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XXX Reserve Funding is Debt for Federal Tax Purposes

By Seth L. Rosen and Arthur C. Schneider¹

Before the onset of the current capital markets crisis, the market for “insurance-linked” securities (“ILS”) had been experiencing rapid growth. ILS is a generic name for a number of innovative market solutions that have allowed insurers to access capital markets funding for various purposes. These transactions, which have tapped both bank and capital markets sources for financing, are often referred to as “securitizations.” Over the years, there have been a number of insurance industry securitization transactions including closed block securitizations, embedded value financings, and the issuance of catastrophe or mortality bonds.

Among the most common life insurance industry capital markets funding transactions have been “XXX” reserve financings, and those transactions are the subject of this article.

On several occasions in the past two years, officials from the Internal Revenue Service (“IRS”) have indicated publicly that they are studying issues relating to the federal income tax treatment of XXX reserve financings. In August 2008 officials of the IRS and United States Treasury Department (“Treasury”) met with industry representatives to discuss common structures for the transactions. While IRS officials have recently indicated that they continue to study the issues, no official guidance has been issued.

As discussed below, the key to understanding the appropriate federal income tax treatment of typical XXX reserve financings is to understand that they are structured so that lenders providing the financing take on risk of loss commensurate with highly rated investment grade debt and

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This issue of *TAXING TIMES* marks a very special event—the 25th anniversary of the 1984 Tax Act (DEFRA). This legislation, along with the TEFRA legislation passed in 1982, had significant implications for the taxation of life insurance products and companies. As such, the *TAXING TIMES* editorial board thought that a retrospective from several of the industry players who were around during the birth of DEFRA would be a good way to mark this anniversary. Their collaborative efforts offer us insight into the thinking at the time the legislation was implemented and the results of 25 years of living with it.

Such insight is especially significant today given the very real possibility of an onslaught of new regulations and possible legislation impacting the taxation of all aspects of the insurance industry. Much of this anticipated regulation and legislation is a reaction to the current economic condition and our new administration. The recent banking crisis, coupled with the troubled times of several large insurers, placed all financial institutions under substantial scrutiny. We find by looking to the past, that often times an influx of new regulations is a reaction, or perhaps overreaction, in a time of crisis. Our country is in a time of financial crisis.

In addition, Washington's "bailout" of financially troubled companies comes with a very big price tag. How do we pay for these bailouts? Oftentimes tax reform comes from a need to raise revenue. This issue contains an article which looks at a shelf proposal, developed as a collaborative effort by academics, to raise revenue through taxes. The shelf proposal that is the topic of this article considers taxing the inside buildup of life insurance products. In addition at the state level, a proposed Oregon House Bill (H.B. 2854) suggested taxing life insurance proceeds. Massachusetts and California have also considered tax initiatives which have targeted insurance benefits. As is evidenced by this shelf proposal and this state activity, the insurance industry is not immune to revenue generating tax policy. Changes in how our industry and our products are taxed are a very real threat.

Finally, evidence of the increase in recent government activity in our industry is seen in the many articles in this issue which look at new regulatory notices that have been implemented which impact our industry and its products. We hope you find these articles informative and timely.

Enjoy the issue! ◀

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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FROM THE CHAIR

By Kory J. Olsen

This “From the Chair” article is the last in my two-year run as chair of the Taxation Section. The time has gone by quickly.

The Taxation Section has achieved a lot during the past two years. I attribute that success to the great volunteers. The Section Council and the Friends of the Council have given freely of their time and talents. It is under their great contributions that the Section has grown and prospered.

I would like to expressly thank Jim Reisky¹ whose term on the Council will be ending in October, as will mine. Like many of the Council Members before us, we will continue to be involved. It is just that our title will change from Section Council Member to Friend of the Council.

The accomplishments of the Section over the last two years are many. They cover a variety of areas, including education (continuing and basic), *TAXING TIMES* and research.

The Section Council has responded to the adoption of Continuing Professional Development requirements with added tax educational opportunities. The first Taxation Section webcast was done this past March and was very successful. Additional webcasts are soon to follow. In November, the Section will be sponsoring our bi-annual Company Tax Seminar. To complement the Company Tax Seminar, the Section is also preparing a Tax Reserve Seminar.

In addition to seminars sponsored by the Section, the Council has continued to expand the Section involvement at other meetings. The Section has sponsored sessions at ReFocus, Product Development Symposium, Life Spring

Meeting, Health Spring Meeting and the Annual Meeting. The Section has also been represented at non-SOA events such as the South East Actuary’s Club and the American Bar Association.

In addition, the Section was involved in expanding the tax content on the SOA exams. Extensive tax material was developed and included on the FSA modules. A system was also put in place so that the Taxation Section is available to the SOA exam committees to review tax related questions and answers. All of this increases the exposure of newer actuaries to tax topics.

TAXING TIMES has been a great publication from the beginning. During my term as chair, we have maintained its high standard of excellence. The publication provides timely information and thoughtful opinions on a variety of insurance tax topics written by the industry’s top tax experts.

With the writing of this article, I assembled the *TAXING TIMES* publications from the last two years. It was my intent to mention a few of the articles that I thought were particularly interesting. I was unable to do this for two reasons. First, I wasn’t able to narrow the interesting articles down to just a few. Secondly, a stack of *TAXING TIMES* for a two-year period takes on the form of a book. The stack totaled about 300 pages of high quality articles.

The Section also has some research projects under development. The Taxation Section has tackled everyone’s favorite topic, Deferred Taxes. A Deferred Tax Monograph is the result of this research. This monograph clarifies the theory behind deferred taxes and discusses how they are addressed under current accounting regimes. Another research project

that is being developed is a Tax Actuary Survey. The intent is to provide an overview of where actuaries are involved in a company's tax functions, where they could be involved and how the tax actuary position is structured.

There have been significant achievements over the past two years. However, from my perspective, we have just begun. The Taxation Section will soon be entering its sixth year and there are many opportunities ahead.

The next few years will be an interesting time for the Taxation Section and its members. The Obama administration has already presented a few tax proposals that would impact the life insurance industry, if adopted. It is expected that there will be more tax proposals coming that will also impact our industry. In addition to proposed federal tax law changes, the first wave of Principle-Based Reserves (VACARVM – AG 43) will be effective on Dec. 31, 2009, impacting both statutory and tax reserves. The product tax actuaries haven't been left out with the recent publication of Notice 2009-47.

The future of the Taxation Section will hold many challenges. However, I know, as in the past, the dedicated and talented volunteers of the Section will continue to exceed all expectations. ◀

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are compensated accordingly. Thus, under the case law relating to the tax treatment of surplus notes and general tax law principles distinguishing debt from equity, securities issued in typical XXX reserve financings are appropriately treated as debt for federal income tax purposes. As discussed in more detail below, this result is entirely consistent with the economics of the transactions, and the financial expectations of the participants in the transactions, because the investors in XXX securitizations are taking on credit risk and not insurance risk.

BACKGROUND ON REGULATION XXX AND LEVEL PREMIUM TERM INSURANCE

Regulation XXX is the short-hand name for the Valuation of Life Insurance Policies Model Regulation issued by the National Association of Insurance Commissioners (“NAIC”). This regulation prescribes the Commissioners’ Reserve Valuation Method (“CRVM”)² applicable, with some exceptions, to all life insurance policies issued on and after Jan. 1, 2000. However, it perhaps most significantly impacts long-duration term life insurance contracts with a period of guaranteed level premiums (“level premium term”).

Level premium term, which generally provides term life insurance coverage renewable to a certain age, has in recent years been the most popular form of term life insurance. As its name implies, the premiums for a level premium term policy remain the same for a specified period of years. After that time, the contract is typically renewable at higher premium rates that may not be guaranteed. So, importantly for reserve calculations, level premium term does not have level premiums for the duration of the contract. Level premium term is typically used for life insurance needs that do not exist for the whole of a policyholder’s life – e.g., the need for coverage while children are dependent. The advantage to the policyholder is in having a contract with affordable premiums that do not increase during the guaranteed period.

Prior to Regulation XXX, reserves for level premium term contracts could be determined on a unitary basis by taking into account the higher (often much higher) premiums to be charged beyond the guaranteed period, even though such premiums were generally not expected to be, and in many cases were not, paid. Effectively, for reserving purposes, premiums from beyond the guaranteed period were being used to fund benefits during the guaranteed period.

Under Regulation XXX, basic reserves are the greater of segmented reserves or unitary reserves. Segmented reserves are calculated using periods of time (“segments”) produced by

the contract segmentation method, which divides the duration of the contract into successive segments. Essentially, the contract segmentation method requires that net premiums within each segment fund the death benefits arising within that segment. Unitary reserves, on the other hand, are calculated by taking into account guaranteed benefits and modified net premiums for the entire duration of the contract. Deficiency reserves may also be required to be held.

