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Working Through Uncertainty

By Cindy D. Barnard, Housseine Essaheb, Sheryl B. Flum, James P. Van Etten,
and Peter H. Winslow

**3 From the Chair
Our Volunteers!**

By Housseine Essaheb

4 Working Through Uncertainty

By Cindy D. Barnard, Housseine
Essaheb, Sheryl B. Flum, James P.
Van Etten, and Peter H. Winslow

10 In the Beginning ...

A Column Devoted to Tax Basics
Why Section 7702 (and 7702A, too)?
Some Historical Perspectives
By John T. Adney

**14 Guideline Policy Forceouts
Effects on Policy Values and
Administration of Universal Life
Policies**

By Larry Hersh

**22 The Scope of Reserve Valuation
Rules Used to Compute Life
Insurance Reserves Defined In
Section 816(b)**

By Emanuel Burstein

T³: TAXING TIMES Tidbits

**26 Changes to IRS Appeals Conference
Procedures May Increase the Role of
Actuaries**

By Samuel A. Mitchell



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From the Chair Our Volunteers!

By Housseine Essaheb

As the new chair of the Taxation Section, I want to take this opportunity to thank the outgoing council members for their service and introduce the new council members. Over the past two years, I've had the pleasure to learn from three distinguished actuaries: Mark Biglow, Brian McBride and Don Walker. Their significant contributions, great leadership and dedication to the Taxation Section have established a precedent and they will surely be missed.

This year, the council is comprised of individuals with broad and diverse experiences, which I believe will provide great value to the overall actuarial community. I look forward to partnering with everyone during what promises to be an exciting year (especially if tax reform is your cup of tea). Joining me as officers for 2018 are Bill Lehnen (treasurer/secretary) and Tony Litterer (vice chair). The new council members joining this year are Sivakumar Desai, Tom Edwalds and Vincent Zink.

The council is comprised of individuals with broad and diverse experiences, which I believe will provide great value to the overall actuarial community.

I would also like to thank the SOA staff, Beth Bernardi and Dee Berger, for their ongoing support. Beth and Dee have been instrumental to the Taxation Section and have helped keep us working through our collective goal of providing timely education to our members.

Finally, I would also like to take this opportunity to reach out to our section members, including our many partners that come from outside the actuarial community. It will be more



important than ever to get involved with the section over the next few years. With tax reform becoming a reality, I ask all of you to consider getting more involved. It's as easy as joining as a friend of the council and participating in our monthly calls. This is a great platform to share ideas and raise concerns. Feel free to reach out to anyone on the council or to me for more information. ■

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Working Through Uncertainty

By **Cindy D. Barnard, Housseine Essaheb, Sheryl B. Flum, James P. Van Etten, and Peter H. Winslow**

Editor's Note: Due to publication deadlines, it was necessary for this dialogue to occur before the Conference Committee reconciliation process and enactment of H.R. 1, The Tax Cuts and Jobs Act.

Sheryl: As we write this article, both the House of Representatives and the U.S. Senate have passed versions of the Tax Cuts and Jobs Act. Both proposals include significant changes to how life insurance companies are taxed. The Senate version includes a change to the computation of life insurance reserves for purposes of determining taxable income that applies a haircut to statutory reserves. An early version of the House's bill included a similar approach.

The uncertainty tax lawyers must deal with is not over once tax legislation has been enacted. The new laws have to be interpreted and often there is ambiguity.

We are also in the middle of the transition period for implementing principle-based reserves (PBR). Life insurance companies have been working on creating systems to support PBR, determining the ideal time to adopt PBR, and developing new life insurance products that will have reserves determined using PBR, even though the exact method for computing reserves for tax purposes remains unclear. The life insurance industry has been working with the IRS through an industry issue resolution process (IIR) to determine the tax consequences under the existing Internal Revenue Code (Code). But Congress is on the cusp of passing a new Code that will likely affect the tax issues surrounding principle based reserves.

Wow! We are experiencing a lot of unknowns in how life insurance companies will be taxed. But business continues

regardless of these uncertainties. New life insurance products are being developed. Taxes are being paid. How do we manage to get this done with all these unknowns? In this article, we attempt to provide some guidance on working in the current environment. I posed questions to Peter Winslow, a tax attorney, and actuaries Cindy Barnard, Housseine Essaheb, and Jim Van Etten. Their responses follow.

Question 1: As a tax lawyer representing insurance companies, how does uncertainty caused by potential tax legislation come into play in the advice you give to your clients?

Peter: Advising clients on potential tax legislation is a major aspect of the practice of many tax lawyers, particularly in D.C., and our firm is no exception. Since I joined ScribnerHall, tax legislative advocacy has changed dramatically. In representing clients during consideration of the 1982, 1984 and 1986 Tax Acts, a tax lawyer could advocate on Capitol Hill on behalf of a single client and obtain results. He or she did not have to be a lobbyist. That has changed. Now, virtually all tax legislative advocacy is done on behalf of a coalition of companies with a common legislative agenda. Tax lawyers tend to play more of a technical role in support of full-time in-house government affairs personnel or full-time Washington lobbyists. So, over the years my tax legislative practice has changed quite a bit. We still have a major role to play, but typically we do not make the congressional visits anymore.

I assume that your question does not relate to this aspect of practicing tax law, however. You have asked how the uncertainty caused by potential future tax law changes affects our tax advice to life insurance companies. Not surprisingly, dealing with uncertainty caused by potential changes in tax law usually involves dealing directly with actuaries.

The first area where potential tax legislation needs to be addressed in assisting companies and consulting actuaries is in developing pricing assumptions. Actuaries need to make expense assumptions in pricing, and tax expense is a major category to consider. In general, pricing adjustments usually are not made based on the likelihood that corporate tax rates may go down in a future tax bill, or that, for example, the alternative minimum tax will be repealed. It is too risky to assume in pricing that Congress will provide future tax relief. However, pricing assumptions do need to consider potential changes to the tax law that could affect particular products. When Congress makes a change to the policyholder's tax on insurance products, generally the tax effects on previously-issued contracts are grandfathered. Grandfather protection is usually not the rule for company-level taxes, however. Therefore, pricing actuaries need to consider whether future tax legislation will impact product-specific tax costs. For example, because of the



long-term nature of life insurance products, pricing actuaries must consider whether future tax legislation will have a material impact on the statutory-to-tax reserve adjustment for the product, as well as any increased deferred acquisition costs. As a tax lawyer, I frequently am called upon to look into a tax legislation crystal ball and make an informed guess.

A second aspect of my practice, somewhat related to the issues a pricing actuary faces, is to assist actuaries in making the tax assumptions for valuing a block of business for an acquisition or for a reinsurance transaction. As in the case of pricing a product, tax expense assumptions need to be made for future cash flows and the uncertainty of potential future tax legislation can be a major factor. In addition to the valuation issues, in indemnity reinsurance in particular, the uncertainty caused by the tax legislation sometimes can be managed by determining which company will bear the risk of a tax law change and then drafting the reinsurance agreement accordingly with, for example, an elective termination provision.

A third, and perhaps a less obvious, impact of uncertainty caused by potential tax legislation is in resolving disputes with the IRS over issues that extend into future years. Here, we are dealing with a company's tax department, not the actuaries. For example, in drafting a closing agreement with the IRS that resolves an issue with a future tax impact, we always have to consider the implications of the possibility that the agreement may no longer apply if the tax law changes.

Managing risks of uncertainty is much of what we do as tax lawyers, and the risk of possible changes in future tax legislation frequently is part of the equation.

It is important to bear in mind that the uncertainty tax lawyers must deal with is not over once tax legislation has been enacted. The new laws have to be interpreted and often there is ambiguity. This is particularly true for life insurance companies because general tax provisions intended to apply to all corporate taxpayers frequently do not fit well with the insurance companies' unique accounting methods and business models. Another frequent area of uncertainty is how the transition rules from the old to new laws operate.

Tax professionals need to make reasonable interpretations of the law to file tax returns and then must ascertain whether the positions are uncertain. Documentation of uncertain tax positions is required for GAAP and statutory accounting and tax provisions must be estimated and reported under ASC 740 (previously known as FIN 48) rules. Then, these provisions must be disclosed to the IRS in a Schedule UTP filed with the tax return. The enactment of major tax legislation would create significant ASC 740/Schedule UTP compliance work to address the uncertainty.

Question 2: How do changes occur in the regulation of life insurance reserves, particularly changes to actuarial guidelines and mortality tables?

This is a time of extreme uncertainty regarding tax reserves for life insurance and annuity products subject to PBR. ... The keys to dealing with all this ambiguity are communication and flexibility.

Jim: As a result of the introduction of principle-based reserves (PBR), the process for making changes to mortality tables (as well as changes to statutes that relate to reserve determination) has been streamlined. In lieu of action by state legislatures, implementation can now be effected through action by the NAIC. The mortality tables are included in the Valuation Manual, and there is a defined process for updating the Valuation Manual. Actuarial guidelines are contained in the Accounting Practices and Procedures Manual. The process for updating actuarial guidelines was not changed by the introduction of PBR.

Prior to PBR, there were a number of steps to developing and implementing a change in reserve determination. First, development and discussion of the idea occurred within the National Association of Insurance Commissioners (NAIC) as well as among interested parties within the industry. The end result of this process, which in general included exposure drafts and opportunities for industry comment, was that the NAIC developed a new or amended model Standard Valuation Law (SVL)¹ or a new or revised model regulation. Then, to make the new or amended SVL effective, each state (or other jurisdiction) adopted the law through its legislative procedures (it typically takes several years before all states adopt a new or amended model law). New or revised regulations could generally be implemented in a state by action of its insurance commissioner. This process is simpler than legislative action, but in practice there could be delays in adoption by some states.

With respect to mortality tables, until the adoption of the 1980 CSO Tables, the valuation mortality tables were specified in the SVL. Before the 2001 CSO Table was adopted, the SVL was amended to permit use of

“any ordinary mortality table adopted after 1980 by the NAIC, which is approved by regulation promulgated by the commissioner for use in determining the minimum standard of valuation for such policies.”²

The NAIC also adopted a corresponding model regulation.³

The NAIC has also promulgated a number of actuarial guidelines over the years to define the standards to be followed in making specific types of reserve determinations or for other types of actuarial standards.

Under PBR, the Introduction to the Valuation Manual (in VM-00) contains the following statement under the heading “Process for Updating Valuation Manual”:

“The NAIC is responsible for the process of updating the Valuation Manual. The Life Actuarial (A) Task Force (LATF)⁴ is primarily charged with maintenance of the Valuation Manual for adoption by the NAIC Plenary. LATF will coordinate with the Health Actuarial (B) Task Force (HATF), the Statutory Accounting Principles (E) Working Group (SAPWG), and other NAIC groups as necessary when considering changes. HATF will be primarily charged with developing and maintaining the health sections ... As provided under Section 11C of the Standard Valuation law (Model #820), any change to the Valuation Manual ultimately requires adoption by the NAIC by an affirmative vote representing (a) at least three-fourths (3/4) of the members of the NAIC voting, but not less than a majority of the total membership, and (b) members of the NAIC representing jurisdictions totaling greater than 75% of the relevant direct premiums written.”

