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WEB's ***Benefits Insider*** is a member exclusive publication providing the latest developments from the Nation's Capital on matters of interest to benefits professionals. The content of this newsletter is being provided as a result of a partnership with the American Benefits Council, a premier benefits advocacy organization, which provides its core content, and is edited by Christopher M. Smith, Employee Benefits attorney and Principal of Flexible Benefits Systems, Inc., csmith@fbsi.com.

Articles in this Edition

RECENT LEGISLATIVE ACTIVITY

Small Business Jobs Bill Includes Benefits Provisions, Could Be Vehicle for Pension Funding Technical Corrections

Senate Finance Committee Chairman Max Baucus (D-MT) has introduced a revised substitute amendment to the Small Business Jobs Act (H.R. 5297), including provisions related to employee benefit plans. An official summary of the revised substitute is also available.

The measure provides for "in-plan" conversions from traditional 401(k) or 403(b) defined contribution plan accounts to "Roth"-style accounts (for amounts that would otherwise be distributable from the plan) and creation of Roth accounts for state and local 457 plans. (These provisions are referenced on Page 5 of the official summary document.) This provision was designed as a federal revenue raiser, generating $5.1 billion over ten years.

The measure also provides for partial annuitization of a nonqualified annuity contract, holders of nonqualified annuities (i.e., annuity contracts held outside of a tax-qualified retirement plan or IRA) may elect to receive a portion of the contract in the form of a stream of annuity payments (and remit income taxes accordingly), leaving the remainder of the contract to accumulate income on a tax-deferred basis. This provision also raises federal revenue, generating $956 million over ten years.

As H.R. 5297 proceeds to consideration on the Senate floor, it remains possible that lawmakers will attempt to attach technical corrections language related to the defined benefit plan funding relief provisions of the Preservation of Access to Care for Medicare Beneficiaries and Pension Relief Act (H.R. 3962). The timeline for a vote on the bill is still uncertain.

President Obama Signs Pension Funding Relief Into Law

O June 25, President Obama signed into law the Preservation of Access to Care for Medicare Beneficiaries and Pension Relief Act (H.R. 3962), a measure providing for a six-month delay in the reduction in Medicare payments to doctors as well as long-awaited defined benefit pension plan funding relief.

The funding relief provisions are essentially the same as those included in the American Workers, State and Business Relief Act (H.R. 4213, passed by the Senate in March). Specifically, the legislation includes an extended period for single defined benefit plans to amortize "the shortfall amortization base" (i.e., the portion of the funding shortfall that is recognized in any one year under the funding rules). Along with this relief, the legislation attaches conditions applicable to single employer plans on the use of relief in the form of a "cash flow rule."

Plan sponsors may take advantage of the funding relief provisions immediately.

Senate Aging Committee Hearing Focuses on Lifetime Income

On June 16, the Senate Special Committee on Aging held a hearing titled "The Retirement Challenge: Making Savings Last a Lifetime" that included testimony from two panels.

The first panel, which included Phyllis Borzi, Assistant Secretary of Labor, Employee Benefits Security Administration, Department of Labor (DOL), and J. Mark Iwry, Senior Advisor to the

Secretary of the Treasury and Deputy Assistant Secretary for Retirement and Health Policy, Treasury Department (Treasury), focused primarily on the responses received by the agencies in response to the joint DOL-Treasury Request for Information (RFI) on Lifetime Income.

Borzi reported they received nearly 800 letters in response to the RFI, including more than 600 ordinary citizens who were primarily concerned about a government takeover of the employer-sponsored retirement system. Borzi said she does not support a government takeover and that the RFI was intended to start a dialog about lifetime income. She said many of the comments disagreed on whether employers should be required to offer lifetime income options, including annuities. She also stated that giving employees "account specific" information about the income that the balances in their own account could generate as lifetime income would be good.

Iwry stated that he is not suggesting that more annuitization is right for everyone but thinks more transparent, user-friendly options should be made available to participants. He thinks that participants could benefit from involvement by their employers who have fiduciary obligations and more buying power.

One focus of the second panel was an Aspen Institute proposal for "Security Plus Annuities" that would allow individuals to buy more Social Security income at the time of retirement with annuities underwritten by private insurance companies that would become part of the Social Security payments, according to a description given by Lisa Mensah, Executive Director, Aspen Institute's Initiative on Financial Security, and one of the panelists.

