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SECTION 7702 & 7702A: AN UPDATE

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Lawyers representing the American Council of Life Insurance (ACLI), the IRS and the law firm of Davis & Harman will discuss:

- Status of the IRS Rulings
  - -- Review of Private Letter Rulings
- ACLI Activities
  - -- Section 7702 "Algorithm"
  - -- Submission to the IRS on examples and simplifying assumptions for Section 7702's tests
  - -- Report from the ACLI working group regarding material changes in Section 7702A
- Other topics
  - -- Legislative initiatives including the ACLI proposals
  - -- International reach of Section 7702 and 7702A: branch and foreign subsidiary sales to nonresident aliens

MR. TIMOTHY P. SCHILTZ: Our first speaker is Steve Hooe who is the current Chief of the Insurance Companies and Product Branch in the office of the Financial Institutions and Products of the Internal Revenue Service (IRS). He develops and administers the IRS position papers for insurance companies and products, and he reviews letter rulings and technical advice memoranda. He also is involved in developing revenue rulings and regulations for both insurance companies and their products. Steve will provide an update on the regulations projects that the IRS currently is working on with respect to Section 7702 and 7702A.

MR. STEPHEN D. HOOE: Before I start, let me give you the disclaimer that all government speakers are required to give. Anything that I say represents my personal views. They haven't been cleared with the Office of Chief Counsel, the Treasury, or anyone else connected with the Service or Treasury. So, what I say and 49 cents will buy you a cup of coffee in the IRS coffee shop or whatever. That being the case, I will try to give you the information that I can make available.

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I want to start off by talking a little about the status of the various regulations projects. I also will talk briefly about the revenue ruling that the Service recently issued, dealing with the reporting and withholding requirements for failed contracts.

As I'm sure all of you are aware, the Technical and Miscellaneous Revenue Act of 1988 (TAMRA) amended Section 7702 to require the use of reasonable mortality charges. TAMRA did not, however, define what reasonable mortality charges are, other than to limit those charges to amounts not greater than those in the prevailing Commissioner's tables used to compute life insurance reserves. Rather, what Congress did was leave the job of defining reasonable mortality charges to the Service and Treasury. Pending the issuance of regulations, however, the conference report did indicate that mortality charges would be deemed to be reasonable if they did not materially differ from charges actually expected to be imposed by the company, taking into account any relevant characteristics of the insured of which the company is aware. The statute also instructed the Service to issue regulations with respect to the reasonableness of mortality charges by January 1, 1990.

In response to that mandate, the Service issued Notice 88128. Notice 88128 set forth two safe harbors. The first safe harbor provided that mortality charges would be deemed to be reasonable if they did not exceed 100% of the applicable mortality charges set forth in the 1980 CSO tables. This reference to the 1980 CSO tables was intended to refer to the 1980 CSO standard ordinary mortality tables of the National Association of Insurance Commissioners for males or females insured without select factors. The notice also provided that if a state required the use of unisex charges which resulted in higher charges for female insureds, those higher charges would also be permitted.

The second safe harbor in the notice really was a transition rule. There were certain contracts that had been issued between October 21, 1988 and December 31, 1988, based on the 1958 CSO tables. It was our understanding that commencing with 1989 there would be uniformity across the country requiring the use of the 1980 CSO tables. The second safe harbor allowed certain contracts that were issued during this interim period to be based on the 1958 CSO tables. In order to use the second safe harbor, however, the contract could not be a modified endowment contract, and it had to have been a contract for which the policy blank had been approved by the appropriate state regulatory authority before October 21, 1988. While it was not clear in the notice as to how you tested a contract to determine whether it was a modified endowment contract, it was intended that you do that test using the 1958 CSO tables. You didn't have to use the 1980 CSO tables to determine your eligibility for the second safe harbor.

The two safe harbors will apply to contracts that are issued up to 90 days after the issuance of effective regulations setting forth standards for determining the reasonableness of mortality charges. So, the notice did provide that there would be a 90-day window period, once effective regulations are issued. This does not mean proposed regulations, but effective regulations. During the window period, contracts issued consistent with the notice would still be deemed to meet the reasonable mortality charge requirement.

There were a number of questions that were left unanswered by Notice 88128. I will run over a few of these. These questions include: whether the mortality charges under the 1980 CSO tables will be allowed as a safe harbor under the regulations; whether the unisex rule in the notice will be extended to situations in which the state permits, but does not require the use of unisex tables; whether the 1980 CSO smoker/nonsmoker mortality tables will qualify as reasonable mortality charges; and whether the regulations will specify standards for reasonable mortality charges in the case of substandard risk or simplified underwriting. The reasonable mortality regulations project will provide guidance with regard to several of these questions in the near future. The project is in the final stages of review, and I expect that proposed regulations will be issued before the summer. I would like to note, though, that I'm talking about proposed regulations. So we're not talking about regulations that will be immediately effective.

The advantage for proposed regulations, obviously, is that affected taxpayers have the opportunity to comment on the regulations before they take effect. In view of the complexity that's inherent in Section 7702, and in defining the reasonableness of anything, much less reasonable mortality charges, we'll be extremely interested in hearing any comments that taxpayers may have concerning the proposed rules, or anything that we've omitted from the proposed rules.

I want to turn now to the 7702 regulation project. Section 7702 has been with us now since DEFRA, since the 1984 act, and no proposed regulations have been issued. Notwithstanding that, over the last 18 months, the people in the insurance branch have devoted considerable time and effort to the study of the provision. During this period, we have identified several issues. We also have received submissions from the ACLI and various taxpayers. We hope to issue proposed regulations that will deal with these issues.

Some of the issues that we have identified, if we break them down into categories, include issues arising under applicable law. Just what is the meaning of applicable law? Is it limited to state or foreign law? Does it include federal law? It's an important question, for example, because the federal plan, Federal Employees Group Life Insurance (FEGLI), may not be regulated under state law as an insurance contract. Do we want to say that FEGLI is violative of 7702? The answer is probably not. But to satisfy an applicable law requirement may require that we look to the parts of the U.S. Code that deal with FEGLI, as opposed to state or local law. By the same token, if a state were to have a plan for state or municipal employees that closely resembles FEGLI, but was not subject to regulation of the state insurance commissioner, would that violate the applicable law requirement?

