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NEW PLR ADDRESSES TAIL-DESIGN LTC-ANNUITY RIDER

By Bryan W. Keene and Eric G. Lanning[1]

On Feb. 4, 2011, the Internal Revenue Service (IRS) released PLR 201105001, which addresses the federal income tax treatment of a tail-design long-term care ("LTC") insurance rider to a deferred annuity contract. A tail design generally means that all LTC benefits that are payable during an initial period are offset completely by reductions to the annuity contract's cash value. If and when those benefits are exhausted, LTC benefits continue for a subsequent period without affecting the cash value. Thus, net amount at risk ("NAR") is payable only during the tail end of the benefit stream. The new ruling addresses whether the taxpayer's particular tail design exhibits sufficient risk shifting and risk distribution to be treated as an "insurance contract," and thus as a qualified long-term care insurance ("QLTCI") contract, for purposes of section 7702B.[2]

FACTS OF THE RULING

The taxpayer in the ruling proposes to offer a QLTCI rider (the "Rider") with certain deferred annuity contracts it plans to issue to a large number of insureds (the "Contracts"). Some of the Contracts are fixed contracts and others are variable. Different versions of the Rider will be available depending on the Contract type, but each Rider will operate in essentially the same way.

Subject to certain waiting periods and a deductible, LTC benefits will become payable under the Rider if the insured is a chronically ill individual who is receiving qualified long-term care services.[3] The LTC benefits will be payable throughout two successive periods—Phase 1 (the self-funding period) and Phase 2 (the NAR period). Together, the two phases are scheduled to last 72 months. Phase 1 will be scheduled for either 24 or 36 months, while Phase 2 will be scheduled for either 48 or 36 months, as necessary for the two phases to total 72 months. The actual length of each phase could be longer than scheduled, depending on the LTC benefits actually paid.

The LTC benefits during each phase are subject to two types of caps: a monthly benefit cap and an aggregate or total benefit cap. The total benefit cap during Phase 1 is determined by reference to the Contract's cash value. The monthly benefit cap is generally determined by dividing the total benefit cap by Phase 1's scheduled duration. For example, if Phase 1 was scheduled to last 24 months and the Contract had a $50,000 cash value, the total benefit cap during Phase 1 would be $50,000 and the monthly benefit cap during Phase 1 would be about $2,083 ($50,000 divided by 24 months).

During Phase 2, the total dollar cap on LTC benefits is determined by reference to Phase 1. Specifically, if the two phases are scheduled for equal durations, the total benefit cap will be the same for each phase. If Phase 2 is scheduled to last twice as long as Phase 1, the Phase 2 total benefit cap will be twice that of Phase 1.

The monthly benefit cap remains the same, in essence, throughout both phases; however, the available monthly benefit may be reduced below the cap amount. If the insured is receiving qualified long-term care services in a nursing home or as a part of hospice care, LTC benefits equal to the full monthly dollar cap are available. If, however, the insured is receiving qualified long-term care services outside of a nursing home or hospice care, the available monthly benefit is cut in half. This has no effect on the total benefit caps under the Rider. Rather, the effect of a reduced monthly dollar cap is that the actual length of Phase 1 or Phase 2 could be longer than scheduled, because the same aggregate LTC benefits would be paid out more slowly. Phase 1 ends, and Phase 2 begins, when the total LTC benefits paid equal the total dollar cap on Phase 1 benefits. Likewise, Phase 2 ends when the Phase 2 total benefit cap is exhausted by the payment of monthly LTC benefits.

Some versions of the Rider also provide for certain LTC benefits in excess of the foregoing dollar caps. The ruling refers to such additional benefits as "Augmented Payments." The mechanics for calculating the Augmented Payments differ somewhat depending on whether the Contract is a fixed or variable annuity. In general, however, they are determined on each Rider anniversary based on increases in the Contract's

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cash value relative to the cash value that was used in determining the total benefit cap for Phase 1. Thus, continuing the foregoing example, if the Contract's cash value on a Rider anniversary had increased from $50,000 to $75,000, there would be $25,000 in Augmented Payments available under the Rider. These additional benefits would be payable in equal monthly installments over the remaining scheduled durations of Phase 1 and Phase 2, subject to the same 50 percent limitation described above for non-nursing home and non-hospice care. The Rider includes an ordering rule under which Augmented Payments are available in a month only if all other LTC benefits have been exhausted for that month.

If the insured is not chronically ill on the Contract's maturity date, the Phase 2 benefits will remain payable as paid-up insurance, but all other Rider benefits will expire.

LTC benefits paid under the Rider will have different effects on the Contract's cash value depending on the type of benefit and when it is paid. In general, all LTC benefits paid during Phase 1—whether the base benefits or Augmented Payments described above—will reduce the Contract's cash value dollar-for-dollar. Augmented Payments made during Phase 2 also will reduce the Contract's cash value dollar-for-dollar. All other LTC benefits paid during Phase 2, however, will have no effect on the Contract's cash value. Rather, such LTC benefits will be comprised entirely of NAR that the issuing life insurance company pays from a reserve or its own surplus.

If the insured is receiving LTC benefits under the Rider when the Contract reaches its scheduled maturity date (when annuity payments otherwise would be required to begin), the Rider benefits will continue and annuitization will be delayed until the insured recovers or the LTC benefits are exhausted. If the insured is not chronically ill on the Contract's maturity date, the Phase 2 benefits will remain payable as paid-up insurance, but all other Rider benefits will expire.

