TAXATION SECTION
"A KNOWLEDGE COMMUNITY FOR THE SOCIETY OF ACTUARIES"

VOL. 3 ISSUE 2
MAY 2007

TAXING TIMES

Actuary/Tax Attorney Dialogue on Selected Tax Issues in Principles-Based Reserves (Part II)

by Christian DesRochers and Peter H. Winslow

The February 2007 issue of *Taxing Times* included our first interdisciplinary dialogue between a tax attorney and an actuary on selected tax issues related to principles-based reserves (PBR). This is the second in our series of dialogues. It is between Peter Winslow, a tax attorney, and Christian DesRochers, an actuary.

There has been much discussion in the insurance industry as to whether, and how, PBR will be recomputed for tax purposes under Section 807(d) of the Internal Revenue Code. Are PBR CRVM reserves as contemplated by Congress in enacting the Deficit Reduction Act of 1984? If so, how should the adjustments for federally prescribed assumed interest rates and the prevailing commissioners' standard mortality tables be made? And how should the contract-by-contract comparisons of tax reserves with statutory reserves and net surrender values be made? Before these issues are addressed, there is a more fundamental question—do PBR qualify as life insurance reserves in the first place? The dialogue between Chris and Peter addresses that basic issue.

Chris: Peter, to get us started, can you explain the function that the qualification of liabilities as life insurance reserves serves under the Internal Revenue Code?

Peter: Sure. Under the Internal Revenue Code, liabilities that may qualify as "life insurance reserves" serve two functions. First, they are used to determine if an insurance company is taxed as a life insurance company under Part I of Subchapter L of the Code or as a non-life company under Part II of Subchapter L. The company will be taxed as a life insurance company if more than 50 percent of its total reserves qualify as life insurance reserves under Section 816(b). Second, they are used to identify reserves that are required to be recomputed for tax purposes under the specific rules set forth in Section 807(d). If a reserve reported on the Annual Statement could satisfy the definition of a life insurance reserve if it were to be properly computed using the criteria of Section 816(b), then it must be recomputed for tax purposes in accordance with rules set forth in Section 807(d), whether or not the Annual Statement reserve actually satisfies the definition of a life insurance reserve under Section 816(b).[1]

Chris: It is important for our readers to keep in mind these two very different functions that life insurance reserves serve. The first function, described in Section 816(b), tells us

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[1] *See* H.R. Rep. No. 432 (Part 2), 98th Cong., 2d Sess. 1414 (1984); S. Prt. No. 169 (Vol. I), 98th Cong., 2d Sess. 539-540 (1984); and Staff of the Jt. Comm. on Tax'n, 98th Cong., 2d Sess., General Explanation of the Deficit Reduction Act of 1984 598 (Comm. Print 1984).

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TAXING TIMES
Vol. 3 Issue 2
May 2007

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SOCIETY OF ACTUARIES

FROM THE EDITOR

BRIAN G. KING

An old adage states: "Time passes quickly." Never has a statement held more truth than when significant and necessary product development, administrative and compliance changes face a rapidly approaching deadline. Such a looming deadline faces our industry concerning the transition to the 2001 CSO.

Under the NAIC Model Regulation enabling the adoption of these new valuation and nonforfeiture tables, the "required" date for using the 2001 CSO for all life insurance products is Jan. 1, 2009. Given this, the 1980 CSO sunset date is rapidly approaching. In Dec. 2002, I was involved with the planning and development of a Society of Actuaries sponsored seminar titled "Assessing your Readiness for the 2001 CSO" held at Disney World. During that time in the "Magic Kingdom," the sunset date seemed like a long time off. Now, fast forward to May 2007 and the countdown is on, with only 17 months to go.

As most of our readers are well aware, this transition to the 2001 CSO has significant implications affecting product development, administration and compliance with the tax laws. Many of these topics have been addressed in great detail in prior issues of *Taxing Times*. Here in this column, I provide you with a quick readiness assessment checklist of some of these implications to think about.

Reasonable Mortality Requirements: Notice 2006-95 (which supercedes and modifies Notice 2004-61), states that "for contracts issued after 2008, use of the 2001 CSO tables will be mandatory" for determining reasonable mortality. Can your compliance systems handle this?

Tax Reserves: Since the 2001 CSO tables became the "prevailing" tables during 2004, the mortality tables' "year of change" within the meaning of the Section 807(d)(5)(B) transition rule was 2005. This means that under this rule—barring any other guidance—the 1980 CSO tables continue to be permitted for use as the prevailing tables for "the three-year period beginning with the first day of the year of change," or until Jan. 1, 2008. Thus, looking solely at the statutory rules, use of the 2001 CSO tables would be required for contracts issued after Dec. 31, 2007 and Section 807 tax reserves must be based on the 2001 CSO starting on Jan. 1, 2008. Is your tax reserve system ready for the new tables?

Maturity Date Provisions: Administrative systems must be able to accommodate the structure of the 2001 CSO (*i.e.*, the end age of the 2001 CSO table is 121 not age 100 as with the 1980 CSO table). Decisions must be made as to how the maturity date will interact with the computational rules of Section 7702(e)(1)(B) which deems a maturity date to be no greater than the date the insured attains age 100. These decisions can either be made knowingly by management or unknowingly through preset system coding that will determine the interaction. Which process would better suit your company?

Attained Age Regulation: 2001 CSO products must satisfy the requirements of the Regulation on Attained Age. The specifics of the attained age guidance are found in Treas. Reg. § 1.7702-2. The final regulations are effective Sept. 13, 2006 and apply to policies either (a) issued after Dec. 31, 2008, or (b) issued on or after Oct. 1, 2007 and based on the 2001 CSO tables. Can your new products satisfy these new regulations?

These are just some of the implications facing companies as they transition to the new 2001 CSO tables. The time to assess your company's readiness is here. System modifications necessary to support the new requirements must be planned, tested and implemented. Management decisions where changes are needed must be made. Are you ready for the 2001 CSO? ◂

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FROM THE CHAIR

LESLIE J. CHAPMAN

Springtime finds the SOA Taxation Section Council focusing its efforts on providing our members with valuable content regarding the intersection of tax matters and actuarial science. Over the next several months you will have the opportunity to partake in a variety of SOA sessions and seminars that will inform you of emerging tax issues and dive more deeply into those tax topics that affect our companies and products.

We are pleased to offer two tax sessions at the SOA Spring Life Meeting in Phoenix: the first session provides an update of recent tax guidance for life and annuity insurers and products and addresses the weighty issue of the tax implications of principle-based reserves (PBR). As a prelude to this session, you can read the opening article in this edition of *Taxing Times*, a dialogue between Peter Winslow, tax attorney, and Chris DesRochers, actuary, regarding PBR and tax issues (our previous edition, February 2007, contained our first interdisciplinary PBR dialogue).

The second tax session at the SOA Spring Life Meeting will be on the morning of May 11, when the Taxation Section will be hosting a hot breakfast; in addition to enjoying a hearty breakfast, attendees will be provided with an in-depth look at current tax topics, and have an excellent chance to network with other tax professionals.

In addition to coordinating our SOA Spring Life Meeting sessions, Chuck Miller is planning our first-ever tax session at the SOA Spring Health Meeting, being held in Seattle, as well as the Federal Income Tax Topics Workshop at the VAS 2007.

Additionally, our council is sponsoring several seminars that will bring focus to key areas of interest. Barbara Gold is leading our efforts to co-sponsor the Product Development Seminar & Symposium in June. Additionally, Barbara has begun planning for the Company Tax Seminar and Capital Efficiency Seminar, tentatively scheduled back-to-back for November.

As the Tax Council continues to focus on providing our members with value, we'd like to hear from you: what tax issues would you like to see covered in a session or seminar? Jot a quick e-mail with your idea(s), and send it to me at *leslie.chapman@securian.com*.

In addition to providing our section members with ongoing educational opportunities, the SOA Taxation Council is working to ensure that actuarial students preparing for the FAP and FSA designations are exposed to meaningful tax information as they work through their SOA modules and exams. Kory Olsen is spearheading these efforts for the Taxation Council; be sure to read Kory's "education" column in this edition of *Taxing Times*.

Special thanks to Chuck, Barbara and Kory, and each of their volunteers and speakers, for their ongoing contributions to the tax-related education of our members!

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Note from the Editor

All of the articles that appear in *Taxing Times* are peer reviewed by our editorial board and section council members. These members represent a cross-functional team of professionals from the accounting, legal and actuarial disciplines. This peer-review process is a critical ingredient in maintaining and enhancing the quality and credibility of our section newsletter.

While this newsletter strives to provide accurate and authoritative information in the content of its articles, it does not constitute tax, legal or other advice from the publisher. It is recommended that professional services be retained for such advice. The publisher assumes no responsibility with assessing or advising the reader as to tax, legal or other consequences arising from the reader's particular situation.

Citations are required and found in our published articles, and follow standard protocol.

Brian G. King

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what tax rules apply to the company. Are we talking about a life insurance company for tax purposes, which has one set of rules, or a non-life company, which has different tax rules? The second function is to determine the amount of the reserve, if any, that will be deductible for tax purposes. Under the 1984 Tax Act, life insurance companies are permitted to deduct the increase in a "Federally prescribed reserve" (FPR) enabling the insurer to offset premium income by some measure of their expected future benefits. Under current law, Sections 805(a)(2) and 807(c)(1) allow a deduction for life insurance reserves as defined in Section 816(b)(1), in amounts described in Section 807(d). Before we can worry about what amount of PBR may be deductible, we must first determine that PBR are life insurance reserves under Section 816. Unlike Section 807, which was added in 1984, there is a long history of regulations, rulings and case law under the predecessors of Section 816. In fact, as an actuary, I find it somewhat ironic that a Supreme Court justice originally authored the current definition of "life insurance reserves" now found in Section 816 of the Internal Revenue Code.[2] Given that history, I am skeptical that PBR will be treated as life insurance reserves. Consequently, I still think that companies will have some major hurdles to overcome in order to have PBR recognized as potentially deductible life insurance reserves. However, opinions among practitioners differ on these PBR tax issues, and the opinions is this article are solely yours and mine. But at the end of the day, the opinions that really count the most are those of Treasury and the Internal Revenue Service (IRS).

Peter: Wouldn't you agree that the IRS has a real incentive to recognize that PBR qualify at least in part as life insurance reserves? After all, if the National Association of Insurance Commissioners (NAIC) adopts PBR, there is no good policy reason for the IRS to take the position that PBR fail to qualify as life insurance reserves. It would mean that more statutory life insurance companies would be subject to the tax rules applicable to non-life insurance companies because they would fail the 50 percent reserve test in Section 816. In particular, companies that previously were taxed as life insurance companies would be eligible for the more favorable tax rules applicable to non-life insurance companies relating to proration of tax-exempt income and the dividends-received deduction, loss adjustment expenses and policyholder dividend reserves.

Chris: Absolutely. It is in the interest of the tax authorities for life insurance companies to be taxed under the life insurance provisions of Subchapter L rather than as non-life insurance companies. To that end, in 1989, the *UNUM* case found the government arguing for a broad definition of life insurance reserves, a departure from earlier cases in which the IRS had generally adopted positions taking a narrow and technical definition of life insurance reserves.[3] But, we are getting ahead of ourselves. Peter, why don't you summarize those requirements?

Peter: OK. Under Section 816(b), a life insurance reserve is defined as one that satisfies the following four criteria. First, it is held with respect to a life insurance, annuity or noncancellable (or guaranteed renewable) accident and health contract. Second, it is held to liquidate or satisfy future unaccrued claims. Third, it is computed or estimated on the basis of recognized mortality or morbidity tables and assumed rates of interest. And, fourth, it is required by law.

In general, the current PBR proposal will be the greater of (i) a deterministic reserve computed on a seriatim basis using a gross premium valuation, or (ii) an aggregate reserve using a stochastic approach. It seems clear that both the deterministic reserve and the stochastic reserve will satisfy several of the criteria in the definition of a life insurance reserve. They will be held with respect to the requisite types of contracts, will be required by law and will be computed using assumed interest rates. However, there are at least three questions that have been raised for PBR under Section 816(b). The first is whether PBR will be considered computed or estimated on the basis of recognized mortality or morbidity tables. The second is whether PBR will be disqualified for life insurance reserve treatment because they use a gross premium valuation approach. The final issue, and in my mind the most difficult, is whether PBR actually are held to liquidate or satisfy future accrued claims, or whether they are held, at least in part, for other reasons.

Chris: Let's start with the issue of recognized mortality or morbidity tables. The proposal would modify the current system of standard tables promulgated by the NAIC. The valuation mortality rates used in the PBR calculation will equal the current commissioners' standard (CS) mortality table for the class of business being

[2] Maryland Casualty v. United States, 251 U.S. 342 (1920).

[3] UNUM Life Insurance Company v. United States, 897 F.2d 599 (1st Cir. 1990).

valued based on company experience, adjusted for the credibility of this experience. Further, the expectation is that, ultimately, a large number of approved tables will be available, and frequently updated with emerging inter-company experience. In setting reserves, a company will select that NAIC table that best "maps" to their blended mortality curve. Do you think that these mortality rates will be considered to be based on a "recognized" table?

In fact, as an actuary, I find it somewhat ironic that a Supreme Court justice originally authored the current definition of "life insurance reserves" now found in Section 816 of the Internal Revenue Code.

