



THE MONTH IN WASHINGTON

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MAY 2012

Financial regulations reform got more attention in May than it has in the preceding two years following the disclosure by J.P. Morgan that it had lost at least \$2 billion in a trade. Lawmakers and regulators discussed and debated how this will affect the drafting of the Volcker Rule – which will prohibit proprietary trading by banks – with Democrats urging that the rule be written in a way that would prohibit such trades and Republicans wanting the federal government to take a more hands-off approach. The first hearing related to the trade was held late in the month, and more hearings are expected through the spring and summer. Meanwhile, a ruling by the U.S. Supreme Court on the constitutionality of the 2010 health care reform law is expected to be handed down in late June.

ISSUES AND EVENTS

Regulators Discuss Volcker Rule, J.P. Morgan at Hearing

It is unclear if the Volcker Rule would have prevented the trade that lost J.P. Morgan at least \$2 billion, two of the nation's top regulators told a Senate panel on May 22.

J.P. Morgan took the loss in a derivatives trade that was supposed to hedge against risk. The Volcker Rule that was included in the 2010 Dodd-Frank financial reform law would prohibit proprietary trading by banks, but some, including J.P. Morgan CEO Jamie Dimon, say that legislative language that allows for hedging of “aggregated positions” would permit banks to hedge against their entire portfolios and make big, risky bets similar to J.P. Morgan's. Commodity Futures Trading Commission Chairman (CFTC) Gary Gensler, at a hearing of the Senate Banking, Housing and Urban Affairs Committee, acknowledged that there is “overlap” between proprietary trading by banks and hedging.

“This is one of the more challenging tasks regulators have been given,” Gensler said.

Securities and Exchange Commission (SEC) Chairman Mary Schapiro was also non-committal, but explained that, in order to be allowed, a trade “must really be a genuinely risk-mitigating hedge.”

Schapiro also said, though, that it would be “extraordinarily expensive and counterproductive” to require that a given hedge be tied to a specific transaction. Gensler appeared willing to be a little more aggressive, saying he “liked it when you could tie the hedge somewhere reasonably to the positions.”

Both Gensler and Schapiro said that their agencies are reviewing the trade.

The SEC, CFTC and other regulators are working to put the Volcker Rule into effect by July 21, though that deadline may not be met. Firms will have two years to comply once the rule is implemented.

Democrats are pushing for regulators to write a tough rule, while Republicans, most of whom opposed the Dodd-Frank bill, are pushing for a different approach.

“The better solution is require more capital,” Sen. Patrick Toomey, R-Penn., said. “Firms ought to be able to make decisions and live with the consequences and taxpayers shouldn’t be at risk. I don’t think you achieve that by micromanaging these institutions.”

Similarly, Speaker of the House John Boehner, R-Ohio, insisted the week before that there is not “anything in Dodd-Frank that would’ve prevented this activity at J.P. Morgan.”

“There’s no law against stupidity, no law against stupid trades,” Boehner said. “And as long as depositors’ money wasn’t at risk and as long as there’s no risk of a taxpayer bailout, they should be held accountable by the market and their shareholders.”

House Financial Services Committee Ranking Democrat Barney Frank of Massachusetts, one of the law’s namesakes, disagrees, however.

“I believe we gave [regulators] enough authority to adopt a rule which would say that what J.P. Morgan did – as I understand what they did – should not happen in a bank,” Frank said in mid-May, “namely they should not be able to hedge against the entire economy.”

House Panel Examines Process for Designating ‘Systemically Important’ Firms

Regulatory oversight of “systemically important” financial institutions will be tailored to be appropriate for a given company, regulators told Congress in May.

The 2010 Dodd-Frank financial regulations reform law created the Financial Stability Oversight Council – a panel of regulators from other agencies – to determine which non-bank financial firms are big enough that their failure could threaten the stability of the U.S. economy. Firms that are so designated will be subject to increased oversight and tighter standards.

