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# INDIVIDUAL POLICY PENSION TRUST

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1. Plan design problems as they relate to plan administration.

2. Technical aspects of handling the Funding Standard Account.

3. Reporting and disclosure.

MR. GLENN A. MATEJA: My assignment today is to discuss the plan design problems with individual policy pension trust plans (IPP) - such plan design problems are encountered in the drafting of prototype plan documents and the administration of small plans. The IPP plan is typically the plan sold to the small unsophisticated employer. Two words are important: sold and unsophisticated. The IPP plan is sold not bought and the concept that is sold is tax deductibility for the owner; the insurance product used is secondary to the sale. The small employer is unsophisticated in terms of his understanding of the law and his plan. Most do not understand their plans nor do they really want to understand the plan; they rely heavily on the expertise and administration provided by the insurance company and its agents.

Based on recent plan termination experience for IPP plans, they may be on the endangered species list and there are at least three reasons for their rapid extermination: Plan Cost, Administrative Cost, and Encroachment of the IRA.

(1) Plan Costs have increased under ERISA because of liberalized eligibility and vesting; believe it or not, most of these plans were installed to take care of the principals, not to promote the social good for the plans.

(2) Plan Administrative Costs have increased tremendously, in some cases more than plan costs. Remember, the small employer is not a "do it yourselfer"; he relies on others to advise and administer. ERISA has increased the need for professional services, created a need to readopt and redesign plans, increased record keeping requirements, created a need for Enrolled Actuaries, and placed a new and expanded burden of government reporting on the administrator. Until ERISA came along, most small employers thought the insurance company was the plan administrator. The reaction of the insurance industry was to unbundle product pricing from plan service costs. This change in philosophy away from the "free lunch" has made us all painfully aware of the cost of servicing a small IPP plan. Today, it is not uncommon for a plan with $5,000 in annual contributions to pay $500 for plan services.

(3) Finally, along came the IRA; this was an encroachment on the sacred territory of the small corporate IPP plan. It provides a means of avoiding the headaches of increased plan and administrative costs and still provides a reasonable level of tax deductible contributions to the small employer. An interesting exercise for an insurer is to review

his current IPP corporate and HR-10 plans and determine which ones would be better off as an IRA. You would be surprised how many fit the bill; you will also be surprised how many have found out for themselves.

Although my foregoing comments have painted a bleak picture of the present IPP situation, let me assure you that I do believe there is a future. That is, there will be a future provided we do our part in plan underwriting, standardization of plan design, and standardization of plan services. If we simplify and standardize plan design, then plan service costs will be minimized; if we underwrite plans for suitability, plan terminations will be minimized. Creativity should be reserved for those that can afford it. The era of the prototype plan is here to stay; however, prototype plan design is no simple task and has taken almost 3 years. After 18 months, we have received approval on our money purchase and profit sharing prototypes; the approved defined benefit plan is anybody's guess and could be 1978, 4 years after ERISA. In the meantime, we must live with temporary regulations, special reliance procedures and ambiguities.

In the approval process for defined contribution plans, three areas created the most problems in plan design: Eligibility, the Section 415 limitations and the Joint and Survivor requirements.

(1) Eligibility

Our desire was to provide a single contribution determination date. We could allow multiple entry dates as long as the plan contribution was set annually. Our final money purchase document allows two options; the first option is an Annual Entry Date (effective date or plan anniversary) following completion of up to ½ year of service and attainment of age 24½. The second option is for semi-annual entry dates (plan anniversary or 6 months after) following up to 1 year of service or attainment of age 25. The first option (annual entry date) is required for insurance contract plans; whereas, the second semi-annual option is not allowed for such plans. The first option also has a caveat required by the IRS that if a fractional period of service is used then the Employee cannot be required to complete any specified number of Hours of Service to receive credit; it is equivalent to our elapsed time test.

