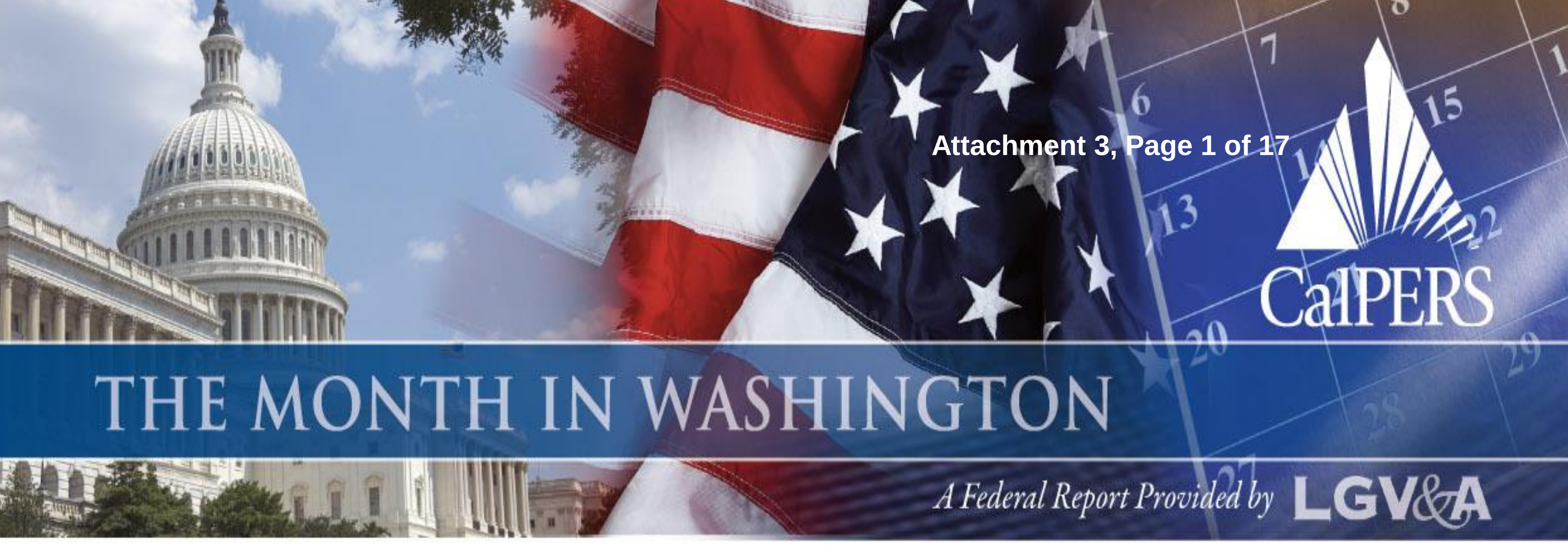

NOVEMBER 2014

November was a tough month for Democrats. On Election Day, Republicans won the Senate in the 114th Congress, which will convene in January, and expanded their majority in the House. GOP lawmakers, though, will not have the numbers to override presidential vetoes. The U.S. Supreme Court, meanwhile, agreed to hear another challenge to the Patient Protection and Affordable Care Act, one that argues that tax credits that subsidize purchases in the health insurance exchanges should be available only in state-run exchanges – of which there will be 14 in 2015 – and not in the 37 exchanges operated by the federal government. Also, the Obama administration had to concede that Republican lawmakers were correct when they charged that enrollment numbers for the first year of the exchanges were overstated by nearly 400,000. And, finally, House Republican lawmakers filed a lawsuit accusing the administration of overstepping its authority in its implementation of the Affordable Care Act.

ISSUES AND EVENTS

GOP Takes Senate; Affordable Care Act, Dodd-Frank Act Likely to Be Targets

Republicans will take over the Senate in 2015 after a dominating Election Day for the GOP, which could lead to some changes for the 2010 laws that reformed health care and financial regulations, but almost certainly will not mean repeal of either one.

As of late November, Republicans will have 53 seats in the Senate next year and Democrats 46 (including two independents who caucus with them). A runoff election is to be held in Louisiana on December 6 between Democratic incumbent Sen. Mary Landrieu and Republican Bill Cassidy. The GOP expanded its majority in the House to at least 244-186.

One of the first votes that Republicans are likely to hold once they have control of both chambers during the 114th Congress will probably be a measure to repeal the 2010 Patient Protection and Affordable Care Act (ACA). A likely filibuster by minority Democrats – though certain procedural moves could get around this – and a certain veto by President

Obama, however, mean that, as presumptive incoming Senate Majority Leader Mitch McConnell, R-Ky., acknowledged before Election Day, the GOP's most hated law will stay on the books for now.

"Remember who's in the White House for two more years," McConnell said. "Obviously he's not going to sign a full repeal."

Republicans could make things more difficult for Obama by attaching measures related to the reform law to larger bills that would be politically costly to veto. This could be especially effective with more narrowly focused revisions, what McConnell described as "pieces of [the law] that are extremely unpopular with the American public and that the Senate ought to have a chance to vote on."

