RECORD OF SOCIETY OF ACTUARIES
1975 VOL. 1 NO. 4

IMPACT OF ERISA ON OTHER THAN PENSIONS

Moderator: RICHARD J. MELLMAN. Panelists: VINCENT W. DONNELLY, WILLIAM A. FEENEY, BUCKNER S. MORRIS

1. Washington developments. Up-to-the-minute report from ALIA-HIAA.

2. Discussion of questions affecting group insurance.

3. Discussion of questions affecting employer-related individual policy insurance programs (split dollar, payroll deduction, salary allotment, etc.).

MR. RICHARD J. MELLMAN: To open our discussion, let me answer a basic question: Isn't the Employee Retirement Income Security Act of 1974, ERISA, really a pension reform act and why are we concerned about its impact on group insurance, group life and group health, and individual policy matters? Section 3, subsection 1 of the law, defines the term "welfare plan." It says, "The term, employee welfare benefit or welfare plan, means any plan, fund or program, heretofore or hereafter established or maintained by an employer or an employee organization or both, to the extent that such plan, fund or program was established or is maintained for the purpose of providing for its participants or their beneficiaries through the purchase of insurance or otherwise, medical, surgical or hospital care or benefits in the event of sickness, accident, disability, death or unemployment." It then goes into a number of noninsurance kinds of things, such as vacation benefits, apprenticeship, training programs, day-care centers, scholarship funds and prepaid legal services. So, we are very much concerned with how the law impacts, not only on group insurance, but also on certain individual policy programs for employees and also on such plans, whether they are uninsured or partially insured, as administrative services only (ASO) or minimum premium plan (MPP) programs.

Our panel this afternoon are members of a joint task force of the American Life Insurance Association (ALIA) and the Health Insurance Association of America (HIAA) which is concerned with the impact of ERISA on other than pension plans.

MR. VINCENT W. DONNELLY: I shall restrict my comments on the status of the various provisions of ERISA to the major reporting, disclosure, and fiduciary provisions.

SECTIONS OF THE LAW APPLICABLE TO WELFARE BENEFIT PLANS

First of all, let me outline briefly the sections of ERISA which have application to employee welfare benefit plans.

1. Section 3 of the Law defines the term "employee welfare benefit plan" and various other terms pertinent to ERISA. The Regulations issued periodically by the Department of Labor have been used as a means of expanding upon the "Law" definition as questions have been raised by our industry and others. For example, the term "plan participant" was defined very specifically in the reporting and disclosure regulations released by the Department of Labor on August 15.

2. Section 4 tells us which plans are covered and which are not. From an employee welfare benefit plan viewpoint, the exclusion of plans maintained by an employer solely to comply with the disability insurance laws of Rhode Island, New York, etc. was an important exemption.

3. To many of us, Sections 101 through 111 of the Law are the most important sections since they are the guts of the reporting and disclosure requirements for insured welfare benefit plans. The scope of the reporting and disclosure requirements (i.e. who reports and when) were detailed in the regulations released by the Department of Labor on August 15.

4. Sections 401 through 414 dealing with the fiduciary responsibilities of employers, administrators, insurers, etc., will eventually become the most important sections of ERISA, if we are not to that point already. Sections 406 (Prohibited Transactions) and 408 (Exemptions from Prohibited Transactions) are vital to the continuation of our business. Later on in these remarks, I shall discuss some specific exemptions which our industry is currently pursuing with the Department of Labor.

5. Section 503 dealing with the claims procedures followed by employee welfare benefit plans is controversial even within our own industry. Our industry will seek an interpretation of the role of the insurer to clarify this obviously confusing (and possibly conflicting) section of the Law.

6. Section 514 preempts state regulation of employee welfare benefit plans with respect to reporting, disclosure, and fiduciary requirements. It is still unclear whether the preemption extends further. To my knowledge there has been no attempt to test the full scope of this section of the Law. The industry has been successful, most notably in California, in convincing state insurance departments that individual state regulations relating to insurance company reporting and disclosure are duplicative of ERISA requirements and are, therefore, costly and confusing to those they are meant to protect.

7. Section 2006 pertains to the so-called "cafeteria" plans, but only those involving a choice between a salary increase and pension-type benefits.

INDUSTRY BULLETIN AND COMMITTEE SYSTEMS

I would like to describe the system which has been set up within our industry for keeping you abreast of current events and for developing an industry "position" on issues of significant importance.

