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The Obama administration's late push for enrollments in the health insurance exchanges paid off, as more than eight million people signed up for coverage, with nearly half of the enrollments occurring after March 1. The six-month open enrollment period ended much better than it began on October 1, when problems with the exchanges' online portal at www.healthcare.gov initially made it nearly impossible to sign up for coverage. Health and Human Services Secretary Kathleen Sebelius, meanwhile, announced in April that she is resigning. Sebelius was heavily criticized for the early failure of the exchanges, but the strong finish allows her to leave on a high note.

ISSUES AND EVENTS

Young Adults 28 Percent of Health Insurance Exchanges' 8 Million Enrollments: HHS

The Obama administration's late push for health care exchange enrollments not only increased the overall numbers, but also boosted the percentage of young adults signing up for coverage, according to the Department of Health and Human Services (HHS).

The 2010 Patient Protection and Affordable Care Act established state-level exchanges to provide marketplaces in which people who cannot get affordable group coverage can buy insurance. The federal government operates exchanges through www.healthcare.gov in 36 states that chose not to establish them, while 14 states and the District of Columbia run their own exchanges.

In a report on the exchanges' October 1, 2013-to-March 31, 2014 open enrollment period, HHS found that 8,019,763 people signed up for coverage. The total includes 910,495 enrollments that occurred April 1-19 by people who had qualifying life events that allowed them to sign up outside the normal open enrollment period and people who started – but did not complete – the enrollment process before the deadline.

California, which operates its own exchange, had the most enrollments, with 1,405,102. Florida was second at 983,775, and Texas was third at 733,757.

The healthcare.gov website got off to a rough start, with technical problems limiting enrollments to fewer than 365,000 through the first two months after the October 1 launch. Nearly half of all enrollments – 47 percent – occurred from March 1 on.

During the final month, the percentage of enrollees who were between the ages of 18 and 34 increased to 31 percent. This raised the percentage of young adults who signed up for coverage during the six-month enrollment period to 28 percent, up from 24 percent. Although this is still below the 40 percent target that had been mentioned by some as being the threshold at which the risk pool would be sustainable without significant premium hikes, officials expressed satisfaction with the results.

"We believe, based on the data we've seen and independent data, that premiums will be stable and that the risk pool is sufficiently large and varied to support that kind of pricing," HHS Office of Health Reform Director Mike Hash said, according to *The Hill*.

The totals reflect people who have signed up for a plan, but not all enrollees have paid their first premiums. The report noted that the Centers for Medicare and Medicaid Services (CMS) "does not yet have comprehensive and accurate data" about how many people have paid for coverage, but "some issuers have made public statements indicating that 80 percent to 90 percent of the people who have selected a Marketplace plan have made premium payments."

Republicans have regularly challenged the administration's enrollment numbers, and GOP members of the House Energy and Commerce Committee on April 30 released a report that concluded, based on their outreach to insurance providers that participate in the federally-operated exchanges, that "only 67 percent of individuals and families that had selected a health plan in the federally facilitated marketplace had paid their first month's premium and therefore completed the enrollment process." One fourth of paid enrollees are between the ages of 18 and 34, according to committee Republicans.

Democrats on the panel, however, released a memo on the same day that asserted that, since premiums for more than 3 million enrollees had not yet come due at the time Republicans collected the information, "The data underlying this [67 percent] claim is so flawed that it is essentially worthless."

"The Republican analysis is rubbish," Rep. Henry Waxman of California, the committee's ranking Democrat said. "It is inaccurate, irresponsible and out-of-date. It is another in a long line of Republican false allegations and scare tactics about the Affordable Care Act."

Short-Term SGR Fix Signed into Law

President Obama on April 1 signed into law another short-term fix to the Medicare 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. Frustration has grown with the annual need for legislation, though, and momentum for enacting a permanent solution grew in 2013. Before leaving Washington for Congress' winter recess in December, lawmakers approved a three-month SGR fix that blocked a 24 percent rate cut that was scheduled to go into effect the first of the year, giving them until March 31 to pass additional legislation.

