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EFFECT OF LEGISLATION ON EMPLOYEE BENEFIT STRUCTURE

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MR. VINCENT W. DONNELLY: As Moderator, I want to make some general statements regarding the topic of insurance regulation. First of all, within the program there is a reference to the increasing volume of legislation. I don't know that we need to be reminded of that, but it strikes me as funny that we in the insurance business are dealing with increasing volumes of laws and regulations at the very time when our major presidential candidates, and government officials in general, are promising deregulation, or at least a lessening of regulation. Our legal staff at the American Council of Life Insurance prepares, at the end of every year, a summary of insurance legislation, both state and federal. I found it interesting that last year, 1979, the state summary encompassed 77 pages while the federal summary encompassed 128 pages. I think those figures not only tell us about the volume of regulation but also tell us something about the changing nature of the regulation of our business. It was also interesting in reviewing the summaries to find that legislation/regulations dealing with solvency-related issues don't seem to be increasing in volume. The major increase is coming from the efforts of the states to get into the regulation of our "marketing practices". That would include the benefit structure, sales practices, advertising, etc. The major insurance industry trade associations have always reflected the feeling of the business that we support effective state regulation. The problem is that as the states move more and more into the regulation of marketing practices, we have discovered that they are having increasing difficulty in maintaining their effectiveness. Obviously this is of concern to the insurance business because of the fact that it brings on, as you might expect, an increased desire for federal regulation. I want to mention this because of the fact that the Council has recently appointed a task force that is looking into the whole issue of how the insurance business can make state regulation more effective. It doesn't mean that we want more regulation - it just means we want to make it more effective. Because of the changing nature of state regulation (i.e. dealing with marketing practices) the task force has been asked to study the possibilities of increased self-regulation within the business. It is probably logical to assume that since we are the ones creating "the problem" that we are the ones who should potentially solve that problem. State legislatures and regulators just cannot be expected to cope with it successfully.

MR. GEORGE J. PANTOS: Trying to explain what actually is happening in Washington ordinarily defies description. This task becomes even more hazardous when one attempts to project what will happen in Washington on any given subject in the future. This morning, however, I would like to try to look down the road, at least into the near term, to risk some general observations on what one might expect in the way of congressional activity next year with a focus on possible new federal legislation which will eventually impact on the Private Pension System.

Let me state at the outset, it is an inescapable fact that retirement issues have become increasingly more important national issues. The ratio of retirees to active workers is increasing and can be expected to increase significantly in the coming decades. Growing political concern over the aging U.S. population, over older people who lack private retirement plan coverage, and over the impact of inflation on retirement income are merely a few issues now on the national agenda.

Moreover, in the aftermath of ERISA, we now have greater Federal Government regulation over employee benefit plans as well as greater public scrutiny over the private retirement system. This has resulted in higher plan costs and greater administrative burdens for all concerned with pensions -- to say nothing about the greater potential for legal liabilities.

Most plan sponsors and practitioners looked at Washington during the first five years following passage of ERISA in 1974, primarily with an eye on proposed regulations from the Department of Labor, IRS, and PBGC in connection with ERISA. During this period, we have seen many important ERISA regulations issued in final form, including regulations on such subjects as reporting and disclosure, notices to interested parties, minimum standards for crediting service, severance pay, joint and survivor requirements, reportable events, and so on. More than 50 regulations have been issued in final form interpreting important substantive provisions of ERISA.

While ERISA regulations are still of concern, emphasis during the past two years has shifted to legislative proposals to amend the current provisions of ERISA. Senate and House Committee hearings were held in 1978 and 1979 on ERISA and Code-related legislative issues. With the exception of the multiemployer pension plan bill enacted this year, no definitive new ERISA legislation has been adopted as yet. However, it is inevitable that we will have new pension legislation amending ERISA, and that such legislation will be shaped by Congress in 1981.

In 1979, the newly-established President's Commission on Pension Policy also launched its two-year program to analyze the overall public and private retirement systems and to make recommendations to Congress in 1981 on future changes to these systems. A number of critical longer-range policy issues are before the Commission which could have a significant impact on the future operation of the private retirement system. I shall discuss a few of those issues in a few minutes.

Since my time today is limited, I would like to make some general observations on only three federal legislative possibilities for 1981 that could impact on pensions which should be of interest:
(1) possible action by Congress to amend ERISA's Title IV termination insurance provisions as they relate to single employer plans;

(2) possible amendments to ERISA's Title I and Title II provisions; and (3) legislative possibilities flowing from the recommendations of the President's Commission on Pension Policy.

MULTIEMPLOYER TERMINATION INSURANCE LEGISLATION

Turning first to Title IV, the long-delayed Multiemployer Pension Plan Amendments Act of 1980 has been passed by Congress and signed into law by the President. This means that benefits under a multiemployer plan that terminates on or after August 1, 1980 now must be guaranteed by PBGC. This bill undoubtedly is the most important piece of pension legislation enacted by Congress since the passage of ERISA. The bill substantially restructures ERISA's Title IV termination insurance provisions as they apply to multiemployer pension plans.

As you know, multiemployer plans are collectively-bargained defined benefit plans which have two or more unaffiliated contributing employers. These plans have played a significant role in the growth of private defined benefit pension plan coverage over the past three decades. In 1950, multiemployer plans covered about one million participants, or about one-tenth of the 10 million participants in all private pension plans. Currently, about 8 million (one fourth) of the approximately 33 million participants in all private defined pension plans are covered by multi-employer plans. Thus, multiemployer plans have accounted for a substantial proportion of the increase in private pension plan coverage over the past three decades.

Multiemployer plans were distinguished from single employer plans in the PBGC program established under ERISA in three important ways:

(A) the premiums were different ($.50 per participant per year for multiemployer plans vs. $1.00 per participant per year - since raised to $2.60 - for single employer plans;

(B) separate trust funds were set up within PBGC for multiemployer and single employer plans; and

(c) coverage became automatic for single employer plans with the passage of ERISA in 1974, but was scheduled to begin January 1, 1978 for multi-employer plans.

Serious study by the PBGC revealed that the multiemployer plan universe had some weak plans along with the strong ones. The problem was linked to declining industries, where the number of active employees - the contribution base - was declining, the number of retired employees was becoming burdensome, and the employers were in financial difficulty.

