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HEALTH INSURANCE TAX RESERVES

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- Standard morbidity tables and adjustments to them
- Impact of statutory requirements
- Effective issue date for choice of interest rate
- When are additional reserves deductible?
- Is there a chance for one-year preliminary term on certain coverages?

MR. EDWARD L. ROBBINS: This is a session on taxation and Las Vegas certainly is a fitting city for presentations about taxes. You've heard tax practitioners refer to the process by which an IRS agent is assigned to your company as "the luck of the draw," and the items that the IRS agent decides to look at in your company as "the audit lottery." So I think we're in the right city for this type of presentation.

In any case, we are fortunate to have a distinguished panel. Of course, that's what everybody says about their panelists, but I really believe it. We have two highly experienced insurance tax practitioners with us, plus a health actuary who is down in the trenches calculating tax reserves. Joe Michel is a corporate actuary at Wausau Insurance Companies, and Joe will update you on the results of a very recent survey of companies that he took, with respect to how they're handling tax reserves on the various types of health insurance coverages, and with respect to how they're responding to various types of technical issues, ambiguous or otherwise. Chuck Auer is an insurance tax partner with Peat Marwick. Chuck will talk about various items related to the health insurance tax reserve environment. Chuck will cover certain relevant, recent changes in the code, and cases and rulings relevant to company taxation of health insurance. And since the deferred acquisition cost (DAC) tax, recently brought to you by your 1990 Tax Act, is basically a timing difference very much like reserves, he will stretch our topic outline a bit to cover certain health insurance DAC tax issues. Rich Burness, our anchor man, is also a guest speaker. Rich is the assistant vice president for Tax Planning at Aetna Life and Casualty. Funny, I always thought that tax planning and compliance were contradictory terms, but he assures me that's not so. Rich will concentrate on an emerging area, HMO tax issues.

Health insurance tax reserves have been rather problematic ever since the 1984 Tax Act. Noncancelable and guaranteed renewable (GR) health insurance don't fit neatly into Code Section 807, nor does cancelable health insurance fit neatly into Code

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Section 846. Each of those sections is designed for a different line of business, and kind of crowbars health insurance into it. And that's given us some problems. One of the chief problems is that there's very little state uniformity on morbidity tables. Another stumbling block, just to give you a example, has been the fact that two-year preliminary term is a requirement for noncancelable and GR health insurance active life reserves. Notice that for life insurance, the Code says, in effect, to use Commissioners Reserve Valuation Method (CRVM) *where applicable*. For annuities, it says to use Commissioners Annuity Reserve Valuation Method (CARVM) *where applicable*. But for health insurance, it says to use two-year preliminary term, period. That's been very problematic for certain types of coverage like long-term care, for example, where it's arguably equitably better treated under a one-year preliminary term, or perhaps even a net level approach. Is there a chance of getting to one-year preliminary term on long-term care, or on return of premium disability income? In our current, rather unsympathetic political climate, I think that would be very unlikely.

MR. JOSEPH W. MICHEL: As Ed mentioned, I am an actuary at an insurance company, and as such I have many responsibilities, one of which is tax reserving. So some of the things that I say may not be 100% technically correct. I'm by no means an expert at tax reserves, but I do some work with them. I sent out a survey to several companies. The survey was sent to those on the list of preliminary attendees, asking them about their practices in terms of doing tax reserves. I ended up with only 12 responses, so most of the comments I make may not follow a strict interpretation of the code. As a result, care should be exercised in interpretating these.

To give you an idea of what types of companies responded, there were seven stock companies, three mutual companies, and three consultants making responses. The consultants generally gave either the results of their average company or a particular company that they were working with, which they thought would be interesting as part of the survey.

In terms of company size, five of them were under $100 million of health premium in force, three were between $100 million and $250 million, and four had over $250 million. Company size for DAC tax purposes included three with less than $5 million of amortizable expenses, three between $5 million and $15 million of expenses, and six over $15 million. If you're familiar with the DAC taxes, each of those categories gets a little bit different treatment in how expenses are amortized.

In terms of types of products, there's a fairly wide distribution, with most of the companies having some disability income. There were three companies with some long-term care, and one each of Medicare supplement and cancer coverage. Group product representation was similarly distributed, with most companies having disability income, and some having hospital indemnity and AD&D health.

The survey asked if the DAC tax issue had any effect on the products that were offered. If anybody is familiar with the DAC tax, there's a group called "other life," and if your company combines annuity or any life product with what's considered a guaranteed renewable or noncancelable policy, it has to amortize 7.7% of premium, so it could have a big impact on your profitability. None of the companies responding made any changes in the types of products that they offered as a result of the DAC tax.

It also asked if there was any impact on the way businesses reinsured. Currently, the IRS is somewhat undecided as to how it wants to treat reinsurance, and so while all of the respondents answered none, one company did say that it was waiting to hear what the IRS decides, before it makes a determination as to whether or not it is going to change the way it reinsures. Several of the companies did say, though, that they raised rates to cover the cost of tax.

The next topic was individual disability tables in use. One company is still using the 1926 disability table for active life reserves on policies that were issued prior to 1965, and the rest of the respondents are either using the 1964 Commissioners Disability Table (CDT), or the 1985 Commissioners Individual Disability Table A (CIDA). Three of the companies said they exclusively use the 1964 table, and the rest of the companies use a table based on year of issue. The year of issue ranges anywhere from 1986-90 for the breaking point between using one table or the other, so there's no uniformity as far as when one table ceases to be used and the other starts to be used. As I mentioned earlier, what companies are doing may or may not comply with what the code says should be done.

