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FEDERAL INCOME TAX: POLICYHOLDER ISSUES

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- o Single premium products
- o Inside buildup
- o Corporate owned life insurance

MR. STEVEN A. EISENBERG: The first speaker will be Doug Hertz who is going to tell us how you become a modified endowment contract (MEC), what the rules are. The second speaker will be Mark Smith who is going to tell us what happens if you become a modified endowment contract, what the consequences are. He is also going to give us some ideas on how to do reporting and what to tell a policyholder. John Palmer will be the third speaker, and he'll talk about aggregation rules, mortality and expense limitations, and long-term-care issues. Finally Doug will have an opportunity to give some comments on other areas of legislation and possible changes in the future.

MR. DOUGLAS N. HERTZ: My subject is the definition of a MEC. There are two ways to become a MEC. The first is to have a contract, entered into after June 20, 1988, which meets the definitional requirements of section 7702 as life insurance but which fails to meet the accumulative seven pay test. The second way is to have a contract which is received in exchange for such a contract. Actuaries might feel that two exchanges can remove the contract from the MEC category. Your first exchange gives you a MEC because it's a contract that's received in exchange for one that failed the seven pay test. Exchanging this second contract gives a third contract which technically wouldn't seem to meet the statutory requirement. Lawyers view actuaries who argue this way as too literal-minded. The committee report clarifies that the intent of the statute was that a contract received in exchange for a MEC is a MEC.

The seven pay test that you fail in order to have a MEC was set by an intense political process. The industry proposed five years. House Ways and Means Chairman Dan Rostenkowski proposed fifteen. He got mad when the industry wouldn't buy that, so he proposed twenty. Political negotiations finally brought it to seven. The moral is that this is a random number, subject to change at any time.

If we use 4% interest, and the 1980 CSO mortality table, for a male age 55 and $100,000 of face amount, the net single premium is $45,825. The seven pay premium is $7,593, and the net level premium is $3,253. Looking at amounts at risk in the contract at inception, paying in a net single premium leaves you roughly $55,000 of amount at risk. Paying in a seven pay premium leaves you about $94,000 of amount at risk and paying in a net level premium leaves you about $97,000 of amount at risk. For contracts that are not MECs, this forces more amount at risk into the contract, thereby driving up both the cost of insurance and the need to underwrite.

The seven pay test is a cumulative test. You're okay as long as the total amount that has been paid in at any time in the first seven years is no more than the sum of the net premiums which would have been paid by that time had the contract provided for seven level annual premiums. It would be possible, for instance, in a universal life contract to pay one premium at inception and then pay in nothing more until duration eight or later. It could be made paid-up at that time by paying in a large enough premium. There's no requirement that you actually make seven premium payments. Nor is there any guarantee even if you do make seven or more level premium payments

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that you will have passed the seven pay test. Ten pay contracts, for instance, may fail the seven pay test solely because of loading charges.

The seven pay premium limits for purposes of this test are computed using the new reasonable mortality charges as defined in section 7702, and interest at the greater of 4% or the rates guaranteed at issue at the contract. Qualified additional benefit charges are taken into account in the computations, but expense charges are not. Generally what we're dealing with is a net premium calculation for determining the gross premium limitation on what can be paid into the contract. Small contracts (contracts up to face amount $10,000 subject to an aggregation rule) which require at least seven non-decreasing annual premiums get an extra $75 in their seven pay limit to allow for expenses. Also there's regulation authority to make an allowance for collection expenses for premiums that are paid more frequently than annually. The American Council on Life Insurance (ACLI) has asked for a regulatory notice on that so that we can get some notion of what kind of relief we're going to get and actually get the relief.

The initial death benefit when you're doing the computation is deemed to be provided until contract maturity. Reductions after seven years are simply ignored. Reductions that occur within the first seven years cause the test to be applied as if the lower benefit amount had applied from issue of the contract. I heard a rumor that some people believe this deeming of benefits only causes reductions after seven years to be ignored and that, for example, option two increases can be taken into account as in section 7702(e)(2)(A). The directions in this area of the statute make reference to the provisions of section 7702(c) instead of saying 7702(e)(1), where the computational rules are. This would seem to take in 7702(e)(2), which has the exception allowing increases in benefits to be taken into account in limited circumstances. Frankly, I don't believe this, since the exception in 7702(e)(2)(A) is a narrow exception which by its own term seems to apply only to the calculation of guideline level premiums.

The role of a seven-year term rider in these calculations is also a bit unclear. If term rider counts as a basic death benefit, then it has a large impact on the seven pay calculations because that benefit is deemed to continue until contract maturity. If instead the term rider is viewed as a qualified additional benefit, then the effect is small, for all you would count in the computation would be charges for the qualified additional benefit. I personally think that it should count as a death benefit. A level base contract with a rider attached to it should be treated in the same way as a contract that has unlevel basic contract benefits. There's sort of a tension in the legal analysis of the thing. The TEFRA blue book seems to refer to term riders insuring the primary insured under the contract as qualified additional benefits. On the other hand, the Senate Finance Committee report language indicated that the contract riders were to be treated as part of the basic contract. The Conference Committee implicitly accepted this by adopting the Senate Report without modifying this point.

So far it's fairly simple. If you have a contract entered in after June 20 which fails the seven pay test, it's a MEC. Things get complicated when you try to control abuses. We have something called the material changes rule. A material change in benefits or other terms of a contract causes a contract to be treated as entered into on the date of the change. An off-anniversary change would appear to create a contract that will have tax anniversaries, if you will, different than the basic contract anniversaries. We may want to get regulations deeming changes to occur at the prior contract anniversary just to avoid the administrative mess that this would create. At any rate, if you have a material change, the effect of treating the contract as newly entered into is that you get a new seven pay test.

Absent any special rule, the existing contract cash value would be deemed to be premium coming into the new contract and would in most cases cause the contract immediately to fail the new seven pay test. They didn't do that to us. What they did was to reduce the new seven pay limit to allow for the existence of the cash value that was in the prior contract. That is, the seven pay premium computed for the new contract is multiplied by a factor (1-cv/NSP).

Roughly what they're trying to do is to reduce the limit to allow for that portion of the contract already fully funded by previously existing cash value. So for example, at age 50, if you have a $100,000 contract with $15,000 in cash value, and you want to increase it to have a $150,000 face amount, you compute a seven pay premium for $150,000, and that's about $10,000. You compute a net single premium for $150,000 at age 50, and that comes out being about $60,000. So you take one minus $15,000 cash value divided by $60,000, you multiply that times the $10,000 seven pay

premium, producing $7,500 as your new seven pay limit for testing the newly entered into contract.

Well then, what's a material change? Generally, any increase in future benefits is a material change. So is an exchange or a term conversion. Benefit reductions are not material changes. There is a potential problem with this rule, and that is that a sequence of trivial changes treated as material changes may allow what looks like an abusive situation. You buy a contract, and at contract inception you pay in a seven pay premium. The next day you increase the benefit by some nominal amount like a dollar, and treat it as a material change. The new limit is roughly 80% of a seven pay premium. Pay that in on day two. On day three do the same thing. Increase the benefit by some negligible amount, get a new limit, about 65% of the original seven pay premium, and pay that in. You thus generate a geometric sequence of premiums that you're allowed to put into the contract. After you do about seven changes, you will have paid in an amount that is greater than a guideline single premium for the contract without failing the seven pay test. I have not heard of anybody doing this, but I've heard a number of people comment on the theoretical possibility of doing it. I would caution people that Treasury knows about this and will close it off. A remarkable number of possible ways are available to do so. But basically they're waiting for the industry to propose a favorite method for handling the thing.

