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IRS Allows Health Care Premium Exclusion for Retired Public Safety Officers in Self-Insured Plans

On December 3, 2007, the IRS issued Notice 2007-99, relating to the \$3,000 exclusion from gross income of qualified health care premiums paid from a governmental plan for an eligible retired public safety officer. The Notice clarifies that an accident or health insurance plan receiving the payments includes a self-insured plan.

In 2006, Pension Protection Act (PPA) § 845 added Internal Revenue Code (IRC) § 402(l) allowing "eligible retired public safety officers" to elect to exclude from gross income certain distributions made from an "eligible government plan" to pay "qualified health insurance premiums." Eligible government plans include governmental defined benefit and defined contribution plans described in IRC § 401(a), tax-sheltered accounts or annuities under IRC §§ 403(a) and 403(b), and governmental deferred compensation plans under IRC § 457(b). Qualified health insurance premiums include premiums for accident and health insurance or long-term care insurance contracts for the eligible retired public safety officer, his or her spouse, and dependents. The exclusion is limited to the aggregate amount of actual annual premiums paid, up to \$3,000. To be eligible, the premiums must be paid directly by the retirement plan to the insurance provider. The provision applies to distributions in taxable years beginning after December 31, 2006.

On January 10, 2007, the IRS issued Notice 2007-7 providing implementation guidance on several provisions of the Pension Protection Act. In discussing § 845, Notice 2007-7 explained that the provision did not apply to self-insured health plans, but only to plans "providing insurance issued by an insurance company regulated by a State (including a managed care organization that is treated as issuing insurance.)" In August, both the House and Senate introduced technical corrections bills including provisions to amend PPA § 845 to apply to self-insured plans. In Notice 2007-99, the IRS modifies its earlier position and states that self-insured plans are included among the accident or health insurance plans eligible to receive the qualified premium payments.

Notice 2007-99 is available at: http://www.ncpers.org/News/PageText/documents/IRS_Notice_2007_99.pdf

GASB Issues Statement Requiring Endowments to Report Real Estate Investments at Fair Value

On November 21, 2007, the Governmental Accounting Standards Board (GASB) issued Statement No. 52, *Land and Other Real Estate Held as Investments by Endowments*. The statement requires endowments of state

and local governments to report land and other real estate investments at fair value. According to the GASB, the change will help provide more useful information about the composition, current value, and changes in value of endowment assets. Previously, these investments were reported at historical cost, which only provides information on investment results in the year the investments are sold.

The change is also intended to improve the consistency of reporting across governments. Entities that perform investment functions similar to endowments (including pension plans, other postemployment benefit (OPEB) plans, external investment pools, and § 457 deferred compensation plans) are already required to report land and real estate investments at fair value. Statement No. 52 also requires governments to report the changes in fair value of land and real estate investments as investment income, as well as disclose the methods and assumptions used to determine fair value. GASB Statement No. 52 applies to financial statements for periods beginning after June 15, 2008; however, earlier implementation is encouraged.

Further information is available at: <http://www.gasb.org>

IRS Issues Final Regulations on Payments Made Under Salary Reduction Agreements

On November 14, 2007, the IRS issued final regulations (T.D. 9367) providing guidance on salary reduction agreements for public schools and other organizations that purchase § 403(b) annuity contracts for employees. The final rules adopt the temporary and proposed rules issued in 2004 (T.D. 9159), defining the term “salary reduction agreement” for certain Federal Insurance Contributions Act (FICA) tax purposes.

To pay benefits under Social Security, FICA taxes are levied on employers and employees based on a percentage of employee wages. Internal Revenue Code (IRC) § 3121(a) defines “wages” for FICA purposes as “all remuneration for employment,” unless specifically excluded by law. Under IRC § 3121(a)(5)(D), payments made to a 403(b) annuity contract are excluded from wages, except for payments made “by reason of a salary reduction agreement” (whether written or otherwise). Consequently, payments made under a salary reduction agreement to purchase a 403(b) annuity are included in wages subject to FICA tax.

The newly issued final regulations adopt the temporary and proposed regulations without change. Under the final regulations, a salary reduction agreement includes “a plan or arrangement ... whereby payment will be made by an employer, on behalf of an employee or his or her beneficiary, under or to an annuity contract described in section 403(b)” if:

- The employee elects to reduce his or her compensation pursuant to a cash or deferred election (defined in Treasury Regulations § 1.401(k)-1(a)(3)) allowing the employee to change the election;
- The employee elects to reduce his or her compensation pursuant to a one-time irrevocable election made at or before the time of initial eligibility to participate in such plan; or
- The employee agrees as a condition of employment to make a contribution that reduces his or her compensation.

