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A Look at the Annuity Market after Department of Labor (DOL) Interpretive Bulletin 95–1: Where Have All the Insurers Gone?

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Summary: Now that plan sponsors are required to purchase only the "safest available" annuities, companies encounter a number of difficulties when they attempt to terminate a defined-benefit plan. This session addresses:

- *the lack of available insurers and the resulting effect on competition*
- *a situation in which the plan sponsor may have difficulty finding any insurer to take plan benefits*
- *the effect on prevalence of lump-sum distributions and their effect on retirement security*
- *the role of the Pension Benefit Guaranty Corporation (PBGC) as "insurer of last resort"*

Mr. Richard G. Schreitmueller: I'm from the Alexander Consulting Group in Baltimore. We have two very good speakers. Anything that's said here is the opinion of the person who speaks. We work for companies within industries, but these are our own opinions as professionals.

Our first speaker is Brian Clark. Brian is representing what we call the "buy" side of the annuity process, because he works on behalf of employers and pension plans and participants. Brian is a graduate of Kenyon College in Ohio. He's also a

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Certified Employee Benefits Specialist (CEBS) with fellowship. Brian started out in the sell side of the business in 1985 with Allstate Life Insurance Company, where he was pricing and installing guaranteed investment contracts (GICs) and terminal funding annuity contracts. His involvement with annuities pre-dates all the fuss and commotion we had six or seven years ago. Brian moved into the buy side with Mercer in 1987–88, where he was doing GIC placements. That's where Brian began keeping databases of insurance companies and providers so that he wouldn't have to reinvent the wheel every time a new proposal came along.

I first met Brian in 1988 after he moved to Foster Higgins in Princeton, New Jersey, where I was working at the time. Brian has stayed with Foster Higgins, providing advice as a consultant to plan sponsors and consultants about annuities and GICs. He works with a big base of clients, with annuity contracts ranging from $10,000 to $600 million. He also issues due diligence reports for employers trying to do their fiduciary job on carrier quality for a $10 billion client base, so he has substantial experience as a specialist in this field.

Our other speaker represents the "sell" side of annuities, and many of you know her, Zenaida Samaniego, Fellow of the Society of Actuaries (FSA). Zenaida has been with Equitable Life since 1985, and before that she was with New York Life. At The Equitable she is a vice president and actuary responsible for individual annuity product development and research. She has previous experience in financial areas with The Equitable, pricing individual annuities and group pension plan closeouts. Zenaida has a B.S. degree in math from the University of the Philippines and she obtained her master's degree at the University of Michigan. She's also a member of the DOL Employee Retirement Income Security Act of 1974 (ERISA) Advisory Council. As a member of the Society of Actuaries (SOA) Committee on Retirement Systems Research, Zenaida chairs a project oversight group that's doing research on the safest annuity rule. As she will tell us, there's a considerable amount of research being done in this field.

First, those of you in the audience who are pension actuaries, do you think of yourselves primarily as representing employer plans and plan sponsors? It looks like at least half of the group. Next, let's see those of you who are primarily from the insurance-industry side, either a company or something closely related to that. A good representation. Finally, is there anyone who represents the regulatory side, federal or state? We've got at least one. Is it federal or state? State level, legislative auditor. Any categories that we haven't covered, feel free to raise your hands. The guaranty associations. We're very happy to have you and hope you'll contribute to our discussion.

Mr. Brian Clark: I'm going to go over some history, starting off with how I became involved in the annuity market in 1985. At that time, the single premium annuity market was booming, for three big reasons. I may refer to single premium annuities as annuity buyouts or terminal funding, but it's the same animal. First, at that time, the defined-benefit market had matured, and plan sponsors and employers were faced with increasing regulations, the costs and burden of administering plans and of paying consultants to keep their plans in compliance. Second, at that time, we had the advent of 401(k) plans and growth in the defined-contribution area. I think employees, especially younger ones, were more interested in defined-contribution plans and 401(k) plans. Third, coupled with those trends was the tremendous growth in the defined-benefit-plan assets. Most defined-benefit plans found themselves overfunded thanks to good investment performance. So we had growth in plan terminations and the single premium annuity contract market.

We had pension plans that terminated where the employer may have replaced the plan with a defined-contribution plan. We also had clients who would transfer blocks of annuities, typically retiree liabilities, to an insurance company to relieve themselves of the burdens of administering the contracts. Also at that time, employers could use the excess of assets over liabilities for other corporate purposes, to help finance an acquisition, or whatever. It was a point in time where there was raiding of pension surplus. You wouldn't take anything away from participants, but you could use the excess for other purposes. Most major life insurance companies were interested in bidding on these plans. For most, they represented a good block of business, particularly the retiree liability, because the mortality assumptions and, at that time, the investment assumptions, were fairly reliable. There was a great deal of competition.

One of the first major players to gather a great deal of attention in this market was a small company called Executive Life, which I think began in the early 1980s, mainly as a writer of individual annuities and single premium deferred annuities. They got into the group pension market with both annuity buyouts and GICs. They bid on these plan terminations and Financial Accounting Standard Board (FASB) settlements very aggressively. The bigger companies, like Aetna, Travelers, Equitable, Mutual of New York, and a host of others, wanted in on this market too.