Members of Congress were unable to agree on a way to pay for an SGR replacement, however, so they, instead, passed legislation (H.R. 4302) that increases payments by 0.5 percent through the end of 2014 then freezes them through April 1, 2015, and that makes funding adjustments to certain other Medicare and Medicaid programs. Obama signed the bill into law after the House passed it on a voice vote on March 27 and the Senate approved it by a 64-35 vote on March 31.

In addition to making the SGR fix, the legislation would also delay implementation of the ICD-10 diagnostic codes until October 1, 2015; delay until March 2015 enforcement of the "two midnight rule," under which hospital stays spanning at least two midnights qualify for Medicare Part A payments while those of shorter duration are treated as outpatient services; and repeal a provision of the 2010 Patient Protection and Affordable Care Act (ACA) that caps deductibles in small group health insurance plans.

The SGR fix, itself, would cost $15.8 billion, according to the Congressional Budget Office .

Some lawmakers expressed frustration at having to pass another short-term bill.

"There have now been 16 of these patches [before the current one] – 16, and every senator that I talk to says that that just defies common sense, and it seems bizarre even by Beltway standards," Senate Finance Committee Chairman Ron Wyden, D-Ore., who has proposed a bill to replace the SGR (S. 2110), said on the Senate floor before that chamber's vote.

Wyden tried to bring to a vote an SGR replacement bill that would use money saved from decreased spending on overseas military operations to cover the cost, but Sen. Jeff Sessions, R-Ala., objected. Sessions then tried to bring to a vote a bill using repeal of the ACA's individual mandate as a funding mechanism, but Wyden objected.

Plans to enact a permanent fix fell apart in mid-March when the House passed a bill (H.R. 4015) that contains a bipartisan reform model, but amended to postpone the implementation of the individual mandate for five years. That amendment all but eliminated the bipartisanship that had formed around the issue, with just 12 Democrats

supporting the bill in the 238-181 vote. Senate Majority Leader Harry Reid, D-Nev., said that the amended bill had "no credibility," and Obama promised to veto it if it reached his desk.

The American Medical Association (AMA) released a statement after the Senate vote that expressed disappointment regarding the short-term fix.

"This bill perpetuates an environment of uncertainty for physicians, making it harder for them to implement new innovative systems to better coordinate care and improve quality of care for patients," AMA President Ardis Dee Hoven said. "Remarkable progress was made this past year in reaching a bipartisan, bicameral agreement on policy to repeal the SGR, and the AMA encourages Congress to continue its work and resolve outstanding issues. On behalf of Medicare patients and physicians across the country, it is critical that we achieve permanent Medicare physician payment reform."

Sebelius Resigns as HHS Secretary

Health and Human Services (HHS) Secretary Kathleen Sebelius announced on April 10 that she is resigning.

Sebelius, who took office in April 2009, oversaw the implementation of the 2010 Patient Protection and Affordable Care Act (ACA). She was heavily criticized last year following the dismal October launch of www.heathcare.gov, the website through which people enroll in the health insurance exchanges created by the ACA. Though website repairs have since made the site workable, and exchange enrollments have exceeded projections, several Republican lawmakers had, in the past six months, called for Sebelius to resign or be fired.

On April 11, Obama praised Sebelius's performance, saying she "will go down in history for serving as the secretary of health and human services when the United States of America finally declared that quality, affordable health care is not a privilege, but it is a right for every single citizen of these United States of America."

"Kathleen has been here through the long fight to pass the Affordable Care Act," Obama said. "She helped guide its implementation, even when it got rough. ... Under Kathleen's leadership, her team at HHS turned the corner, got it fixed, got the job done, and the final score speaks for itself. There are 7.5 million people across the country that have the security of health insurance, most of them for the very first time. And that's because of the woman standing next to me here today."