In commenting on the 2004 proposed regulations, several commentators argued that the term “salary reduction agreement” was only intended by Congress to apply to voluntary agreements and not to those required as a condition of employment. However, in the final regulations, the IRS held that the critical distinction is whether the contributions to provide the benefit are paid from employer funds or from employee funds through a salary reduction. Moreover, citing *Public Employees’ Retirement Board v. Shalala* (153 F.3d 1160, 10th Cir. 1998), the IRS held that the distinction between voluntary and mandatory salary reduction is irrelevant, i.e., an “employee’s decision to work ... constitutes conduct manifesting assent to the salary reduction.”

The term “salary reduction agreement” is also used in IRC § 3121(v)(1)(B), relating to governmental “pick ups.” Under IRC § 414(h)(2), governmental employers are permitted to “pick up” mandatory employee contributions to qualified retirement plans established by state and local governments. As a result, the picked-

up employee contributions are treated as employer contributions and are not subject to federal income tax when contributed (although they are subject to income tax when later distributed). However, under § 3121(v)(1)(B), employer pick-ups are considered wages for FICA tax purposes if the employer picks up the contribution pursuant to a salary reduction agreement (whether written or otherwise). The final regulations state that the Treasury Department and IRS believe it is appropriate to consistently interpret the definition of salary reduction agreement for both §§ 3121(a)(5)(D) and 3121(v)(1)(B) purposes.

For an example of a 414(h)(2) employer pick up that is not treated as a salary reduction agreement, readers are referred to IRS Office of Chief Counsel Advice 200714018. In this case, the governmental employer (1) paid the picked up employee contributions from its own funds without withholding funds from employees' salaries and (2) continued to increase employees' salaries in amounts consistent with historical salary increases. Consequently, the Chief Counsel found that the employer contributions in question were not paid pursuant to a salary reduction under § 3121(v)(1)(B) and, therefore, were not wages for FICA tax purposes. The Chief Counsel Advice is available at: <http://www.irs.gov/pub/irs-wd/0714018.pdf>

The final regulations apply to contributions made to an annuity contract under 403(b) plan, and are effective on or after November 15, 2007. They are accessible at: <http://benefitslink.com/taxregs/07-5730.pdf>

IRS Issues Model 403(b) Plan Language for Public School Employers

On November 27, 2007, the IRS issued Revenue Procedure 2007-71 providing model 403(b) plan language that public schools (and other 403(b) plan sponsors) may use to either adopt or amend a written plan to reflect IRC § 403(b) and recent final regulations. The revenue procedure also explains the rules regarding when the adoption of written plan documents and amendments is required.

In July 2007, the IRS issued comprehensive final regulations for 403(b) plans (T.D. 9340), including those offered by non-profit, governmental, and church organizations. The final regulations replaced regulations issued in 1964 and made numerous changes regarding: written plan documents, universal availability, nondiscrimination testing, limitations on contributions, catch-up contributions, plan-to-plan transfers, and plan terminations. Generally, the final regulations apply to tax years beginning after December 31, 2008. However, certain plans are subject to delayed effective dates and explicit transition rules.

The final regulations include a requirement that 403(b) contracts must be maintained pursuant to a written plan. Recognizing this requirement could impose significant costs for employers currently without written plans (such as public schools), Rev. Proc. 2007-71 provides model language to help alleviate the costs of complying with the written plan requirement.

As provided in Rev. Proc. 2007-71, if a public school employer “adopts the model language on a word-for-word basis or adopts an amendment that is substantially similar in all material respects,” it can rely on the model language as meeting the 403(b) requirements as if it had received a favorable private letter ruling from the IRS. However, if a public school employer does not adopt the model language or substantially similar language, and subsequently seeks a private letter ruling, the employer will be required to clearly highlight and describe how the plan provisions differ from the model language.

Additionally, a tax-exempt entity, other than a public school, that is eligible to sponsor 403(b) arrangements may also use the model plan language to assist in compliance with the final 403(b) regulations. However, since the model language was primarily designed for public schools, the IRS warns that a non-public school employer must determine the extent to which the model language is appropriate for use in connection with its 403(b) plan. The IRS also warns that non-public school employers may not rely on adoption of the model plan language as if it were a favorable private letter ruling. However, if the employer had received a favorable private letter ruling prior to the 2007 regulations, adoption of the model language would not jeopardize its reliance on the private letter ruling for periods prior to the effective date of the 2007 regulations.

