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Enterprise Risk Management (ERM) for Small Insurers—An Evolving Concept

By Norman E. Hill

Over the last few years, considerable interest has been expressed in ERM. The Society of Actuaries (SOA) is concerned that ERM should rightly be the province for actuarial dominance. The SOA defines ERM as “the discipline by which an organization in any industry assesses, controls, exploits, finances and monitors risk from all sources for the purposes of increasing the organization’s short- and long-term value to its stakeholders.”

Other professions have also prepared their own definitions of ERM similar to the SOA’s definition. The professional organizations include the Risk Management Association (aimed at bankers), the Committee of Sponsoring Organizations of the Treadway Commission (COSO, emphasizing internal accounting controls) and other groups.

Insurance companies are in the business of assuming risks. These risks affect assets, as to whether they provide interest and appreciation as projected, and liabilities, as to whether they require more cash flow than projected. Possibly, if different names had been used originally, insurers today would be called “risk assuming organizations.” In any event, proper management of these risks is the key to companies’ survival and prosperity. If the challenge is thrown, “How do you manage your busi-

ness?” the correct answer would involve proper application of ERM.

One principle, though not the only one, is a key part of ERM. Arguably, it is even more important for small insurers, namely, that each company’s approach to ERM should be consistent with the risk profiles of its assets and products.

Other elements of a sound approach to ERM include the following suggestions for actuaries:

1. Use the phrase “enterprise risk management” very frequently in communication with and presentations to senior management and boards of directors. At least once, the above definition from the SOA is worth stipulating. From time to time, it may call for repeating, or shorter versions could be used.
2. Use that same phrase very frequently in communications to all levels of employees.
3. Emphasize the vital importance of proper ERM management to the above groups.
4. Projections of total company performance should be used as a tool of ERM management

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Chairperson's Corner

What a Difference a Year Makes!

By Christopher H. Hause



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The following are some news headlines from August 2008 and one year later:

- 2008: “Wal-Mart Suggests Obama Victory Would Lead to Unionization”
 2009: Wal-Mart, along with Andrew Stern, President of the Service Employees International Union, sends a letter to President Obama in support of an employer mandate for health insurance
- 2008: “Unemployment Rate Jumps to 5.7%; GM Loses \$15 Billion.”
 2009: Unemployment is 9.5% and rising; GM is bankrupt.
- 2008: “Black Activists to Obama: ‘What about the Black Community?’”
 2009: Obama arranges a “Beer Summit” at the White House to defuse national tension over what might have morphed into a “Black vs. White” incident in Cambridge, Massachusetts.
- A year ago, the Dow was at about 11,500. It bottomed out at about 6,500 and has since bounced back to about 9,000 (August 2009).

Every once in awhile, it is both entertaining and informative to look back and see where we started, the path we took and where we are now.

Most of us in our personal and business lives make goals and formulate plans to reach those goals. Success in reaching goals usually takes equal parts of the following:

- 1) Vision,
- 2) Hard work, and
- 3) Honest self-assessment.

While not the focus of this article, I believe that the Society of Actuaries’ (SOA) leadership and staff have done an outstanding job of setting their goals and tracking their progress toward them. As busy individuals and employees, we do not always have the health and perception of our profession in the front of our minds. For that reason, we need and are indeed fortunate to have the SOA leadership and staff that we have, and I call on every one of us to support their valiant efforts.

More locally, about one year ago, the Smaller Insurance Company (SIC) Section had its first ever (I think) annual face-to-face planning meeting. The theme of the meeting was primarily self-evaluation. For instance, are we doing everything we should to support SOA meetings and symposia? Are our publications timely and effective? Are we providing maximum value to our members?

Several new directions came about because of this evaluation and brainstorming.

Due to the sizable contributions from Alice Fontaine and Norm Hill (friends of the council), and Robert Hrischenko (*Small Talk* editor) we have supplemented the biannual newsletter with a more timely blast e-mail containing valuable information about regulatory happenings.

The SIC Council has also focused on Principle-Based Reserves (PBR) and the impact on small companies. Thanks to Bill Sayre (friend of the council), and Joeff Williams and Karen Rudolph (council members), we are assisting and promoting studies on the Stochastic Exclusion Test and the expenses of compliance with PBR for smaller companies.

Consistent with SOA direction and the emphasis on risk management, we are sponsoring annual meeting sessions on Enterprise Risk Management (ERM) for the smaller company. After all, the “big boys” are not the only ones with complex and interacting risks.

So in some ways, it seems like a year is a long time, but it can easily slip by. I have enjoyed my stint as chairman and I look forward to staying on as a friend of the council in the future.

What I want to ask of you is to support the efforts of your section council in at least one of the elements of successful strategies:

- 1) Provide vision. Let us know what challenges you see and how we can help address them.
- 2) Help with the hard work that it takes to put on meetings and symposia. Volunteer your services.
- 3) Be brutally honest. If your section falls short of your expectations, do let the leadership know.

I invite you all to come to the Smaller Insurance Company Section breakfast on Monday at the SOA 09 Annual Meeting and see what your council is planning in the coming year, and I invite you all to contribute to our future success. ●

Enterprise Risk Management (ERM) ... | Continued from page 1

and communication. This is especially important for senior management and boards.

5. Projections included in actuarial opinions and asset adequacy studies should serve as the bases for ERM projections.
6. These projections may be expanded for ERM, to show more alternatives and ranges.
7. Implications of these projections must be thoroughly conveyed to senior management and boards. The worst end of ranges of results should often be considered as the point of maximum risk the company is willing to bear. From inspection and analysis, some range among various alternatives may represent the company’s “maximum appetite for risk.”

In some cases, the worst end of projections has been called an identification of tail risk or material tail risk. This label seems to have arisen with variable products providing minimum guaranteed benefits. At the unfavorable or tail end of projections, at some point, massive amounts of liabilities for the general account will suddenly be generated.

For other products, given a reasonable amount of projections, worsening results should appear gradually.

8. Often, the worst and best results of ranges of projections can be described with terms such as “stretch” and “remote.” If worst-case projections are sufficiently severe, they may deserve a label similar to “nuclear holocaust.” For many companies, this degree of severity would not be useful.
9. In some companies, recipients may ask for assigned probabilities of occurrence of these results. If actual policy reserves have a 70 percent Conditional Tail Expectation (CTE) and risk-based capital plus reserves have a 90 percent CTE, these may be used for assigned probabilities. Confidence levels are similar to CTE and may be preferred by some actuaries. The exact meaning of CTE would usually have to be explained.

Some years ago, an actuary for a very large company told me that one board member demanded that policy reserves have a 99.999 percent confidence level. While this hardly seems realistic, actuaries should be able to express various degrees of confidence in their projections. These statements may be qualitative, quantitative or a combination of both.

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To nonprofessionals, qualitative answers may often work better than quantitative. If the latter approach is used, it should be supplemented by a considerable amount of qualitative descriptions. The latter emphasis could serve to identify the actuary as one businessperson conversing with another, instead of a back office computer specialist attempting to communicate technical or remote ideas.

10. Small companies are less likely to need a separate officer designated as chief Risk officer (CRO). If this title seems important, the chief actuary of a company seems the logical one to assume the responsibility.