As far as the disabled life reserve tables, two of the companies exclusively use the 1964 table, another four go between the two tables, one exclusively uses the 1985 table, and one company that has policies that have a benefit under two years uses its own experience. With respect to the relationship between the tax table and the statutory table, six of the eight companies responding use the same table for both. The one using its own experience, of course, would have to use the statutory table or the tax table. As mentioned, the interest rate is something that is different between the two, which I think is to be expected, and one company still uses a conference modification class three disability on old claims for its statutory basis.

The survey asked what kinds of adjustments are made to the published tables, to take into account things like substandard and the like, and almost all of the respondents said that they make no adjustments for that. We also asked what kinds of simplifying assumptions are made. About half the companies responded with no simplification, and another five use five-year age brackets, so they're evenly split between the two. One company responded that it does do some product grouping; in other words, similar products are grouped together in order to calculate the tax reserve. The next question asked was how the effective issue date is determined to arrive at the interest rate that's going to be used for tax reserves. There were basically seven responses; four said that they use the incurred date, and three use the policy issue date. So in practice it is still pretty much uncertain or up in the air as far as the correct way to determine the effective date. In terms of using preliminary term for an individual disability, two-year preliminary term is used at six of the companies, and another two use level reserves.

Next we also looked at other individual products, and these are just some of the tables that are currently being used. The 1956 intercompany hospital and surgical study is still being used by two of the companies. The 1974 hospital and surgical tables are also being used, and the other three tables are being used, but the number of companies responding to each of those is just one. So as far as the active life reserves, these are the tables in use. In terms of claim reserves, each company that responded to that question uses its own experience to calculate the claim reserve.

With regard to the relation of tables used for tax purposes, relative to those used for statutory purposes, in terms of the active life reserves, four of the six responding companies use the same table. For claim reserves, all six use the same table for tax reserves as they do for statutory. Some other tables that are used are the NAIC cancer tables and the medical experience tables from 1974. The only difference generally stated was that they do change the interest rate. As far as adjustments to the tables, one company mentioned that it does percentage modifications to the morbidity statistics in order to calculate substandard reserves. Generally, companies do reflect the different benefits that they offer too. About the only simplifying assumption that's used by the respondents was five-year age brackets, used by half of the respondents. And then on claim reserves, they all use no simplifying assumptions; they go direct. For issue date, incurred date and policy issue date are again used, and it's split evenly between the two. Incidentally, of the six companies responding to this question for other than the individual-disability-type products, four use two-year preliminary term and two continue to use that level of premium reserves.

The tables in use for group disability income are the 1964 CDT and the 1987 Commissioners Group Disability table. All the companies use the same table for statutory as they do for tax. Out of five companies responding, two use 1964 CDT exclusively, two use the Commissioners Group Disability table exclusively, and one uses a combination. The company using the combination will be switching to the Commissioners Group Disability table exclusively beginning in 1992.

As far as adjustments to the tables, three of the companies said they use no adjustment, one adjusts for AIDS, and some modification is done to the two tables for the company's own experience in the first two years. About half the companies use age grouping, and the other half use none, so there are some simplifying assumptions, but generally it's about half and half between grouping and not grouping.

With respect to effective issue date, most of the companies use the claim date, and one company uses the group issue date. For long-term care, three companies responded to the survey. Most of the companies in doing their active life reserves will use their pricing tables with some margins added, and the source of their pricing was generally using combinations of the National Nursing Home Survey from 1985 and the 1982-84 National Long-Term Care Study. They also tie into that the 1981 Group Annuity Mortality (GAM) Table or some modification of the 1980 CSO using a five-year projection. For disabled life reserves, two of the companies responding said they use the same tables as they do for active life reserves, and the other uses its own experience, but compares the results with the desired loss ratio that it gets from its pricing model. All the companies responding said they use the same tables for tax reporting as they do for statutory reporting. The only way they differ is in the use of preliminary term and interest rate. What kinds of adjustments did they make? Two of the companies said they don't make adjustments, and one said that it uses the 1985 nursing home study and adjusts the incidents and the lengths of stay upward. For disabled life annuities, one company uses the 1983 A table graded into the experience from the 1985 nursing home study.

With respect to simplifying assumptions, one company combines the male and female experience, another uses five-year age grouping, and then some do interpolation between ages.

For use of preliminary term, this is somewhat interesting. One company uses one-year preliminary term exclusively, one uses two-year preliminary term exclusively, and one splits the preliminary term by year of issue. Policies coming on the books before 1991 use two-year preliminary term, and those after use a one-year preliminary term.

The IRS right now is concerned about the lack of nonforfeiture provisions, and so that's the hot issue right now, as far as the IRS is concerned. The IRS tends to ignore most of the other issues apparently, and these are the issues that they're concerned about. All three companies on their new issues have some sort of a nonforfeiture provision. When asked about their experiences with the IRS, one company responded that it is finding that the IRS is as confused as it is, and I know I'm confused with a lot of things that go on at the IRS. But the interest in the nonforfeiture aspects of the long-term care was mentioned.

Going by what we've seen here, I think we can see that there's a real lack of uniformity in the way different companies do their tax reserves, and I think the IRS seems to be confused about what it wants us to do, and I think that's part of the reason that we're so confused.

MR. CHARLES J. AUER: Ed alluded to the fact that sometimes accident and health insurance doesn't fit real conveniently in the tax rules, and Ed's right, they don't. It is my observation over the course of my career that accident and health is a little different kind of animal for federal income tax purposes. That stems from the obvious reason that it can be written by both types of insurance companies; life can write it, and so can property casualty. I don't have any statistics. I suppose it's written more by life insurance companies, but both types of companies can write it.

The other thing that emanates from that that's interesting from a tax perspective, is that a life insurance company can write a contract, but it could be taxed as a property casualty company. Conversely, a company writing accident health could be a property casualty company as far as the states are concerned, but it could be taxed as a life insurance company.