That brings us to the next question, What do we really mean by applicable law? Does a contract have to be regulated by the state insurance commissioner? Or is it enough that the contract be recognized as life insurance under state law? We've heard from folks who have different views with regard to this. The ACLI view, and I guess the industry view, is that a contract should be both recognized and regulated as life insurance in order to meet the requirement. I'm not sure how the regulation will come out on this issue.

Another issue is when must a contract satisfy the applicable law requirement? Is it enough that it satisfies the requirement at the contract's issue date? Or must it satisfy the requirement at all times during the life of the contract?

Still another issue is, How are the holders of contracts that fail the applicable law requirement taxed? Unlike contracts that fail the computational test, for which there are specific rules in 7702(g), the statute is silent with regard to contracts that fail the applicable law requirement. What is the characterization of the contract? Is it subject to the Original Issue Discount (OID) rules? Do the economic benefit rules apply? There are a whole host of questions as to how the holder of a contract that fails the applicable law requirement is taxed.

Another issue involves combination arrangements. Some have argued that the legislative history indicates that if you have a term life-annuity arrangement, the death benefit under the term contract should qualify for the exclusion under 101(a), notwithstanding that the insured's early death produces a gain for the insurance company on the annuity policy that exactly offsets the loss on the insurance policy.

Turning to the computational test, in relation to the cash-value accumulation (CVA) test, we've been asked whether the contract's cash value includes amounts for which the policyholder cannot borrow. The legislative history would suggest that these amounts are excluded. That legislative history may be designed to accomplish something or had something specifically in mind with regard to credit insurance. I would be hesitant to infer from the legislative history that the mere fact that one cannot borrow will exclude the amounts from the cash surrender value. Another request that we have received is whether, with regard to the CVA test, the regulations should construe the term "at any time" in 7702(b)(1) to not require daily testing. I think we recognize the administrative difficulties under 7702. And I have some sympathy for practical approaches to problems that will insure compliance, or prevent abuses of Section 7702, but do not impose a heavy administrative burden on the company.

With regard to the guideline premium cash-value corridor test, some of the issues that we've identified include how to take alternative interest rates, or secondary interest rate guarantees, into account. I know John is going to be talking about some of the private letter rulings that have been issued and I may have some additional comments on those rulings at that time. I want to say that the regulations are going to do make it clear that you have to search for the interest rate that's implicitly stated in the guaranteed nonforfeiture values, and not just use the interest rate that's explicitly stated in the contract, to determine what is the interest rate guaranteed on issuance of the contract.

Another question is whether there should be a de minimis guarantee for short-term duration guarantees. I don't know how that one is going to come out. Obviously, there is a de minimis rule created in the legislative history. The issue is whether or not that rule ought to be extended.

Finally, another issue is how to apply the cash-value corridor test in the case of second-to-die or last-to-die contracts. One of the questions that we're facing here is whether the regulatory authority under 7702 is broad enough to allow the Service to

create wider corridors for second-to-die or last-to-die contracts. The current corridor in 7702 just doesn't make sense when you're dealing with a second-to-die contract. Congress viewed 7702 as regulating the investment orientation of life insurance by insuring that significant mortality charges would be imposed. If you backload the mortality with a second-to-die contract, it defeats the Congressional intent underlying the whole scheme of the statute.

We have also identified some issues arising under the computational rules and under 7702(f)(7). For example, one of the letter rulings, 8816015, deals with an exchange of a pre-1985 contract for a new contract subject to 7702, followed by a withdrawal from the new contract. The ruling treats the withdrawal as a distribution under 7702(f)(7). When I was reading the ruling coming down on the plane, I almost came out of my seat when I saw that conclusion. It seems fairly clear to me that where you have an actual exchange and a withdrawal that is incident to an actual exchange, or a step in an integrated transaction, the withdrawal should have been treated as boot under 1031(b) and not tested under 7702(f)(7). I understand the amendment that was made to 7702(f)(7) with regard to the deemed exchange rule that existed when the statute was originally enacted. But the change from the deemed exchange rule in the original statute to the present version of 7702(f)(7) does not, in my view, change the rules at all with regard to actual exchanges.

We've also examined various rules arising from the transition rules under 7702 and 7702A. For example, one issue currently under consideration is whether or not the addition of an accelerated death benefit will result in a contract losing its grandfathered status.

We also have had discussions with representatives of the industry and with the ACLI about developing an easily administered safe-harbor-type test for establishing compliance with the tax net single premium and guideline premium limitations. Jack, I think, is going to be talking about the ACLI submissions. At this point, we are still waiting for that submission from the ACLI, so the only thing I'll say is Jack, we look forward to hearing from you. We don't expect to issue any regulations under 7702 until we've had a chance to consider the ACLI submission.

I would invite all of you, to the extent that you have questions arising under 7702, to submit ruling requests. The Service will rule under 7702 and 7702A. When I say the Service will rule, I mean the Service does not have a no-rulings policy in effect with regard to those two sections. With a particular ruling request, we always reserve the right to refuse to rule in the sound administration of the tax system. But as a general matter, we will make every attempt to rule, and provide guidance under 7702 and 7702A, even though we haven't put regulations out.

With regard to the modified endowment project, we all know that in addition to the reasonable mortality charges, TAMRA also gave us a new category of life insurance contracts called modified endowment contracts (MECs). There are a whole lot of computational issues associated with 7702A. The insurance industry, through the ACLI, has requested clarification on several issues. Included among these are guidance on the $75 expense allowance of small contracts under 7702A(c)(4). Specifically, it has asked us to indicate whether a contract can retroactively lose the $75 expense allowance, if the aggregate death benefits for the current and all

previously issued contracts exceed $10,000. It has also asked us whether or not contracts that do not use the $75 allowance, because they're either modified endowment contracts or because they do not need the allowance, should be excluded from the aggregation for purposes of determining the $10,000 death benefit.

In addition, it asked us to issue regulations under 7702A(c)(5) to adjust the seven-pay premium to take into account collection expenses with respect to premiums paid more frequently than annually. It also asked for clarification of whether the net amount of the premium used to compute the amount of the necessary premium for the cash-value accumulation contracts should be limited to premiums paid with funds external to the policy. It also asked us how to compute the deemed cash value for purposes of the necessary premium exception. The insurance branch has an open project to address some of these issues, as well as some other issues arising under 7702A. There has been some progress on the project, but at this point, the project is still in a preliminary stage. I wouldn't expect to see any proposed regulations under 7702A before 1992.

