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It is 1998–Are Your Life Insurance Products Compliant with §7702/A?

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Summary: Expert panelists explore practical considerations of maintaining compliance with federal income tax definition of life insurance rules. Topics include:

- *The current status of IRS positions regarding unresolved §7702 and §7702A issues*
- *Practical company experience of §7702 and §7702A compliance*
- *§7702 and §7702A compliance within due diligence procedures of a merger or acquisition*

Mr. Larry N. Stern: I'm with the Indianapolis office of Tillinghast, and I will be the moderator for this session. We have three distinguished panelists this morning. They are John Adney, David Nunley, and Cherri Divin, whom I will introduce individually as we go through the presentations.

To get started, our first speaker is John Adney. To many of you, we hope he is not someone who is new to SOA meetings and discussions of this topic, but for those of you who have not known John in the past, I'll read his short biography. He's a partner in the Washington, D.C. law firm of Davis & Harmon. He received a BA

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Note: The charts referred to in the text can be located at the end of the manuscript.

from Millican University in 1972 and graduated from the Yale Law School in 1975. During 1977 through 1991, he became an expert on taxation issues with regard to life insurance products. He knows a lot about TEFRA, DEFRA, the Tax Reform Act, the Technical and Miscellaneous Revenue Act of 1988 (TAMRA), and the enactment of these special sections of the Internal Revenue Code (IRC). He has authored many articles on the subject, and we are very glad to have him here this morning. He will discuss current events in Washington that are still on the table regarding unresolved issues pertaining to §7702 and §7702A.

Mr. John T. Adney: We want to talk with you briefly about four topics:

- term insurance as an additional benefit and the effect of that under the statutes,
- extending the maturity date of life insurance contracts, a topic on which we often get questioned,
- a grave consideration—loss of grandfathering—and
- the proposed revenue procedure allowing the correction of inadvertent or accidental modified endowment contracts (MECs).

In the case of term insurance, it's a question of how long and whether term insurance, added by a rider, is a death benefit or a qualified additional benefit (QAB) under §7702 and §7702A. We want to go through briefly what the issue is, and IRS rulings given in 1995. We want to focus on Private Letter Ruling 9741046, and then finally talk about all the implications.

Here comes the first surprise. As you know, term insurance can be added to a life insurance contract by rider, and the term insurance can cover not only a spouse or a child, but also the primary insured under the policy. That is our issue today.

§7702's guideline premiums and net single premiums will differ, depending upon whether we're dealing with death benefits or QABs. Because the death benefits may be discounted at the guaranteed interest rate, a QAB (in that case, the present value of the charges) would be added into the guideline single premium or the net single premium. Also, the charges themselves can differ depending upon whether we're talking about a death benefit or a QAB. In the case of a death benefit, the discounting will be done using full 1980 CSO mortality and the safe harbor. Cherri will talk more about whether or not you should use that safe harbor or not.

In the case of a QAB, it may very well be that what we have are expense charges, if not mortality charges. So rather than using 1980 CSO mortality, the charge the company actually expects to impose, something like the current charge for the QAB would be the appropriate item to be used in determining the guideline premium or

net single premium. Hence, the issue that comes up is although we have term insurance on the primary insured, is this family term insurance QAB, which would attract the QAB treatment for the guideline premium or net single premium calculations, or is the term insurance on the primary insured a death benefit?

What has the Service said before? The Service has issued a couple of rulings under §7702/§7702A. All three rulings we will talk about in this segment were orchestrated by the ACLI committee that was looking at this question. The idea was to take several fact patterns into the Service to get a comprehensive set of private rulings. The private rulings are merely private rulings. They are not precedential guidance, but it's the best we ever do these days under §7702 or §7702A.

In the rulings, the Service said that the right answer under §7702A was that it was a death benefit and not a QAB. The rulings were specifically based on wording differences between §7702A and §7702, and that's critically important for this discussion. In those rulings, the Service felt that the statute would best be carried out by treating the term on the primary insured as a death benefit.

The rationale indicated that the term coverage may be a QAB under §7702, which is what got us to the next ruling. This ruling, 9741046, took the Service a while to get to. It dealt with the circumstance where a rider provided the term coverage. In that ruling, the Service held that, despite what it had said in the prior rulings, the term coverage should be treated as a death benefit rather than a QAB. Again, this is term coverage on the primary insured. One of the key facts was that the coverage, although provided by rider, helped level the death benefit. These were variable lifetime contracts that were involved. That was not necessary to the decision, but it was one of the elements. The idea was to provide the insured with a level death benefit, a target death benefit, so the term and the variable component would interact to level that amount, at least until the term was no longer necessary.

An essential fact in the ruling was the rider coverage was not going to end before age 95. As far as it was scheduled, it certainly could end. The policyholder could come in and change things. The insured could go off the rider, but the idea was that the term coverage, really the whole target death benefit, was scheduled together and would not lapse at least until age 95. That prompted the IRS to distinguish the term on the primary insured from a QAB, which the Service thought of more as coverage that would end before age 95. The ruling makes the point that term on the primary insured, like other family term, principally should be considered as a QAB. The legislative history under §101(f) has said so.

The Service wanted to hold out the QAB treatment as a key to the calculations under §7702 so as to preclude any unjustifiable increase in the investment

orientation that is in the net single premium or the guideline premium by application of the (e)(I)(c) rule. That's the rule that says the death benefit that is there at issue will be deemed to continue until maturity. The Service was basically saying if it's a death benefit, fine, it'll abide by that rule. That allows the full funding of the contract. But if it's more of a short-term benefit, it does not want to allow use of that rule, so we will use the QAB rule.

The Service basically said, we, the Service, haven't given you much guidance, and more particularly, it's very difficult to distinguish term coverage lasting at least until age 95 from a permanent contract death benefit. Based on that, the Service made the rulings that what we have is a death benefit and not a QAB.

