ERIC The ERISA Industry Committee
Driven By and For Large Employers
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Submitted via regulations.gov

CC:PA:LPD:PR (REG-112324-15)
Room 5203
Internal Revenue Service
P.O. Box 7604
Ben Franklin Station
Washington, DC 20044

RE: Mortality Tables for Determining Present Value Under Defined Benefit Pension Plans (RIN 1545-BM71)

Ladies and Gentlemen:

The ERISA Industry Committee (ERIC) is pleased to respond to the request by the Internal Revenue Service ("IRS") for comments regarding the provisions contained in the proposed rule, Mortality Tables for Determining Present Value Under Defined Benefit Pension Plans (the "proposed regulation")[1] and to request the opportunity to testify at the April 13, 2017, hearing on this subject. Our testimony will address the points made in this comment letter and a separate letter that we jointly filed with the American Benefits Council.

ERIC's Interest in the Mortality Tables

ERIC is the only national association that advocates exclusively for large employers on health, retirement, and compensation public policies at the federal, state, and local levels. ERIC's members provide comprehensive retirement benefits to tens of millions of active and retired workers and their families. ERIC has a strong interest in proposals, such as the proposed rule, that would affect its members' ability to provide predictable and secure pension benefits in an efficient and tax-compliant manner.

Predictability and stability are cornerstones of the voluntary pension system for both plan sponsors and participants. This is particularly true when it comes to defined benefit plans, many of which are either closed to new participants or frozen for all participants.

[1] Internal Revenue Service, *Mortality Tables for Determining Present Value Under Defined Benefit Pension Plans*, 81 Fed. Reg. 95911 (Dec. 29, 2016).

Regulatory guidance that makes it difficult to budget for required contributions can drive plan sponsors further away from offering important and meaningful retirement benefits.

General Comments

We support the continued use of static annuitant and nonannuitant mortality tables for all plans and combined static tables for small plans. The proposed method of developing these static tables reasonably balances accuracy with simplicity. While not specifically addressed in the proposed regulations, we also support continuation of the current method for developing the 417(e)(3) applicable mortality table as a 50/50 unisex blend of the combined static tables. However, we are concerned that revisions to mortality improvement rates could make it difficult for plan sponsors to budget for future cash flows and for participants to plan for retirement. Therefore, we urge the IRS to commit to publishing updated mortality improvement scales, static mortality tables, and the 417(e)(3) applicable mortality table at least a year before the start of the first plan year these assumptions will be used to determine minimum funding requirements and optional payment forms.

We have greater concerns with the proposed rules for using plan-specific substitute mortality tables (§ 1.430(h)(3)-2), which do not give adequate weight to plan experience, fail to consider the significant and well-documented differences in mortality experience between blue-collar workers and white-collar workers, and allow insufficient transition time and impose unnecessarily burdensome data collection requirements for newly acquired plans.

Specific Recommendations

§ 1.430(h)(3)-1 Mortality tables used to determine present value

Recommendation: § 1.430(h)(3)-1(a)(2)(C) should be modified by adding the text in italics and underlined below:

> (C) Mortality improvement rates. The mortality improvement rates for valuation dates occurring during 2018 are the mortality improvement rates contained in the Mortality Improvement Scale MP-2016 Report (issued by the Retirement Plans Experience Committee (RPEC) of the Society of Actuaries and available at www.soa.org/Research/Experience-Study/Pension/research-2016-mp.aspx). For later years, updated mortality improvement rates that take into account new data for mortality improvement trends of the general population are to be provided in guidance published in the Internal Revenue Bulletin *no later than December 31 of the second year preceding the calendar year containing the valuation date (for example, mortality improvement rates for valuation dates occurring during 2019 will be published in the Internal Revenue Bulletin no later than December 31, 2017)*. See §601.601(d)(2)(ii)(b) of this chapter.