There are exceptions to the idea that any increase in future benefits is a material change. The first exception is for an increase attributable to the payment of premium necessary to fund the lowest benefit in the first seven years. This takes into account the limited increases that you're allowed to use in section 7702(e)(2)(A) or (B). Any increase attributable to the payment of premium necessary to fund those lowest benefits (or to earnings in respect to such premium) is not a material change. So we have a new concept; necessary premium. Necessary premium becomes an important concept because once any unnecessary premium exists in the contract, such things as paid up additions or corridor increases in universal life contracts will trigger a retesting due to the existence of a material change. For a cash value test contract, you're allowed to pay an amount such that, after expenses are deducted from the premium, the residual going into the contract would bring the deemed cash value up to the attained age net single premium for the contract. The deemed cash value is the cash value that would have resulted if premiums paid into the contract earned guaranteed interest and if the applicable expense and mortality charges had all been assessed. It's going to be a little hard to deal with this. My own attitude is that at least for traditional products without fancy pour-in riders, the base contract cash value is the deemed cash value.

For a guideline premium cash value corridor test contract, premium is necessary if it does not exceed the excess of the initial guideline premium limitation over previously paid premiums. So you're allowed to bring yourself up to the initial guideline premium limitation, and all of the premium in the contract is still necessary.

Another exception given to the material change rule is that regulation may provide that cost of living increases based on a broad index such as the consumer price index and funded ratably over the life of the contract are not material changes. There are all sorts of questions here. For instance, how does this work for flexible contracts? And what do you say about limited pay traditional contracts? The requirement that it be funded ratably over the life of the contract makes it difficult. Further, there are technical problems, such as the need to clarify that premium paid for cost of living increases does not count against seven pay limit of the basic contract. There's a need to eliminate cost of living adjustment premium in defining contract necessary premium. ACLI is preparing a position paper on this. We'll send the paper over to the IRS asking the people there to provide some guidance and perhaps relief on the subject. Contracts providing for cost of living adjustments are on the market now, and everybody is kind of taking a leap of faith.

What increases are attributable to the payment of necessary premium or to earnings thereon? One very narrow reading of the language would attribute an increase premium or earnings thereon only if the contract triggers the increase automatically. For instance, dividend additions, corridor increases, option two increases on payment of premium and so on. Many companies are taking a much broader view of what that word attributable might mean and attribute all increases to necessary premium until unnecessary premium is in fact put into the contract. It's going to be hard to devise a rule here that will keep everyone happy. The difficulty is sometimes you want a

retest (to raise the limits) and other times you don't want a retest. A lot of companies just don't want to be bothered doing a whole lot of retesting. It's an administrative burden.

A couple of comments about grandfathering. Only contracts entered into after June 20 can be MECs. But then you have further rules to control abuses. The addition of death benefits or a qualified additional benefit, which the owner did not have a unilateral right to obtain, causes the contract to be treated as newly entered into and then seven pay tested. Further, even where you have benefit increases to which the policyholder had a unilateral right, if the death benefit increases to more than $150,000 over the benefit existing on October 20, 1988, the material change rules are then applied using the June 20, 1988 benefit rather than the lowest benefit in the first seven years to determine necessary premium. It doesn't mean you flunked. It doesn't even necessarily mean that you have to retest. It just means that you now apply the material change rules to find out if you do have a retesting. Was the change that occurred actually a material change?

There are questions that have been raised here about the role of corridor increases and dividend additions and about the role of increases generated by earnings already internal to the contract. The question is do these amounts count against the $150,000 limit? A literal reading of the committee report would seem to say that they count against it. As a policy matter, I suspect that they shouldn't, but frankly the situation is just a little bit unclear. There's an exception to this $150,000 increase rule which is badly drafted. The statute creates an exception for a contract which on June 21, 1988, required at least seven level annual premiums and under which the policyholder makes level annual premium payments for the life of the contract. That seems to be sort of an inconsistent requirement. The conference report, on the other hand, makes more sense. It says that you have an exception for contracts which require at least seven level annual premiums on June 21 and in which the policyholder pays in accordance with the contract terms. It's an awkward situation. The conference report makes sense. The statute does not. But most lawyers tend to feel that in most circumstances statutes control over committee reports.

My final comment is that where a grandfathered contract becomes subject to testing, its cash value gets handled as in the material change rules, so you don't have a situation where the cash value of the old contract is deemed to be premium into a new contract, causing an automatic flunk.

MR. EISENBERG: Would anybody like to ask a question at this time?

MR. EDWARD L. ROBBINS: I have a situation where I have a group universal life policy. They're all Option Bs. They're all under the cash value accumulation test. How do you calculate the necessary premium? Which lowest death benefit do you use to calculate?

MR. HERTZ: The way the test works for guideline premium contracts is that your necessary premium is essentially the guideline premium limitation for the lowest death benefit in the first seven years, except that under the rules of 7702(e)(2)(A) you can take future increases into account. While there is a guidance for cash value accumulation test products, a parallel rule might perhaps apply. For necessary premium, you take into account the lowest death benefit of the first seven years plus any option B increases to date. Of course I can't guarantee that will be the rule. It's one of those areas that will have to be clarified by regulation.

MR. LARRY H. RUBIN: Is it your opinion that a policy rider offering an option to purchase one year term insurance for the change in CPI would cause a material change in the contract?

MR. HERTZ: It sounds like something that should qualify for the exception for cost of living adjustments. But unfortunately, that provision would appear by its terms not to become active until regulations come out. So I can always hide under that and say, well you're going to have to wait for regulations. And maybe that really is the right answer. As a pure guess, it sounds to me as if it's the sort of thing that should be protected by whatever regulations do come out. But we just have to wait for some kind of regulatory notice to clarify what the exception really means.

MR. PAUL D. REABURN: I have a couple of questions. On an increasing plan on universal life, at issue, do you include lump sum payments or 1035 exchanges in the death benefits?

MR. HERTZ: I would say that there's been a lot of discussion at ACLI over the question of how to do computations under 7702, even in basic situations, with regard to option B contracts. For

instance, if you have a $100,000 stipulated amount and the policyholder pays $10,000 into the contract, do you take into account $110,000 in computing the definitional limitations or do you take into account just the $100,000? The industry seems split on the answer to that. ACLI has sent something off to IRS saying that we really ought to be able to just do it either way. I would say that a similar thought would apply here. If you have increases attributable to the payment of necessary premium, they do not trigger material changes. So you start out thinking in terms just of the stipulated amount. When money actually comes into the contract, provided it's not unnecessary premium, it would not trigger a material change.

MR. REABURN: What about in the case where you end up with a negative seven pay premium because of the high cash value on a material change?

MR. HERTZ: You're asking about a situation where you compute a limitation for the new contract benefits, you hold that to one side, and then you compute this multiplier: one minus the prior contract cash value divided by a net single premium for the new contract. It's entirely possible that, the cash value divided by the net single premium comes out being larger than one, in which case you wind up with a negative limitation for your new contract. There's a colloquy, I believe in the Senate, on this subject which said that under such circumstances, the contract would be okay. It would not be deemed to have failed the test unless or until new premium is paid into the contract. So you just don't pay any more premium and you're still okay.

MR. REABURN: Would level to increasing or increasing to level changes be considered either a material change or a reduction in benefits, depending on which one you're doing?

