

THE MONTH IN WASHINGTON

A Federal Report Provided by LGV&A

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Elections, Ebola, and ISIS dominated the news in Washington, D.C., in October. With the mid-term elections approaching on November 4, Republicans appeared to have a good chance of taking over the Senate, while holding on to the House. The potential GOP majorities, though, would not be sufficient to override presidential vetoes, so the Obama administration's priorities – notably the Affordable Care Act and the Dodd-Frank Act, both of which were passed in 2010 – should be no more likely to be repealed. Ebola, meanwhile, for all the fear and near-panic it has caused, has still claimed just one life in the United States. Overseas, ISIS continues to display both its brutality and military acumen in Iraq and Syria, even amidst U.S. airstrikes targeting the organization in both of those countries.

ISSUES AND EVENTS

Two Senators Cite Concerns with Certain Pension 'De-Risking' Strategies

Two senior Democrats have written to federal regulators to express their concerns with how “de-risking” strategies in private sector defined benefit pension plans could affect retirees.

In an October 22 letter to the Treasury Secretary, Labor Secretary, Pension Benefit Guaranty Corporation Acting Director and Consumer Financial Protection Bureau Director, Senate Finance Committee Chairman Ron Wyden of Oregon and Senate Health, Education, Labor and Pensions Committee Chairman Tom Harkin of Iowa wrote that the de-risking issue is “of paramount importance to those of us who are entrusted with protecting [retirees'] savings.”

Wyden and Harkin noted that some employers mitigate their pension funding risks by using certain strategies. While they allowed that some of these are “win-wins for employers and their employees and retirees,” others, they stated, can pose risks to beneficiaries, particularly methods that involve lump-sum buy-outs to retirees or the off-loading of risks and liabilities to outside insurance companies.

“For instance, in an insurance company transfer, participants lose vital participant protections under the Internal Revenue Code and Employee Retirement Income Security

Act (ERISA), including the insurance coverage of the Pension Benefit Guaranty Corporation (PBGC), key disclosures, and protection from creditors,” the senators wrote. “In a lump-sum buy-out, participants lose all of ERISA’s protections and must take on all the risks of investing the money to make it last over their lifetime. In addition, lump-sums have no spousal protections and retirees looking to invest a lump-sum could be victims of poor financial advice.”

Writing that there is a “lack of clear and specific rules to protect participants and retirees in these transactions,” they asked the regulators “to consider guidance establishing procedures and clarifying fiduciary duties for the de-risking of pension plans, recognizing the rights of employers to terminate parts of their plans but in a way that does not increase the risks or reduce the benefits promised to workers and retirees.”

New Guidance Promotes Annuities in 401(k) Plans

Regulators on October 24 released guidance aimed at expanding the use of annuities in 401(k) plans.

The guidance provides a “special rule” that enables defined contribution plans to include, in their investment options, a series of target date funds – that is, funds in which the investment mix is automatically adjusted as a worker approaches a given retirement date – that include deferred income annuities. Even if some of the target date funds are available only to older participants, the guidance makes clear that, as long as certain conditions are met, this would not violate nondiscrimination requirements.

While target date funds are already commonly available, and, in fact, are frequently used as default investment options in 401(k) plans, the new guidance, by specifying that target date funds with annuities are allowed, is intended to address the issue of individuals having a pool of money at retirement that they must make last for an unknown number of years.

“As boomers approach retirement and life expectancies increase, income annuities can be an important planning tool for a secure retirement,” Deputy Assistant Treasury Secretary J. Mark Iwry said. “Treasury is working to expand the availability of retirement income options for working families. By encouraging the use of income annuities, today’s guidance can help retirees protect themselves from outliving their savings.”

The Obama administration in recent years has implemented several measures with the goal of encouraging the increased use of annuities by retirees.

Regulators Release Risk Retention Rule

Six federal agencies on October 22 released a final rule that will require sponsors of asset-backed securities to retain at least 5 percent of the credit risk of the assets that compose the securities.

The collapse of the mortgage-backed securities market is generally regarded to have been a major factor that led to the financial crisis of the late 2000s. Mortgages of questionable credit risk were packaged into lucrative – for a time, at least – investment vehicles that were commonly given high credit ratings. This created an incentive for banks to offer mortgages using little, if any, discretion, since they would immediately be sold to buyers who thought the mortgage holders were good credit risks anyway. When the holders defaulted in large numbers, the market imploded.

