RECORD, Volume 30, No. 2*

Spring Meeting, San Antonio, TX
June 14–15, 2004

Session 46 PD
What's New and Exciting in Insurance Product Taxation?

Track: Product Development

Moderator: Brian G. King

Panelists: John T. Adney†
Douglas N. Hertz

Summary: The U.S. life insurance industry has not escaped the attention of the Treasury. Products sold by life insurers can be a source of additional tax revenue. Hear industry and tax leaders discuss recent, ongoing and potential issues, including initiatives affecting various products and markets, Internal Revenue Code Sections 7702 and 7702A and 2001 CSO Mortality Table. Attendees learn the current and potential impact of tax issues on insurance products and are in a better position to address current issues and anticipate new ones.

MR. BRIAN G. KING: The first thing I'd like to mention is that the SOA is in the process of developing a new product taxation section. Everybody should have received an application form. The SOA Taxation Section isn't quite up and going at this point. One of the requirements is that we have 200 paid members in order for this to become a full-fledged section. If you do have an interest, it's important to get the application in as soon as you can. What we're trying to do with this section is to get a coordinated effort within the SOA to address tax issues. We're going to focus on insurance tax issues and product tax issues, as well as issues regarding qualified and nonqualified employee benefit plans. this organization will create networking and research opportunities. We're going to try and form a newsletter that will be published on a regular basis to update its members on current events and issues that are coming up, as well as doing sessions like these at SOA meetings. It would be worthwhile.

---

†Mr. Adney, not a member of the sponsoring organizations, is partner at Davis and Harman LLP in Washington, D.C.

Note: The chart(s) referred to in the text can be found at the end of the manuscript

One thing that is going to make this a little unique is that we're going to open membership up to non-SOA members. Tax attorneys within companies and certainly those who practice in tax issues who have an interest in joining should feel free to do so. When you go back, you might want to let those people know about the tax section and see whether or not there's an interest there, as well.

One of the other tax-related issues that's going on now is a product tax seminar that's scheduled September 15—17 in Washington, D.C.. We're anticipating that we will have 200 members for the section, and one of the first efforts is going to be to sponsor a tax seminar. This is going to be the third year that the SOA is running a product tax seminar. Seminars were put together in 2000 and in '02 that were co-sponsored by Aon Consulting and the SOA. The prior sessions tended to focus more on life insurance product tax. What we've decided to do this year is to expand the syllabus to include annuity tax issues, as well. We're trying to broaden the scope of the product tax seminar.

The structure this year is going to be a little different from what we've done in the past. We're going to offer what is called "boot camp," which is going to be a one-day intensive seminar, targeted more for those who probably don't deal with the tax issues on a day-to-day basis. We're going to run two concurrent seminars. One is going to focus on life insurance product tax and the Sections 7702 and 7702A requirements. The second is going to run alongside on the basics of annuity taxation. That will be on Wednesday, and that will be followed up on Thursday and Friday with some more advanced topics on some product tax issues.

The IRS has agreed to participate in this seminar, as well. Mark Smith, the branch chief, will be there. The organization's participation in the past has been well-received. It's going to be a good seminar.

What we're planning on providing to participants who attend the seminar is a book. This is a book that is scheduled to be out in time for the seminar. The printing date is about a week or so before the seminar. The book is called *Life Insurance and Modified Endowments Under Internal Revenue Code Section 7702 and 7702A*. As far as I know, this is the first book of its kind to be developed dealing with life insurance product tax. For those who do get involved in product tax issues, trying to get your hands on available resources, guidance, legislative history and so on is not easy. What we put together here—the authors are Chris DesRochers, John T. Adney, Doug Hertz and Brain King—is a comprehensive book covering from start to finish the requirements under Sections 7702 and 7702A. It gives the historical background that led to the development of these sections, the calculation rules, adjustment rules and so on.

We have three topics that we're going to cover in our session. I'm a vice president and consulting actuary with Aon Consulting. I'm going to spend some time going over the issues regarding product tax as it relates to the 2001 CSO. Doug Hertz, also a vice president with Aon, is going to follow up with a discussion on Sections

7702 and 7702A issues. He'll talk about some of the recent rulings that have come out in the past year or so, as well as the revenue procedure that was issued last year that talks about taxation of distributions under Section 7702.

John Adney, a partner at Davis and Harman LLP in Washington, D.C., is going to follow that up with a discussion on some of the corporate-owned life insurance (COLI) and business-owned life insurance (BOLI) issues that are out there, as well as some of the recent guidance that's been issued that affects Section 412(i) plans.

What I'm going to talk about are the 2001 CSO issues as they relate to Section 807 reserves, as well as the issues that you're going to need to be aware of as they relate to our funding limitations under Section 7702 and to our modified endowment contract (MEC) limitations under Section 7702A.

Both the reserve calculations and the funding limitations under 7702 have associated mortality requirements that place a limitation on the level of mortality that we can use in those calculations. Our reserves are limited by way of what is called a "prevailing commissioners' standard table." That sets our mortality requirements for our Section 807 reserves. Similarly, our calculations under 7702 and 7702A have limitations on the mortality, as well. Those are limited by what is referred to as "reasonable mortality." We don't have a definition that explicitly tells us what "reasonable" means, but we do know that if we exceed the mortality in the prevailing table, we've crossed over that line. There's a connection between our mortality requirements under 7702 because that ties back to the Section 807 definition of the prevailing commissioners' standard table.

What is a prevailing table? Section 807 provides a definition for it. I broke it up into pieces, and we'll talk about those pieces individually. The prevailing table is the most recent commissioners' standard table prescribed by the NAIC. In December '03 the NAIC went through its approval process and adopted the model regulation for the 2001 CSO, so that standard has been met. The 2001 CSO is the most recent table prescribed by the NAIC.

The prevailing table also needs to be a table that's permitted for use in valuing reserves for that contract. The key word here is "permitted." The model regulation, as it's written, has both a permitted date and a required date. The permitted date is the date that companies can begin to use the 2001 CSO for purposes of reserves and nonforfeiture. There's also a sunset date, which is January 1, 2009, when all contracts sold in those states are required to use the table. What we're looking for is the states need to permit its use, so they need to go through their own state adoption process that would allow companies to use the table. We need 26 states to approve the table to allow for its use in order for the 2001 CSO table to be viewed as the prevailing table. This is a standard that would apply to newly issued contracts.

I believe we have reached the 26-state level, so I would expect that the 2001 CSO would be prevailing July 1, 2004. Most of the adoptions were retroactive back to the beginning of '04. A few of those had a prospective date of July 1, so even though I believe we've had 26, I think maybe 27 states approved it. Some of those approvals have a forward date associated with those. On July 1, 2004, the 2001 CSO should become the prevailing table. In the handouts that were printed, I had January 1, 2005, but I think it's going to be earlier than that.