MR. HERTZ: Well, increasing to level should have no effect because you weren't allowed to take the increase amounts into account in the first place. That's assuming I'm right that they are not counted in the basic seven pay testing.

Where you go from level to increasing, you probably have to monitor the situation to see to it that you don't get unnecessary premium present in the contract at any time in the future. Any increase to take place thereafter would trigger a material change. But up until that time, I would say they would not.

MR. W. MARK SMITH: Now that we have definitively identified modified endowment contracts, each of us can go home and catalogue everything we have in one camp or the other.

We need to spend a minute figuring out what the consequences are if the contracts are treated as MECs. And really there are only a few basic rules here. The first rule is that amounts not received as an annuity or death benefits are taxed in the same manner that annuity contracts are. That is, those amounts are first treated as taxable earnings to the extent of any gain in the contract and then as return of investment in the contract. Second, distributions are subject to a premature distribution penalty, comparable to annuities. The penalty tax is 10% of the taxable amount of the distribution unless distributed after age 59.5 or after disability or basically as a life annuity income stream. Third, policy loans are deemed to be distributions subject to the foregoing rules, a very significant change from the treatment of non-MEC life insurance contracts. Fourth, statute provides a so-called drag-back rule for anticipatory distributions. That is to say, if there are distributions from the contract in anticipation of becoming a MEC, those distributions are retroactively recast and their tax results are retroactively changed. The statute tells us that distributions made within two years prior to becoming a MEC will automatically be dragged back under this rule and gives the Secretary of the Treasury authority to devise additional regulations to implement that provision.

Maybe there is a little bit more to talk about here before we leave those consequences. And why don't we do that by focusing on a few specific transactions and considering how they might be treated under these rules? Certainly there are a variety of transactions that are conventionally treated as distributions, and there's no doubt in anyone's mind that, if these transactions occur under a MEC, they will be subject to these unconventional MEC taxing rules: cash withdrawals, surrender proceeds, dividends received in cash. Legislative history provides us with some additional guidance with respect to a handful of other transactions, for example, dividends used to repay policy loan interest or principal. The Senate Report had a favorable rule on this. The Conference Report reversed that, and the ultimate legislative history indicates that those dividends used to repay policy loans will be treated and taxed as distributions for purposes of

these rules. On the other hand, the Conference Report indicates that dividends retained to pay premiums either on the base coverage or on a qualified additional benefit or to purchase paid up additions are not distributions. So those sorts of transactions continue to be treated in the present manner.

The final category of transaction for which we have a little guidance at this point is policy loans. We have an express rule in the statute that policy loans, including pledges or assignments, are to be treated as distributions for these purposes, subject to a special exception for burial policies. The legislative history, after some back and forth as the legislation evolved, indicates that premium loans will be treated as distributions. And there seems to be, in my mind, no basis for distinguishing automatic premium loans from any other sort of policy loan. The good news is that we do get a basis adjustment for taxable loans to the extent that the loan is treated as a taxable distribution. The taxable portion of the loan is to be added to the basis in the contract. A variety of other adjustment rules were suggested at various stages in legislative process, but ultimately the only rule that we have ended up with is the basis adjustment for the taxable portion of the policy loan.

What about capitalized interest on a loan? There is no specific guidance on that in the legislative history but it seems rather difficult to argue that incremental interest added each year to the amount of the policy (when the interest is not repaid in cash or by other means) is not an additional loan. And as such, it would seem that amount of interest capitalized each year would trigger yet another potentially taxable event in a MEC.

This is a very serious administrative development. It gives rise to a secondary question of what is taxable: the gross amount of that capitalized interest or the net amount? There is some significant debate on that issue in the industry, but it seems likely that the gross amount of the interest on the loan is the taxable amount. If that's the case, then no-cost or similar loans in MECs, whatever their prior status, now have unintended consequences: the gross capitalized interest will be treated apparently as a distribution taxable to the intent of gain in the contract, but with no cash in the policyholder's hands with which to pay the tax on that amount. If the policyholder withdraws from the contract to pay the tax, apparently he or she would have yet another taxable event, leading to a pretty horrible series of consequences for your policyholder. These issues will have to be thought through carefully in terms of the ongoing attractiveness of these features in contracts that are MECs or have a reasonable likelihood of becoming MECs.

These are the handful of transactions for which there is specific guidance in legislative history. There are, of course, many more for which the legislative history is silent. Many of these issues pre-dated the Technical and Miscellaneous Revenue Act of 1988 (TAMRA). Many of these issues have been out there in one form or another, ever since the relevant features first started appearing in products. TAMRA puts additional pressure on the intended tax results of those transactions. The change in the basis ordering rules, from basis first to basis last, puts a higher premium on determining whether a particular transaction is taxable or not. Accordingly we have additional pressure on some anticipated tax consequences which have been handled by the industry without official guidance for a number of years. For example, consider dividends used to purchase a rider that is not a qualified additional benefit (QAB). Legislative history is perfectly clear that dividends used to purchase QABs will not be treated as distributions. But what if you have a rider that is not a QAB for some reason or another? The traditional position in the industry would be to think that sort of a transaction is internal to the contract and does not generate any sort of potential tax recognition event. But if that conclusion is not correct, then you have an event that may indeed have immediate consequences to the taxpayer because of the change in the basis ordering rules. So there is now additional pressure on that sort of question. As another example, consider surrender of paid up additions to pay premiums, or typical vanishing premium arrangements. There is no guidance to date with respect to the treatment of that sort of transaction either before TAMRA or after TAMRA. Again the notion to date has been that those sorts of transactions are wholly internal to the contract and do not generate any sort of tax recognition event at all. But again there is no guidance to date on that. I believe ACLI has already petitioned the IRS for guidance on that point in a variety of contexts.

You might rightly ask why we are to be concerned about these somewhat arcane or perhaps unusual circumstances for our products. Certainly they are of concern to our policyholder. But what's the concern to the company? Aside from product design and marketing, they concern the company because of reporting and withholding obligations. Remember that a modified

endowment contract remains a life insurance contract for tax purposes. In fact, a fundamental part of the definition is to be a life insurance contract that goes on and fails these various other tests before it becomes a MEC. And as we all know, the familiar rules for reporting and withholding on pension and annuities apply to life insurance contracts as well: the rules of sections 3405 and 6047 of the code. Section 3405 requires federal income tax withholding on the taxable proportion of so-called designated distributions, unless the policyholder properly elects no withholding or unless some other exception applies. Even if there is no withholding, designated distributions are to be reported on Form W-2P or 1099-R as relevant, pursuant to 6047(d) of the code.

So now we find that once a contract is a MEC, you have a whole new range of reporting and withholding considerations. You have to start working through them in order to figure out how you're going to handle them. You take on that task with no small amount at stake. The pension and annuity withholding rule which includes life insurance generally incorporates the procedures that apply to employer-employee wage withholding. That scheme provides for secondary liability for the substantive tax due if the payor as the withholding agent fails to withhold. So if there is failure to withhold, the Service is entitled to go after the payor for the actual amount of tax the ultimate tax payer had due, with the obligation on the payor to prove that the tax has been paid. This to my mind gives the Service a very strong enforcement tool that we will probably see with increasing frequency on both 7702 and 7702A issues over the next several years as the Service increases its sophistication and understanding of these issues.

In addition, there's a whole panoply of penalties for reporting and withholding failures. They appear to overlap to a substantial degree. There is no significant experience to tell us which of these various penalties would be applied in various circumstances. But I think it's sufficient to know that they are out there and they can add up to some significant dollars if the right circumstances are triggered.