Also on April 11, Obama announced that he was nominating Office of Management and Budget Director Sylvia Mathews Burwell to be the new HHS secretary.

GOP Questions Trial Lawyers' Involvement in Development of Generic Drug Labeling Rule

Congressional Republicans wrote to the Food and Drug Administration (FDA) in April to ask about the role of trial lawyers in the development of a proposed rule on the labeling of generic drugs.

The FDA in November proposed allowing generic drug manufacturers "to change the product labeling to reflect certain types of newly acquired information in advance of FDA's review of the change." Currently, generic companies cannot change a label until the brand name company updates the safety information on its product. Brand name companies are allowed to use a process similar to what is being proposed for generics and update labels while the change is under review.

The proposed rule is a response to the 2011 Supreme Court decision in Pilva v. Mensing, which shields generic manufacturers from state "failure-to-warn" lawsuits related to adverse reactions to drugs as long as the companies have complied with the FDA's labeling requirements. The proposed rule states that this ruling "alters the incentives for generic drug manufacturers to comply with current requirements to conduct robust postmarketing surveillance, evaluation, and reporting, and to ensure that the labeling for their drugs is accurate and up-to-date."

Many Democrats support the proposal, arguing that it would enhance the safety of drugs that are no longer on patent, since generic manufacturers tend to have the bulk of the market share for such medicines, giving them "the best knowledge of adverse events." Many Republicans, though, oppose the measure, charging that it "would conflict directly with the [Hatch-Waxman Act], thwart the law's purposes and objectives, and impose significant costs on the drug industry and healthcare consumers."

On April 22, House Energy and Commerce Committee Chairman Fred Upton, R-Mich., and 18 GOP colleagues on the committee wrote in a letter to FDA Commissioner Margaret Hamburg that the panel "has significant questions about FDA's primary motivation for initiating this rulemaking, the agency's legal basis for proceeding in this manner and the consequences such an approach would have on providers and patients."

The letter noted that "the only outside interest group agency officials apparently met with while developing the proposal was the American Association for Justice (AAJ), otherwise known as the Association of Trial Lawyers of America."

"Based on FDA's stated rationale for proposing this rule, and considering the agency's past concerns about the impact tort litigation has had on effectively communicating

appropriate warning information to physicians, it is not at all clear why plaintiffs lawyers would have any role in the development and review of the proposed rule," the letter stated.

The lawmakers requested that Hamburg provide the committee with all documents and communications records related to a February 15 meeting between the FDA and the AAJ.

CBO Lowers 10-Year Price Tag for Health Care Reform Law by $104 Billion

The health care reform law is expected to cost $104 billion less over the next decade than had previously been projected, according to a report from the Congressional Budget Office (CBO).
CBO forecasts that the net cost of the coverage provisions of the 2010 Patient Protection and Affordable Care Act will total $1.383 trillion through 2024. This is $104 billion less than the estimate in a February CBO report. The agency attributed the reduction to several factors, most notably, lower-than-expected premiums in the exchanges, which reduces the amount of subsidies that the federal government will provide to exchange consumers.

"The plans being offered through the exchanges this year appear to have, in general, lower payment rates for providers, narrower networks of providers, and tighter management of their subscribers' use of health care than employment-based plans do," the report states. "CBO and [the Joint Committee on Taxation] anticipate that, as enrollment in the exchanges rises, the differences between employment-based plans and exchange plans will narrow. Therefore, projected premiums during the next few years were revised downward more than were premiums for the later years of the coming decade."

CBO expects that the cost of subsides during the next 10 years will be $165 billion lower than previously projected, but it also reduced by $61 billion the amount that is expected to be collected from the law's revenue measures, including penalties related to non-compliance with the individual mandate and the employer mandate.

CBO projects that the number of uninsured non-elderly people will drop from 42 million today to 26 million in 2024. Without the reform law, according to the agency, the uninsured population in 2024 would total 57 million.