Many insurance companies at that time also developed or began group pension departments, both for annuities and GICs. At that time, the insurance companies took risks, mainly investment risks, in the single premium annuity market. Typically the lowest price won. The main thing that insurance companies reached for was yield. They looked for the highest yielding assets and used what they thought were reasonable assumptions for the default risk associated with the assets. Many of these contracts might have 30- or 40-year liabilities if there were deferred annuities.

They used what they thought were reasonable reinvestment assumptions and default assumptions in their pricing. But given that the lowest price often won during that time, they had to be as aggressive as possible in order to win the business.

The process of underwriting contracts was very labor intensive too. It would take four to six weeks to manipulate all the data and make your assumptions, so there was a great deal of work involved in quoting on these cases. The fact that they had devoted so much time to this would mean that they wouldn't want to lose a case after working on it for four to six weeks.

Executive Life was the biggest user of junk bonds backing the investments in the contracts. A few other insurers used noninvestment grade bonds to a degree, but Executive Life was the main culprit. Other companies would use a mix of junk bonds and real estate, and at that time real estate was doing great. It was a Texas boom, the Northeast was doing great, and in my recollection there were about 25 insurance companies involved in this market. The only government involvement was that the PBGC would want to know who the insurance company was within 30 days of selecting the contract, but it was done after the fact.

The rating agencies also seemed to reinforce the view that insurance companies were rock solid. I think in late 1985, Standard & Poor's (S&P) first issued their rating of Executive Life and that was AAA. Executive Life remained AAA until very late 1989. Big insurance companies just didn't fail. They were known for conservative, risk-averse management, they were household names of course for over 100 years. Besides the safety and the conservative view of insurance companies, state regulation was perceived as being effective.

Insurance companies, as you probably all know, have to file detailed statements every quarter, and even more detailed statements every year. They were subject to state audits, most big annuity writers were licensed in New York, and New York has probably the toughest insurance laws. As a third safety net, there were state guaranty funds, and the PBGC. They were thought to be the insurers of last resort, nothing had every really happened. I think in 1983, Baldwin United was the largest insurance company to fail at that time, and I believe Metropolitan took over the obligations of that company. There weren't group annuity contracts involved, but there were no losses. That's generally the way the annuity market was through about 1989.

Towards the end of 1989 Executive Life really started to get a tremendous amount of negative publicity. First were some reports of how they may have manipulated their surplus or overstated their surplus. Then on their junk bond holdings, reports said they may have repackaged some of their junk bonds to make them appear as

investment grade. That got a great deal of press in *The Wall Street Journal.* At that time, in the fall of 1989, I was talking to the rating agencies once or twice a week, and they all held firm on their opinion that Executive Life was, in fact, sound and safe, and the company merited the ratings they had. They were triple A from S&P, and just single A by Moody's, but the rating agencies did not feel that a recession would really adversely impact the company.

January 1990 is when Executive Life abruptly announced there would be about $500 million in bond write downs, and the agencies dropped Executive Life two full tiers. Again, there was a lot of negative publicity in the press. Clients were concerned not only about Executive Life, but also about other insurance companies in this boat. In the spring of 1990, I think what really started the ball rolling as far as government involvement in this was a case from Coleman Company out of Kansas. It had just bought a single premium annuity contract from Executive Life. Senator Bob Dole and his wife, Elizabeth, who I believe was secretary of labor at that time, and the other senator from Kansas, Nancy Kassebaum, put pressure on Coleman to get out of the deal because they just felt that Executive Life was not safe and something wasn't kosher. It's very rare for a transaction like that to be reversed, but it was.

At that time, Senator Metzenbaum from Ohio became a proponent for federal regulation of insurance companies. There were Senate hearings about what had happened with Executive Life. The General Accounting Office (GAO) did a report on basically the shortfall of guaranty funds and what they felt was the inadequacy of state regulation from one state to the next.

In the spring of 1990 the PBGC announced a new procedure, which I guess they had just revised three or four months after their last instructions. At that point, in March 1990, they changed the rule to make the plan sponsor notify the PBGC of the choice of insurance company 45 days before they would buy the contract, or before the purchase became final. If you didn't know who you were going to buy it from, you would submit a list of possible carriers. And the PBGC began to question some of the names on the list.

They did not disclose what their criteria were or what went into their decision making. I think they were looking at ratings, concentrating on companies that had junk bond exposure (and all major life insurance companies have some junk bonds), but I think they were concentrating on the companies that came closest to what Executive Life had.

Early 1991 is what I consider the turning point in the group annuity market, both for annuity buyouts or single premium annuity contracts and GICs; that was finally the

collapse of Executive Life. Over the last year, beginning with the adverse publicity, Executive Life became subject to a run on the bank of sorts. Individual contract holders were surrendering their policies. Group annuity contracts could not, the single premium annuities are irrevocable commitments, you can't get out of them. Most of Executive Life's GICs were also nonsurrenderable.

What happened over 1990 was that about 25% of their liabilities were being surrendered, and to fund those surrenders they liquidated what were the better assets, or what they could liquidate without a loss. So by the end of the first quarter of 1991, I think Executive Life's investment portfolio was about two thirds in junk bonds, and many of those could not really be valued as it turned out later. Drexel Burnham had underwritten many bonds, and when Drexel went under, there were many questionable values of bonds to begin with.