So we're looking at a scheme where not only the policyholder's tax results are in play but also potentially some very significant liability for the insurance company, through the reporting and withholding back door, for the positions taken on these various issues. To some extent, the position that companies take on these MEC issues will fit into their general culture, their general philosophy with respect to withholding and reporting matters, which ultimately comes down to who bears the risk on the tax issue. Does the company bear it by not withholding and reporting in cases of doubt? Does it instead put the burden on the policyholder to take a contrary return position if he wants to? Perhaps most likely, resolution will involve some combination of the two depending on various issues as they move along the spectrum of risk that the company is willing to accept.

For example, we now rather clearly have to face the problem of the company's withholding obligation if a taxable event occurs under a MEC but is not accompanied by a cash payment from the insurance company to the policyholder. For example, anything that arises under the drag back rule is going to be in this situation because that rule may be taxing amounts potentially two years later, after the switch in the contract from non-MEC to MEC status. The company is not in a position to withhold on those amounts. The same applies to many loan transactions: automatic premium loans (APLs), capitalized interest, third party pledges or assignments to the extent the company even knows about it. All those are examples of transactions where there may well be taxable events but the company is not distributing cash to the policyholder. You don't have anything to withhold on. The normal wage withholding rules, which I mentioned earlier, require the payor to make necessary arrangements for deducting and withholding on non-cash wages. And there is a similar rule in the regulations, under section 3405, life insurance and annuity withholding. So there is some suggestion that we are obliged to find a way to withhold even though we're not distributing any cash to the policyholder at the point of the taxable transaction. That's the bad news. There may be a small amount of good news here; there is a potential argument that taxable events without cash payments are not designated distributions for 3405 purposes. For example, from the rules in the regulation for dealing with loans from qualified plans and certain other circumstances, you might be able to develop an argument that a taxable distribution unaccompanied by cash is not a designated distribution. In that case, you're not subject to the 3405 withholding obligation. However, there is a question in that circumstance, whether you fall back into the catch-all 1099 miscellaneous reporting and backup withholding obligations.

Do withholding obligations give you an extra-contractual right to go into the cash value and pull money out of the cash value to satisfy your withholding obligation without some sort of consent from the policyholder? The answer is probably not. So unless you make some other arrangements, the company has its withholding obligation with nothing to withhold on, unless you can find a way to get out of designated distribution treatments.

When does a contract become a MEC for withholding and reporting purpose? If you become a MEC during the course of the contract year, but kick-out an appropriate amount within 60 days of the close of that contract year, you can avoid MEC status. Contract years will not usually coincide with the tax year. As a result you may be in a position where a contract looks like it's a MEC on the day you owe a W-2P form to the policyholder, or on the day that you must send those forms to the IRS. But you could have a subsequent kick-out so that the presumed tax results no longer apply because the policyholder subsequently avoided MEC status. I find myself troubled by the position that a contract is not a MEC until 60 days after the close of the contract year, essentially giving you a one-year leeway on any sort of taxable distribution. On the other hand, it seems that we have a reporting and withholding scheme that's bound to create all sorts of misinformation for both policyholders and the Service unless some sort of adjustment is made to it.

MR. ALBERT K. CHRISTIANS: Is there any requirement in the statute regarding payment of interest and taxability of interest on these amounts that are refunded within sixty days after the end of the policy year to avoid modified endowment treatment?

MR. SMITH: Yes, I believe there is a specific requirement that you pay back with interest, and I believe that intent is that the interest be taxable.

MR. CHRISTIANS: Is there a specified interest rate that you have to pay, or is it whatever interest was credited to the funds while they are in the policy?

MR. JOHN J. PALMER: I think the idea is to restore the contract as it would have been had the excess not been put in. It's not totally free from doubt as to how you would do that.

MR. SMITH: For example, the kick-out rules under IRAs and 401(k) plans work in that manner to require a kick-out of the interest. There are very detailed mechanical rules for doing that which might bear looking at, until the time we get that guidance under 7702A.

MR. HERTZ: The difference here is that you have a mortality interplay in there as well which can affect it slightly.

MR. REABURN: I have just one question on the sixty-day rule. If the contract becomes modified endowment where there is a distribution, is there any way to reverse the distribution during the sixty-day period?

MR. SMITH: Unfortunately, some of these contracts may have gone back because of the seven pay rule all the way to issue, if the distribution was large enough.

MR. PALMER: You're not talking about a case where you have excess premium paid in that you're in a position to refund. So I'm not sure that you're within the perimeters of the statutory kick-out rule.

MR. REABURN: The only thing is I think a lot of companies may not even know is that it's modified endowment at the time it happens. In fact, between June and the time when the legislation was finalized, our company had a lot of policies become modified endowments.

MR. SMITH: There certainly has been a substantial amount of talk about normal recision practices. I can't point to much in the language or the history of the statute that gives you much comfort on that. But there certainly has been a great deal of consideration given around the industry to the effectiveness of normal recision practices to try to undo unintended results in particular.

If you want to try to undo the transaction even though you haven't technically got a method in the law that allows you to undo it, I think I'd be inclined to apply for a waiver or something like

that. In talking to the IRS on some of these waiver issues, the people there seem to be relatively liberal unless people wait six years, or some long time, after failure and then try to come in and make a correction, and want a waiver. They seem to put a lot of weight on the degree of promptness and the degree of interest you show in trying to do the right thing.

MR. PALMER: It's always a challenge to talk to people about taxes after lunch. It's difficult to keep people awake and attentive, even on such a scintillating topic as we have here. I want to make a couple of observations on some of the additional items that we found of interest. One that I guess you're probably all wrestling with is the administrative consequences of TAMRA. How do you track and detect and measure all these limitations and rules and transactions? A threshold issue is your company's view on tolerating the presence of MECs in your book of business. You can take the view of prohibiting them outright to the extent that you can detect them and control the factors that bring them into being. Or you can choose to accept them in some limited pockets, for example, single premium life contracts that people still sell because they are just like single premium deferred annuities (SPDAs) only with low cost life insurance. But I think you do need to pay attention to the kinds of situations that you can get in to generate MECs. Administration will be much easier if you don't have any.

The second general area where we found a lot of concern is field education. Most of our efforts have been directed internally, getting the software to do all the right things and getting the policy service people to do the right things. But really the problems are created to a large extent out in the field. It's important to make sure the field tells the policyholder that he has, in fact, a MEC, if he is buying one at issue. You also have kind of a downstream effect. The agent needs to tell the policyholder when the policyholder is doing some transaction that will cause a MEC to come into being, for example, putting in too much money or reducing the benefits so that you have a retroactive MEC. Probably the most insidious situation is when the policyholder is doing something that has some sort of deferred consequence. In the sixth year of the seven pay test, he decides to add a $5,000 rider on his child, and as a result he starts the whole seven pay limit all over again. Now he may not know that, and the agent may not know that. Later he wants a policy loan and finds he's got a retroactive MEC because he put this little rider on six years earlier. You really do need to spend time educating your agents about these issues. That's always difficult and chancy. You probably want to make sure they all have errors and omissions coverage.

MR. SMITH: Let me ask about your first point on thinking about your tolerance for MECs in your book of business. How many contracts can you guarantee will never become MECs?

MR. PALMER: You might have fixed premium contracts that limit the amount of money coming in and that don't allow for reduction of benefits.

If partial withdrawals or reduced paid-up benefits are available during the first six years, then theoretically you can get into trouble. But it depends on your contract forms.

