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American Institute of Certified Public Accountants. Employee Benefit Plans Committee

EXPOSURE DRAFT

PROPOSED STATEMENT OF POSITION

ACCOUNTING AND REPORTING BY HEALTH AND WELFARE BENEFIT PLANS

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

SEPTEMBER 5, 1991

Prepared by the Employee Benefit Plans Committee
Federal Government Division
American Institute of Certified Public Accountants

Comments should be received by November 5, 1991, and addressed to
Susan W. Hicks, Technical Manager, Federal Government Division, File Q-1-502
AICPA, 1455 Pennsylvania Avenue, N.W., Washington, D.C. 20004-1007

SUMMARY

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

This proposed 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 proposed 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 multiemployer, should account for and separately report benefit obligations, including postretirement benefit obligations (see paragraphs 36 through 49).
- 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).

The recommendations in this proposed SOP are effective for audits of financial statements for plan years beginning after December 15, 1992; the application of this proposed SOP to plans with no more than 500 participants in the aggregate shall be effective for plan years beginning after December 15, 1994. Earlier application is encouraged. Accounting changes adopted to conform to the provisions of this proposed SOP shall be made retroactively. Financial statements of prior plan years are required to be restated to comply with the provisions of this proposed SOP *only* if 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 proposed SOP, that fact shall be disclosed when financial statements for the year in which this proposed SOP is first applied are presented either alone or with financial statements of prior years.

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September 5, 1991

Accompanying this letter is an exposure draft of a proposed AICPA statement of position (SOP), *Accounting and Reporting by Health and Welfare Benefit Plans*. A summary of the proposed SOP also accompanies this letter.

The proposed SOP discusses those aspects of accounting that are unique to health and welfare benefit plans and was developed to assist accounting practitioners and auditors in the preparation of financial statements of health and welfare benefit plans. The exposure draft conforms to new accounting and financial reporting requirements issued by the Financial Accounting Standards Board (FASB).

The purpose of the exposure draft is to solicit comments from preparers, auditors, and users of financial statements of health and welfare benefit plans and from other interested parties. The proposed SOP would amend chapter 4 of the AICPA Audit and Accounting Guide *Audits of Employee Benefit Plans*.

Comments or suggestions on any aspect of this exposure draft will be appreciated. The Committee's consideration of responses will be helped if the comments refer to specific paragraph numbers and include reasons for any suggestions or comments. Commenters are requested to give particular attention to the disclosure of actuarial gains and losses. Commenters are requested to comment on whether these amounts should be included with the effects of additional benefits accumulated or be separately disclosed (see paragraph 51).

Responses should be addressed to Susan W. Hicks, Technical Manager, Federal Government Division, File Q-1-502, AICPA, 1455 Pennsylvania Avenue, N.W., Washington, DC 20004-1007, in time to be received by November 5, 1991.

Written comments on the exposure draft will become part of the public record of the AICPA and will be available for public inspection at the AICPA's offices for one year.

Sincerely,

Andrew J. Capelli
Chairman
Employee Benefit Plans Committee

Gerard L. Yarnall
Director
Audit and Accounting Guides

Employee Benefit Plans Committee
1990–1991

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The Employee Benefit Plans Committee gratefully acknowledges the contributions of Dale L. Gerboth, Melissa A.R. Krause, and Harvey J. Nuland, former committee members; Daniel J. Cronin; the Office of Chief Accountant, Pension and Welfare Benefits Administration; and the Office of the Inspector General, U.S. Department of Labor.

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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 (separate 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, housing subsidies, or legal services.

This 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 reimbursement to the covered plan participant or direct payment to providers or third-party insurers for the cost of specified services. Such plans also may 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 the substance of the plan 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 how contributions to participants' accounts are to be determined, 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.

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, benefits are paid solely and directly out of the general assets of the employer), are fully insured (by premiums paid directly 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) are not required to include financial statements in their ERISA filings.[1] An understanding of the health and welfare benefit plan is needed to determine the accounting and reporting requirements of the plan.

5. This SOP describes generally accepted accounting principles 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.

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

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 objective of financial reporting by a defined-benefit pension plan (see paragraph 19).
- Defined-benefit health and welfare plans, both single employer and multiemployer, should account for and separately report benefit obligations, including postretirement benefit obligations (see paragraphs 36 through 49).
- The requirement to recognize claims incurred but not reported has been clarified. For a self-funded plan, the cost of claims incurred but not reported 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 requirement that the current insurance premium rates used in determining the obligation for accumulated eligibility credits generally should consider mortality rates and the probability of employee turnover has been clarified (see paragraph 43).