What are the implications? First of all, I think this private ruling, like all private letter rulings, should be limited to its facts. If a company wants to pursue a fact pattern like this ruling, I think the company will be well advised to get its own private letter ruling paralleling this. I'm sure the Service, on similar facts, would be willing to give it again, but my watchword is that term coverage should be presumed QAB until it can be proved otherwise. While this ruling should not be relied on, I think the Service would replicate it on the same fact. It's essential to the Service that what you have is term coverage on the primary insured that is scheduled to go until at least age 95. That was the key determinant in this case.

Our next topic is extending the maturity date. Again, I guess the question is how long the insured will live. We want to talk about the background, what has caused changes, what the possibilities are for extending the maturity date, and what the tax results are.

As you all know, permanent insurance has been around a long time in both the endowment form and the whole life form. The endowment form has the maturity date that we have to deal with. The whole life form does not. Universal life (UL) in particular from its earliest stages adopted the endowment form, endowment at age 95 or endowment at an age before 95. This predated the enactment of §7702. Since §7702 took effect at the beginning of 1985, the typical endowment date has been age 95, where an endowment form is used.

What's changed? Why are we worried today about extending maturity dates? Insureds started living longer. I understand there's another program here that will talk about people living to age 120 or even age 150. If that gets serious, we may need to go back and talk to Congress about that. Estate planners began worrying about things around the margin, which was, in particular, the income tax due when the endowment endows at age 95. So interest arose in various plans and schemes

to defer the maturity date that was in the contract form that people had already purchased.

What can you do about that? There were several possibilities:

- One would be, today go out and endorse the contract; delay the maturity date, maybe picking age 99, 100, or 105; or do something to defer or possibly obliterate the maturity date on the thesis that maybe that will help with the tax problem and push off the date in fact until beyond the death of the insured.
- Another possibility would be to add that endorsement, but don't do anything now, wait until you need it, maybe when the insured is age 94.
- Yet another possibility would be to exchange the contract for one with no maturity date, a whole life contract, or a UL contract that does not have an endowment date.
- Ignore the whole thing. Maybe you want to ignore it on the grounds that very few people will ever have to deal with this problem. (I understand from a marketing standpoint and when estate planners and lawyers are talking to marketers about things, you can't always follow this path).

Why are we concerned about all of this, and what does it mean to extend the maturity date? I'm approaching this one principally with a set of questions. I think that's important. The idea, with the endowment at age 95, is that tax will be due on all the income from the contract at age 95 when the contract endows. That will be due by constructive receipt, whether the amounts were taken in cash or not. The idea of adding the extension of the maturity date endorsement is we can push off that date and avoid the tax implication.

If the endorsement is well drafted, one probably can push maturity off for a while, but then the next question is, how do we really delay it beyond age 100? At age 100, the 1980 CSO table says everyone is dead, all of the amounts by then should have been paid. What do we really have if we have a life insurance contract that endows at, say, age 105? Have we avoided constructive receipts at age 100? I think that's a very serious question.

It's not at all clear to me that that would be the case. In many contracts, and indeed under the mandate of many states, there cannot be a net amount of risk in the contract after age 100. Some states differ on that, but some states say no, you will not have a net amount of risk. Your cash surrender value will equal your death benefit. If that is the case, have we really avoided an endowment event? I think that's a serious question.

I wonder just how tax-effective these endorsements really are. But then I fall back and ask, “who should really argue this case?” If the IRS decides that someone living to age 100 owes tax at that point, I think it has as much a political problem as we have a technical problem. I've suggested that the ACLI should never argue this case. The American Association of Retired Persons should argue this case if it ever comes up. I think our job is to simply position ourselves so that they'll have a chance to do that. I suspect the IRS knows that if they tried to collect tax on centenarians simply because they got there, Congress would not look upon that favorably, and we probably would see a change in the law.

This is a strategic question. It's a matter of positioning, and we want to put ourselves in the best situation. In particular, we don't want to be in a tax-reporting position. That's the whole idea of extending the maturity date. We don't want to put the companies in the position of having to file the 1099Rs under §6047(d) of the IRC.

I think where we want to wind up with all this is not certain. I don't think you can really give people certainty that if you extend the date beyond age 100 they won't be taxed. What you want to do is provide yourself with an appropriate basis for reporting, or, in this case, not reporting until the delayed endowment date is reached; then sit back and wait and see what happens. If you add the endorsement, will we have §7702(f7) material changes or adjustments? Probably.

In the case of a new age 95 contract, age 95 should be used as the endowment date. If we then delay it to age 100 or beyond, or obliterate it altogether, we should be using age 100 as that date. This is an adjustment event. I think it's more of a technical item than anything else, and we probably also have a material change under §7702A, so that at the age of 95 or 96, we're having to do the rollover calculations and trying to find out what the future paid premium is. It probably shouldn't matter at that point anyway.

An endorsement could lead to a loss of grandfathering. We will talk more about that in a moment, but that is, I think, a critical point. Adding the endorsement is probably a material change in the broader sense of the tax law as we will define that, so if a contract that is being endorsed is living under various grandfather rules, §101(f) or §7702, it is important to watch that.

Finally, regarding an exchange of contract—if that's the way we're going to go about extending the date—give them a contract (§1035 exchange) that has no maturity date or a delayed date from the one they have. That clearly will lose grandfathering.

Generally speaking, that shouldn't be a big problem. I would hope the new contract they're given is fully §7702 compliant, but the new contract now will pick up the MEC rules. Again, that should not be a large problem, but it's a technical one to watch out for.

Loss of grandfathering is one of the major topics that I think will be emerging and that this whole industry needs to pay close attention to.

What I want to do is take you through a brief teaching session, if you haven't heard it before, on what we mean by a material change and a loss of grandfathering. I want to note the specific problems under the legislation in the 1980s, what changes can lose grandfathering, and the current status of the whole issue.