Also I wanted to talk briefly about second-to-die contracts. As I indicated earlier, we are aware that second-to-die contracts are being marketed by several companies. And we are aware that by backloading the mortality that's inherent in a second-to-die contract, one can increase the internal rate of return during early durations to something approaching the rate of return that one would receive if one had purchased a deferred annuity. We do view this back-loading the mortality as potentially abusive of the Congressional policy underlying 7702. Thus, I think that it would be wise to proceed with some caution here.

I would remind you that allowable values for second-to-die contracts, like all other contracts qualifying under 7702, have to be determined on the basis of reasonable mortality charges. And it seems to me that it is at least arguable that in determining what is a reasonable mortality charge -- that is, in determining whether or not those charges are actually expected to be imposed -- which is the standard that Congress set pending the issuance of regulations, one ought to take into account the likelihood of surrender of the contract. So, if you backload all the mortality, or virtually all the mortality to ages after age 65, and you expect all your policyholders to surrender at age 65, it seems to me that the charges may not pass a reasonable mortality charge requirement, and you may have a problem under 7702.

One other point about second-to-die contracts: The Service does have the regulatory authority under 72(e)(5)(c) to change the distribution rules for life insurance contracts other than MECs. As products like second-to-die or last-to-die contracts develop, it does increase the pressure on the Service to exercise that regulatory authority and impose annuity withdrawal rules. If we're looking at products that essentially offer rates of return that are equivalent to the rates inherent in a deferred annuity, it would seem reasonable that the withdrawal rules that are applicable to deferred annuities also ought to apply to withdrawals under those contracts. Obviously, to date we haven't exercised the regulatory authority. All I'm saying is that we read the code; we know 72(e)(5)(c) is there.

Finally, I'd like to talk a bit about Revenue Ruling 91-17. The Service recently published Revenue Ruling 91-17, which sets forth a life insurance company's -- any

insurance company's -- reporting, withholding, and deposit obligations with respect to income on a failed contract. I'm not going to walk through 3405 and the various penalty provisions that are all cited there. It is sufficient to say that the ruling concludes that there are reporting, withholding, and deposit obligations with respect to income on the contract, and that there are civil penalties for the failure to comply with those requirements. The aspect of the ruling that I would like to talk about is the window period for issuers with failed contracts to come in, cure the contracts, and to avoid civil penalties. Currently, the ruling indicates that if a company has failed contracts, and it can come in under the 7702(f)(8) waiver provisions and receive a waiver, there will be no civil penalties imposed.

The ruling also indicates, although, if it's not a reasonable error, (for example, you've assumed increasing death benefits for a guideline single premium policy, or if you used mortality charges that were not reasonable mortality charges) that is, if you violated a clear statutory rule, then you're going to need to come in to the Service and propose to enter into a closing agreement. The ruling makes it clear that if you will come in before June 3 and propose to execute a closing agreement, and basically make the government whole by paying the tax and interest that would have been due the government, the Service will waive civil penalties. But the key aspect of this is that the window period does not remain open forever. The ruling makes it clear that the window stays open only until June 3. So it is a limited opportunity to come in and get right with the Service with regard to failed contracts.

One other thing I'll just note in passing, since this is really a company tax issue, and I didn't come to speak on company issues, we are currently working on regulations under 848. This project is a priority project in the insurance branch, and it is absolutely necessary that we get some guidance out to insurance companies so that they will be able to file their returns. So we're going to need to issue guidance before the end of the summer. One of the things that we've looked at is whether there should be a contract-by-contract approach, or whether you should use a funds-inside-the-company approach. I think it's at least arguable that a contract-by-contract approach makes more sense, in which case, if you have 1035 exchanges or other exchanges, it may be that deferred acquisition cost (DAC) is imposed for a second time. We would welcome any comments that any taxpayer, or anyone else, would like to make concerning the operation of Section 848. But there is a limited time frame for submitting those comments. If we're going to try to be going forward with guidance between now and the middle of the summer, we would need to get those comments in as quickly as possible. If any of you wish to make comments, we would like to see them. With that, I will turn it back to Tim.

MR. SCHILTZ: Our next panelist is Jack Holt, who is a senior counsel at the American Council of Life Insurance. Prior to joining the ACLI, Jack tried cases in tax court for the IRS as director of the corporation tax division of the Office of Chief Counsel. While at the Service, Jack was responsible for establishing the position of the IRS with respect to corporate issues. He'll be giving you an update on the current ACLI activities and the international reach of Section 7702.

MR. JOHN W. HOLT: I'd like to say to Steve that it is the ACLI's position that the case of *Helvering* v. *Le Gierse* remains alive and well and that there's nothing in 7702 that overrules *Le Gierse* as a concept. Section 7702 basically establishes a risk

corridor and prescribes a certain level of risk. *Le Gierse* merely tells you what kind of risk it is and how you go about analyzing the required nature of the necessary risk.

Basically, I'm going to cover three areas. ACLI's consideration of material changes under 7702A, General Bulletin 4321, was distributed this year to the companies. It'll be difficult to describe the numerous nuances in the paper, but I'll try and give you a rough overview of it.

Most of you know that ACLI submitted a calculations memorandum to the IRS. Steve referred to it. And as Steve also commented, we're now working on a simplified calculation approach to be used as a company safe harbor. And I think, quite candidly from the Service's point of view, it is also an audit guide for the IRS. The foreign area is becoming more active. ACLI has a relatively small number of companies marketing insurance abroad. There are more companies now that are interested in trying to market insurance in the international marketplace. Some U.S. definitional provisions, including Section 7702, apply to such foreign operations and are causing some substantial problems in companies trying to sort out what their competitive posture is in the foreign marketplace.

The work we did in the material change area was driven by the need of the companies for some guidance. We view what we did there as an interpretative measure. However, we contemplate sending a paper to the IRS for its information and background concerning how the ACLI interprets the material change rules. Basically, the concept of what is a material change is probably fairly well known to you. Certainly an exchange is a material change. The conversion of term life into permanent life is a material change. A change in the terms or benefits of the contract which would affect the seven-pay limit is a material change.

Some of the terms and benefits that would affect the seven-pay limit are guaranteed interest at issue, mortality charges, death benefits, endowment benefits, qualified additional benefits, the rating characteristics of the insured, and the identity of the insured, as we were recently advised in Revenue Ruling 90-109 put out by the Service.