As we move through the transition process to the new table, there are a couple of issues of which you need to be aware. This is the first time the industry has had to go through a transition process from one CSO table to the other. Back in 1984 when Section 807 was added to the Tax Code, the 1980 CSO was already the prevailing table so there was no need to transition for 807 purposes. Similarly, when the reasonable mortality requirements were implemented in '88, we had a ' short window where you could continue to issue products under the '58 CSO table, so the whole concept of transition in that regard was never a concern because essentially all products sold at that time were based on the '80 CSO. This is the first time we're going forward through a transition to a new table.

The good news for Section 807 is that the statute anticipated the transition to a new table. There was an expectation that over time the CSO tables would be updated. They had enough forethought to put transition rules directly into the tax law. From a transition perspective, things are somewhat clearer under Section 807 than they are under Section 7702. The transition rules under 807 essentially give us a three-year window that would start on the first of the calendar year following the 26th state adoption and continuing for the next three calendar years. We'll have a period now of three-and-a-half years, from July 1, 2004, to the end of '08, where companies have a choice of using either the old table or the new table. What I think you'll find is that as you move your products over from a 1980 CSO to a 2001 CSO, you'll move the reserve basis over to the new table as well.

What this creates is a one-year period, from '08 to '09, where the model regulation gives you the ability to sell products using a 1980 CSO mortality basis but puts you in a situation where your tax reserves need to be based upon the new mortality table. That last year may be problematic from a reserving perspective as you need to move those over to the new table.

There's also another rule in 807 that tells us which version of the 2001 CSO table we need to use for tax reserves. The 2001 CSO isn't a single table; it's a collection of tables. I believe there are upward of 84 different tables. You have an ultimate version, select and ultimate, a number of unisex versions, as well as smoker, nonsmoker and composite tables. There's a rule in 807 that says when we have more than one table to choose from, we choose the table that generally yields the lowest reserves. Part of the development of the 2001 CSO was to construct the tables in such a way that the ultimate version of the table would generally yield the

lowest reserves. I think that's a good thing because it eliminates the need to have to implement select and ultimate tables into our reserve calculations.

The other choice for companies is whether to use the aggregate versus the smoker-distinct tables. Here you need to take a look at your in force and see what your distribution of smokers to nonsmokers is and how that compares to the underlying mortality in the tables. Then decide whether or not you want to use the smoker-distinct versus the aggregate table for reserves. Essentially you'll end up with a choice for smoker/nonsmoker or a composite and generally use the ultimate table. This is an area where we should get some guidance from the IRS that will at least confirm what the Academy assumed in the development of its tables.

I'm going to move to over to the Section 7702 requirements. I mentioned earlier that we do have this requirement that says that we use reasonable mortality in developing our limitations under Sections 7702 and 7702A. Again, we don't have an explicit definition of what reasonable mortality is, but we do know that if we start to exceed the rates in the prevailing table, we've crossed that line. This is going to affect our guideline premium calculations, our net single premium calculations under the cash value accumulation test and our 7-pay premiums.

Again, we have similar issues that we have under Section 807. We have an issue as to when we're required to use the 2001 CSO in our tax law calculations. Again, which table should we use? We have a collection of tables, so which one is appropriate for these calculations? There's also another issue. The 2001 CSO has some unique characteristics that distinguish it from its predecessor tables. Not only is it select and ultimate, but it also has a terminal age now that runs out beyond age 100. This table goes out to age 121. This creates a little tension with the calculation rules under Section 7702, which are designed for a terminal age of age 100. The question becomes, if we do start to take advantage of the fact that the 2001 CSO runs out to age 121, what implications does that have under our 7702 requirements? How do we incorporate that? *Can* we incorporate that into our calculations? I'll get into that.

When is a 2001 CSO reasonable? Again, here we're talking about our transition rules. Section 807 was somewhat straightforward. That statute tells us what our transition period is and how we go through the transition from an old table to a new table. We don't have that in 7702. There isn't an explicit set of transition rules. Section 7702 does refer back to Section 807 in terms of setting the prevailing table as the upper bound on reasonable mortality. Some feel that because it does that, it would encompass the transition rules under 807, as well.

It's not clear that that's what ultimately will be decided upon for transition here. At the time this seminar was scheduled, there was an expectation that the IRS would have issued guidance on this question or that the Treasury would have issued guidance dealing specifically with transition as well as some of these other issues that I am going over this morning. As far as I know, the IRS has forwarded its

recommendations to the Treasury. The problem is that the person to whom it forwarded those recommendations is no longer at the Treasury. That position has been vacant, which has held up the issuance of guidance in this area. I'm hoping that by the end of this year we have something. The IRS is certainly aware of the issue, and the Treasury is aware of the issue. They just need to figure out how best to deal with this situation given that that position has been vacated.

The ACLI has been active in this area. It has put forward its recommendations to the Treasury as to what the transition rules should look like. Its suggestions are that as we move products over to the 2001 CSO, that table would be a safe harbor for our reasonable mortality requirements, we would still have the 1980 CSO tables as a safe harbor as long as we issue products under those plans, and we would have this ability up through January 1, 2009, which is the required date under the model regulation for using the 2001 CSO. That might be a bit aggressive. It certainly extends the transition period out beyond what 807 would give us for reserves. That's been its recommendation going forward.

One of the other issues that the ACLI is asking for is that material change treatment on contracts, whether that's through an adjustment or a material change under Section 7702A, would not cause a contract to lose grandfathering and subject the contract to the 2001 CSO requirements. I'm guessing we probably won't get guidance that deals specifically with this, but they wanted to put forth that premise, as well. This is not a new issue; it certainly exists with our 1958 CSO contracts. The industry might be better off just allowing the current practice to continue than to go ask the specific question of how we deal with this issue.

We have a collection of tables here. The question becomes which tables will satisfy our reasonable mortality requirements? The hope is that we do get safe harbor treatments for using the 2001 CSO, and that our guidance would allow us the full use of 100 percent of the CSO tables. Guidance has been issued in the form of a notice and a proposed regulation for the 1980 CSO tables. It gives us safe harbor treatments for those tables. The notice was issued back in '88. The one thing the notice didn't give us is that it didn't include all versions of the 1980 CSO. It was focused specifically on the sex-distinct versions, smoker/nonsmoker and aggregate. It didn't include the blended tables for unisex contracts. Proposed regulations were much broader in their coverage and included safe harbor treatments for all versions of the 1980 CSO. Hopefully that will serve as the premise for guidance that we'll get on the 2001 CSO.

