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Articles in this Edition

RECENT LEGISLATIVE ACTIVITY

Health Plan Tax Equity Bill Introduced in House

On March 29, Representative Jim McDermott (D-WA) introduced the Tax Equity for Health Plan Beneficiaries Act of 2007 (H.R. 1820), which clarifies employer health coverage provided to domestic partners (and other non-spouse, non-dependent covered individuals) will no longer result in taxable income to the employee and will no longer be counted as "wages" that trigger payroll tax obligations on the part of both employee and employer. The bill will not establish a federal definition of (or required criteria for) eligibility for domestic partner status, leaving that determination to employers themselves.

Other notable provisions would permit employees saving on a pre-tax basis through a cafeteria plan to do so for the portion of the premium attributable to the coverage of their domestic partner (or other non-spouse, non-dependent beneficiary); allow self-employed individuals to take an income tax deduction on premiums attributable to coverage of domestic partners; clarify that expenses of the domestic partner (or other non-spouse, non-dependent beneficiary) may be reimbursed from a flexible spending account and from a health reimbursement arrangement. The bill does not, however, resolve the obstacles for domestic partners under health savings accounts.

An official summary of the legislation, prepared by McDermott's office, is now available, along with a "Dear Colleague" letter for attracting cosponsors to the bill. McDermott introduced a similar bill in the 108th Congress but the measure was not enacted. Senators Gordon Smith (R-OR) and Chuck Schumer (D-NY) also sponsored similar legislation previously and are expected to reintroduce it in the near future.

Executive Compensation Update: House Committee Approved Executive Compensation Legislation, Senate Measure Attached to Spending Bill

On March 28, the House of Representatives Financial Services Committee completed consideration of the Shareholder Votes on Executive Pay Act (H.R. 1257), sponsored by Committee Chairman Barney Frank (D-MA), by approving the measure in a 37 to 29 vote. This legislation would not set limits on executive pay, but would require public companies to include in their annual proxies a non-binding advisory shareholder vote on the executive compensation disclosed in the annual proxy statement and a separate shareholder vote on "golden parachutes."

Chairman Frank has repeatedly stated he proposed the legislation because the Securities Exchange Commission (SEC) does not believe it has the statutory authority to require such nonbinding, advisory shareholder votes. Republican members have generally expressed a desire to allow the new SEC executive compensation disclosure rules to function prior to considering any additional legislation involving executive compensation, and questioned whether this legislation would be the first step in requiring shareholder votes on other matters of corporate governance.

During the three separate days of debate, the committee approved only one Republican amendment, which aims to prevent "frivolous" stockholder lawsuits against boards of directors. Other Republican amendments, which would have instituted various exemptions or triggers to shareholder votes, were defeated by the panel. Notably,

Representative Patrick McHenry (R-NC) offered two unsuccessful amendments: one which would have excluded pension funds from voting on executive pay, and one which would have required pension funds to disclose to its beneficiaries how they had voted on corporate pay packages.

In other executive compensation news, the Small Business and Work Opportunity Act of 2007 (H.R. 2), the minimum wage and small business tax incentives bill already passed by the full Senate, was added to the supplemental spending bill – which contains politically controversial provisions for the funding and strategy of the Iraq War.

As previously reported, the Senate minimum wage and tax bill included revenue-raising provisions that would have severely limit nonqualified deferred compensation by:

- Amending Internal Revenue Code ("Code") Section 409A to impose a dollar cap on the annual accrual of nonqualified deferred compensation that is the lesser of $1 million or the individual's average annual compensation determined over five years. Failure to satisfy the cap would trigger ordinary income tax plus the 20-percent additional tax under section 409A.

- Amend Code Section 162(m) ("million dollar deduction" limit) to treat any former employees (and their beneficiaries) as continuing to be covered by the section 162(m) limits in the future (e.g, after termination of employment).

Neither the House-passed version of the minimum wage bill nor the House-passed small business tax relief bill contains these provisions. Considering the likely necessity of a congressional conference to resolve the differences in the House and Senate measures, House Ways and Means Committee Chairman Charles Rangel (D-NY) took the unusual step of calling a hearing after the legislation has already been approved. "Since the Senate-passed bill was intended to help offset the costs associated with an increase in the Federal minimum wage, it seems only fair that the business community should be given an opportunity to explain the effect these revenue increases would have on businesses," Rangel said in a statement.

