



**SOCIETY OF  
ACTUARIES**

**TAXATION  
SECTION**

# Taxing Times

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# From the Chair

By Tim Branch

Continuing the decennial celebration of the Taxation Section, I thought I'd keep with the 10-year retrospective theme for my column. In the October 2014 issue of *TAXING TIMES*, Brenna Gardino reminded us of the founding members of the Taxation Section. In the June 2015 issue, Brian King, Kristin Norberg and other members of the Editorial Board provided an overview of this newsletter's growth during its first 10 years. I'd like to continue in this vein and recognize the past chairs of the Taxation Section (see below) and their contributions toward making our section what it is today.

This is an impressive list of actuaries and tax professionals, and I am honored that my name will be added to this list at the end of my tenure as chair this year. I'm also look-

ing forward to seeing the next 10 names that will be added to this list. We have made an effort over the past two years to reach out to newer actuaries and increase our visibility at professional development events. It's time to see the next generation of tax actuaries (or "taxuaries," as I like to call us) continue to step up and take the lead!

I'd also like to thank the section members who took the time to participate in the Taxation Section survey a few months ago. Your responses provided us with valuable feedback that will be used to make the section more useful and relevant to our membership. We will use this information to better tailor our professional development offerings, *TAXING TIMES* content and other member services. We heard from our members that emerging issues are a top priority, and this message has been

heard across all sections. We'll do our best to address this area in our 2016 strategic goals for the section. Jeff Stabach, the current vice chair of the Taxation Section, has summarized the survey results in an article later in this issue.

In conclusion, I'd like to thank the Taxation Section Council, Friends of the Council and section membership for making this past year as the Taxation Section chairperson both fulfilling and rewarding. One of the greatest strengths of our section is the willingness of our members to volunteer and participate, whether by writing articles and participating in the production of *TAXING TIMES*, speaking at professional development events or representing our section throughout the insurance industry. It's been both my pleasure and honor to serve in this role, and I look forward to continuing my participation in the section.

*Note: The views expressed are those of the author and do not necessarily reflect the views of Ernst & Young LLP.*

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# The Road to Tax Reform— An Interview with Chairman Dave Camp

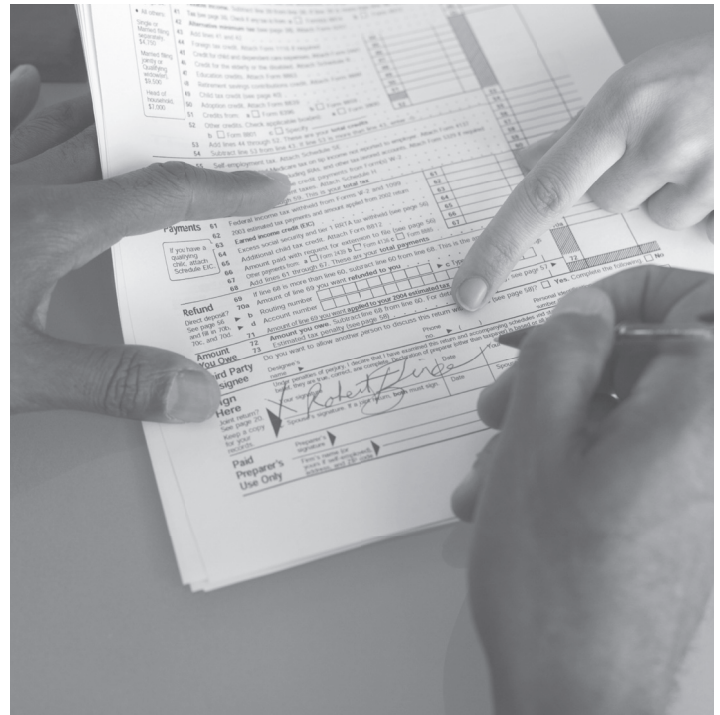
**A**t the beginning of this year, Representative Dave Camp (R-MI) retired from the House of Representatives after 12 terms, the last two terms serving as Chairman of the Committee on Ways and Means. Chairman Camp has played a central role in the national conversation on tax reform, primarily through a series of discussion drafts addressing international tax reform, financial products tax reform, small business tax reform and, most recently, a comprehensive tax reform discussion draft that we explored in a special edition of *TAXING TIMES* last fall.<sup>1</sup> Following Chairman Camp's retirement from Congress and return to the private sector as a senior policy advisor with PricewaterhouseCoopers, LLP, the *TAXING TIMES* Editorial Board thought it would be enlightening and valuable for our readers to have an opportunity to get to know him. Kristin Norberg, *TAXING TIMES* editor, recently sat down with Chairman Camp to talk about his career in the House, the development of the Tax Reform Act of 2014, and some of its potential impacts on the insurance industry.

**Kristin Norberg:** First of all, welcome, and thank you so much for spending some time with us here at *TAXING TIMES*. We're excited to have the opportunity to get to know you a little better and to hear more

about the Tax Reform Act of 2014. Could you start by telling us a bit about your background? Specifically, after starting your career in a private law firm in Michigan, why did you decide to serve in Congress?

**Dave Camp:** Thank you for inviting me. I'm happy to be here. I didn't grow up thinking that I would run for office. I went to law school in order to work in a small law firm in a small town, which is what I did for 10 years. It's the nature of that type of firm that you get asked to update the bylaws of volunteer organizations, so I got involved in a lot of those organizations. Additionally, I was representing my clients in front of various councils and boards and government entities, and I started to think a lot about who is making the rules, and why. One of my partners at the law firm ran for judge (which in Michigan is a non-partisan race) and I helped with his campaign. I liked volunteering and being an advocate, so I continued getting involved with volunteer organizations and political campaigns, including as a precinct delegate and participating in state conventions.

Then the representative from my district in the Michigan House of Representatives de-



ecided not to run for re-election. Michigan law allows you to continue to practice law while being a state representative, so I could get involved in politics without giving up my practice. I was elected to the statehouse in 1988. Eventually, it became a case of my hobby overtaking my profession. Our representative in the U.S. House also decided not to run for re-election, and so I took the leap and gave up private practice.

In order to be a good Congressman, you have to be aware of current events and what people are concerned about, and that was something I was always interested in.

**Norberg:** How did you choose tax as a focus?

**Camp:** I initially wanted to be on the House Appropriations Committee, but in my first

term, I wasn't selected by the Committee of Committees for that role. I spent time on the House Agriculture and Small Business Committees.

Then Representative Bill Gradison retired from Congress, creating an opening on the House Ways and Means Committee. It's another campaign, really, to get the committee appointments you want. A mentor of mine told me that the real action was on the policy side rather than appropriations, so I decided to aim for Ways and Means. I called Gerald Ford, a former Michigander, for his support, and he actually answered the phone. He had previously been the House Minority Leader before he became Vice President. He said to me, "Somebody owes me a favor." The next thing I knew, someone walked up to me on the floor of the House and said

he would get me on Ways and Means, and it worked.

**Norberg:** What led you to retire from Congress?

**Camp:** I had reached my term limit as Chairman of the Ways and Means Committee. I'd seen some people stay in Congress after having a major role like that, and it often didn't work. I had been in Congress for 24 years, so I decided that it was time to move on. I had been able to achieve a lot in tax, trade, health care, etc., and I wanted to have a chance to try to work on those issues from the private sector perspective. Also, I had a strong potential successor in Congressman Paul Ryan, so the timing was right.

**Norberg:** When you were in the House, and particularly while chairing the Ways and Means Committee, how did you establish priorities and choose the projects where you wanted to commit time, energy and political capital?

**Camp:** All the issues I've been involved in have been important to me. Tax reform became a clear priority to me when I was Ranking Member on Ways and Means, and I was working extensively with Treasury Secretary Geithner, Senate Finance Chairman Baucus and Treasury Secretary Lew, trying to extend expired tax provisions. It became clear to me that the system didn't work, and I wanted to find a better solution.

At the same time, we were concerned that the economy wasn't recovering as quickly as we wanted after the financial crisis. We needed a tax system that

was fairer, flatter, simpler, and that could help grow the economy. There was also a changing international environment, and the United States was out of step internationally. It became clear that there was an imperative to do tax reform.

Generally, I tried to be on top of all the issues the Committee oversees, and keep moving them all forward. I worked a lot on how health care providers are paid by Medicare (Sustainable Growth Rate (SGR)), and we were able to get that passed and signed into law. Another priority of mine was foster care and adoption. I co-authored the 1996 Welfare Reform Act. What it comes down to is doing the right thing and trying to move the United States forward. I'm a firm believer that good policy is good politics.

We also were able to get trade agreements with Colombia, Panama and Korea while I was Chairman. It is very important that the United States be engaged internationally, and I was proud we were able to get those agreements over the finish line.

**Norberg:** Let's shift now to your bill, the Tax Reform Act of 2014, introduced on the House floor last December as H.R. 1. Can you give us some more color and perspective on its development? What is the process for putting such a massive proposal together? How many people are involved, and what types of backgrounds do they have? Was there significant collaboration with other members of the Committee on Ways and Means?

**Camp:** It was critical to me that there be a very open process. We didn't want a repeat of the partisanship surrounding the Affordable Care Act. Additionally, we had a Republican House, a Democratic Senate, and a Democratic President when we started this work, so we needed to engage openly with others.

So, I engaged with my counterpart Chairman Baucus. We set up bipartisan working groups, working with Congressman Levin, the Ranking Member of Ways and Means. We held a lot of hearings, including the first joint hearing of the House and Senate on tax matters in 70 years. Chairman Baucus published several white papers. We also set up a website, where we received over 14,000 suggestions on tax reform.

Chairman Baucus and I toured the country, seeing the different regions, sectors and businesses—everything from family-owned businesses to multinational firms. We wanted both to get a sense of people's thoughts and also to make the case for tax reform. We found that there were exciting things going on in the private sector. We met dedicated, hard-working people who were trying to deliver a service or a product, and I wanted to make it possible for them to do that better and more easily.

I felt it was important that we have discussion drafts and make them available to the public. I worked with the members of the Committee to put these together. We included some Republican ideas, some Dem-

ocratic ideas, and some things from the President's budget. In October 2011, we released our first discussion draft, which addressed international tax reform. We released another on small business and a few others, culminating in February 2014 in the comprehensive tax reform discussion draft.

Again, it was critical to have an open process and seek public comments. It's the best way to get the best ideas, and we need the experts in each area to understand and get involved. What I really wanted people to do, though, was to look at the draft holistically. Rather than focusing narrowly on the provisions that affect your particular industry, think about whether it helps the country, increases wages, and encourages growth.

**Norberg:** Could you speak more about those goals and other objectives of the bill?

**Camp:** Overall, our top objectives were simplification of the Tax Code, economic growth, and making it possible for U.S. companies to be competitive around the world.

The Tax Code is complex, so simplification was one of our key priorities. Closing loopholes was also important. We had heard about impressions that if you had a sophisticated tax adviser, you could work around the system, and that the guy down the street was getting a better deal. So, we increased the standard deduction so that 95 percent of people would no longer need to itemize and could file a two-page return. We repealed a lot of provisions. Similarly, small business own-

ers were saying they had a tax return an inch thick, and they really didn't know what was in it—they just signed it. We wanted a simpler form, to increase understanding about their responsibilities as taxpayers.

Economic growth was also a key priority; incomes had been flat or declining since 2008. Polling showed that people thought the country was on the wrong track, that it wasn't sustainable. What was new was that they thought it wasn't going to get better—it seemed the American dream was at risk, that people no longer thought their children would have a better life than they did. Something needed to change.

We wanted this to be politically feasible, of course, so that put some constraints around the process. It needed to be revenue-neutral and distributionally neutral, so it wouldn't immediately get shot down. We needed to address international vs. domestic issues. We wanted lower rates, a broader base, and simplification of the Tax Code.

This is the first fundamental, comprehensive tax reform proposal that had been analyzed by the Joint Committee on Taxation's (JCT's) staff using a dynamic scoring process. The draft needed to have enough details so that we could get JCT's staff to take a look at it and work with the dynamic scoring. What they estimated was 20 percent growth in gross domestic product (GDP), \$1,300 annual increases in median income, and 1.8 million new private-sector jobs. These

This is the first fundamental, comprehensive tax reform proposal that had been analyzed by the Joint Committee on Taxation's (JCT's) staff using a dynamic scoring process.

estimates were also supported by outside analysts, some of whom found even more favorable results than JCT.

It was also important to me that it get introduced as a bill before the end of the term. Bills have a status that discussion drafts don't. The bill is the same as what was in the February draft; now it is an official document and will be maintained. Plus, the bill was numbered H.R. 1!

**Norberg:** Were any reforms considered that did not make it into the bill? What were the reasons they were discarded?

**Camp:** There were a couple of approaches we realized pretty quickly were off the table. A value-added tax (VAT) was not considered as a viable option; the Senate had voted 85-13 against a VAT, and it was seen as just another layer of taxation.

Also, the Fair Tax/Flat Tax approaches just couldn't generate the revenue needed to maintain revenue-neutrality. We chose the strictest baseline for our comparison. On top of this, we had the Fiscal Cliff in the middle of our work on tax reform and Congress had to raise an additional \$600 billion of revenue.

**Norberg:** Can you describe some of the responses you have received on the discussion draft? Has the reaction been what you anticipated?

**Camp:** The bottom line is that I wanted people to take it seriously and to see it as a serious proposal, and that's the reaction that we got. It's a detailed document. The JCT looked at it at a very detailed level and prepared detailed revenue estimates. We were very transparent. Of course different people would make different trade-offs, but whenever people came in to make different suggestions, we said to them: "What does it mean in light of the 25 percent rate?" I had an open-door approach through the entire process. I wanted to see people, and I wanted my staff to see people.

I knew, of course, that this wasn't the bill that would go to the President's desk. There would be a Senate bill and a Conference Committee.

**Norberg:** What were some of the thought processes in including the significant revenue raisers related to insurance companies? The modifications to life insurance reserves, property/casualty reserve discounting, and the IRC §848 deferred acquisition cost (DAC) capi-

talization rates together were estimated to raise over \$54 billion of revenue over 10 years in the JCT's revenue estimates.<sup>2</sup> Was there a sense that the insurance industry should offer more revenue because of the decision to retain tax deferral of inside build-up on life insurance products, or because of a perception that financial services organizations tend to have higher effective tax rates and might be seen as benefiting more from a lower corporate tax rate, or other reasons?

**Camp:** The insurance industry came to us and said that their No. 1 issue was inside build-up. We faced challenging assumptions and restrictions to meet the revenue targets in order to get the rate reduction; thus there was going to have to be some pain to all taxpayers. It is important to keep in mind that the industry's key issue was not touched.

I'd like to add that I believe insurance is incredibly important. Insurance provides people with economic security. Insurance can minimize financial hardships, and it's hard to think about a world without that. We need a viable, vibrant private insurance industry for people to rely on.

We should recognize also that tax reform will address some of the country's problems, but energy policy, regulatory reform and other issues also are important. Compliance costs are a huge burden to the economy, and I think we need to look at simplification on the regulatory

side. Years go by without addressing regulatory reform.

**Norberg:** Do you think there is a real appetite for comprehensive tax reform? What would the political environment need to look like to make that feasible?

**Camp:** Chairman Hatch and Chairman Ryan are both committed to this. A lot of the members want to do this. We know growth isn't where we want it. We can't hire all the kids coming out of college, and more of them are living at home than ever before. There are also a lot of people who have left the workforce, so although the official unemployment rate is low,

the real rate including the underemployed is double the official rate.

Additionally, there are new companies every week that are bought, merged, or otherwise inverted to get lower tax rates outside the United States. There is pressure internationally, and the Organisation for Economic Co-operation and Development's (OECD's) Base Erosion and Profit Shifting project adds to that pressure. I think people realize we need to do this sooner rather than later, that we can't afford to wait. I think the President needs to make it a priority. The President has said he won't accept

lower individual tax rates, but even if he won't support comprehensive reform, I think business, corporate and international tax reform may still be doable. We will run out of time with the 2016 election coming up, although it's hard to tell when the clock will expire.

In the end, the international issues create an imperative for tax reform. It just can't wait.

**Norberg:** Thank you so much for joining us and sharing your insights! ■

## END NOTES

<sup>1</sup> See *TAXING TIMES Supplement*, October 2014.

<sup>2</sup> Joint Committee on Taxation, *Estimated Revenue Effects of the "Tax Reform Act of 2014"* (JCX-20-14) (Feb. 26, 2014).

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# In the Beginning ... A Column Devoted to Tax Basics Qualification of Life Insurance Contracts under the Internal Revenue Code

By Brian King, John Adney and Craig Springfield

Qualifying a life insurance contract under the federal tax law requirements seems like a relatively straightforward exercise ... right? Simply limit the premiums and/or cash values to satisfy the section 7702 requirements and make sure you identify whether a contract satisfies the 7-pay test of section 7702A, and you're all set. If it were only that simple! Those who have responsibility for designing and administering life insurance contracts to conform to the section 7702 and 7702A requirements know the devil is in the details.

This edition of the "In the Beginning..." column presents the basic actuarial requirements imposed by the Internal Revenue Code on life insurance contracts, focusing on the four actuarial tests in sections 7702 and 7702A. Yes, there are four actuarial tests. While most generally think of the "Big 3"—the guideline premium test (GPT), the cash value accumulation test (CVAT) and the 7-pay test—

there is a fourth test lurking inside section 7702A, the so-called necessary premium test (NPT). What follows is a presentation of the basic rules underlying each of the actuarial tests and some more detailed thoughts on this fourth test, which is one of the more mysterious aspects of dealing with contractual changes under these statutes. The column does not endeavor to answer the many questions that arise with implementing any of the qualification tests, but instead attempts to set forth the general concepts underlying them. It will not look to cite the legislative history, delve into the nuances or technical aspects of defining the actuarial limitations, or attempt to set forth details on precisely how the actuarial tests should be applied. This being said, we hope that this column's discussion of the tests, and particularly the concepts underlying the NPT, will be helpful as further technical questions arise. With respect to the NPT, the thoughts expressed herein are based on our

own interpretations of that test and in part on our experiences and understanding of how insurance companies have implemented it.

## SECTION 7702 AND 7702A QUALIFICATION REQUIREMENTS

Life insurance provides a number of benefits to its policyholders under the federal income tax, including the tax-free receipt of death benefits. In addition, absent a distribution while the insured is alive, the increments in the cash surrender value of permanent life insurance contracts—such as whole life, universal life, variable life and some level premium term life insurance—due to the crediting of interest, earnings and policyholder dividends generally are not currently includible in the gross income of policyholders for federal tax purposes (the so-called "inside buildup"). Further, the manner in which income is taxed upon distributions (including loans) of cash value to policyholders will depend on whether the contract is characterized as a "modified endowment contract" or MEC. Today, Internal Revenue Code sections 7702 and 7702A define the actuarially based limitations that, if complied with, serve as the gateway for a life insurance contract to receive the tax treatment just referenced.

Life insurance companies and administrators of life insurance contracts are charged with the responsibility of developing and administering their contracts within requirements imposed by section 7702 and with properly identifying whether contracts constitute MECs, which are defined by section 7702A. This

involves, among other requirements, the determination of actuarial funding limitations and the monitoring of funding levels (e.g., premiums paid and/or cash surrender values) to ensure that contracts are administered within actuarial limits. Both sections 7702 and 7702A impose bright-line tests for establishing compliance, and the consequences of being on the wrong side of the line can be significant, jeopardizing the tax treatment of the life insurance contract that is expected by policyholders.

## TAX DEFINITION OF A LIFE INSURANCE CONTRACT

Section 7702 provides a statutory definition that a contract must meet to be treated as a life insurance contract for federal tax purposes. To qualify under section 7702, a contract must satisfy either of two alternative actuarial tests that are designed to limit investment orientation: (1) the cash value accumulation test (CVAT) or (2) the guideline premium test (GPT). Each actuarial test is designed to limit the allowable premium and/or cash value for a given death benefit in order for the contract to be respected as life insurance for federal tax purposes.

**Cash value accumulation test:** The CVAT regulates the relationship between a contract's cash value and its death benefit (and certain other benefits or riders). Provided the cash value does not exceed a net single premium required to fund the future benefits provided under the contract, the contract will generally satisfy the requirements of the CVAT. The CVAT commonly applies to traditional fixed premium



contracts, although it can also apply to flexible premium contracts such as universal or variable universal life insurance.

**Guideline premium test:** The alternative to the CVAT is the GPT, which almost exclusively applies to flexible premium contracts. The GPT is a dual-element test that is met if (1) the total of the gross premiums paid under the contract does not exceed the guideline premium limitation and (2) the death benefit is at least as great as a specified percentage of the contract's cash value (sometimes referred to as the cash value corridor requirement). The guideline premium limitation at any time equals the greater of the guideline single premium (GSP) or the sum of the guideline level premiums (GLPs) to that time. The cash value corridor requirement is similar in concept to the CVAT requirement, providing for a maximum permissible cash value for a given death benefit. Under the GPT however, the maximum permissible cash value is generally greater than what is provided for by the CVAT, in part because of the funding limitation the GPT imposes on the allowable premium.

#### MODIFIED ENDOWMENTS AND THE 7-PAY TEST

Section 7702A defines a class of life insurance contracts called modified endowments, or MECs. MECs are intended to represent life insurance contracts with a relatively high investment orientation. A MEC is a life insurance contract that

satisfies the section 7702 requirements but fails to meet a premium-based test that is designed to measure the rate of funding of the contract, called the 7-pay test. Unlike the GPT, which applies over the life of a contract, the 7-pay test only applies for the first seven contract years, as its name would suggest (or for the seven-year period following certain contractual changes—more to come on this). MECs are accorded the same tax treatment as all other life insurance contracts, with the exception that, prior to the death of the insured, the distribution rules governing deferred annuities will generally apply. Distributions from MECs are therefore taxed on a last-in, first-out (LIFO) basis, where income is distributed first before returning a policyholder's cost basis, or investment in the contract. Further, pre-death distributions from MECs, which would also include policy loans and assignments, may also be subject to an additional 10 percent penalty tax, if, for example, the owner of the contract is younger than age 59 ½ at the time of the distribution. In contrast, pre-death distributions from a contract

that is not a MEC (a non-MEC) are taxed on a first-in, first-out (FIFO) basis, meaning that the investment in the contract is viewed as returned (tax-free) to the policyholder before any income is distributed. Identifying whether a contract is a MEC is therefore of critical importance in order for an insurer to properly tax-report and withhold on pre-death distributions paid to policyholders.

#### CONTRACT CHANGES UNDER SECTIONS 7702 AND 7702A

Life insurance contracts are often designed with an inherent level of flexibility, allowing a policyholder to increase or decrease existing benefits, add new benefits or even adjust the insured's risk classification (e.g., changes from smoker class to nonsmoker class) relative to what applied when the contract was originally issued. Section 7702 has built-in adjustment rules that are designed to adjust the actuarial funding limitations to reflect contractual changes so as to keep the actuarial limitations in line with the changed contract and the corresponding

funding needed for its revised future benefits.