Michael Gibson, director of the Federal Reserve’s division of banking supervision and

regulation, said at a May 16 hearing of a House Financial Services Committee subcommittee that there are “some nonbank companies for which the bank-like standards that we’ve proposed would likely be a bad fit.”

“We have committed to looking at that when those companies are designated and doing what we can to tailor the standards,” Gibson said.

Insurers, for example, are often considered to be less likely to engage in risky investments than certain other firms, and an Ohio lawmaker said he doesn’t “see the need to drag the insurance companies into this rule.”

Metlife President William Wheeler said at the hearing that being tagged as systemically important “would force [the company] to raise the price of the products they offer, reduce the amount of risk they take on or stop offering certain products altogether.”

Treasury Department Deputy Assistant Secretary Lance Auer, though, said that the council has the flexibility “to address the diverse range of business models among non-bank financial companies.”

“Ultimately, in accordance with the Dodd-Frank Act, all designations will be based on a determination that a company’s material financial distress – or the nature, scope, size, scale, concentration, interconnectedness or mix of the activities of the company – could pose a threat to U.S. financial stability,” Auer said.

The council is expected to produce its first list of systemically important firms by the end of the year.

Capital Controls May be Prohibited by Free Trade Agreements, Congressmen Worry

Two senior House Democrats on May 23 expressed concerns that free trade agreements could block the United States and other countries from using capital controls in the event of financial crises.

Though Obama administration officials have asserted that such treaties allow for capital controls as long as they are not used to impede trade, Reps. Barney Frank, D-Mass., and Sander Levin, D-Mich., noted in a letter to Treasury Secretary Timothy Geithner that several organizations have concluded otherwise, with the International Monetary Fund, for example, finding that some agreements to with the United States is a party “do not permit restrictions on either capital inflows or outflows.”

Frank and Levin requested that Geithner provide “an official written statement of U.S. policy” that free trade agreements allow nations “the ability to deploy capital controls on the inflow or outflow of capital without being challenged by private investors.”

Frank is the ranking Democrat on the House Financial Services Committee, and Levin is the ranking Democrat on the House Ways and Means Committee.

Increase in Health Care Costs Driven by Price Increases: Study

Rising prices are driving the overall increase in health care spending in the United States, according to new study that researchers say is the first to use claims data from the nation's largest private insurers.

The *2010 Health Care Cost and Utilization Report* from the Health Care Cost Institute (HCCI), a new independent, non-partisan research organization, found that per-capita health care spending rose 3.3 percent to \$4,255 in 2010 for beneficiaries under age 65 with employer-sponsored coverage. This was more than double the 1.6 percent increase in the consumer price index.

Utilization of services generally stayed flat or declined from 2009 to 2010, but the prices of health care products and services increased. The average cost for brand name prescription drugs, for example, jumped 13 percent – generics declined 6.3 percent – an emergency room visit cost 11 percent more and outpatient surgery expenses went up 8.9 percent.

“We hope this report will help people get a much clearer picture about what triggers health care growth and spending,” HCCI Executive Director David Newman said. “Having this amount of data allows us to drill down and examine the underlying causes of health care spending among a population that hasn't been studied extensively in a way that can provide answers to important questions.”

The study is based on data from Aetna, Humana, Kaiser Permanente and UnitedHealthcare. The four companies' membership, according to HCCI, includes almost 40 percent of the country's privately-insured population.

Half of Individual Health Plans Would Not Qualify for Insurance Exchanges, According to Report

More than half of Americans who bought health care coverage in the individual market in 2010 have plans that would not qualify for inclusion in the insurance exchanges that are to begin in 2014, according to a study supported by The Commonwealth Fund.

The Patient Protection and Affordable Care Act established state-based insurance exchanges in which individuals can buy coverage, with participating plans required to cover at least 60 percent of health care expenses. The study, based on a sampling of individual plans from five states, including California, found that 51 percent of plans in the current individual market fall short of this standard, and the average coverage level for all individual plans was just 60 percent. The average for group plans was 83 percent, and only 0.5 percent of group plans were below the 60 percent threshold.