Even on a UL contract or Flexible Premium contract, you may or may not be willing to accept premiums that cause the policy to become a MEC. You can write your contract to allow you to refuse them.

You have a lot of tools in your hands to limit the amount of difficulties that you can get into. It's a question of whether there is some price to be paid in the marketplace for putting on those sorts of restrictions.

MORTALITY AND EXPENSE LIMITS

TAMRA made some changes to Section 7702(c)(3)(B) of the Internal Revenue Code, and added an additional subparagraph (D) to impose more stringent limits on mortality charges and other charges that could be taken into account in making the computations under Section 7702, as well as those required under the newly added Modified Endowment Contract provisions of 7702A. Before describing the rules and their consequences and their interpretations, it may be useful to provide a little background. Prior to this change, mortality charges and other charges to be used for the calculation purposes of 7702 were those charges that were stated in the contract.

Some companies, it is not clear how many, have taken advantage of the letter of this requirement by stating in the contract rather large mortality charges (such as a large multiple of 1980 CSO

mortality) in order to develop extremely large limits. Under the guideline premium tests, there is some level of mortality charge (varying by age) which would permit a single premium contract to reach the guideline premium corridor at the time of issue.

There may have also been some abuses of the stated expense charge limit (by guaranteeing a charge which is not actually imposed) but to my knowledge, no one has produced evidence that this abuse in fact exists. The possibility of the expense charge abuse was discussed with Treasury officials as far back as the development of Section 101(f) under TEFRA. The Treasury position at that time was that such excessive charges would not be a serious problem since the IRS would be able to attack such an abuse on the grounds that it constitutes a sham.

Focus on these potential abuses arose more recently during the development of the definitional proposal by the National Association of Life Underwriters and the companies which participated with it. They pointed out the mortality charge abuse potential and provided in their proposal a method to control it. This set of discussions led directly to the limitations that we are discussing.

Section 7702(c)(3)(B) limits mortality charges to "reasonable mortality charges which meet the requirements, (if any) prescribed in regulations and which (except as provided in regulations) do not exceed the mortality charges specified in the prevailing commissioners' standard tables (as defined in Section 807(d)(5)) as of the time the contract is issued." Section 807(d)(5) referred to is part of the Code which deals with the computation of tax reserves.

Expense and other charges somewhat similarly are limited to "any reasonable charges (other than mortality charges) which (on the basis of the company's experience, if any, with respect to similar contracts) are reasonably expected to be actually paid."

Section 7702(c)(3)(D) goes on to provide that "If any company does not have adequate experience for the purposes of the determination . . . [just described], to the extent provided in regulations, such determination shall be made on the basis of the industry-wide experience." It's not completely clear whether the determination referred to is the one of reasonableness or expectation of charge. The Treasury Department is directed to issue regulations not later than January 1, 1990. TAMRA went on to provide that in the interim: "Mortality charges which do not differ materially from the charges actually expected to be imposed by the company (taking into account any relevant characteristic of the insured of which the company is aware) shall be treated as meeting the requirements" of the new limitations. After reading language like that, I'm always reminded of the observation of one commentator that the language of the Internal Revenue Code governing life insurance products sometimes appears to have been co-authored by James Joyce and Casey Stengel.

The industry has been able to achieve some further clarification of all this by way of an IRS notice. This is Notice 88-122 which was published on December 27, 1988. This notice provides two safe harbors. A safe harbor is provided for mortality charges which do not exceed 100% of the applicable rates set forth in the 1980 CSO Tables, but to the extent that a state requires contracts to use unisex tables, such unisex charges can be taken into account as safe harbor charges. Similarly, a second safe harbor is provided for 1958 CSO Mortality. By the way, the notice also seems to believe there is something called a 1958 CSO Morbidity Table. The 1958 CSO safe harbor is limited in that it applies only to a non-MEC that is issued on or before December 31, 1988, pursuant to a plan of insurance or policy blank which was approved by the appropriate state authority on or before October 21, 1988. There's a little bit of circularity on this last provision since one must use the safe harbor rule to determine whether or not the safe harbor rule is available.

The following are some of the immediate issues raised by these new rules. First, the safe harbor treatment of unisex tables clearly does not go far enough, since it is limited only to those situations in which a state requires contracts to use unisex tables. There are situations in which unisex tables are permitted by the states and must be used by insureds in employer-provided benefit situations pursuant to the Supreme Court decision in the case of *Arizona Governing Committee* v. *Norris*. There are also situations in which companies use unisex tables for administrative convenience. For 24 companies recently surveyed by the ACLI, the amount of insurance under the state mandated unisex policies is about 11% of all unisex business for those companies. The Norris business is about 83% and the voluntary business is about 6% of the total. So they really have missed the major problem by focusing only on the state mandated unisex. Secondly,

there is a somewhat similar problem regarding the permissible use of smoker distinct tables for limit calculation purposes. This issue is currently being addressed by the ACLI through an attempt to expand the definition of "prevailing commissioners' standard table" contained in 807(d)(5), since the new rules in 7702 refer back to that section and since clarification is also needed for tax reserve purposes. Third, a number of questions arise with regard to substandard mortality. First, let's examine the reference in the new language back to Section 807(d)(5). That definition of prevailing commissioner's standard tables does not include reference to an appropriate adjustment for mortality to reflect substandard risks. There is no clear sanction for the typical use of multiples of 1980 CSO for substandard lives. The interim language does allow for mortality charges which "do not differ materially from the charges actually expected to be imposed . . . (taking into account any relevant characteristic of the insured of which the company is aware), "but this does not translate into multiples of safe harbor. Furthermore, the phrase "of which the company is aware" raises questions about the treatment of guaranteed issue or other simplified underwriting business where the insurance company is purposely unaware of relevant characteristics of the insured. These issues were discussed with the Treasury Department during the development of the notice. They seem to be reasonably supportive and understanding of that issue. However, they were unwilling to include any language to this effect in the notice. I think the problem was that they were unable to figure out how to write anything particularly specific that would give guidance and that they were willing to live with over the long term. They seemed to feel that the clear authority to use, for limit calculations, charges which do not "differ materially" (whatever that means) from the actual charges would give the company sufficient latitude to carry on their business. Fourth, another issue of which the government officials are vaguely aware is that abuses may still be possible since the only elements in the definitions under 7702 and 7702A that are constrained tightly are the mortality and expense charges. Thus, an inflated mortality or expense charge could be explicitly stated and apparently charged, but effectively rebated through a dividend or excess interest mechanism. This raises the unwelcome spectre of IRS intrusion into dividends and pricing formulas. Some recognition will also need to be given to the situation where there are changes in prevailing tables. For reserve purposes, we have a three-year lag period before prevailing tables need to become tax tables. But this three-year rule would generally be inadequate for definitional purposes. A company could be forced to build a prevailing table of charges into contracts before some states (presumably less than twenty-six) would permit their use.

Another issue -- what does the term "differ materially" really mean? Do we really want to know? Would we really want the IRS to prescribe some maximum percentage difference between current charges and guaranteed charges? What are reasonable charges? Company experience seems relevant in the law only to the determination of whether charges are reasonably expected to be paid, not with respect to whether they are reasonable. If so, intercompany experience (referred to in the legislative history if the company's own experience is not meaningful) would seem to be of limited value.

What mortality assumption should be used in the case of a material change? Does a change in guaranteed mortality or in current mortality require recalculation of the limit under either 7702 or 7702A?

