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The following news summaries were developed by Gabriel, Roeder, Smith & Company to inform clients and other benefit professionals of news in the benefits industry. Our thanks to Mary Ann Vitale for her diligent work on this issue. Thanks also go to Amanda Barker for the updated *News Scan* design.

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GRS in the News: International Foundation Publishes GRS Article on GASB OPEB

The May 2006 issue of *Benefits & Compensation Digest* published by the International Foundation of Employee Benefit Plans (IFEBP) features an article written by GRS consultants Brian Murphy and Paul Zorn titled "Managing the Impact of GASB Statement 45." The article is intended to facilitate a smoother transition by state and local governments in complying with the Governmental Accounting Standards Board's new rules for measuring and reporting the long-term costs of retiree health care and other non-pension postemployment benefits.

The article is available on the IFEBP website at: <http://www.ifebp.org/pdf/webexclusive/06may.pdf>

EBSA Publishes Retirement Planning Booklet

On February 15, 2006, the U.S. Department of Labor's Employee Benefits Security Administration released a new publication, *Taking the Mystery Out of Retirement Planning*. The booklet is designed to aid individuals who are within 10 years of retirement to financially prepare for retirement. Worksheets are included for calculating current income and expenses, projecting future income and expenses, and computing additional savings needed before retirement. In addition the booklet describes ways to improve savings and investments, reduce expenses, and ensure sufficient assets are available during retirement. It also provides a resource section listing additional sources for information on retirement, personal savings, and investments.

Free copies of the booklet are available by contacting EBSA at 866-444-3272 or online at: <http://www.dol.gov/ebsa/publications/NRTOC.html>

* The authors of these news summaries are not attorneys and the statements made are not intended as legal advice or opinion. Qualified legal counsel should be consulted to ensure plan provisions and documents comply with applicable laws and regulations.

California Legislative Office Recommends State Pre-Fund Retiree Health Care

On February 17, 2006, the California Legislative Analyst's Office (LAO) issued a report, *Retiree Health Care: A Growing Cost for Government*. According to the *2006-07 Governor's Budget*, the projected annual cost for providing health care to retired state employees and dependents will exceed \$1 billion and will continue increasing yearly. By 2010, the annual cost is expected to reach \$1.6 billion, a 60 percent increase over a four-year period.

Under Governmental Accounting Standards Board Statement No. 45 (GASB 45), new rules related to the measurement and reporting of other postemployment benefit (OPEB) costs and liabilities are effective for large governments starting in 2007. When measured under these new rules, the state government's unfunded liabilities associated with providing retiree health care are estimated to be between \$40 billion to \$70 billion or more.

Currently, like most public OPEB plans, the state plan uses a "pay-as-you-go" method to fund retiree health care. Retiree health benefits are earned during an employee's working years, but paid out after retirement as retirees use various health services. However, the LAO reported that unless adequate funds are allocated and invested to cover the normal costs of OPEB benefits during employment, much of these costs will be shifted to future taxpayers. As an alternative, the LAO recommended pre-funding retiree health care liabilities in a manner similar to that used by the state's pension plans. Pre-funding retiree health care liabilities would:

- Help secure employees' expected benefits;
- Leverage investment earnings to help reduce future required contributions, and
- Help prevent deterioration of the state's bond ratings.

The estimated annual cost for fully pre-funding the State's OPEB benefits under GASB 45 would be about \$6 billion. To ease the State's financial burden, the LAO suggested partially pre-funding the benefits by initially paying at least the normal costs each year (about \$1 billion more than the pay-as-you-go approach). Then, after several years, the state could ramp up its contributions to pay a higher portion of the unfunded liabilities.

A copy of the report is available at: http://www.lao.ca.gov/2006/ret_hlthcare/retiree_healthcare_021706.htm

Chicago OPEB Liabilities Estimated at \$1.4 Billion

Recently, the City of Chicago released preliminary estimates of its other postemployment benefit (OPEB) liabilities, finding that they would not exceed \$1.4 billion after December 2006. The estimates were disclosed in financial statements prepared for a general obligation bond offering totaling \$650 million in March. Chicago is one of the first municipalities to report its OPEB liabilities.

According to City officials, the estimated \$1.4 billion is about 25 percent of the city's overall operating budget. Joseph O'Keefe, Senior Director of Fitch Ratings, commended the city's early disclosure of its OPEB liabilities. However, he also predicted that the substantial amount could potentially result in more stringent collective bargaining negotiations, tax increases, and cuts in services.

Source: *BNA Pension & Benefits Reporter*, April 4, 2006.

GASB Discusses Differences Between Public and Private Sector Accounting

On March 16, 2006, the Governmental Accounting Standards Board (GASB) published a white paper discussing why accounting and financial reporting for state and local governments should be different from those of for-profit businesses. According to the GASB, this is due to fundamental differences between

governments and businesses related to their purposes, stakeholders, sources of revenues, obligations, and potential longevity. Generally, a government's primary purpose is to maintain or enhance the well-being of its citizens by providing public services financed through taxes; whereas a business's primary purpose is to benefit its shareholders by creating wealth based on voluntary transactions with its customers. Other fundamental differences that generate the need for unique information include:

- Governments serve a broader group of stakeholders, including taxpayers, citizens, elected representatives, oversight groups, bondholders, and others in the financial community.
- Monitoring actual compliance with budgeted public policy priorities is central to a government's public accountability.
- Governments generally exist longer than for-profit businesses and are not typically subject to bankruptcy and dissolution.