Medicare Advantage Payment Rates to Increase 0.4 Percent

Contrary to earlier indications, payment rates to Medicare Advantage plans will increase in fiscal year 2015, though, in the end, plans may still receive less money.

Medicare Advantage offers managed care plans through private companies, which receive a fixed amount of money from the federal government per beneficiary each month. As of 2013, 14.4 million people were in Medicare Advantage plans, representing about 28 percent of all Medicare beneficiaries.

A preliminary rate announcement released by the Centers for Medicare and Medicaid Services (CMS) in February proposed a spending reduction of 1.9 percent in Medicare Advantage for the fiscal year that begins October 1.

The final rate announcement, which was released on April 7, though, forecasts an increase in payments of 0.4 percent. The actual amount will vary by provider, locality and other factors.

Payments fell by 4-6 percent in 2014.

Many members of Congress, particularly Republicans, had advocated strongly against the proposed spending cut. CMS officials, however, attributed the revised numbers not to lobbying by lawmakers and the insurance industry, but, rather, to a dramatic decrease in per capita Medicare costs and an adjustment to the program's risk calculation methodology that reflects a healthier beneficiary pool.

The insurance industry expressed only limited satisfaction with the announcement. America's Health Insurance Plans (AHIP) President Karen Ignani said that the newly announced rates would "help mitigate the impact on seniors," but that, given other factors, such as local conditions, a plan's quality rating and the new tax on health insurance policies, "the Medicare Advantage program is still facing a reduction in payment rates."

AHIP released a report from Oliver Wyman in late February that concluded that the planned reduction of 1.9 percent would result in an actual average payment cut of 5.9 percent.

CMS officials had said before the final announcement that the planned spending reductions corrected for several years of overpayments in Medicare Advantage and that "efforts to reduce overpayments for medical services have corresponded with falling premiums for consumers."

CMS Releases Data on Payments to Doctors

The Centers for Medicare and Medicaid Services (CMS) in April made public for the first time data on Medicare payments to individual doctors and other health care providers.

The released data includes information about 880,000 providers who were paid a total of $77 billion under Medicare Part B in 2012.

"Data transparency is a key aspect of transformation of the health care delivery system," CMS Administrator Marilyn Tavenner said. "While there's more work ahead, this data release will help beneficiaries and consumers better understand how care is delivered through the Medicare program."

A court injunction had prevented the release of payment data since 1979, but that injunction was lifted by a federal judge in June of last year after it was challenged by Dow Jones & Company, the publisher of *The Wall Street Journal*, *Barron's* and other publications. The Department of Health and Human Services supported the challenge.

The American Medical Association (AMA) has expressed concerns about the release of the data, with the group's president, Ardis Dee Hoven, saying, "the broad data dump today by CMS has significant shortcomings regarding the accuracy and value of the medical services rendered by physicians."

"Releasing the data without context will likely lead to inaccuracies, misinterpretations, false conclusions and other unintended consequences," Hoven said. "Thoughtful observers concluded long ago that payments or costs were not the only metric to evaluate medical care. Quality, value and outcomes are critical yardsticks for patients. The information released by CMS will not allow patients or payers to draw meaningful conclusions about the value or quality of care."

On April 8, the AMA released a nine-point "guide to media reporting" on the data.

The Associated Press reported that, based on its analysis of the data, just 2 percent of all providers accounted for one-fourth of Part B payments in 2012, and that 344 doctors received more than $3 million in Medicare payments apiece that year. Of those 344, 87 practiced in Florida, the most of any state, and 38 in California, the second-most.

One Florida ophthalmologist received $20.8 million from Medicare in 2012, making him the program's biggest recipient. Ophthalmologists accounted for 141 of the 344 providers who received $3 million or more.

Treasury Office of State and Local Finance Will Oversee Public Pensions

The U.S. Treasury Department is creating an office that will coordinate the agency's oversight of public pensions, municipal bonds and other state and local fiscal issues.