I mentioned earlier that we have the issue regarding the terminal age of the new table. It runs out beyond age 100. That becomes a problem because Section 7702 and its calculation rules require that we deem a contract to mature between ages 95 and 100. The question becomes what if we have an actual maturity date in a contract that runs out beyond that point? Do we reflect benefits that are provided out beyond age 100?

We also have questions regarding the corridor requirements under the guideline test. The corridor itself is published as part of the statute. It stops at age 100. Can we take the age-100 factor and extrapolate that out? At that point the factor is actually "1"; there is no requirement for insurance in a contract at that point. It seems unlikely the IRS would be comfortable saying that you have up to 25 years of a contract that doesn't require any insurance in it to qualify as life insurance under the tax laws. You need to use some care here in deciding whether you run your terminal age and your contracts out beyond age 100, and at least consider how you should impose the corridor requirements under 7702.

The problem with dealing with these questions is that this is something that's hard-coded in the statute. Guidance isn't going to address this in the manner that it can change what's in the statute. I think the only way that they can come out and deal with this issue is by opening up 7702 to legislation. That may be a dangerous area for us to go down. Once they decide to open that up, there's no guarantee that they're going to focus specifically on this issue. History has shown that the more times they open it up, the funding levels go down and the investment orientation goes down and certainly it puts at risk the inside buildup that exists today in our contracts. I'd be surprised if we do have this issue specifically addressed in the form of guidance.

What we should find as we move over to the new table is that we're going to get a reduction in allowable funding in life insurance contracts. It certainly won't be uniform across the board. The difference between the 1980 CSO and the 2001 CSO mortality does vary with risk classifications, but you should see a 15 percent to 25 percent reduction in your funding for males and a slightly lower reduction for females. The effect of running our guideline premium calculations out to the terminal age of the new table under the guideline level premium option 2 mechanics is that you get a significant bump in your funding limits (an increase of 50 percent to 60 percent for males and an increase of 55 percent to 70 percent for females), which is a little counterintuitive given that we now have lower mortality. But given the nature of how the option 2 contract works, results are somewhat surprising.

Chart 1 shows you what little difference there is in all the other calculations for a terminal age of 100 versus age 121. As you develop products, if you do choose to extend your maturity dates out beyond age 100, you can see what the effects would be on your funding limitations. Again, you can see the huge increase in the option 2 contracts. I wouldn't suggest that we all start running our calculations out to age 121 for option 2 because that would be the one big area where you're going to run a risk in terms of exceeding what may ultimately be allowed under the option 2 calculations.

What do we do pending guidance? As you do develop plans based on the 2001 CSO, it would be a safe bet to assume that we could use the 2001 CSO as a safe harbor. I think we need to follow consistency rules, and as we develop products on

a smoker-distinct basis, we need to use smoker-distinct versions of the table. Choose the table that's consistent with the way the product has been developed. I think the transition to the new tables is likely to focus on our death benefit products first, and so that's going to have the biggest effect of lower premiums. There, the age-121 problem is less likely to be an issue. I would suggest staying within the current rules for 7702 as they're written. Limit your terminal age to age 100 and use your current company's practice regarding extended maturity.

The last thing I want to mention is that we do have a table that has some unique characteristics. Make sure your systems are able to support those. We have a table that goes out beyond age 100, and getting systems, especially legacy systems and homegrown systems, to support a table that has a different structure to it may be difficult. Don't wait until the end to develop products and then go tell the systems people that you have this new table. I would anticipate not just all your administrative systems, but your illustration systems, as well.

Now I'll turn it over to Doug.

MR. DOUGLAS N. HERTZ: I'm going to talk about Revenue Ruling 2003-95. My first comment is that the lack of published guidance under 7702 is truly comprehensive. We have, I think, Revenue Ruling 91-17, which wrote down in great detail all of the varied ways the IRS could beat you up if you had failed contracts. Now we have 2003-95. There's a decade where things just got lost. Nothing happened. Revenue Ruling 2003-95 has as its seeming purpose to explain the operation of 7702(f)(7)(B), (C), (D) and (E). We'll have to take a look at this. We'll see how it works, and then we'll see that it wasn't really necessary.

Normally, distributions from a non-MEC are taxed on a first-in, first-out (FIFO) basis. If a distribution is taken from a non-MEC life insurance contract, it's deemed first to be a recovery of your basis, the premiums paid, and not taxable. Once you've recovered all of your basis in the contract, what Section 72 calls "the investment" in the contract, then amounts that come out are deemed taxable. The other extreme you could go to is last-in, first-out (LIFO), under which the first thing that is deemed to come out of the contract is whatever gain is in the contract. You get taxable income on the first nickel that comes out if there is gain in the contract. Life insurance gets a favorable rule subject to an exception created by 7702(f)(7)(B), (C), (D) and (E).

I must say that this is the most widely ignored provision in Section 7702. I know of a lot of companies where no one in the company has any idea these provisions even exist. The way the rule works is that if benefits are reduced during the first 15 contract years (it's important to note that it applies just during the first 15 contract years), and the result is a cash distribution to the policyholder, then we're going to change the order of things and apply a LIFO rule to that part of the distribution that does not exceed something they call in the statute the "recapture ceiling." You shouldn't pay too much attention to the results in a cash distribution. If there is a

cash distribution and a benefit reduction, the IRS is probably going to think that this rule applies. There's a two-year look-back, so that if you take a distribution and do a benefit reduction some other time, the IRS still has the ability to beat up on you.

In the first five contract years, one rule applies, and then in years six to 15 there's another rule. During the first five years, the recapture ceiling depends on the 7702 test applicable to the contract. You've got the cash value accumulation test and the guideline premium limitation and the cash value corridor. Those are the two tests. One of them has to apply to the contract. What the recapture ceiling is will depend on which test applies. The amount of the recapture ceiling is literally going to be the amount of cash that is forced out of the contract in order to allow it, after the benefit reduction, to continue to comply with the requirements of Section 7702.

After the fifth year, in years six through 15, a milder rule applies. You take the premium test corridor from 7702(d) and ask what that would have forced out of the contract. It doesn't matter whether the 7702(d) corridor applies to the contract or not. Whether it's a cash value test contract or a premium test contract, in years six to 15 the question is what would the premium test corridor have forced out of the contract?

In years six to 15 we get a milder rule. Roughly speaking, you can say that in the first five years we're going to beat up on you to the full extent of your sin, your sin being that you've accumulated cash value in the contract in excess of what would be allowed in the contract once the reduction had occurred. In years six to 15, a gentler rule will apply.

Starting in '88 with the coming of the MEC legislation, I've had something of a problem with the continued existence of these rules. Aside from extreme situations bordering on the bizarre, these rules don't do a lot. That's why I think it's almost justifiable that at a number of companies, these rules are widely ignored. Sometimes revenue rulings just have random numbers in them. The numbers in the published ruling do more or less cohere, and you can make some actuarial sense out of them. I changed them a bit to make them something that I had computed because I wanted to see how it really works.