11. Models of actual in force, instead of the complete master record, are almost always used for projections. If print-outs of model results are included in reports, their output should be comprehensible to nonprofessionals.

12. If model results are shown to insurance departments and outside auditors, the workings and detailed model calculations should be auditable.

13. At least one individual, preferably more, in an organization should understand completely and in minute detail how the company's model(s) operate. In other words, models should never serve as "black boxes" that cannot be comprehended by even the most intelligent nonprofessionals. Recent horrendous experience of banks, rating agencies and AIG, with assets, derivatives and swaps that were not understood, should serve as a valuable lesson for proper ERM.

Rating agencies have expressed interest in ERM. Insurers who deal with them may need to formulate written plans of their ERM approach to present to them. The above principles and resulting projections may serve as a basis for the insurer's ERM.

As stated above, a range of projections should convey a range of likely outcomes, so that the company can be comfortable (or not) with the possible impacts of these outcomes. In those situations where they are not comfortable with some outcomes, they need to formulate plans to mitigate unfavorable aspects.

ERM Aspects of Liabilities and Cash Flows

A robust set of projections should provide ranges of cash flows from product liabilities. Within the range, some sets may call for reduced new business production, which usually means

less statutory surplus strain. Other sets may call for increased use of reinsurance, either due to riskiness of certain products or the same surplus strain.

Insurers should formulate detailed plans for reinsurance risk transfer. These plans should include what types of reinsurance to explore, and which reinsurers to contact. If unauthorized or offshore reinsurers are considered, the types of assets to be ceded, or bank lines of credit, should be listed.

Usually, assets ceded to unauthorized reinsurers should be retained in a domestic trust. If bank lines of credit or similar devices are used in lieu of assets ceded, their costs should be considered. They often require renegotiation, more frequently than the life of liabilities ceded.

"... a range of projections should convey a range of likely outcomes, so that the company can be comfortable (or not) with the possible impacts of these outcomes.."

For various types of risk transfer, alternative projections, involving variables such as cost and recapture periods, should be included as part of ERM.

ERM Aspects of Invested Assets

Portfolios of many insurers have become increasingly complex. Some companies have purchased assets with considerable risk, not always known at time of purchase. As a result, risk mitigation techniques, such as from derivatives, swaps and hedging, have become popular.

Often, smaller companies have avoided these devices. They require degrees of knowledge and sophistication that may not be available to the staff of smaller insurance companies. Also, they carry a cost, and require constant monitoring.

Outside investment managers may be able to provide these devices. However, as part of ERM, projections should be made of how these devices would perform under various economic scenarios.

Other following terms have recently become popular and seem closely tied to ERM.

Systemic Risk

This type of risk has not yet been properly defined. One definition is the risk that, if actualized within one insurer, would almost certainly spread to other insurers or the entire industry. An investment professional defined it as a risk that cannot be mitigated by being spread out. By this,

he meant that a volatile mortgage pool, if converted to several smaller volatile mortgage pools, would retain the same risk and thus constitute systemic risk. A third individual said he could not articulate systemic risk, but would always recognize it if he saw it.

Recently, the American Academy of Actuaries, in Congressional testimony, endorsed the concept of a federal regulator for systemic risk. One recently proposed federal bill would provide federal regulation of systemic risk in large insurers. The exact threshold for “large” in this instance is not specific. In any event, oversight would be from the Federal Reserve.

Small insurers need to watch for any federal or state regulations of systemic risk, and any projections to identify such risks that may be imposed on them.

Economic Capital

For some years, Risk-Based Capital (RBC) has been specified as a device to identify weakly capitalized companies. A new term has evolved recently, “economic capital.” It appears to mean the “proper” amount of capital for an insurer. Such capital should be consistent with the risk profile of a company’s assets and products. Some rating agencies may compute desired capital for a particular company, such as the “B CAR” calculations.

If an insurer attempts to compute economic capital, or project ranges of economic capital, it should formulate in advance a very clear idea of how it defines this capital. Perhaps, for starters, multiples of RBC might be used. Alternatively, it might be tied in some way to present values of profits in both in force and projected new business.

Just as with systemic risk, small insurers should watch closely any legal developments that may try to incorporate economic capital. These could include required projections for computing such capital that may be imposed on them.

Solvency Modernization Initiative (SMI)

The Solvency Modernization Initiative (EX) Task Force is to coordinate all National Association of Insurance Commissioners (NAIC) efforts to successfully accom-

plish the Solvency Modernization Initiative which has five focus areas:

- 1) Capital requirements
- 2) International accounting
- 3) Group supervision (of insurance groups and conglomerates)
- 4) Valuation issues in insurance
- 5) Reinsurance

It has stated that the ideas that merit study and consideration include ERM, economic capital and internal models of companies, full or partial. The PBR EX Working Group is one committee that reports to the new SMI Task Force.

By themselves, the items above do not appear objectionable. But since they are newly stated and not precisely defined, this task force deserves close attention from small insurers.

Summary

ERM and related terms are becoming quite popular in the insurance industry. Small companies need to stay informed of these terms, as they become more precisely defined, as well as how they may be useful in fulfilling their own management responsibilities.

Insurers may be presented with new programs and methodologies that claim to be the cutting edge for ERM. These may come from vendors or from regulators. With PBR, I believe that—partly due to the long delay without resolution—companies are inclined today to demand demonstrations of value from implementation. Similarly, with ERM, regardless of the source, companies should always demand detailed demonstrations of value from such new implementations. These demonstrations should show, among other things, how the new implementations would interact with existing risk profiles of assets, liabilities and products, and of IT systems. They should always be comprehensible by the company, whether by actuarial staffs or by senior management and boards of directors. This way, small insurers especially can keep on top of the evolving field of ERM. ●

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How to Select Actuarial Software

By David Fishbaum

In many ways, buying actuarial software is like buying a house. It is a major financial commitment and a difficult decision. You are going to be living with it, and paying for it for some time to come. It is a somewhat painful and expensive process to find, choose, buy and then make it livable. You will likely find unexpected problems that need to be fixed. There is only so much you can learn from the sales brochure and the walk-through. And you certainly can't completely trust the vendor or his sales agent! No wonder many actuaries put off the decision to change even when their current software is past its prime.

So how should you go about choosing new software that's right for you? However you decide to approach it, I suggest you keep the following two rules in mind: first, take the long-term view; and second, take the time to do it right.

A Critical Strategic Decision

You must put effort into finding a solution that will last and pay proper return on the investment of your time and resources in the investigation and the subsequent implementation required. It's not just a financial investment you are justifying. The choice of software will impact your ability to cope with changing demands and emerging risks, and your company's ability to introduce new products and support those new products with appropriate financial reporting and risk assessment tools. The productivity and the job satisfaction of your actuarial staff are at stake, and that will also drive the overall cost of the actuarial function for your firm and your ability to attract new staff when needed. Moreover, it will take substantial effort to make the transition.

Create a Long-Term Vision

When taking the long-term view, you should first drive a clear and appropriate definition of the needs to be addressed

by the software, and the corresponding criteria used for ranking alternatives available. When thinking of needs, don't restrict yourself to handling current reporting requirements and addressing current frustrations and bottlenecks, but also look longer term and try to imagine how actuarial functions are expected to change in the coming years. In fact, what you really need is a vision of how you want your actuarial function to work, and how the software used can make that vision real. Don't let your current frustrations impact your vision of a perfect solution.