In a 1978 report to Congress, PBGC concluded that about 10% of all multi-employer plans, covering 15% of all multiemployer plan participants, were experiencing financial difficulties that under ERISA could result in plan termination over the next 10 years. If all of these plans were to terminate, the cost under ERISA's termination insurance program would be approximately $4.8 billion and would require an annual premium of about $80 per participant.

PBGC projected last month that at least 30 multiemployer plans are presently in sufficient financial difficulty so as to immediately qualify to be placed in the status of plan reorganization under the new legislation. These plans cover about 500,000 participants. These plans are spread throughout several industries including construction, **anthracite** coal, water transportation, and **apparel.** If they were to terminate the cost to PBGC under the previous Title IV provisions would be an estimated $3 billion.

There are currently about 1800 plans filing with PBGC as multiemployer plans. While multiemployer plans represent a small fraction of all plans covered by Title IV of ERISA (less than 3 percent), because of their size (an average of 4,000 participants as compared to an average of 300 participants for non-multiemployer plans), it is obvious that even a few terminations of such plans during one year would have had a significant impact on the PBGC insurance program.

Broad support by business and labor for this bill was based upon the following considerations:

-- allowing original ERISA premium and withdrawal standards for multiemployer plans to become effective would have resulted in massive withdrawals from multiemployer plans;

-- this massive expected withdrawal would have produced a huge shortfall in the PBGC funds available to pay guaranteed benefits for these plans;

-- political pressure would have mounted for either the **separate** single employer insurance fund to bail out the multiemployer fund (probably causing the single employer insurance system to fail) or use of a massive injection of general tax revenue funds - thus increasing the federal deficit and further aggravating inflationary pressures within the economy.

The legislation was controversial, highly technical and complex. However, after numerous delays which threatened passage, the Congress finally adopted H.R. 3904, and the President signed the bill into law on September 26, 1980. While not a perfect bill, H.R. 3904 does take a positive step in the direction of remedying a defective and financially unworkable ERISA insurance program. It should create a workable termination insurance program for multiemployer pension plans.

This bill is also important because it completes the process begun by ERISA of changing the historically accepted role of employers participating in these plans - from one of being merely a contributor to one of financial responsibility for the benefit promises of the plan. Generally, the new legislation enacted by Congress this year which was designed to avoid the anticipated problem, includes the following key elements:

-- Employers who withdraw from multiemployer plans are required to continue contributing to the plan to cover their proportionate share of the plan's unfunded vested benefits (this is intended to prevent situations where most of a plan's contributing employers withdraw and leave the remaining few employers with substantial liability);

-- Plan insolvency, rather than plan termination, becomes the event insured by the PBGC;

-- The new Act calls for faster funding. Unfunded past service must now be funded over 30 years, rather than the current 40 years. Plans experiencing financial difficulties are placed in mandatory "reorganization" and are required to meet even faster funding requirements;

-- Special benefit guarantee levels are established for multiemployer plans. (Those are lower than the guarantee levels for single plans.)

This legislation was supported by a broad coalition of single employer associations who favored the principles embodied in the proposal. This included support by such organizations as ERIC, the U.S. Chamber of Commerce, NAM, APPWP, American Bankers Association, American Council of Life Insurance, and the Financial Executives Institute.

The impact on the insurance program of even a few terminations of medium-sized multiemployer plans is illustrated by the termination of the Millinery Workers Retirement Fund and the Milk Industry Local 680 Pension Plan, which were granted discretionary coverage by PBGC. These plans represented a combined net claim of nearly $4 million on the insurance system. One estimate indicates that the potential claim on the PBGC insurance system if the UMW fund alone terminated would be $2 billion. PBGC's multiemployer fund has assets of approximately $16 million. Benefit payments and administrative expenses amount to $5.5 million annually and annual premium income is about $4 million. The actuarial deficit of the multiemployer fund is over $10 million (PBGC has authority to borrow up to $100 million for the treasury). Thus, it is not surprising that during the period from the passage of ERISA to this year, automatic coverage of multiemployer plans was postponed by Congress - and only discretionary coverage by PBGC was permitted.

SINGLE EMPLOYER PLANS

Now that the termination insurance program for multiemployer plans has been revised, Congress is expected to act next year to revise the termination insurance program for single employer plans. The same basic concepts in H.R. 3904 which Congress deemed applicable to multiemployer plans are equally applicable to single employer plans.

A fundamental restructuring of Title IV is needed to provide for a more effective administration of the termination insurance program for single employer plans. There are significant weaknesses in the present single employer termination insurance program. It is presently too easy for single employer plan sponsors voluntarily to end their obligations to fund pension plans by terminating the plan and shifting the responsibilities of plan sponsorship onto other employers who are contributing premiums to the program.

Currently, an employer who wishes to end an obligation to fund a pension plan can simply terminate the plan. Under present ERISA provisions, that plan sponsor's commitment on plan termination would be to pay a single sum payment of the unfunded guaranteed benefits, but not more than 30% of net worth. Each such voluntary termination is an insurable event so

that premium dollars are always available to fund those unfunded guaranteed benefits not provided through plan assets and employer liability, even if the plan sponsor continues in business.

For several years, the PBGC has been inundated with terminations. Over 90% of these terminations have been adequately funded. Many underfunded plans have not terminated because the single sum payment of the unfunded is very painful. The few terminations that were not fully funded generally occurred because the plan sponsor was bankrupt. However, even in these cases, the administrative burden of allocating plan assets and distinguishing guaranteed from vested benefits has proved difficult, time consuming and expensive.

Under the legislative approach being contemplated for single employers, an employer could still terminate at any time, but the single sum payment of unfunded guaranteed benefits would be eliminated at plan termination. Instead, the employer would retain financial responsibility for full vested rather than guaranteed benefits. If the plan was not sufficient at termination, the sponsor would be required to fund the unfunded vested benefits over a period of 15 years or less without regard to net worth. Thus, the employer would have a continued funding obligation to the plan, not a contingent liability to the PBGC.