This statement is clarified by further description of the process. Information and issues with respect to amendment of the Valuation Manual can be presented to LATF/HATF for consideration. This can be formally proposed by other NAIC work groups or by interested parties.⁵ LATF/HATF may then choose to move the issue to a “Rejected List” or an “Active List.” Items on the Active List will be identified as Substantive (that would alter the meaning, application or interpretation of a provision), Non-Substantive or an Update to a Table.

With respect to Updates to Tables there is a further distinction. Certain tables are “Designated Tables.” The Introduction to the Valuation Manual states:

“Certain designated Tables contained in the Valuation Manual are intended to be updated on a periodic basis, as they provide current reference data integral to annual calculations (e.g., those tables located in Appendix 2 of VM-20,⁶ which have a process for annual and quarterly updates specifically prescribed in the Valuation Manual). Updates to these tables in accordance with this process are not considered to be an amendment of the Valuation Manual itself, and are not subject to the requirements of Section 11C of Model #820 for the amendment of the Valuation Manual.”

Mortality tables are not “Designated Tables.”

Proposed changes will be exposed to the public for a comment period before LATF/HATF votes on adoption.

Proposed changes are also required to be consistent with existing model laws, including the Standard Valuation Law, and, to the extent determinable, with models in development. To the extent the proposed changes have an impact on accounting and reporting guidance and other requirements referenced by the *Accounting Practices and Procedures Manual*, proposed changes must be reviewed by SAPWG for consistency with respect to content and implementation timing. Once these steps have been taken, the Valuation Manual changes will be forwarded to parent committees⁷ and ultimately to consideration of NAIC adoption by the Executive and Plenary Committees.⁸ Updates to Tables will be reported to the appropriate committee, but will not require a separate vote.

Appendix C of the Valuation Manual incorporates a list of actuarial guidelines that are contained in the *Accounting Practices and Procedures Manual* which are identified for continued use after the operative date of the Valuation Manual. Changes to these requirements, including introduction of a new actuarial guidelines, would require a change to the Valuation Manual and therefore would be subject to the Process for Updating Valuation Manual.

Appendix M of the Valuation Manual defines Valuation Mortality Tables and Industry Experience Valuation Basic Tables applicable under PBR. The use of these tables in valuation is specified in Section 3.C. of VM-20 for life policies where PBR is applicable and in VM-21 for variable annuity contracts where PBR is applicable. VM-02, Minimum Nonforfeiture Mortality and Interest, includes in Section 5 the mortality tables applicable for use in determining minimum nonforfeiture values for life policies issued on and after the operative date of the Valuation Manual. The Valuation Manual anticipates that these mortality tables will be supplemented in the future. In fact, in both VM-02 and in VM-20, a transition period of 4.5 years is recommended for implementation following the introduction of new tables. More specifically, it is recommended that a table be adopted by July 1 of a given year, that the table be permitted for use beginning on Jan. 1 of the second following calendar year, and that it remain optional until Jan. 1 of the fifth following calendar year. Thereafter, the tables become mandatory.

Introduction of new valuation or nonforfeiture mortality tables would require a change to the Valuation Manual and therefore would be subject to the Processes for Updating Valuation Manual.

As noted above, implementation of a new mortality table via a change to the Valuation Manual is generally expected to be accomplished without any changes to state statutes and, as a

result, will be implemented in all states simultaneously. Prior to PBR, when changes to state statutes were required, there were times when companies had to delay product implementation in one or more states due to the timing of legislative actions.

Question 3: How do the pricing and valuation actuaries deal with the VUCA (volatility, uncertainty, complexity and ambiguity) of PBR tax reserves?

Cindy: This is a time of extreme uncertainty regarding tax reserves for life insurance and annuity products subject to PBR. Not only is there ambiguity on how to account for PBR reserves under the current tax code, we are in the midst of tax reform, which puts forth further unpredictability.

As any material change that affects the profitability of a life insurance company, a modification to the tax reserve methodology permeates throughout the financial modelling of the company including pricing, valuation, business planning and capital management. Though actuaries are used to dealing with uncertainty, this adds an additional layer of complexity because tax reserves are not always theoretically relatable to other accounting reserves.

The keys to dealing with all this ambiguity are **communication** and **flexibility**. It is imperative for the pricing and valuation actuaries to keep an open line of communication with their tax departments to not only understand the methodology changes but also to influence the outcomes. Actuaries need to opine on both the feasibility and financial implications of any changes. Identify all key personnel across the business lines and functions to make sure any methodologies changes are communicated and understood. Sharing ideas on how to implement the changes can only benefit everyone. Making sure that all business areas appropriately reflect tax methodology changes consistently is important. If there are differences in implementation, **documentation**. This helps future personnel who need to understand why something was done and if it needs to be updated.

Because the nature of PBR reserves is to move away from a formulaic—one path solution, actuaries will need to build in flexibility to their models. Having an in-house system may provide more flexibility and timeliness on instituting PBR tax reserves if the resources are available to make changes. However, companies may benefit from vendor systems that rely on diversity of thought from multiple companies' input to come up with innovative solutions. For those using vendor systems, it is important to communicate with their support staff early in order to communicate a company's view of flexibility needed for PBR tax reserves.

Another important factor to be considered with systems and data is maintaining availability to audit and to determine any

adjustments that the IRS may require. Companies will need to consider how re-computations can be provided as systems upgrades occur.

Question 4: Are there differences in the way you think about the uncertainty associated with lack of guidance under PBR and the uncertainty inherent in tax law change?

Jim: The change to the use of PBR is very significant, but its scope is relatively limited when compared to proposed tax legislation. In the case of legislation, at this time the situation is very fluid, with two different versions of legislation—one passed by the House and one passed by the Senate. We anticipate clarification of the proposed provisions in the Conference Committee reconciliation process, which will be followed by a vote in both houses.

We have been discussing and analyzing PBR for some time and at this stage the state law requirements are fairly well understood. Companies are at various stages in deciding when to begin using PBR and in many cases have begun implementation efforts. The greatest source of uncertainty relates to exactly how the tax reserves will be determined, and how any transition rules will operate.

With respect to the tax legislation, it is probable but not certain that legislation will be enacted by the time this article is printed. But even after enactment, there will doubtless be instances where further guidance is needed.

In terms of impact, life PBR's effects are limited to new business so many companies can better afford to proceed without certainty on how tax reserves are determined. Also, companies have some flexibility in implementation timing for PBR.

The legislation may have far greater impacts, because it will affect existing business as well as new business. This means that the immediate financial impacts could be far more significant, and companies need to understand the potential impacts and then make decisions on repricing actions for existing business as well as on whether product changes are in order for new business. The timing of these financial impacts will be governed by the legislation, and companies will not have flexibility in complying with the new requirements. If past is prologue, time will be of the essence in making these decisions once legislation is enacted. Therefore, companies should be upgrading their price testing systems to incorporate the various proposals now so they can analyze the legislative proposals. On a second track, companies should be taking the organizational steps necessary to "clear the decks" so they are positioned to react as quickly as possible when legislation is enacted.

Question 5: How should companies think about system upgrades that appropriately consider the need to accommodate changes in law and PBR? In particular,

- What are the timing and retention requirements?
- What is the benefit of using an in-house developed or vendor system?
- How can modeling teams stay up-to-date with evolving changes?
- What is the impact of having separate systems for pricing and reserves?

Housseine: Generally, all actuaries should stay up to date on pending regulation, whether it relates to Tax, Statutory or GAAP requirements. Some changes might require significant effort to implement, and adequate planning is necessary for successful and timely implementation. Modelling teams can stay up to date on regulation by keeping an open line of communication with their corporate actuarial department, tax department and other oversight governing departments. Periodic meetings, preferably monthly, with these groups are important to get updates and start quantifying potential impacts. In addition, actuaries should take advantage of education provided by actuarial organizations, such as the Society of Actuaries. This is critical for both teams utilizing in-house valuation systems or third-party vendor systems. Adequate planning and testing is required even if your company is using a vendor system. Vendors are usually up to speed on outstanding regulation, but having discussions with them early on would be beneficial to all parties.

In the face of uncertainty, companies should also be thoughtful about how much implementation work it is appropriate to undertake prior to new rules being finalized. For example, the tax bill recently passed by the House differed from the preliminary tax plan that was put out by the Ways and Means Committee just few weeks earlier as it relates to the calculation of tax reserves. I think it's important to keep modelling teams informed and to scope out the work but not to get too anxious and implement something that might not be a final regulation.

Sheryl: We hope that you find these musings helpful in navigating the current tax environment for life insurance companies. One thing is certain—things will change! ■

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ENDNOTES

- 1 The technical development of model laws and regulations generally occurs through committees and/or task forces of the NAIC. A description of the processes to accomplish this is beyond the scope of this article.
- 2 See Section 4. A. (3) of the Standard Valuation Law (NAIC Model 820).
- 3 Recognition of the 2001 CSO Mortality Table for use in Determining Minimum Reserve Liabilities and Nonforfeiture Benefits Model Regulation (NAIC Model 814).
- 4 LATF is organized under the Life Insurance and Annuities (A) Committee of the NAIC. Its mission is to identify, investigate and develop solutions to actuarial problems in the life insurance industry. Its membership consists of regulators from approximately 20 states.
- 5 Interested parties may include individual companies or even individuals, but it is very common for proposals to be submitted by industry groups such as the ACLI or the American Academy of Actuaries.
- 6 The heading for Appendix 2 is "Tables for Calculating Asset Default Costs and Asset Spreads."
- 7 The Life Insurance and Annuities (A) Committee (A Committee) or the Health Insurance and Managed Care (B) Committee (B Committee) will consider any Valuation Manual amendments at any regularly scheduled meeting. Such amendments must first be approved by LATF or HATF, as applicable. Updates to Tables will be reported to the appropriate Committee, but will not require a separate vote.
- 8 The NAIC Executive/Plenary will generally consider Valuation Manual amendments at the National Meeting following adoption by the appropriate Committee. The voting requirements for adoption at Executive/Plenary are as set out in Section 11C of Model #820. Unless otherwise specified, all Valuation Manual amendments shall be effective January 1 following adoption by the NAIC.

PRODUCT TAX SEMINAR

SEPTEMBER 12–14, 2018

Industry experts from the legal, tax and actuarial communities will be presenting their views on the latest policyholder tax issues at the 2018 Product Tax Seminar in Washington, D.C.

The 1 ½ day seminar will feature general sessions addressing current issues effecting the taxation of life insurance, annuities and other products sold and administered by life insurance companies. Don't miss the one day optional "boot camp" addressing the basics of life insurance and annuity taxation.

Look for more information from the Tax Section soon!



In the Beginning... A Column Devoted to Tax Basics

Why Section 7702 (and 7702A, too)? Some Historical Perspectives

By John T. Adney

In the deep, dark mists of pre-history, say around 1980, the Internal Revenue Code made no effort to define the term “life insurance contract” in a thorough-going fashion, even though it used the term (or referenced its alter ego, “life insurance policy”) many times. True, the term “life insurance contract” was defined in Section 1035,¹ but only for purposes of applying the tax-free exchange rules of that provision. Instead, recognition of a contract as life insurance for federal tax purposes generally was based on the contractual form of the coverage provided, subject to common law (judge-made) rules requiring, *e.g.*, that the arrangement involve the shifting and distribution of mortality risk.