The Office of State and Local Finance will "serve as Treasury's liaison to state and municipal officials and associations, monitor developments in municipal bond markets, support policies to improve the management of public pensions and other liabilities, and develop potential federal policy responses to issues that emerge in municipal financing markets," a department spokesman said.

Starting in mid-May, the office is to be directed by Kent Hiteshew, who is now a managing director at J.P. Morgan Chase.

Court Strikes Down Part of SEC's 'Conflict Minerals' Rule

A federal court in April struck down part of the Securities and Exchange Commission's (SEC) "conflict minerals" rule.

The 2010 Dodd-Frank Act directed that the SEC 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, the U.S. Court of Appeals for the District of Columbia, in a case originally brought by the U.S. 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 First Amendment rights to free speech.

"At all events, it is far from clear that the description at issue – whether a product is 'conflict free' – is factual and nonideological," the majority opinion stated. "Products and minerals do not fight conflicts. The label 'conflict free' is a metaphor that conveys moral responsibility for the Congo war. It requires an issuer to tell consumers that its products are ethically tainted, even if they only indirectly finance armed groups. ... By compelling an issuer to confess blood on its hands, the statute interferes with that exercise of the freedom of speech under the First Amendment."

The parts of the rule that were upheld by the court include a requirement that companies determine – but not publicly disclose – whether their products contain any of the minerals in question. The court rejected charges that the SEC failed to conduct an adequate cost-benefit analysis, stating that the benefits, if any, would "occur half-a-world away in the midst of an opaque conflict about which little reliable information exists, and concern a subject about which the [SEC] has no particular expertise. Even if one could estimate how many lives are saved or rapes prevented as a direct result of the final rule, doing so would be pointless because the costs of the rule – measured in dollars – would create an apples-to-bricks comparison."

One member of the court's three-judge panel did not sign on to the opinion, stating that the judges should have waited until the D.C. Court of Appeals issued an en banc ruling in a case involving similar free speech issues.

The business groups that challenged the regulation said in a joint statement that they were pleased with the ruling, adding that they "understand the seriousness of the humanitarian situation in the Democratic Republic of Congo and abhor the violence in that country, but this rule was not the appropriate way to address this problem."

The SEC stated that it is reviewing the ruling.

The court remanded the case to a lower court. The regulations are scheduled to go into effect on June 2.

On April 21, six Democratic senators, including Barbara Boxer of California, and six Democratic representatives, including Maxine Waters of California, wrote to SEC Chairman Mary Jo White to urge that the commission "move forward as promulgated" with the reporting requirements of the conflict minerals rule, stating, "With strong court decisions affirming the key components of the rule, no delay is warranted in the implementation of those requirements while any remaining free speech issues are resolved."

Coalition Seeks Reissue of SEC's Disclosure Rule for Energy Companies

A coalition representing individuals and groups in 40 countries is urging the Securities and Exchange Commission (SEC) to reissue a rule that requires energy companies to disclose payments to foreign governments.

A provision of the 2010 Dodd-Frank Act directed the implementation of the rule in order to increase the transparency of money flowing to regimes that may be more likely to pocket it than use it for the good of their nations.

The SEC approved a rule in August 2012 that would have implemented the disclosure requirement, but in July 2013, a federal judge struck the rule down in a case brought by the American Petroleum Institute (API), the U.S. Chamber of Commerce, the National Foreign Trade Council and the Independent Petroleum Association of America. The commission's analysis of the rule's potential impact, the judge concluded, "was arbitrary and capricious and independently invalidates the Rule." The SEC is working on a new version of the regulation.

The London-based Publish What You Pay coalition, which describes itself as "a global network of civil society organizations united in their call for an open and accountable extractive sector," wrote to SEC Chairman Mary Jo White on April 14 to ask that the commission reissue the rule to help "reduce natural resource related corruption and conflict, and help ensure these resources are transformed into lasting public benefits."