The proposed change for single employer plans would have the following consequences:

-- Before plan termination, there would be no change from the present;

-- Before termination, there would be no single sum payment. The annual payments would almost always be substantially below recent contributions since no further normal cost would be generated;

-- There would be no need to allocate plan assets either on termination or when funding is finished;

-- There would be no need to go through the calculation of guaranteed benefits - or to reduce benefit payments to those levels;

-- Only if the sponsor goes into bankruptcy or liquidates his business before funding all vested benefits would it at least be necessary for the PBGC to intervene, calculate guaranteed benefits, and allocate assets.

It can be expected that changes along these lines will be proposed in the next Congress, to parallel the multiemployer program. Obviously the present Title IV rules allow opportunity for substantial abuse and are dangerous to sponsors of continuing plans. Specifically, where the unfunded liability is far above 30% of net worth, the plan sponsor may decide under present law financially to terminate the plan and get rid of his full unfunded for so many cents on the dollar. The sponsor is then free to set up an identical plan the next day, and even provide a past service benefit equal to the old accrued benefit less the benefit guaranteed by PBGC. For five years, this has been only a possible contingency. It has now begun to happen. It is important to plug this loophole before many more plan sponsors conclude they can no longer overlook this bonanza.

The legislation being drafted will be designed to alter the present structure of employer liability within the basic guarantee program. It will broaden the financial responsibility of employers by preventing them from dumping unfunded vested benefits on the government guarantee program - and thus on all other employers participating in the insurance program. It will strengthen the basic guarantee program by preventing abuse by viable employers who may terminate plans to avoid funding obligations for plans with unfunded vested benefits that exceed 30% of employer net worth.

Given the underlying similarity of the basic concepts and purposes behind the multiemployer bill and the potential single employer bill, it is expected that Congress will hold hearings on this type of legislation next year and act expeditiously to pass such legislation.

ERISA AMENDMENTS LEGISLATION

Obviously, passage of ERISA did not sound "the last hurrah" on the pension reform front. I would like to touch now on some of the other pension issues which are likely to be considered by Congress next year.

Congress has been considering possible changes to ERISA since 1975. In 1979, the ERISA Improvements Act of 1979 (S.209) cosponsored by Senators Williams and Javits, was introduced in the Senate. Hearings were held on S.209 last year. Strong opposition was registered to the bill by some because it would add new costs and administrative burdens to plan sponsors. In spite of this opposition, the bill was reported out of the Senate Human Resources and Labor Committee last year.

The basic thrust of S.209 is to increase pension plan coverage, and secondarily to increase the level of benefits under plans. The greatest expected coverage increase is anticipated in the smaller plans. S.209 was designed primarily to remove some of the disincentives for small employers to the establishment of new plans. This would be done primarily through proposals which create a series of tax incentives for small employers.

However, the bill includes certain important amendments to ERISA which could affect the current operation of all plans and which would have cost impact on even the larger plans. The bill is pending before the Senate Finance Committee for further consideration of the tax-related proposals. While no action is expected this year by the Senate Finance Committee, it is highly likely that certain provisions of S.209 could be tacked onto other legislation next year.

Select provisions of S.209 which would impact on employers include:

1. Reductions in Retirement Disability Plans. A proposal has been made to prohibit the reduction of pension benefits by the amount of worker's compensation awards. Plans are now designed on a widespread basis with the knowledge that such offsets are permitted. At present, IRS regulations specifically allow pension benefits to be reduced to take into account benefits provided under worker's compensation laws.

The policy against double benefits has long existed in Social Security and was recently reaffirmed by the Congress by requiring reduction of Social Security survivors' benefits for persons receiving Civil Service annuities. This proposal, if enacted, could have a significant impact on pension plan costs. There is presently no counterpart provision pending in the House but it can be expected that participant representatives will push hard to include a provision of this type in any future pension legislation.

2. Preemption. It is clear from the statutory federal law language and from the legislative history that ERISA unequivocally preempts state laws relating to employee benefit plans. Employers have consistently emphasized that the broad ERISA preemption provisions, presently in the statute, should be maintained and that efforts to dilute the ERISA preemption provisions would be detrimental to the private plan community. Section 155 of S.209 underscores that ERISA clearly preempts any state insurance law which mandates the inclusion in any group insurance policy of a specific benefit. This amendment will assist in preventing the promulgation of disparate and confusing state laws and conflicting judical decisions in this area.

   However, S.209 contains another proposal which would not preempt state laws requiring that a participant be allowed to convert or continue protection after it has been terminated under the plan. Such a requirement could apply for example to a terminated employee or to a relative of an employee when his status as a dependent terminates.

   There are now more than a dozen non-uniform state health conversion or continuation laws, and plan sponsors are deeply concerned that the state-to-state variations will confuse employees and plan administrators and create needless administrative expense, and, possibly, litigation. Insurance companies would have to assure that policies meet all of the various (and possibly conflicting) state provisions. Conversion and continuation privileges are also expensive, and employers and employees often may wish to use "benefit" dollars for different types of employee benefits.

3. Cranston Amendment. Following extensive debate, the Labor Committee adopted an amendment to ERISA's preemption provisions which would permit states to regulate health plans. ERISA now preempts the right of States to regulate welfare plans. The amendment was proposed by Senator Cranston (D-Cal.) and was strongly supported by Senator Kennedy (D-Mass.), and Chairman Williams.

   Unless deleted later, this amendment will deal a severe blow to the present broad ERISA preemption provisions and will create serious administrative burdens and new costs for plan sponsors, particularly those which operate on a multi-state basis and which have designed uniform benefit systems. It will result in fragmented state regulation of health plans. Both insured and self-insured employee welfare plans would be regulated by state law under the Cranston-Kennedy proposal.

   Efforts in the multiemployer legislation by Senators Cranston and Matsunaga to permit the Health Acts of the states of California and Hawaii to be excluded from the federal preemption provisions were defeated.

4. Anti-Alienation Provisions. An amendment is included in S.209 which would create an exception to ERISA's Section 206(d), anti-assignment and alienation provisions. It would permit compliance by plan sponsors with state court orders pursuant to marital dissolution proceedings ordering plans to pay alimony in the form of retirement benefits to non-employee spouses.