“Investors did not have access to the same information about the assets collateralizing asset-backed securities as other parties in the securitization chain (such as the sponsor of the securitization transaction or an originator of the securitized loans),” the rule explains. “In addition, assets were resecuritized into complex instruments, which made it difficult for investors to discern the true value of, and risks associated with, an investment in the securitization, as well as exercise their rights in the instrument.”

The new risk retention rule, which was required by the 2010 Dodd-Frank Act, is intended to “provide securitizers an incentive to monitor and ensure the quality of the securitized assets underlying a securitization transaction, and, thus, help align the interests of the securitizer with the interests of investors,” the rule states.

The rule is to go into effect for securities backed by residential mortgages in one year and for all other securities in two years.

The rule was developed by the Department of Housing and Urban Development, the Federal Deposit Insurance Corporation, the Federal Housing Finance Agency, the Federal Reserve, the Office of the Comptroller of the Currency, and the Securities and Exchange Commission.

SEC Commissioner Warns of Distracting New Mandates

The Securities and Exchange Commission is facing “a crushing burden of congressional mandates,” as a result of the 2010 Dodd-Frank Act, that are distracting the agency from its primary purpose, a Republican SEC commissioner said in October.

During an October 16 speech at Fordham Law School, SEC Commissioner Daniel Gallagher said that, “the SEC is, first and foremost, a disclosure agency” – in contrast to the assertion on the SEC website that it is “first and foremost ... a law enforcement agency” – and that its “continued relevance and success” depend on the agency maintaining its “focus on the basic, blocking-and-tackling, everyday regulation for which the commission was established.”

“We must not let the prudential regulators’ shiny new issues du jour distract us from our core mission,” Gallagher said.

The many directives of the Dodd-Frank Act, though, threaten to move the SEC away from that mission, he added.

“To be blunt, many, if not most, of the 100 mandates imposed upon the commission by the Dodd-Frank Act do not, by any measure, represent the best use of the commission’s time and resources,” Gallagher said. “Most obviously, whether one views the SEC as a disclosure agency or an enforcement agency, sociopolitical issues such as conflict minerals and extractive resources, while perhaps worthy of attention by the right entities, should not be part of the SEC’s agenda. Rulemakings for such issues contribute neither to the maintenance of fair, orderly and efficient markets, nor the facilitation of capital formation, nor investor protection. They are the creations of special interest groups every bit as strong as K Street lobbyists, and they severely sap the finite bandwidth of the SEC.”

Dodd-Frank directed the SEC to issue a “conflict minerals” rule requiring certain companies to disclose their use of tantalum, tin, gold and tungsten that originated in the Democratic Republic of Congo or an adjoining country. The mandate was an attempt to address human rights violations in the region and the use of mineral sales to finance armed conflicts. It also directed the implementation of an “extractive resources” rule requiring energy companies to disclose payments to foreign governments in order to increase the transparency of money flowing to regimes in resource-rich nations that may be more likely to pocket it than use it for the good of their people.

Even a mandate closer to the SEC’s traditional role – regulating securities-based swaps – has “forced the commission to radically restructure its priorities,” Gallagher said.

“To be blunt once again, our swaps rulemaking has taken up a wildly disproportionate amount of the commission’s attention,” Gallagher said. “If we are to survive for the next 80 years as the independent, expert agency that has produced the imperfect but unparalleled successes of the past eight decades in overseeing capital markets and protecting investors, we simply must regain control of our agenda. As I’ve said many times over the past three years, even if we did nothing other than Dodd-Frank work from this point forward, it would still take over half a decade or more to address all of those mandates, by which point the agency would be unrecognizable and potentially irrelevant.”

Gallagher said that the SEC needs to work with Congress and the White House “to remove the useless or counterproductive elements of the Dodd-Frank Act”; become “savvier” in overseeing capital markets and gathering and analyzing information; and work with other regulators and officials on policy issues.

Next Wave of Dodd-Frank Rules to Cost \$10.3 Billion, Conservative Group Says

The cost of implementing parts of the 2010 Dodd-Frank Act that are still in the proposal stage is expected to exceed \$10 billion, according to a conservative research and advocacy group.

