current table being used, the new rates could increase liabilities by 20% or more.

Current studies are reportedly underway that focus specifically on a union workforce, although release dates for the results of those studies are yet unknown. The recent studies that have been released do include a blue collar set of mortality rates, but these don't necessarily reflect a fully union workforce, or even one that is specifically in the construction trades.

Note that for purposes of paying lump sums from multiemployer plans, the IRS already mandates the use of published tables. The delay will avoid the overhaul in rates that would cause even higher lump sums. But the continual decline in interest rates can be expected to cause lump sum amounts to keep climbing. Plans that pay lump sums should be aware that amounts are likely to be higher in 2017 than in 2016.

For more information please contact: Brad Rigby, Director, Retirement & Actuarial Services at 412.394.9980.

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Offering One-Time Lump Sums for Defined Benefit Plans

Defined benefit plans are attractive to employees because they offer the security of steady income after retirement. But these plans come with costs to the employer, as the company must manage investments and pay for administrative costs and government insurance protection. In some cases, it can make more sense for the employer to offer a one-time, lump sum payment that replaces the annuity payment. If the employee accepts the payment, the employer is free of the associated risks.

Things To Consider Before Offering

A defined benefit plan is supported by investments that maintain the pool of money from which pension payments are drawn. Like any other investments, no matter how conservative, there is an element of risk. Offering a lump sum payout program allows the employer to reduce that risk by shifting it to the participant. Pay the participant a large, one-time amount, and then they are responsible for investing that amount however they feel is best.

A lump sum also reduces the costs of managing your defined benefit plan by reducing administrative overhead and lowering PBGC premiums, since the payment cashes the participant out of the program entirely.

When making the decision whether to offer a lump sum payout program or not, certain factors must be considered. You should be aware of how upcoming changes in interest rates, PBGC premiums, or mortality tables will affect your plan and calculate if paying out lump sums will stave off negative impact. You must analyze which participants would most decrease your risk if they took the lump sum. You need to decide what plan assets you will use to pay out the lump sums. Lastly, how will this program affect the company balance sheet?

Of course, the process of collecting data and then making the actual offers has its

own administrative and investment costs. If those costs overshadow the benefits of making a lump sum offer, then such a payout may not be in the employer's best interest.

Making The Offer

As with any change to your defined benefit plan, communication is critical. You should send a pre-election announcement to all affected participants outlining the payout offer. Participants may find the offer confusing or have trouble weighing the pros and cons of taking the lump sum versus staying with their annuity. Your announcement should encourage them to seek out a financial advisor who can help them make sense of it all.

You must also communicate to each participant the details of their election package. This should describe how the lump sum amount was calculated. You should also prepare reminders to be sent to participants during the election period, reiterating the process and informing them of their remaining time to choose.

Deciding to implement a lump sum payout program and managing it is complicated. Cowden Associates has the expertise to help you analyze the data, develop a payout plan, and communicate it to your participants clearly and efficiently. Contact us for more information on our actuarial and retirement services.

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Webinars

The ACA's Newest Nondiscrimination Rules and How They Apply to Group Health Plans

The Patient Protection and Affordable Care Act (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 the Department of Health and Human Services (HHS) on the basis of race, color, national origin, sex, age, or disability. The rules apply 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. Regulations implementing Section 1557 have raised a number of questions for group health plans and their sponsors.

This webinar will:

- Explain the background of Section 1557 and what it prohibits
- Discuss which employer group health plans are affected
- Outline when self-funded health plans are required to follow Section 1557
- Discuss whether the new rule requires group health plans to cover sex reassignment surgery or medications
- Discuss what “federal financial assistance” can mean
- Describe how a self-funded health plan’s TPA could be obligated to report non-conforming health plans to the government
- Discuss a health plan’s obligations in relation to the limited English proficiency rules
- Provide tips for benefit plan design

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

Lorie Maring is of Counsel in the Atlanta, Georgia office of Fisher Phillips. She focuses her practice on helping employers navigate Employee Retirement

Income Security Act (ERISA) and other state and federal laws impacting the design, implementation, and ongoing compliance of their employee benefit plans and programs.