Of course, your vision will have to consider the demands of pending changes in approaches to reserves and capital requirements with PBA, C3 Phase III and IFRS coming from different directions. These influences are not well defined in detail or timing, and many different interest groups are wading in on the discussions. So don't worry about the specific details of these future changes as much as the overall picture they paint. The only thing certain is that the actuary is likely to have to cope with new and changing requirements, and his or her software will have to be responsive to these changes.

Understand the True Need

In identifying business needs, do not fall into the trap of confusing the business need with the possible solution itself. This is particularly relevant to the need for responsive software and flexibility. Your ability to respond to changing needs by adapting your models is not equivalent to owning and maintaining the underlying code yourself. That's just one approach, and it may not make the most sense in the longer term. There is a range of options in terms of how much programming you will need to do, and who will be responsible for the code and its ongoing accuracy and functionality. Think about who is best suited to do this in the longer term.

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Most often, flexibility is required in the details of product design and assumptions. Less often, new reserve methods and actuarial calculations will be required. Occasionally, the fundamental system architecture and data flow will need to be revisited. Think about all these things, and how the total solution proposes to address them—who will do the work, and how that impacts your ability to adapt from a total solution point of view.

To assess alternative software solutions properly, you must keep an open mind. The approach taken by your existing vendor, and the experiences and challenges you have faced with your previous system or systems may not be comparable to what a different vendor's solution may offer. Jumping to conclusions without taking time to examine all the options carefully while applying a long-term perspective may result in a shortsighted decision you will ultimately regret.

Making an Informed Decision

This is where thoroughness comes in. Take the time to buttress opinion with supporting evidence. Test out any software you are seriously considering with a specific testing plan that addresses each of the long-term needs you have identified. Make sure competent and experienced staff lead the testing, and that they are allowed the time to devote to it so that sound assessments are reached. If you can't afford this commitment, think about hiring an objective consultant to assist with the project.

Yes, it is good to identify any functional shortcomings in terms of available reports or current methodologies supported. But keep in mind that such things as actuarial methods and specific report formats will constantly evolve. It is the fundamental software framework and the vendor competence and commitment to enhancing their product that in combination supports your ability to make those changes, to address new demands, and to implement new assumptions. These are much more important to you in the longer term.

Sometimes it is more difficult for end users of the software to approach software assessment with an open mind. Users by nature may resist change, fear the unknown or place undue weight on interface differences compared to underlying architectural issues. Users may find threats to their own roles when

a fundamental change in approach is required. That does not mean their needs are not important and that they should not be consulted. No change will be successful without buy-in at all levels, but the balance of a higher perspective and a long-term outlook that considers the company's overall financial interest and risk is needed in this important decision. It is important to consider the needs of each level within each functional area, but in the end it is senior management that must deal with business realities of missed deadlines, unexplainable results or shortsighted decisions if those decisions are based solely on gut reactions of end users.

Testing is important, but you only have the time and resources to test so much before making a decision. Verify the conclusions you reached, with and without testing, and any claims made by the vendor, by crosschecking the experience of current users of the software. How has the vendor support been? How have they dealt with requests for changes? How have the system implementation projects actually gone? Has the system lived up to the expectations, or is it about to be returned to the vendor?

A Long-Term Approach to All Issues

The actuary should also thoroughly look at the long-term prospects for the software and its vendor. How committed are they to actuarial software and its support versus other potential businesses? Will they continue to maintain and support this specific software offering or provide smooth upgrade paths to any new software offering? How much effort is involved in implementing a new release? What evidence is there to support statements they make on these issues? Again, check their references.

A long-term and comprehensive view should also be taken on the cost-benefit analysis and comparisons of alternatives. Up-front costs of each approach should include training, implementation support and consulting assistance, as well as vendor license costs. Initial costs should be amortized over a period the solution can be reasonably expected to last, and added to maintenance costs of all types. The expected lifetime of the software and its vendor should be considered in choosing that period. Above all, look for long-term value, not short-term costs.

A good home is where a family grows. Following the above two rules, the right actuarial software will allow your actuarial team to grow in professionalism and stature within the company. Instead of just producing numbers, you will provide value-added information indispensable in the running of a world class insurance company. ●



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SOA Continuing Professional Development (CPD):

Have Questions? We Have Answers!

Do you have questions about the SOA's CPD Requirement? Want to make sure you are meeting the Basic Requirement or one of the Alternative Compliance provisions?

Visit www.soa.org/cpd to read about how to meet the Requirement's provisions, attest compliance and review the Frequently Asked Questions (FAQs).

Some highlights...

- The SOA CPD Requirement became effective on Jan. 1, 2009.
- Member input has helped to create a Frequently Asked Questions (FAQs).
- Now is the time to start earning and tracking your credits.
- Most SOA members will easily meet the Requirement with Alternative Compliance provisions.
- Members must report compliance with the SOA CPD Requirement as of Dec. 31, 2010.





Impact of Proposed Health Care Reform on Smaller Insurance Companies

By Cabe Chadick and David Dillon

Disclaimer

This commentary includes observations and opinions that are solely attributable to the authors and not their firms, their clients, or actuarial organizations. If federal health reform is enacted, we are confident that many of our observations are likely to prove incorrect by a measure and that we have missed remarking on consequences realized, both intended and unintended.

There are several key issues under the umbrella of “health reform” currently being considered by five congressional committees. The key issues as we see them, and in no particular order, are:

1. Individual Mandate
2. Individual and Small Group Reform
3. Low Income Subsidies
4. Health Insurance Exchange Gateways
5. Mandated Benefit Packages
6. Employer Mandate
7. Public Option
8. Medicare and Medicaid Expansion
9. Tax-cap on Employer Deduction of Health Insurance

The above reform categories include many specific proposals, and this heightens importance of the phrase “the devil is in the details.” We will quickly go over a few key details we have observed to likely have consequences to small health insurers. Each of the details below is worth its own discussion and further study by the insurers and parties impacted. We apologize for our brevity of coverage.

Individual Mandate/Low Income Subsidies/ Employer Mandate

The proposed individual mandate would require all

Americans to have health insurance. To assure access to affordable coverage, the proposals would expand the Medicaid program and provide premium subsidies for families earning some defined multiple (e.g., 400 percent) of the federal poverty limit. Similarly, the proposal contains a mandate that employers employing 25 or more employees must provide health insurance coverage. Such mandatory purchase of health insurance and financial incentives can be considered a good thing, even for smaller insurers. We would expect there would be an initial boom in additional business for health insurers. However, if the enacted health reform legislation includes a public option, instead of a “boom” there may be a “bust”—lost business from the private sector to the public.

Individual and Small Group Insurance Reform

The insurance reforms proposed for the individual and small group markets have the biggest and most obvious potential for changing the way that small health insurers act. These insurance reforms would apply to all coverage sold inside and outside of the health insurance exchange gateways.