We're going to discuss later a case called the United Fire case. And offhand, if I were to ask you what you thought was at issue at United Fire Insurance, most people would probably not guess that it was the life insurance company tax status for federal income tax purposes. It just doesn't evoke a situation where you'd be thinking about life insurance company status. But that was that issue in the United Fire case, which was my client at the time when all this was going on, so I have a little bit of the inside skinny as to what happened.

The other thing that's sort of different about A&H is the fact that the terminology draws from both the life insurance industry and the property casualty industry. They use the term *unearned premiums*, which is a casualty concept, but then use the concept of *additional reserve*, which requires knowing something about mortality and morbidity tables, and assumed rates of interest, and I guess that's a life insurance

concept. In the same vein, you get into the issue of what minimum reserves are for guaranteed renewable contracts. Anyway, the terms get mixed up. The minimum reserves can be expressed as mean reserves less deferred premiums, which is a life insurance concept, or they can be expressed as midterminal reserves plus either gross or net unearned premium reserves, which is sort of a mixture of both life and property casualty terminology all within the same definition. So against that backdrop, it's not surprising that we get some divergences of treatment with respect to accident and health.

The other thing that's unique about accident and health, I suspect, is that in the past, and continuing even until today, the federal income tax laws gave different treatments for accident and health insurance contracts, depending on the tax character of the issuer. For example, back in the 1959 act days, if a life insurance company and a property casualty company wrote an identical guaranteed renewable contract, the life insurance company would get to revalue its reserves for that contract from preliminary term to net level just because it was a life insurance company, and it got a bunch of other little special tax goodies that were available only to life insurance companies. If a property casualty company wrote the same contract, it didn't get that. It couldn't revalue its reserves to net level, because it was a property casualty company. It wasn't allowed to revalue. Even today there is still that same type of disparity, although it's been diminishing over the years.

Since 1984 I think we've seen an attempt to harmonize the treatment of accident and health between life and P&C writers. Tax issues, at least in my career, getting the most attention deal with those issues relating to noncancelable and guaranteed renewable contracts. Cancelable contracts, on the other hand, don't seem to evoke many tax controversies. In fact, from a tax accountant's perspective, they're pretty boring.

From a pure tax standpoint, as opposed to actuarial calculation and the like, cancelable contracts were not where the action was over the last 20 years. Most of the controversies tend to come from guaranteed renewable (GR) and noncancelable (NONCAN) contracts, and I'll tend to blur those two as I go forward. Definitions of noncancelable and GR are found in the regulations. When all else fails, go back and read the instructions. The Regulation Sections 801-3(C)&(D) are really 1959 Act regulations, not 1984 Act regulations. But I have it on good authority that the definitions still work even under the 1984 Act, because there's no reason for them to be different. The 1984 Act basically says the old precedents will survive under the new law. So it's a pretty good bet that they are the same definitions as were under the 1959 Act. Obviously, when a company writes a guaranteed renewal contract, it would undertake some additional obligations beyond what it does in a cancelable contract. I'm not an actuary, but I think it means that it is undertaking an obligation to pay claims in the future, when premiums that it can charge will not be sufficient. That's a real nonactuarial way of expressing it, but that would indicate, even to a nonactuary perhaps, that you have to set something aside to cover that shortfall in the future. And that's where the reserve, in addition to the unearned premium comes in. In those regulation sections, that is, in essence, one of the distinctions, or one of the parts of the definition, that says you must carry an additional reserve to cover the obligation that we just discussed, above and beyond the current year claim cost. That gets wound up in a bunch of actuarial calculations, which I'm not equipped or

able to talk about. But the reserve, in addition to the unearned premium, is where the source of litigation has been over the last 10 or 15 years, because whether you carry reserves or not has certain consequences.

The first thing I want to talk about under the heading of contrary precedence is Revenue Ruling 71367. This probably doesn't ring any bells for you, but it's one of my favorite, all-time revenue rules. It was issued by the time I started in my career, and I used it very early on in my career to basically beat the IRS at its own game. It's always nice from a tax perspective, or I guess from any perspective, to shoot the bad guy with his own bullets. So sometimes its revenue rulings can be used against the IRS, and we did it back then. It has to do with the issue of qualification as a guaranteed renewal contract. We had a situation where a company issued, what were for all intents and purposes, guaranteed renewal contracts, except that in the first three years of the contract, it didn't hold an additional reserve, and in the fourth year, it started carrying an additional reserve. The ruling doesn't say why they don't carry a reserve in the first three years, they just say that they aren't required. So the IRS looks at the facts, reads the definitions under the regulations, and says quite mechanically, "You don't have a reserve up in the first three years, therefore, your contracts can't be guaranteed renewal in the first three years. But in the fourth year, when you put the reserve up, then your contracts qualify. So, it's a very mechanical or formalistic approach to qualification.

In 1971, the IRS was doing whatever it could to deny a company the ability to be a life insurance company for tax purposes. Back then there were all kind of tax goodies associated with being a life insurance company. They were really the good old days, when you could do all those fun things, with phases and all that type of stuff, and there wasn't any DAC tax, and life was a whole lot simpler. In any event, what it was after, I believe, in issuing this ruling was it was trying to say you can't be a life insurance company, because there's a qualification fraction that you have to go through to determine life status. What that says is that 50% of reserves have to be life insurance reserves. The numerator in the fraction is the life insurance reserves; the denominator is the total reserves, which includes the life reserves. But again, accident and health insurance gets special treatment in the qualification fraction, and if your contracts qualify as guaranteed renewable, then all the reserves on those contracts, unearned premiums, claims, and additional reserves, all go into the numerator, because that's what the Internal Revenue code sections say. If they don't qualify, then they don't go into the numerator. So in this particular case, if you want to be a life insurance company, the more you put in the numerator the better off you are. The government doesn't want to say this, but it is intending, in this particular case, that reserves don't go into the numerator for the first three years of the contract, as you're not a life insurance company. That's what they were after in Revenue Ruling 71367.