Discussion: In general, we support the base mortality tables, generational mortality tables, mortality improvement scale for 2018, static mortality tables, and small plan tables detailed in § 1.430(h)(3)-1 of the proposed regulation. We applaud the IRS for continuing to permit all plans to use static annuitant and nonannuitants mortality tables, and for allowing small plans to use simpler combined static tables. This avoids costly system enhancements that might otherwise be required if IRS were to require plans to use fully generational mortality tables – particularly with respect to benefit administration that depends on the use of 417(e) assumptions. While the methodology used to create the static tables seems

counterintuitive, in combination with the interest rates we would expect to use over the next several years, it closely replicates lifetime annuity factors at ages 50 and over where pension plan liabilities are heavily concentrated. The proposed methodology reasonably balances the difficult-to-reconcile objectives of accuracy (relative to the generational projection of mortality improvement) and simplicity.

Our concern with this portion of the proposed regulation is around the timeliness of updates to mortality improvement rates as provided in § 1.430(h)(3)-1(a)(2)(C). This section indicates mortality improvement rates for plan years after 2018 will be provided in guidance published in the Internal Revenue Bulletin. Plan sponsors need to know the assumptions that will be prescribed for the coming year to develop their cash flow budgets — a process that begins several months before the start of the year. Likewise, participants planning to retire in the next year need accurate projections of their plan benefits. In the past, IRS has met sponsors' and participants' needs by publishing static tables and 417(e)(3) applicable mortality tables for multiple years. For example, Notice 2008-85 provided § 430 static tables and § 417(e)(3) applicable mortality tables for 2009-2013 plan years, and Notice 2013-49 provided tables for 2014 and 2015 plan years. But more recently, this guidance has been published quite late in the year—2016 tables weren't published until July 31, 2015 (Notice 2015-53), and 2017 tables weren't published until September 2, 2016 (Notice 2016-50). This has created problems for plan sponsors, both in budgeting contributions for the coming year and preparing qualified joint and survivor explanations and benefit estimates for participants planning to retire in the coming year.

To avoid budget or benefit surprises, the IRS should commit to publishing updated mortality improvement scales, static mortality tables, and the 417(e)(3) applicable mortality table at least a year before the start of the first plan year these assumptions will be used to determine minimum funding requirements and benefits. This should align with the Society of Actuaries' Retirement Plans Experience Committee (RPEC) anticipated release schedule for new projection scales. If these scales are released in late October each year, the IRS would have the necessary time to decide whether the new scale should be applied for plan years that start just over a year later. If an updated improvement scale is not published by this deadline, the prior year's scale should remain in effect.

Recommendation: Continue to develop the 417(e)(3) applicable mortality table using the method outlined in Rev. Rul. 2007-67.

Discussion: The proposed regulation does not include the 417(e)(3) applicable mortality table for 2018. Instead, it indicates it will be a modified version of the generally applicable mortality tables under section 430, and will be specified in guidance published in the Internal Revenue Bulletin after the regulations are finalized. We encourage IRS to continue to use the current methodology for developing the 417(e)(3) applicable mortality table. As detailed in Rev. Rul. 2007-67, the 417(e)(3) applicable table is currently determined as a fixed blend of 50% of the static male combined mortality rates and 50% of the static female combined mortality rates promulgated under § 1.430(h)(3)-1(c)(3) for the corresponding plan year. And as noted in the preceding recommendation, the 417(e)(3) applicable mortality table should be published at least a year before the start of the first plan year the table will be used to determine plan benefits.

§ 1.430(h)(3)-2 Plan-specific substitute mortality tables used to determine present value
Recommendation: Allow plans to aggregate male and female mortality experience when assessing credibility and calculating mortality ratios.

Discussion: When determining whether the plan's mortality experience is fully or partially credible, the plan's partial credibility weighting factor, and the plan's mortality ratio, the proposed regulations allow plans to aggregate the experience of participants of all ages within a gender, and of blue-collar and white-collar participants of the same gender. In doing so, the proposed regulations make an implicit assumption that a plan's underlying experience relative to a standard table can be reasonably represented by a uniform adjustment to that standard table across all ages. We agree that this is a reasonable approach from the perspective of developing overall plan liabilities. However, it can be observed for many plans that mortality relative to the standard table is not, in fact, uniform with respect to different age groups or different population subgroups.