What is the principle of a material change? Under the tax law, an exchange or disposition or major change in property can give rise to a taxable event. That's what §1001 is all about. This is the provision that's typically associated with capital gains treatment, although that's clearly not the case for life insurance. The specific rule as enunciated several times by the Supreme Court is that if it changes entitlement to property, it is a material change (not in the sense of §7702(a)(c3), which is just a subspecies of this.

In the broader sense of the tax law, a material change is a deemed exchange for tax purposes. Let's focus on that change of entitlement to property. Specifically, an exchange within the meaning of §1001 normally will trigger tax on property; it will trigger a new date of acquisition for the property; it will forfeit grandfathering; hence, any new statutory rules that came about after the first acquisition of the property, where the old ones were grandfathered, will now fly. Taxation in our case may very well be deferred. We have the nonrecognition rule under §1035 for the deemed exchange of insurance contract.

Other kinds of property have lifetime exchange rules, which will also defer taxing. The main point is that when we have the material change, whether or not we have triggered tax, we can very well forfeit grandfathering and pick up new statutory rules. We have a lot of opportunity to do that in the insurance business.

Congress is very busy, as you know, aided and abetted by many of the people in this room in first enacting §101(f) in 1982. That applies to contracts issued before 1985 that are flexible-premium in nature. The 1984 law brought us §7702 in its original incarnation, and that applies to contracts issued after 1984. The key thing to watch out for in all these phrases is “issued before” and “issued after” because that's what we're talking about here. Under §7702A, the MEC rules will apply to contracts entered into or issued after June 20, 1988. We also have the TAMRA

amendments, the reasonable mortality and expense rules of §7702, that apply to contracts entered into after October 1988.

The question is, do material changes that are deemed exchanges under §1001, these changes of entitlement to property, create new dates on which contracts will be considered issued or entered into for purposes of those various rules? Will we flip from a contract that was a §101(f) contract into a post-TAMRA §7702 contract, and if we do, because of the material change that was made, how are we going to have that contract comply with post-TAMRA §7702?

What kinds of changes could give rise to this? The easy one is an actual exchange, whether §1035 covers it or not. If we are swapping pieces of paper with the policyholder, we know we have a new contract. Normally you lose all grandfathering under the tax law, and the result of all of that is you'll pick up whatever new statutory rules applying for contracts issued on the date of that exchange.

It's a bit more slippery to deal with changes in guaranteed terms, but those do go on. Interest rate guarantees can change. Charges can change. Benefits can change. Generally speaking, those are changes in entitlements that are deemed exchanges and material changes under §1001 that would cause the contract to pick up new rules.

The good news is that if the policyholder has an option under a contract to make a change, the policyholder can walk into the company and say, "I demand you increase my death benefit; my contract gives me the right to demand that," and the company does it. Under normal material change rules that is not a material change; it's merely carrying out the term preexisting in the contract. The situation gets a little dicier perhaps if the company can demand underwriting, which normally companies can in death benefit increase changes, that is changes in options of death benefit option one to option two. It may be more clear-cut that those are unilateral rights of the policyholder.

I would suggest that even a right of the company to demand evidence of insurability, as long as it's constrained by a rule of reasonableness and the construction of the contract, probably is not enough to convert this from carrying out the terms of the contract into a material change. Generally speaking, I would expect execution of preexisting options in the policy not to give rise to material changes. Execution of options by the insurer—the right to declare excess interest—would make one hope that that would not be a material change, but even this has been debated. This is a bit of a minefield, and we are constantly meeting ourselves

coming around the corner and arguing with the IRS about whether we have a material change or not.

If you want more information on what Congress has said regarding material changes, the 1984 legislative history under §7702 spells that out in some depth. So does IRS Notice 88128, giving the 1980 CSO safe harbor. The TAMRA transition rules for §7702A went to great lengths to spell out what would and what would not be a change that would attract the new statute.

Given this and the potentially scary nature of it, what's the current status? This is a highly controversial subject. Compliance difficulties are potentially gray. The government warned in proposed long-term care regulations in 1997 that as far as the IRS and the Treasury are concerned this is a live question. Material changes in contracts and the government's view generally should pick up the new statutory rules. There's a gray question there in many instances whether the new rules apply and grandfathering has been lost. The industry has various arguments and theories, one of which is the statutes have their own adjustment rules, so why should we ever forfeit grandfathering? We don't know what the courts will say. Some day it may come to that, and, indeed, I think we will see a good deal more on this subject.

I want to move on to something that I believe you will be hearing much more about in the near future, at least I hope so, and that is correcting inadvertent MECs. We want to talk about what the problem is, which I think many of you are familiar with, the proposed solution and its details, and when we may see some relief.

The problem in brief is §7702A is a bit complex, and the IRS has told us very little about it. The early-day systems were poor. I think we're still in the early days. People have learned more over time. Innocence has been lost, and as a result, people have become more concerned. In particular, as newer systems are installed, more and more MECs are cropping up and people are wondering what to do about the challenge this presents, not only with the IRS, but with the policyholders.

What are we going to do about all of this? As I think many of you also know, it's a comparable area to qualified pension plans and the like. The IRS has provided relief programs, such as the voluntary correction resolution (VCR) program and the like. VCR is a set of initials often connected to what we're talking about here. The industry has proposed something like a VCR program for §7702A. Because we don't have the waiver authority under §7702A as we do with §7702, the government agreed years ago to do this.

On the 1998 business plan, dealing with this kind of a correction program is one of the top priorities of the government. That's the good news. The bad news is we're

not in the best position to negotiate all of this. As you can well imagine, we have our hat in our hand as we cross the street to the Treasury Department saying please help us.

What we're probably going to wind up with is a revenue procedure that is an official announcement in the Internal Revenue bulletin that spells out what a taxpayer or the insurer must do to obtain relief. Specifically, the IRS is supposed to enter into a closing agreement with the insurer or the policyholder. It's a contract saying that if the insurer does certain things, the IRS will do certain things. Under the proposed revenue procedure, proposed in the sense of discussions between the industry and the government, the insurer would return excess premiums and earnings to the policyholder; it would pay tax based on prior distribution, plus the excess earnings. The IRS would treat the contract as non-MEC once the corrections were made and the taxes have been paid.