7. FASB Statement No. 35, *Accounting and Reporting by Defined Benefit Pension Plans*, does not apply to health and welfare benefit plans; however, as 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 that Statement does not apply to health and welfare benefit plans, this SOP adopts certain of the measurement concepts of FASB Statement No. 106 (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 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.

12. A self-funded plan may process benefit payments directly or 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 for benefit payments or claims have been transferred to the insurance company.

14. In a fully insured, pooled arrangement, specified benefits are paid by the insurance company. The insurance company pools the experience of the plan with other similar businesses and assumes the financial risk of adverse experience. In such an arrangement, the plan generally has no obligation for covered benefits other than 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 company. 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 carried over to future periods until recovered by the insurance company (see paragraphs 41 and 42). The plan generally has no obligation to continue coverage or to reimburse the carrier for any accumulated loss.

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

[2] Refer to chapter 7 of the guide.

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 pre-set 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. Details of such stop-loss arrangements must be reviewed carefully 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 and charges the plan for those payments as well as a fee for 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 financial statements of defined-benefit health and welfare plans 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 how 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. Unless the financial statements of a defined-benefit health and welfare plan are not intended to be prepared in accordance with generally accepted accounting principles, they 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 (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).

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[3] It should be recognized that (a) information in addition to that contained in the 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.

Information regarding the benefit obligations may be presented either on the face of one or more financial statements or in the notes thereto. The information should be presented in such reasonable detail as is necessary to identify the nature of the obligations.[4]

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 employee benefit plans to include a statement of cash flows in their financial statements 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 defined-contribution health and welfare plans 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 how 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.[5]

23. Unless the financial statements of a defined-contribution health and welfare plan are not intended to be prepared in accordance with generally accepted accounting principles, they 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).
- A statement of changes in net assets available for benefits of the plan for the year then ended (see paragraphs 34 and 35).

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

24. ERISA established annual reporting requirements for employee benefit plans, including health and welfare benefit plans.[6] 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 in default or uncollectible, and reportable transactions.

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

[5] See footnote 3.

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

STATEMENT OF NET ASSETS AVAILABLE FOR BENEFITS

Investments

25. Plan investments, whether 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.[7] 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 expected cash flows, discounted at a rate commensurate with the risk involved, may be used to estimate fair value.[8]

26. Whether or not the plan is subject to ERISA, contracts with insurance companies that are included as plan assets *should be included* in the manner dictated by ERISA annual reporting requirements and should be reported in a manner consistent with the requirements of Department of Labor Form 5500 or 5500-C.[9]

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 otherwise determined (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 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

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[7] 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.

[8] For an indication of the factors to be considered in determining the discount rate, see paragraphs 13 and 14 of Accounting Principles Board (APB) Opinion No. 21, *Interest on Receivables and Payables*. 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).

[9] 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. Further discussion of *unallocated* insurance contracts is provided in chapter 7 of the guide (pending resolution of the FASB project on accounting for insurance contracts).

employer's recognition as of the financial statement date of a contribution payable to the plan.[10] Contributions receivable should be reported net of 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 whether it merely represents a deposit will depend on the circumstances of each insurance 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 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.

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 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 deposits by the plan to 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.

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[10] The 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.

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. 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 depreciation[11] 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.
- Payment of premiums to insurance companies to purchase contracts that are excluded from plan assets.[12]
- Operating and administrative expenses.
- A change during the period in net assets available for benefits.
- Other changes, such as transfers of assets to or from other plans, should be presented 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 obligations for health and welfare benefit plans should include the actuarial present value of the following, as applicable:

- 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 participants

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[11] 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.

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

- 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

Payments expected to be made for future health or other benefits (for example, death benefits) for active participants during the term of their employment should not be included. Benefit obligations should be reported as of the end of the plan year.[13] 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, presented with other information on another financial statement, or in a note to the financial statements. 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 plan will be paid by the insurance company. Consequently, they should be excluded from the benefit obligations of the plan. The financial statements or notes of a self-funded plan should present the amount of claims payable and currently due for active and retired participants, dependents, and beneficiaries and claims incurred but not reported for active participants. Claims incurred but not reported for retired participants are included in the postretirement benefit obligation.

39. For a self-funded plan, the cost of claims incurred but not reported should be measured at the present value 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.

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[13] Postretirement 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.

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 refunds[14] and (b) the 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. The obligation is generally determined by applying current insurance premium rates, which generally should consider mortality rates and the probability of employee turnover, to accumulated eligibility credits or, for a self-funded plan, by applying the average cost of benefits per eligible participant to accumulated eligibility credits.

