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Accounting and reporting by health and welfare benefit plans, August 3, 1992 : amendment to AICPA audit and accounting guide, Audit of employee benefit plans; Statement of position 92-6;

American Institute of Certified Public Accountants. Employee Benefit Plans Committee

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**Statement of
Position**

92-6

**Accounting and Reporting by
Health and Welfare
Benefit Plans**

August 3, 1992

**Amendment to
AICPA Audit and Accounting Guide
*Audits of Employee Benefit Plans***

**Prepared by the
Employee Benefit Plans Committee**

**American Institute of
Certified Public Accountants**

AICPA

NOTE

Statements of position of the Accounting Standards Division present the conclusions of at least a majority of the Accounting Standards Executive Committee, which is the senior technical body of the Institute authorized to speak for the Institute in the areas of financial accounting and reporting. Statement on Auditing Standards No. 69, *The Meaning of Present Fairly in Conformity With Generally Accepted Accounting Principles in the Independent Auditor's Report*, identifies AICPA statements of position as sources of established accounting principles that an AICPA member should consider if the accounting treatment of a transaction or event is not specified by a pronouncement covered by rule 203 of the AICPA Code of Professional Conduct. In such circumstances, the accounting treatment specified by this statement of position should be used, or the member should be prepared to justify a conclusion that another treatment better presents the substance of the transaction in the circumstances.

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Table of Contents

	<i>Page</i>
Summary	5
Scope	7
Background	10
Arrangements With Insurance Companies	11
Financial Statements of Defined-Benefit Health and Welfare Plans	13
Financial Statements of Defined-Contribution Health and Welfare Plans	14
ERISA Reporting Requirements	15
Statement of Net Assets Available for Benefits	15
Investments	15
Contributions Receivable	16
Deposits With and Receivables From Insurance Companies and Other Service Providers	17
Operating Assets	18
Accrued Liabilities	18
Statement of Changes in Net Assets Available for Benefits ..	18
Benefit Obligations	19
Claims	20
Premiums Due Under Insurance Arrangements	21
Accumulated Eligibility Credits	22
Postretirement Benefit Obligations	22
Changes in Benefit Obligations	24

	<i>Page</i>
Additional Financial Statement Disclosures	25
Terminating Plans	30
Effective Date and Transition	31
Appendix – Illustrations of Financial Statements:	
Employee Health and Welfare Benefit Plans	32
Exhibit A – Allied Industries Benefit Plan	33
Exhibit B – Classic Enterprises Benefit Plan	42

SUMMARY

This statement of position (SOP) amends chapter 4 of the AICPA Audit and Accounting Guide *Audits of Employee Benefit Plans* in effect as of March 31, 1991 (hereafter referred to as the *guide*).

This SOP updates the guide to conform to the following accounting standards:

- Financial Accounting Standards Board (FASB) Statement of Financial Accounting Standards No. 105, *Disclosure of Information about Financial Instruments with Off-Balance-Sheet Risk and Financial Instruments with Concentrations of Credit Risk*
- FASB Statement No. 106, *Employers' Accounting for Postretirement Benefits Other Than Pensions*, as applicable

This SOP also makes the following changes or clarifications in accounting and reporting requirements set forth in the guide:

- The objective of financial reporting by a defined-benefit health and welfare plan has been clarified (see paragraph 19).
- Defined-benefit health and welfare plans, both single and multi-employer, should account for and separately report benefit obligations, including postretirement benefit obligations (see paragraphs 36 through 49). Information regarding benefit obligations should be presented on the face of one or more financial statements. Note disclosure is not appropriate (see paragraph 20).
- The requirement to recognize claims incurred but not reported has been clarified (see paragraph 39).
- Benefit obligations should not include death benefits actuarially expected to be paid during the active service period of participants (see paragraph 36).
- Defined-contribution health and welfare plans are distinguished from defined-benefit health and welfare plans (see paragraphs 3 and 23).
- The requirements for determining the obligation for accumulated eligibility credits have been clarified (see paragraph 43).

This SOP is effective for audits of financial statements of single-employer plans for plan years beginning after December 15, 1992, except that the application of this SOP to plans of single employers with no more than 500 participants in the aggregate is effective for plan years beginning after December 15, 1994. This SOP is effective for audits of financial statements

of multiemployer plans for plan years beginning after December 15, 1995. Earlier application is encouraged. Accounting changes adopted to conform to the provisions of this SOP shall be made retroactively. Financial statements of prior plan years are required to be restated to comply with the provisions of this SOP *only* if they are presented together with financial statements of plan years beginning after December 15, 1992. If accounting changes were necessary to conform to the provisions of this SOP, that fact shall be disclosed when financial statements for the year in which this SOP is first applied are presented either alone or with financial statements of prior years.

Accounting and Reporting by Health and Welfare Benefit Plans

Scope

1. Health and welfare benefit plans include plans that provide—
 - a. Medical, dental, visual, psychiatric, or long-term health care; life insurance (offered separately from a pension plan); certain severance benefits; or accidental death or dismemberment benefits.
 - b. Benefits for unemployment, disability, vacations, or holidays.
 - c. Other benefits such as apprenticeships, tuition assistance, day care, dependent care, housing subsidies, or legal services.

This statement of position (SOP) applies to both defined-benefit and defined-contribution health and welfare benefit plans (referred to hereafter as *health and welfare benefit plans*).

2. Defined-benefit health and welfare plans specify a determinable benefit, which may be in the form of a reimbursement to the covered plan participant or a direct payment to providers or third-party insurers for the cost of specified services. Such plans may also include benefits that are payable as a lump sum, such as death benefits. The level of benefits may be defined or limited based on factors such as age, years of service, and salary. Contributions may be determined by the plan's actuary or be based on actual claims paid or other factors determined by the plan sponsor. Even when a plan is funded pursuant to agreements that specify a fixed rate of employer contributions (for example, a collectively bargained multiemployer plan), such a plan may nevertheless be a defined-benefit health and welfare plan if its substance is to provide a defined benefit.

3. Defined-contribution health and welfare plans maintain an individual account for each plan participant. They have terms that specify the means of determining the contributions to participants' accounts, rather than the amount of benefits the participants are to receive. The benefits a plan participant will receive are limited to the amount contributed to the participant's account, investment

experience, expenses, and any forfeitures allocated to the participant's account. These plans also include flexible spending arrangements.

4. Health and welfare benefit plans generally are subject to certain fiduciary, reporting, and other requirements of the Employee Retirement Income Security Act of 1974 (ERISA). Plans that are unfunded (that is, those whose benefits are paid solely and directly out of the general assets of the employer), are fully insured (through the direct payment of premiums to the insurance company by the employer; see paragraphs 14 and 15), or are certain combinations thereof (for example, self-funded plans with stop-loss coverage; see paragraph 17) may not be required to include financial statements in their ERISA filings.¹ An understanding of the health and welfare benefit plan is needed to determine its accounting and reporting requirements. It is also important to consider the new forms of funding vehicles that are emerging, particularly with respect to post-retirement health benefits.

5. This SOP describes generally accepted accounting principles (GAAP) that are particularly important to defined-benefit and defined-contribution health and welfare plans. Generally accepted accounting principles other than those discussed in this SOP may also apply. This SOP does not address the preparation of financial statements on a comprehensive basis of accounting other than GAAP; however, the presentation of a plan's benefit obligation information in GAAP-basis financial statements, as required by paragraph 20, is consistent with the disclosures required in financial statements prepared on such bases as the cash basis or modified cash basis, as defined by the requirements of financial reporting to the Department of Labor (DOL).

6. The most significant changes in accounting and reporting by health and welfare benefit plans that this SOP makes to the AICPA Audit and Accounting Guide *Audits of Employee Benefit Plans* are the following:

- The objective of financial reporting by a defined-benefit health and welfare plan has been clarified and is the same as the objec-

¹Refer to appendix A of the AICPA Audit and Accounting Guide *Audits of Employee Benefit Plans*.

tive of financial reporting by a defined-benefit pension plan (see paragraph 19).

- Single-employer, multiemployer, and multiple-employer defined-benefit health and welfare plans should account for and separately report benefit obligations, including postretirement benefit obligations (see paragraphs 36 through 49). Information regarding benefit obligations should be presented on the face of one or more financial statements. Note disclosure is not appropriate (see paragraph 20).
- The requirement to recognize claims incurred but not reported (IBNR) has been clarified. For a self-funded plan, the cost of IBNR includes the present value of the estimated ultimate cost of settling the claims, including estimated costs to be incurred after the financial statement date (for example, the cost of disability; see paragraph 39).
- Benefit obligations should not include death benefits actuarially expected to be paid during the active service period of participants (see paragraph 36).
- Defined-contribution health and welfare plans are distinguished from defined-benefit health and welfare plans (see paragraphs 3 and 23).
- The calculation of the obligation for accumulated eligibility credits has been clarified and generally should consider mortality rates and the probability of employee turnover (see paragraph 43).