And, of course, we figured that out in a particular case we were working on. We used it against the IRS, because it can't have it both ways, but that's really what it was after. Revenue Ruling 71367 said that for the first three years, the company didn't hold reserves. That was bad as far as the IRS was concerned. But we knew that a lot of companies didn't hold reserves for the first two years, because they were on two-year preliminary term methods. So the question became, what about these

guys who are holding two-year preliminary terms? It looks like they're holding zero the first two years.

United Fire and some other companies were holding nonreserves, and the IRS said that 71367 aplied to them. "You're not a life insurance company, Mr. United Fire, because all your contracts in the first two years are not guaranteed renewal, because you're holding two-year preliminary term. Fortunately when United Fire went to court, the court told the IRS it couldn't be the intention of Congress to distinguish contracts based solely on when reserves are put up, because the obligations are identical, whether you reserve for the contracts on a net level basis, where reserves would be up from day one, or preliminary term, where putting up reserves is deferred for two years. So in essence, without really coming out and saying 71367 was wrong, they give you the clear view. That 71367 probably wasn't right also went to appeals courts. United Fire was a life insurance company, even though it held preliminary term reserves on its guaranteed renewal contracts in its first two years. Interestingly enough, however, for United Fire and those other cases, the government never acquiesced in them. Sometimes when the government feels it has been beaten, it says, "Okay, you win; we'll acquiesce in the decision." Not done here. It has never repealed Revenue Ruling 71367; it's still on the books, and it's still their view, at least officially.

Along comes the 1984 Act, Section 807(d)(3)(A)(iii), which now requires you to use, at least for income determination purposes, the two-year preliminary term method. So we have sort of an anomalous situation. The code says to use the two-year preliminary term method on guaranteed renewable contracts, but the IRS says that if you use the two-year preliminary term method, you don't have guaranteed renewable contracts. So it's not that anomalous, but it does seem a little bit silly that they would continue or persist in this two-year preliminary term situation.

That brings us to another situation involving two-year preliminary term. Ed alluded to the fact that we have the 1990 Tax Act, and the DAC tax is now happily, or I guess unhappily, part of the landscape. If you write guaranteed renewable contracts, you have to capitalize 7.7% of the premiums, and amortize them over 5 or 10 years. If the contracts are not guaranteed renewable contracts, then you don't have to capitalize under DAC, but there is a 20% unearned premium reduction, the technical term is haircut, I guess, to the unearned premium reserve. I haven't taken any surveys, but it seems pretty clear that the clients I deal with would much prefer the 20% haircut to the 7.7% capitalization. Can anybody see where this is going? Revenue Ruling 71367 is still on the books. Could a company interpret 71367 and say that during the first two years it doesn't have additional reserves up, ergo it doesn't have guaranteed renewable contracts, and can thereby avoid or at least defer, the effect of the DAC tax for the first two years. Now ordinarily, all of us are allowed, in fact encouraged, to rely on published revenue rulings. That's why it's important that Revenue Ruling 71367 has never been revoked. It's still out there, and it basically says very mechanically that the reserves are not held, that there are no guaranteed renewable contracts. I suspect that if enough people were to begin to take the position that 71367 could help them avoid the DAC tax, the IRS may do what it has done before, and that is repeal Revenue Ruling 71367. There may be some modicum of benefit to the IRS for having it on the books, but I would think it would sweep that one away pretty quickly if it knew people were using it to avoid

the DAC tax for two years. We'll have to wait and see. I think enough people will take the position because you are entitled to rely on published revenue rulings.

However, the other thing you have to consider is that there is contrary precedent that United Fire and the other cases like United Fire basically say that Revenue Ruling 71367 isn't right. So again we have another anomaly. The IRS is saying one thing, and it's turning out to be to their detriment now. Usually anomalies, at least of this type, tend to get mitigated or taken away at some point in time, and the anomaly would be taken away if the IRS did revoke the ruling. So at the moment, I think it's an interesting speculation. Anybody who did take advantage of the anamoly would probably be well advised to disclose it in their tax return.

We already talked about the qualification as a life insurance company, the numerator and denominator, and why guaranteed renewable contracts get special treatment. Lots of consequences determine whether you qualify, or don't qualify, as a life insurance company. There are some good guys and some bad guys. If you're qualified as a life company, you get the small-company deduction if you're otherwise qualified. If you continue to qualify as a life insurance company, you can continue deferral of phase-three taxes, because if you fail to qualify, you have to give back the deferral of phase-three taxes. If a mutual qualifies as a life insurance company, it may not be such a great deal, because it has to deal with something called the Section 809 differential earnings amount. So being a life company in that circumstance is probably bad. There's a whole raft of consolidated return issues that come up as a result of either qualifying or not qualifying as a life insurance company. Who you consolidate with, what losses can offset other losses, when you consolidate -- those questions all come up depending on your status as a life insurer or nonlife insurer.

