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POSTRETIREMENT HEALTH BENEFIT FUNDING

Moderator: JAMES L. HESS
Panelists: FRANKLIN B. BECKER
CHRISTOPHER SNYDER*
Recorder: ALLEN J. ROTHMAN

- Leveraged corporate-owned life insurance
- Trust-owned life insurance
- Settlement contracts
- 401(h)
- Pension plan asset transfers
- Other

MR. JAMES L. HESS: Postretirement health benefit funding is an issue which most major employers are currently addressing. For each employer, the decision to prefund or not to prefund will be based on several financial and human resources considerations. Both the financial and human resources considerations must be examined in light of the specific funding vehicles which might be employed.

We are going to examine the various available funding vehicles, with a particular emphasis on the insurance products which have been developed to fund post-retirement health benefits.

Our panelists are Frank Becker and Chris Snyder. Frank Becker is vice president and managing actuary at Actuarial Sciences Associates. Frank has extensive experience consulting with a number of Fortune 500 companies on various pension and employee benefit matters, including postretirement health benefit funding. Frank is going to give an overview of the principal funding vehicles which are available to employers, including both insurance and noninsurance vehicles.

Chris Snyder is managing director of Spectrum Funding. Spectrum Funding is involved in marketing various insured arrangements aimed at addressing the problem of financing and delivering postretirement health benefits, in particular, the so-called "settlement contract." The settlement contract is an extremely interesting concept and is designed to transfer the postretirement health benefits liability from the employer to an insurer. Chris is one of a very small handful of people with direct experience in dealing with settlement contracts.

Finally, I will discuss some of the various life insurance vehicles which are currently under consideration by a number of large employers as possible funding vehicles.

MR. FRANKLIN B. BECKER: SFAS 106 has made us painfully aware that post-retirement health benefits, for the most part, are unfunded. Unfortunately, there's a dearth of funding vehicles available for funding postretirement health benefits, and the

- * Mr. Snyder, not a member of the sponsoring organizations, is Managing Director of Spectrum Funding Corporation in Long Beach, California.

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reason for that is the federal budget deficit. Tax effective funding implies tax deductible contributions. As long as there's a federal budget deficit of the size that we have now, we're not going to have completely tax effective funding available any time soon. The challenge is to be innovative in working with the currently available vehicles.

Employers and plan sponsors ask, "why fund in the first place?" There are several advantages for funding. First, it's a pay me now or pay me later decision. To the extent that you fund today, the employer's future cash outflow will be reduced. Second, an important reason is that after SFAS 106 implementation, which for most plan sponsors is in 1993, there would be a closer matching between cash flow and earnings if you do fund. Third, employee benefit security is enhanced to the extent that employers fund. To the extent that the benefit security is enhanced, labor relations and employee morale will be enhanced. There are a few disadvantages for funding, however, and they're basically the flipside of the advantages. There's a reduction in initial cash flow to the extent that you put away money. From a legal perspective, there have been a lot of court cases recently under which employee groups have challenged the right of employers to unilaterally curtail postretirement benefits. To the extent that you fund you're strengthening the employees' case that you have a commitment to provide postretirement benefits.

If the employer chooses to fund, we look for a tax effective funding vehicle. There are basically four elements needed – tax deductible contributions; tax-exempt investment earnings; you want to be able to anticipate medical inflation since this is what drives up postretirement health benefit liabilities; and you want flexibility in determining the year to year contribution amounts since you don't want to be restricted in the amount that you can contribute.

Unfortunately, there's nothing available today which meets all four of those desirable characteristics completely. A 401(h) account is available – the 401(h) account within a pension plan. Also, 501(c)(9) trusts are available. There's two variations of 501(c)(9) trusts that we're going to explore in more detail: collectively bargained trusts and trust owned life insurance. Under a 401(h) account, the employer contributes to the pension for postretirement medical benefits. A separate account must be established for this purpose and the assets in a separate account can revert to the employer only after all of the postretirement medical liabilities are satisfied.

How does the 401(h) account score against those four criteria we established? Well, it meets three of them. Contributions are tax deductible, investment earnings are tax-exempt, and you can anticipate medical cost inflation. However, it has one major drawback. For plans that are fully funded, it's completely inflexible. The medical and death benefit or ancillary benefit contributions cannot exceed 25% of the total contributions to the plan. Twenty-five percent of zero is zero, so if the plan is fully funded, no 401(h) funding is permitted.

With 501(c)(9) trusts, in general, contributions cannot reflect future medical cost inflation or utilization increases. Furthermore, although contributions are deductible within limits, investment earnings are generally taxable as unrelated business income. However, the assets do serve to offset the SFAS 106 liability as long as the assets are dedicated to providing benefits to participants, but the assets can't revert to the

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employer or the plan sponsor or else there's a 100% excise tax. There are exceptions to some of those general requirements for a 501(c)(9) trust for collectively bargained trusts. Under collectively bargained trusts, contributions are tax deductible, investment earnings are tax-exempt, you can anticipate medical inflation, and there is flexibility in determining contribution amounts. Yet there are some drawbacks to a collectively bargained Voluntary Employees' Beneficiary Association (VEBA). First, you have to bargain at least over the postretirement health benefits. It's desirable to bargain over the establishment of the trust and you'll strengthen your case that it's a collectively bargained trust even further if you bargain at least a minimum level of contributions to the trust. Another big drawback is your management or nonbargaining employees will ask, "You've enhanced the benefit security of the union employees, but what about us?" What's been looked at with respect to management employees is 501(c)(9) VEBA trusts with trust-owned life insurance. The basic idea is that cash value life insurance investment income buildup escapes taxation under current tax law. So you wrap a 501(c)(9) trust around a cash value life insurance product, and in that way, the investment earnings are tax-exempt. Contributions are tax deductible, but they're limited in the sense that you still can't anticipate medical inflation, and furthermore, there's risk of tax law changes.

