RECORD OF SOCIETY OF ACTUARIES
1994 VOL. 20 NO. 3A

SINGLE-PREMIUM GROUP ANNUITIES—A GOLDEN OLDIE IS ALIVE AND KICKIN'!

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This session will cover group annuities in today's environment.

MR. ROBERT R. LYNCH: Rhoni Seguin was with Wyatt Asset Services. As many of you probably know they were recently acquired by PRIMCO Capital Management. She works in the Portland Office for PRIMCO. I am with MetLife in New York. We both have a number of years of experience in the annuity business.

We have a formal presentation, but we would love to see audience discussion, so feel free to ask questions during the session.

Single-Premium Group Annuities—A Golden Oldie is Alive and Kickin'! is the topic. I'm not that creative, so I must give the Society of Actuaries committee credit for naming the session.

I will spend a few minutes talking about the evolution of the product and the market. If we go back to the 1970s, the typical type of insurance company funding vehicle for defined-benefit pension plans was the general-account participating annuity. This type of vehicle featured annual premiums, and it was a funding vehicle generally utilized for ongoing plans. The 1970s were years in which there was rapid growth in defined-benefit plans and assets. There were few major plan terminations during the 1970s. A significant amount of general-account participating annuities is still on the books of insurance companies.

A few examples of general-account participating annuities are immediate-participation guarantee (IPGs) and deposit administration (DA). This type of product typically has dividends that are determined by the insurance company based on the experience of the contract and of the general account.

General-account nonparticipating annuities came to the forefront during the 1980s. One key change was the fact that these annuities were typically single premium as opposed to annual premium. They were also more often than not used in plan termination situations. They had a low, initial one-time consideration, and there were never dividends payable on these products. They were similar to the participating annuities from the prior decade in that they were general-account products.

During the 1980s, we saw a tremendous amount of this type of business sold in the marketplace. It was a period when there were numerous plan terminations. The market was partially driven by the fact that there were very high interest rates during most of the 1980s.

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During the period from 1983 to 1987, there was typically between $5 and $10 billion worth of this type of business purchased annually in the marketplace. I'm certainly not implying that this product is a dinosaur. We still see this type of product being written in the 1990s. As Rhoni can tell you, in many situations, it's the preferred product. It's often what the plan sponsor wants when there's a desire to purchase a single-premium group annuity.

In the last six years or so, the market has slowed significantly. We no longer see $5 to $10 billion of this business written in the marketplace each year. I would estimate that the volume is currently in the neighborhood of $2 billion per year.

The separate-account participating annuity has been introduced during the last six years or so. If we compare it to the prior generation, it's still single premium. However, there is typically a great deal of flexibility in the design. It's not an off-the-shelf product as is often the case with the nonparticipating general account type of product. It also has formula dividends that can be very easily verified by a consultant or the client. As I mentioned, we also still see the general-account nonparticipating annuity being sold in 1994.

Let's move ahead and talk about some of the forces that lead to annuitization. These forces often lead to plan termination, and the plan termination leads to annuitization. The two often go hand in hand.

The first force that leads to annuitization is the emphasis on defined-contribution (DC) plans. Over the last decade or so, we have found that participants understand and value defined-contribution plans more than they value defined-benefit (DB) plans. I don't think that's totally justified. I know when I was in my 20s, I valued the defined-contribution plan more. But now that I have longer service and I see how the accruals ratchet up on the defined-benefit plan, I appreciate the value of it more. That's my vantage point, but it's very difficult for 25-year-olds to see the advantages of a defined-benefit plan when they can see their account balance in the defined-contribution plan.

In addition, plan sponsors often see the defined-benefit plan administrative burdens. With DC plans, there's significant administration, but it is often contracted out. It's not quite as noticeable. So, an overall theme is the trend towards defined-contribution plans, and it's leading to annuitization situations.

I certainly don't want to leave the impression that defined-benefit plans are dinosaurs. Most of you in the audience realize that most major institutions in this country still have defined-benefit plans and probably will continue to have them going forward. It's not like we're going to come back here ten years from now and be in a world of no DB plans.

The buying and selling and consolidation of business units has led to annuitization over the years especially during the 1980s. There was much corporate restructuring during that interval (corporate restructuring often led to plan terminations or partial plan terminations and then to annuitization).

Economic difficulties at the plan sponsor level have led to plan termination and annuitization. It's commonly known that in the 1980s there were many companies in distress situations that chose to terminate their DB plan and annuitize.

Government regulation has been a real sore point with plan sponsors, and I'm not claiming it's unjustified government regulation. If you go back to the pre-ERISA era, it is clear that regulation was sorely needed, but it just was not available. However, without question, plan sponsors see government regulation as being very onerous at times. They have scarce resources, and they have to apply them to satisfy government regulations.

It's always been my impression that government regulation is viewed much more unfavorably by small plan sponsors. Small plan sponsors tend to have less resources to apply to satisfying government regulations. That's probably one of the prime reasons why, over the past decade or so, we've seen a high level of small plan terminations in this country.