Executive Life was in very bad shape when it was taken over. Participants' benefits were cut a few months down the road, but for annuity benefits, there was a year or more when participants were getting only seventy cents on the dollar of their retirement benefits. There was much concern about the insurance industry at that time, but still Executive Life always had somewhat of a bad reputation, not only for the investments and their strategy that they used in getting business, but also because of their management. The man who ran Executive Life was not of the typical conservative, old-school type of insurance executive.

Executive Life was considered an exception only for a couple of months until May 1991 when Mutual Benefit announced that they were trying to merge with a large insurance company (I think it was Met), and those talks fell short. Mutual Benefit disclosed that they were having a great deal of real estate problems that were going to materialize in the next year or two. That was more of a shock in my mind, to our client base and to the group annuity industry because Mutual Benefit was one of the oldest, blue-chip companies, and they were perceived as having conservative management. At that point, in May and June, there was a big drain on Mutual Benefit as well. They had a great deal of 403(b) money and some GIC money that could easily be surrendered within 30 days or less. Many of these policies could be surrendered with no penalty, and in some cases at a market value gain, the way that the contract formulas were written.

So there was a tremendous outflow from Mutual Benefit from worried plan sponsors who suddenly saw an Executive Life situation happening again. That went on for only about six weeks until the New Jersey insurance department stepped in and shut the company down, putting a halt to all the surrenders. This, in turn, led to a panic among our clients, not necessarily the clients that we had placed group annuity contracts with. The plan termination single premium annuity contracts

were more stoic. There was nothing they could have done anyway. It was the pension market that was very concerned.

The Wall Street Journal, Money magazine*, USA Today*, and much of the press were doing stories on insurance company practices, alleged abuses, and mismanagement. There were many sensational stories on topics that frankly weren't that scintillating to begin with, but it really did cause a panic. The commercial real estate markets that backed many insurance company investments were not doing well. There were increasing mortgage delinquencies in the northeast and the southwest. As soon as Executive Life went belly up, and maybe before, I'm not sure of the timing, the DOL sued plan sponsors who purchased Executive Life contracts, for breach of fiduciary duty.

The DOL also began going after other employers that purchased annuity contracts from companies that were not, and were never, under state receivership or conservation. There was a plan sponsor, Strauss Adler from Connecticut, who purchased a group annuity contract from Presidential Life. Presidential Life was another company that invested relatively heavily in junk bonds (not to the extent that Executive Life did, but their ratings were probably in the triple B to the low single A; that's still investment grade, but not triple A.) The DOL issued there also for breach of duty, for not fully considering the financial safety of the insurance company.

In conjunction with their lawsuits and all of the Senate hearings and the Congressional hearings, the PBGC and DOL began a project to help or guide or tell sponsors how to select insurance companies—the beginning of the "safest available" standard. The three main points of their project were, first, to really recognize the interest of participants—that purchasing annuity contracts was a fiduciary duty.

Second, they wanted to put the burden of proof on the fiduciaries that they were fulfilling their duty and that they were looking at all relevant factors of an insurance company's financial strength. Third, they wanted to support the lawsuits and claims that they had already filed against the sponsors.

In late 1991, when this project was first announced, I think the term "safest available annuity" first surfaced, or the concept first surfaced. That caused a lot of concern among the insurance industry, for the sell side as well as the buy side, and the plan sponsors. We did not know who was going to be deciding what the safest company was, how that was to be determined, and also how that would affect the deals that had been done and decided a long time ago. In 1992, 1993, and 1994, the DOL worked on the interpretive bulletin (IBs) drafts involving the American Council of Life Insurance (ACLI) and any interested party through the official process of issuing these IBs. The comments and input took a few years, and they came out

in March 1995 with IB 95-1, where the "safest available" rule applies whenever the annuity obligation is irrevocably transferred to an insurer.

When you unload annuities to an insurance company and can't get them back, that's when this bulletin would apply. It would apply to a defined-benefit plan, a defined-contribution plan, an ongoing plan that may settle a certain block of annuities, and any plan subject to ERISA. It would not apply to insurance contracts solely for investment purposes, such as a GIC, but it would apply if the sponsor purchased an individual annuity under a GIC, and that's very rare.

The bulletin reinforced the idea that purchasing annuities is a fiduciary act, and you have to consider solely the interest of the participants for whom you're buying benefits. And it explicitly stated that the plan fiduciary must conduct a thorough, objective analysis of all insurance companies that they're considering, and if they did not have the expertise, then they must use an independent expert to help them with that decision. Finally, they formally stated this safest available insurer standard, but they did say that more than one insurance company could meet the safest available criteria. I think that was one of the main, if not *the* main, concerns among the insurance industry and plan sponsors initially. For example, would carrier "X," say New York Life, be the only "safest available?" Would there only be a number one company that was only there, and then what would happen if New York Life was downgraded? What would be the effects on the market, as well as the potential for lawsuits for any sponsor who had not chosen the "safest?"