7. Financial Accounting Standards Board (FASB) Statement of Financial Accounting Standards No. 35, *Accounting and Reporting by Defined Benefit Pension Plans*, does not apply to health and welfare benefit plans; however, as set forth in the guide, the methods of valuing plan investments and requirements for financial statement disclosures are the same as those specified in FASB Statement No. 35 and are not changed by this SOP.

8. FASB Statement No. 106, *Employers' Accounting for Postretirement Benefits Other Than Pensions*, establishes standards of financial accounting and reporting by *employers* for health and welfare benefits expected to be provided to a participant during retirement. While FASB Statement No. 106 does not apply to health and welfare benefit plans, this SOP adopts certain of its measurement concepts

(see paragraphs 44 through 49). Terminology used in discussing postretirement benefits in this SOP is intended to follow usage and definitions provided in FASB Statement No. 106.

9. FASB Statement No. 105, *Disclosure of Information about Financial Instruments with Off-Balance-Sheet Risk and Financial Instruments with Concentrations of Credit Risk*, applies to financial instruments of a pension plan other than the plan's obligation for pension benefits. This SOP conforms to the relevant disclosure requirements of FASB Statement No. 105 for financial instruments of health and welfare benefit plans other than obligations for benefits (see paragraph 53).

Background

10. Plan participants may be active or terminated employees (including retirees), as well as covered dependents and beneficiaries, of a single employer or group of employers. Employer contributions may be voluntary or required under the terms of a collective bargaining agreement negotiated with one or more labor organizations. Plans may require contributions from employers and participants (contributory plans) or from employers only (noncontributory plans). During periods of unemployment, a noncontributory plan may require contributions by participants to maintain their eligibility for benefits. Benefits may be provided through insurance contracts paid for by the plan (an insured plan), from net assets accumulated in a trust established by the plan (a self-funded plan), or both.

11. As noted above, a plan may establish a trust to hold assets to pay all or part of the covered benefits. The assets may be segregated and legally restricted under a trust arrangement (such as a voluntary employees' beneficiary association or a 501(c)(9) trust, a 401(h) account, or other funding vehicles). Generally, if a separate trust exists, financial statements are required under ERISA. A trust always exists for a multiemployer plan. Such trustee plans with more than 100 participants generally will require an audit. For ERISA filings, the DOL will not accept an accountant's report that covers the assets of more than one plan. For example, where the assets of more than one plan are held in a 501(c)(9) Voluntary Employees' Beneficiary Association (VEBA) trust, separate reports must be prepared for each

plan. If the trustee of the VEBA is a bank or trust company, and the trust holds the assets of more than one plan sponsored by a single employer or by a group of companies under common control, it is a master trust subject to the DOL's master trust filing requirements.

12. A health and welfare plan may process benefit payments directly or it may retain a third-party administrator (see paragraph 18). In either case, a plan that is fully or partially self-funded is obligated for the related benefits (see paragraphs 36 through 49).

Arrangements With Insurance Companies

13. The nature of, and method of accounting for, the assets and benefit obligations of a health and welfare benefit plan may be determined by the arrangement with the insurance company. The insurance company may assume all or a portion of the financial risk (see paragraphs 14 through 17), or it may provide only administrative services (see paragraph 18) or investment management services.² It is important to have an understanding of the insurance arrangement to determine whether any or all of the risks associated with benefit payments or claims have been transferred to the insurance company. Also, other arrangements are being developed that may involve new types of contracts that involve other parties, including those involving payments to providers, risk sharing of administrative expense with carriers, and so on. Details of these arrangements must also be reviewed carefully.

14. In a fully insured, pooled arrangement, specified benefits are covered by the insurance company. The insurance company pools the experience of the plan with that of other similar businesses and assumes the financial risk of adverse experience. In such an arrangement, a plan generally has no obligation for benefits covered by the arrangement other than the payment of premiums due to the insurance company (see paragraph 40).

15. In a fully insured experience-rated arrangement, specified benefits are paid by the insurance company that assumes all the financial risk. Contract experience is monitored by the insurance

²Refer to chapter 7 of the guide.

company. Contract experience may or may not include the experience of other similar contract holders. To the extent that benefits incurred plus risk charges and administration costs are less than premiums paid, the plan is entitled to an experience-rating refund or dividend (see paragraphs 29 and 30). If the total of benefits incurred, risk charges, and administrative costs exceeds premiums, the accumulated loss is generally borne by the insurance company but may be carried over to future periods until it has been recovered (see paragraphs 41 and 42). The plan often has no obligation to continue coverage or to reimburse the carrier for any accumulated loss, although there are certain types of contracts that require additional payments by the plan.

16. In a minimum premium plan arrangement, specified benefits are also paid by the insurance company. The insurance contract establishes a dollar limit, or *trigger point*. All claims paid by the insurance company below the trigger point are reimbursed by the plan to the insurance company. The insurance company is not reimbursed for benefits incurred that exceed the trigger point. This type of funding arrangement requires the plan to fund the full claims experience up to the trigger point. Minimum premium plan arrangements may have characteristics of both self-funded and fully insured experience-rated arrangements. Details of each arrangement must be reviewed carefully to determine the specific benefit obligations assumed by the insurance company.

17. In a stop-loss insurance arrangement, a plan's obligation for any plan participant's claims may be limited to a fixed dollar amount, or the plan's total obligation may be limited to a maximum percentage (for example, 125 percent) of a preset expected claims level. These arrangements are commonly used with administrative service arrangements. The insurance company assumes the benefit obligation in excess of the limit. Stop-loss insurance arrangements may have characteristics of both self-funded and fully insured arrangements. Stop-loss arrangements of this type may be described by a variety of terms; therefore, details of all insurance or administrative arrangements should be reviewed carefully to determine if stop-loss provisions are included and to determine the specific benefit obligations assumed by the insurance company.

18. In an administrative service arrangement, the plan retains the full obligation for plan benefits. The plan may engage an insurance

company or other third party to act as the plan administrator. The administrator makes all benefit payments, charges the plan for those payments, and collects a fee for the services provided.

Financial Statements of Defined-Benefit Health and Welfare Plans

19. The objective of financial reporting by defined-benefit health and welfare plans is the same as that of defined-benefit pension plans; both types of plans provide a determinable benefit. Accordingly, the primary objective of the financial statements of a defined-benefit health and welfare plan is to provide financial information that is useful in assessing the plan's present and future ability to pay its benefit obligations when due. To accomplish that objective, a plan's financial statements should provide information about (a) plan resources and the manner in which the stewardship responsibility for those resources has been discharged, (b) benefit obligations, (c) the results of transactions and events that affect the information about those resources and obligations, and (d) other factors necessary for users to understand the information provided.³

20. The financial statements of a defined-benefit health and welfare plan prepared in accordance with GAAP⁴ should be prepared on the accrual basis of accounting and include —

- A statement of net assets available for benefits as of the end of the plan year (see paragraphs 25 through 33).
- A statement of changes in net assets available for benefits for the year then ended (see paragraphs 34 and 35).
- Information regarding the plan's benefit obligations as of the end of the plan year (see paragraphs 36 through 49).
- Information regarding the effects, if significant, of certain factors affecting the year-to-year change in the plan's benefit obligations (see paragraphs 50 and 51).

³ It should be recognized that (a) information in addition to that contained in a plan's financial statements is needed in assessing the plan's present and future ability to pay its benefit obligations when due and (b) financial statements for several plan years may provide more useful information in assessing the plan's future ability to pay benefit obligations than can financial statements for a single year.

⁴ Financial statements prepared on a comprehensive basis of accounting other than GAAP should disclose information regarding benefit obligations (see paragraphs 13.16 through 13.19 of the guide, which discuss auditor's report considerations).

Information regarding the benefit obligations should be presented on the face of one or more financial statements. The information should be presented in such reasonable detail as is necessary to identify the nature and classification of the obligations.⁵

21. FASB Statement No. 102, *Statement of Cash Flows—Exemption of Certain Enterprises and Classification of Cash Flows from Certain Securities Acquired for Resale*, provides that employee benefit plans other than pension plans (such as health and welfare plans, both defined benefit and defined contribution) that provide information similar to that required by FASB Statement No. 35 are not required to provide a statement of cash flows. However, FASB Statement No. 102 encourages that a statement of cash flows be included in the financial statements of an employee benefit plan when such a statement would provide relevant information about the ability of the plan to meet future obligations (for example, when the plan invests in assets that are not highly liquid or obtains financing for investments).

Financial Statements of Defined-Contribution Health and Welfare Plans

22. The objective of financial reporting by a defined-contribution health and welfare plan is to provide financial information that is useful in assessing the plan's present and future ability to pay its benefits when due. To accomplish that objective, a plan's financial statements should provide information about (a) plan resources and the manner in which the stewardship responsibility for those resources has been discharged, (b) the results of transactions and events that affect the information about those resources, and (c) other factors necessary for users to understand the information provided.⁶

23. The financial statements of a defined-contribution health and welfare plan prepared in accordance with GAAP⁷ should be prepared on the accrual basis of accounting and include—

- A statement of net assets available for benefits of the plan as of the end of the plan year (see paragraphs 25 through 33).