   Plan sponsors have been experiencing difficulty complying with such court orders, because compliance has placed them in the position of violating ERISA. The new provision makes it clear that the ERISA and Code provisions which prohibit assignment and alienation of benefits are not to be applied to defeat such court orders. The effect of this change would be to specifically permit compliance and allow plans to send checks to both the retired employee and to the divorced non-employee spouse.

5. Tax Proposals. Several proposals to amend the Internal Revenue Code were also included in S.209, including provisions to permit deductions for employee contributions to qualified plans. Business generally supported this proposal. These deductions would encourage employee savings and capital formation and increase retirement income security. Business also argued that the limits on deductions should be uniform and that the legislation should:

   (A) reject the proposed unnecessary, costly, unadministerable and counterproductive additional discrimination tests;

   (B) allow employers to decide whether and to which plans employee contributions may be made; and

   (C) impose no duty on employers to monitor or certify employee deductions.

   Senator Bentsen has introduced legislation calling for deductions for employee contributions. There is a provision on this subject in the Senate in connection with proposed tax cut legislation. Congress will most likely turn to this issue again in 1981.

A proposed bill (H.R. 6053) consistent with many industry recommendations was jointly introduced on December 6, 1979, by Representatives Erlenborn and Conable. Several substantive ERISA Amendments supported by industry were included in the legislation, including proposals to:

(A) reduce notification to interested parties;
(B) permit more flexibility in defining supplemental pay and gratuitous pay arrangements;
(C) simplify the anti-alienation provisions as they apply to plan sponsors making pension payments to non-employee spouses pursuant to divorce decrees;
(D) codify the DOL elapsed time rules; and
(E) strengthen the preemption provisions.

The bill does not include either the anti-fraud provisions which are incorporated in S.209 or provisions precluding offset arrangements in pension plans for workers receiving worker's compensation payments. While there are proposals in the bill which will be controversial, and the bill's future is uncertain since it does not yet have the support of Chairman Thompson, I believe H.R. 6053 is a step in the right direction and gives us a bill which, with certain exceptions, can generally be supported. Hearings will probably be scheduled next year.

PRESIDENT'S COMMISSION ON PENSION POLICY

On July 12, 1978, President Carter signed an Executive Order establishing an 11-member Commission on Pension Policy. C. Peter McCollough, Chairman and Chief Executive Officer of Xerox Corporation, is the Chairman of the Commission. The Commission will have a two-year life and a $2 million budget and is expected to produce a series of reports on retirement issues - which will surely result in further pension legislation down the road.

A major focus of the Commission will be to study the role of the federal government in establishing new rules in the area of retirement policy. A hard look will be taken by the Commission at the national policy implications of private and public pension issues.

Three study groups have been set up by the Commission. The first is looking into the present and future needs of the retired population. The most challenging goal of this study group is to determine "what constitutes an adequate standard of living upon retirement" - what is an adequate retirement income? Wage replacement ratios of pension benefits as well as budgetary needs and consumption patterns of the retired will be evaluated to develop retirement income goals.

The second study group will look at the ability of the various retirement systems to meet the needs of the retired population. This will include a study of non-coverage among the retired, the disabled and their survivors.

The final group will analyze the issues of tax policy, capital formation and economic growth (a very broad mandate).

So far the Commission has held numerous public hearings and has published an Interim Report. The Commission's Final Report will be completed next year. Proposals to be considered by Congress next year will likely include suggestions by the President's Commission. The fundamental issue underlying consideration of pension issues by the Commission ultimately involves the question: How much responsibility should the government assume and how much should be allocated to the private sector in meeting the retirement needs of the American population. Most of the suggestions now being considered by the Commission call for significant changes in government policy toward the private pension system. Many of these ideas reflect growing concern over the nation's increasing elderly population and lack of coverage of many working Americans under a private pension plan. If adopted, the Commission's recommendations would represent a substantial expansion of existing government authority over the private retirement system.

In its Interim Report, the Commission endorses the present aggregate of means for providing retirement security -- the famous three-legged stool of Social Security, private pensions, and individual savings. Further, in seeking to increase retirement income, the Commission has confirmed the historic rationale of Social Security as a minimum floor of protection; it has endorsed the value of private pensions, even considering making them mandatory; and it has advocated several measures that could add greatly to the prospect of an important role for individual savings.

Conversely, the Commission has not yielded to the expedient of expanding the role of Social Security, which even now has long-range problems that must be addressed and solved in this decade.

It is expected that the President's Commission may recommend to Congress and the President - as the centerpiece of its Final Report - that all private employers be required to provide mandatory private pensions on an advanced funded basis for their **employees.** The proposal would require a minimum contribution of 3 percent of payroll into such a pension system. The proposal for universal private pension coverage has drawn much criticism. It is contemplated by the Commission that the cost of the proposed 3 percent employer contribution will be paid by the consumer in higher prices or by the employee in lower wages. The impact of a mandatory pension scheme will undoubtedly be more severe on small businesses.

The mandatory pension proposal is premised on statistics introduced by Commission which states that only 49% of working Americans are covered by a private pension. But, if those who do not meet the present ERISA eligibility standards of age 25 and one year of service are screened out, the coverage percentage rises from 50% to 70%. During recent hearings, witnesses suggested that further study of the cost implications of this proposal should be undertaken. Such studies are now underway.

If the scheme is included in the Commission's Final Report, the President could accept or modify the Commission's recommendations before submitting them to Congress. It is likely that a bill will be introduced next year - and that hearings may even be held next year.

Another legislative proposal flowing from the work of the Commission - as well as from current tax cut legislation - relates to tax law changes to encourage retirement savings. For example, current law allows employer contributions to pension plans to be **deducted.** With exceptions for the self-employed, employees do not receive tax deductions for contributions to their own pensions. As a result, most pension plans are non-contributory. The Commission would allow contributions to be deductible - up to a certain limit. A proposal to permit deductible employee contributions which are made to a qualified plan or to an IRA has been incorporated in the Senate tax cut bill and will be considered further when tax cut legislation is taken up by the House Ways and Means Committee next year.

Another Commission idea that can be expected to be considered by Congress involves the rights of non-employee spouses to private pensions. Women's groups are pressing to prevent married women from losing benefits in the event of a divorce or a husband's death. In many instances, if a couple divorces or the husband dies and the wife had not worked on her own, the wife can be left entirely without benefits.