Peter: I do, based on the history of life insurance reserves. The introduction of the requirement that "recognized mortality or morbidity tables" be used in computing life insurance reserves goes all the way back to the Revenue Act of 1942, which codified the definition of "life insurance reserve" previously contained in the regulations. Although the House version of the bill provided that the reserves had to be based on "recognized experience tables," the Senate version, which was enacted, changed the requirement from recognized experience tables to "recognized mortality or morbidity tables" to eliminate any possibility of excluding reserves that were based on sound tables that were not compiled from actual experience.[4] Thus, the recognized mortality or morbidity tables were intended to provide a more general requirement to allow the use of a prescribed table in lieu of using a table based only on the company's actual experience. Because there has been no change in the statutory definition since 1942, the IRS generally has adopted a liberal interpretation of "recognized mortality or morbidity tables."[5]

In general, therefore, a reserve computed on the basis of a company's own experience should be considered computed using a "recognized" table if the experience has been assembled in an organized actuarial manner (*i.e.*, it becomes tabular) and is accepted ("recognized") by state regulators as an appropriate reflection of mortality. If I am right in my interpretation of this history, there is good support for the conclusion that PBR should be considered computed or estimated on the basis of recognized mortality or morbidity tables.

Chris: Even if you are right, your conclusion does not mean that the company's own experience can be used in computing the tax reserve under Section 807(d). Section 807(d) requires tax reserves to be computed using the most recent CS tables prescribed by the NAIC which are permitted to be used by 26 states at the time the contract is issued. In technical advice memoranda, the IRS has considered circumstances under which an insurer may adjust the underlying mortality table. In TAM 200416009, the IRS held that an insurer "may not adjust the applicable mortality table in connection with its immediate and supplementary annuity contracts." The IRS observed that the company "did not perform any study or analysis that would identify a characteristic of its annuitant population associated with greater risk or a characteristic not identified with the characteristics of the mortality table pool in general," and "[t]he only analysis performed by the Taxpayer was an analysis of mortality." Their conclusion was based on the argument that the proposed adjustments to the table were for risks incurred that were already taken into account in computing the applicable prevailing commissioners' standard mortality table and, therefore, were not risks "incurred under the contract, which aren't otherwise taken into account." The IRS took the view that in order to adjust a mortality table, an insurer must "show that its policyholders have risk characteristics that differ from the typical risk characteristics of the population" measured by the underlying mortality table (examples being poor health, living in a dangerous country or not

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[4] *See* H.R. Rep. No. 2333, 77th Cong., 1st Sess. (1942), 1942-2 C.B. 372, 454, and S. Rep. No. 1631, 77th Cong., 2d Sess. (1942), 1942-2 C.B. 504, 612, respectively.

[5] *See*, for example, GCM 37594 (Jun. 29, 1978), which confirmed the conclusion of GCM 33183 (Feb. 7, 1966), that any mortality or morbidity table that is predicated upon valid actuarial principles would be considered to be recognized within the meaning of the term as used in the definition of a life insurance reserve. *See also* Rev. Rul. 69-302, 1969-1 C.B. 186, (reserves computed on the basis of premiums which themselves reflect a recognized mortality table and assumed rate of interest, and reserves computed on the basis of an average age representative of the group of insured persons qualify as life insurance reserves); Rev. Rul. 68-185, 1968-1 C.B. 317 (reserves that are determined by application of an average age and average duration against a recognized mortality and morbidity table qualify as life insurance reserves).

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underwritten) and that the table does not take these atypical risk characteristics into account.[6] In an earlier TAM, the IRS permitted an insurer to adjust the 1964 Commissioners' Disability Tables (1964 CDT), where "after an extensive study of the disability risks, [an independent] actuary advised the taxpayer that the experience data which served as the basis for the 1964 CDT differed significantly from the disability benefit provisions in Taxpayer's policies."[7] I think it may be important for the NAIC to continue to provide standard tables.

Peter: In fact, it is important that the NAIC prescribes standard tables for another reason—so that the definitions of a life insurance contract and a modified endowment contract can continue to work under Sections 7702 and 7702A. Let's turn to the second issue: What effect does the inclusion of factors other than interest and mortality have on the status of the reserves? What is the effect of the introduction of non-guaranteed elements and expenses? Can you address that issue, Chris?

Chris: Yes. In 1965, the Supreme Court defined life insurance reserves as "that fund which, together with future premiums and interest will be sufficient to pay future claims" of policyholders.[8] Courts have generally permitted factors other than interest and mortality to be recognized in the calculation of life insurance reserves, but have tempered that view by adding "[w]e do not believe that Congress intended to permit an insurance taxpayer to exclude any amount it saw fit from its taxable income by creating reserves."[9] Thus, some factors, including lapse rates, appear to be permissible in the calculation of tax reserves, but it may be tempered by the admonition in *Union Mutual* concerning the reasonableness of the assumptions. In Revenue Ruling 77-451,[10] which is discussed further in GCM 37209, the IRS considered the treatment of reserves established using a gross premium valuation methodology. The GCM elaborates on the conclusion of the Revenue Ruling in saying "we think we are bound to conclude that the Code section 801(b) [now 816(b)] definition of life insurance reserves describes a net-premium valuation method," explaining "[t]here is no indication in the Code or the legislative history that a life insurance reserve computation can also take into account factors which are unrelated to the risk, such as the business experience or expense savings of the company. If the Code did allow life reserves to reflect factors that are actuarially unrelated to the insured risk, there would be no way to ascertain the proper size of the reserve, making the definition of life insurance reserves useless for purposes of determining whether an insurance company is a life insurance company, under Code section 801(a)." I think this ruling and GCM will create deduction problems for PBR because factors other than mortality and interest are considered.

Peter: Although I agree that there are serious tax issues that arise because of the gross premium valuation method used in PBR, I do not think it is because of the rationale in Rev. Rul. 77-451. It is true that the IRS ruled that an additional reserve for excess mortality under group conversion contracts, which was computed using a gross premium valuation method reflecting expenses and an adjusted mortality table, was not a life insurance reserve. However, the reasoning of Rev. Rul. 77-451 was rejected in the *Lincoln National* case,[11] where the court held that a life insurance company may include, as part of the calculation of its life insurance reserves, elements other than the basic tabular reserve factors of mortality, morbidity and interest without the inclusion of these additional elements causing the reserves to be disqualified for tax purposes.[12] After its loss in *Lincoln National*, the IRS issued an Action on Decision[13] in which it stated that continued reliance by

[6] TAM 200416009 (Dec. 15, 2003).

[7] TAM 9251005 (Sept. 9, 1992).

[8] United States v. Atlas Life Insurance Co., 381 U.S. 233, 236 n. 3. (1965).

[9] Union Mutual Life Insurance Company v. United States, 570 F. 2d 382, 397 (1978).

[10] 1977-2 C.B. 224; 1977 WL 46142.

[11] Lincoln National Life Ins. Co. v. United States, 582 F.2d 579 (Ct. Cl. 1978).

[12] *See also* Mutual Benefit Life Ins. Co. v. Commissioner, 488 F.2d 1101, 1107 (3rd Cir. 1973), *cert. denied*, 419 U.S. 882 (1974); Equitable Life Ins. Co. of Iowa v. Commissioner, 73 T.C. 447 (1979).

[13] AOD (Nov. 7, 1980).

the IRS on the argument that consideration of non-mortality factors precludes life insurance reserve qualification is not warranted. In our experience, the IRS has not relied on the rationale in Rev. Rul. 77-451 after its loss in *Lincoln National*. Therefore, for me, the more difficult issue is not whether factors other than mortality and interest can be taken into account, but rather whether these other factors may cause the IRS to contend that PBR are not held exclusively to liquidate or satisfy future unaccrued claims. What do you think about this issue, Chris?

...the more difficult issue is not whether factors other than mortality and interest can be taken into account, but rather whether these other factors may cause the IRS to contend that PBR are not held exclusively to liquidate or satisfy future unaccrued claims.

Chris: To put this issue in perspective, it may be useful to review some more history that goes back even before the 1942 Act that you talked about. At least some part of the reserves held by life insurance companies has been deductible since the very inception of the income tax. The Revenue Act of 1909 allowed a deduction for "the net addition, if any, required by law to be made within the year to reserve funds." This naturally led to litigation over the definition of reserves, in which the Supreme Court defined the term as "having reference to the funds ordinarily held against the contingent liability on outstanding policies," cautioning that: "[t]he act of Congress, on the other hand, deals with reserves not particularly in their bearing upon the solvency of the company, but as they aid in determining what part of the gross income ought to be treated as net income for tax purposes."[14] In *McCoach* and similar cases, the Supreme Court established a standard that "the net addition required by law to be made within the year to reserve funds does not necessarily include whatever a state official may so designate; that reserve funds has a technical meaning . . . as something reserved from premiums to meet policy obligations at maturity."[15] In *Maryland Casualty*, the Supreme Court provided a further definition of the term "reserve," which provided the basis for the definition of "life insurance reserves" found today in Section 816, noting "[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, either 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."[16]

Peter: I think we are in general agreement that the calculation of reserves may include factors other than just a mortality table and an interest rate. Are there some factors that may be more problematic than others when we try to decide whether some part of PBR fails to satisfy the *McCoach* and *Maryland Casualty* standards?

Chris: The treatment of expenses may be a real sticking point. *Maryland Casualty* established the principle that reserves were funds "set apart as a liability in the accounts of a company" to pay future claims, but that "provision for the payment of ordinary expenses was not intended to be provided for and included in 'reserve funds' as the term is used in the acts of Congress."[17] Treas. Reg. § 1.801-4(e)(5) would also appear to specifically exclude expenses from inclusion in reserves. Like the basic reserve definition, the language originates in Justice Clarke's opinion in *Maryland Casualty*. Defining "reserve," the opinion goes on to note that "it has nowhere been held that 'reserve' in this technical sense, must be maintained to provide for the ordinary running expenses of a business, definite in amount, and which must currently be paid by every company from its

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[14] McCoach v. Insurance Company of North America, 244 U.S. 585, 589 (1917).

[15] New York Life v. Edwards, 271 U.S. 109, 119 (1926).

[16] Maryland Casualty v. United States, 251 U.S. 342, 350 (1920).

[17] Maryland Casualty v. United States, 251 U.S. 342, 351-2 (1920).

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income if its business is to continue, such as taxes, salaries, reinsurance and unpaid brokerage."[18] Following along in this tradition, present day Sections 816(b) and 807(d), which define respectively the type of reserve that is a life insurance reserve and the amount of such a reserve that is deductible, both are clearly claim or benefit-based reserves, not reserves regarding future expenses, dividends or profits.

Peter: I agree with you, and Ed Robbins and I talked about this same issue in our prior dialogue although in a different context. Not only does Treas. Reg. § 1.801-4(e)(5) preclude a reserve for expenses from being treated as an insurance reserve, but Section 811(a)(1) requires an accrual method of accounting for non-reserve items, and Section 808(c) limits the deduction for policyholder dividends to the amounts paid or accrued during the taxable year. Therefore, it will be essential for companies to be able to prove either that no part of PBR represents reserves for future unaccrued expenses or policyholder dividends, or that there is an identifiable portion of PBR that is non-deductible under these Code provisions. Ideally, a standard actuarial method will be developed to determine the non-deductible portion of PBR. If this is not possible then I agree that we may be forced to revert to pre-PBR CRVM reserves as the default tax reserves to qualify as life insurance reserves and to serve as the starting place for the Section 807(d) tax deduction.

Chris: It may not be as easy as you think to develop a standard actuarial method to identify the non-deductible components of PBR. The views of the IRS aside, there are fundamental differences in the emergence of income under PBR than results under the current valuation system. A key characteristic of a gross premium valuation (GPV) reserve system is that the present value of future profits is recognized at issue.[19] The initial valuation of a block of policies "capitalizes" the difference between the pricing assumptions and the valuation assumptions, while subsequent valuations capitalize the difference in valuation assumptions. That is, a GPV system effectively "fronts" the present value of gains and losses. A continual "unlocking" of assumptions "capitalizes" the effect of the assumption change (either positive or negative) instead of releasing the differences as they are realized against the original valuation assumptions. This is fundamentally inconsistent with accrual accounting under the Code as expressed by the "all events" test, which restricts the timing of the recognition of deductions.[20] In other words, the annual unlocking of PBR may make it difficult to conform to basic tax concepts. In addition, statutory reserves under the proposed PBR system are likely to be more volatile than under the current system, particularly given lower minimum reserves, and annual unlocking of assumptions, leading to higher volatility of annual income, which will affect the timing of income and losses.

Peter: Another potential issue as to whether PBR are held exclusively for future unaccrued claims is the question of margins, both in the contingent tail expectation (CTE) and in the use of prudent best estimate assumptions. Do you think the stochastic reserves are likely to be considered non-deductible "solvency" or contingency reserves because of the CTE assumptions?

Chris: I do. Values based on a CTE methodology only capture the "tail" of the distribution, not the expected value. The fact that the stochastic reserve by its nature is based on an average of a percentage (depending on the placement point for the contingent tail expectation) of the "worst case" scenarios, and not on the expected value of an amount "set aside to mature or liquidate . . . future unaccrued claims," makes the stochastic reserves (or at least the excess of the stochastic reserve over an "embedded" life insurance reserve) appear to be a non-deductible "solvency reserve" as the term has been

[18] 251 U.S. at 350. Compare to Treas. Reg. § 1.801-4(e)(5), which excludes "reserves required to be maintained to provide for the ordinary operating expenses of a business currently paid by every company from income if its business is to continue, such as taxes, salaries and unpaid brokerage."

[19] For example, an embedded value calculation, which shares many elements in common with a gross premium valuation, is intended to show the present value of all amounts that will be distributable to shareholders based on best estimate assumptions. The present value of gains or losses from the sale of a block of policies will be recognized in the year in which the policies are sold.