The situation in the ruling is that a male age 46 buys a $350,000 life insurance contract. Four years later at age 50, he takes away 60 percent and reduces it by $210,000, so that he winds up with a $140,000 contract and takes $36,000 in cash out. The premise of the ruling is that the premium paid in those first four years had been $45,000, and the cash value that had accumulated in the contract was $60,000, so he had $15,000 of gain in the contract.

I computed a 7-pay premium for the contract, and it came out as $18,760. As the ruling states, the contract doesn't have to be an MEC, so you can assume it isn't. That could be accomplished, for instance, by paying $11,250 each year for four

years. If it's a cash value test contract, the ruling proceeds to show what happens if we've got a cash value test contract and what happens if we've got a premium test contract, and what happens in years six to 15. The net single premium at age 50 is roughly $358 per $1,000, or roughly $50, 195 for the resulting $140,000 contract after reduction. As far as the recapture ceiling, how much had to get squeezed out of that contract to maintain compliance? There was $60,000 in it by assumption, and the limitation is $50,000, so $9,805 got forced out of the contract. The gain in the contract was $15,000. That's higher than $9,805, so $9,805 is the taxable amount and the excess is not taxable. I take the $36,000 distribution, I subtract off the taxable amount $9,805, and I get $26,195. That's the amount that the basis gets reduced, from $45,000 down to $18,805. We have some effect here, but it's not exactly a big deal. Something like 27 percent of the distribution wound up being taxable. That is out of a fairly extreme reduction of taking away 60 percent of the face amount of the contract.

If we have a guideline premium test contract, issue age 47, we have $245 per $1,000 as the guideline single premium. For a $350,000 contract—recall that's the size of the contract that was issued—we've got to compute the guideline premium limitation and then go through an adjustment calculation. The guideline single at issue was $85,932. The guideline level at issue is $21.32 per $1,000, or $7,462 for a $350,000 contract. At the time of reduction, the guideline single is $85,932 and the sum of the guideline levels to that date (assume there are four of them) is $29,848, so the overall guideline premium limitation at the time of the reduction is $85,932, the greater of the two.

At age 50, the guideline single and guideline level premiums per $1,000 are $278.47 and $24.81, respectively. For the $210,000 decrement (the amount that got taken away from the contract), we get $58,478 for the single premium for the amount that was removed, and we get $5,210 for the level premium for the amount that was removed. After reduction, what's the guideline single premium now for the contract? It's the original $85,932 minus the $58,478, so I get $27,454. The sum of the guideline level premiums before reduction was $29,848. We take away one guideline level for the amount removed and that gets us down to $24,638. In the future, people tend to just put the two together. They say that they've got a plus amount and a minus amount, they'll just put them together and in the future there will be increments of $2,252 each year in the sum of the guideline levels to date.

The new guideline premium limitation for this contract right after the benefit reduction is $27,454. We had premium in the contract. In the cash value test, we played with the cash value, $60,000. Now we're at the premium test. The amount of premium paid was $45,000. I take $45,000 minus the $27,454, which is the guideline premium limitation now, so $17,546 is forced out by the guideline premium limitation. There's another part to the guideline test, and that is the cash value corridor. At age 50, the corridor is 1.85. The requirement is that the face

amount, the death benefit in the contract, has to be at least 1.85 times the cash value in the contract.

Another way of looking at that is to say that if you know the benefit amount, you divide it by 1.85, and that's a cap on the cash value that can be in the contract. The cash value maximum in the contract is $140,000 divided by 1.85, and that's $75,675. The corridor produces no amount forced out. Then the definitional test forces out of the contract the $17,546 that's forced out by the guideline premium limitation. That's the greater of the two numbers we've computed. We don't have $17,000 of gain in the contract; we have only $15,000, so the taxable part of my distribution is $15,000. Notice here how weak the corridor force-out is. Even with a rather extreme reduction, we came nowhere near to having a corridor force-out.

The amount of the distribution, $36,000, minus $15,000 is $21,000. That's the amount by which we reduce basis in the contract from $45,000 down to $24,000. An odd provision, 7702(f)(1)(A), says as a special sort of exception to the way things would normally work, if you have amounts that are taxed under 7702(f)(7)(B), (C), (D) or (E), even though it was a taxable amount that came out of the contract, it still reduces premiums paid. The premiums paid amount gets reduced further by the $15,000. The odd thing to note then is that premiums paid and basis can, in fact, be different.

The contract was an MEC the minute you took the reduction. In my experience, that's the way the world works. I have tried to construct examples where this five-year rule actually has an effect on a contract that is subject to the MEC legislation. I have not succeeded. Section 7702A says that when you have a reduction in benefits in the first seven years of the contract during the time of a 7-pay test, you have to go back to the start of the contract and recompute your 7-pay premium as if the reduced benefit amount had always been the benefit in the contract. When you do this for this $140,000 benefit that's left, you get $7,504 for your 7-pay premium. The contract became an MEC because within four years, $45,000 of premium was paid. At some point you had to have put in too much.

The moral of the story is that it's hard to find any use for 7702(f)(7)(B) because today any contract subject to the rule, which applies only for the first 15 years of the contract, is automatically subject to 7702A. About the only thing that's left (if I'm correct in what I'm saying) is that extreme reductions in years eight to 15, when the reduction rule in 7702A no longer applies, can produce some tax. But that's about it.

What did we get? Was there any real reason to talk about this? I think there was. We've got official guidance now on how adjustment calculations are done. The answer is something called attained age layering, or attained age increment or decrement, depending on whether things are going up or down in your adjustment event. If your company has been doing something else other than attained age layering, it's time to rethink your position because the IRS is now formally on

record as to how this stuff is supposed to be done. I know there are a lot of companies out there where some bright young actuary has taken a look at the crazy effects attained age layering can give, such as negative guidelines when you have large reductions after the passage of a long period of time. The actuary looks at it and says, "That's crazy. I can do better." The actuary comes up with a new rule. The IRS has now more or less said, "You know, that isn't the way it's done." Think about it if you've been doing something other than attained age layering.

Let's go to a new topic: family term and other qualified additional benefits (QABs). Family term coverage is a QAB under Sections 7702 and 7702A. Charges for QABs are treated as future benefits. A further point is that in '88 they changed the rule from mortality and other charges as specified in the contract to reasonable mortality charges and reasonable charges for things other than mortality. Other charges are reasonable if the amount that you take into account is an amount that is reasonably expected to actually be paid.