This began to change in 1982, in reaction to the development of a new generation of life insurance products that featured a dazzling array of innovations and creative names to go with them. Prompted in part by the beginnings of the cyber revolution in the 1960s and in part by the advent of high interest rates and inflation of the 1970s, the life insurance industry brought forth products that were more flexible and attractive to consumers than the industry’s historic offerings. The insurance marketplace thus witnessed the arrival of Northwestern Mutual’s Extraordinary Life, Adjustable Whole Life introduced by Minnesota Mutual (now Minnesota Life) and Bankers Life of Iowa (now Principal Life), variable whole life as first marketed by The Equitable (now AXA), term insurance and annuity combinations hawked as substitutes for whole life, indeterminate or nonguaranteed premium whole life products, interest sensitive whole life plans such as Executive Life’s Irreplaceable Life, and ultimately the flexible premium adjustable life insurance contract everyone knows today as universal life.

It was a taxation crisis of sorts enveloping universal life that fomented, in 1982, the first congressional foray into defining life insurance in the Internal Revenue Code. The Internal Revenue Service had issued favorable rulings on the income tax treatment of universal life in the prior year,² but soon began having second thoughts on the subject, and by May of 1982 the agency concluded that it should withdraw those rulings. This prompted the companies issuing the new product to seek help from Congress, which obliged by enacting Section 101(f) in the Tax Equity and Fiscal Responsibility Act of 1982. While the new statute specifically addressed the flexible premium universal life insurance product to assure its tax treatment as life insurance, the legislation also imposed limits on the amount of premiums that could be paid for the product, constraining the product’s possible use as mainly a tax-preferred savings vehicle (sometimes called investment orientation) and thereby allaying the tax policy concerns underlying the IRS’s discomfort with the rulings it had issued. But Congress made those rules temporary and immediately undertook the crafting of a new Code Section dedicated to defining “life insurance contract” for all purposes of the Code. This work resulted in the creation of Section 7702 in 1984, and while the new section was modelled on the temporary rules, its reach extended to all forms of life insurance.³ Then, following on the heels of a major reform of the federal tax law in 1986, Congress enacted Section 7702A in 1988, defining a new tax creature called a “modified endowment contract” (or MEC) and substantially altering the tax treatment of pre-death distributions from life insurance contracts that meet the MEC definition.⁴

What led Congress to take such steps? In other words, why do Sections 7702 and 7702A exist? And, to what are some of the two statutes’ more notable features attributable? The answers require an exploration of the pertinent life insurance and political history along with a review of certain aspects of federal income tax policy. Let us begin.

THE RISE OF SECTION 7702

As the ink was drying on the 1982 legislation that enacted Section 101(f), the realization was setting in that the advent of newer types of life insurance products warranted a formal reaction within the federal income tax law. In addition to flexible premium universal life, fixed premium versions of that product had made an appearance, and single premium products with guaranteed increases in their death benefits—and hence containing small amounts of pure insurance risk relative to their build-up of cash values—found a willing group of buyers among those seeking tax-efficient investments. Within a year after the enactment of Section 101(f), the Treasury Department noted in testimony before the House Ways and Means Committee that the investment features of insurance

products were increasingly emphasized in the marketing of those products. In particular, the Treasury suggested that Congress consider whether single premium life insurance policies, and life insurance policies that endowed at an early age, should be treated as life insurance for federal tax purposes.

The question that all of these new products posed for tax policy could be reduced to this: how much pure insurance risk must a contract provide to be treated as life insurance rather than as a deferred annuity, a mutual fund, or a form of debt or equity investment? The stakes here were high, both for the Treasury and for the life insurance industry, as the life insurance contract benefitted from non-taxation of its death benefit and of its cash values (the inside build-up) prior to any distributions during the insured's life, and also, at the time, from the treatment of pre-death distributions as first recovering investment in the contract and the treatment of borrowing against that cash value as merely a non-taxable loan. In contrast, distributions of income from a deferred annuity were fully taxable, and, compliments of the 1982 legislation, distributions other than annuity streams were considered to carry out income first, possibly with a penalty tax. Further, interest credited to bank accounts was taxable when credited, whether or not withdrawn, and dividends paid by mutual funds or by corporations on their shares of stock were likewise currently taxable. Some in the tax policy community therefore asked, why is the inside build-up of life insurance not taxed as it accumulates? (Indeed, this question was posed as part of the Treasury's Ways and Means testimony.) Moreover, the early 1980s was a period of very high interest rates—when considering just how investment-oriented Section 101(f) permitted a universal life contract to be, it was said that the Treasury Department tested the results under the statute then being drafted assuming a “reasonable” long-term interest rate of 12 percent. Hence, tax-deferred accumulations, always of some value, enjoyed a particularly high value, and that value was even greater when they ultimately became tax-free.

With this in mind, Congress embarked on the line-drawing exercise that became Section 7702, unveiling the first version of the statutory draft in the fall of 1983. From that first version, it was clear Congress was willing to leave the inside build-up of life insurance untaxed so long as the build-up was limited and remained inside. Accordingly, it can be said that the principal reason Section 7702 exists is to preserve the historic tax treatment of the inside build-up, *i.e.*, that the build-up of cash values under a permanent life insurance contract is not to be taxed as it accrues simply because it accrues, and that this build-up may pass to the death beneficiary free of income tax.⁵ The proviso that Section 7702 layers onto this, however, is that the historic treatment remains only if the contract provides a death benefit that is at least a minimum multiple of the

contract's cash surrender value (ignoring surrender charges), *i.e.*, only if the contract provides at least a minimum amount of pure insurance protection or “net amount at risk.” The minimum so defined is at the heart of the statute's line-drawing exercise.

How much pure insurance risk must a contract provide to be treated as life insurance?

As actuaries know, the minimum net amount at risk required under a contract striving to qualify as life insurance is defined by Section 7702 in actuarial terms. This was done because the model employed as the general limit on the investment orientation allowed for a life insurance contract was itself an actuarial construct: the single premium whole life insurance contract.⁶ Hence, for a contract to be in compliance with the statute's “cash value accumulation test” (or CVAT), its cash surrender value cannot, by the terms of the contract, exceed the net single premium (NSP) for the contract's death benefit.⁷ And recalling the evil of the single premium contract with a guaranteed increasing death benefit, Congress made it clear in the statute the death benefit used in determining this NSP cannot be increasing. In addition, since Section 7702 was modeled on the Section 101(f) temporary rules for universal life contracts, it continued the practice of allowing contracts to meet its requirements by complying with an alternative set of limitations, *i.e.*, the “guideline premium test” and its companion “cash value corridor.”⁸ Unlike the CVAT, which focused on the relationship between a contract's cash value and its death benefit and required a minimum pure risk amount separating these two, the guideline premium test directly restricted the gross amount of premiums that could be paid for a contract relative to the contract's death benefit, again employing actuarial concepts. It also mandated, via the cash value corridor, that in any event a minimum risk amount must remain in the death benefit being provided, at least until the insured reached age 95.

Accordingly, the statute provided two paths by which permanent life insurance contracts—those providing for a cash value build-up—could comply with its limitations and avoid the taxation of the inside build-up. The CVAT was designed to enable compliance by whole life contracts, while the guideline premium test and cash value corridor were written to accommodate (and limit the investment orientation of) flexible premium universal life, although the statute technically made both of its compliance paths available to both types of contracts.

While the two paths were viewed at the time as more or less equivalent, they diverged in a number of respects. The CVAT was built on the premise that the NSP must use an interest rate assumption of at least 4 percent—the thought being that that was a reasonable long-term interest rate and surely rates would not fall below such a figure—while the guideline single premium was required to be calculated using not less than 6 percent. Hence, the amount of a single premium that could be paid into a contract tested for compliance using the CVAT was materially larger than that which could be paid for a contract subject to the guideline premium test. On the other hand, the minimum risk amount required by that test's cash value corridor was lower, as a function of the contract's cash value, than was the case under the CVAT. This result could be thought of as a trade-off engineered to bring about overall equivalence between the two paths, although the history of the enactment may not support such a view.

As noted earlier, Section 7702 was enacted in light of, and in support of, the congressional decision to leave the inside build-up of life insurance untaxed solely because it builds up over time. The deal was: the historic tax treatment of the inside build-up would be preserved, so long as the limits imposed by the CVAT or the guideline premium and corridor tests are respected. To make this perfectly clear, the statute spells out the tax treatment of what has become known as a “failed” life insurance contract, *i.e.*, the interest or earnings credited to the contract are taxed in the year credited, with no offset for the cost of insurance charges, although the net amount at risk may still pass to the death beneficiary free of income tax.⁹ In this respect, it may be said that Section 7702's limits perform a second function, namely, to draw lines differentiating the tax treatment of life insurance from that of annuities, mutual funds, and various forms of debt and equity investments.

By the way, the reader may want to note that Section 7702, for all its words and references to actuarial concepts, makes no effort to define a term even more fundamental than life insurance: the term “insurance” itself. The statute is premised on the understanding that insurance, within the meaning of the tax law, is present within the life insurance contract to which it refers. Answering the question “What is insurance?” remains the subject of continuing court cases and IRS rulings.

THE (BUMPY) ROAD TO SECTION 7702A AND THE AMENDMENT OF SECTION 7702

Not long after President Reagan signed the legislation enacting Section 7702, his administration proposed a broad rewrite of the federal income tax law, one element of which was to impose current taxation of the inside build-up. The life insurance industry withstood this assault, and a major reason was

the then recent enactment of Section 7702. However, the legislation that resulted from the Reagan Administration's proposal, the Tax Reform Act of 1986, closed down many tax-favored investments as well as outright tax shelters, and this incidentally increased the attractiveness of single premium life insurance for those seeking income tax deferral and the ability to draw on contract cash values via loans without adverse tax consequences (if the contract remained in force until the insured's death). Some very aggressive advertising promoting single premium life insurance contracts as “the last great tax shelter” caught the attention of Congress, as did gimmickry involving mortality and expense charges deployed to dilute the impact of the Section 7702 limits on the investment orientation of such contracts. As had been the case before with life insurance and with other financial instruments, such “poster children” prompted Congress to act, and not so graciously. Here, as elsewhere, Pogo's observation may apply: “we have met the enemy, and he is us.”

Specifically, in the Technical and Miscellaneous Revenue Act of 1988, Congress enacted the MEC rules enshrined in Section 7702A and also amended the provisions of Section 7702 that made use of a contract's specified mortality and expense charges in calculating the CVAT and guideline premium limits. By means of the MEC rules, to defeat the use of life insurance as the tax shelter of choice, Congress substantially altered the tax treatment of pre-death distributions from contracts considered to be funded at so rapid a rate that they provided significant tax-deferred inside build-up. Accordingly, a Section 7702-compliant contract entered into on or after June 20, 1988—the date, by the way, that the Ways and Means Committee agreed to the legislation—and that fails a so-called 7-pay test detailed in Section 7702A is characterized as a MEC. Further, pre-death distributions from a MEC are taxed on an income-first basis (that is, the gain in the contract's inside build-up is deemed to be distributed before any recovery of the investment in the contract); loans taken under or against the MEC are treated as distributions, and in many circumstances a 10 percent penalty tax is imposed on the income otherwise subject to tax.¹⁰ This resulted in the tax treatment of the contract being “turned upside down” from the treatment of a life insurance contract that is not a MEC, as to which distributions are viewed as coming from investment first, loans are considered loans, and no penalty tax is to be found. Happily, for both the MEC and the non-MEC, the cash value build-up itself remains untaxed while inside the contract, and the death benefit may be paid to the beneficiary free of income tax.