Other than funding, what other ways are there to address postretirement health benefits? There are design alternatives, employee stock ownership plans, and transfers of excess pension plan assets. Under the design alternatives, the basic thrust is to shift the risk of medical cost inflation from the plan sponsor to the employee. For example, under a defined dollar plan, the plan sponsor no longer provides the benefit no matter what it costs. Instead they will provide a certain dollar amount towards the cost of the benefits, and if the cost of the benefits exceeds that dollar amount, the employee or retiree will have to pay the difference. Another approach is to vary the employer contributions by age or service. This has been done for a long time in defined benefit pension plans, and it also makes sense with health plans. The cost for early retirement under a health plan is a lot higher relative to that of a pension plan. Before age 65, the cost is very high for postretirement health benefit plan because Medicare kicks in at 65. So the reduction to an employee's benefit for retiring early should be higher than it is in a pension plan. However, typically, there is no reduction for age or service in employer-sponsored health plans. More and more employers are no longer paying for dependent coverage for retirees. Under flexible benefit approaches employers are using the pricing and crediting mechanism to control what they will pay towards the benefit. They're limiting their benefit commitment. They can also index deductibles to the medical (CPI). In that way, the portion of the benefit that the employer will be paying will not increase.

Under employee stock ownership plans (ESOPs), basically an employer institutes an ESOP and at the same time phases out postretirement health benefits, again, shifting the risks, the costs, to the employees. The employer still provides, typically, the group insurance vehicle that the employee can purchase the benefits under. However, if the ESOP provides for insufficient benefits, or if the amount exceeds what is needed, the employee bears the risk. As examples, Ralston Purina instituted this in late 1988 or early 1989; Gillette is doing this for retirees after January 1, 1992. Proctor and Gamble had a slightly different approach. They established a money purchase pension plan with a 401(h) account, and the employee stock ownership plan was included within it.

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Another idea which was allowed under the Omnibus Budget Reconciliation Act (OBRA) in 1990, is to transfer excess pension plan assets. It makes sense to relieve a lack of funding in the postretirement health area with an overfunded situation in the pension plan area especially when the same participants are involved in both plans. Under Code Section 420, the assets can be transferred to a 401(h) account. The assets must be excess in the year of transfer and one transfer per year is allowed over the years 1991 through 1995, and there's a special retroactive rule which applies for 1990.

There are some caveats. The plan sponsor must agree to maintain the current level of medical benefit expenditures per year, per retiree for five years after the transfer. That's not as difficult as it may seem unless your plan sponsor is anticipating significantly curtailing benefits, because the cost of benefits has been increasing at double digit rates recently. Furthermore, benefits must vest immediately. The accrued benefit to date must be vested 100%.

What are excess pension plan assets? The excess assets are defined such that immediately after the transfer, the plan must remain fully funded, and furthermore, the assets cannot exceed 125% of the current liability. The reason that the plan must remain fully funded gets back to our federal budget deficit problem. This transfer provision will actually increase federal revenues in the near term. The reason for that is since the pension plan must remain fully funded after the transfer, employers still don't receive a tax deduction under the pension plan, and they also don't get a tax deduction for the health benefits which are paid for with transferred assets. After all, they got a deduction when money was contributed into the pension plan in the first place. Over time, that will reverse itself when the plan does come out of full funding, but in the near term, it's a federal revenue raiser. The reason for the 125% asset level is so that pension benefits remain secure if the plan should terminate in the near future. The determination is as of the valuation date preceding the transfer. There are limits on the amount that can be transferred. It's based on paid claims. It's only for a limited period, years 1991 through 1995. To the extent that revenues are raised, the period may be extended.

It's not an all-the-years or none-of-the-years decision. You can transfer, for example, in 1991, in 1992, and not transfer for 1993. There is a special retroactive rule for 1990, but you have to make the transfer by the time you file your tax return for 1990. Make sure you don't transfer too much. If you transfer too much, you have to pay a 20% excise tax on all unused amounts, and the unused amounts plus the investment income reverts to the pension plan. So, typically, you'd want to transfer near the end of the plan year when you know what your claim payments were.

Furthermore, transfer amounts are reduced if the plan sponsor should have established a 501(c)(9) trust or other vehicle to fund for postretirement medical benefits. You can't transfer amounts which were already set aside in such trusts and you can't transfer for key employees. As we said earlier, the pension plan benefits vest as of the date of transfer. It's more of an administrative burden than it is of a cost concern. For most employees with less than five years of service who are not yet vested, the cost for their benefit accrued to date is very small.

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There is also a 60-day advance notice requirement. If you're thinking about transferring for 1990, you don't have much time left because you have to get this notice out 60 days before your tax filing due date. You have to notify the participants, the Department of Labor (DOL), the Treasury, and the unions. Now the DOL said in Technical Release 91-1 that the notice to them will satisfy the IRS as well. What's included in the notice is the amount of the excess assets, the portion to be transferred, claims to be paid, and the portion of the benefit that is vested. There's also the minimum cost requirement as we said earlier. There's a five-year requirement that cost per participant, cost per retiree cannot decrease, and the baseline is the highest cost within the last two years.

So to summarize, there isn't a lot available. Ideally, you'd have tax effective funding as we see currently in the pension plan area. Since that's not available, we have to look at what is available and determine innovative ways to use them.