[20] The "all events" test is the general rule in the Internal Revenue Code for determining whether items of income and expense can be recognized or deducted in determining taxable income in any period. The statutory definition provides that the "all events" test is met if "all events have occurred which determine the fact of liability and the amount of such liability can be determined with reasonable accuracy." *See* IRC § 461(h)(4). Section 461(h)(1) adds to this a requirement of "economic performance" further described in 461(h)(2), (3). *See also* Regs. 1.451-1(a).

applied in cases and rulings, particularly Rev. Rul. 67-435,[21] in which the IRS held that a reserve computed on "the basis of a percentage of life insurance reserves" is not a life insurance reserve under Section 801(b). Case law reaching a similar result can be traced back to the 1920s. In *Old Line Insurance Company v. Commissioner*,[22] the Board of Tax Appeals refused to recognize a "mortality fluctuation" fund equal to 10 percent of the net value of its policies, commenting: "[t]he fund herein involved was maintained to provide against possible losses in reserves invested and anticipated excessive mortality losses due to the influenza epidemic. That the losses anticipated would result was speculative. Future liability on outstanding policies, on the other hand, is relatively certain and it is this liability for which a reserve is required." In *Standard Industrial Life Insurance Co. v. Commissioner*,[23] the Board of Tax Appeals found "solvency" or "business" reserves rather than life insurance reserves to exist when the taxpayer based its reserves on a percentage of the reserves required under the mortality table.

Peter: I'm not sure that I agree with you. The fundamental question to begin with is whether a reserve that is intentionally conservative—that is, it includes an express or implied provision for adverse deviation, is a deductible insurance reserve or is instead a non-deductible solvency reserve, at least to the extent it exceeds the actuaries' "best estimate." The answer under the current tax law is that reserve deductions will not be disallowed merely because they include a margin for conservatism.

Most of the controversy on this topic has arisen in the analogous rules for loss reserve deductions for non-life companies. IRS auditing agents have argued that a non-life company's loss reserves for tax purposes must be the company's "best estimate" because Treas. Reg. § 1.832-1(b) provides that their computation must be a "fair and reasonable estimate of the amount the company will be required to pay." This position has been rejected in the case law and even by the IRS itself. In TAM 200115002 an IRS agent argued that the phrase "the amount the company will be required to pay" in the regulations precludes the taxpayer's loss reserves from being greater than the most accurate estimate and precludes a margin for conservatism. The IRS National Office rejected this contention. Instead, the TAM held that reserves must be tested under the fair and reasonable standard using the following criteria:

Most of the controversy on this topic has arisen in the analogous rules for loss reserve deductions for non-life companies.

> A taxpayer's estimate of unpaid losses will typically be considered fair and reasonable for tax purposes if the taxpayer estimates its unpaid losses on the basis of a recognized methodology that is appropriate for its particular line of business, calculates the estimate in accordance with actuarial standards, and properly takes into account its prior experience.

Consistent with the holding in the TAM, the case law supports the position that a margin for conservatism is permissible where it is consistent with general industry practice and based on actuarial analysis after taking into account historical claim patterns and consideration of volatility of reserves.[24] On the other hand, an arbitrary margin added to the reserves by management is not deductible as part of fair and reasonable reserves.[25]

Applying these analogous principles to PBR, I think that the fact that there is a margin for conservatism built into

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[21] 1967-2 C.B. 232.

[22] 13 B.T.A. 758 (1928).

[23] 42 B.T.A. 1011 (1940).

[24] Utah Medical Ins. Assoc. v. Commissioner, T.C. Memo. 1998-458, 76 T.C.M. (CCH) 1100; *See also* FSA 199952011 (Sept. 22, 1999).

[25] Minnesota Lawyers Mutual Ins. Co. v. Commissioner, T.C. Memo. 2000-203, 79 T.C.M. (CCH) 2234, aff'd, 285 F.3d 1086 (8th Cir. 2002).

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prudent best estimate assumptions should not mean that the reserves are contingency reserves held for something other than future claims. It may be a closer question as to whether the CTE similarly will be considered held exclusively for future unaccrued claims so that the stochastic reserve cannot qualify as a life insurance reserve. But I come out on the side that it should. I think that it is entirely proper to hold a reserve for the CTE, and the fact that it is computed in a conservative manner, in my judgment, does not convert it into a non-deductible contingency reserve. The key is that PBR will be computed in an actuarial manner, and are not merely percentage add-ons to the reserve mandated by state law, as was the situation in several of the cases you cited. Of course, the IRS and Treasury could disagree.

Chris: In concluding, it is clear that changes are needed, and are indeed coming, in the way in which statutory reserves are computed. Having said that, given the history of the definition of life insurance reserves, I believe that it is highly unlikely that either the deterministic or stochastic elements of the PBR will qualify in their entirety as life insurance reserves under Section 816. The basic definition of life insurance reserves, in Section 816, as amounts "set aside to mature or liquidate, either by payment or reinsurance, future unaccrued claims," in itself, as well as the significant body of case law restricting the definition of life insurance reserves to life insurance benefits would seem to provide an insurmountable barrier to Treasury concluding that PBR are life insurance reserves under Section 816. However, as we discussed earlier, it is clearly in the interest of the tax authorities for life insurance companies to be taxed under the life insurance provisions of Subchapter L rather than as non-life insurance companies. Thus, some measure of peaceful co-existence must be found between the state insurance commissioners whose "object is to exercise abundant caution to maintain the [life insurance] companies in a secure financial position," and the tax authorities who view the deduction of life insurance reserves "not particularly in their bearing upon the solvency of the company, but as they aid in determining what part of gross income ought to be treated as net income for purposes of taxation."[26] One approach could be to revisit Proposed Reg. § 1.804-1(g), and require that PBR policies have their reserves recomputed under the current CRVM net premium method for purposes of determining qualification under Section 816. Another might be to identify that portion of PBR that are "life insurance reserves." This might require disclosure of the components of the PBR, either in the Annual Statement or the tax return. However, more discussion is needed. There are other issues to be considered, including the interaction of the so-called "statutory cap" and the treatment of increases and decreases in reserves that result from the "unlocking" of assumptions. I only hope our *Taxing Times* dialogues are the start of meaningful discussions among practitioners of the tax implications of PBR. These conversations are long overdue. ◂

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[26] McCoach v. Insurance Company of North America, 244 U.S. 585, 589 (1917).

Proposed Model Closing Agreements for Life Insurance Contract Failures: Comments Requested

by Brian G. King, John T. Adney, Craig R. Springfield and Lori A. Robbins

On Jan. 26, 2007, the Internal Revenue Service (the "Service") released Notice 2007-15 (the "Notice"),[1] which provides guidance regarding closing agreements under Sections 7702, 7702A and 817(h).[2] This guidance also requests comments from taxpayers on a number of issues that in some respects may be very material to the manner in which the Service processes these closing agreements in the future.

Draft Model Closing Agreements

The Notice includes four model closing agreements, in draft form, that the Service anticipates using. While it is beyond the scope of this article to describe these draft agreements in detail, the following briefly identifies some noteworthy aspects of each draft.

(1) Draft Model Closing Agreement for Correcting Failures under Sections 7702 and 101(f) (Exhibit A of the Notice). The draft model closing agreement providing a correction mechanism for failures to comply with Section 101(f) or 7702, as applicable, is similar to those which have been executed by insurance companies over the years pursuant to Rev. Rul. 91-17[3] and Notice 99-48.[4] Under Rev. Rul. 91-17, the Service indicated that it would waive civil penalties for failure to satisfy the reporting, withholding and deposit requirements for income deemed received under Section 7702(g) if the insurance company enters into a closing agreement with the Service. Further, under the terms of that closing agreement, the amount to be paid would be determined based upon "(i) the amount of tax that would have been owed by the policyholders if they were treated as receiving the [Section 7702(g)] income on the contracts, and (ii) any interest with regard to such tax."

While the draft model closing agreement generally follows past practices, there are some features worthy of comment. One is that the draft agreement is limited to failures under the guideline premium test. (As noted below, the request for comments asks whether it would be appropriate for the Service to provide an additional model closing agreement to address failures under the cash value accumulation test.) A second noteworthy feature relates to the Service's long-standing practice of allowing an offset to the toll charge under Rev. Rul. 91-17 to reflect Forms 1099-R that had been provided to policyholders, such as upon contract surrenders. It appears that the Service has reversed its view in this regard, and such reversal is reflected in a lack of provision for some appropriate offset or adjustment in the Notice's draft model closing agreement. This runs contrary to the view expressed in Rev. Rul. 91-17 that the tax collected under the closing agreement should be what "would have been owed by the policyholders…."

(2) Draft Model Closing Agreement under Alternative C of Rev. Rul. 2005-6[5] *(Exhibit B of the Notice).* Also includ-

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[1] 2007-7 I.R.B. 503. A copy of the Notice may be downloaded from the Taxation Section area of the Society of Actuaries' Web site *(www.soa.org)*.

[2] Unless otherwise indicated, all references and citations to "section" are to sections of the Internal Revenue Code of 1986, as amended.

[3] 1991-1 C.B. 190, *amplified* by Rev. Proc. 92-25, 1992-1 C.B. 741.

[4] 1999-2 C.B. 429.

[5] 2005-1 C.B. 471.

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ed in the Notice is a draft model closing agreement for submissions under "Alternative C" of Rev. Rul. 2005-6, relating to contract failures under Sections 7702 and 7702A that are due to improper application of the reasonable expense charge rule of Section 7702(c)(3)(B)(ii) with respect to qualified additional benefits (QABs). Unlike "Alternative B" closing agreements that were permitted prior to Feb. 8, 2006, an "Alternative C" closing agreement does not "grandfather" either contracts or an administration system's treatment of charges for QABs. As anticipated from Rev. Rul. 2005-6, the draft model closing agreement under "Alternative C" requires that taxpayers: (1) identify the failed contracts and inadvertent MECs for which they are seeking relief, (2) pay an amount to the Service (determined pursuant to a schedule set forth in Rev. Rul. 2005-6), and (3) take certain corrective action with respect to the contracts for which relief is requested.

(3) Draft Model Closing Agreement under Rev. Proc. 2001-42 [6] *for Correcting Inadvertent Modified Endowment Contracts ("MECs")* (Exhibit C of the Notice). The Notice includes a draft model closing agreement to address inadvertent MECs that would replace the model closing agreement contained in Rev. Proc. 2001-42. In most respects, the new draft model closing agreement is identical to the former one. There is, however, at least one important difference that is worthy of consideration.

Specifically, the new draft model closing agreement adds the representation that the "taxpayer" intended that the contracts covered by the closing agreement would not be MECs. Seemingly, this reference to "taxpayer" is to the insurance company rather than the policyholder, since the first "whereas" clause in the new draft model closing agreement refers to the "taxpayer" as the issuer of one or more life insurance contracts under Section 7702. This being said, the relief provided by Rev. Proc. 2001-42 often is needed in situations where an insurer believes policyholders did not intend for their policies to be MECs, such as where there is an inadequate consent to MEC status. It would be helpful if the Service were to clarify that, in adding this representation to the draft model closing agreement, it did not intend to preclude relief for such situations.

(4) Draft Model Closing Agreement under Rev. Proc. 92-25[7] *for Correcting Diversification Failures (Exhibit D of the Notice).* The draft model closing agreement for Section 817(h) investment diversification failures in the Notice would replace the model closing agreement contained in Section 5 of Rev. Proc. 92-25. The new draft model closing agreement includes language prohibiting an increase in the "investment in the contract" by any portion of the amount which the taxpayer represents to be the income on the contract, rather than just by the income on the contract for the period of non-diversification.

The Service's Request for Comments

In Section 5 of the Notice, the Service requests taxpayers to provide comments by June 12, 2007 with respect to: (a) each of the draft model closing agreements contained in the Notice, and (b) certain specific questions set forth in the Notice. In particular, Section 5.03 of the Notice sets forth specific questions that we have replicated below. In connection with these questions, we have noted some points that we believe insurers and other taxpayers should consider in formulating a response to the Service's request for comments.

- "(a) Under what circumstances, if any, should the Service retain the discretion to negotiate different terms and conditions for failures that otherwise would be covered by the final model closing agreement[s]?"

  While use of a model agreement may be appropriate in perhaps the majority of circumstances, it may be necessary to tailor closing agreements to specific facts pertaining to a taxpayer. For example, are there situations where a change to the model might be needed in order to describe the facts accurately? Also, are there circumstances in which an alteration of the substantive provisions of the model closing agreement, including its toll charge calculation, might be justified?

- "(b) Would additional model closing agreements be useful to remedy other failures involving life insurance or annuity contracts, such as the failure of a life insurance contract to satisfy the cash value accumulation test of § 7702(b), or the failure of an annuity contract to contain the distribution provisions required under § 72(s)? If so, please describe the specific failures."

[6] 2001-2 C.B. 212, *modified and amplified* by Rev. Proc. 2007-19, 2007-7 I.R.B. 515.

[7] 1992-1 C.B. 741.

The draft model closing agreements do not address failures to satisfy the cash value accumulation test that were not waivable under Section 7702(f)(8), although the Service has in the past entered into such closing agreements. Thus, it would be helpful if the Service would clarify that the absence of a model closing agreement for a particular kind of failure should not be construed to mean that the Service is unwilling to enter into such other types of closing agreements. The key question, then, is whether a model closing agreement is suitable for use in connection with other types of failures. For instance, are the types of corrective action necessary for failures of the cash value accumulation test so varied that a model agreement is less practicable?

While use of a model agreement may be appropriate in perhaps the majority of circumstances, it may be necessary to tailor closing agreements to specific facts pertaining to a taxpayer.

- "(c) Could the process for obtaining a waiver of reasonable errors under § 7702(f)(8) be simplified? If so, please describe."

