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Assets in 401(k) Plans Aren't Severely Affected by Equity Market Volatility
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FIDUCIARY RESPONSIBILITY: Practitioners say plan fiduciaries may face risks, including personal liability, when corporate decisionmakers turn their attention to retirement and welfare plan administration as a source of savings in perilous economic times. The authors discuss some of the most notable areas for possible ERISA violations when fiduciaries face corporate cost-cutting pressures. **Page 2253**

ACCOUNTING: The chairman of the Financial Accounting Standards Board urges a redrawing of the ''highly fragmented, balkanized regulatory structure'' in the United States and suggests he favors a cap on executive pay at $20 million. **Page 2204**

BNA CONFERENCES: BNA will hold an audioconference on § 409A proposed rules on income exclusion on Oct. 8, from 1:30 p.m. to 3 p.m. If the proposed rules have not been released by that date, the audioconference will be rescheduled. BNA also will hold a comprehensive employee benefits update conference, Nov. 17-18, for plan sponsors, corporate counsel, consultants, investment advisors, industry analysts, and attorneys, with speakers from IRS, DOL, SEC, and Capitol Hill, Washington, D.C. Go to http://legaledge.bna.com for more information and to register.

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Assets in 401(k) Plans Not Severely Affected By Equity Market Volatility, PSCA's Wray Says

The impact of current equity market volatility on tax code Section 401(k) plan assets is probably not as severe as is occurring in the equity market overall, David L. Wray, president of the Profit Sharing/401(k) Council of America, told BNA Sept. 26.

While the ''markets are extremely volatile, Section 401(k) assets are only down somewhat,'' Wray said, adding that one-third of such assets are in fixed investments, not equities.

He said participant behavior to date has been ''moderate'' regarding the movement of equity assets into fixed assets. ''The amounts have been very small,'' Wray said.

Wray was responding to questions from BNA following release of PSCA's *51st Annual Survey of Profit Sharing and 401(k) Plans*, which PSCA said provides information on current practices and trends in profit-sharing and Section 401(k) plans.

''Section 401(k) assets are only down somewhat.''

PSCA PRESIDENT DAVID L. WRAY

The survey reports on the 2007 plan year experience of 1,011 plans with 7.4 million participants and more than $730 billion in plan assets, representing plans of companies of all sizes and regions across the United States, PSCA said.

Money Management. For the first time, the survey, asked how money is being managed, Wray said. Survey respondents were asked if they were using a mutual fund, collective trust, pooled general account, exchange-traded fund, or a separately managed account to manage Section 401(k) plan assets.

''We did this to set a baseline as there appears to be a change in how the assets are managed,'' Wray said. This year's results show that for smaller companies, except for stable value funds, the money is mostly managed in a mutual fund.

But a larger number of very large companies are using nonmutual money fund approaches, Wray said. ''Over time, we expect to see a greater use of collective trusts and managed accounts, especially in larger companies,'' he said.

Automatic Enrollment. The survey found that following a big increase in automatic enrollment in 2006, more plans of all sizes added automatic enrollment features in 2007. More than half of large plans utilize this feature, while usage by small plans doubled.

''The Pension Protection Act gave a boost to a trend already in place,'' Wray said. ''The PPA will certainly be helpful in expanding the system beyond 'early adopters' of automatic enrollment.''

Asset Allocation. The survey found that the typical plan has approximately 65 percent of assets invested in equities, most frequently invested in:

- actively managed domestic equity funds (29.1 percent of assets),
- indexed domestic equity funds (10 percent),
- stable value funds (8.6 percent), and
- balanced stock/bond funds (8.0 percent).

Catch-Up Contributions. Catch-up contributions for participants aged 50 and older are permitted in 99 percent of plans, the survey found.

Thirty-three percent of those plans offer a match on the catch-up contributions, according to the survey. The percentage of eligible employees who make catch-up contributions ranged from 43.1 percent at the smallest companies to 12 percent at the largest, it said.

''Catch-up contributions are universally available and benefit older workers,'' Wray said. He suggested that employers periodically remind plan participants that they have this opportunity to improve their retirement savings.

Company Contributions. Company contributions averaged 4.4 percent of payroll, according to the survey. They are highest in profit-sharing plans (8.6 percent) and lowest in Section 401(k) plans (3.2 percent), it said.

Numerous formulas are used to determine company contributions, the survey report said. The most common formula is a fixed match only, present in 24.8 percent of plans, including plans with safe harbor matches, it said.

For plans with fixed matches, the most common matches are:

- $.50 per $1 up to the first 6 percent of pay (26.2 percent of plans),
- $1 per $1 up to the first 4 percent of pay (10.4 percent of plans), and
- $1 per $1 up to the first 3 percent of pay (8.1 percent of plans).

Investment Options. The number of funds offered to plan participants have plateaued, according to the survey.

It said plans offer an average of 18 funds for participant contributions. The funds most commonly offered for participant contributions are:

- actively managed domestic equity funds (76.8 percent of plans),
- actively managed international equity funds (73.4 percent of plans),
- indexed domestic equity funds (70.4 percent of plans), and
- actively managed domestic bond funds (63.8 percent of plans).

Other Findings. Other findings from the survey included:

- Recent regulatory changes have resulted in a decrease in the number of stand-alone profit-sharing plans, as they have increasingly been adding a Section 401(k) component.
- The number of plans offering Roth 401(k) plans increased by two-thirds in 2007.
- More than 83 percent of survey respondents said they had an investment policy statement.
- Investments most often are monitored on a quarterly basis (60 percent), followed by annually (21.6 percent).
- In plans with a loan feature, an average of almost 24 percent of participants have loans outstanding, with an average loan amount of $7,655. Loans account for 1.6 percent of total plan assets among plans with loans.

BY MICHAEL W. WYAND

The survey is available for purchase for $375 for non-PSCA members and $145 for members. To place an order call (312) 419-1863.

Investments

Plans Should Stick to Long-Term Strategies Despite Financial Turmoil, Consultants Say

With financial turmoil wreaking havoc on retirement and investment plans, consultants at Hewitt Associates advised defined benefit plan pension sponsors during a Sept. 23 Webinar not to panic, but rather to stick to their established long-term investment and funding strategies, while continuing to monitor the implications of events on their plans' funding status.

During the presentation, titled *Financial Turmoil is Wreaking Havoc on Retirement and Investment Plans—How Should You React?*, Joe McDonald, who heads Hewitt's Global Risk Services in North America, Bridgewater, N.J., told plan sponsors that although they should not ignore what was happening, they should not ''overreact either.'' Instead, he advised that plan fiduciaries continue to implement the long-term strategies they already have in place.

McDonald said fiduciaries should monitor the potential implications of their fund's ''eroding funding status'' and should implement investment rebalancing strategies already in place. In addition, he said, they should move forward with any liability driven investment strategies but reflect on the speed and method of such implementation.

Of utmost importance, McDonald said, plans must implement risk management and monitoring programs, if they are not already operating. Such risk management and monitoring, which incorporates the amount of risk the plan fiduciaries are comfortable with, must be ongoing, he added.

'Bad News' in Short-Term. Colin Robertson, global head of asset allocation in Hewitt's Global Investment Practice in London, told plan sponsors the ''systemwide solution'' to the existing financial crisis offered by the U.S. Treasury has restored some confidence to the system; however, he said, ''we have little idea how it will work in practice.''

In the short-term, expect ''plenty of bad news,'' he said. Such bad news could arise from:

- revelations of problems facing financial firms outside the United States,
- concerns about a recession in the United States and worldwide,
- the decline of corporate profits, and
- revelations about the high cost of the financial industry bailout now being formulated.

Such bad news is likely to result in a further decline in stock prices for several months or longer, Robertson said.

However, he added, ''long-term, things are not so bad.'' Stocks are getting cheaper relative to bonds, and many new opportunities are being created. Robertson also said because the United States has been ''aggressive'' in finding a solution to the crisis, and other nations have not, the U.S. dollar will likely strengthen relative to other world currencies as a result.

Funding Ratios. Matt Clink, director of U.S. Asset Allocation for Hewitt in Chicago, pointed out that despite the recent equity market decline, the funded ratio for plans in the Standard & Poor 500 Index has not decreased as much.

He said that the although pension plan assets have declined by about 15 percent since the start of the year, the funded ratio has declined only by about 3 percent. This is due to the fact that credit spreads have widened considerably, thereby causing plan liabilities to fall, he said. However, he cautioned that those credit spreads are likely to revert to more normal levels, thereby causing plan liabilities to increase.

Clink added that a recent sell-off in corporate bonds in favor of U.S. Treasury instruments has made investments in investment grade corporate bonds attractive. While he recommended that plans consider moving money to such investments, he cautioned that they find others skilled in active investment management to direct the timing and selection of such investments.

Equity Rebalancing Strategy. McDonald cautioned plan fiduciaries to monitor their plan's funding status, pointing out that provisions of the Pension Protection Act of 2006 (Pub. L. No. 109-280) will be triggered if the plan's funded ratio declines to as little as 80 percent. He said in such circumstances there will be benefit restrictions, additional reporting required to the Pension Benefit Guaranty Corporation, accounting implications, and likely increased borrowing costs as well.

Clink told fiduciaries that ''volatility is back.'' With the decline in equities, he said many plans are now underweighted in their investment allocation to equities and should be thinking about moving funds back to their equity targets.

However, given the high transaction costs involved in trading during volatile times, which Clink explained as incorporating not only actual commission costs but ''how the market moves'' in reaction to such trades, he said it would be prudent for plans to rebalance to the lower range of their targeted equity allocation. He referred to this strategy of not fully rebalancing to the plan's target allocation as ''hedging your regret.''

Robertson added that such a strategy makes sense given that (1) it is important for plans to be disciplined in implementing their established rebalancing strate-

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gies, and (2) he expects there will be more bad news that will cause stocks to decline further.

BY DAVID B. BRANDOLPH

PBGC

Tax Panel Questions PBGC's Soundness In Light of Current Financial Market Turmoil

Members of the House Ways and Means Oversight Subcommittee said Sept. 24 that they are deeply concerned about the financial condition of the Pension Benefit Guaranty Corporation and find its financial situation troubling, especially in light of current market turmoil.

''I am deeply concerned about the current financial condition of the PBGC,'' Subcommittee Chairman John Lewis (D-Ga.) said. ''Recent Wall Street events make examination [of the agency] even more important,'' he said.

Ranking Member Jim Ramstad (R-Minn.) said he found PBGC's financial situation ''troubling,'' particularly in view of its $14 billion deficit. He noted the Government Accountability Office's finding that the agency's new investment policy involves more risk than acknowledged by PBGC.

Other committee members expressed similar concerns about the turmoil in the financial markets and its impact on PBGC. Several expressed concern that ultimately taxpayers would be held responsible for the costs of underfunded defined benefit pension plans. Barbara D. Bovbjerg, director of GAO's Education, Workforce, and Income Security, told the subcommittee that it is ''hard to say'' whether taxpayers would have to bailout the agency.

There is no risk of taxpayers having to bailout PBGC currently or for years to come, Bovbjerg said. ''It is not an immediate problem. The problem is down the road,'' she said.

Rep. Earl Pomeroy (D-N.D.), a member of the full committee, called on Congress to enact asset smoothing and revise the Pension Protection Act of 2006 (Pub. L. No. 109-280) to help defined benefit pension plan sponsors through ''these difficult economic times.'' He said asset smoothing would allow businesses to balance out the ups and downs that occur with market investments.

Asset smoothing provisions currently pending in Congress would allow a plan to determine the value of plan assets in a manner that is based on fair market value, that smooths unexpected gains or losses within a two-year period, and that does not result in a value that is less than 90 percent or more than 110 percent of the fair market value

New Investment Policy. Charles E. F. Millard, director of the PBGC, told the subcommittee that his ''number one concern'' is any changes to the agency's new investment policy.

Notwithstanding the current turmoil in the financial markets, Millard told the subcommittee that any changes to the new investment policy may detract from the PBGC meeting its long-term obligations and reducing the agency's deficit.

Bovbjerg said that recent economic events could impact PBGC and that the agency's new investment policy needs closer scrutiny.

PBGC's new investment policy allocates 45 percent of the agency's assets to a diversified set of fixed-income investments, 45 percent to diversified equity investments, and 10 percent to alternative investment classes, according to the agency (33 PBD, 2/20/08; 35 BPR 447, 2/26/08).

Millard told BNA in a telephone interview Feb. 19 that the new investment policy addresses the agency's long-term time horizon and diversifies the asset mix. ''Those two things give us a potential for higher returns with less risk than we are currently taking,'' he added.

Magnitude of Risks. Lewis questioned Millard about the magnitude of the risks for the agency regarding the recent financial difficulties of the Federal National Mortgage Association (Fannie Mae), the Federal Home Loan Mortgage Corporation (Freddie Mac), IndyMac Federal Bank (IndyMac), American International Group Inc. (AIG), and Lehman Brothers Holdings Inc. (Lehman).

According to Millard, the aggregate pension underfunding risk for all five entities is $400 million. He said only $100 million of that is insured by the PBGC due to limits on the maximum amount the agency can pay to any one individual.

''This is the magnitude of the risk,'' Millard said. However, the PBGC is not necessarily going to have to take over any of the plans, he said. He noted that Fannie Mae, Freddie Mac, and AIG are not bankrupt.

According to Millard, the risk the PBGC faces is a ''long-term risk.'' The prior policy of the agency relied on Congress to address the PBGC's deficit. The agency was not necessarily trying to reduce or close its deficit, he said.

Citing the PBGC's new investment policy, Millard said, ''We are trying to close the deficit.''

Rep. Ron J. Kind (D-Wis.) asked Millard why Congress was not included in the development of the PBGC's new investment policy. Millard responded that since 1974, determination of the agency's investment policy has been in the purview of its board of directors and that director meetings are not open to the public under current law.

''I am not comforted by that response,'' Kind said.

Securities Held by PBGC. Ramstad asked Millard about the securities held by the agency, given that the five entities identified by Lewis are largely associated with mortgage backed securities.

Six percent of PBGC's portfolio includes mortgage backed securities as of Sept. 30, 2007, Millard responded. He pointed out that the agency does not select securities for its portfolio. It hires managers to do that, he said.

Ramstad asked Millard about PBGC investments in derivatives. According to WikipediA, derivatives are financial instruments whose value changes in response to the changes in underlying variables. The main types of derivatives are futures, forwards, options, and swaps. Derivatives can be based on different types of assets such as commodities, equities (stocks), bonds, interest rates, exchange rates, or indexes.

According to Millard, the PBGC has $2.8 billion in notional value in derivatives. These derivatives are credit default swaps, a PBGC spokesman told BNA following the hearing. The spokesman said that if the assets were to drop to zero in value, the agency's potential loss would be $1.7 billion.

Smoothing and Funding Phase-In Level. Pomeroy said that the PPA requires pension plans to increase their funding target to 100 percent of the plan's liabilities but provides a transition to allow plans to phase-in the new target from the 90 percent funding target most plans had before the PPA.

According to Pomeroy, if a plan is at 94 percent funding in 2009, it has no shortfall to fund. But if a plan is at 92 percent funding in 2009, it is ineligible for the transition rule and must fund based on an 8 percent shortfall, not based on the 2 percent shortfall needed to get to 94 percent funding, he indicated.

According to Pomeroy, this is an extremely onerous result for companies trying to recover from challenging economic times. Because of the lack of asset smoothing, the number of plans subject to the benefit restriction in 2009 will likely rise, he suggested.

A plan sponsor may face a big unbudgeted pension plan contribution because of recent market conditions, Pomeroy emphasized.

He called on Congress to enact asset smoothing and to revise the PPA to use the phase-in level as the funding target to help pension plan sponsors through these difficult economic times.

''It is ridiculous that Congress has failed to pass smoothing,'' Pomeroy stated.

BY MICHAEL W. WYAND

Additional information is available on the full committee's Web site at http://waysandmeans.house.gov/hearings.asp. Click on 9-24-2008 Hearing on the Pension Benefit Guaranty Corporation.

Executive Compensation

Relief From Section 409A Deadline Needed As Financial Crisis Takes Toll on Resources

Some practitioners have suggested that tax code Section 409A's documentary compliance deadline of Dec. 31 be extended for another year, as companies struggle with the financial crisis, according to comments made to BNA Sept. 24.

With ''no official leeway in anything but perfect compliance,'' and the continued uncertainty over even the most basic principles governing Section 409A, ''we need the [Internal Revenue Service] to tell us officially that good faith compliance with the regulations will do for now,'' Michael J. Segal of Wachtell, Lipton, Rosen & Katz, New York, told BNA.

The financial crisis has required single-minded focus on this issue for a wide variety of institutions, Andrew L. Oringer, White & Case, New York, told BNA Sept. 24. He said ''to now ask those institutions to continue to devote the necessary resources to attain full 409A compliance by the end of the year would result in distraction from critical business decisions.''

Agreeing that an extension of the transition period would be beneficial, Daniel L. Hogans, Morgan, Lewis & Bockius, Washington, D.C., told BNA that ''in some industry sectors and some regions of the country like the Gulf Coast, there are serious resource issues to be considered in light of all that is happening right now. Many companies are just fighting for survival.''

In addition to resources issues, the complexity of the Section 409A regulations continues to challenge employers' best efforts to meet the Dec. 31 deadline. Oringer said there is disagreement over ''an extremely broad range of interpretative issues, some of which are basic and some of which are detail oriented.'' Both Oringer and Segal said those issues continue to be debated among practitioners and in some cases ''may not even be the subject of a coalesced regulatory view,'' according to Oringer.

Segal said they are not asking for a further delay of the regulations, but rather another extension of the documentary compliance period. As Oringer explained, what is being suggested is that a ''reasonable interpretation of all the authority, including the final regulations would be permitted.''

In written comments, Hogans said Sept. 24, ''On the whole, the major benefit of a further extension would accrue to employers outside the *Fortune 500*.'' He explained that ''many medium and smaller employers are still coming to grips with the scope, breadth, and complexity of these rules, which truly represent an enormous paradigm change. Given the extraordinarily punitive effects of noncompliance, another year would be enormously beneficial to medium-sized and smaller employers.''

An Alternative to Full Relief. In the absence of a full extension of the good faith compliance period, Segal said, IRS should apply the 2008 documentary compliance deadline only to executive officers of public companies. ''Because [Section 409A] implicates a broad range of arrangements up and down the entire workforce, given the disruption in the markets, it is asking too much to have perfection in the documents for employees up and down the line,'' he said.

Segal said everything IRS has done to extend the good faith compliance period in the past has been appreciated by employers. Nevertheless, Segal said, the financial crisis is a new development that should be considered by IRS and Treasury in granting additional transition relief.

BY MARY HUGHES

Accounting

FASB's Herz Urges Regulatory Reform, Caps On Executive Pay, Evokes 'Lessons Learned'

NORWALK, Conn.—In a bluntly worded, wide-ranging speech, the chairman of the Financial Accounting Standards Board Sept. 18 urged a redrawing of the ''highly fragmented, balkanized regulatory structure'' in the United States and suggested he favors a cap on executive pay at $20 million.

''Our financial system architecture has been built up on a patch-work basis and it is time to rethink it,'' Robert Herz told a private audience in New York at a workshop attended by bankers, corporate executives, attorneys, broker-dealers, and accountants. In the speech, made public on FASB's website, Herz said he spoke for himself and not for FASB.

On executive compensation, the FASB chairman said that ''it really rubs many people the wrong way when the CEO of a large company'' is paid $150 million per

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year and ''then, after he's run the place into the ground, is given another $50 million to leave.''

''Personally, I am concerned that it may be eating away at the fabric of our capitalist society,'' he said in a speech titled ''Lessons Learned, *Relearned*, and *Relearned Again* from the Credit Crisis—Accounting and Beyond.''

''I know this may be unreasonable and overly harsh,'' Herz continued, ''but I think almost any CEO should be able to get along with $20 million annually. Call me crazy!''

A former auditor, Herz spoke at a technical forum on structured finance at his old firm, PricewaterhouseCoopers, toward the end of a week in which Lehman Brothers went bankrupt, followed by announcements that AIG would receive an $85 billion bailout by the Federal Reserve Board and Merrill Lynch would be bought by Bank of America.

Those events gave impetus to the FASB chairman's message, which he had considered delivering ''since earlier in the summer,'' a board spokesman told BNA Sept. 19.

Herz tied events from the weeks of Sept. 8 and Sept. 15 to the issue of fair value reporting. He cited some companies' periodic complaints that mark-to-market accounting ''understates the 'true value' of securities in illiquid markets, thereby overstating the extent of 'true' losses.''

He continued: ''Unfortunately, so far these assertions have proven Pollyannaish, with the values of the securities in question falling fairly steadily over the course of the last year and with some of the institutions making these assertions amongst those that have failed and/or had to be rescued by the Treasury and the Fed.''

Broad Strokes, Finer Points. In his 23-page speech, delivered in broad strokes and in finer points that drilled down to accounting nitty-gritty, Herz admonished those whom he suggested have financially maneuvered around accounting standards.

He also targeted lenders who make loans to those who probably would not be able to repay them and companies that fail to properly convey risk to their investors and the markets, ''just because there is no specific FASB or SEC requirement.''

In addition, the FASB chairman described ''an apparent continued addiction by some in corporate America to 'off-balance-sheet' treatments, and an aversion to providing full and forthright disclosures'' on risks facing those enterprises.

''Effective oversight and regulation are also key ingredients of sound markets,'' said Herz, who pointed to lessons ''relearned'' during the savings and loan crisis of the 1980s as well as in 2001-2002, the bursting of the dot-com bubble, and the Enron and WorldCom reporting scandals.

He also cited a particular brand of derivative deals, credit default swaps, in which troubled insurer American International Group reportedly did business. Herz said such activities, which appear to some observers to be a '' 'Wild West' version of financial markets,'' prompted the question: ''Where were the regulators?''

The FASB chairman also spoke of the impact of events in the United States beyond the nation's border.

''While the credit crisis may have originated in the U.S., the shock waves have reverberated around the world,'' Herz said.

''So it's not surprising that while some may accuse China of exporting toxic toys, we are being accused by some of our foreign partners of exporting toxic securities,'' he added.

Value in Fair Value. Herz spoke positively about the value of fair value accounting, which has become a controversial topic and blamed in some quarters for the current credit crisis and mortgage meltdown.

He cautioned the audience to ''ignore current market/fair value at your peril for it may provide a critical signal of underlying problems and truths.

''Our financial system architecture has been built up on a patch-work basis and it is time to rethink it.''

FASB CHAIRMAN ROBERT HERZ

Accounting has consequences,'' he added. ''It's meant to. Otherwise, why do it?''

The U.S. accounting standard-setter also spoke of limits on solutions coming from Norwalk or Washington.

''The harsh reality is that we can't just suspend or modify the financial reporting when there is bad news,'' Herz said, according to his speech text. ''That's not to say that fair value is the universal panacea. There are difficult issues, particularly in illiquid markets.''

In the final analysis, he said, ''better regulation, sounder standards and more effective enforcement can only go so far. Market-led reforms and solutions are also critical to ensuring the sound and effective functioning of our financial and capital markets and to help avoid a repeat of recurring problems.''

Securitizations, Consolidations Rules Not 'God's Gift.' In his speech, Herz acknowledged that the key FASB guidance on securitizations (Statement No. 140) and consolidations of ''variable interest entities'' or VIEs (Interpretation No. 46)—such as the investment vehicles that have figured in the huge write-downs of mortgage-backed securities—are not ''God's gift to accounting.''

However, he suggested that in the case of FASB No. 140, on transfers of financial assets, the rules have been stretched far beyond their intended purpose. A key provision, affording business-friendly sale accounting to what the board calls a ''qualifying special-purpose entity'' (QSPE), has been used ''by some folks'' as ''a punch bowl to get off-balance-sheet treatment while spiking the punch.''

FASB issued proposals Sept. 15 to remove the ''QSPE'' designation and accounting treatment and, related to that, to eliminate the exception in FIN 46R that prevents such entities and their holdings from being included in the umbrella financial statements of the parent entity. The proposals also have drawn the attention of federal banking regulators, who have disagreed with certain proposed accounting policy changes by FASB over the years.

FASB believes that those ''significant revisions,'' said Herz, ''will result in many, if not most, securitizations and VIEs being on balance sheet.''

''These changes are needed in the short run in response to reporting issues that have arisen in our country.''

Handling the Truth. Peppered throughout Herz's speech was a catchphrase from the film *A Few Good Men*. In that film, a character played by actor Jack Nicholson challenges someone else that he ''can't handle the truth.''

In recent years, Herz has employed the line or a variation as a virtual mantra regarding what proper accounting reveals.

''Can we handle the truth?'' the FASB chairman asked. ''External financial reporting is not merely a compliance exercise, nor is it an opportunity for spin.

''Rather, the primary intent is to inform investors and the capital markets,'' he continued. ''What you measure matters. And accountability requires honest accounting and informative disclosures, even when the news is bad.''

BY STEVE BURKHOLDER

Text of the FASB chairman's speech is available at http://www.fasb.org/news/09-18-08_herz_speech.pdf.

Public Plans

National Groups Say Public Pension Funds Are Sufficiently Diversified to Weather Crisis

Public pension funds are sufficiently diversified to weather the unfolding financial crisis, the National Association of State Retirement Administrators and the National Council on Teacher Retirement said in a joint statement issued Sept. 25.

Public pension funds are prefunded with more than $2.5 trillion in assets that are diversified and professionally managed, according the statement aimed at reassuring teachers, firefighters, police officers, and other state and local public employees, NASRA said in the statement.

''Pension fund investments in companies making headlines comprise only a small percentage of public pension fund portfolios,'' the statement said. ''By holding on to their investments and providing liquidity to the market, pension funds are aiding the recovery of the capital markets,'' it added.

Of the more than $2.5 trillion in public pension fund assets, about 60 percent is in global stocks, 30 percent in government and corporate bonds, 5 percent in real estate, and the rest in cash and alternatives, the statement said.

Public pension funds have the liquidity necessary to pay promised benefits for the near term and the accumulated assets and funding mechanisms that will allow them to continue to do so indefinitely, it said.

It also said many public pension funds halted securities lending before the Securities and Exchange Commission issued additional regulations designed to curb predatory short sales and restore investor confidence.

The statement included links to the Web sites of more than two dozen retirement systems that are members of NASRA and NCTR and have posted information about the financial crisis.

The Web site of the California Public Employees' Retirement System, the nation's largest public pension fund, has posted a notice of a temporary pullback of shares of four financial institutions in its securities lending program: Goldman Sachs, Morgan Stanley, State Street, and Wachovia (184 PBD, 9/23/08).

CalPERS began its securities lending program in the early 1980s to earn additional income on its existing portfolios, according to the notice. CalPERS has assets of $220 billion.

BY FLORENCE OLSEN

More information is at http://www.nasra.org/ and http://www.nctr.org/.

Public Plans

CalPERS Halts Securities Lending For Four Firms Until Market Stabilizes

SACRAMENTO, Calif.—The California Public Employees' Retirement System announced Sept. 18 it will temporarily stop lending its securities from the firms of Goldman Sachs, Morgan Stanley, State Street, and Wachovia until the market is less volatile.

The decision to pull back lending of shares applies only to the four financial institutions, not to any other institutions in the pension system's portfolio. The temporary restriction is intended to improve market stability.

Through its Securities Lending Program, CalPERS lends securities to borrowing institutions as a way to earn more income on its portfolio.

''We want to do our part and help mitigate the current instability of the market and any potential adverse short-selling impact on these important financial institutions,'' CalPERS Interim Chief Investment Officer Anne Stausboll said. ''Our Securities Lending Program otherwise will remain the same.''

Stausboll said CalPERS will lift the loan restrictions once the financial markets stabilize. The pension system otherwise will remain active in securities lending as a tool to provide liquidity and orderly, efficient operations of the global financial system.

CalPERS launched its securities lending program in the 1980s. In the past eight years, CalPERS has auctioned off $799 billion in assets through 30 auctions. The program has $38 billion in shares and cumulative net earnings of nearly $1.2 billion.

CalPERS is the nation's largest public pension fund with assets totaling approximately $220 billion.

BY LAURA MAHONEY

Retiree Health

House Committee Debates Need for New Law To Bind Employers to Retiree Health Benefits

Lawmakers and witnesses debated Sept. 25 whether a new law is needed to protect retiree health benefits during a hearing held by the House Education and Labor Committee.

Several witnesses representing large companies said the problem is too large for employers to solve by themselves. Some said Congress should address it by pass-

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ing the Emergency Retiree Health Benefits Protection Act (H.R. 1322). The bill, sponsored by Reps. John Tierney (D-Mass.) and Dale Kildee (D-Mich.), would prohibit profitable companies from canceling or reducing promised retiree health benefits.

It also would establish an enforceable obligation to restore promised health benefits previously taken away from retirees and create an Emergency Retiree Health Loan Guarantee Program to assist plan sponsors in meeting their obligation to restore retiree health benefits, Tierney said.

The bill uses language originally written for the Employee Retirement Income Security Act of 1974 but taken out before passage to increase the chances of enacting the ERISA legislation, a supporter of H.R. 1322 said at the hearing. Similar language is part of a separate bill (H.R. 6143) introduced in May to modify the Pension Protection Act of 2006 (103 PBD, 5/29/08; 35 BPR 1209, 6/3/08).

ERISA Omission. ERISA was enacted without provisions for mandatory vesting of health benefits, Norman Stein, professor of benefits and tax law at the University of Alabama, testified. ''In retiree health plans, the relevant statutory question is whether the employer has made a binding promise to its employees to pay them health benefits after they retire,'' Stein said.

Federal judges often are called upon to determine whether an employer has made such a promise to its employees and ''the courts have not, for the most part, been sympathetic to employee claims,'' Stein said.

Employer, Regulatory Obstacles. Employers would oppose a bill that required mandatory vesting of health benefits, especially with the increasing cost of health care, said speaker Scott Macey, senior vice president and director of government affairs at Aon Consulting, speaking on behalf of the ERISA Industry Committee. ''Few companies will risk offering retiree health benefits if they are confined in the legal straightjacket that the bill [H.R. 1322] would impose, '' Macey said.

The loss of retiree health benefits is part of a pervasive problem in the American health care system that prevents working and nonworking Americans from receiving affordable health coverage, Macey said. ''These are societal problems that require a comprehensive solution,'' he said.

Another speaker, Dale Yamamoto, president and founder of Red Quill Consulting and former chief health care actuary at Hewitt Associates, said increasing health care costs are only one reason for a dramatic decline in the percentage of employers that offer retiree health benefits.

Various regulatory measures have contributed to the loss, Yamamoto said. Tax legislation in the 1980s that restricted the ability of plan sponsors to prefund retiree benefits caused an erosion of benefits, he said. Another culprit is a 1990s Financial Accounting Standards Board rule, FAS 106, that required an advanced accounting of retiree health care benefits, Yamamoto said.

A 2007 rule by the Equal Employment Opportunity Commission made it more difficult to protect health benefits for retirees, said Bill Kadereit, president of the National Retiree Legislative Network, an advocacy group for legislation to protect pensions and benefits. The EEOC rule permits companies to eliminate health care benefits for older retirees if that becomes necessary to maintain benefits for younger retirees, Kadereit said. ''The EEOC rule and the fact that ERISA does not vest retiree benefits are the real culprits,'' he said.