The unearned premium issue is not one of those that is particularly exciting, but every once in a while, you focus on something that's relatively mundane. And unearned premium is in that category, I believe. The one issue that has come up over the years is whether we should be using gross or net unearned premiums. Apparently, either gross or net are acceptable for guaranteed renewable contracts, at least from a statutory accounting standpoint. I'm not going to get into all the minimum reserve requirements, but they do refer to a concept of both gross or net unearned. No one paid attention until the 1984 Act, when some companies using gross unearned premium at the end of 1983 decided to go to net unearned premium at the beginning of 1984 and fresh-start the difference. When all that was going on, we took a little informal survey to try and determine who was using gross and who was using net, and we wound up with about a 50-50 split. I guess this is further evidence that both are acceptable. One thing that also points up the anomaly of tax treatment between life and property and casualty is in the 20% unearned premium adjustment arena. Prior to the 1990 Act, the 20% unearned premium haircut didn't apply to Section 816 life insurance companies.

We don't have a 20% adjustment and there's a high content of equity in the unearned premium. The ability to hold unearned premium reserves is a much better vehicle for tax deferral in a life insurance company with these types of things. But as often happens when something like that exists, the tax writers eventually uncover it, and uncover it they did in the 1990 Act. Now, at least as far as cancelable A&H is

concerned, the unearned premium would be subjected to a 20% haircut, whether it's written in a life or a P&C company.

I'm going to switch focus for a moment and start talking about guaranteed renewable accident and health contracts. It's clear that if they're written by a life insurance company, there is not a 20% adjustment. However, it's not completely clear, at least to me, that you could make the same statement about the unearned premiums for guaranteed renewable contracts issued by a property casualty company. I think they're trying to harmonize it, so that you get the same treatment, regardless of the character of the issuer. But I think they still haven't quite got to clarifying that point yet, so we still have one of those remaining anomalies.

The last item I want to talk about deals with claim reserves. This is a little bit of a quieter topic than noncancelable or additional reserves on noncancelable contracts. In the calculation of the life qualification test, the test basically says to make life insurance reserves the numerator of your qualifying fraction, and unpaid claims or claim reserves would go in the denominator. So the more unpaid claims you put in the denominator, the less likely you'll be a life insurance company.

Revenue Ruling 72115 basically addressed the situation where there were unpaid losses on life insurance claims. It basically concluded that the unpaid claims on life insurance contracts weren't reserves at all. They were more in the nature of accrued liabilities, and therefore ruled that they were not reserves that went into the denominator, because they were not reserves. Stepping back for a second, they try to make a distinction between accrued and unaccrued claims, and in this ruling we get the first hint that the government felt that accrued claims were not reserves, but that unaccrued claims, which we'd find in exhibit 9, were reserves that had to go into the qualification fraction. So that's what happened in 1972. In 1977, it issued a private letter ruling to a company that wrote a disability contract that paid off in a lump sum. Essentially it said the same thing in the Letter Ruling 7735008 as it said in 72115. These are accrued liabilities. They're not reserves, because reserves really are for unaccrued claims. These items do not go in the qualification fraction at all.

Harco Holdings case was another case that we had some involvement with. Harco was a subsidiary of International Harvester, and it had a couple of insurance company subsidiaries. We proposed that it take the rationale in 72115 and 7735008 and use it to become a life insurance company. If all the accrued claims on disability were taken out of the qualification fraction, its subsidiaries became life insurance companies. So Harvester, Harco, did that, and eventually, unfortunately, it went to court over it. And one day before the court reached its decision on Harco Holdings, the government issued letter ruling 9112011, which basically repealed Letter Ruling 7735008 14 years later. What that was hinting at was that it changed its mind, that it was litigating the fact that there shouldn't be a distinction or that we should not create a distinction between accrued and unaccrued claims for qualification purposes. An unpaid loss is an unpaid loss is an unpaid loss. There really shouldn't be any distinction based on the fact of the timing of the payment. Revenue Ruling 72115 is still out there. However, the letter rulings have essentially canceled each other out. And the court basically held that the repeal was correct, that you shouldn't be drawing a distinction between accrued and unaccrued claims for qualification purposes. A claim is a claim and Harco did not win its case.

MR. RICHARD J. BURNESS: Chuck has gone through what I'll call relatively settled law. I'm going to venture into an area that is open to a lot of debate. I have lots of suggestions, I don't have a lot of answers, and I think as we walk through this you'll see that it's going to be a while before we get some answers. But we're starting to make some progress in the area of taxation of HMOs. Just to make sure that we're all using the same terms, let me define a couple for you.

An HMO is an organization that arranges for the provision of medical services between the subscriber and the provider. It may do so by providing services itself, in which case it is a staff model, or it may provide services through either what I'll call a group model or an individual practice association (IPA) model. In a group model, traditionally there are a number of medical providers who get together and either form a partnership or a corporation, and then contract with the HMO to provide services. In an individual practice association, individual service providers each contract with the HMO for the provision of services to the subscribers of that HMO. There is always a fixed, predetermined premium that is paid monthly.

There are two types of arrangements that I'm going to talk about in an HMO. One is fee-for-service, where the HMO negotiates fees for specific services that are performed, either by the preferred provider, or by specialty providers and hospitals. The other is capitation. Capitation is where there is some risk-sharing with respect to services provided by the doctor to the subscriber, with the HMO in the center. The HMO is essentially paying a predetermined amount per subscriber to the doctor.

Why does it make a difference, and why are we talking about the taxation of HMOs? Well, the critical question is, what is an HMO? Is it an insurance company, or is it a general business corporation? Why do I really care about that? The fundamental reason is that we need to figure out what to do with claim reserves. Incurred But Not Reported (BNR) claim reserves, and as we talk about them in the indemnity business, property and casualty for instance, are only deductible by insurance companies. General corporations cannot deduct reserves for events that have been incurred but have not been reported. The Service has an old revenue ruling out there that essentially breaks from general corporate tax and says that if an insurance company has IBNR, then it doesn't need to meet the test that I'll soon talk about, and the increases can be deducted in those reserves. The first part is whether or not you can deduct the loss prior to the time that it is paid.