“This study shows that millions of Americans currently have coverage that does not accord them access to timely care and potentially leaves them exposed to catastrophic medical bills,” Commonwealth Fund Vice President Sara Collins said. “The provisions of

the Affordable Care Act will not only extend new coverage to millions of uninsured Americans but vastly improve the coverage of many who are insured but poorly protected by their health plans.”

In a separate study, meanwhile, the Kaiser Family Foundation found that 13 states have halted planning of their exchanges while waiting for the U.S. Supreme Court to rule on the constitutionality of the health care reform law, and another four are holding off on exchange legislation, though they have continued planning. Six more states never began the planning process, but it is unclear how much, if at all, this had to do with the court case. California is proceeding without waiting for the ruling, according to Kaiser.

States have until Nov. 14 of this year to submit proposals for the exchanges to the federal government, the Department of Health and Human Services announced in May as it released guidance for the exchanges. States are not required to establish exchanges, but the federal government will create one in any state that does not do so.

Medical Groups Weigh in on Medicare SGR Formula

The American Medical Association (AMA) on May 25 offered Congress more than two dozen pages of suggestions on how to replace Medicare’s “flawed sustainable growth rate (SGR)” formula.

The SGR was intended to be used by Congress to automatically set Medicare’s physician payment rates. Lawmakers have annually overridden the SGR during the past decade, however, to avoid payment cuts that, it has been feared, would drive doctors out of the Medicare program. This year, Congress is expected to prevent a more than 30 percent cut that is scheduled to go into effect on Jan. 1.

House Ways and Means Committee Chairman Dave Camp, R-Mich., in April requested that about 70 physician groups and related organizations submit comments by May 25 on how to fix the SGR, and the AMA responded with a letter that endorsed “innovative payment models” that it said would improve quality of care while controlling costs. The association noted, specifically, the potential of multi-payer systems, saying they “hold much promise when Medicare and private payers align their programs so that physicians can implement reforms in the way they deliver care to all their patients, with a consistent set of financial incentives and quality metrics.”

The Medical Group Management Association (MGMA), meanwhile, also wrote to Camp in May to urge Congress to “repeal the SGR, provide stable payments for a period of several years to allow testing of different payment and delivery models, and then allow for a transition to new models.”

The association backed the testing of new models including “bundled payments, partial capitation, accountable care organizations (ACOs), medical homes and other hybrid approaches that couple fee-for-service payments with a risk-based bonus opportunity.”

“Moving away from fee-for-service will take time,” the MGMA stated in the letter. “It will be challenging for many physician practices and the infrastructure investments needed for success will be substantial. An array of tools must be developed going forward. These include adequate risk adjustment methods and quality measurement. Many of these have been developed for the Medicare Advantage program and are continually being improved. As we pursue this path of transition, we must recognize that for some practices, it may be necessary to remain in a traditional fee-for-service Medicare model. For others, ACOs and additional approaches may work, but a transition period is needed so that new payment systems may be appropriately tested across a broad variety of practice types and settings.”

While lawmakers are seeking a replacement for the SGR, it is more likely this year that they will once again enact only a short-term fix.

Treasury Releases Regs on Health Care Premium Tax Credit

The Treasury Department on May 18 released regulations implementing new tax credits that are aimed at making health care coverage more affordable for lower and middle-income Americans.

The health care reform law established tax credits for families and individuals who obtain coverage through the state-level insurance exchanges that are to begin in 2014 and have incomes between 100 and 400 percent of the federal poverty level. A family with an income as high as \$89,400 in 2011 would be eligible for the benefit. People who have coverage through Medicare, Medicaid or an affordable employer-sponsored plan are not eligible.