She regularly advises clients on the Affordable Care Act, health and welfare benefits, qualified plans, executive compensation, Multiple Employer Welfare Arrangements (MEWAs), and multiemployer plan issues.

Starts: Tuesday, September 13, 2016 at 2:00 pm
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 28 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.

Jeanne Michaud
Consultant

Why I Enjoy My Job: I enjoy interacting with clients and other professionals and having the opportunity to continually develop in my profession.

Something Interesting About Me: I love to travel, especially to the beach. I have been to the most northern and southern tip of Africa.

Vince Wolf
Director

Why I Enjoy My Job: I learn something new everyday I'm here.

Something Interesting About Me: I play poker in Las Vegas for a week every year.

Bob Hazy
Senior Consultant and Actuary

Why I Enjoy My Job: I work for a great employer. Cowden is a throwback, to the days when companies actually believed the mantra that “our employees are our greatest asset." We are treated well. The most rewarding part of my job is being viewed as a “trusted advisor” (sorry, another cliché) by my clients and my colleagues.

Something Interesting About Me: My passion is jazz. I play piano and trumpet

with the Swingin’ BopCats Big Band.

Amanda McGourty
Consultant

Why I Enjoy My Job: I enjoy working with my clients and getting to know the various industries they work in.

Something Interesting About Me: I like to travel to new places and go scuba diving.

Heather Erfort
Controller

Why I Enjoy My Job: I enjoy the challenges and the people I work with.

Something Interesting About Me: I love Rottweilers and have owned them since the late 90s.

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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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Talking to Your Doctor Via Computer - What Role Will "Telehealth" Play in the Future?

While watching the televised coverage of the Summer Olympics, I took notice of an ad for a local health network. It showed a Doctor sitting in front of a computer screen interacting with a patient, also "examining" this patient, by suggesting movement and asking a variety of questions. It seemed like it was working well – as it was a TV commercial and they would not show it otherwise (the patient was even smiling…). But, it got me to thinking about what the current and future state of this could possibly be.

The theory behind this seems relatively straight forward: Telehealth aims to make health care services even more accessible to patients, by accessing care any time through a variety of outlets such as a web browser, mobile phone, or a tablet. The goal is to create a pro-active self-care environment (not having to call and make an appointment and wait) with the potential to reduce the cost of treatment by keeping people away from the emergency room, doctor's offices, etc.

In addition, under new value-based payment models that reward outcomes (including lower total cost of care) rather than utilization, telehealth may be a cost-effective solution to provide access to care. Certainly with every new introduction of technology or service models, providers and health plans will have to consider creating and monitoring strategies and policies. These would include how to better encourage self-care and steps to monitor each patient's success in following the prescribed steps, including medication adherence. From a cost standpoint, one would assume that there would be fees associated with licensing changes, liability insurance, and tracking systems that don't exist today. In addition, federal and state regulations will ultimately be implemented to protect consumers and providers. Other issues will have to be solved relating to Medicare and Medicaid reimbursement levels for these services, as it appears that not much has been implemented for these functions.

On the other hand, twenty eight states have laws requiring private insurers to reimburse for telehealth services at the same rate as in-person services. On the

surface, this would appear to be a bad answer (unless you are a telehealth provider), but as other payment models evolve (e.g. value-based models), payment parity regulations would become less relevant. It would seem that under a shared risk and shared savings model, a natural solution would be to increase the incentives for health plans, to encourage the use of telehealth services. The telehealth service would act in a way to reduce or eliminate costs through a patient interaction that would ideally avoid hospital readmissions and, if needed, suggest an alternate course of action such as urgent care centers or the physician offices.

Imagine turning on your phone and a nurse says: "the doctor will see you now" (cue the Jetsons theme song).

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How Are We Doing?

Please let us know how we're doing by submitting a Cowden Gram!

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