They did make the bulletin; its nine or ten pages, and very broadly worded. I think that was through a great deal of help from the insurance industry, as well as any plan sponsors that had commented on this. But they also specifically said that considering ratings alone in your choice of an insurance company was not enough and did not fulfill the bulletin's requirements. I think that was important because in the mid-1980s, many plan sponsors used ratings alone, and that was pretty common. And that was their defense in a lot of the Executive Life lawsuits.

At that point in time Executive Life had the highest ratings of anyone out there, and so that was very pointed, because the bulletin was retroactive to 1975; that was the kicker. Besides ratings, the bulletin spelled out six other main factors to consider. You must look at the investments of the insurance company, the investment portfolio, the type of investments, bonds, mortgages, the quality, and how well they are they diversified. That was a big problem with Mutual Benefit, for example. They had a great deal of real estate and many very large investments within their real estate portfolio.

The bulletin says you also need to look at the size of the carrier in relation to the contract you're purchasing, the level of capital and surplus, and I would say that should also extend to the quality of the surplus. As far as surplus notes, I don't think there's too much in the way of financial reinsurance left, which was part of Executive Life's fault. The carrier's lines of business, the diversification, how many different products they have, whether they are strictly an interest-sensitive product issuer, their distribution channels, and their franchise strength are all considerations. Also something that sponsors should consider is the contract structure, which is either a nonparticipating general account structure, or a participating contract, which is held in an insurance company's separate account, still owned by the insurer, but the assets are specifically earmarked for the block of business that it backs.

They also said that the sponsor should consider the state guaranty funds available. And that might be where the annuitants live, and the limits of coverage in the states where the annuitants live. At this point in time all states have guaranty fund coverage. However, the limits vary; I think the most typical limit is $100,000. Some states may have $300,000 for the present value of benefits, but it does vary.

The bulletin also said there are two exceptions where the sponsor may choose a carrier that's not the safest available. That would be in situations where a "safest company," (or a marginally less safe company) and that again could be more than one, costs disproportionately more than the next level, and the participants bear the cost or a substantial portion of that cost, or where the safest available company can't administer the benefits of the contract. Those are the only situations where the sponsor may have a little bit of leeway. Under no circumstances can they choose an unsafe company. You can't consider the cost of the contract if there's a reversion going to the employer or participants don't share in that reversion.

Now that the bulletin is formal and official, sponsors must either set standards themselves or have someone help them. We've been setting standards with clients since I joined Mercer in 1987. Ratings, in our mind, were never enough. The rating agencies would not go on record as saying that they are the end expert on all of this, so we were always looking at most of the items the bulletin was talking about, but there were many sponsors who would just use ratings. And now that's clearly not enough.

When we work with clients, we look at the pension plan document first. We've had a number of clients whose plan document has requirements that probably were antitakeover provisions. For example, if the company was purchased and the acquiring company tried to dump the annuities on the first insurance company that came along, there were certain protective measures built in that, by virtue of being a

plan-provided benefit, that couldn't be avoided. Some measure were: you have to be licensed in all 50 states, you have to have a minimum size of surplus, etc. We work with a client to see what its comfort level is with, for example, claims-paying ratings. What's its minimum? Is it comfortable with a double A minus? Does it want a double A plus?

We also work with the company's legal counsel. We've had many clients whose counsels just aren't satisfied with separate account protection; either they're not satisfied with it or they just don't want to sign off on that. It seems to me that the more conservative legal counsel you have, the more they just want to stick to nonparticipating. We may be different from other firms, but that's what I've found. We construct a standards document that covers all the points in the bulletin, and lists them out. Obviously we document this by having a paper trail, and it's part of the permanent file.

I will now go over four quick examples of how the bulletin can be applied in different situations that may work differently from one client to the next. The first case would be a noncontributory defined-benefit plan in which the plan is terminating, where any excess assets after all the taxes, etc. would go to the employer. The choices that the bulletin may bless would be the "safest available" nonparticipating contract or the marginally less-safe participating contract. With the participating contract you'd have separate account protection, which the bulletin seems to recognize as being safer. You can pay participants lump sums instead of buying annuities for them, or offer lump sums, I should say, because if you're over $3,500, you can't just cash them out. In my experience, most of our clients first will offer lump sums to any active employees, especially when they're reinstituting a defined-contribution plan. Most of the time, deferred vested employees get the choice. We've only had one client that offered retirees lump sums instead of continuing their monthly payment.

The next situation, and these are situations that Dick described in his article by the way, is the case of a defined-benefit plan where employees had made contributions. And there again, your choices would include the safest available nonpar contract, a marginally less-safe participating contract, or the option of paying people lump sums or offering lump sums. Or you may be able to select a marginally less safe nonparticipating contract if all the "safest" nonparticipating contracts are disproportionately more expensive and, as a result, there's less excess assets to go back to employees in the form of an increased benefit. In that situation, it could be argued that participants would bear the cost by going to the safest available; they wouldn't get as much in the form of a monthly benefit. In that situation, all of our clients, and we've had three in this situation that had contributions, they still stuck to the safest available nonparticipating contract.

What I think is unclear about the bulletin is that "disproportionately" is not defined in any way, (neither is the term "marginally safe,") and without any more clarification on that, the default is to take the more conservative route.