House Ways and Means Chairman Charles Rangel (D-NY) has stated his desire to eliminate revenue-raising provisions such as those described above from the final minimum wage bill being negotiated with the Senate.

Meanwhile, the Treasury Department (Treasury) issued final regulations under Code Section 409A on April 10th.

The Council submitted written testimony for the record and released a statement to the media opposing the inclusion of the deferred compensation-related provisions in final minimum wage or tax legislation. "The dollar cap contained in the Senate bill sets a dangerous precedent by putting arbitrary limits on deferred compensation, including incentive compensation and retirement-type programs," said Lynn Dudley, Council vice president, retirement policy.

The Council's testimony provides a number of technical reasons why the Senate provisions represent shortsighted policy: taxing employees before they are actually paid on funds that are "at risk" is fundamentally unfair, which could be the result under the

Senate-passed provision if a nonqualified plan exceeded the dollar caps. Imposing dollar limits under the Internal Revenue Code skews behavior — for example, Sections 162(m) and 280G, two provisions that impose tax penalties for exceeding compensation dollar limits, have been uniformly criticized as causing greater harm than benefit. Furthermore, Congress has already addressed election and payout rules for deferred compensation under Code Section 409A and employers are still awaiting final rules.

As expected, committee members' questions for the panel focused on the unintended consequences of the legislation, particularly the effect of retroactive provisions. There were numerous questions about nonqualified deferred compensation, with several questions specific to the nonelective nature of some programs. Some committee members asked the panelists about the possibility of modifying the provisions, notably the dollar cap, and the possibility of setting the annual cap at a flat $1 million. Rangel seemed sympathetic to the business community perspective and reiterated his desire to eliminate the revenue-raising provisions from the final legislation.

Mental Health Parity Legislation Introduced in House and Considered by House Committee

On March 7, The Paul Wellstone Mental Health and Addiction Equity Act (H.R. 1367) was introduced, which requires the cost-sharing requirements or limits on the duration of coverage for mental health benefits offered by employer-sponsored group health plans with 50 or more enrollees to be no more restrictive than coverage for other medical conditions. The legislation has reportedly attracted 256 cosponsors, which constitutes a majority of the House of Representatives. The sponsors' summary of the bill is now available.

Previously, the Senate Health, Education, Labor and Pensions (HELP) Committee passed its own mental health parity legislation. The Mental Health Parity Act (S. 558), introduced by HELP Committee Chairman Edward Kennedy (D-MA) and Senators Peter Domenici (R-NM) and Michael Enzi (R-WY), similarly require that any cost-sharing requirements or limits on the duration of coverage for mental health benefits be no more restrictive than those applied by the plan for medical and surgical benefits. The Senate bill was negotiated with groups representing employers, health plans, mental health care providers and patient advocates which indicated our support was conditioned on there being no changes to the Senate measure during the legislative process which would weaken or remove an of the key employer or health plan protection provisions in S. 558.

In general, the House bill would be much more restrictive of plan practices than its Senate counterpart. For example, unlike the Senate bill, the House bill would mandate that employer-sponsored plans provide coverage for the same mental health and substance abuse benefits as are included in the health plans for federal employees. The Senate bill does not include a mental health benefits coverage mandate, but instead applies its parity requirement to any mental health or substance abuse benefits are covered under the terms of the plan. The House bill also would not preempt State laws which provide "greater consumer protections, benefits, rights or remedies" than those which would be established by the legislation. By contrast, the Senate measure includes provisions which would preempt State laws which "differ from" the parity requirements in S. 558. There are other significant differences between the House and Senate measures, including a provision in the House bill which would mandate that plans

provide coverage for out-of-network mental health or substance abuse services if the plan provides out-of-network coverage for other services covered by the plan. The House bill also fails to include comparable language to provisions in the Senate measure which are intended to protect plan medical management practices and instead includes new disclosure requirements to plan participants and health care providers concerning the criteria used by a plan for making medical necessity determinations.