Roughly in order of most likely to be enacted to least likely, some of the ACA-related measures that Republicans will probably try to push through include:

- **Repealing the medical device tax.** The ACA imposed a 2.3 percent tax on medical devices starting January 1, 2013, that is intended to raise $29 billion over 10 years. Many members of both parties support eliminating the tax – the Democrat-controlled Senate voted 79-20 in March 2013 to approve a non-binding measure supporting repeal of the levy – but Senate Majority Leader Harry Reid, D-Nev., supports the tax. Since the tax helps to fund other parts of the reform law, Democrats will likely try to insist on finding a way to offset the lost funds.
- **Changing the ACA's definition of full-time employee.** The law defines a full-time employee as one who works for at least 30 hours each week. This affects who is subject to the law's employer mandate – which requires employers with at least 50 full-time employees to offer health insurance that meets certain standards for benefits and affordability to their workers or pay a penalty – and critics argue that it is inconsistent with the traditional 40-hour definition of a workweek and could lead to employers cutting back on employee hours to stay below the threshold. The change has a significant amount of bipartisan support, and it is also backed by several unions, including the Teamsters, United Food and Commercial Workers and UNITE HERE.
- **Eliminating the "risk corridor" program.** The ACA created the risk corridor program to ensure a certain amount of financial stability for insurers offering coverage through the new state-level exchanges, but only through 2016. It requires insurance companies to pay certain fees to the federal government, which then will cover a portion of a company's losses if spending in the exchanges is significantly higher than had been projected. Alternatively, if spending is significantly lower, the company must share the surplus funds with the government. The program has become a favored, if somewhat obscure, target for Republican critics of the health care reform law, who characterize it as a bailout for insurance companies.
- **Repealing the employer mandate.** Republicans argue that the mandate inhibits job growth. To support their cause, GOP lawmakers could point to a May 2014 report from the Urban Institute, a liberal think tank, that argued that the employer

mandate should be repealed because it would increase the uninsured population by just 200,000 people while saving workers from several potential negative effects, such as companies employing more people part-time, limiting staff size to stay below the mandate's threshold and passing the cost of penalties on to employees.

- **Repealing the individual mandate.** The ACA requires all Americans, with certain exceptions, to have health insurance or pay a penalty. This was the pivotal issue in the major legal challenge to the constitutionality of the law. The U.S. Supreme Court ruled 5-4 in 2012 that the mandate was a permissible exercise of Congress' power to impose taxes. Republicans continue to argue that people should not be required to buy coverage, while supporters of the law note that it is a critical part of the ACA's structure, since the law does not allow insurance denials based on pre-existing conditions, which means that no individual mandate would likely produce a fiscally unsustainable risk pool. One way in which the GOP might try to repeal the mandate is by using legislation to reform Medicare's sustainable growth rate (SGR) formula. The SGR, which was intended by Congress to automatically set Medicare's physician payment rates, annually threatens to slash the federal government's payments to doctors for services provided to Medicare patients. Congress has overridden the SGR calculations every year since 2003 in order to avoid payment cuts that, it has been feared, would drive doctors out of the Medicare program. Bipartisan momentum for enacting a permanent solution grew in 2013, but it mostly vanished in March when the House passed an SGR bill (H.R. 4015) that included a bipartisan reform plan, but that would cover its $138 billion cost over the first 10 years by postponing implementation of the individual mandate for five years.

Republicans are also likely to take some well-aimed shots at the Dodd-Frank Act, given that Obama would veto attempts to repeal the law in its entirety. Revisions that stand the greatest chance of success are probably those that would provide relief to smaller banks. Some Democrats could be expected to go along with GOP lawmakers in easing the burden of Dodd-Frank regulations on entities too small to have contributed to the financial crisis of the late 2000s.

Possible changes include easing capital standards for small and regional banks, providing them with certain exemptions from the Volcker rule's prohibition on proprietary trading, and increasing the threshold – currently $50 billion in assets – at which banks become subject to tighter regulations.

Several Dodd-Frank-related measures have had bipartisan support in the House, but have gone nowhere in the Senate. For example, legislation (H.R. 1564) that would prohibit the Public Company Accounting Oversight Board from requiring that the audits of a particular issuer be conducted by specific auditors, or that such audits be conducted by different auditors on a rotating basis – a measure that is opposed by CalPERS – passed the House 321-62 in June 2013, but never had a committee hearing in the Senate. Such bills could have new life in the next Congress.

Republicans will also probably try to eliminate the Consumer Financial Protection Bureau and strip the Financial Stability Oversight Council of its authority to designate nonbank entities as systemically important, but they are highly unlikely to get much Democratic support for either measure, and Obama would surely veto both of them.

Supreme Court to Hear Challenge to Health Insurance Subsidies

The U.S. Supreme Court has agreed to hear the legal challenge to certain subsidies for the purchase of health insurance.