Next we have the case of a defined-contribution plan, where each employee's account balance as a lump sum can be converted into an annuity of "Y" dollars. There again you've got the safest available nonparticipating contract. You don't really have the option of a separate account contract, at least I'm not aware of any insurance company that has a vehicle for a defined-contribution plan. The other option is a marginally less-safe nonparticipating contract. In that case, if the safest available contract provides for less of a monthly benefit, perhaps you could go to the slightly less-safe insurance company, thereby giving the participant a greater monthly benefit. Or you could offer people a lump sum instead of an annuity and let them go wherever, roll it over or choose another carrier, or amend the defined-contribution plan to specifically give the participant the choice of the insurance company. We have a couple of clients that did that, and they feel that absolves the employer of what they hope is all of the liability involved in that, but is probably most of it.

The last case, a relatively common situation, is a defined-benefit plan in which there is an immediate participation guarantee (IPG) or an older-type contract as the funding vehicle. Those were fairly popular contracts in the 1970s or before, and in these contracts, when a participant retires, the insurance company guarantees an annuity. If you have that type of contract, what we typically advise our clients is to first renegotiate the contract terms. There are often better funding vehicles or better ways to invest the money. The other thing is to stop purchasing guaranteed annuities if the carrier does not meet the bulletin's requirements.

Another thing I'll talk about is life after the bulletin came out in 1995. Frankly, life hasn't been that much different for me or our firm than it was before it came out. It certainly is different than it was before all of the mess in the early 1990s. The main change between then and now is that there are fewer insurance companies in this market. Most of them dropped out in the early 1990s. Zenaida may have more on that, if the bulletin specifically had an impact. I know of three companies that left; the bulletin was the nail in their coffins. I think there are fewer intermediaries or fewer buyers involved. The pension plan termination market also shrank quite a bit. Most of the plans that wanted to terminate have done so. The excise tax that was imposed in the early 1990s or thereabouts took a great incentive out of terminating defined-benefit plans or settling liabilities. I think there are fewer intermediaries mainly because of the legal exposure that intermediaries may now be faced with. There's concern that a consultant or a broker may become a de facto fiduciary by

taking the role of an independent expert, or providing the sponsor with the information that they may need to become the expert themselves.

Another effect of the bulletin, in my mind, is that it makes it harder on small plans, where the annuity liability is, say, under $2 million or under $1 million. There have never been many insurance companies that offered group contracts or terminal funding contracts for those plans, and now there are fewer. And the costs associated with terminating a plan are very expensive, so it's almost as expensive to terminate a small plan as it is a large plan. There are many fixed costs involved in analyzing insurance companies, and setting the standards adds an awful lot to their cost. But I think on the positive side, now versus then, the focus of a plan sponsor's decision is on safety. In the late 1980s it was really cost, and the finance people on the plan sponsor's side usually had the ultimate decision and made the choice. Now it's more the human resources (HR) side and the safety issue, the safest available, and the finance people typically wince instead of having their way.

The last point, which I found interesting, is that we don't really know what's happening with the ongoing enforcement of this rule. The PBGC has the rule I mentioned earlier about notification about the insurer; that still applies. For example, we had a client that was in the process of terminating their plan, and in their Form 500 to the PBGC, they listed about 12 possible insurance companies. The PBGC spotted two companies on that list that they deemed as not acceptable, and they sent our client a letter saying that, as you know, Bulletin 95-1 requires you to consider only the participants, etc. They referred the matter to the DOL. We called the caseworker first to clarify that we had not chosen these two companies, that the termination and actual purchase was a while off. The two companies on the list that generated the letter were not A+ rated by Best. That was the only reason I could see that was the reason for the letter.

When we called PBGC, the caseworker confirmed that the reason these companies were flagged was because of the Best's rating. I thought that ironic because the whole purpose of this six-year project was to look beyond ratings and evaluate all other relevant factors. Her response was, there's no way an A-rated company could be considered the safest available essentially because Best is an easy grader. The caseworker was looking at a list of companies who were on a hit list, and she had no real decision-making power in this; it seems to defy logic but perhaps even makes a bit of sense when you consider what is going on. She would neither confirm that there is an A+ litmus test, nor would she specify what the remedy was, or what the DOL was even doing with any referrals. So I guess that has to be worked out or remains to be seen as the bulletin is relatively new.

Ms. Zenaida M. Samaniego: Brian has given you a lot of background on the evolution of the safe annuity rule (SAR) from here on forward. Let's take a closer look at the insurance industry for a moment. Certainly the failures of a few insurers did not mean the entire insurance industry was in trouble, although as Brian pointed out, there was a great deal of public concern that threatened the stability of the insurers' operating environment.

I'll point out some of the reasons why insurers remain strong even now. For the majority, investments are conservative and diversified, and the majority of the liabilities are also predictable. In addition, insurance companies are state regulated for long-term solvency and interest-rate risk. Conservative statutory accounting principles are used to report assets and reserves, and there is a requirement for an opinion and certification that assets backing liabilities are adequate to meet obligations under various economic scenarios. On top of that, there are capital and surplus requirements.