Rather than taking the step of dividing the world of Section 7702-compliant life insurance into MECs and non-MECs, Congress could have dispensed with the 7-pay test and its numerous complexities and simply applied the MEC rules to

all life insurance contracts. This was in fact considered, with two members of the Ways and Means Committee who were prominent in the development of Section 7702, Rep. Pete Stark (D-CA) and Rep. Bill Gradison (R-OH), introducing legislation in 1987 to do just that. Many in the life insurance industry found this objectionable, for it would impair the tax treatment of what was referred to as “garden variety” life insurance for everyone solely because some had used the single premium product for tax-favored investment purposes. Hence, it may be said that a principal reason Section 7702A exists is to protect the garden variety product from the more adverse tax treatment visited upon MECs.

Even so, Section 7702A is a difficult statute to interpret and administer, as actuaries and others who work with it will attest. Unlike Section 7702, it was developed in an atmosphere of some hostility between congressional tax-writers and the life insurance industry. But, one may ask, why a 7-pay test? Why is the minimum not 5 premiums, or perhaps as high as 20 premiums? The number 7, being a figure classically denoting completeness or perfection, has played a role in history generally—the 7 wonders of the world (ancient and modern), the 7 articles of the U.S. Constitution, the 7 voyages of Sinbad—and in insurance tax history as well, such as in the 4 of 7 premium test embedded in Section 264. Yet in the case of Section 7702A, nothing quite so romantic was at play. The use of 7 in this instance was a matter of political compromise, for Ways and Means Chairman Rostenkowski had proposed a 20-pay test, the life insurance industry expressed preference for a 5-pay test, and the Ways and Means Committee voted to go with 7.

Beyond enacting the MEC rules, the 1988 legislation made substantial changes affecting Section 7702, as noted above. Section 7702 (and based on it, Section 7702A) operates by use of actuarially computed limits, and the legislation amended Section 7702 to require that for contracts entered into on or after Oct. 21, 1988 – the date the House-Senate Conference Committee made its decision on the subject—only “reasonable” mortality and expense charge assumptions may be used in calculating the limits. As originally enacted, Section 7702 had allowed the use of mortality and expense charges specified in a contract, on the theory that market forces would produce charges that were reasonable in amount. Unfortunately, this theory failed in some of the more investment-oriented sales. Rather, in several cases it was discovered that the mortality charges “specified” in the contract aligned, more or less, with what one would charge based on the 1792 Northampton mortality table, even though the charge actually imposed for the cost of insurance under the contract was no more than the going rate in 1988. Congress was not amused, and proceeded to impose reasonableness requirements on the Section 7702 (and 7702A) charge assumptions, spawning a parade of IRS Notices

on reasonable mortality charges and much head-scratching on the meaning of reasonable expenses. While this aspect of the 1988 legislation may be viewed as protecting, once again, the inside build-up from current taxation and preserving the historic tax treatment of pre-death distributions for garden variety life insurance, the reader might again refer to Pogo’s observation, above.

A CONCLUDING RECOMMENDATION

The foregoing is but an abbreviated account of the birth of, and rationales for, Sections 7702 and 7702A as they exist today. Some may chafe at the application of the two statutes and even rail against them (the author often does as to the latter one), but the reasons they exist and the protections they provide are undeniable. If the reader now has an interest in following the prompting of the Library of Congress to “read more about it,” recourse may be had to chapters 1, 8, and 9 of the second edition of *Life Insurance & Modified Endowments*, the Society of Actuaries textbook on Sections 7702 and 7702A, from which this writing has liberally drawn. ■

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ENDNOTES

- 1 References to “Section” are to sections of the Internal Revenue Code of 1986, as amended (the Code).
- 2 PLR 8116073 (Jan. 23, 1981); PLR 8121074 (Feb. 26, 1981) (clarifying PLR 8116073).
- 3 Some refer to section 7702 as the DEFRA rule, since it was enacted by the Deficit Reduction Act of 1984.
- 4 Some refer to section 7702A as the TAMRA rule, since it was enacted by the Technical and Miscellaneous Revenue Act of 1988.
- 5 This tax-free treatment is provided via section 101(a)(1).
- 6 It may be noted that the very first draft of section 7702 that became public in the fall of 1983 did not embody a single premium design, but rather one calling for premiums to be paid over a minimum number of years. In the mark-up of the proposed statute by the Ways and Means Committee, this was changed to the single premium design. In retrospect, this decision was a fortunate turn in events for the functionality of the life insurance definition, as it avoided all the complexity in interpreting and administering a multi-premium test that came to exist under section 7702A. But the decision also set the stage for the marketing abuse of certain life insurance products that led to section 7702A’s enactment.
- 7 See Section 7702(a)(1) and (b).
- 8 See Section 7702(a)(2), (c), and (d).
- 9 This is approximately the rule in Section 7702(g), although the details can be somewhat devilish.
- 10 This treatment is found in Section 72(e) and (v).

Guideline Policy Forceouts

Effects on Policy Values and Administration of Universal Life Policies

By Larry Hersh

Universal Life Insurance and the Guideline Premium Test have been around for a little over 30 years. Now that these policies have matured, there is a growing need to address and re-think how we administer these policies. When the policies were sold, the focus was on the payment of premiums to establish the benefits. But now that clients are older and perhaps even retired, the focus is on maintaining policy value to either maturity or death.

Perhaps more than any other contributing factor, the decline of interest rates over the last 20 or so years to record low levels has impacted policy owners as well as insurance companies, making it difficult for owners to have policies they can maintain into the future. But even if interest rates rise, the increase in performance may not be enough to salvage the value of these policies, because the increase in cost of insurance rates at older ages will outpace the gains from any increase in the interest rate. This is facilitating a re-thinking of the relationship of benefits and cash value by many policy owners.

Managing the inforce block is undoubtedly on many companies' collective conscience. It is in their best interest to help their clients meet their needs, but this cannot be done by the wave of a magic wand. There are many constraints present: the ability to find good assets that raise the interest rates; whether mortality experience can warrant a reduction in cost of insurance rates; the ever-increasing expenses of maintaining the business.

There is an additional constraint, however. As policyholders begin to change their benefits, either as a reduction in benefits to lower costs or through withdrawals and distributions of excess cash value, the Guideline Premium Test values also change. These can create a larger and sometimes unknown

liability for the policy owner, should such changes trigger a forced withdrawal of cash value (Guideline Forceout).

This article will focus on the constraints and effects of the Guideline Premium Test. First, we will define what Guideline Forceouts are and how they arise. Then we can consider the effects on policy values. Finally, we can consider how to administer policies in light of these constraints.

DEFINING A GUIDELINE PREMIUM FORCEOUT

How Does a Guideline Premium Forceout Occur?

Section 7702(c)(1) defines the Guideline Premium Test for a policy as requiring that "the sum of the premiums paid under such contract does not at any time exceed the guideline premium limitation as of such time." Further, Section 7702(c)(2) defines the Guideline Premium Limitation as the greater of the Guideline Single Premium (GSP) or the sum of the Guideline Level Premiums (GLP) to the date of measurement.

If a policy does not adjust its benefits or make any other changes, the administration of this test is fairly straightforward. By its design the use of the Guideline Premium Test provides for the flexibility of premium payments to Universal Life policies, and is of paramount importance to how these policies are maintained.

This is well established and understood by all. The key provision that we are focusing on in this article, however, is 7702(f)(7)(A), which states that "If there is a change in the benefits under (or in other terms of) the contract which was not reflected in any previous determination or adjustment made under this section, there shall be proper adjustments in future determinations made under this section."

Section 7702(f)(7)(A) defines what is referred to as an "Adjustment Event." It applies to both CVAT and Guideline policies, but in general its effect is critical to the administration of Guideline Policies. The reason for this is that CVAT policies tend to self-correct upon an Adjustment Event, whereas Guideline Premium Test policies do not. The effect on the guideline premiums depends on the amount of change in the benefits and any associated expense charges.

Adjustment Events can come in several different types. The most obvious is due to a benefit adjustment—such as a change in death benefits (including changes in death benefit options such as from an increasing benefit to a level benefit) or riders that are considered as Qualified Additional Benefits. The scope of Section 7702(f)(7) also includes provisions for changes in "other terms" such as a change in expense factors or risk classification, if permissible under the terms of the contract. For purposes of this paper, we will limit ourselves to changes due



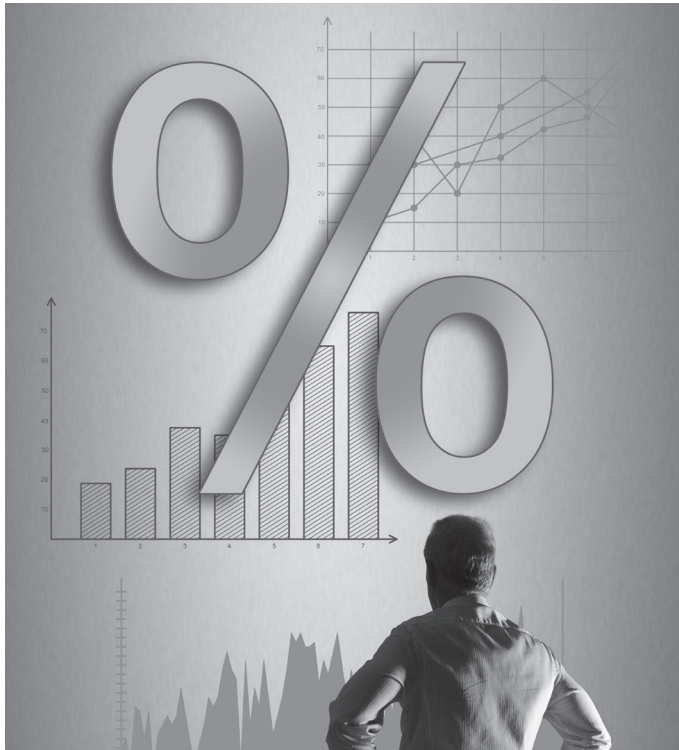
to adjustments in the benefits, as these are the most common and therefore are the most likely to give rise to Guideline Forceouts.

Adjustment Events are calculated using the Attained Age Decrement Method, which is best described in the article by Christian DesRochers¹ and further documented and explained in *Life Insurance and Modified Endowment Contracts*.² Under the Attained Age Decrement Method, the incremental difference in guideline premiums at the benefit adjustment date is added to or subtracted from the existing guideline premiums. For the same change in the benefits, the amount of change in the corresponding guideline premium can become larger the older the insured becomes. This makes perfect actuarial sense—the same coverage costs more as you get older. The result, however, is that there is an increasingly larger swing in guideline values as a policy ages, which can create a negative guideline premium and a reducing Guideline Premium Limit.

This, in turn, can create a Guideline Forceout. If the resulting guideline premiums are negative, then it is necessary to remove cash value from the policy either immediately or over time in order to maintain compliance with Section 7702. Even though Section 7702(f)(1) and 7702(f)(2) refer to sum of the

“Premiums Paid” (Sum of Premiums Paid, or SOPP) and the return of such premiums, the nature of this effort is not to refund premiums but to process a withdrawal of cash value.