Section 7702A takes a different approach in dealing with contractual changes, providing for two adjustment rules that fundamentally differ in how they apply. The first adjustment rule deals with reductions in benefits. Provided benefits are contractually reduced in the first seven years (the period over which the 7-pay test applies), the reduction in benefit rule requires a retroactive application of the original 7-pay test, but with a new 7-pay premium that is based on the reduced level of benefits. Reapplying the 7-pay test with a reduced 7-pay premium limitation can cause a contract to become a MEC due to prior premiums exceeding the revised 7-pay premium limitation based on the lower benefits. (A special, more onerous rule applies in the case of death benefit reductions under survivorship contracts.)

A second adjustment rule applies under section 7702A for contractual changes that are called "material changes." The material change rules are broadly defined in section 7702A to include any increase in benefits

General Tax Treatment of a Life Insurance Contract				
Does Contract Comply with Section 7702?		Yes		No
MEC Status		Non-MEC	MEC	Not Applicable
Tax Characterization of the Contract		Life Insurance Contract		Insurance Contract
Death Benefits Treatment		Tax Free	Tax Free	Tax Free for Net Amount at Risk Only
Tax Treatment of "Earnings" on Cash Value		Deferred until "Distributed"		Taxed Annually
Taxation of Distributions of Cash Value	Applicability of 10% Penalty Tax	Not Applicable	Yes, with Exceptions	Not Taxable
	Partial Surrenders and Withdrawals	FIFO	LIFO	
	Distributed Dividends	FIFO	LIFO	
	Loans, Assignments and Pledges	Not Taxable	LIFO	

CONTINUED ON PAGE 10

(including increases in qualified additional benefits, or QABs) and may also include other contractual changes such as a change in the underwriting status of the insured from a smoker class to a non-smoker class. When a material change occurs, section 7702A views the contract as newly entered into and requires the calculation of a new 7-pay premium and the start of a new 7-pay testing period. Unlike the reduction in benefit rule, which requires the retroactive reapplication of the 7-pay test, the material change rule starts a brand new 7-pay test period, as if the contract were newly entered into on the date of the material change.

#### THE SECTION 7702A MATERIAL CHANGE RULES AND THE NPT

Perhaps one of the most complex aspects of administering such changes deals with the NPT, which provides conditional relief from the section 7702A material change rules. As mentioned above, the definition of material change in section 7702A is broad, referring to *any* increase in benefits. Section 7702A, however, provides for an exception to the material change rules—specifically, the NPT—that allows certain increases in benefits to escape the material change rules if certain requirements are satisfied.

It is common practice for insurance companies to rely on the NPT to avoid material change treatment for certain increases in death benefits that occur normally under the operation of the contract, including increases in death benefits resulting from:

- The growth in cash value under an option 2 death benefit (where the death benefit equals the face amount plus the cash value)
- Increases in death benefit necessary for contracts to remain in compliance with the GPT or CVAT (commonly referred to as “corridor increases”)
- Dividend purchased paid-up additions for participating whole life insurance.

For some, there may be a misconception that these types of death benefit increases are not material changes under section 7702A. Such a misconception may be based on the fact that these changes usually do not result in an adjustment to guideline premiums under the section 7702 adjustment rule, and thus one might expect similar treatment to apply in the context of section 7702A. These types of death benefit increases, however, are material changes under the general rules of section 7702A, but may escape material change treatment because of the NPT. The relief from the material change rules provided by the NPT is not automatic, however, and requires either monitoring of premium payments to ensure that premiums are “necessary” or a demonstration that only “necessary” premiums are possible based on the contract’s design ... more to come on what it means for a premium to be necessary. If an unnecessary premium (i.e., a premium that is not “necessary”) is paid, a previous increase in death benefit or QAB that was not administered as a material change would need

to be recognized as a material change at the time of that payment, resulting in the calculation of a new 7-pay premium and the start of a new 7-pay test period. Thus, the conditional relief provided by the NPT may be temporary, in that it may only defer recognition of the material change until a later unnecessary premium is paid. The remainder of this column will expand on application of the NPT, focusing on how to determine when a premium is “necessary.”

The key to understanding the NPT lies with how benefits are accounted for in the application of both the 7-pay test and the test for determining whether a premium is “necessary.” It involves a line drawing exercise to separate the death benefit and QABs present upon issuance of the contract (the “7-pay tested benefits”) from the increased death benefits or QABs, for which recognition as a section 7702A material change has been deferred due to the NPT. The 7-pay tested benefits are the benefits present at contract issuance and taken into account in the calculation of the original (or most recent) 7-pay premium. They are the benefits that form the basis for the initial (or again, most recent) application of the section 7702A 7-pay test and are also those that form the basis of the limitation for determining whether a premium is a necessary premium. In contrast, increased death benefits or QABs for which material change treatment has been deferred because of the NPT are conceptually sitting “outside” the 7-pay test; they are not part of either the 7-pay premium limitation or the necessary premium limitation.

The NPT allows for funding that is “necessary” to support the 7-pay tested benefits, providing relief from material change treatment of increased benefits until such time that premiums “unnecessary” to support the 7-pay tested benefits are paid. The NPT looks to section 7702 for the standard to apply in identifying whether a premium is a necessary premium.

**GPT Contracts:** In the case of a contract that satisfies the GPT, a premium is necessary to fund the 7-pay tested benefits to the extent premiums paid do not exceed the excess, if any, of:

- (1) the greater of the guideline single premium (GSP) or the sum of the guideline level premiums (GLPs) to date based on the 7-pay tested benefits, over
- (2) the sum of premiums previously paid under the contract.

For a GPT contract, the standard for determining whether a premium is necessary will therefore be based on guideline premiums and premiums paid in a manner similar to the normal operation of the GPT. A couple of observations for GPT contracts:

- As noted, the GSP and GLP are based on the 7-pay tested benefits only (the “NPT GSP and GLP”), not on the actual GSP and GLP used for purposes of qualifying under section 7702 (the “Section 7702 GSP and GLP”).
  - o The NPT GSP and NPT GLP are used to define

the maximum allowable funding under the NPT.

o To the extent a benefit increase results in an adjustment to the Section 7702 GSP and GLP but is deferred from treatment as a material change due to the NPT, there will be a difference between the Section 7702 GSP and GLP and the NPT GSP and GLP.

- The cumulative premium paid represents the extent to which the contract is currently funded and is generally the same amount for both NPT and section 7702 qualification purposes.
- A premium is a necessary premium to the extent it does not cause premiums paid to exceed the guideline premium limitation based on the NPT GSP and GLP:

$$\text{Necessary Premium}^{\text{GPT}} = \text{Max}[\text{NPT GSP}; \text{Sum of NPT GLP}] - \text{Premiums Paid}$$

**CVAT Contracts:** For a contract that is designed to satisfy the requirements of the CVAT, a premium is a necessary premium to the extent it does not exceed the excess, if any, of:

- (1) the attained age net single premium (NSP) for the 7-pay tested benefits immediately before the premium payment, over
- (2) the guaranteed cash surrender value (also referred to as the “deemed cash surrender value”) of the contract immediately before the premium payment reflecting certain assumptions dictated

by section 7702 (or actual cash value if less).

A couple of observations for CVAT contracts:

- The attained age NSP for the 7-pay tested benefits is used to define the maximum allowable funding under the NPT (i.e., the maximum permissible deemed cash surrender value), and, once this limit is reached, any further premium is treated as unnecessary.
- The deemed cash surrender value for the contract represents the extent to which the contract is currently funded by all premiums and how that cash value would develop based on guaranteed and certain other assumptions of section 7702.
- Unlike the CVAT, which restricts the actual or current cash value, the NPT uses a guaranteed or deemed cash value for determining whether a premium is a necessary premium.
- A premium is necessary to the extent it does not cause the deemed cash value of the contract to exceed the attained age NSP for the 7-pay tested benefits.

$$\text{Necessary Premium}^{\text{CVAT}} = \text{NSP}^{\text{7-pay Tested Benefits}} - \text{Deemed Cash Value (or actual cash value, if less)}$$

**Further Thoughts on the NPT:** While there are different standards used to determine whether a premium is a necessary premium based on the section 7702 qualification test selected (i.e., the GPT and the CVAT), similar principles apply

to contracts under both tests. A necessary premium is a premium that is needed to fund the 7-pay tested benefits based on contractual guarantees (subject to the general limitation on actuarial assumptions imposed by section 7702). Whether a premium is needed to fund the 7-pay tested benefits is a function of the contract’s current funding level relative to the amount needed to fully fund the 7-pay tested benefits based on these assumptions. Put differently, the necessary premium represents the additional funding needed to fully fund the 7-pay tested benefits:

$$\text{Allowable Necessary Premium} = \text{Funding Limit for 7-Pay Tested Benefits} - \text{Current Funding for the Contract}$$

Provided a policyholder has not fully funded the 7-pay tested benefits (i.e., all premiums are needed to fund the 7-pay tested benefits based on the methodology prescribed by the NPT), all future increases in death benefits or QABs can escape the section 7702A material change treatment until a later unnecessary premium is paid (i.e., an amount is paid that exceeds the section 7702 funding limit for the 7-pay tested benefits). Once an unnecessary premium is paid, a section 7702A material change must then be recognized where prior material change treatment of excluded benefits has been deferred, bringing the previously increased benefits into the purview of the 7-pay test and including them in the calculation of the new 7-pay premium.

**CONCLUDING THOUGHTS**  
While the basic concepts underlying the actuarial qualification

requirements of sections 7702 and 7702A may seem on the surface to be relatively straightforward, having the responsibility for product tax compliance oversight for an insurance company is not for the faint of heart. It requires effective oversight that involves wearing many different hats, including tax, actuarial, legal, policyholder administration and information technology, to name a few. Errors in the design or administration of contracts can lead to noncompliance with section 7702 or unknowing MECs that can expose insurers—and potentially their policyholders—to significant costs and liabilities. Dedicating the proper resources and establishing appropriate procedures for an effective oversight program are critical to managing and mitigating product tax compliance risk. ■

*Note: The views expressed herein are those of the authors and do not necessarily reflect the views of Ernst & Young LLP or Davis & Harman LLP.*

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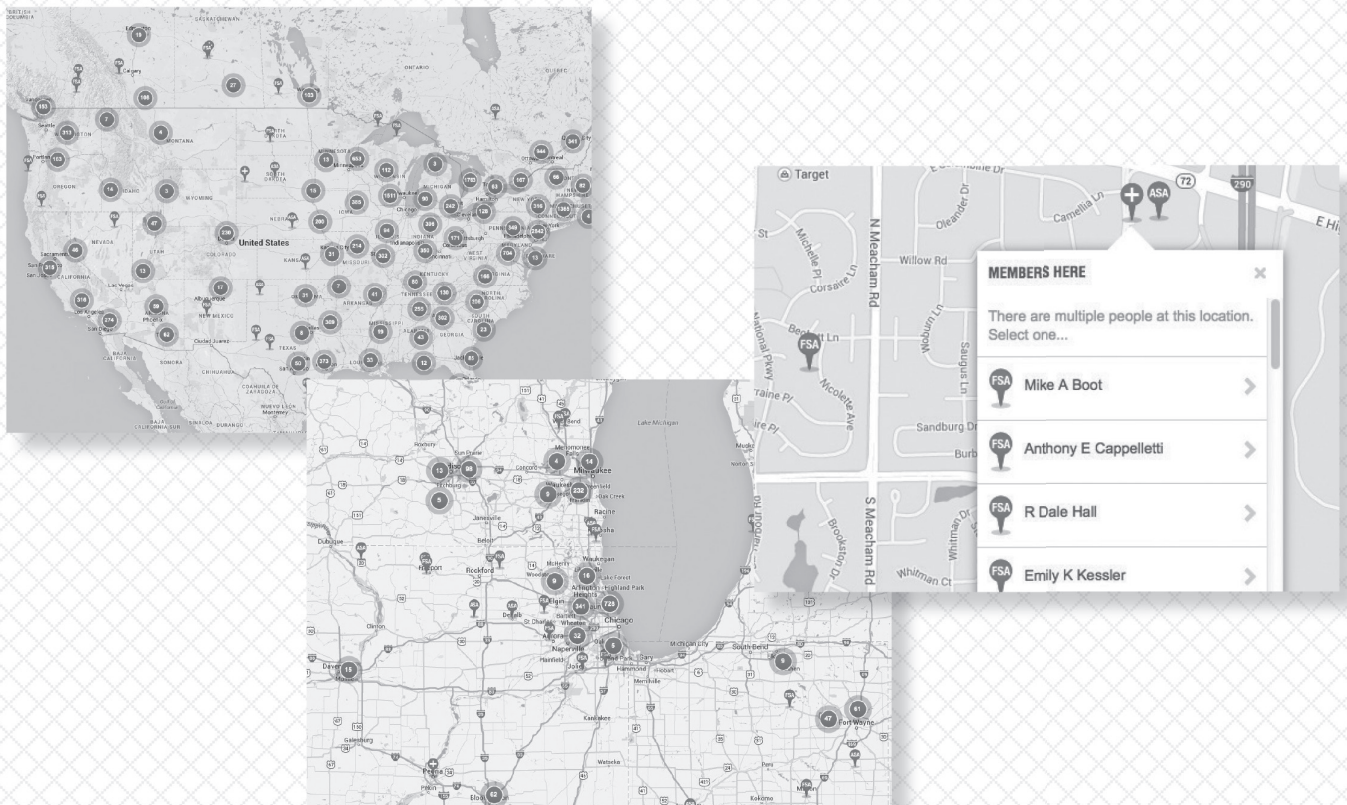
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# Actuary/Accountant/Tax Attorney Dialogue on Internal Revenue Code Deference to NAIC: Part II: Policyholder Tax Issues

By Peter Winslow (Moderator), John T. Adney, Sheryl Flum, Susan Hotine, Brian King and Mark S. Smith

## Note from the Editor:

Welcome back to our series of dialogues on the important and evolving topic of the extent to which federal tax law defers to the National Association of Insurance Commissioners (NAIC) in taxing life insurance companies and products. This is the second of three parts and focuses on product taxation, including life insurance, annuities, long-term care insurance, and a related feature—accelerated death benefits (ADB). Part I of the dialogue, in the previous issue of *TAXING TIMES*, explored many aspects of tax reserves, including their deductibility, classification and computation. Part III of the series will be a catch-all of other life insurance tax provisions where deference to the NAIC may be relevant.

I'd like to thank the panel of highly experienced tax professionals joining us for this discussion. Peter Winslow of Scribner, Hall & Thompson, LLP developed the concept for the dialogue and serves as moderator. Peter is joined by Mark Smith of PricewaterhouseCoopers, LLP and Sheryl Flum of KPMG LLP (both of whom have previously headed the Inter-

nal Revenue Service (IRS) Chief Counsel's Insurance Branch), along with Susan Hotine of Scribner, Hall & Thompson, LLP and John T. Adney of Davis & Harman, LLP. Susan, John and Peter were all active in the legislative process "in the beginning"—during the enactment of the Tax Reform Act of 1984. Additionally, Brian King of Ernst & Young LLP joins the panel for Part II of the series, providing an important actuarial perspective on the issues at hand.

Readers will notice that our "In the Beginning..." column in this issue also addresses the taxation of life insurance products. The column explores the conceptual and computational underpinnings of the tax law requirements, including a special discussion of the necessary premium test. This dialogue will put the topic in the context of the wider regulatory framework for insurance products in the United States. Our panel will also incorporate discussions of past and potential future guidance from Treasury and the IRS, and explore the treatment of other products in addition to life insurance. While "In the Beginning..." is targeted

for our readers with less experience in the technical area addressed, we believe the dialogue will be an interesting and entertaining read for insurance professionals of all backgrounds. Enjoy!

**Peter Winslow:** This is the second installment of our three-part dialogue on the issue of federal tax law's deference to insurance regulation rules. This time we are shifting from tax reserves to policyholder tax issues. It seems to me that the role of state insurance regulation in the context of policyholder taxation may involve a two-part analysis. First, we need to see whether, and to what extent, the tax law defers to the NAIC or state regulators in classifying the types of contracts that are entitled to favorable (or unfavorable) policyholder tax treatment. And, second, to the extent the Internal Revenue Code imposes qualification requirements for specific tax treatment, to what extent do those tests rely on the meaning the NAIC or regulators give to the components in the tests?

John, I would like you to set the stage for us. Could you give us a short beginner's guide to the general rules of policyholder taxation for the various types of products offered by life insurance companies?

**John Adney:** Certainly, Peter. The products to be considered are life insurance, annuities and long-term care insurance, and a feature warranting special consideration is the acceleration of death benefits. A complete discussion of these products' federal income tax treatment in policyholders' hands would fill

a couple of books, so let's boil that treatment down to its essence with the theme of this dialogue (deference to the NAIC) in mind, running the risk that the simplified explanation here will make seasoned practitioners wince at the imprecision. At this time, I will describe the tax treatment of life insurance and annuities, and will defer the discussion of long-term care insurance and ADBs until a little later.

Since the beginning of the income tax in the United States, life insurance death benefits generally have been tax-free, and the cash value build-up of permanent life insurance—sometimes called the inside build-up—is not taxed unless and until it is distributed while the insured is alive, and maybe not then. For this to be true, however, the contract must qualify as a life insurance contract for federal tax purposes under one of two actuarially based tests set forth in section 7702 of the Internal Revenue Code. Depending upon the test used, this tax definition of life insurance limits the cash value that may be available or the premiums that may be paid for a given amount of death benefit. Section 7702 applies to whole life insurance, universal life insurance, variable and indexed forms of life insurance, and even to term insurance. Also, for the death benefit to be received tax-free, it is necessary that the applicant for the coverage have an insurable interest in the insured's life under state law, and the contract must not have been transferred for valuable consideration, such as a sale of the contract in a life settlement.

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How and when such cash value distributions are taxed depends on whether the contract is classified as a modified endowment contract, or MEC; a MEC is a contract that is fully paid for in just a few years, as defined in tax law rules discussed later. Simplistically described, a cash distribution, as well as a loan, taken from a MEC is included in income to the extent the contract's cash value exceeds the policyholder's investment in the contract, which generally equals the premiums paid. This is sometimes called income-first treatment. It may also be subject to a 10 percent penalty tax. If the contract is not a MEC, which we artfully call a non-MEC, the rule is reversed: a cash distribution is not included in income unless it exceeds the investment in the contract, and a loan is not taxed at all unless the contract terminates before the insured dies. Finally, premiums paid for life insurance generally are not tax deductible, with exceptions where life insurance is used to provide employee benefits; interest deductions of business taxpayers that own life insurance may be limited; and if the insurance covers the life of an employee, the death benefit paid to an employer will be taxable unless the employee is in a highly compensated group and has been notified of and consented to the coverage.

Deferred annuities share some of the tax treatment of MECs. The build-up of their cash values generally is not currently taxed, but if a distribution or loan is taken before the contract is annuitized, it is taxed on an income-first basis, and

Once a contract is annuitized, meaning that fixed or determinable payments will be made periodically, each payment is partly includible in income and partly excludable based on a ratio described in regulations.

a penalty tax will apply unless the contract owner is over age 59½ or some other exception to the penalty is available. On the other hand, unlike the case with life insurance, any amount paid as a death benefit under a deferred annuity is taxed to the beneficiary to the extent it exceeds the owner's investment in the contract. Once a contract is annuitized, meaning that fixed or determinable payments will be made periodically, each payment is partly includible in income and partly excludable based on a ratio described in regulations. For any of this treatment to apply, the contract must be recognized as an annuity within the customary practice of insurance companies, must provide for the systematic liquidation of its principal and interest or earnings increments, and must provide for its liquidation after the death of the owner within the time frame and manner specified in section 72(s) of the Code.

Three other comments about annuities are in order. First, for a variable annuity (or a variable life insurance) contract to receive the treatment just described, its separate account must comply with certain investment diversification

requirements and its policyholder must not be viewed as controlling the separate account investments. Second, if the owner of an annuity is a corporation or other non-natural person, the inside build-up may be currently taxable. Third, payments from annuities are subject to the investment income tax (the so-called Medicare tax) that took effect in 2013.

**Peter:** Now that we know the general policyholder tax rules, let's start with life insurance and annuities. John, where were we on the deference issue before the 1984 Tax Act?

**John:** There was no comprehensive tax definition of life insurance before the 1984 Act, although section 101(f) of the Code (as enacted in 1982) provided rules for universal life insurance comparable to those in today's comprehensive definition. Instead, the governing law was case law, which looked to state law and customary practice, with the Supreme Court's caveat that insurance must involve risk shifting and risk distribution. There were no MEC rules, so the tax treatment of distributions and loans during the insured's lifetime followed

the non-MEC rules I just described. While premiums paid for life insurance generally were not tax deductible, many of the restrictions on the interest deductions of business taxpayers owning life insurance had yet to be enacted, and no rules taxed the death benefit paid to an employer on an employee's life unless the employer lacked an insurable interest.

The tax treatment of annuity contract distributions was already in place for the most part before 1984, although the investment diversification rules for variable contracts were not added until the 1984 Act, and the tax treatment of corporate-owned annuities was the subject of legislation in 1986.

**Peter:** Susan, how did Congress deal with these issues in the 1984 Act? What role did deference to the NAIC or state regulators play?

**Susan Hotine:** In 1984, Congress recognized that state regulation of insurance differentiated between life insurance, endowment and annuity contracts based on the type of risk assumed for payment of benefits and set forth minimum reserve requirements for a life insurance company to ensure the company had the assets to pay the benefits. Although state regulation recognized a need for consumer protection by also requiring certain minimum cash surrender values for such contracts to provide the contract owner with some current economic value, or societal protection by requiring an insurable interest, the states did not necessarily focus on the varied reasons for purchasing

life insurance or annuity contracts. I think the development of flexible premium life insurance, which unbundled whole life insurance for the consumer, and the crediting of excess interest, which served a policy dividend purpose in the context of non-participating policies, gave legislators and their tax staff a better understanding of the fact that whole life insurance and annuities might be viewed and purchased sometimes as investments rather than merely as financial protection against early death or outliving retirement assets.

Whereas the tax benefits afforded life insurance and annuity contracts may have been grounded in the concept of providing financial protection, the tax benefits applied generally to any life insurance or annuity contracts issued, irrespective of whether the contracts carried significant insurance risk for the issuer as compared to the investment elements. So a life insurance contract was generally defined as a contract with an insurance company which depends in part on the life expectancy of the insured and which is not ordinarily payable in full during the life of the insured.<sup>1</sup> In 1984 (and even in 1982), Congress concluded that the tax law did not have to be restricted to what was considered to be life insurance or an annuity within the customary practice of insurance companies. So I suppose one could reasonably conclude that in 1984 Congress did not think it needed to defer to state regulation completely regarding what should be taxed as life insurance and annuity contracts.

**Peter:** What about the reference to “applicable law” in section 7702? Isn’t that an element of deference to state regulation?