Reservation of Rights Clause. Another significant obstacle to safeguarding retiree health benefits is the reservation of rights clause, which many large employers began to add to their benefits plans in the 1980s, said C. William Jones, chairman of the board of ProtectSeniors.org, an advocacy group for retiree health benefits. With that clause, employers reserve the right to amend their health benefit plans at any time, he said.

''This week there is much talk about bailing out the geniuses of Wall Street whose phony schemes threaten our economy, but when will Congress start protecting the people who spent a lifetime doing the real work that made America great?''

RETIREE DAVID LILLIE

Rep. John Kline (R-Minn.), ranking member of the Education and Labor Committee's Health, Employment, Labor, and Pensions Subcommittee, said the current statutory and regulatory system for protecting employer-provided retiree health benefits, although flawed, still works reasonably well.

''Current law already prohibits employers from reducing or terminating promised benefits unless they expressly reserve the right to do so and fully disclose this intent under their ERISA benefit plan,'' Kline said. H.R. 1322 would go too far by ''declaring that no changes could ever be made to benefits once a worker reaches retirement, irrespective of unforeseen circumstances,'' he added.

'Protecting the People.' The committee also heard from David Lillie, a retired tool and die maker employed by Raytheon Missile Systems in Tucson, Ariz. ''This week there is much talk about bailing out the geniuses of Wall Street whose phony schemes threaten our economy, but when will Congress start protecting the people who spent a lifetime doing the real work that made America great?'' he asked.

BY FLORENCE OLSEN

Text of the bill H.R. 1322 is at http://thomas.loc.gov/home/gpoxmlc110/h1322_ih.xml

Stock Options

Survey Says Exchange Programs Gain Ground For Replacing Employees' Underwater Options

Companies are finding ways to exchange employees' worthless stock options for new options or restricted stock, according to a report released Sept. 22.

In a review of 61 firms, Aon Consulting's Radford Surveys + Consulting looked at the popularity of three

types of exchange programs: options-for-options, options-for-stock, and options-for-cash. The survey found that ''companies are nearly evenly split between using options-for-options and options-for-stock programs.''

Among the three programs, the choices were:

- **Options-for-stock**: 49 percent picked cancellation of underwater options followed by an immediate re-grant of significantly fewer new shares of restricted stock or restricted stock units.
- **Options-for-options**: 46 percent cancelled underwater options followed by an immediate re-grant of fewer new options.
- **Options-for-cash**: only 5 percent cancelled underwater options for a cash payment.

Brett Harsen, vice-president of Radford Surveys, told BNA Sept. 23 the study was based on tender offer (TO) filings with the Securities and Exchange Commission. Radford reviewed all TO filings from 2005 to date that they could identify, Harsen said. He added that any data before 2005 would be irrelevant because of changes in the accounting rules.

In addition to high-tech industries—about 30 of the 61 firms—the TOs represented a broad cross-section of industries, Radford's Fabiola Price told BNA Sept. 23.

Accounting Concerns. Terry Adamson, Radford senior vice president, said in the Sept. 22 release that the accounting goal is cost neutrality. ''No additional charges to a company's earnings will be incurred as long as the fair value of the new award is no greater than the fair value of the surrendered underwater options,'' the report said.

To achieve this goal, Adamson said, ''Shareholders and company auditors are requiring increasingly complex modeling to determine what the right cost-neutral exchange ratio should be in these programs.″ It is more difficult to predict employee exercise behavior with underwater options compared to a new at-the-money award,'' Adamson said in the release.

BY MARY HUGHES

For more information, contact Fabiola A. Price (408) 321-2653, fprice@radford.com, or Kelly St. Denis, (408) 321-2584, kstdenis@radford.com at Radford Surveys + Consulting.

Tax Legislation

House Passes Extenders Again; Stand-Off With Senate Continues

The House voted 257-166 Sept. 26 to pass a revenue-neutral $60.3 billion energy and tax extenders bill, asserting its legislative and constitutional prerogative in the face of immense opposition from both the Senate and White House.

The next step for the legislation (H.R. 7060) is murky. The White House said Sept. 25 it would veto the House bill and urged the House to pass the Senate's bill (H.R. 6049), which is vastly different. Both chambers were headed into a weekend session at loggerheads and with little to no contact between the principals, staffers and members said.

The House Democratic leadership stuck to its belief that the House position of paying for the entire package should be a top priority, while the Senate Democratic leadership maintained that the House should pass the Senate bill.

Much of the recent debate focused on House Democrats maintaining their pay-as-you-go principles on tax extenders and on House Republicans hammering them for being steadfast on pay-go for one priority but not others, such as the approximately $600 billion continuing resolution (H.R. 2638), a $61 billion economic stimulus package (H.R. 7110), and a forthcoming $700 billion bailout bill.

Senate Refuses to Send Its Bill Back to House. One of the issues lawmakers from both chambers brought up Sept. 26 was the Senate's refusal to send back to the House the Senate-passed bill.

Staffers and lobbyists read it as an attempt by the Senate to back the House into a corner on the theory that perhaps the Senate would send it to the House and then adjourn, leaving the House with two options—pass the Senate bill or leave for the elections not having provided middle-class and business tax relief.

Key Relief Provisions in the House Legislation. Much of the debate in both chambers during the past two weeks has been about the breadth of tax relief that is being delayed because of congressional bickering.

The House bill would offer $15 billion in energy tax incentives including an extension of a renewable energy production tax credit, a solar energy and fuel cell investment tax credit, and a residential energy-efficient property credit.

To help pay for those energy provisions, Democrats included revenue-raising provisions that would freeze the value of the tax code Section 199 manufacturing deduction at 6 percent of oil and gas company qualified production activities income and eliminate the distinction between foreign oil and gas extraction income and foreign oil-related income.

The package includes a $42 billion package of extensions of individual and business temporary tax provisions. Included with the individual extenders is a deduction for state and local general sales taxes, a deduction for qualified tuition and related expenses, and an above-the-line deduction for teacher classroom expenses.

Other pay-fors included in the bill would come in the form of a provision to eliminate a tax benefit on deferred compensation used by hedge fund managers and other executives, and a six-year delay in the application of the worldwide interest allocation.

Tax Legislation

Senate Passes Tax Bill With AMT Patch, Tax Cut Extensions, Deferred Comp Tax

The Senate voted 93-2 Sept. 23 to pass a $120 billion package extending dozens of existing tax incentives and exempting roughly 21 million additional people from paying the alternative minimum tax this year.

A major provision of the legislation would eliminate a tax benefit on deferred compensation used by hedge fund managers and other executives.

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To bring the Tax Extenders and Alternative Minimum Tax Relief Act of 2008 (H.R. 6049) to a vote, senators agreed not to try to offset the $61.8 billion AMT with new revenue raisers and to only offset about half of the $42.2 billion tax extenders package. An amendment to pay for the AMT ''patch'' failed in a 53-42 vote. The provision required 60 votes to pass.

The bill's AMT patch raises the exemption for individuals to $46,200 and to $69,950 for married couples filing jointly. In 2007, the exemption levels were $44,350 and $66,250, respectively. The bill would also allow personal credits to be used against the AMT.

House leaders continued to express a desire to pay for more of the tax cuts and were preparing their own version of the legislation.

One difference between the Senate package and the House version is a provision to offset the costs of the mental health parity language with another delay in the implementation date of the worldwide interest allocation provision. The worldwide interest allocation provision is a tax cut in current law that would reduce the burden of double-taxation on many multinational businesses. The provision was set to become effective in tax year 2009 but was delayed until 2011 as a $7.6 billion offset for the housing bill that passed in July (Pub. L. No. 110-289).

Deferred Compensation Curbed. The most significant changes to current law in the bill include a new $25 billion provision eliminating a tax benefit on deferred compensation used by hedge fund managers and other executives and a long-expected provision to require securities brokers to report the cost basis for transactions to the Internal Revenue Service. The reporting requirement would apply to transactions of all stock, debt, commodities, derivatives, and other items specified by the Treasury Department, raising $6.7 billion over 10 years.

The deferred compensation provision says companies providing individuals receiving deferred compensation via a ''tax indifferent party,'' such as an entity based in an offshore tax haven, would no longer be able to defer the taxes owed to the federal government.

In instances in which an individual is paid deferred compensation by an offshore corporation in a low-tax or no-tax jurisdiction, there would be no offsetting deduction that can be deferred, according to a Senate Finance Committee summary of the provision.

Tax Breaks Extended. The bill extends nearly three dozen expiring tax breaks. For individual taxpayers, the bill would extend the deduction for state and local general sales taxes and a deduction for qualified tuition expenses through the end of 2009. Teachers would continue to be allowed to expense cost for classroom supplies.

Adjusted gross income limits for the refundable AMT credit would also be removed and the usage rate of unused credits would be raised from 20 percent to 50 percent, the Finance Committee said. The provision also includes language to reduce the taxes faced by individuals who received stock options from paying taxes on ''phantom income,'' money that was lost quickly after the options were exercised because of a drop in stock prices.

BY BRETT FERGUSON

Executive Compensation

Section 409A No-Ruling Policy Modified As it Applies to Issues 'Indirectly Involved'

The Internal Revenue Service issued Sept. 26 guidance modifying its no-ruling position on questions relating to the tax consequences of Section 409A.

In Revenue Procedure 2008-61, IRS said the no-ruling/no determination letter policy in Rev. Proc. 2008-3, as it relates to tax code Section 409A, ''unnecessarily restricts the ability of the Service to issue private letter rulings'' with respect to certain other tax law provisions that do not directly involve the application of Section 409A.

Other tax law provisions are, for example, estate and gift tax consequences of certain transfers of rights and issues relating to application of the Federal Insurance Contributions Act under nonqualified deferred compensation plans.

IRS will continue its no-ruling policy on issues concerning the income tax consequences of establishing, operating, or participating in a nonqualified deferred compensation plan described in Section 409A. Specifically, it will not issue rulings with respect to:

- the income and withholding tax consequences of establishing, operating, or participating in a nonqualified deferred compensation plan as defined in the final regulations;
- whether a plan is subject to a totalization agreement, or whether it is a broad-based foreign retirement plan as described in the final regulations;
- whether a plan is a bona fide vacation leave, sick leave, or compensatory time plan described in the final regulations; and
- whether a plan provides for the deferral of compensation, including whether an amount is a short-term deferral and whether certain stock rights, foreign plans, and separation pay plans are subject to Section 409A.

According to Rev. Proc. 2008-61, IRS is modifying the earlier revenue procedure in light of the Jan. 1, 2009, effective date of the final regulations under Section 409A, and in light of its request for comments in Notice 2007-100, which introduced a transitional corrections program for certain operational failures of plans subject to Section 409A (231 PBD, 12/4/07; 34 BPR 2869, 12/11/07).

Revenue Procedure 2008-61 will appear in Internal Revenue Bulletin 2008-42, dated Oct. 20, 2008.

BY MARY HUGHES

IRS

Senate Set for Continuing Resolution Vote Funding IRS Through Early March 2009

The Senate is scheduled to consider a continuing resolution as early as Sept. 27 that would fund the government, including the Internal Revenue Service, through the first months of the next administration.

Senate Majority Leader Harry Reid (D-Nev.) filed cloture on the resolution Sept. 25.

The House Sept. 24 passed its version of the resolution (H.R. 2638), which would give IRS a prorated amount of the $10.89 billion it received the previous fiscal year (187 PBD, 9/26/08). It would keep the IRS operational through March 6, 2009.

Because the CR only continues current programs for IRS, any attempts by lawmakers to kill the controversial private debt collection program will have to wait until early 2009, when congressional Democrats will try to move the appropriations bills with a new president in the White House.

Plan Fees

CRS Report Analyzes Bills That Would Require 401(k) Plans to Disclose Fees

The Congressional Research Service summarized plan administration fees, investment fees, and individual service fees associated with tax code Section 401(k) plans in a report dated Sept. 22 and made available Sept. 24.

The report, *Fee Disclosure in Defined Contribution Retirement Plans: Background and Current Legislation* (Order Code RL34678), described the structure of Section 401(k) fees, the impact of fees on account balances in those plans, and three bills that would change when and how those fees are disclosed to plan sponsors and participants.

Congress is interested in fee disclosure as Section 401(k) plans become a major source of retirement security for millions of U.S. employees, the report said. ''Small differences in fees can yield large differences in account balances at retirement, especially in the case of yearly or recurring fees,'' CRS said.

CRS looked at plan fees in earlier reports (204 PBD, 10/23/07; 34 BPR 2563, 10/30/07) and (117 PBD, 6/19/07; 34 BPR 1523, 6/26/07). Lawmakers are considering new legislation because current law requires only minimal fee disclosures to plan participants.

Three bills introduced in the 110th Congress would require service providers to disclose service fees and expenses to plan sponsors before signing a contract or modifying a contract, the report said. The legislation would require plan sponsors to disclose investment fees and expenses to plan participants before participants contribute to the plan.

The bills would also require plan sponsors to periodically disclose detailed fee and expense information to participants.

Disclosure Provisions. The report analyzed disclosure provisions in all three bills: the Fair Disclosure for Retirement Security Act of 2007 (H.R. 3185), which the Education and Labor Committee approved April 16; the Defined Contribution Plan Fee Transparency Act of 2007 (H.R. 3765); and the Defined Contribution Fee Disclosure Act of 2007 (S. 2473).

CRS reviewed provisions in the legislation that address timing and frequency of disclosure, bundled service charges, permissible estimates, third-party payments, investment comparison charts, annual statements, assistance to small employers, and other issues.

BY FLORENCE OLSEN

To order the CRS report for a fee, call BNA PLUS at 800-372-1033, or send e-mail to bnaplus@bna.com.

Plan Administration

IRS Will Have Correction Schedules Online, Program Official Tells D.C. Bar

The Internal Revenue Service is preparing to publish online nearly a dozen voluntary plan correction schedules, an IRS official said Sept. 23 at a luncheon series sponsored by the District of Columbia Bar.

Wilbert Laird, program coordinator for employee plans voluntary compliance at IRS, said the schedules will be online in a couple of weeks. Practitioners who use the IRS schedules to correct their plans can complete their corrections in a matter of weeks, Laird said.

All nine schedules found in Appendix F of the IRS Employee Plans Compliance Resolution System document, released Aug. 14 as Revenue Procedure 2008-50, will be available to practitioners to fill out online, Laird said (158 PBD, 8/15/08; 35 BPR 1893, 8/19/08). The schedules will be posted on the IRS Web site on the Retirement Plans Community Web page under Correcting Plan Errors.

The schedules, if used exactly according to instructions, will also function as compliance statements, Laird said. ''This is the part I really like about Rev. Proc. 2008-50,'' he said.

IRS is reviewing its options for the next revision of EPCRS, Laird said. For example, IRS is considering whether to issue a relatively speedy revision of EPCRS focused mainly on voluntary corrections for tax exempt and governmental plans under tax code Section 403(b).

BY FLORENCE OLSEN

Compliance

DOL Announces Online Calculation Tool For Plan Administrators to Pay Civil Penalties

The Department of Labor's Employee Benefits Security Administration announced Sept. 22 a new online tool that it said would make it easier for employers and plan administrators to pay online civil penalties for delinquent filings of annual reports.

EBSA also announced new online tools to give workers access to financial information. The site provides user-friendly ways for workers and plan officials to search for plan information by such categories as plan name, employer identification number, or date, a department news release said.

The new employer and plan administrator tool is an improved calculator for paying online civil penalties under EBSA's delinquent filer voluntary compliance program (DFVCP), the department said. Users now can ''accurately and simply calculate'' the amount of civil penalties and pay those penalties online with a credit or debit card as an alternative to paying by check, it added.

The tool provides three examples of how a penalty is calculated.

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Use of the online calculator or making payments electronically is not required to participate in the DFVCP, the department said. However, by using those options, employers and plan administrators can avoid making errors that would unnecessarily delay participation in the program, it said.

The DFVCP encourages plan administrators to file already overdue annual reports required under the Employee Retirement Income Security Act, the department said. Delinquent filers can avoid potentially higher civil penalty assessments by satisfying the program's requirements and voluntarily paying a reduced penalty amount, it said.

How the Calculator Works. The calculator is designed to calculate the penalty for each plan's filings submitted under the DFVCP, the department said. After entering the required fields, the calculator determines the amount owed for each individual plan filing. It then provides a final amount due for all the filings being submitted for that plan. it said.

The calculator can be used for only one plan at a time, the department said. Penalty calculations are required to be separated if filing under the DFVCP for more than one plan.

Filings for multiple years must be included in a single submission for a plan, the department said. Penalties are capped at $1,500 per submission for ''small plans'' (generally, fewer than 100 participants at the beginning of the plan year) and $4,000 per submission for ''large plans'' (generally, 100 participants or more at the beginning of the plan year).

Actuarial Information of Pension Plans. The Pension Protection Act of 2006 required the posting on the department's Web site actuarial information of pension plans filed with the Form 5500 annual reports, the department said.

The ERISA Public Disclosure System can be used to find a Schedule SB or Schedule MB filed as part of a pension plan's annual Form 5500 financial report, the department said. The Schedule SB is filed by single employer plans and the Schedule MB by multiemployer plans.

The schedules include technical data about whether, according to the plan's actuary, a plan has enough funds to pay promised benefits and is complying with the funding rules under federal pension law, the department said.

The system can be used to get a Schedule SB or MB for 2008 and later plan years, the department said. Searches can be performed for a plan by plan name, employer identification number, plan number, plan year, and type of schedule.

Information about tax code Section 401(k) plans and other individual account retirement plans is not on that system, the department said.

BY MICHAEL W. WYAND

Employers and plan administrators can access the tool that allows them to electronically pay civil penalties at http://www.dol.gov/ebsa/calculator/dfvcpmain.html. The Form 5500 site is at http://www.dol.gov/ebsa/actuarialsearch.html.

Cafeteria Plans

Proposed Regulation on Cafeteria Plans Lays Out Plan Document Requirements

The Internal Revenue Service has yet to release a final regulation on tax code Section 125 cafeteria plans, but practitioners should prepare their cafeteria plan documents to meet the requirements of the proposed regulation (REG-142695-05), speakers said at a Sept. 18 audioconference sponsored by the American Law Institute-American Bar Association.

Practitioners anticipate that the Treasury Department and IRS will give employers additional time to comply with the final regulation, even though the proposed effective date of the new regulation is Jan. 1, 2009, said Thomas Hoffman, a partner in the Dallas office of law firm Gardere Wynne Sewell, who spoke during the audioconference.

Another speaker said employers should begin now to make their cafeteria plan documents comply with the proposed rules (150 PBD, 8/6/07; 34 BPR 1821, 8/7/07). The proposed regulation contains no provisions for correcting plan document errors or omissions, which makes it doubly important to have a written document that complies with the rules, said Martin Bolt, an attorney at law firm Martin Bolt in Austin, Texas. The written plan document requirements reemphasize longstanding prior guidance and include some additional specific rules, Bolt said.

Bolt outlined the top requirements for cafeteria plan documents in the proposed regulation.

Document Requirements. Documents must include a description of the benefits available under the sponsor's plan. Cross-references to other documents, such as medical plan or flexible health spending arrangement documents, are permitted, Bolt said. However, the proposed regulation says a cafeteria benefits plan must be a separate document, he said.

''The IRS has informally commented that to use a wrap document is OK,'' Bolt said. However, he added, ''Make sure you properly cross-reference the documents and don't pull in any provisions from the wrap plan into the cafeteria plan that would violate the wrap plan requirements. Hopefully, because of the amount of comments on this, the IRS will clarify this in the final regs,'' he said.

If a cafeteria plan includes group term life insurance, the plan document should describe how excess group term life insurance will be taxed, Bolt said. The proposed regulation provides a new calculation for that purpose.

A cafeteria plan document must describe the plan's participation requirements, Bolt said. ''The proposed regs include a requirement that only employees are eligible to participate in a cafeteria plan,'' he said. ''However, the term ''employee'' covers former employees, he said.

''Self proprietors, partners, directors, and 2 percent S corporation shareholders can't participate,'' Bolt said. The proposed regulation also says spouses and dependents cannot participate. ''They can't be given the opportunity to make elections, even though they may benefit from the plan,'' he said.

30-Day Rule. The document must state clearly when employees may make elections under the cafeteria plan, Bolt said. A cafeteria plan may provide employees 30 days after their hiring date to make elections between cash and qualified benefits, which would be retroactive to an employee's hiring date, he said. The salary reduction amount used to pay for such elections must be from compensation not available on the date of the election, so employers must create a mechanism for catch-up salary reductions, he added.

In particular, the proposed regulation says if a cafeteria plan offers health savings account contributions as a qualified benefit, the plan document must describe the HSA contributions and allow participants to prospectively change their salary reduction elections for HSA contributions on a monthly or more frequent basis, Bolt said.

Next, the plan must describe the method the employer will use to make contributions to the plan, whether by salary reduction elections, employer flex credits, or both, Bolt said.

"The effect of the grace period is that employees may have up to 14½ months to use their benefits under the 'use it or lose it' rule."

ATTORNEY MARTIN BOLT

Plan documents also must describe the maximum amount of employer contributions, including salary deferrals, available to employees under the plan, Bolt said. The maximum amount, usually stated as a percentage or dollar amount, must be separately stated for each component of the cafeteria plan, he added.

In addition, plan documents must describe the plan year. A plan year must be a consecutive 12-month period and that period can be altered only for a valid business purpose, such as when an employer changes insurers and that decision means the plan year must change, Bolt said. ''Hopefully, in the final regs we'll get more guidance on what is considered a valid business purpose,'' he said.

The cafeteria written plan must include explicit ordering rules for elective time off, if the plan includes paid time off, Bolt said.

Use It or Lose It. Furthermore, if a plan includes a flexible spending account, the written plan must explain the ''use it or lose it'' rule for flexible spending accounts (FSA), Bolt said. Similarly, if the plan includes a health FSA, which requires that the maximum amount elected be available to the employee at all times regardless of the employee's year-to-date contributions, the plan must make that rule explicit, he said.

If a cafeteria plan has a grace period, the written plan document must explain how the grace period works, Bolt said. ''The effect of the grace period is that employees may have up to 14½ months to use their benefits under the 'use it or lose it' rule,'' he said. However, the plan document must state that any unused benefits can be used only for their original purpose. ''A health care FSA election not fully used in the plan year can only be used for the health FSA and not, for instance, for a dependent care assistance program,'' he said.

Finally, a written plan document for cafeteria plans that offer distributions from a health flexible spending account to an employee's health savings account must comply with the HSA distribution rules in the proposed regulation, Bolt said.

BY FLORENCE OLSEN

Accounting

FASB Decides to Delay Effective Date For Guidance on Benefit Plan Assets

NORWALK, Conn.—Amended accounting guidance on companies' disclosures about the assets held by postretirement benefit plans will be effective no earlier than for fiscal years ending after Dec. 15, 2009, the Financial Accounting Standards Board has tentatively decided.

That timeline, spelled out at a board meeting Sept. 24, reflects a one-year delay from an earlier tentative timetable. A March draft of the proposed FASB staff position, FSP FAS 132(R)-a, Employers' Disclosures About Postretirement Benefit Plan Assets, called for the planned disclosures to be applied prospectively for fiscal years ending after Dec. 15, 2008 (30 PBD, 2/14/08; 35 BPR 404, 2/19/08).

The goal of the proposed FSP is to improve transparency about types of assets held in postretirement benefit plans by amending FASB Statement No. 132R, Employers' Disclosures About Pensions and Other Postretirement Benefits. The planned guidance is intended to provide, for example, information about how asset investment decisions are made and what concentrations of risk are presented in the holdings of benefit plans.

FASB staff accountants hope to issue the final guidance by mid-December.

Drilling Down. At its Sept. 24 meeting, FASB tentatively settled on a list of examples of detailed categories of plan assets as it drew up language on how it would drill down into information to be disclosed in the forthcoming guidance, according to a staff-written summary of decisions made at the board's weekly meeting.

The categories of plan assets would include a bin for investment funds. FASB's staff cited examples of mutual funds, hedge funds, and commingled funds.

According to the staff-written summary, other changes to FASB No. 132R decided by the board at the meeting would address ''the overall objectives of disclosing information about plan assets that provide users of financial statements'' with an understanding of:

- the major categories of assets held in an employer's plan or plans;
- how investment allocation decisions are made by management, including the factors that are relevant in helping to understand the employer's investment policies or strategies; and
- significant concentrations of risk within plan assets.

In addition, FASB decided Sept. 24 to include in the planned amendments a requirement to report ''the significant investment strategies for investment funds dis-

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closed as major categories of plan assets,'' according to the staff summary.

FASB expects to take up fair value measurement disclosures at a meeting in late October.

Ratification of EITF Guidance. Separately at its Sept. 24 meeting, FASB ratified a single final consensus view, or item of guidance, settled on by the board's Emerging Issues Task Force at that panel's Sept. 10 meeting—EITF Issue No. 08-5, Issuer's Accounting for Liabilities Measured at Fair Value With a Third-Party Credit Enhancement.

In addition, FASB cleared for release and public comment the following proposed pieces of advice sent to the board by EITF, also products of the task force meeting earlier in September:

- Issue No. 08-6, Equity Method Investment Accounting Considerations;
- Issue No. 08-7, Accounting for Defensive Intangible Assets; and
- Issue No. 08-8, Accounting for an Instrument (or an Embedded Feature) With a Settlement Amount That Is Based on the Stock of an Entity's Consolidated Subsidiary.

BY STEVE BURKHOLDER

The proposed FSP on disclosures about plan assets is at http://www.fasb.org/fasb_staff_positions/prop_fsp_fas132r-a.pdf. The summaries of decisions reached at the Sept. 24 meeting on plan assets are posted at http://www.fasb.org/news/SDR_FAS132R_09-24-08.pdf.

Descriptions of EITF's current issues are at http://www.fasb.org/eitf/eitfissu.shtml.

Public Plans

Union Seeks to Persuade State Pension Plans To Influence Ongoing Labor Relations Dispute

The Service Employees International Union is engaged in a nationwide campaign to convince public employee pension plan investors in a private equity real estate firm to support the union's effort to organize a chain of senior living facilities owned by the firm.

As part of this effort, union representatives planned to address a meeting of the Illinois Municipal Retirement Fund in Oak Brook, Ill., Sept. 26 to try to convince the fund's trustees to put pressure on the managers of the Lazard Freres Strategic Reality Investors Fund II, New York, to resolve labor issues with the union at facilities operated by the Atria Senior Living Group, headquartered in Louisville, Ky.

Union representative Deepak Pateriya told BNA Sept. 19 that the Illinois retirement fund was one of a number of public and private pension funds that held limited partner interests in the Lazard closed-end real estate private equity fund, which Pateriya said owned the senior living facility company.

Pateriya said it was the union's intent to call on the limited partners to challenge Lazard's management to change its practices that were responsible for poor investment performance by both Atria and Lazard.

Earlier in September, the union sent representatives to picket a meeting of the State of Wisconsin Investment Board in Madison, Wis., and to speak at a meeting of the Pennsylvania Public School Employees' Retirement System in Harrisburg, Pa.

Pateriya said other Lazard limited partners included public plans in New York, Colorado, Utah, and Virginia, as well as public plans in Canada and the Netherlands. Private plan limited partners also included at least one plan sponsored by General Motors, Pateriya said.

Protection of Retirement Investments. Pateriya, a staff member of the union's Capital Stewardship Program in Oakland, Calif., said the union had a dual purpose for the campaign. The first is to protect the retirement security of its members, which he said included thousands of participants in the targeted public plans. Pateriya said the equity real estate fund has produced a negative return since its inception in 1998, during a period in which most real estate funds performed well. The campaign was aimed at improving the investment return of the plans, he said.

The second motive for the union was to improve standards for workers in the assisted living industry, Pateriya said.

He said if the union is successful in its goal, the result would be higher morale and lower turnover among Atria workers, which would improve the quality of Atria facilities for its residents. This in turn would enhance the reputation of Atria and improve the company's earnings in a highly competitive industry, he said. This ultimately would result in greater investment returns for Atria, Lazard, and its investors, Pateriya predicted.

Response from Plans. Linda B. Horrell, communications manager with the Illinois plan, acknowledged to BNA Sept. 25 that the plan is a limited partner in the Lazard investment fund. She said the plan's investment in the Lazard fund represented less than two tenths of 1 percent of the value of the plan's total assets.

Horrell said the plan viewed the matter as an issue between the union and the senior living company, not as an investment issue. She added that the plan had no influence on or knowledge of the day-to-day operations of Atria.

In response to the union's protest on Sept. 19, Jeffrey Clay, executive director of the Pennsylvania Public School Employees' Retirement System (PSERS) issued a statement.

''We've been made aware that the Service Employees International Union has been contacting members of the Pennsylvania Public School Employees' Retirement System, via an e-mail campaign, in an attempt to persuade PSERS to exert its perceived influence in one of its investments to force a business to organize,'' Clay said.

''The assertions made in this correspondence are misleading and have created confusion and concern among members who have been targeted with the SEIU message. Let me be clear: the SEIU's assertions are untrue,'' he said.

''PSERS' mission is to prudently invest the Retirement Fund, and towards this end, the PSERS thoroughly evaluates and monitors its investments to ensure the optimal use of the PSERS' assets. Consistent with its fiduciary duty to its membership, PSERS investments are based exclusively on the best interests of the members of the System, and not on the separate goals

or agendas of special interest groups like SEIU,'' Clay added.

BY DAVID B. BRANDOLPH

Disability Benefits

N.Y. Governor Calls For Congressional Inquiry Into Payments by Railroad Retirement Board

ALBANY, N.Y.—Gov. David A. Paterson (D) asked the leaders of two congressional committees Sept. 23 to look into allegations that an extraordinarily high number of retirees from the Long Island Rail Road have received disability payments from the U.S. Railroad Retirement Board (RRB), plus retirement benefits.

Paterson also asked the inspector general of the Metropolitan Transportation Authority, the agency that oversees the Long Island Rail Road, to open an investigation.

The RRB's Office of Inspector General is investigating the matter, as is New York Attorney General Andrew M. Cuomo (D), who said he has issued subpoenas to LIRR officials.

The investigations follow an article in the New York Times that said 93 percent to 97 percent of LIRR retirees since 2000 retired early and collected disability payments from the RRB.

Paterson asked for the congressional inquiry in letters to the chairman and ranking members of the House Transportation and Infrastructure Committee, U.S. Reps. James Oberstar (D-Minn.) and John Mica (R-Fla.), and the chairman and ranking member of the Senate Health, Education, Labor, and Pensions Committee, Sen. Edward Kennedy (D-Mass.) and Sen. Michael Enzi (R-Wyo.).

''I respectfully request that your committee look into the practices of the Railroad Retirement Board and investigate why such a high percentage of LIRR workers are provided disability retirement benefits post retirement, when they had not been deemed disabled at the time of their retirement,'' Paterson said in his letters.

In a statement, the RRB said it is ''committed to paying benefits accurately and timely, and to safeguarding its customers' trust funds.'' It said the LIRR case in ''not typical'' for the occupational disability program, nor for the average railroad retiree population.

''The Board is concerned about the anomalous issues relating to the Long Island Rail Road,'' it said. ''The investigation into this matter is ongoing. The agency will continue to work with the Board's Office of Inspector General to ensure the integrity of all its programs, including addressing the issues raised in the New York Times' articles.''

BY GERALD B. SILVERMAN

A copy of Paterson's letter is at http://www.ny.gov/governor/press/press_0923082.html.