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 (not yet fully eligible) should be measured over the participants' credited period of service up to the date when full eligibility for benefits is attained.[15]

46. If a multiemployer health and welfare benefit plan provides postretirement benefits, the benefit obligations must include the postretirement benefit obligation. The fact that the

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[14] This determination should consider (a) the extent to which the insurance contract requires payment of such deficits and (b) whether the plan intends to transfer coverage to another insurance company.

[15] 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.

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. Death or disability (when the employee is considered to be retired) benefits provided outside of a pension plan should also be considered in the calculation of the postretirement benefit obligation. Benefits that are provided through an insurance contract should be excluded.[16]

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.
- 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).
- Probability of payment (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
- Obligations related to active or terminated participants, other than retirees, who have attained full eligibility for 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 may be presented either within the body of the financial statements or in the notes; they may be presented in either a

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[16] 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.

reconciliation or a narrative format. Providing such information in the following three categories will generally be sufficient: (a) claims payable and premiums due to insurance companies, (b) claims incurred but not reported 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,[17] 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 purchasing annuities with amounts allocated from existing investments with the insurance company) should be included in benefits paid.[18] 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—[19]

- A description of the methods and significant assumptions used to determine the fair value of investments and the reported value of insurance contracts.
- 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 also should disclose other information. 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.

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[17] 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 disclosed, those effects should be included in benefits accumulated.

[18] 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.

[19] See APB Opinion 22, *Disclosure of Accounting Policies*.

- 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.[20] For a contributory plan, the disclosure should state the method of determining participants' contributions.
- The federal income tax status of the plan, if a favorable letter of determination has not been obtained and/or maintained. Additionally, ERISA requires information about whether or not a tax ruling or determination letter has been obtained.
- 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).
- 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, or a significant change in the market value of a significant portion of the plan's assets, 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.
- For health and welfare benefit plans that have financial instruments with off-balance-sheet credit risk: (a) the face or contract amount, or the notional principal amount if there is no face or contract amount; (b) the nature and terms including, at a minimum, a discussion of the credit and market risk of those instruments, the cash

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

requirements of those instruments, and the related accounting policy pursuant to the requirements of APB Opinion 22; (c) the amount of the accounting loss the plan would incur if any party to the financial instrument 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 plan; and (d) the plan's policy of requiring collateral or other security to support financial instruments subject to credit risk, information about the plan's access to that collateral or other security, and a brief description of the collateral or other security supporting those financial instruments.

- For health and welfare benefit plans that have concentrations of credit risk arising from financial instruments: (a) information about the (shared) activity, region, or economic characteristic that identifies the concentration; (b) the amount of accounting loss due to credit risk the plan would incur if parties to the financial instruments that make up the concentration 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 plan; and (c) the plan's policy of requiring collateral or other security to support financial instruments subject to credit risk, information about the plan's access to that collateral or other security, and a brief description of the collateral or other security supporting those financial instruments.
- Termination provisions of the plan and priorities for distribution of assets, if applicable.

This list does not include information required by ERISA to 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 Department of Labor.

EFFECTIVE DATE AND TRANSITION

The recommendations in this SOP are effective for audits of financial statements for plan years beginning after December 15, 1992; the application of this SOP to plans with no more than 500 participants in the aggregate shall be effective for plan years beginning after December 15, 1994. 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 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 only 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—

- *Illustration 1*: Bizco Corporation Benefit Plan, a single-employer plan that obtains insurance for current benefits.
- *Illustration 2*: Allied Industries Benefit Plan, a multiemployer plan that pays all benefits directly from plan assets.

A.2 It is assumed that both plans provide health benefits and life insurance coverage to both active and retired participants. Illustration 2 also assumes that the plan provides long-term disability benefits and limited coverage during periods of unemployment based on accumulated eligibility credits.

A.3 Illustration 1 displays the benefit obligation information in the notes to the financial statements. Illustration 2 displays that information in separate financial statements.

A.4 The examples do not illustrate other provisions of this SOP that might apply in circumstances other than those assumed in these examples. The format presented and the wording of accompanying notes are illustrative only and are not necessarily the only possible presentations. For purposes of illustration, only single-year financial statements are shown. However, the alternative method of reporting under ERISA requires comparative statements of net assets available for benefits.