**Susan:** In 1984, Congress’ concern was focused primarily on the investment orientation of the life insurance and annuity products being marketed by life insurance companies. Section 7702 built on the model in section 101(f) for recognizing a flexible premium life insurance contract, but provided a definition of life insurance for tax purposes that had broader application. You are right that the section 7702 definition starts with a contract that is “a life insurance contract under the applicable law,” so the tax definition of life insurance starts with an explicit deference to the NAIC and state regulators as to what contracts constitute life insurance. The tax definition then requires that the contract, which otherwise would be life insurance, meet one of two tests. Both of these tests were designed to suppress the contract’s investment orientation—that is, the amount of the cash surrender value in relation to the face amount or the amount at risk under the contract. Congress wanted to preserve the role of life insurance as financial protection against early death while at the same time discouraging purchasers from using it purely as an investment.<sup>2</sup> Note that the section 7702 definition of life insurance eliminated the typical investment-oriented endowment contract as a contract entitled to life insurance tax benefits.<sup>3</sup>

**Peter:** What about annuities? How did Congress approach those in the 1982 and 1984 reforms?

**Susan:** Congress wanted to preserve the use of annuity contracts for additional retirement savings while limiting their use as pure investment. The income-out-first rule, a penalty for withdrawals before age 59½ and the distribution-at-death rules, which brought annuity contracts more in line with the rules for qualified pension contracts, were all aimed at that point.

The Code does not contain a comprehensive tax definition of an annuity contract (like section 7702 does for life insurance), but section 72(s) does provide that a contract shall not be treated as an annuity contract for tax purposes unless it provides for certain required distributions if the contract holder dies before the entire interest in the contract is distributed.<sup>4</sup> Likewise, section 817(h) provides that, for purposes of subchapter L and section 72, a variable annuity based on a segregated asset account shall not be treated as an annuity unless the investments in the account are adequately diversified. But, as John indicated earlier, for tax treatment as an annuity to apply generally, the contract must be recognized as an annuity within the customary practice of insurance companies, and must provide for the systematic liquidation of its principal and interest or earnings increments.<sup>5</sup> Although the Code does not provide an explicit statutory reference, based on

general rules of statutory construction, I would say that the Code gives implicit deference to the NAIC and state regulatory authorities regarding when a contract constitutes an annuity contract for tax purposes and then adds a tax twist with the distribution-at-death rules and the diversification rules for variable contracts.

**Mark Smith:** Susan, I agree with that, and would add there’s almost nowhere else to turn as a starting point for defining an annuity contract. Section 1275(a)(1)(B) makes it clear that an insurance company subject to tax under subchapter L may issue a term annuity that is still an annuity contract for tax purposes. A bank, for example, that issues the same contract would be treated as issuing a debt instrument. So at least as a starting point, the differentiator for tax purposes almost has to be the NAIC and state regulatory rules that apply to insurance companies and define an annuity contract.

**Peter:** John and Susan have focused on the classification of the types of contracts that qualify as life insurance and annuities for the policyholder. Brian, let’s go to the second part of the analysis—in the case of life insurance, what is the role of deference to the NAIC and state regulation in the elements of the guideline premium and cash value accumulation tests?

**Brian King:** As John and Susan alluded to, section 7702 imposes qualification requirements on life insurance in order for the contract to be eligible for

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the tax treatment provided under the Internal Revenue Code—generally the tax-free receipt of death benefits and the tax deferral of the inside build-up. For a tax qualifying life insurance contract, section 7702 requires—in addition to the applicable law requirement—that the contract satisfy one of two actuarial tests: the guideline premium and cash value corridor test (GPT) or the cash value accumulation test (CVAT). Each test works to restrict the investment orientation of a life insurance contract by limiting either the allowable premium and/or cash value for a given death benefit. The GPT largely applies in practice to flexible premium products like universal and variable universal life insurance and imposes a limitation on the cumulative premiums paid to the greater of a guideline single premium or the cumulative guideline level premium. The CVAT generally applies to fixed premium products like nonparticipating and participating whole life insurance, and limits the cash surrender value to that of a net single premium necessary to fund future benefits.

It is worth noting that section 7702 does not define an explicit funding limit under either the GPT or the CVAT. There are no prescribed tables that define a dollar amount for either guideline premiums or net single premium. Instead, section 7702 defines the allowable benefits, expenses, interest and mortality assumptions that can be used in calculating the limit and leaves it up to the actuaries to determine what they are for a particular contract.

While contractual benefits and guarantees serve as the starting point for these assumptions, section 7702 also imposes limitations on what is allowed in calculating the guideline and net single premiums. For example, the guideline single premium requires the use of an interest rate that is not less than 6 percent, while the guideline level premium and net single premium require a rate not less than 4 percent. These restrictions are not intended to limit or impose constraints on contractual terms, but were instead put in place as a safeguard to control the magnitude of the actuarial limitations and to prevent potential manipulation of assumptions or benefits that may potentially overstate the limitations. That being said, there is not a direct reliance on the NAIC or state regulators in defining the section 7702 limitations nor is there a requirement by regulators that a contract qualify as life insurance for tax purposes.

That is not to say the NAIC does not play a role with how contracts qualify under section 7702. Because section 7702 defines the actuarial limitations by reference to policy guarantees, the NAIC has indirect influence on how guideline and net single premiums are calculated to the extent of their control over policy guarantees. The role of the NAIC is of particular importance in determining the mortality standards for calculating guideline and 7-pay premiums, particularly with the advent of the reasonable mortality standards introduced in 1988. For contracts issued after Oct. 20, 1988, guideline

and net single premiums must be calculated using “reasonable mortality.” While the statute does not provide a definition of reasonable mortality, it does provide for a limit on charges that would be considered reasonable. The limit is based on the prevailing commissioners’ standard tables in effect at the time a policy is issued. Since the prevailing tables are those approved for use by the NAIC for purposes of both valuation and nonforfeiture purposes, Congress is effectively deferring to the NAIC for defining reasonable mortality under section 7702.

It is also worth noting the NAIC gave deference to the Internal Revenue Code recently with regard to setting a 4 percent floor on the Standard Nonforfeiture Law (SNFL) maximum interest rate. This change was put in place as a safeguard to ensure that minimum cash values required for state law purposes don’t exceed the section 7702 net single premium under the CVAT. Since the nonforfeiture maximum interest rate is defined by a formula, it is theoretically possible the formula could produce an interest rate less than 4 percent under an extended period of low interest rates. This change was effected through amendments to the SNFL for policies issued prior to the operative date of the Valuation Manual, and to VM-02, which defines mortality and interest standards for nonforfeiture values on policies issued once the Valuation Manual becomes operative, which appears likely to occur in 2017.

**Peter:** That’s interesting. The deference issue now seems to

be a two-way street with the Internal Revenue Code sometimes deferring to NAIC standards and the NAIC sometimes deferring to the Internal Revenue Code’s requirements to avoid tax problems. Is there some deference to the NAIC or state regulation in deciding what qualifies as, for example, a premium paid under the contract, or, say, the cash surrender value of the contract in applying these 7702 tests? Where do we look for defining these terms?

**Brian:** As I just mentioned, section 7702 defines actuarial limitations on the permissible funding for a life insurance contract in the form of guideline and net single premiums. The GPT places a limit on the premiums paid for a qualifying life insurance contract, while the CVAT limits the cash surrender value. Thus, both premiums paid and cash surrender values serve as the measuring stick for investment orientation under section 7702. These terms have very specific meaning in section 7702 and also play an important role in defining the gain or income on the contract for purposes of taxing distributions paid to policy owners under section 72(e).

What’s interesting and maybe somewhat confusing to some with the section 7702 definition of premiums paid is the circular nature of its definition, which uses the term “premiums paid” to define premiums paid. While there isn’t a technical definition of what constitutes premiums paid, it tends to follow what is commonly characterized as the



cumulative amount of the gross premium payments for a life insurance contract. Also, withdrawals of cash value or distributions from a life insurance contract will generally reduce the premiums paid to the extent of the nontaxable portion of the distribution. As John mentioned earlier, a contract's characterization as a MEC will be important, as it will determine the income ordering rules for identifying the taxable portion of the distribution. Since only the nontaxable amount of a distribution reduces premiums paid, identifying whether a contract is a MEC is necessary for properly adjusting premiums paid.

**Mark:** Great point. It's also interesting that deferring to the NAIC in defining "premiums" would provide only limited guidance as to some issues. Sections 72 and 101 refer to premiums and "other amounts" or "other consideration paid." So, even if an item isn't part of premiums for regulatory purposes, the policyholder might nevertheless get credit for investment in the contract or under the transfer-for-value rule if the item is "other consideration." In this sense, even full deference would be only half an answer for these provisions.

**Peter:** What about the cash surrender value? How is that defined?

**Brian:** Like premiums paid, section 7702 also provides for a somewhat circular definition of cash surrender value, defining it as the contract's cash value without regard to surrender charges, policy loans or rea-

sonable termination dividends. However, the statute does not define the fundamental term cash value. Because of its importance in qualifying a contract under the CVAT or meeting the cash value corridor requirement for the GPT, insurance companies need to be able to properly determine a contract's cash surrender value. For most contract designs, determining the contract's cash surrender value is a relatively straightforward exercise and generally aligns with what is commonly referred to as the contract's policy or account value. However, for more complex product designs that provide for payments to policy owners in excess of or in addition to what would otherwise be available as a policy value, it becomes more challenging to precisely define the contract's cash surrender value, particularly given the currently available guidance.

The section 7702 definition of cash surrender value or, more broadly, the definition of cash value, has had a rather controversial past, having been the subject of several private letter rulings (PLRs) and a 1992 proposed regulation that attempted to provide a definition for the term cash value. The IRS is aware of the need for further guidance on defining cash surrender value and has been working on this initiative for some time now, having first appeared on their Priority Guidance Plan back in 2010. There was some expectation last year that guidance would be forthcoming, but with the recent turnover at the IRS and Department of Treasury, it seems to have delayed things for the time being.

To circle back to your first question, Peter, the Code does not explicitly refer back to the NAIC in determining premiums paid or cash surrender value as they relate to qualification under section 7702.

**John:** Brian, I agree with most of your comments, although I may have a different philosophical viewpoint about Congress' deference. When I think of the deference we are discussing, I view it as referring to congressional reliance on state law and state regulatory practices in the application of the tax statutes, and I believe those practices subsume a good deal of insurance tradition and the actuarial role in that tradition. Congress built section 7702, and section 101(f) before it, on this structure. You mentioned the applicable law rule in section 7702(a)—the requirement that a contract be treated as life insurance under the law of the jurisdiction in which it is issued—which Susan discussed earlier. The legislative history of section 7702 deems the applicable law to be state or foreign law, which as Susan indicated represents deference to the NAIC and the system of state insurance regulation for U.S.-issued contracts. Also, as you explained in detail, the statute uses the concept of a premium, both a net premium and a gross premium, to define the limits of a contract's permitted investment orientation. While Congress could have imposed a limit based on a present value concept as such, it reached instead into insurance tradition and concepts defined in and regulated under state law. For that matter, Congress de-

finied the CVAT specifically to enable whole life insurance, as it had developed in insurance tradition and consistently with state regulation, to continue to qualify as life insurance for tax purposes. In doing so, Congress was acquainted with the meaning of "cash value" based on industry practice as of the early 1980s.

**Peter:** Brian mentioned several PLRs that provide guidance on the definition of cash surrender value. To me, that is a term of art in insurance lexicon and ought to be given some deference as John suggests, yet Brian notes that deference to the NAIC may be limited, at least according to the IRS. What was the IRS National Office's view on this issue in its rulings? According to the IRS, where do we look for a definition?

**Mark:** That's a good question, as deference may arise for different reasons in different circumstances. In Part I of this dialogue, we talked about reserves and we talked about examples where the Internal Revenue Code specifically instructs taxpayers and the IRS to use statutory concepts for federal income tax purposes. For example, section 807 incorporates CARVM (the Commissioners' Annuity Reserve Valuation Method) or CRVM (the Commissioners' Reserve Valuation Method) in the federally prescribed reserve, and the statutory reserve cap specifically refers to amounts set forth in the company's annual statement. (The same is true for property and casualty insurance reserves, by the way.)

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John points out that as a practical matter, Congress is acquainted with insurance tradition and regulation and those sources therefore have a role even absent a congressional instruction to defer. In fact, there is case law to the effect that where Congress uses terms that are terms of art in the insurance industry, the terms should be applied consistent with their usage in the industry. I'm thinking, for example, of cases like *Best Life*<sup>6</sup> and *Central Reserve Life*.<sup>7</sup> Those cases don't necessarily address product issues, but do provide a framework, or approach to interpreting the Code. I think of this framework as more than just a theoretical rule that courts or the IRS uses to interpret the statute, or even a rule that by design may provide the best evidence of what Congress means when it uses particular terms. For some non-tax technical product issues, the IRS would do well to benefit from the experience and work of non-tax regulators, or for that matter the actuarial profession. It is common sense that the tax system would look to the work of these professions as a starting point for defining product terms like annuity, or premium, or cash value.

In my experience, most companies take conservative positions in the product area so as not to create tax problems for their policyholders, and the IRS is less active in examining technical compliance in the area than in addressing broader issues like corporate-owned life insurance (COLI) and investor control. As a result, there's less guidance on life insurance product qualification, and the guidance that exists—the cash value proposed regulation, revenue rulings, notices, PLRs—is largely driven by the IRS. This, in turn, means that existing guidance may demonstrate more independence from non-tax concepts than a court would show.

**Peter:** Sheryl, was that your experience when you were the head of Chief Counsel's Insurance Branch? Did the IRS feel it could show independence from state regulatory rules in the product tax area?

**Sheryl Flum:** The starting point for a deference analysis differs significantly for company and product taxation purposes. In the company tax area, the Code refers directly to amounts, such as reserves, that are reported and visible on

a company's annual statement. Products aren't specifically "reported on" in the same way for statutory purposes. But for the definition of cash surrender value, it's appropriate (and maybe even necessary) for the government to supply a definition for federal tax purposes because no regulator has crafted a workable definition, not even one that stems from industry tradition and common usage. When we attempt to classify life insurance products into the various categories for federal tax purposes (i.e., life insurance, annuity, fixed or variable contract, etc.), there are instances where it is helpful to look to the statutory classification and there are also times where the regulator's classification is not appropriate for tax purposes. While I was the Branch Chief of the Insurance Branch, there were several instances where life insurance companies came in for PLRs and requested that the IRS treat the product for tax purposes differently than the product would be treated for regulatory purposes. One product that sticks out in my mind was an annuity that was treated as variable by the state, but was more appropriately classified as fixed under the Code. This is part of the reason why it is so difficult to come up with definitional guidance for life insurance products, and why deference to the NAIC should not be absolute.

**Mark:** Fair point. Peter and Susan talked earlier about the "applicable law" requirement in section 7702, that is, the requirement that for a contract to qualify as life insurance for tax purposes, it must be a life in-

surance contract under "the applicable law." They both rightly identified this requirement as an example of congressional deference to state regulators, because it basically looks to what is a life insurance contract under state law as a prerequisite to federal tax qualification. I also think this is an issue where the National Office has shown a surprising degree of independence from non-tax regulation. The 1984 legislative history explains that to satisfy the applicable law requirement, a contract must be a life insurance contract "under the applicable State or foreign law."<sup>8</sup> Recall, federal law generally pre-empts the application of state law in situations where ERISA (the Employee Retirement Income Security Act of 1974) applies. And, under the McCarran-Ferguson Act, regulation of insurance is a matter left to the states, not the federal government. Nevertheless, a series of PLRs<sup>9</sup> in the late 1990s and early 2000s applies federal tax case law to conclude the applicable law requirement was met and death benefits paid under employee welfare benefit plans were excludable from gross income as they were paid under "life insurance contracts."

The "applicable law" PLRs were very controversial, and the competing tax policies could be the subject of their own dialogue. But for purposes of this discussion, I think it is fascinating that the IRS by PLR looked to law that neither technically governed the arrangements nor was state or foreign. One could quarrel over what it means for law to be "applicable." For ex-



ample, does it really need to apply and govern, or does it merely need to be relevant? But, the approach taken by the IRS in reverting to federal tax case law, which arguably was superseded by section 7702 itself, at least shows tremendous independence on the IRS' part and is a departure from what one usually thinks of as "deference."

Although the issue is not on the Priority Guidance Plan, for several years it has been identified as an issue that is "under study,"<sup>10</sup> meaning no further PLRs will be issued.

**Sheryl:** Given the contentious nature of the "applicable law" issue, I don't expect to see guidance in this area anytime soon. Nor do I expect to see the issue removed from the "no-rule" list. There are some open questions that are best answered by Congress.

**Peter:** So, the IRS has shown independent thinking as to the applicable law requirement. Is this also the case for the definition of cash surrender value?

**Mark:** For the cash surrender value definition, unlike the references to CARVM, or the annual statement, or even "applicable law," the Code itself does not specifically instruct the IRS and taxpayers to defer to state law or regulation. But, that doesn't mean they shouldn't do so.

Existing regulations under section 7702 were proposed in 1992 and define cash surrender value so broadly as even to require an exception for death benefits paid under the con-



tract. This has been a matter of some controversy over the years and, as Brian points out, has been on the Priority Guidance Plan since 2010 without publication. One might reasonably ask: Why not define cash surrender value as the term is applied for state regulatory purposes? Wouldn't a court, for example, look to non-tax authorities to define such a term of art within the insurance industry?

I think on one level this lays bare an administrative conundrum that perhaps can't be avoided. That is, the breadth of the definition of cash surrender value under the existing proposed regulations would require companies to approach the IRS and ask for exceptions as issues emerge under new product designs. From an administrative perspective, it is better for the IRS if there is dialogue upfront around new product features. Merely deferring to state law or regulatory definitions of cash value could in some cases leave the IRS in the position of needing to add to the definition of cash value to accommodate product fea-

tures that frustrate tax policy as the IRS interprets it. One might not necessarily expect companies to come in and discuss such circumstances.

With or without deference, and whether a broad definition of cash value or a narrow one, administration of this area and adaptation to new products are hampered by the difficulties in producing timely guidance that responds to new products.

**Sheryl:** It's true that product innovation stays ahead of tax rule changes, and that likely will always be true. I don't think this means the IRS should give up on its efforts to provide guidance, though, as taxpayers generally appreciate having more rather than less information from the IRS regarding its position on product issues. The process for publishing guidance is very time-consuming due to the level of review afforded. However, the IRS has issued timely private guidance on new products as they are being developed. It is important for insurance companies to consider requesting a PLR as part of the product development process if the tax treatment for the

product is not clear. Since the amount of published guidance is limited, it is also imperative that the insurance industry continue to communicate with the IRS and Treasury on which issues should be prioritized.

With regard to the definition of cash surrender value, having the proposed regulation remain on the books, so to speak, has caused problems for the IRS to issue PLRs on certain life insurance features. Even though the proposed regulation has never been finalized and taxpayers and courts are not obligated to rely on it, unless and until the proposed regulation is finalized or withdrawn, it reflects the IRS' position and the IRS must follow it. Thus, the IRS could not issue rulings on contract designs that have, for example, critical illness riders. Because the best way to get timely guidance on a product design is by PLR, and the proposed regulation is hampering the issuance of the private guidance, it is important for the IRS and Treasury to act.

**Peter:** John, at this stage I think it would be a good idea to proceed with the discussion of long-term care (LTC) insurance and ADBs that you deferred earlier. As before, can you give us a short overview of the policyholder tax rules for the LTC product and the rules governing ADBs?

**John:** Sure. LTC insurance first was developed, I believe, in the 1980s, but the tax treatment of LTC insurance benefits was unclear. It seemed possible that the benefits would be tax-free as accident and health insurance

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benefits under section 104, but the deductibility of the premiums was in doubt since the coverage went beyond the scope of insurance for medical expenses, and the treatment of employer-provided coverage was quite uncertain. In the Health Insurance Portability and Accountability Act of 1996—HIPAA—Congress stepped in to clarify the tax treatment of LTC insurance coverage, provided that the coverage met a then-new definition of “qualified” LTC insurance enacted as section 7702B. According to that statute, if the coverage is qualified, then the benefits that reimburse LTC expenses are excludable from income under section 104, an employer plan providing the coverage is treated as an accident and health plan, benefits paid on a per diem basis are excludable subject to specified dollar limits, and the premiums are deductible as medical insurance within limits.

Under section 7702B, in very general terms, an LTC insurance contract is qualified if it is guaranteed renewable and provides coverage only of a statutorily specified list of services needed by a chronically ill individual, whom the statute defines as a person certified as needing prescribed assistance in performing two of the six activities of daily living or due to severe cognitive impairment. Also, the contract may not provide a cash surrender or loan value, although in limited circumstances it can pay a refund of premiums, and the issuing insurer must offer a nonforfeiture benefit. In terms of deference to the NAIC, subsection (g) contains a formidable list of consumer protection require-

ments drawn from the 1993 Long-Term Care Insurance Model Act and Model Regulation that a contract must meet in order to be qualified, and beyond this, penalty taxes are imposed on the issuing insurer unless it complies with additional NAIC-prescribed requirements in the Model Act and Model Regulation. Further, a section 7702B regulation finalized in 1998 treats compliance with state law as compliance with such requirements where a state enacts requirements comparable to those of the Model Act and Model Regulation.

The definition of a qualified LTC insurance contract acts as a safe harbor, in that the Code does not expressly specify the tax treatment of LTC insurance coverage that is not qualified.

**Peter:** And what about ADBs?

**John:** The acceleration of death benefits—the payment of all or a portion of a life insurance contract’s death benefit while the insured is still alive—also dates from the 1980s, when insurers began offering ADB payments for terminally ill insureds. Since nothing in the tax law classified ADBs as death benefits excludable from income under section 101(a), the Treasury Department took the step of deeming them to be excludable under certain conditions in regulations proposed in 1992. The regulations also addressed ADBs that were then being offered if the insured became chronically ill. Those regulations were never finalized, but Congress took up the matter in HIPAA, enacting

section 101(g) to treat ADBs as equivalent to death benefits where the insured was certified by a physician as having an illness or condition likely to result in death within two years. HIPAA also extended death benefit treatment to ADBs under both section 101(g) and section 7702B for insureds certified as chronically ill, subject to the limits imposed by section 7702B on per diem payments. For an ADB that constitutes qualified LTC insurance under section 7702B, compliance with the consumer protection rules of the NAIC’s 1993 Model Act and Model Regulation referenced in the statute is required. For other ADBs, section 101(g) mandates compliance with NAIC rules, if any, applicable to the ADBs, or to more stringent rules under state law in order for the benefits to be tax-free. In the mid-2000s, interest also arose in combining qualified LTC insurance with a non-qualified annuity contract, so that the annuity’s benefits could be paid out when an individual became chronically ill. Since qualified LTC insurance cannot provide a cash surrender value and can only cover qualified LTC services, it was unclear whether such a combination was permissible under section 7702B, but again Congress stepped in to clarify matters. In the Pension Protection Act of 2006, section 7702B was amended to enable the annuity-LTC combination product to move forward.