⁵The appendix of this SOP provides illustrative financial statements of two health and welfare benefit plans.

⁶See footnote 3.

⁷See footnote 4.

- A statement of changes in net assets available for benefits of the plan for the year then ended (see paragraphs 34 and 35).

Because a plan's obligation to provide benefits is limited to the amounts accumulated in an individual's account, information regarding benefit obligations is not applicable.

ERISA Reporting Requirements

24. ERISA established annual reporting requirements for employee benefit plans, including health and welfare benefit plans.⁸ The financial statements required by ERISA are a statement of assets and liabilities and a statement of changes in net assets available for benefits. The schedules required by ERISA include assets held for investment purposes, transactions with parties in interest, loans or fixed-income obligations due that are in default or uncollectible, leases that are in default or uncollectible, and reportable transactions.

Statement of Net Assets Available for Benefits

Investments

25. Plan investments, whether they are in the form of equity or debt securities, real estate, or other investments (excluding contracts with insurance companies), should be reported at their fair value at the financial statement date.⁹ The fair value of an investment is the amount that the plan could reasonably expect to receive for it in a current sale between a willing buyer and a willing seller, that is, other than in a forced or liquidation sale. Fair value should be measured by the market price if there is an active market for the investment. If there is no active market for the investment but there is a market for similar investments, selling prices in that market may be helpful in estimating fair value. If a market price is not available, a forecast of

⁸ ERISA annual reporting requirements, as well as the common exemptions, are described in appendix A of the guide.

⁹ The accrual basis of accounting requires that purchases and sales of securities be recorded on a trade-date basis. However, if the settlement date is later than the financial statement date and (a) the fair value of the securities purchased or sold just before the financial statement date does not change significantly from the trade date to the financial statement date and (b) the purchases or sales do not significantly affect the composition of the plan's assets available for benefits, accounting on a settlement-date basis for such sales and purchases is acceptable.

expected cash flows, discounted at a rate commensurate with the risk involved, may be used to estimate fair value.¹⁰

26. Whether or not a plan is subject to ERISA, contracts with insurance companies are to be included as plan assets in the manner required by ERISA's annual reporting requirements and are to be reported in a manner consistent with the requirements of DOL Form 5500 or 5500-C.¹¹ The current Form 5500 (1990) permits the reporting of unallocated insurance contracts either at current value or as determined on Schedule A, "Insurance Information," that is, contract value. This is an exception to the general requirement that plan investments be presented at fair value. The exception applies only to investments in contracts issued by insurance companies; investments in similar contracts issued by banks, savings and loan associations, or other financial institutions are presented at fair value. Further discussion of insurance contracts is provided in chapter 7 of the guide.

27. Information regarding a plan's investments should be presented in enough detail to identify the types of investments and should indicate whether reported fair values have been measured by quoted prices in an active market or have been determined otherwise (paragraph 53 specifies additional disclosures related to investments).

Contributions Receivable

28. Contributions receivable are the amounts due, as of the date of the financial statements, to the plan from employers, participants, and other sources of funding (for example, state subsidies or federal grants), each of which should be separately identified. They include amounts due pursuant to firm commitments, as well as legal or

¹⁰ For an indication of the factors to be considered in determining the discount rate, see paragraph 27 of FASB Statement No. 107, *Disclosures about Fair Value of Financial Instruments*. The fair value of an investment should be reported net of the brokerage commissions and other costs normally incurred in a sale, if significant (see also paragraphs 2.9 and 2.10 of the guide).

¹¹ In April 1990 the FASB added to its agenda a project on accounting and financial reporting by employee benefit plans for guaranteed investment contracts issued by insurance companies and for similar contracts issued by noninsurance entities. In March 1992, the FASB issued an exposure draft of a proposed Statement, *Reporting by Defined Benefit Pension Plans of Investment Contracts*. Further discussion of *unallocated* insurance contracts is provided in chapter 7 of the guide (pending resolution of the FASB project on accounting for investment contracts).

contractual requirements. With respect to employers' contributions, evidence of a formal commitment may include (a) a resolution by the employer's governing body approving a specified contribution; (b) a consistent pattern of making payments after the end of the plan year, pursuant to an established funding policy that attributes such subsequent payments to the preceding plan year; (c) a deduction of a contribution for federal income tax purposes for periods ending on or before the financial statement date; or (d) the employer's recognition as of the financial statement date of a contribution payable to the plan.¹² Contributions receivable should include an allowance for estimated uncollectible amounts.

Deposits With and Receivables From Insurance Companies and Other Service Providers

29. Whether a premium paid to an insurance company represents payment for the transfer of risk or merely represents a deposit will depend on the circumstances of the arrangement. As noted earlier, the nature of payments made to an insurance company should be analyzed to determine the extent to which financial risk has been transferred from the plan to the insurance company. Insurance companies may require that a deposit be maintained that can be applied against possible future losses in excess of current premiums. These deposits should be reported as plan assets until such amounts are used to pay premiums. Similarly, premium stabilization reserves, which exist when premiums paid to an insurance company exceed the total of claims paid and other charges, are held by an insurance company and used to reduce future premium payments. Premium stabilization reserves generally should be reported as assets of the plan until such amounts are used to pay premiums. Disclosure of the nature of this type of deposit or reserve should be made. If such reserves are forfeitable if the insurance contract terminates, this possibility should be considered in recognizing this asset.

30. Certain group insurance contracts covering health and welfare benefit plans include a provision for a refund, at the end of the policy year, of the excess of premiums paid over the total of paid claims, required reserves, and the fee charged by the insurance

¹²The existence of an accrued liability in the employer's statement of financial position or a plan's benefit obligations exceeding its net assets available for benefit obligations does not, by itself, provide sufficient support for recognition of a contribution receivable by the plan.

company. Often such experience-rating refunds (or dividends) are not determined by the insurance company for several months after the end of the policy year. In this event, and in cases when the policy year does not coincide with the plan's fiscal year, the refund due as of the financial statement date should be reported as a plan asset if it is probable that a refund is due and the amount can be reasonably estimated. If the amount of the refund cannot be reasonably estimated, that fact should be disclosed.

31. Service providers may require that deposits by the plan be applied against claims paid on behalf of plan participants. Such deposits should be reported as plan assets until the deposit is applied against paid claims.

Operating Assets

32. Plan assets used in plan operations (for example, buildings, equipment, furniture and fixtures, and leasehold improvements) should be reported at cost less accumulated depreciation or amortization.

Accrued Liabilities

33. A plan may have liabilities (other than for benefits) that should be accrued. Such liabilities may be for amounts owed for securities purchased, income taxes payable by the plan, or other expenses (for example, third-party administrator fees). These liabilities should be deducted to arrive at net assets available for benefits.

Statement of Changes in Net Assets Available for Benefits

34. The statement of changes in net assets available for benefits should be presented in enough detail to identify the significant changes during the year including, as applicable—

- Contributions from employers, segregated between cash and noncash contributions. A noncash contribution should be reported at fair value at the date of the contribution. The nature of noncash contributions should be described either parenthetically or in a note.

- Contributions from participants, including those collected and remitted by the sponsor.
- Contributions from other identified sources (for example, state subsidies or federal grants).
- The net appreciation or depreciation¹³ in fair value for each significant class of investments, segregated between investments whose fair values have been measured by quoted prices in an active market and those whose fair values have been otherwise determined.
- Investment income, excluding the net appreciation or depreciation.
- Income taxes paid or payable, if applicable.
- Payments of claims, excluding payments made by an insurance company pursuant to contracts that are excluded from plan assets.
- Payments of premiums to insurance companies to purchase contracts that are excluded from plan assets.¹⁴
- Operating and administrative expenses.
- Other changes (such as transfers of assets to or from other plans), if significant.

35. The list of minimum disclosures is not intended to define the degree of detail or the manner of presenting the information, and subclassifications or additional classifications may be useful.

Benefit Obligations

36. Benefit obligations¹⁵ for health and welfare benefit plans should include the actuarial present value, as applicable, of the following:

¹³ Net appreciation or depreciation includes realized gains and losses on investments that were both purchased and sold during the period. Ordinarily, information regarding the net appreciation or depreciation in the fair value of investments is found in the notes to the financial statements.

¹⁴ Refer to paragraphs 7.25 and 7.26 of the guide for further discussion of allocated insurance contracts.

¹⁵ Administrative expenses expected to be paid by the plan (not those paid by the sponsor) that are associated with providing benefit obligations shall be reflected by appropriately adjusting the assumed rates of return. The adjustment of the assumed rates of return shall be separately disclosed.