With regard to pensions and other postemployment benefits, the GASB noted that it was appropriate for both governments and businesses to account for such benefits on an accrual basis, since deferred costs should be recognized when the benefits are earned, rather than when they are paid. However, the longevity of governments and the importance of allocating the costs of public services equitably among taxpayers supports the need for certain differences in accounting and reporting standards. According to the white paper, the current governmental accounting approach "explicitly harmonizes accounting with the actuarial funding characteristics of public plans." The approach makes it possible to "allocate expenses to periods in a way that charges each period with a level percentage of payroll for normal cost" and "equitably spreads the ongoing benefit program among different generations of taxpayers."

Appendix D of the report emphasizes the significance of state and local governments in the U.S. economy. Based on federal data, the white paper reports that revenues collected by state and local governments totaled \$1.8 trillion in 2002, 20 percent of U.S. gross domestic product. State and local government employees make up 12 percent of total U.S. employment.

The GASB white paper is available at: http://www.gasb.org/white_paper_mar_2006.html

U.S. Supreme Court Dismisses Michigan Judges' Constitutional Claims of Unequal Benefits

On March 20, 2006, the U.S. Supreme Court let stand a federal appellate court decision dismissing the claim of Michigan state court judges that the state violated the Equal Protection Clauses of the U.S. and Michigan Constitutions by paying unequal benefits based on locality (*Ernst v. Rising*, U.S., No. 05-934, cert. denied 3/20/06).

The state judges had argued that Detroit-area state court judges were paid better retirement benefits than those in other locations around the state. At issue is whether the claim can proceed in federal court, since the Tenth and Eleventh Amendments to the U.S. Constitution are deemed to bar citizens' lawsuits against states. In October 2005, the U.S. Sixth Circuit Court of Appeals ruled that a state judges' retirement system is an arm of the state rather than a political subdivision. Therefore, the judges' action against the retirement system could not proceed in federal court.

The Sixth Circuit found the most important factor in deciding if a retirement system is an arm of the state was the state's potential liability for a judgment against the entity. Other deciding factors were: the degree of state control over the entity's actions; whether the state or local officials appointed its board members; and whether its functions were within the typical purview of state or local government. In applying these factors to the case at hand, the appeals court found that the retirement system: was established by state legislation; served state

officials; was funded by the state treasury; and if there was a monetary shortfall, the state treasurer would make up the difference with state funds as legislatively required.

Source: *BNA Pension & Benefits Reporter*, March 28, 2006.

IRS Strengthens Enforcement Initiatives

On March 20, 2006, Michael Julianelle of IRS's Tax Exempt/Government Entities (TE/GE) Division spoke at the Benefits Conference of the South, sponsored by the American Society of Pension Professionals and Actuaries (ASPPA). He indicated that the IRS will be increasing its enforcement activities at both the regional and national levels, in part through its new Employee Plans Compliance Unit (EPCU). The unit employs 17 professionals with responsibility for auditing companies that require more extensive examinations.

He also said that the IRS is taking a more focused approach to its audits. For example, in early 2006 the IRS's Gulf Coast Area Employees Plans TE/GE Division began examining new cases using a more concentrated list of criteria rather than conducting full-scope examinations. This division is also extending its compliance initiatives to 403(b) and 457 plans in Alabama, Louisiana, and Mississippi. Additionally, it will be examining more multiemployer plans in Florida, Kansas, and Missouri.

Source: *BNA Pension & Benefits Reporter*, March 28, 2006.

Medicare Drug Plans Study Finds Hidden Restrictions in Obtaining Medications

On March 23, 2006, House Representative Henry Waxman (D-CA.) released a new report *Medicare Drug Plans: Restrictions on Access to Formulary Drugs*. The report was written by the U.S. House of Representatives Special Investigations Division, based on its analysis of over 1,470 plans in the Medicare database, a telephone survey of plans available in Rep. Waxman's California district, and the websites of Medicare and individual Medicare drug plans.

The report found that 97 percent of Medicare drug plans use restrictive tactics to limit participants' access to drugs on the plan formularies, but in most cases prior disclosure of the restrictions to participants is nonexistent. The average plan restricts access to more than 10 percent of the most common drugs listed in its formulary while some plans restrict more than 40 percent of the 100 most common formulary drugs. The three most common restrictions used to limit access include:

- "Prior authorization" requirements for either the patient or physician to submit paperwork to the plan sponsor for approval before a drug is covered.
- "Step therapy" requirements for the patient to try the plan's preferred formulary drugs before administering the medication of choice.
- "Volume limits" that restrict the quantity or dosage of the drug regardless of the prescribed amount determined to be clinically necessary by the patient's physician.