We have included several additional eligibility requirements in our prototype plans to minimize administrative costs (compensated by salary or hourly, contributory, and not covered by another plan to which the employer contributes to, or excluded by good faith bargaining). In our plans, the eligibility for insurance is separate from plan eligibility and may be more restrictive. A single insurance contract date is used whenever insurance is involved in these plans.

The basis for eligibility, vesting and accrual is the definition of an Hour of Service. Our plan provides for an actual count of hours for which an employee is paid as well as several equivalents (days, weeks, months). However, when using an equivalent, a single hour gives credit for the whole equivalent. We normally recommend that the employer use actual hours; although this does increase his record keeping responsibilities, it can keep costs down. The Hour of Service itself is defined to include both hours paid for performance of duties, and hours paid during which no duties are performed (sick time, vacation, jury duty, disability, etc.); such non-performance hours are limited to 501

hours. The eligibility compensation period commences on date of employment and goes for 12 months; the subsequent 12 month periods commence on the plan anniversary prior to the first 12 month period. This is more liberal than needed, but allows us to have a single year for all participants after the first year. The vesting computation period and accrual computation period are measured over the Plan Year.

For money purchase plans, on the effective date and each subsequent plan anniversary, the employer estimates the number of hours of service that will be credited to each participant. On the basis of this estimate, he makes contributions on behalf of all participants who are expected to have 1,000 hours of service during the coming year. The contribution is based on a specified definition of effective compensation. On the next plan anniversary, the actual hours or equivalent hours are determined for the prior year. If an overcontribution was made because of the estimate, it is forfeited and used to reduce the next year's contribution. Undercontributions are made up immediately on the last day of the plan year. Profit sharing plans are done retrospectively for the prior year so no estimate is necessary.

The contribution itself is based on effective compensation. Our plan provides two options: compensation actually paid or compensation accrued. If accrued is chosen, then the employer must provide a written resolution as to the method. The effective compensation is for a 12 consecutive month period, from X to Y, where Y can be the plan anniversary, a date preceding plan anniversary or a date following the plan anniversary. For simplicity, we recommend using the plan year or the prior calendar year.

(2) Section 415 Limitations

Section 415 of the Code caused many problems in the drafting of prototype plans. The concept of the limitation year was introduced to define the 12 month period over which the 415 limits were applicable. For a while, the IRS had an earned income test which precluded making contributions in excess of the maximum applied to income earned at a point in time. The current approach is to allow an estimate of the annual compensation for the limitation year on a uniform basis for all participants. Any employer contributions made in excess because of an erroneous estimate are disposed of at the end of the limitation year based on the actual facts. Although the 415 limits are complex to administer, the plans affected by them tend to be more sophisticated and are financially able to pay for the extra services.

The 415 limits are an area that has created some difficult plan design questions for the professional corporations (PC). Many of these plans were installed by accountants who favor money purchase and profit sharing. The 25%, $25,000 limits have caused some to look toward defined benefit alternatives. The combination of defined benefit and defined contribution plans brings the 1.4 rule into play and termination of the prior plan does not totally eliminate this test. Some PC's have gone to Joint and Survivor normal annuity forms and early normal retirement (age 55) to maximize contributions under a defined benefit plan. (Neither require a reduction in the defined benefit plan limit.) There are many outstanding issues which have not been resolved, such as reasonable compensation tests and actuarial equivalents on lump sums.

(3) Joint and Survivor Requirements

Finally, I would like to discuss Joint and Survivor problems for IPP plans. I feel that the IRS outdid itself in the January 7, 1977 regulations. They are the most complex and burdensome of ERISA; for the small employer, they are virtually impossible to live with.

The Joint and Survivor section of ERISA IRS 401(a)11 provides two distinct provisions. First, it is a requirement that normal retirement benefits be paid on a qualified Joint and Survivor basis, unless the participant elects otherwise and, secondly, the law provides that plans which provide benefits before normal retirement age must provide a spouse's annuity. The regulations cover both situations.