American Action Forum (AAF) estimates that Dodd-Frank costs through 2014 have already totaled about \$24 billion, and it projects that the mandates not yet in place will add at least another \$10.3 billion. The total is likely to be even higher, according to the group, because its calculations include only those remaining rules that have been proposed, but dozens of others have not even been proposed yet.

“At some point, we have to ask, ‘Are we getting our money’s worth out of this,’” AAF President Douglas Holtz-Eakin, a former director of the Congressional Budget Office, said. “I don’t think so.”

The biggest single price tag for the remaining regulations in proposed form is \$5.2 billion for margin and capital requirements for swaps. The conflict minerals rule, under which certain companies must disclose their use of tantalum, tin, gold and tungsten that originated in the Democratic Republic of Congo or an adjoining country, is expected to cost \$1.4 billion, while a rule requiring companies to disclose the ratio of CEO compensation to the average pay of rank-and-file workers is projected to cost \$218 million.

A proposed conflict minerals rule from the Securities and Exchange Commission (SEC) was struck down in federal court in April. The SEC is appealing the ruling.

“Business as usual with Dodd-Frank implementation means billions of dollars in higher costs, millions of more compliance hours, and additional barriers to home ownership,” AAF stated. “Perhaps these are the reasons regulators refuse to give timelines for final rules and courts routinely strike down the expansive use of new regulatory power.”

Government Officials Give Selves Middling Scores on Controlling Health Care Costs

Government officials do not consider themselves to have been very successful in controlling health care costs, according to the results of a survey conducted by Cobalt Community Research.

Cobalt’s “Health and OPEB Funding Strategies” report found, through a survey of 1,516 governments, that, when gauging the effectiveness of their efforts to control health care costs on a scale of 1 to 10, governments gave themselves an average rating of 5.1. Small governments – those with 50 or fewer employees – had the lowest rating at 4.7. Large governments – those with more than 500 employees – had the highest at 5.7. More than seven in 10 government employers pay at least 80 percent of the premiums for their active employees.

Just over three out of five respondents indicated that they are not prefunding the costs of retiree health care and other post-employment benefits (OPEB), but, instead, are continuing to use a pay-as-you-go approach. The pay-as-you-go percentage is up 10 points from 2011. Almost half of governments – 46 percent – provide no retiree health care benefits, though this is much more likely to be the case with smaller governments than with larger ones. Among those with more than 500 employees, just over half provide

benefits to early retirees, as well as to those age 65 and older. One-fourth of large governments provide coverage to early retirees only.

Government officials gave themselves an average score of just 4.5 when asked how knowledgeable they are about the 2010 Patient Protection and Affordable Care Act. The average was 3.3 for governments with 10 or fewer employers, then rose steadily to 6.0 for those with at least 501 employees.

When asked about innovations in providing health care coverage, the top three identified by respondents were pooling, wellness/disease management, and employee engagement.

Sunshine Act Website Goes Live

A Centers for Medicare & Medicaid Services (CMS) website that provides information about drug company payments to doctors is now live.

The 2010 Patient Protection and Affordable Care Act requires manufacturers of drugs and medical devices that are covered by Medicare, Medicaid or the Children's Health Insurance Program (CHIP) to submit records of their payments to physicians and teaching hospitals to CMS so that the information can be posted on a public "Open Payments" website.

Required disclosures under the "Sunshine Act" involve payments for food, entertainment, gifts, consulting fees, honoraria, research funding or grants, education or conferences, royalties or licenses, and charity. CMS released a rule implementing act in February 2013, 16 months after it was due.

The site, at launch, included 4.4 million payments totaling \$3.5 billion to 546,000 physicians and 1,360 teaching hospitals that were made during the last five months of 2013.

"Using this new data, it is now possible to conduct a wide range of analyses of payments made by drug and device manufacturers," CMS Deputy Administrator Shantanu Agrawal said. "Open Payments does not identify which financial relationships are beneficial and which could cause conflicts of interest. It simply makes the data available to the public. So while these data could discourage payments and other transfers of value that might have an inappropriate influence on research, education and clinical decision-making, they could also help identify relationships that lead to the development of beneficial new technologies."

CMS has indicated that it plans to upgrade the site soon to make it more searchable and user-friendly.

Notwithstanding Agrawal's comments, the website has been controversial in the medical community. The American Medical Association (AMA) said that it is "very concerned

about the accuracy of the data released” on the website, noting that only 26,000 physicians had the opportunity to review the information submitted about them.