Other findings revealed:

- Over two-thirds of the Medicare drug plans contacted by phone survey were unable to accurately describe plan restrictions to beneficiaries.
- A number of Medicare drug plans provided erroneous or conflicting information about restrictions to beneficiaries.
- In most cases, Medicare and plan sponsors fail to provide sufficient information about restrictions on their websites.

The report concludes that seniors “cannot make fully informed decisions about Medicare drug plans without knowing how the restrictions will affect the drugs they use, yet they have no practical way of determining what these restrictions are until after they subscribe to a plan and are denied access to drugs.”

The Pharmaceutical Care Management Association (PCMA) responded to the report by arguing that it failed to recognize the value of the pharmaceutical management tools for promoting quality and controlling costs.

The report is available at: <http://www.democrats.reform.house.gov/Documents/20060323101029-28542.pdf>

Mississippi Governor Signs Pharmacy Practice Bill to Regulate PBMs

On April 5, 2006, Mississippi Governor Haley Barbour signed the “Pharmacy Practice Act” (H.B. 542), authorizing the state pharmacy board to regulate pharmacy benefit management companies (PBMs). The Act requires PBMs to register with the state board, update their price lists every three days, and pay pharmacies within 15 days or be subject to fines up to a maximum of \$25,000. The new law becomes effective June 30, 2006, with exemptions for the state employees’ health plan and Medicaid. The Mississippi House and Senate had unanimously approved the bill.

The Pharmaceutical Care Management Association expressed concerns that the new law will result in higher health care costs for the state’s consumers and employers. The Mississippi Manufacturers Association also opposed the bill on the grounds that it would raise employers’ health care costs.

H.B. 542 is available at: <http://billstatus.ls.state.ms.us/documents/2006/pdf/HB/0500-0599/HB0542SG.pdf>

CMS Announces Indexed Medicare Part D Amounts for 2007

On April 5, 2006, the Centers for Medicare and Medicaid Services (CMS) updated the statutory parameters for the standard Medicare Part D drug benefit for 2007. The Medicare Modernization Act (MMA) requires CMS to announce indexed Medicare amounts each year that reflect the increase in drug costs. As required by statute, the parameters include the standard deductible, initial coverage limit, out-of-pocket thresholds and other related factors.

For 2007, CMS’s Office of the Actuary estimated annual increases were 6.86 percent, reflecting both higher utilization among seniors and reduced prescription drug costs negotiated by Part D prescription drug plans. The increase was based on two indexing methods: (1) the annual percentage increase in average Part D drug expenses per Medicare beneficiary and (2) the annual percentage increase in the Consumer Price Index.

In 2007, the standard benefit deductible will be \$265 (up from \$250 in 2006), with coinsurance of 25 percent after the deductible up to an initial coverage limit of \$2,400 (up from \$2,250). Participants then pay 100% of drug costs from \$2,400 to \$5,451.25 (up from \$5,100), after which the plan pays 95 percent. Total out-of-pocket costs before reaching the 95 percent catastrophic coverage threshold will be \$3,850 in 2007 (up from \$3,600 in 2006).

In the release, CMS indicated that most Medicare Part D participants are not covered by the standard benefit, but instead are in plans with lower deductibles and no gap in coverage.

The update is available on the CMS website at:

http://www.cms.hhs.gov/MedicareAdvtgSpecRateStats/downloads/2007_Part_D_Parameter_Update.pdf

West Virginia Teachers Vote to Merge DC and DB Plans

On April 3, 2006, the West Virginia Teachers' Defined Contribution Plan and the West Virginia Teachers' Retirement System (a defined benefit (DB) plan) announced that the plans will merge on July 1, 2006. In a recent vote by the defined contribution (DC) plan participants, 61 percent of those who voted favored merging with the DB plan. The rules of the election required that at least half of the DC plan's approximately 23,000 participants vote, and that a simple majority prevail. Since 56 percent of the participants cast ballots in the election, the merger passed.

In 1990, the state legislature voted to close the teacher's DB plan for new teachers, placing them instead in the newly created DC plan. However, over time, the state found that the DC plan was not as cost effective as the defined benefit plan. Moreover, concerns were raised that the teachers would not receive adequate retirement income from the DC plan. Therefore, in 2005, the state legislature closed the DC plan for newly hired teachers, placing them instead in the DB plan. Teachers remaining in the DC plan were then allowed as a group to collectively choose whether to either remain in the DC plan or transfer to the DB plan.

The merger is expected to save the state about \$24 million in 2007 and a total of 1.9 billion over the next 30 years. However, a lawsuit was filed by a group of DC plan participants against the retirement board seeking an injunction to temporarily block the planned merger until the issue can be reviewed. The suit alleges a breach of contract if authorities changed the plan terms without the majority consent of participants and also alleges that the merger is unconstitutional under state law.

The results of the election are posted on the West Virginia Consolidated Retirement Board's web site at: <http://www.wvretirement.com/tdctrscertificate.pdf>