1. Bulletin System: The Bulletin System serves as a means of keeping our member companies abreast of the developing scene. Beginning with that notable day no more than 14 months ago, ALIA has issued more than 60 Bulletins dealing with substantial ERISA developments. True, a majority have dealt with issues of primary importance to the pension business, but a significant portion have had direct application to welfare benefit plans. ERISA represents the most prolific subject in the annals of the Association. In fact, we who deal with ERISA daily become dismayed when our string of consecutive Bulletins happens to be broken by an occasional Bulletin on an SEC, tax or other issue. Because of this volume of activity, beginning in July we changed our distribution system. We did this because of concern that the ERISA material may not have been reaching those of you in your respective companies who had the most need of the information. We wrote directly to the corresponding officer of each member company asking that he provide us with the name(s) of the individual(s) within his company who had such need and we then set up our ERISA distribution

system with those persons specifically in mind. Because ERISA's application to welfare benefit plans crossed Association lines (ALIA - HIAA) we included within our ERISA Bulletin System those companies with HIAA membership but not ALIA membership. If you were a casualty of the deficiency of the previous communication system, we hope you have now been brought aboard. If you are still adrift, then you should contact your company's corresponding officer and see to it that he is made fully aware of your ERISA information needs. We are now entering a period of high activity on the part of the Department of Labor, when you need to be informed -- and we need your viewpoints.

2. Committee System: Our Committee System keeps us abreast of the individual company positions and allows the industry to present a unified position when it is called for. But this is not to the exclusion of individual company submissions -- when such submissions have been made, they have generally been helpful to the overall industry position.

Our Committee structure is significant and far-reaching. We have six Task Forces which deal with ERISA subject matter -- five prepare the pension viewpoint and one considers the welfare benefit plan aspects. This last Task Force meets approximately every six weeks, with special meetings when Labor Department activity warrants it. This Task Force was especially valuable in developing a strong industry position in response to the Labor Department's June 9 proposed reporting and disclosure regulations that would have required contributory welfare benefit plans of less than 100 participants to meet the full reporting and disclosure requirements of the Law. As you know, the August 15 final regulations provided these plans with a needed exemption, assuming such contributions are transferred to the insurer within three months of their collection by the employer. This same Task Force will soon be preparing industry positions regarding the Annual Report (IRS 5500) and Plan Description (EBS-1) forms recently released by the Department of Labor. This Task Force is chaired by our panel Moderator, Dick Mellman, and is comprised of eleven representatives from our industry. The HIAA staff contact is Tom Gillooly and the ALIA staff, in addition to myself, are Bill Gibb, Steve Krause, Dick Minck, and Bruce Nickerson.

ADVISORY COUNCIL

I would be remiss if I did not make mention of the Advisory Council which was appointed by the Secretary of Labor to assist the Department in its interpretation and application of the Law. The Council is composed of 15 members from all walks of life, including two from the insurance industry. The Advisory Council is actually broken down into "work groups" dealing with such areas as investments, recordkeeping, seasonal industries, prohibited transactions, and, most recently, small plans (the effect of ERISA thereon).

PLAN DESCRIPTION (EBS-1)

Back in April, Dick Mellman, in speaking before an overflow crowd at the HIAA Group Forum on this very same subject, reported that Labor Department officials were said to be trying to avoid inundating everyone in a "paper blizzard." A few days thereafter, April 21 to be exact, Jim Hutchinson took over ERISA responsibility within the Labor Department. On that same day the initial version of EBS-1 was released and its volume led many of us to seriously question the avowed intentions of the Labor Department officials. Subsequently, this initial version of EBS-1 was retracted and between that time and October 10, Jim Hutchinson and his staff made a lot more "paper blizzard" speeches. On that latter date (October 10) the revised EBS-1 form was released and went a

long way towards eliminating the "paper blizzard" -- the form is now only six pages long but,more importantly, the narrative portion of the earlier form has been completely replaced by a "check-block" format. Comments are due by November 9, and our ERISA committees are hard at work preparing industry comments and suggestions. Your viewpoints are welcomed.

ANNUAL REPORT (IRS 5500)

On September 30, the Labor Department released the proposed format of the Annual Report required under Section 103 of ERISA. Consistent with the Government's avowed intention to avoid the collection of duplicate information by the Department of Labor and IRS, welfare benefit plans need submit the report only to the Department of Labor. Such plans having fewer than 100 participants throughout the plan year are exempt, including contributory plans. Comments are due by October 30 and are currently being prepared by the aforementioned committees. Again, your suggestions are welcomed.