Normal Retirement Age Election - Annuity payments at normal retirement ages will be paid in the form of a Joint and Survivor unless the participant elects otherwise. A participant's non-election of the Joint and Survivor must be in writing and must clearly indicate that the participant is electing to receive all or part of his benefits in a form other than Joint and Survivor. The plan can require the signature of both the participant and his spouse of this election. The election period must extend at least 90 days after the administrator provides written notice to the employee and ends before the commencement of benefits. In no event may the election period end earlier than the 90th day before the commencement of benefits. If the employee requests additional data within the election period, the election period must be extended 90 more calendar days from the date the information is supplied to the employee.

The administrator is required to notify the employee, in written non-technical language, of his right to make an election. This notification must provide a general description or explanation of the Joint and Survivor provisions, the circumstance under which it will be provided unless the participant has elected not to have benefits provided in that form, and the availability of such election. It must further include a general explanation of the relative financial effect on the participant's annuity. Notice of this election must be given at least 9 months before normal retirement age. Our prototype money purchase and profit sharing plans provide a normal annuity form of Joint and Survivor.

Early Retirement Age Election - The regulations provide that the administrator must provide written notification to participants of the right to elect a survivor annuity for their spouse in the event of the participant's death while still employed and while eligible for early retirement. An employee's election under this option must be in writing and must clearly indicate that he is electing the survivor annuity. The administrator's notification to the participant must include, in written non-technical language, a general description of the survivor annuity, the circumstances under which it will be paid if elected, and the availability of such election. It must also include a general explanation of the relative financial effect on the participant's annuity if the election is made. This notification must be given to the participant at least 90 days before the latest date, which can be the beginning of the election period for the survivor annuity.

The election period shall begin not later than the latter of either the 90th day before the participant attains his qualified early retirement age or the day on which his participation begins and shall end on the date the participant terminates employment.

A plan is not required to provide this election if:

(a) The plan provides that an early survivor annuity is the only form of benefit payable under the plan with respect to a married participant who dies while employed.

(b) For defined contribution plans, the plan provides a survivor benefit at least as great as the value of the vested portion of the participant's accrued benefit with respect to a participant who dies while employed.

In closing, I would like to say that plan design has become a full-time job since ERISA. It is terribly important that this job is not wasted on plans that cannot afford to exist under ERISA; the day of the marginal plan is over.

MR. WILLIAM A FARQUHAR: Before discussing the Funding Standard Account (FSA), I will first describe the characteristics of individual policy pension trust plans. These are small plans both in terms of the number of participants and the size of the contribution; therefore, the level of administrative expenses must be kept as low as possible. Also, the enrolled actuary is working through an agency field force to provide actuarial services.

One of the first considerations in preparing the FSA is a determination of the plan year, the fiscal year, and the valuation or servicing year. We have found that for many plans these do not coincide; in fact, for many plans the valuation date is the last day of the plan year rather than the first day. For plans in effect prior to January 1, 1974, they must establish an FSA for the 1976 plan year; if the valuation is performed on the last day of the plan year, then the 1977 valuation would be used. For plans that were established between January 1 and September 1, 1974, they must establish an FSA for the plan year beginning in 1975. Plans established post-ERISA must start the FSA immediately.

We usually prepare the Schedule B to Form 5500 at the same time we prepare the auxiliary fund valuation for the next plan year. All of the necessary information is submitted to our Pension Computer Services Department and they perform the calculations. The valuation includes any new insurance policies to be issued. An actuarial analyst reviews the valuation and prepares the Schedule B for the prior plan year. The valuation and Schedule B are reviewed by an actuarial assistant: and then the Schedule B is certified by an Enrolled Actuary. I will not get into a discussion of funding assumptions; however, if you have any questions, I will be glad to answer them.