MR. HESS: Because of the tax favored nature of life insurance, in particular, the tax-free inside buildup and tax-free death benefit, a number of life insurance based vehicles have been developed or proposed for funding or financing postretirement medical benefits. There are several variations, but there are essentially three types of life insurance programs which are specifically aimed at financing postretirement medical benefits.

First, there is life insurance held within a VEBA trust. This is called trust owned life insurance (TOLI). Unlike many other life insurance programs, TOLI can be a true funding vehicle and can provide an asset for SFAS 106 purposes and, perhaps more importantly, provide an asset base for increased benefit security.

Second, there is leveraged corporate-owned life insurance (COLI) or leveraged COLI. Leveraged COLI has been used extensively in the past, often for financing executive deferred compensation programs. However, leveraged COLI is not a true funding vehicle. In fact, leveraged COLI typically involves a relatively small cash outlay and virtually no net asset base. The primary appeal of leveraged COLI, and the reason it is frequently considered as a benefits financing vehicle, is the extremely attractive rates of return which can be generated.

Finally, there are various individual life insurance programs which could be used to finance postretirement medical benefits. These individual life insurance programs can be integrated with changes in the design of the postretirement medical benefit program. These design changes would typically involve transferring some or all of the responsibility for financing the benefits from the employer to the employees. Also, certain efficiencies could be realized with these individual programs if the individual life insurance program is integrated with a change in the group life insurance program. However, while such a program could be an important element in an overall benefits delivery strategy, it is not likely that an individual life insurance program would, by itself, be capable of funding any substantial portion of a typical employer's liability.

For employers who have decided to fund the medical liability, the VEBA trust will often be the best alternative. A collectively bargained VEBA is especially advantageous. But for a plan which has not been collectively bargained, while the VEBA

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trust has certain advantages, the approach has less appeal because the investment earnings on the VEBA assets are subject to Unrelated Business Income Tax (UBIT).

There have been a number of strategies proposed to reduce the taxable income of a trust subject to UBIT, and thus increase the after tax rate of return on the trust assets. One investment alternative would be to invest in tax-exempt municipal bonds. The problem is that, while UBIT is avoided, the expected after tax returns are not significantly improved. Another possibility would be to invest in high growth equities with minimal trading, in order to maximize the deferred gain element of the investment return. Among other problems, this approach significantly limits investment flexibility. On the other hand, TOLI has the potential to provide attractive current yields on trust assets along with a great deal of investment flexibility, with the further advantage of not generating unrelated business taxable income.

Conceptually, the structure of a TOLI program is very straightforward. As noted, employer contributions to the VEBA, subject to the IRC Section 419A limitations, are currently tax deductible. The trust contributions, then, are used to pay life insurance premiums for life insurance coverage on the lives of trust participants.

The VEBA trust is the owner and the beneficiary of the TOLI policies. The assets underlying the life insurance can be invested in a variety of funds, including both equity funds and bond funds. The trustee directs the investment of the underlying assets either through an investment manager affiliated with the insurer or possibly through an unaffiliated investment manager named by the trustee.

The life insurance cash value growth, the inside buildup, is not taxed unless it is distributed from the policy. The intention of the TOLI program is to not distribute the gains but to hold the insurance until the returns are eventually realized in the form of tax-free death benefit proceeds. If the program is properly administered, the TOLI can be a fully income tax-free investment medium.

How does TOLI compare to a taxable trust investment? Table 1 compares the internal rate of return of TOLI to an alternative taxable VEBA investment over various time horizons from 1 to 20 years. (It may be noted that the taxable investment in this illustration does have some element of deferred gain.) Here we see that, over the 20-year period, the TOLI returns are significantly greater than the returns under the taxable investment strategy.

It can also be seen that, initially, TOLI returns are below the level of the taxable vehicle returns. Comparing the in-force numbers, the cumulative TOLI returns do not exceed the taxable investment returns until some time during the third policy year. This difference in the incidence of returns between TOLI and the traditional taxable investment gives rise to one of the principal risks of TOLI. That is, if the TOLI program is not in place for a sufficiently long period of time, an opportunity loss will be realized. However, the opportunity loss is never large and the length of time to break even is typically short (in this example, three years).

The columns labeled "Surrender Basis" on the right side give a worst case view of the risk of early unwind. Here the TOLI and the taxable investment are compared under the assumption that the tax is paid on all deferred gains in the year displayed.

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On this "liquidation basis," the break-even year for the TOLI moves out from year three to year eight. However, it should be kept in mind that, depending on the reasons that the TOLI was being discontinued, there may be a number of ways to unwind the TOLI without realizing a taxable gain.

TABLE 1
TOLI Versus Taxable Trust Investment
(Assumed 11.0% Gross Yield)

End of Year	Inforce Basis		Surrender Basis	
	TOLI	Taxable Alternative	TOLI	Taxable Alternative
1	7.14%	8.72%	5.70%	7.45%
2	8.29	8.72	6.34	7.49
3	8.89	8.72	6.71	7.53
4	9.25	8.72	6.98	7.57
5	9.49	8.72	7.21	7.60
6	9.66	8.72	7.39	7.63
7	9.79	8.72	7.56	7.66
8	9.89	8.72	7.69	7.69
9	9.97	8.72	7.83	7.72
10	10.04	8.72	7.97	7.74
15	10.27	8.72	8.50	8.03
20	10.44	8.72	9.02	8.20

There are currently seven or eight insurers with products aimed at the large case VEBA market. Even with this small number of companies involved, there's a great deal of diversity in products.