This is a run-down of some other regulatory requirements from the states and the guaranty associations. There are investment laws that insurance companies need to abide by that govern the types of investments they could get into and impose limits on those various types. The states require deposits that need to be made consistent with the liabilities held by insurance companies. There is the matter of solvency surveillance. This would be the high-risk ratios and independent audits that state insurance departments conduct. There are financial regulations and standards, such as examinations, and minimum capital requirements, which we all know are referred to as the risk-based capital. There are state accreditation programs and, as Brian pointed out, all states are accredited by the National Association of Insurance Commissioners (NAIC). On top of that, there are state guaranty associations that basically handle the problem companies when they go into receivership.

When the DOL and PBGC first came out with an annuity standard; the industry took a position (the ACLI as well as some other interested parties), that we do not need federal government intervention and the fiduciary standard under ERISA is adequate. However, the industry shared the concern that plan participant benefits need to be protected and therefore supported proper guidance in terms of selecting annuity providers. They cautioned, however, that any bright-line test is dangerous.

What they mean by this bright-line test is basically the credit ratings of insurance companies being used as a minimum standard for selecting insurers. Among the reasons they pointed out that ratings are not appropriate are that it is merely an expression of opinion; therefore, it can be volatile and subjective. It only shows you the relative accredited strength of companies within the industry, and such ratings vary by accrediting agency. It also is a current snapshot and therefore does

not foretell the future, especially when you realize that annuities are very long-term. You couldn't tell whether this same company that is highly rated now will remain highly rated forever. Of course, it did not prevent the Executive Life or Mutual Benefit Life debacle of many years ago.

At that time, the ACLI had commissioned an economic impact study of what a minimum rating standard would do to the insurance industry. They thought that only the highest rated companies would issue annuities, and if you consider companies rated AAA or even AA, that would mean 30–70% of potential annuity suppliers would be eliminated and this insurer could be competitive at any price. This impacts otherwise strong, viable companies who would be anti-selected because they would not be highly rated by these accrediting agencies, and this will have a destabilizing impact, not just on their annuity business, but also on the other business that they write.

To the extent that there is an increased demand for these annuities these eligible companies must absorb these additional annuities. To do that, they need to set aside additional capital, which, on average, would probably run about a 4–6% drain in your surplus. Also, this would mean a shift from some of the higher-profit-margin products. There's also so much that you could absorb by way of annuity business, if it were to come to that, and the diminishing returns would translate to higher marginal costs. On top of that, there will be a very undue concentration of risk in just a few companies, thereby reducing competition, and higher prices. And when you think about a great deal of this annuity business being concentrated in just these few companies, the risk of insolvency of these companies increases.

Some additional disadvantages of minimum rating standards would be that insurance companies would be at the mercy of ratings agencies. There are a lot of factors that rating agencies consider that are beyond a company's control. Higher capital ratio requirements also would lead to lower rates of return. And last, but not least, plan sponsors could well decide not to purchase annuities and, in an effort to reduce costs, they would retain the plans and provide lower benefits to participants. If plans become insufficient, of course, the PBGC gets involved. And if the plan sponsor decides he just wants to set up a defined-contribution plan, it's ironic, but there the plan sponsor ends up shifting the investment risk to the participants.

Let's pause for a moment and take a look at what the sales process means for the insurers. Insurers use different types of contracts or products for this, although the majority of the group annuity products sold reside in the general account. Both assets and liabilities are there subject to a creditor's claims when something happens to the insurance company. There are also the separate account products, where the asset and liabilities are segregated from the general account assets. You

also have the additional benefit of the general account assets backing these liabilities, and they're also insulated from the creditor's claims. While there are coinsurance arrangements, they are rare.

Typically, when a group annuity purchase process starts, there is a request for proposal (RFP) that takes about four to six weeks. The insurers, in considering what price they are going to set, assuming they're going to bid, take into account the size of the plan, the plan provisions, and their pricing assumptions with respect to mortality (they tend to prefer a high proportion of immediate). When they see a many defers, they typically would shy away from such cases. Certainly they look at their capacity for surplus strain, the kinds of investments they can get into, the available returns, and their capability to administer the plan provisions and the costs. Once the award is made the annuity purchase takes about six to eight months, taking into account changes in participant data, proofs of age, finalizing the contract terms, hammering out the final premium, and finally distributing the annuity certificates.

Now let's take a look at the potential impact of the safe annuity rule. This is after the interpretive bulletin was issued. We know that the market for annuities is already strengthening, with interest rates having reached a peak in the 1980s. If you bought an annuity now the cost is much higher than before. As Brian also pointed out, the higher excise tax on reversions is not very conducive to plan terminations. As recently as December 1995, the legislation that passed appeared not too favorable to lump sums. So the question we asked was whether the SAR has an additional impact on annuity markets.

Let's discuss the group annuity sales from 1983 to the first quarter of 1996 from the Life Insurance Marketing and Research Association (LIMRA) group pension survey. The types of sales from annuities will include terminal funding and some other ongoing general account products, GICs, and separate accounts. Sales of group annuities peaked in 1986 or 1987, at about $8 billion or $9 billion, and came down to about half that until about 1990, when the Executive Life-Mutual Benefit debacle occurred. Since 1991 it has been inching downward to about $1 billion at the most. The companies that sold annuities in 1996 were rated at least A2 or higher by Moody's. The ratings by company vary among the different credit rating agencies, such as S&P and Duff & Phelps.