What do I mean by an excess premium that must be returned? It would be those premiums that are credited to a contract over the then cumulative pay limit, and, of course, the amount of the excess will change over time. You may very well have a contract that has an excess at one point and then the next year does not.

The earnings subject to tax will probably be calculated based on what the revenue procedure says to use. That's what's been holding up this whole procedure, determining what that proxy rate should be. Some companies have offered to do exact calculations. The Treasury said no, that would be too difficult, in particular, for the IRS, so they are looking at a proxy rate and maybe also the idea of a haircut, which is to not cause people to have to pay tax on the full amount of what would otherwise be the excess income. That's an ameliorative rule, and the idea is that because many contracts will not have longer distributions on them, the government would be collecting too much tax from the insurers if it wanted tax on the whole amount. We'll see whether there is a haircut.

Finally, the tax rate will probably be 28%, and the likely exclusions will be corporate-owned life insurance (COLI), maybe including split dollar, which is a problem for us, but as you know, the Service has a bit of a war going with many on leveraged COLI. For that reason, they do not want COLI near this revenue procedure. Other exclusions include things that are called egregious cases. I don't know what egregious cases are. The bad news is that this revenue procedure was supposed to come out two years ago. We're still working on it. Much has been done. The government has invested a lot of time, which leaves me to believe that maybe we’ll see it by year-end 1998. If not, then the first quarter of 1999. I don't think they'll walk away from it at this point.

Where will we go from here? If and when we get the §7702A correction to various programs, we'll go back to industry requests that said §7702A was merely the initial target. Our other targets are amelioration of the rules under §7702, §72(s17)(h) as far as correcting failures is concerned. How contentious will the next step be? I suggest we have an uphill battle. We'll just have to stay tuned, but I want you to know that the ACLI and other people like me are trying very hard to make this a success, and I hope we will.

Mr. Stern: Our next speaker is David Nunley. He is vice president of tax for American General Life Insurance Companies. He has been with American General since November 1994. His current responsibilities include overseeing of tax compliance and tax planning functions for the American General Life Companies, which is a division of the American General Financial Group. In that capacity he also serves as cochair of the Section Product Compliance Task Force. Prior to joining American General in 1994, David was senior tax manager at KPMG. His part of the discussion will deal with the practical company experience of §7702 and §7702A compliance.

Mr. K. David Nunley: We will spend a few minutes talking about the waiver process, which is a big part of my role at the American General group as far as §7702 is concerned. One of the most difficult things that we have to deal with from a tax standpoint is what to do if we have failed contracts. Do you get a waiver? Sometimes that's good and sometimes it's not. I will talk a little bit about what you hear from the IRS, and what your tax people are getting from the IRS when they question §7702. There is a question that the IRS agents will present to your tax people.

I'll spend a few minutes discussing the procedure. How do you go about getting a §7702 waiver? Who is getting the waivers? What type of errors qualify for the waivers? What happens if you don't get it? You'll discover as we go through this process that it's certainly not automatic. What do you do? What's the next step?

This is the question that tax people get in reference to the information document request (IDR). The agent will say this: "Please state if any insurance contract failed to pass the requirements of §7702 of the IRC. If so, please explain."

Very simple, very direct, and, for the most part, very worthless. I think it's probably indicative of the fact that the IRS, the people giving the waiver request, and the agents do not have a lot of expertise and don't really understand the inherent complexities of a half-million contracts. Now, they do understand the law, they understand §7702, or at least some of them do, but they don't understand the

mechanics of the day-to-day testing process, and that creates an uphill battle for us. That hopefully will change over time, but it's going to take time to get there.

Here's what I call the "flip-the-switch" mentality. When they come in and look at this process, they treat it as if it's a very simple process, but you have to flip the switch. If your switch is flipped on, everything's getting tested and you have no failures; you have nothing that can fall through the cracks. If you have it flipped off, you're going to have problems.

Do you have it flipped on or do you have it flipped off? It's really not that simple. Those of you who deal with §7702 know that it's not that simple at all. There are many complexities involved in day-to-day testing that create failure. There's not much we can do about them; they just happen. That's a hard sale for the IRS. We have Code sections, which are a little bit short on details. We have committee reports, which are probably a good indicator of what Congress was thinking when they passed the act years ago. We have a very limited number of cases, and we have a very limited number of rulings. They only give us the top of information that we need to determine what is a good, fair contract that would qualify for labor. It's just not out there yet.

I'm on several different committees and several different task forces for mostly tax director people. We talk about different types of failures, what's going on in our companies and how we resolve these issues.

As you go through this process, there's always one new guy, one tax drafter, and it has happened several times since I've started this process, who says, "I've have the perfect answer. Why are we going through all this stuff, we don't really need to do this. Let me tell you what I do. I tell my actuaries that if they see failed contracts or something that's going to create a failed contract, don't tell me about it. I don't want to hear it. Don't even let me know. So when the agent comes, I can tell him I am not aware of any failed contracts."

§7702(f)(8) is the section that allows us to get a waiver. Let me read the language to you. §7702(f)(8), correction of errors: "The taxpayer establishes to the satisfaction of the Secretary (that's the secretary of the Treasury) that the requirements were not satisfied due to reasonable error, and reasonable steps are being taken to remedy the error."

Reasonable is the key word here. The Code told us that we could get waivers. We have a statutory right to get a waiver of these contracts as long as it's reasonable. The problem is they didn't define reasonable. Who determines what a reasonable

error is? The IRS determines it. It's determined by a group of individuals who are giving waivers. It's very subjective, and it's a very narrow definition.

The testing process that you are going through whenever you're asked to look at a particular contract for a waiver provision is done on a contract-by-contract basis. It's not done in general terms.