"The Court's ruling does not preclude the SEC from requiring full public disclosure of project-level payments or denying exemptions, and we believe the SEC has the discretion to retain these critical provisions in the final rule, as long as sufficient justification is given," they wrote. "Project-level reporting will bring great benefits to citizens' groups in resource-dependent countries. Some of the signatories to this letter work in areas where numerous extractive companies are active, and in order to ensure that each company is

meeting its fiscal obligations to the host government and community, we need to know the identity of [the] individual company making the payment."

The letter advised that the SEC's rule should:

- Ensure full public disclosure of payments, including the identity of reporting companies.
- Require contract-based project-level reporting.
- Include no country exemption.
- Set a reporting threshold of $100,000.

The letter's 530 signers all hail from developing countries "rich in natural resources, but blighted by corruption, conflict and poverty. We see on a daily basis the destructive effects that poor governance of natural resources has on our communities."

In 2012, the U.S. and Mexico signed the Transboundary Hydrocarbons Agreement, which concerns oil and gas exploration in the Gulf of Mexico. The House passed a bill in June 2013 that would implement the pact and would also exempt energy companies from the disclosure law. The Senate passed a version of the legislation in October without the exemption. Lawmakers are now seeking a compromise bill.

Reps. Maxine Waters of California, Peter DeFazio of Oregon and Eliot Engel of New York – the ranking Democrats on the House Financial Services Committee, the House Natural Resources Committee and the House Foreign Affairs Committee, respectively – wrote to Senate Majority Leader Harry Reid, D-Nev., on November 18 to urge him to reject House Republican efforts to include the exemption in the compromise bill.

The oil industry supports implementation of the agreement – which, among other things, would open up 1.5 million acres for development and clarify certain legal uncertainties – so much so that it is backing off its advocacy of the exemption. A spokesman for API, one of the plaintiffs in the court case that challenged the SEC's 2012 rule, said, "We are urging the transboundary agreement to get passed by both sides. I think the cleanest way you would see that occur is through a bill that doesn't have the ... [exemption] attached to it."

CalPERS, in February 2011, wrote to the SEC to support the rule, which was then under consideration by the agency, stating that it "is especially vital for companies operating in countries where governance is weak resulting in corruption, bribery and conflict that could negatively impact the sustainability of a company's operations and our ability to more effectively make investment decisions."

House GOP Budget Plan Would Cut Spending, Target SEC

The spending outline proposed on April 1 by the chairman of the House Budget Committee would reduce federal expenditures by $5.1 trillion over the next decade, relative to current projections, and make significant changes to entitlement programs.

The "Path to Prosperity" plan from Rep. Paul Ryan, R-Wisc., the 2012 GOP vice presidential nominee, aims to balance the budget within 10 years and, to do so, it "targets wasteful Washington spending and reforms the drivers of the debt." The plan would, among other things:

- Repeal the 2010 Patient Protection and Affordable Care Act.
- Starting in 2024, allow seniors who are newly eligible for Medicare to choose a private plan – and receive a "premium support" payment – rather than the traditional program.
- Replace Medicare's sustainable growth rate formula with a "reimbursement system that fairly compensates physicians who treat Medicare beneficiaries while providing incentives to improve quality and efficiency".
- Convert federal Medicaid spending into block grants that states could spend as they saw fit.
- Build on the Social Security recommendations of the National Commission on Fiscal Responsibility and Reform and require the president and Congress to present proposals to address the program's financial challenges; the plan stresses, "To be clear, nothing in this budget calls for the privatization of Social Security".
- Fund the Consumer Financial Protection Bureau through congressional appropriations, rather than through the Federal Reserve, as is now the case.

- Reduce the number of tax brackets from seven to two, and lower the top tax rate from 39.6 percent to 25 percent.

The document also takes aim at the Securities and Exchange Commission (SEC) in a section titled, "Tighten the Belts of Government Agencies," citing a House Financial Services Committee report that asserted, "In the run-up to the financial crisis and its aftermath, the SEC repeatedly failed to fulfill any part of its mission."