H. R. 7597

The fiduciary provisions of the Law (Section 401 through 414) are fast becoming the most controversial (and therefore most important) sections of ERISA to the insurance industry. The U.S. Senate was responsible for the "Prohibited Transactions" concept. It was born out of compromise and is yet to be proven workable. If this section proves unworkable (that is, if the Labor Department becomes bogged down in a completely impossible volume of requests for legitimate exemption) then a procedure originally pursued by the House of Representatives and currently described in H. R. 7597 (the House Bill being sponsored by Representatives Dent and Erlenborn) may well be the solution. At this particular moment, H. R. 7597 is being opposed by both the Treasury and Labor Departments (primarily because they believe the exemption procedure will work) and has not passed the House Labor Committee. Even if it were to pass this Committee, a similar Bill would still have to be passed by the Ways & Means Committee for the proposal to have some legislative life. To date we have seen no activity in that regard.

With respect to the sections on prohibited transactions (Sections 406 and 408 of the Law), let me refer to two recent requests for exemption from the prohibited transactions provisions that were directed to the Labor Department (and the IRS) by our industry.

1. Agent - fiduciary question. On October 14, the American Life Insurance Association, the National Association of Life Underwriters, and the Association for Advanced Life Underwriting jointly submitted a request to the Department of Labor and IRS for the promulgation of a regulation under ERISA making clear that the normal sales presentation and recommendations made by a life insurance agent or broker to an employee benefit plan do not constitute the rendering of investment advice which, if ruled otherwise, would serve to classify such agent or broker as a plan fiduciary. In conjunction therewith, these same associations filed an application for an administrative class exemption under Section 408(a) of ERISA (and the appropriate IRS section) which would permit an agent or broker who becomes classified as a fiduciary to receive commissions and other compensation for the sale of life insurance company products to an employee benefit plan. These subjects have been a source of constant concern to our entire industry since the advent of ERISA and a favorable response to the noted requests is considered essential to the continuation of our business. The details of this issue are being sent to all recipients of ERISA bulletins within the next few days.

2. Prohibited transactions. A more minor issue, but one of significant importance to many of our companies, involves Section 408(b)(5)(A) of the Law. This section permits by exemption an insurance company to underwrite its own employee benefit plan and also permits a non-insurance company to insure its employee benefit plan through a wholly owned subsidiary as long as the premiums for such plan do not exceed 5% of the total premium income of the insurer. The Association has requested a similar exemption for the reverse situation -- that is, one where the insurance company is the parent corporation of a group of life and non-life insurance corporations. While it was recognized that there were a myriad number of situations in which life insurers could find themselves which would not be satisfied by this general exemption (and which would, therefore, require that company to seek an individual exemption), it was the feeling of the Association that this limited extension of the existing exemption was both rational and attainable.

CONTRIBUTORY WELFARE BENEFIT PLANS

One final area of earlier concern should be included in my remarks. During the HIAA Group Forum held in April, Dick Mellman alluded to the possibility of the Labor Department issuing a regulation which would require the establishment of a trust by an employee welfare benefit plan which involved employee contributions. The ALIA submitted comments to the Labor Department explaining the massive problems inherent in such a requirement. To date, the Labor Department has issued no such regulation. Based upon the recently released reporting and disclosure regulations as they related to contributory plans, it seems apparent that, if the Department ever requires a trust for employee contributions, it would relate such a requirement only to employee contributions which are not conveyed to an insurer within three months of their receipt by the employer. It is presumed that such a regulation, if ever proposed, would be acceptable to our industry.

CLAIMS FIDUCIARY

One final point of new information. As I mentioned earlier in discussing the fiduciary provisions of ERISA, there has been a great deal of concern within our industry over the claim procedure requirements of Section 503. That section, among other things, mandates the availability of a review of any claim denial. At the same time, the Labor Department seems to add the interpretation that the party performing the review must meet fiduciary standards. The conflict comes from the fact that the insurer wants to perform the review function but either cannot or will not accept fiduciary responsibility. Without going into a lot of detail, the industry approached the Department of Labor today requesting an interpretation of the Law which will:

1. allow the insurance company to retain full responsibility for the review of claims denied under the provisions of its contract;
2. not attach fiduciary standards to the insurance company because of its performance of such functions; and
3. permit the "plan" to fully satisfy the requirements of Section 503. The details of this request will be made generally available shortly.

MR. BUCKNER S. MORRIS*: Let us see what happens to group insurance plans as a result of ERISA requirements. Note that it will be the responsibility of the group policyholder--and not the insurer--to meet these requirements. Insurers know, however, that they will need to advise their group policyholders of these requirements.

*Mr. Morris, not a member of the Society, is Vice President and General Counsel of Provident Life and Accident Insurance Company.

Basically the group policyholder will at a minumum need to do all of the following:

1. He will need a plan document which is separate from the group policy. This will describe the welfare plan, and when it consists of only those benefits provided by a group policy, may do this simply by reference to, for example, "those benefits provided by group accident and health policy No. 1234 issued by XYZ Insurance Company." This document will also name the plan administrator, who may be the policyholder or employer, and at least one fiduciary who will assume trustee duties with respect to certain aspects of the plan. This fiduciary may be, but normally will not be, the insurer.