Frozen defined-benefit plans are characterized by the absence of continuing benefit accruals. They are often viewed as being an interim status. In other words, most plan sponsors don't wake up and say, "I want to have a frozen plan." It's usually the first step towards eventual plan termination and annuitization. Sometimes the plan sponsors are trying to buy some time to clean up their data before they annuitize. Sometimes they're anticipating an increase in interest rates, which can make the annuity purchase much more attractive.

In the past two years I've been made aware of a number of frozen plan situations in the marketplace. We think it's just a matter of time before they are terminated and annuitization takes place.

Another force is the desire for relief from in-house administration. This goes back to the restructuring of corporate America. There has been significant downsizing in many large corporations, not just among small corporations. Some of the Fortune 500 corporations in this country have found that they don't have the staff available to administer defined-benefit plans, which has led to plan terminations and annuitization.

Plan sponsors utilize annuitization as an investment decision. They may feel it's an appropriate time to lock in an annuity purchase. In addition, annuitization offers a guarantee on the investment results. In other words, it's not just a promise of a level of asset performance; it's an investment performance guarantee where the insurance company is on the hook.

Pension Benefit Guaranty Corporation (PBGC) premiums are often a sore point with plan sponsors. When ERISA first came into being in 1974, PBGC premiums for defined-benefit plans were $1 per participant per year. They're now in the range of $19 to $72 per participant per year based on the funding status of the plan. In addition, there are often proposals to increase the PBGC premiums.

Personally I try to encourage plan sponsors not to focus too much on PBGC premiums. I think, in the overall scheme, they are not a major cost. However, plan sponsors see the premiums and they think of alternatives. One alternative is to

terminate the plan and annuitize. Once annuitization occurs, the plan sponsor is not liable for PBGC premiums. It should be noted that a plan termination and annuitization are not required to eliminate PBGC premiums. A plan sponsor can eliminate the premiums by annuitizing terminated vested and/or retired participants.

The *Financial Accounting Standard (FAS) 88* on settlement gains is another event that triggers annuitization. With annuitization, any gain may be taken in the corporate financials. We saw quite a bit of *FAS 88* business five years ago. In recent years we haven't seen much of it, and I think that's partially due to low interest rates and high annuity considerations which have reduced or eliminated any gain.

I have finished discussing some of the critical forces that could lead to annuitization. I will now spend a few moments talking about various annuity design choices for a plan sponsor.

One of the critical questions to insurance companies has been, "Why do I want to annuitize? Why don't I just immunize? I will have assets matched to liabilities. My funding position is protected, and down the road I have the freedom to take various actions with my pension plan."

I will compare immunized investment portfolios and annuities. I will also compare nonparticipating annuities and participating annuities. I should start by telling you how these broad categories of annuities are very similar in nature.

An annuity provides an irrevocable guarantee of benefits by the insurance company. In both nonparticipating and participating annuities, there is a single-premium consideration. If experience is negative, the insurance company can never come back and ask for additional consideration for the previously purchased benefits.

The first area we'll look at is investment structure. The plan sponsor has full flexibility of design with an immunized portfolio. The sponsor can immunize in house or go to an investment manager to establish an immunized portfolio. An insurance company can be used to establish the immunized portfolio.

Let's discuss nonparticipating annuities. There's essentially no investment flexibility for the plan sponsor. The insurance company is investing these monies in the general account, and it makes all of the investment decisions.

The participating type of annuity has significant flexibility. Typically, as I mentioned, these are not off the shelf. They're designed by the insurance company, the plan sponsor and the plan sponsor's consultants. The three groups work together. There's quite a bit of flexibility; one example is investment flexibility.

We are now looking at PBGC premium treatment for the three options. When a plan sponsor establishes an immunized portfolio, whether they are doing it in house or with an outside investment manager, there's no insurance company annuity guarantee. You still have to pay PBGC premiums. With any type of annuity, whether it's nonparticipating or participating, there are no future PBGC premiums if there are no future accruals for the participant.

Let's now look at mortality. This sounds gruesome, but favorable mortality experience occurs for an insurance company or plan sponsor when people die more quickly than anticipated. That's one side. The other side of the coin is if there are mortality breakthroughs, where people start living longer, which results in lower mortality rates. Those are the two sides of mortality.

If you look at an immunized portfolio, the favorable experience accrues to the plan sponsor. In other words higher mortality means a plan sponsor pays out fewer benefits. Lower mortality is a charge to the plan sponsor. Obviously the plan sponsor has to pay out more in benefits. In conclusion, with an immunized portfolio, the plan sponsor realizes all the mortality gains and losses. With a nonparticipating annuity, the mortality experience accrues to or is charged to the insurance company.

Let's examine the category of higher mortality rates in a participating type of arrangement. The favorable experience accrues to the plan sponsor and goes back to the plan sponsor in the formula dividend, which I'll talk about in a few moments.