On March 27, the Health Subcommittee of the House of Representatives Ways and Means Committee did hold a hearing on mental health parity legislation. The Subcommittee called for Congress to "end discrimination" in mental health coverage by requiring health plans and Medicare to establish cost-sharing requirements or allow limits on covered days or visits for treatment that are no more restrictive for mental health benefits than they are for medical and surgical services covered by the same plan. The lead witnesses at the subcommittee hearing were the primary sponsors of the Paul Wellstone Mental Health and Addiction Equity Act (H.R. 1424), Representatives Patrick Kennedy (D-RI) and Jim Ramstad (R-MN), both of whom have also sponsored a series of field hearings around the country to generate support for their legislation.

The subcommittee also heard from Michael Quirk, PhD, director of behavioral health service for Group Health Cooperative. While supporting the enactment of mental health parity legislation, Dr. Quirk also emphasized that any parity legislation needs to allow "flexibility to make reasonable determinations of medical necessity in order to determine who will benefit from care" and urged that any federal legislation not interfere with the ability of health plans to "ensure that clinical care will be appropriate and effective."

The House bill would add new disclosure standards that would apply solely to mental health benefits which would require plans to disclose their criteria for making medical necessity decisions and their reasons for making any denials of mental health care claims. Another key defect of the House bill is that it expressly allows States to add their own consumer protection, parity and remedy requirements beyond those in the federal bill, which would almost certainly guarantee that employees enrolled in the same health plan but who reside in different states would have unequal standards applied to their mental health benefits.

Genetic Nondiscrimination Bill Clears House Committees

A bill prohibiting discrimination in health insurance and employment practices on the basis of genetic information has been approved by both the House Ways and Means and the House Energy and Commerce committees, clearing the way for floor vote. Title I of the Genetic Information Nondiscrimination Act of 2007 (H.R. 493) amends ERISA and the Public Health Service Act to prohibit employer-sponsored group health plans and health insurers providing group and individual health insurance from restricting enrollment or adjusting premiums based on genetic information and prohibits such entities from requiring or requesting genetic testing. Title II of the bill relates to employment practices and prohibits employers from using genetic information to discriminate against an individual in hiring or other employment opportunities.

The House Ways and Means Committee adopted an amendment in the nature of a substitute that includes an excise tax for noncompliance on group health plans, similar to that imposed under HIPAA's portability provisions. According to a summary of the

amendment, prepared by the Joint Committee on Taxation, the excise tax is equal to $100 per day during the period of noncompliance and is imposed on the employer sponsor.

At its markup of the bill on March 23, 2007, the House Energy and Commerce Committee approved an amendment which addresses concerns by clarifying that Title I requirements or remedies are exclusive for group health plans; health or other insurance coverage issued in connection with group health plans; individual health insurance coverage; and Medicare supplemental policies and that Title II should not be construed to provide rights or remedies with respect to those entities. The amendment also allows group health plans and insurers to request genetic testing or information, subject to a minimum necessary standard, for purposes of claims processing and benefit management.

A companion bill, S. 358, has been approved by the Senate Health, Education, Labor and Pensions Committee. The bipartisan legislation is also supported by the Bush Administration and the president is expected to sign it.

House Education and Labor Subcommittee Holds Hearing on the Uninsured

On March 15, the House Education and Labor Committee's Health, Employment, Labor and Pensions Subcommittee held the first in a series of hearings on our nation's health care system and how all system stakeholders – government, employers and individuals – can reduce the growing number of uninsured. The hearing, Examining Innovative Approaches to Covering the Uninsured Through Employer-Provided Health Benefits, according to Subcommittee Chairman Rob Andrews (D-NJ), inaugurated a more thorough examination of the U.S. health care system and how changes to it could reduce the number of uninsured; improve health care quality and control costs.