  It has often been necessary, under existing Service procedures, for the Service and taxpayers to expend significant resources in ascertaining whether errors are "reasonable" under Section 7702(f)(8). This has been the case even though the dollar amount or percentage by which contracts provided excessive investment orientation was very small. It would be useful if existing procedures could be modified with respect to common and non-abusive problems that taxpayers have faced. This is discussed further under questions (e) and (f) below.

- "(d) Do the three alternatives set forth in Rev. Rul. 2005-6 provide an appropriate model for remedies of other errors under § 7702 that would have been considered reasonable within the meaning of § 7702(f)(8) before, but not after, the Service published guidance on the underlying legal issue?"

  It is likely that many taxpayers would be pleased by the extension of this model to other types of errors involving ambiguities under Sections 101(f), 7702 and 7702A, especially in light of the significant grandfather relief provided by "Alternative B" of Rev. Rul. 2005-6. This being said, it is difficult to conclude categorically that this solution would always be most appropriate. There may be, for example, circumstances where the formal regulatory process should be used to resolve an ambiguity (with some form of effective date relief being provided by such regulations). In addition, the issuance of guidance from the Service resolving an ambiguity should not be relevant to whether an error predating such guidance is reasonable within the meaning of Section 7702(f)(8).

- "(e) Could the amounts that are required to be paid under the model closing agreements be determined more simply, without altering the incentives already in place for complying with § 72, 817(h), 7702 and 7702A and for coming forward voluntarily once errors are discovered? For example, do the existing procedures require issuers to produce information not otherwise generated in the normal course of administering the contracts? Are there circumstances in which the amount paid under the model closing agreements would more appropriately be determined based on factors other than total income on the contract?"

  A fundamental problem underlying existing procedures is that there is no allowance of an intermediate sanction that would comport more equitably with the errors causing failures. In particular, under existing procedures for Section 7702 failures, the result is either a waiver (in which case no toll charge is required) or a closing agreement (in which case a potentially very large toll charge is required). The amount of such charge may have little to do with the severity of the error committed *(e.g.*, such as whether it arose from an overly aggressive interpretation of the law in an attempt to increase investment orientation). Rather, toll charges for non-waivable Section 7702 failures are dictated more by the size of contracts, how long they have been in force, and the period of time since their failure.

  While existing procedures attempt to make the government whole (based on the tax that would be due

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if Section 7702(g) income were treated as received by policyholders), one can argue that the government could be made whole, in an equitable sense, by a toll charge based on the degree of excess investment orientation, similar to what is done under Rev. Proc. 2001-42 closing agreements for inadvertent MECs. Thought should be given to each of the four types of model closing agreements and the toll charges required under them.

Under the Service's existing practices for processing Section 7702 closing agreements, in certain instances the methodology for computing the toll charge can produce excessive toll charges for contracts with little or no economic gain. This can be particularly true of variable life insurance contracts where the underlying investment returns generate a pattern of Section 7702(g) income on the contract that is positive in some years and negative in others. The Service historically has not allowed negative Section 7702(g) income on the contract in certain years to offset positive income in other years.

With respect to the information required under closing agreements, one initial thought is that more flexibility should be permitted regarding the dates used in making the calculations. For example, information for periods from one December "monthaversary" (*i.e.*, the monthly processing date during December) to the next December monthaversary may be much more readily available to an insurer than information on a calendar year basis.

- "(f) Do the amounts required to be paid under the model closing agreements strike an appropriate balance between making the government whole for the tax that otherwise would be due, and encouraging voluntary compliance with the underlying provisions once an error is discovered? If lesser amounts might be appropriate in some circumstances, what are those circumstances and how should those amounts be limited?"

See our commentary under question (e) above. Any toll charge assessed under a closing agreement should be restorative (*i.e.*, to make the government whole), not punitive in nature. Consideration in this regard should be given to whether a more expansive interpretation of "reasonable error" under Section 7702(f)(8) is needed (and how it might be expanded), given that the taking of reasonable steps to correct an error also is a requirement for a waiver. In addition, where errors are non-waivable, it seems that strong arguments can be made in favor of shifting the paradigm for calculating the toll charge from one of viewing contracts as either tax-deferred or fully taxable to one mirroring the approach of Rev. Proc. 2001-42, which examines the degree of overfunding involved. Insurers also should consider how best to respond to the Service's concern with respect to voluntary compliance, which would include seeking correction of errors from the Service within a reasonable time after discovery of errors.

- "(g) Should each model closing agreement contain language to the effect the agreement is null and void if the taxpayer does not remit the required payment and undertake the required corrective actions within the time frames set forth in the agreement? Do the time frames in the draft model closing agreements allow taxpayers enough time to satisfy their obligations under those agreements?"

It may be appropriate for the model closing agreements to contain some flexibility as to the time frames by which correction should be completed. For example, for certain types of contract failures, corrective action may involve adding an endorsement to contracts. In such situations, a reasonable period of time should be allowed to file corrective endorsements with the appropriate state regulatory bodies, and a further reasonable period of time should be allowed to add the corrective endorsements to contracts once they are approved by the states. Still other circumstances may be cited that would merit special terms in a closing agreement with respect to corrective action.

In addition, it is possible to conceive of a circumstance in which a small proportion of the contracts covered by a closing agreement were not properly corrected by the deadline stated in the agreement. If not all of the contracts are corrected by the stated deadline, should the entire agreement be null and void, or should it be ineffective only with respect to those contracts that were not properly corrected in a timely fashion? It would be helpful to receive some guidance from the Service as to this "real world" circumstance.

Business as Usual

Section 6 of the Notice provides that the Service will continue to process closing agreements under Sections 72, 817(h), 7702 and 7702A pursuant to existing procedures until those procedures are modified by publication in the Internal Revenue Bulletin. This will allow failure cases currently pending in front of the Service to continue to be processed. It also will allow new correction proceedings to be brought to the Service while comments requested by the Notice are being considered and the draft model agreements are being revised as appropriate.

Concluding Thoughts

The Service should be commended on its efforts in the Notice to streamline procedures for processing closing agreement offers. It also should be commended for its willingness to explore, more fundamentally, the best way in which to strike a balance between encouraging ongoing compliance and allowing for an equitable resolution of compliance failures.

Insurers also should consider how best to respond to the Service's concern with respect to voluntary compliance, which would include seeking correction of errors from the Service within a reasonable time after discovery of errors.

The Notice presents insurers and other taxpayers with a significant opportunity to explore these points with the Service as well as to clarify details pertaining to closing agreements. Indeed, this may be the only chance in a decade to achieve substantial improvement in life insurance contract compliance and remediation processes. As noted above, comments on the Notice must be submitted to the Service by June 12, 2007.

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Age Defined: IRS Issues Final Regulations on "Attained Age" Under Section 7702

by Brian G. King, John T. Adney and Craig R. Springfield

In September of 2006, the Department of Treasury (Treasury) and the Internal Revenue Service (IRS) issued final regulations providing guidance on determining an insured's "attained age" for certain purposes under Section 7702.[1] The specifics of this guidance, which covers for both single and multiple life attained age determinations, are found in Treas. Reg. § 1.7702-2.

Proposed regulations on this issue, published by Treasury and IRS on May 24, 2005, were described in detail in an article in the September 2005 issue of *Taxing Times*. Although the final regulations reflect much of what was proposed in May 2005, several changes were made in the final regulations, the substance of which is discussed below.

Rules for Attained Age

As noted in the earlier *Taxing Times* article, an insured's attained age is a necessary component in applying many of the tests under Section 7702 and, by reference, Section 7702A, the Code's definition of a "modified endowment contract." The final regulations, consistent with the proposed regulations, establish a general rule for determining an insured's attained age for purposes of calculating the guideline level premium under Section 7702(c)(4), applying the cash value corridor of Section 7702(d) and utilizing the computational rules of Section 7702(e).

Significantly, the preamble to the final regulations states that the regulations are "not, nor are they intended to, endorse or prohibit any methodology for determining reasonable mortality charges under Section 7702(c)." This limitation on the scope of the new rules was reiterated, and emphasized, by representatives of Treasury and IRS during discussion of the subject at the Society of Actuaries' (SOA) Product Tax Seminar on Sept. 13, 2006, the day after the final regulations were published. Hence, the new attained age rules apply for limited, specific purposes: (1) determining the level premium payment period under Section 7702(c)(4), which refers to payments until age 95, (2) applying the Section 7702(d) corridor factors, which are age-specific and (3) making the various calculations in accordance with the endowment or maturity date rules of Section 7702(e), which reference ages 95 and 100. The computational rules apply to the Section 7702(b) cash value accumulation test as well, and they also apply, derivatively, in determining the Section 7702A "7-pay" premiums.

Single Life Contracts: According to both the proposed and the final regulations, the attained age of the insured under a contract covering a single life is either: (i) the insured's age determined by reference to the individual's actual birthday as of the date of determination (actual age), or (ii) the insured's age determined by reference to contract anniversary (rather than the insured's actual birthday)—sometimes called the "insurance age"—so long as the age assumed under the contract is within 12 months of the actual age. Under the approach taken in the regulations, which is consistent with the legislative history of Section 7702, both age-last-birthday and age-nearest-birthday assumptions continue to be permitted. This is illustrated in Examples 1 and 2 of the final regulations, summarized below.

> *Example 1:* An insured born on May 1, 1947 becomes 60 years old on May 1, 2007. On Jan. 1, 2008, the insured purchases an insurance policy on his or her life. January 1 is the contract anniversary date for future years. The insurance company determines the insured's premiums (or cost of insurance) based on an age-last-birthday method. Under this method, the insured has an

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[1] Unless otherwise noted, all references to "sections" are to sections of the Internal Revenue Code of 1986, as amended (the "Code").

attained age of 60 for the first contract year, 61 for the second contract year, and so on.

Example 2: The facts are the same as under Example 1, except that the insurance company determines the insured's premiums based on an age-nearest-birthday method. Under this method, the insured's nearest birthday to Jan. 1, 2008, is May 1, 2008, when the insured will be 61 years old. Thus in this example, the insured has an attained age of 61 for the first contract year, 62 for the second contract year, and so on.

Multi-Life Contracts: For multiple life contracts, the determination of age will depend on the structure of the contract—

(i) The attained age of the insured under a contract insuring multiple lives on a last-to-die basis—joint and last survivor contracts—is the attained age of the youngest insured; and

(ii) The attained age of the insured under a contract insuring multiple lives on a first-to-die basis is the attained age of the oldest insured.

The final regulations add a clarification in response to a comment letter on last-to-die contracts that undergo a change in both cash value and future mortality charges as a result of the death of an insured (*i.e.*, the contract reverts to a single life structure upon the death of an insured). The letter asked whether, if the youngest insured should die, the attained age used for testing should continue to be the attained age of the deceased insured or, instead, should be the attained age of the "youngest surviving insured." The final regulations provide that the attained age of the "youngest surviving insured" should be used for such policies (see Example 5 below). In this way, the attained age used for federal income tax purposes is consistent with that used under the terms of the policy.

Examples 4, 5 and 6 in the final regulations illustrate attained age calculations for multiple life contracts and are summarized below.

Example 4: An insured born on May 1, 1947 becomes 60 years old on May 1, 2007. In addition, a second insured covered by the contract was born on Sept. 1, 1942, and becomes 65 years old on Sept. 1, 2007. On Jan. 1, 2008, the insureds purchase a last-to-die insurance policy. Because the insured born in 1947 is the younger insured, the attained age of 60 must be used for purposes of Sections 7702(c)(4), 7702(d) and 7702(e), as applicable.

Example 5: The facts are the same as under Example 4, except that the younger of the two insureds dies in 2012. After the death of the younger insured, both the cash value and mortality charges of the life insurance contract are adjusted to take into account only the life of the surviving insured. Because of this adjustment, the attained age of the only surviving insured is taken into account (after the younger insured's death) for purposes of Sections 7702(c)(4), 7702(d) and 7702(e), as applicable.

Example 6: An insured born on May 1, 1947 becomes 60 years old on May 1, 2007. In addition, a second insured covered by the contract was born on Sept. 1, 1952, and becomes 55 years old on Sept. 1, 2007. On Jan. 1, 2008, the insureds purchase a first-to-die insurance policy. Because the insured born in 1947 is the older insured, the attained age of 60 must be used for purposes of Sections 7702(c)(4), 7702(d) and 7702(e), as applicable.

...both the September 2005 *Taxing Times* article and a comment letter received by the IRS raised a concern regarding the proposed regulations' restrictions with respect to use of a derived age that does not correspond to the attained age of any of the insureds under the contract.

Use of Derived Ages

For multiple life contracts, both the September 2005

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Taxing Times article and a comment letter received by the IRS raised a concern regarding the proposed regulations' restrictions with respect to use of a derived age that does not correspond to the attained age of any of the insureds under the contract. This would include the use of a "joint equal age" for contracts insuring more than one life and the use of a "rated age" to reflect a substandard mortality risk associated with a particular insured. In a comment letter received by the IRS, a request was made to allow for a derived attained age determination in these instances to avoid administrative difficulties resulting from utilizing different attained ages. The requested change is not reflected in the final regulations, and thus joint equal ages and rated ages cannot be used for purposes of applying Sections 7702(c)(4), 7702(d) and 7702(e). In this connection, as noted above, the preamble to the final regulations disclaims that the regulations have any bearing on the determination of "reasonable mortality charges under Section 7702(c)." While this statement appears to offer some leeway in applying Section 7702(c)(3)(B)(i) pending the issuance of further guidance, the practical implication of the regulations on derived joint equal age mortality assumptions remains to be seen.

Changes in Benefits between Policy Anniversaries

As indicated above, the attained age for testing under the final regulations is either the insured's actual age or the insured's contract age (provided it is within 12 months of actual age). The final regulations further state that: *"Once determined…, the attained age with respect to an individual insured under a contract changes annually."* (Emphasis added.) Example 7 of the final regulations, summarized below, details and clarifies the intent of the regulations in dealing with benefit changes off-anniversary.