If there's a mortality loss, on the other hand, the experience has the impact of reducing the dividend but, the experience is shared. If there is a catastrophic negative situation, for example a cure for cancer or heart disease, the catastrophic downside experience is picked up by the insurance company. The insurance company can never go back to the plan sponsor and ask for more consideration in a participating annuity situation.

Let's look now at investment gains and losses where the situation is very similar to the story on mortality. With an immunized portfolio, gains accrue to the plan sponsor and investment losses are charged to the plan sponsor. With a nonparticipating annuity it's the same story again. Favorable and unfavorable results are borne by the insurance company.

With a participating annuity, the gains accrue to the plan sponsor in the form of a dividend. Any losses are shared. The plan sponsor receives reduced dividends in the event of investment losses. However the catastrophic down side is borne by the insurance company, because the insurance company, again, cannot go back and ask for additional consideration.

Let's talk about these three possibilities again and look at the administrative side. We will examine administrative expenses; a related element is the actual payment of benefits. With an immunized portfolio the plan sponsor does not know what the administrative expenses will be in advance. It's an ongoing plan and the plan sponsor bears the expenses whatever they may be. They could be higher or lower in the future. The plan sponsor continues to make the same benefit payments that were made before the immunization occurred.

In a nonparticipating annuity arrangement, the insurance company guarantees the expenses. It generally builds inflation into the single payment consideration.

The insurance company can take over the actual payment of benefits in a participating or nonparticipating annuity purchase. Alternatively, the plan sponsor can elect to continue to pay their benefits in the same manner it did prior to the annuity purchase.

Participating annuity arrangements also reflect administrative expenses. Typically, the insurance company in the arrangement will offer a guarantee of these expenses, and typically there is inflation built into that guarantee. It is often a guarantee with some cap on it.

We will examine the insurance company credit risk. Speaking from the insurance company viewpoint, there's no such thing as insurance company credit risk! I'm sure there are individuals in the audience who will challenge me on that statement. So let's talk about the topic. The credit issue does not apply to an immunized portfolio because the plan sponsor has not made an annuity purchase from the insurance industry.

With a nonparticipating annuity, there's the potential of general account credit risk with an insurance company. A few years ago, there were solvency situations such as with Executive Life and Mutual Benefit. Everyone in the business just hopes that's something in the past. However, it was definitely an issue that was on the front burner for several years. How safe is an annuity when it's guaranteed by the general account of an insurance company? The issue has to be addressed when a nonparticipating annuity is purchased from an insurance company.

With participating annuities, there is a separate account that's walled off from any potential general account creditors of an insurance company. The only mild concern is if the separate account of the insurance company for the particular client has very negative experience, then the backstop is the insurance company's general account. A situation, however unlikely, could exist where the experience was so negative that it totally wiped out the assets in the separate account. Then the general account would have to support the guarantee. In most situations that would be no problem. Obviously, if the insurance company in the meantime had developed financial difficulties, the credit safety issue would arise, most likely for just a portion of the benefits.

Let's look at the considerations. The topic does not apply to immunized portfolios, so we will discuss nonparticipating and participating annuities. The sponsor pays a one-time consideration for a nonparticipating annuity. There are no dividends. So the initial consideration is essentially the ultimate consideration.

With a participating annuity, there's an initial consideration that may be 1-10% higher than that for a nonparticipating annuity. The difference might be referred to as the cushion which is there because the insurance company is going to pay out favorable experience and bear the downside experience.

What's the ultimate consideration on any annuity participating arrangement? You don't know that at the point of sale. You start to get a feel five years down the road as to what it might be. The ultimate consideration is the initial consideration less the present value of any future dividends that are paid out under the arrangement.

That wraps up the comparison of immunized portfolios with the two types of annuities, a participating annuity and a nonparticipating annuity. I'll turn it over to Rhoni who will discuss the role of the consultant in the annuitization process.

MS. RHONI SEGUIN: Let me make one point. The role of the consultant, as I've outlined in my presentation, is one point of view. It's one way that it has been done, in my view, very effectively.

Our Wyatt Group in Portland, Oregon places about a billion dollars a year in annuities. Back in 1987, we did a little over $3 billion. Obviously in those days there was more of this business around. So, these are methods that we have fine tuned based on our experience with plan sponsors in the U.S. through the Wyatt company.

To begin, the process needs to be determined. The consulting actuary or the plan sponsor needs to determine which is the best route for purchasing the annuities. There are brokers, consultants, actuaries, and plan sponsors. I think you need to look at the project and the scope of it and say, who is the best possible provider for this level of service when going out to the market to purchase annuities?

If you, as an actuary, are seeing only one of these a year or maybe one every other year, you may feel that the use of a qualified expert could be of value. I've met some actuaries who do one of these every couple of years. They'll call me and ask for advice and say, "I was going to go to Met and Pru. Can you think of anybody else?" And I'll reply, "I'll send you a list of about 20 insurance companies and their addresses." There's definitely a real market here. It's just like anything else; if you're going to buy a service you want to make sure that you're covering the entire scope.