The 2010 Patient Protection and Affordable Care Act (ACA) created state-level exchanges that were launched this year, in which people who do not have access to affordable group coverage can buy insurance, in many cases using income-dependent tax credits. States were not required to establish exchanges, but the federal government created one in any state that did not. During the first year, 36 exchanges were operated out of Washington, D.C., through www.healthcare.gov – either solely or in combination with a given state – while 14 states and the District of Columbia ran their own exchanges. There are now 37 federally-operated exchanges and 14 run by states and the district.

Several lawsuits were filed challenging the federal government's ability to provide tax credits to consumers in exchanges operated from Washington – as a rule issued by the IRS would do – on the grounds that a section of the ACA directs that subsidies are to be available for insurance plans "enrolled in through an Exchange established by the State." The case involves more than just subsidies since, if the tax credits are not available, the ACA's individual mandate and employer mandate would effectively cease to apply.

On July 22, a three-judge panel of the U.S. Court of Appeals for the Fourth Circuit in Richmond, Va., unanimously upheld the IRS rule allowing for subsidies in all 50 states and the District, stating that the rule is a "permissible construction" that "advances the true purpose and means of the Act." The judges, though, conceded that "the court cannot ignore the common-sense appeal of the plaintiffs' argument; a literal reading of the statute undoubtedly accords more closely with their position," and they stated that the government's interpretation is "only slightly" stronger than the one favored by the plaintiffs.

The challengers took their appeal directly to the U.S. Supreme Court, and the justices announced on November 7 that they will hear the case. Oral arguments are expected to be heard in March, with a ruling coming in June.

In a separate case that was also decided on July 22, a three-judge panel of the U.S. Court of Appeals for the District of Columbia Circuit sided 2-1 with the challengers to the rule, striking down subsidies in those states that have exchanges run by the federal government because upholding them would require "disregarding" the law's "plain meaning." However, on September 4, the full appeals court granted the Obama administration's request for an en banc hearing and vacated the July 22 ruling. A hearing was scheduled for December 17. With the nation's highest court now set to decide the issue, though, the plaintiffs asked for a delay until after that ruling. The judges agreed and issued an order on November 12 that directed that the case be "held in abeyance pending disposition by the Supreme Court" of the challenge from the Fourth Circuit.

The Department of Justice had filed a brief in the D.C. case on November 3 that stated that, "It is unfathomable that Congress would have imposed plaintiffs' regime in a law expressly designed to deliver 'near-universal coverage.'"

"Accepting plaintiffs' account of the Act requires accepting not merely that Congress would adopt this punitive, self-defeating scheme at all, but that Congress would do so exclusively through isolated phrases buried in the technical formula for calculating the size of an individual's tax credit, rather than forthrightly in provisions putting States and their citizens on notice of what Congress had done," the brief stated. "To say that plaintiffs purport to have discovered an elephant hidden in a mousehole ... understates the audacity of their enterprise."

Two Democratic senators, four Democratic representatives, and one former Democratic senator – all of whom had major roles in the writing of the reform law – also filed a brief in the case on November 3 in which they said that, without nationwide subsidies, "the Exchanges themselves would be rendered inoperable, and, indeed, the effectiveness of other major components of the law, such as guarantees of affordable insurance for people with pre-existing health conditions and the 'individual mandate' to carry insurance or pay a penalty, could be gravely jeopardized."

"The purpose of the tax credit provision was to facilitate access to affordable insurance through all exchanges, state-run or federally-facilitated, and to ensure that all Exchanges could work with other fundamental components of the law in order to provide near-universal access to insurance," the lawmakers stated in the brief.

Several dozen state legislators also signed on to the brief.

In a third case, a U.S. District Court judge, in a case filed by the state of Oklahoma, on September 30 rejected the IRS rule, stating that, "The court is upholding the act as written," and asserting that the government's interpretation "does not appear to comport with normal English usage." The federal government appealed to the 10th U.S. Circuit Court of Appeals in Denver, but Oklahoma Attorney General Scott Pruitt wants the Supreme Court to take the case before it goes through the appeals process, and hear it along with the challenge out of the Fourth Circuit, because, "It is absolutely paramount the court takes up Oklahoma's lawsuit to ensure states' rights are at the table when a decision is made."

A fourth case, filed by the Indiana attorney general and 39 school districts in that state, is pending in U.S. District Court in Indianapolis.

CalPERS, 62 Others Back SGR Fix During 'Lame Duck' Session

CalPERS signed on to a letter to congressional leaders in November in which 63 organizations urged lawmakers to replace Medicare's sustainable growth rate (SGR) formula before the end of the year.

The SGR, which was intended by Congress to automatically set Medicare's physician payment rates, annually threatens to slash the federal government's payments to doctors for services provided to Medicare patients. Congress has overridden the SGR calculations every year since 2003 in order to avoid payment cuts that, it has been feared, would drive doctors out of the Medicare program.