A copy of the Railroad Board's statement is available at http://www.rrb.gov/pdf/board/lirr_rrb_statement.pdf.

Funding

Mercer Says Some Plan Sponsors Lack Funding Policies for Defined Benefit Plans

More than a quarter of plan sponsors lack a funding policy for their defined benefit pension plans, according to a Mercer survey of its clients released Sept. 22.

Economic turbulence, demands for increased financial disclosure, changes in financial reporting, and increased pension funding requirements are combining to make defined benefit pension plan risks more obvious, requiring more proactive management by plan sponsors, Mercer said.

''Yet, an analysis of the funding policies of more than 250 defined benefit plans conducted by Mercer reveals that 27 percent fail to develop and then adhere to a formal, well-documented funding policy,'' Mercer said. ''Altogether, 51 percent of sponsors surveyed fund only the minimum amount required by law, either by default or intentionally,'' Mercer said.

''The employers surveyed were Mercer clients,'' a Mercer spokeswoman told BNA Sept. 23. Because of this, ''the sample is not necessarily representative of all employers,'' she said.

''[A]n analysis of the funding policies of more than 250 defined benefit plans conducted by Mercer reveals that 27 percent fail to develop and then adhere to a formal, well-documented funding policy.''

MERCER REPORT

The survey also found that 82 percent of plan sponsors value liabilities using the Pension Protection Act's segmented yield curve as the interest rate, as opposed to a full yield curve. The segmented yield curve results in expected lower year-over-year volatility in required contributions and greater predictability of discount rates, which facilitates more accurate budgeting. Mercer said it expects plans that strategically invest their assets to closely resemble their plan liabilities (such as liability driven investing) will want to use the full yield curve, and that more plan sponsors will use the full yield curve in the future.

Twenty-one percent of plan sponsors surveyed said they intend to terminate their defined benefit plans if economic conditions are right. Among these, just one third have developed an exit strategy for a formal termination of the plan.

Funding Level. By raising the minimum funding level to 100 percent of a pension plan's target liability, up from 90 percent under prior law, the PPA highlighted the need for plans to have an articulated funding policy, Mercer said. The Employee Retirement Income Security Act has always required a written funding policy, which could be as simple as a statement of intent to fund the minimum required amount.

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The PPA now requires that each plan sponsor must provide participants with a written annual funding notice that includes a description of the plan's funding policy along with the funded ratio, Mercer said.

Nearly one-fourth (23 percent) of the plans surveyed by Mercer have implemented an explicit funding policy.

Another 49 percent have an implicit funding policy; 24 percent fund the minimum, while 25 percent fund some other amount (such as the fiscal year pension cost, an amount to cover accrued accounting liabilities or an amount to cover the projected accounting liabilities to extinguish any balance sheet unfunded obligation), Mercer said.

The remaining 27 percent are contributing the minimum as required by law but without benefit of an articulated policy, Mercer said.

Mercer's July 2008 survey included 260 defined benefit plans. The employers that sponsor these plans represent a range of industries including both for-profit and not-for-profit organizations. Twenty-eight percent of the plans have assets of at least $500 million each; 13 percent have assets of $250 million to $500 million; 17 percent have assets of $100 million to $250 million; and 42 percent have less than $100 million in assets.

Mercer is a provider of consulting, outsourcing, and investment services.

BY MICHAEL W. WYAND

Additional information is available on Mercer's Web site at http://www.mercer.com/summary.htm?idContent=1322355.

Accounting

FASB Staff Drafting Guidance to Help Gauge Fair Value in Inactive Markets

NORWALK, Conn.—The staff of the Financial Accounting Standards Board is working on guidance intended to help companies apply the board's two-year-old rules on fair value accounting in situations in which there is little or no market activity, a FASB staff director told BNA Sept. 26.

''The staff believes this is a priority,'' Russell Golden, technical director at the accounting board, said. ''We expect to go to the board in the near term.''

As deadlines for reporting third-quarter results near, many banks and other financial companies are finding themselves in situations in which ''unobservable inputs'' of market-related information used in valuation of assets and liabilities may have to be used, for example in the current illiquid markets for many mortgage-backed securities that figure in the tense legislative debate on the Wall Street rescue bill.

Watching the end of the third quarter with concern is the American Bankers Association, whose executive in charge of tax and accounting policy, a long-time critic of current accounting rules on fair value for financial instruments, said Sept. 26 that the ABA is looking to the staff of the Securities and Exchange Commission for a reading with clout.

''We strongly encouraged the SEC to issue authoritative guidance,'' and to issue that by Sept. 30, the ABA's Donna Fisher told BNA, summarizing the meeting that delegates of the bankers group had Sept. 25 with the chief accountant of the commission, Conrad Hewitt, and a key deputy, James Kroeker.

Fisher suggested that the requested guidance on fair value cannot come from the accounting profession.

''This is a big issue for our entire industry and has to be resolved by Sept. 30,'' Fisher added.

SEC officials did not return telephone calls seeking comment on the ABA's specific request. A commission spokesman offered a brief general comment on the meeting Sept. 25, saying its purpose was for the regulators to hear bankers' views and concerns related to current market conditions.'' Another spokesman declined further comment Sept. 26.

FASB Staff Working on Examples. The ''unobservable inputs'' in the current discussions in Washington and Norwalk are in the third level of the formal ''fair value hierarchy'' in FASB Statement No. 157, Fair Value Measurements, issued in September 2006.

While ''Level 1'' inputs connote easily observable information, such as quoted prices in markets, ''Level 3'' inputs are at the opposite end of the spectrum.

''The staff believes this is a priority. We expect to go to the board in the near term.''

FASB TECHNICAL DIRECTOR RUSSELL GOLDEN

''Unobservable inputs shall be used to measure fair value to the extent that observable inputs are not available, thereby allowing for situations in which there is little, if any, market activity for the asset or liability at the measurement date,'' FASB wrote in Statement No. 157.

''The staff is working on some examples to help constituents understand when it's appropriate to apply Level 3'' inputs in making valuations under the fair value measurements standard, FASB's Golden told BNA.

In the middle of the fair value hierarchy are Level 2 inputs, which are defined by FASB as ''inputs other than quoted prices included within Level 1, either directly or indirectly.''

Examples of Level 2 inputs include ''quoted prices for similar assets or liabilities in active markets'' and ''quoted prices for identical or similar assets or liabilities in markets that are not active.'' On the latter situation, the board described conditions in which ''few transactions take place, the prices are not current, or price quotations vary substantially.''

The work by FASB's staff on potential guidance stems in part from deliberations of the board's Valuation Resource Group. That panel met Sept. 23 to consider ''observable vs. unobservable fair value measurements in the current credit environment,'' according to information on the board's Website and an interview with an observer of the VRG meeting, Gregory Scates, deputy auditor at the Public Company Accounting Oversight Board.

Banks Seeking Alternatives, Clarification. Banks in particular have been seeking authoritative readings or advice from securities regulators and FASB that would be especially relevant during the current credit crisis and long-running slide in the markets. Fisher said ABA is

seeking ''clarification'' of the accounting rules, not ''suspension'' of FASB No. 157 or ''forbearance.''

In addition, ABA held talks during the week of Sept. 22 with congressional staff about including language in the impending financial institutions rescue bill that would effectively put on hold fair value accounting for the kinds of troubled assets at issue that have figured in headlines and the debates on Capitol Hill, Fisher told BNA Sept. 22.

She said the fair value measurement standard ''was not written with today's dysfunctional marketplace in mind.'' The current market for mortgage-backed securities and other instruments is ''illiquid and lacks actual marketplace participants,'' she said.

Fisher said that auditors from eight major accounting firms, some of whose partners have been arguing with banks over use of asset impairment rules and associated fair value guidance, attended the ''productive'' meeting at the SEC Sept. 25. Others in attendance, at which decisions were not made, included observers from FASB and the Public Company Accounting Oversight Board and top accountants from the federal banking agencies, said the ABA senior vice president.

At the meeting, Fisher and financial executives from several member banks, including Wells Fargo and SunTrust, ''focused on determining fair value in the current economic environment for the purpose of estimating 'other than temporary impairment.' '' Such asset impairment accounting is covered in FASB Statement No. 115, on investments in debt and equity securities, and in an SEC staff accounting bulletin (SAB 59).

FASB Webcast Seminar on Fair Value Postponed. In separate but related action, FASB has postponed a Webcast seminar on use of fair value measurements that was scheduled for Sept. 29. The board tied that postponement to the current news, including developments in Washington on the bailout bill.

The seminar is expected to be held within ''the next few weeks,'' FASB said.

''In light of recent events in the financial markets, and the legislation under consideration by the Administration and Congress, the FASB plans to redesign the Webcast to provide real-time insights about the role of accounting standards in providing transparency to investors,'' according to a message on the board's Internet home page.

''Postponing the Webcast will give auditors, preparers, users of financial statements and regulators an opportunity to consider the application of '' FASB No. 157, the board added.

Leslie Seidman, a FASB member, said in an interview Sept. 26 that the board decided to postpone the Webcast ''so that we would be most responsive'' questions that are likely to be asked in the seminar.

BY STEVE BURKHOLDER

FASB Statement No. 157 is available at http://72.3.243.42/pdf/aop_FAS157.pdf. s

Information on FASB's Valuation Resource Group is at http://72.3.243.42/project/valuation_resource_group.shtml.

Accounting

Bankers Seek Alternative to Fair Value Accounting in Pending Financial Bailout Bill

NORWALK, Conn.—The American Bankers Association is holding talks with congressional staff about including language in the impending financial institutions rescue bill that would effectively put on hold fair value accounting for the kinds of troubled assets that have figured in news stories in the recent months' market turmoil, an ABA accounting official told BNA Sept. 22.

''We've had discussions about the possibility of including a provision in the bailout legislation,'' said Donna Fisher, the banking group's senior vice president for tax and accounting. She said the group's representatives have been talking ''with Hill staff'' but declined to elaborate.

In addition, the ABA has written and spoken with top accountants at the Securities and Exchange Commission to voice its concern on two issues: the use of fair value measurement rules issued by the Financial Accounting Standards Board (FASB Statement No. 157) and how auditors disagree with their member banks on readings of ''other than temporary impairment'' of assets.

That finding, in a process prescribed in FASB Statement No. 115 on investments in debt and equity securities, triggers the recording of a loss and use of mark-to-market accounting for the written-down asset.

Pointing to what ABA sees as a problem in use of the accounting rules, Fisher said the fair value measurement standard ''was not written with today's dysfunctional marketplace in mind.''

''Our preference would not be to include it in the legislation,'' the ABA's Fisher said of the language it was seeking. ''Our preference would be for the SEC to take care of it.''

''[The fair value measurement standard] was not written with today's dysfunctional marketplace in mind.''

ABA SENIOR VICE PRESIDENT DONNA FISHER

Ask to describe the provision that her group had in mind, Fisher spoke of the SEC staff being about to fill a ''void'' in accounting policy ''by recommending that registrants temporarily use intrinsic value or economic value as an appropriate proxy for fair value.''

Fisher suggested that the provision or guidance sought by ABA would be applied in the expected scenario of the federal government taking over troubled assets of banks and other financial companies under a bill yet to be hammered out.

''This solution should address concerns about future government acquisitions that may be less than fair value in a normal market,'' she said.

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Financial Services Roundtable Seeking Similar Action. The Financial Services Roundtable, a trade group that counts many banks as its members, has asked lawmakers and regulators to suspend use of accounting standards that many bankers argue result in valuations that are less than the purported true values of the assets at issue, according to a Bloomberg News report Sept. 22.

''Due to the current market situation, the Roundtable urges the SEC to step in and address the issues associated with fair value accounting that the current illiquid market has illustrated,'' the roundtable said in a statement sent by e-mail to BNA.

Companies ''should not be required to rely on an uncertain market to price such assets or to create an educated guess of such an asset's value,'' the group continued.

The Financial Services Roundtable recommends a new subcategory under FASB No. 157 ''that would permit investors to use alternative definitions of fair value that focus on the value to the investor if the security does not require immediate liquidation in an illiquid market,'' the e-mail statement said. ''Instruments that would be eligible to use this sub-category would need to meet clearly defined criteria. The value of assets in this subcategory would be based on a refined valuation methodology which includes the financial instrument's expected future cash flows,'' it said.

''We also recommend qualitative disclosure in a footnote on the balance sheet for this sub-category that would include, among other items, the number of securities in this category and the effect that the sale of these securities in the current market would have had should they be sold,'' it added.

''We do not support returning to historic cost accounting,'' FSR added in its statement.

ABA Letters to SEC and FASB. The American Bankers Association this summer wrote letters to FASB and to the chief accountant at the SEC and his top deputy for accounting policy, citing what ABA called ''a major problem with the reliability of value'' under FASB No. 157, use of which is marked by ''mechanical implementation and interpretation.''

In its Aug. 7 letter to FASB seeking ''clarification'' of the standard, ABA's Fisher wrote of ''growing awareness that today's marketplace is not providing quality fair values.''

In its Sept. 11 letter to the SEC staff's Conrad Hewitt and James Kroeker, ABA reiterated a theme it had sounded in the earlier letter to the accounting board: ''Although [FASB No.] 157 intended to create better accounting and greater transparency by disclosing these levels, what it may have created is greater skepticism as to the reliability of financial statements.''

Center for Audit Quality Takes Issue with ABA. At the Center for Audit Quality (CAQ), an affiliate of the American Institute of Certified Public Accountants, Sam Ranzilla defended the actions of auditors in interpreting FASB and SEC guidance with regard to other than temporary impairment (OTTI) and the resulting measurement of written-down securities at fair value.

Ranzilla argued against an ABA-suggested 24-month recovery period for the time in which a particular kind of security detailed by the bankers group, perpetual preferred securities, would be checked to gauge whether the security returned to par value before an OTTI was determined to exist.

On a question posed by ABA as to how an entity should determine the amount of impairment if other than temporary impairment exists, Ranzilla, chairman of the center's Professional Practices Executive Committee, wrote that CAQ believes that generally accepted accounting principles clearly answer the question.

FASB No. 115 states ''that if a decline in fair value is judged to be other than temporary, the cost basis of the individual security shall be written down to its fair value as a new cost basis and the amount of the write-down shall be included in earnings (that is, accounted for a realized loss),'' Ranzilla wrote.

He said he also disagreed with the way in which ABA was seeking guidance from the SEC staff.

An immediate comment on the debate from the SEC was not available Sept. 22.

FASB Response. ''We'd like to review the complete details of the federal bailout plan in order to fully assess the related role of accounting standards in providing transparency to investors,'' FASB spokeswoman Christine Klimek told BNA.

''The bailout plan may have an impact on third-quarter reporting—or much longer term. Knowing the full scope of the plan soon is important for all participants in the markets, she said.

''We will work closely with the SEC—and assist any way we can—to insure there's continued appropriate accounting and greater transparency for investors,'' Klimek added.

Counterpoint: Don't Blame Fair Value Accounting. In accounting and other circles outside banking—from former securities regulators, for example—the message is to not blame fair value accounting. Those defenders of current accounting suggest that mark-to-market reporting accurately reflects the values of troubled financial assets and liabilities, the dealings in which have led to failures and near-failures at leading investment banks and insurance giant AIG.

''To fully understand and appreciate the results of accounting,'' critics such as the one who wrote a strongly worded anti-fair value accounting opinion piece that appeared in *The Wall Street Journal* Sept. 18, ''should put themselves in the shoes of investors,'' Walter Schuetze, a former SEC chief accountant and former chief accountant of the agency's Division of Enforcement, wrote in a Sept. 19 letter. He wrote the letter in response to the Sept. 18 *Journal* op-ed piece.

Schuetze cited the example of holders of mutual funds that own the kinds of investments in which AIG and others had holdings. ''Look at the accounting by mutual funds where mark-to-market accounting has a long, successful history of communicating valuable information to investors, where that information forms the basis for trading of mutual fund shares on a daily basis,'' Schuetze wrote.

'' The marketplace says these prices indeed are real,'' concluded Schuetze, a retired KPMG partner.

BY STEVE BURKHOLDER

Accounting

Full Fair Valuing Derivatives Difficult But Necessary, IASB's Leisenring Says

NEW YORK—Although moving to full fair value accounting ''in times like this'' actually increases the complexity of accounting for some financial instruments, ''we're not going to back off from fair valuing derivatives,'' International Accounting Standards Board member James Leisenring said Sept. 25.

Leisenring told attendees at the 2008 Banking Conference sponsored by the Foundation for Accounting Education that he has not minimized the problems that are being faced.

Leisenring said he sympathizes with the banking industry. Fair value in today's market is exasperating, he added.

He said, however, that it is not clear what constituents who say ''no fair value'' actually mean. ''Do they mean cease to account for derivatives?'' he asked.

The purpose of Financial Accounting Standards Board Statement No. 157, Fair Value Measurements, was to provide improvements to financial reporting by increasing consistency, reliability, and comparability. The standard defines fair value as ''the price that would be received to sell an asset, or paid to transfer a liability, in an orderly transaction between market participants at the measurement date.''

The standard establishes a hierarchy, with level 1, the most reliable measure of fair value, representing quoted prices in active markets. The second level is for quoted prices in similar markets, and the third level is for unobservable inputs, where there is no active market or prices on similar trades. Additional disclosure of how values are derived are required for assets that fall in level 3.

FAS 157 took effect in January financial statements, although FASB agreed to delay the effective date for certain nonfinancial assets and liabilities.

Banking groups such as the American Bankers Association have been seeking an alternative to fair value accounting pending the passage of a financial bailout bill for Wall Street.

BY DENISE LUGO

Fringe Benefits

IRS Updates Guidance for Calculating Business Expenses Paid for Travel, Meals

The Internal Revenue Service issued Sept. 25 Revenue Procedure 2008-59 updating the rules for determining the amounts that an employee or self-employed individual may be reimbursed for ordinary and necessary business expenses for lodging, meals, and incidentals while traveling away from home.

Among other things, IRS provided the transition rules for the last three months of calendar year 2008, set the per diem rate for travel to high-cost localities and for travel to other localities in the continental United States, and described circumstances in which a payer's reimbursement or expense allowance arrangement shows evidence of abuse of the rules under tax code Section 62.

The per diem rate for travel to high-cost localities in the updated guidance is $256. For all other sites within the continental United States, the rate is $158, IRS said.

The meal expense daily allowance for high-cost localities is $58 and $45 for other locations within the continental United States, according to the guidance.

IRS added Jackson/Pinedale, Wyo., to the cities and counties from 14 states and District of Columbia on the list of high-cost localities.

For certain cities, the guidance indicated a change in the portion of the year during which they are considered high-cost localities, such as Ocean City, Md., Phoenix/Scottsdale, Ariz., Palm Beach, Fla., Vail, Colo., and Martha's Vineyard, Mass.

Rev. Proc. 2008-59 also identified cities that have been removed from the high-cost localities list, including Palm Springs, Calif.; Yosemite National Park, Calif.; Conway, N.H.; Virginia Beach, Va.; and Lake Geneva, Wis.

IRS said Rev. Proc. 2008-59 updates guidance issued in 2007, which set a per diem rate of $237 for travel to any high-cost locality or $152 for travel to any other continental U.S. location (188 PBD, 9/28/07).

Transition Rules. In the guidance, IRS provided transition rules for the fourth quarter of 2008.

IRS said taxpayers may continue to use the rates for other localities in the continental United States in effect for the first nine months of 2008 for the remainder of the calendar year in lieu of updated General Services Administration rates. However, the taxpayer ''must consistently use'' either the calendar-year or updated rates from Oct. 1 through Dec. 31, IRS said.

Likewise, a payer or employer must be consistent in the method used to substantiate an individual's travel expenses, IRS said.

According to IRS, if any payer's reimbursement or expense allowance arrangement shows a pattern of abusing the tax code Section 62 regulations, all payments made under the arrangement will be treated as made under a nonaccountable plan. This means the reimbursement amounts will be included in the employee's gross income, reported on the employee's Form W-2, and subjected to withholding and employment taxes.

Rev. Proc. 2008-59 also updated the reimbursement rules for individuals or groups who are in ''the transportation industry,'' whose regular work-related travel ''usually involves travel to localities with differing federal [meals and incidental expense] rates.''

Effective Date. The effective date for per diem allowances paid to an employee is on or after Oct. 1 and applies to travel on or after that date, IRS said. The same date applies for purposes of computing the amount allowable as a deduction for meals and incidental expenses during travel away from home, IRS said.

Rev. Proc. 2008-59 will be published Oct. 14 in Internal Revenue Bulletin 2008-41.

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ESOPs

ESOP Association Releases McCain Statement Supporting Employee Stock Ownership Plans

The ESOP Association released Sept. 23 a statement by Sen. John McCain (R-Ariz.), Republican nominee for president, that supports employee stock ownership through the employee stock ownership plan (ESOP) model.

The statement was sent to the association by a senior policy advisor to the campaign, the association said. ''It was not solicited by the association,'' Michael Keeling, president of the association, told BNA Sept. 23.

''We do not lobby campaigns for support of ESOPs,'' Keeling said. The association has received no communication from Sen. Barack Obama's (D-Ill.) presidential campaign regarding ESOPs, he added. A BNA search of the Obama/Biden Web site found no reference to ESOPs.

McCain Statement. ''For millions of Americans owning a stake in the company they work for is extremely rewarding,'' McCain said in the statement released by the association. ''Many Americans are able to 'work for themselves' through their participation in Employee Stock Ownership Plans (ESOPs). These broadened ownership plans allow American workers the ability to participate directly in the growth and success of the companies for which they work,'' the statement added.

''About 90 percent of ESOPs are in small businesses with less than 500 employees,'' McCain said. ''We all know that small and entrepreneurial businesses are the lifeblood of the American economy. These businesses that are often unable to match the substantial health care and other benefits that are normally provided by major corporations, due to the cost, are able to provide employees increased retirement benefits and stable employment because of ESOPs. Research has shown that ESOP-owned companies are usually more productive and profitable than other companies, as well as having better survival rates,'' he said.

''For these reasons, I am proud to support ESOP-owned companies and the role they play in the American economy,'' McCain said. ''As President, I would endorse efforts to learn from the successes of ESOP companies and see how their positive impact can be expanded.''

The association is a national membership organization with 18 local chapters with approximately 2,500 ESOPs.

BY MICHAEL W. WYAND

Plan Administration

Cross-Border, International Benefits Targeted By IRS Advisory Committee in E-Mail Survey

The Internal Revenue Service Advisory Committee on Tax Exempt and Government Entities said it would like to receive responses by Sept. 30 to an e-mail survey on international and cross-border challenges involving qualified and nonqualified U.S. retirement and fringe benefit plans.

The committee, which makes recommendations to IRS on taxation issues (113 PBD, 6/12/08; 35 BPR 1385, 6/17/08), said the survey is part of a study to identify impediments related to plan design, coverage, portability, and tax administration.

The survey asks stakeholders—employers, plan administrators, trustees, custodian, practitioners, and consultants—to share information they have about:

- U.S. employee benefit plans that cover employees working outside the United States, including expatriates, seconded employees, leased employees, nonresident aliens, or others who receive U.S. or foreign compensation;
- U.S. employee benefit plans that cover foreign nationals, green card holders, resident aliens, or others on temporary visas or assignments in the United States;
- coverage issues, such as controlled groups and separate lines of business, compensation definitions and discrimination testing, involving U.S. subsidiaries with foreign parents or U.S. companies with foreign operations;
- reporting, withholding and other tax issues involving Puerto Rico and other U.S. possessions and territories under Rev. Rul. 2008-40; and
- reporting and withholding on contributions and distributions, double taxation, treaties, rollovers, and other tax-related issues.

The advisory committee is also interested in hearing from anyone willing to participate in a discussion by conference call or attend a meeting in Washington, D.C., in October this year or January 2009.

BY FLORENCE OLSEN

Section 403(b) Plans

Health Care Employers Foresee Plan Changes In Response to Revisions in Section 403(b)

The Internal Revenue Service's revised regulations under tax code Section 403(b) are reshaping aspects of retirement plan administration in the health care industry, according to a survey report by the American Hospital Association and Diversified Investment Advisors made available Sept. 25.

The report, *Retirement Plan Trends in Today's Healthcare Market—2008*, was based on a survey that asked plan sponsors how Section 403(b) rules governing tax-sheltered annuities have changed the way they administer their retirement plans. Responses from the survey's 311 participants showed that 14 percent plan to use fewer service providers as part of their Section 403(b) compliance strategy.

''What we're seeing as a result of the 403(b) regs is a lot of these plan sponsors are making changes from multivendor to single vendor'' arrangements, David Ray, vice president and nonprofit practice leader at Diversified Investment Advisors, told BNA Sept. 26.

The survey found that the percentage of plans offering participants a choice among 16 to 20 funds rose from 24 percent last year to 27 percent this year and that 84 percent of plan sponsors said employee education was a top priority.

BY FLORENCE OLSEN

Request the survey report at http://www.aha-solutions.org or at 800-242-4677.

Public Plans

Texas Attorney General Launches Web Site on Pension Fund Information

HOUSTON—In the wake of instability in financial markets, Texas Attorney General Greg Abbott (R) Sept. 24 launched a pensions Web page to help public employees and taxpayers understand how the state pension system works and become more vigilant about unfunded liabilities of pension plans.

''Improperly managed public employee pensions pose a financial threat to public employees and the taxpayers alike,'' Abbott said in a statement. ''With our nation's financial markets in turmoil, now is the time to ensure taxpayer-funded pensions are transparent and accountable.''

Data obtained from the Texas Pension Review Board, which oversees state and local government retirement systems, revealed that more than 80 taxpayer-funded pensions had unfunded liabilities that exceeded $20 billion as of July 2008, according to Abbott.

Governments must meet their funding obligations, managers must wisely manage pension funds, and pensions must give taxpayers access to adequate information about their financial health, Abbott said.

Although the Office of the Attorney General does not have direct regulatory authority over public pension plans, Abbott recommended public employees review plan information and become familiar with retirement benefits provided by their pension plans. He also suggested public employees contact pension plan administrators, who can provide information about a particular plan including fund performance measures, plan trustee and manager experience, and pensions' unfunded liability data.

Abbott further suggested public employees contact the Texas Pension Review Board, which serves as a clearinghouse for information about each public pension fund.

''Improperly managed public employee pensions pose a financial threat to public employees and the taxpayers alike.''

TEXAS ATTORNEY GENERAL GREG ABBOTT (R)

First Assistant Attorney General Kent Sullivan told BNA that the pensions Web page will include up-to-date self-reported information by the pension funds in a more ''user friendly fashion'' so that taxpayers, legislators, and pension beneficiaries can access information about how funds are managed and strategies used by pension funds.

''This is an effort to increase the level of transparency and accountability of the system,'' Sullivan said. Pension fund information has been available to public employees in ''raw form'' and difficult to understand, he said.

Because of the financial impact that pensions have, ''it is much better to be pro-active and inform every one of these issues at the front end rather than wait for some potential for problems and deal with them at the back end,'' Sullivan said.

The pension Web page is set up so the data is much easier to see in some context, making it more meaningful to the average user, Sullivan added.

In April 2007, Abbott warned about underfunding of Texas's public pension funds and conflicts of interest that could impair investment decisionmaking. In an address before the Texas Pension Review Board Conference annual meeting, the attorney general called for transparency with public retirement systems fully complying with Texas law requiring them to file annual financial reports with the Pension Review Board, good governance, realistic actuarial assumptions, and elimination of conflicts of interest.

Jerry Strickland, spokesman for Abbott, said the pensions Web site also was created for taxpayers' benefit as well.

''Obviously taxpayers are the ones who would shoulder the burden of underfunded pensions should they not be able to pay out to those who paid into them,'' Strickland said.

Texas has more than 90 public pension plans including the Teacher Retirement System of Texas and the Employees Retirement System of Texas.

BY SUSANNE PAGANO

The Office of the Attorney General's new pension plan Web page is at http://www.oag.state.tx.us/consumer/pensionplans.shtml.

Disaster Relief

DOL Extends Annual Reports Deadline For Texas and Louisiana Due to Hurricane Ike

The Department of Labor's Employee Benefits Security Administration announced Sept. 22 an extension of the deadline for filing Form 5500 and Form 5500-EZ annual report/returns due to damage from Hurricane Ike in Texas and Louisiana.

Under this relief, Form 5500 series filings required to be filed between Sept. 7, 2008, and Jan. 5, 2009, for counties in Texas and filings for parishes in Louisiana due between Sept. 11, 2008, and Jan. 5, 2009, are granted an extension until Jan. 5, 2009, a department news release said.

Plan filers entitled to an extension of relief should check Part I, Box D on the Form 5500 or Part I on Form 5500-EZ, and attach a statement to the form in accordance with the instructions, the department said.

The extension also applies to firms located outside the affected areas that are unable to obtain the necessary information from service providers, banks or insurance companies whose operations were directly affected by the weather, the department said.

The designated disaster areas for Texas identified by the department include the counties of Angelina, Austin, Brazoria, Chambers, Cherokee, Fort Bend, Galveston, Grimes, Hardin, Harris, Houston, Jasper,

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Jefferson, Liberty, Madison, Matagorda, Montgomery, Nacogdoches, Newton, Orange, Polk, Sabine, San Augustine, San Jacinto, Trinity, Tyler, Walker, Waller, and Washington.

In Louisiana, the disaster areas identified by the department include the parishes of Acadia, Beauregard, Calcasieu, Cameron, Iberia, Jefferson, Jefferson Davis, Lafourche, Plaquemines, Sabine, St. Mary, Terrebonne, Vermilion, and Vernon.

Filers who have additional questions may contact EBSA's EFAST helpline toll-free at 866-463-3278, the department said.

Investments

EU Parliament Approves Report Calling For Regulation of Funds, Private Equity

BRUSSELS—The European Parliament overwhelmingly approved Sept. 23 a resolution calling on the European Commission to propose legislation by the end of 2008 to regulate hedge funds and private equity groups and impose new capital requirements for investment firms on the basis of risk.

Backing for the report, adopted by a vote of 562-86 with 25 abstentions, came despite a clear signal from Single Market Commissioner Charlie McCreevy Sept. 22 during a debate before the EP General Assembly that he opposed any EU regulation on the issue. Only the European Commission has the power to propose EU legislation, which in most cases must be approved by both the Council of Ministers and the European Parliament.

''I do not believe it is necessary at this stage to tar hedge funds and private equity with the same brush as we use for the regulated sector,'' said McCreevy. He added that there are EU member state national regulations that apply to private equity groups and hedge funds.

However, McCreevy made it clear that the two groups needed close monitoring.

''This does not mean we are turning a blind eye to hedge funds and private equity,'' said McCreevy in a speech before the parliament's General Assembly. ''As these business models evolve and their role in financial markets changes, regulators around the world need to remain vigilant.''

''The industries themselves must assume all the responsibilities that accompany a prominent role in European and global financial markets. Several recent market initiatives indicate that this message is understood,'' McCreevy added. ''Our role should be to monitor closely these and other developments in the market and be ready to respond if and when necessary.''

McCreevy outlined how the Commission will be proposing new EU regulations in October for credit rating agencies and capital requirements for banks.