Rev. Proc. 2007-71 also explains that the 403(b) plan will be treated as having been amended in a timely manner if the amendment satisfies the new regulations and (i) is adopted no later than the first day of the first taxable year beginning after December 31, 2008, (ii) is effective as of the applicable effective date of the 2007 regulation requirements, and (iii) the plan is operated as if the amendment is in effect. Rev. Proc 2007-71 also requests comments from interested parties on the model language, especially regarding improvements to better meet the needs of public schools. Comments are due as of March 16, 2008.

Revenue Procedure 2007-71 is available at: <http://www.irs.gov/pub/irs-drop/rp-07-71.pdf>

House and Senate Introduce Legislation for National Medicare-Operated Prescription Drug Plan

On October 22, 2007, two companion bills both titled “Medicare Prescription Drug Savings and Choice Act of 2007” were introduced by congressional Democrats in the House and Senate (H.R. 3932 and S. 2219). The legislation would create a Medicare-operated prescription drug plan by amending Medicare Part D to: (1) establish one or more Medicare-operated prescription drug plans; (2) develop a well-defined appeals process for any denials of benefits under the Medicare-operated drug plans; and (3) develop a system of pharmacy payments under such plans.

The Medicare Modernization Act was enacted in 2003 to establish Medicare Part D, a voluntary prescription drug benefit for Medicare recipients. At that time, Congress did not allow the Department of Health and Human Services (HHS) to offer a national Part D drug plan to compete with privately offered drug plans. However, the proposed bills would require HHS to establish a Medicare-operated drug plan as an alternative to privately offered plans. Moreover, HHS would also be required to negotiate drug prices directly with pharmaceutical manufacturers, establish a formulary, and provide consumers with information about drug safety and effectiveness. Additionally, the HHS Secretary would direct the Agency for Health Research and Quality to assess the clinical benefit of various prescription drugs and make recommendations for their inclusion in (or exclusion from) the Medicare-sponsored Part D plan formulary.

Supporters of the Medicare-operated drug plan argue that the proposed plan would be similar to traditional Medicare. This would make it easier for beneficiaries to understand and help reduce fraud by eliminating sales and marketing scams. One of the Senate bill’s sponsors, Janice D. Schakowsky (D-IL) reported that it would lower drug costs, in part, through a reduction in administrative costs. As reported by the Alliance for Retired Americans, the administrative costs for private insurers are about 10% of the total cost of the drug benefit. By comparison, Medicare’s administrative costs for hospital and outpatient coverage are only 1.7% of total costs. Other supporters argue that a national Medicare-operated Part D plan would have better access to drugs, its formulary would better reflect drug quality and safety, and it could offer a more efficient appeals process than private plans.

Opponents of the legislation defend the current Medicare drug program on the grounds that competition among private drug plan providers and wise consumer choices have resulted in reduced prescription drug costs and enhanced savings. According to Centers for Medicare and Medicaid Services spokesperson Jeff Nelligan, beneficiaries are saving an average of \$1,200 annually on their drug costs and overall program costs are expected to be lower than initial estimates by nearly \$190 billion (30%).

H.R. 3932 and S. 2219 are available at: <http://thomas.loc.gov/>

Senate Finance Committee Revives Measure to Eliminate Social Security GPO and WEP

On November 6, 2007, witnesses testified before the Senate Finance Subcommittee on Social Security, Pensions, and Family Policy regarding elimination of Social Security’s government pension offset (GPO) and windfall elimination provision (WEP). The hearing focused on the Social Security Fairness Act of 2007 (S.

206) which was introduced in January 2007 by Senators Dianne Feinstein (D-CA) and Susan Collins (R-ME) to repeal the GPO and WEP. A companion bill (H.R. 82) was introduced in the House by U.S. Representatives Howard Berman (D-CA) and Howard “Buck” McKeon (R-CA).

The Government Accountability Office (GAO) estimates that about one-fourth of state and local government workers are not covered under Social Security. For a person covered by Social Security, the “dual entitlement provision” reduces the Social Security spousal or widow(er) benefit that the person can receive each year by the amount of their annual Social Security retirement benefit. The GPO was designed to replicate this “dual entitlement” provision for persons receiving a pension from employment not covered by Social Security. In such cases, the GPO reduces their Social Security spousal and widow(er) benefits by two-thirds of their pension benefit. According to Senator Collins, the GPO affects more than 200,000 individuals, reducing their Social Security benefits by more the \$3,600 per year. Over 70% are women.