**Peter:** Susan, has the IRS shown deference to the NAIC and state regulators in its administrative guidance on LTC insurance?

**Susan:** As John says, the statutory language of section 7702B and the regulations issued under that section rely heavily on the requirements of NAIC’s 1993 Model Act and Model Regulation and give explicit deference generally to state regulators that have comparable requirements. In this regard, I think that the industry has been lucky that the deference is built into the statute because the IRS has not been particularly forthcoming with additional tax guidance for LTC insurance products. For example, there has been an item in the Insurance Companies and Products portion of Treasury’s Priority Guidance Plan for “Guidance on annuity contracts with a long-term care insurance feature under §§72 and 7702B” since the 2009–2010 Plan. The 2011–2012 Plan announced the publication of Notice 2011-68 under this LTC item and, although that Notice requested comments by Nov. 9, 2011, there has been no further action taken and no additional general guidance. The Priority Guidance Plans since the 2012–2013 Plan have continued to include the same item referring to LTC insurance, with a slight modification in the description—that is, “Guidance on annuity contracts with a long-term care insurance rider under §§72 and 7702B.” In addition, the Priority Guidance Plans since the 2012–2013 Plan have included a second LTC insurance item, which is “Guidance on exchanges under §1035 of annuities for long-term care insurance contracts.” Other than recognizing that additional guidance on LTC insurance tax

issues may be important, I don't think that the issue of deference to the NAIC and state regulators (or not) has really come into play for the IRS from an administrative perspective.

**Mark:** That's certainly true in recent years, though I think the regulations you refer to on the consumer protection provisions of section 7702B are themselves an interesting case study in deference. First, as to those provisions, deference was arguably a foregone conclusion because the Code itself refers to the NAIC Model Act and Regulations. Second, deference was entirely appropriate as a matter of policy because the NAIC and state regulators are in a much better position to prescribe rules to protect consumers than are the IRS and Treasury. Other areas arguably fall in the same category. For example, section 7702B defines "chronically ill individuals" by reference to the ability to perform activities of daily living—ADLs—and requires the Secretary of the Treasury to prescribe regulations in "consultation" with the Secretary of Health and Human Services. Section 101(g) defines "terminally ill insureds" and "chronically ill insureds" by reference to NAIC guidance on viatical settlements. Wisely, Congress recognized that the IRS and Treasury alone lack the expertise to prescribe rules in these areas without at least consulting non-tax regulation. The guidance projects that Susan has listed from the Priority Guidance Plans since 2009 relate primarily to the Pension Protection Act provisions addressing combination contracts

Wisely, Congress recognized that the IRS and Treasury alone lack the expertise to prescribe rules in these areas without at least consulting non-tax regulation.

and exchanges for LTC contracts. I totally agree one would think of those projects as not implicating deference directly, though hopefully whatever guidance the IRS has been working on since the 2011 notice would take into account the common terms of those contracts and whatever regulatory requirements apply to them.

**Sheryl:** Unfortunately, the IRS' limited resources are to blame for the lack of guidance for qualified LTC riders on annuities and exchanges under section 1035 of annuities for LTC insurance contracts. Even though earnings that are distributed from an annuity are generally taxable, Congress appears to have specifically over-ridden that treatment when the annuity is used to fund LTC coverage. This issue, though, is not really a question of deference to the NAIC or state regulators, but is more of a tax administration concern. The IRS and Treasury need to establish rules to carry out congressional intent and that is what the much-anticipated guidance should provide.

**Peter:** But, do you expect guidance actually to be issued?

**Sheryl:** Guidance is needed, but with the IRS budget con-

straints, I do not expect to see anything soon.

**Brian:** Sheryl, carrying forward your thoughts on tax administration concerns, ADB riders also create administrative challenges under sections 7702 and 7702A. When a triggering event occurs that accelerates the payment of a death benefit, contracts still need to satisfy the section 7702 requirement and companies will still need to monitor for compliance with the 7-pay test to determine whether contracts are MECs. Like exchanges under section 1035 of annuities for LTC insurance, there are a number of administrative questions that surface when trying to figure out how the adjustment rules in sections 7702 and 7702A apply to the payment of an ADB.

First, let's talk about the section 7702 requirements. While there are different product designs, a common feature of an ADB rider is to reduce both the death benefit and the cash value of the contract proportionately when there is an acceleration of death benefit. The CVAT is much better equipped to accommodate this type of design, while still allowing the contract

to qualify with section 7702. The CVAT is prospective in its application and is a proportional-based test that manages the relationship between cash value and death benefit. Proportional changes to both the death benefit and cash value resulting from the payment of an ADB reconcile well with the CVAT requirements, as the same relationship between cash value and death benefit is maintained both before and after an ADB is paid.

Determining how to deal with the payment of an ADB under the GPT is a bit more challenging. While it is clear that death benefits are reduced as a result of an ADB payment, there are a host of questions that come up with how to account for the payment of an ADB under both the guideline premium and the 7-pay test. Some have questioned whether the traditional attained age adjustment methodology under section 7702 results in a "proper adjustment" to guideline premiums for the payment of an ADB. Similarly, which of the two adjustment rules under section 7702A, if any, should apply: the material change rules of section 7702A(c)(3) or the reduction in benefit rules of section 7702A(c)(2)? Further, to the extent the contract's cash value is reduced as a result of an ADB, should there be corresponding adjustment to premium paid? I think it's fair to say that the drafters of sections 7702 and 7702A did not have ADBs in mind when developing the statutory requirements for life insurance contract qualification.

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To date, no regulations or other guidance have been issued regarding the effect of ADBs on premiums paid and how to account for ADBs under the adjustment rules of sections 7702 and 7702A. We can add these administrative items to those mentioned by Sheryl and Susan where additional guidance from the IRS and Treasury would be helpful.

**Mark:** Perhaps this discussion comes full circle. We talked earlier about the existing proposed regulations on the definition of cash value, and the Priority Guidance Plan project that may one day take a fresh look at that issue. The existing proposed regulations were published before Congress added section 101(g) to the Code. At least part of the impetus for including the definition of cash surrender value on the Priority Guidance Plan was a sense that updating those regulations to acknowledge the enactment of section 101(g) would simply be a matter of good housekeeping. The existing proposed regulations are a lesser priority to the industry than other guidance, but if the IRS reaches the point of considering them, it would indeed be helpful if they used the opportunity not only to address cash value but to address other ADB issues you mention, Brian, like application of the adjustment rules, or the effect on premiums paid. It's hard to imagine them doing so without

thoroughly weighing the non-tax treatment of ADBs by the NAIC and by state regulators. In the product space, there is much to be said for a starting point that is cognizant of non-tax regulation, whether or not there is a statutory instruction to defer.

**Peter:** This has been an interesting dialogue and I think it is fair to say that our conclusions have not been as certain as in our first dialogue on tax reserves. Whereas there was general consensus in Part I of our dialogue that deference to the NAIC's tax reserve method is required regardless of arguments by the IRS to the contrary, we do not have a similar consensus that deference to the NAIC or state regulation is required on many important product tax issues. Perhaps, that is because, as we mentioned, companies need to be sure that their products will not fail and, therefore, as a practical matter must avoid controversy and defer to IRS guidance, whether or not it conflicts with NAIC or state regulatory rules.

I want to thank the panelists again and look forward to the upcoming third, and final, installment of our dialogue. ■

*Note: The views expressed herein are those of the authors and do not necessarily reflect the views of their current or former employers.*

**ENDNOTES**

- <sup>1</sup> Section 1035(b)(3).
- <sup>2</sup> Section 817(h) requires that a variable life insurance contract based on a segregated asset account will be treated as life insurance only if the assets in the account are adequately diversified.
- <sup>3</sup> Section 1035(b)(1) defines an endowment contract as a contract with an insurance company which depends in part on the life expectancy of the insured, but which may be payable in full in a single payment during his life.
- <sup>4</sup> Section 72(s).
- <sup>5</sup> Section 1035(b)(2) defines an annuity contract as an endowment contract, but which is payable during the life of the annuitant only in installments.
- <sup>6</sup> *Best Life Assurance Co. v. Comm'r*, 281 F.3d 828 (9th Cir., 2002).
- <sup>7</sup> *Central Reserve Life Corp. v. Comm'r*, 113 T.C. 231 (1999).
- <sup>8</sup> H.R. Conf. Rept. No. 861, 98th Cong. 2d Sess. 1075 (1984), 1984-3 (vol. 2) C.B. 329.
- <sup>9</sup> PLR 200002030 (Oct. 15, 1999), PLR 199921036 (Feb. 26, 1999).
- <sup>10</sup> Rev. Proc. 2015-3, 2015-1 I.R.B. 129, section 5.01(2) (Jan. 2, 2015).

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# A Tax Like No Other: The Health Insurer Fee

By Jean Baxley, Mersini Keller and Lori Robbins

*“A tax, in the general understanding and in the strict constitutional sense, is an exaction for the support of Government; the term does not connote the expropriation of money from one group to be expended for another, as a necessary means in a plan of regulation. . . .”<sup>1</sup>*

—Supreme Court Justice Owen Roberts

The Patient Protection and Affordable Care Act (PPACA) imposed a market-share-based health insurance provider fee, known as the “Section 9010 Fee,” “Health Insurer Fee,” or simply the “HIF,”<sup>2</sup> on each “covered entity” with net premiums written in excess of \$25 million that is engaged in the business of providing health insurance coverage for United States health risks (“U.S. health risks”).<sup>3</sup> The Section 9010 Fee was enacted to collect \$8 billion in the aggregate from the health insurance industry in 2014, \$11.3 billion in 2015 and in 2016, and increasing amounts in each year thereafter.<sup>4</sup> The fee is treated as an excise tax and is not deductible for federal income tax purposes.<sup>5</sup>

The Section 9010 Fee was imposed and payable beginning in 2014, the first “fee year.”<sup>6</sup>

In 2014, each covered entity was required to report its 2013 “data year” net premiums written for health insurance of U.S. risks to the Internal Revenue Service (IRS) on Form 8963, *Report of Health Insurance Provider Information*.<sup>7</sup> The IRS then determined each covered entity’s portion of the \$8 billion total fee for 2014, based on the data from all the Forms 8963 received for the 2013 data year. Each covered entity was billed for its portion of the \$8 billion, and payment for the 2014 fee year was due by Sept. 30, 2014.

Health insurers have now weathered one year of the Section 9010 Fee cycle and are in the midst of year two. A number of definitional and practical issues persist, although the Department of the Treasury and the IRS have generally been very responsive to issues raised by health insurers and have provided timely guidance on certain of these issues.

This discussion provides background information to help unpack the language behind the Section 9010 Fee and highlights a few areas of special interest including merger-and-acquisition-related issues, application of the Section 9010 fee to ex-

triate plans, and considerations regarding fee administration.

## BACKGROUND

When the PPACA was enacted, some lawmakers expressed the belief that health insurance companies would benefit economically from an expanded market for health insurance coverage due to the employer mandate, the individual mandate and state-created exchanges. In exchange for this anticipated health insurance market growth and additional revenue for health insurers, Congress chose to extract a fee from health insurance market participants. To this end, section 9010(a) of the PPACA imposes an annual fee on “covered entities” engaged in the business of providing health insurance for U.S. health risks.

## WHAT IS A COVERED ENTITY?

A covered entity is any entity that provides health insurance for any U.S. health risk during the calendar year in which the fee is due, subject to certain exclusions.<sup>8</sup> The final Section 9010 Fee regulations<sup>9</sup> define the term generally to mean any entity with net premiums written for U.S. health risks during the fee year that is: (1) a health insurance issuer, i.e., a state licensed and regulated health insurance company, insurance service or insurance organization; (2) a health maintenance organization (HMO); (3) an insurance company that is subject to tax under subchapter L of the Internal Revenue Code (IRC), or that would be subject to tax under subchapter L but for being tax-exempt; (4)

an entity that provides health insurance under Medicare Advantage, Medicare Part D or Medicaid; or (5) a non-fully insured multiple employer welfare arrangement (MEWA).<sup>10</sup>

A controlled group rule applies to aggregate entities and treats them as a single covered entity if one of the entities within the group is a covered entity. This rule requires aggregation of all the net premiums written of the controlled group members (generally, entities connected by 50 percent common ownership) for purposes of meeting the \$25 million net premiums written threshold, discussed below, for application of the Section 9010 Fee. The membership of a controlled group is determined as of Dec. 31 of the data year, which is the calendar year immediately preceding the fee year (i.e., 2013 was the first data year and 2014 was the corresponding fee year). Foreign entities are counted for purposes of applying the controlled group rule. A group that is treated as a covered entity must designate one of its members (the “designated entity”) to be responsible for filing IRS Form 8963, receiving IRS communications about the fee for the group, filing a corrected Form 8963 for the group, if applicable, and paying the fee for the group.<sup>11</sup>

## WHICH AMOUNTS ARE INCLUDED IN NET PREMIUMS WRITTEN?

A covered entity’s net premiums written for health insurance of U.S. risks must be reported to the IRS annually via Form 8963. In this regard, there are three questions:

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- (1) Is an amount received by a covered entity an amount received for health insurance?
- (2) Is this amount included in the definition of “net premiums written”? and
- (3) What amount of an entity’s net premium written is attributable to U.S. health risks?

**(1) What types of coverage are treated as health insurance?**

“Health insurance” means benefits consisting of medical care (provided directly, through insurance or reimbursement, or otherwise) under any hospital or medical service policy or certificate, hospital or medical service plan contract, or HMO contract, when these benefits are offered by an entity that is a covered entity.<sup>12</sup> Limited-scope dental and vision benefits and retiree-only health insurance are within the scope of this definition.

The Treasury regulations set forth a host of exclusions from the definition of health insurance, most of which consist of excepted benefits under section 9832.<sup>13</sup> The regulations expressly exclude indemnity reinsurance from the definition of health insurance, and define indemnity reinsurance as “an agreement between one or more reinsuring companies and a covered entity under which the reinsuring company agrees to accept, and to indemnify the issuing company for, all or part of the risk of loss under policies specified in the agreement; and the covered entity retains its liability to, and its contractual relationship with, the individuals whose health risks are insured under the policies specified in the agreement.”<sup>14</sup>

The Preamble to the final regulations notes that Treasury is considering whether stop-loss coverage should be treated as health insurance, and expressly does not treat stop-loss coverage as health insurance for purposes of the Section 9010 Fee. Thus, until further guidance is issued, stop-loss premiums are excluded from a covered entity’s net premiums written subject to the fee.<sup>15</sup>

**(2) Which amounts are included in net premiums written?**

The Section 9010 Fee is allocated among health insurers based upon their respective market share of health insurance coverage, measured by a covered entity’s net premiums written to the total net premiums written for all covered entities. The term “net premiums written” is not defined in the statute. The Treasury regulations provide that a covered entity’s “net premiums written” reportable to the IRS annually on Form 8963 include “premiums written, including reinsurance premiums written, reduced by reinsurance ceded, and reduced by ceding commissions and medical loss ratio (‘MLR’) rebates with respect to the data year.”<sup>16</sup> Net premiums written do not include premiums written for indemnity reinsurance and are not reduced by indemnity reinsurance ceded because indemnity reinsurance is not considered to be health insurance—but do include premiums written for assumption reinsurance and are reduced by assumption reinsurance premiums ceded.<sup>17</sup>

By expressly excluding indemnity reinsurance from the

definition of health insurance, combined with reducing net premiums written for risks ceded under assumption reinsurance, Treasury left a fee that is effectively calculated on the direct business that an insurer writes. By keeping indemnity reinsurance out of the Section 9010 Fee computation, Treasury may have hoped to minimize the likelihood that a U.S. health insurer would cede risk to an unrelated foreign entity on an indemnity reinsurance basis to avoid the fee.

A covered entity’s first \$25 million of net premiums written are not subject to the Section 9010 Fee.<sup>18</sup> Fifty percent of a covered entity’s net premiums written above \$25 million and up to \$50 million are taken into account, and 100 percent of net premiums written above \$50 million are taken into account.<sup>19</sup> So, for example, a covered entity with net premiums written of \$50 million would be subject to the fee on only \$12.5 million of its net premiums written. For a covered entity (or any member of a controlled group treated as a single covered entity) that is tax-exempt and is described in section 501(c)(3), 501(c)(4), 501(c)(26) or 501(c)(29) as of Dec. 31 of the data year, only 50 percent of its remaining net premiums written (after application of the rule described immediately above) are taken into account as net premiums written subject to the fee.<sup>20</sup>

**(3) What types of risks are U.S. health risks?**

The regulations define a U.S. health risk to mean the health risk of any individual who is (1) a U.S. citizen; (2) a U.S. res-

ident within the meaning of IRC section 7701(b)(1)(A)<sup>21</sup>; or (3) located in the United States during the period such individual is so located.<sup>22</sup> For these purposes, the United States includes the 50 states, the District of Columbia, and any possession of the United States, including American Samoa, Guam, the Northern Mariana Islands, Puerto Rico and the Virgin Islands.<sup>23</sup>

Criterion 3, the “location” criterion for U.S. risk, casts a somewhat wider net than would generally apply in determining U.S. risk for other U.S. excise tax purposes relevant to insurers, such as for purposes of the IRC section 4371 federal excise tax. Subject to special exceptions for commuters, individuals in transit, and certain crew members, an individual is “located” in the United States on a particular day if he/she is physically present in the United States at any time during that day,<sup>24</sup> and is located in a possession of the United States if he/she is present in the relevant possession for at least 183 days during the relevant year.<sup>25</sup> Tracking individual insureds who are “located in” the United States may prove difficult for U.S. health insurers; for some companies, special diligence rules and procedures may be necessary to ensure compliance with this location rule.

A presumption rule applies to any covered entity that files the Supplemental Health Care Exhibit (SHCE) with the National Association of Insurance Commissioners (NAIC) whereby the entire amount reported on



the SHCE as direct premiums written will be considered to be for health insurance of U.S. health risks (subject to any applicable exclusions for amounts that are not health insurance) unless the covered entity can demonstrate otherwise.<sup>26</sup> In this regard, special issues have arisen in the context of expatriate plans (see discussion below).

## AREAS OF SPECIAL INTEREST

### Mergers and Acquisitions

There has been and continues to be significant merger and acquisition (M&A) activity and a trend toward convergence in the health insurance market. Daily or weekly reports of potential and completed “deals” in the health care and health insurance industry are commonplace. Each company’s or group’s motivations for engaging in M&A activity differ, but some of the commonly cited reasons include synergies, diversification of health insurance product offerings, and cost savings.

The Section 9010 Fee is non-deductible, and the magnitude of the fee can cause a substantial reduction to economic income. Furthermore, a covered entity may have difficulty predicting the Section 9010 Fee for a particular fee year with a great degree of accuracy as the fee is a set amount to be collected by the U.S. government that is allocated to covered entities based on market share, and market share is continually in flux.<sup>27</sup> In this less-than-predictable tax environment, some health insurer groups may decide to restructure their busi-



ness, for example, to separate their nonprofit entities from their for-profit entities so as to maximize the \$37.5 million exclusion of net premiums written for the for-profit entities.

Some questions that have arisen from the increased M&A activity include the ownership of the fee amongst covered entities and what happens when purchasing excluded entities.

#### Whose fee is it?

The Section 9010 Fee regulations present the potential for mismatches between ownership of a covered entity and legal responsibility for the Section 9010 Fee attributable to the entity. Not all M&A deals close precisely on Dec. 31, yet the Section 9010 Fee regulations determine the members of a controlled group as of Dec. 31 of the data year.<sup>28</sup> The regulations do not include rules for handling acquisitions and dispositions, and do not make provision for partial-year fees.<sup>29</sup> Accordingly, in the M&A due diligence context covered en-

tities face the questions of whether the acquiring group or the selling group will contractually bear responsibility for the fee for a particular fee year, and how the fee will be allocated between the buyer and the seller. If the fee is to be allocated, the basis for the allocation, e.g., by month, percentage of net premiums written, or some other criterion, should be negotiated, agreed to by the parties, and memorialized in the purchase agreement.

The two-year nature of the Section 9010 Fee, i.e., the data year/fee year distinction, raises issues in the M&A context. To determine the members of a controlled group that are treated as a single covered entity for Section 9010 Fee purposes, an entity is treated as being a member of the controlled group if it is a member of the group at the end of the day on Dec. 31 of the *data* year. Yet the IRS determines a covered entity’s fee in the subsequent year, the *fee* year. Application of this rule can produce some unexpected

results if attention is not paid to the rule’s mechanics. Assume, for example, Covered Entity is part of Controlled Group 1 (“Seller”) in Year 1 (2013, the data year), and is sold June 30 of Year 2 (2014, the fee year) and becomes part of Controlled Group 2 (“Buyer”). Covered Entity has net premiums written for U.S. health risks in Year 2 of \$100 million. In Year 2, \$90 million of Covered Entity’s net premiums written are attributable to the period from Jan. 1 through June 29, when it is a member of the Seller group; only \$10 million in Covered Entity’s net premiums written in Year 2 are attributable to the period during which Covered Entity is part of the Buyer group.

- In Year 2, which group, Seller group or Buyer group, is legally responsible for reporting Covered Entity’s net premiums written for the Year 1 data year?
- In Year 2, which group, Seller group or Buyer group, is legally obligated to pay the Section 9010 Fee that is attributable to the Year 1 Covered Entity net premiums written?

Covered Entity was part of the Seller controlled group as of Dec. 31, 2013 of the data year. Covered Entity also had net premiums written as part of the Seller group in 2014, the fee year. Accordingly, the Seller group is legally responsible for reporting Covered Entity’s net premiums written for the Year 1 data year. Yet as of July 15, Year 2, Seller group does not include

Covered Entity. How can Buyer ensure that Seller will report Covered Entity's net premiums written and pay the associated Section 9010 Fee in the 2014 fee year? Ideally, this responsibility would be spelled out in the tax indemnification provisions of the purchase agreement. In the alternative, the parties may adjust the purchase price for the Covered Entity.

- In Year 3 (2015), is Buyer group required to report all of Covered Entity's premiums from Year 2 (2014) on Buyer's Form 8963?
- In Year 3, should Buyer group be responsible for 100 percent of the Section 9010 Fee attributable to Covered Entity's net premiums written in Year 2 even if only 10 percent of these premiums were written while Covered Entity was a member of the Buyer group?

Covered Entity was part of the Buyer controlled group as of Dec. 31, 2014. Covered Entity also had net premiums written as part of the Buyer group in 2015. Accordingly, the Buyer group is legally responsible for reporting Covered Entity's net premiums written for the 2014 data year and paying the Section 9010 Fee that is attributable to these premiums. However, 90 percent of Covered Entity's net premiums written for 2014 (data year) are attributable to the pre-acquisition time period. Should Buyer use this fact to negotiate a reduced purchase price for Covered Entity? Should the purchase agreement require Seller group

Accordingly, entities that would not meet the definition of a covered entity due to their nonprofit status and premiums from government programs should engage in negotiations regarding their contractual exemption from a share of the buyer's and/or seller's Section 9010 Fee.

to indemnify Buyer group for 90 percent of the Section 9010 Fee for 2015 that is attributable to Covered Entity?