In March 1995, the SOA Committee on Retirement Systems Practice Research started to undertake a study of the safe annuity rule in two parts. One is a look at the PBGC standard, the defined-benefit plan termination data over what we deem to be pre- and post-SAR periods. This phase is in process. Also, we hope to look at a

pattern of plan terminations over those periods of study, and the extent of involvement of actuarial consulting and other firms who are on the buy side.

The Society also recently conducted a survey of both the buyers and sellers of annuities over the various study periods shown. On the buy side, there are the consultants, and some of the questions asked had to do with defined-benefit-plan terminations: the volume of terminations that involve annuities; the criteria used to select insurers, including ratings; the pattern of bids, the range of bids as well as the prices that were charged or quoted; and the use of lump-sum options. Meanwhile, on the sell side, and this involves the insurers, we took a look at the volume of new single premium annuity business sold under the two types of arrangements—nonparticipating and participating separate accounts. We also took a look at factors that might have influenced this shrinkage or stoppage in the sale of the group annuity business and the impact of credit ratings on the purchase decision.

These are very preliminary results, but I thought some of the responses we got were quite interesting. The number of defined benefit plans terminated decreased. The mean number in 1989 was about 24, and it's down by about one-third when you look at the present time. When respondents were asked whether minimum credit ratings were a factor in their selection, 64% of the respondents said yes, 36% said no. The 36% of course cited the various criteria set under the SAR as the criteria they had used in selecting annuity insurers. On the other hand, the number of bids that were placed range from as many as, on average, seventeen in 1989 to a little over a dozen at the present time.

The range of prices charged or quoted went from about 60% to 130%, and now it's down to something like 90% to 130%. When the question was asked whether the high-rated companies seemed less flexible in their pricing, 60% of respondents said yes. When the question was asked whether the lump-sum option was used, there seems to have been an increase after the interpretive bulletin was released and a definite increase after the legislation was passed.

If you look at the sell side, again, premiums received under single premium annuities, both nonparticipating and participating, experienced a huge drop since 1989 among the companies that were surveyed, although the pattern is quite dramatic for nonparticipating premiums. Most everybody agreed that the market has decreased. About 89% of respondents said it has decreased. Factors that they had cited as influential in the decreasing trend in the market are, interestingly enough, were the volume of plan terminations and interest rates under defined-benefit plans that impact reversions, again the excise tax.

It didn't seem that the SAR in and of itself would have been responsible for this trend. Those respondents who have not been in this business stopped after 1988 and cited the reasons for getting out of the business as capital, reserve strain, more profits and less risks elsewhere, and that the market is also strong.

These are very preliminary results, and I think what it points out is that, on the buy side, plan sponsors haven't been terminating their plans. We suspect it has more to do with interest rates having peaked back in the 1980s, the excise tax on reversions as well, and I would expect the establishment of many defined-contribution plans certainly has helped. From the sell side, capital requirements seem to be a very big issue, and not just from a regulatory standpoint. Capital is certainly a focus by the rating agencies, and there is, you might call it, a flight to capital at this point. It's a very rare commodity.

Let's take a quick look at who is responsible for participant benefits. We know that with active plans, a plan sponsor is a fiduciary as long as the plan is in-force, whether they're investing their defined contribution plan in GICs or other investments. Under defined benefit plans, they need to balance the risk and return on their investments within a diversified portfolio as well as liquidity considerations. There you have the PBGC benefit guarantees in force as well, and insurers and annuity providers, only come in when a group annuity purchase is made by the sponsor. The consideration at that time is you need to balance the cost of the purchase on the retirees versus the continuing interest of the remaining active workers. When a plan terminates, the plan sponsor exercises his final investment decision with respect to participants, and balances security, administration, and price.

When there are excess assets, there is either an increase in benefits or it funnels the excess assets into a replacement plan. When there are insufficient assets, either the plan sponsor makes additional contributions or there is a transfer of liabilities to the PBGC. And here the insurer, as annuity provider, makes an irrevocable commitment to provide a participant's benefits. So when the insurer becomes insolvent, at the point that the PBGC guarantees cease, there is a claim on the assets of the insurer that only goes so far. The state guaranty associations come in, but again, that only goes so far. Therefore, there is a gap that now becomes a national policy issue. The question is whether the participant, in fact, ends up with an inadequate retirement income.

Mr. Schreitmueller: I want to add to Zenaida's last point about national policy issues. At the end of that magazine article on annuities, you'll see a discussion of some points we mentioned. The DOL bulletin emphasizes safety at the expense of cost or other issues. Why is this so? As Brian has pointed out, in an annuity

contract the guaranteed benefits could run for 20 or 40 years or perhaps even much longer, yet the individuals getting those benefits have all their eggs in one basket. This is a lack of diversification, and in other investments it would raise a lot of eyebrows, yet it's a way of life in the annuity field.