The tax credit amount will generally be equal to the difference between the premium for a “benchmark plan” and the taxpayer’s “expected contribution,” which will be from 2 to 9.5 percent of household income.

Officials estimate that the average credit will be about \$5,000.

Insurers Must Tell Consumers if Medical Loss Ratio is Met or Not

Insurers will have to notify their consumers when the companies meet the medical loss ratio requirements of the health care reform law, not just when they fail to do so, under rules issued by the Department of Health and Human Services (HHS). (HHS also published a correcting amendment to the rules.)

The reform law requires that large group health insurance plans spend at least 85 percent of premiums on medical claims or quality improvements, and that individual and small group plans spend at least 80 percent. Plans that fail to meet those requirements must provide rebates to consumers starting Aug. 1, and the Kaiser Family Foundation recently estimated that the rebates will total \$1.3 billion this year.

HHS released rules on consumer notifications when the medical loss ratio (MLR) is not met in December. It added the new requirement, according to the regulation, in order to “serve the policy goal of greater transparency in how premium dollars are used, and provide an additional incentive for issuers that already met the minimum standard to achieve the highest MLR possible.”

Insurers, generally, are not pleased with the new mandate.

“The mandatory notices to policyholders receiving rebates ignores the real drivers of rising premiums and does not account for many of the consumer services health plans have implemented, such as fraud prevention, that are considered administrative costs under this requirement,” Robert Zirkelbach, spokesman for America’s Health Insurance Plans, said. “The process for providing notices to policyholders not receiving rebates has been improved, but we remain concerned that sending these notices is unnecessary and could increase administrative costs – the opposite of what the MLR is intended to achieve.”

GOP Report Says Reform Law Creates Incentives for Employers to Drop Health Coverage

A survey of Fortune 100 companies found that 71 of the 100 largest employers in the United States could save a combined \$422 billion over 10 years by dumping employee health benefits, according to a [report](#) released on May 1 by Republican members of the House Ways and Means Committee.

The Patient Protection and Affordable Care Act will, starting in 2014, create mechanisms that are intended to make it easier for people to buy coverage in the individual market. This could increase incentives for companies to drop coverage, the report concludes.

Also starting in 2014, companies with more than 50 employees will face penalties of \$2,000 per worker – the amount changes annually after 2014 according to the national average for premium increases – if they don’t offer their workers “affordable” coverage, but health insurance can cost several times that amount.

“Unfortunately, for American families currently receiving [employer-sponsored insurance], it will be far cheaper for employers to simply drop their health insurance and pay the fine, because the costs of meeting the burdensome mandates required for health insurance plans far exceed the price of the fine,” the report states.

The reform law includes, among other things, insurance exchanges, federal subsidies for people whose income is less than 400 percent of the federal poverty level and prohibitions on coverage denials and price hikes based on pre-existing conditions. The latter provision, in particular, some suggest, could make health insurance a less important recruiting tool relative to, say, higher wages, since the tens of millions of Americans with pre-existing conditions will be able to acquire plans outside of the group market much more easily

than they can now.

The survey was conducted through a March 30 letter sent to CEOs of every Fortune 100 company by Ways and Means Committee Chairman Dave Camp, R-Mich. The results reflect responses from the 71 companies that participated.

HHS Launches Health Care Data Website

The Department of Health and Human Services (HHS) on May 15 launched a website that is aimed at helping people monitor the performance of the U.S. health care system.

The Health System Measurement Project provides data in 10 areas, including “cost and affordability,” “quality,” “innovation” and “coverage,” which can be broken down by demographic characteristics.

“Ensuring all Americans have access to these data is an important way to make our health care system more open and transparent,” HHS Secretary Kathleen Sebelius said.

The website is at <https://healthmeasures.aspe.hhs.gov>.

Senate Sends Iran Sanctions Bill to House

The Senate on May 21 passed legislation aimed at tightening economic sanctions on Iran.