You will have noticed that there are far more questions than there are answers. This is the state of affairs which we can expect to persist for quite some time. This kind of discussion tends to demonstrate the correctness of those who said that curing the single premium "problem" by means of tampering with the definition of life insurance would create more problems than it solved. In the meantime, of course, we all must continue to conduct our businesses. The prudent course of action is to make reasonable judgments and to take reasonable positions in the absence of instructions to the contrary. Any time definitional limit laws change, new opportunities are created to locate and exploit loopholes, but recent experiences have demonstrated that the grapevine on Capitol Hill is working extremely well, and that the chances of material abuse going undetected and unpunished for an extended period of time are much smaller than they used to be.

ANTI-ABUSE RULES

One of the last-minute additions to TAMRA in 1988 was the inclusion of paragraph 72(e)11, captioned Anti-Abuse Rules, in the Internal Revenue Code. These rules are also called the Aggregation Rules or the Serial Contract Rules. The new language, not including headings, consists of only 95 words, but it has provoked considerable dispute and controversy. First it may be useful to note what led to the addition of this paragraph. Apparently a marketing letter from

a California broker fell into the hands of one of the tax-writing staff. This letter pointed out how little was really being lost by the proposed Seven-Pay Rule and in particular, how the onerous last in first out (LIFO) taxation of the contract gains might be avoided for annuities and presumably for MECs. The suggested marketing solution was a simultaneous issuance of a number of contracts rather than the issuance of a single contract for the entire amount. In this manner, roughly pro-rata taxation of gain rather than Lifo taxation and its attendant penalty tax could be achieved by means of the surrender of the appropriate number of smaller contracts, to approximate in total the desired amount of partial surrender. The reaction of the tax-writing staff to this technique is embodied in the new Paragraph 72(e)(11). The rule provides that all MECs issued by the same company to the same policyholder during any 12-month period shall be treated as one MEC; and similarly all annuity contracts issued during any 12-month period by the same company to the same policyholder shall be treated as one annuity contract. On the face of it, this language would seem to be reasonably straightforward. However, the paragraph concludes with the following: "The Secretary may by regulations prescribe such additional rules as may be necessary or appropriate to prevent avoidance of the purposes of this subsection, through serial purchases of contracts or otherwise."

Note that the regulatory authority can be exercised to prevent avoidance of the "purposes" of the sub-section, which are not otherwise very clearly specified, except perhaps by way of the "Anti-Abuse" caption. Note that the perceived avoidance need not be achieved only through the serial purchase of contracts. The language of the Conference Committee Report provides some guidance as to the purposes of the sub-section. The stated purposes with respect to MEC aggregation is to stop the marketing of serial contracts designed to avoid modified endowment rules. That's a little peculiar since before the statute was enacted, there was no such thing as a MEC. Therefore, there would be no need to stop the marketing of serial MECs. The purpose with respect to annuities contracts is not clearly stated. The purpose of the regulation described in the report "is to prevent the avoidance of the rules contained in section 72(e) through the serial purchase of contracts or otherwise." Note again the regulatory authority extends beyond the new sub-paragraph 72(e)(11) to the entirety of sub-section 72(e).

In January and February there were widespread rumors about an impending IRS notice. The notice approach, which we have seen before in discussing mortality and expense charges, is to make a statement of an IRS position on rules which will be contained in formal regulations when and if the regulations are ever issued. Thus, the notice can achieve most of the potential effect of the regulation without all the attendant review process that can take a long time. Thus the notice technique is used to promulgate pseudo-regulations.

Following is a description of some of the positions the IRS is reported to be considering.

1. The notion of the 12-month aggregation period as clearly stated in law would be extended substantially by, in effect, requiring that a 12-month period elapse without any contract purchase. Thus if 13 annuity contracts were purchased 11 months apart over a period of 12 years, all 13 would be considered one contract for the purposes of determining gain on distribution from any one of the contracts.

2. The concept of the "same policyholder" would be expanded by aggregating contracts purchased by the policyholder with those of his spouse and contracts purchased by children with those of their parents. Thus a new element would be added to the background investigations otherwise needed by those contemplating marriage or adoption, and a new benefit might be added to divorce.

3. The concept of "same company" would be expanded by considering that two contracts purchased from different companies under an "integrated plan of insurance" would be treated as if they were purchased from the same company. In this connection, it should be noted that the legislative history directs Treasury to consider affiliates as being one and the same company, but gives no hint or further expansion beyond that.

4. The notice would explicitly include immediate annuity contracts within the scope of the aggregation rules. In particular, not only would two immediate annuities be considered one contract, but immediate annuities would also be aggregated with deferred annuities. This particular suggestion appears to have attracted the greatest amount of industry lobbying attention, because of the obvious effect it would have on the marketing of so-called split

annuities. These are a combination of a short-term, say five-year, immediate annuity, with a deferred annuity. This interpretation is arguably beyond the scope of 72(e)(11) since 72(e) itself deals only with distributions under deferred annuities and not under immediate annuities. The Service seems to be motivated not only by concern about the split annuity marketing plan, but also by some disagreement with the manner in which immediate annuities are currently taxed. The IRS people would prefer LIFO taxation on immediate annuities rather than the current pro-rata basis and appear willing to use the newly created regulatory authority to essentially rewrite the Internal Revenue Code to achieve that result.

5. IRS is also considering aggregating MECs together with annuities in applying the aggregation rules, notwithstanding what would seem to be fairly clear separate treatment in the law.

Now for the good news. The single bright spot is that the proposed notice would appear to exclude qualified annuities from the aggregation rules. An obvious key issue here is the effective date of any such sweeping reinterpretations. The Service initially appeared to believe that at least some rules in the notice would be made effective retroactively to the effective date of Section 72(e)(11). The ones that would be prospective only were the ones where there was no clear indication in the statute that such an interpretation might be possible.

Aside from the rather dramatic change in tax policy that these rules would express, there are a staggering number of administrative issues raised by, for example, attempting to aggregate contracts issued by different companies, attempting to aggregate contracts, issued to different people, and by attempting to adjust gain basis and exclusion ratios as a result of contracts subsequently purchased over long periods of time. This notice was originally rumored for release by the end of January but was apparently delayed initially on account of industry lobbying efforts. The draft notice was then sent to Treasury for review, but due to changes in tax staff substantial time has passed waiting for the appropriate new staff to be appointed and to become familiar with the issues. It still seems a completely open question as to what such a notice will contain, when it will be released, and if it will be released at all.

LONG-TERM-CARE RIDERS

The emergence of long-term-care riders in life insurance contracts has raised a whole collection of tax issues affecting both the company and the policyholder. There is increasing interplay between policyholder and company tax these days. To date, there hasn't been very much guidance from the IRS, but on March 21, 1989, the IRS released Revenue Ruling 89-43 which deals with the level premium guaranteed renewable group long-term-care policies. The question at issue here was whether the reserves under these policies qualify as life insurance reserves under Section 816(b). The IRS conclusion was that they did. The following points should be noted with respect to this ruling.

This ruling was issued in response to a request from ACLI for a somewhat more comprehensive ruling. The ruling doesn't define the eligibility requirements for long-term-care benefits, that is, what a beneficiary had to have in order to qualify for the benefit, which in effect ignored the industry's request for some more specific definition. The ruling does state that a recognized mortality and morbidity table could be based on an insurer's own experience if the insured has adequate experience to construct a reasonable table. The ruling does not address at all any of the questions of policyholder taxation. The industry had requested that these issues also be addressed.