Illustration 1

Bizco Corporation Benefit Plan
Statement of Net Assets Available for Benefits

	December 31, 1992
ASSETS	
Investments at fair value (see note 3)	
U.S. government securities	$5,000,000
Corporate bonds and debentures	2,000,000
Common stock	1,000,000
Total investments	8,000,000
Receivables	
Sponsor's contributions	500,000
Participant's contributions	100,000
Accrued interest and dividends	50,000
Total receivables	650,000
Cash	75,000
Insurance premium deposits	65,000
TOTAL ASSETS	8,790,000
LIABILITIES	
Due to broker for securities purchased	250,000
Accounts payable for administrative expenses	25,000
TOTAL LIABILITIES	275,000
NET ASSETS AVAILABLE FOR BENEFITS (see note 4)	$8,515,000

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

Bizco Corporation Benefit Plan
Statement of Changes in Net Assets Available for Benefits

	Year Ended December 31, 1992
Contributions	
Sponsor	$15,000,000
Employees	3,000,000
Total contributions	18,000,000
Investment income	
Net appreciation in fair value of investments	300,000
Interest	500,000
Dividends	50,000
	850,000
Less investment expenses	15,000
Net investment income	835,000
TOTAL ADDITIONS	18,835,000
Insurance premiums paid for health benefits, net of $250,000 experience-rating adjustment for 1991 received in 1992	16,035,000
Insurance premiums paid for death benefits	780,000
	16,815,000
Administrative expenses	105,000
TOTAL DEDUCTIONS	16,920,000
NET INCREASE DURING YEAR	1,915,000
Net assets available for benefits	
Beginning of year	6,600,000
End of year	$ 8,515,000

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

Bizco Corporation Benefit Plan
Notes to Financial Statements

NOTE 1. DESCRIPTION OF PLAN

The following description of the Bizco Corporation 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 the Bizco Corporation (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 55 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 1992 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, 1992. The amendment is not expected to significantly affect the Sponsor's contribution to the Plan in 1993.

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 Bizco Corporation 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. Postretirement 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 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, a 9.5 percent annual rate of increase in the per capita cost of covered health care benefits was assumed for 1993; the rate was assumed to decrease gradually to 8.0 percent for 1998 and to remain at that level thereafter.

The following were other significant assumptions used in the valuations as of December 31, 1992.

Weighted-average discount rate	8.0%
Average retirement age	65
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 1992 the plan's investments (including investments bought, sold, and held during the year) appreciated/depreciated in value by $300,000 as follows:

	Net Change in Value During Year	Fair Value at End of Year
Fair value as determined by quoted market price:		
U.S. government securities	$200,000	$5,000,000
Corporate bonds and debentures	(25,000)	1,750,000
Common stocks	100,000	1,000,000
	275,000	7,750,000
Fair value as estimated by Bizco Corporation Benefits Plan Investment Committee:		
Corporate bonds	25,000	250,000
	$300,000	$8,000,000

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

Commonwealth Power Co., 9.0% bonds due 2014 ($500,000 face amount)	$475,000
ABC Company Common Stock (2,000 shares)	500,000

NOTE 4. BENEFIT OBLIGATIONS

Health costs incurred through December 31, 1992, 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. The net assets of the Plan shown in the accompanying financial statements are available to pay the balance of the insurance premiums due for 1992 and, in part, the insurance premiums for future years. The specific benefit obligations as of December 31, 1992, that are expected to be paid (in part) from the net assets of the Plan as of that date are as follows.

Amounts due insurance companies, including $300,000 estimated additional premiums for major medical coverage, based on estimated experience rating adjustments	$ 1,200,000
Postretirement benefit obligation	11,000,000
	$12,200,000

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 was $9,665,000 as of December 31, 1991. The 1992 Plan amendment referred to in note 1 had the net effect of decreasing the postretirement benefit obligation by $175,000. There were no other factors significantly affecting the comparability of the information regarding the postretirement benefit obligation during the year.

The postretirement benefit obligation at December 31, 1992, principally health benefits, related to the following categories of participants (including their beneficiaries and dependents).

Current retirees	$ 3,900,000
Other participants fully eligible for benefits	2,100,000
Participants not yet fully eligible for benefits	5,000,000
	$11,000,000

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, 1992, by $2,600,000.

NOTE 5. OTHER MATTERS

The trust established under the Plan to hold the Plan's net assets is qualified pursuant to Section 501(c)3 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.