The WEP reduces Social Security benefits for individuals who receive benefits from both covered and non-covered employment. For example, a teacher in a school system not covered by Social Security may have previously been employed in a job covered by Social Security long enough to be eligible for a Social Security retirement benefit. In this case, the WEP would lower the teacher’s Social Security benefit in a manner intended to offset the potential “windfall” that an unreduced Social Security benefit might provide. The Social Security benefit formula is designed to replace a higher percentage of pre-retirement income for lower paid workers than higher paid workers. Because a worker who spent part of his or her time in employment not covered by Social Security would appear to have lower lifetime Social Security earnings, they could potentially receive a higher Social Security benefit than their actual earnings would allow. The WEP is intended to prevent this.

During the hearings, Subcommittee Chairman John Kerry (D-MA) and Senator Feinstein emphasized that while the GPO and WEP were originally intended to prevent public employees from being unduly enriched, they have caused public employees to be unjustly penalized and deprived of benefits. Other witnesses testified that the GPO and WEP are adversely affecting the recruitment of government employees such as police officers, firefighters, and teachers.

With regard to the costs of eliminating the GPO and WEP, Barbara D. Bovbjerg, the GAO’s Director of Education, Workforce, and Income Security, testified that eliminating the GPO could cost Social Security \$41.7 billion over 10 years and increase the long-range deficit by 3%. Additionally, eliminating the WEP could cost Social Security \$40.1 billion and also increase the deficit by 3%.

Bovbjerg also argued that an alternative to eliminating the GPO and WEP could be to make Social Security coverage mandatory for all governmental employees. However, she noted that this approach could increase state and local governments’ pension costs and require modifications to carefully designed pension plans. California Public Employees’ Retirement System board member, Priya Mathur, testified that mandatory Social Security coverage would cause employers to decrease pension plan contributions and lower wages in future negotiations.

The Subcommittee hearings are posted at: <http://www.senate.gov/~finance/sitepages/hearing110607.htm>
The SSA’s website has information on the GPO at: <http://www.ssa.gov/pubs/10007.html> and on the WEP at: <http://www.ssa.gov/pubs/10045.html>.

CRR Reports on Differences Between Public and Private Pension Plans

On November 13, 2007, the Center for Retirement Research at Boston College (CRR) released an issue brief titled “State and Local Pensions Are Different from Private Plans.” The report is part of a multi-year comprehensive study of state and local pension plans that CRR is undertaking for the Center for State and Local

Government Excellence. The brief identifies major differences between employer-sponsored retirement plans in the public and private sectors, including:

- The majority of all active public sector workers (76%) are covered by retirement plans, while less than half of private sector workers (43%) are so covered.
- Of workers covered by public plans, 80% are covered solely by defined benefit (DB) plans, 14% are covered solely by defined contribution (DC) plans, and 6% are covered by a combination of the DB and DC plans.
- Of workers covered by private plans, 10% are covered solely by DB plans, 64% are covered solely by DC plans, and 26% are covered by a combination of plans.
- Only 72% of public plan workers are in Social Security; whereas, virtually all private sector workers participate in Social Security.
- While public DB plans typically provide larger benefits than private DB plans, they rely more on employee contributions. As discussed in the report, public DB plans have benefit multipliers that average 2% of pay per year of service, annual employer contributions that average 7% of pay, and employee contributions that average 5% of pay. By contrast, private DB plans have benefit multipliers that average 1.5% of pay per year of service, annual employer contributions that average 8% of pay, and no employee contributions.
- Most public DB plans offer post-retirement cost-of-living adjustments; private DB plans typically do not.

In addition, the report also describes several similarities among public and private DB plans. On average:

- Both currently invest about 70% of assets in equities;
- Both are currently about 85-90% funded, with investment earnings being the largest source of plan income; and,
- Both assume that the difference between the assumed rate of investment return and the assumed rate of salary growth is about 4%.

Looking to the future, the researchers conclude: “The implication of the unfunded liability for state and local government pensions is that, if current assumptions ... are borne out, sponsors of defined benefit plans will have to come up with funds in addition to the annual cost of accruing benefits to cover future payments. The current unfunded liability at the state and local level is about \$380 billion. To pay off this amount over 30 years, states and localities would have to raise their contribution rate by an amount equal to 0.7% of payrolls.”

Future CRR issue briefs will analyze other aspects of state and local government retirement plans, retiree health care, and financial planning.