Keep in mind that a material change doesn't necessarily mean you have to retest. This is because material changes are subject to the necessary premium exception. The ACLI, in an earlier general bulletin, noted that invoking the necessary premium exception is optional, and where it applies, the companies are not required to retest. However, they may elect to retest.

The real problem in the exchange area is determining what kind of change in the contract will be treated as an exchange. This issue is now being considered by an exchange task force in the ACLI. It is a very difficult area. There's a lot of case law and rulings. Some of the rulings seem to contradict others. Some are in specialty areas. It is often very hard to decide, in a specific situation, whether the change is clearly a constructive exchange.

There are two exchange cases pending in the Supreme Court that were argued this spring. Cottage Savings and Loan is the case. The cases involve the loan swap transactions in the savings and loan industry. That issue brings into sharp focus the

question of, What is a "material difference" under section 1001 which is the operative provision with respect to exchanges? We expect the opinions to be out soon, and I think they will have a very significant effect on the exchange area.

There are a lot of other little problems in the material change area. One, for example, is cost-of-living increases provided in the statute but subject to implementing regulations. As a result, the exception for cost-of-living increases is not operative unless the Service puts out regulations. We would hope regulations would be retroactive when issued. Until then, cost-of-living increases are technically a material change.

A change from option one to option two, where you have a death benefit increase, is a material change. Option two to option one, where you have a decrease, if it occurs in the first seven years, might be a reduction in benefits and require a recalculation. As I noted, a change in the underwriting class, in a substandard rating, or in guaranteed mortality charges which result in a change in the mortality charge used for seven-pay testing are material changes.

You can also go through a list, and the general bulletin does, to determine what changes are not material changes. Generally, a decrease in any of the contract's benefits is not a material change. Other changes which are not material changes are: change in ownership of the policy and a change in the dividend option or the loan interest rate. We hope corrections of misstatements, if they're made early in the contract's existence as of the date of issue, will not be treated as material changes. An addition of or change in a nonqualified additional benefit is not a material change.

One of the other areas of concern is combination changes where you're splitting or merging contracts. This is another difficult area. The ACLI would like to see splits or mergers treated no worse than exchanges for 7702A purposes.

Another involves what cash surrender value should be used in your retesting calculation. The most common interpretation is that the cash amount actually transferred in the exchange from the old to the new contract would be amortized, but there are other possible interpretations. This more common rule would net out any boot-and-surrender charges from the old contract but would not subtract the front-end load of the new policy.

In the simplified calculations area, there is some concern in the industry about providing the IRS with a simplified calculations format. I think it is important to step back a little bit and think about how we get where we are. Initially, the IRS considered ruling that it could split a universal life contract between its term element and its investment element. The Section 101(f) definition stopped that for flexible premium contracts. Section 7702 replaced the temporary Section 101(f) and covered all life insurance contracts. These statutes drew risk corridor lines between the benefits and the cash value in a contract.

The next question is, How does this work? The answer is that it is a formulary approach. And when you realize there are many different products and many different applications of these products, and many events that can happen during the life of a contract, you conclude, "Boy, we've really got a complex problem here." And yet the companies, as Steve noted, have had to deal with this since 1982 in

interpreting the various code provisions. Companies have got a lot of contracts out there based on these required interpretations. In that context, failure to qualify a contract for tax purposes can be very damaging to a company. It can be sued by its policyholders. It can get bad publicity, which would undermine its ability to market its products. Very heavy damage.

Clearly the companies want to comply with these provisions. They need to comply. But they are also operating in a very competitive industry. The companies can't afford to take overly conservative positions, or they risk not being competitive and not being able to market their products. So companies are caught in a Catch 22. In addition, I think it's not inappropriate to say that the general purpose of these policyholder directed provisions has been accomplished. I think they have capped the investment element in life insurance contracts, and that problem is by and large under control.

So what we're talking about now is how tightly the controls can and should be applied. The ACLI believes, and we hope that the IRS believes, that it's unrealistic to be concerned about relatively small differences. Any simplified calculation must be based on that approach.

The ACLI has extensively considered the Section 7702 area. I know Steve's branch has extensively considered the issues. In dealings with the Branch with respect to the Section 7702 regulations project, we were initially requested to try and provide them with an explanation of Section 7702 calculations. That resulted in our original calculations memorandum that included a series of formulas. The complexity and number of algorithms submitted made it difficult for Steve to take that paper and try and come up with a single computational approach that could be applied to the various insurance products in the industry. In submitting the memorandum, the ACLI pointed out that while it thought the algorithms were representative, it also noted that they couldn't be applied to all products. However, it did note that there was a verification approach that you could use which only required accumulating the required data under the terms of the contract to see whether the permitted endowment value was achieved.

When the ACLI subsequently met with the IRS and Steve, he understandably requested us to make a further effort to develop a set of simplifying assumptions and one or more simplified calculations that could be used as a type of safe harbor for the companies. And from Steve's point of view, it could be an audit guide for the agents in testing qualification of the contracts.

This is nervous business for the companies. We are attempting to design a test that can be used by the IRS to come in and audit us. And I think, in that sense, we have to be certain that it's a workable test and a reasonable test and that it'll work with the various products. So, substantial effort has been devoted to developing a simplified calculation by a group of, in my opinion, highly qualified actuaries. We started out with an annual tabular factor approach, with commutation tables. We then phased over into verification approach, and that's basically where we are now. Using a set of simplifying assumptions and a verification approach, we are developing a software program. We will let it be checked out with our companies to see if it's workable. We are trying to design it to be acceptable to the IRS. Assuming we are

successful, we will send it over and see whether it is acceptable to the IRS. We certainly share the concern with the IRS that there's a need to provide a workable and administrable approach to Section 7702.

The other area that I'll comment on briefly is the place of the U.S. definitional provisions in the international area. Section 7702 defines a life insurance contract as one that meets the applicable state or foreign law. In regard to Steve's earlier comments, I think that includes federal law. The reason you have a problem in these U.S. policyholder-oriented provisions, regarding the business you market outside United States, is because of the way the U.S. taxes its citizens, corporations, and residents. The U.S. system taxes such U.S. persons on their worldwide income, regardless of source. To the extent any of this income can be reached, the U.S. system taxes it based on U.S. tax rules. Accordingly, Section 7702 applies in determining income from life insurance contracts earned abroad where the income can be taxed under the broad reach of U.S. tax law. Section 817(h), dealing with nondiversified in contracts, which can operate to disqualify contracts, is applicable. Section 72(s) which deals with the required distribution rules on annuities is applicable.