The submission of factual data, on which the valuation is calculated and hence the basis for preparing the Schedule B to Form 5500, must be verified by the plan administrator with respect to employee data, plan provisions, asset values, contributions, etc. For plans with less than 100 lives, the assets do not require certification by an accountant; however, I do not believe this puts that same burden on the actuary since administrative

expense was the main consideration. Clearly, the actuary must be satisfied that the asset amounts are reasonable.

We handle insurance costs on the Schedule B in the following way. We obtain a statement from the plan administrator that the net insurance premiums have been fully paid; they are included as charges and credits to the FSA. We are essentially treating the annual dividend as a funding gain which is recognized immediately. When policies are surrendered, the cash surrender value should be transferred to the auxiliary fund; therefore, these gains reduce future auxiliary fund contributions. If there are any policy loans, we offset them against the auxiliary fund assets.

Although there are no regulations with respect to the handling of interest as applied to charges and credits, the Schedule B does provide lines to include these amounts. For smaller plans, we have taken a simplified approach which does not apply interest to charges and credits during the year but does apply a full year's interest to the prior year's FSA balance. For larger plans, we take interest into account on a monthly basis.

Each year when we prepare the valuation we calculate the accrued liabilities based on the Entry Age Normal funding method; this is used to determine the full funding limit which is applied with respect to the FSA as of the valuation date.

We do not believe that caveats are permitted on the Schedule B with respect to funding assumptions, the accuracy of plan data, or any other aspects of the Schedule B. Therefore, we do not include caveats.

One problem we have encountered is when no valuation has been prepared for the first year a plan must comply with ERISA (e.g., 1976 plan year). We therefore are going back and preparing a valuation for that first plan year under ERISA in order to establish an FSA balance. The only exception we have made is with respect to Schedule B's for the 1975 plan year which would basically be limited to new plans set up in 1974 or 1975. We believe that after full disclosure to the plan administrator that a Schedule B for that plan year must be prepared; if the plan administrator will not engage an enrolled actuary for that plan year then at his direction we will prepare a 1976 Schedule B and assume the FSA for that plan year starts off at 0. It would seem unreasonable for the government to require the plan administrator to determine the exact charges to the FSA for that year; especially since the 1976 valuation would take into account the actual assets of the plan and properly fund the plan over the future.

MR. BRUCE A. HUSTON: The thrust of these comments regarding ERISA Reporting and Disclosure requirements, as applied to individual policy funding, will be in the form of the thought process Kansas City Life had to go through in order to be able to initiate a plan of action to market our products for use within the 401(a) area.

Someone new to the pension business and not familiar with the use of individual policies to fund small employer plans might think that reporting and disclosure is an after the fact consideration, a by-product if you will, of a marketing system. But once you have worked with ERISA you soon discover that reporting and disclosure becomes one of the prime considerations from a Home Office's viewpoint.

First, a Home Office that is really going to commit itself to marketing in the 401(a) area has to be able to service what is sold. Most employers, at least in the small mid-western and western communities we service, do not have accountants and attorneys available who specialize in qualified plan work. Even if one such specialist is available he is generally so busy that he is more than willing to turn the reporting and disclosure over to us.

So, since we want to be able to service what we sell, we must take ERISA Reporting and Disclosure into consideration at the time we design the plan.

We do this in three ways. First, our prototypes were written to accommodate only the options we know we can service. Our motto is, "If the prototype does not allow for it, the employer probably should not do it."

Secondly, we developed guidelines to assist us in underwriting, from a technical point of view, the employer and his plan. (This is different from underwriting the physical risk.) These guidelines determine, first of all, if we want to write the plan, then what type of funding is available, what type of valuation method is available, the maximum interest assumptions for projecting benefits and/or costs, etc.

Third, we developed a service agreement which spells out in detail the items we will do for a fee and how much the fee is for the plan. If the employer does not want our service package, then we ask him to sign a "non-election" agreement. This non-election form lists what services we will provide without a fee. By taking this approach the employer knows early what services we will and will not be providing. Charging a fee separately has allowed us to keep our premiums as low as possible without lowering our yields or commissions.