The bill (H.R. 1905) would, among other things, require firms traded on U.S. stock exchanges to disclose Iran-related activity to the Securities and Exchange Commission, penalize U.S. parent firms for certain Iran-related activities of their foreign subsidiaries, sanction energy and uranium mining joint ventures with Iran’s government outside of Iran, and impose other measures designed to increase pressure on Iran’s government.

“[Iran] can come clean on their nuclear program and end the suppression of their people and stop supporting terrorist activities around the globe,” Senate Banking, Housing and Urban Affairs Committee Chairman Tim Johnson, D-S.D., said. “Or they can continue to face sustained multilateral economic and diplomatic pressure and deepen their international isolation.”

The legislation, which passed on a voice vote, builds on a 2010 law that tightened sanctions on Iran and authorized public pension funds to divest from that nation. It awaits action by the House.

Small 401(k) Plans Pay More; Half of All Sponsors Do Not Know About Certain Fees, GAO Finds

The administrative fees paid by 401(k) plan sponsors vary widely depending on the size of the plan, and sponsors of plans of all sizes often lack important information about costs, the Government Accountability Office (GAO) has found.

While large plans – those with 500 or more participants – paid an average of 0.15 percent of assets in administrative fees, small plans – those with fewer than 50 participants – paid 1.33 percent, according to a GAO study released last week. Mid-size plans paid 0.24 percent.

Nearly half of plan sponsors, meanwhile, reported that they did not know if their providers had revenue-sharing arrangements with other providers, and the study noted that representatives of a consultant firm said that most of their clients “have no understanding of revenue sharing and the potential impact on plan fees.”

Similarly, almost half of plan sponsors did not know if the participants in their plans were charged transaction costs.

“Plan sponsors may need to be aware of and closely monitor the fees charged by various service providers to help ensure the fees they and their participants pay are not excessive,” the GAO stated in the report. “However, in several instances, sponsors of large and small plans did not know or fully understand the fees charged to their plans, because fee arrangements have become so complex and may be disclosed differently, adding to sponsor confusion about plan fees. In addition, because sponsors of plans of all sizes may not be aware of certain fees that participants are paying, such as transaction costs and wrap fees, it is difficult to get a clear understanding of the total fees that participants are actually paying.”

The GAO recommended that the Department of Labor enhance education initiatives; improve web access to publicly available fee information it collects on the annual Form 5500; and evaluate whether “individuals and service providers who exert significant control” over 401(k) plans should be considered fiduciaries. Department officials generally agreed with the recommendations.

RELATED NATIONAL AND INDUSTRY NEWS

Group Releases Guidance on Public Pension Disclosures

A coalition of public and private organizations that have connections to state and local financial issues on May 17 released guidance regarding disclosure of public pension obligations.

The National Association of Bond Lawyers (NABL) convened the group – which included two CalPERS staff members and five representatives of California’s government – in an attempt to ensure that disclosures about pension liabilities and funding provide bond investors with all of the information they need to assess the risk of buying state and municipal bonds.

The document released last week does not suggest any accounting standards but, rather,

lists “key questions that are important to an analysis of what disclosure about an issuer’s pension funding obligations may be required in a particular instance.” The dozens of questions, divided into the categories of “Budgeting for Pension Obligations,” “Pension Contribution Obligations” and “Information About The Pension Plan,” include inquiries about such topics as the annual required contribution, the sources of revenue for the plan, the funded ratio, the liabilities discount rate, the investment return assumption and the classes of investments in the fund’s portfolio.

“This is a very significant achievement and demonstrates the ability of the industry to voluntarily reach a consensus on a critical issue and produce comprehensive, informed guidance,” NABL President Kristin Franceschi said.

The Government Finance Officers Association was among the groups that participated in the effort, and its representative, John Tuohy, said that the organization will use the guidance to develop a set of best practices “to help state and local governments develop appropriate policies and procedures related to pension disclosures.”