For reasonable mortality, we have a different rule. Treasury Notice 88-128 allows the use of 1980 CSO mortality as a safe harbor regardless of what you charge. There's a reason for this rule. It was so that in the cash value accumulation test, we wouldn't wind up with a federal maximum that was below state-mandated minimums for nonforfeiture values. I think it's well-known in this audience that the 1980 CSO has gotten substantially out of date; the 2001 CSO has substantially lower mortality. Actual charges for family term QABs are often substantially less than the 1980 CSO costs that are allowed as reasonable mortality.

What happens if you make a mistake under 7702? In 7702(f)(8), the IRS was given the authority to waive contract failures caused by "reasonable error." It's done by a private letter ruling. These rulings cannot be used or cited as precedent, but, given the lack of published guidance that we have, we usually find out what the IRS is thinking under 7702 by reading waiver rulings.

There are four letters (200150014, 200150018, 20027036 and 200320020) that address the question of whether charges for family term and other QABs are to be treated as mortality charges or are to be treated as other charges. The difference that will make is does the 1980 CSO safe harbor apply to the charges for family term? The IRS concluded in each case the charges are other charges and are not subject to the safe harbor of Notice 88-128.

Companies have gone in and explained to the IRS their theories of what they thought they were doing. Some people say, "We're buying insurance. It's a mortality cost, right?" Some of us think that it's a gross premium, not a cost of insurance. The IRS got to that result by a different line of reasoning. In one of the letter rulings, the actuaries noted that the QAB charges are treated as death benefits under 7702(f)(5). From that they concluded that mortality charge treatment is the right way to go.

In one of the other rulings, mortality charge treatment was given to waiver riders, and probably on the same theory. You're treating the QAB charge as a death benefit, and so, of course, it's mortality. The answer is no. The IRS noted that 7702 specifically provides that the net single premiums for the cash value test is computed treating QAB charges, all of them, as other reasonable charges. Absent any other statutory guidance, the IRS concludes the other charge treatment applies to guideline premium test contracts, as well. In all four cases, the IRS gave a reasonable error waiver to the issuing companies. It had to pay the cost of getting a private letter ruling but didn't have to pay some horrendous toll charge to have its sins wiped away.

Companies with this problem are in a sticky situation. There are a number of waiver rulings out now announcing the IRS position. If you've got this problem, if you have contracts that fail by virtue of the IRS's position, you might want to go seek a waiver or a closing agreement. The alternative is to sit tight and maintain your present position. That's hardly an attractive choice to have to make. John's firm has got a group of companies addressing the resolution to this. They've gone in to the IRS and started haggling. They want a published ruling with effective date relief. John, where does it all stand?

We asked for a special kind of relief principally because the IRS had said in some public forums that the private rulings that had been issued were the law in its view, and everybody should know it by now. In the not-too-distant future, the IRS would stop issuing waiver rulings and start pushing people into closing agreements if they hadn't shown up before then. The closing agreement, of course, requires payment of a toll charge equal to the tax on the inside buildup of the contracts. This seemed to us to be a little harsh. Also, the other problem that arose for a number of our clients was that many of the contracts involved were on legacy systems; they were not easily changed. In fact, some said they were not changeable at all to conform with the rule that followed the expense charge rule rather than the mortality charge rule in 7702(c).

We sought the transitional relief that Doug described. We sought relief saying that while the new rule in the published revenue ruling would be the rule henceforth, for the past, there would be no need to correct contracts, but you could not issue contracts any longer using the old rule. The IRS has processed our request. We're not sure what it has recommended to the Treasury Department. It's always tight-lipped about those things, but I think it saw the point and was striving toward some means of saying "yes" to our request.

The Treasury seat, as mentioned, is vacant at the moment and has been for some months. As a result, this matter, along with the 2001 CSO and various other things, is backed up and not going anywhere. However, I would expect this would get attention once the Treasury position is filled. We'll have to stay tuned to see where this is. As far as we're concerned, it still has life. The IRS branch certainly sees the

point; it has no problem with getting out guidance. Quite the contrary. It wants to get out official, published guidance on this point.

MR. JOHN T. ADNEY: My job here today is to talk about COLI, BOLI and specifically the Section 412(i) guidance package. I will explain what all that is about and why we should care about it. What I want to talk about today is the COLI legislation pending in Congress. I'll give you a little background on it and some of the context and then go through the details of that legislation. It affects not only the sellers of large-case BOLI and COLI, which is what prompted the legislation, but it affects *every* COLI contract that would be sold if the legislation passed. That would include life insurance sold to small business for traditional deferred compensation funding, key person coverages and so forth.

I also want to spend a few minutes talking about compliance with current law, specifically in the case of BOLI. How did Congress get into the business of writing legislation on COLI? As I think you know, *The Wall Street Journal* in '02 ran a series of articles. These were picked up in other media. The articles were critical of COLI, specifically of leveraged COLI that had been sold to large corporations covering vast numbers of employees without the employees' consent or even knowing that the coverage was there. The articles were critical of the way the insurable interest laws in the states were being administered or perhaps were not being administered. They did brush across the tax treatment of COLI, as well. Representative Gene Green (D-Texas) put in a bill that would have required employees to be notified if COLI was being sought on their lives. Senator Jeff Bingaman (D-NM), a member of the Senate Finance Committee (the tax-writing committee in the Senate), came up with a different plan. His plan was far more sweeping. He would have denied the historic Section 101(a)(1) death benefit exclusion—the COLI contracts—with certain exceptions. It was a sweeping statement reversing rules that had been clarified in the tax law in '21.

The Senate Finance Committee reacted to Senator Bingaman's proposal first by adopting it and then by having second thoughts. It was an extraordinary set of circumstances. The week, I recall, of September 17 was not a great week in Washington because the Finance Committee adopted Senator Bingaman's proposal, and the next day the hurricane came through Washington. We had Senator Bingaman's proposal, we lost electricity, there was flooding and generally it wasn't a good week.

By October, the flood had receded and so had Senator Bingaman's proposal. The members of the Finance Committee understood what they had done and were somewhat mortified by that. They had been thoroughly talked to by every life insurance industry lobbyist who is afoot in Washington. The committee took the extraordinary action of putting Senator Bingaman's proposal, which the committee had unanimously adopted, essentially on hold and said that whatever the committee ultimately did with the proposal, which was being considered as part of a pension bill, would not be effective until it was signed by the president. That itself is

an extraordinary thing—to have tax legislation have an effective date that far in the future when ostensibly an abuse is being closed down.

That's what the Finance Committee did in '03. Then the members went home for Thanksgiving. They came back and on February 2, 2004, they approved, as part of the pension legislation, the National Employees Savings and Trust Equity Guarantee (NESTEG), a proposed new Section 101(j) of the Internal Revenue Code. This replaced Senator Bingaman's more adverse proposal that the committee had adopted first in September and then, with the effective date revision, in October '03.