Example 7: An insured born on May 1, 1947 purchases a policy on Jan. 1, 2008. Jan. 1 is the contract anniversary date for future years. The face amount of the contract is increased on May 15, 2011. During the contract year beginning Jan. 1, 2011, the age assumed under the contract on an age-last-birthday basis is 63 years. However, at the time of the face amount increase the insured's actual age is 64. Treas. Reg. § 1.7702-2(b)(2) provides that, once the attained age is determined it remains that age until the next policy anniversary. Thus, the insured continues to be 63 years old throughout the contract year beginning Jan. 1, 2011 for purposes of Sections 7702(c)(4), 7702(d) and 7702(e), as applicable, even though the insured is age 64 at the time of the increase based on an age-last-birthday determination.

It is important to note that this approach runs contrary to a common insurance industry practice with regard to off-anniversary death benefit increases. Many administrative systems apply a "segment approach" to death benefit increases, where each segment, or layer, of additional death benefit is administered independently from the base contract. Each segment is assigned its own issue date, coverage amount, issue age, etc., and the system calculates guideline premiums according to the characteristics assigned to each segment. Under a segment approach, the system would aggregate guideline premiums for each segment to determine the guideline premiums applicable to the contract. A common practice under this approach is to determine issue age for the segment as if the segment were viewed as a newly issued contract. Therefore, if the contract defines age on an age-last-birthday basis, the segment issue age would be determined on an age-last-birthday basis as of the segment issue date; under the facts of Example 7 above, the insured would have a segment issue age of 64 years. Thus, the segment issue age under an age-last-birthday determination would be greater than the attained age permitted under the final regulations, resulting in a potential overstatement of guideline premiums.

This result was deliberate on the part of Treasury and IRS. A comment letter submitted on the proposed regulations characterized the regulations' language as unclear with respect to the attained age that should be used for changes in a policy's death benefit occurring between policy anniversary dates. The letter requested flexibility in determining which attained age to use in this instance. The final regulations granted the clarifica-

tion, but in a manner contrary to the request made, determining that the attained age of the insured, once determined, remains constant until the next policy anniversary. Again, however, the new attained age rules apply for the limited purposes of Section 7702(c)(4), (d) and (e)—but they do not govern "reasonable" mortality charges, according to the preamble. Off-anniversary changes, then, cannot alter the insured's attained age for purposes of determining the level premium payment period, applying the corridor factors, and making calculations in accordance with the Section 7702(e) maturity date rules.

One question that has arisen concerns the application of the final regulations when there is a material change under Section 7702A(c)(3)(A)(i). Upon a material change in benefits under a contract which was not reflected in any previous determination under Section 7702A, Section 7702A(c)(3)(A)(i) requires the contract to be treated as "a new contract entered into on the day on which such material change takes effect." In Example 7 above, if the contract is considered newly entered into on the date of the face amount increase (May 15, 2011), is it then appropriate to determine age as if the contract were newly entered into on that date for purposes of Section 7702A(c)(3)(A)? It would seem so, in which case the attained age for the 7-pay premium calculation in the example is 64. While calculations of 7-pay premiums under Section 7702A are made, in part, using the computational rules of Section 7702(e), Section 7702A(c)(3)(A)(i) appears to be the more specific statutory rule governing the date when calculations are made and an insured's age is identified. It would be helpful for this to be clarified in future guidance.

Consistency Requirement

The final regulations include a consistency requirement similar to that included in the proposed regulations. Hence, the attained age of the insured (or youngest or oldest insured) with respect to a given contract must be used consistently for purposes of Section 7702(c), (d) and (e), as applicable.

Effective Date

The final regulations are effective Sept. 13, 2006 and apply to policies either (a) issued after Dec. 31, 2008, or (b) issued on or after Oct. 1, 2007 and based on the 2001 CSO tables. A taxpayer may choose to apply the final regulations to policies issued prior to Oct. 1, 2007 provided that the taxpayer does not later determine the policies' qualification in a manner that conflicts with the regulations. This reflects a change from the proposed regulations, under which the new rules were to be effective for policies issued one year or more after the publication of the final regulations. This change was made in response to a request in a comment letter to link the effective date of the final regulations with the adoption dates of the 2001 CSO tables. The purpose was to facilitate state filings and changes in compliance systems needed due to both the new attained age rules and the transition to the 2001 CSO tables.

While certain of the industry suggestions were implemented, some concerns expressed or clarifications requested by industry were not recognized.

Final Thoughts

As issued, the provisions of the final regulations on the attained age determination for certain purposes under Section 7702 do not differ drastically from what was proposed in May 2005. As discussed above, however, there are some differences. While certain of the industry suggestions were implemented, some concerns expressed or clarifications requested by industry were not recognized. Primary among these were the requests for flexibility for off-anniversary benefit changes and the ability to use a derived attained age for multiple life contracts. Both of these changes were sought in part to minimize alterations, complexity and conflict within administrative systems. The ultimate impact of the final regulations remains to be seen.

New Rules and Opportunities for Long-Term Care Insurance Combination Products

by Craig R. Springfield, Bryan W. Keene and Frederic J. Gelfond

Long-term care (LTC) insurance has evolved in many material ways since its introduction—and is still evolving—to meet consumers' needs. Along the way, however, various obstacles affected this evolution, sometimes in ways that hampered the very legitimate goals of insurers, consumers and others seeking solutions that would allow valuable LTC coverage to be provided in as cost-efficient and effective a manner as possible.

Fortunately, the insurance industry and Congress have worked together recently to formulate new products and new tax rules that may provide a very attractive way for acquiring LTC coverage that is both flexible to meet insureds' varying needs and cost-efficient. Those efforts culminated in the passage of the Pension Protection Act of 2006[1] (the PPA) last summer, which included new federal income tax rules for "combination" insurance products. More specifically, the PPA facilitates new products that combine LTC insurance coverage with annuity contracts and improves existing tax rules governing combinations of LTC insurance and life insurance contracts. This article provides a brief summary of the rules in effect prior to the PPA, followed by an overview of the new rules and what they mean for insurers and consumers.

It is important to bear in mind that the new rules generally apply to contracts issued after Dec. 31, 1996, and then only with respect to taxable years beginning after Dec. 31, 2009.

Background

The modern history of the federal income tax treatment of LTC insurance begins with the 1996 enactment of the Health Insurance Portability and Accountability Act (HIPAA).[2] HIPAA added Section 7702B to the Internal Revenue Code, subsection (b) of which sets forth a definition of a "qualified" LTC insurance contract (a QLTCI contract).[3] A contract that meets that definition is treated as an accident and health insurance contract for federal income tax purposes, and insurance benefits paid generally are excludable from the recipient's gross income. In order to meet the definition, a contract must be an "insurance contract" and must satisfy several enumerated requirements, including prohibitions on the contract providing any cash surrender value or covering any risks other than of "qualified long-term care services."[4]

At the time HIPAA was enacted, some insurers foresaw the economic and marketing benefits of combining LTC insurance coverage with life insurance and asked Congress to include rules governing such combinations.

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[1] Pub. L. No. 109-280 (2006).

[2] Pub. L. No. 104-191 (1996). HIPAA's provisions regarding LTC insurance contracts generally were effective for contracts issued after Dec. 31, 1996, with special transition rules for contracts issued on or before that date.

[3] For more detailed discussions of QLTCI contracts under HIPAA, *see* Adney and Springfield, *The New Tax Rules Governing Long-Term Care Insurance*, J. of Am. Soc'y of CLU and ChFC (Sept. 1997, Nov. 1997 and Jan. 1998); Chambers and Gelfond, *Long-Term Care Unfettered: Tax Law Contains State Law Prescription for Long-Term Care*, 11 Ins. Tax. Rev. 1111 (Dec. 1996).

[4] Section 7702B(b)(1). A QLTCI contract will not violate the prohibition on cash surrender values by virtue of providing a return of premium benefit upon death or complete surrender or cancellation of the contract. Section 7702B(b)(2)(C).

The resulting rules, set forth in Section 7702B(e), stated that the "portion" of a life insurance contract that provides LTC coverage (whether "qualified" or not) through a rider on or as part of the contract was treated as a separate contract for purposes of Section 7702B.[5] This "separate contract" treatment was critical to the existence of the life/LTC combination product, due to the above-referenced limitations on cash surrender values and insurance coverages that Section 7702B otherwise imposes on QLTCI contracts. That is, without separate contract treatment, the life/LTC product might be viewed as a single "insurance contract" that, by virtue of its life insurance features, provided both a cash surrender value and coverage of risks (namely, premature death) that were not of qualified long-term care services. By separating the life insurance and LTC "portions" of the combination product, it became possible for the LTC coverage to be "qualified" under Section 7702B.

...without separate contract treatment, the life/LTC product might be viewed as a single "insurance contract" that, by virtue of its life insurance features, provided both a cash surrender value and coverage of risks (namely, premature death) that were not of qualified long-term care services.

The result of these rules for life/LTC combination products was that the QLTCI portion of the product could provide tax-free benefits in the same manner as a stand-alone QLTCI contract. Moreover, the legislative history of HIPAA clarified that both the cash surrender value and the net amount at risk under the life insurance portion of the combination product could be paid out as a tax-free QLTCI benefit pursuant to the QLTCI portion of the product after the insured's chronic illness.[6] Of course, those amounts ultimately would have been received tax-free under Section 101(a) if paid out as death benefits under the life insurance portion of the product, so treating them as QLTCI benefits when paid upon chronic illness simply accelerated their tax-free receipt during the insured's lifetime.

HIPAA's rules for life/LTC combination products also addressed how the imposition of charges against the life insurance portion's cash value to fund the QLTCI portion would affect the application of Section 7702 to the life insurance portion. The rules adopted a "pay as you go" approach under which the guideline premium limitation of Section 7702(c)(2) (*i.e.*, the funding limit imposed on life insurance contracts) was increased by the sum of the charges imposed for QLTCI coverage to the extent that such charges did not reduce the "premiums paid" for the life insurance contract under Section 7702(f)(1).[7] Generally speaking, once premiums are actually paid into a life insurance contract, that figure is adjusted only for subsequent distributions from the contract. More specifically, distributions that are taxable under Section 72(e) generally do not affect the total of premiums paid while distributions that are not taxable under Section 72(e) reduce the total of premiums paid.[8] Thus, by imposing a rule under which QLTCI charges assessed against a life insurance contract affect its guideline premium limitation only if they do not reduce premiums paid, HIPAA implied that such charges were treated as deemed distributions from the contract

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[5] "Portion" was defined in Section 7702B(e)(4), as enacted by HIPAA, as "only the terms and benefits under a life insurance contract that are in addition to the terms and benefits under the contract without regard to long-term care insurance coverage."

[6] Staff of the J. Comm. on Tax'n, General Explanation of Tax Legislation Enacted in the 104th Congress, at 341 (J. Comm. Print 1996) (stating that "if the applicable requirements are met by the long-term care portion of the contract, amounts received under the contract as provided by the rider are treated in the same manner as long-term care insurance benefits, *whether or not the payment of such amounts causes a reduction in the contract's death benefit or cash surrender value.")* (emphasis added).

[7] Section 7702B(e)(2), as in effect prior to the PPA. No similar rule expressly applied for purposes of the cash value accumulation test of Section 7702(b) because funding on a "pay as you go" basis could be accomplished under contracts subject to this test without the need for any special rule.

[8] As a general matter, distributions from a life insurance contract are taxable (1) after all of the investment in the contract has been withdrawn or (2) if the contract is a modified endowment contract within the meaning of Section 7702A (a "MEC"), to the extent of any income on the contract.

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because their treatment as such is the only way that they could affect the "premiums paid" for the contract.[9] If such deemed distributions were taxable at the time the QLTCI charges were assessed, then they generally would not affect the "premiums paid" for the contract and the guideline premium limitation would be adjusted upwardly. If such deemed distributions were not taxable at the time the charges were assessed, then they would reduce the "premiums paid" for the contract and the guideline premium limitation would not be adjusted.

The end result of the foregoing rules was that the federal income tax treatment of products that combined life insurance coverage with QLTCI coverage was relatively clear after 1996. However, the changes that HIPAA made did not address other possible combination products involving LTC insurance coverage, including combinations of annuity contracts and LTC insurance contracts.[10] Without similar rules to provide "separate contract" treatment for such products, they were subject to the same technical obstacles that life/LTC combinations would have faced if HIPAA had not included clarifying rules; namely, the annuity cash value and insurance coverages (*e.g.*, guaranteed annuity purchase rates) could be viewed as attributable to the LTC portion of the product, thereby precluding QLTCI treatment for that portion. With the passage of the PPA last summer, this issue was addressed by repealing Section 7702B(e) and re-enacting it in an amended form that expressly covers annuity/LTC combination products. As indicated above, the PPA also improved the federal income tax treatment of life/LTC combination products. The remainder of this article discusses the specific changes made by the PPA.