2. There must be a plan administrator who will be responsible for all of the following reports to be filed with the Secretary of Labor:

a. A plan description describing many of the administrator's and fiduciaries' duties and the benefits and rights of participants. This is presently EBS-1, now under revision, and due to be filed May 30, 1976. A short version was due August 31, 1975.
b. An updated plan description at least every five years unless the plan has not been amended, then within ten years.
c. A summary plan description to be filed by May 30, 1976.
d. Changes in the plan and information required in the plan description must be filed within 60 days after the change has occurred, but no filing is required until May 30, 1976, for plans that filed an abbreviated EBS-1 in August.
e. A detailed annual report of the financial condition of the plan showing, among other things, the basis for the insurance companies' group rates, commissions, fees, and the like. This must be filed within 210 days after the end of the plan year, beginning in 1975 and annually thereafter. This will be known as Form 5500.
f. Terminal reports when the plan is being terminated. There are no guidelines in this area yet.

All records on these reports must be maintained for six years.

3. On a timetable similar to the reports which must be filed with the Secretary of Labor, the administrator will also be responsible for furnishing the following reports or documents to persons insured under the group policy:

a. A summary plan description.
b. An updated summary plan description.
c. A summary description of plan changes and modifications.
d. Summary annual reports.
e. Copies of documents filed with the Secretary of Labor if requested by a participant.
f. Claim decision notices, and statement of the rights of participants and beneficiaries.

Considering that insurers have at times found it difficult to see that proper group certificates are issued to the persons insured under group policies, it can readily be seen that the responsibilities involved in maintaining a group plan have vastly increased.

Not all group plans will need to furnish all the documentation outlined above. Small groups having fewer than one hundred participants at all times during the plan year will need a plan document establishing the plan and will need only to provide participants with summary plan descriptions. If the plan benefits are provided wholly through group insurance, then it is permissible

for premiums to be paid wholly by the policyholder or partly from his funds and partly by contributions of the insured persons, provided that contributions of participants are forwarded to the insurer within three months of receipt. Where this limited exemption for small plans is claimed, it is also necessary to inform participants of any dividends or experience rating credits to which they may be entitled and to return these to the participants within three months of receipt.

This limited exemption for small plans is also available to the various employers whose employees are insured under a multiple employer group policy. For ERISA purposes, this means a group policy insuring employees of two or more unaffiliated employers, but does not include those groups which ERISA has called, confusingly, "multiemployer groups"; meaning they are labor-negotiated. For employers within a multiple employer group, the plan of each employer is treated separately in determining whether the one hundred life exemption applies, and those employers qualifying need only furnish a summary plan description to the insured persons. The major difference in the exemption for multiple employer groups and other small groups is that an annual report will need to be filed. It is my understanding that the ALIA will shortly approach the Labor Department on the question of whether one annual report is to be filed or whether separate reports must be filed by each employer within the multiple employer group.

Certain trust requirements must be considered. As a general rule, unlike pension plans, no trust will be required for a welfare plan whose benefits are provided through group insurance, although there may be some interesting exceptions to this. Section 403(a) requires all assets of an employee benefit plan to be held in trust by one or more trustees. There is a difference of opinion as to whether a group policy must be considered an asset of the plan. Despite this, Section 403(b) states that this trust requirement will not apply to any assets of a plan which consist of insurance contracts, to any assets of an insurance company or any assets of a plan which are held by such insurance company; hence, the exemption of most group insurance.

There have been some indications within the Department of Labor that, if the employer retains any employee contributions too long before forwarding them to the insurance company, a trust might be required for these contributions, even though they are used to purchase insurance contracts. There is nothing definite on this from the Labor Department, however.

Also, by a proposed regulation issued on December 24, 1974, a trust need not be established for welfare benefit plans under which benefits are paid directly to the plan participants from the general assets of the person who established the plan. This would be considered an unfunded plan. The plan will not be considered unfunded, however, if there are employee contributions or there is a separately maintained bank account or fund out of which plan benefits are provided. This regulation would have no effect on the ordinary insured group plan, but it could become a problem for some administrative services only contracts or where there is an overlayer of insurance in connection with a minimum premium plan.

EFFECTS ON VARIOUS GROUP PLANS

1. Administrative Services Only. If administrative services only (ASO) contracts do not fit into one of the ERISA exemptions (church plan, government plan, etc.), they will be considered as an employee welfare benefit plan for all purposes.