So, with that said, the next point would be determining your carrier list. The carrier list should be very comprehensive. We've also had actuaries say, just pick five good ones. I really think you'd be falling short for the client. I cannot tell you who the winning carrier is going to be from one buyout to the next. I can probably make a really good guess of who is going to be in the top three, just based on experience in the marketplace. But the carriers that are aggressive for the business, and the carriers that are aggressive from one buyout case to the next vary greatly. I'm sure there are several of you who have done annuity buyouts; you can attest to the fact that the carriers who are hot today may not be hot tomorrow. The best way to go to the market is to cover all bases and include anybody who is actively writing annuity business.

You'll find that the list changes too. If you have a list from five years ago, chances are there are many changes. Some of the hot companies from the late 1980s have dropped out, and there are several new ones that are on our list.

The next issue would be the credit quality, credit analysis. Big, big issue. Back in the late 1980s we were providing this, and I know it wasn't that hot. Plan sponsors were looking at price. They were looking to get the most competitive price. They felt that they were dealing with solid insurance companies, and the differentiation between one and the other was just not a big topic. It wasn't something that you were really selling as your value as the consultant. It was more your bidding capability, your negotiating. The credit analysis was viewed as a nonevent.

Nowadays, as you can imagine, the credit analysis is very much in the forefront in the plan sponsor's mind. We have a client that we're working with who wants us to tell him who is the best insurance company. It's difficult to do when you're looking at so

many very strong insurance companies, and you have to determine which is the most solvent, or which is going to be the most solvent, say 40 years from now. That's a tough job and our recommendation is that you use a mix of the external sources available to you and some internal analysis. The National Association of Insurance Commissions (NAIC) database is a very good place to start to do some very in-depth internal analysis on the insurance companies.

We recommend both qualitative and quantitative reviews for internal analysis. These insurance companies, the investment people, and the actuaries open the door to you. They want you to be comfortable with the liabilities. As far as the external sources go, Moody's, Standard & Poor's (S&P), Duff & Phelps, and Towsend & Schupp are very fine companies that are doing a good job of looking at the insurance companies' credit quality. These rating agencies, back in 1990 and 1991, were scrutinized and questioned on the value of their analysis. We've seen a real turnaround over the last few years in the type of analysis they're doing. Now they're rating company by company instead of just rating the whole insurance industry.

Now let's go into the bid-solicitation process. First, you need to interact with your carriers. What I'm saying is know your suppliers and understand this marketplace. For instance, there are companies that want all deferreds. Other carriers won't touch a case that has a single deferred life. They want all retirees, all immediate.

To be successful, it really helps to know who the suppliers are, what they want, and what they're aggressive for. This will help you in determining whether you're going to take the case as a whole, or if you're going to break it into components.

Size is another issue. There are companies out there that can't touch anything over $10 million in premium. Others won't even underwrite unless you have $50 or $25 million. So all of these things help you add value to the process.

Another thing you can do is just talk to the companies, be aware of the underwriting techniques and the kinds of things that they like to see—what's important to them, what helps them get comfortable. Then make sure you're providing this. That takes us right into the next step which is preparing the bid package.

I just can't say enough about the value of having thorough, complete and accurate data to send to the insurance companies. I've heard from insurance companies that sometimes get a plan document in the mail, and a day to call in the quote, and a phone number. You may get a price in response, but how competitively it will be priced is really questionable. We should cover every last detail. We'll go so far as to give them individual disability experience, stating every disability case that's happened over the last 20 years and the incidence and the reason. Do whatever it takes to get that pricing as tight as you can. I don't think you can be thorough enough in this area.

As far as the census data goes, think about how you'd feel if you were the actuary and are taking this on. What would it take for you to provide a price for this case? What types of census data would you need to load into your system? The obvious is the normal census of data features. Then go beyond that and include spousal options, factor tables, or anything you can think of because the insurers do a

considerable amount of work to provide your annuity pricing. If there's a feature in the plan that's really complicated, take the complication out. We have a plan right now in which profit-sharing contributions were made to the pension plan 20 years ago. And then they allowed the participants to make lump-sum employee contributions. Now they have about five different formulas for figuring out how you can get the return of those contributions upon either retirement or termination.

When we first read it, it looked so horrendous, but we found many different ways to simplify it. We did some of the sample calculations where we took A plus B, and just simplified the whole thing so that carriers wouldn't just see it in the plan and say, "What a mess to administer." We turned it into a very simple process. But I believe breaking it down made the insurance companies more likely to take the extra look. Another thing you'll find is that some insurance companies don't want to underwrite a horrendous case. And if you come out with a case that has a bunch of lump sums and disability provisions, and you take it to the market, you may come back with one bidder. Your plan sponsor is going to be disappointed. They're usually expecting ten companies to be vying for their business. So, anything you can do here is just going to add to the competitiveness of the bidding.

Next is the submission of the specifications to the carriers. We recommend allotting a good amount of time. We've had plan sponsors and actuaries come to us and turn one over in a week. You could probably do it, but again I don't know how effective it would be or if it would be as competitive.