- Claims payable and currently due for active and retired participants
- Premiums due under insurance arrangements
- Claims incurred but not reported to the plan for active participants¹⁶
- Accumulated eligibility credits for active participants
- Postretirement benefits for—
 - Retired participants, including their beneficiaries and covered dependents
 - Active or terminated participants who are fully eligible to receive benefits
 - Active participants not yet fully eligible to receive benefits

Benefits expected to be earned for future service by active participants (for example, vacation benefits) during the term of their employment should not be included. Benefit obligations should be reported as of the end of the plan year.¹⁷ The effect of plan amendments should be included in the computation of the expected and accumulated postretirement benefit obligations once they have been contractually agreed to, even if some provisions take effect only in future periods. For example, if a plan amendment grants a different benefit level for employees retiring after a future date, that increased or reduced benefit level should be included in current-period measurements for employees expected to retire after that date.

37. As noted previously (see paragraph 20), information regarding benefit obligations may be presented either in a separate statement or with other information on another financial statement. However, all the information must be located in one place.

Claims

38. In an insured health and welfare benefit plan, claims payable and currently due and claims incurred but not yet reported to the

¹⁶IBNR may be computed in the aggregate for active participants and retirees. When the IBNR for retirees is not included in the postretirement benefit obligation, it may be included in claims incurred but not reported.

¹⁷Postretirement benefit obligations should be determined as of the end of the plan year or, if used consistently from year to year, as of a date not more than three months prior to that date, in accordance with paragraph 72 of FASB Statement No. 106.

plan will be paid by the insurance company. Consequently, they should be excluded from the benefit obligations of the plan. Benefit obligations of a self-funded plan should present the amount of claims payable and currently due for active and retired participants, dependents, and beneficiaries and IBNR for active participants. IBNR for retired participants is included in the postretirement benefit obligation.¹⁸

39. For a self-funded plan, the cost of IBNR should be measured at the present value, as applicable, of the estimated ultimate cost to the plan of settling the claims. Estimated ultimate cost should reflect the plan's obligation to pay claims to or for participants (for example, continuing health coverage or long-term disability), regardless of status of employment, beyond the financial statement date pursuant to the provisions of the plan or regulatory requirements.

Premiums Due Under Insurance Arrangements

40. Benefits to participants may be provided through insurance arrangements that transfer the risks of loss or liability to an insurance company (see paragraphs 14 through 17). Group insurance contracts for health and welfare plans are usually written for a one-year period, although the contract may provide for annual renewal. The contract generally specifies, among other things, the schedule of benefits, eligibility rules, premium rate per eligible participant, and the date that premiums are due. The benefit obligations should include any obligation for premiums due but not paid.

41. If the insurance contract requires payment of additional premiums (for example, retrospective premiums) when the loss ratio exceeds a specified percentage, an obligation for the estimated additional premiums should be included in the benefit obligations.

42. Experience ratings determined by the insurance company or by estimates (see paragraph 15) may result in a premium deficit. Premium deficits should be included in the benefit obligations if (a) it is probable that the deficit will be applied against the amounts of future premiums or future experience-rating refunds¹⁹ and (b) the

¹⁸ See footnote 16.

¹⁹ This determination should consider (a) the extent to which the insurance contract requires payment of such deficits and (b) the plan's intention, if any, to transfer coverage to another insurance company.

amount can be reasonably estimated. If no obligation is included for a premium deficit because either or both of the conditions are not met, or if an exposure to loss exists in excess of the amount accrued, disclosure of the premium deficit should be made if it is reasonably possible that a loss or an additional loss has been incurred.

Accumulated Eligibility Credits

43. Plans may provide for the payment of insurance premiums or benefits for a period of time for those participants who have accumulated a sufficient number of eligibility credits or hours. Eligible participants are provided with insurance coverage during periods of unemployment, when employer contributions to the plan would not otherwise provide coverage or benefits. At the financial statement date, such accumulated eligibility credits represent an obligation of the plan arising from prior employee service for which employer contributions have been received. This benefit obligation is generally determined by applying current insurance premium rates to accumulated eligibility credits or, for a self-funded plan, by applying the average cost of benefits per eligible participant to accumulated eligibility credits. In either case, the obligation for accumulated eligibility credits should consider assumptions for mortality and expected employee turnover, or other appropriate adjustments, to reflect the obligation at the amount expected to be paid.

Postretirement Benefit Obligations

44. Health and welfare benefit plans may continue to provide benefits to participants after retirement (postretirement benefits). Those benefits may commence immediately upon termination of service or payment may be deferred until the participant attains a specified age. If a plan provides postretirement benefits to participants, an estimated amount for those benefits, as described below, should be included in the benefit obligations.

45. The postretirement benefit obligation as of the measurement date is the actuarial present value of all future benefits attributed to plan participants' services rendered to that date, assuming the plan continues in effect and all assumptions about future events are fulfilled. Postretirement benefits comprise benefits expected to be paid to or on behalf of any retired or active participant, terminated participant, beneficiary, or covered dependent who is expected to

receive benefits under the health and welfare benefit plan. Postretirement benefits expected to be paid to or for an active participant, beneficiary, or covered dependent who is still earning his or her postretirement benefits (that is, one who is not yet fully eligible) should be measured over the participant's credited period of service up to the date when full eligibility for benefits is attained.²⁰

46. If a multiemployer health and welfare benefit plan provides postretirement benefits, the benefit obligations must include the postretirement benefit obligation. Consideration should be given to the promises currently made to employees and the history of making such payments to retirees. The fact that benefits may be reduced or even potentially eliminated would not ordinarily affect the promise made as of the end of the plan year unless the change meets the substantive plan criteria of FASB Statement No. 106 (for example, an amendment is in place or has been communicated to employees). The fact that the contributing employers of a multiemployer plan do not record a similar obligation under FASB Statement No. 106 does not affect the accounting for the obligations by the plan.

47. The postretirement benefit obligation should be measured using the plan's written provisions to the extent possible, as well as the substantive plan if it differs from the written plan. In many health and welfare benefit plans, postretirement benefits are not defined as a specified amount for each year of service. FASB Statement No. 106, paragraphs 23 through 44, describes the measurement of the postretirement benefit obligation. For multiemployer plans that do not have date-of-hire information as required by paragraph 44 of FASB Statement No. 106, reasonable estimates thereof should be used to measure the obligation. Death or disability benefits provided outside of a pension plan (when the employee is considered to be retired) should also be included in the calculation of the postretirement benefit obligation. Benefits that are provided through an insurance contract should be excluded.²¹

²⁰ For example, if a participant has worked eight years and must work another sixteen to be fully eligible for benefits after retirement, one-third of the postretirement benefits have been earned and should be included in the postretirement benefit obligation if it is probable that the employee will work the remaining sixteen years.

²¹ Insured plans should be reviewed carefully to determine the extent to which postretirement benefits are insured. Currently, except for single-premium life insurance contracts, few, if any, insurance contracts unconditionally obligate an insurance company to provide most forms of postretirement benefits.

48. In measuring the postretirement benefit obligation explicit assumptions must be used, each of which represents the best estimate of a particular future event. All assumptions should presume that the plan will continue in its present form, unless there is evidence to the contrary. Principal actuarial assumptions used should include —

- Discount rates, used to reflect the time value of money in determining the present value of future cash outflows currently expected to be required to satisfy the liability in the due course of business.
- The timing and amount of future postretirement benefit payments (taking into consideration per capita claims cost by age, health care cost-trend rates, current Medicare reimbursement rates, retirement age, dependency status, and mortality).
- Salary progression (for pay-related plans).
- The probability of payment (considering turnover, retirement age, dependency status, and mortality).
- Participation rates (for contributory plans).

49. The postretirement benefit obligation information should include the following classifications:

- Obligations related to retired plan participants, including their beneficiaries and covered dependents
- Obligations related to active or terminated participants who are fully eligible to receive benefits
- Obligations related to other plan participants not yet fully eligible for benefits

Separate disclosure for each classification for each significant benefit (for example, medical and death) may be appropriate.

Changes in Benefit Obligations

50. Information regarding changes in the benefit obligations within a plan period should be presented to identify significant factors affecting year-to-year changes in benefit obligations. Like the benefit obligation information (see paragraph 37), the changes should

be presented within the body of the financial statements. Providing such information in the following three categories will generally be sufficient: (a) claims payable and premiums due to insurance companies, (b) IBNR and eligibility credits, and (c) postretirement benefit obligations.

51. Minimum disclosure regarding changes in benefit obligations should include the significant effects of (a) plan amendments, (b) changes in the nature of the plan (mergers or spinoffs), and (c) changes in actuarial assumptions (health care cost-trend rate or interest rate). Changes in actuarial assumptions are to be considered as changes in accounting estimates and, therefore, previously reported amounts should not be restated. The significant effects of other factors may also be identified. These include, for example, benefits accumulated,²² the effects of the time value of money (for interest), and benefits paid. If presented, benefits paid should not include benefit payments made by an insurance company pursuant to a contract that is excluded from plan assets. However, amounts paid by the plan to an insurance company pursuant to such a contract (including purchases of annuities with amounts allocated from existing investments with the insurance company) should be included in benefits paid.²³ If only the minimum disclosure is presented, presentation in a statement format will necessitate an additional unidentified “other” category to reconcile the initial and ultimate amounts.