The DOL bulletin does protect workers about as well as it can, and it seems almost inevitable given the process we have for guaranteeing annuity benefits. I see a few problems here, but whether they're worth fixing is for national policy to decide. As we've seen, the guarantees are not bulletproof, and it's possible for an insurance company to go under. If it's the safest company today, chances are it's going to be good for the rest of this century and probably well into the next century; but the annuity benefits are going to be paid for quite a few years, and the best credit risk can go bad over time. That is a potential issue, if not for today's politicians, maybe for tomorrow's.

Another issue is the supply and demand consideration; as the number of insurers who have access to this market becomes limited, the price that the buyer must pay becomes high. The capacity may not be there, particularly if it's a small plan. If you set up a system where annuities are discouraged because of supply and demand and price, then you're encouraging lump-sum distributions, which many people would say are bad policy. In Canada, they often don't even allow them, so I'm told, but in this country they're more and more common for several reasons, as Zenaida has pointed out.

There are also some alternatives, including one that's come along in the last few years called the pension purchase option. If you have a fairly big company with both defined-benefit and defined-contribution plans, you can move defined-contribution money into the defined-benefit plan. That helps solve the problem of paying out benefits from the defined-contribution plan (but at a reasonable price). If the employer's plans go on for a long time, that's a viable way to do annuities, but it's only going to solve a small part of the problem.

Finally, from a philosophical viewpoint, I find something wrong with the system. We have this very elaborate system set up to protect plans before they terminate, to see that money goes in and that benefits are guaranteed. Then when you get to the point of plan termination, you may have a sufficient plan whereby you put all the annuity money with one insurance company and you're into a whole different realm as far as guarantees go. Or, if your plan happens to be underfunded by a dollar or two, the guarantees go with the PBGC, and then you've got a government guarantee. As a participant, I would rather have the government guarantee, but it seems like an anomaly that the only way you can get it is to be in an underfunded plan. It does not seem to be in keeping with the original spirit of ERISA.

Whether these are major problems is going to have to unfold over time. In fact, I'd like to ask if any of you want to cite satisfaction or dissatisfaction. For those of you who are from the insurance company side, how many feel that you're generally satisfied with the status quo in the annuity business? Is anyone here happy and doesn't see room for improvement in this whole thing? Is anyone unhappy from the insurance company side? OK, it's unanimous—one person. How about from the pension consulting side? Is there anybody who is unhappy with this and would like to see some changes? A few people, a dozen or so. Anybody on the other side of the fence, who thinks this is about as good as we can do? There are not many strong feelings; it's a little early. Some ideas and proposals are in the magazine article. I won't go through them.

Mr. Ralph J. Braskett: My question is why is there a lot of whooping and hollering about the no-bright line, when 85%, according to Zenaida's study, of the carriers providing annuities hit the S&P bright line at AA or better. So what's the whooping and hollering about no-bright line?

Mr. Schreitmueller: I would say there's a line, but maybe it's not so bright. What do you think ?

Ms. Samaniego: Well, as I mentioned, it's ironic because even back then, when the DOL and the PBGC had come out with the intent to establish an annuity standard, the industry took a very strong position that there should not be a bright line. I think in the final standard, the DOL and the PBGC had listened to the ACLI and took out any specific test. In fact, they said that ratings are not going to get you there. But as it's starting out, unofficially, Brian cited the litmus test the PBGC seems to be using, and it is quite alarming.

Mr. Clark: I think some companies may be concerned about, say, an A+ cutoff, for example, or an AA cutoff, because they may be AAA now or AA+ now, but three years from now they may be downgraded one notch, and then that business is devastated. So I think they may feel like they're at the mercy of their S&P analyst, or the management team at S&P or Moody's or another agency. That's one concern I can think of.

Ms. Samaniego: I would also say that there are many small plans out there who really don't have the deep pockets to employ an independent expert. They probably don't know what a safe-annuity provider is, and therefore they resort to what seems to be a reasonable test.

Mr. Schreitmueller: Zenaida, I had a short question. I'm very much impressed by all the hard work that Zenaida did, because these results have just come in within

the last few days, and these are preliminary results. Not everyone has responded to the survey yet. Do you plan to be publishing a more complete and full version of this survey fairly soon?

Ms. Samaniego: Yes. As I mentioned, the first phase is ready which is soliciting a proposal to work up the study, and that will be done probably early next year.

Mr. Robert Ozenbaugh: I just lived through what Brian just described. United of Omaha was downgraded by Best this summer from A+ to an A. The reasoning is because we're owned by a health insurance company. It had nothing to do with the financial strength of the company, but it took us out of some markets we were pretty active in—some of the pension areas, some structured settlements, some markets where an A+ is very critical. You're at the mercy of what the rating agencies are looking at, at that particular point in time. Perhaps they feel they have been giving health insurance companies a free ride for several years and have decided they were catching up, or whatever their reasoning is. You're not given the opportunity to plan for that. You're not given the opportunity to change how you approach those markets. You're just in the market one day and out of the market the next.

It's a difficult situation when you are geared up to be growing in those market-places. It's a real-life situation. Whether you think you're safe from it or not, I don't believe any of us are. I don't want to run my company based on what a rating agency feels about my company when I believe we're the same company we were a year ago or two years ago, and probably better, and we have done everything they've asked us to do over the last several years, and we still got the downgrade.