Following are some of the insurance reform proposal specifics within the federal bills under consideration:

- Require guaranteed issue
- Require guaranteed renewability
- Prohibit pre-existing condition exclusions
- Forced participation in the small group market by insurers of individuals and vice versa
- Allow rating only by age, tobacco, geography, family makeup
- Require limited rating bands (e.g. 2:1 ratio for age)
- Require a nationwide minimum loss ratio standard

- Adjust payments to plans based on the risk profile of specific insureds
- Require plans to report data to regulators
- Require plans to implement affordability credits
- Establish uniform marketing standards
- Establish grievance and appeals mechanisms
- Prohibit insurers from rescinding health insurance coverage except in cases of fraud
- Require plans to contract with essential community providers
- Require plans to participate in risk pooling and reinsurance

Health Insurance Exchange Gateways

Health reform proposals establish an “exchange” that would offer a selection of health coverage alternatives. Initially, individuals and small firms would be eligible for the exchange, but the newly created “Commissioner of Health Choices” would have authority to open the exchange to all firms beginning in the third year. Eligibility to participate in the exchange would be phased in over three years. In year one, individuals and employers with 10 or fewer workers would be eligible. In year two, employers with 11-20 employees would become eligible. And in year three, employers with over 20 lives up to a defined limit established by a federal “Health Choices Commissioner” would be eligible.

One presumed intent behind the exchanges is they would be established and operated such that insurers *only* compete on price and “quality.” That is, insurers could no longer compete on benefit offerings or risk selection. Those are both areas in which some insurers, small and large, have excelled. The exchanges would standardize benefits and offerings to consumers such that there would be little difference other than price to differentiate an insurer’s product. However, the silver lining is that insurers who don’t get brokers’ and agents’ attention compared to larger health plans (e.g., because of A.M. Best ratings) may finally get noticed, especially if their pricing is attractive. Another attractive part of the exchanges is that insurers who do not offer the most competitive commission payment structure may get more attention from a distribution basis (i.e., exchange gateway) that is independent of agents.

One of the reform options—popular among members of both political parties at the federal level—is to open up health insurance offerings “across state lines.” That is, state insurance regulation would be pre-empted. This would allow insurers to offer health insurance plans in states where they were previously not allowed. This proposal—while thorny at the state level—could be very attractive to smaller insurers, especially those interested in moving into states whose major barriers to entry include onerous state regulation.

Mandated Benefit Design

The proposals require certain benefit packages to be offered. A standardized benefit design across insurers contrasts with how some smaller health insurers use their offered benefit packages as a means to differentiate themselves in the market. For example, a growing market for some insurers is the group limited benefit plans, or “mini-medical” plans. Depending on outcomes for federal mandated benefits, these types of plans could be out of compliance. Even if an insurer could still offer their mini-medical plans, they may be required to offer the mandated minimum benefit packages (e.g., where the federal “basic” plan provides that all medical cost-sharing doesn’t exceed 30 percent of allowed costs) required under the new federal law or within the framework of the health insurance exchange gateway. This could force smaller insurers who do not want to offer major medical plans to decide between not offering any type of health insurance and writing guaranteed-issue health insurance in the individual and small group markets.

Here are some of the benefit requirements in the health reform proposals that could impact small health insurers:

- Require plans to offer one basic plan for each service area
- Require plans to provide regulatory-defined minimum benefit design
- Increase benefit mandates (e.g., dependent coverage to age 26)
- Require plans to meet network adequacy requirements
- Require plans to make information regarding plan benefits service area, premium and cost-sharing, and grievance and appeal procedures available to consumers
- Require plans to provide culturally and linguistically appropriate services

Public Option

One of the most controversial parts of the health reform proposals would be to establish a public plan that would compete with private insurers for enrollment of individuals and small employers. We anticipated that the plan would have pricing advantages over insurers because of a) leveraging Medicare payment methodology (i.e., participating providers would receive Medicare plus 5 percent), b) lack of profit margin, c) administrative economies of scale, and d) massive taxpayer subsidies.

One advertised presumption is that the new public option would compete under a level playing field with insurers. One would presume that a level playing field would include:

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- Reasonable profit margin
- Risk-based capital requirements
- Premiums that support all costs, both claims and administrative costs
- Deficiency reserves in the case of insufficient premiums
- Cost of the capital to fund operations and losses
- Premium taxes to respective state insurance departments
- Independent examination of financial solvency

However, all of the above requirements that every insurer operating in the United States must meet and pay for, are not likely to be borne by this federally sponsored public option. To emphasize this point further, the estimated 10-year cost of the taxpayer subsidy to this “start-up” health plan is over \$1 trillion. The Lewin Group has estimated that over 100 million Americans would become covered under the proposed public option, assuming the public option is made available to all employer sizes. That equates roughly to \$1,000 per insured per year (i.e., \$83.33 PMPM) taxpayer subsidy, for the public plan to use in its pricing and competition with private plans. Having an insurance competitor with such an advantageous and forgiving capital supporter should scare any private insurer, small or large.

Another drawback to the public option for smaller insurers is possible increases to negotiated medical provider payments (i.e., PPO fee schedules could rise). These changes could occur as the portion of medical providers’ business from Medicare-type payment levels (i.e., via Medicare, the public plan, as well as Medicaid) increases. We could expect that medical providers will want to recover their revenue shortfall through cost-shifting increases in charges to those who continue to be covered under private insurance.

A possible silver lining to the new public option is a drawing away of higher risk insureds. One reason insureds may be drawn to the public plan is a desire to move away from a private health plan’s restrictive network. If the public option has a broad network with very attractive premium prices, then it

is not unreasonable to assume that persons with a worse than average risk profile wanting the broadest provider access at the cheapest price will be attracted to the public option.

Another silver lining to the public option is that private insurers may be able to beat the public option on claims management, which if achieved could be quickly realized in premium price differentiation. Whereas private insurers typically employ utilization management programs (e.g., precertification for high-cost procedures, disease management, concurrent utilization review and discharge planning) designed to avoid unnecessary utilization of health services, Medicare (and likely the public option) does not have pre-authorization or similar management techniques. In fact, the public option is being advertised as a means to “keep the private insurers honest,” which presumably means that the public option will be “friendlier” in its claims management. One can even imagine TV commercials, similar to what one sees today, from durable medical equipment providers offering to get public plan insureds their latest medical device, handling all the claims management with no hassle to the insured. Again, this “friendly” type of claims management will show up as higher public plan premiums, if and only if the public plan truly operates on a level playing field that allows no ongoing taxpayer subsidy to premiums therein.

Medicare and Medicaid Expansion

There are proposals to expand materially who is covered under both Medicare (i.e., through lowering eligibility age to 55) and Medicaid (i.e., through expanding the income limits). One might argue that expanding the income limits for Medicaid eligibility is likely to capture previously uninsureds and not represent too much of an encroachment on private carrier’s prospective individual and small employer markets. However, it is more likely that the potential complete takeover of health insurance for U.S. citizens 55 and older will seriously encroach on the private health insurance markets. The individuals in these ages make up a disproportionate share of the dollars spent on medical care compared to their percentage makeup of the working population.

Tax-cap on Employer Deduction of Health Insurance

This proposal is likely to change materially the benefit designs purchased by employers. One possible consequence is for employers to reduce their benefits offered to the essentials of medical insurance, including higher cost-sharing, as well as not include supplemental coverages such as dental, vision, etc. Similarly, those employers who self-insure or purchase a separate plan to cover portions of the cost-sharing of high-deductible medical plans could possibly reduce those benefits as well. These behaviors would materially affect smaller insurers who offer these employer-paid supplemental coverages. ●



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Updated Regulatory Gamut—From OFC to PBR and In Between

By Norman E. Hill

Things have remained on somewhat of an even keel since the June 2009 National Association of Insurance Commissioners' (NAIC) Meeting. However, there are always some developments worth reporting.