"This resolution questions the premise that more funding for the SEC means better, smarter regulation," the Ryan document states. "Adding reams of regulations to the books and scores of regulators to the payrolls will not provide greater transparency, consumer protection, and enforcement for increasingly complex markets. Instead, the SEC should streamline and make more efficient its operations and resources; defray taxpayer expenses by designating self-regulatory organizations (subject to SEC oversight) to perform needed examinations of investment advisors; and enhance collaboration with other agencies, such as the Commodity Futures Trading Commission, to reduce duplication, waste, and overlap in supervision."

This has drawn some criticism, with the website thecorporatecounsel.net, for example, asserting that, "Blaming the SEC for the financial crisis seems like revisionist history. Blaming cops for crimes committed by others."

"If the SEC couldn't handle supervising Wall Street, etc. before the financial crisis with the resources it had, how will it handle them better going forward with far fewer," the website asked. "At what point does the SEC get slashed so much that it will be completely ineffectual – with the result that there will be no more trust in the market?"

While Ryan's budget plan will most likely be passed by the Republican-controlled House, it has, basically, no chance of being approved by the Senate, where Democrats have the majority.

CII Seeks Rule Requiring Additional Disclosures about Director Nominees

The Council of Institutional Investors (CII) is urging the Securities and Exchange Commission (SEC) to explore requiring disclosure of compensation arrangements between director nominees and the shareholders who nominate them.

Current rules, CII General Counsel Jeff Mahoney stated in a March 31 letter to the SEC, "do not address compensation to be paid to a board nominee by a nominating shareholder if the nominee is elected to a company's board."

"Going forward, we believe that there will be an increasing need for the SEC to act to ensure that investors are provided with information that will enable them to make informed voting decisions," Mahoney wrote. "We encourage the SEC to explore the issuance of interpretive guidance or amendments to the proxy rules that require additional disclosure about these kinds of arrangements. ... Interpretive guidance or amendments to the proxy rules that require the disclosures outlined above will enhance shareholder protection and strengthen the shareowner franchise."

Treasury, IRS Release Guidance to Simplify Rollovers

The Treasury Department and the Internal Revenue Service (IRS) on April 3 released guidance aimed at simplifying retirement plan savings rollovers when changing jobs.

The guidance is intended to make it easier for a receiving plan to confirm the sending plan's tax-qualified status.

"The plan administrator for the receiving plan can now simply check a recent annual report filing for the sending plan on a database that is readily available to the public online," the Treasury Department stated. "This eliminates the need for the two plans to communicate (with the individual as go-between), expedites the rollover process, and reduces associated paperwork."

RELATED NATIONAL AND INDUSTRY NEWS

Public Fund Returns Exceeded Projections During Past 25 Years: NASRA

Public pension funds have achieved a median annual investment return of nine percent during the past quarter-century, according to an issue brief released by the National Association of State Retirement Administrators (NASRA).

The returns during that timeframe exceeded the average projected annual return of 7.72 percent, NASRA noted.

"Over the last 25 years, a period that has included three economic recessions and four years when median public pension fund investment returns were negative, public pension funds have exceeded their assumed rates of investment return," the brief states. "Changes in economic and financial conditions are causing many public plans to reconsider their investment return assumption. Such a consideration must include a range of financial and economic factors while remaining consistent with the long timeframe under which plans operate."

Many critics of public pension plans argue that funds are over-optimistic in their return projections and over-aggressive in their investment strategy. They advocate using much lower return projections that would approximate what could be expected from risk-free investments such as U.S. Treasury bonds.

Since 1982, according to NASRA, investment returns have accounted for 61 percent of public pension revenues, employer contributions for 26 percent and employee contributions for 13 percent.

The NASRA brief noted the importance of using an accurate return projection.

"An investment return assumption that is set too low will overstate liabilities and costs, causing current taxpayers to be overcharged and future taxpayers to be undercharged," the brief states. "A rate set too high will understate liabilities, undercharging current taxpayers, at the expense of future taxpayers. An assumption that is significantly wrong in either direction will cause a misallocation of resources and unfairly distribute costs among generations of taxpayers."