Additional Financial Statement Disclosures

52. Disclosure of a health and welfare benefit plan’s accounting policies should include—²⁴

- A description of the methods and significant assumptions used to determine the fair value of investments and the reported value of insurance contracts.

²² Actuarial experience gains or losses may be included with the effects of additional benefits accumulated rather than separately disclosed. If the effects of changes in actuarial assumptions cannot be separately determined, those effects should be included in benefits accumulated and described accordingly.

²³ Because of the use of different actuarial assumptions, the amount paid by the plan to an insurance company may be different from the previous measure of the actuarial present value of the related accumulated plan benefits. If that information is available, it should be presented as an actuarial experience gain or loss.

²⁴ See Accounting Principles Board (APB) Opinion No. 22, *Disclosure of Accounting Policies*.

- A description of the methods and significant actuarial assumptions used to determine the plan's benefit obligations. Any significant changes in assumptions made between financial statement dates and their effects should be described.

53. The plan's financial statements should also disclose other information.²⁵ Separate disclosures may be made to the extent that the plan provides both health and other welfare benefits. The disclosures should include, when applicable—

- A brief, general description of the plan agreement, including, but not limited to, participants covered, vesting, and benefit provisions. If a plan agreement or a description thereof providing this information is otherwise published or made available, the description in the financial statement disclosures may be omitted, provided that a reference to the other source is made.
- A description of significant plan amendments adopted during the period, as well as significant changes in the nature of the plan (for example, a plan spin-off or merger with another plan) and changes in actuarial assumptions.
- The funding policy and any changes in the policy made during the plan year. If the benefit obligations exceed the net assets of the plan, the method of funding this deficit, as provided for in the plan agreement or collective bargaining agreement, also should be disclosed.²⁶ For a contributory plan, the disclosure should state the method of determining participants' contributions.
- The federal income tax status of the plan. There is no determination letter program for health and welfare plans; however, a 501(c)(9) VEBA trust must obtain a determination letter to be exempt from taxation.
- The policy regarding the purchase of contracts with insurance companies that are excluded from plan assets. Consideration should be given to disclosing the type and extent of insurance coverage, as well as the extent to which risk is transferred (for example, coverage period and claims reported or claims incurred).

²⁵ Certain of the disclosures relate to plans with accumulated assets rather than those with trusts that act more as conduits for benefit payments or insurance premiums.

²⁶ If significant plan administration or related costs are being borne by the employer, that fact should be disclosed.

- Identification of investments that represent 5 percent or more of total plan assets. Consideration should be given to disclosing provisions of insurance contracts included as plan assets that could cause an impairment of the asset value upon liquidation or other occurrence (for example, surrender charges and market value adjustments).
- The amounts and types of securities of the employer and related parties included in plan assets, and the approximate amount of future annual benefits of plan participants covered by insurance contracts issued by the employer and related parties.
- Significant real estate or other transactions in which the plan and any of the following parties are jointly involved: the sponsor, the plan administrator, employers, or employee organizations.
- Unusual or infrequent events or transactions occurring after the financial statement date, but before issuance of the financial statements, that might significantly affect the usefulness of the financial statements in an assessment of the plan's present and future ability to pay benefits. For example, a plan amendment adopted after the latest financial statement date that significantly increases future benefits attributable to an employee's service rendered before that date, a significant change in the market value of a significant portion of the plan's assets, or the emergence of a catastrophic claim should be disclosed. If reasonably determinable, the effects of such events or transactions should be disclosed. If such effects are not reasonably determinable, the reasons why they are not quantifiable should be disclosed.
- Material lease commitments, other commitments, or contingent liabilities.
- The assumed health care cost-trend rate(s) used to measure the expected cost of benefits covered by the plan for the next year, a general description of the direction and pattern of change in the assumed trend rates thereafter, the ultimate trend rate(s), and when that rate is expected to be achieved.
- For health and welfare benefit plans providing postretirement health care benefits, the effect of a one-percentage-point increase in the assumed health care cost-trend rates for each future year on the postretirement benefit obligation.
- Any modification of the existing cost-sharing provisions that are encompassed by the substantive plan(s) and the existence and

nature of any commitment to increase monetary benefits provided by the plan and their effect on the plan's financial statements.

- Termination provisions of the plan and priorities for distribution of assets, if applicable.
- Restrictions, if any, on plan assets (for example, legal restrictions on multiple trusts).

This list does not include information that, in accordance with ERISA requirements, must be disclosed in the schedules filed as part of a plan's annual report. It is important to note that any information required by ERISA to be disclosed in the schedules must be disclosed in the schedules; disclosure of the information in the footnotes to the financial statements but not in the schedules is not acceptable to the DOL.

54. FASB Statement No. 105 requires all entities, including health and welfare benefit plans, to disclose information principally about financial instruments with off-balance-sheet risk. Financial instruments of a pension plan, other than obligations for pension benefits, when subject to the accounting and reporting requirements of FASB Statement No. 35, are included in the scope of FASB Statement No. 105. However, the disclosure requirements in paragraphs 17, 18, and 20 of FASB Statement No. 105 do not apply to (a) financial instruments of a pension plan, including plan assets, when subject to the accounting and reporting requirements of FASB Statement No. 87, *Employers' Accounting for Pensions*; (b) employers' and plans' obligations for pension benefits, postretirement health care and life insurance benefits, employee stock option and stock purchase plans, and other forms of deferred compensation arrangements; (c) insurance contracts, other than financial guarantees and investment contracts as discussed in FASB Statement Nos. 60, *Accounting and Reporting by Insurance Enterprises*, and 97, *Accounting and Reporting by Insurance Enterprises for Certain Long-Duration Contracts and for Realized Gains and Losses from the Sale of Investments*; and (d) unconditional purchase obligations subject to the disclosure requirements of FASB Statement No. 47, *Disclosure of Long-Term Obligations*.

55. Some examples of financial instruments of employee benefit plans with off-balance-sheet risk that are included within the scope of this SOP are obligations to repurchase securities sold, outstanding

commitments to purchase or sell financial instruments at predetermined prices, futures contracts, and interest-rate and foreign-currency swaps.

56. FASB Statement No. 105 requires entities to disclose the following information about financial instruments with off-balance-sheet credit risk:

- The face or contract amount (or notional principal amount if there is no face or contract amount)
- The nature and terms, including, at a minimum, a discussion of (a) the credit and market risk of those instruments, (b) the cash requirements of those instruments, and (c) the related accounting policy pursuant to the requirements of APB Opinion 22
- The amount of the accounting loss the entity would incur if any party to the financial instrument failed completely to perform according to the terms of the contract and the collateral or other security, if any, for the amount due proved to be of no value to the entity
- The entity's policy of requiring collateral or other security to support financial instruments subject to credit risk, information about the entity's access to that collateral or other security, and the nature and a brief description of the collateral or other security supporting those financial instruments

FASB Statement No. 105 requires entities to disclose the following information about financial instruments with concentrations of credit risk:

- Information about the (shared) activity, region, or economic characteristic that identifies the concentration
- The amount of the accounting loss due to credit risk the entity would incur if parties to the financial instruments that make up the concentration failed completely to perform according to the terms of the contracts and the collateral or other security, if any, for the amount due proved to be of no value to the entity
- The entity's policy of requiring collateral or other security to support financial instruments subject to credit risk, information about the entity's access to that collateral or other security, and

the nature and a brief description of the collateral or other security supporting those financial instruments

Terminating Plans

57. The auditing interpretation “Reporting on Financial Statements Prepared on a Liquidation Basis of Accounting” (AICPA, *Professional Standards*, vol. 1, AU section 9508.33–38) contains applicable guidance regarding the auditor’s reporting responsibilities for terminating plans. For purposes of this discussion, a terminating plan includes all plans about which a termination decision has been made regardless of whether the terminating plan will be replaced.

58. When the decision has been made to terminate a plan,²⁷ or a wasting trust—that is, a plan under which participants no longer accrue benefits but that will remain in existence as long as necessary to pay already accrued benefits—exists, complete and prominent disclosure of the relevant circumstances is essential in all subsequent financial statements issued by the plan. If the decision to terminate a plan is made before the end of the plan year, it is also necessary for the plan’s year-end financial statements to be prepared on the *liquidation basis of accounting*, as described below. If the decision is made after the year end but before the year-end financial statements have been issued, the decision is generally a *type two* subsequent event requiring the disclosure described in SAS No. 1, *Codification of Auditing Standards and Procedures* (AICPA, *Professional Standards*, vol. 1, AU sec. 560.5).

59. Plan financial statements for periods ending after the termination decision are prepared on the liquidation basis of accounting. For plan assets, changing to the liquidation basis will usually cause little or no change in values, most of which are current market values. Assets that may not be carried at market values include operating assets, insurance contracts carried at *contract values*, or large blocks of stock or other assets that cannot be readily disposed of at their quoted market prices.