The questions raised above punctuate the need for due diligence around the Section 9010 Fee. The financial burden of the fee should be negotiated by the Buyer and Seller in these (and other) situations.

#### What about excluded entities?

Although the regulations do not address the types of M&A-generated partial year issues noted above, Notice 2014-47<sup>30</sup> does address exclusions from the definition of a covered entity and clarify that a controlled group is not required to report in the 2014 fee year the net premiums written for a controlled group member who would not qualify as a covered entity in the 2014 fee year if it were a standalone entity. Temporary regulations issued in early 2015 continue this rule for the 2015 fee year and beyond.<sup>31</sup>

Under Notice 2014-47 and the temporary regulations, an enti-

ty that was not a covered entity for both the data year and the fee year, such as an entity that qualified for the exclusion as a nonprofit entity with 80 percent of its premiums from certain government insurance programs in one of these years, is not subject to the Section 9010 Fee in the fee year. The temporary regulations adopt a "test year" concept; excluded status for an entity may be tested in either the data year or the fee year, and must be tested consistently.<sup>32</sup>

An excluded entity, however, is still to be treated as a member of the controlled group for other purposes, such as joint and several liability for the fee amount allocated to the controlled group. Accordingly, entities that would not meet the definition of a covered entity due to their nonprofit status and premiums from government programs should engage in negotiations regarding their contractual exemption from a share of the buyer's and/or seller's Section 9010 Fee.

Notice 2014-47 allows entities that reasonably project that

they will qualify for an exclusion from covered entity status under § 9010(c)(2) (as nonprofits with 80 percent or more premiums attributable to certain government health insurance programs) for the entire 2014 fee year to submit a corrected Form 8963 on or before Aug. 18, 2014 for the 2014 fee year. For M&A activity in 2014, potential qualifying entities took into account this special rule.

Buyers of nonprofits should address in their purchase agreements the possibility that a particular acquired entity for which they did not expect to owe a Section 9010 Fee ends up attracting such a fee—due to reduced government health insurance program premiums, loss of nonprofit status, or other unexpected situations.

#### EXPATRIATE PLANS

An issue emerged in the context of expatriate plans—specifically, how to determine a covered entity's net premiums written for U.S. health risks where the entity covers non-U.S. individuals. Under the presumption rule in the final regulations, mentioned above, the entire amount reported on the SHCE of an insurer's Annual Statement is considered to be attributable to U.S. health risks unless the covered entity can demonstrate otherwise. Accordingly, insurance companies that did not issue health insurance policies solely to U.S. persons faced the issue of how to rebut this "100 percent U.S. health risk" presumption. Comments to the proposed

Section 9010 Fee regulations requested clarification regarding how to treat expatriate plans and sought an exemption for these plans. The preamble to the final regulations issued in November 2013 notes that commenters expressed concern regarding the application of the 100 percent U.S. health risk presumption to expatriate policies. The preamble explains that Treasury and the IRS considered methods for a covered entity to account for its expatriate coverage but did not identify a method that would be verifiable and administrable.<sup>34</sup>

To address the expatriate plan concern while the issue was under study, in March 2014 the IRS issued Notice 2014-24,<sup>35</sup> which provided a temporary safe harbor for 2014 and 2015 for a covered entity that reported direct premiums written for expatriate plans on its SHCE that included coverage of at least one non-U.S. health risk. The SHCE includes separate reporting for expatriate plans, which are defined by reference to the definition of expatriate policies in the medical loss ratio (MLR) rules as group health insurance policies that provide coverage to employees, substantially all of whom are: (1) working outside their country of citizenship; (2) working outside their country of citizenship and outside the employer's country of domicile; or (3) non-U.S. citizens working in their home country. Under Notice 2014-24 a covered entity that satisfied the requirements for the temporary safe harbor set forth in the notice was treated as rebutting the presumption that the entire amount of direct

premiums written reported on its SHCE was for U.S. health risks, and could treat 50 percent of its specified premiums written for expatriate plans as attributable to non-U.S. health risks—and, thus, exclude this premium from its net premiums written for purposes of Form 8963 reporting.<sup>36</sup> Certain covered entities applied the Notice 2014-24 temporary safe harbor in reporting their direct premiums written for purposes of determining their 2014 fee, which was due on Sept. 30, 2014.

Meanwhile, a legislative fix was in the works—in December 2014 Congress enacted the Expatriate Health Coverage Clarification Act of 2014 (EHCCA).<sup>37</sup> Relevant sections of the EHCCA provide that the PPACA generally does not apply to expatriate health plans, and the EHCCA specifically excludes expatriate health plans from the Section 9010 Fee. For calendar years after 2015, a qualified expatriate (and any spouse, dependent, or any other individual enrolled in the plan) enrolled in an expatriate health plan is not considered a U.S. health risk. These new rules are generally effective for expatriate health plans issued or renewed on or after July 1, 2015. Furthermore, the EHCCA provides a special rule for the Section 9010 Fee due in fee years 2014 and 2015. That rule provides that expatriate health insurance issuers will pay a fee reduced proportionally for the premiums attributable to those plans but this reduction will have no impact on other fee-payers. To address the 2014 and 2015 fee years, in April 2015

the IRS issued Notice 2015-29,<sup>38</sup> rendering Notice 2014-24 obsolete and providing that expatriate policies should be excluded from the Section 9010 Fee as they do not cover U.S. health risks.

Notice 2015-29 announced that insurance companies that (1) had filed SHCEs for 2014 and/or 2015 reporting direct premiums written for expatriate health plans, (2) had reported some or all of these premiums on Form 8963, and (3) attach a prescribed certification to their 2015 Form 8963 would be eligible for refunds of their overpayments in the form of a reduced Section 9010 Fee for 2015.<sup>39</sup>

Notice 2015-29 also allows covered entities that did not file SHCEs to receive the benefit of a reduced net premiums written amount for 2015 by making the following certifications: (1) the covered entity is filing the statement pursuant to Notice 2015-29; (2) the aggregate dollar amount of direct premiums written for expatriate health

plans that it included on its 2014 Form 8963; (3) the aggregate dollar amount of direct premiums written for expatriate health plans that it included on its 2015 Form 8963; and (4) the source of information that the covered entity has available on request for determining direct premiums written for expatriate health plans for 2014 and 2015.

The methodology to be applied by the IRS to reduce a certifying covered entity's Section 9010 Fee under Notice 2015-29 for the 2014 and 2015 fee years is as follows: (1) calculate the 2015 fee for all covered entities under Treas. Reg. § 57.4; (2) for a covered entity with premiums for expatriate health plans included in total direct premiums written reported for the 2015 fee year, adjust the covered entity's 2015 fee by (a) multiplying its 2015 fee amount by a fraction, the numerator of which is the amount of its expatriate health plan premiums taken into account that is included in net premiums written taken into account for the 2015

CONTINUED ON PAGE 28



fee year and the denominator of which is the covered entity's total net premiums written taken into account for the 2015 fee year; and (b) subtracting this amount from the 2015 fee; (3) for a covered entity with net premiums written for expatriate health plans included in total direct premiums written reported for the 2014 fee year, further adjust the entity's 2015 fee by (a) multiplying its 2014 fee amount by a fraction, the numerator of which is the amount of its expatriate health plan premiums taken into account that is included in net premiums written taken into account for the 2014 fee year and not previously excluded in determining the 2014 fee and the denominator of which is the covered entity's total net premiums written taken into account for the 2014 fee year; and (b) subtracting this amount from the 2015 fee.

As of the date this article is published, the 2015 filing season for the Section 9010 Fee is closed. Nonetheless, the active process that was used to rectify the expatriate plan issue is an excellent example of Treasury and IRS, as well as legislative, responsiveness to a practical problem for many health insurance providers.<sup>40</sup>

#### IRS ADMINISTRATION OF THE SECTION 9010 FEE

Administration of the Section 9010 Fee is still in its early stages. The IRS has been charged with ensuring the accuracy of the fee computation for each covered entity and is responsible for enforcement of the fee and associated penalties, even

though the fee is not found in the IRC.

In each fee year each covered entity (including the designated entity for controlled groups) must report to the IRS its net premiums written for health insurance of U.S. health risks during the data year (e.g., 2013 premiums for the 2014 fee year) on Form 8963. Forms 8963 are due by April 15 of the fee year, and a covered entity's corrections to its previously filed Form 8963 for a given fee year are due by July 15 of the fee year.<sup>41</sup> A covered entity that has net premiums written during the data year is subject to this reporting requirement even if the entity does not have net premiums written in excess of \$25 million or is otherwise partially or wholly exempt from the Section 9010 Fee. If, however, an entity is not in the business of providing health insurance for any U.S. health risk in the fee year, it is not a covered entity and does not have to report its net premiums written on Form 8963.<sup>42</sup> The information reported on Form 8963 is not treated as taxpayer information under IRC section 6103 and is to be open for public inspection and available upon request.<sup>43</sup>

As mentioned above, the IRS calculates each covered entity's portion of the annual aggregate Section 9010 Fee by dividing the entity's net premiums written for the data year by the aggregate net premiums written by all covered entities; this percentage of the total fee due from the entity is multiplied by the Section 9010 Fee to be collected, e.g., \$8 billion for the 2014 fee year.<sup>44</sup> The IRS sends

a preliminary fee determination to the covered entity by June 15 of the fee year, and sends a final bill for the fee to the covered entity by Aug. 31 of the fee year requesting payment of the assessed fee by Sept. 30.<sup>45</sup>

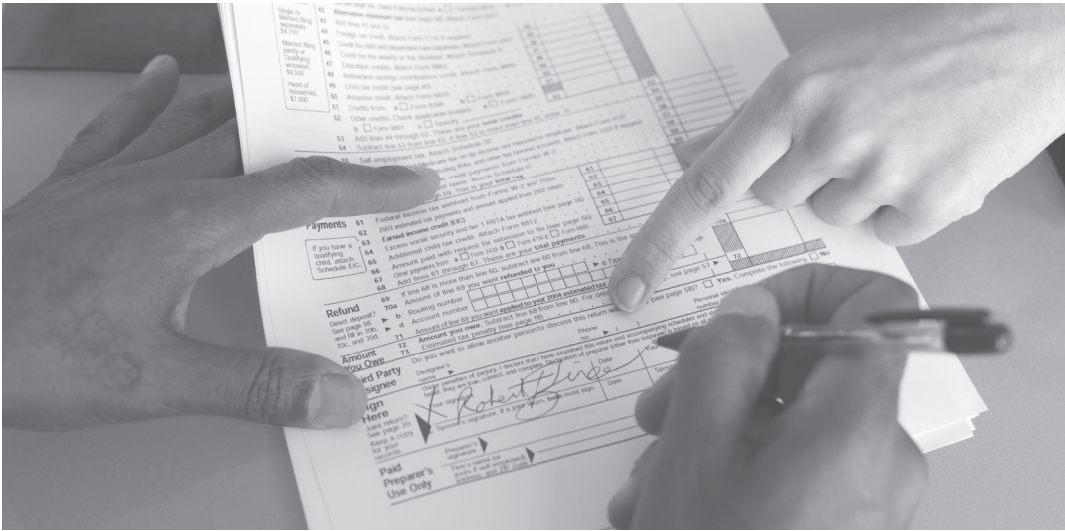
For any fee year, a covered entity has a limited opportunity to contest its assessed fee. A covered entity may file a corrected Form 8963 prior to the date that its fee is assessed. When a covered entity files a corrected Form 8963, this corrected form takes the place of the original filing.<sup>46</sup> The IRS will not accept corrected 8963s that are filed after the correction deadline has passed.<sup>47</sup> The window for filing corrected Forms 8963 in response to a preliminary fee assessment is narrow—from June 15 to July 15 of the fee year. This window is narrow because the final fee must be paid by Sept. 30, and thus the IRS must do everything necessary to provide fee payers with final bills in sufficient time to be paid by this statutory deadline.

The IRS is responsible for reviewing the Form 8963 filings and presumably is checking a covered entity's net premiums written as reported on its Form 8963 by reviewing the covered entity's SHCE, the accident and health experience report, and/or the MLR annual report form that is filed with the Centers for Medicare and Medicaid Services division of the U.S. Department of Health and Human Services. Covered entities should assume that the IRS will be attempting to match the amounts reported as net premiums written with externally available information. Indeed,

there have already been IRS challenges to reported net premium written amounts and to non-filing of Form 8963 in situations where the IRS believes an entity should have filed.

The best enforcer of the accuracy of a covered entity's reporting, however, may prove to be the health insurance market participants themselves. As mentioned above, most large health insurance companies had a reasonable idea, based on their market share, of the amount of their allocated portion of the Section 9010 Fee before the first Forms 8963 were filed. Moreover, every covered entity's Section 9010 Fee filed information is publicly available. Because the Section 9010 Fee is structured as a zero-sum game, it is possible, or even likely, that certain market participants will "call out" other participants that they believe are underreporting net premiums written or not filing Form 8963 at all.

The Section 9010 Fee is treated as an excise tax, and the income tax deficiency procedures do not apply to the fee. There appears to be no method other than filing a corrected Form 8963 for changing a final assessment prior to payment of the fee; thus, a covered entity that believes its assessed fee is too high generally must pay the final fee and file a Form 843, Claim for Refund and Request for Abatement, to recover all or a portion of the Section 9010 Fee it has paid.<sup>48</sup> It will be interesting to see how the IRS will process these refund claims, and how many of the claims are granted.



The Section 9010 Fee reporting and assessment process is similar in some ways to the old differential earnings rate (DER) and recomputed DER (RDER) process under IRC section 809. As the DER was an industry-wide computation, companies were required to report information to the IRS and the IRS would use the information to compute and publish the applicable DER. Once more accurate information was obtained, the IRS published the RDER and companies would be entitled to a true-up of sorts. For Section 9010 Fee purposes, however, there is no true-up process. The preamble to the Section 9010 Fee regulations explains “[c]ommenters suggested that the final regulations create a ‘true-up’ process by which the fee will be continually adjusted from year to year. Because the fee is an allocated fee, allowing a true-up process for one covered entity will result in adjustments to the fee for all covered entities. In the interest of providing finality and certainty

to fee liability, the final regulations do not adopt this suggestion.”<sup>49</sup> Thus, when all is said and done, in some years the IRS may collect more than the statutory amount of the aggregate fee (e.g., in years where they have nonfilers that it is later determined should have paid the fee and are assessed a proportionate amount of the aggregate fee) and in other years the IRS may collect less than that statutory amount (e.g., when refund claims are granted to some fee payers).

The IRS must assess the amount of the fee for any fee year within three years of Sept. 30 of that fee year.<sup>50</sup> The statute does not provide for an extended statute of limitations for non-filers.

### PENALTIES

A covered entity that fails to timely submit Form 8963 is liable for a failure to report penalty of \$10,000, plus the lesser of (1) \$1,000 for each day nonfiling continues or (2) the amount of the covered entity’s Section

9010 Fee.<sup>51</sup> A reasonable cause exception to the penalty may apply if the covered entity “exercised ordinary business care and prudence” and was nevertheless unable to submit the report within the prescribed time. In determining whether the reasonable cause exception applies, the IRS is to consider all the facts and circumstances surrounding the failure to submit the report, and the burden of showing reasonable cause is on the taxpayer.<sup>52</sup>

If a covered entity files a Form 8963 but “understates” its net premiums written for health insurance of U.S. health risks, the entity will be liable for an accuracy-related penalty in the amount of the difference between the covered entity’s Section 9010 Fee for the fee year that the IRS determines should have been paid in the absence of any understatement, and the amount of the covered entity’s Section 9010 Fee for the fee year based on the understatement.<sup>53</sup>

Liability for any non-filing or accuracy-related penalties incurred by a controlled group that is treated as a covered entity is joint and several.<sup>54</sup> This rule may raise issues in the M&A context and as an entity enters or exits a controlled group.

### WRAP-UP

As an allocated fee, the Section 9010 Fee involves a number of moving parts significantly impacting the bottom line of most health insurers covering U.S. health risks. This article covers only some of the issues that have been seen to date, and time will tell whether these issues smooth themselves out. It is also worth noting again that the final regulations and IRS notices have provided helpful guidance to the industry; however, some open questions remain. Therefore, as discussed, covered and excluded entities alike would benefit from taking the 9010 Fee into consideration during M&A negotiations. It also is important to keep records of the U.S. health risks and those that would qualify as expatriate plans, since this may not be obvious within the financial statements or other public filings. To date, the administration of the Section 9010 Fee has been relatively smooth, and the government’s responsiveness in addressing specific situations and unintended consequences of the originally enacted statute have helped the process. ■

*Note: The views expressed herein are those of the authors and do not necessarily reflect the views of KPMG LLP.*

**END NOTES**

<sup>1</sup> *United States v. Butler*, 297 U.S. 1 (1937).

<sup>2</sup> Pub. L. No. 111-148, § 9010, 124 Stat. 118, 865, as amended by Pub. L. No. 111-148, § 10905, 124 Stat. 118, 1017 (March 23, 2010) (PPACA), and further amended by Pub. L. No. 111-152, § 1406, 124 Stat. 1029, 1065 (March 30, 2010) (HCERA). We note that “section 9010” does not refer to an Internal Revenue Code section, as the fee is an off-Code provision enacted as Section 9010 of PPACA.

<sup>3</sup> See Treas. Reg. § 57.1(c).

<sup>4</sup> See Treas. Reg. § 57.4(a)(3) for the “applicable fee” schedule.

<sup>5</sup> PPACA § 9010(f)(2) provides that the fee is treated as a nondeductible excise tax under IRC § 275(a)(6). See also Treas. Reg. § 57.8(d); Rev. Rul. 2013-27, 2013-2 C.B. 676 (health insurer’s recovery of the fee is included in insurer’s income).

<sup>6</sup> The “fee year” is the calendar year in which the fee must be paid to the government. Treas. Reg. § 57.2(g).

<sup>7</sup> The “data year” is the calendar year immediately before the fee year. Treas. Reg. § 57.2(d).

<sup>8</sup> PPACA § 9010(c). Self-insured employers, governmental entities, certain nonprofit corporations, voluntary employees’ beneficiary associations (VEBAs), and states, the District of Columbia, and U.S. possessions are excluded entities. Treas. Reg. § 57.2(b)(2).

<sup>9</sup> Treas. Reg. § 57.1-5.10, 57.6302-1, T.D. 9643, 78 Fed. Reg. 71476 (Nov. 29, 2013).

<sup>10</sup> Treas. Reg. § 57.2(b)(1).

<sup>11</sup> Treas. Reg. § 57.2(e)(1).

<sup>12</sup> Treas. Reg. § 57.2(h)(1).

<sup>13</sup> These exceptions include generally: accident and disability income insurance; coverage that is supplemental to liability insurance; liability insurance (including general and automobile liability); workers’ compensation or similar insurance; automobile medical payment; credit-only insurance; coverage for on-site medical clinics; other insurance coverage that is similar to the aforementioned coverages under which benefits for medical care are “secondary or incidental to” other insurance benefits; long-term care, nursing home care, home health care, community-based care; coverage only for a specified disease or illness; hospital indemnity or other fixed indemnity insurance; Medicare supplemental health insurance; coverage supplemental to the coverage provided under chapter 55 of title 10, United States Code for uniformed services, and similar supplemental coverage provided under a group health plan; certain cov-

erage under employee assistance plans, disease management plans or wellness plans; student administrative health fee arrangements; travel insurance; and indemnity reinsurance. Treas. Reg. § 57.2(h)(2).

<sup>14</sup> Treas. Reg. § 57.2(h)(5)(i).

<sup>15</sup> Preamble to Treas. Reg. §§ 57.1-57-10, 78 Fed. Reg. 71476, 71481 (Nov. 29, 2013).

<sup>16</sup> Treas. Reg. § 57.2(k).

<sup>17</sup> Treas. Reg. § 57.2(k).

<sup>18</sup> PPACA § 9010(b)(2)(A); Treas. Reg. § 57.4(a)(4)(i).

<sup>19</sup> PPACA § 9010(b)(2)(A); Treas. Reg. § 57.4(a)(4)(i).

<sup>20</sup> Treas. Reg. § 57.4(a)(4)(iii). To qualify for this exclusion, an entity also must not be taxable under section 501(m) for providing commercial-type insurance. PPACA § 9010(b)(2)(B); see Joint Committee on Taxation, Technical Explanation of the Revenue Provisions of the ‘Reconciliation Act of 2010,’ as amended, in Combination with the ‘Patient Protection and Affordable Care Act,’ 90, fn. 201 (March 21, 2010). The IRS intended to, but has not, issued proposed regulations regarding section 501(m). IRS Notice 2003-31; 2003-1 C.B. 948 (requesting comments regarding the content of proposed regulations under section 501(m)).

<sup>21</sup> A U.S. resident includes generally (1) a resident alien who is lawfully admitted for permanent residence in the United States, (2) a resident alien who meets the “substantial presence” test, and (3) an individual who makes an election for his/her first year of residence in the United States.

<sup>22</sup> Treas. Reg. § 57.2(n).

<sup>23</sup> Treas. Reg. § 57.2(m).

<sup>24</sup> IRC § 7701(b)(7).

<sup>25</sup> Treas. Reg. § 1.937-1(c)(3)(i).

<sup>26</sup> Treas. Reg. § 57.4(b)(2).

<sup>27</sup> While this is true in theory, many health insurers figured out their “approximate” Section 9010 Fee prior to the first fee year, based on market share data.

<sup>28</sup> Treas. Reg. § 57.2(c)(3)(ii).

<sup>29</sup> The IRS has noted informally that it would expect the parties to an M&A transaction to make an allocation of the fee for partial years, but did not want to complicate administration of the fee by developing allocation rules.

<sup>30</sup> 35 I.R.B. 522.

<sup>31</sup> Treas. Reg. § 57.2T, 80 Fed. Reg. 10333, 10335 (Feb. 26, 2015).

<sup>32</sup> Treas. Reg. § 57.2T(c)(i)-(iii).

<sup>33</sup> See comments from Aetna, America’s Health Insurance Plans (AHIP), and the U.S. Chamber of Commerce dated June 3, 2013: <http://www.regulations.gov/#/docketBrowser;rp-p=100;so=DESC;sb=docId;po=0;s=expatriate;dt=PS;D=IRS-2013-0011>.

<sup>34</sup> 78 Fed. Reg. 71476, 71486.