The second part is discounting. Property and casualty insurance companies have to discount reserves under Section 846. Regular corporations do not, even if they are entitled to set up a reserve and deduct that reserve.

The unearned premium reserve offset as I call it (the 20% disallowance of the unearned premium reserve) is another issue that applies to insurance companies and does not apply to general corporations under Subchapter C of the Internal Revenue Code.

Proration is another issue. Proration is the disallowance of 15% of tax-exempt interest and the dividends-received deduction. It applies to insurance companies. It does not apply to general corporations. And finally, the last major issue is the impact on state taxation. If in fact an HMO is an insurance company, it will have different

treatment for state tax purposes, where there's tax to be paid on income as opposed to premium. In some states, HMOs are taxed purely on premium. In some cases they are not, and are subject to the general rules for income taxation. However, if you look at the income tax rules for purposes of apportioning income, an insurance company may get some different results.

Well what's the status of the law? The whole thing started probably back in the late 1960s with the Revenue Ruling 68-27, which held that a staff model HMO is not an insurance company. I think if there's anything that I'm going to say that is right on point, it's that in today's world, as in the old days, a staff model HMO is not an insurance company. It's merely an arrangement where we're providing services with our own employees to people who sign up for that service. In the ruling, the Service cited as authority Regulations Section 1.801-3(a) which defines an insurance company, as, a company whose primary and predominant business is the activity of issuing insurance or annuity contracts. Primary and predominant is not a term that is defined anywhere, although it does not mean that you're licensed as an insurance company for state purposes. That is not controlling for this purpose. It does have something to do with what contracts you're issuing if you're issuing, insurance or annuity contracts, how many people you have devoted to that business, and what the courts have defined over the years as primary and predominant. I'd say probably in the 30 to 50% range is primary and predominant, but I wouldn't bank on that. It is a facts-and-circumstances-driven analysis that one must go through. In the Revenue Ruling, the Service held that the expenses of the staff model HMO were predominantly service-related and not indemnity related, and therefore, it wasn't an insurance company, it was a provider of service.

The second interpretation of note is private letter ruling 8424058, issued by the Service to a specific taxpayer. It can only be relied on by that taxpayer. However, everybody uses it as an indication of where the Service is moving. In today's world, you can now cite or use private letter rulings and technical advice memorandum as substantial authority for purposes of taking return positions. That was a recent change. This private letter ruling dealt with an IPA model. It held that the IPA was not an insurance company, and, therefore, could be a subchapter S corporation. I mention that now, because it's important that you know that. You're probably wondering who cares about subchapter S. It is important, because it was really the general corporate branch that issued this ruling and not the insurance branch. Presumably, there was some communication between the different branches or the different groups in the Service, but that's not altogether clear, and I guess we'll never know. Although in a big organization, there probably wasn't any communication. That happens from time to time. The important points in this private letter ruling are that the Service ruled that preventive care does not involve the shifting of insurance risk from the enrollee to the HMO. Rather, there is the risk resident with a physician. It does not have indemnification risk. The company did not have risk with respect to hospital care and services specialists; that is the fee for service. In both of those cases, there was a fee-for-service arrangement with the hospitals as well as the specialist. That is important because I'm going to talk about things that will diverge from that ruling in whole or in part.

Well, the world changed, to a significant extent, with the Deficit Reduction Act of 1984. HMOs really had to stand up and be counted. They had to determine

whether or not they thought they were, based on what they were issuing, insurance companies. Because now for the first time that was important. It's really the 1986 Act in part, but the first part is the 1984 Act and Section 461 economic performance which is very important in this concept.

The Service, for a long period of time, and the government were trying to get all companies to pay tax on economic income for proper matching of income and expenses, and they promulgated 461 to try to bring it back into their perspective. We've always had what is known as the all-events test, which says that you can take a deduction for items of income or deduction when the item is fixed and determinable within reasonable estimation. Now people thought, for a long period of time as well, that was pretty easy to do. Calculating actuarial reserves and other things causes no problems. However, the kicker in 461 was the economic performance rule. It says that to be able to deduct a reserve, for instance, you not only have to meet the all-events test, but economic performance must occur within the shorter of a reasonable period of time after the end of the taxable year or 8.5 months. Once again, if you think back to what I just said about that test for an insurance company and a property and casualty company, for instance, economic performance could not be met because reserves are not going to be paid, for the most part, within the 8.5 months after the end of the taxable year. But we could set this aside, because the rulings that have been issued still hold water. That is not necessarily the case with an HMO, if you don't know whether it's an insurance company or not. Can it meet economic performance? Will those expenses be paid within 8.5 months? Most of them probably will, but who knows. It depends, in large part on how things are being reserved.

Generally speaking, when the taxpayer is providing service, economic performance is deemed to occur when the service is being provided. Now if an HMO is establishing a reserve because it has done a precertification and the service is going to be performed after the end of the taxable year, economic performance has not been met.

The 1986 Tax Act comes along and 2 big things happen. One is code section 501(m), which holds that an exempt entity, which is defined in 501(c)(3), which is a general tax-exempt entity, such as a charitable organization, or 501(c)(4), which is a social welfare benefit group, or a group that gets together for exempt purposes, will not be exempt under 501(m), if a substantial part of the activities consist of the issuance of commercial-type insurance. Section 501(m)(3) excludes insurance provided by HMOs from this definition. It appears that the legislative intent was to exclude based on statute because Senator Packwood, who at that time was Chairperson of the Senate Finance Committee, felt strongly, along with the members of that committee, that HMOs were insurance companies. If they weren't insurance companies and were not engaging in commercial types of insurance, there would be no need, one might think, to specifically put in the statutes when defining what an exempt activity is, and to say, "and HMOs are not engaged in this activity." There would be no need to say that if they weren't insurance companies.