What we recommend is a bidding process of anywhere from five to seven weeks from start to finish, which includes all of your biddings, your proposal review—the whole process. About 5–7 weeks is ideal, 8 weeks would be too long, and 4 weeks would be the minimum to turn it around.

Next is the proposal review. This is something that shouldn't be overlooked. You want to make sure that the insurance carriers are underwriting the case exactly to the provisions of the plan. I don't know how many times we found proposals coming that left out features of the plan specifications that were in our bid specifications and in the plan document. They were simply left out or were misinterpreted or an incorrect mortality table was used. If you don't catch them in the proposal review, it will cause problems later.

Also, the carrier may request additional funds based on the error. This is unpleasant because the plan sponsor has already settled the books, and six months later when the error is found you have to be the one to go to him and tell him how much more he owes the insurance company.

The next step is the placement bid negotiation process. This tends to be the most exciting part of the bidding, and unfortunately it goes the most quickly. This is our method for the bidding process.

We believe in doing a preliminary bidding. It could be a week before, or it could be a couple of days before. Preliminary bidding takes a little bit of that shock factor out, especially if the plan sponsor has assets of $40 million and the bids are coming in at

$50 million! A preliminary bid allows the extra time to go to the president to ask for an extra $10 million. This tends to make the bidding day much smoother.

The next reason for the preliminary bidding is to find errors. We had a case years ago in which a major insurance company came in on the pre-bid $3 million cheaper than any other carrier. It was only a $10 million case, so the client said, "Let's buy it!" Well they could have bought it, but they probably would not be buying the right thing. It's like going to the car lot and buying a Mercedes and finding out it has a Pinto engine. You have that Mercedes on the outside, but somehow it's going to come back to haunt you, and you're not going to feel like you got what you wanted out of the deal.

So, we encourage plan sponsors not to jump on a deal. We went back to the insurance company and said, "Listen, you're $3 million off from the next closest insurance company; we think you may want to look at your pricing." And sure enough there was a major pricing error and they found it before the final bidding when their actuary did a final review. The pre-bid is a good way to catch those errors. Then, on the final bidding, you're not locked into something that's going to disappear into thin air, or need correction before the contract comes out.

After the pre-bid, we spend some time spurring the competitive juices with the carriers. We go back to the carriers and give them a great deal of feedback. We tell them where they were in the line up. We had a case about two weeks ago with 13 bidders. These insurers had gone to a great deal of trouble to underwrite the case. We really wanted to give them a good shot going into the final bidding. So we told them everything we could. We gave them the names of all the companies that were bidding so they could compare on a credit basis. We gave them all of the quotes that came in. It really helped the carriers to be aggressive on the final bidding day. I believe this helps keep you on good terms with your carriers. It also allows you to get more competitive bids.

We usually avoid Mondays and Fridays. Bids come in late on Mondays and typically markets close early on Friday. Quotes usually expire at the end of the day. It's very rare that companies will hold their quotes overnight, although there are a few that will. It's always a good idea to get everybody who is involved in the decision-making process in the room at one time ready to make a decision on the final bid day. If you have to hold the carriers over to keep re-bidding, we find that the insurance companies lose a little bit of the sparkle when they come back to bid for the sixth time. We tend to say final when we mean final. We get the client all geared up for the "real" day.

We do not eliminate any carriers from the preliminary bidding. We narrow down the carriers and we look at the four basic factors. First, there's compliance with the bidding specifications. We usually invite the actuary and plan attorney.

Next, we get into financial solvency and strength. We look at the external and internal credit analysis. Then we evaluate the carriers' ability to service and administer the benefits; this tends to get overlooked quite often. I've met with various insurance companies and looked at their systems. There are wide variations between one insurance company and the next. I think this is very important because the first time the

check is late, or the first time somebody calls the insurance company and can't reach the contact person, the plan sponsor will be calling you. And they will not be happy because they'll feel like their service is not up to what the participant was getting when the plan was in their shop. So, you need to be sure that these companies that are putting in bids are going to be able to administer them as well as (or better than) the plan sponsor was administering them in his own shop.

Last is the competitive market price. You must make sure you're getting the most competitive deal for your plan sponsor.

As far as locking in the commitment in the final bidding, our style is to go back to the carriers for one final round. The final bids come in that day, we narrow them down and take out anybody who didn't comply on the four basic compliance terms. Then, we go back to the final three. We get them to sharpen their pencils. We'll give them the three final numbers. We're real honest in that approach. If someone came in number one, we say, "You're number one. You have a margin of about X, and number two and number three are close behind." We give them good feedback.

Then you lock in the quote before the close of business and make sure all the documentation has been faxed and everything has been completed before the plan sponsor rushes out to find out what to do with the extra money.

The final step is the documentation. This is something we started back in 1986 in case the plan sponsor ever looked back and said, why did I buy Metropolitan Life? People change, they move from one company to the next. Memories get blurry as the years go by. We felt it was important for them to have a very thorough documentation of what happened on that day and what went on and why that decision was made.