²⁷ See paragraph 12.11 of the guide, which states that the auditor should obtain from the plan trustee, administrator, or administrative agent written representation about whether there is a present intention to terminate the plan. Refer also to paragraph 10.33 of the guide, which states that the auditor should consider confirming with the plan’s actuary knowledge of an intent on the part of the employer to terminate the plan.

60. Benefit obligations should be determined on a liquidation basis, and their value may differ from the actuarial present value of benefit obligations reported for an ongoing plan. Consideration should be given upon termination to whether any or all benefits become vested.

Effective Date and Transition

61. This SOP is effective for audits of financial statements of single-employer plans for plan years beginning after December 15, 1992, except that the application of this SOP to plans of single employers with no more than 500 participants in the aggregate is effective for plan years beginning after December 15, 1994. This SOP is effective for audits of financial statements of multiemployer plans for plan years beginning after December 15, 1995. Earlier application is encouraged. Accounting changes adopted to conform to the provisions of this SOP shall be made retroactively. Financial statements of prior plan years are required to be restated to comply with the provisions of this SOP *only* if they are presented together with financial statements for plan years beginning after December 15, 1992. If accounting changes were necessary to conform to the provisions of this SOP, that fact shall be disclosed when financial statements for the year in which this SOP is first applied are presented either alone or with financial statements of prior years.

APPENDIX

Illustrations of Financial Statements: Employee Health and Welfare Benefit Plans

A-1. This appendix illustrates certain applications of the provisions of this SOP to the annual financial statements of two hypothetical health and welfare benefit plans that have assets in underlying trusts. They are —

- a. Allied Industries Benefit Plan, a multiemployer plan that displays the benefit obligation information in separate financial statements (exhibit A).
- b. Classic Enterprises Benefit Plan, a single-employer plan that displays the benefit obligation information on the face of the financial statements along with the net asset information (exhibit B).

A-2. The plan in exhibit A pays all benefits directly from plan assets. The plan in exhibit B obtains insurance for current benefits from its assets. It is assumed that both plans provide health benefits and life insurance coverage to both active and retired participants. Exhibit A also assumes that the plan provides long-term disability benefits and limited coverage during periods of unemployment based on accumulated eligibility credits.

A-3. The examples do not illustrate other provisions of this SOP that might apply in circumstances other than those assumed. The format presented and the wording of the accompanying notes are illustrative only and are not necessarily the only possible presentations. For purposes of illustration, two-year comparative financial statements are shown. (Generally accepted accounting principles encourage but do not require comparative financial statements; however, the alternative method of reporting under ERISA requires comparative statements of net assets available for benefits.)

ALLIED INDUSTRIES BENEFIT PLAN

Allied Industries Benefit Plan
 Statements of Net Assets Available for Benefits
 December 31, 19X2 and 19X1

	<u>19X2</u>	<u>19X1</u>
<u>Assets</u>		
Investments, at fair value (see note 3)		
U.S. government securities	\$5,000,000	\$4,000,000
Corporate bonds and debentures	2,000,000	1,600,000
Common stock	<u>1,000,000</u>	<u>600,000</u>
Total investments	<u>8,000,000</u>	<u>6,200,000</u>
Receivables		
Participating employers' contributions	500,000	430,000
Participants' contributions	100,000	80,000
Accrued interest and dividends	<u>50,000</u>	<u>40,000</u>
Total receivables	<u>650,000</u>	<u>550,000</u>
Cash	<u>140,000</u>	<u>115,000</u>
TOTAL ASSETS	<u>8,790,000</u>	<u>6,865,000</u>
<u>Liabilities</u>		
Due to broker for securities purchased	250,000	240,000
Accounts payable for administrative expenses	<u>25,000</u>	<u>25,000</u>
TOTAL LIABILITIES	<u>275,000</u>	<u>265,000</u>
NET ASSETS AVAILABLE FOR BENEFITS	<u><u>\$8,515,000</u></u>	<u><u>\$6,600,000</u></u>

The accompanying notes are an integral part of the financial statements.

Allied Industries Benefit Plan
Statements of Changes in Net Assets Available for Benefits
Years Ended December 31, 19X2 and 19X1

	<u>19X2</u>	<u>19X1</u>
Contributions		
Participating employers	\$15,000,000	\$14,500,000
Participants	<u>3,000,000</u>	<u>2,800,000</u>
Total contributions	<u>18,000,000</u>	<u>17,300,000</u>
Investment income		
Net appreciation in fair value of investments	300,000	200,000
Interest	500,000	450,000
Dividends	<u>50,000</u>	<u>50,000</u>
	850,000	700,000
Less investment expenses	<u>15,000</u>	<u>25,000</u>
Net investment income	<u>835,000</u>	<u>675,000</u>
TOTAL ADDITIONS	<u>18,835,000</u>	<u>17,975,000</u>
Benefits paid to participants		
Health care	16,000,000	15,750,000
Disability and death	<u>770,000</u>	<u>750,000</u>
	16,770,000	16,500,000
Administrative expenses	<u>150,000</u>	<u>175,000</u>
TOTAL DEDUCTIONS	<u>16,920,000</u>	<u>16,675,000</u>
NET INCREASE DURING YEAR	1,915,000	1,300,000
Net assets available for benefits		
Beginning of year	<u>6,600,000</u>	<u>5,300,000</u>
End of year	<u>\$ 8,515,000</u>	<u>\$ 6,600,000</u>

The accompanying notes are an integral part of the financial statements.

**Allied Industries Benefit Plan
Statements of Plan's Benefit Obligations
December 31, 19X2 and 19X1**

	<i>19X2</i>	<i>19X1</i>
Amounts currently payable to or for participants, beneficiaries, and dependents		
Health claims payable	\$1,100,000	\$ 975,000
Death and disability benefits payable	100,000	75,000
	1,200,000	1,050,000
Other obligations for current benefit coverage, at present value of estimated amounts		
Claims incurred but not reported	350,000	290,000
Accumulated eligibility credits	200,000	225,000
Long-term disability benefits	800,000	485,000
	1,350,000	1,000,000
Total obligations other than postretirement benefit obligations	2,550,000	2,050,000
Postretirement benefit obligations		
Current retirees	3,900,000	3,500,000
Other participants fully eligible for benefits	2,100,000	2,000,000
Other participants not yet fully eligible for benefits	5,000,000	4,165,000
	11,000,000	9,665,000
PLAN'S TOTAL BENEFIT OBLIGATIONS	\$13,550,000	\$11,715,000

The accompanying notes are an integral part of the financial statements.

Allied Industries Benefit Plan
 Statements of Changes in Plan's Benefit Obligations
 Years Ended December 31, 19X2 and 19X1

	<i>19X2</i>	<i>19X1</i>
Amounts currently payable to or for participants, beneficiaries, and dependents		
Balance at beginning of year	\$ 1,050,000	\$ 850,000
Claims reported and approved for payment	16,920,000	16,700,000
Claims paid (including disability)	<u>(16,770,000)</u>	<u>(16,500,000)</u>
Balance at end of year	<u>1,200,000</u>	<u>1,050,000</u>
Other obligations for current benefit coverage, at estimated amounts		
Balance at beginning of year	1,000,000	925,000
Net change during year:		
Long-term disability benefits	315,000	50,000
Other	<u>35,000</u>	<u>25,000</u>
Balance at end of year	<u>1,350,000</u>	<u>1,000,000</u>
Total obligations for current benefit coverage	<u>2,550,000</u>	<u>2,050,000</u>
Postretirement benefit obligation		
Balance at beginning of year	9,665,000	8,665,000
Increase (decrease) during the year attributable to:		
Benefits earned and other changes	1,250,000	1,000,000
Plan amendment	(175,000)	—
Changes in actuarial assumptions	<u>260,000</u>	<u>—</u>
Balance at end of year	<u>11,000,000</u>	<u>9,665,000</u>
PLAN'S TOTAL BENEFIT OBLIGATIONS AT END OF YEAR	<u><u>\$13,550,000</u></u>	<u><u>\$11,715,000</u></u>

The accompanying notes are an integral part of the financial statements.

Allied Industries Benefit Plan
Notes to Financial Statements

NOTE 1: DESCRIPTION OF PLAN

The following description of the Allied Industries Benefit Plan (the Plan) provides only general information. Participants should refer to the Plan agreement for a complete description of the Plan's provisions.

General. The Plan provides health and other benefits covering all participants in the widgets industry in the Greater Metropolis area. The Plan and related trust were established on May 8, 1966, pursuant to a collective bargaining agreement between the Allied Employers' Trade Association and the Allied Union, Local 802. It is subject to the provisions of the Employee Retirement Income Security Act of 1974 (ERISA), as amended.

Benefits. The Plan provides health benefits (medical, hospital, surgical, major medical, and dental), permanent disability benefits, and death benefits to full-time participants (with at least 450 hours of work in the industry during a consecutive three-month period) and to their beneficiaries and covered dependents. Retired employees are entitled to similar health benefits (in excess of Medicare coverage) provided they have attained at least age sixty-two and have fifteen years of service with participating employers before retirement.