I'll go into some of the details in a minute, but what Section 101(j) essentially would do would be to limit the employees who could be covered and still have the corporate policyholder death beneficiary receive the death benefit income tax-free. It also, in order to get the good tax treatment, would require the consent of the employees covered, other notices to them and certain reporting by the employer. Essentially, this is a federal insurable interest and consent requirement. The proposal that was adopted on February 2, 2004, would maintain as the effective date the date the president signs it into law.

What does Section 101(j) do? First, it implements Senator Bingaman's general rule. The death proceeds of COLI that would be covering an employee (not all COLI, but employer-owned life insurance—something that an employer, or a corporation related to an employer, was holding on an employee) would now be taxable to the employer in excess of premiums paid. This is just like the transfer-for-value rule under Section 101(a)(2). That's the general rule, but there are exceptions. The exceptions run this statute. The exceptions essentially allow certain of the proceeds to remain tax-free.

There's also a significant "key employee" exception. As originally drafted, the key employee exception ("key employee" in this bill is a very broad term) was designed as an exception to the definition of "employer-owned" life insurance. The bill was recently released in statutory form by the Finance Committee when it reported out the NESTEG bill. When the members rewrote it, they moved the key employee exception up with all the other exceptions. It's no longer an exception to the definition of "employer-owned"; it's just an exception. It was a movement in form. It could have some strategic significance later on, but we're not going to worry about that now.

One exception to the general rule exists for employee death during employment or within 12 months of leaving employment. That's the basic Bingaman rule. It's okay for an employer, provided consent and notice requirements were met, to receive death benefits tax-free if the employee dies while employed or within 12 months after leaving employment. That's in the statute.

In addition, in the original Bingaman proposal there were exceptions for proceeds payable to the employee's family, to certain other designated individuals, to trusts for them or to buy out an interest in the employer. This is a typical cost purchase kind of funding.

The big change is in the key employee exception. Generally speaking, an employer-owned life insurance contract is a contract owned by and directly or indirectly benefiting the business. It's someone engaged in a trade or business, usually a corporation. It can be an affiliate. An employee for this purpose includes any officer, director or highly compensated employee (HCE), as well as any other employee. These definitions are intentionally broad because we want to cast the net broadly and then carve exceptions into it.

Now comes the big one—the key employee exception. This was heavily negotiated between the industry and the Finance Committee, particularly the Finance Committee staff. This was not in Senator Bingaman's proposal; this is the opposite of Senator Bingaman's proposal. This is why Senator Bingaman filed dissenting views in the report on the NESTEG bill. Senator Bingaman, as far as I know, is alone in his opposition at this point.

The key employee exception is that the restriction in the bill, the loss of the death benefit, does not apply where you have an HCE as defined in the pension rules Section 414(q), or a highly compensated individual as defined in the health insurance nondiscrimination rules, Section 105(h)(5). Substitute 35 percent for 25 percent in 101(h)(5). What all this means is that for employees who are in the top 35 percent by pay and for any director, coverage on these people will still get the death benefit exclusion under proposed Section 101(j). All the traditional uses of COLI are still okay in terms of the death benefit exclusion and coverage of the top 35 percent, provided that the consent and notice requirements are met. That's the way this bill works. The industry is very much at peace with this proposal. In my view what it really means, again, is that we have a federal insurable interest and consent law here, not something that is going to pare back the use of COLI, as Senator Bingaman had originally proposed.

Under the notice and consent requirements, the employee must be notified of the employer's intent to get the coverage. The ultimate amount that might be obtained must be stated in the notice. The employee must consent in writing. The employee must be notified that the coverage could continue after he or she leaves employment.

There's a reporting requirement imposed on employers. The employer reporting requirement is that the total number of employees, the total number of insureds, the total COLI face amount and a few other things must be reported annually to the IRS. The report must certify compliance with the notice and consent requirements. These latter two were amendments sponsored by Senator Bingaman during the

mark-up of the COLI provision of the NESTEG bill on Groundhog Day. That's what the proposal is about.

The effective date is date of enactment. There's an exception in here, interestingly enough, for Section 1035 exchanges. An exchange of an old contract for a new contract after the effective date that is tax-free under Section 1035 will not pick up the new rules. This was requested by the banking industry, which owns a large portion of COLI, particularly the larger contracts. It wanted the ability to do 1035 exchanges without meeting the new requirements. I'm not sure that gives it much, but it is a somewhat extraordinary rule in tax legislation.

There's also a rule that material death benefit increases and other material changes are new contracts. For purposes of the effective date, the reporting is supposed to begin this year.

What are the prospects for enactment? What are the prospects that any of this will take effect this year? There is certainly agreement in the Finance Committee for this to move forward. But for it to move forward, it needs to be plucked out of the NESTEG bill, which is not going to pass this year, and moved into some legislation that will pass. There needs to be a political will to do that. Political will is generated by people asking for things to happen. It's up to the life insurance industry to push the enactment of what is now considered a favorable piece of legislation and to bring this matter to closure. From what I can tell, this has unfortunately slipped from being a top priority to a middle-range priority. That is not good enough to get this enacted. If this lays over to the next Congress, it could change dramatically. I doubt that the make-up of the Congress is going to change too much, but the White House is at the moment a flip of the coin, I think. A different Treasury Department could have a big impact on the shape of this legislation, and it could turn into something much more adverse to the life insurance industry after the election.

I'd like to say prospects for enactment were good because it turns out to be a good bill for the industry, but I can't say that. I don't think the industry, through its organizations in Washington, is pushing this hard. It needs to get its act together and push this. It needs to be on the train when the train leaves the station. There will be a train; there are possibly two. One is the Foreign Sales Corporation (FSC)/Extraterritorial Income Act (ETI) legislation that's currently pending to get rid of the Foreign Sales Corporation regime that was ruled World Trade Organization-(WTO-) noncompliant. That's a hard thing for the Congress to pass this year. It's been working hard on it, but this could be added to that. It's more likely that there will be some kind of a bill moving through on what we call "budget reconciliation." This is protected from filibuster. It's part of the budget process. It would be possible to attach this to that. But you have to ask, and "ask" in Washington means spending some political chips. The industry hasn't done much on that yet, but I hope it will. It certainly needs to before this Congress leaves town.

Let me say a few words on BOLI. The IRS has been out auditing banks. It has an information and document request (IDR). A subpoena that is given as part of the audit process to any taxpayer that's under audit. What the IDRs have been asking in the case of BOLI are things that we all need to be concerned about, and we have to try to design products or deliver products that are on the right side of these issues. These are all predictable issues. What the IRS has raised is insurable interest and insured consent. Is there compliance with whatever state law is applicable? If not, the contract doesn't meet Section 7702, the applicable law requirement in the opening ordinances of Section 7702(a). That's one thing that the IRS asks about. The IRS hasn't formed much of an opinion about whether insurable interest is met or not, but if it becomes obvious in a given case that it's not met (we'll talk about that further in a minute), then the IRS certainly would write up the bank as saying the bank doesn't have life insurance inside buildup anymore, it bought itself a CD, and please report the interest on your tax return.