Separate Contract Treatment

In general—The most significant change that the PPA made to the federal income tax treatment of LTC insurance was to expressly bring annuity/LTC combination products within the ambit of the "separate contract" rule of Section 7702B(e). More specifically, Section 7702B(e)(1) now provides that "in the case of any long-term care insurance coverage (whether or not qualified) provided by a rider on or as part of a life insurance contract *or an annuity contract* … [t]his title shall apply as if the portion of the contract providing such coverage is a separate contract."[11] Thus, the QLTCI portion of an annuity/LTC combination product or a life/LTC combination product can provide tax-free benefits in the same manner as a stand-alone QLTCI contract. Moreover, similar to the legislative history of HIPAA, the legislative history of the PPA clarifies that if the LTC portion otherwise qualifies as a QLTCI contract, "amounts received under the contract as provided by the rider are treated in the same manner as long-term care insurance benefits, *whether or not the payment of such amounts causes a reduction in the life insurance contract's death benefit or cash surrender value or in the annuity contract's cash value."* [12]

Significance of tax-free treatment for cash values—As discussed above, in the case of life/LTC combinations, tax-free QLTCI treatment for distributions of the life insurance contract's cash surrender value and net amount at risk merely accelerates the tax-free receipt of a benefit that otherwise would be excludable under Section 101(a) when paid as a life insurance death benefit. However, in the case of annuity/LTC combinations, the same treatment for the annuity contract's cash value has much greater significance because distributions from an annuity contract—including those made at death—otherwise are taxable on an "income first" basis pursuant to Section 72. Thus, in the context of annuities, the rule has the

[9] HIPAA's treatment of QLTCI charges as distributions was further implied by Section 7702B(e)(3), as in effect prior to the PPA, which denied a deduction under Section 213(a) for such charges unless they were includable in gross income under Section 72(e)(10), which governs distributions from MECs. As discussed *infra*, the PPA modified the manner in which charges for QLTCI coverage are treated under Sections 72 and 7702.

[10] One possible answer to the question of why annuity/LTC combination products were not included in HIPAA's provisions is that the product was still in its infancy at the time of HIPAA's enactment, and thus there likely was no significant consideration given to extending HIPAA's rules to expressly cover such products.

[11] Emphasis added. For purposes of this provision, the PPA followed HIPAA's incremental approach to defining the LTC "portion" of a contract, *i.e.*, it is defined as the terms and benefits that are in addition to the terms and benefits of the contract without regard to LTC coverage. Section 7702B(e)(3).

[12] Staff of the J. Comm. on Tax'n, Technical Explanation of H.R. 4, the "Pension Protection Act of 2006," as Passed by the House on July 28, 2006, and as Considered by the Senate on Aug. 3, 2006, at 195 (J. Comm. Print 2006) (emphasis added).

effect of transforming amounts that certainly would be taxable into amounts that will never be taxed.[13]

This aspect of the separate contract rule as it applies to annuities is almost certain to be one of the key features driving the attractiveness of annuity/LTC combination products. Moreover, by encouraging the use of annuity cash values to pay LTC benefits, the rule promotes product designs that could offer an attractive—and possibly more affordable—alternative to stand-alone LTC coverage. In that regard, under stand-alone coverage, all of the insurance benefits come from net amounts at risk to the insurer due to the lack of any available cash value under the contract to at least partially fund LTC benefit payments. In contrast, a combination product uses some portion of the annuity (or life insurance) contract's cash value to pay the insured's LTC expenses. This typically will result in lower costs for the LTC coverage as compared to a stand-alone LTC contract, with other factors being equal, because the insured is using one of his or her existing assets (the contract's cash value) to fund part of the LTC costs incurred. As a result, the timing for some or all of the "pure" LTC insurance benefit payments (*i.e.*, benefits paid from the net amount at risk) is delayed. At the same time, prior to receiving LTC benefits the annuity cash value generally provides liquidity to meet retirement or emergency needs, thus providing valuable flexibility and helping to avoid the "use it or lose it" concern that some consumers might have with respect to stand-alone LTC coverage.

The new rules for annuity/LTC combination products appear to be crafted broadly enough to facilitate a wide array of product designs that couple LTC coverage with both deferred and immediate annuities.

Application to deferred and immediate annuities—The new rules for annuity/LTC combination products appear to be crafted broadly enough to facilitate a wide array of product designs that couple LTC coverage with both deferred and immediate annuities. For instance, an LTC rider could be issued with a deferred annuity and provide that LTC benefits would come proportionately (or on some other basis) from net amounts at risk and the annuity's cash value. Thus, for example, each dollar of LTC insurance benefits might reduce the annuity's cash value by $0.50. In such case, the entire LTC insurance benefit (comprised of amounts from the annuity cash value and from net amount at risk) generally would be tax-free.[14]

Similarly, an LTC rider could be issued with an immediate annuity and provide that the periodic payments will be increased by a certain amount or percentage if the insured becomes eligible for LTC benefits. In such case, it appears that, at a minimum, the incremental increase in periodic payments could be received tax-free. In addition, given the legislative history discussed above confirming that LTC benefits do not lose their character as such even if they reduce cash value, it would seem that *all* of the periodic payments made under the contract after the insured becomes eligible for LTC benefits should be treated as LTC benefits for tax purposes, not just the incremental increase in payments. Such a result would treat immediate annuity/LTC combinations in the same manner as deferred annuity/LTC combinations, and is an appropriate outcome given both the legislative history and, more generally, the societal benefits of annuitizing savings to generate reliable income streams in retirement. With respect to immediate annuity/LTC combinations, however, it may be critical that the payment, in form, represents an LTC benefit. In addition, the potential tax consequences of such characterization on the annuity portion of the contract should be considered as insurers design products.

It also should be noted that for an LTC rider to be treated as a QLTCI contract, it must be an "insurance contract" in the first instance. Under general tax principles, insurance exists only where there is adequate risk shifting and risk distribution.[15] Thus, for example, a rider

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[13] This will be the case where LTC benefits exhaust the value of the annuity contract. Where part of the value of the annuity contract remains (such as at the annuitant/insured's death), amounts thereafter payable may be taxable. There is some uncertainty regarding the effect of LTC benefits upon an annuity or life insurance contract's "investment in the contract" under Section 72(e)(6).

[14] In the case of benefits reimbursing qualified long-term care services, the entire benefit would be tax-free. In the case of benefits paid on a per diem or other periodic basis, benefits would be tax-free to the extent of the per diem limitation of Section 7702B(d).

[15] See Helvering v. LeGierse, 312 U.S. 531 (1941).

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that merely characterized the cash value under a deferred annuity or the otherwise scheduled payments under an immediate annuity as LTC benefits seemingly would not qualify as a QLTCI contract without identifiable insurance elements that exhibit the requisite features of risk shifting and risk distribution.

Limited to non-qualified annuities—While the separate contract rule would appear to apply to both deferred and immediate annuities, it clearly is limited to such annuities that are issued on a "non-qualified" basis, *i.e.*, annuities purchased with after-tax dollars and with no connection to an employer-sponsored or individual retirement arrangement. More specifically, Section 7702B(e)(4) provides that separate contract treatment is not available with respect to annuity/LTC combinations involving a qualified retirement plan described in Section 401(a), or with respect to (i) any contract that is purchased in connection with a qualified retirement plan described in Section 401(a) or 403(a), (ii) any contract described in Section 403(b), (iii) any contract purchased in connection with a plan described in Section 818(a)(3), (iv) any contract that is (or is part of) an individual retirement account or annuity, or (v) any contract purchased by an employer for the benefit of the employee or the employee's spouse. The last provision would appear to apply even in circumstances where an employer's purchase of an annuity contract for an employee is treated as currently taxable compensation to the employee such that the contract resembles any other typical non-qualified annuity contract that is purchased with after-tax dollars. Although not entirely clear, the intent with respect to this last rule may have been to ensure that Section 106, providing an exclusion from income for employer-provided coverage under an accident or health plan, could not apply with respect to a LTC/annuity combination product.

Technical correction—As a final note regarding the separate contract treatment of the LTC portion of a combination product, the PPA also included a "technical correction" to clarify that separate contract treatment applies for purposes of the entire "title" (*i.e.*, the entire Code), not just for purposes of "Section" 7702B. This change appears to make it even clearer that charges for QLTCI coverage under a life insurance or annuity contract are treated as distributions from the life insurance or annuity contract that are then paid into the LTC rider. As indicated above, such treatment was implicit in the HIPAA-enacted version of Section 7702B(e), which perhaps explains the PPA's characterization of the change from "section" to "title" as a mere technical correction. In that regard, the change was given retroactive effect to the original enactment of HIPAA, such that it applies to contracts issued after Dec. 31, 1996.

Tax Treatment of Charges to Fund QLTCI Coverage

In addition to indirectly addressing charges through the technical correction described above, the PPA includes new rules effective for tax years beginning after Dec. 31, 2009, that provide more beneficial tax treatment of charges assessed against the cash value of a life insurance or annuity contract to fund the QLTCI portion of the contract. Specifically, under these rules, such charges continue to be treated as deemed distributions, but they are excludable from gross income in all cases, even if a distribution from the contract at the time the charges are imposed otherwise would be includable in gross income. Consistent with this treatment, the charges also reduce the life insurance or annuity contract's after-tax "investment in the contract" (but not below zero). The new rules do provide, however, that the amount of the QLTCI charges cannot be deducted under Section 213(a), which otherwise allows deductions for certain medical expenses that exceed 7.5 percent of adjusted gross income.[16]

Coordination with Section 7702

The PPA also modified the manner in which Section 7702 applies to the life insurance portion of a life/LTC combination product. Specifically, the PPA repeals the rule providing for an increase in the guideline premium limitation under Section 7702(c) with respect to the charges imposed to fund LTC coverage after 2009. As described above, under that rule the charges for QLTCI coverage were treated as distributions from the life insurance portion of the contract that affected the guideline premium limitation only if they otherwise were taxable when made from the contract. Such a rule is no longer necessary due to the PPA's treatment of QLTCI charges after 2009 as non-taxable distributions in all instances. As such, these charges for QLTCI coverage under a life

[16] A similar deduction disallowance rule existed under Section 7702B(e) as enacted by HIPAA. *See supra* note 9.

insurance contract will always reduce the "premiums paid" for the contract after 2009.[17]

Tax-Free Exchanges

The PPA also amended the federal income tax rules governing tax-free exchanges of insurance contracts. Specifically, the PPA allows a life insurance contract, endowment contract, annuity contract or QLTCI contract to be exchanged for a QLTCI contract tax-free. In addition, tax-free exchanges among life insurance and annuity contracts that were allowed under prior law will not be prevented by reason of a life insurance contract or annuity contract including a QLTCI rider or feature. The amendments with respect to tax-free exchanges generally apply with respect to exchanges occurring after Dec. 31, 2009.

DAC Tax Treatment of Combination Products

Under current law, the deferred acquisition cost or "DAC tax" rules of Section 848 require the capitalization of "specified policy acquisition costs." Such costs are 1.75 percent of the net premiums paid in any year for an annuity contract, 2.05 percent of the net premiums paid in any year for a group life insurance contract and 7.7 percent of the net premiums paid in any year for any "other" insurance contract (including non-group life insurance contracts and stand-alone QLTCI contracts). The PPA amends the DAC tax rules to provide that any life insurance contract or annuity contract that includes a QLTCI component will be treated as an "other" contract for purposes of these rules, meaning that the specified policy acquisition costs for such combination products will equal 7.7 percent of net premiums paid. In the case of non-group life insurance contracts that include a QLTCI component, this rule maintains current law. However, in the case of an annuity contract issued with a QLTCI component, the new rule may change the applicable DAC rate because the annuity portion of the contract would be subject to the 7.7 percent rule rather than the 1.75 percent rule that normally applies to annuity contracts. (It is not entirely clear, however, that such a change in rates will result from the PPA's amendments because, under Section 848(e)(3) and the regulations thereunder, the combination of an annuity contract with noncancellable accident and health insurance already is treated as an "other" insurance contract that is subject to the 7.7 percent DAC rate. Because QLTCI is a type of noncancellable accident and health insurance, it would appear that LTC/annuity combinations already are subject to the higher DAC rate.) The amendments to the DAC tax rules apply with respect to policy acquisition costs determined for taxable years beginning after Dec. 31, 2009.

The PPA amends the DAC tax rules to provide that any life insurance contract or annuity contract that includes a QLTCI component will be treated as an "other" contract for purposes of these rules...

Reporting Requirements

The PPA also imposes certain reporting requirements on issuers of QLTCI combination products. In particular, issuers will be required to annually report (1) the amount of the aggregate charges against the contract to fund QLTCI coverage; (2) the amount of the reduction in the investment in the contract resulting from the imposition of such charges; and (3) the name, address and TIN of each contract owner. Payee statements with this information also will be required. The new reporting requirements will apply with respect to charges made after Dec. 31, 2009.

Effective Date

The effective date provision of the PPA states that the new rules generally apply to "contracts issued after Dec. 31, 1996, but only with respect to taxable years beginning after Dec. 31, 2009." This effective date rule presents a number of questions regarding how combination products will be treated prior to 2010.

For example, if an insurance company were to issue annuity/LTC combination products prior to 2010, it seems clear, by implication, that the LTC portion of the contract could not constitute QLTCI because such por-

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[17] Interestingly, the version of the PPA that was passed by the House of Representatives (H.R. 4) would have treated a QLTCI rider to a life insurance contract as a "qualified additional benefit" within the meaning of Section 7702(f)(5), which would have permitted pre-funding of future LTC charges. This provision was dropped from the PPA as enacted, and the general "pay as you go" approach was retained, albeit without the need for any adjustment to the guideline premium limitation for charges after 2009.

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tion would not be treated as separate from the annuity portion of the contract, regardless of how the products are viewed under state insurance or contract law principles. (At the same time, it may be possible to issue such a product today and provide, consistent with the notice requirements of Sections 4980C(d) and 7702B(g)(3), that the LTC portion of the contract is intended to be a QLTCI contract beginning after Dec. 31, 2009.) It is less clear, however, whether this single, integrated contract view would also apply for purposes of determining the tax treatment of charges assessed against the annuity cash value to fund LTC coverage. There may be, for example, an implication under the PPA's rules addressing the treatment of charges after 2009 that charges imposed prior to that time would be treated as distributions from the annuity contract.