Aging Committee Chairman Herb Kohl (D-WI) asked other panelists for their opinions on the idea and they appeared to have significant concerns. Fellow panelist Kelli Hueler, Founder and CEO of Hueler Companies, stated that participants place a lot of trust in their employers and it would be difficult to get employers excited about what they would perceive as another large government-sponsored program. Panel member William Mullaney, President, U.S. Business, MetLife, (representing the American Council of Life Insurers) stated that there is a robust market for annuities and solutions for individuals are very specific. The remaining panelist was Ted Beck, President and CEO of National Endowment for Financial Education, who stated that individuals needed to be aware of the pluses and minuses and be able to compare options.

RECENT REGULATORY ACTIVITY

Agencies Release Interim Final Regulations on PPACA Requirements for Preexisting Conditions, Annual & Lifetime Limits, Rescissions, Patient Protections

The Department of Labor's (DOL) Employee Benefits Security Administration (EBSA) has published interim final regulations relating to the Patient Protection and Affordable Care Act (PPACA) requirements for preexisting conditions, annual and lifetime limits, rescissions and patient protections.

The agencies have also released the following model notices for compliance with the law's notification requirements:

- Model Notice on Patient Protections
- Model Notice on Lifetime Limits No Longer Applying and Enrollment Opportunity

- Model Notice of Opportunity to Enroll in Connection with Extension of Dependent Coverage to Age 26

Under PPACA, group health plans and individual health insurance coverage are prohibited from imposing preexisting condition exclusions, effective for plan years beginning on or after January 1, 2014. But for individuals under age 19 they become effective for plan years on or after September 23, 2010. The prohibition includes denial of coverage under a plan or insurance coverage and denial of specific benefits based on the preexisting exclusion.

Under PPACA and the IFR, group health plans and health insurance issuers are generally prohibited from imposing lifetime and annual limits on the dollar value of health benefits. The regulations' preamble explains that the annual limit does not apply to flexible spending arrangements (FSAs, which are subject to a $2,500 limit beginning in 2013 under another PPACA provision), medical savings accounts (MSAs) or health savings accounts (HSAs). Health reimbursement arrangements (HRAs) are not subject to the annual limit when they are integrated with other coverage as part of a group health plan that otherwise complies with lifetime and annual dollar limits. Retiree-only HRAs are also not subject to the annual limits. The agencies have specifically requested comments regarding application of the annual limits to stand-alone HRAs.

PPACA prohibits annual limits on the dollar value of benefits generally, but allows "restricted annual limits" with respect to "essential health benefits" as defined by the statute up to 2014. The statute also provides that a plan or insurance issuer may impose annual or lifetime per-individual dollar limits on covered benefits that are not essential health benefits. The IFR defines "essential health benefits" by referencing the statutory definition and "any applicable regulations." The preamble explains, however, that such regulations have not been issued yet, and for purposes of enforcement, the agencies will take into account "good faith efforts to comply with a reasonable interpretation" of the term.

The IFR adopts a three-year phased approach for restricted annual limits for "essential health benefits":

- $750,000 for plan or policy years beginning on or after September 23, 2010, but before September 23, 2011
- $1.25 million for plan or policy years beginning on or after September 23, 2011, but before September 23, 2012
- $2 million for plan or policy years beginning on or after September 23, 2012, but before September 23, 2014

Since these are minimums for plan years, plans or issuers may use higher annual limits or impose no limits. The preamble clarifies that the minimum annual limits for plan years beginning before 2014 apply on an individual-by-individual basis, meaning that any overall annual dollar limit for families may not operate to deny a covered individual the minimum annual benefits for the plan year. The IFR also requires that a special enrollment opportunity be offered for individuals who are not eligible for benefits because of the prior application of an annual and lifetime limits rule.

According to the preamble, the restricted annual limits provided in the IFR are designed to ensure that individuals would have access to needed services with a minimal impact on premiums. To ensure that individuals with certain coverage – including coverage under a limited

benefit plan or so-called "mini-med" plans – would not be denied access to needed services or experience more than a minimal impact on premiums, the IFR provides for the HHS Secretary to establish a program under which the requirements related to restricted annual limits may be waived if compliance with these interim final regulations would result in a significant decrease in access to benefits or a significant increase in premiums. The preamble states that guidance from the HHS Secretary regarding the scope and process for applying for a waiver is expected to be issued in the near future.