While all reserving requirements for NAIC-based financial reporting (“statutory accounting”) are generally conservative to reflect the solvency concerns of state insurance regulators, it is generally acknowledged that XXX reserving requirements are exceptionally conservative, resulting in extraordinary strain on the capital of companies that write level premium term business. The strain arises primarily because the net premiums used in the determination of reserves under the contract segmentation method required by Regulation XXX are based on more conservative assumptions relating to mortality, interest, and lapsation than the assumptions used in pricing or in an economic best estimate of the net future liability.³

FINANCING XXX RESERVE CAPITAL STRAIN

As with any reserve requirement, this is essentially a long-term timing issue—reserves grow in the early years to an amount that exceeds the expected economic liability by a substantial amount, then decline for a long period of years until the required regulatory reserves and the economic best estimate of the insurer’s net future liability are the same.

In the meantime, the statutory capital strain must be funded. The strain could, of course, be funded through retaining or increasing statutory capital and surplus. However, the financial returns of a life insurance company, like any business, can be enhanced by leveraging the cost of capital. In the case of level premium term insurance, the discontinuity between the regulatory reserves and the perceived economic liability created a market opportunity for life insurance companies to reduce their cost of capital by borrowing from banks or capital markets to fund their XXX reserves.

Initially, life insurance companies used reinsurance to help fund the reserving requirements imposed by XXX, but reinsurance markets tightened and letters of credit needed for off-shore solutions (and which, in any event, generally did not match the duration of the financing need) became less available and more expensive. To fill this void, banks and the capital markets in general stepped in with innovative financing alternatives.

ACTUARIAL MODELING AND STRESS TESTING

The key to the XXX funding structures is that actuarial models can be built to demonstrate (using a wide range of deterministic and stochastic scenarios) that with an appropriate capital cushion there is a very high likelihood that loans to fund XXX reserves will be repaid. Using the model, the business can be subjected to extensive stress testing to satisfy all parties that the likelihood of repayment is commensurate with high investment grade (*e.g.*, AA) debt.

Investment grade credit ratings are achieved by providing a very high degree of comfort that cash flows relating to the business (as further supported by equity capital) are more than adequate to service the required payments on the debt financing. Stress testing of the actuarial model determines the equity capital requirements needed to provide investment grade levels of assurance that the structure not only supports repayment of the debt, but is capable of absorbing reasonably expected, or even extreme, adverse developments in the business. Furthermore, because assets held to fund the reserves are subject to regulatory requirements, investment parameters can be set to control asset risk.

As noted above, stress testing uses deterministic and stochastic scenarios, and involves both actuarial assumptions (*e.g.*, mortality and lapse) and asset assumptions (*e.g.*, earnings rates and default rates). These assumptions are stressed separately and in combination. For example, mortality might be stressed by adding a factor (*e.g.*, 20 percent) to estimated mortality rates. Or lapsation might be stressed by adjusting a baseline lapse rate (*e.g.*, 2 percent) up or down (*e.g.*, +/- 50 percent). Another variation of mortality stress might be to assume a one-time catastrophic shock (*e.g.*, a three times mortality event) in a particular year. The possibilities are nearly endless, but all these stresses are selected to facilitate the determination of a level of equity capital commensurate with AA or higher debt ratings.

As a result, lenders in these transactions do not see themselves as taking on insurance risk, but rather as taking high investment grade debt risk.⁴ Accordingly, XXX reserve funding can be accomplished at reasonable interest rates commensurate with investment grade commercial lending. This is, of course, attractive to life insurance companies that write level premium term business because such borrowing can be used to lower the cost of capital required to fund XXX reserves, and thereby improve financial returns and allow a greater volume of new business.

ISOLATION OF XXX BUSINESS IN A WELL-CAPITALIZED CAPTIVE REINSURER

The modeling and stress testing of a block of XXX business assumes that the business is isolated from the life insurer's other business. This assumption enables lenders and rating agencies to perform due diligence on the isolated cash flows. Therefore transactions have been structured to achieve this isolation through reinsurance to a special purpose captive reinsurer.⁵ Isolation of business in an appropriately capitalized captive reinsurer provides assurance to lenders that they will be repaid out of the cash flows emerging from the block (as supported by the equity capital cushion) without running the risk that those cash flows will be absorbed by unrelated liabilities of the ceding company. Accordingly, the perceived risk (and rating of the debt) can be based on an analysis of the cash flows and capital within the isolated structure, and not on the general creditworthiness of the direct writer.

In summary, the key to successful XXX reserve funding transactions has been 1) modeling to show that lenders are not exposed to insurance risk but rather are lending on a highly-rated investment grade basis; 2) adequate capitalization to assure lenders, rating agencies, monolines, investment banks, etc. that 1) was true; and 3) isolation of the cash flows through reinsurance into an appropriately capitalized special purpose captive reinsurer.

TAX CONSOLIDATION OF CAPTIVE REINSURER RESULTS IN TAX NEUTRALITY

From a federal income tax perspective, XXX transactions are structured to achieve tax neutrality. That is, XXX financing transactions do not create tax losses or excess tax deductions, but simply preserve the group's tax position, in the same manner as if the direct writer had retained the XXX business on its own balance sheet.

In general, tax neutrality is achieved as long as both the ceding company and the captive reinsurer are members of the same affiliated group. Because the captive reinsurer will sustain a tax loss in the initial year of the transaction (and generally for a number of subsequent years), it is usually essential that the captive and ceding company be members of the same life-life or life-nonlife consolidated return group from day one. Tax consolidation is appropriate and consistent with the underlying economics of the transactions. In XXX financings, the ceding company's consolidated group generally provides the equity capital, described above, that protects lenders' repayment expectations, in exchange for common stock.

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As the equity owner bears the risk of loss from extraordinary events, it also has the opportunity for gain. Unlike the lender, which (as described below) will receive a fixed return on its investment, the residual equity interest evidenced by the common stock will be worth more or less depending upon the success or failure of the reinsurer's business. Thus, the holder of the common equity is appropriately treated as the controlling shareholder for purposes of IRC section 1504.

Where the captive reinsurer can be established as a subsidiary of another life company that is not a member of a life-nonlife consolidated return, consolidation is rather straightforward. Where, however, it is desired to include the captive reinsurer in a life-nonlife consolidated return, it is necessary to rely on the "tacking rules" of Treas. Reg. § 1.1502-47(d)(12)(v), which "tack" the membership period of an "old" life company member of the group onto a newly-formed life company. Without tacking, the captive reinsurer would be unable to join the life-nonlife return for a period of five years.

While a discussion of the tacking rules is beyond the scope of this article, one point is especially worth noting. In order for tacking to apply, four conditions must be satisfied. Prior to 2006, there was a fifth condition which provided that a transfer from the "old" life company to the new one not be reasonably expected to result in the separation of profitable activities from loss activities. Life insurance industry submissions had been made to the Treasury urging repeal of this separation condition specifically to accommodate XXX funding transactions.⁶ While the preamble to the regulations which deleted the separation condition did not specifically mention XXX transactions, it is undeniably true that the Government was aware that the change would facilitate XXX funding.

The tax neutrality achieved in the initial year of the transaction continues throughout the life of the XXX reserve funding transaction, so long as consolidation of the captive reinsurer is maintained. In other words, the same reserve deductions and the same taxable income emerging as reserves increase and decrease that would have been reported by the direct writer are reported in the consolidated return that includes both the ceding company and the reinsurer. The purpose of XXX reserve funding transactions is to provide cost-effective regulatory capital for life insurers—the transactions themselves do not create or increase tax reserve deductions. There are, of course, tax deductible interest deductions relating to the debt incurred in the transaction. But as with the reserve deductions, those interest deductions are no different than those that would be allowed if the direct writer had been the borrower.

For the captive reinsurer to meet the ownership requirements for tax consolidation, the debt issued to finance the reserve requirements must be treated as debt for federal income tax purposes.⁷ In fact, the key to XXX funding transactions from a tax perspective is the treatment of the bank or capital market financing as debt for tax purposes. In turn, the key to the conclusion that the funding is debt is the modeling of the block and the adequacy of the capital buffer. That is, it must be demonstrable that the investors are taking creditor risk typical of lenders who buy investment grade paper, and that they therefore are not taking the entrepreneurial risk that is the hallmark of equity.⁸

DESCRIPTION OF COMMON STRUCTURES

The diagrams on page 9 illustrate two common structures for XXX reserve funding transactions.⁹ The first is a "private" transaction in which a bank provides financing to the captive reinsurer and receives "surplus notes" in exchange. As discussed below, surplus notes are treated as debt for federal income tax purposes, but are includable in capital for statutory accounting purposes. In this structure, a parent life insurance company forms the captive reinsurer and contributes equity capital in an amount dictated by the results of the financial modeling. The bank then purchases surplus notes from the reinsurer. The parent or an affiliated life insurance company (the direct writer) then cedes XXX business to the reinsurer. This business is collateralized by amounts held in a trust so that the direct writer is allowed a reinsurance reserve credit on its statutory financial statements. Generally, a rating agency would be involved—perhaps to issue an explicit or shadow rating on the notes, but certainly to ensure that the notes receive operating leverage treatment. The structure may provide for periodic review of reserves and capital adequacy, and may provide restrictions on dividends from the captive reinsurer. Typically, some type of parent company credit support would be required. All of this is, of course, subject to approval by the appropriate state insurance regulators.