There is a general exception to the broad reach of the U.S. system. The exception is that if you are a shareholder in a foreign corporation, you don't have to report the income of the foreign corporation until it is distributed to you. This exception is viewed as a type of tax deferral by Treasury and Congress. Congress has enacted a series of exceptions to the shareholder deferral exception. Some of which are the controlled foreign corporation provisions, foreign personal holding company provisions, foreign investment company provisions, passive foreign investment company provisions, provisions concerning gain from sales or exchanges of stock in certain foreign corporations, and others. Companies have to deal with these provisions if they are selling products outside of the United States.

Our companies normally operate abroad in either branch form or using a foreign insurance subsidiary. The branch is considered a part of the U.S. corporation and is taxed as such. Therefore, where a branch makes distributions to its nonresident alien policyholders, one of the issues now pending is whether that distribution is subject to the 30% U.S. withholding tax rules. The issue arises in countries like Taiwan that require branch operation by foreign insurance companies. This means that if you make a distribution to the policyholder under the contract, for whatever reason, you may have to withhold 30%. The minute you withhold 30% from these Taiwanese policyholders, they're going to cancel the contract. This situation is unworkable if we are going to do business in countries that require us to be in branch form.

The Controlled Foreign Corporation (CFC) provisions tax the U.S. shareholders on the annual earnings of the foreign company whether distributed or not. The income automatically goes over and it is taxed. This attribution creates problems. One problem is the so-called mutual fund issue. The CFC rules have tiering rules, so if the U.S. company's foreign insurance subsidiary controls a mutual fund in which it is investing policyholder funds, the tiering rules make the foreign mutual fund a CFC. This results in the mutual fund's investment income "leapfrogging" over the foreign insurance company and going directly to the U.S. shareholder in the year earned. This is a cataclysmic event that the companies can't live with. By leaping over the

investing foreign insurance subsidiary, the income is not offset by the otherwise applicable reserves and is taxed in full.

Another issue is that insurance products that can be marketed in foreign countries will not necessarily qualify under section 817(h) and 7702. If enough contracts fail to qualify the CFC will fail to qualify as an insurance company under Section 816. In addition, there are problems as to what kind of reserve you get for so-called failed foreign contracts.

The issue comes down to a tax policy question of whether these policyholder directed provisions should be applied at the company level, against companies selling insurance abroad to nonresident aliens. The other side of the question that may eventually have to be confronted by the industry and Congress is whether the United States or foreign definitional rules should apply to insurance products involving nonresident aliens.

I think we're going to see more activity in the foreign area by our companies. It's expensive to get into the foreign marketplace; it takes both time and a capital commitment. But there's a lot of business out there. We have foreign companies moving into the U.S. marketplace. The ultimate question is, What kind of a presence are the United States companies going to have in the rapidly developing international insurance marketplace? Clearly, to have any effective presence, we must deal with some of these U.S. tax provisions that make it virtually prohibitive for the U.S. companies to compete abroad.

MR. SCHILTZ: Our final panelist is John Adney, who is a partner in the Washington, D.C. law firm of Davis & Harman. John has provided legislative assistance to the Stock Information Group over the past decade in all areas of company and product taxation. He has been involved in product taxation issues since 1977. John has spoken at numerous Society of Actuaries meetings and brings a wealth of information to every session at which he speaks. John will discuss current legislative issues and recent private letter rulings (an index of the rulings is appended to the end of this session). After he finishes, Steve will comment on the current applicability of the rulings.

MR. JOHN T. ADNEY: By and large, I think the legislative side of Sections 7702 and 7702A is fairly quiet right now, maybe mercifully quiet. We are not expecting much out of the Congress this year in the tax area, and that would certainly include insurance product taxation. There's always the possibility of something happening later this year, or sometime in 1992, but I think the likelihood of significant change in Section 7702 or 7702A is very remote.

Nonetheless, there are a couple of technical issues in this area that could arise in legislation and a couple of substantive issues that you should be aware of. The ACLI, last fall, began discussions with the government staff on the Hill about making technical changes to Section 7702A. The Joint Committee staff tentatively indicated that they would be receptive to several technical corrections, though very minor ones. One of these would simply clarify that the so-called reduction rule in 7702A(c)(2), which requires a retroactive recalculation when there is a reduction in benefits during the first seven years or seven years following a material change, would not apply if

the reduction came about simply because a benefit was paid. The ACLI's concern, in particular, was that a qualified additional benefit might be paid out, causing a benefit reduction from an overall standpoint.

The reason for the reduction rule was to stop tax abuse. The Joint Committee staff reasoned that the payment of a benefit was the reason the contract was there and was not abusive. So it said it would be willing to clarify that the payment of a benefit is not a reduction. It also was willing to remove some apparent inconsistencies between the definition of the "amount paid" under Section 7702A and the definition of the premiums paid under Section 7702, which are, by and large, the same item.

On the other hand, the ACLI asked for a number of other changes that would be beneficial to the industry and to the administration of Section 7702A's "modified endowment" rules, to which the Joint Committee staff showed little or no sympathy. Included in these, first of all, was a provision to correct failures of the seven-pay test; Section 7702, as Steve mentioned earlier and as is covered in Revenue Ruling 91-17, permits a company to obtain a waiver from the Service if there has been a failure to comply due to reasonable error and if reasonable steps are being taken to correct the failure. The ACLI was asking for a similar rule under Section 7702A. The Joint Committee staff, however, thought that that would not be appropriate. Apparently, it noted that failure to comply with Section 7702A carried with it a penalty not as draconian as that for failing Section 7702: a policyholder still had life insurance if his or her contract "flunked" the seven-pay test. Loans under such a contract simply became taxable as distributions under the so-called annuity rules. The Joint Committee staff also felt that Congress intended for Section 7702A to be a tough rule, and the committee thought it important to continue to apply it in that manner.

Also, for a variety of good technical reasons, the ACLI asked for clarification that there could not be more than one "material change" under Section 7702A(c)(3) during any policy year. There were good reasons from an administrative standpoint and from an antiabuse standpoint to avoid multiple material changes during a policy year. But the Joint Committee staff felt that the statute was clear enough that, whenever a material change occurred, it was treated as the issuance of a new contract, starting a new contract year under the statute. And that's probably the way it will remain, unless and until it finds a more compelling reason to change anything.