Frustration has grown with the annual need for legislation, though, and momentum for enacting a permanent solution grew in 2013. The momentum faded, though, and Congress ended up passing two short-term fixes, the latter of which (H.R. 4302) blocked a planned 24 percent payment cut through March 2015 by increasing payments by 0.5 percent through the end of 2014 then freezing them for the next three months.

The November 13 letter stated that, "repeated short-term patches leave healthcare providers uncertain about payment rates they will receive year after year."

"Without both repeal of SGR and broader improvements to reimbursement, Medicare payment policy will continue to disadvantage physicians and health professionals who provide better care at lower costs," the letter stated. "The result of this volume centric approach will be ever-increasing costs for consumers, employers and taxpayers."

Lawmakers will meet in a "lame duck" session to complete work on several items before the end of the year and the seating of the 114th Congress in January. Some indicated recently that they may try to push through an SGR bill during this session.

"I know it's absolutely doable, I know it is, but not without solid work over the next six weeks," House Ways and Means Committee Health Subcommittee Chairman Kevin Brady, R-Texas, said in late September.

It is widely thought that a standalone SGR bill would not pass, so the measure could be attached to other legislation, such as an omnibus spending bill or a package of "tax extenders," temporary provisions of the tax code that are regularly extended, such as a research and development tax credit and a tax deduction for energy-efficient commercial buildings.

SGR bills have already been approved by committees in both the House and Senate. If no legislation is enacted before the 113th Congress adjourns, the process would have to start anew, and without several of the key lawmakers who forged a bipartisan compromise on the issue in 2013 and are about to retire or are already gone.

Other organizations signing the letter included the National Coalition on Health Care – an advocacy group to which CalPERS belongs – AARP, the U.S. Chamber of Commerce, and dozens of medical associations.

Open Enrollment Begins for Second Year of Exchanges

The second open enrollment period for the health insurance exchanges began on November 15.

As previously stated, the 2010 Patient Protection and Affordable Care Act (ACA) created state-level exchanges, which started providing coverage this year, in which people who do not have access to affordable group insurance can buy policies, in many cases using income-dependent tax credits. States were not required to establish exchanges, which are also known as marketplaces, but the federal government created one in any state that did not. During the first year, 36 exchanges were operated out of Washington, D.C., through www.healthcare.gov – either solely or in combination with a given state – while 14 states and the District of Columbia ran their own exchanges. There are now 37 federally-operated exchanges and 14 run by states and the district.

Enrollment experiences varied across the country during the opening days, though, even when the process was slow, it was nowhere near the disastrous launch in 2013 when major website problems made it nearly impossible to sign up for coverage initially. Enrollments in the federally-run exchanges totaled fewer than 27,000 in the first month and fewer than 164,000 through the first two months.

The Department of Health and Human Services (HHS) announced that 462,125 people had signed up for coverage in the 37 federally-operated exchanges through November 21. About half of the people making up that total are new enrollees, and half are renewals.

After the exchanges' first enrollment period from October 1, 2013, through March 31, 2014, the Obama administration announced that more than 8 million people had signed up for coverage. HHS recently indicated that, as of October, 7.1 million of those enrollees had actually paid premiums. House Republicans, though, pointed out in November that almost 400,000 of those 7.1 million had signed up for dental-only plans, and the administration conceded that its numbers were incorrect.

"This mistake was unacceptable," Centers for Medicare & Medicaid Services (CMS) Administrator Sylvia Burwell wrote in a Facebook post. "I will be communicating that clearly throughout the department. While we understand some will be skeptical, our clarity that this is a mistake and the fact that we have quickly corrected the numbers should give people confidence."

Some Republicans are not willing to accept assertions that this was just an honest mistake, however.

"Faced with large numbers of Americans running for an exit from Obamacare, instead of offering the public an accurate accounting, the administration offered numbers that obscured and downplayed the number of dropouts," House Oversight and Government Reform Committee Chairman Darrell Issa, R-Calif., said in a written statement. "Now they're saying this was just a 'mistake.' The claim that this was only [an] accident stretches credulity."

Issa has previously made an issue of the decline in enrollments from the 8 million announced in the spring. Administration officials and many outside observers, though, say that the amount of attrition has been within the expected range.

For the White House, the news complicates things because it comes at a time of heavy coverage of comments by Jonathan Gruber – a consultant who worked on crafting the ACA – about the legislation intentionally being written to not be transparent in order to shape the Congressional Budget Office's (CBO) scoring of its cost and to leverage the "stupidity of the American voter" to make passage more likely.

Also, the adjustment drops enrollment below 7 million, which became an unofficial goal after the CBO projected in 2013 that that many people would sign up. The agency lowered its projection to 6 million, though, after major website problems in October and November of 2013 produced a disastrous launch of the exchanges and severely limited enrollments.

HHS projected on November 10 that the total number of enrollees will increase to between 9 and 9.9 million by the time this enrollment period ends on February 15.

That total includes a projected 5.9 million renewals from the first enrollment period. HHS estimated that the pool of potential new enrollees includes 23 to 27 million people. The agency calculated the expected number that would sign up for coverage using the "median state take-up rate" from the first enrollment period.