Separately, the Governmental Accounting Standards Board (GASB) is expected to issue guidelines for disclosure of public pension obligations this summer. In June 2011, GASB released **proposed rules** that would require a disclosure of “net pension liability” in government financial statements and would require that the discount rate used for liability calculations blend the plans’ expected rate of investment returns with the rate that would be expected from “a high quality municipal bond index rate.” This would be a significant change that would likely swell projected liabilities, at least on paper.

Report Says Accounting Rules Should Not Stop Pension Conversions

Concerns about accounting rules are mostly misguided and should not prevent states and localities from moving away from defined benefit pension plans, a new report released by the Arnold Foundation concludes.

The report, which was written by Robert Costrell, a professor at the University of Arkansas and a fellow at the George W. Bush Institute at Southern Methodist University, opens by defining “true public pension reform” as one that “replaces traditional Defined Benefit (DB) plans with structures that tie benefits more closely to contributions.” The report notes that objections to such transitions often focus on concerns that Governmental Accounting Standards Board (GASB) rules require an acceleration of payments to amortize the old plan’s unfunded liability.

While acknowledging that GASB rules require an accelerated amortization schedule for the annual required contribution (ARC), the report rejects claims that the rules determine state funding policy and drive actual contributions. It notes that state and local officials “are not bound by GASB accounting standards in setting funding policy, and actual contributions often differ from the ARC.”

In addition, it rejects assertions that, since the number the employees who are in a DB plan

ceases to grow once it is closed, the GASB rules are sound policy. All workers, whether in the plan or not, can be sources of revenue for covering its liabilities, the report notes, and since total payroll would be unaffected by the closing of the plan, “there is no policy reason to change amortization methods.”

“Pension reform is a separate issue from amortization,” the report states. “These two issues have been conflated by those invoking the GASB proviso for closed DB plans, but this has only sown confusion. ... The funding schedule for amortization is a red herring, irrelevant to the fundamental policy decision for pension reform. Amortization pays for past debts; pension reform lays a path toward a responsible future.”

CALIFORNIA CONGRESSIONAL DELEGATION NEWS

Boxer, Feinstein, 20 Other Democrats Urge Implementation of Volcker Rule ‘Without Delay’

Both of California’s senators, Barbara Boxer and Dianne Feinstein, joined 20 other Democratic senators in urging regulators to “implement a clear, strong, and effective Volcker Rule without delay.”

The Volcker Rule, which was included in the Dodd-Frank financial regulations reform law, would prohibit banks from engaging in proprietary trading, which some critics say contributed to the 2008-09 economic downturn. The rule is unpopular in the financial community, which has been working to weaken or delay it. The rule became a much hotter topic after the letter was sent when J.P. Morgan disclosed that it had lost at least \$2 billion in trade that many Democrats say would have been prevented by a tough Volcker Rule. Most Republicans disagree, and regulators appear to be undecided.

“Numerous inquiries into the causes of the financial crisis, including the hearings of the Senate Permanent Subcommittee on Investigations and the Financial Crisis Inquiry Commission, established the need for these provisions,” the senators stated in the April 26 letter. “Conflict-ridden, high-risk trading activities played a central role in big banks’ accumulation of the failed toxic assets that helped freeze credit to businesses and families, and led to trillions of dollars of taxpayer-backed bailouts of the largest financial firms.”

A proposed rule was released in October. Senators wrote in the letter that the proposal “is not perfect, but it should not be delayed or scrapped. Rather, we urge you to –

- adopt the best elements from the proposed rule;
- eliminate loopholes;
- draw clear lines based on objective data and observable markets;
- strengthen CEO and board-level accountability and public disclosure; and
- provide coordinated and consistent enforcement, including data sharing by regulators.”

The letter followed a recent announcement by regulators that banks would have two years to comply with the rule once it is in effect. The law is supposed to be in place by July 21, but it is widely thought that that deadline is unlikely to be met.