Optional Federal Charter (OFC)/Federal Oversight

The latest insurance-related bill from Treasury Secretary Timothy Geithner did not contain any provision for OFC or a mandatory version. However, it did propose federal regulation for various investment-related products, including annuities. The bill was not specific on how broad reaching this regulation would be. However, inclusion of annuities could be very significant for the insurance industry, including some smaller companies.

In addition, the bill proposed some type of federal regulation of large insurers that posed systemic risk to the economy. As reported before, systemic risk is not a well-defined term. Large insurer is an equally ill-defined term but surely includes AIG. The bill called for the Federal Reserve to be the oversight agency.

International GAAP Accounting and Fair Value

Finally, the International Accounting Standards Board (IASB) has published an international GAAP accounting guide for small and medium enterprises (SMEs). IASB designed the guide for smaller, private companies. Supposedly, it would be easier to implement than full-blown International Fair Value (IFRS) would be.

It does not address insurance issues, particularly the long-standing contentious issue of fair value methodology for policy reserves. However, a recent discussion paper revived the controversy over why realized capital gains could be booked upon a company's credit rating downgrade. Unfortunately,

the paper implies that another objectionable provision would eventually remain, namely, that policy reserves should reduce in similar fashion when credit ratings deteriorate.

As before, there is still confusion about the full implications of international accounting replacing U.S. GAAP. There is no reason why U.S. Statutory accounting for insurers must be replaced if GAAP is changed or replaced. Unfortunately, several presentations made to the NAIC have implied that such replacement is the case.

Part of President Obama's regulatory reform proposal calls for clarification of fair value accounting and making substantial progress towards the development of a single set of global accounting standards. The deadline is the end of 2009. Therefore, small insurers who report on GAAP or are concerned about the viability of U.S. Statutory accounting need to follow events here.

Risk-Based Capital (RBC)

As reported previously, the NAIC deferred the implementation date for C3 Phase 3 for life insurance until 2010. Shortly before the June 2009 NAIC meeting, the industry raised numerous theoretical objections to various methodology components of the American Academy of Actuaries' (the Academy) RBC proposal.

At the time of this article, no further work has been done on testing an appropriate threshold for the Stochastic Exclusion Test (SET) for nonparticipating traditional life products. The question remains whether results below the proposed 4 percent threshold would allow retention of current C3 factors.

National Conference of Insurance Legislators (NCOIL)

As reported previously, at least one legislator was very critical

Continued on page 14

of the currently proposed Principle-Based Reserves (PBR) during the July 2009 NCOIL meeting. He stated that small companies are all strongly opposed to PBR.

Actually, this assertion seems to be an overstatement. Many small insurers are not necessarily opposed to PBR, especially if the scope is defined appropriately. It is true that small and large insurers have questioned the value of PBR, especially after three years of uncertainty over its final resolution and structure.

I believe some legislators may have become disenchanted with PBR, for various reasons. Several of these reasons probably relate to the way in which PBR was presented to them previously, including:

- 1. The assertion that the current valuation system is broken.** In my opinion, this is simply not true; the system can be described as flawed for certain products.
- 2. PBR is the wave of the future, completely supported by the insurance industry and everyone should climb aboard.** In my opinion, this is simply not true. This is based on my numerous conversations and correspondence over the last three years with company actuaries, ACLI actuaries, regulatory actuaries, company executives, insurance commissioners, state legislators and some consultants as well. I have seen this skepticism and lack of support grow over the last three years. One memorandum that summarizes the situation was prepared in June 2008 by Robert Meilander, FSA, MAAA, and sent to the LHATF chairman.
- 3. Under PBR, all reserves will be significantly reduced.** Again, this is not true, although it probably is accurate for certain products, such as competitive term and Universal Life with Long Term Secondary Guarantees (UL2G). Moreover, since PBR would only apply to new issues, this reserve reduction would be very small for at least a decade.
- 4. The surplus relief proposal from November 2008 may have originally been described as an expansion of PBR to all issues in force.** Actually, proposed reserve reductions were confined to those for term and UL2G and not literally on a PBR basis. However, other surplus relief was a significant part of the package (deferred tax assets and risk-based capital for certain other invested assets). This proposal came

“Many small insurers are not necessarily opposed to PBR, especially if the scope is defined appropriately.”

about simultaneously with the solvency and image problems of banks and AIG. Therefore, any proposed surplus relief seemed to trouble some legislators greatly. They were concerned that last-minute reserve releases would make state regulation appear weak and inept, and give fuel to advocates of OFC. Most likely, they knew that several large companies supporting these changes were also strong advocates of OFC.

Surplus Relief

As previously reported, the NAIC rejected the proposed surplus relief measures to be effective Dec. 31, 2008. However, the same package was reviewed again by NAIC groups for possible 2009 implementation. The portion dealing with reserves, that is, the term portion, was approved again by the LHATF in June. However, one contentious portion of this was a separate provision that, on heavily coinsured term insurance, direct versus ceded modal premium differences would cause negative reserves.

This favorable reserve effect had to be removed. Otherwise, the 2001 CSO Preferred mortality tables could not be used for reserves going back to the original approval date for the 2001 CSO.

At the Life Insurance and Annuities Committee (“A” Committee), one of the parents of LHATF, other re-serve changes from the latter group were confirmed by the parent. However, at the behest of one state and its actuary, the issue of restricting the above reserve effect of modal differences was reopened, for a subsequent conference call.

Principle-Based Reserves (PBR)

At the time this article was written, no new developments have occurred.

The proposed Net Premium Reserve (NPR) seemed to be on a fast track in December 2008. Since then, adoption appears to have been slowed by certain technical problems. NPR was supposed to be a floor for gross premium reserves on term policies. However, obtaining the desired balance between a floor and gross premium reserves otherwise held may be very treacherous.

A related proposal on PBR scope was presented to the LHATF before the June 2009 NAIC meeting. Several alternatives for excluding certain plans were provided, including deferring certain plans or deferring some plans at a company’s option. So far, LHATF has not reacted to this proposal.

The new Standard Valuation Law (SVL) proposal, including a Corporate Governance provision, was completed at the LHATF level. On July 28, 2009, a joint call was held by the A Committee, the PBR EX Working Group, and the Solvency Modernization Initiative (EX) Task Force (SMI). These groups approved the revised SVL. At the start of the meeting, Commissioner Thomas Hampton also reaffirmed the commitment to prepare a package of SVL and VM as the combined documents that would be sent to legislatures from the NAIC.

However, when the A Committee call tied in this topic with the Preferred Table/reinsurance modal premium controversy, the ACLI said they did have a few last-minute, fairly minor technical changes they would like to suggest for SVL. Therefore, there will be a Sept. 9, 2009 call held by the A Committee to go over this wording and, presumably, approve SVL. If the law gets changed this way, I believe that the other groups will revise their approval to reflect the changes.

Many small insurers and other parties hope they will retain the stated intent that only a package of SVL and substantially completed Valuation Manual (VM) will be submitted to state legislators.