ERRP Application Now Available, with Updated FAQ

The U.S. Department of Health and Human Services (HHS) has posted the Official Early Retiree Reinsurance Program (ERRP) Application, with the address to which completed forms should be sent, along with application instructions and a new document, Application Submission Dos and Don'ts. The $5 billion EERP program established under the Patient Protection and Affordable Care Act (PPACA) provides reimbursement to participating employment-based plans for a portion of the cost of health benefits for early retirees and their spouses, surviving spouses and dependents.

HHS subsequently posted an updated Frequently Asked Questions document with new information about definitions; applications; claims submissions and reimbursement requests; use of reimbursement; reporting data inaccuracies; fraud, waste and abuse; maintenance of effort and miscellaneous issues.

All of these documents are available on the agency's Office of Consumer Information and Insurance Oversight (OCIIO) "Regulations and Guidance" Web site.

Agencies Issue Interim Final Regulations for "Grandfathered" Health Plans

Long-anticipated regulations implementing the "grandfather" provisions of the Patient Protection and Affordable Care Act (PPACA) were released by the Departments of Labor, Health and Human Services (HHS) and Treasury during an agency press conference. A 60-day public comment period began on June 17, 2010.

Section 1251 of PPACA (as modified by the Reconciliation Act), specifies that group health plans or insurance coverage existing on the date of enactment (March 23, 2010) are not required to comply with certain plan requirements under PPACA. These include, for example, the requirement for coverage of preventive care at no cost to the participant or insured. As explained in the preamble to the IFR, however, PPACA does not address at what point changes to such group health plan or health insurance coverage are significant enough to cause the plan or health insurance coverage to cease to be a grandfathered plan, leaving that question to regulatory guidance.

The interim final regulations (IFR) set out the specific requirements that a group health plan or insurance carrier must comply with in order to maintain status as a "grandfathered" plan. In general, the rules provide that grandfather plans will lose their status if "they choose to make significant changes that reduce benefits or increase costs to consumers", according to a fact sheet issued by the agencies. Specific requirements with respect to these changes are set out in further detail in the IFR. These include rules with respect to changing benefits, employee cost sharing and employer contributions. The regulations also provide a good faith compliance standard and grace period for plans that may have changed their plans subsequent to March 23, 2010, to allow them to comply with the new IFR.

This IFR also addresses whether PPACA's plan requirements apply to retiree-only coverage and whether a delayed effective date applies to plans subject to collectively-bargained agreements (CBA). According to the preamble, the current law exception for certain retiree-only plans is preserved under PPACA and as a result, its reforms do not apply to such plans.

The preamble also states that collectively bargained plans, (both insured and self-insured) that are grandfathered plans are subject to the same requirements as other grandfathered plans and are not provided with a delayed effective date for the provisions with which other grandfathered plans must comply. Thus, according to the preamble, the provisions that apply to grandfathered health plans apply to collectively bargained plans before and after termination of the last date of the applicable collective bargaining agreement.

ERISA Advisory Council Discusses Retirement Plan Audits

On June 29, the U.S. Department of Labor's (DOL) ERISA Advisory Council (EAC) met to hear testimony on Employee Benefit Plan Auditing and Financial Reporting Models. The EAC intends to study whether the audit requirement and financial reporting model contained in ERISA Sections 103 and 104 provide the protections to plan participants and beneficiaries that Congress originally intended when it enacted ERISA in 1974.

The EAC panel focused on independent plan audits performed in conjunction with Form 5500 annual report filings rather than DOL audits. Witnesses included Ian Dingwall, chief accountant for DOL's Employee Benefit Security Administration (EBSA); Joe Canary, deputy director of EBSA's Office of Regulations and Interpretations; and senior members of the American Institute Certified Public Accountants (AICPA).

Ian said they have identified four problem areas in audits: (1) inadequate technical training and knowledge, (2) lack of background knowledge of ERISA and unique nature of auditing employee benefit plans, (3) lack of internal controls and processes for high quality products, and (4) lack of understanding of limited scope audits. The DOL officials also noted that the current rate of noncompliance is high.

Several EAC members asked whether the DOL could require that auditors have additional knowledge of plans in order to perform audits of plan assets and the DOL representatives said they are constrained by the statute. The DOL brochure Selecting an Auditor for Your Employee Benefit Plan is currently posted on the EBSA Web site.

The AICPA witnesses spoke in favor of repealing the "limited scope audit," currently allowed when plan assets are held by financial institutions subject to extensive oversight and regulations and the assets are "certified" by those institutions. Such audits examine only assets not held by the certifying entities while examining whether plan contributions, distributions, etc., are properly handled. AICPA representatives estimated that 60 to 70 percent of the 80,000 plan audits they handle per year are limited scope audits.