Such a withdrawal is similar to, but not quite the same as, a withdrawal under the policy. Like a typical withdrawal, a Guideline Forceout could be taxable to the owner (for example, if the policy is classified as a Modified Endowment Contract). This means that the treatment of the Guideline Forceout relative to the Sum of Premiums Paid in the Guideline Test may be different than the treatment of premiums towards the policy cost basis. In addition, the policy may have a limitation on distributions to not exceed the policy’s net cash value (cash value after reduction for loans). For Guideline Forceout Purposes, the definition of cash surrender value under Section 7702(f)(2) applies, which by definition does not take such loans into consideration.³ Hence, in such high-loaned situations, some of the Guideline Forceout is paid in cash and the balance is treated as a repayment of policy debt. Such repayment of debt is also treated as a deemed distribution of policy value and may become taxable.



WHAT ARE THE EFFECTS OF GUIDELINE FORCEOUTS ON POLICY VALUES

Any reduction in the Guideline Premium Limits can have a long-lasting effect on policy values and become a burden on the policy owner’s ability to maintain their benefits and cash values. Some of the effects that can occur include:

- An immediate distribution of cash value when the Guideline Premium Test Limit is equal to the Guideline Single Premium (GSP).
- A continuing set of distributions under the Cumulative GLP (when the Guideline Level Premium is negative) that may begin immediately or may be deferred for many years.
- Ability to pay premiums, including the premiums to prevent lapse under Section 7702(f)(6).
- Combination events; multiple transactions where each independently does not cause a problem but combined do create a Guideline Forceout condition.

An immediate withdrawal subject to the GSP limit is a situation typically reserved for highly funded policies. What can happen here is more important, insofar as it may trigger either a MEC condition under the reduction retest rules of Section 7702A(c)(2) or a partial taxation under the recapture ceiling rules of Section 7702(f)(7).

The more interesting (but also more nettlesome) case is for those that are subject to a continuing decline in the cumulative

GLP. These withdrawals may begin many years after the actual reduction. Transactions such as these may never happen, as the policy may terminate by surrender, death or lapse due to insufficient policy value before the Guideline Forceout occurs.

But as they say—“Buyer Beware!” Guideline values are locked in, and when these events occur it is very costly to try to unwind them. A policy owner may suggest that they increase their face amount by the same amount of the decrease. However, they will generally need to increase by a larger amount if the increase occurs at a later point in time. For guideline premiums, this is the same effect as what triggers the negative guidelines, just in reverse. For example, say that a reduction in face amount of \$50,000 at, say, age 60 would trigger Guideline Forceouts in 10 years at age 70. If the owner decides that they wish to avoid such Forceouts, they may need to add back \$55,000, \$60,000 or more depending on how long they wait to request such an increase to completely offset the effect of the initial reduction (and assuming they qualify).

The delayed effect of a cumulative GLP Forceout can have a corresponding impact on premiums paid. If a policy decided to both reduce their face amount and increase their premiums to prevent a policy from lapsing, then the crossover of premiums to the cumulative GLP limit will occur even earlier. In effect the policy pays premiums (and a premium load) only to have it shortly returned as a withdrawal, without a corresponding premium load refund.

No description of Guideline Forceouts would be complete without consideration of the premium exception granted in Section 7702(f)(6). This section allows the payment of a premium in excess of the test limit, but only to prevent against a policy from terminating in the current policy year. More importantly, the contract must have no cash surrender value (in the context of Section 7702(f)(2)) at the end of that policy year. Administering this ending cash value is difficult on policies with increasing charges and changing interest rates which is an integral part of Universal Life policies.⁴ So, a policy owner may be able to use this to prevent lapse, but due to increasing costs it may be difficult to maintain over a long period of time.

Lastly, a reduction in the face amount today may limit the ability to do another one tomorrow; what is referred to as a combination event above. For example, consider a policy that has reduced their face to the exact amount needed to prevent a Guideline Forceout (such as suggested below). Their policy is now at the limit where any future reductions would trigger forceouts. Then assume the policy owner requests a withdrawal. Typically, the design of a contract will provide that such withdrawals reduce the death benefit in order to preserve the net amount at risk and prevent anti-selection risk.

This reduction in the face amount then triggers an Adjustment Event which reduces the Guideline Premiums and causes a Guideline Forceout to occur if the amount required as a Forceout exceeds the amount requested as a withdrawal.

These considerations place a pragmatic limitation on what types of solutions a company can provide for their policy owners. No system can adequately predict how a sequence of transactions will affect the long-term capabilities of a policy with any real precision. It is therefore important to design any administrative systems to retain some level of conservative benefit amounts in the calculations to help provide for the changing needs of the consumer.

Solving for Guideline Premiums

A company is very likely to be asked the question—“What benefit can I reduce to without being forced to take withdrawals?” One way is to have your administrative people use the tried and true method of “hunt and peck” for an answer (we have all used goal-seek at one time or another).

As actuaries, this is a solvable problem, and it can be a very useful way to turn what seems like a negative (you will have forceouts) into a positive (but not if you do this instead). In this section we will set up a generalized model for doing such solves.

To help set context, a policy’s life-cycle can be thought of as generally following four stages:

- Stage 1. Premium Paying Period
- Stage 2. Holding Period (no premiums or distributions)
- Stage 3. Distribution Period (withdrawals and/or loans)
- Stage 4. Benefit Maintenance Period (keeping policy from lapsing until death)

Obviously, policies vary widely and for many reasons, but for purposes of solving what benefits serve what purpose this is a particularly useful way to frame the issues.

The math necessary to do such a calculation is relatively straightforward conceptually. First, you do the same routine twice; first for the Guideline Single Premium (GSP) and then for the Guideline Level Premium (GLP). To be conservative, you would generally take the higher face amount from the two solves. You also need to provide a few assumptions as input:

- Guideline Premium Limit Target (GPTgt) = What your ultimate guideline premium limit is assumed to be (either GSP or GLP).
- Sum of Premiums Paid (SOPP) = The cumulative premiums used in testing against the Guideline Premium Limit as of the current date.

- For the GLP, what year the cumulative GLP should equal the GPTgt.

1. Define a Guideline Premium Test Limit Target (GPTgt). This is the defined final result of a GSP or GLP calculation using the Attained Age Decrement method.

The “stage” of the policy is important in how you would set the target. If the policy is in a premium paying mode, then the target may be to accept all projected premiums paid. If instead the policy is in a benefit maintenance mode, you may simply want to solve for the face amount so as to prevent any Guideline Forceouts from occurring.

The goal is in two parts—the Final GPT limit that is needed, and the Duration that the limit should equal the Target.

For example, if the case is to not have any forceouts during the policy’s lifetime, then the targets for each solve are

For GSP solves, set the target to:

$$GPTgt = (SOPP - GSP)$$

For GLP solves, set the target to:

$$GPTgt = \frac{(SOPP - cumGLP)}{Age100 - AttAge}$$

2. Define this in terms of the Attained Age Decrement Method

Using the terminology in the aforementioned TSA Article:⁵

- A = Current GSP or GLP on the policy.
- B = GSP/GLP “After” = value calculated using new Benefit Package as of the Adjustment Event Date.
- C = GLP/GSP “Before” = the existing benefits recalculated but as of the Adjustment Event Date.

The (B-C) portion of this calculation represents the incremental new guideline premium based on the change in benefits. But using the formulation above, the observation is that what we are solving for is the benefits to support the “B” premium.

Thus, we end up with this as our next step

$$GPTgt = A + B - C$$

$$B = GPTgt - (A - C)$$

3. Redefine the “B” premium in terms of the new face amount.

$$B = \frac{F \times \bar{A}_{x+t} + F \times PV(VE) + PV(FE)}{\ddot{a}_{x+t}}$$

Where:

F = the face amount to be solved for

VE = Variable Expenses per unit of Face Amount

FE = Fixed Expenses not related to Face Amount (including QAB charges)

Premium loads are built into the annuity factor.

4. The final solution is therefore:

$$\frac{F \times \bar{A}_{x+t} + F \times PV(VE) + PV(FE)}{\ddot{a}_{x+t}} = GPTgt - (A - C)$$

$$F \times (\bar{A}_{x+t} + PV(VE)) = [GPTgt - (A - C)] \times \ddot{a}_{x+t} - PV(FE)$$

$$F = \frac{[GPTgt - (A - C)] \times \ddot{a}_{x+t} - PV(FE)}{\bar{A}_{x+t} + PV(VE)}$$

Note: the result of a guideline premium solve are calculated without any assumed constraints. The result can be below a policy’s minimum face requirements and can even be negative. Once these solves are computed, a secondary step is necessary to consider these types of constraints based on the contract’s provisions and the company’s administrative practices.

EFFECT ON POLICY ADMINISTRATION

Administering these tests will take a coordinated effort between the tax actuary, legal counsel, systems, client services and company management. You have to consider many things:

- What restrictions (if any) your contract puts on policy activity due to the Guideline Premium Test?
- Are your administrative systems complete, and can they “do the math”?
- What information is provided in an illustration, and more importantly, what information is not?
- How will you communicate such news to an owner, without overstepping and providing them advice?

Administrative Systems and Procedures

Unlike many policy value considerations, the ability to do the math associated with Guideline Premiums does require policy administrative systems, which precludes manual policy calculations.

Administrative systems are built for the here and now. The system processes the transaction, records the new Guideline Premium Values, and tests for immediate compliance. Administrative systems generally rarely have logic to try to project values forward unless you build such logic. That is the purpose of the illustration, but it too is limited to take into account all the possible transactions that may be considered.

If you wish to build administrative safeguards or notifications, your systems need to consider the following:

- Projecting if and when a GPT Forceout event may occur.
- Creating warning messages or other error conditions that notify administrative personnel of impending issues.
- Calculating face amounts (or other benefit packages) that can provide alternate solutions to the client or administrative staff.
- Coordinating this information to illustrated values.
- Providing information to correspondence such as confirmations or statements.

Building these systems is costly and will be competing with other organization objectives. Since the bulk of it may not occur for some time, many may choose to not begin work until the demand is sufficiently high to justify the cost. This becomes a circular problem, as the cost of delaying such activity only increases with time.

The problem is your ability to forecast this demand. In considering administrative system changes and policy procedures, you should first consider performing a study of your inforce block. Stratification of your inforce block by relative funding sufficiency will help you identify those policies that are currently at risk. That is also essential if you need to consider training or augmenting your staff to handle any increased volume of questions or requests.

Also, bear in mind that any such study cannot project the types of actions policy owners may take that could add to the difficulties of administration, particularly when there are few contract limitations to inhibit such activity. As such, a periodic check of your inforce is probably warranted to make sure that any issues you wish to address are not a growing concern.

Illustrations are not the answer

Many people in your organization will assume that the job of projecting forward values belongs to the illustration system. This seems like an easy answer, but it is often not. Instead, you are now risking making your illustration system into an administrative system, which only works if the illustration is complete in its programming and is supported by the administrative systems. For example, a contract may allow for the

There is a central question about what responsibility the company has to help their policy owners manage their benefits, and what level of information should be provided.

owner to change their benefits at any time, but the illustration cannot process the transaction until the next policy anniversary. In such a case, the illustration cannot be relied upon, but for lack of administrative system information the illustration is relied upon as the only source of information.