Besides NPR, numerous contentious issues remain in life VM-20 exposure drafts. One is the discount rate. Although tentatively, the Academy's proposal for the investment grade portfolio earned rate was adopted; at least one state still wants a rate corresponding to a risk-free rate plus 50 basis points or so.

The Academy has also proposed a special approach to computing default rates, resulting in higher rates than normal actuarial methodology. This approach has not yet been exhaustively tested, but it appears very difficult to explain to Boards of Directors and to regulators for review purposes. One key question remains: If higher default rates are computed for this approach and are offset against portfolio gross rates, will the net result wind up comparable to risk-free rates reduced by normal default rates?

Other unresolved issues described before include:

1. The margin question for assumptions remains: Must separate margins be added to each assumption or should overall margins be relied on, so that effects on reserves remain reasonable?
2. Also with regard to margins, what methodology should be used for margins on lapse and expense rates? When company experience is partially credible, what techniques should be employed to blend company and industry experience?

3. On nonguaranteed elements, dividends and excess interest credits, some companies may pay additional amounts that were not included in original pricing or projections. Several companies want these amounts excluded from PBR reserve calculations.
4. For stochastic calculations, one technical point involves use of "working reserves." Currently, these amounts are not includible in projections. A related point is the required number of years for projections—until, literally, no events in the projection remain, no material amounts remain, or another alternative is available.
5. The Academy has presented to the LHATF the results from its interest rate generator program. Long-term Treasury rates have been studied. Most regulators want this program to operate on a prescribed interest assumption basis. In a conference call, they requested the Academy to test further to see if its program is biased towards high interest rates, as opposed to low or volatile rates.
6. Just as with RBC, the suitability of the Stochastic Exclusion Test 4 percent threshold for traditional nonparticipating products remains unresolved. There are significant differences between PBR and RBC as to how the test would be applied:
 - a. Under PBR, only new issues after the PBR effective date would be tested. All issue years would require RBC testing.
 - b. Under PBR, broad product groups such as term, UL with secondary guarantees and traditional nonparticipating products would be tested separately. For RBC, on the other hand, it appears that all products and issue years could be tested together.
7. So far, no definitive PBR proposals have been presented for nonvariable annuities and health insurance, including long-term care.

Summary

As always, there are a host of regulatory proposals and developments—at state and federal levels—that call for small insurer vigilance. Most of these will not be resolved soon, and will carry over to future years. ●

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Tax Update

Small Talk has included regulatory updates in most issues of our newsletter over the last several years but has been virtually silent on tax-related topics. We're turning that around and giving tax a voice in this issue. The following three articles in this "Tax Update" discuss general tax issues that should be of interest to those associated with smaller insurance companies. I hope you find them relevant and informative.

— Robert Hrischenko

IRS Issues Guidance Regarding Section 7702 Qualification for Contracts Maturing After Age 100

By Brian G. King

The adoption of the 2001 Commissioners' Standard Ordinary Mortality Tables (the 2001 CSO Tables) in 2004 placed a spotlight on the tax qualification requirements for life insurance contracts that mature after age 100. Unlike prior CSO tables, the 2001 CSO Tables have a terminal age of 121, facilitating the development of life insurance contracts that mature beyond age 100. These contract designs raise some fundamental questions regarding how such contracts should be administered under Internal Revenue Code section 7702 or 7702A requirements.¹ Many of these questions are linked to the computational rules of section 7702(e)(1) which place limitations on the future benefits that can be incorporated into the section 7702 or 7702A test premiums, with particular focus on section 7702(e)(1)(B), which deems the contract to mature between the date the insured attains age 95 and the date the insured attains age 100.

In 2006, the Taxation Section of the Society of Actuaries created a task force (the SOA Task Force) to address issues relating to life insurance contracts that extend coverage beyond age 100. The SOA Task Force published its recommendations in the May 2006 issue of *TAXING TIMES* titled "2001 CSO Implementation Under IRC Sections 7702 and 7702A,"

which set forth a recommended methodology for applying sections 7702 and 7702A that would be "actuarially acceptable" in the case of life insurance contracts that do not provide for an actual maturity date before the insured attains age 100.

Earlier this year, the IRS responded to the industry's request for guidance on this matter, issuing Notice 2009-47², proposing a safe harbor addressing the application of sections 7702 and 7702A for life insurance contracts that mature after the insured attains age 100. The Notice acknowledges and draws upon the recommendations put forth by the SOA Task Force. Provided a life insurance contract satisfies *all* of the requirements of the safe harbor, referred to in Notice 2009-47 as the "Age 100 Testing Methodologies", the IRS "would not challenge the qualification of a contract as a life insurance

"The Notice acknowledges and draws upon the recommendations put forth by the SOA Task Force."

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contract under § 7702, or assert that a contract is a MEC under § 7702A.”

“The Age 100 Testing Methodologies”

Requirement 1: All determinations under sections 7702 and 7702A (other than the cash value corridor of section 7702(d)) would assume that the contract will mature by the date the insured attains age 100, notwithstanding a later contractual maturity date (such as by reason of using the 2001 CSO Tables).

Requirement 2: The net single premium determined for purposes of the cash value accumulation test under section 7702(b), and the necessary premiums determined for purposes of section 7702A(c)(3)(B)(i), would assume an endowment on the date the insured attains age 100.

Requirement 3: The guideline level premium determined under section 7702(c)(4) would assume premium payments through the date the insured attains age 99.

Requirement 4: Under section 7702(c)(2)(B), the sum of the guideline level premiums would increase through a date no earlier than the date the insured attains age 95 and no later than the date the insured attains age 99. Thereafter, premium payments would be allowed and would be tested against this limit, but the sum of the guideline level premiums would not change.

Requirement 5: In the case of a contract issued or materially changed within fewer than seven years of the insured’s attaining age 100, the net level premium under section 7702A(b) would be computed assuming level annual premium payments over the number of years between the date the contract is issued or materially changed and the date the insured attains age 100.

Requirement 6: If the net level premium under section 7702A(b) is computed over a period of less than seven years by reason of an issuance or material change within fewer than seven years of the insured’s attaining age 100, the sum

of the net level premiums would increase through attained age 100. Thereafter, the sum of the net level premiums would not increase, but premium payments would be allowed and would be tested against this limit for the remainder of the seven-year period.

Requirement 7: The rules of section 7702A(c)(2) and (6) concerning reductions in benefits within the first seven contract years would apply whether or not a contract is issued or materially changed fewer than seven years before the date the insured attains age 100.

Requirement 8: A change in benefits under (or in other terms of) a life insurance contract that occurs on or after the date the insured attains age 100 would not be treated as a material change for purposes of section 7702A(c)(3) or as an adjustment event for purposes of section 7702(f)(7).

Requirement 9: Notwithstanding the above described methodologies, a contract that remains in force would additionally be required to provide at all times a death benefit equal to or greater than 105 percent of the cash value.

“Requiring a minimum death benefit that is at least 105 percent of the cash surrender value after age 100 seems inconsistent with the statutory requirements before age 100.”