The next thing that happened in 1986 was the discounting of loss reserves for property/casualty companies. Then 1987 rolls around, and the General Dynamics decision is issued by the Supreme Court. General Dynamics had an administrative-services-only contract with a number of carriers. Under the terms of the contract,

claims were paid when presented to the insurance company for payment. What General Dynamics attempted to do was, based on some actuarial work that was done, take a deduction for services that had been provided to its employees, for which claims had not been presented to the insurance company for payment. In what I believe is a wrongly decided decision, the court held that the reserves were not deductible by General Dynamics, because General Dynamics' liability was contingent until such time as the employee presented the claim to the insurance company for payment. Merely having the service provided by the doctor prior to the end of the taxable year was not sufficient under the terms of the contract to establish a liability. The court cited, in its opinion, situations where an employee may not want you to know that he's undergoing substance abuse counseling or that he was involved in an auto accident or whatever, and under that logic if you will, the Supreme Court held that the reserves were not deductible. In large part, people thought that was sort of the final nail in the coffin for HMOs. As to whether or not they were insurance companies. What's the difference between an HMO and what's going on in General Dynamics? Moreover, how do you distinguish a Supreme Court decision? It is the law of the land.

Well, a couple of things have happened since then. One was the issuance of technical advice Memorandum 9203002, I believe it's United Health Care. It involves providing of services. It's a mental health care HMO, and it did a lot of work with its own employees. When the counselors felt that they were not able to handle a patient's needs, they sent the patient outside of the HMO to see specialists or go into the hospital, so forth and so on. In the memorandum, the Service held that reserves established based on precertified services, rendered after the end of the year, even though the precertification took place before the end of the year, resulted in no deduction being allowed because economic performance had not occurred. Economic performance only occurs when the service is provided. It did suggest that a recurring item election could be made. The recurring item election under 461 says that if an item, which doesn't meet economic performance by the end of the taxable year but does within 8.5 months, is recurring in nature, an election can be made to report it along with the income in the prior year.

Unfortunately, in this holding, and you can't tell from the facts why, the Service said that the company can't avail itself of the recurring item election because it didn't make a valid recurring item. I don't know enough about the facts of the decision to know what it did wrong, but it suggests that companies who are in this situation should make sure that they've got a good recurring item election, just in case they're determined to be noninsurance companies.

I think the latest thing that's happened, and I just stumbled upon this technical advice memorandum, is 9204003. Stumble is really a good word, because it involves advertising expenses, and you might ask what that has to do with insurance and HMOs. Well, interestingly enough, the Service distinguishes General Dynamics in this ruling. It involved a supplier, a manufacturer I believe, that when it supplied its goods to the wholesaler, under the terms of a contract it entered into with the wholesaler, allowed the wholesaler to take promotional advertising credits prior to any submission on behalf of the wholesaler that said it performed these services and it has taken advantage of this. All the wholesaler had to do was, in its invoice or remittance, just deduct an amount that would be disclosed as being for promotional advertising. The

Service says that economic performance occurred when the services were provided to the taxpayer, and then launches into a discussion that you might think is contrary to General Dynamics, but we don't think so and here's why.

Essentially what the Service has said is that when there is an act that is ministerial in nature, and this is supported by some cases back in 1939, and in the 1950s, which is merely the presentation to the taxpayer of here's what was done to claim this credit, but that doesn't mean that the liability is contingent in nature at the end of the taxable year. Was the service performed? Yes. Well, you don't have to take this extra step to submit the paperwork to ensure that you are entitled to this deduction.

It is the Service's logic, and I think this is helpful, because as Chuck said earlier, it's always nice to shoot them with their own bullets. This is a fee-for-service HMO. Once the service is performed, the doctor (whether it be the primary care physician or the specialist) is performing services under the terms of a contract which the HMO and the doctor have signed. The mere providing is ministerial in nature. It should mean that if there is a fee-for-service HMO, with the logic in 9204003, it should be a slam dunk. I mean you can throw this in their face and it should work. I'd probably set up a reserve for a contingency that you might not win. As one of my mentors always said, when it comes to taxes, a sure bet is an 80% win. That's as good as it ever gets, and it's about right, because everything might go to court.

So where are we? Do I have any answers? Well, I think that if there is a capitated plan, there is probably not an insurance company arrangement. However, technical advice memorandum 9203002 probably says that if you do a good job and you do the precertification, you can probably get all that stuff, and that will get you a long way there. In my mind, predominantly fee-for-service is probably an insurance company, and therefore that means that you have to discount reserves, disallow 20% of the increase on the unearned premium reserve, and all those things.

I think some interesting things, and that's really my perspective, are what's going on within the service. John Tucker, who is the health care industry coordinator within the Service is running around the country saying that HMO's are not insurance companies. Does he have any authority? Well, it's not a coordinated issue, which means that they don't have to seek out this guy for his guidance. The thrust of the industry specialist program is to decontrol most of these coordinated issues to let the decisions be made at the field office or the field agent level. So it's unclear to me whether Tucker will be successful. I really don't think he will be.

I think what's more problematic from the government's perspective is that the national office believes that exempt HMOs do insurance business. It wants to bring them under this umbrella in 501(m) and say, "You do an insurance business, you're not exempt anymore, you're subject to tax." Well, taking that position has a problem when you're talking about for-profit HMOs. You can't say, for one purpose of the code, "You're doing commercial-type insurance business. It's your primary business. You're an insurance company. We're going to tax you." Then there is the identical for-profit HMO doing exactly the same thing and hearing, "We were already taxing you. You're not taxable as an insurance company, even though we told the not-for-profit over here that it is taxable because it is an insurance company." That's a real problem.