ASO plans will need to draw up a plan document as any other group welfare plan would be required to do; and if there are any employee contributions involved or separately maintained bank accounts, the trust obligations of Section 403 would also have to be met. A possible trouble spot in this area could mandate a trust requirement in almost all ASO plans regardless of whether there are employee contributions. This would be the case if the Department of Labor determined that the insurance company by paying the benefits was doing so from a segregated fund. This question is difficult to cope with because ERISA does not address ASO plans directly.

2. Minimum Premium Plans. When ERISA was drafted minimum premium plans were definitely not in mind. It is very difficult to pigeonhole minimum premium plans for reporting, exemptions, and trust requirements. In a sense these plans can be considered fully insured because an insurance company stands behind the entire arrangement at all times and wraps its guarantees around the plans. If this position is taken, normal reporting and disclosure requirements would be met and no trust would be required. But this position might bring about problems with state regulatory authorities where the position has been taken that the plan is not fully insured and thus not fully subject to state premium taxes.

If the minimum premium plan cannot be considered as fully insured, then the trust requirements are troublesome. Unfunded plans without employee contributions and without any segregated accounts do not need a trust. Neither do those assets held by an insurance company or those assets consisting of insurance contracts. Does this mean that,if there are employee contributions,a trust for the self-insured portion is necessary but not for the portion handled by the insurance company?

These are touchy problems with little or no guidance as yet from regulations. In any event, a plan document needs to be created establishing the plan.

3. Taft-Hartley Plans. Taft-Hartley plans do not seem to raise any difficult problems because these are already maintained pursuant to a trust and almost all of them have more than one hundred participants--preventing any limited exemption for small welfare plans. Nonetheless, these plans will still have to be maintained pursuant to a plan document.

PREEMPTION

Section 514 is the preemption section and has probably been the subject of discussion by group insurers more than any other because it could be construed to remove state regulation in connection with uninsured group plans. I do not, however, think this is altogether the case. Section 514(a) preempts state regulation of welfare plans with respect to reporting, disclosure and fiduciary requirements. Section 514(b) exempts uninsured employee benefit plans (other than those providing primarily death benefits) from being regulated by the states as being engaged in the insurance business. There is controversy as to the extent of this preemption. Before ERISA, many states took the view that an employer who provides employee benefits directly for his employees is engaged in the business of insurance and subject to regulation by the insurance department. Such a position could also be the basis for preventing a licensed insurance company from entering into an administrative services only contract on the grounds that in so doing the company would be aiding and abetting an unauthorized insurer. Section 514(b) would appear to remove this stumbling block but there has been little direct comment on this from the states, except in New York and Pennsylvania where attorney generals' opinions published

earlier this year take the view that because of ERISA an uninsured employee welfare plan is not subject to state insurance regulation. On the other hand, an Illinois court has taken the view that an uninsured multiple employer trust is not exempt from state insurance department regulation. This does not mean, however, that Illinois would not recognize ERISA's preemption provisions in a case dealing with a single employer.

I believe most current thinking of the effect of Section 514 is that it would not preclude a state from regulating in areas not covered by ERISA. If this is so, a state could prescribe minimum benefit levels under insured as well as uninsured welfare plans. Also, while ERISA may prevent a state from imposing an insurance premium tax on uninsured plans, a tax such as Connecticut's which is levied on the benefits payable under the plan would not be preempted. I think it inevitable that the true meaning of Section 514, as well as a number of other provisions of ERISA, must ultimately be determined by the courts.

MR. WILLIAM A. FEENEY: My intent is to share with you my understanding of ERISA's application to certain types of individual insurance plans. The discussion will be restricted primarily to insurance plans (both life and health) involving some form of employer participation which could bring them within the definition of an "employee welfare benefit plan." For the most part, I will not be talking about individual insurance policies used to fund pension plans, although I will have a few comments about non-tax-qualified deferred compensation arrangements.

The definition of welfare benefit plan is very broad in its reference to insurance benefits in the event of sickness, accident, disability or death and our concern is to determine how much of ERISA is applicable to individual insurance plans which are "established or maintained by an employer."

Compliance with ERISA is primarily the responsibility of the employer. However, companies will be getting questions from their agents and as a matter of policyholder service they may wish to make available concise summaries of the requirements as they become known. Also, companies have direct responsibility in the area of providing information to employers to help them complete Annual Reports to the Labor Department, in situations where such reports are required.

The areas of reporting (i.e., filing with the Secretary of Labor) and disclosure (i.e., making plan information available to participants) represent major responsibilities for those employers who are subject to these requirements. One important filing deadline - August 31 - has just passed, but more will be coming up.