With one or two minor exceptions, all of the TOLI products are flexible premium variable life insurance policies. Under these contracts, premium can be paid on any schedule, and the assets underlying the policy cash values can be invested in any of a number of insurer-provided investment options. Furthermore, given sufficient assets, the insurers may be willing to establish an investment fund to meet the specific objectives of the TOLI purchaser, if so desired. The insurer may also agree to contract with an outside investment manager named by the employer.

Guaranteed issue underwriting is an absolute necessity. Any need to secure medical evidence from the potential insureds would introduce a great deal of administrative complexity as well as potential communications problems. Therefore, coverage is usually issued subject only to an actively-at-work requirement. Coverage may also be issued on retired lives subject to those lives having been actively at work on date of retirement.

Perhaps the most significant distinction among products is whether the policy is a group policy or an individual policy. The group products will utilize some form of experience rating, and a case with a large number of lives may be given full credibility from inception. On the other hand, mortality charges under individual policies must be prospectively set, although if the policy is participating, the dividend may help to keep

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the overall mortality charges in line with actual experience. From the purchaser's perspective, the objective with the respect to mortality charges is to achieve as close to break even as possible. Therefore, experience rating with full credibility will be preferred.

There are a number of risks and associated issues which need to be considered, and to the extent possible, dealt with in the process of establishing and maintaining a TOLI program. Given that the fundamental advantages of TOLI relate to its income tax treatment, it is not surprising that the principle TOLI risks are likewise tax related.

Insurable interest is a primary TOLI issue. Generally, in order for a contract of life insurance to be valid, the policy owner must have an insurable interest in the life of the insured at the time of policy issue. But insurable interest laws vary from state to state, and may vary depending on whether the insurance contract is an individual or a group product. Also, a growing number of states now have insurance law provisions which expressly provide for the existence of insurable interest in the case of life insurance owned by an employee benefits trust.

In the absence of any specific statutory guidance, the TOLI concept appears to comply with the principle of insurable interest, especially in the case of an experience rated policy. During the period of active funding, deaths tend to generate losses rather than gains because the death proceeds represent cash that must be reinvested. If the proceeds are reinvested in life insurance, premium tax and other policy loads will be incurred. Thus, the TOLI sponsor has a direct interest in the continued lives of the covered insureds. Also, insurable interest could arguably be seen to arise from the employment status, as well as from the nature of the medical benefit itself, under which expenses are frequently greatest near the time of death.

A negative finding with respect to insurable interest could have any of several adverse results. The primary concern is that the IRS could use the insurable interest argument as a basis for declaring the insurance contract to be invalid. Another possibility is that a third party could use an argument of lack of insurable interest as a basis for arguing that the death benefit should be payable to the insured's heirs and not to the trust. A less likely possibility is that the insurer could use lack of insurable interest as an argument in defense of a death claim.

Related to the insurable interest issue is the issue of notification and consent. To the extent statutory requirements exist, they vary from state to state and can vary as well by whether the contract is group or individual.

Most states do not require written consent, although most do require that the employee be notified of the TOLI program and be given the right to be removed from the covered group. This type of arrangement is frequently referred to as "negative consent." Employers are probably more comfortable with negative consent than with the idea of obtaining positive written consent from each proposed insured, but the two major VEBA-owned TOLI cases which have been installed to date were both done with positive written consent.

Where notification or consent is required, insured employees should be notified of the amount of insurance on their lives, the purpose for which the insurance will be used,

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and the fact that the death benefits will be paid to a trust, and no direct benefit will be received by the insured employees, their dependents, or their estates.

The next item is the possibility of a future tax law change. Perhaps the biggest threat would be legislation aimed at reducing or eliminating the tax-favored treatment of the inside buildup. Also, other types of legislation adversely effecting TOLI would be possible (for example, the elimination of the ability of an employee benefits trust to receive tax-free death proceeds), but there is nothing currently on the horizon. The other side of the coin would be the possibility of legislation which would favor an alternative funding medium. Such a development could necessitate unwinding both the TOLI and the trust itself.

Another risk is in an experience rated policy, where it could be held that there is no substantial transfer of mortality risk to the insurance company and, therefore, that TOLI is not insurance. While there are no clear-cut guidelines here, the risk is probably substantially eliminated if the mortality element of the TOLI product is rated in the same manner as an otherwise similarly experience-rated group-term life insurance policy.

Many employers considering TOLI would prefer that the assets underlying the insurance policy be managed by an investment manager who is not affiliated with the insurer. The presence of an outside investment manager could give rise to significant risk that the transaction will not qualify as insurance. The preamble to the Treasury decision containing the Section 817 diversification regulations states that the regulations, "do not provide guidance concerning the circumstances in which investor control of the assets may cause the investor, rather than the insurance company, to be treated as the owner of the assets in the account." It was indicated that guidance on the control issues would be provided in regulations or rulings under Section 817(d), relating to the definition of a variable contract.

The IRS has been looking into the issue of policyholder control for some time, although to date, no regulations or rulings have been issued. Thus, it is not clear how much control over assets can be relinquished by an insurer before the TOLI will no longer be considered an insurance contract. It has been established (although subject to change) that a policyholder may direct that the assets be invested in certain types of investments (for example, bonds versus stocks). But the ability to choose an investment manager may indicate that the insurance company has relinquished too much control.

Finally, there is the issue of the potential mismatch between the benefits cash flows and the insurance cash flows. Actually, it is not difficult to virtually eliminate any such mismatch. In the early years of the program when the contributions to the trust exceed benefit payments, it is desirable to minimize the insurance cash flows. This is accomplished by reducing the face amounts to minimum levels. While the insurance cash flows cannot be eliminated, they can be held to very low levels.