HHS' estimate is well below the 13 million projected by the Congressional Budget Office (CBO). CBO has also said that it expects enrollments to grow to 24 million by 2016, then reach a "steady state" of 25 million in 2017. HHS has expressed doubts about that growth rate, noting that there is "mixed evidence" concerning the CBO's projections of "significant shifts" during the next three years from employer-sponsored coverage to exchange coverage.

"In addition, recent experiences with new insurance coverage provide a range of data points," HHS stated. "For example, programs established particularly for a defined set of individuals (such as Medicare Part D), support a rapid ramp-up period. The evidence from the Children's Health Insurance Program and early Medicaid expansions under the Affordable Care Act suggest that the long-run steady state may not be achieved for as much as five years. If one extends CBO's ramp-up from three years to four or five years (which is more consistent with experience in the programs mentioned above), the estimate of 2015 Marketplace enrollment becomes approximately 11.5 million or approximately 9 million (respectively)."

House Republicans File Lawsuit Against Obama Administration

House Republicans on November 21 filed a lawsuit against the Obama administration for not implementing the health care reform law as written.

The lawsuit charges that the Executive Branch overstepped its authority in two actions: delaying by one-year the employer mandate – which requires employers with 50 or more employees to offer health coverage that meets certain cost and benefit standards or pay a penalty – and providing about $178 billion to insurance companies to subsidize the coverage of health insurance exchange enrollees in the absence of specific congressional appropriations for that purpose. The suit names Health and Human Services Secretary Sylvia Burwell and Treasury Secretary Jacob Lew as defendants, but President Obama is the true target for the plaintiffs.

"Time after time, the president has chosen to ignore the will of the American people and rewrite federal law on his own without a vote of Congress," House Speaker John Boehner, R-Ohio, said. "If this president can get away with making his own laws, future presidents will have the ability to as well. The House has an obligation to stand up for the Constitution, and that is exactly why we are pursuing this course of action."

The House voted 225-201 on July 30 to authorize Boehner to initiate a lawsuit "regarding the failure of the President, the head of any department or agency, or any other officer or employee of the United States, to act in a manner consistent with that official's duties under the Constitution and laws of the United States with respect to implementation of (including a failure to implement) any provision of the Patient Protection and Affordable Care Act." All but five Republicans voted for the measure, while all Democrats opposed it.

At the time of the vote, President Obama dismissed the threat of a lawsuit by saying, "they're mad I'm doing my job," and criticizing GOP lawmakers for refusing to work with him.

"We could do so much more if Congress would just come on and help out a little bit," President Obama said. "Stop being mad all the time. Stop just hating all the time."

The lawsuit charges that the administration "has made no secret of its willingness, notwithstanding Article I of the Constitution, to act without Congress when Congress declines to enact laws that the Administration desires."

"Not only is there no license for the Administration to 'go it alone' in our system, but such unilateral action is directly barred by Article I," the lawsuit states. "Despite such fundamental constitutional limitations, the Administration repeatedly has abused its power by using executive action as a substitute for legislation."

SHOP Enrollments Fall Below Projections During 1st Year

Enrollments in the health insurance exchanges for small businesses fell far short of projections in their first year, a report from the Government Accountability Office (GAO) has found.

The Small Business Health Options Program (SHOP) was created by the 2010 Patient Protection and Affordable Care Act to provide a marketplace in which businesses with 50 or fewer workers can buy coverage for their employees. The law also provides tax credits that, in certain cases, could cover as much as 50 percent of an employer's contribution to premiums. The health care reform law's employer mandate does not apply to businesses with no more than 50 employees.

The SHOP website was scheduled to go online in late 2013 along with the exchange site for individual coverage. Amid major problems with the launch of the individual coverage site at www.healthcare.gov, however, the federal government announced that it would delay full functionality of the federal SHOP site – which covered 33 states – for a year, though businesses could still enroll workers using paper applications starting October 1, 2013. Most of the SHOP sites operated by 17 states and the District of Columbia offered online enrollment.

The 18 state-based SHOP plans had enrolled just 76,000 people, as of June 1, 2014, with sign-ups ranging from 33,696 people in Vermont to one person in Mississippi. California had 9,563 enrollments. Data for enrollments in the 33 federally-operated exchanges was not available, but the report stated that Centers for Medicare & Medicaid Services (CMS) officials "said they do not have reason to expect major differences in enrollment trends" between the state exchanges and the federal ones. The Congressional Budget Office (CBO) had projected that nationwide SHOP enrollment would total 2 million during the first year.

Factors identified as possible reasons for the lower than expected enrollment numbers included:

- The tax credit for employers being "too small and administratively complex to motivate many small employers to enroll"
- The lack of online enrollment in many states and delays in other SHOP features
- Limited awareness of and misconceptions about SHOP availability
- Renewals of existing noncompliant plans
- Technical challenges and administrative burden

"Despite the various factors that may have restrained SHOP enrollment to date, many stakeholders noted that certain other factors suggest that the SHOPs have the potential to experience future enrollment growth," the report stated. "According to some stakeholders, central to enrollment growth will be the phasing out of noncompliant plans, the resolution of the technical challenges and reduction of the administrative burden cited as hampering current enrollment, and the demonstration of a 'value proposition' that gives employers a reason for preferring SHOP-based coverage to coverage available outside the SHOP."