Also, the ACLI asked for some kind of legislative relief, pending the issuance of regulations, under the cost-of-living-adjustments rule which is part of the material change rules of 7702A. The joint committee staff declined to agree to any such interim guidance and left it to the Service to issue regulations on the subject. Thus, in general, the staff seemed unwilling to go along with any further legislative change, by relief or otherwise, in Section 7702A. The committee feels that Congress has spoken, and now Steve, it's your turn.

I would mention two other subjects on the legislative side. One is, again picking up what Steve mentioned, joint-and-last survivor life insurance contracts. I think it's possible you will see further Congressional attention on this subject for the reason Steve mentioned -- the mortality charges in such contracts tend to be quite small in

their early years, making it possible to use the contracts as an investment-oriented vehicle as well as an insurance-oriented one. That is classic modified endowment territory. It therefore would not surprise me to see some further focus on the joint life policy, a subject which was visited by Congress in 1989 as part of the 1989 substantive and technical amendments to Section 7702A. I think we could well see coming out of the process either legislative change or possibly some sort of agreement that the regulatory authority under Section 72(e)(5)(C) should be invoked, for the first time ever, to deal with this sort of situation.

The other area where I think we could see legislative action during this Congress relates to another subject that Steve touched on -- that is, the addition of long-term care or terminal illness benefits to in-force life insurance policies. A very serious question had been raised whether the addition of such a benefit to an existing contract would be considered a material change in the broad sense of Section 1001 of the code, causing the contract to be considered newly issued. This would, in turn, cause Section 7702 to apply to it for the first time, or cause the new mortality and expense charge limits to apply, or cause Section 7702As rules (or its material change rule) to apply. There is legislation pending on Capitol Hill that would clarify that none of the foregoing would happen, namely that the addition of a long-term care or terminal illness rider or benefit onto an existing policy is not a material change in the broad or the narrow sense. It is so provided in Congressional Representative Kennelly's bill on terminal illness benefits, H.R. 134, Senator Bradley's similar bill, S. 281, and in the more sweeping bill introduced by Congressman Gradison earlier in April, H.R. 1693, which is essentially the ACLI's long-term-care proposal in its current form. So that kind of relief may be coming, assuming it is correct as reported, that this Congress could be known as a health care or long-term care Congress.

That disposes of my legislative topic. My other topic is rulings issued by the Service under Section 7702. You have been provided a rather formidable collection of papers that constitute a compendium of all prior thought on the subject of Section 7702, at least in the form of the Service's private letter rulings. I should mention that private letter rulings are not precedential in any formal sense. They are not necessarily the vehicle used to make law or interpret law directly, to the extent that taxpayers or the government may rely on them. On the other hand, they do show, at the time they're issued, the current thinking of the Service on the subject that is discussed in the ruling. And so they're quite interesting to all of us, particularly in an area like Section 7702 where there is very little guidance.

None of these private rulings deals directly with Section 7702A, although the first one I want to get to, private letter ruling 9106050, probably has more implications for Section 7702A than for the definition of life insurance itself. You may be wondering what all those numbers that appear on each ruling -- the seven digits -- are doing there. Just in case you haven't ever heard before, the reason for the seven digits is not that the Postal Service insisted on it, but it is to identify each ruling as follows: the first two digits show the year of the ruling, the next two show the week in the year that the ruling was made public, and the last three show the order in which the ruling was disclosed that week. Three numbers are reserved to allow for the possibility of 999 rulings being issued in one week, although I don't think the Service has yet reached that maximum.

You may have heard of private letter ruling 9106050, particularly if you've been following Section 7702 closely. In that ruling, the Service held that term insurance on the primary insured under a base contract is a qualified additional benefit under Section 7702(f)(5). The Service also held that a long-term care rider, which was associated with the base contract (in this case the universal life policy), was not a qualified additional benefit (QAB). The long-term care rider involved was virtually a stand alone, level premium, long-term care policy, not an accelerated benefit of any sort. The Service further held that charges for that rider were considered distributions out of the contract which would be taxed on a FIFO basis under Section 72(e) unless, of course, the contract was a modified endowment, in which case they would be taxed on a LIFO basis, possibly with a penalty tax. The last of these holdings certainly has caught the interest of people issuing modified endowments with long-term care riders. However, it may or may not apply in the case of an accelerated benefit rider.

The industry's primary focus on this ruling to date has been on its holding that the term insurance rider was a qualified additional benefit. That was premised on the 1982 legislative history of Section 101(f) of the code, which was the precursor of Section 7702. When Congress enacted Section 7702, it indicated that unless it changed the statutory form, it meant to pick up on and build on Section 101(f). So, Section 101(f)'s legislative history provides a general background to Section 7702, and is used in this ruling to lead to the conclusion that term insurance on the primary insured is a QAB. In this case, the rider provided fairly short-term, level, term insurance, situated "on top" of a universal life contract, and it was clear that the benefit was an "additional" benefit. The significance of it being a QAB, as far as Section 7702 is concerned, is merely that, instead of using the term insurance as a benefit in the calculation under Section 7702, the present value of the charges for the benefit is used in the calculation instead. All that may serve to do is to increase, rather than decrease, the guideline or net single premium limits. But that's what Congress had in mind, I think, and I don't know that they were all that troubled by it.

Where, however, this holding does raise a lot of question is under the modified endowment rules. To perform a seven-pay premium calculation it is necessary to regard, of course, all the benefits. The qualified additional benefit rules do carry over to Section 7702A, but it makes a difference in the calculations under the seven-pay test whether you're using the benefits or the charges. In particular, it can make a lot of difference when the rider benefit varies over time, as it tends to do under some of the arrangements being marketed. If the rider benefit increases, that may be a material change, but if it reduces during the first seven years, or at any time in a joint life contract, that may be a reduction event requiring retroactive retesting. And so, the QAB holding of the ruling tends to "make hash" out of some prior assumptions that companies have made in designing contracts with term insurance riders on the primary insured and trying to qualify those under the seven-pay test of Section 7702A. The ACLI will be working on that, trying to see whether it can get further clarification as to what the reach of this ruling really is.