In the later years, when the benefit payments are expected to exceed contributions to the trust, several mechanisms exist which provide for a more exact cash flow matching to be achieved. First, if the policy is not classified as a Modified Endowment Contract, policy cash values up to cost basis can be withdrawn with no incurral

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of income taxes. Policy loans provide another mechanism for cash flow control, and again, provided Modified Endowment Contract status is avoided, loans are not treated as taxable distributions. Finally, the policy face amount can be adjusted from time to time according to projected cash flow needs. With a sufficiently large group of insureds, the ability to adjust face amounts can lend a great deal of precision to the process of controlling the insurance cash flows.

As was mentioned earlier, leveraged COLI is distinctly different from TOLI. Although the sale of leveraged COLI is often tied to financing postretirement medical benefits, leveraged COLI does not directly fund these benefits. The appeal of leveraged COLI is that it's capable of generating very high rates of return. The returns are largely a result of tax arbitrage. They will only be minimally affected by outside economic factors.

The tax arbitrage under leveraged COLI stems from the loan interest deductions provided on corporate-owned life insurance policies, in conjunction with a contractual tie between the policy loan interest rate and the crediting rate on the loaned portion of the cash value. Typically, leveraged COLI contracts provide for a "spread" of 50 or 100 basis points.

Let's discuss the tax arbitrage assuming a 10% loan interest rate, a 100 basis point interest spread, and a marginal corporate income tax rate of 40%. The after-tax loan interest rate is 6%. Thus, the corporation effectively pays 6% interest and earns 9% interest on loaned values with a net gain of 3%.

It's obvious that a higher loan interest rate produces a greater element of tax arbitrage. But in order for the transaction to have some validity, the loan interest rate must be determined in some reasonable fashion. The loan interest rate is commonly linked to an index, frequently, Moody's Baa. However, there are some policies under which the loan interest rate is set equal to the higher of the previous year's loan interest rate and the current index rate. Under these contracts, the loan interest rate will ratchet upward over the long run.

The mechanics of leveraged COLI can be somewhat complex. The corporation purchases and is the owner and beneficiary of policies on the lives of employees. Premiums are level, usually at an amount equal to \$5,000 or \$10,000 per life. The premiums are typically payable over a limited period, often ten years.

In order to qualify for the loan interest deduction under IRC Section 264, four of the first seven premiums must be paid through means other than borrowing. An aggressive interpretation of Section 264 leads to the concept of using policy dividends and partial surrenders to reduce the amount of cash outlay in the policy years during which the required premium payments are made. The more conservative approach is cash payment of each of the required four premium payments.

Policy loans are taken in each of the first three policy years, and again in policy years eight and later until a total loan amount of \$50,000 per life is reached. The loan interest deduction only applies on loans up to \$50,000 per life, so loans are usually not taken beyond that point.

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Table 2 compares the aggressively illustrated and conservatively illustrated leveraged COLI. Both are based on an assumed 10,000 lives with premium equal to \$5,000 per life for a total first year premium of \$50 million. The aggressive illustration produces a 62.6% internal rate of return over the life of the program, versus 20.6% under the conservative illustration. However, although the rate of return is dramatically higher, there is very little actual investment under the aggressive approach.

TABLE 2
"Aggressive" Versus "Conservative" Product
 (Loan Interest Rate = 10%; Tax Rate = 40%)

	Aggressively Illustrated Product	Conservatively Illustrated Product
Total First Year Premium	\$ 50.0M	\$ 50.0M
Internal Rate of Return (After Tax)	62.6%	20.6%
NPV of Policy Gains @ 12% After Tax Cost of Capital	\$ 43.3M	\$ 54.1M
Cumulative Cash Flow (After Tax)		
End of Year:		
1	\$ (.03)M	\$ (.03)M
2	1.5	1.5
3	2.0	2.0
4	8.0	(54.9)
5	11.2	(111.4)
10	36.3	124.4
20	137.2	285.3
30	285.1	422.4
Maximum Cumulative	\$ 5.9M	\$ 233.0M
Cash Outlay	Year 3, Quarter 1	Year 7, Quarter 1

The maximum cumulative corporate cash outlay under the aggressive approach is \$5.9 million at the beginning of policy year three, whereas, the cumulative cash outlay under the conservative illustration reaches \$233 million at the beginning of policy year seven. Thus, the net present value of policy gains (discounted at 12%) is \$43.3 million under the aggressive approach, which is actually less than the \$54.1 million net present value under the conservative approach.

There are several risks inherent in the leveraged COLI transaction. Probably the biggest risk is the risk of IRS challenge. An IRS challenge could be based on a lack of insurable interest or the failure of the program to meet the requirements of Section 264. Also, an IRS challenge could be based on the argument that the leveraged COLI has no material economic substance other than tax avoidance (referred to as a "sham transaction").

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Public relations is a major concern for most employers considering COLI. Often these programs are installed with no notification given to the insureds. This can pose significant problems if the insureds later learn that the employer is "profiting" from the deaths of employees.

A change in the employer's tax position will impact the leveraged COLI returns. For example, if the employer goes into AMT, there can be a significant deferral of the tax benefits.

Internal Revenue Code Section 7702 is also a concern. In particular, the force-out rules under 7702(f)(7) could make it difficult to unwind the program in the future if it becomes necessary to do so. And, if such unwind were necessary, a full surrender could be out of the question because, while the policies typically have no net equity value, there could be a substantial amount of tax due at termination.