The process for filing a waiver is like any other ruling request. There's documentation, a revenue procedure that the Treasury releases the first part of each year. It tells you what to attach and what kind of documents to put on there. They require you to re-create the scenario as exactly why that particular contract went out of compliance, right down to the individual who didn't catch it. If the system didn't catch it, then who messed up and didn't make it work? It's those types of details that are very time consuming and require a very significant use of resources to get there, but that's the situation that we've been put into.

It's bad enough if you're trying to re-create these data from this contract file if it happened last month, last year, or even two years ago. It's very difficult if it happened eight or ten years ago. One of the biggest problems out there now is an assumption reinsurance contract. You may not have that file there to re-create why and when exactly it went out of compliance, and you see a lot of that in assumption reinsurance contracts dealing with a sold company.

You may absorb a number of contracts from a company that went out of existence, assume all of its contracts, and, when you clean them up, find out they were in violation when you brought them over. Now you have to re-create exactly what happened, when it went out of compliance maybe ten years ago with the other insurance company. You get no credits for that. The Service is very clear. If you cannot tell exactly why it went out of compliance, whether you had anything to do with it or not or whether you have contracts, now it's your problem and if you can't tell the IRS the information, the data, as to exactly why it went out, tough luck. You have to be careful to make sure you do it right when you assume those contracts.

The Service has this file-and-wait procedure that they use for these things. Typically, when you file a ruling request, it will take time to put it together. You file it with the Service and you may hear back from them in about six months, if you're lucky. You will get something back from the Service that says, "We don't understand this and this and this, we need all this information, these data, etc. You have 21 days to respond." If you're lucky, sometimes they'll give you a 31-day extension. You hurry up, you get your resources together, you pull all of your administrative people off; you put everything together and try to redo what they're asking for—to re-create. You give them the data and get it to them in the 21 days

and they sit on it for another 6 months to a year. It's a very common problem. Many companies have started waiver processes two or two-and-a-half years ago and they're still going through this file-and-wait process. It's like the ten-day, six-month rule.

Who is getting waivers? The IRS has a motto that's very simple. "The only good error is a human error." Sometimes you hear the words "clerical error" used interchangeably. If there is any indication that you have something faulty in your system that your system should have caught, the Service will deny it. If the facts surrounding that contract are not very clear, the Service will deny it. Keep in mind these are not business people making the waiver decisions. Although they're very technically competent regarding the tax law, they don't understand administration systems. If they don't understand why that would happen, why it's going to end up complying, they'll deny it.

You would think the fact that the number of contracts that failed relative to your total contracts is insignificant. That would be a positive factor. That would have a bearing on getting your waiver. It really doesn't. If you're 99.99% compliant, then that .01% contracts still have to stand on their own, and they have to be deemed reasonable by individuals at the national Washington tax office. They have to be deemed to be reasonable irrespective of the fact that 99.99% ought to be reasonable. They don't look at that big picture. It's really not a factor in the decision process.

We have a similar ruling problem in the tax reserve calculation process called 9471. You might hear the tax reserve actuaries talk about that. That is a similar situation. The Service came out with a ruling in 1994 that said when you have a change in your calculation of tax reserves, what is the change in basis versus the correction of an error? They so narrowly defined what is a correction of an error, which has different treatment than a change in basis, that they simply said the only thing that is a correction of an error is, in fact, a mathematical error. That is the only thing that qualifies.

Twenty years ago when people were doing tax reserves with pencils and big tablets, we had many mathematical errors. That's not the case anymore. How often do you have a pure mathematical error in computation of tax reserves that is unrelated to the software or the system that you're using to compute them? That's the problem we're dealing with. This is the same type of thought process.

Let's talk about what happens if you don't get this waiver denied. What's the next step? We've seen situations in these groups. This is an actual history that occurred

probably two months ago with a group and part of our task force, another insurance company here in this country. They went through the same process for two years. They filed these things that had to be due in 21 days; they waited for 6 months, etc. This went on for about two years. In February, after sitting on it for nine months, the Service sent them a letter that said, "We don't understand this information, we need all of these data. We want much more information, many more examples, etc., and you have 21 days to respond."

The taxpayer wrote back and said, "We can't do that, we're doing reserves, we need another 30 days. We'd love to give you the information, but we just can't extract those kind of data right now; we don't have the people to do it." What do you think the Service said? They came back and said extension denied, waiver denied, case closed. They pulled the plug on it and they have the right to do that any time they want. They shut it down and said you've lost your waiver, we're through. So trying again may or may not be a good deal. If you have the resources with people with nothing to do, maybe you can do it, but for most companies it's going to be a tough process to get there.

The second one was a closing agreement. The Service likes a closing agreement. We're not very sure exactly what closing agreements entail because closing agreements are not necessarily released for public information. We think if you agree to a closing agreement with the Service, you will agree to pay all of the taxes that the policyholder would have paid had that all been taxable back to the date of issue, i.e., savings account and interest. You'll pick up all of the taxes and interest, and they'll waive the penalties. Then they'll send you back a letter that kind of pretends they're waiving the problems for you. That's the closing agreement, and many companies are starting to think about them.

The last one is to do nothing. You go through the process, and they deny your waiver. You don't want to enter into a closing agreement because it's a big number amount. You don't want to pay the taxes; you don't want to do anything.

Probably what the Service would do, and this is another thing that's sort of unclear, is come in and attempt to hit the maximum 1099 penalties that they can for failure to file 1099s. Keep in mind these should have been taxable back to the date of issue because they're failed back to the date of issue. Who knows what that is. The maximum penalties change all the time. They're going to try to get you with 1099s. Worse than that, they're going to probably come in and attempt to require you to disclose policyholder Social Security numbers so they can go after the policyholder to recover the taxes from them. Now, you can imagine the relationship with your policyholders when the IRS agent knocks on the door and says, "So and so insurance company gave me your Social Security number and we're going to do an

audit and we're going to assess your penalties and interest," etc. It creates a major problem and the Service knows this. That's why most taxpayers have to grudgingly go into the closing agreement if they can't get their waiver. It puts them in that kind of a position.