“CMS provided a short period of time to review and correct any inaccurate data that was submitted by industry,” the AMA stated. “Several factors unfortunately hindered participation by many of the physicians impacted, including a complex, non-user friendly and cumbersome registration process to review data and request corrections of any inaccuracies. Meanwhile, the government website was plagued by repeated shutdowns and other issues. Notably, CMS has indicated problems with one-third of the data, which raises significant questions about the accuracy of the data content.”

In August, CMS announced that, “because of data inconsistencies,” it would withhold about one-third of the data submitted to the website when it went live. This followed the discovery by a Kentucky doctor that payments that had been linked to him actually had been made to a Florida doctor with the same name. This led CMS to shut down the website from August 3- 15 to, as the agency put it, “resolve a technical issue.”

When the site went back up, a CMS spokesman said that the agency was “returning about one-third of submitted records to the manufacturers and [group purchasing organizations] because of intermingled data, and will include these records in the next reporting cycle. “ The withdrawn records are expected to be posted in June 2015.

In addition, 40 percent of the records that were posted contained no personally identifiable information because CMS lacked confirmation of the payments to specific people or teaching hospitals. Those payments are expected to be republished next year with more information.

The AMA on August 15 asked CMS to push back the public launch of the site until March 31, 2015, citing “continued poor functionality of the government website and poor communication to physicians and the public .” The six-month delay, AMA stated, would give doctors more time to register on the site and review information.

On August 5, the AMA and more than 100 other medical associations wrote to CMS Administrator Marilyn Tavenner to request a six-month delay.

Health Care Provider Groups Urge Health IT Focus on Interoperability

Eight health care provider organizations wrote to Health and Human Services (HHS) Secretary Sylvia Burwell on October 15 to express their concerns regarding health information technology (HIT) meaningful use (MU) standards and their effect on interoperability.

The groups warned Burwell of “growing barriers” to achieving the HIT goals of improved patient safety, care quality, and efficiency.

“Currently, health information stored in most [electronic health records]/[electronic medical records] and other HIT systems and devices do not facilitate data exchange but ‘lock-in’ important patient data and other information that is needed to improve care,” they wrote. “These barriers to data exchange proliferated as result of a variety of factors; include [sic] strict MU requirements and deadlines that do not provide sufficient time to focus on achieving interoperability. This dynamic is also in part due to the strict EHR certification requirements that have forced all the stakeholders involved to focus on meeting MU measures as opposed to developing more innovative technological solutions that will enhance patient care and safety while growing the marketplace.”

The groups recommended making four changes to the meaningful use rules:

- Allow “a flexible and scalable standard based on open system architectural features”
- Promote collaboration among stakeholders
- Eliminate policies that stifle innovation
- Allow time for the development and implementation of new systems before enforcing meaningful use requirements

The letter was signed by the American Academy of Family Physicians, the American Medical Association, the Medical Group Management Association, the National Rural Health Association, Memorial Healthcare System, Mountain States Health Alliance, Premier Healthcare Alliance, and Summa Health System.

The letter was sent on the same day that the Office of the National Coordinator for Health Information Technology convened the first joint meeting of the Health Information Technology Policy and Standards Committees to discuss interoperability.

Karen DeSalvo, the national coordinator for health information technology, and Erica Galvez, the office’s interoperability and exchange portfolio manager, wrote in a blog post on October 15 that their agency has “heard loudly and clearly that interoperability is a national priority.”

“It is also apparent that there is enthusiasm, capability and a willingness to cooperate and collaborate in ways not previously seen,” they wrote.

HHS in October released a report that found that progress has been made in building a HIT infrastructure during the past decade, but “practice patterns have not changed to the point that health care providers share patient health information electronically across organizational, vendor, and geographic boundaries.”

“Electronic health information is not yet sufficiently standardized to allow seamless interoperability, as it is still inconsistently expressed through technical and medical vocabulary, structure, and format, thereby limiting the potential uses of the information to improve health and care,” the report states. “Patient electronic health information needs to

be available for appropriate use in solving major challenges, such as providing more effective care and informing and accelerating scientific research.”

In addition, the report noted that facilities that are not eligible for incentive payments under the HITECH Act, such as long-term care, post-acute care, and behavioral health settings, tend to make the adoption of health IT systems less of a priority.