Finally, there is the possibility of adverse future tax law change. Legislation which would either tax the inside buildup of leveraged COLI policies or legislation to eliminate the loan interest deduction would be disastrous. And, although existing policies have been grandfathered in the past, there is no guarantee that any new legislation would include a grandfathering provision.

So, to make a brief comparison between trust-owned life insurance and leveraged corporate-owned life insurance, TOLI is a funding vehicle. Although TOLI has some associated risks, these risks are significantly mitigated by the presence of substantial cash values which provide the flexibility to respond to emerging issues. For an employer who has an existing taxable VEBA or has made the decision to establish one, TOLI very well may represent the best investment alternative for the VEBA assets.

On the other hand, leveraged COLI is a financing vehicle rather than a funding vehicle. Since leveraged COLI does not have a significant asset base, it does very little to enhance benefit security. Furthermore, the absence of significant net surrender values can make it difficult to unwind the leveraged COLI program, or to otherwise restructure the program should it become necessary to do so. Therefore, the risks associated with leveraged COLI tend to be a good deal more significant than the risks associated with TOLI.

MR. CHRISTOPHER SNYDER: My presentation is on single premium group health. There's probably a lot of other names for this product or this transaction. It's been called a settlement contract referring to the language in the SFAS 106 Accounting Statement. It's been called a buyout contract. But the idea is that this product is a permanent nonparticipating contract for a closed group of existing retirees. It shifts the liability and responsibility for providing their benefits to an insurance company irrevocably and the employer is, through the payment of the single premium, discharging itself of future liability for the benefits covered in the contract.

In and of itself, the contract is simple. The complicated areas are working your way through the particular situations and predicaments that the employers are in when they find themselves in need of this contract.

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This product covers a closed group of retirees. When we're pricing the contract and when we're working our way through the situation, we have identified a closed group of eligible retirees for coverage, and after the insurance contract is in place, no new participants are added to the group or subtracted. The contract provides coverage for a multiple number of years and almost invariably, it's the lifetime of the participants. So we're really transferring that liability to the insurance company. We're not just setting up a fund or buying health insurance coverage for a year. It's a permanent transfer and permanent coverage. The premium is payable in a single sum. The coverage that is offered and is provided through this contract is the same coverage that we're all used to. It has deductibles, copayments, annual out-of-pocket limits, etc. It's a very familiar type of health coverage, and the contract is nonparticipating. Table 3 will give you, if you just take annual premium group health insurance which is fully insured, the type that smaller employers tend to buy.

TABLE 3
Annual Premium Group Health Versus
Single Premium Group Health

Annual Premium Group Health	Single Premium Group Health
Coinsurance feature with out-of-pocket maximum	Coinsurance feature with out-of-pocket maximum
Annual deductibles	Annual deductibles
Specific lifetime maximum	Specific lifetime maximum
Other standard provisions	Other standard provisions
Premium quoted is for one year of coverage	Premium quoted is for lifetime of group or other specified period

The features such as the coinsurance, the annual deductibles, the specific lifetime maximums, and other standard provisions are all the same. The real difference is that in annual premium group health we get premiums one year at a time, groups tend to move around from carrier to carrier while in the single premium group health contract, the premium is quoted once since it's a single premium, and when it's paid, the coverage is guaranteed for the lifetime of the group.

This product is very expensive. The insurance company that issues it is, by nature, going to be conservative in its assumptions, particularly in the area of the health care cost trend rate.

This product, therefore, is useful in situations where a plan sponsor is faced with some element of closure or finality. These would be acquisition/divestiture situations, plant closings, bankruptcies, terminations of the benefit plan where there has been an examination of other alternatives such as Frank and Jim have discussed. When they're finished looking at those alternatives, if they're not satisfied with any of those and they still want to pursue a permanent buyout of the benefit, then we can look at

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it and start to work with them. But usually there needs to be some other compelling business reason other than just pure price considerations for this contract.

One example is an acquisition/divestiture situation where we had an orphaned group left over as a result of one company acquiring another, breaking it up, and finding itself in a position where it needed to provide coverage for what we have come to call an orphaned group. A second example is what I call the "no obligation – get out of the loop" example. This was a foreign-based parent company with some small operations in the U.S. They were closing all of those and felt a moral obligation, not a legal obligation, to provide benefits. They had a budget which was nowhere near large enough to provide the benefit plan that they had in place for years, and we were told to design whatever that budget would buy. The third example is a plant shutdown with a group of about 1,000 people, composed of 800 retirees and 200 actives who would be retiring within a few months as a result of this plant shutting down.

In the acquisition/divestiture example, the corporation acquired a company for breakup purposes. They were a leveraged buyout (LBO) mode company not paying any income taxes. This was in the late 1980s and there was a lot of that going on. They sold most of the assets of this company and one of the remaining assets was the shell corporation, which had as an asset some tax loss carry forwards that were quite valuable. However, they were not very valuable to the acquiring company because they were not paying income taxes and didn't expect to. So in order to sell the remaining shell corporation, they either had to eliminate the postretirement medical liability for a group of about 3,000 retirees or they could absorb the liability for providing the benefit into the parent company which is something that they didn't want to do since they had no other operating units that provided postretirement medical coverage. This is an example of what the economic balance sheet looked like (Table 4).