The second transaction is similar, but illustrates a transaction with the broader capital markets. In this case, a trust purchases the surplus notes, and the public creditors purchase trust certificates.¹⁰ Prior to the financial crisis, the trust certificates would have been wrapped by a monoline financial guaranty insurance company to enhance the credit rating of the debt issuance to an AAA level.¹¹ Similar to the first structure, there would be rating agency involvement, and the other structural features designed to ensure adequate cash flows to fund the required interest and principal payments on the debt would be present. (*Refer to diagrams on page 9.*)

TERMS OF THE SURPLUS NOTES

As noted above, XXX financings typically have taken the form of surplus note offerings, because they provide capital for statutory accounting purposes. The notes have a stated maturity tied to the expected development of the block—typically 20 to 30 years—and provide for periodic payments of stated interest. Interest payments may be fixed or variable based on an objective index, but the interest rate is not based on the profits or other results from operations of the issuer.

Usually, there is no sinking fund for repayment of principal prior to maturity, but frequently profits emerging from the block must be applied to pay down the debt as they emerge (so-called “flexible amortization” notes). As a result the “weighted average life” of the notes is usually expected to be substantially less than the stated maturity under the modeled “base case” scenario and other reasonably expected scenarios for the development of the block. However, the lender usually has no right to be repaid before stated maturity.

Generally, for the notes to qualify as surplus notes for statutory accounting purposes all payments of interest and principal require as a matter of state law prior approval or non-disapproval of state insurance regulators based upon a showing that following the payment the borrower will have adequate capital and surplus. Ultimately whether or not stated payments can be made is generally a matter of regulatory discretion. In most transactions, the reinsurer issuing the surplus notes covenants to use a high level of effort to obtain regulatory approval. Failure to exert the requisite degree of effort to secure consent is usually not an event of default that can accelerate the notes, but can result in a suit for damages.

Other common characteristics of surplus notes dictated by statute or regulations include:

Deep Subordination

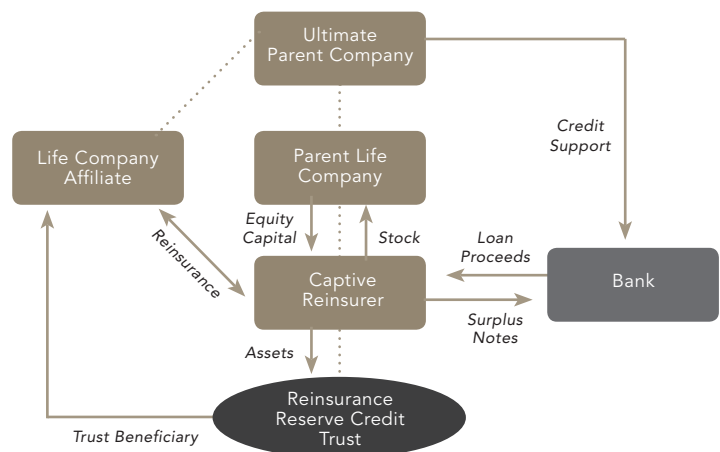
In the event of the liquidation of the issuer, surplus notes will rank senior to equity in priority of payment, but subordinate to all payments to policyholders, debts for borrowed money (other than other surplus notes) and trade creditors.

Limited Creditors’ Remedies

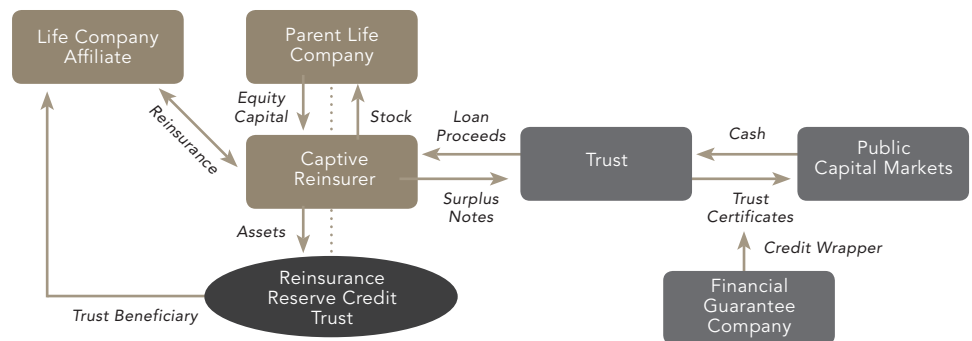
Regulatory approval is necessary to make payments on surplus notes

even if an event of default has occurred that would result in an acceleration of payment obligations under more typical debt. Moreover, if regulatory approval for scheduled payments of principal and interest is not received, a failure to pay will not result in an acceleration of principal. In that event interest will continue to accrue on the unpaid principal amount, but “interest on interest” will not accrue. Breach of a non-payment covenant—including a failure to use required efforts to obtain regulatory approval for payments—can result in a suit for damages, but not in acceleration of the debt.

PRIVATE XXX FUNDING TRANSACTION



CAPITAL MARKETS XXX FUNDING TRANSACTION



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An acceleration can occur, however, if payments of interest and principal are not made after regulatory approval is received or if there is a bankruptcy event with respect to the ceding company, the reinsurer or (sometimes) their affiliates. Despite the acceleration, no payments can be made without regulatory approval.

TAX ANALYSIS OF SURPLUS NOTES

The most important element of the tax analysis of notes issued in XXX financings is the parties' understanding of the results of the financial modeling described above. That is, under the base case and a full range of other scenarios that can be reasonably expected to occur (except occurrences the possibility of which are remote) during the term of the debt, are the notes expected by the issuer and investors to be repaid in accordance with their terms?

Stress testing will result in a relatively high investment grade rating and treatment as operating leverage, indicating confirmation by the independent rating agencies that the debt is highly likely to be repaid in accordance with its terms from the operating cash flow produced by the reinsured block, as supported by an appropriate equity capital buffer, under all reasonable scenarios. In other words, based on adequate capitalization of the issuer and rigorous analysis of the model, the issuer and investors agree that regardless of the occurrence or non-occurrence of insurance risks the investors are highly likely to be paid all interest and principal due under the notes.

The capital elements of a typical XXX financing can be contrasted with the securitization of natural catastrophe risk via catastrophe-linked ("CAT") bonds. CAT bonds are typically structured so that if a catastrophic loss occurs from one or more specified insurance events the CAT bond investors bear the burden of the loss. In the typical CAT bond transaction an insurance company enters into a risk transfer contract with an offshore Special Purpose Vehicle ("SPV"). The SPV issues "notes" to investors in the capital markets and the proceeds are invested in securities and held in a collateral trust. Assets held in the collateral trust may be drawn upon by the insurance company in the event of occurrence of the specified contingency. Unlike the reinsurer in a XXX financing, the SPV in a CAT bond structure is not capitalized with funds beyond those contributed by capital markets investors. Accordingly, the parties to the transaction fully expect that losses will pass through to the investors.

As a result, the investors are treated for federal income tax purposes as equity owners of the SPV. Thus, a CAT "bond" is really CAT "equity," because it transfers the risk of insurance losses to the SPV investors. In contrast, losses incurred in a XXX financing structure are meant to be covered, even in stress scenarios, first by the cash flows from the underlying block of reinsured business, and then by the capital contributed by the sponsor in the structure. Only after these sources are exhausted do the investors bear any risk and, as noted above, their risk is that of a creditor in investment grade debt not that of an equity owner.

STANDARDS APPLIED UNDER CASE LAW AND IRS RULINGS

"The essential difference between a stockholder and a creditor is that the stockholder's intention is to embark upon the corporate adventure, taking the risk of loss attendant upon it, so that he may enjoy the chances of profit. The creditor, on the other hand, does not intend to take such risks so far as they may be avoided, but merely to lend his capital to others who do intend to take them."¹²

The IRC, regulations, case law and IRS rulings do not provide a bright line for distinguishing debt from equity. Instead, the case law and IRS pronouncements identify a number of economic and legal factors indicative of either debt or equity treatment, and the determination of whether an instrument should be treated as debt or equity turns on the presence or absence of a predominance of those factors. No one factor is determinative, and the importance of each factor to the analysis is determined based on the facts and circumstances of each case.

The factors identified by the IRS and the case law are all intended to illuminate the central question described above: To what extent did the purported debtor and creditor intend to create (and in fact create) either a debtor/creditor relationship—in which the investor does not participate in the risks and rewards of the issuer's business—or an equity holder's relationship—in which the investor takes on the entrepreneurial risk inherent in the business in exchange for the possibility of greater reward if the business is ultimately profitable.

As described above, surplus notes have a number of characteristics that are normally considered to be indicative of equity for federal income tax purposes. However, courts have uniformly held that the existence of these characteristics does not prevent

surplus notes and similar instruments that are issued by an insurance company, in compliance with the state regulatory regime applicable to the issuer, from being treated as debt for U.S. federal income tax purposes. Instead, the courts have looked to other factors traditionally considered by the IRS and the courts to determine whether the parties intended to create (and did create) a debtor/creditor relationship, despite the legal or regulatory restrictions imposed by state law or regulation. Thus, the courts have found surplus notes or similar instruments to be properly characterized as debt for federal income tax purposes despite the fact that the instruments in question were subordinated to all of the company's other indebtedness; were issued proportionately to equity owners; lacked a fixed maturity date because principal payments were linked to surplus levels; required regulatory approval for payments; or were payable solely in the discretion of the board.¹³ Thus, the fact that the surplus notes issued in XXX financings include some equity-like characteristics mandated by state law and regulations should not affect the federal income tax analysis. In fact, as discussed in detail below, surplus notes issued in XXX securitization transactions typically have fewer equity-like characteristics than surplus notes that have been treated as debt by the courts.