Specific Requests. Other specific requests called for in the report approved by the European Parliament General Assembly include the following:

- risk-based capital requirements should be applicable to all market actors,
- initiators of hedge funds should be obliged to hold shares of the attested credits,
- bookkeeping of funds should illustrate ownership as well as profits and losses,
- requirements should be imposed that force rating agencies to eliminate information gaps and declare uncertainties as well as clashes of interest in their business model, and
- openness and transparent trade with derivatives should be promoted.

Industry Reactions. Immediately after the vote, lobby groups representing a hedge fund industry lobby group issued a statement warning of what it considered the consequences of any legislative measures that might evolve from the parliament's vote.

''The measures have the potential to create several unfortunate consequences, including an increase in the cost of capital for banks, at a time when it is most needed and incorrect pricing of index products, with negative implications for mainstream retail products,'' the Alternative Investment Management Association said in a statement.

The European Venture Capital and Private Equity Association also weighed in on the issue with its own caveats.

''Any regulation of this sector should be proposed in the context of cost and benefits,'' said EVCA Secretary General Javier Echarri. ''Our work to achieve the maximum understanding of our business model and its role in the European economy continues, but we welcome the prudent approach of the Commission outlined by Commissioner Charlie McCreevy.''

BY JOE KIRWIN

Foreign Plans

Sweden's 2009 Budget Plan Extends Tax Relief for Low-Income Pensioners

COPENHAGEN—Sweden's 2009 budget plan, announced Sept. 22, would extend a June government commitment to reduce taxes on low-income pensions and provide new incentives for older workers to remain in the labor market.

The previous plan granted a tax break of 2,500 kroner ($380) per year to anyone receiving a state pension but lacking a private, income-based plan (126 PBD, 7/1/08; 35 BPR 1601, 7/8/08). Those receiving smaller private pension payments on top of their state income would receive tax breaks in relation to their income up to an annual ceiling of 131,000 kroner ($20,000).

The revised plan would provide an upward adjustment of the basic income tax deduction for people who are at least 65 and whose income is less than 363,000 kroner ($55,200). According to a Sept. 22 statement issued by the Finance Ministry, the proposal will primarily benefit low-income pension recipients, although more middle-income recipients will now be affected.

''For people paying an average municipal tax, the higher basic income tax deduction provides tax relief of about 2,600 kroner [$395] per year for a single pensioner who was born in 1938 or later, and is receiving a full guarantee pension but no income related pension'' the statement said.

''For incomes between 133,000 kronor [$20,200] and 337,000 kronor [$51,200], the tax relief amounts to about 800 kronor [$122] annually [on] average.''

Finance Ministry official Susanna Larsson confirmed to BNA Sept. 24 that the new proposal would extend the plan both in terms of the number affected and the amount of tax relief.

''In the current proposal, around 90 percent of all Sweden's pension recipients are affected, compared to 28 percent in the June proposal'' she told BNA. ''The cost of the proposal has also risen, from 800 million kronor [$121 million] in June to around 2 billion [$303 million] today.''

The previous proposal had been criticized by business leaders, including the Confederation of Swedish Enterprise (SN), who had complained that retirees earning above 131,000 kronor would get nothing out of it.

The 2009 budget plan also proposes a number of new initiatives to support those wishing to continue working beyond retirement age, including linking the proposed tax reduction directly to earned income for those aged 65 and over. In addition, the plan includes an upward adjustment of the so-called ''reasonable standard of living'' criteria used to calculate special housing supplements and state maintenance support for lower-income pension recipients.

The new tax relief is valid from the beginning of the 2009 financial year.

The budget still needs legislative approval, but that is considered a formality due to the government's parliamentary majority.

BY MARCUS HOY

Labor Department Exemptions

Final

Sale of Note: allows the sale of a note by Wholesale Electronic Supply; Employees Profit Sharing Plan and Trust, located in Dallas, to Levco Enterprises Inc., a party in interest with respect to the plan, provided certain conditions are met, to include the sale is a one-time transaction, PTE 2008-09, 75 Fed. Reg. 55,527, 9/25/08.

Classes of Transactions Involving Employee Benefit Plans: allows Merill Lynch & Co. and Black Rock Inc., for a temporary period of five years, certain classes of transactions involving employee benefit plans, certain broker-dealers and bankers underwritings, market-making, mutual fund in-house plans, investment companies, and closed-end investment company in-house plans, provided certain conditions are met, to include the maintenance for six years of records associated with such transactions for purposes of determining whether the conditions of the exemption were met, PTE 2008-10 (91 PBD, 5/12/08; 35 BPR 1071, 5/13/08) 73 Fed. Reg. 55,527, 9/25/08).

Sale of Property: allows the sale of certain unimproved real property by the Pileco Inc. Employees Profit Sharing Plan, located in Houston, to Pileco Inc., the sponsor of the plan and a party in interest with respect to the plan, provided certain conditions are met, to include the sale is a one-time transaction for cash, PTE 2008-11 (131 PBD, 7/9/08; 35 BPR 1654, 7/15/08) 73 Fed. Reg. 55,540, 9/25/08).

Cash Sale of Notes: Allows the cash sale of medium term notes by the EB Daily Liquidity Money Market Fund to the Bank of New York Mellon Corp., a party in interest with respect to employee benefit plans invested in the money market fund, provided certain conditions are met, to include the fund did not bear any commissions or transaction costs with respect to the sale, PTE 2008-12, 75 Fed. Reg. 55,540, 9/25/08.

In Brief

Groups Launch IRA Research Project

The Investment Company Institute and the Securities Industry and Financial Markets Association announced Sept. 25 that they are launching a new research project to improve understanding of investors' use of individual retirement accounts.

The two associations will use the database, the first of its kind, to produce an annual research report beginning in 2009, a joint news release said.

According to ICI and SIFMA, their member firms hold more than 85 percent of all IRA assets. IRAs are growing rapidly, fueled by assets rolled over from employer-sponsored retirement savings accounts, including tax code Section 401(k) and similar plans. From 2002 to 2007, IRA assets nearly doubled, from $2.5 trillion to $4.7 trillion, according to ICI and Internal Revenue Service data.

The new database will be an important source for policy-oriented research and benchmarking surveys for ICI and SIFMA members, the media, academics, and policy makers, the news release said.

COPA Merges With ASPPA

The College of Pension Actuaries announced Sept. 24 that it is merging its work in the pension actuarial profession with the American Society of Pension Professionals & Actuaries.

The group formed by this combination will be the ASPPA College of Pension Actuaries (ACOPA), a joint news release said.

ACOPA will provide a new platform serving the specific needs of pension actuaries in the United States, the news release said.

Treasury Asks OMB to Review Guidance

The Treasury Department asked the Office of Management and Budget to review an Internal Revenue Service final regulation, notice, and form, according to a notice published Sept. 25 (73 Fed. Reg. 55,595, 9/25/08).

The specific items are:

- final regulations (T.D. 9079, REG-165868-01) addressing plan compliance information for 10-or-more employer plans;
- Notice 2002-27 on individual retirement account required minimum distribution reporting; and
- Form 8717, User Fee for Employee Plan Determination Letter Request.

Comments are due by Oct. 27 and should be sent to the OMB reviewer, Alexander Hunt, OMB, Room 10235,

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New Executive Office Building, Washington, D.C. 20503; and to the Treasury Department Clearance Officer, Treasury Department, Room 11000, 1750 Pennsylvania Ave. N.W., Washington, D.C. 20220.

IRS Seeks Public Comment on Rules, Form

The Internal Revenue Service is asking for public comment on rules and a tax form, according to notices released Sept. 26.

The items are:

- final and temporary rules (T.D. 8716, REG-253578-96) on health insurance portability for group health plans;
- final and temporary rules (T.D. 9423) on Redesigned Form 990, Return of Organization Exempt From Tax, Other Exempt Organization Issues;
- Form 56, Notice Concerning Fiduciary Relationship.

Comments are due by Nov. 28 to Glenn Kirkland, IRS, Room 6516, 1111 Constitution Ave. N.W., Washington, D.C. 20224.

Collective Bargaining

Private Sector

Woodworkers OK Four-Year Pact With Boise-Cascade

PORTLAND, Ore.—Members of the Carpenters Industrial Council, a division of the Carpenters and Joiners of America, ratified Sept. 12 a new four-year labor agreement with Boise-Cascade LCC, the last major company that had been negotiating with unions representing woodworkers during the past summer.

Union woodworkers at most of the other major western wood products firms have ratified similar four-year labor agreements in the past three months.

The Carpenters told the company Sept. 12 that a majority of workers ratified a new contract, John Sahlberg, spokesman at the company's headquarters in Boise, told BNA Sept. 15.

The council represents some 8,000 workers in the western states, and another 7,000 western woodworkers are represented by the Woodworkers District No. 1 of the International Association of Machinists.

The Boise-Cascade agreement is similar to the other western wood products contracts over this past summer on wages and employer contributions to the unions' health and welfare trusts. However, Boise-Cascade's contributions to the workers' retirement accounts differed somewhat from those of some of the other wood products companies, Sahlberg said.

Under the Boise-Cascade pact, the pension benefit will continue to be $40 per month per year of service for years worked in the past. The benefit will be increased to $42 per month per year of service in 2009 and 2010, and then $45 per month per year in 2011 and beyond.

The company's tax code Section 401(k) matching contribution of 50 percent will be increased from 5 percent of salary to 6 percent of salary. In addition, the company will contribute $500 per worker for each Section 401(k) account in each year of the second, third, and fourth years, said Sahlberg.

UAW Members OK Michigan Blue Cross Pact

United Auto Workers members have approved a three-year collective bargaining agreement with Blue Cross Blue Shield of Michigan covering 2,700 workers employed throughout the state, the union announced Sept. 16.

The contract provides a $2,500 signing bonus, wage increases of 9 percent over the contract term, and an increased pension benefit. It adds a two-tier wage and benefits scale for new hires and eliminates their retiree health care benefits.

In a ratification vote held Sept. 9-13, members of UAW Local 1781 in Southfield, Local 2145 in Grand Rapids, Local 2256 in Lansing, and Local 2500 in Detroit voted 74 percent in favor of the contract, according to a union spokeswoman.

''The bargaining team was able to protect not only the excellent benefits of members but maintain health insurance for current and future retirees,'' UAW President Ron Gettelfinger said Sept. 16 in a statement.

''This agreement improves wages and benefits, and it addresses the job security needs of our members,'' said UAW Vice President Jimmy Settles, who directs the union's Technical, Office and Professional Department. ''Our members at Blue Cross will be able to realize economic improvements that are necessary to live in this time of rising prices and economic uncertainty.''

Employees will receive 3 percent per hour wage increases in each year of the contract effective Sept. 6, 2008; Sept. 5, 2009; and Sept. 4, 2010. In addition, workers who are below their maximum pay grade will receive an additional 3 percent per hour automatic progression increase each year. Currently, employees at the top of the automatic progression in pay grade 12 earn $887 weekly, according to UAW-prepared highlights of the agreement.

For new hires, the contract establishes a second tier with wages based on the 2006 wage scale for employees hired on or after Sept. 1, 2008. New hires, however, will receive the same 3 percent wage increases and 3 percent wage progressions.

The existing traditional health care plan will remain in effect only for employees already enrolled in it.

The current preferred provider organization option will be replaced with the Community Blue PPO that adds full coverage for routine childhood immunizations and specific vaccines; laboratory tests and x-ray services; prenatal and postnatal care; surgery in the physician's office; and 80 percent coverage for inpatient and mental health care and substance abuse treatment after a deductible is paid.

Eligibility dates for retiree health care that were modified under the previous contract negotiated in 2005 were restored under the new contract.

No employees hired on or after Jan. 1, 2009, will be eligible for retiree health care.

The new agreement boosts the pension benefit multiplier under the defined benefit plan $1 in each contract year to $38 in 2009, $39 in 2010, and $40 in 2011. Employees can choose to leave a higher pension benefit of 65 percent of their monthly pension for their surviving spouses, up from 50 percent, without an increase in the cost.

New employees hired on or after Jan. 1, 2009, will have a cash balance pension plan.

During employees' anniversary years upon reaching 30, 35, and 40 years of service, they will receive an additional week of vacation leave for the anniversary year only.

Expanded bereavement leave now will allow one day for the death of a brother-in-law or sister-in-law.

To address job security issues related to contracted work and movement of jobs into nonbargaining unit positions, the contract provides for a new joint classification review committee to review job classification and selection criteria and identify training to ensure bargaining unit members receive opportunities for advancement. The contract also provides for bimonthly meetings of union and company representatives to explore methods to return vendor work to the bargaining unit.

The new contract creates a paid time-off program combining vacation and personal leave and adding two additional days of leave per year. The contract eliminates the first four ''direct access'' sick days, substituting the two new days of leave as a ''corridor'' for sick time.

An additional $500 in tuition assistance increases the maximum reimbursement to $4,250 for undergraduate work and to $4,500 for postgraduate programs.

The contract expires Aug. 31, 2011.

Blue Cross Blue Shield declined to comment on the contract.

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Health Care&Benefits

Health Insurance

House, Senate Approve Parity Bills With Different Funding Mechanisms

The House and Senate Sept. 23 approved legislation requiring health plans offering mental health coverage to provide the same benefits for mental illness as they do for other medical conditions.

By a 376-47 vote, the House approved stand-alone parity legislation (H.R. 6983). By a 93-2 vote, the Senate approved H.R. 6049, energy and tax legislation that includes parity language the same as that in the House bill.

The bills would amend the Employee Retirement Income Security Act and the Public Health Service Act to prohibit employer group health plans from adopting mental health treatment limitations, financial requirements, or out-of-network coverage limitations unless comparable limitations and requirements were adopted for medical and surgical benefits.

Employers with fewer than 50 workers would be exempted from the parity requirements.

"Mental health and addiction disorders can be as painful and debilitating as those of a medical and surgical nature, and as such, should be treated equally."

REP. JOHN D. DINGELL

The House bill, the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, is paid for by a delay in the implementation of the worldwide interest allocation tax benefit for multinational companies. The cost of the parity bill is not directly offset in the Senate energy and tax measure.

Passage of the bills is a major step toward getting parity legislation enacted this year, but parity legislation still faces several hurdles before becoming law. It was unclear late Sept. 23, for example, how the bills and their parity provisions would be reconciled.

House and Senate negotiators reached agreement on policy provisions for compromise mental health parity legislation in June and have since been searching for ways to fund the legislation. Congress is expected to adjourn for the year within two weeks. The parity legislation will cost an estimated $3.9 billion over 10 years, according to the Senate Finance Committee.

The original Senate parity bill also did not contain funding offsets. The House funded its original parity bill partly via a specialty hospital provision, which was dropped in H.R. 6983 due to likely Senate opposition.

Asked whether the Senate would accept the House mental health parity funding vehicle, Finance Committee Chairman Max Baucus (D-Mont.) told reporters Sept. 23 ''it would be best for the House to take up what the Senate passes.''

Finance Committee ranking minority member Chuck Grassley (R-Iowa) told reporters Sept. 23 that whatever the House passes ''will be obviated'' by Senate passage of H.R. 6049. The House bill ''will kind of be a nonentity'' once it reaches the Senate, Grassley said.

A parity stakeholder told BNA Sept. 23 that a likely scenario will be for the House to take up the Senate energy and tax bill with the parity provision due to Senate concerns over how the House bill will be paid for.

However, House Majority Leader Steny Hoyer (D-Md.) said in a statement after the Senate vote on the tax and energy bill the House would craft its own tax and energy legislation.

In a Statement of Administration Policy on H.R. 6049 released Sept. 23, the Bush administration said it supported the mental health parity legislation embedded in the Senate energy and tax bill.

Widespread Bipartisan Support. The parity bills enjoy widespread bipartisan support, with Democrats and Republicans Sept. 23 supporting passage of the legislation.

''Mental illness and addiction can have a significant effect on an individual's life and well-being,'' House Energy and Commerce Committee Chairman John D. Dingell (D-Mich.) said on the House floor. ''Millions of Americans are challenged by serious mental health conditions which are the leading cause of disability in the United States for individuals between the ages of 15 and 44.''

''Mental health and addiction disorders can be as painful and debilitating as those of a medical and surgical nature, and as such, should be treated equally,'' Dingell added. ''The strains of these illnesses affect individuals, families, and society as a whole. Ensuring appropriate parity in cost sharing, treatment limitations, and out of network benefits should be an important priority.''

''We are on the cusp of enacting legislation that is critically important to those with mental illness and their families,'' Sen. Pete V. Domenici (R-N.M.), a prime sponsor of the Senate parity bill, said after the Senate vote. ''We have a finite amount of time to get this through Congress and we are anxious to see get it done. Thousands of hours have been put into coming up with a good bipartisan bill that will at long last place insurance coverage for mental health care on par with medical and surgical coverage,'' Domenici said.

BY STEVE TESKE

Text of the House bill is available at http://op.bna.com/hl.nsf/r?Open=sfak-7jrqh7. The House Ways and Means Committee score for the bill is available at http://op.bna.com/hl.nsf/r?Open=sfak-7jrq9s.

Health Care Costs

Hewitt Says Employer Measures to Control Increases in Health Care Costs Are Working

Large companies are facing a 6.4 percent average increase in employee health care costs in 2009, down sharply from a 15.2 percent average annual increase in 2002, according to a Hewitt Associates analysis of health care cost data released Sept. 22.

That projected increase reflects a recent trend toward moderating cost increases in employer-sponsored health care, Hewitt reported. The consulting and outsourcing company based its projections on health care cost data from more than 1,800 U.S. employer health plans with more than 13 million participants.

"Employers continue to diligently manage health care costs through a combination of approaches, including continued cost shifting, tougher negotiations with health plans and expanded health and wellness programs with incentives to encourage behavior change."

HEWITT OFFICIAL JIM WINKLER

The 6.4 percent projected increase means that average health care costs per employee at large companies will be $8,863 in 2009, compared with $8,331 in 2008, Hewitt said.

Hewitt reported that decreases in the rate of health cost increases began in 2003, when the national percentage increase was 14.7 percent, followed by a 12.3 percent increase in 2004; a 9.2 percent increase in 2005; a 7.9 percent increase in 2006; and a 5.3 percent increase in 2007. Since then, U.S. companies ''have seen average rate increases settle in around 6 percent to 7 percent,'' Hewitt said.

Employers themselves are largely responsible for the lower rate of health cost increases, Hewitt said, a development confirmed by other recent survey data (181 PBD, 9/18/08; 35 BPR 2160, 9/23/08).

''Employers continue to diligently manage health care costs through a combination of approaches, including continued cost shifting, tougher negotiations with health plans and expanded health and wellness programs with incentives to encourage behavior change,'' Jim Winkler, North American practice leader of Hewitt's health management consulting business, said in a statement released with Hewitt's analysis.

Employers are shifting a larger portion of health care costs to employees, according to the analysis, *Hewitt Data Reveals Little Change in U.S. Health Care Cost Increases for 2009*. Employees will pay about 22 percent, or $1,946, of their health care premium costs in 2009, compared with $1,806 in 2008, Hewitt said. Employees will pay about 8.9 percent more in 2009 for out-of-pocket health care costs, such as copayments, coinsurance, and deductibles, the company reported.

Hewitt, which analyzed health cost increases in 2008 by plan type, found that average annual costs for traditional indemnity plans increased 10.1 percent; for health maintenance organizations, 8 percent; for preferred provider organizations, 4.8 percent; and for point-of-service plans, 3.9 percent.

Hewitt's forecast for 2009 shows that HMO costs will again increase 8 percent, more than for any other plan type.

Among the measures employers are taking to reduce health care costs, audits designed to reduce plan costs for employee dependents who do not qualify for coverage, are increasing, Hewitt said.

Employers also are streamlining plan administration by offering fewer plans and are demanding more accountability from their health plans by measuring participation levels, clinical outcomes, reduction in claim costs, and employee satisfaction with the plans, Hewitt said.

Experimentation With Incentives. In addition, employers are increasing their investment in employee health and wellness programs and experimenting with providing employees financial incentives to participate in those programs, according to Hewitt. Many companies plan to target chronic health conditions, such as diabetes, with health programs that provide incentives for employees with those conditions to comply with recommended therapies.

A value-based approach to designing employer health care plans is relatively new, Hewitt said. However, because it involves reducing employee costs for health care services that have proved to be effective for treating chronic conditions and increasing employee costs for services that have not proved as effective, two-thirds of the plans Hewitt studied said they intend to introduce that approach in the next three to five years.

BY FLORENCE OLSEN

More information is at http://www.hewittassociates.com/Intl/NA/en-US/AboutHewitt/Newsroom/PressReleaseDetail.aspx?cid=5604.

Health Insurance

Senate OKs Bill to Prevent College Students From Losing Insurance Due to Medical Leave

The Senate passed by unanimous consent Sept. 25 a bill (H.R. 2851) to create a new tax code Section 9813 to ensure dependent college students who take a medically necessary leave of absence do not lose health insurance coverage.

The bill, which the House passed July 30 (147 PBD, 7/31/08; 35 BPR 1816, 8/5/08), now goes to the president.

Known as Michelle's Law, the bill would require group health plans to continue coverage for dependent college students on medical leave for one year after the first day of the medically necessary leave of absence, or until the date on which such coverage otherwise would terminate under the terms of the plan.

Tax code Section 4980D(a) imposes an excise tax of $100 per day per individual on failure to meet the group health requirements of Chapter 100 (Sections 9801-9833). The new tax code section would amend the

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group health plan requirements relating to dependent coverage.

Many health insurance plans cover dependents only up to age 23 if they are enrolled as full-time students.

Medicare

Senate Approves Legislation to Help Low-Income Seniors Pay Part B Premiums

The Senate Sept. 25 by unanimous consent approved a legislative package of health care technical changes that includes a provision to help low-income Medicare beneficiaries pay their Part B premium.

S. 3560, the QI Program Supplemental Funding Act of 2008, now goes to the House for its consideration.

The legislation would increase funding for Medicare's Qualifying Individuals program by $45 million, according to a summary of the bill. Under the QI program, individuals with income between 120 percent and 135 percent of the federal poverty level may be eligible for payment of their Medicare Part B premium (187 PBD, 9/26/08).

The bill also includes a provision to expand education activities under the Medicaid Integrity Program.

Text of the bill is at http://www.finance.senate.gov/sitepages/leg/LEG%202008/092508legstaffsum.pdf.

Health Insurance

House OKs Breast Cancer Patient Bill; Congress Passes Other Insurance Bills

The House passed Sept. 25 by a vote of 421-2 legislation (H.R. 758), which would offer protections to patients who require hospitalization following treatment for breast cancer as well as restrict the rescission powers of health plans.

H.R. 758, the proposed Breast Cancer Patient Protection Act of 2007, one of several insurance-related measures that lawmakers have acted on prior to adjourning for the year, would require health plans to provide coverage for a minimum hospital stay if a patient needs to remain in the hospital following a mastectomy, lumpectomy, or lymph node dissection.

''A mastectomy is not an easy surgery—it is physically and emotionally traumatic,'' Rep. Rosa L. DeLauro (D-Conn.), the bill's lead sponsor, said in a floor statement. ''The last thing any woman should be doing at that time is fighting with her insurance company.''

The bill would prohibit insurers from restricting hospital stay benefits to less than 48 hours for a patient who undergoes a mastectomy or lumpectomy and to less than 24 hours for a patient who has a lymph node dissection. The bill also would provide for secondary consultations and ensure women have access to the most medically appropriate treatment (181 PBD, 9/18/08; 35 BPR 2167, 9/23/08).

A spokeswoman for DeLauro said it is unclear when the Senate will take up the measure and whether it will consider H.R. 758 or a Senate version of the bill (S. 459) sponsored by Sen. Olympia J. Snowe (R-Maine).

Industry Opposes Rescission Measure. The House bill includes a provision that would prohibit individual health plans from rescinding coverage if a patient inadvertently omitted health information when they originally applied for coverage about a condition unrelated to an illness for which they seek benefits.

America's Health Insurance Plans, a trade group that represents most major insurers, has voiced opposition to the provision, as well as to the bill as a whole.

Separate legislation (H.R. 2851) to ensure dependent college students who take a medically necessary leave of absence do not lose health insurance coverage was approved by the Senate by unanimous consent Sept. 25, following approval by the House July 30 (147 PBD, 7/31/08; 35 BPR 1816, 8/5/08).

The bill, known as Michelle's Law, would require group health plans to continue coverage for dependent college students on medical leave for one year after the first day of the medically necessary leave of absence, or until the date on which such coverage otherwise would terminate under the terms of the plan (see related story in this section).

Many health insurance plans cover dependents only up to age 23 if they are enrolled as full-time students.

A third bill (H.R. 6908) approved by the House Sept. 23 by voice vote and sent to the Senate would require health plans to notify individuals of any exclusions or limitations on their health benefits in a timely and understandable manner (181 PBD, 9/18/08; 35 BPR 2167, 9/23/08).

The bill would make technical corrections to the Health Insurance Portability and Accountability Act.

Medicare

Stable Premiums Available to Rx Enrollees In 2009, Even as Largest Plans Raise Prices

Medicare beneficiaries will have access to prescription drug plans in 2009 for the same or lower monthly premiums as they paid in 2008 even though each of the 10 largest Part D plans will be more expensive next year, according to new Medicare Rx plan data from the Centers for Medicare & Medicaid Services.

CMS acting Administrator Kerry N. Weems told reporters Sept. 25 that there were significant changes among some Part D plan offerings in 2009 and that those changes could include higher premiums and new plan designs.

He said CMS was encouraging beneficiaries to carefully review changes to their current plans and evaluate other products that might meet their needs better. Weems noted that beneficiaries will be notified no later than Oct. 31 about changes to their current plans for the 2009 benefit year.

Analysis by Avalere Health of the plan data released Sept. 25 by CMS found that the top 10 Part D standalone prescription drug plans by enrollment had raised monthly premiums for 2009, some by as much as 60 percent.

The top plan by enrollment, AARP Medicare Rx Preferred, offered through UnitedHealthcare, will raise monthly premiums by nearly $5, more than 15 percent over 2008. Humana PDP Standard and Humana PDP

Enhanced, the second and third largest plans by enrollment, will increase monthly premiums they charge by about $15, as much as 60 percent more than 2008.

Weems said that despite premium increases by some plans, beneficiaries in every state but Alaska would have access to at least one Part D plan with monthly premiums of less than $20. In Alaska, beneficiaries will have access to one plan with monthly premiums of $23. The average monthly premium among all Part D plans is $28.

He also said there would continue to be plans with no deductibles and plans that cover at least generic drugs in the Part D benefit coverage gap. By law, the Medicare drug benefit covers prescription drugs up to a certain limit. Beneficiaries are responsible for all drug costs in the gap between the Medicare spending limit and the catastrophic spending threshold when Medicare begins covering drug costs again.

Medicare Advantage Options. Medicare Advantage plans with Part D drug coverage options will continue to outpace stand-alone PDP plans in 2009. According to the Avalere analysis, there will be 185 fewer PDPs in 2009 and 60 more MA-PDs.

MA-PD plans will offer more robust gap coverage than PDPs in 2009, Abby Block, director of CMS's Center for Beneficiary Choices, said. Few plans will offer coverage that includes brand-name drugs, and of those that will, most are MA-PDs, Block and Weems said. Most plans that offer gap coverage in any form will include generic drugs only.

Overall, fewer plans will offer gap coverage in 2009, Weems said. Much of the decrease among MA-PD plans is because three large companies that accounted for 102 plans withdrew gap coverage for 2009. He did not specify which insurance companies no longer will offer the coverage.

Plans can begin marketing 2009 Part D insurance products beginning Oct. 1, and Part D enrollment begins Nov. 15. Weems said CMS will launch an expanded and improved Plan Finder tool on the Medicare consumer Web site (http://www.medicare.gov).

The Plan Finder allows users to compare plans available in their area based on their specific needs, such as drugs they take.

Low-Income Enrollments. CMS spokesman Jeff Nelligan told BNA Sept. 25 that CMS would reassign 1.2 million low-income beneficiaries who are auto-enrolled in Part D plans because their current plans bid above the 2009 low-income subsidy benchmark.

Avalere's review of plan data found that eight of the top 10 plans by enrollment would lose auto-enrolled beneficiaries because they bid above the low-income subsidy benchmark in some regions.

Humana PDP Standard lost eligibility in all 43 states where it was eligible to accept auto-enrolled beneficiaries in 2008, according to the Avalere analysis.

Humana said in a Sept. 11 filing with the Securities and Exchange Commission that it expected to lose 308,000 Part D enrollees because its bids in 34 regions were higher than the low-income subsidy benchmark.

Plan-specific data for 2009 are at http://www.cms.hhs.gov/PrescriptionDrugCovGenIn/. State fact sheets about drug plans are available at http://www.cms.hhs.gov/Partnerships/STDrugPlanInfo/list.asp.

Health Care Reform

Rising Costs Could Threaten Continuation Of Massachusetts Plan, Senate Panel Told

Massachusetts' health care reform initiative has provided health insurance to 439,000 previously uninsured, a quarter of the recent decline in national uninsured numbers, and produced a 40 percent drop in the number of residents using state health care safety-net programs, the Senate Finance Committee was told Sept. 23.

But despite the success of the reform plan, rapidly rising health care costs threaten its continued viability, Andrew Dreyfus, executive vice president of Blue Cross Blue Shield of Massachusetts, told the committee. The state's sweeping reform plan was enacted in 2006 (87 PBD, 5/5/06; 33 BPR 1173, 5/9/06).

Dreyfus said Massachusetts successfully has implemented reform because the state had a relatively low number of uninsured compared with other states, employer-provided coverage already was high, the state already was spending $1 billion a year on services for the uninsured and underinsured, numerous insurance market regulations already were in place, and there was the threat of the loss of $385 million in federal funding if its Medicaid waiver was not renewed.

'Higher Than Anticipated Enrollment.' Dreyfus said the state ''has become the victim of its own success and is currently experiencing a shortfall paying for reform efforts.'' Much of the reason for the shortfall can be linked to ''higher than anticipated enrollment'' in the program's state-subsidized reform plan, he said.

Because of the increased enrollment of individuals in employer-sponsored insurance, Massachusetts also has not raised as much revenue as anticipated through employer assessments, Dreyfus testified.

To help contain rising health care costs, the legislature in July approved a cost containment measure focusing on reducing hospital-acquired infections, serious reportable events, information technology, and a primary care expansion, Dreyfus said.

The state also is beginning to use a new provider payment method that rewards providers for providing appropriate, quality care rather than care based on volume and complexity of care, Dreyfus said.

''We believe this alternative payment model can—over several years—cut in half the current medical cost trend, which has been rising at 12 percent a year,'' he said.

Coverage Denials. The committee also was told that as many as 15 percent of applicants for health insurance coverage will be denied coverage in the 45 states that do not require health insurers to offer policies to all applicants.

RAND Corp. adjunct staff member John Bertko testified that in states in which health insurance policies are underwritten—meaning past health conditions of individuals are examined and rates set according to health risk of applicants—70 percent of applicants will quality for standard policies, between 15 percent and 20 percent will be offered policies at higher rates or with preexisting conditions not covered, and between 10 percent and 15 percent of applicants will be denied coverage.

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There is another group that will not apply for coverage because they are told they will be denied a health insurance plan, Bertko testified.

High-Risk Pools. In 32 states, individuals denied coverage might be able to get it via high-risk pools if they can afford the premium, Bertko said. About 200,000 Americans now get coverage via high-risk pools, but premiums usually are up to 250 percent more than those with standard coverage, he added.