In his opening statement, Andrews cited the 47 million Americans who are without health insurance and stated there is a "moral imperative" to do something now to address this growing number. At the same time, Andrews noted that American companies are hamstrung in the global economy by rising health care costs. Ranking Republican Member John Kline (R-MN) highlighted in his statement the appropriateness of starting immediately to examine the employer-based health care system, and the innovations companies are pursuing within that framework. Both Kline and Andrews acknowledged the substantial and long-standing role that employers have played in providing health care to their employees. The subcommittee then heard comments from the witnesses who included: Joan Alker, deputy executive director and senior researcher at the Center for Children and Families/Health Policy Institute of Georgetown University; Brian England, owner of British American Auto Repair, of Columbia, MD; Andrew Webber, president and chief executive officer of the National Business Coalition on Health; and Dr. Linda Blumberg, economist and principal research associate at the Urban Institute.

During his testimony, Webber, focused on the accomplishments of the employer-based health care system and companies' leadership in addressing still-pressing concerns. Webber cited, as an example, employers' joining with the Department of Health and Human Services' (HHS) effort to integrate value-driven purchasing practices into both the public and private sector through the "Value Driven Health Care Initiative."

The subcommittee's next hearing will focus on recently implemented and currently proposed state coverage initiatives including those in Massachusetts, California, New

Jersey and Minnesota, said Andrews. Thereafter, the panel intends to consider proposals for greater employer involvement with the SCHIP program. There were indications that the subcommittee may also consider possible modifications to ERISA to encourage employers to participate in such new programs and accommodate the expansion of state-based plans. This, of course, would have important implications for major, multi-state employers.

An archived Webcast of the proceedings and statements of subcommittee leaders and hearing witnesses can be accessed by clicking here.

Bush Administration Rejects Recommendations from Citizen's Health Care Working Group

In a letter to the U.S. Senate, HHS Michael O. Leavitt rejected the recommendations of the Citizen's Health Care Working Group, comprised of representatives from academia and various segments of the health care community. The creation of the working group was mandated by the Medicare Modernization Act of 2003 for the purpose of engaging in an "informed national public debate to make choices about the services they want covered, what health care coverage they want, and how they are willing to pay for coverage." The group conducted hearings and community meetings and presented its recommendations in September 2006.

Leavitt's letter to the Senate noted that while the Bush Administration "share[s] many of the Working Group's Goals for the U.S. health care sector, the Administration disagrees with the Working Group's recommendations on how these shared aspirations should be achieved."

The Administration's opposition is "based on mandates and government intervention, rather than an approach emphasizing consumer choice and options." In particular, the Administration disagreed with the establishment of a national commission to define a core health benefit, limits on patient choice through the development of a core health benefit, and the lack of recommendations on cost control and affordability. The Administration opposed the entire notion of "core benefits," asserting that "market competition among private plans is proving to provide affordable health care that meets consumer needs better than mandated benefits," and pointed to Medicare Part D implementation as an example. The Administration's health care proposals include a standard tax deduction for purchase of health insurance, expansion of HSAs and association health plans and medical liability reform.

Senate Finance Committee Holds Hearing on Universal Health Care

Also on March 14, the Senate Finance Committee held the first of a series of hearings intended to examine five guiding principles of health care reform set out by Committee Chairman Max Baucus (D-MT). The hearing, Charting a Course for Health Care Reform, focused on the first principle: universal coverage. The other principles are:

- Using pooling arrangements to provide affordable coverage
- Controlling health care costs
- Encouraging primary prevention of disease; and
- Shared financial responsibility of individuals, government and employers.

In his opening statement, Baucus summarized the failings of the current health care system and his belief that universal health care is a right, rather than a privilege: "Universal coverage is essential if we are to make meaningful progress on the other four principles. We cannot address the health care system, and leave a growing portion of the country behind."

In his statement, Ranking Minority Member Charles Grassley (R-IA) described the financial burdens of health care costs on American business, noting that the vast majority of the 46 million Americans without health insurance are employed. Describing the health care situation as untenable, Grassley stated that he was heartened by the fact that more new health care proposals are being made and that he supported ideas that include incentives to achieve greater private coverage. He cited the President's budget proposal that uses the tax code to create private incentives as, while not perfect, a good place to start: "Real solutions for the uninsured will involve proposals that use many tools, not just a one-size fits all approach."