When an illustration provides values, there are a few obvious alternatives to start from:

- Allow the transactions and disclose the results.
- Program protective measures to not allow transactions to occur in the illustration.
- Have a “switch” that allows both of the above alternatives.

These are all useful, but again not necessarily complete. Some of the considerations:

- If the GPT Forceout is deemed to occur after the illustration is projected to lapse, the values will not be shown.
- If you place a higher face amount to avoid the transaction, you may not be following the terms of your contract.
- Or, using a higher face amount is not perfect. If there is a subsequent transaction that reduces benefits, the Guideline Forceouts may occur anyway. Consider a policy that does a face reduction to the minimum, and then takes a withdrawal that triggers a further reduction. Since the withdrawal cannot be predicted, and the face amount is a function of the withdrawal itself, there is no clear way to avoid having a forceout event commence.
- Switches are useful for home office personnel, but add a complexity for most producers. This requires training, and on a topic that is not going to garner much attention.

Communication of Guideline Premium Values is Difficult

For an insurance company and their tax actuary, there is a central question about what responsibility the company has to help their policy owners manage their benefits, and what level of information should be provided. Actuaries need to be part of this process, as their expertise in the complex math is necessary to a good explanation of the results provided to the policy owner or producer.

How a company handles these cases poses clear risk to the reputation of the company which could result in litigation against the company. It all hinges on the information that a company provides to the owner, aspects of which include:

- Prior Communication to the owner. Have you told them this information before, or is this new information to them?
- Timing—When is the best time to communicate such information, particularly if the event may never occur?
- What information should you provide?

Perhaps the most important aspect is the style of communication. Imagine the reaction an owner may have to a letter that states the objective truth:

“Your policy is intended to qualify under the Guideline Premium Test of Internal Revenue Code Section 7702. Under this test, the sum of premiums paid cannot exceed your Guideline Premium Limit. If you reduce your benefit, the Guideline Premium Limit is reduced. This may require you to take one or more distributions from your policy in order to remain qualified under the test. Please consult your qualified tax advisor for more information.”

When a client who is older, perhaps on a fixed income, and is generally ignorant of such matters receives this letter, the response is very likely to be negative and, perhaps unfairly, blaming of the insurance company.

History Lesson: Are you a Monday Morning Quarterback?

What information a company feels is needed or required to be provided to an owner has itself changed over time.

Back in the 1980's, insurance policy forms and disclosures were generally shorter and more general than they are now. Much of this has to do with the level of complexity built into the product but also to the lessons that are learned over time.

But if you provide information now that is new to the owner, the natural question is “why didn't you tell me this before?” This question is particularly troubling if the activity that gave rise to the forceout occurred in the past. You may have provided the information, but not in a format that was understandable to the client. Or you may not have provided it at all because of system limitations, statement formats or other constraints. In the case where information was either insufficient or nonexistent this does change the way you would communicate today. The problem only grows more difficult to manage and costs more the later you wait. Add to this that if the information seems conflicting in any way it will be held against you.

Guideline Policy Forceouts

A Case Study

In 1990, Mrs. Olsen purchased a Universal Life Policy that was qualified under the Guideline Premium Test. Her initial purchase was as follows:

- A \$750,000 Face Amount, for a Female Nonsmoker Age 45, under a level face amount (Option 1) death benefit.
- \$10,000 Annual Premium payments for 15 years (to Age 60, in 2004).
- A 10 percent Illustrated Rate that provided benefits to maturity at age 100.
- Provided to her: a GSP = \$150,000 and a GLP of \$15,000.

Mrs. Olsen paid all her premiums as billed to her, and extended premiums for an additional five years until she was age 65 based on illustrations that showed that her policy was underperforming. After 20 years of premium payments, she retired and stopped making payments.

As interest rates neared her 4 percent guarantee, the illustrations still showed declining performance. In 2020, when she turned 75 and after 30 years of ownership, it looks like she would lose her policy completely in a few short years at age 85. Premiums would be too costly, so she instead chose to reduce her benefit by 50 percent, to \$375,000.

A funny thing happened. Her illustration showed her having to take \$15,000 in distributions from her cash value beginning at age 90, and the policy would still lapse at age 92. Her producer explained to her that the Guideline Premium Test Values would reduce when she drops her benefits to a GSP of \$50,000 and a Negative GLP of \$15,000. She would be able to pay premiums to prevent the policy from lapsing, but in her 90s these would be very expensive.

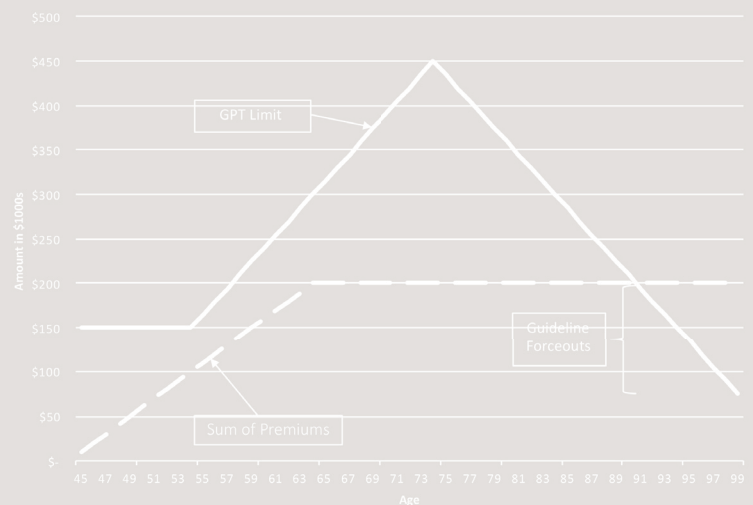
Her conundrum is a difficult one:

- If she keeps her benefit at \$750,000, she has effectively “locked in” the higher cost of insurance costs, and may end up with no benefits at all if she lives long enough.

- But if she tries to cut her costs, she gives up 50 percent of the benefits that may be needed in a short timeframe after all, and may still have to pay premiums later to maintain this lower level of benefits.

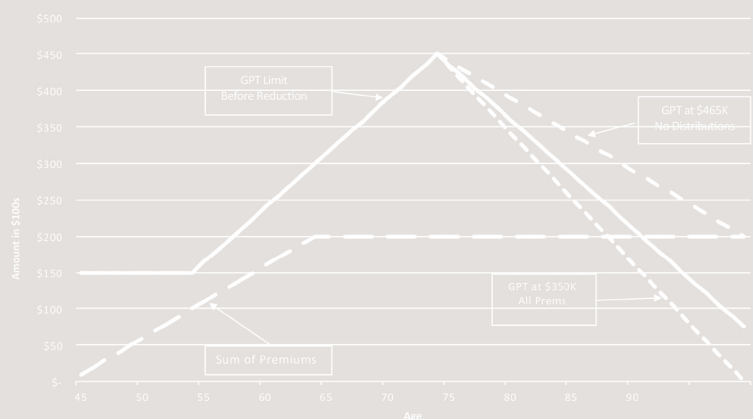
Figure 1 is a graphical way to show how the Guideline Limits have influenced this policy. It is obvious that she had paid premiums well under the Guideline Premium Limit, but the change had a large impact and ultimately causes forceouts to occur.

Figure 1
Forceouts based on 50% reduction to face



When she asks what she can do to both preserve her policy and prevent forceouts, it is possible to use solve for the policy face amounts that can assist in her decision making. Figure 2 provides two alternatives.

Figure 2
Solving for Face Amounts



There are now 3 alternatives provided to Mrs. Olsen:

- Alternative 1: Reduce the benefits from \$750,000 to \$375,000, and take forceouts beginning at age 91.
- Alternative 2: Reduce the face from \$750,000 to \$465,000, and avoid any forceouts. In this case there is higher cost of insurance, but without any forceouts the policy may continue to a longer period.
- Alternative 3: Reduce from \$750,000 to \$350,000. This saves some cost of insurance rates, but the forceouts now begin at age 88.

The question is, what alternatives do you present? In the case of Mrs. Olsen, it would appear that case number 3 would be

the least likely to meet the situation—where forceouts are triggering a potential lapse of the policy. But do you make that assumption for her? Because these alternatives are services provided that are not within the scope of the owner's contract, care must be taken to not cross the line and assume that you know what her needs are. The company is bound only by the terms of the contract, and needs to be very careful in how any recommended benefit changes are disclosed. That said, you are the one who has the ability to provide the information.

So, which alternative would you recommend?

Do We Tell the Owners Now, or do We Tell Them Later?

This is deceptively difficult. In our simple case study for Mrs. Olsen (see sidebar), the Guideline Forceouts are not projected to occur for several years and in the later years of her life.

Let's consider a counterexample: Mrs. Olsen's case was one where the illustration shows the policy taking forceouts and then lapsing. But many cases have so little cash value that even with the changes in benefits they are shown as lapsing before a Guideline Forceout occurs.

In such a case, the illustration won't show the Guideline Forceout at all. The reduction is taken, and if the policy stays in force regardless (interest rates rise, they pay premiums, and so forth), there is a large surprise when it does eventually happen.

Is there an obligation for the company to contemplate results that may not ever happen? The easy argument is no—this is just an illustration and not a contract. However, unless other answers are provided in a different communication format, the illustration will be relied upon. This is the very fine line by which the illustration becomes your administrative solution.

CONCLUSION: WHAT'S A POOR ACTUARY TO DO?

The difficulty in writing an article such as this is that it focuses on a single issue and can seem very alarming as a result. The flexibility of a Universal Life policy is overall a good thing. When used properly, it can help an owner meet their insurance needs. But those needs change over time, and it is quite likely that the owners have not taken the kinds of actions necessary to ensure that their needs are met. This is only exacerbated by the very long period of low interest rates and the corresponding effects on policy cash values. No one could have projected the type of economic conditions that gave rise to these issues.

As policies continue to age, the scope of these issues may only grow over time. Companies are well advised to understand the nature of their business, even when they do not focus on highly funded sales. The cost of not understanding this to your business could be very high indeed.

As the saying goes, "The best defense is a good offense." Guideline Premium problems may be solvable, but only if your company is willing to be proactive and timely in doing so. With proper explanation, solutions can be a way for companies to provide service to their clients to help them meet their needs. This is a service that we actuaries are well-suited to provide to our clients and companies. ■

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ENDNOTES

- 1 "The Definition of Life Insurance Under Section 7702 of the Internal Revenue Code," *Transactions of Society of Actuaries*, Volume XL, page 228.
- 2 Christian DesRochers, John Adney, Brian King and Craig Springfield, *Life Insurance and Modified Endowments under Internal Revenue Code Sections 7702 and 7702A*, Second Edition, Chapter 4.
- 3 Section 7702(f)(2)(A) Cash Surrender Value – The cash surrender value of any contract shall be its cash value determined without regard to any surrender charge, policy loan, or reasonable termination dividends.
- 4 Note that some of the administrative difficulties can be aided using methods such as a premium deposit fund that holds the premiums outside of the life insurance contract until they are required to prevent lapse. Interest earned on such a fund will typically be taxable.
- 5 *Ibid*, Page 229.