Then there's transfer of risk and experience rating. A number of the large BOLI contracts have experience rating provisions. Some of them have managed to obliterate risk shifting by the nature of the experience rating provision. The IRS is well aware of this and is in the process of auditing banks and raising lots of questions about whether there has been adequate risk shifting. We don't know where to draw the line on how much risk shifting is enough, but we do know that if there's none, that's not enough. Again, that would trigger tax on the inside buildup of the arrangement.

Investor control applies for variable contracts, but essentially, if the bank is in running its own money, managing its own money just as it had been doing, then this is not life insurance, and the inside buildup is taxable. The IRS asks whether there's a business purpose, whether it has been adequately documented or whether there is some other purpose afloat for this.

All of these issues have come up in the BOLI audits. These are applicable as well outside of BOLI to any COLI. There needs to be, in the delivery of products, good answers to these questions. Care needs to be exercised that the insurable interest laws are followed and that there is no investor control, but the insurance company has charge of the money or has charge of the investment advisor running the money. The IRS also asks about basic questions under Section 264, the deductibility of interest and the deductibility of expenses related to the delivery of life insurance policy.

Where I think there could be fallout that would cause the IRS to go further on the issues we just mentioned is in recent case law. There was the *Mayo v. Hartford Life* case, which was decided in Texas. This was the case against Wal-Mart. Wal-Mart had established a Georgia trust to hold its COLI. This was not a tax case. This was an action brought by the heirs of insureds under the Wal-Mart leveraged COLI plan. The insureds hadn't been notified that Wal-Mart had coverage on them. The heirs said that there was no insurable interest in Wal-Mart and therefore, the heirs, not

Wal-Mart, would get the death benefits. The issues raised in the case were insurable interest, therefore, as well as choice of law. What law applied? Was it Georgia law or Texas law?

The District Court and the Fifth Circuit Court of Appeals both held that Wal-Mart lacked insurable interest, that Georgia law did not apply and that Texas law did apply. Under Texas law at that time in the early '90s (it changed in '99), Texas insurable interest law was unfavorable to employer-owned life insurance. As a result, the Fifth Circuit—in a dramatic and I think well-articulated, well-reasoned opinion—said that since the insureds were in Texas, Texas had the primary interest in protecting them. That's what the insurable interest laws do. As a result, the law of Georgia was essentially irrelevant. It didn't matter where the trust was that owned the COLI. The fact is the insurable interest rules will attach where the insured resides. This is something that will get the attention of the IRS. It already has. I think the IRS will be asking about insurable interest and choice of law more and more in the audits.

Wal-Mart lost everything in this. It lost all the tax and economic benefits. The good news is it didn't owe tax; the bad news is it didn't have anything. It's a bad situation where insurable interest is not found to exist. But even if the heirs didn't recover, the IRS probably could. Either way, the taxpayer is going to lose.

The other litigation that's going to have some fallout is the leveraged COLI litigation. Many of you are familiar with this. Insurable interest as a Section 7702 requirement has been raised in the litigation. I think the first recorded decision ever that mentioned Section 7702 is the District Court decision in *Dow Chemical*. This is the Eastern District of Michigan. Dow won the leveraged COLI litigation protecting its interest deductions on a large-case COLI. One of the issues that got raised was whether Dow had insurable interest. The court said that it did. The court made it clear that if it didn't, it would flunk Section 7702 and Dow would have been taxable on all the inside buildup, for which the Justice Department was hoping. This is the "applicable law" requirement under Section 7702, and generally it means that state law, including insurable interest laws, consent laws and so forth, would attach.

The other issue that got raised in the *Dow* case and in the predecessor leveraged COLI cases was risk shifting and whether that risk had been shifted. As a result of the leveraged COLI litigation, the IRS is now heavily focused on the risk shifting as the potential Achilles heel of BOLI. This is something to watch. It's the old story that pigs get fat and hogs get slaughtered. That's all that's going on here. In the leveraged COLI cases, there had been schemes designed to make them mortality-neutral. Namely, the employer is paying for its own death benefits. The courts were not amused at this. They felt that this was not insurance. There was a positive result in *Dow* on the experience rating, but we still don't know where that line is drawn. We just know that zero is a bad answer. There will be fallout from these cases on the way the IRS conducts audits of BOLI and COLI in the future.

I have a few words about tax shelters. As you know, there's a Treasury campaign against tax shelters. It's been issuing pending regulations. It has a tax return disclosure requirement, a listed transaction requirement and a list maintenance requirement, if you have a tax shelter. Sometimes it's difficult to figure out whether you have a tax shelter, however. There is a broad definition and specific triggers. My only point here as regards COLI is that the tax shelter reporting triggers are relevant to COLI and BOLI.

If they are confidential transactions, then there is a need to disclose, and probably a need for the promoter, whoever that is, to maintain a list of everyone that has purchased the COLI and BOLI, not that that would be that hard to get. To meet the confidentiality trigger, the confidentiality must relate to tax strategies and there must be a minimum fee for the advisor imposing the confidentiality requirement. Generally speaking, the confidentiality trigger is not going to be a problem for COLI and BOLI. It's not going to trigger a reporting, but it has to be dealt with properly in order to get there.

The other possible problem is the "book-tax difference" as a trigger for tax shelter reporting. The good news is there's an exception for life insurance proceeds and inside buildup, so that's not going to trigger it. However, if you had a circumstance where you violated investor control or didn't have insurable interest—one of the other key issues for COLI in general and BOLI in general—then the consensus is there would be a reporting requirement because the corporation would be buying a tax shelter. Again, it's doubly important to abide by all those rules and sidestep the IRS issues. If the transaction didn't, then it would not only generally have its inside buildup tax, but it would pick up the tax shelter rules, and coming with that would be an additional 20 percent of the tax penalty and maybe worse.

The last thing I want to talk about is the Section 412(i) guidance package that came out February 17. It's a series of proposed regulations, revenue rulings and a revenue procedure. The purpose of this was to end tax abuse in Section 412(i) plans. These are tax-qualified pension plans based solely on life insurance and annuity contracts. These have generally been ignored for years, but they rose in importance as interest rates came down. Particularly for smaller employers, these became items of choice, and the industry sold heavily on 412(i) plans. The IRS detected abuse in these plans, so it issued guidance. This guidance has ramifications for these plans and beyond. The proposed regulations say a number of things that are probably not shocking, but certainly were a bit of a shock to the 412(i) market. They were not shocking to anybody outside of that market.