With regard to reporting and disclosure, a number of clarifications and specific exemptions have already been announced by the Department of Labor. The best possible situation with regard to an individual insurance arrangement is a determination that it's not considered to be a welfare benefit plan and therefore not subject to any of ERISA. The law specifically provides complete exemption for governmental or church plans. Our trade associations earlier this year approached the Labor Department with arguments as to why "individually negotiated agreements" between an employer and employee should not be considered as constituting welfare benefit plans. This suggestion was not adopted in the final regulations published on August 15. The final regulations do, however, include a complete exemption for certain group and "group-type" insurance programs satisfying certain conditions. This exemption I believe can reasonably be interpreted as applying to a typical individual life or health insurance salary allotment arrangement where the premiums are paid entirely by the employees.

The exemption applies to insurance programs offered by an insurance company to employees of employers under which:

1. No contributions are made by the employer.
2. Participation by employees is voluntary.
3. The sole functions of the employer are, without endorsing the program, to permit the insurer to publicize the program to employees, to collect premiums through payroll deductions and remit them to the insurer; and
4. The employer receives no consideration other than reasonable compensation for expenses incurred in handling the payroll deduction.

In this area, I would have been happier if the August 15 final regulations had not used the term "group-type" insurance programs, but the requirements certainly fit the typical salary allotment arrangement. I personally believe we would be making a reasonable interpretation of the Labor Department's intent in reading this exemption to be applicable to such an arrangement. Incidentally, when agents are selling such plans to employers, they would be well advised to stress to their clients that any employer letters or other communciations to employees should not "endorse the program"; otherwise, the exemption would be in jeopardy. The Labor Department explains that employer neutrality, that is, the absence of employer involvement, is the key to exemption.

Some individual policy salary allotment arrangements include contributions by the employer towards the premiums. There is, so far, no complete exemption from reporting and disclosure requirements for such arrangements and they would have to fall into our next category.

This category covers limited exemptions for small welfare benefit plans.

The final regulations exempt from most of the reporting and disclosure requirements, employee welfare benefit plans with fewer than 100 participants which satisfy a number of conditions. First, benefits are paid as needed solely from the general assets of the employer; or benefits are paid through insurance contracts or policies, the premiums for which are paid by the employer alone or partly by the employees. In addition, employee contributions to insurance premium payments must be forwarded to the insurance company within three months after they are made and any "rebates" under an insurance plan (presumably dividends) to which the contributing employees are entitled are returned to them within three months of receipt by the employer.

As I see it, this partial exemption would have broad application to a significant number of employee fringe benefit plans which use individual life or health insurance. I believe it would include arrangements such as:

1. Split Dollar Plans - where the employer and employee usually both share the premium cost.
2. Salary Allotment arrangements - other than those plans funded solely by employee contributions for which there is a complete exemption, as I mentioned earlier.
3. Keyman Security Plans - where the employer pays the premiums but the employee owns the policy and names the beneficiary.
4. Keyman Health Insurance Plans - where benefits are paid to employees. (Incidentally, it should be appreciated that keyman and buy-sell plans where the employer owns the policy and gets the benefits are not subject to ERISA, since there are no benefits to employees.)

5. Employee Death Benefit Plans - where the employer agrees to pay a death benefit to the employee's spouse and funds the arrangement through a policy in which the employer is the owner and beneficiary.
6. Personal Term Insurance Riders on corporate-owned policies.
7. IRS Section 79 plans.

The limited exemption provides that the employer maintaining such plans for employees will not be required to file any reports or documents with the Labor Department with respect to such plans, unless specifically requested to do so. In addition, employers will not be required to furnish any reports or documents with respect to such plans to plan participants or beneficiaries, except:

1. A Summary Plan Description by May 30, 1976, or within 120 days after a plan becomes effective if set up after January 31, 1976.
2. A Summary of Material Modifications of a plan within 210 days after the end of the plan year in which such modifications are adopted.

Another category provides limited exemptions for welfare benefit plans for select groups of employees.

The final regulations exempt certain welfare benefit plans from all reporting and disclosure requirements, except for filing plan documents if requested by the Secretary of Labor. This exemption is provided for plans maintained by an employer primarily for a "select group of management or highly compensated employees." Under these plans, benefits must be paid as needed solely from the general assets of the employer, or be provided exclusively through insurance contracts or policies purchased by the employer.

However, the regulations do not define what is meant by a "select group of management or highly compensated employees." Therefore, unless an employer and his counsel are satisfied that a plan is for such a select group, or unless clarifying regulations are issued before May 30, 1976, it may be safer to rely on the broader exemption provided for plans with less than 100 participants I mentioned before. The difference is merely in the requirement of furnishing certain information to participants and beneficiaries.