In 1990 and 1991, the Department of Labor (DOL) started going to plan sponsors and asking questions. It was real helpful that we already had the plan sponsors fully documented so they could explain why they made that purchase, what kind of due diligence was done, and how they used qualified experts. These were the types of questions the DOL was asking when they were doing their investigations. I think their investigations took place from about 1990 to 1992. I haven't seen any investigations of any of our buyouts in the last year.

The summary should really give an itemization of the bidding process; who the specifications were sent to, what data was sent to the carriers, and an outline of everything. Go back through the file and outline everything you've done so it's available for anybody's use at a later date.

The next thing to do is help with the transfer of the liability to the winning insurance company. Make sure this happens in a smooth fashion and the way it was previously committed to. You'll get tighter pricing with a 48-hour wire transfer. You definitely don't want to get to the wire transfer date and find out that the assets aren't liquid, which has happened. Make sure this is settled prior to the final bid date.

Next you need to review the contract. Our experience shows the contracts can take anywhere from two months to two years. We like to hit a target of about six

months, but it can be a very lengthy process depending on the insurance company and the complexity of the plan.

Finally, you will want to review certificates. We typically review sample certificates. We don't review every single participant's certificate because the documentation of the contract with the census data is similar to putting A and B together to equal C. We've had problems where immediate certificates were going to go to the deferreds, or small errors similar to that. So we review a sample of immediate, deferred, and term vested, and then we send those to the plan sponsor to review also. Make sure the sponsor is comfortable with the language.

MR. LYNCH: We will spend a few moments on current issues.

One act that has been proposed is the Retirement Protection Act of 1993. It's concerned with minimum funding standards. It also involves a phase out of the PBGC premium cap fund for underfunded plans. This bill calls for better employee communications from the plan sponsor on certain events.

At the same time, there's also another bill that's being proposed. It's the Pension Bill of Rights which Senator Howard M. Metzenbaum (D-OH) supports. It calls for opening pension plans to all workers and for immediate vesting in defined-contribution plans. The bill also requests that the DOL find ways to increase coverage and adequacy of pension plans.

Also, a number of organizations are calling for Congress to set a national retirement policy. This is obviously a very broad issue. I think people feel there's not good integration of Social Security and the private pension system. In addition, items like the tax laws and personal savings do not blend to provide the right type of retirement benefits in this country. The goal is just a dream at this point; however, there is an understanding that there has to be better coordination. It's not clear how far the various proposals will go this year or even next year. There's probably people in the audience who might have their finger on the pulse more than I do. One item that's hanging over everything is the focus on national health policy, and because of that, there's probably a feeling that Congress just won't have the time to address any substantial pension issues. So it remains to be seen what happens and when.

Let's move from that topic to the interest environment. Long interest rates are up approximately 100 basis points just from the beginning of the year. That development has real implications on the annuity business as I mentioned earlier today.

The higher interest rates are resulting in lower annuity prices and make annuity purchases look much more attractive to plan sponsors. That has been my impression over the past few months. I've been getting more phone calls from consultants and from plan sponsors inquiring about annuitization. It largely ties into the fact that interest rates have shot up very quickly in recent months. There will be a lag effect as Rhoni said. It's going to take months of preparation by consultants and sponsors before we see more annuitizations in the marketplace.

Our formal presentation has concluded. We'd be pleased to entertain any questions that you might have.

MR. VINCENT F. SPINA: When determining whether to use a broker or a consultant, one issue is whether there's going to be savings to the client or not. What kind of commissions typically go to an agent or a broker from an insurance company's side? Then, you can make a decision for your client about whether to go through to bid on an hourly basis or a fee-for-service basis as opposed to letting the broker get a piece of the assets.

MS. SEGUIN: Let me address that first and then I'll let Bob handle the insurance company fees. I'm going to be a little bit biased because I'm a consultant. I've been in bidding situations where there have been consultants and brokers. The client pitted us to compete against each other.

Basically the consultant is charging for the time spent to handle the process. In our experience, that time spent is not typically as much as a percentage of the assets of the plan. That's been our experience unless it was a very, very small buyout. Then the broker's percentage would be less than a consultant's fee. The consultant works for the plan sponsor and for the plan actuary. The broker, on the other hand, is paid by the insurance company, so there have been situations in the past where we've had brokers who did not represent as wide of a base of insurance companies as what we deemed necessary for very competitive bidding.

Again that may be a biased view because we are consultants. Bob will talk about the actual percentage point fees the broker would take from the premium.

MR. LYNCH: Our experience in the insurance industry shows that most of these situations come through consultants and actuaries who are billing for their time. We don't see too many situations where there is a broker involved. We tend to see brokers on very small plans. The plan sponsor typically pays the hourly fees directly to the consultant. Where there is a broker, the plan sponsor will often agree to have it built into the consideration. Sometimes the broker's fees appear, on the surface, to be very, very high. Other times they appear to be medium range or low range. There has really been no consistency on such fees. I will say our experience is limited because we don't see very many broker situations come to market.