The DOL witnesses also mentioned the limited scope audit in response to a question about roadblocks to legislation, noting that previous legislative proposals faced objections from the business community. During discussion, the EAC panel expressed opposition to outright repeal of limited scope audits, though some favored tightening up the rules. Absent repeal of the limited scope audit, AICPA witnesses suggested that DOL inform fiduciaries of their obligations with respect to the audits (including guidance on acceptable certifications) and require that 5500

filings include the certifications as well as the limited scope audit. The AICPA representatives also requested separate accounting rules for 403(b) plans.

During discussion, the EAC panel also discussed the applicability of these audits to health plans, specifically "partially funded" health plans (perhaps where only the employee contributions are trusteed), emphasizing the importance of a plan sponsor's financial stability. AICPA representatives requested that changes be made to the audit requirements for health plans, stating that they can be very complex and costly while providing little benefit to plan participants. However, the panel also acknowledged that the current implementation of broad health care reform would overshadow separate DOL activity at this time.

The EAC plan audit working group will hold another hearing on August 31 focusing on the limited scope audit and 403(b) plan issues.

Proposed TDF Rule Formally Published

On June 23, the Securities and Exchange Commission (SEC) formally published a proposed rule that changes the rules applicable to mutual fund advertising and marketing materials to add new disclosure requirements for target retirement date funds (TDFs). The Commissioners of the SEC voted unanimously to propose the new rule in a June 16 meeting.

The proposed rules would require that:

- Marketing materials for a target date fund that includes the target date in its name need to disclose, together with the first use of the fund's name, the asset allocation of the fund at the target date;
- Marketing materials that are in print or delivered through an electronic medium need to include a table, chart, or graph depicting the fund's glide path, together with a statement that, among other things, would highlight the fund's asset allocation at the landing point (when the fund becomes most conservative);
- Radio and television advertisements need to disclose the fund's asset allocation at the landing point;
- Marketing materials need to state that a TDF should not be selected based solely on age or retirement date, that a TDF is not a guaranteed investment, and that a TDF's stated asset allocation may be subject to change;

The last three items above apply regardless of whether the TDF includes a target date in its name.

The proposal also provides additional guidance regarding statements in marketing materials for TDFs and other investment companies that could be misleading (which the proposal labels "Antifraud Guidance"). The proposed rule indicates that a statement suggesting that securities in an investment company are an appropriate investment could be misleading in two circumstances. First, such a statement could be misleading because it places emphasis on a single factor, such as an investor's age or tax bracket, as the basis for determining that an investment is appropriate. Second, a statement could be misleading because of representations, whether express or implied, that investing in the securities is a simple investment plan or requires little or no monitoring by the investor.

The SEC has requested comments and the proposed rule includes a number of questions it would like to see addressed. Comments on the proposed rule are due on or before August 23, 2010.

IRS Provides Disaster Relief to Sponsors of Pre-Approved Defined Contribution Plans

On June 21, the Internal Revenue Service (IRS) issued Notice 2010-48, providing relief to sponsors of defined contribution pre-approved plans (i.e., master and prototype ("M&P") and volume submitter ("VS") plans) affected by recent federally declared disasters in certain parts of Alabama, Connecticut, Massachusetts, Mississippi, New Jersey, Rhode Island, Tennessee and West Virginia. Section III.B of the notice establishes the definition for an "affected plan" eligible for relief.

The relief provided by this notice extends the deadline for restating affected pre-approved defined contribution plans (and, if applicable, for submitting determination letters to the IRS) from April 30, 2010, to July 30, 2010. The remedial amendment period with respect to these plans under tax code Section 401(b) is also extended to July 30, 2010. The relief provided by this notice is in addition to relief already provided by IRS with respect to these federally declared disasters.

Plan sponsors submitting a determination letter pursuant to this notice should write "Extension Relief per Notice 2010-48" in the upper margin of the cover letter (do not write this on the determination letter application form).

Treasury Issues COBRA Premium Assistance Interim Report

In 2009, approximately two million households benefitted from COBRA premium assistance at a cost of just over $2 billion, according to a report released on June 18. The Department of the Treasury (Treasury) released an interim report to Congress today as directed under the American Recovery and Reinvestment Act of 2009 (ARRA) to detail how many have participated in the COBRA premium assistance program and the related administrative expenses.