Similarly, although male and female participants in a single plan do not necessarily demonstrate the same relative mortality, for most populations the relative mortality of males and females is directionally similar. Given that for most plans male and female participants are subject to many of the same economic, environmental, and behavioral factors that influence mortality, we believe it is appropriate to allow the option to aggregate male and female mortality in deriving a plan-wide adjustment factor.

The theory behind separating male and female experience is that the factors that influence male and female mortality can vary in some circumstances. This is less likely, however, to be the case when the experience is drawn from the same pension plan. As an added safeguard, the IRS could require that in order to aggregate male and female experience a plan sponsor must first demonstrate that the experience of both groups is directionally similar. For example, consider a plan covering a blue collar population. Based on the blue collar variations of the RP-2014 tables, you might expect roughly 9% higher mortality rates for females and 15% higher mortality rates for males. Combining the populations would produce a single load to both the standard male and female tables that would be somewhere in between and that would produce roughly the same overall effect on liabilities if both male and female experience were fully credible. If both groups fell short of full credibility, then combining the two groups would increase the credibility of the result and produce an outcome that was more in line with the underlying blue collar experience.

If participants of all ages in both blue- and white-collar jobs may be aggregated by gender when assessing credibility and calculating mortality ratios, there is no reason not to allow the experience of both genders to be aggregated. The difference between male and female mortality rates will be reflected in the determination of expected mortality rates in the same way as the difference between mortality rates for 50-year-olds and 100-year-olds of the same gender.

The requirement to separately assess credibility and mortality ratios by gender means the closer a plan's male/female participant mix is to 50/50, the less credibility is given to that plan's mortality experience, compared to plans of similar size with predominantly male or predominately female participant populations. Allowing the plan-wide aggregation of mortality experience would improve the overall credibility of the plan's results and would thereby better meet the objectives of the statute. It would also simplify a plan's ongoing monitoring of experience against the 100-death threshold for partial credibility.

Recommendation: Allow industry-based tables or voluntary groupings of all plans sponsored by two or more employers in the same industry, even though the employers are not members of the same controlled group.

Discussion: Some studies have shown variations in mortality based on industry. Employers without

fully credible data should be permitted to aggregate experience with plans sponsored by similar employers to achieve a higher level of credibility. This could be done either by allowing employers within a given industry to elect to follow the rules that would otherwise apply to a controlled group by aggregating experience for multiple controlled groups. The rules applicable to continued use of a table would apply to the aggregation of employers. Alternatively, employers within a given industry could be permitted to use an industry-based table or industry-based adjustment to a standard table. To confirm the appropriateness of an industry-based adjustment for a given employer, the regulations could require that the employer's mortality ratio (before adjusting for partial credibility) be sufficiently close to the mortality ratio for the aggregation of employers or industry-wide ratio.

Recommendation: Allow plans to develop base substitute mortality tables from the RP-2014 blue-collar and white-collar tables.

Discussion: Proposed regulation § 1.430(h)(3)-2(d)(4)(iii)(A) requires all plans to develop substitute tables by multiplying standard mortality tables by the plan's mortality ratio. Standard mortality tables are the tables in § 1.430(h)(3)-1(d) multiplied by the cumulative mortality improvement factor for the period beginning with 2006 and ending in the base year for the substitute table (using the mortality improvement scale for the calendar year in which the application is submitted). The standard mortality tables in § 1.430(h)(3)-1(d) are the RP-2014 total dataset tables for employees and healthy annuitants, after factoring out mortality improvements from 2007 to 2014 (calculated using the Scale MP-2014 rates).