MS. SEGUIN: David, do you know the percentage? I've heard 1–5%. If you have something more accurate please speak up.

MR. DAVID L. STONE: You don't get much more than 5%.

A current issue that you didn't have up there that might have dramatic impact on this market is the fact that the DOL is currently drafting guidelines that would force an employer wanting to be relieved of PBGC responsibility on liability benefits to purchase the annuity from the safest insurance company out there. The words they are proposing to use are the safest. Are you aware of this development? If so, could each of you comment for the insurance side of it and also consulting as to how you think this might impact this market?

MS. SEGUIN: I'll talk from the consulting side. We're delighted with the legislation. We just couldn't find anyone who could give us a definition, which was a little frustrating. We agree you should be purchasing annuities from the safest insurance

company that you can find, being that all other points of consideration are covered. We worked with the DOL and asked for the definition. We learned that the DOL was working with another force within Washington. It was my opinion that the DOL recommend the insurance company be the safest. We tried to find out what party could give us a definition of safest, and we have been unable to come to that determination.

MR. LYNCH: Does the plan sponsor purchase from the safest, regardless of price, regardless of administrative capabilities? How would you determine the safest? Would safest be determined on the basis of ratings? What would the role of the consultant be? It would force all annuity business into one insurance company. There's only one insurance company, I'm aware of, that is in the group annuity market and has the very top ratings from all the rating agencies.

MS. SEGUIN: For instance, I have three buyouts I'm working on right now. New York Life won't underwrite any of them. So in that situation, you go to the safest that would write the case. I haven't received a definition yet that is quantitative and qualitative. Is that external or internal? You could have ten companies on a bidding list. You should go to the safest company.

MR. LYNCH: Does that mean your role would be to try to assemble a group of companies to make offers? Once you have the group of companies together, the safest one is going to win the case regardless of price. Therefore, all the other issues you talked about, for example squeezing insurance companies for a little more rate, have no value.

MS. SEGUIN: Well again, the safest depends on whose definition we're going to use. If the safest is the only triple A rated company that's out there, then you're right. I wouldn't have a job and none of the other insurance companies would write group annuity business anymore. But the safest may be determined by what we're doing now. That's the exact same process that I just outlined. You should go to the safest company. In a bidding situation, I could come up with about ten companies that could be coined the safest. And all those other factors would be the value that we would continue to add.

MR. LYNCH: Depending on the definition.

MS. SEGUIN: Depending on the definition. I don't think anyone is going to be able to come up and say, the highest rating by the four rating agencies is the top company. Because that's one insurance company, and that insurance company does not write highly deferred group annuities. They also won't write cases that are of various sizes.

MR. STONE: I would think they might start if they were guaranteed to get the business. It's just a guess.

MS. SEGUIN: Interestingly enough, David, there have been several situations where we've gone to them and said, "You're a dead ringer for this case; would you please quote?" They've turned it down. So apparently there is more of a liability issue regarding the types of business they want on their books. It's not just a matter of

getting the business. There have been several buyouts where we could really hand it to them. Another company, American International Life, has top ratings; all of the ratings that they have are the very highest. Again, you could go to them and say, "I think this could be handed to you," but they would turn it down because it isn't the type of liability they want on their books. If the legislation wants to come out with that, they're going to have a real problem when all the plan sponsors who are buying are coming and saying we have no suppliers. I think we're going to have to turn around and ask people who are experts in credit analysis to determine what the safest definition is. Or you can throw out the legislation all together.

MR. LYNCH: I guess what comes to the surface is that the whole concept comes down to redlining. You could determine the safest insurance company in all lines of business. Then you would just have one insurance company writing personal insurance policies.

A very similar type of proposal came up several years ago on this same issue. It didn't go anywhere because there were so many concerns about who decides which company is the safest.

FROM THE FLOOR: I have a question about the demographic assumptions that tend to be used by the annuity providers. Is there any standard right now? And how responsive do they tend to be to mortality studies or other kinds of experience studies that are presented to them in the course of bidding?

MR. LYNCH: Obviously mortality assumptions have real implications as to whether we make or lose money on a particular case. You can't be too conservative or you won't win the business. At the same time, you don't want to be aggressive and experience mortality losses. We subscribe to and follow industry studies on mortality. We also do very extensive analyses of all the business that we have on the books in this marketplace.

We study it at least annually if not more often. We get a very good update as to where we think projected mortality will be down the road. We immediately reflect that in our pricing bases. It is a very critical factor in the pricing process.

FROM THE FLOOR: What is the response of the annuity providers when a company provides them with a mortality study of their own population?

MR. LYNCH: We're very pleased to get that information. We use those studies extensively. Obviously no one comes to us and says, our people are going to live forever. They always come to us and claim the participants are going to die the day after we write the annuity business. But all joking aside, we find it very helpful. The more the consultant can educate the insurance company, the more precise the pricing will be.