Appeals Court to Hear Conflict Minerals Case

A federal court will hear an appeal of a ruling that struck down the Securities and Exchange Commission's (SEC) conflict minerals rule.

The 2010 Dodd-Frank Act directed the SEC to issue rules requiring certain companies to disclose their use of tantalum, tin, gold and tungsten that originated in the Democratic Republic of Congo (DRC) 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.

The SEC in August 2012 adopted a rule implementing the disclosure requirement. On April 14 of this year, a three-judge panel of the U.S. Court of Appeals for the District of Columbia Circuit, in a case originally brought by the Chamber of Commerce, the Business Roundtable and the National Association of Manufacturers, struck down part of the rule, concluding that requiring companies to identify their products as "DRC conflict free" or not would violate their free speech rights. The judges, who remanded the case to a lower court, upheld other parts of the rule, including filing requirements.

The full appeals court on November 18 issued an order stating that it would grant the SEC's request for an en banc hearing of the case by all of the court's judges.

The same court issued a ruling in a similar case this summer, and the judges, in their order, directed the parties in the conflict minerals case to submit briefs addressing how that ruling affects their arguments. On July 29, the D.C. Appeals Court, in an 8-3 en banc ruling that affirmed a March decision by a three-judge panel of the court, ruled that a regulation that requires labels on meat products to identify the country of origin and certain other information may be enforced. The American Meat Institute (AMI) and several other trade associations representing the meat industry had argued that the regulation, "by compelling speech in the form of costly and detailed labels on meat products that do not directly advance a government interest," violated their First Amendment rights. They sought an injunction preventing the rule from being implemented, but the court turned down the request.

While case law has established that the government can require commercial disclosures to prevent or correct deception, the court extended the principle in this case and decided that, "'government interests in addition to correcting deception' ... can be invoked to sustain a disclosure mandate."

Critics of the conflict minerals rule will likely note that the majority opinion in the meat labeling case put some emphasis on the rule requiring disclosure of "purely factual and uncontroversial information."

"We also do not understand country-of-origin labeling to be controversial in the sense that it communicates a message that is controversial for some reason other than dispute about simple factual accuracy," the opinion stated. "AMI does not suggest anything controversial about the message that its members are required to express."

The panel that struck down the conflict minerals rule in the spring stated that, "At all events, it is far from clear that the description at issue – whether a product is 'conflict free' – is factual and non-ideological."

Federal Reserve Issues Rule Limiting Financial Company Mergers

The Federal Reserve on November 5 issued a final rule further limiting mergers in the financial industry.

The rule, which implements a provision of the 2010 Dodd-Frank Act, generally prohibits financial companies from merging if their combined liabilities would exceed 10 percent of the aggregate liabilities of all financial firms. A rule is already in place prohibiting mergers of companies whose total deposits would exceed 10 percent of all firms' deposits.

The limits are aimed at preventing financial companies from becoming "too big to fail."

The rule provides an exemption that allows a financial company to continue to engage in securitization activities even if it has reached the limit. The exemption is a change from the rule as it was proposed in May.

The Fed explained that, "liabilities of a financial institution are generally defined as the difference between its risk-weighted assets, as adjusted to reflect exposures deducted from regulatory capital, and its total regulatory capital. Firms not subject to consolidated risk-based capital rules would measure liabilities using generally accepted accounting standards."

The rule, which will go into effect on January 1, 2015, will apply to insured depository institutions, bank holding companies, savings and loan holding companies, foreign banking organizations, companies that control insured depository institutions, and nonbank financial companies designated by the Financial Stability Oversight Council for additional supervision.

RELATED NATIONAL AND INDUSTRY NEWS

GAO Report Examines Pension Discount Rates

The Government Accountability Office (GAO) has released a report on pension plan discount rates, but the agency did not provide any recommendations on what rates are most appropriate.

One of the most contentious issues in pension funding – especially for public pensions, given the involvement of taxpayer dollars – is the projected rate of investment return, which has a large role in determining funding levels and required annual contributions. The GAO report surveyed the arguments for various discount rate levels, but it did not endorse any particular method. It did note, though, that it "found one significant area where there is some, but not universal, room for agreement. Specifically, many experts supported providing multiple measures of liabilities for different purposes to provide a more complete picture of pension plan finances."

"There may be value in providing multiple measures of liability and cost, using both assumed-return and bond-based discount rates – carefully labeled to describe their purpose (e.g., with some measures, such as funding targets, not even necessarily labeled 'liabilities') – and with explanations of what these measures do and do not represent," the report stated. "The measurements resulting from these different discount rate approaches can ultimately improve the understanding, management, and governance of the finances of pension plans. In short, there may be value in having multiple liability measures to arrive at funding, benefit, and investment policies that will better balance risks and rewards to plan participants and all other stakeholders."