In the event of a divorce. the Commission would treat accumulated pension benefits of the employee spouse as property to be included in any divorce settlement. In other words, the Commission would propose a change in Federal law whereby the non-employee spouse would have a legal right to a portion (half) of the employee spouse's pension. This would, in effect, extend current state community property law concepts vis-a-vis pensions to the entire nation.

The Commission also favors a change in law to make it impossible for one partner (usually a husband) to reject survivor's benefits unless the decision is approved by both partners.

MR. ALEXANDER D. BRUNINI: Traditionally, in the field of life, disability and health plans there has been a great deal of flexibility in plan design. The insurance laws of the states impose certain modest requirements and Section 79 of the Code requires some attention, particularly with respect to contributory life insurance plans. However, in general these are not onerous and plan administrators in conjunction with their carriers or their advisors are free to design and operate plans in accordance with perceived market forces and needs. There is, for example, no set of pervasive requirements analogous to the IRS qualification for retirement plans. As testimony to these facts, witness the tremendous variety in plans of various employers.

In recent years there has been a trend toward limiting that flexibility, largely stemming from egalitarian or consumerist concepts, as well as the efforts of special interest groups. These requirements have limited the flexibility as to what may or may not be provided and reducing somewhat the universe of possibilities.

Many examples have been imposed at the state level, with the passage of legislation via the insurance laws which mandate that insurance contracts, particularly health policies, provide certain coverages or certain benefits. There is a whole class of what have come to be known as "practitioners" laws, which require that if a medical service would be covered if provided by an M.D., it must also be covered if provided by other health professionals acting within the scope of their license. A recent tabulation tells me that such laws are in effect in one form or another for chiropractors (38 states), dentists (36 states), occupational therapists (1 state), optometrists (43 states), osteopaths (16 states), podiatrists (37 states), psychologists (32 states), and speech pathologists (2 states).

Another good example is the requirement to provide coverage for mental, nervous, or psychiatric treatment, which applies in 23 states.

Similar trends are observable in the area of continuation of coverage under the group medical plan for persons whose eligibility would otherwise have terminated. Eighteen states require such coverage for some period of time for surviving dependents of a deceased employee, 35 states require it for handicappedchildren reaching the maximum age under the policy, 4 states require it for employees on layoff, and so forth.

Also, with respect to long-term disability, 19 states now have required so-called Social Security freeze.

Although conversion of group life insurance upon termination has been a standard requirement for many years, a few states are following the New York pattern of requiring a conversion for medical care. Colorado and Ohio are among those who made this change.

At the Federal level, the tax laws also influence plan design. A recent example pertains to medical plans which are not insured and which are not made available to all employees. There is reason to believe that in the future, wherever a tax break is legislated or modified for non-qualified types of fringe benefit plans, the IRS may very well attempt to include in the legislation a non-discrimination requirement akin to that which applies to qualified plans.

In the past two years, Federal legislation on age discrimination and sex discrimination have provided major impetus for plan changes. The Age Discrimination in Employment Act has been a particularly active area for plan designers and actuaries because of the very detailed approach to regulating which was taken by the Federal regulatory agency. This area has now reached some level of stability but will probably be re-opened in the future as the concepts of equality are tested in the courts. It is notable here that the regulatory authority has used a concept of measuring equality by cost, and has implied that benefits must in certain circumstances be designed such as to result in certain cost relationships. This, it seems to me, is the opposite of the classic approach in which the benefit design was dealt with first, the overall cost was dealt with as a limiting factor, and the internal cost relationship between age groups were dealt with hardly at all.

You also are doubtless aware that in the Spring of 1979 Federal legislation became effective which required that disability income plans and medical care plans treat maternity the same as other causes of illnesses or disability.

Now to deal with the impact on us as a carrier. First of all, none of these changes have caused us serious problems from an underwriting or risk standpoint. Most, if not all, of the new mandated benefits were available on an optional basis prior to becoming mandatory, and pricing them has not been difficult.

Employers have, of course, been faced with cost increases ranging from marginal to moderate in order to provide the new levels of benefits. As a practical matter, employers are generally unable or unwilling to make permissible reductions in other benefits to offset the increased cost of mandated benefits.

Aside from pricing and cost, there have been some problems. Perhaps the most serious issue is that of fragmentation of plans. The items which I mentioned as having come about through the insurance laws of the various states cause difficulties for larger nationwide employers who wish to have uniform plans for all their employees, but for whom the varying requirements in all of the states are making it increasingly difficult. Extraterritorial interpretation of state laws exacerbate this problem. Metropolitan, with its block of larger policyholders, has probably had more than its share of difficulties along these lines. Furthermore, attempts to mandate coverage through the insurance laws provide fuel for arguments favoring uninsured plans, which generally fall outside of the

scope of this legislation either directly or through ERISA preemption. From the vantage point of the state government, this attempt to regulate more intensively may ultimately have the effect of reducing the volume of business to be subject to their regulation.

We spend a great deal of effort internally on analyzing the requirements of these laws, keeping track of which states require what, and changing our standard contracts as necessary. We have a systematic approach of minimizing the possibility of unintentional non-compliance.

It is important to keep in mind that many of these requirements are technically and legally matters of the employer's responsibility, not of the insurance company. Thus, in general, we do not take unilateral action, but rather we communicate to our field force and to our customers the existence of the new requirements along with our suggestions and interpretations. Wherever possible, we attempt to outline their alternatives and assist them in deciding what changes, if any, to make. At one extreme, our large customers also have their own benefits experts and/or other advisors to help them. At the other extreme, for our smaller group customers, where the product we sell is fairly standardized, we make the decision for them by changing the standardized plans offered in this market so that each of the alternatives we sell meets the requirements.

In order to accomplish all this, we have a staff of about ten whose responsibilities include monitoring this legislation and regulation and seeing to it that we act appropriately. Naturally, they will seek assistance from our claim managers, lawyers, actuaries, or whomever, in order to handle these matters. This is quite **separate** and in addition to any position we may take on proposed legislation.