First the IRS said that if you transfer a life insurance contract from a qualified plan to a participant, or just from an employer to an employee, you have to account for it at its fair market value. We tax people when they get property as compensation. There's no great news there. However, the IRS then went on to say that you probably cannot use the cash surrender value of the contract to measure that income when it's distributed from a qualified plan, used in a Section 79 plan or

transferred under Section 83. This was hinted at before, but this is the first time it was formally stated that cash surrender value may not be the answer to what is the fair market value of a contract. It's a valuation question.

Interestingly enough, while the proposed regulations came out and said all this, they did not bother to define "fair market value." They just said to go find it and use it, then come back when you find it and report it. That may be a perfectly sensible rule because these things are hard to define. Valuation is always an issue somewhere in the tax law. Maybe it's something we shouldn't get too excited about, but the industry is nonetheless excited because for years the industry knew that the fair market value reporting was the cash surrender value. However, plans were developed that abused the tax law by artificially depressing the cash surrender value. In the Section 83 regulations, instead of saying "cash surrender value," what's being proposed is the "policy cash value." That's a defined term in the split-dollar regulations. It's essentially the account value, or the accumulation value. It's the value without regard to surrender charge, real or imagined.

There's a safe harbor in Revenue Procedure 2004-16 that says essentially that you can use the accumulation or account value as the fair market value until further notice. This has been criticized heavily by the industry in comments that have been filed with the IRS for a couple of reasons. One is that the IRS defined the accumulation value as premiums, plus interest or earnings on a variable contract, less mortality and other charges. It left out partial withdrawals. We asked the Treasury about it. It apologized and said it forgot it. The second reason is this doesn't work at all for traditional contracts, which by and large had been the source of the problem under 412(i), where cash values had artificially been depressed.

The ACLI is trying to work out some accommodation where some type of rule defining "fair market value," both for the interim and once final regulations come out, will be stated that will apply for ordinary life as well as for universal life, and also to refine the variable life rule. What this shows is that we have two warring camps here—the industry and the Treasury. The Treasury is intending to win this battle and certainly can win this battle. It's going to be necessary to build a bridge between the two and get the two talking in order to make this come out right.

There were other rules issued that are specific to 412(i) plans. Briefly, 412(i) plans—the annuity or life insurance funded pension plans—can't use contracts that fund for more than the plan retirement benefits. This had been one scheme that was afoot that was a type of cost recovery mechanism for the employer. The IRS said no, that doesn't work; it's not a qualified plan. Not only that, but if the employer tries to deduct contributions for contracts that fund more than the plan benefits, it has a tax shelter on its hands. That's a listed transaction, there's a reporting requirement, it will probably get picked up on audit, and it will probably have the 20 percent penalty tax unless it folds its tent and leaves right now. That's what that rule says.

It also says that the 412(i) plan cannot allow HCEs to purchase contracts preretirement on more favorable terms than non-HCEs. The dentist can't get the contract out on more favorable terms than the dentist's nurse, who probably wasn't entitled to anything anyway under the plan. In other words, you can't do that anymore. That's what Revenue Ruling 2004-21 says. This is a general crackdown on abuse in this area. The Treasury Department, in announcing all this, said that there's nothing inherently wrong with the 412(i) plan, but the way this has been pushed to the edge is very wrong and it's not going to tolerate it anymore.

FROM THE FLOOR: Brian, you said you're supposed to choose the version of the mortality table that gave you the lowest reserve. Can you talk specifically about how that's worded to make you do that? Let me give an example. If you had a product that's 80 percent smokers, would you be expected to use the composite version since that might give you lower reserves in total than if you did it on the smoker-distinct basis? Is there any connection where, for statutory, if you use smoker-distinct tables you have to also use that for tax?

MR. KING: I think you'd want to be careful in choosing a composite table where you're looking at a distribution in your business that's predominately smoker. I think there you're probably better served to use mortality that is reflective of the overall book of business that you're setting your reserves up for.

The Academy report certainly addressed the fact that the ultimate table would generally produce lower reserves than the select and ultimate. But I think, based on the distribution of smokers and nonsmokers implicit in the experience used to develop the table, that the composite results, the unismoker version of the table, produced reserves that were approximately equal to those based on the smoker-distinct. When you start to diverge from that, I think you're going to be better off following the distribution underlying your book of business.

FROM THE FLOOR: Even if that didn't give you the lowest reserves?

MR. ADNEY: I think we're operating off the edge of knowledge here. The IRS might enlighten us or they might not. I don't know that it has looked at this issue in detail either. I believe Brian's advice is good. While we can generally figure out what the lowest reserve rule means for 807 reserves, it doesn't make a lot of sense in the 7702 context. I don't think that will necessarily be the focus of IRS inquiry. Sometimes what you have to do is read the law based on what people will focus on, not what it might otherwise be.

FROM THE FLOOR: Is the lowest reserve rule determined on an industry basis or is it something that should apply on a company-by-company basis?

MR. ADNEY: I don't think it's an industry-wide rule. There are some rules in 7702 and elsewhere that look to general industry practice, you're right. But I think that the lowest reserve rule is frankly phrased in the statute on a contract-by-contract

basis. The corporate tax law Section 807—Section 807(d) in particular—views the requirements contract by contract, as if you went out and set up a specific reserve for one contract. That's the way the rule is phrased. I think a court having to interpret it would say that the lowest reserves rule has to apply contract by contract. I'm not going to tell you that makes any particular sense, but that is the way it's phrased.

MR. KING: They also throw in the word "generally" in that requirement to give you a little flexibility.

MR. ADNEY: Congress knew what it was shooting at, which was low reserves equals higher taxes. It was apprised of this problem late in the process, in '83 or '84. It threw up its hands and said, "Generally we want the lowest reserves, so we'll go write a rule that says 'generally lowest reserves.'" It is possible we'll get more enlightenment on what all this means for 807 sometime in the next five years because the IRS has purchased software that it's trying to use now in audits under 807. If it can figure out how to work the software, the result of the whole thing may be that we get more issues brought up to the national office such as the ones you're raising. The national office in turn will respond and say what it thinks it means. I think if you went in there right now and asked, it'd have no idea what you're talking about.

Chart 1

Change in Tax Limitations: An Example

2001 CSO ANB Ult.: Endowment Age 100 v. 121 (Male 55 NS - Rate per 1,000)		
Test Premium	Endow @ 100	Endow @ 120
GSP	271.60	270.86
GLP – Option 1	25.64	25.52
GLP - Option 2	53.74	107.38
7-Pay	65.39	65.21
NSP	400.01	398.89