Concluding Thoughts

As noted above, the “Age 100 Testing Methodologies” generally follow the recommendations of the SOA Task Force, with one material exception—the requirement that a contract provide a death benefit that is at least 105 percent of the cash value. As expected, the minimum death benefit requirement has not been well received by the life insurance industry and is perceived as being inconsistent with the minimum death benefit requirement currently required by section 7702, which generally grades to 100 percent of the cash surrender value for contracts that mature between ages 95 and 100. Requiring a minimum death benefit that is at least 105 percent of the cash surrender value after age 100 seems inconsistent with the statutory requirements before age 100. A number of industry trade groups are expected to respond to the IRS with comments on the proposed safe harbor, with particular focus on this requirement. Comments are requested to be filed with the IRS by Oct. 13, 2009. ●

IRS Issues Guidance on Tax Treatment of Life Settlement Transactions

By Brian G. King

The growth of the life settlement market continues to create opportunities for owners of life insurance contracts willing to sell their contract to investors for amounts in excess of the contract's cash surrender value. A number of questions exist regarding the tax consequences of this type of transaction for both sellers and buyers of life insurance contracts, as current tax law does not anticipate the development of a secondary market for the sale of life insurance contracts. On May 1, 2009, the Internal Revenue Service (IRS) answered a number of these questions by issuing a pair of revenue rulings addressing the tax treatment of certain types of life settlement transactions. The first of these two rulings (Revenue Ruling 2009-13) addresses the tax consequences when an original individual owner surrenders or sells his life insurance contract. The later ruling (Revenue Ruling 2009-14) provides guidance to investors who purchase life insurance contracts.

Guidance for Individual Policyholders

Revenue Ruling 2009-13 addresses three situations in which an individual enters into a life insurance contract under which the individual is the insured and a family member is the named beneficiary. The first situation addresses the surrender of the life insurance contract for its cash surrender value, while in the second and third situations, the individual sells the life insurance contract to an unrelated person. In each of these three situations, the ruling determines the amount of income that the individual must recognize upon the surrender or sale of the life insurance contract, and in addition, the characterization of the income (capital gain or ordinary income).

In Revenue Ruling 2009-13, the IRS concludes that the tax rules for determining income differ depending on whether an individual owner surrenders or sells a life insurance contract, even though there is no substantive difference between these two transactions from the perspective of the policy owner. Revenue Ruling 2009-13 confirms that in the case of a surrender, the individual must recognize income to the extent the amount received exceeds the *investment in the contract*, as determined by section 72(e) of the Internal Revenue Code.³ Section 72(e) generally defines investment in the contract to be the premiums paid, without any reduction for cost of insurance or other charges applicable to the contract. The ruling concludes that income is the excess of the cash surrender value over premiums paid, and further specifies that this income is characterized as ordinary income, and not capital gains.

In the case of a sale of a life insurance contract to an unrelated person, the individual recognizes income to the extent the amount realized in the sale exceeds the individual's *basis in the contract*. In determining the amount of income, the ruling determines that the individual's basis in the contract is the individual's investment in the contract, reduced by the already incurred costs of providing life insurance on the insured's life (*i.e.*, the cost of insurance). The ruling then concludes that the amount realized, up to the contract's inside buildup (*i.e.*, the amount of income that would have been realized had the individual surrendered the contract) is ordinary income, and the amount of income realized that exceeds the inside buildup is capital gain. A consequence of the position taken by the IRS on this issue requires policyholders who sell their policies to third parties to obtain "cost of insurance" information from the life insurance company in order to fill out their tax returns—information that may not be regularly provided to policyholders. A further complicating factor likely to arise is in the determination of "cost of insurance." The identification of the cost of insurance for a life insurance contract is not always a straightforward calculation, particularly in the case of a whole life contract or other forms of life insurance that do not explicitly define the cost of insurance.

Revenue Ruling 2009-13 indicates that the IRS position on excluding cost of insurance from basis, and treating a portion of the gain on sale as ordinary income, will not be applied to sales occurring before Aug. 26, 2009.

Guidance for Life Settlement Investors

In conjunction with Revenue Ruling 2009-13, the IRS also issued Revenue Ruling 2009-14, which addresses the tax treatment of transactions involving the purchase and sale of life insurance policies by investors. Revenue Ruling 2009-14 presents three situations where a U.S. citizen purchases a life insurance contract and then receives death benefits or sale proceeds from the life insurance.

Revenue Ruling 2009-14 confirms that when an investor buys a policy as an investment and holds it until the death of the insured, the investor is taxable on an amount equal to the death benefit received, less the cost to acquire the policy and the amount of premium subsequently paid. This conclusion reflects a straightforward application of the section 101(a)(2) transfer for value rules. The ruling concludes that the taxable portion of the death benefit is ordinary income, and not capital gain. If the investor is a foreign corporation not engaged in a

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trade of business within the United States, the taxable portion of the death benefit would be subject to U.S. tax as the income is “fixed or determinable annual or periodical income” and should be regarded as U.S. source income generally subject to a 30 percent withholding tax.

Revenue Ruling 2009-14 also addresses an investor’s resale of a life settlement policy prior to the death of the insured. The ruling concludes that an investor’s tax basis in the life insurance contract includes the acquisition costs and the full amount of premiums paid by the investor, without reduction for cost of insurance (as was required by Revenue Ruling 2009-13 in the case of the sale of a life insurance contract by the original owner). The income received on the resale (*i.e.*, the sale proceeds less the investor’s tax basis) would be a capital gain.

Concluding Thoughts

Revenue Rulings 2009-13 and 2009-14 address many of the income tax consequences of transactions in the life settlement market, including the determination of basis, the amount of income to be recognized and the character of that income. As a result, policyholders involved in the sale of their life insurance contract may be looking to their insurance company to provide the necessary cost of insurance information needed to complete their tax returns. In addition, insurance companies may also be subject to additional withholding and reporting requirements on the payment of death benefits to investors. While these rulings provide some welcome guidance, they highlight the importance for insurance companies to monitor life settlement transactions within their in force, as well as the evolving tax consequences of these transactions. ●

Update on U.S. Statutory Deferred Taxes

By Edward L. Robbins

Currently in the United States, the accounting bases utilized by the insurance industry include regulatory (Statutory) accounting and accounting under Generally Accepted Accounting Principles (GAAP). Deferred taxes constitute an important element of both accounting systems. The primary purpose of the deferred tax concept is to account appropriately in the balance sheet for future taxable income whose incidence is expected to differ from future book income. A deferred tax asset (DTA) is established for the tax already paid or accrued on income to be recognized in a latter accounting period. DTAs therefore represent amounts that an insurance company may be able to use to offset future tax liabilities if the insurer ultimately will have other future taxable income. Similarly, a deferred tax liability (DTL) is set up to represent that tax liability arising when book income is taxable in a latter accounting period.

Insurance company DTAs and DTLs can arise from many different sources, including insurance contracts, invested assets and business combinations. Basis differences between statutory and tax reserves are one of the major drivers of insurance company DTAs in the United States. This difference is commonly referred to as a “temporary difference” as the effects tend to reverse themselves over time. Typically, a DTA is established when policies are issued, as taxable income generally exceeds statutory income due to the higher statutory reserve or section 848 (Tax DAC) require-

ments. The future reversal of this temporary difference occurs as reserves draw down over time, creating future tax deductions relative to future pre-tax statutory income, thus reducing the DTA balance.