The final result of all our analyses generally takes the form of a release to our employees and our customers and these are made available to the brokerage and consulting community by our field force. I brought some samples, and anyone who would like to pick one up is welcome to. Our basic vehicle we call a BULLETIN. It generally has a printing run of about 3,500 some of which are used by Metropolitan employees themselves, most being distributed as I indicated. This is our basic form of communication which outlines legislative or regulatory changes and our suggestions and advice. Also, on occasion, in a situation of particular complexity we publish what we call PERSPECTIVES when we feel the need to go into greater depth on some subject. I also brought along some copies of the PERSPECTIVES we published on the ADEA last year. We generally print about 10,000 of these and are willing to make them available to anyone in the benefits field in addition to the normal distribution.

So, as you can see, we are spending a fair amount of time and effort and money by merely keeping track of all this activity. As a final comment - I'd like to deal with the question of what this trend means in the long run. Basically, in the U.S. the fundamental legislative situation has not changed a great deal, despite the fact that these various requirements which we have discussed are causing some administrative headaches. We must learn to live with these things. One of the reasons we have all these laws is that we still live in a very pluralistic world. Fundamentally, we can do as we please in designing a plan except as specifically limited or excluded by certain requirements. This merely limits flexibility. I urge you to keep in mind that it is distinctly different

from the opposite approach which would be legislation which said that the only permissible variations are ones which are specifically included by the law.

MR. NORMAN R. MINOR: I'll cover the impact of legislation on plan design in the disability, death and medical areas. The legislative scope is the same as Lex Brunini's. He considered the role of the insurance company; I'll deal with the employer's viewpoint. First, some general observations:

Laws (by which word I refer to statutes, regulations, rulings, interpretative bulletins and precedent-setting court cases) come in three groupings:

(A) What I'll call mandating laws (thou shall do such and such) - example, the disability benefit laws. These are easy to contend with once they become laws. You have very few design options.

(B) The next group is the cause and effect laws (if you do this--then you'll do this also) - examples: if I have an early retirement provision then I must offer the preretirement spouse benefit. If I have a medical coverage then I must have pregnancy coverage. These laws introduce an element of individual decision -- although practically, very little in light of competitive forces.

(C) The third group of laws is the group that seeks to encourage or discourage by taxation -- whether income tax, gift tax, estate tax, or excise tax. Example: the survivor income benefit, or the group term benefit. These usually tax the plan designer's talents, if a main goal of design is to produce the most attractive net benefit, or to put it another way, to have a benefit/cost ratio as close to "2" as possible. That is, when the employer gets a deduction and the employee has no taxable **income. This is a very important job for the designer: best benefits/ cost ratio within the desired competitive level of benefits.**

Note that there don't appear to be any clearly negative laws in employee benefits. You can do almost anything so long as you are willing to pay the Piper.

Note where the laws are coming from. We'd expect laws to come from the legislative bodies (federal, state) but we're also getting laws from the Internal Revenue Service, the Department of Labor, the Equal Employment Opportunity Commission and the courts. We have to be alert to all sources if we're to properly design benefit plans. Also look for conflicts among the regulators (e.g. As of October 1, 1980 insurance policies in New York can cover non-employee directors. This still leaves us with the problem that IRS will call the premiums imputed income).

Note that some laws are specific: for example, DBL or group term. Whereas, some have general (often indirect) application. These latter include such laws as the Revenue Act of 1978 (for example, cafeteria compensation, cash or deferred plans, executive medical) or the 1978 ADEA amendments, which affected just about all employee benefits. It's the general laws that drive the designer buggy. They usually hit an extreme of verbosity: either too brief (the 1978 amendment to ADEA added

just 33 words) or too wordy (the Title IV amendment for multiemployer plans must have worn out about 10 typewriters). In either case, these general laws are an open invitation for our Civil Service agencies to legislate (as to the multiemployer amendment we understand that PBGC **alone** had to write about 60 regulations).

The last general comment refers to Social Security and Medicare: the public benefit programs. The extent to which they can be coordinated or integrated into private employee benefit programs is an ongoing challenge, magnified and distorted by the tax-free nature of public benefits vis-a-vis taxable private benefits.

I'm not going to go into any particular law per se, but rather to see in general how laws affect plan design and net benefits in the death, disability and medical areas.

Also, in the time allowed, I cannot be all-inclusive, so in each of the three benefit categories, I'll cite a few examples to indicate how the law affects plan design, and leave further development to the discussion period.

IN THE DEATH BENEFIT AREA

Suppose we want to provide as a death benefit monthly income to the beneficiary of the employee:

-- If we pay this out of a pension plan, we provide fully taxable income. For example, a gross benefit of $200 per month, or $2,400 per year, and 20% tax, would give the beneficiary $ 1,920 of spendable income.

-- If we pay this under the so-called Survivor Income benefit plans, the beneficiary is taxed under the Internal Revenue Code as follows:

   $2,400 minus $1,600 under an exclusion ratio (IRC 101(a)) minus up to $1,000 a year if there's a spouse (IRC 101(d)). This produces no taxable income, thus no tax. So, a full $2,400 of spendable income is generated as compared with the $1,920 of spendable income produced under the pension scheme.

-- With proper assignment for estate tax purposes and ignoring for the moment the possibility of imputed income to the employee and gift tax to the assignee, we'd be encouraged to provide an income benefit under a survivor income benefit approach.

Suppose I want to change my group insurance carrier. If I don't concern myself with IRS's "contemplation of death" rulings and an employee dies within three years, estate taxes can gobble up a piece of the death benefit that the employee attempted to get out of his estate with absolute assignment unless I use a "safe harbor" as provided by Revenue Ruling 80-289. So I may wish to provide extra death benefits for the three year period, either by individual policy or by a group term schedule.

Suppose I either have post-retirement death benefits or large numbers of my employees are working to older ages. In either case, my group term rate will rise. I have various options to level the cost, including cash

value life insurance or a concept which we call, in the alternative, retired life reserves or continuance funding. Which way we use it will be a function of several factors, including:

-- the deductibility or non-deductibility of the premium;
-- whether or not the premium is imputed income to the employee;
-- the growth of the reserves, whether under a tax-shelter or not;
-- the taxability of the benefit to the recipient.