The Scope of Reserve Valuation Rules Used to Compute Life Insurance Reserves Defined In Section 816(b)

By Emanuel Burstein¹

Editor's Note: Due to publication deadlines, this article was completed before the Conference Committee reconciliation process and enactment of H.R. 1, The Tax Cuts and Jobs Act. The principles addressed in this article, however, continue to apply under the tax law as amended by it.

Section 816(b) provides that to qualify as a life insurance reserve, a statutory reserve must be,

1. “computed or estimated on the basis of recognized mortality or morbidity tables, and assumed rates of interest;”
2. “set aside to mature or liquidate, either by payment or reinsurance, future unaccrued claims arising from life insurance, annuity, and noncancellable accident and health insurance contracts” (including certain other specified contracts) “involving, at the time with respect to which the reserve is computed, life, accident, or health contingencies;”
3. required by law.

This article addresses the scope of reserve valuation rules that satisfy the first requirement; that is, to compute or estimate reserves “on the basis of recognized mortality or morbidity tables, and assumed rates of interest.”

THE DEFINITION OF LIFE INSURANCE RESERVE UNDER SECTION 816(B)

The definition of life insurance reserve under Section 816(b) draws from the Supreme Court's opinion in *Maryland Casualty*.² The Court stated,

[t]he term “reserve” or “reserves” has a special meaning in the law of insurance. While its scope varies under different laws, in general it means a sum of money,

variously computed or estimated, which, with accretions from interest, is set aside, “reserved,” as a fund with which to mature or liquidate, by payment or reinsurance with other companies, future unaccrued and contingent claims, and claims accrued, but contingent and indefinite as to amount or time of payment.³

SIGNIFICANCE OF QUALIFYING AS A LIFE INSURANCE RESERVE

A life insurer deducts an increase, and includes in gross income a decrease, in its Section 807(c) reserves (after certain adjustments) for a given taxable year.⁴ A reserve qualifies as a life insurance reserve under Section 807(c)(1), which is the most comprehensive of the six tax reserve categories for life insurers, if it is defined as a life insurance reserve in Section 816(b). For contracts issued in taxable years beginning before Jan. 1, 1984, the value of a life insurance reserve described in Section 807(c)(1) generally was based on the value of the statutory reserve for the contract.

For contracts issued in taxable years beginning after Dec. 31, 1983, the value of a Section 807(c)(1) reserve is determined by rules provided in Section 807(d). The value of the reserve generally is the federally prescribed reserve, which is determined by applying prescribed actuarial factors. Congress enacted these rules so that reserve computations would more closely reflect realistic economic assumptions, and in that sense to enhance the accuracy of the valuation of the reserves for tax purposes.⁵ Section 807(d)(1) provides that the reserve for a given contract cannot be lower than the contract's net surrender value nor greater than the statutory reserve as defined in Section 807(d)(6).

Whether a reserve qualifies as a life insurance reserve under Section 816(b) also influences the tax status of an insurance company as a life or nonlife insurer. An insurance company qualifies as a life insurer under Section 816(a) if more than half of its total reserves, defined in Section 816(c), are life insurance reserves (defined in Section 816(b)) plus unearned premiums and unpaid loss reserves on noncancelable accident and health insurance (not already included in life insurance reserves).⁶

IMPACT OF APPLYING FACTORS IN ADDITION TO RECOGNIZED TABLES AND ASSUMED INTEREST RATES

In *Mutual Benefit Life Insurance Co. v. Commissioner*,⁷ the government argued that “additional reserves” for certain life insurance contracts were not life insurance reserves under (the predecessor of) Section 816(b), in part, because factors in addition to mortality tables and assumed interest rates were used in the reserve valuation methodology. Beneficiaries of the life

insurance contracts could choose to receive death benefits in a lump sum or under one of several settlement options. Under one option, a beneficiary would receive installments for the rest of his life (although Mutual Benefit had to pay at least a specified number of installments).

The beneficiaries lived longer than Mutual Benefit anticipated when it issued the contracts so it had to pay more than it expected when beneficiaries chose this option. Mutual Benefit established an additional reserve to cover the increase in its liabilities. It determined the additional reserves by applying mortality tables and assumed interest rates as well as the proportion of instances in which beneficiaries chose to apply the option.⁸

The Third Circuit held that the additional reserves qualified as life insurance reserves, stating,

[t]here is nothing in the statute which states that these two elements [mortality tables and assumed rates of interest] are the only factors which are permissible and that all others must be excluded.⁹

The scope of the requirement that life insurance companies had to base life insurance reserves on recognized actuarial tables and assumed interest rates was not so limited as to prevent the use of additional factors that would enable a life insurer to value reserves more accurately. The court stated, “[i]n the factual context present here, we can perceive no considerations which would require us to adopt a construction of the Act so narrow as to mandate the exclusion of circumstances which would tend to make the calculation of the reserve more exact.”¹⁰

RESERVE METHODOLOGIES MUST BE BASED ON SOUND ACTUARIAL STANDARDS

In *Union Mutual Life Insurance Co. v. United States*,¹¹ a life insurer issued policies that allowed beneficiaries to choose to exercise guaranteed insurability rider options to “acquire specified additional amounts of insurance at specific future dates without having to present evidence of current insurability.”¹² The First Circuit concluded that the reserve valuation methodology was not valid because it assumed that all option holders would exercise their option although far fewer did so. The court stated,

it is difficult for us to give any meaning to this part of the statute [, prior law Section 801(b)(1), the predecessor of Section 816(b)(1),] if the taxpayer is permitted to write into the computation a factor as unsubstantiated as the company’s assumption that it will be necessary to establish reserves for every possible contingency which any option-holder might elect to exercise at several

future dates. This is especially true in view of the fact that the record demonstrates that the assumption is a false one.¹³

IMPACT OF OTHER FACTORS

The tax reserve valuation methodology prescribed for annuities—the Commissioner’s Annuity Reserve Valuation Method (CARVM)¹⁴—is influenced by numerous factors in addition to mortality tables and assumed interest rates. The reserve under CARVM for a given valuation date is the largest of a set of reserve computations. Separate amounts are computed to determine the amounts that—with future premiums and interest—would be needed to fund all guaranteed benefits, including nonforfeiture benefits, other than disability and accidental death benefits, until the end of each period until the maturity of the contract.¹⁵

CARVM would apply to value tax reserves for annuities under Section 807(d)(3)(A)(ii) for a given annuity contract, only if the factors that are taken into account did not prevent the reserve from qualifying as a life insurance reserve for the contract under Section 816(b), and therefore did not prevent the reserve from qualifying as a reserve described in Section 807(c)(1). Treating CARVM as the prescribed reserve valuation methodology for annuities supports the view that guaranteed benefits can be taken into account to compute life insurance reserves that qualify under Section 816(b).

IMPACT OF APPLYING TABLES BASED ON AN INSURER’S EXPERIENCE

In Revenue Ruling 89-43,¹⁶ the IRS concluded that “recognized mortality or morbidity tables” can include a table based on a life insurance company’s experience if the life insurer has adequate experience that it can use to construct a reasonable table. In the ruling, a life insurer issued level premium, guaranteed renewable, group long-term care policies that cover certain costs for individuals who become chronically impaired. The life insurer used “either a recognized morbidity table reasonably adjusted to reflect the Policies’ risks that are not otherwise taken into account or a morbidity table based on [the life insurer’s] experience (provided [that the life insurer] has adequate experience upon which to construct a reasonable table)”¹⁷ to determine active lives reserves and various other reserves, other than unearned premium reserves, for these policies.

The IRS concluded that the tables qualify as recognized morbidity tables, reasoning,

[a]lthough neither the Code nor the regulations define the term “recognized mortality or morbidity tables,”

the legislative history of the term provides useful guidance. The Revenue Act of 1942 substituted the term “recognized mortality or morbidity tables” for the term “recognized experience tables” in prior law. The Senate Finance Committee Report accompanying the Act indicates that the change was designed to expand rather than to restrict the types of mortality or morbidity tables that would qualify.¹⁸

RESERVE METHODOLOGIES FOR UNIVERSAL LIFE INSURANCE CONTRACTS

Life insurers started issuing universal life insurance contracts in the late 1970s.¹⁹ The NAIC responded by issuing a model regulation that “codified the application of the CRVM to Universal Life”²⁰ in December 1983. Statutory reserves for these contracts are determined by applying highly complex reserve valuation rules.

Congress was sensitive to the impact of the implementation of the NAIC Model Regulation for universal life insurance contracts on the application of Section 807(d) to compute tax reserves, when it considered legislation enacted as the Tax Reform Act of 1984. The Joint Committee on Taxation indicated in the *General Explanation of the Tax Reform Act of 1984* that life insurers must apply prescribed CRVM rules for universal life insurance contracts issued after 1983, stating,

[a]n example of a life insurance contract not covered until recently by an NAIC prescribed method was a universal life insurance contract. The NAIC prescribed a CRVM for universal life insurance for the first time in December 1983. Thus, reserves for such contracts issued after 1983 must be computed using the prescribed CRVM;^[21] reserves for such contracts issued prior to the NAIC recommendation could be computed using the newly prescribed CRVM and would be considered to be computed on a method consistent with CRVM.²²

Section 807(d) could not apply to compute tax reserves for these contracts if the statutory reserves for the contracts did not qualify as life insurance reserves under Section 816(b).

CONCLUSION

Congress, the courts, and even the IRS, in at least one ruling, interpret the scope of the requirement that a life insurance reserve defined in Section 816(b) must be “computed or estimated on the basis of recognized mortality or morbidity tables, and assumed rates of interest” broadly. A reserve valuation method can include factors other than a recognized actuarial table and assumed interest rates although a qualified reserve methodology must be based on sound actuarial principles.

Reserve valuation methods for complex life insurance products, such as universal life contracts, also can qualify. ■

Emanuel Burstein is the author of *Federal Income Taxation of Insurance Companies* (4th edition), published in May 2017 by Bloomberg BNA. He can be reached at manny@insurancetax.com.