The case law that has developed with respect to surplus notes recognizes that insurance companies can from time to time require substantial capital because of state law reserving and surplus requirements. State laws and regulations have developed an instrument—the surplus note—through which that required capital can be provided for a limited duration and be repaid when the capital is no longer needed. Where there is a high likelihood (and the parties clearly intend) that the borrowed capital will be repaid, the provider of that capital (the surplus note holder) does not share in the entrepreneurial risk inherent in the business and will typically accept and receive a rate of return on investment indicative of debt—a reasonable fixed rate of interest, or an interest rate based on an objective index, that is not in any way tied to the issuer's profit.

Thus, the courts that have considered the tax treatment of surplus notes have uniformly concluded that the surplus notes are properly treated as debt for federal income tax purposes where equity-like features were mandated by state law and the evidence indicated that the parties clearly intended to create, and did create, a debtor-creditor relationship.¹⁴

The IRS has not asserted a contrary position in published or private rulings.¹⁵ For example, a 1996 written determination addressing the federal income tax treatment of surplus notes issued by a stock insurance company states:

[W]e anticipate that an attack on the surplus note would fail. Over the past 30 years, the [IRS] has attempted at least four times to defeat similar instruments. In each instance, the [IRS] failed to overcome the form of the transaction. An effort to repudiate the surplus note in this case would likely meet a similar fate. Not only can ... show that its notes possess characteristics of bona fide debt. It can also show a genuine business purpose for borrowing the funds. We recommend against adjusting the parties' returns as a result of this transaction.¹⁶

XXX securitization transactions are exactly consistent with the rationale that supports the tax cases and IRS authorities that have respected the treatment of surplus notes as debt. The insurer needs capital to satisfy state law XXX reserving requirements for a limited period of time. State law provides a mechanism for raising that capital and repaying it when it is no longer required. There is a high likelihood that the debt will be repaid, and the parties clearly intend it to be repaid in accordance with its terms. The lender receives a reasonable rate of return typical of a debtor/creditor relationship. Thus, each transaction should be analyzed based on recognized criteria for distinguishing debt from equity within the context of the existing surplus note authorities.

APPLICATION OF CRITERIA IDENTIFIED BY THE IRS TO DISTINGUISH DEBT FROM EQUITY

IRS Notice 94-47, largely following established case law precedents, lists a number of factors for the purpose of distinguishing debt from equity.¹⁷ As described above, the analysis of whether surplus notes issued in XXX financings should be treated as debt for tax purposes should be based on the multi-factor test articulated in Notice 94-47 and identified by the case law and that is generally applicable to all debt instruments. However, case law clearly stands for the proposition that, in applying the multi-factor analysis, characteristics of surplus notes that might otherwise be treated as "equity like," but that are required to comply with state law or regulations applicable to the issuer, should not be treated as negative factors.

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The factors identified by Notice 94-47 are as follows:

An Unconditional Promise to Pay and Fixed Maturity in the Reasonably Foreseeable Future

A fixed maturity date “in the reasonable future” at which time the holder can unconditionally require payment of a sum certain is a central element of the true debtor-creditor relationship.¹⁸ While the term of surplus notes issued in XXX financings may be longer than that of many other debt offerings, it is still consistent with debt treatment.¹⁹ Moreover, the duration of the debt is linked to the duration of the issuer’s need for the borrowed capital—the period during which the XXX reserve is expected to exceed the amount required to fund the expected payment pattern under the block.²⁰ In transactions with flexible amortization of principal, the amortization of the debt is tied directly to the decreasing need for capital. By contrast, equity usually has a longer term or is of infinite duration.

The interest payments on the surplus notes issued in XXX financings must be paid as scheduled, and all outstanding principal must be paid no later than the stated maturity, subject to regulatory approval or non-disapproval of payment. Although the possibility that payment might be delayed as a result of the approval requirement could be regarded as equity-like, i) the approval requirement is mandated by state law and typical of surplus notes that have been characterized by the courts as indebtedness, and ii) the issuer is generally under a contractual obligation to use significant efforts to secure consent and holders have the right to pursue legal remedies to enforce that obligation. Thus, the unconditional promise to pay a sum certain by a fixed maturity date in the reasonably foreseeable future, weighs in favor of characterizing surplus notes as debt, despite the fact that it is conditioned on regulatory approval of payment.

Right to Enforce Payment of Principal and Interest

Holders of surplus notes in XXX financings have many typical creditors’ remedies in the event of non-payment or of the breach of covenants that do not involve payments. While the holders of the surplus notes do not have a right to accelerate maturity upon a failure to make a payment of principal or interest if due to failure to obtain required approvals, the lack of such a right, when required by state law or regulation, is not viewed as inconsistent with the treatment

of surplus notes as debt. Moreover, holders of surplus notes are generally entitled to other legally available remedies to enforce the terms of the surplus notes. Equity holders do not typically have such rights.

Subordination

The subordination of a purported debt to other creditors is a strong indication that such debt should be treated as equity for federal income tax purposes. However, the authorities described above indicate that subordination should not affect the determination of debt or equity treatment in the case of surplus notes. Thus, while usually treated as an equity-like characteristic, the subordination of the surplus notes to the interests of other creditors is a neutral factor for characterizing the surplus notes issued in XXX financings as debt.

Participation in the Management of the Issuer

Participation by a lender in the management of the borrower is a factor that would weigh in favor of treating an instrument as equity. Generally, surplus notes issued in XXX financings do not provide the holders with any rights to participate in the management of the issuer, beyond rights to vote on particular matters affecting their interests as creditors, or to protect the cash flows that are expected to pay debt service by ensuring performance under and enforcement of project documents in the event of non-payment or other default. These do not rise to the level of participation by holders in the management of the issuer that are indicative of an equity interest.²¹

Adequate Capitalization

The issuer’s debt-to-equity ratio is a significant element in characterizing a purported debt instrument for federal income tax purposes.²² The debt-to-equity ratio bears “on the reasonableness of the expectation of repayment, reflecting the extent of the cushion by which the purported creditors are shielded against the effects of business losses and declines in property values.”²³ No particular ratio is required by Notice 94-47, IRS rulings or case law. Rather the question is whether the equity cushion is adequate to protect the purported lender against a loss of principal (and required interest) in the event of reasonably foreseeable adverse developments. Courts have considered high debt-to-equity ratios to be acceptable for debt characterization purposes when the borrower could reasonably be expected to service the debt.²⁴

In XXX transactions, as described above, modeling establishes a high likelihood that the notes will be repaid in accordance with their terms under all scenarios that might be reasonably

expected to occur—including stress scenarios that measure spikes or systemic increases in mortality, lapse rates and other relevant factors (including combinations of adverse factors). This analysis is often supported by ratings that characterize the notes as investment-grade debt and operating leverage, which indicate that an independent credit rating agency also believes there is a very high likelihood that the debt will be paid in accordance with its terms. The existence of objective indices that the equity provided in XXX structures is adequate to ensure payment in all reasonably foreseeable circumstances strongly supports debt treatment.

Debt Holdings Proportionate with Holdings of Equity Interests

If a purported debt instrument is held in substantially the same proportion as the equity interests in the issuer, an inference arises that the debt instrument should be treated as equity, because there is frequently no economic consequence if proportionate shareholder advances are labeled as debt or equity. However, XXX debt holders are not controlling shareholders of the issuer.

Denomination as Debt

Surplus notes issued in XXX transactions are denominated as debt instruments in all related documentation.

Treatment for Nontax Purposes

Surplus notes are treated as debt for financial accounting purposes and as surplus notes for regulatory accounting purposes.

ADDITIONAL SIGNIFICANT FACTORS UNDER CASE LAW

The courts have identified additional factors—beyond those articulated in Notice 94-47—that are deemed to be indicative of a debtor-creditor relationship. These include:

Likelihood of Payment

A debtor-creditor relationship exists when the creditor expects full and timely repayment.²⁵ As described above, the high likelihood of full and timely repayment weighs in favor of characterizing surplus notes issued in XXX financings as debt.

Adequate Interest

Failure to provide for an adequate interest rate evidences an attitude of a shareholder, not a lender.²⁶ The presence of an adequate interest rate weighs in favor of characterizing surplus notes issued in XXX financings as debt for federal income tax purposes.