The study states that "it is not possible to determine the percentage of former employees eligible for COBRA premium assistance who actually received the premium assistance". However, today's report sites a previous Treasury study of beneficiaries in New Jersey to estimate that approximately 15 percent of those eligible received support, while "between a quarter and a third of COBRA premium assistance eligible Unemployment Insurance beneficiaries enrolled in subsidized continuing health insurance".

Administration of the program falls to three executive agencies – the Internal Revenue Service (IRS, to process payments), the Department of Labor (DOL, reviews claims regarding private employers with more than 20 employees) and the Department of Health and Human Services (HHS, reviews claims for other types of employers). Of note in the interim report, employers filed more than 300,000 claims with the IRS during 2009 for credits of over $2 billion. DOL received more than 20,000 requests to expedite review of specific cases and has closed more than 19,000 of these cases during this period. Of those closed, approximately 22 percent upheld the employer's determination of a beneficiary's eligibility, while 65 percent overturned the employer's decision.

The DOL's outreach and education programs added to the agency's total cost of administering the COBRA assistance program of $4.2 million. Less than $2 million was spent by the IRS, the report states – highlighting that because the program was administered through the payroll tax withholding process program costs were "modest". In total, costs for the program so far reached less than $8 million, or less than .5 percent of the assistance provided to participants.

As directed, the Treasury intends to release a final report shortly after the COBRA premium assistance program closes. The current closure date is August 31, 2011.

IASB Issues FAQ on Pension Accounting

The International Accounting Standards Board (IASB) has released a set of Frequently Asked Questions related to its recent exposure draft on Defined Benefit Pension Plans.

The IASB has published an exposure draft of changes to IAS 19, *Employee Benefits*. If adopted, these changes would amend the accounting rules for defined benefit plans such as pensions and post-employment medical care. A snapshot of the amendments produced by the IASB is also available.

Specifically, the amendments would change IAS 19 by requiring plan sponsors in affected countries to:

- account immediately for all estimated changes in the cost of providing these benefits and all changes in the value of plan assets (often referred to as removal of the 'corridor' method);
- use a new presentation approach that would clearly distinguish between different components of the cost of these benefits; and
- disclose clearer information about the risks arising from defined benefit plans.

GASB Issues Preliminary Views On Pension Standard Revisions

The Government Accounting Standards Board (GASB) has released a document on pension accounting and reporting by state and local government employers. It also issued a companion supplement that more generally describes its views. Only the official document is open for public comment. The GASB plans to begin deliberations in July on possible revisions to the pension note disclosures and supporting information. This is the result of a research project that began at the GASB in 2006 that included an invitation for comment in 2009 to which it received more than 120 comments. The GASB has received criticisms that the current financial disclosures related to these plans are not particularly useful.

Currently funding and disclosure for public plans tends to be closely linked. The newly released official document would potentially delink disclosure from funding. However, as many private employers learned when the Financial Accounting Standards Board delinked disclosure from funding for their plans under FAS87, investors applied pressure for private plan sponsors to fund toward their financial reporting results. We could anticipate similar pressure on public plan sponsors.

There is widespread belief that the true unfunded pension liabilities for state and local governments are much greater than are currently reported. To the extent that public disclosure

of more significant unfunded liabilities impacts their credit ratings or induces more meaningful funding of these obligations, state and local tax burdens could also be impacted.

PBGC Issues Technical Update Offering Relief on Alternative Premium Funding Target Elections

On June 16, the Pension Benefit Guaranty Corporation (PBGC) released Technical Update 10-2, outlining how plan sponsors can obtain relief for failure to check "box 5" when the intent was to elect the Alternative Premium Funding Target (APFT) when submitting their comprehensive premium filing for their defined benefit plan. Plan sponsors will have the later of 30 days after the publication of the guidance (which was June 16, 2010) or the due date for the premium filing to submit a notice affirming their intent to use the APFT. For many employers, this date would be July 16, 2010. This deadline follows what was mentioned in Acting PBGC Director Vincent Snowbarger's recent letter to Congressional leaders, notifying them of the PBGC's intent to offer this relief.

In order to obtain relief, the Technical Update requires that the premium filing concern a plan year commencing in 2008 or in 2009 (if the plan's comprehensive premium filing is due on before July 15, 2010). The original filing must have been completed on time with the alternate method selected on line 7d(1) and the premium must have been paid using the APFT. If all of the above conditions are met and the plan administrator files a timely notice with all of the required information and plan sponsor attestations with the PBGC, the PBGC will review the notice and comprehensive premium filing and then notify the plan sponsor that the plan is deemed to have made a valid election to use the APFT, first effective for the applicable plan year. The Technical Update notes that relief is available even if the plan sponsor previously amended its comprehensive premium filing to use the standard premium funding target. Upon approval of the relief request (notice), the PBGC will disregard the amended submission.