House Financial Services Committee to Hold Hearing on Executive Compensation

House of Representatives Financial Services Committee Chairman Barney Frank (D-MA) conducted a focus on proposals to strengthen the role of shareholders in setting executive compensation. Frank introduced legislation in 2005 to strengthen shareholder authority over executive compensation (The Protection Against Executive Compensation Abuse Act, H.R. 4291) and was expected to do so again this year.

The hearing will likely generate additional press coverage on executive compensation "abuses" and may focus additional attention on the provision in the Senate-approved (and still pending) minimum wage bill to cap annual accruals/deferrals into nonqualified deferred compensation arrangements. Frank has generally taken the position that he does not favor provisions such as the one in the Senate bill that limit nonqualified deferred compensation but would rather see stepped up oversight of such compensation by corporate boards and shareholders.

House Education and Labor Committee Holds Hearing on 401(k) Fees

The House of Representatives Education and Labor Committee held a March 6 hearing on 401(k) fees. The hearing was very well attended by both Democratic and Republican members of the committee who actively engaged in questioning the witnesses. Committee Chairman George Miller (D-CA) said in his opening statement that the purpose of the hearing was to "examine the growing role that 401(k)-style plans are playing in helping people pay for their retirements, and to find out if hidden fees are eating into workers' retirement savings account balances without them even knowing it."

Witnesses expressed support for enhanced disclosure and reporting requirements, noting that hard questions are being asked regarding various plan services and fees. Further, that fiduciaries are obtaining answers that give them the tools to negotiate effectively for lower fees and to provide meaningful information to participants and that could create enhanced disclosure to plan fiduciaries, participants and the government overly complicated and burdensome rules which could undermine the employer-sponsored retirement system.

Appearing on the witness panel were Barbara Bovbjerg, director for education, workforce and income security issues at the U.S. Government Accountability Office; Matthew

Hutcheson, an independent pension fiduciary from Tigard, Oregon; and Stephen Butler, president and founder of Pension Dynamics Corporation, a third-party 401k plan administration firm.

During the question-and-answer period, committee members asked a wide range of questions including whether ERISA should be amended to require greater disclosure between service providers and plan sponsors and whether there were undisclosed conflicts of interest at the service provider level that affect the fees plan participants pay. Several members asked questions about the importance of balancing information about fees with other factors that should be considered in selecting investments and the risk of an overemphasis on fees.

Miller has indicated that legislation with provisions intended to address concerns about 401(k) fee disclosure is a possibility. Additional hearings are expected to be held by the committee to further examine the issues and to learn more about the DOL's efforts to address concerns about the need for more 401(k) fee disclosure.

RECENT REGULATORY ACTIVITY

DOE Seeks Advice on Managing Cost of Contractor Benefits

In a March 28 notice in the Federal Register, the U.S. Department of Energy (DOE) began soliciting input and recommendations on how to address the increasing costs and liabilities of contractor employee pension and medical benefits. According to a news release accompanying the notice, benefit costs reached approximately $1.1 billion for the 2006 fiscal year, a more than 226 percent increase since 2000 – and are expected to grow in future years. "The Department of Energy is committed to finding ways to help ensure the long term viability of our contractor employee pension and medical benefit plans while managing our long term financial commitments," said Ingrid Kolb, Director of DOE's Office of Management.

On April 27, 2006, the DOE announced a new procurement policy that would have denied its private sector contractors reimbursement for defined benefit retirement savings plans and certain health benefits for newly hired employees, instead reimbursing contractors only for the costs of their market-based defined contribution pension plans and market-based medical benefit plans. Under pressure from lawmakers and outside groups like the American Benefits Council, the DOE officially shelved this policy in June 2006.

IRS Provides Deduction Limit Guidance

On March 13, the Internal Revenue Service (IRS) released Notice 2007-28, which provides guidance on the 2006 and 2007 changes made by the Pension Protection Act of 2006 (PPA) to the deductibility of contributions to qualified plans. The guidance does not address the rules that will be effective in 2008 and later tax years.