Participation by Note Holder in Success or Failure of Borrower

A high rate of interest—particularly if it is based on the profits of the borrower—could indicate that the holder of an instrument is primarily interested in participating in the earnings and growth of the borrower's business, which is an equity-like interest.²⁷ A high rate of interest may also indicate uncertainty concerning full and timely repayment. The interest rate on surplus notes issued in XXX transactions is not calculated by reference to the profits of the issuer; surplus notes are not convertible into equity of the issuer; do not provide for any payments other than principal and interest at a rate unrelated to the earnings and growth of the issuer's business; and do not include any other elements that would typically have the effect of lowering the interest rate on debt (*e.g.*, by allowing the purported creditor to share in the success of the issuer).

In summary, the factors identified by the IRS and the case law are intended to facilitate an analysis of whether the holder of an instrument denominated as “debt” is in the position of a true creditor, who expects to be paid out of the ordinary operating cash flows of the borrower, or an equity investor, who has assumed entrepreneurial risk. As applied to surplus notes (and other debt) issued in typical XXX financing transactions these factors establish that debt treatment is appropriate.

As with any form of complex financial transaction, each XXX securitization transaction should be analyzed on its own terms. The analysis in this article discusses what the authors believe, based on their own experience and knowledge of the industry, to be typical financial terms. Where financial modeling and testing establish that there is a high degree of likelihood that the debt issued in XXX transactions will be paid in accordance with its terms—regardless of the occurrence or non-occurrence of a verse insurance experience—then treatment as debt for federal income tax purposes is consistent with the form and underlying economics of the transactions, with the case law and with the IRS's own standards (as articulated in Notice 94-47). As a result, XXX securitization transactions should achieve the desired goal of “tax neutrality”—so that they can provide reasonably priced regulatory capital without changing the federal income tax consequences inherent in the underlying business. ◀

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END NOTES

- ¹ The authors would like to acknowledge that helpful comments were received from Nicholas F. Potter and Neil A. Dubnoff of Debevoise & Plimpton LLP.
- ² The federally prescribed tax reserve under section 807(d) of the Internal Revenue Code ("IRC") follows the CRVM, with certain required adjustments.
- ³ A similar issue arises for reserves required with respect to secondary guarantees on universal life insurance contracts under Actuarial Guideline XXXVIII, The Application of the Valuation of Life Insurance Policies Model Regulation (often referred to as Guideline "AXXX"). However, structured solutions for XXXX reserve funding are similar to those used for XXX reserve funding, and XXXX funding is not separately discussed in this article.
- ⁴ Before the financial crisis, "monoline" financial guaranty insurers were sometimes involved in reserve funding transactions, essentially to lend their AAA credit ratings to the debt structure. The monoline's purpose was not to assume insurance risk, but rather to wrap its highest level investment grade rating around a lower rated (AA) debt financing. Typically, the monoline company would engage its own actuarial consultants to review the modeling and stress testing. In cases where the monoline was not satisfied with the results of the modeling, additional equity capital would be committed to the structure.
- ⁵ Several states, e.g., South Carolina, Vermont, and Delaware, have enacted statutes authorizing special purpose financial captives. These captive companies are insurance companies for state law purposes and are subject to regulation by the state insurance authorities.
- ⁶ See Letter from Lori J. Brown and Susan J. Hotine to Eric Solomon, Acting Assistant Secretary (Tax Policy), Department of the Treasury (July 13, 2005), 2005 TNT 145-26; Letter from Laurie D. Lewis and Mark A. Canter to Gerald B. Fleming, Senior Technical Reviewer, Internal Revenue Service and Mr. Solomon (Oct. 21, 2005), 2005 TNT 212-28.
- ⁷ Or, if treated as stock, then it must be so-called "plain vanilla" preferred stock as described in IRC section 1504(a)(4).
- ⁸ State special purpose financial captive statutes typically provide that a security issued by such a captive (or by a third party where the funds are then provided to the captive) is not subject to regulation as an insurance or reinsurance contract, and that an investor or holder of such a security is not considered to be transacting the business of insurance solely by reason of having an interest in the security.
- ⁹ While the diagrams illustrate a brother-sister relationship between the ceding company and the captive reinsurer, the parent life company also could be the ceding company.
- ¹⁰ In a variation on this structure, a limited liability company ("LLC") which issues its own debt certificates is interposed between the parent life company and the captive reinsurer. The LLC then makes a capital contribution of the proceeds of its debt issuance to the captive reinsurer.
- ¹¹ The New York Insurance Department has ruled that the issuance of a financial guaranty policy in connection with a XXX transaction does not constitute the issuance of guaranties of life insurance and such activity is therefore not the conduct of a life insurance business by the financial guaranty insurer. In an opinion dated Oct. 17, 2005, the Department's Office of General Counsel stated: "[T]he financial guaranty company in a Regulation XXX transaction is simply providing a guaranty that the principal and interest payable to the purchasers of the Notes (which are 'investment grade') issued by the SPV will be paid by the SPV. The fact that the source of funds for the payments to be made on these bonds may be ultimately derived from a block of life insurance policies does not warrant a recharacterization of the financial guaranty policy in question since neither the SPV nor the purchasers of the Notes have any obligation to the insurer or the reinsurer should either be unable to meet its insurance obligations." (Emphasis added).
- ¹² *United States v. Title Guarantee & Trust Co.*, 133 F.2d 990, 993 (6th Cir. 1943); see also David P. Hariton, *Distinguishing Between Equity and Debt in the New Financial Environment*, 49 Tax L. Rev. 499 (1995).
- ¹³ See, e.g., *Jones v. United States*, 659 F.2d 618 (5th Cir. Unit B Oct. 1981); *Anchor Nat'l Life Ins. Co. v. Comm'r*, 93 T.C. 382 (1989).
- ¹⁴ See *Harlan v. United States*, 21 A.F.T.R.2d 969 (N.D. Tex. 1968), *aff'd*, 409 F.2d 904 (5th Cir. 1969); *Union Mut. Ins. Co. of Providence v. Comm'r*, 46 T.C. 842 (1966), *aff'd*, 386 F.2d 974 (1st Cir. 1967); *Theodore v. Comm'r*, 38 T.C. 1011 (1962), *acq.*, 1966-2 C.B. 7.
- ¹⁵ See, e.g., Rev. Rul. 68-515, 1968-2 C.B. 297; TAM 199942005 (Oct. 25, 1999); TAM 9714003 (Apr. 4, 1997). Written determinations such as private letter rulings, technical advice memoranda and field service advice memoranda may not be used or cited as precedent. See IRC section 6110(k)(3). Nevertheless, "they may be cited as evidence of administrative interpretation." *True Oil Co. v. Comm'r*, 170 F.3d 1294, 1302 (10th Cir. 1999) (quoting *ABC Rentals of San Antonio, Inc. v. Comm'r*, 142 F.3d 1200, 1207 n.5 (10th Cir. 1998)).
- ¹⁶ 1996 IRS NSAR 5975 (also listed as 1996 FSA LEXIS 583) (July 30, 1996) (omission in original).
- ¹⁷ 1994-1 C.B. 357.
- ¹⁸ *John Kelley Co. v. Comm'r*, 326 U.S. 521, 526 (1946); see also *Wood Preserving Corp. of Baltimore v. United States*, 347 F.2d 117, 119 (4th Cir. 1965).
- ¹⁹ See, e.g., *Comm'r v. H.P. Hood & Sons*, 141 F.2d 467 (1st Cir. 1944) (40-year income debentures subject to subordination respected as debt); *Monon R.R. v. Comm'r*, 55 T.C. 345 (1970) (classifying 50-year subordinated income debentures as indebtedness because term was not unreasonable based on the facts and circumstances), *acq.*, 1973-2 C.B. 3; *Shannon v. Comm'r*, 29 T.C. 702 (1958) (49-year installment obligation for purchase of ranch respected); *Chas. Schaefer & Son v. Comm'r*, 9 T.C.M. (CCH) 1035 (1950) (50-year notes respected as debt because "[t]he time of maturity, while distant, was not unreasonable under the circumstances"); *Hemenway-Johnson Furniture Co. v. Comm'r*, 7 T.C.M. (CCH) 380 (1948) (30-year term respected), *aff'd*, 174 F.2d 793 (5th Cir. 1949); see also *Mountain State Steel Foundries, Inc. v. Comm'r*, 284 F.2d 737 (4th Cir. 1960) (44-year redemption notes not questioned as being unreasonable).
- ²⁰ See, e.g., *Ruspyn Corp. v. Comm'r*, 18 T.C. 769, 779 (1952) (89-year term respected because substantially coextensive with term of lease on property owned by corporation), *acq.*, 1952-2 C.B. 3.
- ²¹ See William T. Plumb, Jr., *The Federal Income Tax Significance of Corporate Debt: A Critical Analysis and a Proposal*, 26 Tax L. Rev. 369, 448-49 (1971) ("[T]he power of purported creditors to vote on particular matters affecting their interests, such as mergers, sales or encumbrance of assets, or the like, is not inconsistent with indebtedness.").
- ²² See *Lots, Inc. v. Comm'r*, 49 T.C. 541, 549 (1968), *acq.*, 1968-2 C.B. 2.
- ²³ *Plumb*, *supra* note 21, at 512-13 (and citations therein).
- ²⁴ See, e.g., *Baker Commodities, Inc. v. Comm'r*, 48 T.C. 374, 396-97 (1967) (debt-to-equity ratio of almost 700-to-1 was not dispositive on issue of whether a shareholder advance was debt or equity because, given issuer's earnings history, there was reasonable expectation that cash flows of issuer would be sufficient to service debt), *aff'd*, 415 F.2d 519 (9th Cir. 1969); *Truschel v. Comm'r*, 29 T.C. 433, 439 (1957) (upholding characterization of instruments as debt for U.S. federal income tax purposes where a corporation had \$22 million in bonds and a stated capital of \$1,000), *acq.*, 1960-2 C.B. 7.
- ²⁵ *Gilbert v. Comm'r*, 248 F.2d 399, 406 (2d Cir. 1957); *Am. Processing & Sales Co. v. United States*, 371 F.2d 842, 852 (Ct. Cl. 1967).
- ²⁶ See *Curry v. United States*, 396 F.2d 630, 634 (5th Cir.); *cert. denied*, 393 U.S. 967 (1968).
- ²⁷ See *Fin Hay Realty Co. v. United States*, 398 F.2d 694, 698 (3d Cir. 1968).