Bertko testified that rising health care costs are affecting even those with employer-provided coverage. The average health insurance premium is about $13,000 for family coverage, and even with an average employer-paid subsidy of 75 percent, employees' are responsible for paying $3,000 in premiums per year, not including out-of-pocket spending, which accounts for about 20 percent of covered services, Bertko said.

More information on the hearing is at http://finance.senate.gov/sitepages/hearing092308.htm.

Health Insurance

Tax Assistance Should Be Provided to Help Individuals Get Health Care, Witnesses Say

Extending tax assistance to people who buy health insurance in the individual market would help expand health care access to those without coverage, witnesses and members told a House panel Sept. 23.

As they exist now, individual health plans ''represent the weakest part of the health insurance market. Such plans are characterized by high administrative costs, poor benefits, and in most states, they exclude poor health risks,'' Karen Davis, president of the Commonwealth Fund, told the House Ways and Means Health Subcommittee.

In addition, small group coverage continues to erode. While 99 percent of employers with more than 200 employees offer health insurance, those with fewer than 10 employees offer coverage just 45 percent of the time, and small firms must pick up more of the costs than their larger counterparts, Davis said.

Rep. Dave Camp (R-Mich.), ranking member of the subcommittee, said he supports extending tax assistance to the individual market.

''For those people who have no other choice but to purchase insurance in the individual market, we ought to do something that will allow you to choose the health insurance that best meets your needs while receiving financial assistance through the tax code,'' Camp said in a statement.

Roger Feldman, the Blue Cross professor of health insurance at the University of Minnesota, said he believes the tax exclusion for employer-sponsored insurance can be eliminated without harm to the system.

''ESI can and should stand on its own without special tax assistance'' because of the advantages associated with it, such as protection from premium increases for an employee if his or her health status changes and low administrative costs, according to Feldman.

The tax subsidy, however, distorts workplace choice, encourages over-insurance, and is unfair, he said.

Feldman said that tax advantages should at least be extended to the self-employed and those who buy insurance that is not related to work, to create a more equitable system.

More information is available at http://waysandmeans.house.gov/Hearings.asp?congress=18.

Federal Plans

FEHBP 2009 Premium Costs Up 7 Percent; Enrollee Increase Expected to Be 7.9 Percent

Health insurance premium costs for the Federal Employees Health Benefits Program are expected to rise by an average of 7 percent in 2009, Nancy Kichak, associate director for strategic human resources policy at the Office of Personnel Management, told reporters Sept. 25.

Kichak said FEHBP enrollee costs are expected to increase by an average of 7.9 percent next year. The government's share of premium costs is expected to rise by an average of 6.5 percent, she said.

For individual enrollees, biweekly costs will go up by an average of $4.83, while enrollees in FEHBP family plans will pay an average of $11.12 more per pay period, Kichak said. According to information provided to BNA by OPM after the briefing, the new average biweekly totals for individuals and families will be $64.63 and $146.52, respectively.

Blue Cross/Blue Shield standard option individual enrollees will see their biweekly premiums rise to $70.18, up $8.03 from last year, while family enrollees will pay $164.58, up $19.44 from last year, Kichak said. Roughly 60 percent of FEHBP's 8 million enrollees are in a Blue Cross/Blue Shield plan, with the great majority of those in the standard option plan.

Given the variations in individual plan costs, she said, it is important for enrollees to look carefully at the plans available to them out of the 269 regional and national plans in FEHBP, including 10 nationwide fee-for-service options available to all enrollees. To make it easier for enrollees to compare the plans, OPM has redesigned the FEHBP plan comparison tool on its Web site, she said.

Users will be able to use the tool to compare the 2009 plans on OPM's Web site beginning Nov. 3, a week before the beginning of the federal open season, which will run from Nov. 10 to Dec. 8, Kichak said.

Costs Higher Than Anticipated. Asked to explain why FEHBP premium costs were expected to rise by an average of 7 percent in 2009 after expected increases of 2.1 percent in 2008 and 1.8 percent in 2007, Kichak said health care costs had risen more than OPM anticipated based on earlier ''good experience.''

Enrollees and the government are in part paying costs for trends in 2008 that ''did not develop,'' she added.

For the third year in a row, OPM allowed FEHBP providers to draw down premium reserve funds to hold down the average premium increase for next year. According to Kichak, the expected increase without the use of the reserves would have been an additional 3.1 percentage points higher.

She emphasized, however, that FEHBP's average 2008 increase is in line with increases expected by other large U.S. employers. For example, she said, a recent

study from Aon Corp. found that private sector premium costs are expected to rise 10.6 percent in 2008. A ''large manufacturer'' cited by Kichak, which she identified as one of the big three auto companies, is expecting an 8 percent premium increase next year.

''The need to leverage the size of FEHBP becomes even more apparent when you take into account that OPM once again dipped into the plan's cash reserves to hold down the increase.''

NTEU PRESIDENT COLLEEN M. KELLEY,

Kichak also announced that premiums for the federal government's dental insurance program will rise by an average of 5.7 percent. Premiums for the government's vision program will increase by an average of 1.1 percent, she added. Employees pay the full cost of dental and vision coverage offered in addition to FEHBP plans, although they can pay for their premiums with pretax dollars.

OPM Urged to Force Providers to Compete. Colleen M. Kelley, president of the National Treasury Employees Union, in a statement issued Sept. 25, urged OPM to force insurers to compete for FEHBP's business.

''The need to leverage the size of FEHBP becomes even more apparent when you take into account that OPM once again dipped into the plan's cash reserves to hold down the increase,'' she said.

Even more troubling, Kelley said, are the increases announced by OPM for those covered by FEHBP's most popular health care program, the Blue Cross/Blue Shield standard plan. ''This is an enormous increase that erodes federal employees' standard of living,'' she said.

Kelley reiterated NTEU's support for an increase in the government's share of FEHBP premiums from an average of 72 percent to an average of 80 percent, a figure she said is common among private sector employers.

House Majority Leader Steny Hoyer (D-Md.) introduced legislation in February 2007 calling for such an increase but the bill never made it out of the House Oversight and Government Reform Subcommittee on Federal Workforce, Post Office, and the District of Columbia.

BY LOUIS C. LABRECQUE

FEHBP 2009 rate charts are at http://www.opm.gov/insure/health/09rates/index.asp.

The plan comparison tool, which will be operative for the 2009 plans beginning Nov. 3, is available at http://www.opm.gov/insure/08/spmt/plansearch.aspx.

Medicare

Private Fee-for-Service No Longer Center Of Marketing Enforcement, CMS Official Says

Private fee-for-service plans will not be the main focus of the Centers for Medicare & Medicaid Services' private plan enforcement efforts going forward, the director of CMS's Center for Drug and Health Plan Choice, said Sept. 22.

While PFFS plans were the focus during the 2008 plan year, provisions in the Medicare Improvements for Patients and Providers Act (MIPPA), passed by Congress in July, and findings from surveillance activities undertaken in 2007 ''established the need for additional and more sophisticated marketing surveillance across all product types'' in the Medicare Advantage (MA) program, Abby L. Block told a health insurance industry group.

PFFS plans had been the focus of attention because of higher payments and limited regulatory requirements compared to other MA plans.

Expanded monitoring of MA plan marketing, which begins on Oct. 1, will include call center performance monitoring, verification calling, and secret shopping to gauge performance, Block said at America's Health Insurance Plans Medicare & Medicaid Conference.

CMS State Relations. ''We hope to leverage our relationship with the states to enhance the comprehensive marketplace surveillance program we're putting in place,'' she added.

Block spoke during a session with Guenther Ruch, chairman of the National Association of Insurance Commissioners MA Private Plans Subgroup.

Ruch said that, despite increased cooperation from CMS and enhanced authority in MIPPA to address marketing practices, his group remains concerned that states may not hold plan sponsors responsible for marketing violations.

''We can deal with agent specific problems on a case-by-case basis,'' according to Ruch, administrator of the Division of Regulation and Enforcement for Wisconsin's Insurance Department. However, when it comes to ''systemic'' issues with plan sponsors and holding them accountable for the actions of their sales force, ''our hands are tied behind our backs.''

Beginning on Jan. 1, 2009, MIPPA requires that plan sponsors comply with state information requests during investigations, only use agents and brokers licensed by the states, and follow state appointment laws, including reporting the termination of individuals.

However, the bifurcated enforcement situation still ''isn't working to benefit of beneficiary,'' Ruch said.

White Paper. A ''white paper'' on the federal/state marketing situation is set for NAIC adoption Sept. 24, when it will become an official document of the organization, he said.

In a draft of the paper, NAIC said the preemption of the states by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 ''divorces the regulation of agents from the regulation of plans so that states cannot hold plans responsible for the acts of their agents nor can states proactively require plans to comply with their unfair trade practices laws and address the marketing and sales standards on their agents.''

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Block countered that federal preemption of state law is needed because MA is funded by the federal government and plans contract with CMS.

She said CMS would like to see an increase in the flow of information about consumer complaints from the states to CMS.

Block disagreed with Ruch that the level of plan sales commissions to agents inappropriately spurs marketing and sales abuses.

MIPPA requires that guidelines established by CMS ensure that sales compensation creates incentives for agents and brokers to enroll individuals in plans best suited to their needs.

''Compensation is considered administrative costs and is reflected in bids submitted by the plans to CMS each June,'' Block said. While 25 percent of the difference between the plan bid and the benchmark remains in the Medicare trust fund and 75 percent may only be used by the plans to reduce beneficiary cost sharing or provide benefits, there is nothing in the rebate for sales commissions, she said.

Ruch said he was pleased that the compensation issue was addressed by MIPPA but that it would be a while before it is apparent whether the language achieves the goal.

November Election. Discussing the Oct. 1 start of marketing and the Nov. 15 open enrollment period, CMS acting Administrator Kerry N. Weems said during another session that, ''regardless of the outcome of the November election, the political system will not tolerate'' plan marketing violations.

Weems said CMS may now impose a $25,000 penalty per beneficiary per plan violation when a plan's conduct adversely affects just one beneficiary.

Domestic Partner Benefits

Federal Agencies Should Offer Same-Sex Partner Benefits, Senate Committee Told

The federal government should offer same-sex domestic partner benefits both as a matter of equity and as a way of improving its ability to compete with private sector employers, witnesses and panel members said during a Sept. 24 hearing of the Senate Homeland Security and Governmental Affairs Committee.

Sen. Joe Lieberman (I/D-Conn.), the committee's chairman, noted that he introduced the Domestic Partner Benefits and Obligations Act (S. 2521) late last year. The bill would make same-sex domestic partners of federal employees eligible to participate in federal benefits programs—including health and life insurance, family and medical leave, long-term care insurance, workers' compensation, and retirement—under the same conditions as spouses of married employees. Employees and their eligible domestic partners also would assume the same obligations that apply to married employees and their spouses, such as being subject to anti-nepotism rules and financial disclosure requirements, he said.

Lieberman added that the Congressional Budget Office has estimated that the measure would increase federal benefit costs by less than one-half of 1 percent. Approximately 10,000 private sector companies—including more than half of Fortune 500 companies—already offer domestic partnership benefits, meaning that the federal government is behind on this issue, he said.

Although it is too late for the measure to be adopted this year, Lieberman said that he intends to reintroduce the bill in the next session of Congress. In the meantime, it is important to begin a discussion about the need for federal same-sex domestic partner benefits, he said.

Sen. Susan Collins (R-Maine) said she also supports providing domestic partner benefits to federal employees. A large portion of the current federal workforce will be eligible to retire within the next five to 10 years, she said, suggesting that domestic partner benefits can help the government compete with the private sector for top employees.

Collins added that the state of Maine has established a domestic partner registry, and health insurers under state law must offer the same coverage to both same- and opposite-sex domestic partners that they do to married couples. The federal government might consider a similar approach, she said.

OPM Points to Drawbacks. Testifying in opposition to the bill, Office of Personnel Management Deputy Director Howard C. Weizmann said it may run afoul of the Defense of Marriage Act, a federal statute that defines marriage as only between a man and a woman and states that the government may not treat same-sex relationships the same as marriage.

OPM also is concerned about fraud and abuse, Weizmann said, asserting that the affidavits of domestic partnership required under the bill amount to ''self-certification.''

Yvette C. Burton, a business development executive with IBM, said that her company, which employs 350,000 employees in 74 countries, has had a positive experience with offering domestic partner benefits.

Offering such benefits allows IBM not only to attract gay, lesbian, bisexual, and transgender employees, but also young people generally who want to work for a company ''that values and respects all employees,'' Burton said. According to Burton, the cost of offering such benefits has been ''negligible.''

Frank A. Hartigan, a deputy regional director with the Federal Deposit Insurance Corporation who testified before the committee in a personal capacity, said that as a gay federal executive he is particularly familiar with the consequences of not offering domestic partner benefits.

Due to the lack of such benefits, gay and lesbian employees experience ''extra stress and burdens'' in coping with family issues, he said. The lack of benefits amounts to less pay for gay and lesbian employees, Hartigan said.

He added that the federal government's position puts it behind the times and many other employers. ''If I were starting out . . . I would look elsewhere'' due to the lack of domestic partner benefits, he said.

No Proof of Marriage Required. Colleen M. Kelley, president of the National Treasury Employees Union, said in her testimony that union members have approved resolutions of support for federal domestic partner benefits at every convention for the past 10 years.

Providing such benefits is especially important at a time when the federal government must compete with private sector and state and local employers for not only

entry-level workers, but also mid- and senior-level employees due to a lack of hiring during the 1990s, she said.

Kelley said it was ''really unfair'' for OPM to suggest that offering domestic partner benefits presents a fraud risk. Married federal employees are not required to provide marriage certificates in order to qualify for spousal and family benefits, she noted.

''If there's a real risk, we're willing to work together'' to address it, she said.

BY LOUIS C. LABRECQUE

Witnesses' prepared testimony and a video of the hearing are available at http://hsgac.senate.gov/public/index.cfm?Fuseaction=Hearings.Detail&HearingID=4567a0c5-c026-461d-8b28-d30898f5e3d9.

Medicare

Medicare Less Generous Than Typical Large Employer Plans, Kaiser Study Finds

Medicare is on average less generous than a typical large-employer health plan or the most popular plan available to federal employees—even with the program's new drug benefit, according to a report released Sept. 22 by the Kaiser Family Foundation.

The average Medicare benefits, including the prescription drug benefit, were valued at $10,610 in 2007. That figure lagged behind the benefit value of both the typical large employer preferred provider organization (PPO) plan, valued at $12,160, and the Blue Cross/Blue Shield (BCBS) standard nationwide PPO option available to federal employees through the Federal Employees Health Benefits Program (FEHBP), valued at $11,780, according to the report, *How Does the Benefit Value of Medicare Compare to the Benefit Value of Typical Large Employer Plans?*

As Medicare was updated to provide access to a subsidized prescription drug benefit offered through a private plan, how Medicare stacked up against employer plans had important implications for ongoing policy discussions about health reform, according to the Kaiser foundation study. Policymakers and 2008 presidential candidates also took the question into account to estimate Medicare and other plans as models for establishing a ''standard'' benefit design for uninsured people.

The study also examined the value of Medicare for low-, moderate- and high-cost beneficiaries. In each case, Medicare's benefit package was less generous than the other large employer plans.

Four Major Differences. The results stemmed from four major differences between Medicare and other plans for the average senior. First, Medicare had comparatively higher cost-sharing for inpatient care under Part A, particularly for relatively short hospital stays. In 2007, Medicare covered 74 percent of costs for an individual with average health care costs ($14,270), while the typical large employer PPO paid 85 percent of costs and the FEHBP standard plan paid 83 percent.

Second, Medicare did not include a limit on beneficiaries' out-of-pocket spending under Part B. To help cover expenses that were not covered by Medicare, most people on Medicare had some form of supplemental insurance, such as Medigap, a retiree plan offered by employers, or Medicaid, for those with very modest incomes.

Third, Medicare paid less for prescription drugs, on average valued at $1,590, compared with $2,270 by the typical employer PPO and $2,500 under the FEHBP standard option.

The standard Medicare Part D with a coverage gap also lowered the cost shared by Medicare.

Finally, Medicare did not provide dental care, which was typically covered by large employer plans.

Dale Yamamoto, principal and national group actuarial practice leader at Hewitt Associates, conducted the study with researchers at the Kaiser Family Foundation. They used benefit features based on Hewitt's 2007 proprietary database of large employer plans and the median 2007 plan design information for 900 major employers in the United States.

The report is at http://www.kff.org/medicare/upload/7768.pdf.

Health Insurance

Health Plan Premiums Up Slightly in 2008; Workers Face High Deductibles, Survey Says

Premiums for employer-sponsored health insurance increased 5 percent in 2008, following a steady decline since peaking at 13.9 percent in 2003, but a growing number of workers are facing higher deductibles, according to a survey released Sept. 24 by the Henry J. Kaiser Family Foundation and Health Research and Education Trust.

In 2008, 18 percent of all workers covered by their employers had a general plan deductible of at least $1,000, up from 12 percent in 2007. The percentage of small-business workers with at least a $1,000 deductible increased even more dramatically, rising from 21 percent last year to 35 percent this year, according to the *Employer Health Benefits 2008 Annual Survey*.

''We may be seeing the tip of the iceberg. . . . We're seeing a change, in this survey, in the comprehensiveness of the coverage workers get, especially in small firms,'' Drew Altman, president and chief executive officer of the Kaiser foundation, said during a briefing. ''More people are in less comprehensive plans, where they pay more out of pocket for health care.''

These less comprehensive health plans, combined with other factors such as insurance companies underestimating costs, could be what kept premiums from rising at a faster rate, according to Gary Claxton, the study's co-author and director of Kaiser's Health Care Marketplace.

Average annual premiums for family health coverage rose to $12,680 in 2008, with employees contributing $3,354, according to the survey. The costs were up compared with rates reported in the 2007 survey, when premiums for family coverage averaged $12,106.

From 2007 to 2008, premiums increased by 5 percent, a decline from 2007, when they rose by 6.1 percent over the previous year, and from 2006, when they rose by 7.7 percent from 2005.

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Consumer-Directed Plans Increase Market Share. The increasing number of workers paying higher deductibles is partly driven by growth in consumer-directed health plans (CDHPs)—plans with high deductibles that include a tax-preferred savings option such as a health savings account (HSA) or a health reimbursement arrangement, according to the survey findings.

Workers covered by CDHPs increased to 8 percent in 2008 from 5 percent last year. This increase was largely driven by small firms (three to 199 workers), where 13 percent of insured workers are covered by this type of plan compared with 8 percent in 2007. The number of employees enrolled in CDHPs at larger firms was statistically unchanged from last year, according to the survey findings.

Premiums for all CDHPs are generally lower—both for the worker and for the firm—than for other health plans. Employers may contribute money to HSAs, and health reimbursement arrangements are entirely employer-funded, which can add to the total cost of the plan for the firm. However, more than half of the workers covered under CDHPs do not have a savings option.

Even with the contribution to the HSA, firms' total estimated average cost of family coverage for a HSA-qualified plan is still less than the cost of family coverage in non-CDHPs: $8,291 compared with $9,495, according to the survey. High deductible plans with a health reimbursement arrangement can be more costly once the employer's commitment to the arrangement is included, but because that commitment is not transferred until the expenses are incurred, the employer does not necessarily pay it all out.

''Less comprehensive skimpier insurance is cheaper,'' but it also shifts more of the costs to the employee, Altman said.

Future Outlook. The percentage of firms offering health benefits was roughly the same in 2008 as it was in 2007, but a decline in coverage next year is likely because of the state of the economy, study co-author Jon Gabel, senior fellow at the National Opinion Research Center at the University of Chicago, said. Because firms made health benefit decisions for 2008 in September or October of 2007, these decisions occurred before the economic troubles really started to set in, Gabel said.

In the survey, 14 percent of firms said they were ''very likely'' to increase the amount employees pay for health insurance in the next year, and 40 percent said they were at least ''somewhat likely.'' A large percentage of firms also said they were at least ''somewhat likely'' to increase deductibles (41 percent), increase copayments (45 percent), and increase the amount employees pay for prescription drugs (41 percent).

Slower Rise in Premiums, but Problems Loom. Despite modest increases in premiums in 2008, ''the long-term picture in terms of premiums and costs to people is absolutely unchanged,'' Altman said, adding that there is no evidence that anything has been done to deal with the drivers of increased health care costs. From 1999 to 2008 premiums more than doubled, but during the same period workers' wages increased by just 34 percent and general inflation rose 29 percent, according to the study.

''Unless we enact significant reforms, people will continue to fall through the cracks of insurance company rules, employers will continue to drop coverage, and out-of-pocket costs will continue to rise faster than wages,'' Rep. Fortney ''Pete'' Stark (D-Calif.), chairman of the House Ways and Means Health Subcommittee, said in a statement. ''Until we have universal coverage, these cost shifts away from insurers to consumers will continue.''

Karen Ignagni, president and CEO of America's Health Insurance Plans, said in a statement that the survey showed progress, but reform is needed to reduce rising medical costs.

''The slowing rate of growth in health insurance premiums shows we are moving in the right direction, but much more needs to be done to make health care coverage more affordable for consumers and employers. Health insurance plans have implemented a variety of innovative strategies that are helping to rein in skyrocketing health care costs and improve the quality of care that patients receive,'' she said.

BY KATE NASEEF

The full survey is available on the Web at http://ehbs.kff.org/.

Health Insurance

Consultant Provides Tips for Cutting Costs In Health Plans With Comprehensive Strategy

Health plan administrators and employers should be trying to drive their health trends below the consumer price index, a goal that is ''doable,'' a Segal Co. consultant said Sept. 23 at the Benefits Forum & Expo.

According to Christopher Matthews, vice-president and total health management practice leader at Segal's Washington, D.C., office, the fixes that employers used in the past to reduce health care costs ''are in the past'' because the health care system is in transition.

Employers and plan sponsors who are looking to reduce health costs must transition to new roles of ''facilitators, advocates, and leaders,'' from their old roles of financial and fiduciary oversight, Matthews said.

Matthews described several elements of health care plans that are in transition, such as plan design, program offerings, plan eligibility, funding approaches, and legal considerations and options.

Consumer driven health plans by themselves are not in a position to influence employee behavior, Matthews said.

Employers should ''ignore cost-shifting methods, and focus on cost drivers,'' he said.

For example, poor quality hospital care drives higher costs, he pointed out. He said a 2003 Institute of Medicine study reported that nearly 98,000 people die each year in hospitals because of nondrug-related preventable errors.

The Centers for Medicare & Medicaid Services published final rules in 2007 stating that it would not reimburse costs for these ''never events,'' such as surgery on the wrong part of the body or wrong patient, mismatched blood transfusion, a foreign object left in a patient's body after surgery, major medication errors, severe pressure ulcers acquired in the hospital, and preventable post-operative deaths.

Several states, including Illinois, Minnesota, and New Jersey, also require hospitals to report never events as

listed on the National Quality Forum. According to NQF, never events are errors in medical care that are clearly identifiable, preventable, and serious in their consequences for patients, and that indicate a real problem in the safety and credibility of a health care facility.

Matthews also pointed to a 2003 RAND study which found that the quality of health care individuals received averaged only about 54 to 55 percent. The quality of care ranged from a low of 10.5 percent for alcohol dependence to a high of 68.5 percent for low back pain; but in all cases, the low percentages drove up health care costs, he said.

According to Matthews, ''the only way to effectively reduce spending is to prevent the claim from ever happening.''

Tips for Reducing Costs. What is needed is a multiprong approach to tackling health costs, which Matthews called total health management. THM consists of examining multiple aspects of medical plans, including vendor management, individual health management, plan design management, and data analytics, Matthews said.

THM uses:

- data analytics to identify sources of health risks and treatment gaps,
- support and outreach to assist plan participants to access timely and appropriate high quality care,
- collaboration among primary care physicians to identify gaps in care and develop treatment plans to close those gaps in medical care, and
- the promotion of good health habits among plan participants.

In terms of vendor management, employers should use aggressive procurement, looking at areas such as broker commissions and service and contracting. Pharmacy benefit managers, for example, are ''enormously'' competitive, Matthews said.

Employers also should consider raising their stop-loss insurance, while at the same time considering dropping their aggregate stop-loss insurance.

Employers also should implement dependent eligibility audits, he said.

Under the category of individual health management, Matthews recommended programs for health condition and disease management. He noted that different hospitals in the same geographic area have different success rates, or mortality rates, and charge very different fees, for the same procedures. When an individual needs to undergo an angioplasty, it stands to their benefit to go the hospital with the best record for that procedure, he said.

Medical management organizations offer employers another opportunity to save money through coordination of care among multiple physicians in different specialties, Matthews said.

Employers can focus on lowering health costs through plan design to high value health care or waiving costs to preventive health screenings. At the same time, employers can raise barriers to wasteful spending, such as the use of emergency room visits for non-ER healthcare, he said.

A fourth area to look at is data analytics, Matthews said. Under this category, employers should consider health risk profiling, predictive modeling of diseases, and identifying health cost drivers based upon the employee population.

After an employer creates a vision and sets a strategy to reduce costs, Matthews said that he ''can't underestimate the importance of communication; don't use vendor boilerplate'' when communicating the strategies for reducing costs to its employees.

BY SEAN FORBES

Health Insurance

Incentives Provide Challenges to Employers In Designing Wellness Plans, Speaker Says

Employers need to be mindful of the legal and regulatory issues regarding the incentives they attempt to implement in their wellness plans, Susan Relland, a benefits attorney with Miller & Chevalier, Washington, D.C., said Sept. 23.

Employers commonly attempt to encourage employees to enroll in wellness plans with such incentives as cash payments, gift certificates, airline points, or payments of gym memberships, but all of these must be imputed as income to the employee, Relland told attendees at the Benefits Forum & Expo.

Relland noted that there is no de minimis rule in the tax code or regulations, so any amount that an employer gives to an employee must be recorded as imputed income.

For example, a potentially problematic incentive is when employers offer items such as iPod Nanos. Although the very popular musical devices cost only about $149, employees must report their value as imputed income. Lower income workers who find out they have been taxed on the value of the iPod—the reward for enrolling in the wellness program—may become disgruntled with the wellness program, Relland said.

There are some gray areas in the tax code, Relland said. For example, if an employer negotiates a discounted rate for employee gym memberships, then the discounted rate probably will not be counted against workers who sign up at the gym, she said.

Different programs also may be subject to tax rules prohibiting discrimination in favor of highly compensated employees. Such plans include self-funded health plans, cafeteria plans, flexible spending accounts, and health reimbursement arrangements, Relland said.

ADA and EEOC Issues. Mandatory wellness programs give rise to issues under the Americans with Disabilities Act, Relland said. The ADA generally prohibits employers from discriminating against individuals with disabilities with regard to employments and benefits. However, health plans are exempted if:

- participation in the program is voluntary (a ''sticking point,'' Relland said),
- the health information obtained remains confidential and separate from other employment records, and
- the information obtained is not used to limit health plan coverage or eligibility or to take adverse employment action or deny promotional opportunities.

According to informal guidance from the Equal Employment Opportunity Commission, a wellness program is voluntary, and therefore disability-related questions would be permissible, if the employer does not require participation, and the employer does not penalize employees for nonparticipation, Relland said.

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As with tax issues, monetary incentives can be problematic, Relland pointed out. If the employer makes a wellness program incentive too sweet, such that no reasonable employee would choose not to participate in the program, then EEOC would likely deem the program involuntary. For example, if an employer provided a $100 per month premium discount if an employee completed a health risk assessment for one year, then the program would be involuntary, she said.

Although EEOC has not provided any specific guidance on dollar amounts that would qualify a program as voluntary as opposed to involuntary, the department has stated that any penalty would invalidate a wellness program, Relland said.

EEOC also has stated that there is no distinction between an employer and the health plan asking its workers questions. A violation has occurred as soon as the question has been asked, she said. Furthermore, she added, courts have concluded that all employees, not just those with qualifying disabilities, are entitled to this ADA protection.

Relland added that no EEOC regulations are expected in the near term, and many employers are balancing the risk of ADA litigation with the need to address rising health care costs.

Employers who are dealing with escalating health plan costs are taking a ''so sue me'' approach when designing their wellness program strategies because EEOC guidance is informal and scarce, Relland noted.

Mandatory Wellness Programs. Some mandatory wellness programs may comply with the ADA, Relland said. For example, employers may require workers to get annual physicals, ban smoking at the workplace, or mandate that only healthy food be provided for onsite working lunches, she said.

However, a mandatory wellness program that asks about a person's health would violate the ADA, Relland said. For example, if an employee had to complete a health risk assessment through the employer's vendor, that would violate the ADA.

Questions about an individual's health may be okay if they do not include disability inquiries or allow the employer to discover the existence of a disability, or if they do not include a medical exam, she said.

Moreover, employers may specifically ask about a worker's behavior, but not about their health, without violating the ADA. For example, an employer may require a person to have a health risk assessment performed by his doctor and only report whether he completed the HRA, without asking for the information in the HRA.

'Navigating the Legal Issues.' In addition to the ADA and tax issues, employers also need to take into account Health Insurance Portability and Accountability Act issues, as well as any applicable state laws.

Relland said that so long as employers ''navigate the legal issues,'' they have several options when designing their wellness programs. Among the options she listed were:

- voluntary programs, perhaps with incentives;
- mandatory programs focused on behavior (but not on outcomes); and
- changes to medical plan design, such as generous coverage of preventive care, zero dollar copays for diabetes supplies, and reimbursing doctors for conversations about wellness rather than only when individuals are sick.

BY SEAN FORBES

Health Insurance

State Subsidies Help Small Businesses Provide Health Insurance, Blues Plans Say

Representatives of Blue Cross Blue Shield plans in Oklahoma and Arizona Sept. 22 detailed their states' efforts to expand health insurance coverage for small businesses through premium subsidies, saying that simplicity is the key to their success.

Studies have found that the smaller a business, the less likely it is to offer health insurance to its employees, a problem that hits low-wage workers particularly hard, according to Paul Fronstin, director of the health research and education program at the Employee Benefit Research Institute.

While small employers say there are various reasons for their decision not to offer coverage, 79 percent agree when surveyed that their business cannot afford to do so, Fronstin said during a briefing by the Blue Cross and Blue Shield Association.

The state initiatives in Oklahoma and Arizona aim to help employers through premium subsidy programs that both BCBS plans and other insurers can participate in.

Oklahoma's Premium Subsidy Program. For example, the Insure Oklahoma program has brought coverage to nearly 10,000 small business employees by offering premium subsidies to employers with two to 50 workers, according to Bert Marshall, president of Blue Cross and Blue Shield of Oklahoma. Of those enrollees, 56 percent were previously uninsured.

Under the Insure Oklahoma program, employees receive a state subsidy if they have incomes less than 200 percent of the federal poverty level. Each employer is responsible for 25 percent of each employee's premium, the employee pays 15 percent, and the state covers the rest.

Each employer chooses an ''off-the-shelf'' plan—offered by 20 insurers—for all of their employees, which allows choice and eliminates the stigma associated with public programs, according to Marshall.

''This is the same insurance that the *Fortune* 500 companies are carrying. The card is the same, there's no difference. This is commercial insurance,'' Marshall said.

Small business employees who do not qualify for the subsidies also benefit from the program because more employers offer coverage. For every state-subsidized employee in Oklahoma, 1.4 employees are offered coverage without the state subsidy but with an employer subsidy, according to Marshall.