Apart from that one area of semi-agreement – which was, as noted, by no means unanimous: "some advocates of each of the assumed-return and bond-based approaches did not see value in the other approach" – the report stated that "experts sharply disagree" on the proper way to calculate pension obligations. While the report examined both public and private plans, private pension funding is regulated by federal law, so much of the debate concerns public pensions. Many public funds use discount rates of 7 to 8 percent, arguing that this approximates long-term average returns. Some critics, though, argue that this is over-optimistic and encourages risky investments. They argue that a rate closer to the returns that could be expected from low-risk bonds – around 4 percent – should be used instead. The differences can be large. As the report noted, a $1,000 benefit payable in 15 years is a $315 liability today using an 8 percent discount rate, but a $555 liability today using 4 percent.

"Some experts said that the assumed-return approach could incentivize public plan sponsors to invest in riskier assets because doing so can increase the assumed-return discount rate, thereby lowering reported liabilities and reducing funding requirements," the report stated. "In addition, some experts said that some public plan sponsors have sometimes inverted the recommended practice of first determining plan asset allocation – based on an assessment of investment goals and the amount of risk that can be taken on – and then deriving a discount rate based on an assumed long-term average return for that mix of assets. Instead, these experts said that some plan sponsors have set a target discount rate and then asked the plan's investment team to develop an asset allocation to support it. Other experts stated that this practice does not occur."

Some proponents of using a lower discount rate also advocate the conversion of public pensions to defined contribution accounts similar to 401(k)s, though this issue is not directly addressed in the report. A lower discount rate would inflate projected liabilities and with it, possibly, government expenditures, which could make public pensions harder to sustain in their current form. The report stated that, “One expert noted that requiring public plans to report a bond-based measure could result in pressure to fund to this much higher measure, and two experts said requiring state and local governments to fund their plans using a bond-based measure could put pressure on them to change their pension plans from DB to DC.”

The report identified six “key considerations” in selecting a discount rate: level and predictability of cost; benefit security and risks to stakeholders; plan and sponsor characteristics; intergenerational equity; system sustainability; and transparency and comparability.

The report concluded by noting that, if policies are enacted concerning the use of discount rates in public pensions, “any such options should also be sensitive to the crucial need to ensure that benefits remain adequate to current and future retirees and their families.”

The report was completed at the request of Senate Health, Education, Labor and Pensions Committee Chairman Tom Harkin, D-Iowa, a leading congressional supporter of both public and private pension plans.

Shortfall in PBGC’s Multiemployer Program Spirals

The finances of the Pension Benefit Guaranty Corporation’s (PBGC) multiemployer pension program have “dramatically worsened,” the agency stated in its annual report.

The program, which provides benefits to participants in multiemployer pension plans that have become insolvent, has a $42.4 billion deficit, more than five times the shortfall that was reported in 2013. The deficit increase of more than $34 billion in the past year is primarily the result of new liabilities from additional pension plans that are expected to become insolvent soon. While the report states that PBGC “will be able to meet its obligations for a number of years,” the agency projects that there is a 50 percent chance that the program, itself, will become insolvent by 2022 and a 90 percent chance that it will by 2025.

In contrast, finances for the PBGC’s single-employer program, which provides benefits to plan participants when underfunded plans terminate, improved by more than $8 billion since last year, reducing the program’s funding deficit to $19.3 billion.

“The improving economy during the past year strengthened the funding status of many defined benefit plans,” Secretary of Labor Thomas Perez stated in the report’s introductory letter. “Fewer underfunded single-employer plans terminated and changes in premiums improved the financial position of the single-employer program.”

Perez also stated, regarding multiemployer plans, that the pension funds cannot avoid insolvency on their own, and "Congress and stakeholders need to work together to provide solutions and additional tools."

Sens. Ron Wyden, D-Ore., and Orrin Hatch, R-Utah, the chairman and ranking member, respectively, of the Senate Finance Committee, issued a joint statement after the report was released, saying that they are "very concerned with the further deterioration of the multiemployer pension program."

"We're committed to addressing the problems with the multiemployer system," Wyden and Hatch stated. "We owe it to American workers to do everything feasible to ensure that retirees receive the promised pension benefits they worked hard to achieve."

Report Criticizes Public Pensions' Investment Return Projections

Public pension funds are using investment return projections that are too high, a report from a conservative think tank has concluded.

The report from the Pioneer Institute, which is based in Massachusetts and focuses much of its analysis on plans in that state, states that the processes used by public pensions to project return rates – and, subsequently, discount rates – "are lacking in robustness and objectivity; the existing standards and enforcement mechanisms are opaque and pliant."

Public pensions typically use investment return projections of 7.5 to 8 percent, but the report states that this is too high when compared to historical rates of return. It advocates "the adoption of clear and robust guidelines [that] will make it easy for bondholders and plan members alike to benchmark and compare the financial condition of pension plans." Specifically, it advocates "an objective methodology based on historical returns."