ANALYSIS AND CONCLUSION

The taxpayer in PLR 201105001 requested a ruling that the Rider constitutes an "insurance contract" for purposes of section 7702B(b)(1). Under that provision, a QLTCI contract is defined as an "insurance contract" that meets certain requirements. Thus, by addressing whether the Rider is an insurance contract, the ruling effectively addresses whether the Rider is a QLTCI contract, assuming that all other requirements of section 7702B are met.

The IRS notes in the ruling that neither the Internal Revenue Code (the "Code") nor the regulations under the Code define "insurance" or "insurance contract." The ruling observes, however, that in *Helvering v. Le Gierse*,[4] the Supreme Court held that an arrangement must exhibit both risk shifting and risk distribution in order to constitute insurance for federal income tax purposes. The ruling also discusses various criteria identified in other judicial decisions and IRS rulings as necessary for an insurance characterization, including that (1) the risk transferred must be a risk of economic loss and not merely an investment or business risk,[5] (2) the risk must contemplate the fortuitous occurrence of a stated contingency,[6] and (3) the arrangement must constitute insurance in the commonly accepted sense.[7]

With regard to risk shifting, the ruling states that it occurs "if a person facing the possibility of an economic loss transfers some or all of the financial consequences of the potential loss to the insurer, such that a loss by the insured does not affect the insured because the loss is offset by a payment from the insurer." With regard to risk distribution, the ruling states that it incorporates the phenomenon of the law of large numbers, and that "by assuming numerous relatively small, independent risks that occur randomly over time, the insurer smoothes out losses to match more closely its receipt of premiums."[8] Finally, the ruling states that the "commonly accepted sense" of insurance derives from all the facts and circumstances of a particular case, with emphasis on how the arrangement compares to others that are known to constitute insurance.

Based on the foregoing, the ruling concludes that the Rider is an insurance contract for purposes of section 7702B(b)(1). In reaching this conclusion, the IRS focused particularly on the risk shifting requirement from *Le Gierse.* The IRS framed that issue as whether there is any possibility that any particular insured could incur a loss that the Rider would reimburse. In that regard, the ruling states that if the Rider were structured so that benefits would always be offset by the Contract's cash value, then the Rider could not constitute insurance because there would never be a reasonable possibility that the Rider would reimburse an economic loss incurred by the insured person. The IRS concluded, however, that this was not the case with

respect to the Rider. Rather, the IRS found that the taxpayer life insurance company had assumed the risk under the Rider that the insured would become eligible for LTC benefits in excess of those offset by the Contract's cash value.

The IRS also concluded that the risk of chronic illness is a morbidity risk that can give rise to economic loss, that the taxpayer would distribute that risk of loss across a large number of insureds and therefore satisfy the risk distribution element of *Le Gierse*, and that the Rider constitutes insurance in the commonly accepted sense. As a result, the ruling concludes that the Rider is an insurance contract.

FINAL OBSERVATIONS

The new ruling is the first to address the federal income tax treatment of an LTC-annuity rider that follows a tail design. In 2009, the IRS issued a private letter ruling addressing the risk shifting characteristics of a coinsurance or *pro rata* design, where each LTC benefit was offset only partially by reductions in the annuity contract's cash value, with the remaining portion of each benefit payment being comprised of NAR.[9] The new ruling confirms that not every benefit payment needs to include NAR, and that a tail design also can qualify as insurance for purposes of section 7702B(b)(1) —as was the case under the facts presented in the ruling. The ruling reflects the fact that the Pension Protection Act of 2006,[10] which authorized LTC-annuity products, provides considerable flexibility for insurers in designing such products, so that they may best address consumers' needs for affordable LTC insurance coverage.

END NOTES

1 The authors would like to thank John Adney and Craig Springfield, both of Davis & Harman LLP, for their helpful comments on this article.
2 Each reference to a "section" is to a section of the Internal Revenue Code of 1986, as amended.
3 See section 7702B(c)(1) and (2) for the definition of qualified long-term care services and chronically ill individual, respectively.
4 312 U.S. 531 (1941).
5 *See* Allied Fidelity Corp. v. Comm'r, 572 F.2d 1190, 1193 (7th Cir. 1978); Le Gierse, 312 U.S. at 542; Rev. Rul. 2007-47, 2007-2 C.B. 127.
6 *See* Comm'r v. Treganowan, 183 F.2d 288, 290-92 (2d Cir. 1950).
7 *See, e.g.*, Ocean Drilling & Exploration Co. v. U.S., 988 F.2d 1135, 1153 (Fed. Cir. 1993); AMERCO, Inc., v. Comm'r, 979 F.2d 162 (9th Cir. 1992), *aff'g* 96 T.C. 18 (1991).
8 *See* Clougherty Packing Co. v. Comm'r, 811 F.2d 1297, 1300 (9th Cir. 1987).
9 PLR 200919011 (Feb. 2, 2009).
10 P.L. 109-280.

Bryan W. Keene is a partner in the Washington, D.C. law firm of Davis & Harman LLP and may be reached at *bwkeene@davis-harman.com*.

Eric G. Lanning is an assistant vice president and senior counsel at The Lincoln National Life Insurance Company and may be reached at *eric.lanning@lfg.com*.