Arizona's Program. In Arizona, a premium subsidy program has provided coverage to more than 4,700 people, including the families of employees, according to Chuck Bassett, vice president of government relations at Blue Cross Blue Shield of Arizona.

The program subsidizes small employers for the lesser of 50 percent of the premium for their employees

or $1,000 per employee with individual coverage and $3,000 per employee with family coverage.

Bassett said the program is designed to help employers get a foothold in the insurance market because eligibility is limited to three years. The program has not yet reached the three-year mark, but observers are interested to see whether employers continue to offer coverage, according to Bassett.

'No Need for Connector.' Marshall said the Insure Oklahoma plan has benefited from the simplicity of its design and limited bureaucratic interference.

''There is no need for a connector,'' Marshall said, referring to the health insurance purchasing agencies included in some reform proposals and used in Massachusetts.

The Blue Cross and Blue Shield Association has said in position briefs that it does not support the use of connectors, known also as exchanges, for individuals and small employee insurance purchasers.

BCBSA says connectors increase costs, limit choices, constrain competition, and increase government regulation.

In Brief

Report Compares State Retiree Benefits

A report examining similarities and differences between state retiree health plans offered by each of the 50 states was issued Sept. 23 by the Washington-based Center for State and Local Government Excellence, which describes its mission as helping ''state and local governments become knowledgeable and competitive employers so they can attract and retain a talented and committed workforce.''

Included in the report, *Retiree Health Plans: A National Assessment*, are details such as eligibility requirements for coverage and the cost to employees and to state governments for the benefit.

According to the center, which teamed up with researchers from North Carolina State University's School of Public and International Affairs and College of Management to produce the report, future publications will examine the myths and realities of the state and local government retiree health care crisis, what states and localities are doing to finance retiree health care, policy alternatives, intergenerational issues, and benchmarking.

The report is at http://tinyurl.com/rhpnatlassessment.

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Legal News

Retiree Benefits

Retirees Whose Benefits Aren't Vested Lack Standing, Divided Ninth Circuit Rules

Retirees of Simpson Paper Co. lack standing to sue the company alleging it violated federal labor laws by terminating their postretirement health benefits, the U.S. Court of Appeals for the Ninth Circuit ruled Sept. 22 in a 2-1 decision (*Poore v. Simpson Paper Co.*, 9th Cir., No. 05-36060, 9/22/08).

The appeals court majority found that the retirees' health benefits were not vested under the Employee Retirement Income Security Act and, as such, they lacked standing to pursue their claim that Simpson Paper violated ERISA when it eliminated their health benefits in 2004.

In addition, the majority found that the retirees lacked standing under the Labor Management Relations Act because their right to health benefits came from collective bargaining agreements that had expired at the time Simpson Paper terminated their benefits.

In a dissenting opinion, Judge Susan P. Graber argued that the majority ''confused subject matter jurisdiction with the merits'' of the retirees' ERISA and LMRA claims.

''Regardless of what Simpson is required to do in satisfying its obligation to negotiate, it ultimately retains the exclusive authority to change retirement health benefits irrespective of the outcome of such negotiations.''

JUDGE DIARMUID F. O'SCANNLAIN

Graber said the retirees' federal claims under ERISA and LMRA were ''not frivolous'' and that the court should have looked to whether Simpson Paper's ability to eliminate retiree health benefits was subject to negotiation with the union that had once represented the retirees.

CBAs Contain Reservation-of-Rights Clause. Simpson Paper closed a mill in West Linn, Ore., in 1996. Up until the time of the mill's closing, hourly employees of Simpson Paper were represented by the Association of Western Pulp and Paper Workers. During the time in which Simpson Paper owned the mill, it was party to three collective bargaining agreements with the union.

The CBAs incorporated by reference a benefit booklet providing that retirees over the age of 55 would receive health benefits until they became eligible for Medicare or attained the age of 65. Among other things, the benefit booklet specifically reserved to Simpson Paper the ''right to alter, amend, delete, cancel or otherwise change'' the retiree benefits ''at any time, subject to negotiation with the Union.''

Prior to its closure of the West Linn mill in 2006, Simpson Paper negotiated an agreement with the union providing that employees who lost their jobs because of the closure and who were eligible to receive pension benefits would be eligible for retiree medical coverage.

In 2002, Simpson Paper notified all of its retirees that it intended to phase out and eventually eliminate retiree health benefits. By July 2004, Simpson Paper stopped providing retiree health benefits.

A group of retirees sued Simpson Paper under ERISA and LMRA, contending that their health benefits were vested and as such could not be eliminated by the company. The U.S. District Court for the District of Oregon in 2005 ruled in favor of Simpson Paper, finding that the retirees failed to meet their burden of establishing that their retiree health benefits were vested and thus protected from elimination (201 PBD, 10/19/05; 32 BPR 2321, 10/25/05; 37 EBC 1130).

Majority Finds No Standing. Noting that it had an ''independent obligation'' to ensure that it had federal subject matter jurisdiction over the case, the appeals court said the retirees had to first establish that they were ERISA plan ''participants'' with standing to sue. To make this determination, the appeals court looked to whether the retirees' health benefits had vested, as ERISA does not require that health and welfare benefits actually vest.

Looking to Black's Law Dictionary, the appeals court said that a ''vested right'' is commonly defined as a ''right that so completely and definitely belongs to a person that it cannot be impaired or taken away without the person's consent.'' By applying this interpretation of vesting, the court found that the retirees' health benefits here were not vested.

According to the court, the CBAs and closure agreement between Simpson Paper and the union both incorporated the benefit booklet, which expressly reserved to Simpson Paper ''the right to alter, amend, delete, cancel or otherwise change welfare ... plan benefits at any time, subject to negotiation with the Union.''

The appeals court found that, while the benefit booklet provided a specific duration in which the benefits at issue applied, which can in some circumstances indicate vesting, when read together with the reservation-of-rights provision, the plan allowed benefits to be altered, or even terminated, without the retirees' consent, which showed that their benefits were not vested.

The court rejected the retirees' contention that the ''negotiation qualifier'' in the reservation-of-rights provision demonstrated that Simpson Paper did not have a unilateral right to change their benefits.

''Whatever authority Simpson may have relinquished, on the express terms of the clause, the retirees

do not control their continued receipt of benefits. A duty to negotiate is not of the same character as a duty to secure consent. Regardless of what Simpson is required to do in satisfying its obligation to negotiate, it ultimately retains the exclusive authority to change retirement health benefits irrespective of the outcome of such negotiations,'' Judge Diarmuid F. O'Scannlain said in writing for the majority.

The majority thus concluded that because the retirees did not have vested rights to the health benefits, they lacked standing under ERISA, and thus the court lacked subject matter jurisdiction over their claims.

The appeals court also found that it did not have subject matter jurisdiction under the LMRA because once a CBA has expired and the parties are released from their respective contractual obligations, any dispute between them cannot be said to arise under that CBA. ''[T]he retirees' rights to health benefits under the now expired CBAs were not vested. Thus, their claim seeking recovery of such benefits does not arise under contract sufficient to trigger the LMRA's grant of federal subject matter jurisdiction because their *contractual* rights to such benefits'' no longer exist, the court said.

The majority opinion was joined by Judge Consuelo M. Callahan.

Dissent: Majority 'Closed Courthouse Door.' In her dissenting opinion, Judge Graber argued that the majority ''shirked'' its responsibility ''by closing the courthouse door to plaintiffs who raise colorable claims under federal law.''

Graber argued that even if the retirees eventually lose on the merits of their claims, the claims were not frivolous and subject matter jurisdiction existed under both ERISA and LMRA.

Graber looked to the CBAs and argued that the ''most reasonable reading'' of the CBAs' reservation-of-rights provision was that the CBAs granted the retirees the continuing benefit of health insurance until age 65, which Simpson Paper retained the right to end at any time, ''but not unilaterally.''

According to the dissent, Simpson Paper and the union contracted for a benefit to survive termination of the CBAs, and therefore the court had jurisdiction under LMRA to examine disputes that arose under those CBAs.

Graber further argued that the CBAs' ''subject to negotiation'' clause was not explained, and thus an issue of fact remained as to whether Simpson Paper engaged in any sort of negotiations that would have allowed it to terminate the retirees' benefits.

In addition, Graber took issue with the majority's definition of ''vested right,'' arguing that the definition used by the majority applied specifically to the vesting of constitutional rights, not generally to contractual rights.

''[T]he majority's holding violates basic principles of contract law. The majority holds that Plaintiffs' benefits are not vested because Defendant can terminate them 'subject to negotiation with the Union.' But, under the terms of the CBAs, Plaintiffs have an absolute contractual right to their benefits *unless and until* such negotiation occurs (or until they turn 65). The act of negotiation therefore operates as a condition subsequent,'' Graber said.

The retirees were represented by Thomas K. Doyle of Bennett, Hartman, Morris & Kaplan, Portland, Ore. Simpson Paper was represented by Douglas S. Parker of Preston Gates & Ellis, Anchorage, Alaska.

BY JO-EL J. MEYER

Funding

Court Approves Agreement to Transfer $3.4B Pension Liability From Delphi to GM

Two days after it authorized Delphi Corp. to freeze its defined benefit pension plans, the U.S. Bankruptcy Court for the Southern District of New York issued an order Sept. 25 authorizing Delphi to transfer $3.4 billion in pension liabilities to General Motors Corp. (*In re Delphi Corp.*, Bankr. S.D.N.Y., No. 05-44481 (RDD), 9/25/08).

The transfer of Delphi's pension liabilities to GM, its former parent company, is aimed at helping the automobile parts manufacturer emerge from bankruptcy protection.

Pension Benefit Guaranty Corporation Director Charles E.F. Millard hailed the pension transfer as a ''victory'' for Delphi's workers and retirees. ''We applaud Delphi and General Motors for their leadership in crafting an agreement that addresses the concerns of Delphi's stakeholders. We will continue to work with all stakeholders to support Delphi's restructuring efforts,'' Millard said in a Sept. 25 news release.

Millard added in the release that the transfer of Delphi's pension plan to GM would have an ''immediate impact'' on PBGC's funded status well in excess of $1 billion. ''This transfer is exactly what we have been urging all along and we are very pleased with this result,'' Millard said.

''We applaud Delphi and General Motors for their leadership in crafting an agreement that addresses the concerns of Delphi's stakeholders.''

PBGC DIRECTOR CHARLES E.F. MILLARD

In August, Millard urged Delphi to transfer its pension obligations to GM by Sept. 30 (159 PBD, 8/18/08; 35 BPR 1895, 8/19/08).

On Sept. 12, GM and Delphi entered into a settlement and restructuring agreement under which GM agreed to provide support for Delphi's emergence from bankruptcy. One provision of this settlement called for a substantial portion of Delphi's pension plan for hourly workers to be transferred to GM.

As part of the agreement, Delphi filed a expedited motion with the bankruptcy court asking for authorization to freeze its defined benefit pension plans before they could be transferred to GM.

Delphi Files Expedited Motion. Earlier this month, Delphi filed an expedited motion to implement an agreement with GM that would allow for Delphi to transfer its $3.4 billion unfunded pension liabilities to GM. The agreement required that Delphi freeze its defined benefit plans ''as soon as possible,'' according to Delphi's Sept. 12 expedited motion.

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Delphi said in the motion that approval of the agreement with GM was ''critical to the transformation of Delphi.'' According to Delphi's motion, ''consummation of this pension transfer before September 29, 2008 will avoid Delphi's having an accumulative funding deficiency of $2.1 billion to $2.4 billion for its hourly pension plan as of September 30, 2008, and therefore will substantially reduce the Debtors' required emergency contribution to their pension plans.''

The official committee of Delphi's unsecured creditors filed objections to the expedited motion Sept. 19. The committee said that, while it supported Delphi's decision to freeze its defined benefit plans and establish defined contribution plans, it did not support the creation of a new SERP for executives. ''[I]t simply makes no sense for the Debtors to establish replacement retirement plans for executives while the Debtors have no revised plan of reorganization to present to creditors,'' the committee said in its objection.

The committee further argued that modifications to the defined benefit plans should not take place without union consent, as it was ''certainly possible that one or more of the unions may condition its consent on the receipt of additional consideration or other modifications to the transaction.''

In the days after the committee filed its objection, at least two unions—the United Steel Workers of America and International Union of Electronic, Electrical, Salaried, Machine and Furniture Workers—filed limited objections to Delphi's motion for expedited approval of its agreement with GM. The unions' limited objections pointed out that they had not yet had time to negotiate with Delphi over the proposed pension freeze and transfer to GM.

The motion to freeze the pension plans was granted by Judge Robert D. Drain on Sept. 23 (187 PBD, 9/26/08). In a four-page order, Drain authorized Delphi to freeze its defined benefit plans, in whole or in part, effective ''as soon as practicable'' following receipt of consent from the applicable unions and satisfaction of Delphi's notice obligations under Section 204(h) of the Employee Retirement Income Security Act.

The Sept. 23 order also authorized Delphi to institute a new defined contribution plan effective Oct. 1.

Two days later, Judge Drain issued another order authorizing Delphi to implement the agreement it had reached with GM to transfer $3.4 billion in pension liabilities. In the order, Drain said the settlement with GM was ''essential'' to Delphi's restructuring and provided material and substantial consideration to Delphi.

Under the order, Delphi is authorized to implement, deliver, and perform its obligations in accordance with the agreement with GM, with the first part of the pension transfer taking place Sept. 29.

In addition, the court order authorized Delphi to take ''any and all action,'' including modifying the relevant provisions of the applicable union memoranda of understanding, necessary to freeze the pension plans and implement the GM agreement. The court order noted that several unions, including the United Automobile Workers, have executed implementation agreements with Delphi and GM.

BY JO-EL J. MEYER

Employer Stock

Court Refuses to Dismiss Breach Claims Tied to Executives' Stock Options Backdating

A former employee of Analog Devices Inc. (ADI) has standing to sue the company's executives contending they breached their fiduciary duties by failing to disclose to those employees who invested in ADI stock that the executives were backdating their stock options, the U.S. District Court for the District of Massachusetts ruled Sept. 24 (*Bendaoud v. Hodgson*, D. Mass., No. 06cv11873-NG, 9/24/08).

Judge Nancy Gertner found that the former employee had standing under the Employee Retirement Income Security Act, even though he cashed out of ADI's company stock fund more than two years before the company made public disclosures about the backdating of stock options.

While the court rejected several of the theories the employee used in attempting to establish that he had standing, the court ultimately agreed with the employee that he had standing under ERISA to assert that the plan fiduciaries breached their duties by exposing him to an unacceptable level of risk in offering ADI stock as an investment option while stock options were being backdated.

''If a defined contribution plan participant sues for a breach of fiduciary duty, his financial recovery must be entirely, and only, to his own accounts.''

JUDGE NANCY GERTNER

The court thus refused to dismiss the lawsuit, and found that the employee may be able to recover monetary damages if he can show that an alternative investment would have garnered a greater return than what he received from investing in the ADI company stock fund.

However, the court agreed with the defendants that the corporate acts of setting executive compensation and backdating stock options were not actionable under ERISA because they were not fiduciary acts. But the court said the employee's complaint was not that the defendants breached their duties by backdating options; instead, the employee charged that the breaches occurred when the defendants, in Securities and Exchange Commission filings that were incorporated into plan documents, made misrepresentations about the stock options.

The ADI Stock Fund. ADI established a defined contribution plan in 2000. The plan's participants could direct their investments toward any of several investment options offered under the plan, including the ADI stock fund. The ADI stock fund purchased exclusively ADI stock on the open market, according to the court.

Soufiane Bendaoud began participating in the plan in 2000 and selected the ADI stock fund as one of his investment options. When he first started investing in the ADI stock fund, the price of a share of ADI stock was approximately $71, according to the court. Bendaoud

cashed out of the ADI stock fund in December 2002, when the price of a share of ADI common stock was approximately $30. The court noted that despite this decline, Bendaoud made a ''modest profit'' on his investments in the ADI stock fund.

Nearly two years after Bendaoud cashed out of the stock fund, ADI disclosed publicly that the SEC had been investigating its stock options practices for the preceding five years. ADI later reached a tentative settlement with the SEC, admitting that it should have disclosed to the public that certain stock options had been backdated for its executives.

Bendaoud alleged that in November 2004 after the backdating scheme was disclosed, the value of ADI stock ''plummeted.''

In his lawsuit, Bendaoud claimed that the improper options practice hurt the value of ADI stock, thereby diminishing the value of his investments, as well as the investments of other ADI employees who selected the ADI stock fund. Bendaoud further alleged that the ADI executives acted imprudently in allowing him to invest in the ADI stock fund because they knew or should have known that its value was ''not what it seemed.''

Bendaoud Has Standing for Himself, Not Others. The defendants filed a motion to dismiss, arguing that Bendaoud lacked standing and that he failed to state a claim upon which relief could be granted.

In deciding whether Bendaoud had standing, the court looked to the U.S. Supreme Court's recent decision in *LaRue v. DeWolff, Boberg & Assoc.*, 128 S.Ct. 1020, 42 EBC 2857 (2008) (34 PBD, 2/21/08; 35 BPR 467, 2/26/08). According to the district court, although the Supreme Court did not address standing in *LaRue*, the high court examined the remedies available for fiduciary breaches under ERISA Section 502(a)(2) and the Supreme Court's reasoning ''illustrates the limits on a defined contribution plan participant's ability to sue 'on behalf of' the plan.''

The district court noted that the Supreme Court in *LaRue* held that a plaintiff suing for recovery to his or her own defined contribution pension plan accounts under ERISA Section 502(a)(2) seeks recovery for the entire plan. ''The negative implication of that holding is clear: One defined contribution plan participant has no pecuniary interest in the accounts of another. If a defined contribution plan participant sues for a breach of fiduciary duty, his financial recovery must be entirely, and only, to his own accounts,'' the district court said.

The court thus reasoned that Bendaoud could not seek recovery on behalf of other plan participants' financial losses. But the court noted that a fiduciary's breaches can affect more than one defined contribution plan participant and in that situation, the proper approach would be joinder of the affected participants or the certification of a class.

''If Bendaoud suffered a financial injury as a result of the breach, he may properly represent the class. But he may not elide his own lack of injury by claiming that the breach harmed other plan participants even if it did not harm him,'' the court said. The court thus concluded that because Bendaoud could not sue on behalf of the plan, he was limited to seeking to recover benefits that were owed to him but which he did not receive.

Possible Injury-in-Fact. The court went on to agree with the defendants that Bendaoud could not show that the defendants' action of backdating stock options caused the value of his ADI stock to decline, because the stock price did not drop due to this backdating until two years after Bendaoud cashed out of the stock fund.

But the court agreed with Bendaoud that he suffered a possible injury-in-fact under the theory that he would have not made any investments in the ADI stock fund if the defendants had not breached their duties by failing to remove the stock fund as an investment option despite the increased risk it carried due to the backdated stock options. The court also noted that Bendaoud had stated another injury-in-fact sufficient to establish standing, that being a breach of his statutory entitlement under ERISA to be presented with prudent investment options.

The court acknowledged that it might have some difficulty assessing the relief to which Bendaoud might be entitled, but found that if Bendaoud is able to prove there was a fiduciary breach, his damages could be calculated if he could show that an alternative investment would have garnered a greater return during the period when he invested in the ADI stock fund.

In addition, the court agreed with the defendants that the act of backdating stock options was a corporate business activity, not a plan activity. However, the court focused on the allegations in Bendaoud's complaint and found that the defendants may have been acting in their fiduciary capacities, rather than in their corporate capacities, when they incorporated into plan documents affirmative statements in SEC filings about the company's executive compensation practices.

''Merely signing a securities filing, even one that the signer knows will be incorporated into an ERISA document, does not create ERISA fiduciary status; it is a solely corporate act. But a person who is already an ERISA fiduciary may make a misstatement by incorporating a false document in the materials distributed to plan participants,'' the court said.

Bendaoud was represented by Stephen J. Fearon Jr. of Squitieri & Fearon, New York; Thomas J. McKenna of Friedman, Wittnestein & Hochman, New York; and Thomas G. Shapiro and Adam M. Stewart of Shapiro Haber & Urmy, Boston.

The defendants were represented by Michael R. Dube, Colin M. Huntley, Charles C. Platt, and Jeffrey B. Rudman of Wilmer Cutler Pickering Hale and Dorr, Boston.

BY JO-EL J. MEYER

Enforcement

Trial to Proceed Against Attorney Charged With Helping Contractors Evade Wage Laws

In perhaps the first criminal enforcement action of its kind, the U.S. District Court for the Eastern District of New York refused Aug. 29 to dismiss the indictment of an attorney who is charged with devising an employee benefit trust fund that allegedly allowed contractors in New York to evade state and federal prevailing wage laws (*United States v. Coren*, E.D.N.Y., No. 07-CR-265 (ENV), 8/29/08).

In refusing to dismiss the indictment against attorney Steven Coren, Judge Eric N. Vitaliano rejected Coren's contention that the Contractor's Benefit Trust (CBT) complied with the Employee Retirement Income Secu-

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rity Act and that federal and state prevailing wage laws cannot dictate how funds in an ERISA-qualified plan can be distributed.

''Coren's argument, though provocative, is fatally flawed,'' the court said, finding that nothing in the state and federal prevailing wage laws required that the payment of fringe benefits come from an ERISA-qualified trust. According to the court, public contractors' obligations under the prevailing wages laws cannot be discharged simply by making contributions to ERISA-governed fringe benefit funds.

''ERISA and [the Davis-Bacon Act] need not work at cross-purposes, and when an employer chooses to utilize an ERISA-qualified trust to satisfy its Davis-Bacon obligation, compliance must be had with both,'' the court said.

The Prevailing Wage Laws. The federal Davis-Bacon Act requires that federal contractors pay prevailing wages to their employees. The prevailing wage has two components: a basic rate of pay and a fringe benefit amount. According to the court, a contractor can discharge its prevailing wage fringe benefit obligations by, among other things, making contributions to a fringe benefit fund, plan, or program. The Davis-Bacon Act does not require that the contributions be made to an ERISA-governed plan.

New York's Little Davis-Bacon Act, which governs public contracts in New York, contains essentially the same provisions as the federal prevailing wage law. Section 220 of the Little Davis-Bacon Act states that the prevailing wage consists of both a basic hourly rate and supplemental benefit rates, which is defined as ''all remunerations for employment paid in any medium other than cash . . . or any payments which are not 'wages,' including but not limited to health, welfare, nonoccupational disability, retirement, vacation benefits, holiday pay, life insurance, and apprenticeship training.''

Both the federal Davis-Bacon Act and the New York Little Davis-Bacon Act require contractors, on a regular basis, to submit transcripts of their payroll to a public agency and to certify under penalty of perjury that they complied with the prevailing wage requirements.

Coren Establishes the CBT. In 1993, Coren established the CBT. The CBT's declaration of trust stated that it was created ''to provide benefits under New York State Labor Law Section 220 (and other similar state laws in other states), the Davis-Bacon Act, or any other state or federal rule requiring the payment of prevailing supplemental benefits which include pension, annuity, vacation, health and welfare, or like benefits.''

The CBT, as devised by Coren, allowed for Coren's contractor clients to make prevailing wage fringe benefit payments to the trust. The CBT then served as a ''benefits bank,'' funding various types of employee benefits. According to the court, Coren served as trustee of the CBT.

In April 2007, Coren was indicted on charges that he aided and abetted his contractor clients' violation of federal and state prevailing wage laws. In particular, the indictment charged Coren knew, and in fact intended, that contributions to the CBT would not be used exclusively to provide fringe benefits to the prevailing wage employees on whose behalf credit had been claimed by his client-contractors.

''[T]he funds in the CBT were used for the purchase of welfare benefits for company employees without regard to the type of work performed by that employee. In some instances, the benefits paid by the CBT inured solely, or, at least, mostly, to the benefit of the owners and operators of the companies themselves,'' the court said in detailing the indictment against Coren.

The indictment charged that Coren advised, counseled, and assisted his client-contractors in using the CBT to claim fraudulently to state and federal agencies that they were in full compliance with their prevailing wage obligations, even though a significant portion of the funds contributed to the CBT were not used to provide fringe benefits for the workers on whose behalf the contribution had been made and prevailing wage credit received.

ERISA Is No Safe Harbor. In his motion asking the court to dismiss the indictment, Coren focused on the intersection of ERISA and prevailing wage laws, arguing that because ERISA controlled the operation of the CBT, the prevailing wage laws could require only that employers who are subject to prevailing wage requirement contribute a defined amount to an ERISA-qualified benefits trust, but cannot dictate how those funds are then distributed.

According to the court, Coren argued that employers can properly claim prevailing wage credit for contributions to ERISA trusts in the name of prevailing wage workers, regardless of whether or how those contributions relate to benefits ultimately provided to those workers. In addition, Coren pointed out that ERISA precludes discrimination by employers among employees who are ''qualified'' to receive benefits and that, under ERISA, employees have no ownership interest or specific right to any asset in such a fund.

Coren thus claimed that, because his client-contractors contributed to the CBT which satisfied ERISA requirements, both he and his clients were in full compliance with ERISA and the indictment failed to state a crime.

In rejecting Coren's argument, the court said even if the CBT complied with ERISA, the government's indictment did not take issue with the CBT's compliance with ERISA, but instead the indictment asserted that Coren and his client-contractors criminally violated state and federal prevailing wage laws.

According to the court, the government took the position that the prevailing wage laws require that there be a reasonable relationship between contributions to a trust on behalf of prevailing wage workers and benefits actually received by those workers in order for an employer to properly claim credit. Coren argued, on the other hand, that the government's position was untenable because ERISA controls plan benefit payments to workers and, under ERISA, an employee has no ownership interest or other specific rights.

The court sided with the government, noting that nothing in the prevailing wage laws requires the payment of supplemental benefits through a ERISA-qualified plan. ''[W]hatever an employer's obligations are under Davis-Bacon, they are not discharged *solely* because dollars *claimed* to satisfy payment of a prevailing supplement wage obligation are in fact contributed to an ERISA qualified-fund, plan or program,'' the court said.

In addition, the court said there was no conflict between ERISA and the government's enforcement of the prevailing wage laws. According to the court, the gov-

ernment's indictment did not suggest that the structure of the CBT itself was illegal or that use of a trust like the CBT to pay benefits to nonprevailing wage workers violates prevailing wage laws. ''Rather, the indictment charges that, on the advice, counsel and with the assistance of Coren, Coren's client-contractors defrauded government agencies by falsely claiming credit for paying their public workers the prevailing wage for work performed on public contracts,'' the court said.

The court noted that had Coren's clients used the CBT as a pooled trust and accepted only contributions from prevailing wage workers while providing benefits to nonprevailing wage workers and prevailing wage workers alike, but adjusted the amount of prevailing wage credit they claimed, ''there would be no fraud, and, consequently, no crime.'' Instead, the court said it was the contractors' alleged use of the CBT, on the advice and counsel of Coren, to give the appearance to government agencies that the employers were paying prevailing wages, while instead effectively using the money to pay other expenses, that ''makes out the crimes charged.''

Statutes Aren't 'Unconstitutionally Vague.' Moreover, the court rejected Coren's contention that the indictment's mail and wire fraud charges were themselves ''unconstitutionally vague'' because they incorporated provisions form the Davis-Bacon Act and Little Davis-Bacon Act, which provided no guidance on the relationship between funds deposited into a trust account and the benefits paid from the account in order to claim prevailing wage credit.

While noting that the criminal case against Coren was ''the first criminal case of its kind,'' the court said there was an ''abundance of authority which patently establishes'' that the conduct alleged in this ''inaugural'' criminal action was prohibited. ''The relevant prevailing wage laws, the regulations implementing those laws, as well as caselaw all make clear that, in order to take credit for payments to prevailing wage workers, there must be, at a minimum, a reasonable relationship between the credit take and the benefit received by the prevailing wage workers for whom the credit is taken,'' the court said.

According to the court, the legislative history of the Davis-Bacon Act signaled that funds contributed to fringe benefit fund must be used to cover an employer's expenses related to the wages required to be paid to prevailing wage workers. ''If an employer could make contributions to a fringe benefit plan that were not reasonably related to the benefits actually received by such an employee, the prevailing wage statutes would have no effect: employers would incur no or little cost with respect to these employees and the covered class of employees will not receive the appropriate full 'wage,' '' the court said.

Finally, the court rejected Coren's argument that he could not be held criminally liable because he did not advise his clients as to the propriety of any prevailing supplemental wage credit they claimed. Coren argued that determining the amount of prevailing wage credit that can be claimed by a contractor is an accounting function performed by the contractors, and as such was outside his role as counsel or CBT trustee.

''While Coren's involvement in the contractors' fraud will undoubtedly be the issue for trial, the indictment clearly alleges that Coren devised the CBT with the specific intent to help contractors shirk their prevailing wage obligations and divert money that should have been spent on benefits for prevailing wage workers back into their own pockets. That is enough,'' the court said.

The government was represented by Sarah Mary Coyne and Richard T. Faughnan, both of the U.S. Attorneys' Office, Brooklyn, N.Y.

Coren was represented by Marc Lee Mukasey of Bracewell & Giuliani, New York, and Lawrence H. Schoenbach of New York.

Mukasey told BNA Sept. 22 that ''We respectfully disagree with Judge Vitaliano's interpretation of this complex area of the law and believe that Mr. Coren is innocent of any wrongdoing.''

Decision Could Make 'Big' Splash. Attorney Laurent Drogin of Tarter Krinsky & Drogin, New York, told BNA Sept. 22 that, depending on how the case against Coren is resolved, the decision could make a ''big splash'' or even a ''tremendous splash'' beyond what the court might have anticipated.

According to Drogin, the court faulted Coren for relying on ERISA to guide a client and concluded that the ERISA issue was not relevant to the prevailing wage issue. Drogin noted that the problem with this approach is that there are very common scenarios in various industries where employees who work in prevailing wage jobs never receive benefits, either because of the transient nature of their work or because of coverage waiting periods imposed by their plans.

This opinion suggests that, to the extent an employer claims credit for making contributions for prevailing wage employees, it will be a violation of prevailing wage laws if the employee never receives those benefits, Drogin told BNA.

In the construction industry, for example, there are transient employees and you may have money building up for the employees in ERISA benefit funds that is never paid, while at the same time the employers are receiving prevailing wage credits, Drogin said. He noted that it is perfectly lawful under ERISA to make contributions that are never paid to employees, but the court here is making it unlawful.

''ERISA practitioners need to really be aware,'' Drogin said. According to Drogin, ERISA practitioners may not be familiar enough with prevailing wage laws or may not even know that their client is doing prevailing wage work, and they could get themselves in trouble if they advise their clients on making contributions that ultimately do not get paid to the prevailing wage workers.

The labor bar ''is very troubled because there are a multitude of employment and labor law statutes that have criminal liability attached to them,'' Drogin noted. He said precedent is being set in the Coren case that if a client is charged with a crime under a labor law and is acting on the advice of counsel, the attorney can be charged as an aider and abetter.

BY JO-EL J. MEYER

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Vesting

General Motors Is Equitably Estopped From Denying Employee Retirement Benefits

General Motors Corp. is equitably estopped from denying an employee health care and life insurance coverage because the employee detrimentally relied on GM's representations that a 13-month break in employment would be bridged so that he would be eligible for certain retirement benefits, the U.S. District Court for the Eastern District of Michigan ruled Sept. 19 (*Thate v. General Motors Corp.*, E.D. Mich., No. 07-11370, 9/19/08).