There's probably a war going on right now within the Service trying to figure out what to do. I know that Senator Packwood has sent some notes on to the national office saying, "Guys, when we did 501(m), I was serious. The intent was that these companies are insurance companies, and they're not subject to tax if they're operating an HMO business, so get off the case." Now does that work? Well, if you think back, for those of you who are involved in modified coinsurance (modco) and the moratorium on IRS activity, we had modco, son of modco, grandfather, grandson, and great grandfather of modco in the Service until the 1984 Act changed. Even the 1984 Act said they were serious about this, to leave modco alone, it's a done deal. The IRS is stubborn, it doesn't always abide by its own rules, it makes them up, and it uses them as best it can, and whenever it suits its purpose. In the end, only time will tell where we're going to come out on this issue.

MR. ROBBINS: We recognize that it's hard to keep up with everything that's going on in this area, and some people in the audience may be more up to date on a particular issue than we are, so feel free to share with us what you know on any late-breaking events.

MR. MARK M. HOPFINGER: On the questionnaire that was sent out for those companies that were using the original issue date for purposes of establishing the interest rate for tax purposes, were they also using the original issue date for purposes of choosing their disability table, or were they independent?

MR. MICHEL: I believe they were consistent in both.

MR. HOPFINGER: Chuck, did I understand you correctly in that you said you could throw all of your Exhibit 11 claim liabilities in the denominator for purposes of the life insurance qualification or nonlife insurance qualification?

MR. AUER: I guess the rule would be that whatever you show in Exhibit 11, except for life claim reserves, which apparently are still not claims as far as the IRS is concerned, go in the denominator.

MR. ROY GOLDMAN: Chuck, this is obvious, but I just want to be sure. You discussed a company that takes two-year preliminary term reserves on a GR product, but it adds zero to the calculation in a numerator, I guess a start-up organization would not be taxed as a life insurer, at least for a few years, until it started to put up some reserves.

MR. AUER: That depends on whether you believe Revenue Ruling 71367, or you believe United Fire.

MR GOLDMAN: But if you hold the preliminary term reserves and you have zero in the numerator. . .

MR. AUER: That was the issue at United Fire. Was a zero reserve a reserve? The issue wasn't really stated quite that way, but it's sort of been paraphrased to be the issue. You can make a calculation, and the calculation comes up with a result of zero. Do you have a reserve with a zero balance, or do you have no reserve at all? It's a little bit like the tree falling in the forest I guess, and no one's around to hear it.

Did it really make a noise? It seems to me that United Fire was saying Congress intended that these things qualify as guaranteed renewable contracts, regardless of the reserving method, and the government has never acquiesced to that, and yet, in addition, Revenue Ruling 71367 is still on the books.

MR. GOLDMAN: Yes, but is the fact that they qualify as guaranteed renewable contracts enough to make that company taxable as a life insurer, unless they ratio as that?

MR. AUER: It would depend on the other businesses that they had. But if that was their only business, I think they could qualify in the first two years.

MR GOLDMAN: They could?

MR. AUER: Yes, that's the legacy of United Fire.

FROM THE FLOOR: You commented about a capitated HMO and whether or not, it was likely that it could qualify as not being an insurance company for tax purposes. Wouldn't that depend upon physician services as a percent of total services?

MR. BURNESS: Yes, you have to go back to the primary and predominant test. If it is a fully capitated HMO, my comment stands. If there is capitation for primary care, and fee-for-service for hospitals and specialists, you have to figure out where you are.

FROM THE FLOOR: Could you repeat again your final comments about Section 501(m)?

MR. BURNESS: The national office of the Internal Revenue Service is trying to suggest that previously exempt HMOs are insurance companies involved in a commercial insurance business, and are therefore taxable under 501(m), or they're excluded from 501(m), and most would go into 832 and would be subject to tax. So they're saying, "You are an insurance company, we're going to tax you." That's hard to square with their position on for-profit HMOs, where they seem to be going down the trail that says they're not insurance companies.

FROM THE FLOOR: So 501(m) only applies to entities that were not for profit.

MR. BURNESS: Correct.

FROM THE FLOOR: . . . and thought to be exempt before that.

MR. BURNESS: Traditionally, I would say the old Blues, that whole network that exists.

MR. JOHN E. HEWITT: Ed what's the current position of the IRS on the reserve table to use for nonlife reserves? It defines the table for life reserves. I understand for nonlife reserves, though, you can use your statutory table, but that's a problem if you're on the CDT and you have to use the applicable federal interest rate (AFIR). It really weakens the reserve.

MR. ROBBINS: You're basically talking about cancelable types of health insurance subject to Section 846.

MR. HEWITT: Yes, I'm talking mainly about group disability that the IRS is calling cancelable.

MR. ROBBINS: Right. There are basically three types of health insurance under Section 846, credit disability, disability income other than credit, and all other. Credit disability has specific Treasury tables that you use for discounting. The "all other" is subject to one-half-year discounting for disability income other than credit, which is usually the lion's share of a company's reserves if it sells group LTD, it's a table that "reflects the experience of the taxpayer." That's what it says, which means it can be independent of what you're doing statutorily, at least literally.

FROM THE FLOOR: So you could use the group table modified and come up with a reserve that can't be greater than your stat reserves, right?

MR. ROBBINS: There is a limit, there is a ceiling, and the ceiling basically is "line of business" and "accident year." *Accident year* is a P&C term of *ART*; it means incurral year, in this case, and for group LTD, we would construe an incurred year as the aggregation level at which you test your cap. Just another comment on that. The code says, "shall use" (a table reflecting the experience of the taxpayer) and the committee reports say "may use." The code wins.

MR. BURNESS: That depends.