The Plan also provides health benefits to participants during periods of unemployment, provided they have accumulated in the current year or in prior years credit amounts (expressed in hours) in excess of the hours required for current coverage. Accumulated eligibility credits equal to one year's coverage may be carried forward.

Health, disability, and death claims of active and retired participants, dependents, and beneficiaries are processed by the Administrator Group, but the responsibility for payments to participants and providers is retained by the Plan.

In 19X2 the board of trustees amended the Plan to increase the deductible under major medical coverage from \$100 to \$300 and to extend dental coverage to employees retiring after December 31, 19X2. The amendment will not affect participating employers' contributions to the Plan in 19X3 under the current collective bargaining agreement.

Contributions. Participating employers contribute 5.5 percent of wages pursuant to the current collective bargaining agreement between employers and the union (expiring February 19, 19X5). Employees and retirees may contribute specified amounts, determined periodically by the Plan's actuary, to extend coverage to eligible dependents.

Other. The Plan's board of trustees, as Sponsor, has the right under the Plan to modify the benefits provided to active employees. The Plan may be terminated only by joint agreement between industry and union, subject to the provisions set forth in ERISA.

NOTE 2: SUMMARY OF ACCOUNTING POLICIES

A. Valuation of Investments. The Plan's investments are stated at fair value. Securities traded on the national securities exchange are valued at the last reported sales price on the last business day of the plan year. Investments traded in the over-the-counter market and listed securities for which no sale was reported on that date are valued at the average of the last reported bid and asked prices. For certain corporate bonds that do not have an established fair value, the Plan's board of trustees has established a fair value based on yields currently available on comparable securities of issuers with similar credit ratings.

B. Postretirement Benefits. The postretirement benefit obligation represents the actuarial present value of those estimated future benefits that are attributed to employee service rendered to December 31. Postretirement benefits include future benefits expected to be paid to or for (1) currently retired or terminated employees and their beneficiaries and dependents and (2) active employees and their beneficiaries and dependents after retirement from service with the participating employers. Prior to an active employee's full eligibility date, the postretirement benefit obligation is the portion of the expected postretirement benefit obligation that is attributed to that employee's service in the industry rendered to the valuation date.

The actuarial present value of the expected postretirement benefit obligation is determined by an actuary and is the amount that results from applying actuarial assumptions to historical claims-cost data to estimate future annual incurred claims costs per participant and to adjust such estimates for the time value of money (through discounts for interest) and the probability of payment (by means of decrements such as those for death, disability, withdrawal, or retirement) between the valuation date and the expected date of payment.

For measurement purposes, a 9.5 percent annual rate of increase in the per capita cost of covered health care benefits was assumed for 19X3; the rate was assumed to decrease gradually to 8.0 percent for 19X8 and to remain at that level thereafter. These assumptions are consistent with those used to measure the benefit obligation at December 31, 19X1.

The following were other significant assumptions used in the valuations as of December 31, 19X2 and 19X1.

Weighted-average discount rate	8.0% –19X2; 8.25% –19X1
Average retirement age	60
Mortality	1971 Group Annuity Mortality Table

The foregoing assumptions are based on the presumption that the Plan will continue. Were the Plan to terminate, different actuarial assumptions and other factors might be applicable in determining the actuarial present value of the postretirement benefit obligation.

C. Other Plan Benefits. Plan obligations at December 31 for health claims incurred by active participants but not reported at that date, for accumulated eligibility of participants, and for future disability payments to members considered permanently disabled at December 31 are estimated by the Plan’s actuary in accordance with accepted actuarial principles. Such estimated amounts are reported in the accompanying statement of the Plan’s benefit obligations at present value, based on an 8.0 percent discount rate. Health claims incurred by retired participants but not reported at year end are included in the postretirement benefit obligation.

NOTE 3: INVESTMENTS

The Plan’s investments are held by a bank-administered trust fund. During 19X2 and 19X1 the Plan’s investments (including investments bought, sold, and held during the year) appreciated in value by \$300,000 and \$200,000, respectively, as follows.

(continued on next page)

	19X2		19X1	
	<i>Net Increase (Decrease) in Value During Year</i>	<i>Fair Value at End of Year</i>	<i>Net Increase (Decrease) in Value During Year</i>	<i>Fair Value at End of Year</i>
Fair value as determined by quoted market price:				
U.S. government securities	\$200,000	\$5,000,000	\$(75,000)	\$4,000,000
Corporate bonds and debentures	(25,000)	1,750,000	50,000	1,375,000
Common stocks	<u>100,000</u>	<u>1,000,000</u>	<u>200,000</u>	<u>600,000</u>
	275,000	7,750,000	175,000	5,975,000
Fair value as estimated by Plan's board of trustees:				
Corporate bonds	<u>25,000</u>	<u>250,000</u>	<u>25,000</u>	<u>225,000</u>
	<u><u>\$300,000</u></u>	<u><u>\$8,000,000</u></u>	<u><u>\$200,000</u></u>	<u><u>\$6,200,000</u></u>

The fair value of individual investments that represent 5.0 percent or more of the Plan's net assets are as follows:

	19X2	19X1
Commonwealth Power Co., 9.0% bonds due 2014 (\$500,000 face amount)	\$475,000	\$450,000
ABC Company common stock (2,000 shares)	500,000	450,000
U.S. Treasury bond, 8.5% due 19X6 (\$360,000 face amount)		350,000

NOTE 4: BENEFIT OBLIGATIONS

The Plan's deficiency of net assets over benefit obligations at December 31, 19X2 and 19X1, relates primarily to the postretirement benefit obligation, the funding of which is not covered by the contribution rate provided by the current bargaining agreement. It is expected that the deficiency will be funded through future increases in the collectively bargained contribution rates.

The weighted-average health care cost-trend rate assumption (see note 2B) has a significant effect on the amounts reported in the accompanying financial statements. If the assumed rates increased by one percentage point in each year, it would increase the obligation as of December 31, 19X2 and 19X1, by \$2,600,000 and \$2,500,000, respectively.

NOTE 5: OTHER MATTERS

The trust established under the Plan to hold the Plan's assets is qualified pursuant to Section 501(c)9 of the Internal Revenue Code, and, accordingly, the trust's net investment income is exempt from income taxes. The Plan has obtained a favorable tax determination letter from the Internal Revenue Service, and the Plan sponsor believes that the Plan, as amended, continues to qualify and to operate as designed.

CLASSIC ENTERPRISES BENEFIT PLAN

Classic Enterprises Benefit Plan
 Statements of Benefit Obligations and Net Assets Available for Benefits
 December 31, 19X2 and 19X1

	<u>19X2</u>	<u>19X1</u>
<u>Benefit Obligations</u> (see note 4)		•
Amounts due insurance companies	\$ 1,200,000	\$ 1,000,000
Postretirement benefit obligations	<u>11,000,000</u>	<u>9,665,000</u>
Total benefit obligations	<u>12,200,000</u>	<u>10,665,000</u>
<u>Net Assets</u>		
Investments at fair value (see note 3)		
U.S. government securities	\$ 5,000,000	\$ 4,000,000
Corporate bonds and debentures	2,000,000	1,600,000
Common stock	<u>1,000,000</u>	<u>600,000</u>
Total investments	<u>8,000,000</u>	<u>6,200,000</u>
Receivables		
Sponsor's contributions	500,000	430,000
Participants' contributions	100,000	80,000
Accrued interest and dividends	<u>50,000</u>	<u>40,000</u>
Total receivables	<u>650,000</u>	<u>550,000</u>
Cash	75,000	60,000
Insurance premium deposits	<u>65,000</u>	<u>55,000</u>
TOTAL ASSETS	<u>8,790,000</u>	<u>6,865,000</u>
<u>Liabilities</u>		
Due to broker for securities purchased	250,000	240,000
Accounts payable for administrative expenses	<u>25,000</u>	<u>25,000</u>
TOTAL LIABILITIES	<u>275,000</u>	<u>265,000</u>

(continued on next page)

	<u>19X2</u>	<u>19X1</u>
NET ASSETS AVAILABLE FOR BENEFITS	<u>8,515,000</u>	<u>6,600,000</u>
EXCESS OF BENEFIT OBLIGATIONS OVER NET ASSETS AVAILABLE FOR BENEFITS	<u>\$3,685,000</u>	<u>\$4,065,000</u>

The accompanying notes are an integral part of the financial statements.