WHAT'S ON THE SHELF? A PROPOSAL TO TAX THE INSIDE BUILDUP

By Brian G. King¹

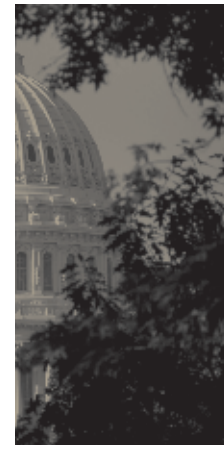
The current condition of the United States economy can easily be characterized as a period of severe economic downturn. Congress and the American people face numerous financial challenges with the massive bailouts of banks and the auto industry and the potential need for additional bailouts looming ahead as other industries struggle in this economy. Where does the revenue come from to finance these bailouts? Can the deficit continue to grow?

If the repeal of the Alternative Minimum Tax (AMT) becomes a reality, this could result in a significant reduction in federal revenue dollars at a time when the need for these dollars is increasing significantly. This will place even greater pressure on the government to find new ways to generate tax dollars. It's been more than 20 years since the Tax Reform Act of 1986, when Congress last made significant modifications and reforms to the tax base. However, as in the past, the need for revenue can often drive tax reform. Our current economic predicament has created a need for revenue. What will be the nature of the tax reform?

For some, the expectation of this next wave of tax reform has precipitated the development of tax proposals to answer the call of Congress when the need arises. The "Shelf Project"² is one such example of this tax reform readiness initiative. One of the proposals currently sitting on the shelf,³ would have very significant consequences for the United States life insurance industry and its policyholders.

WHAT IS THE "SHELF PROJECT?"

The Shelf Project is a collaborative effort by academics in the tax community with the stated intention of developing "well thought out" tax proposals, which Congress can consider when the need arises to raise revenue. The theory behind developing these proposals in advance of their need is that shelf proposals can sometimes take years to develop. By having them ready to go, Congress has proposals to "take off the shelf" when the need to raise revenue does arise. Under this paradigm, it is believed that such planning can eliminate the potential for the passage of flawed tax policy by Congress in its haste to start generating revenue.



The goals of the shelf proposals are to raise revenue, defend the tax base, reduce tax-caused harm, follow the money and improve the rationality and efficiency of the tax system. Through the collaborative efforts of those working on the Shelf Project and the peer review process that accompanies this process, the thought is, at least theoretically, that the shelf proposals can achieve these goals.

One such proposal that sits on the shelf involves changing the tax treatment of life insurance policies. This proposal would tax the earnings on the insurance contract in all cases as it occurs, even if the contract qualifies as a "life insurance contract" under current law. The actuarial gain (*i.e.*, the net amount at risk) would remain tax exempt under this proposal. The rationale behind this exemption is that the dollars used to pay for the contract are after-tax dollars and thus represent amounts already taxed.

However, the rationale for taxing the earnings is based on the viewpoint that life insurance competes with other investment vehicles and there is no justification for taxing investment returns accomplished through a life insurance company more generously than any other vehicle. As such, this proposal views the cash value as an investment, not as a prepayment of future mortality costs. If passed, this proposal quite obviously would impact United States life insurance products and their policyholders, but more significantly, the impetus for developing this policy marks a fundamental change in the tax treatment of life insurance products. It would likely result in a shift in the marketplace from cash value life insurance to term or other less investment-oriented life insurance products.

WHAT ARE THE CURRENT TAX BENEFITS OF LIFE INSURANCE AND HOW HAS THIS TAX TREATMENT EVOLVED?

Since the 1913 inception of an income tax in the United States, life insurance death benefits paid to the beneficiary have been free of federal income tax. In addition, increases in the cash surrender value of life insurance contracts have not been included in the taxable income of policyholders. This benefit is called the tax-deferred inside buildup, or simply the inside

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buildup. Thus, under current federal income tax rules, the recognition of income earned inside a life insurance contract is deferred until the contract is surrendered and is limited to the gain in the contract (*i.e.*, the excess, if any, of the cash surrender value over the policyholder's investment in the contract). If the policy is held until the death of the insured, no income tax is payable at all.

This current tax treatment of life insurance contracts recognizes the social good that life insurance death benefits offer beneficiaries in the event of the premature death of the insured. In addition, it implicitly acknowledges that the cash value is an integral component of a life insurance contract, as it serves as a prefunding mechanism to offset the higher mortality cost of providing a death benefit at older ages.

Although this tax treatment of life insurance death proceeds has remained basically unchanged for nearly a century, the tax treatment of the inside buildup periodically has come under scrutiny, largely due to changes in product designs and marketing initiatives that have accompanied new products. Understanding the history of these product changes helps in understanding the corresponding changes that have emerged in product tax treatment.

Initially, traditional whole life insurance arose out of a need to make life insurance affordable for the "whole" life of the insured. Yearly renewable term policies had premiums that increased each year, becoming prohibitive for many individuals at the older ages. With traditional level premium whole life insurance, the basic design allowed a prefunding of mortality charges in the early years (the premium exceeded the cost of

insurance charges) which were held to pay mortality charges in the later years (when the level premium was less than the cost of insurance charges). This excess prefunding was increased by interest each year to help fund the policy until maturity. Thus this "income" on the policy is actually an integral component of the financing of the policy. It is not, nor was it ever intended to be, a separate "investment component" in traditional whole life insurance.

The availability of a cash surrender value to the policy owner in the event of early termination was introduced as a consumer protection device. It was intended to refund this prefunding amount to the policyholder in the event of early termination since the death benefit would no longer need to be funded. Access to the cash surrender value through loans and withdrawals emerged out of the recognition that granting access to the cash surrender value buildup through these mechanisms could possibly provide further consumer protections—*i.e.*, loans for premiums, emergency access to cash—while keeping the death protection in force.

Life insurance companies through the years have endeavored to develop and market new and innovative life insurance plans. This was especially true during the product revolution of the late 1970s and early 1980s with the transition from basic traditional whole life products to unbundled product designs that explicitly exposed the development of the cash value, including its growth with interest. These new excess interest and universal life product designs were, at times, more investment-oriented than their traditional counterparts. This created a natural tension between those who believe that the current tax treatment of life insurance is an exception from general income tax principles, and would therefore seek to minimize the revenue loss from the life insurance tax "preference," and those who would seek to expand the sale of life insurance products, taking advantage of the applicable tax rules.

Congress's response to these new products and marketing initiatives has generally followed one of two paths: definitional limitations restricting qualifying product designs or limitations in the tax treatment applied to pre-death distributions. The enactment first of section 101(f) and then section 7702 was a response following the first path, while the enactment and enhancement of the section 264 rules (limiting the deduction of interest on borrowing used to finance the purchase of life insurance) and the introduction of the

modified endowment contract (MEC) legislation (section 7702A and section 72(e)(10)) which applied the income-first rules to pre-death distributions of certain investment-oriented life insurance contracts was a response following the second path.

Currently, sections 7702 and 7702A, introduced in 1984 and 1988 respectively, define actuarial requirements that serve as the gateway for a life insurance policy sold today to receive the tax treatment described above. More specifically, these sections have resulted in a full definition of the phrase “life insurance contract” in section 7702, and, further, a division of the class of life insurance contracts into those that are MECs, to which more stringent rules regarding policy loans and pre-death distributions will apply, and those that are not MECs.

DISCUSSION OF THE SHELF PROPOSAL TO TAX THE INSIDE BUILDUP

The taxation of life insurance contracts under federal tax law is best understood in the context of the differing views of the current federal income tax rules that apply to life insurance contracts. While the current income tax treatment of life insurance—allowing deferral of tax on the inside buildup—has consistently been the policy of Congress since the very beginning of the income tax, it also has been criticized by some theorists who believe that all accretions to wealth, including the increase in life insurance cash surrender values, should be a part of a comprehensive tax base. In their view, the inside buildup of a life insurance policy would be properly taxed to the policyholder as it accrues, and the failure of the Code to do so results in a tax advantage, or tax preference, giving rise to a “tax expenditure” equal to the untaxed inside buildup.