Various ACLI groups have been dealing with questions arising under long-term-care riders. One difficulty in coping with these questions is the wide variety of riders that are involved. Some riders are what you might call independent riders, that is, they provide long-term-care benefits which do not interrelate with the death benefits under the life insurance contract, but merely access life insurance contract cash values in order to pay premiums. Another type of rider provides reductions in the life policy's benefits by dollar-for-dollar reductions in the net amount at risk or in the cash value, as benefits are paid out. This type of rider might affect life insurance contracts indirectly by means of establishing a lien against life contract benefits rather than by reducing them directly. Under this latter approach, there may be some question as to whether these liens are merely funds advanced against policyholder values or are in fact distributions, as under the former approach.

Somewhat different tax questions or at least different answers arise for each of these types of riders. First I'll deal with treatment of the long-term-care riders under 7702 and 7702A. Under

7702 charges, qualified additional benefits are treated as benefits under the life contract and consequently are taken into account in figuring the limit calculations. Thus they increase those limits by their presence. Correspondingly, the presence of a qualified additional benefit will increase premiums paid under the contract which count against the limits. On the other hand, other additional benefits, that is non-qualified additional benefits, do not increase the guideline premium limits, but charges, to the extent pre-funded, still count as premiums paid and count against the limit. Qualified additional benefits are specifically listed in Section 7702 and long-term-care riders are not included in this list. The question, therefore, is whether they should be added to the list of qualified additional benefits. As an alternative, you might hold that long-term-care riders are not additional benefits at all, but rather are separate contracts. Recall that 7702(a) speaks of a life contract under applicable state law. If the states treated long-term-care riders as not being an integral part of the life contract, then there would be some support for this non-additional benefit view. However, states so far seem to have ignored this distinction.

Current discussion on these issues appears to have resulted in something like the following preference. For dependent long-term-care riders, at least those not using the lien approach, qualified additional benefit treatment is desirable and should be pursued by means of regulatory authority under 7702 or by legislation, in order to avoid other additional benefit treatment. For independent long-term-care riders, qualified additional benefit treatment should not be pursued because of the lack of interrelationship of benefits. Qualified additional benefit treatment could lead to very large long-term-care rider benefits and premiums being supported by a very small life policy. It is thought that this would not be a particularly saleable kind of position to Treasury. However, it should be clarified that independent long-term care riders should be treated as separate contracts for all purposes; thus, life contract funding to pay long-term-care rider premiums would be treated as a series of partial withdrawals from the life contract.

Now let's take a look at the taxation of the benefit payments themselves. The taxpayer's gross income does not include certain death benefits under Section 101, does not include compensation for injuries or sickness under Section 104, and does not include payments under certain accident and health plans under Section 105. However, such excluded amounts reduce Section 72 basis in the underlying annuity, life, or endowment benefit contract. Questions raised for a long-term-care rider are: (1) Are the benefits paid excludable under any of these provisions? (2) If so, do they reduce the life contract's basis? That is, are they treated as received under the life contract? (3) If there is a basis reduction, could it be limited to some mini-basis allocated to the long-term-care rider alone? If these benefits do reduce basis, then a life contract with a long-term-care rider could rapidly run through its basis.

The consensus so far seems to be that for independent long-term-care riders there is no basis effect from the long-term-care rider benefit. The lack of qualified additional benefit treatment would support this position. For dependent long-term-care riders, the consensus is that the basis should be reduced only to the extent that the cash value of the life policies is used to pay the long-term-care rider benefit. However, an ACLI group concluded that pursuit of explicit clarification would not be a useful thing at this time. Note that the same basis issue potentially exists with respect to benefit payments under some other qualified additional benefits. There are additional 7702 and 7702A issues for dependent long-term-care riders, namely whether the reductions in life benefits made as long-term-care benefits are paid would cause limit adjustments to be made under 7702, and whether they could incur the dreaded retroactive seven pay limit recalculation under 7702A.

I hope all the foregoing gives you some flavor of the issues involved in long-term-care riders. In contrast to the other areas I have discussed, there is precious little statutory guidance. Within the industry there is not a great deal of consensus on what we'd like to see written into the law if we had the opportunity. In closing, I'll note that some of the same kinds of questions arise in connection with other forms of accelerated benefit riders; the so-called dread disease riders which prepay some of the death benefit, in case of stroke, cancer, AIDS, and so forth, and the so-called living benefits riders which pay a substantial part of the death benefit in case of demonstrated terminal illness. There are plenty of obscurities in the tax law when we're dealing solely with life insurance. When we intermingle non-life benefits, the questions really begin to get out of hand.

MR. HERTZ: Given the good news you've heard so far, I guess the last thing you really want to know is that there's something more that they might actually do to us. But there are areas of future threat that we might at least take some note of. The first of these is the whole area of

corporate owned life insurance. Corporate owned life insurance seems perennially to hang by a thread. The inside buildup on corporate owned life insurance is included in the adjusted current earnings preference calculation of the alternative minimum tax for corporations. For alternative minimum tax payers then, you get a 15% tax on the inside buildup. Mr. Rostenkowski has recently proposed changes in the alternative minimum tax which among other things would have the effect of fully including inside buildup on corporate owned contracts in the alternative minimum. That would give you a 20% tax on corporate owned inside buildup for alternative minimum tax payers. Tax staff people often include something as a preference in the alternative minimum tax as a kind of a memorandum to their successors of things that still need to be done.

Treasury representatives, in testimony in March of 1988 to the Sub-committee on Select Revenue Measures of the Ways and Means Committee, ran through a kind of a litany of what's wrong out there with life insurance. First they noted the abuse as they see it, of the $50,000 limit in Section 264(a)(4) by simply insuring more bodies. That $50,000 limit is a limit on the amount of indebtedness that would be recognized for deductibility of interest in corporate owned plans. They question, in fact, the existence of insurable interest within some of these programs. If there's a lack of insurable interest, the contracts might not be life insurance under the applicable state law and, hence, might not be life insurance for federal income tax purposes. They also noted the use of life insurance as a substitute for deferred annuities, whose inside buildup would be taxed under present code section 72(u). The position that Treasury finally came down to was that inside buildup should not be available indirectly through the holding of insurance where it would not be allowed directly, in areas such as retiree health plans or non-qualified deferred compensation. The Treasury can't seem to find any good use for corporate owned life insurance. One of the problems in trying to defend it is the lack of obvious widows and orphans to hide behind.

The second favorite target is deferred annuities. There are people who used to be in the Treasury Department who, every time they said something about deferred annuities, it was to the effect that those annuities really ought to be taxed. The inside buildup on deferred annuities owned by corporations is already taxed by the 1986 Act. The comparison with non-deductible IRAs is very damaging. In a non-deductible IRA, you are allowed to contribute a limited amount to your IRA, but you get no deduction for the contribution. All you get is inside buildup. Staff predictably uses this comparison as a reason why you should put strict limits on deferred annuities as opposed to a reason why the limits should be removed on non-deductible IRAs. An area that comes up and has been coming up for quite some time is the question of basis. Staff has long wanted to force an adjustment for cost of mortality into the computation of investment in the contract under section 72. Basically, staff sees the value of coverage that the policyholder has had as something that the policyholder has received out of the contract and feels that the policyholder's basis in the contract should be reduced for that value just as you would reduce it had the policyholder taken money out of the contract. There is a precedent for this in present code section 7702(g). That is the section that tells you how you tax contracts that are life insurance contracts under state law but which fail the definition requirements of section 7702. It used to be that we could say that's how you tax flunks, but that certainly isn't how you tax life insurance contracts. It's getting a little bit harder to say since those specific provisions in 7702(g) are referenced for use in the alternative minimum tax on corporate owned life insurance. On the other hand, we should note that the essential thrust of 7702 and 7702A was a deliberate attempt to increase risk coverage under life insurance contracts. That seems like a better tax policy than taxing the risk element. Another argument that the industry leans on is the question that we always ask; why should we come first? Let them adjust homeowner's basis for the rent value taken out of homes, then come around and talk to us about taking cost of mortality as a value in computing the contract basis.