More than half of the 126 funds included in NASRA's Public Fund Survey have reduced their return projections since fiscal year 2008, according to the brief.

Judicial Seminar on Public Pension Reform Funded by Corporations, Conservative Groups: CPI

Corporations and conservative groups funded a seminar for judges on public pension reform, the Center for Public Integrity (CPI) reported.

The George Mason University School of Law's Law and Economics Center held a "Judicial Symposium on the Economics and Law of Public Pension Reform" in Charleston, S.C., April 27-29. The event was held to "discuss the looming financial and structural crisis facing state pensions systems across the nation. ... This symposium will comprehensively outline the underlying structure of pension systems, address the differences between public and private pensions, and detail the unfunded liabilities and potential bankruptcy issues arising from this crisis. It will also discuss the legal challenges to reform efforts under state constitutions citing both the contacts clause and the takings clause."

CPI noted that the conference "funders" include dozens of corporations that "could benefit from efforts to slash benefits for public employees. Alternative approaches to shore up state budgets would likely require higher corporate taxes, fewer corporate subsidies and reduced government services, all of which would be bad for business." Other financial supporters include the U.S. Chamber of Commerce and other business associations, as well as conservative foundations, such as the Charles G. Koch Charitable Foundation.

"It's unclear which judges – and how many of them – will be attending the conference, although George Mason's judicial seminars are traditionally open to both state and federal judges," the CPI report stated. "George Mason does not publicly list conference attendees, and federal judges who attend privately funded educational seminars aren't required to publicly disclose which conference they attended until 30 days after it ends. ... What is clear from the conference's agenda is that attending judges will spend most of their time ... listening to lectures and panel discussions led mainly by advocates of public pension reform."

85 Percent of Public Pensions Face Bankruptcy within 30 Years: Investment Firm

An investment firm is forecasting that more than four out of every five public pensions could go bankrupt within 30 years.

State and local pension funds have a $7 trillion shortfall over the very long term, according to Bridgewater Associates, with just $3 trillion in expected revenues available to cover promised payments of $10 trillion. To cover these obligations, the firm projects that funds would need to earn a nine percent annual return on their investments. However, it expects them to earn just four percent, which would translate to 85 percent of them going bankrupt within the next three decades.

Even returns of 7-8 percent, figures that are commonly used by public pensions in their projections, would leave funds with a 20 percent shortfall, according to the firm.

Bridgewater, one of the world's biggest hedge fund firms, reached its conclusions by using models to "stress test" the performance of public funds in a variety of market conditions.

CALIFORNIA CONGRESSIONAL DELEGATION NEWS

California Lawmaker Requests Climate Change Hearing

A California lawmaker is once again pushing for a congressional hearing on climate change issues.

House Energy and Commerce Committee Ranking Democrat Henry Waxman of California and the ranking Democrat on the panel's Energy and Power Subcommittee, Rep. Bobby Rush of Illinois, wrote to the committee's GOP leadership on May 1 to ask that hearings be held "with the world's leading climate scientists about the findings of [recent Intergovernmental Panel on Climate Change (IPCC)] reports."

"The IPCC's mitigation report demonstrates that we must act now if we are to avoid the worst impacts of climate change," Waxman and Rush wrote. "If serious action to reduce carbon emissions is not taken soon, the world is on a path to dramatically overshoot the atmospheric concentration of 450 parts per million of carbon dioxide required to limit global warming to two degrees Celsius. ... As the Committee responsible for the nation's energy policy, we should hear directly from the IPCC about the risks posed by climate change and the opportunities to mitigate those risks in a cost-effective manner."

The Energy and Power Subcommittee held a hearing on September 18 to examine the Climate Action Plan that President Obama unveiled in June. Before that, Waxman and Rush had submitted written requests for a hearing on climate change issues 26 times in a little more than two years, but no hearings were held.