One of the changes addressed by the notice is the newly revised combined plan limit on contributions where the employer maintains both a defined benefit (DB) and defined contribution (DC) plan. The combined plan limit generally limits total deductible contributions (other than elective deferrals) to the greater of 25 percent of the participants' compensation or the minimum required contribution to the DB plan (but no less than the DB plan's current liability). Under the PPA, the combined plan limit only

applies to the extent employer contributions exceed 6 percent of compensation. Unfortunately, the Notice makes clear that the combined plan limit will continue to apply to the DB plan even if contributions to the DC plan do not exceed 6 percent of compensation. This surprising interpretation may somewhat negate the ability of plan sponsors to take advantage of the PPA's new rule permitting deductible contributions up to 150 percent of current liability.

DOL Releases Interim QDRO Regulations

On February 27, the DOL issued interim regulations affecting qualified domestic relations orders (QDROs). The regulations were required by the PPA, which directed DOL to issue regulations that clarify that a second domestic relations order (DRO) may be issued after or modify an initial QDRO and still qualify as a QDRO. The regulations contain examples that show how this second QDRO rule functions. The rule is effective on April 6, 2007.

RECENT JUDICIAL ACTIVITY

U.S. Supreme Court Declines to Hear Xerox Pension Case; Harmful 9th Circuit Decision Stands

The U.S. Supreme Court has declined to rehear the case of *Xerox Corp. Retirement v. Miller, et al.,* allowing a troubling 9th U.S. Circuit Court of Appeals decision to stand. The 9th Circuit determined that any time a defined benefit pension plan takes into account benefits under another retirement arrangement in determining accruals, the "offset" must be calculated using a particular technique outlined by the court. Xerox was ruled to have violated ERISA by accounting for prior distributions by overestimating prior distributions and resulting benefits. Xerox, meanwhile, had asserted that ERISA itself does not require that plans use any particular technique for calculating offsets.

The Council, in support of Xerox's appeal to the U.S. Supreme Court and in a previous amicus (friend-of-the-court) brief, had argued that by specifying a single method of calculating offsets, the 9th Circuit's decision conflicted with ERISA's goals of preserving employer flexibility in order to provide incentives for employers to maintain voluntary pension plans. The Council had been joined by the ERISA Industry Committee in filing the amicus brief.

The final ruling is a blow to pension plan flexibility and, as Xerox officials said in a statement, "the lawfulness of numerous other pension plans is called into question."

Amicus Brief Filed in *Drutis v. Rand McNally* Age Discrimination Case

An amicus ("friend of the court") brief in the case of Drutis v. Rand McNally & Co., currently pending in the U.S. Sixth Circuit Court of Appeals has been filed by the Council. The case centers on the original decision by the U.S. District Court for the Eastern District of Kentucky, which ruled that cash balance pension plans are not inherently age discriminatory under ERISA (and, by extension, the Age Discrimination in Employment Act (ADEA) and the federal tax code). The plaintiffs have appealed this ruling, arguing that cash balance plans are unlawful and suggesting that the Court define the rate of an employee's benefit accrual by reference to a projected benefit payable at

normal retirement age. A similar case, Hirt v. Equitable, is also pending in the U.S. Second Circuit Appeals Court.

The primary argument in the amicus brief is that taking into account the time value of money should not be deemed to be age discriminatory. The amicus brief demonstrates that the district court's decision is supported by the overwhelming weight of authority, statutory language and legislative history. The brief also explains that a reversal of the district court ruling would have staggering financial consequences for employer-sponsored retirement plan participants.

Oral Arguments Heard in Appeal of AARP v. EEOC

On February 27, the U.S. Court of Appeals for the Third Circuit heard oral arguments in the ongoing litigation between AARP and the Equal Employment Opportunity Commission (EEOC) regarding the agency's authority to promulgate a rule permitting the coordination of retiree health care benefits with Medicare eligibility. AARP had filed a lawsuit with the appeals court in February 2005 blocking the implementation of the EEOC's rule.

The EEOC proposed the exemption in response to a 2000 decision by the U.S. Court of Appeals for the Third Circuit in the Erie County case, which held that the ADEA applies to retirees and prohibits altering, reducing or eliminating health benefits for retirees when the participant becomes eligible for Medicare or comparable state health benefits. The EEOC asserted that the retirement benefit age cutoff does not contradict federal antidiscrimination law and that it is in the public interest to allow businesses to limit health benefits for retirees aged 65 and older when they become eligible for Medicare.

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