"Although a fund's discount-rate-setting process can never be insulated completely from undue influence by political interests or individual predilections, having a clear exclusively data-driven methodology makes those influences more readily observable because they are constrained to changing the asset allocation or formally modifying the discount-rate methodology itself," the report states.

The report endorses the use of a "market rate of return" (MRR) that is "based on clear-cut computational techniques and all available long-term historical data rather than assumption and opinion." It includes an MRR calculator.

The Pioneer Institute is one of many conservative organizations that has advocated for reductions in the discount rates used by public pensions. Notably, though, it does not suggest nearly as large a decrease as others. Recommendations by many public pension critics typically involve the use of a "risk-free" rate of return – as would be expected from, say, U.S. Treasury bonds – which would be around 3.5 to 4 percent. The report finds that the "typical asset allocation of a pension fund justifies an MRR of about 6.5 percent," and suggests that some "reasonable adjustments" in portfolios could push that number to as high as 7 percent.

Public pension funds have said that their discount rates have proven accurate over the long-term. The National Association of State Retirement Administrators (NASRA) released an issue brief in October that found that public funds have earned a median annual return on investments of 8.8 percent over the past 25 years, despite the financial crisis and market decline of the late-2000s, as well as the recessions of the early 1980s and early 1990s. The brief noted that, even over the past decade, a good chunk of which included a declining or shaky stock market, median annual returns have nearly met projections, at 7.3 percent.

The Government Accountability Office (GAO) released a report this month on pension plan discount rates, but the agency did not provide any recommendations on what rates are most appropriate.

Conservative Group Calculates Public Pension Shortfall of $4.7 Trillion

The combined unfunded liability for state pension plans is approaching $5 trillion, according to a report form a conservative think tank.

The "Promises Made, Promises Broken" report from State Budget Solutions calculates that more than 250 state-level public pension funds have a total shortfall of $4.7 trillion, $600 billion more than the group estimated in a report last year, putting the overall funding level for these pensions at just 36 percent. California, according to the report, has an unfunded liability of $754 billion and a funding ratio of 39 percent.

"This spells trouble for the millions of Baby Boomers who are quickly approaching retirement age and expect to collect the pensions promised to them by government officials," the organization stated. "Furthermore, state taxpayers who are not government employees will also feel the pinch, which could result in reduced government services, as larger and larger portions of the states' budgets must be allocated to cover the public pension shortfall."

The report's shortfall estimate is several times larger than projections made by the public pension community, and is well above even the estimates made by other conservative organizations and public pension critics. The difference comes from State Budget Solutions using a discount rate equal to a 15-year Treasury bond yield. (Technically it used the 2013 average of the 10 and 20-year bond yields.) With interest rates at historic lows, this discounted future liabilities by just 2.734 percent.

Public pensions typically use a discount rate that is based on the expected rate of investment return, usually 7.5 to 8 percent, but State Budget Solutions, like other critics of state and local funds, says that "discount rates based on the assumed rate of investment return are far too risky."

"Using fair market valuation does not allow state officials to simply hope for the best and shortchange the pension funds," the organization stated. "Because of the way that public pension plans currently discount liabilities, it distorts how much money is needed to fund the plans today to guarantee pension benefits in the future. Ultimately, this will result in broken promises to government employees."

The report's calculations also imply a different timeframe than the one used by public pensions. State and local funds, as a rule, amortize liabilities over 30 years, not 15. Using a 30-year Treasury bond yield – rather than the average of 10 and 20-year yields – likely would have increased the discount rate by 0.5 percent or more.

CALIFORNIA CONGRESSIONAL DELEGATION NEWS

Democratic Lawmakers Urge SEC to Enforce Whistleblower Protections

Eight Democratic members of Congress, including one from California, wrote to the head of the Securities and Exchange Commission on October 27 to "strongly encourage" the SEC to enforce corporate whistleblower regulations.

The 2010 Dodd-Frank Act included provisions that protect employees who alert authorities to misdeeds by their companies, and the lawmakers, led by House Financial Services Committee Ranking Democrat Maxine Waters of California, wrote that they are "concerned about reports that some corporate practices may deter whistleblowers from reporting violations of the securities laws." They referred, specifically, to media reports about certain corporate non-disclosure agreements.

"While there are legitimate reasons for companies to use confidentiality agreements to protect sensitive information, such agreements should be structured as narrowly as possible," they wrote. "Employees should also be clearly informed that these agreements in no way restrict their right to voluntarily report securities law violations to the Commission. The use of confidentiality agreements, attestations, and other employment arrangements that do not abide by these principles appears to be in direct contravention to the SEC Rule 21F-17 that nothing shall 'impede communications to the Commission about a possible securities law violation, including enforcing, or threatening to enforce, a confidentiality agreement.'"

Adding that they have also heard of companies using legal retaliation and on-the-job harassment against whistleblowers, they urged the Commission "to send a strong message to industry, including by bringing enforcement actions if necessary, that such acts will not be tolerated."