Until we continue to educate the IRS on these administration systems and let them understand the complexities of what we're dealing with, it's always going to be an uphill battle for us. On that note, I'm going to turn it over to Cherri.

Mr. Stern: Our last speaker is Cherri Divin, who is a senior manager with KPMG Actuarial Services Group. While at KPMG, she has worked extensively with due diligence related to the taxation of life and annuity products. She has more than 20 years of experience in product development and often consults on product taxation issues related to new products. Her topic this morning will be compliance with §7702 and §7702A within due diligence procedures of a merger or acquisition.

Ms. Cherri R. Divin: I will talk about the hands-on part of the business. I think we've had a very good discussion on the theory behind it and what's going on as far as the interpretations. Now we will discuss the nuts and bolts of the issue and how to handle due diligence in mergers and acquisitions. We will also talk about the interpretation to be taken in going through the due diligence process and how that interpretation may vary by what you're actually doing at the time. This can be a very big part of the whole due diligence effort in §7702 and §7702A issues. From time to time, I'm sure there have been people in the audience who found that occasionally this becomes a real toe stubber in an acquisition and may slow the whole process down or eliminate it.

One thing that comes up when people talk about their interpretations of the Code is basically whether there are any audits going on right now. We don't know of any actual instance where the Service has come in and performed an audit themselves or an insurance company as David referred to. There is an IDR and the questions sometimes vary. These are very similar to the ones that David mentioned earlier. If you have a compliance system, describe the system. Do you know of any failed policies? These sound like easy, short questions but they're really not. They're pretty difficult questions that may take time.

The first step when you're starting due diligence is to understand your company's interpretation of the Code. I think John pointed out to you there are many areas that are gray and ambiguous, so each company has their own interpretation of what their standards are and how aggressive or not aggressive they want to be in certain situations.

Once you understand where you are in your current in-force block and where you are in new sales, you need to go ahead and think about due diligence. Should you decide to take these same interpretations and these same standards that you use on your in-force block and apply those in due diligence? You may be making a mistake.

On your own in-force blocks, you may take a more or less aggressive approach on interpretation of the Code. For example, if you stumbled across a portion of your in-force block that you weren't aware of and you found a mistake, you may be willing to take a fairly aggressive position as far as defining that policy as a life insurance policy. However, in a due diligence process when you look at an acquisition, you may not want to do that. You may not want to take that same standard or impose that same standard; you may want to take a more or less aggressive approach. You need to think a lot about the gray issue.

When we look at due diligence, one good way to do it is when you look at your interpretation, you can group the policies into three areas: policies that have clearly passed, the good guys; policies that have clearly failed, the bad guys; and then this big, wide spectrum in between, the gray area. When you look at a block of business, you'll have many policies that fall into the gray area, or many processes that fall into the gray area. That's where you want to understand that you need to raise the red flag—these are concerns, but they may or may not pass or fail as you take a position on those.

I'm going to focus a lot on these gray areas. They're areas that you want to look at to see whether you want to change your interpretation. When you look at your interpretation of the Code, there are several areas you need to look at. You need to look at where you are today as far as the products that you're selling. How do you interpret the Code for those? What are your procedures right now for your current in force, any enhancements you've had and how you handled those, and any of your illustrated policy values? You need to look at all of those.

I'm going to provide a very brief overview on the actual steps you would take when looking at policies. The first step is knowing the actual Code sections that are relevant. As far as the definition of life insurance, that's the first one I'm going to address. You have §101(f) and §7702.

§7702 basically has two methods of compliance. One is the cash value accumulation test, and that's a compliance by design. When a policy is issued on a cash value accumulation test basis, if there is any theoretical way those policies could fail at any point in time, the policy is deemed to have failed at issue. That's a

compliance by design and if you have policies that you're looking at, you need to make sure that the policies will comply in all situations.

The other test is the guideline premium and cash value corridor test, and it's typically used for flexible premium plans. In that, you calculate guideline premiums—the guideline level and the guideline single premiums. These premiums are based primarily on your interest and mortality. Those are functions that you're very familiar with, those calculations, and you can determine the interest rate and mortality standards that you expect.

You need to be very careful. Way back when we first started doing the calculations, many companies used their maximum expense load. The Code clearly says that the expense loads are to be based on those expected to be paid. When you calculate the guideline single premium, you need to check all of the policy forms to see whether there's a difference between current and guaranteed loads, and you might find some violations there that you need to be aware of. Those typically go across broad product lines. If you have a company that doesn't recognize the current versus the guaranteed loads, you may find some very wide exposure there.

Regarding riders and benefits, some riders, for example, a spouse rider, would have current charges that are much lower than 1980 CSO guarantees. As John pointed out earlier, some of the term riders, on the base insured, will be based on 1980 CSO and some are QABs and will not be. You need to watch that carefully if you stand through the in force on a due diligence process.

The cash value corridor test is usually quite easy. It's one of the easier tests that we ever perform. What I'd watch for carefully is when you look at the older policies, the policies issued in the early 1980s, you'll see that some of them were issued before TEFRA and they would, for example, have a corridor of $1,000. This would be your net amount at risk at all times or the minimum. You need to go back and make sure those policies actually have a true TEFRA or DEFRA corridor in them.

The other place you're going to be watching is §7702A. Basically you're looking for MECs on a due diligence process. You want to be sure that the MECs are identified. If they're not, you may be missing some 1099 reporting, which could be very costly. You want to make sure that those are identified correctly. There are a couple areas I would watch for on that. One is a reduction in benefits, and you know that if you have a reduction in benefits during the testing period, you need to go back and recalculate MEC seven-pay premiums at that level during the entire policy.