This accretion to wealth view is shared by the collaborators of the current shelf proposal. Under this proposal, the earnings on the insurance contract would be taxed in all cases as they arise, even if the transaction qualifies under the limitations of “life insurance contract” under current law. Based on the belief that life insurance competes with other investment vehicles, proponents of the shelf proposal feel that there is not sufficient justification for providing more generous tax treatment for investment returns accomplished through a life insurance company than any other investment vehicle. This proposal views the cash value as a pure investment, not as a prepayment of future mortality costs. As such, this investment vehicle needs to compete with other investments based on its non-tax characteristics rather than its tax advantages. Under

this viewpoint the current and historic tax treatment of life insurance products has acted as a subsidy.

This view fails to acknowledge the social utility of level funding inherent in cash value life insurance and also fails to acknowledge the significance of the limitations imposed by section 7702, which are based on the concept of prefunding the future costs of the life insurance contract. As such, these limitations are complex and necessarily depend on actuarial concepts and calculations.

While the proposal arguably contains flawed logic⁴ that is used to support why the tax deferral on the inside buildup is unjustified, it is not the intent of this article to challenge the positions taken in the proposal. The larger and more troublesome issue inherent in this shelf proposal lies with the concern that Congress may be seeking to broaden the tax base for all taxpayers, thereby eliminating tax preferences that have long been part of the tax code. States are also facing pressures to increase revenues in these difficult economic times. While the shelf proposal preserves the tax-free status of the pure death benefit element of a life insurance contract (*i.e.*, the net amount at risk) for federal income tax purposes, Oregon House Bill 2854,⁵ for example, introduced into the 2009 Oregon Legislative Session proposed to include death benefits in the income base of taxpayers.⁶ These proposals show an alarming trend, at both the federal and state level, toward drastic changes in the customary taxation of life insurance products for the purpose of increasing revenues.

In the past, when Congress and the courts have felt the need from time to time to draw lines distinguishing life insurance contracts from other financial instruments it was in response to product design and marketing initiatives taken by the insurance industry. Historically, the intent of these responses has been to continue to permit deferral of tax on the inside buildup but only to the extent that it is needed to fund life insurance benefits, and, in some cases, only to the extent that it remains inside the contract. In the past, rather than subjecting the inside buildup to current taxation, Congress has chosen to limit the amount of inside buildup eligible for life insurance tax treatment.

This proposal views the cash value as a pure investment, not as a prepayment of future mortality costs.

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SUMMARY

It is important to note that the current shelf proposal is not a reaction to the creative minds of talented actuaries who from time to time have come up with new designs for life insurance policies which are tax driven investment vehicles and/or tax shelters. Unlike in the past, this is not Congress drawing the line to lower the temperature of too hot a product. Rather, a major motivation for this proposal is purely revenue generation and an increased tax base and its target is the inside buildup of all policies, whether or not they qualify under the definition of life insurance and whether or not the investment component stays within the contract. If successfully implemented, this new tax policy would mark a significant change in the way the life insurance industry is taxed.

The shelf proposal to tax the investment earnings of all life insurance products as they occur is a significant change from the way such policies have been treated in the past. Thus, if passed, there are numerous issues that companies and policyholders will need to address to transition to this different

tax treatment. A fair question will be whether cash value life insurance will continue to exist at all? It is important to understand that the shelf proposal to tax the investment component of life insurance policies is currently still sitting on the shelf. However, elements of this proposal are starting to surface. The "Green Book" includes a proposal that would repeal the section 264(f) exception from the pro-rata interest expense disallowance rule for most corporate owned life insurance (COLI) contracts. This repeal would effectively apply a proxy tax on the earnings credited to COLI contracts by denying an otherwise deductible interest expense. Similarly, the recent life settlement rulings (Revenue Rulings 2009-13 and 14) incorporate certain elements of the shelf proposal in the taxation of a life settlement contract. The life insurance industry needs to be aware that the shelf proposal, and others like the Oregon bill, do exist or have been proposed. To the extent that the current administration is looking for ways to raise revenues, simplify the tax code by reducing the number of "preferences" that currently exist, and as a result, broaden the income tax base, the current tax benefits of life insurance will continue to be a target. ◀

END NOTES

- ¹ The author would like to thank John Adney for his input and comments on this article.
- ² C. Johnson, *The Shelf Project: Revenue-Raising Projects That Defend the Tax Base*, Tax Analysts, Dec. 10, 2007.
- ³ C. Johnson, A. Pike & E. Lustig, *Tax on Insurance Buildup*, Tax Analysts, Feb. 2, 2009.
- ⁴ In an attempt to highlight the investment nature of life insurance contracts, the shelf proposal article references both a level premium and single premium ordinary life insurance contract that matures at age 78, assuming earnings at an annual effective rate of 5%. Under the current tax law requirements of section 7702, it is unlikely that either example would qualify as a life insurance contract, and therefore be eligible for the tax deferral on the inside buildup.
- ⁵ The Oregon bill was strongly opposed by the life insurance industry and was subsequently withdrawn.
- ⁶ California and Massachusetts are also considering proposals targeting tax benefits of life insurance.

Deferred Tax Asset Monograph Now Available

AS A RESULT OF THE RECENT HIGH VISIBILITY OF THE STATUTORY DEFERRED TAX ISSUE IN THE UNITED STATES INSURANCE INDUSTRY,

the Society of Actuaries' Taxation Section Council appointed a task force to research this topic and share their findings. The result is a monograph which provides a comprehensive view of deferred taxes, both from a theoretical perspective of the concept and from the perspective of the current rules under United States statutory accounting. It also provides a brief comparison of the treatment of deferred taxes under other financial reporting bases. The focus of the paper is on deferred tax issues with respect to policyholder liabilities.

Download a copy at www.soa.org under the Taxation Section Web page.

IRS ISSUES PROPOSED SAFE HARBOR PRESCRIBING "AGE 100 METHODOLOGIES"

By John T. Adney, Craig R. Springfield,
Brian G. King and Alison R. Peak

When a resident of the United Kingdom turns 100 years of age, he or she receives a letter bearing congratulations and best wishes from the Queen. In the United States, the new centenarian receives a similar letter from the President, but under a recent proposal from the Internal Revenue Service (IRS) that might just be accompanied by a Form 1099-R reporting all the gain on policies insuring the centenarian's life.

From the inception of the federal tax definition of "life insurance contract" in section 7702,¹ enacted as part of the Deficit Reduction Act of 1984,² insureds have occasionally had the audacity (or hope) to live past age 100, even though the computational rules of section 7702 require that the deemed maturity date for a contract not be beyond the insured's age 100.³ This dichotomy between tax rules and physical reality has helped engender speculation regarding whether any tax consequence might be associated with an insured reaching this milestone. In Notice 2009-47,⁴ the IRS addresses this question by proposing a safe harbor, and requesting comments, on the circumstances where continued tax deferral and life insurance tax treatment after an insured's age 100 should apply.

BACKGROUND

While the question of how to treat life insurance contracts after an insured has reached age 100 has existed since the enactment of section 7702, some related questions, such as the interaction between the tax law's constructive receipt doctrine and section 72, predated that enactment. Attention especially focused on the post-100 treatment of contracts after the adoption, in 2004, of a new mortality table by the National Association of Insurance Commissioners (NAIC)—*i.e.*, the 2001 Commissioners' Standard Ordinary Mortality Tables (2001 CSO Tables), which extended to the insured's age 121, whereas the prior 1980 Commissioners' Standard Ordinary Mortality Tables (1980 CSO Tables) had terminated at the insured's age 100. Early in 2005, for example, the American Council of Life Insurers (ACLI) asked the IRS to issue guidance on the subject.⁵ Also, the Taxation Section of the Society

of Actuaries established the 2001 CSO Maturity Age Task Force (SOA Task Force) to study the interaction of the new mortality tables and the tax law, including the application of section 7702's requirement of a deemed maturity date between the insured's age 95 and 100 to a contract that may provide coverage through the end of the 2001 CSO Tables at the insured's age 121. In the May 2006 issue of *TAXING TIMES*, the SOA Task Force published an article entitled "2001 CSO Implementation Under IRC Sections 7702 and 7702A," which set forth a recommended methodology for applying sections 7702 and 7702A that would be "actuarially acceptable" in the case of life insurance contracts that do not provide for an actual maturity date before the insured attains age 100.

PROPOSED SAFE HARBOR— AGE 100 TESTING METHODOLOGIES

On May 22, 2009, the IRS issued Notice 2009-47 proposing a safe harbor with respect to calculations under sections 7702 and 7702A for contracts that satisfy the requirements of those provisions using *all* of the "Age 100 Testing Methodologies" described in the Notice. This proposed safe harbor generally follows the recommendations of the SOA Task Force, with some exceptions (one of which is very material) as discussed below. The Notice actually cites to the publication of those recommendations in the May 2006 issue of *TAXING TIMES*—the first time that the Taxation Section newsletter has been cited in a government document.