<sup>35</sup> 2014-1 C.B. 942

<sup>36</sup> Notice 2014-24, section 3.01. To qualify for the temporary safe harbor under Notice 2014-24, a covered entity was required to (1) file one or more SHCEs with the NAIC reporting direct premiums written for expatriate plans, (2) report direct premiums written for expatriate plans reported on its SHCE(s) that include coverage of at least one non-U.S. health risk, and (3) attach a certification statement to its Form 8963 certifying the following: (a) the covered entity’s aggregate direct premiums written for expatriate plans reported on its SHCE include coverage of at least one non-U.S. health risk, (b) the covered entity is relying on the temporary safe harbor provided in Notice 2014-24, (c) the aggregate dollar amount of direct premiums written for expatriate plans reported on the covered entity’s SHCE, and (d) the covered entity has excluded 50 percent of this aggregate amount in determining the amount of direct premiums reported on Form 8963.

<sup>37</sup> Pub. L. No. 113-235, 128 Stat. 2130 (Dec. 16, 2014).

<sup>38</sup> 2015-15 I.R.B. 873.

<sup>39</sup> The certifications required by Notice 2015-29 for SHCE filers are as follows: (1) the covered entity filed the SHCE for 2014, 2015, or both; (2) the covered entity is filing the statement pursuant to Notice 2015-29; (3) the aggregate dollar amount of direct premiums written for expatriate health plans reported on its SHCE for 2014 for that covered entity; (4) the amount of direct premiums written for expatriate health plans the covered entity excluded under Notice 2014-25 in determining the amount of direct premiums written reported in column (f), direct premiums written, on its 2014 Form 8963; and (5) the aggregate dollar amount of direct premiums written for expatriate health plans that is reported on the SHCE for 2015 for the covered entity and included in direct premiums written reported in column (f), direct premiums written, on the covered entity’s 2015 Form 8963.

<sup>40</sup> IRS Notice 2015-43, 2015 IRB LEXIS 292 (June 30, 2015), provides additional, interim guidance regarding the application of certain PPACA provisions to expatriate health insurance issuers, expatriate health plans, and employers as sponsors of expatriate health plans. The Notice

does not address the Section 9010 Fee so is not discussed herein.

<sup>41</sup> The regulations authorize the IRS to provide published guidance regarding the manner of reporting by a covered entity, Treas. Reg. § 57.3(a)(2). For the 2014 fee year the IRS exercised this authority to extend the due date for a covered entity’s corrections to Form 8963 from July 15, 2014 to Aug. 18, 2014. Notice 2014-47, 35 I.R.B. 522.

<sup>42</sup> Treas. Reg. § 57.3(a)(1).

<sup>43</sup> PPACA § 9010(g)(4); Treas. Reg. § 57.3(a)(3). For the 2014 fee year, the IRS affirmatively published each covered entity’s net premiums written, even though it was not required to do so. It seems likely the IRS would follow the same procedure for subsequent fee years rather than face requests for net premiums written information pursuant to the Freedom of Information Act.

<sup>44</sup> Treas. Reg. § 57.4(a)(2).

<sup>45</sup> Treas. Reg. § 57.7(a)-(b).

<sup>46</sup> Treas. Reg. § 57.6(a).

<sup>47</sup> Treas. Reg. § 57.6(c).

<sup>48</sup> Treas. Reg. § 57.9.

<sup>49</sup> 78 Fed. Reg. 71476, 71484.

<sup>50</sup> Treas. Reg. § 57.8.

<sup>51</sup> Treas. Reg. § 57.3(b)(1).

<sup>52</sup> Treas. Reg. § 57.3(b)(1).

<sup>53</sup> Treas. Reg. § 57.3(b)(2).

<sup>54</sup> Treas. Reg. §§ 57.3(b)(3), 57.7(e).

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# Taxation Section Survey Profile of the Taxation Section

By Jeffrey Stabach

As a member and incoming chair of the Taxation Section Council, I've been curious as to who makes up the Taxation Section. Where do they work? How much experience do they have? Where do they spend the majority of their tax-related time? More important, how can we as a section better serve our members? With the help of the Society of Actuaries (SOA) staff, the Taxation Section conducted a survey of its membership this past spring. The intent of this survey was to understand the demographics of our members, determine areas of interest and focus, and understand how our members use the various tools (e.g., *TAXING TIMES*, SOA meetings, section website and podcasts) that the Taxation Section produces. By understanding our members, our goal as a section is to determine how we can better address our members' needs in the future.

The survey was distributed via an email link that was sent to our 800-plus members. Of these members, 87 completed the survey. While the overall response rate was low, the Taxation Section has historically been driven by a smaller, actively engaged group. We assume that this group comprised the majority of respondents to the

survey. This article summarizes the responses we received.

## PROFESSIONAL AFFILIATION AND EMPLOYER TYPE

It is no surprise that the majority of respondents are actuaries with an FSA or ASA designation. However, the Taxation Section also includes representatives from the accounting and legal fields with professional designations including CPA, JD and LLM, as seen in chart 1 at right.

While the majority of respondents work for insurance companies, roughly 20 percent work for consulting firms (including actuarial, accounting and law firms; see chart 2). Of those who work for consulting firms, respondents were split fairly evenly between actuarial (41 percent) and accounting firms (36 percent), with the remaining professionals employed by law firms (9 percent) and other firms (14 percent).

## EXPERIENCE WITH AND TIME SPENT ON TAX PRACTICE

The majority of respondents (57 percent) spend less than a quarter of their professional time on tax-related issues; however, almost 30 percent of respondents spend 75 to 100

Chart 1 Professional Affiliation

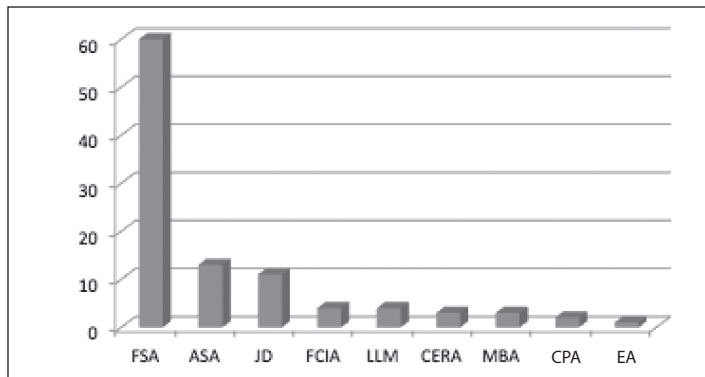


Chart 2 Employer Type

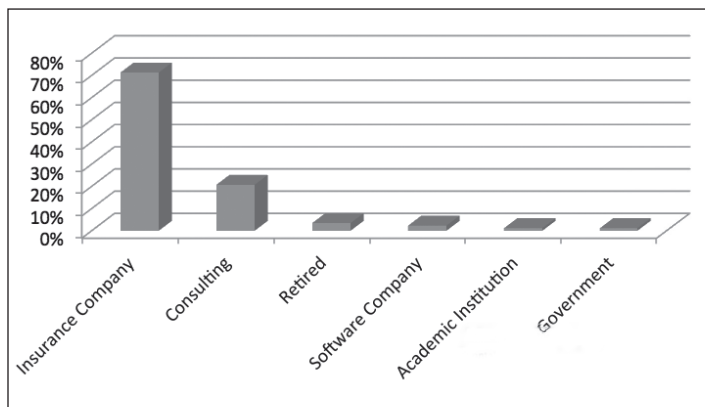
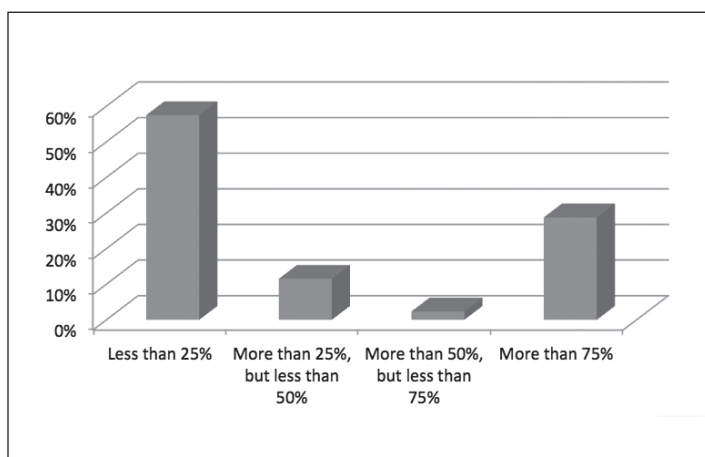


Chart 3 Time Spent on Tax Practice



CONTINUED ON PAGE 32

Chart 4 Years of Experience

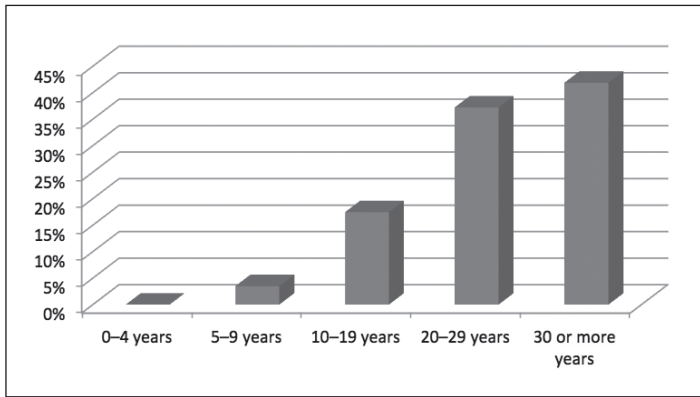


Chart 7 Reasons for Reading *TAXING TIMES*

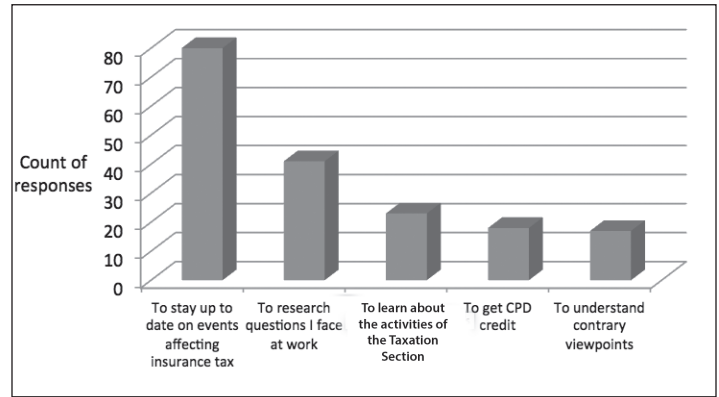


Chart 5 Area of Focus

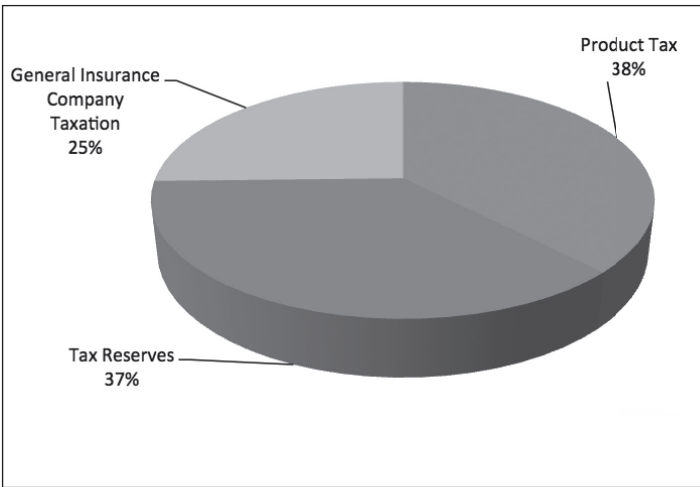
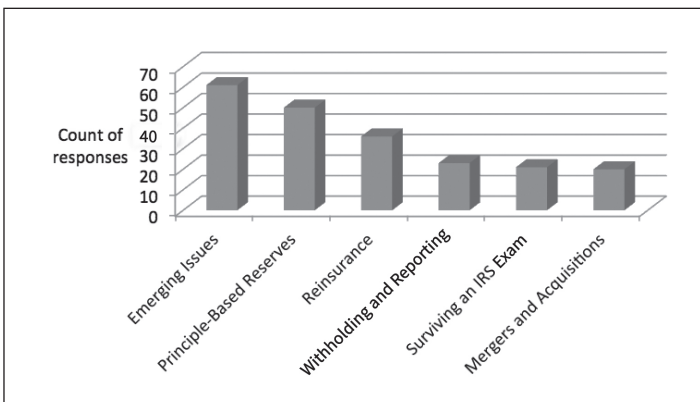


Chart 6 Topics to Address



percent of their time with taxation issues, as noted in chart 3.

Taxation is a highly specialized topic, so it makes sense that most respondents spend either little time or a high percentage of their time on tax-related issues. Along the same lines, the respondents to the Taxation Section Survey are an experienced group. Roughly 80 percent of respondents have more than 20 years of professional experience (see chart 4). While we absolutely value our experienced members and would not be where we are without them, this is also a noteworthy trend for the Taxation Section Council because the majority of respondents are nearing retirement. Over the past few years, the Taxation Section Council has been actively seeking ways to increase membership to include less-experienced professionals.

#### AREA OF FOCUS

In terms of the time respondents spend doing tax-related work, their focus was about

evenly split between product and company tax topics, as seen in chart 5.

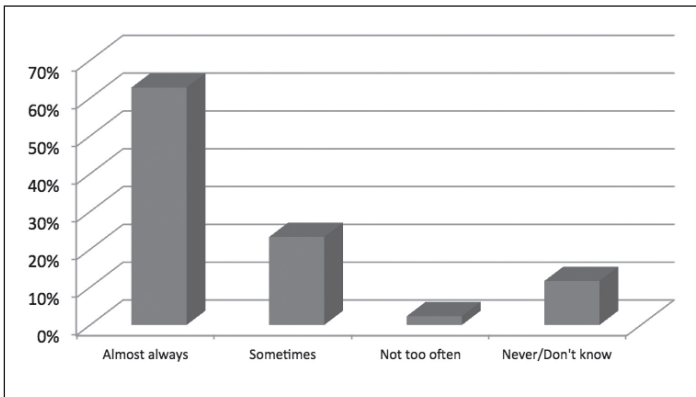
Besides the three areas listed above, chart 6 shows some of the topics that respondents would like to see the Taxation Section address in the near future.

#### SECTION RESOURCES

The survey included a number of questions regarding how our members use the various resources that the Taxation Section produces. The section is actively involved in producing content at SOA meetings, maintaining the Taxation Section page on the SOA website, producing podcasts and distributing *TAXING TIMES*. The goal of these questions was to better understand how our members use these media so that section resources can be focused on bringing members the content they use the most. The results of the survey show that the majority of respondents (55 percent) read *TAXING TIMES* from cover to cover. Respondents use



Chart 8 Attendance at Tax-Related Meeting Sessions



*TAXING TIMES* for a variety of purposes, as shown in chart 7.

Most respondents (55 percent) do not share *TAXING TIMES* with other colleagues. We encourage you to do so, especially with younger or less-experienced actuaries who may benefit from exposure to insurance tax issues or who may be interested in joining the section (or with non-actuarial insurance professionals who may find value in becoming affiliate members). Other Taxation Section media, such as the section website and podcasts, are rarely utilized, with nearly 80 percent of respondents visiting the website less frequently than once a month and only 11 percent having listened to any of the section's podcasts.

When attending SOA meetings, respondents often attend the tax-related sessions, as shown in chart 8.

#### CONCLUDING THOUGHTS

Although there were no real surprises with the survey results, the exercise has given the Taxation Section Council a

snapshot of our membership to get a sense of their interests and concerns. The results will help us better address our members' needs in the future. I'd encourage readers to make sure there is adequate tax awareness in their companies, distribute *TAXING TIMES* to those who do not receive it and ask others to join the Taxation Section—either as actuarial members or affiliate members from other professions. That way, the Taxation Section Council can ensure that the excellent content being developed can find its way to those who value it. ■

*Note: The views expressed are those of the author and do not necessarily reflect the views of Ernst & Young LLP.*

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# ACLI Update

By Pete Bautz, Mandana Parsazad and Jim Szostek

**R**egulatory activity earlier this year at the Department of Labor (DOL) and Treasury Department/Internal Revenue Service (IRS) has drawn significant interest from the life insurance industry and resulted in the recent submission by ACLI and its members of several detailed comment letters.

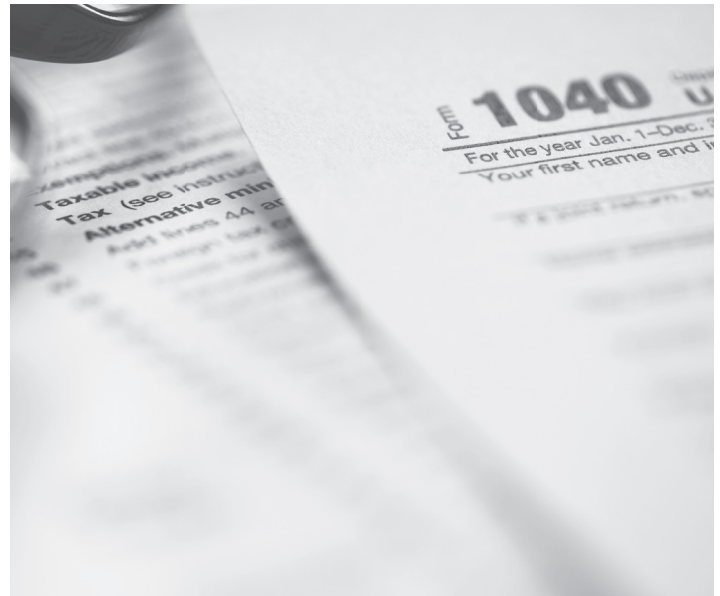
## DOL PROPOSED FIDUCIARY RULE

On April 20, 2015, the DOL released a significant, detailed new proposal to change the definition of fiduciary under ERISA. It would apply to recommendations made to: (1) plan sponsors; (2) participants and beneficiaries of welfare benefits and retirement plans; and (3) individuals owning individual retirement accounts (IRAs) and certain medical and education savings accounts. Key aspects of the new proposal raise serious concerns as to whether workers and retirees, as well as small business owners, will continue to enjoy the access they have to financial products and meaningful education and guidance on investments and retirement income. The proposal purports to provide support to existing business models; however, it likely will require significant changes to sales and compensation prac-

tices to avoid costly prohibited transactions.

This new proposal is far broader, more comprehensive and voluminous than DOL's 2010 proposal. It includes new and amended Prohibited Transaction Exemptions (PTEs) that, under limited circumstances, permit fiduciaries and their affiliates to receive compensation/revenue. The proposal is justified by an extensive, but flawed, economic analysis. If finalized as proposed, the rule would run counter to the joint initiative—launched in 2009 by the DOL, the Department of Treasury, and IRS—highlighting the importance of guaranteed lifetime income and seeking to address regulatory barriers that prevent greater access to lifetime income products for workers. This rule would be such a barrier.

ACLI filed a lengthy comment letter with the DOL on July 21. The ACLI letter contends that the DOL's proposed regulation regarding the definition of the term "Fiduciary," together with the Department's proposed "Best Interest Contract" Exemption (BICE), and proposed amendments to PTE 84-24, will have a dramatic negative impact on retirement savers' ability to obtain the guidance,



products and services they need—including access to guaranteed lifetime income solutions. Additionally, without substantial changes, ACLI expressed serious concerns that, under the proposal, insurers and their distribution partners will no longer be able to engage small business owners to encourage them to establish savings plans for employees, resulting in workers being less likely to save and secure additional guaranteed lifetime income beyond Social Security.

From Aug. 10 to 13, DOL will hold a public hearing on its proposed rule. Following the hearing and the release of the record of the hearing, DOL will reopen the comment period for a limited time. A final DOL rule is expected in the spring of 2016. Prior to that time, ACLI and its members will continue to work with all interested stakeholders to improve the rule.

## PROPOSED HEDGE FUND REINSURANCE REGULATIONS

On July 23, ACLI submitted its comment letter to Treasury and IRS on REG-108214-15, the proposed regulations that provide guidance regarding when a foreign insurance company's income is excluded from the definition of "passive income" under section 1297(b)(2)(B) (the "proposed regulations"). In the letter, we also commented on Senator Ron Wyden's Off-shore Reinsurance Tax Fairness Act (the "bill") since the bill was introduced during the comment period and was in the public discourse.

Investment income is intrinsic to the life insurance business model and constitutes an active component of the business of a life insurer or reinsurer. The Internal Revenue Code recognizes this by providing a carve-out from the Passive Foreign Investment Company (PFIC) rules for investment income

received in the active conduct of an insurance business. Specifically, section 1297(b)(2)(B) excepts from the definition of passive income, income “derived in the active conduct of an insurance business by a corporation which is predominantly engaged in an insurance business and which would be subject to tax under subchapter L if it were a domestic corporation.” The proposed regulations and the bill elaborate on when a foreign insurance company’s income satisfies this exception.

Earlier legislative proposals to amend these rules suggested that premiums be a certain percentage of the company’s gross revenue to qualify as a company predominantly engaged in an insurance business. We commended Treasury and IRS for not including such a test in the proposed regulations. We noted that Senator Wyden’s bill also recognized that there are business reasons why an active insurance company may not meet a formulaic premium to gross revenue test and excluded any such test.

We noted that the approaches for determining whether a life insurance company’s investment income is “derived in the active conduct of an insurance business” in the proposed regulations and in Senator Wyden’s bill were acceptable. We recommended the use of local reserves as the basis for determining the amount of a life insurance company’s assets that should be treated as active under either approach. We wrote that, for life reinsurers, it may be appropriate to use a compa-

ny’s capital as the basis, since they underwrite several products for which the life-insurance-related liabilities are very high. We further recommended that the reserves or liabilities not be modified under either approach. Finally, we stressed the need for Treasury and IRS to provide recourse for life insurance companies to illustrate why they should qualify for the active insurance exception even if they do not meet the numeric guidelines provided in either approach, and stated that such relief should not be temporary.

ACLI expects to continue its dialogue with the Treasury, IRS and Senator Wyden’s staff to assure that life insurers are not negatively impacted by any final anti-abuse rule in this area.

#### NEW NOTIONAL PRINCIPAL CONTRACT REGULATIONS

On July 27, 2015, ACLI submitted a comment letter to the IRS and Treasury regarding final and temporary regulations (T.D. 9719) and proposed regulations (REG-102656-15) published in the Federal Register on May 8 (collectively referred to as the “New Regulations”), relating to the treatment of notional principal contracts (NPCs) with non-periodic payments.

NPCs are financial instruments, such as interest rate swaps, that provide for payments by one party to another at specified intervals, calculated by reference to a specified index on a notional principal amount, in exchange for specified consideration or a promise to pay similar amounts. NPCs

typically provide for three types of payments: (i) periodic payments, (ii) nonperiodic payments, and/or (iii) termination payments.

The New Regulations revised Treas. Reg. §1.446-3(g)(4) (the “Prior Regulations”) that provided for deemed loan treatment for certain, but not clearly defined, “significant” non-periodic payments with respect to NPCs. The New Regulations simplified the embedded loan rule by eliminating the exception for non-significant, non-periodic payments while creating two new exceptions to the embedded loan rule: for a non-periodic payment made under an NPC with a term of one year or less, and for contracts with non-periodic payments subject to prescribed margin or collateral requirements.