Next, there is the agent to consider. Operating through agents is a two-edged sword. On the one hand the agent makes possible the sale of an insured plan to a small employer. But on the other hand, the agent can be an additional complicating factor when it comes to servicing the plan.

Traditional non-tax sheltered agent's training has been based somewhat upon the "3-Get" method; i.e., Get the application, get the money, and get out. This will not work for pension plans. The agent has to be made to realize the continuing service required to prepare the forms for reporting and disclosure. He must be aware of, and committed to, proper installation of the plan together with the annual maintenance involved.

Kansas City Life operates through General Agents who recruit and train their agents. This system, which has worked to varying degrees of success in the non-tax sheltered market, can provide communication problems when trying to gather, process, and finally transmit data for reporting and disclosure. Agents by nature are not detail oriented.

Another agent-related problem is that of commission disclosure. It looks like, as far as Schedule A of Form 5500 is concerned, commissions will not have to be disclosed in the 1976 Annual Report. Of course the problem may surface again through the agent-fiduciary exemption question. But if and when commission disclosure takes place, this will be another example of how ERISA Reporting and Disclosure has been an instrument of change in our marketing strategies.

Once disclosure is required, the client, or his advisors, may not find palatable the traditional agent compensation method. Our agents are complaining now about the low commissions paid on annuity products. If disclosure forces us to change to some level-type commission schedule on life products sold in pension plans, this will only compound the problems of the agent.

Another difficulty a Home Office faces in trying to cope with ERISA Reporting and Disclosure when individual policies are used to fund the plan is that traditional computer processing systems were developed for administration of individual non-tax sheltered policies. These systems view each policy as a separate unit having its own records. If an insured has more than one policy and has a question about his insurance program, the individual records of each policy must be searched and the data collected from each policy.

Also, traditional computer systems were developed to perform various internal functions which operate separately from anything which affects the policyholder. One such system is the commission program. This program is not geared to gather the data for a particular employer's plan for a certain plan year. It's meant to pay agents their compensation.

This individual policy-oriented computer system does not work well for pension plans serviced by the Home Office. A computerized group master record is needed which ties all the individual policies together for reporting and disclosure purposes.

We have been working on our system for over three years. It has required the use of the most talented of our data processing staff, and yet it still falls short of meeting the demands of ERISA Reporting and Disclosure.

It is difficult to measure the true cost of such a system. We can go back through accounting records and come up with the directly allocatable costs. But one item that is hard to put a figure to is the "Missed Opportunity Cost". How many projects have we had to pass up because of the commitment to the pension project?

Another problem in attempting to cope with ERISA Reporting and Disclosure requirements is the staffing problem. Our staff has more than tripled, and the people we have added were not just at the clerical level.

Where do you find these people who can perform the reporting and disclosure functions? We have discovered that if they have experience and are qualified, they want more money than our salary structure can adjust to. If they have experience and their salary expectations are in line with our practices, then they probably are not worth the money they are asking.

So, our approach has been to hire good quality people without experience and hope we can train them fast enough.

In summary: Is there a light at the end of the tunnel? Will we be able to successfully market pension plans funded with individual policies? The answer to these questions, as well as many more, rests with the government officials and in our ability and commitment to communicate with them.

They must be made to realize that there is genuine justification for simplified reporting on plans which have all their assets held by an insurance company. The small exemptions granted "fully-insured" plans are not workable.

It is also not practical for us since we only market two types of individual policy-funded plans. One is funded with a flexible annuity and the other with whole life and an auxiliary fund. The definition of fully-insured needs to be modified so as to encompass these two methods.

We must seek to counsel the Federal Officials regarding disclosure. The price of disclosure must be weighed against the benefits. The current outlook seems to be disclosure at any price.