Other questions have arisen regarding the purpose of the general effective date rule's reference to contracts issued after 1996. While it seems clear, for example, that it should not be permissible to combine an annuity contract with pre-1996 LTC coverage that is grandfathered under HIPAA, it is unclear what scope the effective date rule has beyond this. Does this aspect of the general effective date render separate contract treatment inapplicable, for example, if a LTC rider is added after 2009 to a life insurance or annuity contract that was issued prior to 1996? While this issue might be easily avoided by simply exchanging the life insurance or annuity contract for another one after 1996, such exchanges themselves could have undesirable effects.[18]

Moreover, the special effective date of the new tax-free exchange rules (which are effective for exchanges occurring after Dec. 31, 2009) present questions themselves. For example, how should life insurance exchanges occurring before 2010 be treated when either the original contract or the contract received in the exchange has an LTC rider? Life/LTC combination products already enjoy separate contract treatment by virtue of the HIPAA-enacted version of Section 7702B(e) and the PPA's technical correction thereto. With this in mind, if the original contract has a LTC rider, but no value attributable to such rider is assigned or otherwise transferred to the contract received in the exchange, it appears that the transaction should be treated under Section 1035 as merely the exchange of one life insurance contract for another, *i.e.*, as entirely tax-free. Tax-free treatment similarly would appear appropriate where the new contract, rather than original contract, has the LTC rider, but no portion of the value received from the original life insurance contract is allocated to the LTC rider of the new contract at the time of the exchange. (If the LTC rider is funded with charges imposed after issuance of the life/LTC combination product, such charges seemingly would be treated as distributions prior to 2010, and would be subject to the reduction in "investment in the contract" rule described above thereafter.)

Conclusion

As health care and LTC costs continue to rise, more and more people will explore cost-efficient means to cover the risks they face. Combination insurance products provide consumers with the ability to leverage an asset, such as an annuity or life insurance contract, to provide more modestly priced coverage as part of a flexible benefits package. As a result, the PPA's amendments to the rules governing LTC combination products could go a long way towards helping consumers better prepare for their future LTC needs. Moreover, the new rules for combination products appear to be flexible enough to facilitate future innovative product designs that can evolve as consumers' needs continue to change. ◂

[18] For example, the contract received in the exchange generally would be newly subject to Section 7702, and cash values of the prior contract treated as premiums into the new contract might not be supported by the guideline premium limitation for the new contract. Similarly, the exchange would result in a material change under Section 7702A(c)(3) and thus could cause a contract to become a MEC, and additional issues could arise under Section 264 (governing deductions by businesses that own life insurance) and Section 848 (governing DAC taxes).

Taxes and the New Exam Structure

by Kory J. Olsen

The Society of Actuaries (SOA) examination structure is currently in transition to the new structure. If you haven't taken an exam in years, chances are that you haven't kept up with the exam changes. This article will provide a concise summary of the new exam structure as well as a discussion of the inclusion of taxes.

The transition to the new exam structure began in 2005 and it is scheduled to be complete by the end of the year. It is easiest to think of the structure in two parts: ASA Education and FSA Education.

ASA Education

The ASA Education has a variety of pieces. The core educational piece is four SOA written exams, designated by letters instead of the old number system. These exams are supplemented by three topics that require Validation by Educational Experience (VEE), something new that will be discussed below. There are also eight interactive, Web-based modules. The group of modules includes end-of-module exercises as well as multiple-choice questions and a Final Assessment. The final requirement is the Associateship Professionalism Course (APC).

VEE is new with this redesign and supplements the examinations conducted by the SOA. Credit for the VEE topics can be received from either college courses, standardized examinations and other educational experiences, or through a transitional exam (offered for a limited time). The topics covered by VEE are Applied Statistical Methods, Corporate Finance and Economics.

The eight Web-based modules are called the Fundamentals of Actuarial Practice (FAP). Each module is targeted to take between 30 and 50 hours for the student to complete, including both on- and off-line work. Each module focuses on a particular topic of being an actuary and relates it to the preceding modules. There are some external readings as well as checkpoint questions to make sure that the student understands the important points. The FAP includes a multiple-choice examination as well as a Final Assessment.

FSA Education

The FSA Education is also broken into exams and modules, and they differ by track. The tracks include Finance and ERM, Investment, Individual Insurance, Retirement and Group and Health. Each track includes two written exams and two modules with end-of-module projects. There is also a Strategic Business Management Module (SBM) that is applicable to all tracks. Once all of these are complete, the student attends an expanded Fellowship Admissions Course (FAC).

Tax Content

Taxation of life insurance companies and their products is primarily found in the FSA Education. Most of the FSA exams contain some tax content. Some of the modules also contain tax content. The type and amount of tax content depends upon the track that one is taking. For example, the Individual Insurance track contains a lot of tax topics covering both product tax and company tax. However, the Investment track is much lighter on tax topics.

The taxation content covers both U.S. and Canadian topics. Some exams are split by country and contain more focused country-specific tax information. The modules are not split by country, exposing all the students taking the module to taxation topics of both countries.

Taxation Section

The Taxation Section has been consulted on tax content and, in some cases, been actively involved in the creation of the exam or module. Taxation is an important element in activities of an insurance company. The Taxation Section wants to make sure that new FSAs have at least a basic understanding of the tax element.

Further details on the new exam structure or exam content can be found on the SOA Web site *(www.soa.org).*

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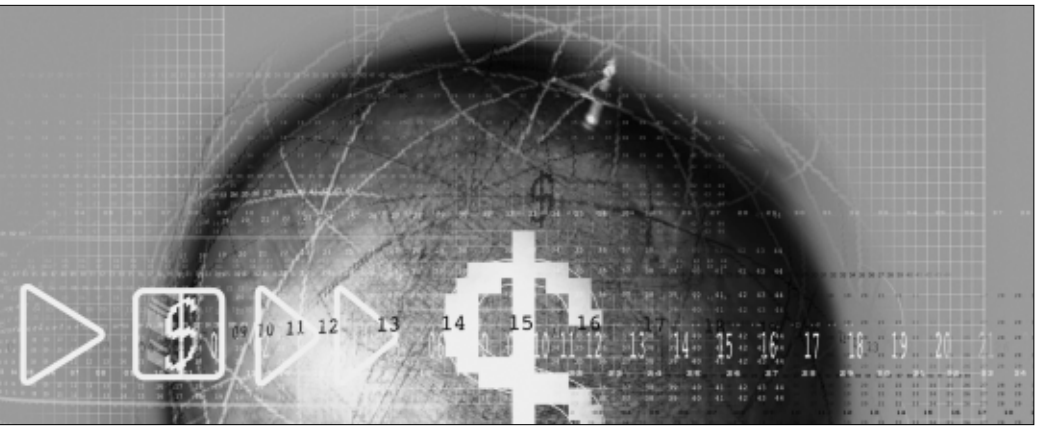
Capital Efficiency Seminar

by Edward L. Robbins and Hubert B. Mueller



On Sept. 19 and 20, 2006, the Taxation, Financial Reporting and Risk Management Sections co-sponsored a seminar entitled, "Increasing Economic Value through Greater Capital Efficiency." The primary organizers of the seminar were Ed Robbins (Taxation) and Hubert Mueller (Risk Management), with assistance from Charles Gilbert and Dave Ingram. Other faculty members were Tim Gaule, Steve Blaske, Dominique Lebel, Chris DesRochers and Kory Olsen.

This seminar was intended to be the rollout of a new Society of Actuaries (SOA) promotional initiative. This capital efficiency initiative intends to roll up several actuarial technical skill sets into a coherent whole, in such a way as to enable the company actuary to be a valued business partner at the senior management table. In that respect, it is well-aligned with the SOA's Marketing and Market Development Program (MMDP) for the profession, in its objective to increase the influence of actuaries in their organizations. Specifically, the program was intended to enable the actuary to measure capital efficiency, to communicate it, and to assist in optimizing it.

Capital efficiency is best defined by example, as a relative term. An alternative that provides greater shareholder value or economic value (by some objective measure) is more "capital efficient." Shareholder value is a function of three drivers: pretax cash flows, taxes and balance sheet values, and the capital efficiency initiative concentrates on the latter two categories. The tools to measure capital efficiency are already in the public actuarial domain, but in the perception of the seminar coordinators those tools are not sufficiently used in our industry in the United States.[1] Shareholder value is of primary importance to senior management, as one of its primary objectives. Consequently, there is a need for actuaries and financial officers to be able to measure economic value and be familiar with the drivers of economic value, to produce the most capital-efficient courses of action for their organizations.

The tools covered by the seminar revolved around capital efficiency as measured by statutory accounting, not GAAP, inasmuch as statutory accounting determines the stream of distributable earnings available to investors.

The four components of the seminar were Embedded Value (EV), Life Insurance Company Taxation, Asset Liability Management and Risk Management. The concept of the seminar was to roll all four topics together in a coordinated manner, in order to give the actuary some tools to communicate shareholder value and increments to economic value to senior management.

Traditional EV, together with its recent refinements, constitutes a convenient measuring tool for economic value of a life or health insurance enterprise. Not only can it give the value of the enterprise; it can also provide a metric for the incremental value of a management strategy—that is, whether it is accretive or erosive to economic value. EV equals the value of future distributable earnings from the current in-force business, plus the adjusted net worth of the enterprise. Future sales are not included in EV.

The panelists first covered traditional EV and its limitations and then they went on to cover European embedded value (EEV), market-consistent embedded value (MCEV) and stochastic embedded value. European multinationals, including their subsidiaries in the United States, have published on an EEV basis since 2005. Increasingly, companies are showing EV results on a market-consistent basis, using MCEV reporting. Both EEV and MCEV require a stochastic calculation of

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[1] Embedded Value was the metric chosen in our initiative as a metric for measuring capital efficiency. Unlike in the United States, all major insurance organizations in Western Europe publish Embedded Value results, and it is a required disclosure item in the United Kingdom.

the cost of options and guarantees. The presenters covered the implications of doing EV on a stochastic basis, and recent changes in typical EV and EEV disclosures.

Taxation is an immensely important component of EV, and one that has received far too little attention from the actuarial profession, considering that tax reserves are a vitally important driver of life company taxation. As an example, $1,000,000 post-tax economic value added from a tax reserve planning strategy is typically not difficult to achieve in a medium-sized life insurance company. How much term insurance would a company have to produce in the current environment to generate that kind of economic value? Chances are that in most companies the required amount would be far greater than the production of the largest sales agency in the company.

The seminar discussed the basic rules of life insurance company taxation and provided convenient references for those who wished more in-depth education on this important issue. We then gave various illustrations of how to evaluate the effect of a tax planning strategy on EV. We also discussed the nature of statutory deferred taxes, and how a company can optimize its admissible deferred tax assets, thereby increasing EV.

Asset liability management and risk management are also important capital efficiency topics. The purpose of both those topics is to reduce the volatility of the capital efficiency of the enterprise—at a bearable cost.

The seminar was well-attended (approximately 110 attendees). The evaluation forms gave it a much better than average score, indicating that this initiative generated significant interest and should be pursued.

The basic question was: "How should this initiative be further pursued?" The evaluation form responses to this question varied, as expected. However, some attendees desired more in-depth education on taxation, while others desired more in-depth education on EV and economic capital.

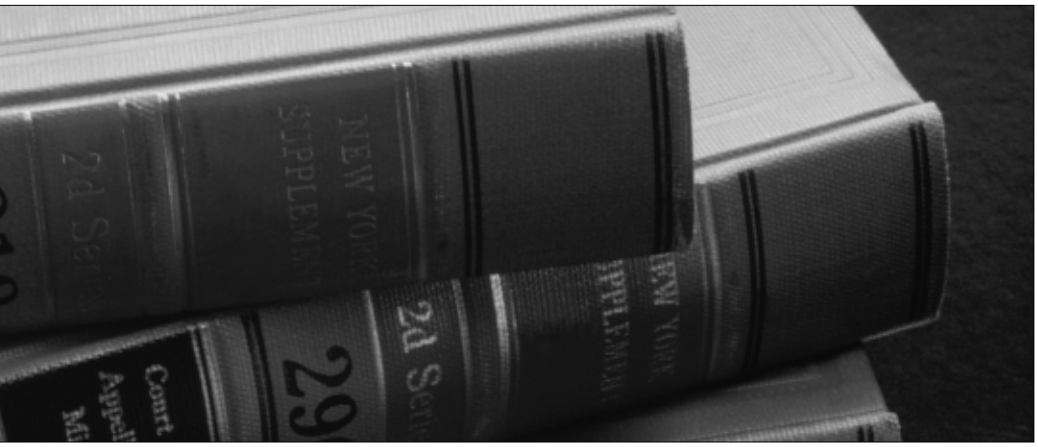
The ability of an economic enterprise to "look down the road" and perceive future threats and opportunities is essential to its success.

The question that this seminar begged was: "Are these four subjects sufficient for the actuary as a business partner?" Should we later include certain non-actuarial topics that might also be useful in this effort?

Techniques of environmental scanning would be a likely non-actuarial topic. The ability of an economic enterprise to "look down the road" and perceive future threats and opportunities is essential to its success. The ability to perceive future "inflexion points," major regime shifts, leading indicators and the like, is possibly a teachable skill—and not a strictly actuarial skill. As Wayne Gretzky once said, when he was asked the secret of his success: "I skate to where the puck is going to be."

We would be happy to hear from our readers as to how to enrich the capital efficiency initiative and make it a part of the insurance company actuary's management tool kit. Please contact Ed Robbins at *erobbins@smartgrp.com*, or Hubert Mueller at *hubert.mueller@towersperrin.com*.