“Effective communication and information sharing across all health care providers is essential for improving care quality and community health,” the report states. “Better alignment of health IT solutions among all provider types could promote electronic exchange and care coordination activities among all providers.”

The top three “major barriers” to EHR use identified by both adopters and non-adopters were the same: cost of purchasing a system, loss of productivity, and annual maintenance cost.

Proposed Changes Likely Coming in ACO Payments, CMS Official Says

The methods used to pay accountable care organizations (ACOs) may soon change, a senior Centers for Medicare & Medicaid Services (CMS) official indicated on October 20.

Medicare ACOs, which were created by the 2010 Patient Protection and Affordable Care Act, are intended to encourage health care providers to coordinate care for patients in a way that improves quality, cuts costs and moves providers and patients away from the traditional fee-for-service payment model. As long as quality standards are met, ACOs and Medicare share the cost savings that result from coordinating care. Around 5.6 million Medicare beneficiaries receive care through about 360 ACOs.

CMS is expected to propose a new rule on ACOs soon, and agency Deputy Administrator Sean Cavanaugh indicated that payment revisions could be included in the new regulation.

“We need to improve the incentives that the ACOs receive, improve the information and help build the capacity of the ACOs,” Cavanaugh said.

CQ reported that ACOs particularly object to existing requirements that the amount of savings produced has to reach a certain point before the ACOs share in them and that cost targets be based on national Medicare averages – which have been nearly flat in recent years – even though costs in certain communities are much higher. In addition, they reportedly have concerns about savings leading to ever-lower cost targets that, eventually, would become impossible to hit.

Cavanaugh said that reforming these and other aspects of payments “are all ideas we’re taking seriously and considering as we propose a new rule.”

In July, CMS proposed putting greater emphasis on patient outcomes in ACOs.

The proposed rule would overhaul the quality measures that CMS uses to determine whether ACOs are eligible for bonus payments, adding 12 that are “more outcome-oriented” and deleting eight that “have not kept up with clinical best practice, are redundant with other measures that make up the quality reporting standard, or that could be replaced by similar measures that are more appropriate for ACO quality reporting.” This would increase the total number of measures from 33 to 37.

The public comment period for the proposal closed on September 2.

In June, Medicare Payment Advisory Commission (MedPAC) Chairman Glenn Hackbarth wrote to CMS Administrator Marilyn Tavenner about five issues “essential to the success of the program that will require changes in either regulation or legislation to be resolved.” In his letter, Hackbarth identified recommendations related to two “near-term” issues (listed first below) and three “longer-term” issues:

- ACOs should know who their beneficiaries are and what their financial targets are. (Now they know neither.)
- Quality measurements and evaluations should be simplified. (ACOs report that they are overly complex and expensive.)
- ACOs should face “two-sided” risk, in which they would receive bonuses for cutting costs, but would also be penalized for excessive costs. (Most ACOs face no penalties now.)
- Allow for innovative models of care. (This now tends to be allowed more for Medicare Advantage beneficiaries than for traditional fee-for-service beneficiaries.)
- Clarify what communication is allowed between ACOs and beneficiaries. (Communication now is very limited.)

“A program with more equitable targets, stronger tools for beneficiary engagement, and ACOs at two-sided risk will provide stronger incentives for providers to make the needed changes to help move the program from one that rewards volume to one that rewards value,” the letter stated.

CMS announced in September that ACOs produced net savings of \$372 million in 2013, and participating organizations qualified for \$445 million in payments. Those payments, though, went to only 64 of the 243 participating organizations whose performance was assessed. (The remaining ACOs were too new to have been included in the most recent CMS report.) Four ACOs overspent their targets by so much that they had to pay penalties to the government.

Expected Savings from Dual Eligible Benefit Coordination May Be ‘Optimistic’: GAO

Integrating Medicare and Medicaid benefits for “dual eligibles” may not save much money, the Government Accountability Office (GAO) has concluded.

About 10 million people are eligible for Medicare and have incomes low enough to qualify them for Medicaid, as well. Of that number, about 4 million are under age 65, but can get Medicare benefits because of a disability. Dual eligibles represent about one-fifth of each program's beneficiary population, but they account for more than one-third of the expenditures for each program.