We use those studies. As a matter of fact, I can remember a number of situations in which we've had very extensive dialogue with a consultant after we received that type of study. We don't want to sit in a vacuum and use one particular mortality table for all different types of business.

In every situation we underwrite, we ask the right questions to get a good understanding of the make-up of the population. We'll also go to outside sources, such as to business libraries, to get a better understanding of the nature of the business. We make sure that we have the best information that we can get, in order to arrive at the right mortality projections.

MR. LALL BACHAN: Rhoni, you said that during the process, you were really honest with the carriers and you tell them where they are in the process. Do you actually tell them the name of the company they're competing against and what the actual quote has been?

MS. SEGUIN: I must be honest and factual, but remember that I work for the plan sponsor so it's my job to get him a good deal. I give them the name of the top three carriers, and I give them the top three quotes. I don't line those up with the insurance companies. And I'll remind them that we're going to have a final round, so that all three of those numbers should change one more time and supposedly drop.

MR. BACHAN: Bob, you were just about talking mortality tables. I work in a multiemployer area and we seem to find that mortality for those folks is much higher than it is for the white collar folks. We've done some quotes with you in the past. I'm just wondering if you took that into account when you were quoting on our business.

MR. LYNCH: You want me to squirm and then answer the question. We did take it into account in those situations where we worked together. We examined that mortality very closely, and that went into the way we structured our pricing basis.

MR. BACHAN: I guess I should ask what the experience has been?

MR. LYNCH: I've got that back in the office. I just don't have it at my finger tips.

MS. SEGUIN: There was an interesting study that we did at one time. It said some of the insurance companies actually use mortality that says white collar workers live longer and others use mortality that says the blue collar workers live longer. There are different studies on the levels of stress and the physical requirements of the job. It is interesting to see that if you look at all the insurance companies, they don't have the same assumption although you would think there would be a common thought of which lived longer, based on some kind of medical data. It's interesting.

MR. LYNCH: I will make one closing comment on that mortality issue. It is treacherous and it has been our experience that actual mortality has been lower than expected. That would obviously be a negative for our pricing basis. You have the possibility of mortality breakthroughs on heart disease and cancer. There has always been the flip side which is the possibility for new diseases hitting this country and causing mortality rates to be much higher. So it's something you really have to stay very close to and do your best to project.

MR. GENE BRYANT FIFE: How do you deal with lump sums and other subsidized forms of payment?

MS. SEGUIN: There are several insurance companies that will effectively underwrite those. We try to clean the data out the best we can. We've had plans that send a letter that says, "Remember you have X dollars that can be withdrawn at any time." And that tends to cause some money to flow out the door. If you can minimize the amount of the lump sum that's sitting on the books that can be withdrawn at any time, I think you can get better pricing.

The other thing is, if you have a provision that allows for withdrawal just at retirement or death, it's a much easier provision to take to the carrier. So do as much clean-up as you can as far as it having an open-ended withdrawal period. A problem exists with the federal mid-term rate. It used to be that the plan could set the withdrawal rate or the lump-sum determination rate; things were much easier in those days. But there are companies that cannot deal with the federal mid-term rate pricing on the lump sum. So, you get a smaller list of final bidders.

MR. WILLIAM CARROLL: In the last several years, there has been a big focus on quality because of the problems in the business. Can a quality company charge a premium? And can it get more for the same promise than a company of less quality can get?

MS. SEGUIN: In the guaranteed investment contract (GIC) area, the answer is definitely. I would say that's an easy answer. It's not as efficient on the annuity side. There are still times when we get the top-rated company with the most aggressive pricing. And that tells you there's inefficiency.

We consider quality to be something that we determine internally as well. So when you say quality company maybe you're talking double A1 Moody's or triple A S&P. I don't know your definition of quality. I've got a group of companies that our internal analysis tells us are very good quality companies. And yes those companies are all in a realm with each other. When we drop down to what we consider second-tier companies, then those would definitely be required to pay a premium above. And so far we've yet to have a plan sponsor on a buyout want to go to a second tier even though they were getting a cheaper price for it. It's possible that we have very conservative plan sponsors or that we're pushy about our opinions. You can get a cheaper deal through a second-tier company; but again, I've yet to see anyone go for the lower price.

MR. LYNCH: My view is from the insurance company's side. It's my distinct feeling that plan sponsors are not willing to pay the proper premium for quality. That's my impression of both the annuity and the GIC market. It has been my experience that there's a real compression in price or interest rate, obviously depending on whether you're looking at annuities or GICs. There is not the proper spread that you might see for varying levels of quality.

For example, we do not see the same spreads you would see if you went into the marketplace and bought a triple A corporate bond as opposed to a single A corporate bond. Some of the problem might be due to the insurance industry not pricing those quality differences effectively into their annuity and GIC offerings.

MS. SEGUIN: The whole quality issue is really confusing. What is the definition of quality? Does anyone have a thought on that? No? No wonder it's such a confusing issue. Nobody has an opinion on how to determine quality.