T³: *Taxing Times* Tidbits



Magistrate Finds "[H]aystack has no needle!" Recommends Denial of Summary Judgment Motions in Pre-1986 COLI Case

by Frederic J. Gelfond

This article does not constitute tax, legal or other advice from Deloitte Tax LLP, which assumes no responsibility with respect to assessing or advising the reader as to tax, legal or other consequences arising from the reader's particular situation.

Despite foreboding during the Oct. 12, 2006 hearing on the subject motions[1] that he could not weigh the credibility of experts, or their conflicting opinions, "as a jury would ultimately do," the Chief U.S. Magistrate Judge in the Xcel Energy leveraged COLI[2] case, "thoroughly thrashed the 'stacks of papers ever so many more times,'" and concluded that summary judgment in favor of either party in this economic substance matter "would be legally impermissible."[3] As such, the magistrate judge recommended that the parties' cross-motions for summary judgment regarding the taxpayer's right to a COLI-related interest deduction be denied. In addition, the magistrate recommended that portions of the government's motion to strike testimony of certain taxpayer witnesses be granted, and that the taxpayer's motion to strike certain government testimony be denied.

This was actually the second set of cross motions for dispositive relief in this case; the first set having been submitted before the completion of discovery. In reaching his conclusion, the magistrate judge noted, without further asserting they were the determinative tests, the following open questions that the district court set forth in denying the initial summary judgment motions: (1) whether the subject life insurance policies presented a real opportunity for a risk-based gain or loss based upon the actual mortality of the insured employees; and (2) whether, absent the interest deductions, the plan could generate a pretax profit for the taxpayer.[4]

While the parties naturally sought to respond to these open items in this second round of summary judgment motions, the magistrate judge observed the parties' vastly differing views of the transactional facts, the varying standards under which the opposing expert witnesses contended such facts should be interpreted, and the diverse tests the two sides argued should be applied in deciding an economic substance case involving insurance.

In 53 pages of text, the report generally describes several of the parties' arguments and factual assertions relating to such items as the existence or meaning of positive, unencumbered inside build-up of cash values in the policies, positive pre-tax cash flows and profits, expected mortality gains and the use of "out-of-pocket" cash to pay premiums in four out of the first seven policy years. Noting that some of these factors were deemed relevant in other recent tax cases, the report indicated that they were not necessarily determinative with respect to the matter at hand.

The one substantive recommendation the report does make, however, involves the taxpayer's argument that it is entitled to summary judgment as a result of the taxpayer's compliance with the Internal Revenue Code[5]

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[1] Xcel Energy v. United States, Transcript of Hearing on Oct. 12, 2006, at page 5.

[2] Corporate-owned life insurance.

[3] Xcel Energy, Inc. v. United States, Report and Recommendation of Chief U.S. Magistrate (Feb. 14, 2007), note 5.

[4] *See* Order, Docket No. 64 (Oct. 12, 2005).

[5] Section references herein are to the Internal Revenue Code of 1986, as amended.

Section 264(d)(1) four-out-of-seven rule.[6] That rule provides an exception to the general policy loan interest deduction disallowance provision contained in Section 264(a)(3). The magistrate judge cited several cases that relied on *Knetsch*[7] in finding that the inapplicability of the Section 264 interest deduction disallowance rule does not, by itself, entitle a taxpayer to an interest deduction under Section 163. In other words, Congress did not overrule *Knetsch* through its enactment of the exceptions contained in Section 264.

The report does not contain a recommendation on whether the law in the Eighth Circuit on economic substance requires a taxpayer to demonstrate both objective economic substance and subjective business purpose for entering into a transaction, or whether a showing of either one or the other is sufficient.

The trial in this case is currently slated to begin on July 24, 2007. At that time, it is expected the district judge, or potentially a jury, will provide a new set of eyes in searching for that "needle in the haystack" the magistrate judge worked so hard to find.

Supreme Court Will Not Hear Dow Chemical Co. COLI Case

by Samuel A. Mitchell

The Supreme Court has denied Dow Chemical Company's *petition for certiorari* in its corporate-owned-life-insurance (COLI) case. *Dow Chemical Co. v. United States*, 75 U.S.L.W. 3207 (Feb. 20, 2007). Dow is the only COLI litigant thus far to convince a trial court that its COLI program had economic substance aside from the tax benefits from interest deductions on plan borrowings. However, last year the U.S. Court of Appeals for the Sixth Circuit Court, over a strong dissent, reversed the trial court's ruling. *Dow Chemical v. United States*. 435 F.3d 594 (6th Cir. 2006). Thus, the appeals court disallowed Dow's interest deductions. Litigants in COLI cases typically try to demonstrate that a program has economic substance aside from tax benefits by showing, among other things, that the plan has positive cash flow and unborrowed inside build-up (net equity) over time. Dow convinced the trial court that its plan met both of these requirements. However, the Sixth Circuit held as a matter of law that Dow could not demonstrate economic substance because it based much of its analysis on speculative future cash infusions. According to the Sixth Circuit, in analyzing whether a transaction has economic substance for tax purposes, a trial court cannot consider evidence of an intent to make future cash infusions unless the party shows that it is required by contract to make the infusions or unless they are consistent with past practice. The tax bar in general perceived this unworkable legal standard as a misapplication of Supreme Court precedent in the economic substance area. Dow highlighted the issue in its *petition for certiorari* to the Supreme Court, and the U.S. Chamber of Commerce, among other *amici* supporting Dow's position, argued that the holding has the potential to wreak havoc in normal corporate tax planning, well beyond the COLI context. The Supreme Court, evidently unmoved by this argument, let the lower court's ruling stand. This may not be the end of the story as far as the Supreme Court is concerned. There are a number of other COLI cases in the administrative process, and at least one case, *Xcel Energy v. United States*, Civ. No. 04-1449 (D. Minn.), is scheduled for trial in the near future. See the accompanying tidbit on the Magistrate's decision in *Xcel*. The Supreme Court usually does not take cases unless they create a clear conflict among the lower courts. The Sixth Circuit's holding presents an opportunity for a conflict arising from one of the other cases to be decided in the next few years.

The tax bar in general perceived this unworkable legal standard as a misapplication of Supreme Court precedent in the economic substance area.

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[6] Section 264(d)(1) provides an exception to the Section 264(a)(3) policy loan interest deduction disallowance rule if the taxpayer pays four out of the first seven years' annual premiums due with unborrowed funds.

[7] Knetsch v. United States, 364 U.S. 361 (1960).

from pg. 31

IRS Updates MEC Closing Agreement Procedures in Rev. Proc. 2007-19

by Stephen P. Dicke

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On Jan. 26, 2007 the IRS released Rev. Proc. 2007-19, which basically updates the procedures for obtaining an IRS closing agreement to correct I.R.C. § 7702A failures (creating a "MEC" or modified endowment contract) under Rev. Proc. 2001-42. More specifically, Rev. Proc. 2007-19 updated Rev. Proc. 2001-42 by (1) updating and revising the indices used to compute the "toll charge" for the MEC closing agreement, in part to make these indices more accessible to taxpayers; (2) confirming that exhibits for closing agreement requests may be submitted in PDF, CD-ROM or other acceptable electronic formats; and (3) updating the address for submitting the executed closing agreements with the "toll charge" payments. In addition, Rev. Proc. 2007-19 recognized that further changes to Rev. Proc. 2001-42 may be warranted, and referred specifically to the companion IRS Notice 2007-15 (released on the same date and discussed in another article in this *Taxing Times*), which requested comments by June 12, 2007 on a variety of issues affecting closing agreements for life policies under I.R.C. § 7702A, § 7702 and § 817(h). Notice 2007-15 also published the latest IRS model closing agreements for such issues. However, neither Rev Proc. 2007-19 nor Notice 2007-15 discussed the IRS procedures for allowing "companion" closing agreements that correct both I.R.C. § 7702 and § 7702A failures simultaneously in the same policies (for a reduced overall "toll charge").

IRS Uses Reserve Questionnaire on Audit

by Peter H. Winslow

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For several years, IRS auditing agents have used a standard "IRS Section 807 Reserve Questionnaire" in their audits of life insurance companies. The questionnaire usually is given to the company in an Information Document Request (IDR) at an early stage of the audit. The answers to the questionnaire typically are used by the auditor to examine general tax reserve compliance and to identify particular areas for follow-up IDRs and examination. A former version of the questionnaire can be found in the Internal Revenue Manual at 4.42.4.6.5. In 2005, the questionnaire was revised with relatively minor changes.

Other than ensuring that all aspects of I.R.C. § 807(d) generally have been complied with, the reserve questionnaire focuses its attention in three broad areas. First, the questionnaire asks for a comparison of statutory reserves to tax reserves broken down by both the type of insurance coverage and the reserve category under I.R.C. § 807(c). The Internal Revenue Manual at 4.42.4.6.4 instructs agents to compare stat/tax reserve differences to guideline ratios that were developed by the IRS Life Insurance Industry Specialist from Forms 8390 filed before the repeal of Section 809. The objective is to identify tax reserve amounts that fall outside the industry norm when compared to statutory reserves so that the audit can be focused on the most likely problem areas.

In our experience this reserve ratio analysis usually will not result in many reserve issues where the stat/tax ratios fall outside the industry norms. Differences are usually explained by such factors as the introduction of new products, reinsurance or maturing business in run-off mode. Most of the audit adjustments that result from the ratio analysis arise where tax reserves equal statutory reserves. Agents want to know why this is the case. Is it because the statutory cap on tax reserves applies? If so, IRS agents may ask why tax reserves otherwise would exceed statutory reserves, but for the cap. If statutory reserves capping is not the reason why statutory reserves equal tax reserves, than other potential Section 807(d) compliance issues naturally arise.

The second general focus of the reserve questionnaire is to identify instances where approximations have been used to compute tax reserves. The questionnaire asks whether contract-by-contract comparisons have been made with net surrender values and statutory reserves, or whether approximations have been used. It also asks whether approximations have been used in calculating net surrender values, the reserve methods, interest rates and mortality or morbidity tables. The Internal Revenue Manual does not tell agents what to do when they discover that approximations have been made. Some agents are satisfied with a demonstration by the company actuary that the approximation is reasonable and does not yield a tax reserve deduction in excess of the amount that would result from a precise Section 807(d) calculation. Other agents have insisted on an exact calculation, and if it is not forthcoming, have proposed to disallow reserves that exceed the amounts of the net surrender values. As I described more fully in the December 2005 issue of *Taxing Times*, page 8, these proposed adjustments arising from tax reserve approximations usually are resolved at Exam and Appeals by a reasonable compromise.

The third focus of the reserve questionnaire is the one that results in the most proposed adjustments. The questionnaire asks whether there were any changes made in reserve methods or assumptions from one year to the next, and, if so, to provide the affected reserves, a description of the old and new methods and the amount of the increase or decrease in the reserves as a result of the change. The Internal Revenue Manual instructs agents to examine whether the company complied with Section 807(f) and Rev. Rul. 94-74, 1994-2 C.B. 157, with respect to these changes. Many, if not most, reserve disputes recently raised by IRS agents involve changes in basis of computing reserves, particularly with respect to the retroactive application of Actuarial Guidelines 33 through 39. If the I.R.C. § 807(f) issues cannot be resolved at the Exam level and go to IRS Appeals, any settlement must by coordinated through the Appeals Life Insurance Industry Coordinator. This coordination usually has not been an impediment to settlement, except in cases dealing with the retroactivity of actuarial guidelines.

We will have to wait to see whether a new questionnaire will result in a change in the IRS' approach in auditing tax reserves and cause new reserve issues to be raised.

IRS officials have informally said that they are working on another reserve questionnaire to replace the one currently in use. We will have to wait to see whether a new questionnaire will result in a change in the IRS' approach in auditing tax reserves and cause new reserve issues to be raised.

IRS Auditing Agents for I.R.C. § 412(i) Plans Are Making Many Inappropriate Challenges

by Stephen P. Dicke

As IRS agents continue their extensive audits of I.R.C. § 412(i) qualified retirement plans and the insurance policies required to fund them, the agents' audit reports are reflecting a variety of novel, and in some cases highly questionable, grounds for challenging the favorable tax treatment of such plans and policies. Among such novel grounds for challenging such tax treatment are the following:

(1) the safe harbor valuation of a life policy under Rev. Proc. 2005-25, which is to be used upon a "rollout" or distribution of such a policy from the I.R.C. § 412(i) plan, also should be used for valuing the policy while held in the plan for various other purposes (*e.g.*, for computing the employer's contribution deduction or for determining overfunding);

(2) a plan is disqualified under I.R.C. § 412(i) because the policy was a "springing cash value policy";

(3) the I.R.C. § 412(i) plan is disqualified because the annuity policy either (a) allows flexible premiums, (b) lacks provisions dealing with excess funding or (c) does not have benefit options that match those under the plan (*e.g.*, joint and survivor options);

(4) the I.R.C. § 412(i) plan is automatically disqualified because the life policy contains loan provisions;

(5) an I.R.C. § 412(i) plan with a "springing cash value" policy is a "listed transaction";

(6) a policy's relatively high early surrender charges or exchange right provisions make the policy an "abusive" product when sold into an I.R.C. § 412(i) plan; and

(7) if the plan administrator buys one or more policies where the total illustrated values at relevant times exceed the plan benefit amounts for a participant, this is the fault (or responsibility) of the insurer (not the plan administrator).

These various grounds for challenge suggest that many IRS auditing agents are using a "shotgun" approach to attack these plans. They also reflect a general failure to distinguish between terms of the life insurance policy and the administration of the plan. For instance, in some cases the agents are inappropriately suggesting that a life insurance policy that otherwise qualifies under I.R.C. § 7702 is "abusive" when, in fact, the basic problem may be with the administration of the plan.

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