According to the court, plan documents contained conflicting information about bridging service, and GM had repeatedly assured and treated the employee as if it had bridged his service, giving him more than 30 years of service.

Although the court required GM to provide the employee with benefits, the court found that GM did not act arbitrarily when it refused to bridge the employee's length of service, therefore rendering him ineligible for health care and life insurance benefits in retirement.

In so ruling, Judge Victoria A. Roberts said that while two different plan documents contained conflicting information about GM's bridging policy, there was no evidence that GM intended to modify its normal bridging policy, which required an employee to return to work with GM within 12 months of the separation to bridge his or her length of service.

Given the fact that GM had discretionary authority to interpret plan terms, the court found that it was reasonable for GM to give effect to its general bridging policy.

Separation of Service. Frederick Thate first became employed by GM on June 6, 1965, as a salaried employee of its Allison Gas Turbine Division (AGT). Thate worked at AGT until Dec. 1, 1993, when AGT was sold to Allison Engine Co. (AEC) Thate continued working for AEC until March 31, 1994, when he was involuntarily separated due to a reduction in workforce. Because GM did not have any jobs available for Thate, his status was listed as ''special separation - return from successor company,'' and he received severance pay, the court said.

After his separation from AEC, Thate participated in a job placement program with GM, which led to a job in Bedford, Ind. On June 1, 1995, Thate recommenced his employment with GM and was assured by human resources that he would receive five weeks of vacation and that ''it would be as if he never left,'' the court said. According to the court, starting in March 1996, Thate's benefits statements erroneously listed that he would only receive two weeks of vacation, not five weeks, which was based on a length of service of more than 20 years. Thate alleged he was told that the error was due to new software and that it was corrected manually, and he took five weeks of vacation each year.

From 1995 to 2005, Thate received annual retirement projections showing he was eligible for a ''30 and out'' retirement, and a 2005 statement showed his hire date as June 1965. In February 2005, GM offered Thate an early retirement option, which Thate was going to accept until he learned on March 17, 2005, that GM would not bridge his length of service due to a break in service as of Nov. 30, 1993. GM refused to bridge Thate's service to his original hire date in 1965, and thus treated him as if he began working for GM in June 1995. As a result, Thate was not eligible for GM contributions to health care and life insurance costs during retirement.

After exhausting his administrative remedies, Thate filed a lawsuit in federal court for benefits, breach of contract, breach of fiduciary duty, and equitable estoppel.

Claim Accrued in March 2005. GM argued that Thate's claim accrued in June 1995 and thus was barred by a six-year limitations period of breaches of contract in Indiana. The court, however, said that the proper Indiana limitations period was 10 years for breaches of written contract. The court found that Michigan had a substantial interest in this case, and thus its six-year limitations period was applicable.

GM argued that under the terms of a GM benefits booklet and separate template of employee benefits, Thate should have known on June 1, 1995, that his length of service would not be bridged. The template provided that under most circumstances, a special separation would break an employee's length of service unless they were rehired by a GM employing unit within 12 months following the separation, in which case the length of service would be determined on an individual basis. The GM booklet provided that an employee's length of service would be bridged only if he or she was re-employed within 12 months following a separation. The court noted, however, that a chart in the template stated that an employee would be eligible for GM contributions for health care and life insurance in retirement unless they were terminated for reasons other than cause by a successor company within three years of the date of transfer, and they returned to and retired from GM and were eligible for coverage in retirement.

The court found that the alleged wrong—the denial of a bridged service and employer-paid retirement benefits—occurred on March 17, 2005, because that is when Thate was first advised that he would not receive retirement benefits. The court thus found that Thate's complaint was well within both Indiana's 10-year limitations period and Michigan's six-year period.

GM Reasonably Interpreted Plan Documents. After the court found that Thate's complaint was timely, it moved on to find that GM did not act arbitrarily when it interpreted the plan documents to deny him bridged service. In so doing, the court rejected Thate's argument that the template and booklet created an ambiguity and thus required GM to agree that there was a three-year window within which Thate could return to GM and retain his continuous length of service.

According to the court, while the documents did create an ambiguity, there was no evidence that GM intended the chart in the template to modify its normal bridging policy. Furthermore, a cover letter that accompanied the template said that it was not a stand-alone document, but rather had to be read in conjunction with the booklet.

Because GM was granted discretionary authority to interpret plan terms, the court said that, in the absence of evidence that the template was meant to supersede the booklet, it was reasonable for GM to interpret the documents as it did.

Thate Detrimentally Relied on GM's Representations. The court went to find that GM was equitably estopped from denying Thate retirement benefits because he was treated like a bridged employee for 10 years and he relied on GM's representations to his detriment. Specifically, the court found that the template and booklet contained conflicting provisions that created an ambiguity, on which Thate reasonably relied. Furthermore, Thate participated in a GM job placement program to continue his employment with GM because he wanted to receive its health care benefits, the court said.

In addition, Thate was treated like a transfer employee, was advised that he would be treated as if he had never left GM, was told to ignore any discrepancies regarding his vacation time, and took five weeks of vacation time each year, which was consistent with employees with more than 20 years of service, the court said. For 10 years, Thate also received annual retirement projections that indicated he was eligible for a ''30 and out'' retirement, and a 2005 statement showed his hire date was June 1, 1965, the court added. ''All these things represented to Plaintiff that he was a bridged employee,'' the court said.

Moreover, in June 2005, Thate filed an ''open door appeal'' challenging the denial of benefits. The court said that a consulting company conducted these appeals and made recommendations on them, and that the GM policy committee did not have the authority to modify the recommendation or consider individual circumstances. The court thus found that GM knew the appeals process was ''illusory and never could have aided someone in Plaintiff's position.''

The court further found that GM breached its fiduciary duties under the Employee Retirement Income Security Act because it was acting in a fiduciary capacity when it made the representations. Finally, the court granted Thate attorneys' fees, finding that GM's refusal to bridge Thate's length of service was in bad faith and would deter it from disregarding other loyal employees.

Thate was represented by Katherine W. Shensky of Farmington Hills, Mich. GM was represented by David M. Davis of Hardy, Lewis & Page, Birmingham, Mich.

BY MEREDITH Z. MARESCA

Plan Amendments

Qwest Didn't Violate ERISA by Ending Death Benefit Payments, Court Rules

Qwest Communications International Inc. did not violate the Employee Retirement Income Security Act when it stopped paying death benefits to the spouses and dependents of Qwest retirees, the U.S. District Court for the District of Colorado ruled Sept. 19 (*Kerber v. Qwest Pension Plan,* D. Colo., No. 05-cv-00478-BNB-KLM, 9/19/08).

Granting summary judgment in favor of Qwest, Magistrate Judge Boyd N. Boland found that the death benefits were welfare benefits rather than pension benefits and as such were not protected by ERISA's anti-cutback rule.

The court rejected, among other things, the retirees' contention that the death benefits were pension benefits because they were identified as such in plan documents. ''Contrary to the plaintiffs' argument, an employer's label for a particular benefit cannot supersede the clear directives of ERISA,'' the court said.

In addition, the court rejected the retirees' argument that the death benefits were an ''optional form of benefit'' protected by ERISA's anti-cutback rule because Qwest gave employees taking early retirement the option of selecting a lump-sum payout of their retirement benefits that included a discounted version of the death benefits that would otherwise be paid to their surviving spouse or dependents.

Qwest Ends Death Benefits. Prior to Jan. 1, 2004, Qwest's pension plan included a provision for death benefits that would be paid to certain survivors of employees and retirees. The amount of the death benefit was equal to 12 months' wages, according to the court.

''Contrary to the plaintiffs' argument, an employer's label for a particular benefit cannot supersede the clear directives of ERISA. . . . The Pensioner Death Benefit is established for the purpose of providing benefits for participants' beneficiaries in the event of death—the very definition of a welfare benefit under ERISA.''

MAGISTRATE JUDGE BOYD N. BOLAND

Qwest amended the pension plan on Jan. 1, 2004, to eliminate the death benefits for employees retiring on or after that date. According to the court, Qwest has since stated that it is contemplating eliminating death benefits for all retirees who retired prior to Jan. 1, 2004.

A group of Qwest retirees filed a lawsuit against the company and its plans, contending that the elimination of the death benefits violated ERISA's anti-cutback rule. The anti-cutback rule prohibits employers from reducing or eliminating accrued pension benefits. The rule does not apply to welfare benefits.

The defendants filed a motion for summary judgment, arguing that the death benefits were welfare benefits and as such were not subject to the anti-cutback rule. The district court agreed and entered summary judgment for the defendants.

Benefits Not Intended as Retirement Income. According to the court, the primary difference between pension plans and welfare plans is that pension plans provide retirement income or other deferred income, whereas welfare plans provide benefits upon the occurrence of various specified contingencies such as death or disability.

Looking to the death benefits offered by Qwest, the court found that the benefits were not intended to provide retirement income but instead were to be paid in the event of a retiree's death. ''In short, the Pensioner Death Benefit is established for the purpose of providing benefits for participants' beneficiaries in the event of death—the very definition of a welfare benefit under ERISA,'' the court said.

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The court rejected the retirees' argument that the death benefit was a pension benefit and not a welfare benefit because it was identified as part of Qwest's pension plan. According to the court, even if the death benefit was labeled as a pension benefit, by its nature of providing benefits upon the death of a retiree, it was a welfare benefit and not a pension benefit.

Not an Optional Form of Benefit. Moreover, the court rejected the retirees' contention that the death benefit qualified as a pension benefit because employees taking early retirement had the option of selecting a lump-sum payout of their retirement benefits, which included a discounted version of the death benefit. The retirees argued that the death benefit was thus an ''optional form of benefit'' protected by the anti-cutback rule.

In rejecting this argument, the court noted that regulations for the anti-cutback rule provide that optional benefits are protected ''to the extent they have accrued,'' which cut against the retirees' contention that the death benefits were an optional form of benefit under the anti-cutback rule.

The court also noted that the retirees offered no authority to support their assertion that the death benefit changed its character from a welfare benefit to a pension benefit once it was included as part of the lump-sum payout of accrued retirement benefits that the retirees received upon early retirement. According to the court, if a retiree elected to have the death benefit included in his or her lump-sum payout of retirement benefits, the death benefit still ''retained its fundamental nature: it remains a benefit that is separate and distinct from the pension benefit.''

No Contractual Vesting. The court went on to find that the death benefits were not contractually vested, which would have precluded Qwest from eliminating the benefits. The court dismissed the retirees' contention that their benefits were vested because the summary plan descriptions they received stated that death benefits ''will be paid'' and that the retirees' beneficiaries were ''entitled'' to collect death benefits.

Language such as ''will be paid'' and ''entitled'' are not clear and express commitments to vest the death benefits, the court found. ''Rather, the language merely describes the benefit assuming it remained available at the time of the retiree's death,'' the court said.

The court also noted that the plan contained a reservation of rights clause which clearly informed retirees that the death benefits could be amended or terminated. ''Examining the plan documents as a whole, a reasonable person in the position of the plan participant would have understood that the Pensioner Death Benefit was not contractually vested and could be amended. The plaintiffs have failed to point to any clear and express language that the welfare benefit right was vested and not subject to change,'' the court said.

The retirees were represented by Curtis L. Kennedy of Law Office of Curtis L. Kennedy, Denver. Qwest was represented by Sherwin S. Kaplan of Thelen Reid Brown Raysman & Steiner, Washington, D.C.; Elizabeth I. Kiovsky and Beth Ann Doherty Quinn of Baird & Kiovsky, Denver; and John Houston Pope of Epstein Becker & Green, New York.

BY JO-EL J. MEYER

Fiduciary Responsibility

401(k) Plan Participants Can Continue With Excessive Fee Claims, Court Rules

Plan participants in Caterpillar Inc.'s tax code Section 401(k) plan can continue with their claims that the plan administrators breached their fiduciary duties under the Employee Retirement Income Security Act by investing in funds that charged excessive fees to generate a profit for their own benefit, the U.S. District Court for the Central District of Illinois ruled Sept. 25 (*Martin v. Caterpillar Inc.*, C.D. Ill., No. 07-cv-1009, 9/25/08).

Judge Joe Billy McDade, however, found that the administrators did not breach their fiduciary duties by failing to disclose revenue-sharing arrangements. While the court denied the administrators' motion to dismiss the complaint, the court agreed with the administrators that ERISA and Department of Labor regulations do not currently require the disclosure of revenue-sharing arrangements.

In denying the administrators' motion to dismiss, the court found that the inadequacy of disclosure was just one aspect of the participants' complaint. With respect to the participants' other claims, the court said those claims must be tested at a summary judgment stage.

Caterpillar's Section 401(k) retirement plan placed many of its investments in the Caterpillar Investment Trust. The trust allowed its participants to choose from 17 preferred groups of mutual funds, which were investment companies sponsored by Caterpillar Investment Management Ltd. (CIML). Plan participants alleged that the plan administrators breached their fiduciary duties by charging excessive fees, collecting fees to manage the funds, and collecting other fees to participate in ''hidden'' revenue-sharing arrangements. The participants further alleged that the CIML was created with money they invested in order to generate a profit for Caterpillar and that the investment in the preferred group of mutual funds was for Caterpillar's financial benefit.

The administrators filed a motion to dismiss the participants' claims, contending they made the disclosures required by ERISA and the Labor Department. The administrators attached to their motion several documents that were disclosed, including an annual report filed with the Securities and Exchange Commission, a prospectus and an annual report containing information about the mutual funds and their performance, and a summary plan description. The administrators also argued that ERISA's safe harbor provisions relieved them of any fiduciary breach liability.

The court rejected the participants' argument that the administrators were required to disclose their revenue-sharing arrangements. In so doing, the court relied on a decision by the U.S. Court of Appeals for the Eighth Circuit holding that it is not a breach of fiduciary duty to fail to disclose information that is not required by ERISA or the Department of Labor. According to the court, ERISA and the Labor Department do not currently require the disclosure of revenue-sharing arrangements, and thus the administrators did not breach their fiduciary duties in not disclosing them. The court said its conclusion was strengthened by the fact that

regulators currently are considering whether to require these kinds of disclosures.

Turning to the administrators' argument that they were protected by the safe harbor rule, the court said it was ''incorrect'' to resolve the defense during a motion to dismiss. In addition, the court said the administrators have not yet proven the participants had control over their accounts, as ERISA Section 404(c) requires for participants in pension plans with individual accounts. As such, the court said these issues had to be resolved at the summary judgment stage, not in a motion to dismiss.

The court went on to deny the participants' attempt to strike the documents the administrators attached to their motion on the basis that they supported their argument that they made the required disclosures. The court found that these documents were not central to the participants' main claim that the administrators breached their duties by not acting in the participants' best interests and charging excessive fees to generate a profit for themselves. The court therefore excluded the documents from the motion to dismiss and denied the motion to strike as moot.

The participants were represented by Jerome J. Schlichter, Daniel V. Conlisk, and Heather Lea of Schlichter Bogard & Denton, St. Louis, and M. Michael Waters of Vonachen Lawless Trager & Slevin, Peoria, Ill. Caterpillar was represented by Mark A Casciari, Ian Hugh Morrison, Ada W. Dolph, and Jason M. Torres of Seyfarth Shaw, Chicago.

Withdrawal Liability

Expiration of MPPAA Arbitration Period Precludes Use of Joint Employer Defense

A trucking company that transported goods for Eckerd Corp. waived its right to assert that Eckerd is a joint ''employer'' under the Multiemployer Pension Plan Amendments Act and has a contractual obligation to pay for withdrawal liability the trucking company owes to a multiemployer pension fund, the U.S. District Court for the District of New Jersey ruled Sept. 22 (*Einhorn v. J&S Inc.,* D.N.J., No. 07-4537 (JEI), 9/22/08).

While Judge Joseph E. Irenas noted that federal courts have jurisdiction to determine whether an entity is an ''employer'' under the MPPAA, he said parties asserting a joint employer defense under the MPPAA must do so prior to the expiration of the time in which the filing of arbitration is required.

''While the [U.S. Court of Appeals for the] Third Circuit has expanded the role of courts in ERISA cases, and it is now the court's responsibility to determine whether a particular entity is an 'employer,' the appropriate time for the employer named by the union to assert that another party is a sole or joint 'employer' is prior to the expiration of the time to commence arbitration,'' the court said.

From the early 1970s until February 2006, J&S Inc. had an agreement with Eckerd and its predecessor-in-interest, Thrift Drug, to transport goods. The transportation agreement provided that Thrift Drug, and then Eckerd, was responsible for paying any contributions J&S owed on behalf of its employees to the Teamsters Pension Trust Fund of Philadelphia and Vicinity.

The agreement further provided that in the event J&S owed withdrawal liability to the fund, the withdrawal liability would be paid at least in part by Eckerd.

Eckerd attempted in February 2005 to terminate the transportation agreement, but eventually reached an oral agreement to extend the transportation agreement. J&S asserted that Eckerd agreed to continue paying for all of J&S's fund contributions and withdrawal liability. Although J&S alleged that the extension was to last for three years, Eckerd notified J&S less than one year into the extension period that it intended to terminate the transportation agreement.

J&S Fails to Initiate Arbitration. In April 2007, the pension fund notified J&S that it owed withdrawal liability. According to the court, J&S did not initiate arbitration and after the statutory period for filing arbitration had passed, the fund filed a lawsuit against J&S to collect the withdrawal liability.

After the lawsuit was filed, J&S filed a third-party claim against Eckerd contending that Eckerd was a joint employer with J&S and as such Eckerd was required to pay at least part of J&S's withdrawal liability.

Eckerd filed a motion to dismiss the third-party claim. The court granted the motion after finding that J&S had waived its right to bring a federal claim against Eckerd under the MPPAA.

According to the court, although arbitration is typically the requisite step to contest a pension fund's claim of withdrawal liability, the Third Circuit and other courts have carved out an exception to this general rule, allowing a district court in limited circumstances to determine an entity's ''employer status.'' If the dispute is over whether an entity has ceased to be an employer within the meaning of the MPPAA, the dispute must be resolved in arbitration, but if the issue concerns whether an entity has ever become an employer within that statute, the matter can be resolved by the courts, the district court explained.

J&S Had Three Options. With this framework in mind, the court agreed with Eckerd that, because J&S failed to initiate and assert a joint employer defense in statutorily mandated arbitration, J&S's joint employer claim against Eckerd failed.

The court said that once J&S received notice that withdrawal liability was due, it had three options. First, it could have initiated arbitration with the fund and during arbitration it could have brought to the fund's attention its belief that Eckerd was a co-employer.

Under the second option, J&S could have filed a declaratory judgment in the district court to determine whether it or Eckerd were employers as defined by the MPPAA, the court said. The court noted that if J&S had pursued this option, it had to do so either concurrently with arbitration or before the statutory period for arbitration had ended.

Finally, J&S could have paid the withdrawal liability and then, in a separate action, sought indemnification against Eckerd, the court said. J&S, however, followed none of these options and waited until the fund filed a collection action under the MPPAA to argue that Eckerd was a joint employer, the court said in finding that J&S could not raise a joint employer defense during the fund's action to collect withdrawal liability.

Moreover, the court noted that an employer who is assessed withdrawal liability has no independent cause of action under the MPPAA or the Employee Retire-

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ment Income Security Act to sue a third-party for contribution or indemnification on the theory that such party was the sole or joint employer for purposes of those statutes.

The court concluded by finding that J&S and Eckerd were required under the transportation and settlement agreements to arbitrate any dispute that arose under those agreements, and thus if J&S wanted to hold Eckerd accountable for the withdrawal liability it must do so by attempting to enforce those agreements through arbitration rather than in the federal courts.

J&S was represented by Barry L. Cohen of Thorp Reed & Armstrong, Lawrenceville, N.J. Eckerd was represented by David I. Rosen of Littler Mendelson, Newark, N.J.

Remedies

Court Says Claims Administrator Not Liable For Untimely Producing Plan Documents

The claims administrator for an employer-sponsored life insurance plan is not liable for penalties under the Employee Retirement Income Security Act for not timely providing a plan participant with plan documents about his retirement benefits, the U.S. District Court for the Western District of Michigan ruled Sept. 19 (*Cortez v. Prudential Insurance Co. of America*, W.D. Mich., No. 1:08-CV-315, 9/19/08).

Granting the claims administrator's motion for summary judgment, Judge Gordon J. Quist found that plan administrators, not claims administrators, are required under ERISA to provide plan documents to plan participants and beneficiaries.

In addition, the court found that Department of Labor regulation 29 C.F.R. § 2560.503-1(h)(2)(iii) does not expand the application of ERISA Section 502(c)'s penalty provision to claims administrators, as the participant argued.

Retiree Benefits for Disabled Employees. Michael J. Cortez worked for Steelcase Inc. for 26 years, when he went on long-term disability leave in December 2004 as a result of injuries he received in a traffic accident. In addition to offering its employees disability benefits, Steelcase also offered its employees life insurance benefits through a group plan that Steelcase sponsored and administered. Prudential Insurance Co. of America served as the claims administrator of the life insurance plan. The plan offered employees, including those who were determined to be permanently and totally disabled under the plan, a waiver of premium and continuation of benefits. Prudential made the determinations of permanent and total disability, the court said.

Under the summary plan description for the life insurance plan, employees who are permanently and totally disabled are terminated from their employment and given retiree status, allowing the employees to select from available retirement plans. An SPD for Steelcase's retirement plan—a separate plan providing retirement benefits—explained the benefits to which a disabled employee with retiree status was entitled, which included an ongoing right to waiver of the life insurance benefit premium, among other things.

After Cortez was determined to be permanently and totally disabled under the disability plan, Prudential granted Cortez's application for continuation of his group life insurance benefits with waiver of the premium. However, the approval only lasted from November 2003 until August 2005, because Prudential determined that there was no medical documentation proving that Cortez was permanently and totally disabled after that date.

After exhausting his administrative appeals, Cortez filed a lawsuit in federal court. Cortez alleged that Prudential violated Department of Labor regulation 29 C.F.R. § 2560.503-1(h)(2)(iii) because it failed to timely provide him with plan documents he requested, and never provided him with a copy of the plan, and thus sought penalties under ERISA Section 502(c). Cortez further brought a Section 502(a)(1)(B) claim for benefits against Prudential and the plan.

Plan, Not Claims, Administrators Liable for Penalties. In finding that Prudential was not liable for ERISA penalties for not timely providing plan documents, the court said that pursuant to ERISA Section 104(b)(4), only plan administrators are liable for penalties, and precedent out of the U.S. Court of Appeals for the Sixth Circuit only holds plan administrators are liable for penalties.

According to the court, Steelcase was listed in plan documents as both the plan sponsor and administrator. Therefore, while Prudential administered claims, it was not the plan administrator or liable for penalties for purposes of Section 502(c), the court found.

Noting that Cortez requested copies of the administrative record under 29 C.F.R. § 2560.503-1(h)(2)(iii), not copies of plan documents under ERISA Section 104(b), the court rejected Cortez's argument that the regulation expanded Section 502(c) to claims administrators because the regulation states that a full and fair review includes a claimant receiving all documents and information relevant to a claim for benefits.

In so doing, the court relied on decisions of other courts finding that the regulation did not broaden the meaning of ''administrator'' in Section 502(c)(1) to include additional parties, and did not extend the application of Section 502(c)'s penalty provision beyond plan administrators. Moreover, the information specified in the regulation is not the same information that must be provided under ERISA, the court said.

Prudential Not Liable for Benefits. The court went on to reject Cortez's argument that Prudential was liable for group life insurance benefits under the plan. According to the court, Prudential's contract with Steelcase terminated in March 2008 and Steelcase stopped paying premiums after that date, and thus Prudential was no longer responsible for administering the plan.

The court similarly found that Prudential was not liable to Cortez for retirement benefits under Steelcase's plan because it had no connection to that plan. The court rejected Cortez's argument that Prudential was liable for the benefits because it made the permanent and total disability determination, on which Steelcase relied when providing retirement benefits. The court said that although Cortez alleged that Steelcase could ''pass the buck'' to Prudential regarding these benefits, Cortez had no claim against Prudential.

Cortez was represented by Troy W. Haney of Dilley-Haney PC, Grand Rapids, Mich. Prudential was represented by Thomas F. Hurka of Morgan Lewis & Bockius, Chicago, and Hans J. Massaquoi of Lewis &

Munday, Detroit. Steelcase was represented by Jon G. March of Miller Johnson PLC, Grand Rapids, Mich.

Accident Benefits

Court Finds Widow of Deceased Beneficiary With Hypertension Isn't Entitled to Benefits

An accidental death and dismemberment plan administrator did not abuse its discretion when it denied benefits to the widow of a plan beneficiary who suffered from hypertension and died after he ceased taking his medication, the U.S. Court of Appeals for the Fifth Circuit ruled Sept. 22 in an unpublished decision (*Young v. Wal-Mart Stores Inc.*, 5th Cir., No. 07-31130, *unpublished* 9/22/08).

In reversing the decision of a lower federal court, the three-judge appellate panel found that the administrator's decision was supported by a medical report from a forensic pathologist who opined that the beneficiary's death was the result of a sickness, disease, or infection, which was excluded under the plan.

Peggy Young was a covered employee of Wal-Mart Stores Inc. in a dependent life and accidental death and dismemberment policy issued through American International Life Assurance Co. of New York. The AI Life policy excluded benefits for injuries that resulted in whole or in part from sickness (i.e., an illness diagnosed by a physician), disease, or infections of any kind. Peggy's husband, Earl, long suffered from hypertension with a history of vomiting, choking, and becoming unconscious. One week prior to his death, Earl ceased taking his hypertension medication. A week later, Earl was admitted to a hospital because he did not feel well, vomited, and became unconscious.

Earl's treating physician at the hospital noted that Earl had severe hypertension and had stopped taking his medication, which eventually led to his death. In his treatment notes, the doctor said the cause of death was choking as a result of hypertension. However, the doctor listed ''respiratory arrest; choking - foreign body aspirated into trachea,'' as the cause of death on the death certificate, and described the death as an accident.

Peggy subsequently filed a claim for accidental death benefits. AI Life engaged a forensic pathologist to perform an independent evaluation, who concluded that Earl's death was natural and resulted from sickness—hypertension. As such, AI Life denied Peggy's benefits claims, and upheld its denial on administrative appeal.

Thereafter, Peggy filed a lawsuit in state court, which AI Life removed to the U.S. District Court for the Middle District of Louisiana. The district court found that AI Life acted arbitrarily when it denied Peggy's claim because the pathologist's report did not causally connect Earl's hypertension and choking. The district court then awarded Peggy attorneys' fees.

In light of the U.S. Supreme Court's decision in *Metropolitan Life Insurance Co. v. Glenn*, 128 S. Ct. 2343, 43 EBC 2921 (2008) (119 PBD, 6/20/08; 35 BPR 1501, 6/24/08), the court considered AI Life's conflict of interest as both the plan insurer and administrator as one of many factors. Given that AI Life did not have a history of biased claims administration, but did not take active steps to reduce potential bias, and did not emphasize any medical report over another, but did not accept the opinion of Earl's treating physician, the factors balanced out such that the conflict was not of great importance, the court said in a per curiam decision.

The court found that there was substantial evidence to support AI Life's decision denying Peggy's benefit claim. According to the court, the forensic pathologist found that Earl suffered from severe uncontrolled chronic hypertension which led to his death, and medical records reflected that Earl said he did not feel well before he vomited and passed out. Earl's statement showed that he did not suddenly choke on a foreign object, as his death certificate indicated, the court said.

Based on his history of hypertension, his noncompliance with his medication, and his admission records, the court found that it was reasonable for AI Life to conclude that Earl's death was caused from sickness or disease.

The court went on to reverse the district court's decision awarding Peggy attorneys' fees, finding that the attorneys' fees factors balanced in AI Life's favor.

The opinion was joined by Judges Thomas M. Reavley, Carl E. Stewart, and Priscilla Richman Owen.

Peggy Young was represented by Christopher Keith Jones of Keogh Cox & Wilson, Baton Rouge, La. Wal-Mart and AI Life were represented by Covert James Geary and Wade Barry Hammett of Jones Walker, New Orleans.

Prohibited Transactions

Court Says Plan Can Enforce Loan Offset That Violates ERISA's Security Provisions

A pension plan is not barred by the Employee Retirement Income Security Act's prohibited transaction provisions from offsetting benefits owed to a plan participant to account for more than $233,000 in loans the participant took from the plan, the U.S. Court of Appeals for the Ninth Circuit ruled Sept. 19 in an unpublished decision (*Reilly v. Charles M. Brewer Ltd. Profit Sharing Plan and Trust*, 9th Cir., No. 06-17345, *unpublished* 9/19/08).

Affirming a lower federal court, the three-judge appellate panel found that if the participant were to prevail on his claim that the plan violated ERISA Section 408(b)(1)'s prohibited transaction rule, the result would be that the participant would receive his benefits twice. ''Such a result would not serve the purposes of ERISA,'' the appeals court said.

According to the district court's decision in the case, Stuart J. Reilly took a series of loans from his employer's profit-sharing and pension plan. In all, Reilly received $233,141 in loans from the plan. The loans were secured by 75 percent of the then-present value of Reilly's vested accrued benefits.

When Reilly requested a distribution of his pension benefits in November 2000, the plan offset the $233,141 in loans that had not yet been repaid by Reilly. In his lawsuit against the plan, Reilly said the plan could not offset his benefits because ERISA Section 408(b)(1) and its accompanying regulations state that ''no more than 50% of the present value of a participant's vested accrued benefits may be considered by a plan as security for the outstanding balance on all plan loans made to that participant.''

The U.S. District Court for the District of Arizona ruled in favor of the plan and Reilly appealed. On ap-

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peal, Reilly argued that the district court erred by disregarding ERISA Section 408(b)(1) and its accompanying regulations by approving of the plan's offset on the balance due on the $233,141 loan with Reilly's retirement plan benefits.

While agreeing with Reilly that the regulations state that no more than 50 percent of the present value of a participant's vested accrued benefits may be used as security for a plan loan, the appeals court said ERISA Section 406(a)(1)(B)'s prohibited transaction rules provided no relief in the event that a plan violates the security requirement of Section 408(b)(1).

The appeals court concluded that if Reilly were to prevail in his claim and the benefit offset was not applied to his benefits, the result would be that Reilly would receive his benefits twice.

The per curiam decision was joined by Judges M. Margaret McKeown and Consuelo M. Callahan, and Judge Eugene E. Siler Jr. of the U.S. Court of Appeals for the Sixth Circuit, sitting by designation.

Reilly represented himself, pro se. The plans were represented by Michael Kent Dana of Snell & Wilmer, Phoenix; C. Frederick Reish Jr. and Michael A. Vanic of Reish Luftman Reicher & Cohen, Los Angeles; and Edwin F. Hendricks Jr. and Edwin F. Hendricks Sr., of Meyer Hendricks, Phoenix.

Fiduciary Responsibility

TPA That Makes Initial Benefit Decisions Is Not a Fiduciary, Federal Court Decides

A third-party health benefit plan administrator that makes initial benefit determinations and communicates about benefit claims with plan participants and beneficiaries is not a fiduciary under the Employee Retirement Income Security Act and therefore is not liable for fiduciary breaches to a plan participant seeking coverage for his son, the U.S. District Court for the Western District of New York ruled Sept. 24 (*Wasmund v. Meritain Health Inc.*, W.D.N.Y., No. 08CV498, 9/24/08).