It has been suggested that better coordinating the benefits provided by the two programs could improve quality of care and reduce costs. To this end, the 2010 Patient Protection and Affordable Care Act directed the Centers for Medicare and Medicaid Services (CMS) to establish the Medicare-Medicaid Coordination Office and the Center for Medicare and Medicaid Innovation.

GAO looked, in particular, at the performance of dual-eligible special needs plans (D-SNPs) in Medicare Advantage (MA), programs that are "designed to target the needs of this population." It found that these plans were "moderately better on health outcome measures" than traditional Medicare Advantage plans, but that participants in D-SNPs made use of certain costly Medicare services at rates about equal to or, in some cases, slightly higher than participants in traditional Medicare Advantage plans. This, GAO concluded, suggests that "CMS's expectations regarding the extent to which integration of benefits will produce savings through lower use of costly Medicare services may be optimistic."

"Despite moderately better performance on health outcome measures for both disabled and aged dual-eligible beneficiaries, the fact that D-SNPs had similar levels of costly Medicare-covered services (i.e., inpatient admissions, readmissions, and emergency room visits) as traditional MA plans for this population has significant implications for program costs," the report stated.

Congress Gets Poor Grades on Health Care Issues from NCHC

An advocacy group to which CalPERS belongs has given Congress an "F" for its performance on health care price and transparency issues.

The "report card" from the National Coalition on Health Care states that "the 113th Congress has thus far failed to make the grade on controlling health care costs."

"Despite repeated congressional hearings, Congress has enacted no legislation related to provider price transparency," the report notes.

The organization also graded Congress on two other issues, giving it a "D+" on strengthening Medicare and an "Incomplete" on modernizing physician payment and reforming Medicare's sustainable growth rate (SGR) formula. The SGR was intended by Congress to automatically set Medicare's physician payment rates, but it has been overridden every year since 2003 because it would slash the federal government's payments to doctors for services provided to Medicare patients. NCHC said it chose these

three issues because they “represented the best opportunities for bipartisan legislation [related to health costs] during this Congress.”

Congress received an incomplete for SGR reform because, after making some progress toward an SGR replacement before momentum stalled, some lawmakers have indicated that they may try to push through legislation during the lame duck session that will follow the elections.

The report stated that the lame duck session represents Congress’ “last chance to go back and change those disappointing grades for the better. They should not squander it.”

“In January, a new term will begin and the 535 members of the new, 114th Congress will take their seats in the Capitol,” the report states. “For the upcoming term, the usual partisan blame game on health costs simply will not make the grade. ... Next year, NCHC will be on Capitol Hill demanding results, not more rhetoric, because with health care costs climbing month in and month out, America’s families cannot afford another two years of failure.”

Social Security Benefits to Increase 1.7 Percent

Monthly Social Security benefits are to increase by 1.7 percent in 2015, the Social Security Administration announced on October 22.

The cost-of-living adjustment (COLA) will apply to retirement benefits and Supplemental Security Income (SSI) benefits.

The COLA calculation is based on a certain version of the consumer price index. The COLA was 1.5 percent in 2014, 1.7 percent in 2013 and 3.6 percent in 2012. Benefits were flat in 2011 and 2010.

The maximum amount of earnings subject to Social Security taxes will increase in 2015 from \$117,000 to \$118,500.

RELATED NATIONAL AND INDUSTRY NEWS

Moody’s Public Pension Report ‘Misleading and Confusing’: NASRA

A September report from Moody’s that estimated that the nation’s 25 largest public pensions have a combined funding shortfall of \$2 trillion is “unrealistic, misleading and confusing,” according to the National Association of State Retirement Administrators (NASRA).

The credit rating agency concluded that unfunded liabilities for the 25 plans tripled between 2004 and 2012, this despite investment returns averaging 7.45 percent, which

nearly matched projections. Moody's stated that the increase in shortfalls at a time when the funds were hitting investment targets "underscores the difficulty of recovering from double-digit asset declines experienced in 2008-09, as well as the broad inadequacy of sponsor contributions. ... In addition to assets falling further behind liabilities, the plans are also facing riskier asset allocations and the burden of an older US population, leading to more risk for the states and local governments that fund them."

In an October 8 letter to Moody's, NASRA Research Director Keith Brainard objected to the findings, stating that the report is "based on Moody's recalculation of pension data for the purpose of rating bonds" and is not "a depiction of the actual financial condition of state and local pension plans." He referred to major changes made by Moody's in 2013 in the way it assesses the financial condition of state and local pensions. Among other revisions, it now calculates a pension fund's actuarial liabilities by using "a high-grade long-term taxable bond index discount rate"; it has replaced asset smoothing with "reported market or fair value as of the actuarial reporting date"; and it amortizes liabilities over 20 years.