ENDNOTES

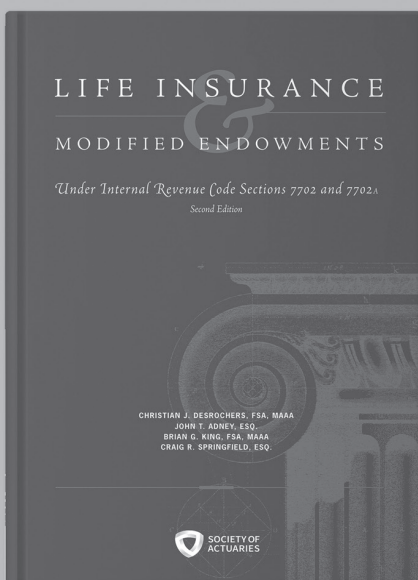
- 1 Emanuel Burstein is the author of *Federal Income Taxation of Insurance Companies* (4th edition), published in May 2017 by Bloomberg BNA. This book provides a comprehensive analysis of “life insurance reserves” as defined in Section 816(b) on pages 6-6 to 6-21.
- 2 251 U.S. 342 (1920).
- 3 *Id.* at 350.
- 4 See Section 807(a) for the gross income inclusion of reserve decreases and 807(b) for the deduction of reserve increases.
- 5 The legislative history of the Tax Reform Act of 1984 stated that the value of life insurance reserves under (the predecessor of) Section 807 generally was “based on [the life insurer’s] statutory reserves, which [were] computed using assumptions under State law. The result [was] a significant overstatement of liabilities in comparison to those measured under realistic economic assumptions.” H.R. Rep. No. 98-432, Pt. 2 at 1397. Congress concluded that “a more accurate measure of liabilities for tax purposes can be achieved by imposing specific rules for the computation of tax reserves [that approximate] the least conservative (smallest) reserve that would be required under the prevailing law of the States.” *Id.*
- 6 Section 816(a).
- 7 488 F.2d 1101 (3rd Cir. 1974).
- 8 *Id.* at 1108.
- 9 *Id.* at 1107.
- 10 *Id.*
- 11 570 F.2d 382 (1st Cir. 1978), *cert. denied* 439 U.S. 821 (1978).
- 12 *Id.* at 394.
- 13 *Id.* at 396.
- 14 Section 807(d)(3)(A)(ii).
- 15 CARVM has been described as the “‘worst case’ valuation method, in that the reserve for a particular contract is calculated taking into account the scenario which maximizes the liability.” Louis Lombardi, *Valuation of Life Insurance Liabilities* (4th edition) 159 (2006).
- 16 1989-1 C.B. 213.
- 17 *Id.* at 214.
- 18 *Id.* The ruling cited S. Rep. No. 1631, 77th Cong., 2d Sess. 142 (1942), 1942-2 C.B. 510, 610.
- 19 See, Dwight Bartlett and Dan McGill, History of the Development of Preliminary Term Valuation of Life Insurance Policies in the United States, *Journal of Insurance Regulation* 382, 397 (Vol 15 No, 3) Spring, 1997.
- 20 *Id.* The reserve valuation method for universal life insurance is illustrated in 94 T.C. 499 (1990), *rev’d. and remanded on other grounds, rev’d. without published opinion* 937 F.2d 606 (5th Cir. 1991), *on remand*, T.C. Memo 1993-18; 65 T.C.M. 1756 (1993).
- 21 Section 807(d)(3)(A)(i), added by the Tax Reform Act of 1984, prescribes CRVM as the tax reserve method for life insurance contracts issued after 1983.
- 22 Staff of the Joint Committee on Taxation, 98th Cong., 2d. Sess., *General Explanation of the Revenue Provisions of the Tax Reform Act of 1984*, at 600 (1984).



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T³: TAXING TIMES Tidbits

Changes to IRS Appeals Conference Procedures May Increase the Role of Actuaries

By Samuel A. Mitchell

There has been a significant recent development in the procedures for IRS Appeals conferences. In May 2017, the IRS Appeals Division announced that Appeals Team Case Leaders (ATCLs) who volunteer for a pilot program will permit IRS examination personnel and chief counsel attorneys to attend Appeals conferences in all cases the participating ATCLs handle.¹ Under the program, the examination team personnel who proposed the issue, and IRS chief counsel attorneys if requested by the examination team, may attend and participate in the ATCL's conference with the taxpayer, although they may not attend the actual settlement negotiations unless the taxpayer consents. There has been some grumbling by tax practitioners that this procedure impinges on the independence of the Appeals function, and there is something to this complaint.² Nevertheless, the program presents an opportunity for the taxpayer to demonstrate the strength of the issue to the examination team and counsel and, possibly, to narrow the issues and project settlements on ongoing issues forward into subsequent cycles.

This is not to minimize the scope and significance of the change in procedure that the pilot program entails. As far as scope is concerned, most large insurance company taxpayers that are still being audited by the IRS likely will encounter the new procedure at some point in the near future. This is because ATCLs are the most experienced and seasoned appeals officers and typically handle the appeals for large life insurance companies. The program is only a pilot program for now, but it is understood that approximately 40 percent of ATCLs have volunteered for the program. A recent FAQ release by the Appeals Division clarifies that taxpayers will not be permitted to avoid the program by seeking a reassignment of the case to another ATCL who has not volunteered for the program.³ Furthermore, these types of pilot programs in the IRS almost inevitably become required

procedure in one form or another. Thus, no one should be surprised one or two years from now when IRS Appeals makes the program mandatory for all cases before ATCLs.

The change in the procedure and practice indicated by the pilot program is also significant. Under the traditional, existing procedures, appeals officers hold two formal meetings for each appeal. The first meeting is called a "pre-conference" and, although it is attended by both parties, its purpose is to allow the IRS examination team to present its position in person to the appeals officer and clarify matters not addressed in the Revenue Agent's Report or Rebuttal to the taxpayer's protest.⁴ The pre-conference is the examination team's meeting and taxpayers are allowed to attend only because of the *ex parte* communication rules that do not permit substantive conversations between Appeals and the examination division unless the taxpayer is present or waives its right to be present.⁵ Accordingly, taxpayers typically just listen to the examination team's presentation at the pre-conference without much active participation. In more high-profile issues, chief counsel attorneys may also attend the pre-conference, and sometimes they present the examination division's position. Even though the pre-conference is the examination team's meeting and the taxpayer's team is there only by virtue of the *ex parte* rules, most ATCLs will allow the taxpayer to ask a few questions of the examination team and counsel to clarify points of agreement and disagreement. This practice can be very useful in narrowing issues and obtaining agreements that are understood by the examination team and the ATCL, even though it is not specifically contemplated in the existing procedures for the pre-conference.

The pre-conference is followed by the second meeting with the appeals officer, which is called the "conference" and up to now has been attended only by the taxpayer's team. At this meeting, the taxpayer's team responds to the points made by the examination team and counsel in the pre-conference and presents its position to the appeals officer. At the conclusion of the taxpayer's presentation in the conference, the taxpayer typically engages in settlement negotiations with the appeals officer. In the recently published FAQ, IRS Appeals correctly points out that ATCLs historically have had the authority under the *Internal Revenue Manual* to invite examination personnel to attend the conferences before settlement negotiations begin,⁶ but, in reality, this rarely occurred. Thus, the pilot program represents a significant change in practice and procedure. In the traditional setting, the taxpayer is permitted to state its position without any interference from the examination team or counsel, whereas the pilot program meetings likely will be more free-wheeling sessions that are more like mediation sessions where the two parties engage in legal arguments with each other in front of the mediator. The FAQ specifically

acknowledges that the Appeals Division already has mediation type programs such as the Rapid Appeals Process (RAP) and states that the pilot program is not intended to convert the conference to a mediation session or a RAP proceeding, but it leaves open the possibility for a mediation approach in the conference if the taxpayer consents.⁷ In the Appeals Division's mediation-type proceedings, usually there is first an extended meeting at which both sides present their positions, followed by an attempt to find common ground and an agreeable settlement, with the appeals officer's help as a mediator. Assuming the two sides can agree on a settlement, the appeals officer then exercises the Appeals Division's settlement authority to resolve the case.⁸ The full participation of both parties and the back-and-forth dialogue the new pilot procedure will feature is similar to mediation, although examination personnel and IRS counsel will not participate in the settlement unless the taxpayer judges this in its best interest and consents to it.

Nevertheless, even if the taxpayer does not consent to engage in a type of mediation and have the examination team and counsel present during the actual settlement negotiations, the back-and-forth dialogue between the taxpayer and IRS examination/counsel and the questions and responses from the ATCL likely will clarify to the examination team, counsel and the taxpayer the strengths and weakness of the case as perceived by the ATCL, and this is the aspect of mediation that is useful for settling cases. This is an important point for tax actuaries to consider for insurance company cases. Life insurance company tax disputes often involve technical reserve issues that are the province of tax actuaries, and there may be more of a need for actuaries to attend and actively participate in the Appeals conference. In traditional cases, the IRS actuaries typically attend the pre-conference either in person or by telephone and state their case. In this setting, there is not much opportunity for interaction with the IRS actuaries outside of the limited dialogue that some ATCLs allow to occur during the pre-conference. In the pilot program conferences, on the other hand, the IRS actuaries who proposed the adjustment will attend the conference and likely will be more engaged in a dialogue with the taxpayer in order to influence the appeals officer. Moreover, the IRS actuaries likely will be backed up by IRS counsel who will be there to place a legal framework on the IRS actuaries' points. In this setting, it may be more important for taxpayers to have their own tax actuaries there to make sure that the ATCL is fully apprised of the taxpayer's position regarding the actuarial issues.

According to the recent FAQ issued by IRS Appeals, the stated purposes of the pilot program are to make Appeals conferences more efficient, identify and narrow factual and legal differences and assist appeals officers in evaluating litigation hazards.⁹ As structured, the pilot program should accomplish these things,

although it may make experienced practitioners uncomfortable to have to contend with the examination team and IRS counsel during the conference and may be one step toward less Appeals independence. The silver lining for taxpayers may be a more efficient process where some issues are quickly dispensed with and that results in settlements that can be applied to future years. Even though there is a procedure under which Appeals' settlement authority can be delegated to the examination team for subsequent years,¹⁰ examination teams are often reluctant to do this for various reasons and end up proposing issues over and over again in subsequent audit cycles. The FAQ asserts that the pilot program may help avoid this because "the insight that all parties may gain from an open discussion of positions could facilitate resolution of the same or similar issues in subsequent cycles."¹¹ This may seem like wishful thinking, but in practice, it can only help in future cycles to have the examination team and the taxpayer both fully aware of how their respective positions are received by a neutral, independent appeals officer. For this reason, there are some advantages that may emerge as the pilot program evolves. ■

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ENDNOTES

- 1 See IRS, *Appeals Team Cases Conferencing Initiative: Frequently Asked Questions about Compliance Attendance at Conferences*, available at <http://www.irs.gov/pub/irs-ut/atclfaqs.pdf> ("Conferencing Initiative: Frequently Asked Questions").
- 2 See American Bar Association Section of Taxation, *Comments on Recent Practice Changes at Appeals* (May 9, 2017), available at <https://www.americanbar.org/content/dam/aba/administrative/taxation/policy/050917comments.authcheckdam.pdf>; Alison Bennett, *Concerns Rise on IRS Letting Examiners Attend Appeals Talks*, Bloomberg BNA Daily Tax Report, at G-2 (Aug. 29, 2017).
- 3 *Conferencing Initiative: Frequently Asked Questions*, FAQ 6.
- 4 I.R.M. 8.7.11.8 (03-16-2015), et seq.
- 5 I.R.M. 8.1.10.3 (06-21-2012).
- 6 *Conferencing Initiative: Frequently Asked Questions*, FAQ 12 (citing I.R.M. 8.6.1.4.4 (10-01-2016)).
- 7 *Id.* at FAQs 2 & 4. The Rapid Appeals Process and Fast Track Appeals are two types Alternative Dispute Resolution procedures in which the appeals officer functions as a mediator. See I.R.M. 8.26.1 (09-24-2013); I.R.M. 8.26.11 (07-01-2017).
- 8 Policy Statement 8-47, I.R.M. 1.2.17.7 (04-06-1987). This is necessary because the examination division does not have the authority to settle based on litigation hazards.
- 9 *Conferencing Initiative: Frequently Asked Questions*, FAQ 1.
- 10 Delegation Order 4-24 (formerly DO-236, Rev. 3), I.R.M. 1.2.43.22 (08-25-1997).
- 11 *Conferencing Initiative: Frequently Asked Questions*, Introduction.



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