The ACLI letter applauded the government’s efforts to draft sensible rules in response to the changing regulatory environment and recommendations from various capital market participants. However, the letter generally agreed with the insightful comments, by letter dated June 18, 2015, submitted on behalf of the North American Tax Committee of the International Swaps and Derivatives Association (ISDA). The ACLI letter specifically requested further clarification or enhancements in the following areas:

- Clarify that the hedge timing rules of Treas. Reg. § 1.446-4 control for the tax treatment of NPCs that are a part of a hedg-

ing transaction under Treas. Reg. § 1.1221-2;

- Provide exceptions from deemed loan treatment for NPCs with non-periodic payments and margin collateral that are below certain de minimis threshold dollar amounts;
- Clarify by way of examples how the deemed loan treatment of the New Regulations is to be applied to NPCs other than plain-vanilla interest rate swaps, such as credit default swaps (CDSs) or swaptions;
- Add a carve-out from deemed loan treatment for NPCs that are marked-to-market;
- Permit an NPC to be eligible for the margin or collateral exception if the collateral or margin posted consists not just of cash but of certain high-grade securities; and
- To allow adequate time for implementation, delay the Nov. 5, 2015 effective date of the New Regulations until the later of one year after the date the New Regulations are published in the Federal Register or Jan. 1, 2017.

#### IRS 2015–2016 PRIORITY GUIDANCE PLAN

In addition to the regulatory activity and comment letters listed above, the IRS on July 31 published its Priority Guidance Plan (PGP, or the “Plan”) for the 2015–2016 year. This PGP identifies the priorities for al-


location of IRS and Treasury resources during the 12-month period from July 2015 through June 2016. ACLI is very pleased that at a time when the Plan list is shrinking in size, as evidenced by the year-over-year decrease in total projects from 317 to 277, the IRS has chosen to include the following project on the PGP list: “guidance under §§807 and 816 regarding the determination of life insurance reserves for life insurance and annuity contracts using principles-based methodologies, including stochastic reserves based on conditional tail expectation.” This expands the project that was included on the last several PGP lists and was described as follows on the 2014–2015 Plan: “guidance clarifying whether the Condi-

tional Tail Expectation Amount computed under AG 43 should be taken into account for purposes of the reserve ratio test under §816(a) and the statutory reserve cap under §807(d)(6).” The expansion of that project in the 2015–2016 Plan to include guidance on issues relating to life principle-based reserving (PBR) has been requested by ACLI for several years, including in its most recent PGP recommendation letter dated April 30. The inclusion of life PBR on this year’s project list also was recommended by the American Bar Association Tax Section in its letter dated June 16, 2015. ACLI and its members hope to work closely with the IRS and Treasury in the development of this guidance. ■

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# Letter to the Editor

Dear Kristin,

The Taxation Section provided a very valuable service by addressing the impact of the Camp proposals on the taxation of life insurance companies in the supplement to the October 2014 edition of *TAXING TIMES*. Daniel Stringham, in his analysis of the proposed changes to the deferred acquisition cost (DAC) rules,<sup>1</sup> and Brian Graber and Peter Winslow, in their analysis of the impact of the Camp proposals on life insurers,<sup>2</sup> articulate a number of concerns about the merit of Camp's proposed changes to the DAC rules. There is another, potentially very significant, issue that influences the merit of the proposed changes in the DAC rules. DAC rules are not the only tax rules that impact the amount of acquisition costs that a life insurer must capitalize. The Commissioners' Reserve Valuation Method (CRVM) and other tax reserve valuation rules also influence the amount of acquisition costs that life insurers must capitalize and therefore should be taken into account in assessing the merit of increasing DAC rates.<sup>3</sup>

In order to determine the proper tax base for an insurer, federal income tax rules require the capitalization and amortization of an appropriate amount of ac-

quisition costs. A Treasury Department official stated in ILM 200220006,<sup>4</sup> "Congress created a proxy system [under] section 848 to serve as the measure of the expenses incurred by an insurance company in connection with specified insurance contracts which should be capitalized."<sup>5</sup> Under this system, an insurance company generally must capitalize a portion of its "general deductions" in an amount equal to the cumulative impact of the "net premium" of each "specified insurance contract" times the prescribed rate for such contract.

The Camp proposal would increase the DAC rates that apply to insurance companies that issue "specified insurance contracts." Under current law, DAC rates are 1.75, 2.05 and 7.7 percent, respectively, for specified insurance contracts that are (1) annuities, (2) group life insurance contracts and (3) not described in (1) or (2). The proposal would decrease the number of categories from three to two and increase the rates that apply to specified insurance contracts. Under the proposal, DAC rates would be 5 and 12 percent, respectively, for specified insurance contracts that (1) are group contracts and (2) are not described in (1).

In order to assess the merit of any changes in the DAC rules,

one should take into account the impact of other tax rules that influence the capitalization of acquisition costs. Life insurers establish tax reserves for life and other insurance contracts that are computed under prescribed preliminary-term methods and modified preliminary-term methods (such as CRVM), which include an expense allowance and a relatively small increase in initial-period reserves. These rules increase the total amount of a life insurer's capitalized acquisition costs.

A senior Treasury official and commentators recognized the impact that acquisition costs have on the amounts life insurers are allowed to add to reserves, long before the Camp proposals and even before Congress enacted section 848 in 1990. When Congress was considering the legislation that resulted in the Tax Reform Act of 1984, which prescribed tax reserve valuation methods for insurance contracts issued by life insurers, John E. Chappoton, the Assistant Secretary of the Treasury Department for Tax Policy, indicated that states permitted preliminary-term reserve valuation methods because life insurers pay significant initial-year loading expenses.<sup>6</sup> He stated, preliminary-term "methods generally acknowledge that virtually all of the first-year premium in a cash-value policy is used to pay loading and mortality charges and do not call for any significant increase to reserves in the first year of the policy."<sup>7</sup> In 1992, a commentator criticized the DAC rules under section 848, in part, because "the enactment of section 848 was undertaken in the total disregard of

the fact that the 1984 act's mandate to use preliminary-term reserves was intended, in part, to effectuate the capitalization of policy issuance expenses."<sup>8</sup>

Capitalizing more than the actual acquisition costs would overstate an insurer's taxable income for a given taxable year; that is, it would impose a tax penalty. Consequently, in order to assess the merit of any changes in DAC rules, Congress should take into account the impact of both DAC and other tax provisions to determine the appropriate amount of acquisition costs that tax rules should capitalize.

Sincerely yours,  
Emanuel Burstein<sup>9</sup>

## END NOTES

<sup>1</sup> *Taxing Times* (vol. 10, issue 3 supp.) at 25 (October 2014).

<sup>2</sup> *Id.* at 5.

<sup>3</sup> Tax reserves for annuities, however, are not determined under rules that raise the concerns addressed in this letter.

<sup>4</sup> Feb. 5, 2002.

<sup>5</sup> *Id.* at 4–5.

<sup>6</sup> See, Tax Treatment of Life Insurance Companies, Hearings Before the Subcomm. on Select Revenue Measures of the House Comm. on Ways & Means, 98th Cong., 1st Sess. at 50–51 (1983) (Statement of John E. Chappoton, Asst. Secretary, Department of the Treasury).

<sup>7</sup> *Id.* at 51.

<sup>8</sup> W. Harman, Jr., Two Decades of Insurance Tax Reform, *Tax Notes* (vol. 57, no. 7) at 912 (Nov. 12, 1992).

<sup>9</sup> Emanuel Burstein is the author of the recently published third edition of *Federal Income Taxation of Insurance Companies*, which is published in print and as an e-book by InsuranceTax.com. The topic of DAC is addressed at pages 175–192, and tax reserves are the subject of Chapter 6.

# T<sup>3</sup>: TAXING TIMES TIDBITS

## PROPOSED REGULATIONS TARGETING HEDGE FUND REINSURANCE ARRANGEMENTS MAY IMPACT TRADITIONAL INSURANCE COMPANIES

By Brion D. Graber

On April 24, 2015, Treasury and the Internal Revenue Service (IRS) published proposed regulations (REG-108214-15) that provide guidance regarding when a foreign insurance company's income is excluded from the definition of passive income under Section 1297(b)(2)(B).<sup>1</sup> As described in the preamble, the proposed regulations are directed at hedge funds that purport to establish a foreign reinsurance company in an effort to avoid treatment as a passive foreign investment company (PFIC). The issuance of the proposed regulations met a 90-day deadline for additional guidance on this issue that IRS Commissioner John Koskinen agreed to early this year during questioning by Senator Ron Wyden (D-OR).<sup>2</sup> It is unclear when final regulations might be issued, but the issue addressed by the proposed regulations is of great interest to Senator Wyden who will presumably continue to prod Treasury and the IRS to act to curtail use of the PFIC insurance exception by hedge funds. The insurance

industry is well advised to monitor developments in this area and provide input to prevent government actions that could have unintended consequences.

### BACKGROUND

The PFIC rules are an anti-deferral regime intended to ensure that U.S. persons cannot avoid current U.S. income tax on their share of passive or highly mobile income by investing through a foreign corporation.<sup>3</sup> If a U.S. person is a shareholder in a PFIC, that person is subject to U.S. tax on its share of the PFIC's income under one of three alternative regimes: (1) an interest-charge regime; (2) an elective full-inclusion regime; or (3) an elective mark-to-market regime.

A foreign corporation is a PFIC if either 75 percent or more of its gross income for the taxable year is passive income (passive income test), or an average of 50 percent or more of its assets produce passive income or are held for the production of passive income (passive asset test). For purposes of applying the passive income test,

Section 1297 provides that the term "passive income" does not include any income that is derived in the active conduct of an insurance business by a corporation that is predominantly engaged in an insurance business and that would be subject to tax under subchapter L as an insurance company if the corporation were a domestic corporation.

In 2003, the IRS issued Notice 2003-34 to address certain arrangements in which taxpayers were deferring recognition of ordinary income or characterizing ordinary income as capital gain as a result of an investment in a foreign company that was a purported insurance company.<sup>4</sup> The foreign company would invest in hedge funds or investments in which hedge funds typically invest. The IRS noted that to qualify as an insurance company for federal tax purposes, a taxpayer must issue insurance contracts and must use its capital and efforts primarily in earning income from issuing such contracts. The IRS stated that it would scrutinize the types of arrangements described in the Notice and apply the PFIC rules in those cases in which the IRS determines the foreign company is not an insurance company for federal tax purposes.

On June 12, 2014, Senator Wyden sent a letter to Treasury and the IRS asking them to outline the actions they have taken to address the types of transactions described in Notice 2003-34. Senator Wyden also asked Treasury and the IRS whether they believe they need any additional authority from Congress

to address the issue. On Aug. 8, Treasury responded that it has in fact scrutinized the arrangements described in Notice 2003-34. Treasury stated, however, that it can be difficult to determine whether a foreign corporation is an active reinsurance company or a passive investment vehicle. Treasury noted that there is no statutory, objective test to apply. In addition, such a determination necessarily involves consideration of the appropriate level of reserves required to satisfy future insurance claims, which in turn may depend on the nature of the risks being insured and the riskiness of the assets in which the reserves are invested.

Treasury's letter prompted Senator Wyden to respond that while there may not be a bright line, he is "concerned that under current tax administration practices and constraints there isn't any line at all."<sup>5</sup> He also released a report on the hedge fund insurance issue that was prepared by the Joint Committee on Taxation (JCT) at his request.<sup>6</sup> The JCT report provides background on the issue, a description of legislative proposals to address the issue that were made by Representative Dave Camp (R-MI) and Senator Max Baucus (D-MT) in connection with tax reform efforts, and background and data on offshore reinsurance generally and in Bermuda specifically.<sup>7</sup> Senator Wyden's letter noted that the JCT report identifies at least two U.S. hedge-fund-backed reinsurance companies that had insurance liability-to-asset ratios of only 1 percent in 2012. Senator Wyden also questioned whether companies with such low ratios could be considered predominantly

engaged in the reinsurance business.

Treasury responded to Senator Wyden on Oct. 21, 2014.<sup>8</sup> Treasury stated that it had conducted an in-depth review of the Camp and Baucus proposals and discussed them with various stakeholders. Based on that review, Treasury expressed concern that those proposals could be both over-inclusive, because a significant percentage of legitimate insurance companies would fail to satisfy the tests, and under-inclusive, because the tests could be manipulated by reinsurance companies acting in concert. Treasury concluded by stating it was working with the IRS and interested stakeholders to identify regulatory approaches that could be tailored to address inappropriate arrangements with objective rules.

On Feb. 3, 2015, Commissioner Koskinen testified in a Senate Committee on Finance hearing on “Internal Revenue Service Operations and the President’s Budget for Fiscal Year 2016.” During that hearing, Senator Wyden noted that the IRS had failed to release definitive guidance on the hedge fund reinsurance issue after it issued Notice 2003-34. Senator Wyden secured Commissioner Koskinen’s commitment that the IRS would try to release new guidance within 90 days. As noted above, that guidance came on April 24 in the form of proposed regulations.<sup>9</sup>

## THE PROPOSED REGULATIONS

The proposed regulations clarify the circumstances under which

The proposed regulations are intended to target hedge fund insurance companies. Nevertheless, “traditional” insurance or reinsurance companies could be affected.

investment income earned by a foreign insurance company is “derived in the active conduct of an insurance business” by defining the terms “active conduct” and “insurance business” for purposes of Section 1297. “Active conduct” is defined to have the same meaning as in Temp. Treas. Reg. § 1.367(a)-2T(b)(3), except that officers and employees do not include the officers and employees of related entities. Temp. Treas. Reg. § 1.367(a)-2T(b)(3) provides that a corporation actively conducts a business only if officers and employees of the corporation and related entities carry out substantial managerial and operational activities. The proposed regulations define “insurance business” to mean the business activity of issuing insurance and annuity contracts and the reinsurance of risks underwritten by insurance companies, together with investment activities and administrative services that are required to support or are substantially related to insurance contracts issued or reinsured by the foreign insurance company. The proposed regulations further provide that an “investment activity” is any activity engaged in to produce income of a kind that would be foreign personal holding company income as defined in Section

954(c), and that investment activities will be treated as required to support or as substantially related to insurance or annuity contracts issued or reinsured by the foreign corporation to the extent that income from the activities is earned from assets held by the foreign corporation to meet obligations under the contract.

Treasury and the IRS requested comments by July 23, 2015, on all aspects of the proposed regulations, and specifically on appropriate methodologies for determining the extent to which assets are “held to meet obligations under insurance and annuity contracts.” The preamble suggests one approach would be to treat assets as held to meet insurance obligations “to the extent the corporation’s assets in the calendar year do not exceed a specified percentage of the corporation’s total insurance liabilities for the year.” The preamble asks for comments on what percentage would be appropriate under this method as well as suggestions for other methods that would be more appropriate.

## ISSUES RAISED

The proposed regulations are intended to target hedge fund insurance companies. Nevertheless, “traditional” insur-

ance or reinsurance companies could be affected. There are at least two areas that merit attention by such companies: (1) the narrow definition of active conduct; and (2) the method for determining what portion of assets are passive rather than active.

As noted above, the proposed regulations do not consider officers and employees of related entities in the “active conduct” determination. The proposed regulations offer no explanation for this narrowing of the Temp. Treas. Reg. § 1.367(a)-2T(b)(3) definition in the case of insurance companies. This restrictive definition appears to ignore how many traditional insurance groups operate. It is quite common for traditional insurance groups to centralize certain activities, such as underwriting, investment management and claims management, for non-tax reasons. Without the ability to consider these activities, many traditional insurance companies that do not present the same tax avoidance concerns as hedge fund reinsurers may be unable to meet the active conduct definition (at least not without restructuring their business operations solely for tax reasons).

It is interesting to note that when Treasury issued proposed regulations governing a similar exception to the PFIC rules for banks, it defined active conduct by cross-reference to Temp. Treas. Reg. § 1.367(a)-2T(b)(3) without modification.<sup>10</sup> That definition seems eminently reasonable as banks, like insurance companies and many other types of business enterprises,

often rely on the services of related entities to conduct their business operations. And yet Treasury has proposed rules for insurance companies that ignore that business reality.

The second aspect of the proposed regulations that traditional insurance companies should consider is the request for comments on how to determine the portion of assets that are passive versus active (i.e., held to meet insurance obligations). No method is provided, making it difficult to know what Treasury thinks would be appropriate on this critical issue. The preamble does suggest one possible approach—treat assets as held to meet insurance obligations to the extent they do not exceed a specified (but currently unstated) percentage of the corporation’s total insurance liabilities for the year. The proposed regulations do not explain why they do not include a specific method, but presumably Treasury recognized how challenging it is to identify a test that will work for all insurance companies. The amount of capital an insurance company needs depends on many factors, including the types and amounts of coverage it writes, the types of investment assets it holds, and other regulatory and rating agency requirements. In addition, companies in different stages of the business life-cycle (for example, start-up, expansion or runoff) have different capital needs.

Similar to the method suggested in the preamble, Representative Camp and Senator Baucus both proposed a bright-line test in their tax reform propos-

als that would look at whether a company’s insurance liabilities constitute more than 35 percent of its assets. Senator Wyden’s recent “Offshore Reinsurance Tax Fairness Act” suggests a three-part test. Under that test, if insurance liabilities are less than 10 percent of assets, the company is not an insurance company. If insurance liabilities are greater than 25 percent of assets, the company is an insurance company. If insurance liabilities are between 10 and 25 percent of assets, then a facts and circumstances test applies. While this approach provides more flexibility than a one-size-fits-all approach, and is certainly an improvement over the Camp and Baucus approach, it nevertheless is a blunt tool. As such, it risks being both over- and under-inclusive.

Whatever approach is ultimately taken by Treasury and the IRS on this point could be of significance to traditional insurance or reinsurance companies, particularly those that underwrite catastrophic risks, are in a start-up phase, or are in runoff. ■

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## END NOTES

- <sup>1</sup> Unless otherwise indicated, all Section references are to the Internal Revenue Code of 1986, as amended.
- <sup>2</sup> Press Release, Senate Committee on Finance, Wyden Recognizes Administration for Responding to His Push to Address Offshore Reinsurance Tax Loophole (April 23, 2015).
- <sup>3</sup> Sections 1291–1298.
- <sup>4</sup> 2003-1 C.B. 990.
- <sup>5</sup> Letter from Senator Ron Wyden, Chairman, Senate Committee on Finance, to Jacob J. Lew, Secretary, Department of the Treasury (Sept. 11, 2014).
- <sup>6</sup> Joint Committee on Taxation, *Background and Data with Respect to Hedge Fund Reinsurance Arrangements* (July 31, 2014).
- <sup>7</sup> The Camp and Baucus proposals are similar and would both replace the “predominantly engaged in an insurance business” test with a gross receipts test. Under the gross receipts test: (1) more than 50 percent of the controlled foreign corporation’s (CFC’s) gross receipts for the taxable year must consist of premiums for insurance or reinsurance; and (2) the CFC’s applicable insurance liabilities must constitute more than 35 percent of the CFC’s total assets as reported on its applicable financial statements for the year.
- <sup>8</sup> Letter from Alastair M. Fitzpayne, Assistant Secretary for Legislative Affairs, Department of the Treasury, to Senator Ron Wyden, Chairman, Senate Committee on Finance (Oct. 21, 2014).
- <sup>9</sup> On June 25, 2015, Senator Wyden introduced S. 1687, the “Offshore Reinsurance Tax Fairness Act.” The bill would provide a bright-line test for determining whether a company is an insurance company for purposes of applying the insurance exception to the PFIC rules. Under the new test, if a company’s insurance liabilities exceed 25 percent of its assets, it would be considered an insurance company for purposes of applying the exception. If insurance liabilities are between 10 and 25 percent of assets, a facts and circumstances test would apply. If insurance liabilities are less than 10 percent of assets, the company could not qualify as an insurance company and thus could not qualify for the PFIC exception.
- <sup>10</sup> Prop. Treas. Reg. § 1.1296-4(f)(1).



## APPEALS COURT AFFIRMS DISTRICT COURT RULING IN VALIDUS CASE—§ 4371 EXCISE TAX INAPPLICABLE ON FOREIGN-TO-FOREIGN TRANSACTIONS

By Edward C. Clabault

On May 26, 2015, the United States Court of Appeals for the District of Columbia Circuit (the Court) affirmed the District Court's grant of summary judgment in favor of the plaintiff in *Validus Reinsurance Ltd. v. United States of America*.<sup>1</sup> The Court held, as a matter of law, that the Federal Excise Tax (FET) on insurance transactions does not apply to foreign-to-foreign reinsurance transactions, including retrocessions.

As we described in a previous *TAXING TIMES* Tidbit,<sup>2</sup> *Validus Reinsurance Ltd.* ("Validus"), a Bermuda reinsurer, had reinsured U.S. risks, and then retroceded a portion of those risks to foreign persons not eligible for an FET exemption under a tax treaty. The Internal Revenue Service (IRS), pursuant to its position as stated in Rev. Rul. 2008-15,<sup>3</sup> assessed an FET of 1 percent on *Validus* for the retrocession. *Validus* paid the tax, and appealed.

Under Internal Revenue Code (IRC) § 4371, there is an excise tax of 4 percent that is imposed on each dollar of premium paid covering U.S. risks on (1) casualty insurance and indemnity bonds, and an excise tax of 1 percent on (2) life insurance, sickness and accident policies, and annuity contracts. There is also (3) a 1 percent excise tax on reinsurance covering any contracts listed in (1) or (2).

The District Court's ruling on Feb. 5, 2014 held, in looking to the plain language of the statute, that the excise tax statute did not apply to retrocession transactions. The District Court noted that the tax imposed on reinsurance transactions only applied to the reinsurance of contracts, as defined under IRC § 4371(1) and (2), and would not apply to retrocessions because reinsurance is not listed in (1) or (2). The District Court noted that the language of the statute was clear and, therefore, did not look beyond it.

The District Court's ruling called into question two situations. First, in cases where a U.S. reinsurer retrocedes risks with a foreign retrocessionaire not eligible for treaty benefits, under the District Court's reading of the statute, no FET would be due on such U.S.-to-foreign retrocessions. This outcome ran counter to long-standing industry understanding and practice where, for FET purposes, retrocessions were treated as a type of reinsurance transaction.

Second, Example 1 in Rev. Rul. 2008-15 states that in cases where a foreign direct writer has insured U.S. risks, then reinsured such risks with a foreign reinsurer not eligible for a treaty exemption, the foreign-to-foreign reinsurance transaction is subject to the FET. The District Court's ruling did not address such sit-

uations, as it limited itself to a discussion of retrocessions, leaving an open question as to whether these transactions are taxable.

On April 3, 2014, the United States gave notice of its intent to appeal. Oral arguments were heard on Feb. 20, 2015, with the Government maintaining that retrocessions were a type of reinsurance and that the plain reading of the statute, on which the District Court based its opinion, should result in retrocessions being subject to the FET. *Validus* countered that the District Court was correct in treating reinsurance transactions as distinct from retrocessions, and further argued that clear Congressional intent to apply the FET in an extraterritorial manner was lacking.