When the changes were proposed in slightly different form in 2012, they were criticized by a coalition that included NASRA and other public sector organizations, which stated, "The introduction of yet another set of calculations will result in increased, widespread confusion and misunderstanding of the meaning and implication of public pension actuarial measures. This, in turn, will be exacerbated by selective use: drawing on the funding level figure that best fulfills the objective of the user."

"With Moody's latest report, concerns regarding the potential mischaracterization and misuse of these manipulated pension numbers have been more than realized," Brainard wrote. "Moody's fails to clarify that these are adjusted numbers, and makes little effort to explain that declining interest rates are the primary cause of the drastic change in liabilities. Yet the report implies, wrongly, that such changes will affect funding. By Moody's own admission in prior pronouncements, the adjusted pension liabilities calculated by Moody's do not represent a funding requirement. Yet the report makes no effort to clarify that vital fact."

Brainard also criticized several other assertions in the report, including Moody's estimate that public pensions have \$5.29 trillion in assets. He cited a Federal Reserve estimate of \$3.7 trillion.

"In sum, the report falls far short of the assurances made that Moody's publication of adjusted pension data would be presented in the context of the analytical framework used by the agency to assess risk. In fact, the report perpetuates the very type of confusion that stakeholders urged Moody's to avoid."

Arnold Foundation Planning Public Pension Reform Campaign

The Arnold Foundation has indicated that it is preparing to launch a public relations campaign focused on “the economic and social costs of governments failing to pay for their pension promises.”

The foundation in September put out a request for proposal seeking a communications firm to develop and execute a research plan, an effort to build a “bipartisan coalition of individuals and groups that recognize the need for reform”; and a “multi-faceted, strategic national communications campaign.”

The RFP closed on October 3. Finalists were to be selected by October 15, with a firm to be picked by November 7.

National Council on Teacher Retirement (NCTR) Executive Director Meredith Williams warned of the potential impact of the foundation’s efforts.

“This new national campaign represents a very alarming escalation of the Arnold Foundation’s drive to destroy the current, cost-effective public sector pension model, built around the goal of an adequate, affordable, modest retirement benefit that a retiree cannot outlive,” Williams said.

The Arnold Foundation, according to its website, focuses on producing “reforms that will maximize opportunities and minimize injustice in our society.” The site also notes that the foundation works “actively in the area of public employee benefits reform.”

“State and local budgets across the nation continue to face considerable financial strain, and the structure of public employee benefits in most states and communities is unsustainable,” the website states. “The economic and social costs of governments failing to pay for their promises are not only harmful to future generations of workers and taxpayers, but also potentially crippling to the nation. We seek to remedy this untenable situation by promoting transparency and concrete structural solutions that address the problem in a manner that is comprehensive, lasting, and fair to all parties.”

In September, the Institute for America’s Future, a progressive think tank, released a report that asserted that the Arnold Foundation has been working with Pew Charitable Trusts since 2011 on “a campaign to reduce guaranteed retirement income for pensioners.”

Public Pension Assets at Record Level: Census Bureau

Assets held by the nation’s 100 largest public pensions totaled \$3.28 trillion in the second quarter, 4.3 percent more than the previous quarter and 14.3 percent more than a year earlier, according to the U.S. Census Bureau.

The value of corporate stock holdings increased 7.4 percent from the first quarter to total \$1.18 trillion, while the value of international securities shrank 2.8 percent to \$656.5 billion. Corporate bond holdings grew 7.1 percent to \$371.5 billion, and federal government securities expanded 12.4 percent to \$307.8 billion.

Government contributions to retirement funds totaled \$24 billion in the second quarter, 6.8 percent less than in the first quarter, but 4.8 percent more than a year earlier. Employee contributions of \$10.9 billion were 3.4 percent higher than the previous quarter but 1.4 percent less than in the second quarter of 2013.

Investment earnings totaled \$129.4 billion in the second quarter.

The \$3.28 trillion is the highest level recorded since the Census Bureau began tracking public pension holdings in 1968.

The 100 funds surveyed account for about 90 percent of all public pension assets.