TABLE 4
Economic Balance Sheet

Assets	Liabilities
Tax Loss Carry Forward	Retiree Health Care Benefits

They had the valuable tax loss carry forwards on the asset side, but they had the limiting effect of the retiree health care benefits which is what they wanted us to remove. The existing plan, fortunately for everyone involved, had a relatively modest lifetime maximum benefit which is probably one of the most sensitive pricing variables in this type of contract. They're low in this situation with a \$100,000 pre-65 lifetime maximum reducing to \$25,000 at age 65. Where they're that low we can come closer to the employer's expectations and what the price should be for guaranteed permanent coverage. Also, this plan had a highly scheduled internal benefit scheme so that the insurance company felt comfortable that it didn't have any outrageous exposures with this, and we were able to put this contract together. Here's a perfect example where the parent company or the buyer of this contract had a very compelling business reason to do this transaction. They wanted to unlock the dollars that were involved with those tax loss carryforwards, and this is one of the things that

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enabled them to do it. This was not something where they thought they were getting a bargain on the pricing.

The next example is the "no obligation - get out of the loop" approach. This corporation did not feel that it could provide the benefits that it had been providing over the years, but it wanted to provide something. Its legal department and counsel told it that it didn't have to provide anything - it could terminate the plan if it wanted to - but they didn't feel that was the right way to go. They felt a moral obligation to the retirees. What they told us to do was design a benefit plan as best we could within their budget, so this is what we designed. The original plan is under the heading "Planned Benefits" (see Table 5) and what we designed is on the right side under "Policy Benefits."

TABLE 5
Plan Benefits Versus Policy Benefits

Plan Benefits	Policy Benefits
\$1 million lifetime maximum	\$250,000 lifetime maximum
80/20 coinsurance feature	80/20 coinsurance feature
\$1,000 annual out-of-pocket limit	No annual out-of-pocket limit
Usual and customary	1990 California NYL PPO with 3% escalator for 10 years
\$150 annual deductible	\$250 annual deductible

They had a one million dollar lifetime maximum which we couldn't support with the budget we were given, but we could support a \$250,000 lifetime maximum. We keep the 80/20 coinsurance feature in place. The plan had a \$1,000 annual out-of-pocket limit. We had to go to an unlimited out-of-pocket limit. The benefit payments were based on usual and customary, but because of the health care cost trend rate risk, we couldn't support that usual and customary. We did something pretty creative here, I think. We used the California New York Life PPO Schedule with a 3% escalator for 10 years, at which point that schedule of benefits became flat and had no more increases and that was the way we were able to limit the insurance company exposure and keep the premium down. There was a \$150 annual deductible and some very modest employee contributions which we eliminated to make it easier to do the administration on, so we went to a \$250 annual deductible in exchange for removing the employee contribution. This example shows you what we can do in terms of design. Sometimes, like in the first example with the acquisition/divestiture, we can replicate the plan and that's what they wanted us to do in that situation. With this one, we never even set out to replicate the plan. We knew we couldn't. The plan sponsor knew that we couldn't. We were told to design something, so we did.

The next situation is a plant shutdown. This was a government contractor who had about 10 or so manufacturing operations around the country. One of them was being closed down. The government had no need for the product they manufactured

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anymore. Unlike some companies where, in a similar situation, they might choose to absorb the liability for providing retiree health care to the group effected by the shutdown into another plan or just use pay as you go, they preferred to not charge the future cost of these benefits against the ongoing revenue streams of these other operations. They felt that they had to be kept separate, and there were some other considerations that came into their decision. But they felt that the only path for them to take was to use single premium group health to permanently shift the liability for the group to the insurance company.

One option considered before they came to the single premium group health, was to take the amount of money that was on hand and set up a trust. Since the actuarial calculations showed the value of the benefits at a certain level, they considered putting this money in a trust, invest it, manage it, do the administration on the claims, and maybe it would last. There were two concerns: maybe the money won't last, and it seemed inequitable to them because there might have been someone with a giant claim and then right after that when the money ran out, there might be someone else with even a modest claim or another giant claim, and that person wouldn't have any benefits. They also thought about cashing out the retirees with the available money. But they were really committed to provide ongoing insurance. That's what they had in mind. They didn't want to cash people out. They had noted the results of a study that was done by the Employee Benefit Research Institute showing where employees, especially recipients of lump sums from qualified plans, in many cases five years later show no signs of having received that lump sum. They tend not to manage that very well, so the employer didn't want to go that route. They used the single premium group health contract as a solution to their problem.

There are two more recent examples of where this contract is useful. We're working on some bankruptcy situations where there has been a law firm appointed by the bankruptcy court, and we're working with that law firm. The firm has been told to try and work out concerns or disputes between the management of the company and the retiree group having to do with continuing coverage for the retirees. Even though the companies are bankrupt in the situations we're working on, there's still money available for these retirees to a certain extent and they're getting quite a bit of priority from the bankruptcy court.

The other situation is a very unique where this product is being used for funding as a general approach. Frank and Jim both talked about ways to set money aside on a deductible basis and fund for the benefits, and we never thought of single premium group health with its permanent guarantees as a funding vehicle, if you will, because most plan sponsors don't really want to transfer risk. They just want to fund in a tax effective way. The unique situation we're involved in now involves a plan that has only a \$10,000 lifetime maximum, and we and the plan sponsor agree that the premium that would be charged would not contain an amount of risk premium that would deter them from using this as a funding vehicle, and that's why they're pursuing it.

The single premium group health is not appropriate for use as a general funding approach other than this unique situation I just described. Three years ago when this product first became available, we had a lot of inquiries from companies that wanted

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to start funding retiree health care benefits, but this doesn't work because we have to be more conservative in our trend rate. There is only one chance to price this contract. We can never take another look, and it's a permanent guarantee. The other reason is that buying a single premium group health contract would in effect represent a total amortization of past service liability in a single sum and that's just unrealistic for most companies. Another point is that corporations are really seeking the kinds of advantages that my other two copanelists here were talking about in terms of tax effectiveness and investment return, and they're not really looking for risk transfer. As I mentioned before, an employer generally needs a compelling business reason to use single premium group health and just having the desire to fund is generally not enough.