Classic Enterprises Benefit Plan
Statement of Changes in Benefit Obligations and
Net Assets Available for Benefits
Years Ended December 31, 19X2 and 19X1

	<i>19X2</i>	<i>19X1</i>
<u>Net Increase in Benefit Obligations</u>		
Increase (Decrease) during the year attributable to:		
Benefits earned and other changes	\$ 1,510,000	\$ 1,000,000
Additional amounts payable to insurance company	200,000	100,000
Plan amendment	<u>(175,000)</u>	<u>—</u>
	<u>1,535,000</u>	<u>1,100,000</u>
<u>Net Increase in Net Assets Available for Benefits</u>		
Contributions		
Sponsor	15,000,000	14,500,000
Participants	<u>3,000,000</u>	<u>2,800,000</u>
Total contributions	<u>18,000,000</u>	<u>17,300,000</u>
Investment income		
Net appreciation in fair value of investments	300,000	200,000
Interest	500,000	450,000
Dividends	<u>50,000</u>	<u>25,000</u>
	850,000	700,000
Less investment expenses	<u>15,000</u>	<u>25,000</u>
Net investment income	<u>835,000</u>	<u>675,000</u>
TOTAL ADDITIONS	<u>18,835,000</u>	<u>17,975,000</u>

(continued on next page)

	<u>19X2</u>	<u>19X1</u>
Insurance premiums paid for health benefits, net of experience-rating adjustments of \$250,000 for 19X1 received in 19X2 and \$275,000 for 19X0 received in 19X1	16,035,000	15,750,000
Insurance premiums paid for death benefits	<u>780,000</u>	<u>750,000</u>
	16,815,000	16,675,000
Administrative expenses	<u>105,000</u>	<u>175,000</u>
TOTAL DEDUCTIONS	<u>16,920,000</u>	<u>16,675,000</u>
NET INCREASE	<u>1,915,000</u>	<u>1,300,000</u>
<u>Increase (Decrease) in Net Assets Available for Benefits Over Benefit Obligations</u>	(380,000)	200,000
<u>Excess of Benefit Obligations Over Net Assets Available for Benefits</u>		
Beginning of year	<u>4,065,000</u>	<u>3,865,000</u>
End of year	<u><u>\$3,685,000</u></u>	<u><u>\$4,065,000</u></u>

The accompanying notes are an integral part of the financial statements.

Classic Enterprises Benefit Plan
Notes to Financial Statements

NOTE 1: DESCRIPTION OF PLAN

The following description of the Classic Enterprises Benefit Plan (the Plan) provides only general information. Participants should refer to the Plan agreement for a complete description of the Plan's provisions.

General. The Plan provides health and death benefits covering substantially all active and retired employees of Classic Enterprises (the Sponsor). It is subject to the provisions of the Employee Retirement Income Security Act of 1974 (ERISA), as amended.

Benefits. The Plan provides health benefits (medical, hospital, surgical, major medical, and dental) and death benefits to full-time employees of the Sponsor (with at least 1,000 hours of service each year) and to their beneficiaries and covered dependents. Retired employees are entitled to similar health and death benefits provided they have attained at least age fifty-five and have at least ten years of service with the Sponsor.

Current health claims of active and retired participants and their dependents and beneficiaries are provided under group insurance contracts with ABC Carrier, which are experience rated after the anniversary dates of the policies (generally March 31). Death benefits are covered by a group-term policy with DEF Carrier.

Contributions. The Sponsor's policy is to contribute the maximum amounts allowed as a tax deduction by the Internal Revenue Code. Under present law, the Sponsor is not permitted to deduct amounts for future benefits to current employees and retirees.

Employees and retirees may contribute specified amounts, determined periodically by the Plan's insurance companies, to extend coverage to eligible dependents.

In 19X2 the Plan was amended to increase the deductible under major medical coverage from \$100 to \$300 and to extend dental coverage to employees retiring after December 31, 19X2. The amendment is not expected to significantly affect the Sponsor's contribution to the Plan in 19X3.

Other. Although it has not expressed any intention to do so, the Sponsor has the right under the Plan to modify the benefits provided to active employees, to discontinue its contributions at any time, and to terminate the Plan subject to the provisions set forth in ERISA.

NOTE 2: SUMMARY OF ACCOUNTING POLICIES

A. Valuation of Investments. The Plan's investments are stated at fair value. Securities traded on the national securities exchange are valued at the last reported sales price on the last business day of the plan year. Investments traded in the over-the-counter market and listed securities for which no sale was reported on that date are valued at the average of the last reported bid and asked prices. For certain corporate bonds that do not have an established fair value, the Classic Enterprises Benefits Committee has established a fair value based on yields currently available on comparable securities of issuers with similar credit ratings.

B. Plan Benefits. The postretirement benefit obligation (see note 4) represents the actuarial present value of those estimated future benefits that are attributed to employee service rendered to December 31. Post-retirement benefits include future benefits expected to be paid to or for (1) currently retired employees and their beneficiaries and dependents and (2) active employees and their beneficiaries and dependents after retirement from service with the Sponsor. Prior to an active employee's full eligibility date, the postretirement benefit obligation is the portion of the expected postretirement benefit obligation that is attributed to that employee's service rendered to the valuation date.

The actuarial present value of the expected postretirement benefit obligation is determined by an actuary and is the amount that results from applying actuarial assumptions to historical claims-cost data to estimate future annual incurred claims costs per participant and to adjust such estimates for the time value of money (through discounts for interest) and the probability of payment (by means of decrements such as those for death, disability, withdrawal, or retirement) between the valuation date and the expected date of payment, and to reflect the portion of those costs expected to be borne by Medicare, the retired participants, and other providers.

For measurement purposes at December 31, 19X2, a 9.5 percent annual rate of increase in the per capita cost of covered health care benefits was assumed for 19X3; the rate was assumed to decrease gradually to 8.0 percent for 19X8 and to remain at that level thereafter. These assumptions are consistent with those used to measure the benefit obligation at December 31, 19X1.

The following were other significant assumptions used in the valuations as of December 31, 19X2 and 19X1.

(continued on next page)

Weighted-average discount rate	8.0%
Average retirement age	60
Mortality	1971 Group Annuity Mortality Table

The foregoing assumptions are based on the presumption that the Plan will continue. Were the Plan to terminate, different actuarial assumptions and other factors might be applicable in determining the actuarial present value of the postretirement benefit obligation.

NOTE 3: INVESTMENTS

The Plan's investments are held by a bank-administered trust fund. During 19X2 and 19X1, the plan's investments (including investments bought, sold, and held during the year) appreciated in value by \$300,000 and \$200,000, respectively, as follows:

	<u>19X2</u>		<u>19X1</u>	
	<i>Net Increase (Decrease) in Value During Year</i>	<i>Fair Value at End of Year</i>	<i>Net Increase (Decrease) in Value During Year</i>	<i>Fair Value at End of Year</i>
Fair value as determined by quoted market price:				
U.S. government securities	\$200,000	\$5,000,000	\$(75,000)	\$4,000,000
Corporate bonds and debentures	(25,000)	1,750,000	50,000	1,375,000
Common stocks	<u>100,000</u>	<u>1,000,000</u>	<u>200,000</u>	<u>600,000</u>
	275,000	7,750,000	175,000	5,975,000
Fair value as estimated by Classic Enterprise Benefits Plan Investment Committee:				
Corporate bonds	<u>25,000</u>	<u>250,000</u>	<u>25,000</u>	<u>225,000</u>
	<u>\$300,000</u>	<u>\$8,000,000</u>	<u>\$200,000</u>	<u>\$6,200,000</u>

The fair value of individual investments that represent 5.0 percent or more of the Plan's net assets are as follows:

	<u>19X2</u>	<u>19X1</u>
Commonwealth Power Co., 9.0% bonds due 2014 (\$500,000 face amount)	\$475,000	\$450,000
ABC Company common stock (2,000 shares)	500,000	450,000
U.S. Treasury bond, 8.5% due 19X6 (\$360,000 face amount)		350,000

NOTE 4: BENEFIT OBLIGATIONS

Health costs incurred by participants and their beneficiaries and dependents are covered by insurance contracts maintained by the Plan. It is the present intention of the Sponsor and the Plan to continue obtaining insurance coverage for benefits. As stated in note 1, the Sponsor is not permitted under present tax law to deduct amounts for future benefits (beyond one year). Insurance premiums for future years in respect of the Plan's postretirement benefit obligation will be funded by Sponsor contributions to the Plan in those later years.

The postretirement benefit obligation at December 31, 19X2 and 19X1, principally health benefits, related to the following categories of participants (including their beneficiaries and dependents):

	<u>19X2</u>	<u>19X1</u>
Current retirees	\$ 3,900,000	\$3,500,000
Other participants fully eligible for benefits	2,100,000	2,000,000
Participants not yet fully eligible for benefits	<u>5,000,000</u>	<u>4,165,000</u>
	<u>\$11,000,000</u>	<u>\$9,665,000</u>

The health care cost-trend rate assumption (see note 2B) has a significant effect on the amounts reported. If the assumed rates increased by one percentage point in each year, that would increase the obligation as of December 31, 19X2 and 19X1, by \$2,600,000 and \$2,500,000, respectively.

NOTE 5: OTHER MATTERS

The trust established under the Plan to hold the Plan's net assets is qualified pursuant to Section 501(c)9 of the Internal Revenue Code, and, accordingly, the trust's net investment income is exempt from income taxes. The Sponsor has obtained a favorable tax determination letter from the Internal Revenue Service and the Sponsor believes that the Plan, as amended, continues to qualify and to operate as designed.

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(1990–1991)

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