For the remainder of my time, I'd like to give you the highlights of some other rulings that appear at the end of this session. The next ruling to be discussed, private letter ruling 9034014, was one of a series of rulings that was issued in 1990 involving an assumption reinsurance. There, a company was planning to sell off one of its

divisions, and the sale would have carried with it, via an assumption reinsurance agreement, a substantial number of the company's in-force life insurance contracts. The question addressed in the ruling was whether the assumption reinsurance, involving the transfer of the contracts to the new company, would be considered a material change in the broad sense of Section 1001. If so, the transaction would cause all the contracts to be considered reissued at the date of the transfer in the assumption reinsurance for purposes of the effective date provisions of Sections 101(f), 264, 7702 and 7702A. The Service held that the assumption reinsurance did not rise to the level of an exchange for purposes of any of those provisions. So, the contracts' "grandfathered" status under a variety of those statutes was not disrupted. There had been an earlier ruling to this same effect under Section 7702 alone, namely, private letter ruling 8645008.

Another recent private letter ruling, 9033023, dealt with the transfer of a contract to a trust in a nonqualified deferred compensation arrangement. This appears to be some sort of "rabbi trust" arrangement, as it is called. The question was whether the transfer of the contract to the trustee would be considered a reissuance of the contract that would trigger the effective date of Section 7702 on the contract -- apparently it otherwise could not meet Section 7702s requirements -- or, alternatively, whether the transfer would somehow be treated as a distribution involving the rule of Section 7702(f)(7). The Service held that neither of these would be the case. The transfer of the contract was treated as merely a transfer between an existing owner and a new owner and was not considered, in any way, the issuance of a contract or a distribution.

Private letter ruling 8839021, along with the companion rulings identified in your materials, dealt with a type of nonparticipating life insurance contract. Each of the rulings addressed, and agreed with, the correctness of the life insurer's proposed Section 7702 calculations at a different issue age. The rulings are quite intriguing because what is involved is not the "mainstream" contract, but rather a nonparticipating, increasing death benefit whole life contract. As far as I know, these are the only rulings ever issued using the Section 7702(e)(2)(B) computational rule. That rule is rarely relied on, in my understanding, because, while it allows increasing benefits to be taken into account (contrary to the normal rule), it requires the use of the "net level reserve" for a contract, assuming only level annual premium payments for life, as the maximum measure of the cash value of the contract. That is very difficult, if not impossible, to work with under a contract that provides for dividends or excess interest that can be retained in the contract.

Private letter ruling 8835059 dealt with a traditional variable life insurance contract, paid for with a single premium, and held that the contract qualified under Section 7702(a)(1), the cash-value accumulation test. In the ruling, the Service virtually required the taxpayer to represent that there had been computational compliance with the statute, and then went on to hold, in light of that representation, that indeed the contract complied with the statute. It's unclear from the ruling precisely how much responsibility the Service was taking in interpreting the rules of the statute, although there does not seem to be anything terribly abusive or odd about the particular contract involved -- an older form of variable life insurance that ought to be able to qualify under the cash value test. The ruling cautioned, however, that there was a

"wraparound" issue present, in that the contract allowed the policyholder to allocate monies among several underlying funds.

Private letter ruling 8827012 dealt with a single premium endowment-at-95 contract, holding that it qualified under the guideline premium test of Section 7702. In that ruling, the Service reviewed sample calculations in order to reach its determination that the contract qualified. The ruling did not discuss precisely how the interest "gross-up" rule applied in that case, but that was specifically dealt with in the next ruling on the reference page, 8816047.

Private letter ruling 8816047 granted a waiver of noncompliance with the statute, pursuant to Section 7702(f)(8), due to failure to follow the gross-up rule. (I might mention that a couple of the waiver rulings appearing at the bottom of the index page, 8843008, 8846018 and 8751025, also dealt with the gross-up rule.) That rule might be the one clearly articulated substantive rule in Section 7702 covered in all these rulings. Under that rule, if a contract does not explicitly charge for mortality, then in performing the Section 7702 calculation, it is necessary to increase the interest rate that is assumed under the contract and used in the calculation to cover the nonexistent, but statutorily assumed, mortality charges. This is an important rule, which has a strong basis in the legislative history of Section 7702, intended to preclude single premium contracts with guaranteed increasing benefits from qualifying as life insurance under the tax law.

Private letter ruling 8816047, along with the waiver rulings listed at the bottom of the reference page, waived the failure of the contracts involved to comply with the statute so long as the death benefits under those contracts were increased to "cover" what would have been the death benefits had the contracts originally been calculated with the gross-up in the interest rate. The ruling shows that it's necessary to search very carefully for the proper interest rate to be used in the Section 7702 calculations for a contract. The interest rate is not always easy to find – it is necessary to look in the cash values to find it.

Private letter ruling 8816015 was the ruling that Steve mentioned earlier. That ruling held, in addition to what Steve said, that where there is a Section 1035 exchange of contracts, in this case involving the carryover of policy loans, the exchange does trigger a new issue date for purposes of 7702. So the new contract must comply with Section 7702 and must deal with Section 7702A. Also, the ruling held that the 15-year period in Section 7702(f)(7)(B) starts running anew on the date of the exchange.

The final nonwaiver ruling in the materials, private letter ruling 8648018, dealt with a situation where an additional investment option was added to a preexisting variable life insurance contract. The Service held that it was not a material change in the broad sense, and that the addition of an investment option, which had no guarantees in it at all, would not trigger the effective date rule of Section 7702. I would submit that if there was some sort of minimum guarantee in the new option, and you will find those now in variable contracts, that this ruling probably would not be issued, and that it probably would be considered a material change that would trigger the effective dates of more recently enacted statutes.

The first two of the waiver rulings listed at the bottom of the reference page granted waivers, under Sections 101(f)(3)(H) and 7702(f)(8), in circumstances where someone at the companies involved was "asleep at the switch" and simply allowed too much premium to be paid in (or didn't get it back out of the company's hands soon enough). Private letter ruling 9042039 dealt with six failures out of 180,000 contracts, while private letter ruling 8844043 dealt with 41 failures out of 26,000 contracts, all of which were discovered when the companies put in new premium monitoring systems. The Service conditioned the waivers on the companies' willingness to correct the overpayment by increasing death benefits, paying back premiums, or canceling the contracts. None of these rulings have granted waivers under the net single premium test.

You will not find in the private letter rulings that become public any of the closing agreement type of resolutions which involve the payment of inside buildup tax by the companies involved. Steve, I don't believe the closing agreements are made public. These involve the sorts of situations where there are, shall we say, less than reasonable errors, for which companies are required to pay "toll charges" to correct the errors.