On MEC testing, many questions you have can be identified or answered simply by looking at the fields on the system. Are they able to go back and look at seven years of historical data? Is the amount paid calculated correctly? Many systems calculate the premiums paid on the §7702 very accurately, but the amount paid is applied differently for §7702A. In other words, whenever you've started with a seven-year period, your amount paid goes with that period. You have to make sure that those fields are on the systems or that the manual processes recognize those. Those are very difficult for many systems to handle.

The other one I would watch for is policies that have a cost of living adjustment (COLA). We know the Code tells us an increase in death benefits is considered a material change, subject to the necessary premium rules. But there's a section in there also that says COLAs would not be a material change to the extent provided by regulations. That's the kicker on that one. If no regulations were passed, for the policies out there that have the COLA, when the adjustment actually takes place, the increase would generally be considered a material change. I would guess that would not be uncommon for companies to recognize, because you'd also have a series of material changes, which are very difficult to handle on a system typically.

Those are basically the nuts and bolts of what I would go through from due diligence and what I would watch for. I will talk a little bit about the systems you look at. We typically look at homegrown systems, and sometimes I would want to look at those more closely than I would a vendor system, but you need to be careful when you do that, especially if you find errors and you need to file for a waiver.

There are two private letter rulings out there. One of them was on a homegrown system and it got a favorable ruling. It was considered a reasonable violation. The error on the vendor system was kind of surprising. The system had problems dealing with dump-in monies and reductions in face amounts. The waiver was not granted because the Service said the company failed its obligation to check out the system. Even vendor systems can have problems. You know most of them are modified a lot or maybe they don't have the correct versions—they're not up to date, so there are many problems with vendor systems. These two private letter rulings almost imply that you definitely have an obligation to check out vendor systems, but if it's a homegrown system it's almost like the same obligation wasn't there.

Dave talked about human errors or clerical errors. If you are looking at a block and you want to tell whether you have a likely chance of getting a waiver on a particular error, you need to have a system in place. You need to prove your compliance system. There's another private letter that came out this year, it's the 9833033. It's different in that it was a favorable ruling that was more of an interpretation error,

and that's something unusual and a little bit new to us. Keep in mind a private letter ruling does not set precedence, so you need to look at the facts of each case.

The reasonable mortality charge is one I think you need to look at very carefully. I think you will stumble across that on almost all blocks that you look at in life insurance and annuities. There are two sections you can rely on. §7702 talks about reasonable mortality charges to be used in the calculations of the guideline premiums. It goes across the board to all types of the tests being performed.

What are reasonable mortality charges for substandard business? What do you use in the calculations? Most companies have their guarantees based on 1980 CSO and their guarantees for substandard policies are based on a multiple of 1980 CSO, a very common situation. The question is when you calculate guidelines, what do you rely on—the multiple or the base guarantee? §7702(c) says mortality charges that meet the requirements of the regulations and that do not exceed the mortality charges are applicable. This is for policies issued after October 20, 1988. But this really does not define substandard mortality; it does not address them and is too vague.

There was a notice that came out, 9888128. It directs the Treasury to issue regulations in regard to substandards; however, no regulations were finalized on this issue. So it is not a clear case. You can't put it in your clearly passed or clearly failed buckets; it's going to be in the gray area. It does say that the mortality charges are considered reasonable charges if they do not differ materially from the charges actually expected to be imposed, taking into account any underlying characteristics of the individual of which the company is aware. It also says that 100% of the 1980 CSO is a safe harbor with certain additions.

The question is, what does that mean, the phrase “differ materially”? Is it materially different from the charges actually expected to be imposed? How do you measure that? Do you measure it by the investment-related performance of the actual cash surrender value, or do you measure it by comparing current cost of insurance (COI) to the guaranteed COIs? How is it measured? That's a gray area. Your company needs to take a stand on how you want to interpret that as far as what to do in your own block, what to do on new issues, and what to do on acquisitions. Consistency is always best.

There is further definition on this. In 1991, there were proposed regulations on the reasonable mortality charges. It doesn't have the force of effective law as the other two items I mentioned. It's guidance, but if you're in a situation where you have a failed policy, it really doesn't have the force of law; it is very specific. It talks about

using the greater of your charges actually expected to be imposed, the current charges, or 100% of the 1980 CSO safe harbor. It's fairly clear on that. In other words, it appears that the multiple of the safe harbor would not be appropriate based on this proposed regulation. However, based on the other two items I mentioned, it's not clear how it stands.

I think it leaves you with the question of which assumptions you want to choose. If you find a block where all the substandard policies have used multiples, you can look at that very carefully and see whether you really want to take that aggressive an interpretation. You may or may not want to do that.

I'm going to discuss company enhancements. I think we addressed that quite well this morning. I want to point out that they're very difficult to identify. They're difficult on due diligence. They're even difficult when you're in the home office and a retention program is in place. They may not hit the radar screen for the tax people until they're almost 90% done.

If you want to find those enhancements on due diligence assignments, typically what you have is the policy form itself, but you need to ask for more than that. You need to get the policy form, the sales literature, any kind of communication from your major policyholder, and the illustrations, because much of this will be disclosed on the illustrations.

This is an example of the guarantee. Say you had a current interest bonus and five years down the road it was guaranteed, or maybe it was not in the policy form as a guarantee but it was guaranteed on the illustrations. These would affect your calculations. You can see the effect of that. If you increase the interest rates, you may reduce your guideline premium requirement. The policy could fall out of compliance. In an attempt to bring the policy back into compliance, you could add benefits that really aren't QABs; they're non-QABs. These wouldn't have a one-to-one relationship between the cost of the rider and the change in the guideline premium. You could actually cause a material change.

I'm going to skip over recapture ceilings. I think we all know that's a very complicated calculation. It's very difficult to administer, and it's not uncommon to have those recaptured ceilings created.