The brief is available at: http://crr.bc.edu/images/stories/Briefs/SLP_1.pdf

CBO Reports on Long-Term Health Care Spending Outlook

On November 13, 2007, the Congressional Budget Office (CBO) released its report, *The Long-Term Outlook for Health Care Spending*. The study presents CBO’s 75-year projections of national health care spending as well as federal spending on Medicare and Medicaid. In the absence of any federal law changes, CBO projects:

- Total health care spending will increase from 16% of gross domestic product (GDP) in 2007 to 25% in 2025, 37% in 2050, and 49% in 2082.
- Federal spending (net of beneficiaries’ premiums) on Medicare and Medicaid will increase from 4% of GDP in 2007 to 7% in 2025, 12% in 2050, and 19% in 2082.

The report's main message is that, "without changes in federal law, federal spending on Medicare and Medicaid is on a path that cannot be sustained." In a briefing on the report, CBO Director Peter R. Orszag, said that the increase in Medicare spending is mainly due to rising costs per Medicare beneficiary. Overall, health care costs are increasing primarily due to the use of new medical technologies and services.

According to the report, higher health care spending is not a problem in itself, provided the increased spending results in commensurate health care gains. However, substantial evidence suggests that more expensive care does not always mean higher-quality care, and the degree to which the current system supports higher quality care is unclear. Consequently, according to the report, "embedded in the country's fiscal challenge is the opportunity to reduce costs without impairing health outcomes overall." In his briefing, Orszag noted that health care costs could be slowed without harming outcomes by implementing comparative effectiveness research, coordinating care for high-cost patients, increasing patient cost sharing, and improving individuals' health habits.

In December, CBO will release a new long-term budget projection showing the crucial role that health care spending plays in the fiscal outlook. CBO is also expected to release a report focusing on comparative effectiveness research.

The report is available at: <http://www.cbo.gov/ftpdocs/87xx/doc8758/11-13-LT-Health.pdf>

Commonwealth Fund Reports Combined Private-Public Group Insurance Plan Has Greatest Potential for Health Care Reform

On October 18, 2007, the Commonwealth Fund's Commission on a High Performance Health System released its report "A Roadmap to Health Insurance for All: Principles for Reform". In the report, leading health policy experts evaluate the various health insurance reform plans proposed by the 2008 presidential candidates, grouping them into three approaches: (1) tax incentives and the individual insurance market; (2) mixed private-public group insurance with shared responsibility for financing; and (3) public insurance.

According to the report, the Commission considers the most pragmatic approach to health care reform to be a combined system of private and public health insurance with shared responsibility for financing by individuals, employers and government. This reform strategy builds on the current system of health insurance by expanding coverage for uninsured Americans in addition to improving quality, efficiency and health care cost containment. Mixed plans would allow workers to retain employer-based insurance and, thereby, reduce federal budget outlays. Additionally, these plans would pool risk and reduce administrative costs. The report also emphasized the importance of providing universal coverage through health plans that maintain affordable out-of-pocket costs.

The study is available at: <http://www.commonwealthfund.org>

District Court Rules Health Plan Covering Public and Private Schools is Subject to ERISA

On October 19, 2007, the U.S. District Court for the Southern District of Indiana ruled that a self-funded group health plan including both public and private school-related entities is not a governmental plan exempt from ERISA (*South Central Indiana School Trust v. Poyner*, S.D. Ind., No. 1:06-cv-1053-RLY-WTL). As a result, the defendant is bound by the plan's subrogation provision.

The defendant, Virginia Poyner, was injured in 2005 when she was struck by a car while riding her bicycle. Her health plan's trust paid over \$194,000 for her medical expenses. After recovering \$110,000 from her personal injury claim, Poyner was expected to reimburse the plan for her medical expenses, due to the plan's subrogation provision. Under this provision, by virtue of accepting benefits under the plan, a participant automatically assigns to the plan any rights to recover payments from an insurer or other third party. Poyner

refused to reimburse the plan and the plan sued in federal court to recover the expenses. At issue was whether the plan was an ERISA plan or an exempt governmental plan.

Poyner argued that because the majority of entities covered by the plan were governmental, the plan was a governmental plan and exempt from ERISA under § 4(b)(1). Consequently, the court did not have jurisdiction to hear the case. However, the court held that because the plan was established and maintained for both public and private employers, it was subject to ERISA. Additionally, the court noted that the plan was administered as an ERISA plan in conformance with ERISA regulations, which helped demonstrate its intent and purpose. Therefore, Poyner was required to reimburse the plan \$110,000, plus interest.

Source: *South Central Indiana School Trust v. Poyner*, S.D. Ind., No. 1:06-cv-1053-RLY-WTL, 10/19/07.