The Regulators also need to be better informed by us as to the impact of the regulations and revenue rulings on our business. The "limitation year" is a good example of the detached thinking of the people responsible for writing regulations. Luckily they listened, and the solution now appears to be workable. Revenue Rulings 77-151 and 77-200 appear to me to be other examples of not taking into account the real world. I don't know if we will be able to live with this type of approach to the minimum funding standard account operating separately from the deductibility of plan costs.

I must say in closing, the government officials our Company has dealt with appear to want to know our problems. However, it's hard for them to take the time for input on every question. It's equally hard for us to find time to respond on every issue. Let's hope that both sides do not lose sight of the basic aims of ERISA.

MR. WARREN WINER: Before opening this session for questions from the floor, I think it would be appropriate in my position as moderator to comment on the presentations you have just heard. I will try to keep my comments brief and simply touch on the points that I feel are of major interest.

From the standpoint of prototype approvals, we at General American filed all of our prototypes with the National Office of the IRS in October of 1975. It took until the latter part of May 1976 before we got our initial comments from the National Office on our money purchase and profit sharing documents. We are also currently working with the Service on our HR-10 documents, and there is as yet no comment on our defined benefit or target plan documents.

When we received the reactions of the National Office to our money purchase and profit sharing plans, we immediately identified several major issues where we disagreed with the National Office and where we felt it was imperative that our point of view would ultimately prevail. It is in the discussion of these issues that we have passed the 12-month period from May 1976 until the current time, and I should note that we have only just recently received our National approval on these two documents.

On the eligibility issue, we are extremely concerned about the single entry date requirement and therefore needed to use a six-month eligibility. However, we also felt it was important to keep part-time people from becoming participants in the plan, and therefore we did not want an elapsed time rule. We developed a definition of months of service that would require both elapsed time and the completion of certain hours requirements. We also had a retroactive entry provision so that in the event an individual fails to become a participant solely because of failure to meet the pro rata hours

requirement, that individual will become a participant in the plan retroactively to the last plan anniversary if he completes a year of service within the six-month period following that anniversary date. The IRS has finally approved that language and to my knowledge we are one of the few companies that have both an elapsed time and an hours requirement for a six-month eligibility period.

We are also very concerned about the definition of compensation that would be allowed for determining contributions in our money purchase plans. We felt it was quite important to be able to use a closed 12-month period on the plan anniversary date in order to lock in the level of contribution for the ensuing plan year. While this is quite a complicated issue, involving considerations about the contribution limitations of Section 415 of the Internal Revenue Code, we did succeed in getting the IRS to allow us to use a choice of closed 12-month periods on the plan anniversary date.

We had a great deal of discussion about the contribution limitations of Section 415 and as most of you know, we finally succeeded in getting the IRS to back off of their pro rata contribution rule. However, we still feel there are significant problems with respect to the 1.4 Rule as well as some problems in the HR-10 area where excess contributions have been made.

Finally, we think there is a significant problem in the prototype area with accrual rules for contribution oriented plans. Despite the fact that revenue rulings allow a plan to make no contribution to an individual who is not employed on the allocation date, that same ruling indicates that prohibited discrimination may result by such a practice. We are, therefore, unsure of what accrual rules should be applied in small contribution-oriented plans. The administrative implications of various treatments are considerable.

On the subject of funding standard accounts, I would only like to say that I urge all actuaries in the room to reread and consider the rules with respect to the full funding limitation. It has been my experience that many actuaries are overlooking these rules with the thinking that the current full funding limitation is not much different than the old maximum deductibility rules prior to ERISA. I do not feel that this is at all true, and I believe the full funding limitation does place a substantial new restriction on contributions and possible deductions, particularly for plans with level funding and no past service liability.

Finally, on the question of reporting and disclosure, I should note that our view at General American is that our full service packages are being designed and offered as a marketing tool rather than as a way for the company to develop a new profit center. We feel these services are an absolute must for the marketing of small pension plans. Therefore,we are providing them as an additional sales tool for our field force.