The funding approach I select may well impact on the net spendable benefit enjoyed by the widow.

IN THE DISABILITY AREA

We've noted DBL, a short term disability income benefit mandated in five states and Puerto Rico.

Next example: Prior to the Tax Reform Act of 1976 employees got the first $5,200 of employer-provided LTD tax free. Now there is a "disappearing exclusion" and when adjusted gross income during disability passes the $20,200 per year level, the whole LTD benefit is taxable. Thus, for the executive group, we need to design tax free LTD benefits so as to treat the executive equitably on a spendable income basis.

Prior to the 1978 amendment to ADEA I could cut off LTD coverage at normal retirement age, say, age 65. Now I have to use one of the various modifications of disability period and/or level of disability benefit.

Although short term disability doesn't enjoy freedom from federal income tax (since the Tax Reform Act of 1976) it does enjoy freedom from FICA. Some employers ignore this and so waste money by paying unnecessary FICA tax. Some take advantage of it, but in so doing, reduce the employee's Social Security earnings (and thus his benefits). This could indirectly increase the employer's cost of LTD or pension benefits, which usually carve-out a portion of the Social Security benefit. Thus, some decisions must be made.

This situation is similar to the case of an employer's paying an employee's FICA tax. Although the employer may enjoy short-term gain, the long-range impact on both employer cost and employee benefits hasn't been adequately treated by many plan designers. We have some legislation pending in this which may clear up the matter.

IN THE MEDICAL CARE AREA

First is the continuing threat of National Health Insurance. So far it hasn't passed, but most feel one version or another will. When it does, we'll be facing a complete overhaul of private plan design in this area. In the meanwhile, the threat of NHI is causing many to take a short-term attitude in the medical area.

Medicare coordination is another example in the medical area. Medical plans have for some time coordinated with Medicare, either by COB or by carve-out. Now along comes ADEA per EEOC, to say that its okay to continue the coordination but only if the employer takes upon himself to explain Medicare and how to apply for it, and, in some instances, pay all or part

of the Medicare Part B premium. In other words, failure to inform and/or pay the premium may add more cost to an employer's medical plan.

Companies have traditionally had executive medical plans, as much for the benefit of the company as for the executive (on the basis that an executive who fusses around with the deductibles, coinsurance and claim forms is distracted from doing "executive things"). Now comes the Revenue Act of 1978, making the benefits of these plans taxable, but only if uninsured. No great grief here - but just another legislative problem to be aware of and to work around.

Hopefully these examples have indicated the scope and types of law-related problems that employers have to contend with in the death, disability and medical areas.

MISS J. CLUNAS McKIBBON: There are four specific problems in relation to Human Rights legislation in Canada. We have ten provincial Human Rights Agencies which govern most employee benefits. The Federal agency regulates interprovincial transport and communications.

The first problem is a conflict between Federal and Saskatchewan regulation in connection with compensation during maternity leave. These agencies rule that if the disability benefit for a regular disability would exceed the Unemployment Insurance benefit, the person on maternity leave must receive the higher benefit while physically disabled. Unfortunately the U.I.C. is by statute the payor of last resort. Thus, the employer must pay the full benefit rather than supplement it. It is possible to establish a Supplementary Unemployment Benefit (S.U.B.) by employer contributions. This has been used to supplement unemployment but not maternity benefits in the past. It is available but likely not very useful for the small or medium sized employer.

The second item relates to Money Purchase pension plans which the Federal agency has ruled must provide equal benefits for men and women. This is a problem which can be solved by use of a "side fund" to fund the women's benefits at retirement. There are problems because the women cannot be given the extra cash. This will rule out shopping for the best rates which had been a general practice. There are other solutions such as setting up a deferred Profit Sharing Plan with the employer's money and a Group Registered Retirement Savings Plan with the employee's contributions. The definitive solution has not been reached.

There is in the discussion stage plans to abolish compulsory retirement. It may be illegal in some provinces now.

There is just passing into legislation rules against discrimination for the physically handicapped. It is not clear exactly what the effects will be on employee benefit plans. It will be illegal to refuse employment because of employee benefit costs. It will probably be possible to include pre-existing conditions in the policy but that effect is likely to be limited.

MS. ANNA M. RAPPAPORT: I have some comments about something that the **panel** didn't specifically mention but which has concerned me greatly as a consultant. Namely, the risks involved in dealing with regulation and what do you tell your clients relative to such risk. I would like to tie this into an example because it is something we worked with in the last couple of years and I think it is a **foreteller of** the future. When the Age Discrimination in Employment Act (ADEA) went into effect in 1979, we didn't have an interpretative bulletin (IB), we didn't have any rules, and we had to tell our clients that they could not comply with the law until they got some rules. Since waiting involved taking a risk of being charged with non-compliance, we attempted to describe some steps that they might take in order to try to comply, while stating that each of them had a lot of business risks attached to it. Even when the IB came out there were those who felt that the IB really didn't properly interpret the law and it might not stand up in court .... and again, there were business risks involved. Our company wants to be able to go and tell its clients "this is what you should do" and thereby make compliance nice and easy. But it really wasn't that way. We could only give them what we thought was our best judgement, knowing that there were risks involved. Mr. Minor mentioned conflicts between regulations. The same things happen when there are conflicting actions that employers may take, each of which involves risks. I see our obligation as a consultant being one of pointing out such risks to our clients, making sure they have legal counsel, and that they are well informed of their benefits, and trying to get them to discuss their intentions with their legal counsel. That is difficult for the client and its difficult for us. Beyond trying to promote this type of discussion, I don't know anything to do. If there are people here who have thought about that and have solutions I would be very interested in hearing from them.

Another thing that bothers me, in terms of what I heard here today, is the question of anticipating regulations and trying to plan so that their effect will be a lot less disruptive. I got the feeling here today that these were all just things that happened to us. But, we are part of the society that makes them happen and we ought to be participants. But I would like to see us be participants in such a way that we are not always opposing. I think one of the problems of the actuarial profession and the institutions that employ us is that as social change comes we try to resist it in a way that we are bound to sink rather than trying to do something constructive. I think we haven't found a good way of dealing with social change and that makes our institutions look like they are against progress.