A further category in the regulations provides simplified filing for Deferred Compensation pension plans for select employees. While the primary focus of my comments this afternoon is on individual insurance which falls within the scope of an employee welfare benefit plan, I mention this category because so many deferred compensation arrangements are funded through individual insurance policies. The important point is that, if the arrangement is primarily to provide deferred compensation to employees through increased retirement benefits, then the arrangement becomes a pension benefit plan under the law and regulations.

In this area, we have an important alternative method of complying with the reporting and disclosure requirements. Employers are permitted to file a simplified statement with the Department of Labor. This statement requires very little information and drastically reduces the burden of compliance. The procedure is applicable to plans maintained by an employer primarily to provide deferred compensation for a "select group of management or highly compensated employees" which satisfy either of the following conditions:

> The first is that benefits are paid as needed solely from the general assets of the employer.
> Alternatively, the benefits must be provided exclusively through insurance contracts or policies purchased by the employer.

For plans in existence on May 4, 1975, the simplified statement should have been filed by August 31 of this year. For plans established after May 4, 1975, the statement should be filed within 120 days after the date the plan becomes effective.

Finally, we come to filing and disclosure requirements applicable to non-exempt plans. Employee benefit plans which do not come within the exemptions I have just outlined would be subject to the full reporting and disclosure requirements of ERISA. Plans in this category would include, for example:

> Employee welfare benefit plans with 100 or more participants, such as salary allotment plans where the employer contributes toward the premiums or Deferred Compensation plans for other than a select group of management or highly compensated employees. (I don't think there are many individual insurance plans in this category.)

For these plans, the plan administrator must file with the Secretary of Labor:

1. The Plan Description - by May 30, 1976. (A short form plan description was required by August 31 of this year.)
2. Substantial modifications and changes of plan - must be filed within 60 days after their effective date.
3. An annual report - starting July 29, 1976 for calendar year plans.
4. Terminal and supplementary reports.
5. A copy of the Summary Plan Description given to participants.

Summary Plan Descriptions must be given to plan participants starting May 30, 1976.

An insurance company has direct responsibility for furnishing administrators of plans in this category certain information, including:

1. The total amount of premiums received and dividends paid.
2. The approximate number of persons covered by each class of benefits.
3. The total claims paid, and
4. Names and addresses of agents to whom commissions were paid, the amount paid to each, and for what purpose.

That, I believe summarizes the reporting and disclosure requirements of ERISA for the types of plans I am discussing. Two main points - First, the reporting and disclosure requirements themselves are not onerous for the bulk of this business, considering the complete and partial exemptions allowed. Second, and of most significance in my view, is the fact that plans other than salary allotment are not totally exempt from ERISA. This means that the remaining parts of Title I are applicable.

I do not want to get into details, but what disturbs me is that the mere mention of requirements having to do with such things as plan documents, fiduciary responsibilities, prohibited transactions, disputed claim review procedures and criminal penalties for non-compliance may often be enough to kill an agent's chances of a sale. Most of the plans I have been talking about are non-tax-qualified. Lacking a tax savings incentive, it wouldn't take much to turn off an employer, for example, who had been thinking of helping his employees pay for individual life or health policies through a salary allotment arrangement.

The Labor Department staff is not insensitive to the adverse consequences of too strict an interpretation of the law. I am convinced they are trying to regulate in a reasonable and practical way, within the constraints imposed by law. At the same time, I believe it is important that we stay on top of developments and work for reasonable regulations with the help of our ALIA and HIAA staffs.

MR. DONNELLY: (In answer to a question concerning Section 408(b)(5)(B).) The request for exemption we have made applies in exactly the same way that the statutory exemption applies, only it proposes to reverse the situation. In other words, where the insurance company previously was the subsidiary, we are addressing ourselves, now, to the situation where the insurance company is the parent. That is the only difference. Also, let me state that ALIA recognizes that some companies are not covered by the existing or proposed exemption and in the case of an individual request will determine on a case-by-case basis whether the Association will support that request.

MR. CONRAD M. SIEGEL: I have a question about the multiple employer trade association plan. There is an exemption for the 100-or-less employer in such a plan if it is fully insured and the employer remits employee contributions within three months. If the entire amount remitted by the employer is not passed along to the insurance company, because that amount includes a small loading added to the premium cost in order to pay the administrative expenses of the association or trust, is that considered to be meeting the spirit of that requirement, even though the loading does provide for a trust fund build-up as the expenses fluctuate?

MR. MELLMAN: We believe that would be okay, provided that the employer contribution is at least as great as the administration charge. In other words, so long as the employees are not contributing more than the entire unloaded premium. Also, the regulations do not specify to whom the employee contributions must be remitted within three months, so we believe an employer would satisfy this requirement if he made his remittance to the trust within three months.