MR. PAUL D. REEDER*: The statutory definition of material change seems to be pretty broad in that it talks about changes in the terms of the contract. Is there any indication of how IRS may interpret non-financial changes, in particular, a change of ownership of a contract?

MR. PALMER: If there is a change in the insured, it is hard for me to see why that would not be a whole new contract. With a change in the life that is used for measuring the contract, it's hard to see how you could cast it as a continuation.

* Mr. Reeder, not a member of the Society, is Assistant Actuary, Product Development of Beneficial Life Insurance Company in Salt Lake City, Utah.

MR. SMITH: If you are speaking of corporate owned life insurance, it is known that the Service is taking a look at that particular issue right now. It may take the position that you may have a deemed surrender and repurchase of the entire contract without regard to what happens to it under 7702A.

MR. HERTZ: I think that addresses the question of substitution of insureds. The question of a change in ownership of the policy is somewhat a different matter. I guess I personally don't see any reason why that should be a cause for retesting, but it would have to be an area where I'd say we just don't know.

MR. THOMAS L. BOWDEN: This is particularly addressed to Mr. Palmer, and substandard issues, whether a substandard issue is either just a flat table rating or as a percentage of standard. Do you think that the seven pay premium should be adjusted by a like amount or calculated using a substandard adjusted table?

MR. PALMER: I would think so. Yes. It's hard to find the authority to do it, but I think that would be the approach to take.

MR. KEVIN A. MARTI: Along the same lines as the last question, if you take a literal reading of the law, it seems to me like if you go beyond 1980 CSO for anything, you're treading on thin ice, whether it be smoker or nonsmoker, unisex other than in Massachusetts, some multiple of the table for simplified issue and guaranteed issue in payroll deduction.

MR. PALMER: That's all true. I think if you took a literal reading of the law, you'd probably go into another line of work. You can't possibly function if you believe everything you see written down. There simply is no definitive guidance, and really you're just stepping out into unchartered waters when you make the assumption that it's appropriate to use.

MR. SMITH: In discussions with Treasury people, they were quite sympathetic to the problem and they had no particular interest in preventing the sale of life insurance to people with mortality problems. But the exact technique by which they will enable that is not known.

MR. MARTI: Are any companies using simplified rules to calculate the amount that should be subtracted from the new seven pay premium? In other words, something as simple as dividing the cash value by seven and subtracting that off with the new seven pay premium?

MR. PALMER: We used a simplified rule before we got proposal software support. It was a safe approximation approach, that would always err on the conservative side. I think that's perfectly okay, so long as you're sure that the approximation is always on the right side of the answer.

MR. CHRISTIANS: If one has a MEC with a gain and receives a distribution from it, but also has another modified endowment in which there is currently a loss, that is combined under serialization rules, would you get to offset the loss against the gain? And avoid payment of the tax?

MR. PALMER: It sounds like it to me. So you apparently can keep buying serial contracts with losses in them in order to keep postponing the emergence of gain.

MR. HERTZ: The one awkwardness there would be is that the aggregation takes place under something that's labelled an anti-abuse rule, and so you're reaching a little bit to claim a benefit out of it. But I would say, go for all the gusto you can get.

MR. LAWRENCE DYKSTRA: We have a fixed premium universal life contract where we allow dump-ins to the contract by use of a paid-up additions rider. When the insured elects not to pay premiums into the basic policy by surrendering paid-up additions, it seems as though we may be counting the same premiums twice in determining the total premiums paid into the contract. Is that the correct interpretation? In other words, the money is counted as premiums in the contract when it's paid for the paid-up additions rider and then again when it's taken out of the paid upp additions rider to pay basic policy premiums. Is it counted twice?

MR. PALMER: No, I don't think it is. As we noted before, there is a question hanging open as to whether the surrender of additions would be deemed to be a distribution out of the contract with a possible LIFO tax consequence, followed by a payment into the contract. But if you took that

viewpoint, the distribution out would reduce your base amount paid in. I think this would have a sort of a cancelling effect. And there is still, I think, an excellent chance that we're going to get the IRS to clarify that in these circumstances, no amount is thought of as having come out of the contract and no amount is thought of as having gone into that contact, and it just doesn't count as an amount paid.

MR. CHRISTIANS: I have a question for Mr. Hertz. You talked about possible taxation on cost of insurance. Would you think that the insurance industry, as a whole, had more of an interest in protecting the current tax status of cost of insurance than it has on protecting the tax status of inside buildup, and do you think that there might eventually be some trade-off there with future generations of legislation as to giving up one and not the other?

MR. HERTZ: Well, I would say inside buildup would have to be the higher priority. The cost of insurance is something that would only be taxed, as I was discussing it at least, on surrender of the contract. It's a matter of adjusting the policyholder's investment in the contract to recognize cost of mortality. With loss of inside buildup, you'd be taxing all gain currently.

I would think that the business of the insurance industry is to accept risks and to provide coverage in exchange for premiums or charges, and this carries over to other things such as employee benefit plans where there have been some suggestions that employees should be taxed on the premiums the employers pay for them. If there could be some general recognition that, since this is not money in hand, it should not be treated as taxable income, that might do the insurance industry more benefit than to maintain the status of sheltering inside buildup.

MR. CHRISTIANS: The circumstance that I was addressing is one where money would be at hand. You're only addressing a question of the investment in the contract, for measuring the amount of possible gain the policyholder has received to something like contract surrender. I agree that questions of employee benefit plans and so forth raise up a whole new series of issues and different companies would have very different lists of priorities in terms of what they think is most important to protect.

MR. PALMER: There was a very interesting article published recently in *Tax Law Review* by Andy Pike who was at Treasury Department during the development of TEFRA. It's a fairly lengthy article, called "Reflections on the Meaning of Life: An Analysis of Section 7702 and the Taxation of Cash Value Life Insurance." It presents reasonably dispassionately and cogently the arguments for modifying the way our products are taxed. It has a lot of interesting thoughts, not all of which are correct. It has a lot of illustrations, and it gives you a very good flavor for the kinds of arguments that our opponents will be bringing against us. It proceeds from an overall policy basis, not just a "let's raise more money" basis.

MR. WILLIAM J. SCHREINER: John, I don't have anything to add to your remarks on substandard mortality. But I do have a thought on the question of changes in the policy. When we were looking at adjustment issues relative to 7702, one of the conclusions we came to was that for something to be an adjustment, it ought to be something that would affect the original calculation under 7702. I think a similar line of reasoning might be appropriate here. If you have a change in the policy that had it occurred at the time the original seven pay calculation was made that would not have affected that calculation, it shouldn't affect it later on when it occurs.

FROM THE FLOOR: With respect to the 60-day correction period where you'd have to return premium plus the appropriate interest, how would you handle that on a variable policy where there is no fund that's earning credited rate?

MR. HERTZ: The effort would be to try and put the contract into the position that it would ocupy had the money never been put in. And that's something for which you would have some knowledge. You know what the unit values were back then. You know what they are now. And you can say what gain occurred in the contract due to the existence of those amounts and make your adjustments accordingly, either a gain or a loss, as applicable.