So both these things have bothered me. I would like to hear more about how you strategise when dealing with regulatory matters. I would see strategising being as much a matter of planning as reacting. Thank you.

MR. PANTOS: I will take a crack at the first question. I think you will recall that period immediately following the passage of ERISA where the statute called for some 80 regulations to be issued. Plan sponsors who were immediately affected by the provisions of the new law were required to make decisions in the absence of guidance - there were no interpretative bulletins, there were no regulations, there were no advisory opinions, and yet people were required to comply. **Fiduciary** liabilities may have been on the line and other liabilities under law were also on the line. Now,

we've seen the passage of time and the issuance of regulations and I think this has brought on a certain degree of stability and certainty to the planning that goes into the area that is affected by ERISA.

A reference was made to ADEA and the fact that there was no IB out, so what do you do? Well, take an example here that I think might be useful in trying to provide some constructive suggestions and also reply to what kind of risk taking is permissible. As many of you know, the Department of Labor has not yet issued any final regulation or even proposed regulation in the area of supplemental pay for retirees. Therefore, an employer who wishes to supplement the income of a retiree who retired prior to the passage of ERISA, and who has been making those supplemental payments out of general assets, would be told by his lawyer "you can't do that any more, you can't make supplemental payments out of general assets for retirees in 1977/78/79". Well, I would suppose there is some rather extensive non-compliance going on out there, where people are making those payments out of general assets rather than pursue it through an ERISA-type plan. So there is a certain amount of decision making regarding non-compliance that goes on. But I think the basic approach that I would suggest would be that there is guidance available for those that don't have official regulations upon which to make decisions. In the Department of Labor you do have an advisory opinion letter procedure where you can take a specific set of facts and circumstances and put them on paper, submit them to the government and ask for a written response. I think that is the right way of resolving a problem where you want to minimize the risk. Also, a number of people have requested legal opinion letters so that they can make business judgements based on the best available internal information. And, of course, there is the informal advisory procedure where people call the government agency and run a set of hypothetical facts and circumstances by them. A memo is then put together for the record saying "based on a **conversation dated such and such** date". These are the short-circuit approaches to the official guidance that is necessary. Of course, once the regulations are out in final form you have about as much guidance as you could expect under the circumstances.

As far as your second point, I must say that I quite agree that all of these areas of governmental decision making are being shaped by individuals, and I think that the big crime is that those who are impacted by these decisions do not get across to the people making these decisions what the expected impacts are. And I quite agree that when the regulations come out with the sharp edges on them - edges that could have been removed during the comment period - I think people just have been asleep at the switch and have not made the appropriate effort.

WILLIAM C. CUTLIP: I would like to echo Anna's concern and the comments that have been made about the concern for risk. We deal with multiple-employer trusts for our group plans. We deal with very small groups because we are insuring employees of credit unions. Our average size is four people. They look to us for direction and guidance but we are always dancing that fine line between giving them our advice, our interpretation of the laws that are coming out, and saying to them "you must go talk to your legal counsel", knowing full well that 99% of them are not going to. So we feel it is a very risky thing.

I would like to direct a question to Mr. Brunini concerning how Metropolitan deals with the laws that are directed to employers by the states. For example, the new California employer law with respect to disability. The Ohio law that came out with respect to providing maternity coverage for employer groups of four or more employees. How do you take upon yourselves the responsibility to inform the employers of these changes? How do you find out about them, and how do you deal with them especially for the small groups where you are talking about standard plans and standard underwriting rules.

MR. BRUNINI: It basically is the same process that I referred to when the legislation that we are talking about is insurance law that is impacting us. I mean we are screening the same body of legislation. It doesn't show up in insurance law, it shows up in the equal rights law or labor law somewhere. But we are scouting for that sort of thing. And, again, it is fundamentally the responsibility of the employer. We write it up in one of our releases, we tell them what is pretty much cut and dried legally, what their responsibilities are, what the alternatives are, and with the caveat, of course, as you indicated, that we are not engaging in the corporate practice of law. We are simply pointing out what the modifications are and what the alternatives are.

MR. CUTLIP: What about your standard plan provisions, your underwriting rules? Do you have to modify these?

MR. BRUNINI: Yes, we certainly would. We wouldn't continue to sell any plan of insurance which violated any law which we know the customer must comply with. But then again, many of these things are manageable within existing contracts. If you are talking about continuation of coverage to such and such a group after layoff, you don't really have to change a contract -- generally there is variable language already filed allowing you to adequately redefine the covered employees.

MR. STEPHEN E. WHITE: We have recently seen a fair amount of activity among certain accounting firms trying to recognize post-retirement life and medical insurance liabilities. In some cases we have seen liabilities that have rivaled pension liabilities depending upon the actuarial assumptions. What activity are we now seeing and what is the prognosis for ERISA-type legislation with respect to post retirement life and medical insurance? And is the actuarial profession assisting and guiding that legislation as opposed to leaving it to the accountants? One of the comments Mr. Brunini made was that certainly we can expect, if we get ERISA-type legislation, to see anti-discrimination rules established along the same lines as ERISA. I don't wish to comment on whether that is good or bad. But needless to say, the direction of potential legislation is something that should concern actuaries. I am not exactly sure what the activity is at this point. Could any one of the panelists comment on that?

MR. MINOR: I think the profession is calling to the attention of employers that post-retirement life and medical coverage is getting out of sight if funded on a pay-as-you-go basis. We have been encouraging employers to go in the direction of so-called continuance funds, or what some call these days, Retired Life Reserves. The legislative impact that I see is that the IRS, or in fact Congress, might pull the rug from under tax privileges for pre-funding post retirement liabilities. It seems to be working backwards to the way it ought to be going.

MR. ALAN N. FERGUSON: I wish to comment on a specific problem area where we don't seem to be having much effect, namely medicare supplement plans. It seems to me that state legislatures are saying that if an insurer wants to have a medicare supplement plan which qualifies, then it has to provide a plan which really does not make sense. Somebody ought to tell the state legislators, federal government, etc., that they are destroying the controls that exist within the medicare. Now, I recognize that there may be some argument over the effect of these controls, but is the HIAA, for example, doing a good job of trying to suggest or bring to the attention of such people that they are creating cost containment problems?