I'm also going to skip over to the private letter ruling. I want to point out to you, as you try to decide whether a policy or a rider or benefit is a QAB or not, the difference whether you base calculations based on your safe harbor or current charges is very important. I think there are many companies that might be using the

safe harbor on quite a few riders. You want to look at that very carefully and decide what kind of interpretation you want to make.

In summary, I want to say that you really need to take a look at where you stand in your interpretation of the Code. You really need to think about how you want to interpret the Code for something that you're buying that you don't have already. It may be different and recognize those standards are different and communicate those to your management. Last of all, be sure as you're going through the due diligence process that you put protective language in any agreement you have, so if your company does assume these risks, you're not endangered by that.

Mr. Thomas T. Lonergran: I'm from CIGNA. Now that interest rates have fallen and long-term rates on Treasury bonds are below 5%, is there movement to use the lower interest rates in calculating guideline premiums and cash value accumulation testing and that sort of thing?

Mr. Adney: I think heretofore the industry has been very hesitant to even talk with Congress about changing §7702 and any of its fundamental structures. It's a major political undertaking to do that, and I think there's a lot of concern that the Treasury Department, if it had to redo §7702 today, would not come up with §7702 as we've come to know it.

The reason is that the Treasury that put §7702 together in the 1980s was very much in favor of a consumption tax system. While I think you have many more in Congress today who are in favor of that, that is not currently the situation in the Treasury Department. Any effort to reopen §7702 on a fundamental point such as the interest rate is one that would bring a good deal of political risk along with it. That's not to say that we don't have to face up to this.

If we are into a long-term interest environment of rates lower than 4%, the §7702 statutory minimum, we probably will need to go back and look at that. What I would suggest to all companies is to take a careful look inside the company about what you think; what sorts of political and other risks you're willing to put up with; what sort of energy you're willing to expend in Washington; and then bring all of those thoughts to the ACLI, to other Washington representatives or groups that you associate with, and begin to have that discussion.

What we will need to do is get the Treasury and the Congress comfortable that a change in the interest rate, a lowering of the interest rate, will not result in greater investment orientation of life insurance contracts. We'll need to make a very strong showing. It will be, at least in the Clinton Treasury, a very difficult group to

convince of that, but if it's going to be a long-term trend, it certainly is one that we need to pay attention to.

Right now, Tom, I don't think there is any official discussion like that going on. I've heard several people mention it and then immediately shy away of it, just at the thought and the magnitude of the operation.

Mr. Stern: For those of you in companies that are anticipating development of UL products with interest rates below 4% of guarantee, we've assisted a number of client companies in that effort and they have run into some difficulty in getting state approval.

You would think the states would say, "We're going to limit the surrender charges to be whatever the maximum expense allowance would be for the contract based on the guarantees. The time period would be how long the 4% guideline annual premium will provide coverage for when accumulated at 3%. So if it's not whole life, it might be term to 90 or term to 85."

Some states have not taken that position. These states have said, "We're concerned by you calling this a whole life contract that you cannot charge a premium that will endow the contract to age 100," and they disapproved the contract flat out. That is something to be considered when you're doing a product development effort. The only way you can get around it in those states is to use a cash value accumulation test.

Mr. Adney: I would mention that the reason we have a 4% guideline level premium was precisely to allow contracts to mature, UL contracts, at age 100. That's the reason it was built in. That's the reason the interest rate got down as low as it did at that time, so certainly changing the rate to something more current on a long-term basis would be consistent with the theory of §7702. But once the theory is over with, then you have to deal with a large variety of politics and lots of questions about fundamentally what is the income tax trying to do. We always take that on whenever we have to go into Congress and have a discussion like this.

Ms. Carolyn J. Eddy: I'm with FBL Financial Group. I have an administrative concern because I work with some of the people who are actually doing it. You'd like to think people keep adding to their policies, but we've seen many people trying to decrease their face amounts. I was wondering what kind of obligation a company has when you create a kind of time bomb where they call in and say you want to decrease their face amount. This is when you recalculate a negative guideline single and negative guideline annual premium, but your sum of annual is

positive enough, although in 20 years it's not going to be. Do you try to go in and judge what the decrease should be?

Mr. Adney: I think telling people what's ahead of them is probably a good idea. Certainly a decrease can, in some circumstances, cause MEC trouble too. So it's always a good idea to project forward.

What we don't know, I think, is exactly what we're going to run into with a declining guideline premium limitation or, more particularly, a negative one. That's never really been defined. A declining guideline premium limit implies that the contract will almost turn itself into an immediate annuity and there will be a distribution coming out of it every year for good or ill. I think telling the policyholder that would be a good idea.

I don't really know whether a negative guideline premium limitation, should such a thing exist, would result in failure of the contract. It might or it might not. It's just an unknown, but I think warning people about that would be a good idea.

In the §7702 and §7702A area, I think policyholder relations is one of the top priorities, and some kind of disclosure, in something approaching plain English if possible, of what is in front of the policyholder would be a good idea.

Ms. Divin: I've seen companies do a couple of different things, and some of them actually look ahead to see whether the policy will fail. When they run into a negative guideline level, they look ahead a year to see whether the policy will fail within a year and then they discuss whether they should really make that kind of reduction in death benefit, but that's more of a manual process.

I've also heard, when you actually project it out, that it does look as if it would eventually fail. This applies to some of these policies that have very significant death benefit reductions. There is an area in the back of §7702 that says you may pay the minimum amount possible if it doesn't improve the cash surrender value. I don't know the exact wording, but there's a section there that's kind of pay-as-you-go to keep the policy in-force. Administratively, that would be very difficult to do, because if you overpay and you have a cash value, I think you'd fail that section. Other companies that I've looked at have thought about doing exchanges, 1035 exchanges, into a new policy. I'm not sure whether that solved the problem or not.

Mr. Nunley: As John pointed out, that may lose the grandfathering.

Mr. Stern: I'd like to again thank our panelists, John, David, and Cherri for their insightful presentations.