The second area which I identify as not really being a very good environment for completing single premium group health transactions is FASB settlements. Single premium group health is really the only alternative to cashing out the participants and settling the obligation pursuant to SFAS 106, but it's just generally not possible. The health trend rate assumption in FASB valuations are aggressive compared to the rates that are used by a guarantor in pricing. When you're comparing the results of an actuarial study of the present value of benefits for accounting purposes or for analysis purposes, you're making a comparison between that and the price that might be quoted by an insurance company for a permanent takeover. The plan sponsor can make ad hoc changes to the benefit plan year by year and rein in the cash outlay that it's facing for benefits and, in effect, manipulate its own trend rate going forward. But that does not have any effect on the health care cost trend rate at large in the medical services community. In other words, simply by cost shifting or by making changes to the benefit plan and reducing your outlay as a plan sponsor, does not change what medical care providers are charging for their services. Be aware of that. In a closed group where the retirees have been given a permanent certificate guaranteeing a certain level of coverage, there is no fear on the part of the retirees that if benefits are not consumed wisely and frugally, the plan might be cut back. They know there is no way to cut back the plan. So those are some of the things to understand and appreciate and realize that this contract generally will not work in a FASB situation.

MR. GERALD R. SHEA: *In the funding vehicles where you are allowed to project for future medical care inflation, are you allowed to anticipate both price inflation in medical services and utilization increases?*

MR. BECKER: *Are you talking about the collectively bargained trust where you are allowed to fund for medical inflation?*

MR. SHEA: *Yes, and also in the 401(h), where you are similarly allowed to recognize medical inflation.*

MR. BECKER: *Yes, under both, the collectively bargained VEBA and the 401(h), medical inflation and utilization increases can be recognized in determining contribution levels.*

MR. KEVIN S. WOLF: *I had a question about TOLI and COLI. Are those vehicles primarily used for funding life insurance benefits, or are they used for health benefits*

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as well? And if they are being used for health benefits, then if there are insufficient assets in the trust (meaning cash values or proceeds from death benefits) to actually pay the health benefits, where does the money come from to pay out the health benefits?

MR. HESS: TOLI is used for prefunding medical benefits. Whether or not there are enough assets in the trust depends on how well the trust has been funded. There are funding limitations under 419A, and there is also the question of the extent to which the employer actually does choose to fund the trust. But those considerations are independent of the investment vehicle itself, which is TOLI.

FROM THE FLOOR: But if there isn't enough in the trust, where does the money come from?

MR. HESS: In that case, the benefit payments would be made directly by the employer, providing that the plan is continued. Neither the existence of the trust nor the TOLI necessarily implies any guarantee that the benefit plan will be continued.

MR. MATTHEW J. SHERWOOD: I have a question for Chris Snyder about the single-premium product. If I were a CEO of a company, even if I had a compelling business reason to look at your product, my concern would be the nonparticipating nature of your product. My thinking would be: "Okay. I've given you all this money. In 1995 we've got national health insurance. I've thrown it all down the drain." Have you had any requests for an emergency participating aspect to your contract or anything like that?

MR. SNYDER: That's never been a serious objection. While it's been mentioned after, most of the companies that were involved didn't think of that as enough of a deterrent not to move forward with the purchase of the product.

MR. SAMUEL M. KIKLA: Mr. Snyder, what trend rate assumption is used when projecting medical costs into the future for purposes of pricing the settlement contract?

MR. SNYDER: The trend rate used is reflective of the trend rates which we've experienced in recent years, based on the insurance company's research and their experience under similar plans. Unfortunately, the trend rates actually used are proprietary information owned by the insurance company so I cannot disclose the rates used in pricing.

MR. CARL F. RICCIARDELLI: Mr. Snyder, my question relates to the comparison of the original plan benefits with the benefits created under your single premium contract, specifically in the area of usual and customary. You identified the movement from usual and customary to the 1990 California NYL. In modifying a benefit plan, how do you handle the hospital benefits under the single premium policy?

MR. SNYDER: We've had plans put into effect where there was a dollar amount limit on the daily room and board rate. That's not the only way that it can be handled, but that's been the typical approach.

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MR. RICCIARDELLI: My second question has to do with how you handle the benefits payable under Medicare in this configuration. Presumably, the policies are covering closed blocks of lives, some of whom are early retirees that are not Medicare eligible, and some of whom are Medicare eligible. Can you explain how the contract distinguishes those groups from a benefit structure standpoint?

MR. SNYDER: In the case of the participants that are under 65 and are not covered by Medicare, the insurance contract or the insurance company is the primary payor for the covered benefits. When the participants reach Medicare eligibility, the insurance company becomes the secondary payor.

MR. BECKER: Does the leveraged COLI represent an asset for SFAS 106 purposes and thus offset the liability?

MR. HESS: No, in general, leveraged COLI is not an asset for SFAS 106 purposes. First of all, under leveraged COLI there's virtually no net asset. But to the extent there is an asset it would not be a SFAS 106 asset. On the other hand, TOLI, if it is properly set up, does provide a SFAS 106 asset.

MR. KIKLA: Is any member of the panel aware of anyone who uses 401(h) accounts in a 401(k) plan with the employee contribution being used to fund retiree medical benefits?

MR. BECKER: The closest I've seen is the money purchase plan that Proctor and Gamble has. I don't believe that it's a 401(k) plan. It's just a money purchase plan. That's the only thing I've seen with a 401(h) account within a pension plan with an ESOP.