First, the Circuit Court addressed the application of the FET to retrocessions, noting that paragraph (3) of IRC § 4371 imposed a tax on reinsurance policies covering those described in paragraphs (1) and (2). Focusing on the statute's use of the word "covering," the Government argued for an expansive interpretation that would result in all reinsurance and retrocessions with underlying U.S. risks being potentially subject to tax. *Validus* argued for a more restrictive interpretation that would make the FET applicable only to reinsurance transactions. The Court found that both the Government and *Validus* presented plausible interpretations, and thus focused its analysis on the purpose of the statute. The Court noted that the statute seeks to level the playing field between do-

mestic and foreign insurance and reinsurance businesses by imposing an excise tax on persons insuring or reinsuring U.S. risks where such persons are not subject to U.S. income tax on the income derived from such U.S. risks. It further stated that because a retrocession is "merely another type of reinsurance," *Validus*' interpretation of the statute would create a distinction between retrocessions and reinsurance issued by foreign persons to domestic insureds that would be at odds with the clear purpose of the FET. The Court thus concluded that retrocessions would be subject to the FET in the same manner as reinsurance transactions.

Next, the Court turned to the application of the FET in the foreign-to-foreign context. Citing *Morrison*,<sup>4</sup> the Court noted that a statute has no extraterritorial application unless such application is clearly expressed in the statute itself, in the statute's context or purpose, or in its legislative history. The Government offered, and the Court found, no indication that the FET was meant to apply in an extraterritorial manner. While acknowledging the Government's argument that the FET is always technically extraterritorial inasmuch as it applies to foreign persons not subject to U.S. income tax, the Court differentiated between U.S.-to-foreign transactions where one party to the contract is in the United States, which clearly were within the purview of the statute, and foreign-to-foreign transactions whose treatment was less clear. The Court further noted that, according to the Government's argument,

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the extraterritorial reach of the FET could extend indefinitely as U.S. risks are retroceded again and again, finding such situation clearly different from that authorized under IRC § 4371. Because IRC § 4371 was ambiguous with respect to wholly foreign retrocessions, the Court relied on the presumption against extraterritorial application and found for Validus.

While the Court's decision was a clear victory for Validus and other offshore reinsurers, it also cleared up two ambiguities that arose from the District Court's decision. First, by stating that retrocessions were a type of reinsurance, the taxability of U.S.-to-foreign retrocessions is confirmed. Second, by limiting the FET's extraterritorial scope, it is now clear that a foreign-to-foreign reinsurance transaction is not subject to the FET.

The IRS' renewed focus on the cascading excise tax, which began with the publication of Rev. Rul. 2008-15, caused many offshore insurers to have an unexpected U.S. tax bill during these past seven years. Some offshore reinsurers were not prepared or able to track specific risks on all underlying contracts and had to estimate the magnitude of their premiums relating to U.S. risks based on such factors as the domicile of the ceding company. This methodology could never provide a fully accurate picture, especially in instances where an underlying contract covers

worldwide risks. Notwithstanding the IRS' assurances that it would not look past the first foreign-to-foreign transaction to assess the FET, as U.S. risks moved further down the chain of reinsurance and retrocessions, the FET exposure remained, but the ability of companies to accurately track the taxable premium became more and more imprecise and difficult. With the Validus decision, this uncertainty is no more.

During the course of the Validus litigation, many foreign insurers that paid the cascading FET submitted protective refund claims, and for those insurers that have not yet acted, it is likely that there will be additional refund claims in the coming months. The deadline for the IRS to file a notice of appeal was August 24, 2015, which passed without any action on their part. We now await word on how the IRS will approach the refund claims. ■

*Note: The views expressed are those of the author and do not necessarily reflect the views of Ernst & Young LLP.*

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## END NOTES

<sup>1</sup> *Validus Reinsurance Ltd. v. United States of America*, 19 F. Supp. 3d 225 (D.D.C. 2014), aff'd, 786 F.3d 1039 (D.C. Cir. 2015).

<sup>2</sup> Edward C. Clabault, "District Court Rules § 4371 Excise Tax Inapplicable on Foreign-to-Foreign Retrocessions," *TAXING TIMES* Vol. 10, Issue 2 (May 2014), at 30.

<sup>3</sup> 2008-12 I.R.B. 633.

<sup>4</sup> *Morrison v. Nat'l Austl. Bank Ltd.*, 561 U.S. 247, 255 (2010).

## THE TAXABLE DEFERRED ANNUITY WITH GUARANTEED LIFETIME WITHDRAWALS

By Bryan W. Keene

In PLRs 201515001 and 201519001 (each dated Oct. 10, 2014), the Internal Revenue Service (IRS) addressed the treatment of a non-qualified deferred annuity contract under the investor control doctrine and other applicable rules. The contract provides a guaranteed lifetime withdrawal benefit with respect to amounts held in the issuer's general account and separate account, the latter of which provides various investment options for the policyholder. Each investment option corresponds to a "publicly available" mutual fund, meaning shares in the fund also can be purchased outside of any variable insurance product. The taxpayer in the first ruling was the proposed purchaser of the contract, and the taxpayer in the second ruling was the issuer.

The taxpayers requested and received rulings that the investor control doctrine will apply to treat the contract purchaser, rather than the issuer, as the owner of the mutual fund shares for federal income tax purposes. The taxpayers also requested and received rulings on various other tax consequences flowing from this conclusion, including the status of the contract under section 72,<sup>1</sup> how the "cash value" and "investment in the contract" will be determined, how distributions from the contract will be taxed, and (in the ruling issued to the proposed purchaser) whether ownership of

the contract and its guaranteed withdrawal benefit feature will limit the availability of certain tax benefits the policyholder would enjoy if he directly owned the underlying mutual funds.

The effect of the rulings is that the contract will be taxed similarly to a contingent deferred annuity (where the policyholder holds the mutual fund shares in his or her own brokerage account), while being structured like a traditional deferred variable annuity (where the insurance company holds the shares in its separate account).<sup>2</sup> The rulings also are noteworthy because they address various specific consequences of the investor control doctrine applying to the contract, including the treatment of in-kind contributions and distributions of mutual fund shares allowed under the arrangement.

### SUMMARY OF FACTS

A life insurance company ("Company") intends to issue a non-qualified deferred annuity contract ("Contract") to an individual ("Individual"). The Contract provides a "Contractual Cash Value" that equals the sum of the "Fixed Account Value" and the "Separate Account Value." The Contract allows the owner to apply the Contractual Account Value to generate "Annuity Payments." The Contract also provides for "Income Benefit Payments" that are similar to guaranteed lifetime withdrawal

benefits. The key features of the Contract are summarized below.

**The Accounts:** The Fixed Account Value is credited with interest and is supported solely by the Company's general account. The Separate Account Value equals the market value of certain mutual funds the Company holds in its Separate Account, based on allocations the Individual makes among the investment options the Company offers, which are subject to certain "Investment Guidelines" that impose parameters around such allocations. Each investment option corresponds to a sub-account of the Separate Account, and each sub-account invests in shares of a corresponding publicly available mutual fund (a "Public Mutual Fund"). The Company will hold legal title to the shares of the Public Mutual Funds.

**Contributions:** Contributions to the Contract may be made in cash or in kind. To make an in-kind contribution, the Individual will transfer to the Company ownership of shares in a Public Mutual Fund that is otherwise available as an investment option under the Contract. To facilitate this, the Contract will require the Individual to maintain a brokerage account with a Company-approved financial institution. A portion of each contribution must be allocated in cash to the Fixed Account according to a fixed percentage listed in the Contract, which may equal zero after a specified time frame.

**Withdrawals:** Withdrawals will be taken *pro rata* from the Fixed Account Value and the Separate

Account Value. All withdrawals from the Fixed Account Value will be made in cash. However, the Individual may choose to receive withdrawals from the Separate Account in kind or in cash. For an in-kind withdrawal, the Company (or the Separate Account) will transfer to the Individual legal ownership of the shares of the relevant Public Mutual Fund(s). For a cash withdrawal, the Company will liquidate shares of those funds and forward the proceeds to the Individual.

**Income Benefit:** The Income Benefit appears to be typical of guaranteed lifetime withdrawal benefits. For example, it guarantees that if the Contractual Cash Value is reduced to zero for reasons other than withdrawals taken in excess of an annual "Guaranteed Amount," the Company will make "Income Benefit Payments" equal to the Guaranteed Amount for the Individual's remaining life.

**Contract Fees and Charges:** Certain "Contract Charges" are payable to the Company under the terms of the Contract. The owner may elect to pay some of these charges out-of-pocket or have them deducted *pro rata* from certain sub-accounts of the Separate Account. Charges will not be deducted from the Fixed Account.

### CONCLUSION UNDER THE INVESTOR CONTROL DOCTRINE

The taxpayers requested and received rulings that the investor control doctrine will apply to treat the Individual, rather than the Company, as the owner of

the Public Mutual Fund shares for federal income tax purposes. Normally, for such purposes, the life insurance company is treated as the owner of the separate account assets it holds in support of variable annuity and life insurance contracts it issues. The IRS established a limited exception to this treatment in a series of revenue rulings colloquially known as the “investor control” rulings. Under those rulings, the policyholder, rather than the insurance company, is treated as the owner of the separate account assets if he or she has sufficient incidents of ownership in them. The result is that the tax benefits of the insurance contract are lost, and the policyholder is currently taxable on income generated by the separate account assets as if he or she held them directly.

The IRS revenue rulings on investor control often focus on the “public availability” of the investments supporting the contract. For example, in Rev. Rul. 81-225 the IRS considered five situations involving a deferred annuity with investment options that each corresponded to a different mutual fund the insurance company selected and held in its separate account. In four of the situations, shares of the mutual funds were publicly available, and in those situations the IRS concluded that the policyholder, rather than the insurance company, would be treated as owning the shares for tax purposes. Similarly, in Rev. Rul. 2003-92 the IRS concluded that interests in a partnership that an insurer held in its separate account as an investment option under life insurance and annuity contracts were owned by the policyholder

for tax purposes because the partnership interests were publicly available.

In considering the applicability of these rulings to the facts in PLRs 201515001 and 201519001, the IRS observed that “each sub-account corresponds to a Public Mutual Fund that is identified in the prospectus or other materials accompanying the Contract ... [and] ... shares of the Public Mutual Funds will be available for direct purchase by the general public, including the Individual, without having to purchase a Contract.” Citing Rev. Rul. 81-225 and related guidance, the IRS concluded that under these facts the Individual will be treated as owning the Public Mutual Fund shares for tax purposes. Expanding on this conclusion, the IRS also ruled as follows:

1. “Each year, the Individual should reflect in his gross income any gains, income, or losses with respect to the Public Mutual Fund shares, with the amount and tax character of such items being the same as if he held the shares directly. For this purpose, any redemption of Public Mutual Fund shares to (1) make a cash payment to the Individual or his designee, (2) reallocate the Separate Account Value among the Separate Account investment options, (3) pay Contract Charges, or (4) be applied to generate Annuity Payments will incur the same tax consequences to the Individual as if he redeemed the Public Mutual Fund shares directly

and received the resulting cash.”

2. “A transfer of legal ownership of Public Mutual Fund shares between the Company (or the Separate Account) and the Individual, whether as a Contribution to or a withdrawal from the Contract, will not be a taxable event.” This conclusion reflects the interpretation that, because the Individual will be treated as owning the Public Mutual Fund shares both before and after any transfer of legal ownership between the Individual and Company, such a transfer will not represent a disposition of the shares.

Because the Company will hold legal title to the Public Mutual Fund while the Individual will be treated as owning the shares for federal income tax purposes, the Company could have information reporting obligations with respect to the shares. In that regard, the taxpayers represented that “[b]ased on Rev. Rul. 81-225, 1981-2 C.B. 12, the Company will be a nominee of the policyholder with respect to amounts the Separate Account receives from the relevant Public Mutual Funds on the policyholder’s behalf. As a nominee, the Company will have, and intends to comply with, obligations to report such amounts to the Service and the policyholder.”

#### ADDITIONAL ISSUES ADDRESSED

The taxpayers also requested and received rulings on various other tax consequences flowing

from the conclusion under the investor control doctrine, as summarized below.

**Tax Status of the Contract:** The IRS concluded that, “[f]or federal income tax purposes, the Contract will constitute an annuity contract taxable under [section] 72, except for the portion of the Contract [comprising] the Separate Account Value where the Individual is treated as the owner of the Public Mutual Fund shares and taxable under [section] 61.” In reaching this conclusion, the IRS observed that “except for the portion of the Contract [comprising] the Separate Account Value where the Individual is treated as the owner of the Public Mutual Fund shares and taxable under [section] 61, the Contract possesses the essential attributes of an annuity.”

**Cash Value of the Contract:** The IRS also concluded that, for purposes of section 72, “the Contract’s ‘cash value’ or ‘cash surrender value’ will be [composed] solely of the Fixed Account Value and not the Separate Account Value.” In reaching this conclusion, the IRS observed that because the investor control doctrine applies to treat the Individual as the owner of the Public Mutual Fund shares for federal income tax purposes, those shares cannot also comprise part of the Contract’s “cash value” for section 72 purposes. Based on the conclusion that only the Fixed Account Value comprises the Contract’s cash value, the IRS went on to rule that “[a]ny withdrawal from the Contract that is allocable to the Fixed Account Value will be taxable under [section] 72(e); and

[a]ny Contract Charges that are deducted from the Fixed Account Value will be treated as internal charges under the Contract that do not give rise to a taxable distribution.”

**Investment in the Contract:** The IRS also concluded that “[a]ny Contributions that are allocated to the Fixed Account, any Separate Account Value that is applied to generate Annuity Payments, and any Contract Charges that are paid from the Separate Account Value or that the Individual pays directly from his checking or similar after-tax account will give rise to ‘investment in the contract’ within the meaning of section 72(c)(1) and 72(e)(6).” Presumably this conclusion is based on the fact that such amounts will be paid to the Company with after-tax dollars. In that regard, because the Individual is treated as owning the Public Mutual Fund shares for federal income tax purposes, any sale or redemption of those shares to generate Annuity Payments or pay Contract Charges will be taxable.

**Exclusion Ratio Treatment:** The IRS also concluded that the Income Benefit Payments and Annuity Payments “will be treated as ‘amounts received as an annuity’ using an ‘exclusion ratio’ under [section] 72(b).” As an exception to this conclusion, however, the IRS stated that “the initial Income Benefit Payment will be treated as an ‘amount not received as an annuity’ that is taxable under [section] 72(e) if such payment is not made within the same interval as the succeeding Income Benefit Payments or is not made on or after the annuity starting

date as defined in [Treas. Reg. section] 1.72-4(b).” That regulation states that one of the requirements for payments to be treated as “amounts received as an annuity” is that the payments must be made in periodic installments at regular intervals.

**Tax Benefits Available from Ownership of the Public Mutual Funds:** Finally, in PLR 201515001, which was issued to the Individual, the IRS ruled favorably on three issues relating to whether the Individual’s ownership of the Contract and right to receive the Income Benefit Payments will limit the availability of certain tax benefits that would be available if he owned the Public Mutual Funds directly. Specifically, the IRS concluded that the Contract will not give rise to a straddle under section 1092 (which would defer the deduction of losses incurred with respect to the Public Mutual Funds), will not reduce the Individual’s holding period with respect to the Public Mutual Funds for purposes of sections 246(c)(4) and 1(h)(11)(A) (which could deny “qualified dividend income” treatment and thus the lower tax rate applicable to dividends received from the funds), and will not constitute “insurance” that would preclude deductions for investment losses or give rise to income under the “tax benefit rule.” The IRS reached these same favorable conclusions in prior rulings involving contingent deferred annuities and followed the same analysis as in those earlier rulings.<sup>4</sup> ■

## END NOTES

<sup>1</sup> Unless otherwise indicated, each reference herein to a “section” is to a section of the Internal Revenue Code of 1986, as amended.

<sup>2</sup> For a discussion of the IRS rulings on contingent deferred annuities, see John T. Adney and Bryan W. Keene, “Additional IRS Rulings on Contingent Deferred Annuities,” *TAXING TIMES* vol. 7, issue 3, at 28 (September 2011); Joseph F. McKeever, III, and Bryan W. Keene, “IRS Confirms Annuity Status of ‘Contingent Annuity Contracts,’” *TAXING TIMES* vol. 6, issue 2, at 1 (May 2010).

<sup>3</sup> Rev. Rul. 2003-92, 2003-2 C.B. 350; Rev. Rul. 2003-91, 2003-2 C.B. 347; Rev. Rul. 82-55, 1982-1 C.B. 12; Rev. Rul. 82-54, 1982-1 C.B. 11; Rev. Rul. 81-225, 1981-2 C.B. 12, modified by Rev. Proc. 99-44, 1999-2 C.B. 598; Rev. Rul. 80-274, 1980-2 C.B. 27; Rev. Rul. 77-85, 1977-1 C.B. 12. See also *Webber v. Commissioner*, 144 T.C. No. 17 (2015); *Christoffersen v. United States*, 749 F.2d 513 (8th Cir. 1984).

<sup>4</sup> See *supra* note 2.

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## SUBCHAPTER L: CAN YOU BELIEVE IT? DEDUCTIBLE TAX RESERVES MIGHT BE GREATER FOR LIFE INSURANCE CONTRACTS THAT FLUNK I.R.C. § 7702 THAN FOR THOSE THAT DO NOT

By Peter H. Winslow

In my column in the last issue of *TAXING TIMES*, I pointed out that, despite contrary authority in Rev. Rul. 91-17,<sup>1</sup> the Internal Revenue Code<sup>2</sup> imposes no withholding and reporting obligations on the issuer of a failed contract that does not satisfy the definition of a life insurance contract under I.R.C. § 7702 even though the inside build-up on the contract in an amount specified in I.R.C. § 7702(g) is currently taxable to the policyholder. This column will now turn to the taxation of the issuer with respect to a failed contract. It may seem counterintuitive, but it is possible for a life insurance company to have a more favorable tax result if a contract flunks I.R.C. § 7702, *i.e.*, it may get a higher tax reserve deduction than if the contract qualified.

Statutory reserves for life insurance contracts generally are required to be recomputed for tax purposes. The recomputation of life insurance reserves under I.R.C. § 807(d) involves a three-step approach. An actuarial reserve is first computed on a contract-by-contract basis, and second, this reserve is compared to the net surrender value of the contract. The larger amount is the tax reserve, except—the third step—in no event can the amount of the tax reserve exceed the amount of the statutory reserves. “Statutory reserves” for this purpose generally refers to the aggregate amount of reserves for the contract which are set

forth in the company’s annual statement.<sup>3</sup>

To compute the actuarial reserve—the “federally prescribed reserve”—a company begins with its statutory reserve and modifies that reserve to take into account six adjustments: (1) the tax reserve method applicable to such contract; (2) the prevailing state assumed interest rate or the applicable federal interest rate (AFIR), whichever is larger; (3) the prevailing Commissioners standard tables for mortality or morbidity; (4) the elimination of any portion of the reserve attributable to net deferred and uncollected premiums; (5) the elimination of any portion of the reserve attributable to excess interest guaranteed beyond the end of the taxable year; and (6) the elimination of any deficiency reserves. Except for the federally prescribed adjustments, the methods and assumptions employed in computing the tax reserve should be consistent with those employed in computing the company’s statutory reserve.<sup>4</sup> These adjustments to federally prescribed reserves, particularly the requirement to use the AFIR discount rate, frequently result in the amount of deductible tax reserves being less than statutory reserves.

What happens when the contract fails to qualify under I.R.C. § 7702? The starting place in the analysis is that the tax reserve computation rules of I.R.C. § 807(d) do not apply. By its terms,

I.R.C. § 807(d) only applies to life insurance reserves, which, in turn, only are held with respect to life insurance, annuity or non-cancellable accident and health insurance contracts.<sup>5</sup> Because I.R.C. § 7702(a) provides that a life insurance contract under applicable law is a life insurance contract “[f]or purposes of this title” only if it satisfies the cash value accumulation test or guideline premium requirements, reserves held for failed contracts cannot be life insurance reserves subject to recomputation under I.R.C. § 807(d); I.R.C. § 807(d) is in the same title as I.R.C. § 7702—Title 26 of the United States Code.

If I.R.C. § 807(d) does not apply, what does? Section 7702, together with the legislative history, offer some guidance. Section 7702(g)(3) provides that if a failed life insurance contract is a life insurance contract under “applicable law,” *i.e.*, state or foreign insurance law, then the contract is nevertheless treated as an insurance contract—again, “for purposes of this title.” This means that the premiums are included in gross income under I.R.C. § 803(a)(1) and reserve items listed in I.R.C. § 807(c) are deductible. The legislative history explains that “[t]he investment portion of any life insurance contract which fails to meet the definition of a life insurance contract under section 7702 is treated as a reserve under section 807(c)(4).”<sup>6</sup> This reserve category includes amounts held at interest in connection with insurance contracts. Presumably, this means that a reserve equal to the contractual account value to which interest is added would be the reserve for the investment portion, *i.e.*, the cash value or account value whichever is applicable.

The legislative history is incomplete, however. The reference

is only to the reserve for the investment portion of the failed contract; it is silent with respect to the reserve for the net amount at risk—the insurance element. It seems that the portion of statutory reserves allocable to the insurance portion of the contract (*i.e.*, not the investment portion) should be treated just like any other pre-claim incidence non-life insurance reserves and be classified as an unearned premium reserve taken into account under I.R.C. § 807(c)(2) and subject to a 20 percent “haircut” reduction under I.R.C. § 807(e)(7).

This being the case, deductible tax reserves for failed life contracts might exceed what I.R.C. § 807(d) would otherwise permit for life insurance reserves. This would be so if the sum of the reserve for the investment portion of the contract (the I.R.C. § 807(c)(4) reserve) plus 80 percent of the statutory reserve for the net amount at risk (the I.R.C. § 807(c)(2) reserve) exceeds the amount of the statutory reserves adjusted for the six federally prescribed items described above that otherwise would apply. ■

### END NOTES

<sup>1</sup> 1991-1 C.B. 190, superseded in part, Rev. Proc. 2008-40, 2008-2 C.B. 151.

<sup>2</sup> I.R.C. § 6047(d), § 3405.

<sup>3</sup> I.R.C. § 807(d)(6).

<sup>4</sup> Joint Comm. on Taxation, JC5-41-84, General Explanation of the Revenue Provisions of the Deficit Reduction Act of 1984, at 599 (1984).

<sup>5</sup> I.R.C. § 807(c)(1), § 816(b).

<sup>6</sup> H.R. Rep. No. 98-432, pt. 2, at 1413 n.128 (1984).

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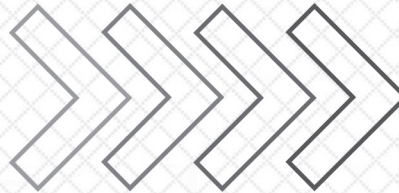
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