I'll throw it open to Tim for any further questions, or if Steve wants to comment on any of this. I think he should have full opportunity to give you any warnings about the prior words of the Service.

MR. HOOE: I'll just comment on some of the letter rulings. With regard to the waiver ones first, what's key is not the number of failures. It is not key that you have 16 out of 40,000, or whatever. What we look for is that you had a system of compliance. You set up a system to try to administer the statute. You prepared manuals or you prepared procedures, or whatever, but your employees, due to human error, clerical error, or whatever, simply failed to follow established procedures. So long as there are people involved, we recognize that they are going to make mistakes. Erasers are still on the ends of everybody's pencils. That being the case, those are the types of things we view as reasonable errors. If you fail to follow a statutory rule -- for example, you assume increasing death benefits in computing your guideline single premium limit, or you use unreasonable mortality charges -- it is not going to be considered a reasonable error, and you're going to have to go the closing agreement route.

With regard to the rulings dealing with the search for the interest rate, we are going to be far more diligent in searching for the correct interest rate than we have in the past. We're reexamining the interest rate that was used there – the interest rate that was grossed up. Quite candidly, I don't think that the proper rate was grossed up on some or all of the rulings. It is sufficient to say, we are just going to be far more diligent in trying to identify what is the interest rate that is implicitly guaranteed in the nonforfeiture values of the contract at issuance.

With regard to the ruling dealing with the contribution to the trust, I would like to point out that the ruling dealt with the situation involving a multi-employer grantor trust in which all of the employers were members of the same affiliated group. Notwithstanding the fact that they were all members of the same affiliated group, the Service required that there be no potential shift of beneficial ownership. The mere

fact that you're contributing something to a grantor trust does not necessarily protect you if the trustee of the grantor trust could use the values of the policy to meet the obligations of another member of the affiliated group.

With regard to the assumption reinsurance ruling, I think the Service is just trying to be practical. The policyholder hadn't materially changed his economic position at all. At least, in our view, the ruling just did not involve the type of situation that Congress intended to trigger the loss of grandfathered status, or the material change rules, or whatever.

With regard to the wrap around ruling, the diversification ruling, I guess my only comment was that the wraparound issue is alive and well. There are obviously discussions going on at the Service and Treasury as to what the rules should be. Different people have different views, even within the Service and Treasury. Ultimately, I think as you increase the number of investment alternatives and increase the ability to reallocate monies among those alternatives, the question does arise. I also think the ruling was unclear, at least it was unclear to me, as to whether the investments met the diversification requirements of 817. You should always remember that 7702, I think, specifically refers back to a variable contract that is defined in 817. Notwithstanding the fact that you meet all the requirements of 7702, a contract can lose its status as life insurance if it fails to meet the diversification requirements under 817(h).

One other thing, going back to what Jack was saying with regard to treatment of reserves for failed contracts, we do have a project in house that's fairly well along which will deal with the treatment of reserves on failed contracts. The legislative history in the 1984 act made it clear that the investment portion held with respect to a failed contract cash value was to be considered, I believe, an 807(c)(4) reserve. I guess the issue is, to the extent you have reserve that's in excess of the cash value, how is that portion of the reserve treated? It can't be a life insurance reserve, since it's not held with respect to the proper kind of contract. Maybe it's an unearned premium reserve. It seems to me there should be some recognition of the company's liability.

FROM THE FLOOR: We're just looking for a little guidance on a specific instance where you'd have a term rider on a universal life (UL) contract on the base insured. And we're looking to have that rider automatically drop off when the contract goes into the corridor. We're just wondering how that would be handled in guideline premium calculations.

MR. ADNEY: In the guideline premium calculation, I think that you would be required to anticipate that the benefit would drop off at some point in the future. You'd anticipate that at the point of issuance. Then, when the benefit did drop off, because that was reflected in your calculations initially, you would not consider it an adjustment event at the time that it drops off. If, for any reason, you were not able to reflect all of the death benefit or the value of the QAB charges in the calculation at issuance -- say, for example, if the base contract was somehow violating the increasing benefit rule -- then, at a later point, there may be an adjustment event. But in a very simple case, where you have a universal life policy with the term rider on it for a number of years, I should think that all of that could be reflected on day one in the

calculations. And then when the rider benefit drops off, you have already anticipated the drop off, and that is not an adjustment event.

Under Section 7702A, I think the statute says that the lowest amounts that are present during the first seven years are deemed to be there for the life of the contract. It's not entirely clear how that rule operates in the case of qualified additional benefits, but I think there's probably some way that it does. So one way to do the seven-pay limit calculation, assuming that the rider does not drop off during the first seven years, is to assume that it's going to be there, at whatever it's lowest level is, for the rest of the life of the contract. An alternative, and it may be a safer alternative since we don't really know how the rule that assumes the benefits will stay there operates on qualified additional benefits, would simply be to take the present value of the future charges on the date of issuance for as long as that amount is going to be there, and just use that to calculate the seven-pay premium. If that's enough to calculate the seven-pay premium, I'd stop there. The last piece of advice I would give is not to have that rider drop off during the first seven years, or during seven years following a material change, because that would likely be treated as a benefit reduction which would require a retroactive recalculation under 7702A(c)(2).

Sections 7702 & 7702A: An Update on Reference Materials

Withholding/Reporting on "Failed" Contracts
Revenue Ruling 91-17, 1991-9 I.R.B. 10

Substantive Rulings
Private Letter Ruling 9106050 (Nov. 16, 1990)
Private Letter Ruling 9034014 (May 23, 1990) (see also 9034015, 9034016, 9034018, 9034021, 9034022, and 8645008)
Private Letter Ruling 9033023 (May 18, 1990) (see also 9109018)
Private Letter Ruling 8839021 (June 29, 1988) (see also 8839022, 8839028, 8839030, 8839032, and 8839033)
Private Letter Ruling 8835059 (June 10, 1988)
Private Letter Ruling 8827012 (March 31, 1988)
Private Letter Ruling 8816047 (January 25, 1988) (also waiver)
Private Letter Ruling 8816015 (January 11, 1988) (see also 9044022)
Private Letter Ruling 8648018 (August 27, 1986)

Waivers
Private Letter Ruling 9042039 (July 23, 1990)
Private Letter Ruling 8844043 (August 9, 1988)
Private Letter Ruling 8843008 (July 26, 1988) (see also 8846018 and 8751025)