Current Statutory accounting rules significantly restrict the ability to fully recognize DTAs. Users of financial statements are better served if the accounting rules and requirements for determining the admitted portion of the deferred tax balance is determined using rules that are sufficiently close to the theoretically proper approach. Thus, the net admitted DTA, if appropriately calculated, should represent the future economic tax benefit (or tax cost) resulting from temporary differences in the reporting of statutory versus taxable income.

History of Deferred Tax Treatment in the United States

U.S. GAAP has long recognized the importance of proper deferred tax treatment. Under U.S. Statutory accounting rules for tax years prior to year-end 2001, however, only current tax expense was considered. Beginning at year-end 2001, under codification of U.S. Statutory Accounting Principles,⁴ statutory deferred taxes were introduced. In general, the statutory rules for deferred tax treatment were made relatively explicit, ostensibly to provide for the possible non-availability of other future taxable income to offset the future tax deductions represented by the DTAs. However, the limitation on the

admissibility of DTAs (*i.e.*, the amount recognized on the Statutory balance sheet) could only be expressed as “severe,” generally far more than necessary to cover such nonavailability. The severity of those constraints was possibly due in part to the regulators’ discomfort with the newness of the concept in 2001 and in part due to their perception that they were dealing with a nonliquid asset. The resulting net admitted DTAs tend to omit the predominant portion of future tax deductions arising from temporary differences resulting from reserves.

The current statutory rules for calculation of DTAs and DTLs are set out in SSAP No.10.⁵ The SSAP No. 10 guidance is summarized in a paper currently on the Society of Actuaries Taxation Section Web page, entitled “Deferred Tax Treatment of U.S. Statutory Policyholder Liabilities in Life Insurance Companies” (the Taxation Section paper). For most life insurers, SSAP No. 10 limits the statutory admissibility of DTAs to the lesser of:

- 1) 10 percent of prior quarter end capital and surplus; or,
- 2) The marginal tax rate on only those temporary differences that are expected to reverse within 12 months of the statement date.

Considering that reserve differences and Code section 848 acquisition costs (another major contributor to the DTA) tend to reverse over a 10 to 40 year time span, and considering the availability of three-year net operating loss carry-backs and 15-year net operating loss carry-forwards, the 12-month limitation is indeed a severe constraint.

Shortly before year-end 2008, the American Council of Life Insurers (ACLI) requested that the statutory rules covering admissible DTAs be revised toward what many in the industry would consider to be a more appropriate basis.⁶ The ACLI brought its proposal to the NAIC, and the NAIC formed a Capital and Surplus Relief Working Group (the NAIC Working Group) to review the ACLI’s request. The NAIC ultimately rejected the ACLI’s request for liberalizing the existing rules for year-end 2008 despite the recommendation of the NAIC Working Group. An account of those negotiations was written by W. Elwell and published in the May, 2009 issue of *TAXING TIMES*.⁷

Shortly after those 2008 year-end NAIC negotiations, several states issued “Permitted Practices” to their domiciled companies, enabling them to increase their admissible DTA balances as of year-end 2008, as had been recommended by the NAIC Working Group in December. The NAIC Statutory Accounting Principles Working Group is continuing to review the issues surrounding the DTA concepts, possibly considering a change for year-end 2009 reporting.

Theoretical Underpinning

The Taxation Section paper, referred to above, discusses the theoretical basis of deferred taxes and illustrates that, under reasonable conditions and under a fully admissible DTA, post-tax statutory book profits are equal to pre-tax statutory book profits multiplied by the complement of the marginal tax rate (MTR).

“The resulting net admitted DTAs tend to omit the predominant portion of future tax deductions arising from temporary differences resulting from reserves.”

The theoretical basis is approximately described below in a simplistic example, avoiding many of the complicating situations that typically arise in practice. The following simplifying assumptions have been made:

- Level future MTR (35 percent, the U.S. MTR for most large insurers);
- The insurer remains “fully taxable” throughout the future time horizon, sufficiently so to accommodate the future tax deductions embedded in the DTA.
- The change in DTA is presumed to be included in the “Summary of Operations,” as opposed to current statutory accounting treatment, wherein changes in DTAs and DTLs are a direct adjustment to capital and surplus.
- Other items, such as the Tax DAC (pursuant to U.S. Internal Revenue Code Section 848) are ignored.
- The DTA is fully admissible, *i.e.*, not subject to the SSAP No. 10 constraints.

As a starting point, assume statutory reserves for a block of business are \$1,000 and tax reserves are 90 percent of statutory reserves, or \$900. In our simplified model, the

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resulting DTA would be 35 percent * (\$1,000 – \$900), or \$35. Future taxable income from the tax reserve release will be \$100 less than the statutory book income from the statutory reserve release, resulting in a tax benefit of \$35. The DTA is thus equal to the future reduction in taxes to be paid as a result of the runoff of this statutory-to-tax temporary difference.

To illustrate the appropriateness of the above DTA, *i.e.*, that the appropriate DTA results in post-tax statutory earnings equal to (pre-tax statutory earnings)*(1- MTR), assume that the block were to terminate in the following year and incur claims of \$800. In such case the statutory earnings with respect to the policyholder liability would be as follows (algebraic signs reflect the effect on capital and surplus):

Statutory Reserve Release	\$1,000 (+)	
Death Claims	800 (-)	
Pre-tax Statutory Earnings	\$ 200 (+)	(1)
Tax:		
35% of Claims	\$ 280 (+)	
35% of \$900 Tax Reserve Release	315 (-)	
Release of DTA	35 (-)	
Post-tax Statutory Earnings	\$ 130	(2)
Ratio of (2) to (1), above	65%	

By reflecting the change in the DTA in the income statement, this example provides the theoretically correct result whereby the ratio of post-tax statutory book profits to pre-tax statutory book profits equals the complement of the marginal tax rate (MTR).

The Taxation Section paper also discusses the theoretical effects of discounting in the determination of DTAs, recognizing that a \$100 tax benefit in year 20 years does not have the same value today as \$100 tax benefit in year two. Suffice it to say that when discounting of deferred tax costs and benefits are factored into the analysis, the above ratio will still hold, although the equivalent calculations are more complex.

It is hoped that, with the continuing negotiations between the industry and the NAIC, an agreement can be arrived at that constitutes a reasonable compromise between proper theory and practicality. ●

FOOTNOTES:

- ¹ Except as otherwise indicated, references to "section" are to sections of the Internal Revenue Code of 1986, as amended (the "Code").
- ² 2009-24 I.R.B. 1083.
- ³ Except as otherwise indicated, references to "section" are to sections of the Internal Revenue Code of 1986, as amended (the "Code").
- ⁴ Codification was pursuant to the "Accounting Principles and Procedures Manual," an annual publication of the NAIC. The primary objectives of the codification project were more complete disclosures, more comparable financial statements for insurers, and a comprehensive guide for use by insurance companies and insurance departments.
- ⁵ Statement of Statutory Accounting Principles No. 10, *Income Taxes, Accounting Practices and Procedures Manual*, National Association of Insurance Commissioners (NAIC), 2008.
- ⁶ Increase in the limits from the above-cited 10 percent of capital to 15 percent, and extension of the "years limit" on reversals from one year to three years.
- ⁷ *TAXING TIMES* is the newsletter of the Taxation Section of the Society of Actuaries.



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