MR. SIEGEL: For that particular kind of plan, the position of the ALIA could be either that a single annual report be prepared for all employers, or one for each participating employer. There seems to be quite a mixup between the 5500 instructions and the EBS-1 instructions as to exactly what the situation is for employers with 100 or fewer participants in that type of plan. On the one hand, the employer doesn't have to file the EBS-1 form; on the other hand, he has to prepare an annual report. It seems to me that very few employers in such a plan would have more than 100 employees. A multiple-employer plan that I'm familiar with has 1,200 employers, of which only two have more than 100 employee participants. It might be simpler to comply with respect to those two; simply provide annual reports for those two and their employees rather than the other 1,198 so that the use of an annual report for those employers who go over 100 may be a far easier approach than a single report for all 1,200 employers.

MR. MELLMAN: This is a topic that is extremely active in our task force right now. ALIA people spent a good part of October 17 discussing this point with the Labor Department. The Department has indicated it does not yet have a definite proposal, and that it will be seeking additional comments on this question in the near future. The Labor people indicated that they are aware of the

difference between the trade association type of case, in which the trustees have an active role, and what you might characterize as the industry-wide trust, the primary purpose of which is really to give small employers an opportunity to obtain coverage at group rates. I believe that they would like to exempt the small individual employers from having to make a financial report, but still get a financial report from the combined case. If you refer back to the proposed regulations, you will see that the exemptions for individual employers with less than 100 participants covered under their own group insurance policy, Section 2520.104-20, and covered under a multiple employer group insurance policy, Section 2520.104-21, differ only in that the latter are not exempted from the various requirements concerning the annual report, such as filing of an annual report, giving the participants a summary of the annual report, and making copies of the annual report available to participants who ask to see it.

MR. ELLIS D. FLINN & MR. FRANCIS X. CODY: Welfare plans call for an annual report by a CPA who may rely on an enrolled actuary for actuarial liabilities in his report if he so states his reliance. Since pension experience is necessary for becoming an enrolled actuary, how can an actuary working on welfare plans only become enrolled? What is being done to get welfare specialists enrolled?

MR. DONNELLY: You raise a good question which our task force has not considered. We will refer it to the Academy of Actuaries for consideration by their Committee on Enrollment of Actuaries.

MR. MELLMAN: (In answer to a question as to how one counts participants.) An employee is a participant, but a dependent is not. There is a question whether the owner or partner is a participant. Clearly, in the sense of being insured, he is. But in the sense of the fiduciary having to operate in the exclusive interest of the participants, if the owner or partner is not a participant, it might be construed that the fiduciary is acting wrongfully if, for example, he informs the owner or the owner's wife how to obtain a review by the insurance carrier of his or her denied claim. So, I expect that the term "participant" does include owners and partners. Thus, if a plan covers 99 employees and two partners, it has more than 100 participants.

MR. DONNELLY: I would amplify on that in one respect. A point of concern in the definition of plan participant under a welfare benefit plan is the individual who is under an extended insurance benefit. For example, most major medical policies provide a 12-month disability extension. The individual so covered would seem to fall within the definition of plan participant. From the standpoint of 100 participants, we may have some concern there. We also are concerned over the practical matter of not knowing who is covered under the extension provision.

MR. WILLIAM E. MASTERSON, JR.: You mentioned that Section 514 preempts state premium taxation of certain uninsured welfare plans. Please elaborate.

MR. MORRIS: The point I was making is that a law, like the one in Connecticut, taxes the benefits payable under an uninsured plan rather than the premiums. I would think that this type of statute is still permissible in the light of Section 514 of ERISA.

MR. ROBERT F. CARBONE: If I understand correctly something you said earlier, that there is a difference in the status of ASO plans versus minimum premium plans on the question of the establishment of a trust, it seems to turn on the question with respect to a minimum premium plan whether it is considered fully insured or not fully insured. If it is not considered fully insured, then presumably it is in the same status as ASO. Could I have either a confirmation or a denial of that understanding and, secondly, an elaboration of any other differences in the status between ASO and minimum premium under ERISA?

MR. MORRIS: I mentioned that, if you consider the minimum premium plan as a fully insured plan, you will lose your ERISA Section 514 exemption, but you do not want to consider it fully insured because you will then lose your premium tax advantage. So, if you consider it not fully insured, then you will have a portion of it that is not insured by an insurance company. If the employer is paying the entire cost, then no trust is required. Where there are employee contributions, I believe a trust is required under both MPP and ASO. I do not see any real difference between MPP and ASO in that regard.