Many companies seeking to use the so-called "alternative method" for determining liabilities for PBGC premium calculation purposes have reportedly been informed that their forms contained technical errors that would invalidate each plan's clear intent to elect the alternative method for 2009, thus substantially increasing each plan's 2009 premium requirements.

On May 20, the Democratic chairmen and ranking Republican members of the Senate committees with ERISA jurisdiction wrote a letter to Pension Benefit Guaranty Corporation (PBGC) Director Vincent K. Snowbarger covering the same basic issues as our April 2nd letter. In reply to the senators' letter, the June 7 Snowbarger letter and the newly released Technical Update represent a significant change in previous PBGC policy compared with the views expressed earlier this spring.

The Technical Update does not cover other situations, such as late filings and discount rate errors. As mentioned in the June 7 Snowbarger letter, these situations will be handled on a facts and circumstances basis in accordance with the PBGC's normal administrative review regulation.

DOL Finalizes QDRO Rule

On June 10, the Department of Labor's Employee Benefits Security Administration (EBSA) published a final rule clarifying certain issues relating to the timing and order of domestic relations orders. The rule finalizes an interim final rule published in March 2007 that was published at the direction of Congress under the Pension Protection Act of 2006 (PPA).

The PPA directed Congress to clarify that (1) a domestic relations order otherwise meeting the requirements to be a qualified domestic relations order (QDRO) would not fail to be a QDRO solely (1) because the order is issued after, or revises, another domestic relations order or QDRO, or (2) because of the time the order is issued (basically allowing a QDRO to be issued after the death of the participant).

PBGC Reconsiders Position on Premium Filing Issue

On June 7, PBGC Acting Director Vincent Snowbarger sent a letter to Congressional leaders, indicating that the PBGC would provide relief for failure to check "box 5" when the intent was to elect the Alternative Premium Funding Target (APFT). Specifically, the agency plans to issue a Technical Update that would provide plan sponsors a period of time, such as 30 days, during which they could submit a letter affirming their intent to use the APFT. For this purpose, the original filing must have been completed on time with the alternate method selected on line 7d(1) and the premium must have been paid using the APFT. The letter indicates that other situations such as discount rate errors and late filing situations might be considered on a facts and circumstances basis.

Many companies seeking to use the so-called "alternative method" for determining liabilities for PBGC premium calculation purposes have reportedly been informed that their forms contained technical errors that would invalidate each plan's clear intent to elect the alternative method for 2009, thus substantially increasing each plan's 2009 premium requirements.

RECENT JUDICIAL ACTIVITY

U.S. Supreme Court Denies Rehearing of San Francisco Health Care Case

The U.S. Supreme Court has denied a petition for *certiorari* in *Golden Gate Restaurant Association (GGRA) v. City and County of San Francisco*, thereby denying any further appeal in this key ERISA preemption case. As we have previously reported, this case centers on a local ordinance that requires employers to make minimum qualifying health care expenditures on behalf of workers or pay the required amounts to the City of San Francisco.

In September 2008, the U.S. Court of Appeals for the 9th Circuit upheld the employer spending requirements of a San Francisco health care ordinance, holding that the requirements are not preempted by ERISA. This ruling rejected the arguments of plaintiff Golden Gate Restaurant Association (GGRA) and reversed an earlier district court decision.

During the George W. Bush administration, the U.S. Department of Labor (DOL) had submitted an *amicus* brief to the Ninth Circuit in support of GGRA, arguing that a rehearing is appropriate because the extent to which ERISA permits state or local governments to require employers to pay for or provide medical benefits to their employees is a "question of exceptional importance due to the significant, disruptive consequences of a ruling that undermines the federal ERISA scheme by exposing employers to the complexity of complying with a potential myriad of state and local laws similar but not identical" to the Ordinance.

In a subsequent brief submitted last month at the request of the Supreme Court, however, DOL recommended against review of the issue. Citing the enactment of comprehensive health care reform, DOL argued that "it significantly reduces the potential that state or local governments will choose to enact health care programs" like the San Francisco employer spending requirement and may also affect the question of whether such programs are preempted by

federal law. For the same reasons, the brief also stated that the DOL had decided not to proceed with a regulation it was considering clarifying when state or local health care programs result in creation of ERISA plans.