In granting the third-party administrator's motion for summary judgment, Magistrate Judge Hugh B. Scott said the TPA merely performed ministerial functions and had no discretionary authority to interpret the plan or adjust claims.

Meritain Health Inc. served as TPA for the Automobile Transporters Welfare Fund of New York, in which Mark Wasmund participated. A board of trustees served as the plan administrator of the plan. Wasmund contended that Meritain unreasonably denied the necessary health care benefits for his son, who was injured in May 2007 and rendered quadriplegic.

Wasmund filed a lawsuit in state court alleging breach of contract, breach of fiduciary duty, improper denial of medical care, and negligence. Meritain removed the case to federal court on the basis of ERISA preemption and filed a motion for summary judgment, contending it was not a fiduciary under the plan.

Wasmund argued that Meritain was a fiduciary under the plan because it exceeded its ministerial functions by contacting plan participants and beneficiaries directly about their claims, by having a nurse make medical determinations, and by denying claims. Meritain argued it merely applied the plan's eligibility rules for participation in benefits and prepared communications on behalf of the plan, and thus its duties were nondiscretionary and considered ministerial under 29 C.F.R. § 2509.75-8.

The court agreed, finding that Meritain merely processed claims, which is a ministerial function under 29 C.F.R. § 2509.75-8. Part of claims processing is the denial of claims, the court said in rejecting Wasmund's argument that the denial of claims was a discretionary function. According to the court, the administrative services agreement between the plan and Meritain provided that Meritain had no discretionary authority to interpret the plan or to adjust claims under the plan and that the plan would be liable for the payment of claims to participants and beneficiaries.

The administrative services agreement further required Meritain to communicate with participants and beneficiaries regarding their claims and thus Meritain was merely performing its duties under the agreement, the court added. Finally, the court noted that under the plan, claimants had to file appeals with the board of trustees, not with Meritain.

Wasmund was represented by John P. Feroleto, Buffalo, N.Y. Meritain was represented by Richard A. Grimm III of Magavern, Magavern & Grimm, Buffalo, N.Y.

Health Insurance

Administrator Properly Found Accessory To Wheelchair Wasn't Medically Necessary

A health benefit plan administrator did not act arbitrarily when it refused to approve coverage as not medically necessary for a wheelchair accessory that helped a near-quadriplegic plan participant move from a sitting to a standing position, the U.S. District Court for the District of Vermont ruled Sept. 24 (*Durgin v. Blue Cross and Blue Shield of Vermont*, D. Vt., No. 1:07-CV-241, 9/24/08).

Denying the participant's motion for summary judgment, Judge J. Garvan Murtha said that although the participant and his treating physician believed that the standing component conferred health benefits on the participant, the administrator had the authority to make the ultimate determination regarding medical necessity.

According to the court, a doctor unaffiliated with the administrator and several doctors who participated in the administrative review process all found that the standing component was not medically necessary, and thus there was support for the administrator's decision.

Richard B. Durgin is an ''incomplete quadriplegic'' who cannot move his legs but has limited ability to move his arms and hands. In 2002, Durgin purchased an accessory for his wheelchair that could lift him into a standing position. Although the standing component was not covered by his employer-sponsored health benefit plan, Durgin alleged it provided a variety of health benefits, including reducing the shearing of his skin, the number of bed sores and urinary tract infections, and back pain.

In 2006, Durgin's doctor sought prior approval for a new wheelchair, including the standing component, from Blue Cross and Blue Shield of Vermont, the plan's administrator. Durgin's doctor said that although he did not have any medical literature to substantiate his opinion, he believed the standing component reduced Dur-

gin's back pain and helped prevent osteoporosis. Blue Cross engaged an independent physician who found that the standing component was not medically necessary because it did not provide a therapeutic benefit.

Based on this opinion, Blue Cross approved coverage for the wheelchair but denied it for the standing component as medically unnecessary. Blue Cross stated in its denial letter that the component was intended primarily for comfort and convenience beyond what was necessary to meet Durgin's needs. After Blue Cross upheld its denial on two administrative appeals, Durgin filed a lawsuit in federal court.

No Evidence of Medical Necessity. The court said that to be considered medically necessary under the plan, the health care must be consistent with the generally accepted practice by doctors providing the same kind of care, and must help restore or maintain a plan participant's health, prevent the deterioration of a participant's condition, or prevent the reasonably likely onset of a health problem. Furthermore, Blue Cross had ultimate authority under the plan to determine medical necessity, despite a doctor's recommendation.

Applying the arbitrary and capricious standard of review, the court held that Blue Cross acted reasonably because its reviewing doctor, and several doctors who reviewed Durgin's claim on appeal, found that the standing component was not medically necessary. Moreover, Durgin's doctor did not provide any evidence other than his personal observations of the benefits Durgin enjoyed because of the standing component, nor did the doctor provide any evidence that standing components are normally included in power wheelchairs for ''incomplete quadriplegics,'' the court added.

Noting that Blue Cross had a conflict of interest because it made eligibility determinations and paid approved claims, the court said the conflict was minor and did not affect its decision because it sought the opinion of an unaffiliated doctor to make the initial determination.

Durgin was represented by Karl C. Anderson of Anderson & Eaton, Rutland, Vt. Blue Cross was represented by Bernard D. Lambek of Zalinger, Cameron & Lambek, Montpelier, Vt.

Health Insurance

Missouri's 50 Percent Cap for Copayments Applies to Health Plan's Prescription Drugs

A group health plan's prescription drug rider is subject to a Missouri regulation capping copayments for prescription drugs to half of the cost of such drugs, and thus the plan violated the regulation when it charged two plan participants copayments that were more than 50 percent of the cost of their prescription medication, the U.S. District Court for the Eastern District of Missouri ruled Sept. 24 (*Vermiglio v. Group Health Plan Inc.*, E.D. Mo., No. 4:07cv0282 TCM, 9/24/08).

Magistrate Judge Thomas C. Mummert III said the plan provided coverage for ''health services,'' which Missouri law defines to include drugs and medicine. Although the plan does not specifically include prescription drugs as a health service, the court said the difference between the plan's definition and Missouri's created an ambiguity that had to be resolved in favor of the insured.

In addition, the court ruled that the health plan could not charge copayments that were more than 50 percent of the cost of prescription medication even if it later refunded its participants any amount that exceeded the cap. Such refunds are not provided for by Missouri law, which specifically prohibits charging copayments in excess of 50 percent, the court said.

Lisa M. Vermiglio and Theresa Andrews were participants in a group health plan administered by Group Health Plan Inc. (GHP), a health maintenance organization. The plan provided its participants with ''basic health services,'' which it defined as health care services that plan members reasonably required to be in good health. The plan included a rider that provided coverage for prescription medications.

The plan's schedule of benefits listed copayments for benefits covered by the rider, which could not exceed 50 percent of the plan's cost of providing a health service, or could not aggregate more than 20 percent of the total cost of providing all basic health services. Vermiglio and Andrews alleged that their copayments for prescription drugs sometimes exceeded 50 percent of the cost of the medication, which was a violation of Missouri law. The court noted that on a quarterly basis, GHP refunded copayments in excess of 50 percent of the cost of the medication.

GHP argued that the prescription drug coverage was not subject to the 50 percent cap and that it was permissible to charge more than 50 percent of the total cost of a single service and then later refund the overcharged amount.

Missouri's Copayment Laws. Missouri regulation § 400-7.100 states that an HMO may not impose a copayment of more than 50 percent of the total cost of providing a single service to its enrollees, or more than an aggregate of 20 percent of the total cost of basic health services. Chapter 300 of the Missouri Revised Statute defines HMOs as state entities that provide basic and supplemental health services to their members, which include eight categories of services, none of which are prescription drugs or medicines.

The court noted that Missouri does not define ''basic health services'' that the plan provides to its members. Rather, it defines ''health services,'' which includes drugs and medicine, and ''basic health care services,'' which does not include drugs or medicine. The court noted that the only context in which ''basic health care services'' appears in Missouri's regulations is the cap on copayments in a calendar year, which is contained in the chapter on HMOs.

According to the court, the state regulation and the plan place a 50 percent cap on copayments for health services. While the plan does not specifically exclude prescription drugs from its definition of ''health services,'' Missouri includes them. The court said the differing treatment created an ambiguity that had to be resolved in favor of Vermiglio and Andrews.

Although the Missouri Revised Statute excludes prescription drugs, as they are not included in the eight categories of covered services, the court said the plan was still ambiguous because the Missouri regulations do not define ''basic health services.'' GHP used the term ''health services,'' not ''basic health services,'' thereby creating an ambiguity, the court said.

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Refund Is Not Allowed by Regulations. The court went on to find that GHP could not escape liability for overcharging its copayments by later refunding the excess charges. In so doing, the court said the Missouri copayment regulation does not provide for any refunds; rather, it clearly states that an HMO ''may not impose'' copayment charges that exceed 50 percent of the total cost of a service.

The court found that the plain meaning of ''may not impose'' was to prohibit inflicting or applying something. As such, the court said that despite the fact that GHP later refunded an excess charge, it was never allowed to impose an excess charge in the first place.

Vermiglio and Andrews were represented by Ralph K. Phalen, Kansas City, Mo., and David J. Spencer of McGonagle Spencer, Kansas City, Mo. GHP was represented by Melissa Z. Baris and Thomas M. Dee of Husch Blackwell Sanders, St. Louis.

Remedies

Inadequate Benefits Denial Letter Warrants Remand of Case, Eleventh Circuit Rules

A federal district court erred when it dismissed instead of remanded a former employee's claim alleging the administrator of a profit-sharing plan and a pension plan did not adequately inform her of why her application for pension benefits was denied, the U.S. Court of Appeals for the Eleventh Circuit ruled Sept. 24 in an unpublished opinion (*Cromer-Tyler v. Edward R. Teitel, M.D., PC,* 11th Cir., No. 07-14752, *unpublished* 9/24/08).

In reversing the decision of the district court, the three-judge appellate panel said the denial letter was inadequate because it did not provide a specific reason for the administrator's determination, or a specific plan provision on which the determination was based. The appropriate remedy in cases where there is an inadequate benefits determination letter is remand to the plan administrator, the court said in a per curiam opinion.

The court, however, affirmed the district court's decision ordering the plan administrator to pay the employee $180,000 in penalties for waiting four and a half years before providing her with a copy of the pension plan and its vesting schedule.

Dr. Robbin Cromer-Tyler worked as a physician for Edward R. Teitel M.D. PC for approximately three years when she left the practice in 1997. While employed by Teitel's practice, Cromer-Tyler participated in both a profit-sharing plan and a money purchase pension plan. Teitel served as the plan administrator of both plans.

After leaving Teitel's practice, Cromer-Tyler received statements from the plan's custodian indicating her account balance, but she did not receive information regarding her investment options or her right to a distribution from the plan. Cromer-Tyler contacted Teitel in September 1998 to inquire about the procedures for obtaining distributions from both plans. Teitel sent Cromer-Tyler a letter informing her that she had no vested account balance in either plan and was not entitled to any distributions.

On Sept. 28, 1998, Cromer-Tyler requested plan documents and vesting schedules for both plans. Teitel provided Cromer-Tyler with a copy of the profit-sharing plan but did not furnish any information regarding the money purchase plan until April 2003.

Cromer-Tyler filed a lawsuit in the U.S. District Court for the Middle District of Alabama under the Employee Retirement Income Security Act claiming she was entitled to statutory penalties for Teitel's failure to timely produce plan documents, and was entitled to distributions from both plans.

The district court dismissed Cromer-Tyler's profit-sharing plan benefits claim, finding that she had not exhausted her administrative remedies, but declined to dismiss for failure to exhaust plan remedies Cromer-Tyler's claim for benefits under the money purchase plan because she had not received any plan documents (159 PBD, 8/18/06; 33 BPR 2015, 8/22/06). Following a bench trial, the district court found that Teitel was liable for $180,000 in statutory penalties for not timely providing Cromer-Tyler with money purchase plan documents (179 PBD, 9/17/07; 34 BPR 2181, 9/18/07; 41 EBC 2400).

Denial Letter Was Inadequate. Cromer-Tyler appealed the dismissal of her claim for a distribution under the profit-sharing plan, contending that because Teitel's determination letter was inadequate, the district court should have remanded her claim, not dismissed it. The appeals court agreed. According to the court, Teitel's letter did not state the specific reason for the denial of benefits, the specific plan provisions on which the determination was based, and the plan's procedures to review the claim, as required by ERISA and Department of Labor regulation 29 C.F.R. § 2560.503-1(g).

The court also rejected Teitel's argument that even if the letter was inadequate, remand is appropriate only if the letter is an adequate determination of benefits after a claim is made, which Cromer-Tyler did not do. ''Teitel cannot avoid the statutory and regulatory requirements of a benefit determination letter merely by preemptively terminating the benefits of participants who are attempting to obtain the information necessary to make a claim, then refusing to answer correspondence requesting more information,'' the court said.

The court went on to affirm the district court's award of statutory penalties against Teitel personally, finding that the district court had the discretion under ERISA Section 502(c)(1) to impose penalties against a plan administrator for not providing requested plan documents. The court further affirmed the district court's ruling excusing the exhaustion requirement from Cromer-Tyler's benefits claim under the money purchase plan because Teitel, who controlled the plan's administrative review procedures, denied Cromer-Tyler meaningful access to those review procedures by not producing plan documents for four and a half years.

The opinion was joined by Judges Gerald Bard Tjoflat and Susan H. Black, and Senior Judge Emmett Ripley Cox.

Cromer-Tyler was represented by C. Clay Torbert III of Capell Howard, Montgomery, Ala. Teitel represented himself, pro se.

Life Insurance

Former Viatical Company Marketing Exec Pleads Guilty to Tax Evasion in Florida Court

TAMPA, Fla.—A former executive with a defunct South Florida viatical company that prosecutors said bilked thousands of investors out of more than $1 billion pleaded guilty Sept. 23 to tax evasion, federal officials announced (*United States v. Swaim*, S.D. Fla., No. 1:08-cr-20696-JIC, *plea entered* 9/23/08).

In a plea agreement filed in U.S. District Court for the Southern District of Florida, defendant Rockey Van Swaim pleaded guilty to one count of tax evasion in connection with income earned while employed at Mutual Benefits Corp. (MBC), a viatical and life settlement company closed by federal regulators in May 2004, Eric I. Bustillo, acting U.S. attorney, said in a written statement.

'Lavish Lifestyle.' According to the statement, Swaim, who was MBC's marketing director, established a consulting company, No Surprises Inc., to evade federal income taxes by funneling MBC sales commissions into a bank account in the name of No Surprises, a shell corporation with no office and no employees.

Swaim then attempted to conceal his lavish lifestyle from the Internal Revenue Service by paying personal expenses directly from the corporation's bank account, the statement said.

In connection with his guilty plea, Swaim admitted that more than $10,000 of the income he failed to report was derived from criminal activities at MBC and agreed to be responsible for approximately $403,000 in restitution payable to the Department of Treasury, the statement said.

Sentencing is scheduled for December 19.

Swaim was among a number of defendants charged in connection with MBC, which prosecutors have said bilked some 30,000 investors nationwide out of $1.3 billion.

In 2007, the company's founding partner and sole shareholder, Peter Lombardi, received a 20-year prison term.

Scheme Outlined. In a viatical or life settlement transaction, an investor purchases an interest in a terminally ill or elderly person's life insurance policy death benefit in return for a lump-sum cash payment.

Investors can realize a profit if the policy benefit is greater than the price paid when the insured dies and the policy matures. The longer an insured lives, the more premium payments must be made to prevent the policy from lapsing and becoming worthless.

Among other things, MBC sales agents and marketing materials allegedly claimed independent, state-licensed physicians would determine the life expectancy of a policyholder after evaluating the insured's health condition, prosecutors said.

Company sales agents and marketing materials allegedly induced clients to invest in viatical settlements touted as safe investments in secure life insurance policies. MBC's viatical and life settlements instead were speculative and risky, prosecutors said.

In addition, the company allegedly improperly acquired policies that could not be bought and sold, pressured physicians to rubber-stamp false life expectancy figures, and mismanaged escrowed premium funds in a Ponzi scheme, prosecutors said.

A federal public defender representing Swaim was not immediately available for comment.

Special Assistant U.S. Attorney Ryan Dwight O'Quinn and Assistant U.S. Attorney Andrew K. Levi, Miami, represented the government. Timothy Day, of the Federal Public Defender's Office, Fort Lauderdale, represented Swaim.

BY DREW DOUGLAS

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Analysis&Perspective

FIDUCIARY RESPONSIBILITY

Plan fiduciaries may face risks, including personal liability, when corporate decisionmakers turn their attention to retirement and welfare plan administration as a source of savings in perilous economic times. The authors discuss some of the most notable areas for possible ERISA violations when fiduciaries face corporate cost-cutting pressures.

Switching 401(k) and Other ERISA Plan Vendors—Inherent Risks for Employers and Plan Fiduciaries

BY J. MARK POERIO AND ERIC R. KELLER

Introduction.

An economic downturn invariably multiplies the instances under which corporate officers and directors face cash-flow issues and cost-cutting initiatives. These issues come packed with fiduciary concerns, conflicts of interest, and risks of personal liability when corporate decisionmakers turn their attention to their company's retirement and welfare plans (together ''ERISA Plans,'' because they are subject to the Employee Retirement Income Security Act of 1974 (ERISA)).

Cash-flow problems may create conflicts of interest with respect to transmitting employer and employee contributions to ERISA Plans, and may prompt employers to consider switching to less expensive ERISA plan service providers, such as trustees, investment managers, and recordkeepers (also known as third party administrators or TPAs). Savings are often possible, at least on the surface, due to often intense competition among ERISA plan vendors.

Any ERISA-related downturn strategies come with subtle costs, however, in the form of fiduciary risks that have increased in part due to active—and escalating—Department of Labor (DOL) oversight of pension and welfare plans. Consequently, ERISA plan sponsors and individual fiduciaries risk personal liability if they underappreciate or overlook their ERISA responsibilities. Hidden fees, inequitable contract terms, vendor selection, and cash-flow pressure are perhaps the most notable sources for ERISA stumbles when fiduciaries face corporate cost-cutting pressures. The reasons are as follows.[1]

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Vendor Selection. When it comes to saving costs for ERISA plan services, the discussion normally centers on assessing current vendor services and considering alternatives. Those responsible for vendor selection have a duty of prudence under ERISA. This requires their careful evaluation of any vendor's qualifications, the nature and extent of the services being offered, and, when plan assets are being used to compensate the vendor, the reasonableness of the vendor's fees in view of the services provided.

The ERISA fiduciary should thoroughly document the process by which it evaluates each of these considerations, as well as why a particular vendor gets selected. One way to do this is by using a formal request-for-proposal (RFP) process.

An RFP is an effective way to solicit the information necessary to make an informed selection and to document that the fiduciary met its fiduciary obligations in selecting the vendor. An RFP request typically will provide basic background information about the employer, the plan, other plan fiduciaries and the services being requested. In addition, it is wise for the RFP to include a proposed form of contract that reflects careful attention to the interests of the ERISA plan and its fiduciaries. By asking vendors to submit their contract changes with their RFP, the employer and ERISA plan fiduciaries may best steer the future contract negotiation toward terms critical and favorable to them.

For tax-qualified 401(k) and other retirement plans, significant cost savings are often possible through the switch from an individualized plan (under which the employer generally pays for the countless refinements necessary to conform with changing tax laws) and a prototype plan (under which the vendor builds those costs into a fee model that is dramatically more cost effective). Another driver for cost savings will come from

[1] Detailed information appears in Keller, E., *Meeting Your Fiduciary Duties in Vendor Selection and Management*, Human Resources 2007, Summer Edition.

bundling plan services, because plan sponsors will often find increased bargaining power with potential vendors.

A holistic assessment of plan services has the further potential to streamline both benefits and systems, and thereby to mitigate the cost magnification that can come from pyramiding plans on a piece-by-piece basis. There are other cost-saving alternatives whose value varies depending on company facts and circumstances. The key for employers is to take the occasional step back for a global benefits assessment.

Vendor Fees. For a few years now, ERISA plan sponsors have been hearing about—or been victimized by—largely gadfly litigation alleging inadequate monitoring of the fees that ERISA plans pay for vendor services (mostly related to plan investments). These cases are still making their way through the courts, with none having yet reached notable resolution. Meanwhile, the DOL has chimed in with three different regulatory initiatives that all require plan fiduciaries to understand and properly disclose the compensation paid to plan service providers.[2] This focus of litigation and regulation on vendor fee arrangements should forewarn plan fiduciaries that they should be ready to justify the financial terms of the contracts that they approve with plan service providers. Consequently, when evaluating vendors from a fee perspective, ERISA fiduciaries need to dig into service proposals for total real costs.

There are marketing strategies that can make promised cost savings appear more significant than they will be. For example, a common tactic shifts fees from employers to plan participants—with the DOL leading efforts to assure full disclosure of these types of charges. Unanticipated fees may also arise from front-end investment loads or back-end surrender charges or service termination charges. Even after negotiating fee arrangements, ERISA fiduciaries should monitor fees to verify that they are not only consistent with the fees agreed to but only that they continue to bear a reasonable relationship to the services received. The latter should be done in conjunction with annual benchmarking that compares the fees charged for current plan services with those charged by competing vendors for similar services.

Inequitable Contract Terms. When ERISA plan sponsors switch providers, they often receive the vendor's standard documents, inclusive of standard terms. It is not uncommon to encounter one-sided indemnification provisions that protect only the vendor, or provisions that limit the vendor's liability to gross negligence or gross misconduct. ERISA fiduciaries should consequently be careful to negotiate for the best possible terms for vendor services—from terms of hire to termination—and work with ERISA counsel to ensure that the contract complies with legal requirements that do not expose the plan's sponsor or fiduciaries to unnecessary risk.

Cash-Flow Problems. The DOL recently released guidance with respect to who has a fiduciary duty under ERISA to pursue the collection of delinquent employer and employee contributions to an ERISA plan.[3] The DOL guidance arises in response to investigations that found instances in which trust agreements purportedly attempted to relieve trustees of any duty to collect delinquent contributions.

According to the DOL guidance, the collection of delinquent contributions is a fundamental trustee responsibility, even if it is not specifically delineated in the plan document. The responsibility may, however, be assigned to

- a plan trustee who maintains discretionary authority over the plan assets,
- a directed trustee who is subject to the direction of a named authority, or
- an investment manager.

If, however, an ERISA plan and trust documents do not impose a duty to collect delinquent funds on any fiduciary, then that duty will fall upon an employer and its board of directors to the extent plan documents relieve the trustee of the obligation to collect.

There is a serious problem with having an employer and its board bear the risk of collecting delinquent contributions—they have conflicts of interest and can be charged with prohibited transactions and personal liability as soon as delinquencies arise. Employer contributions are generally delinquent when they are owing to the plan and have not been transmitted in a timely manner, and employee contributions are delinquent if the employer fails to transmit them to the ERISA plan on the earliest date that such funds could reasonably be sent (and at the latest, 15 days after being withheld from employee pay).

Employers need to be careful to have their ERISA plans or trusts identify who has the duty to collect delinquent contributions (or, at least, not relieve the trustee of that duty). Further, lenders should beware of ERISA plan contribution arrangements that could thrust them into liability for interfering with an employer's duty to make required plan contributions.

Conclusion. Those under pressure to save corporate dollars should be alert to their ERISA fiduciary obligations, not only to protect plan participants but also to avoid liability for plan or participant losses. In its recent *LaRue* decision,[4] the U.S. Supreme Court recently opened the door for individualized recovery from defined contribution retirement plans, notably 401(k) plans. The message is clear for ERISA plan fiduciaries: whether you are dealing with plan funding or cash-flow, or vendor service contracts or fees, be sure to understand your ERISA obligations—and your risks, which run the gamut from criminal sanctions to personal liability.

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[2] *See* 29 C.F.R. §§ 2550.408b; 2550.404a-5; 2550.404c-1; Revision of Annual Information Return/Reports, 72 Fed. Reg. 64,731 (Nov. 16, 2007). For discussion, see http://www.paulhastings.com/assets/publications/982.pdf?wt.mc_ID=982.pdf.

[3] DOL Field Assistance Bulletin 2008-1, Fiduciary Responsibility for Collection of Delinquent Contributions (Feb. 1, 2008).

[4] LaRue v. DeWolff, Boberg, & Assoc. Inc., 128 S. Ct 1020, 42 EBC 2857 (Feb. 20, 2008).

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Taxes

IRS Private Letter Rulings

Summaries of Internal Revenue Service private letter rulings are reported here, grouped by Internal Revenue Code section.

Full texts of the rulings, released weekly by IRS pursuant to § 6110 of the Internal Revenue Code, are published in TaxCore or can be purchased by calling BNA PLUS toll-free at 800-372-1033 (select Option 5, then Option 2), or by sending an e-mail to bnaplus@bna.com or fax to (703) 341-1643. Customers outside the United States should call (703) 341-3500 (select Option 5, then Option 2).

The document numbers assigned by IRS to its private letter rulings are composed of three groups of numbers; the first four numbers represent the year; the second group of numbers represents the week in which the document was released; the last three numbers indicate its position in the series of rulings issued that week. For example, PLR 200848023 would be the 23rd ruling of the 48th week of 2008.

IRS cautions that each ruling is directed only to the taxpayer who requested it. Section 6110(k)(3) of the Internal Revenue Code provides that a private letter ruling may not be used or cited as precedent.

Section 106—Contributions by Employer to Accident and Health Plans

■ *Mandatory salary reduction contributions made to trust established by union to allow pre-funding of retiree health benefits excludable from gross income (PLR 200837002).*

SUMMARY

A union established a trust as a means of funding retiree health benefits by allowing members to pre-fund retiree health coverage while employed, by mandatory contributions through salary reduction. IRS ruled that mandatory salary reduction contributions made to the trust that are used exclusively to pay for accident or health coverage for employees, their spouses, and dependents are excludable from gross income under Section 106.

Section 401—Qualified Pension, Profit-Sharing, and Stock Bonus Plans

■ *Section 401(a)(33) does not apply to proposed amendment to defined benefit pension plan (PLR 200838028).*

SUMMARY

IRS said tax code Section 401(a)(33) and Employee Retirement Income Security Act Section 204(i)(1) do not apply to a proposed amendment to a defined benefit pension plan. Section 401(a)(33) provides a plan is not qualified if an amendment that increases liabilities by reason of certain benefit or accrual changes is adopted while the employer is a debtor in bankruptcy.

A company in Chapter 11 bankruptcy, in order to fulfill collective bargaining agreements with the principal union regarding pension funding, made arrangements to lease certain employees to buyers of certain business units until it emerged from bankruptcy protection. Although this was intended to be a short-term fix, the company did not emerge from bankruptcy as originally scheduled, and no new target date has been set.

The company now proposes to amend the plan to recognize credited service for purposes of benefit accruals following an affected employee's transfer to the buyer of a business unit until the earlier of the participant's termination of employment with the divested unit or the date of the cessation of benefit accruals with the company's emergence from bankruptcy.

IRS noted that the company has a unique history in that its former parent's plans were typically amended to recognize such post-divestiture service with the buyer for purposes of plan eligibility. While the reasons provided for the amendment, in and of themselves, are not sufficient to consider the amendment reasonable, the service said, the company's employees have long-standing expectations regarding their treatment in the event they are transferred to a buyer of their operation.

As such, IRS concluded, the amendment is reasonable because it provides an economic benefit to the company by enabling it to consummate divestiture of non-core businesses and reach consensual agreements with the unions representing its workforce.

Section 408—Individual Retirement Accounts

■ *Waiver of 60-day rollover requirement for distribution of IRA funds granted (PLR 200834021).*

SUMMARY

IRS granted a taxpayer's request for waiver of the 60-day rollover requirement for individual retirement account funds under tax code Section 408 where the failure to timely accomplish a rollover was a result of the taxpayer's impaired physical and mental condition.

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Electronic Resources

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THIS WEEK'S ISSUE

Listed below are the headlines and page numbers of selected articles in this issue followed by Web sites providing related information. The links provided by BNA are to external Web sites maintained by federal or state organizations in the U.S., foreign or international governing bodies, or nongovernmental organizations of interest to our subscribers. BNA has no control over their content, timeliness, or availability.

House Committee Debates Need for New Law to Bind Employers to Retiree Health Benefits (p. 2206)
http://thomas.loc.gov/home/gpoxmlc110/h1322_ih.xml

National Groups Say Public Pension Funds Are Sufficiently Diversified to Weather Crisis (p. 2206)
http://www.nasra.org/

FASB Decides to Delay Effective Date For Guidance on Benefit Plan Assets (p. 2212)
http://www.fasb.org/fasb_staff_positions/prop_fsp_fas132r-a.pdf
http://www.fasb.org/news/SDR_FAS132R_09-24-08.pdf

N.Y. Governor Calls For Congressional Inquiry Into Payments by Railroad Retirement Board (p. 2214)
http://www.ny.gov/governor/press/press_0923082.html
http://www.rrb.gov/pdf/board/lirr_rrb_statement.pdf

FASB Staff Drafting Guidance to Help Gauge Fair Value in Inactive Markets (p. 2215)
http://72.3.243.42/pdf/aop_FAS157.pdf
http://72.3.243.42/project/valuation_resource_group.shtml

House, Senate Approve Parity Bills With Different Funding Mechanisms (p. 2225)
http://op.bna.com/hl.nsf/r?Open=sfak-7jrqh7

Hewitt Says Employer Measures to Control Increases in Health Care Costs Are Working (p. 2226)
http://www.hewittassociates.com/Intl/NA/en-US/AboutHewitt/Newsroom/PressReleaseDetail.aspx?cid=5604

Senate Approves Legislation to Help Low-Income Seniors Pay Part B Premiums (p. 2227)
http://www.finance.senate.gov/sitepages/leg/LEG%202008/092508legstaffsum.pdf

Stable Premiums Available to Rx Enrollees In 2009, Even as Largest Plans Raise Prices (p. 2227)
http://www.cms.hhs.gov/PrescriptionDrugCovGenIn/

Rising Costs Could Threaten Continuation of Massachusetts Plan, Senate Panel Told (p. 2228)
http://finance.senate.gov/sitepages/hearing092308.htm

FEHBP 2009 Premium Costs Up 7 Percent; Enrollee Increase Expected to Be 7.9 Percent (p. 2229)
http://www.opm.gov/insure/health/09rates/index.asp

Federal Agencies Should Offer Same-Sex Partner Benefits, Senate Committee Told (p. 2231)
http://hsgac.senate.gov/public/index.cfm?Fuseaction=Hearings.Detail&HearingID=4567a0c5-c026-461d-8b28-d30898f5e3d9

Health Plan Premiums Up Slightly in 2008; Workers Face High Deductibles, Survey Says (p. 2232)
http://ehbs.kff.org/

INTERNET SOURCES

Listed below are the addresses of World Wide Web sites consulted by editors of BNA's Pension & Benefits Reporter.

Department of Labor
http://www.dol.gov

Internal Revenue Service
http://www.irs.gov/ep

Pension Benefit Guaranty Corporation
http://www.pbgc.gov

BNA PRODUCTS

BNA publishes other information products for professionals in a variety of electronic formats including the titles listed below.

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Benefits Practice Center
http://www.bna.com/products/eb/bpcw.htm

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