Illustration 2

Allied Industries Benefit Plan
Statement of Net Assets Available for Benefits

	December 31, 1992
ASSETS	
Investments, at fair value (see note 3)	
U.S. government securities	$5,000,000
Corporate bonds and debentures	2,000,000
Common stock	1,000,000
Total investments	8,000,000
Receivables	
Participating employers' contributions	500,000
Participants' contributions	100,000
Accrued interest and dividends	50,000
Total receivables	650,000
Cash	140,000
TOTAL ASSETS	8,790,000
LIABILITIES	
Due to broker for securities purchased	250,000
Accounts payable for administrative expenses	25,000
TOTAL LIABILITIES	275,000
NET ASSETS AVAILABLE FOR BENEFITS	$8,515,000

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

Allied Industries Benefit Plan
Statement of Changes in Net Assets Available for Benefits

	Year Ended December 31, 1992
Contributions	
Participating employers	$15,000,000
Employees	3,000,000
Total contributions	$18,000,000
Investment income	
Net appreciation in fair value of investments	300,000
Interest	500,000
Dividends	50,000
	850,000
Less investment expenses	15,000
Net investment income	835,000
TOTAL ADDITIONS	18,835,000
Benefits paid to participants	
Health care	16,000,000
Disability and death	770,000
	16,770,000
Administrative expenses	150,000
TOTAL DEDUCTIONS	16,920,000
NET INCREASE DURING YEAR	1,915,000
Net assets available for benefits	
Beginning of year	6,600,000
End of year	$ 8,515,000

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

Allied Industries Benefit Plan
Statement of Plan's Benefit Obligations

	December 31, 1992
Amounts currently owed to or for participants, beneficiaries, and dependents	
Health claims payable	$ 1,100,000
Death and disability benefits payable	100,000
	1,200,000
Other obligations for current benefit coverage, at present value of estimated amounts	
Claims incurred but not reported	350,000
Accumulated eligibility credits	200,000
Long-term disability benefits	800,000
	1,350,000
Postretirement benefit obligation	
Current retirees	3,900,000
Other participants fully eligible for benefits	2,100,000
Other participants not yet fully eligible for benefits	5,000,000
	11,000,000
PLAN'S TOTAL BENEFIT OBLIGATIONS	$13,550,000

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

Allied Industries Benefit Plan
Statement of Changes in Plan's Benefit Obligations

	Year Ended December 31, 1992
Amounts currently owed to or for participants, beneficiaries, and dependents	
Balance at beginning of year	$ 1,050,000
Claims approved for payment	16,920,000
Claims paid (including disability)	(16,770,000)
Balance at end of year	1,200,000
Other obligations for current benefit coverage, at estimated amounts	
Balance at beginning of year	1,000,000
Net change during year:	
Long-term disability benefits	315,000
Other	35,000
Balance at end of year	1,350,000
Postretirement benefit obligation	
Balance at beginning of year	9,665,000
Increase (decrease) during the year attributable to:	
Plan amendment	(175,000)
Changes in actuarial assumptions	260,000
Other, principally benefits earned	1,250,000
Balance at end of year	11,000,000
PLAN'S TOTAL BENEFIT OBLIGATIONS AT END OF YEAR	$13,550,000

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 62 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 1992 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, 1992. The amendment will not affect participating employers' contributions to the Plan in 1993 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, 1995). 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 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 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 1993; the rate was assumed to decrease gradually to 8.0 percent for 1998 and to remain at that level thereafter.

The following were other significant assumptions used in the valuations as of December 31, 1992.

Weighted-average discount rate	8.0%
Average retirement age	65
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, 1992, 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, 1992, 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 December 31, 1992, are included in the postretirement benefit obligation.

NOTE 3. INVESTMENTS

The Plan's investments are held by a bank-administered trust fund. During 1992 the Plan's investments (including investments bought, sold, and held during the year) appreciated/depreciated in value by $300,000 as follows.

	Net Change in Value During Year	Fair Value at End of Year
Fair value as determined by quoted market price:		
U.S. government securities	$200,000	$5,000,000
Corporate bonds and debentures	(25,000)	1,750,000
Common stocks	100,000	1,000,000
	275,000	7,750,000
Fair value as estimated by Plan's board of trustees:		
Corporate bonds	25,000	250,000
	$300,000	$8,000,000

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

Commonwealth Power Co., 9.0% bonds due 2014 ($500,000 face amount)	$475,000
ABC Company Common Stock (2,000 shares)	500,000

NOTE 4. BENEFIT OBLIGATIONS

The Plan's benefit obligations at December 31, 1992, ($13,550,000) exceeded net assets available for benefits ($8,515,000) by $5,035,000. The deficiency relates primarily to the postretirement benefit obligation, the funding for 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 Plan's net assets are greater than the amounts currently owed to or for participants, beneficiaries, and dependents.

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, 1992, by $2,600,000.

NOTE 5. OTHER MATTERS

The trust established under the Plan to hold the Plan's assets is qualified pursuant to Section 501(c)3 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.