The *RP-2014 Mortality Tables Report* "found very clear evidence for variations in mortality rates by collar." Given this clear evidence, plans should be allowed to develop substitute tables from the MP-2014 blue-collar and white-collar tables, after factoring out mortality improvements from 2007 to 2014 using Scale MP-2014. If relevant, plans would use the approach described in the preamble to extend nonannuitants rates above age 80 (if relevant) and annuitant rates below age 50 (if relevant). (Alternatively, the final regulations could include blue-collar and white-collar male and female annuitant and nonannuitant base mortality tables, which plans could use in developing substitute tables.) The appropriate standard mortality table would be determined from the characteristics of the workforce covered by the plan.

Recommendation: Allow multiple-employer plans where no single employer represents 50% or more of the plan (measured in terms of liability) to use plan-specific experience without imposing any additional obligation on the controlled groups of the participating employers (and vice-versa).

Discussion: A number of large multiple-employer plans comprise an aggregation of many different employers from different controlled groups, with no single employer representing the majority of participants. For these plans it would be helpful if the regulations more explicitly allowed for the development of plan-specific mortality without any implication for the assumptions that must be used for other plans in the controlled groups of the participating employers. The multiple-employer plan may not have any control over other activities of its participating employers and may not be able to impose the analysis necessary to confirm that the other plans, if any, are too small to have credible experience (most likely) or to require the development of a table where another plan has credible experience. Similarly, an employer that participates in one of these plans but also has its own plan should be able to use plan-specific experience for its own plan without requiring that the multiple-employer plan also use plan-specific mortality experience.

This concern is less likely to apply where a single employer dominates the multiple-employer plan. Accordingly, these exceptions could be limited to controlled groups that comprise less than half of a multiple-employer plan's total population. This determination could be made on some reasonable basis, such as the share of the plan's funding target.

Recommendation: Modify § 1.430(h)(3)-2(f) to allow for a longer transition period when a plan is newly affiliated with the controlled group and to allow the new controlled group to collect experience data prospectively from the first day of the first plan year beginning after the date the plan becomes maintained by the controlled group.

Discussion: Proposed regulation § 1.430(h)(3)-2(f)(2) provides a transition period for newly affiliated plans which runs through the end of the first plan year beginning after the plan becomes affiliated with the controlled group. This transition period is too short when combined with the application deadline and the experience study requirement, given the experience study period must be at least one year from the acquisition date (if experience before the acquisition date is excluded), as demonstrated in the next example:

> *Example.* A controlled group has received approval to use substitute mortality tables for its calendar-year plans starting in 2018. A new calendar-year plan becomes part of the controlled group through an acquisition on Nov. 1, 2018. The transition period described in § 1.430(h)(3)-2(f)(2) runs through December 31, 2019. This means the controlled group cannot use the previously approved substitute tables starting in the 2020 plan year unless the sponsor can demonstrate that the newly acquired plan either does not have credible mortality experience or a substitute mortality table is approved that includes the newly acquired plan. If experience before the acquisition date is excluded, an experience study cannot be completed until after Nov. 1, 2019. But the deadline to apply to use substitute tables for the 2020 plan year is June 1, 2019.

Proposed regulation § 1.430(h)(3)-2(f)(3) allows the new controlled group to "either include or exclude mortality experience data for the period prior to the date the plan becomes maintained by a member of the new plan sponsor's controlled group." Sponsors excluding prior experience data must collect experience data beginning from the transaction date — which typically will not align with a date the sponsor would otherwise be collecting participant data. Thus, both options impose special data collection burdens on the plan sponsor.

The solution to these problems is to provide a longer transition period — extending through the last day of the *third* plan year after the date the plan becomes maintained by a member of the new controlled group — and to give the new controlled group the option of collecting experience data prospectively from the first day of the first plan year beginning after the date the plan becomes maintained by the controlled group. In the example above, the transition period would run through December 31, 2021. The new controlled group could collect experience data for the period January 1, 2019–December 31, 2020, and apply to IRS by June 1, 2021, for approval to use a substitute table if the experience for that period was credible.

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If you have any questions concerning our comments, or if we can be of further assistance, please contact Will Hansen at whansen@eric.org or 202-789-1400.

Sincerely,

Will Hansen
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