In describing the background for issuance of the proposed safe harbor, Notice 2009-47 raises the following three categories of tax questions in connection with insureds living (or the possibility of their living) past the deemed maturity date prescribed by section 7702:

- 1) How are calculations under sections 7702 and 7702A affected by the possibility of an insured living past the deemed maturity date prescribed by section 7702?
- 2) How, if at all, is the application of case law requiring risk shifting and risk distribution for insurance contracts,



CONTINUED ON PAGE 20

such as *Helvering v. Le Gierse*,⁶ affected by the fact that there may be little or no net amount at risk (NAR) under contracts after the deemed maturity date prescribed by section 7702?

- 3) In what circumstances, if any, does the constructive receipt doctrine, as described in Treas. Reg. section 1.451-2, apply if there is little or no NAR under contracts after the deemed maturity date prescribed by section 7702?

The proposed safe harbor, which is set forth in section 3.01 of Notice 2009-47, states that "... the Service would not challenge the qualification of a contract as a life insurance contract under § 7702, or assert that a contract is a MEC under § 7702A, provided the contract satisfies the requirements of those provisions using all of the Age 100 Testing Methodologies of section 3.02 of this notice." On its face, the proposed safe harbor clearly addresses the first of the above three categories of tax questions, *i.e.*, calculations under sections 7702 and 7702A, and it can be inferred that the proposed safe harbor was intended to address the other two categories of questions as well. In addition, the Notice does not place any scope limitations on the availability of the proposed safe harbor, other than the statement in section 1 of the Notice that its purpose is to address the application of sections 7702 and 7702A "to life insurance contracts that mature after the insured individual ... attains age 100." Thus, for example, it seems possible that the proposed safe harbor could apply to contracts based on the 1980 CSO Tables as well as to contracts based on the 2001 CSO Tables. Of course, the scope of the proposed safe harbor is implicitly limited to the extent contracts do not meet one or more of the Age 100 Testing Methodologies. Section 3.02 of Notice 2009-47 sets forth the Age 100 Testing Methodologies, which consist of the following nine requirements:

Section 3.02(a) – All determinations under sections 7702 and 7702A (other than the cash value corridor of section 7702(d)) would assume that the contract will mature by the date the insured attains age 100, notwithstanding a later contractual maturity date (such as by reason of using the 2001 CSO Tables).

Section 3.02(b) – The net single premium determined for purposes of the cash value accumulation test under section 7702(b) (CVAT), and the necessary premiums determined for purposes of section 7702A(c)(3)(B)(i), would assume an endowment on the date the insured attains age 100.

Section 3.02(c) – The guideline level premium determined under section 7702(c)(4) would assume premium payments through the date the insured attains age 99.

Section 3.02(d) – Under section 7702(c)(2)(B), the sum of the guideline level premiums would increase through a date no earlier than the date the insured attains age 95 and no later than the date the insured attains age 99. Thereafter, premium payments would be allowed and would be tested against this limit, but the sum of the guideline level premiums would not change.

Section 3.02(e) – In the case of a contract issued or materially changed within fewer than seven years of the insured's attaining age 100, the net level premium under section 7702A(b) would be computed assuming level annual premium payments over the number of years between the date the contract is issued or materially changed and the date the insured attains age 100.

Section 3.02(f) – If the net level premium under section 7702A(b) is computed over a period of less than seven years by reason of an issuance or material change within fewer than seven years of the insured's attaining age 100, the sum of the net level premiums would increase through attained age 100. Thereafter, the sum of the net level premiums would not increase, but premium payments would be allowed and would be tested against this limit for the remainder of the seven-year period.

Section 3.02(g) – The rules of section 7702A(c)(2) and (6) concerning reductions in benefits within the first seven contract years would apply whether or not a contract is issued or materially changed fewer than seven years before the date the insured attains age 100.

Section 3.02(h) – A change in benefits under (or in other terms of) a life insurance contract that occurs on or after the date the insured attains age 100 would not be treated as a material change for purposes of section 7702A(c)(3) or as an adjustment event for purposes of section 7702(f)(7).

Section 3.02(i) – Notwithstanding the above described methodologies, a contract that remains in force would additionally be required to provide at all times a death benefit equal to or greater than 105 percent of the cash value.

The proposed safe harbor would be effective as of the date of publication in the Internal Revenue Bulletin. (The recommendations of the SOA Task Force are reprinted in the sidebar on page 21.)

2001 CSO Maturity Age Task Force Recommendations

The Taxation Section established the 2001 CSO Maturity Age Task Force to propose methodologies that would be actuarially acceptable under sections 7702 and 7702A of the Code for calculations under contracts that do not provide for actual maturity before age 100. The task force recommendations are as follows:

- Calculations will assume that all contracts will pay out in some form by age 100, as presently required by the Code, rather than by age 121 as would occur “naturally” under the 2001 CSO.
- The net single premium used in the cash value accumulation test corridor factors, of section 7702(b) of the Code, and the necessary premium calculations, of section 7702A(c)(3)(B)(i) of the Code, will be for an endowment at age 100.
- The guideline level premium present value of future premium calculations, of section 7702(c)(4) of the Code, will assume premium payments through attained age 99.
- The sum of guideline level premiums, of section 7702(c)(2)(B) of the Code, will continue to increase through attained age 99. Thereafter, premium payments will be allowed and will be tested against this limit, but the sum of guideline level premiums will not increase. If the guideline level premium is negative, the sum of guideline level premiums will also not decrease after age 99.
- In the case of contracts issued or materially changed near to the insured’s age 100, the MEC present value of future premium calculations will assume premium payments for the lesser of seven years or through age 99. This is the case because the computational rules of section 7702A(c)(1) provide: “Except as provided in this subsection, the determination under subsection (b) of the 7 level annual premiums shall be made ... by applying the rules ... of section 7702(e)”, suggesting a need for a new seven pay premium. However, since section 7702(e)(1)(B) requires a maturity date of no later than the insured’s attained age 100, it arguably overrides the computational rules of section 7702A(c)(1) and thus the calculations would end at age 100. Given the lack of guidance, reasonable alternative interpretations may also be available on this point.
- If the MEC present value of future premium calculations assumes premium payments through age 99 because this is less than seven years, the sum of the MEC premiums will continue to increase through attained age 99. Thereafter, premium payments will be allowed and will be tested against this limit for the remainder of the seven-year period, but the sum of MEC premiums will not increase after age 99.
- In the case of contracts issued or materially changed near to the insured’s age 100, followed by a reduction in benefits, the MEC reduction rule, of section 7702A(c)(2), will apply for seven years from the date of issue or the date of the material change for a single life contract. For contracts insuring more than one life, the MEC reduction rule, of section 7702A(c)(6), will apply until the youngest insured attains age 121.
- Adjustments that occur on or after attained age 100 will not necessitate a material change for MEC testing purposes or an adjustment event for guideline premium purposes.
- Necessary premium/deemed cash value testing, of section 7702A(c)(3)(B)(i) of the Code, will cease at attained age 100.
- Policies can remain in force after age 100 with a death benefit greater than or equal to the cash value.

Excerpt from the May 2006 issue of *TAXING TIMES*.

USE OF A SINGLE SAFE HARBOR TO ADDRESS DIFFERENT TAX QUESTIONS

As noted above, an impetus for the insurance industry's request for guidance under sections 7702 and 7702A was the extension of mortality rates in the 2001 CSO Tables to age 121 and how this technically should be accounted for in calculating guideline premiums, net single premiums, and 7-pay premiums under sections 7702 and 7702A, each of which must use a deemed maturity date pursuant to section 7702(e)(1)(B) that is no earlier than the insured's age 95 and no later than the insured's age 100. These technical questions under sections 7702 and 7702A could be very material to compliance with those Code provisions as well. For example, if a contract designed to comply with the CVAT employed a methodology for reflecting a post-age 100 maturity that differed from what the IRS thought appropriate, it might be that the "terms of the contract" would not comply with the requirements of the CVAT and the contract would fail to comply with section 7702 from its date of issuance—*i.e.*, long before there was even an inkling of a question that might be raised under *Le Gierse* or the constructive receipt doctrine.

This highlights one of the fundamental concerns with respect to the proposed safe harbor—that it has created a single, unified safe harbor to address all three categories of tax questions described above rather than creating an independent safe harbor for methodologies under sections 7702 and 7702A and then, separately, addressing concerns under *Le Gierse* and the constructive receipt doctrine. Even if the safe harbor were confined to the permissible methodology (or methodologies) in order to calculate the quantitative limitations under sections 7702 and 7702A properly, there still may be issues worthy of debate. The 105 percent corridor requirement of section 3.02(i) of the Age 100 Testing Methodologies, however, has no relevance whatever to the requirements of sections 7702 and 7702A. It does not relate to whether a contract is life insurance under applicable law, nor does it follow in any manner any of the quantitative requirements of the section 7702 and 7702A tests. Rather, the focus of the 105 percent corridor requirement appears to pertain exclusively to questions under *Le Gierse* and/or the constructive receipt doctrine.

It is questionable whether safe harbor relief is needed under either *Le Gierse* or the constructive receipt doctrines, and if needed, whether a 105 percent corridor requirement properly addresses the issues raised by these doctrines. More fundamentally, however, tying the 105 percent corridor requirement

to the safe harbor needed for calculations under sections 7702 and 7702A is both unnecessary and counterproductive. To illustrate this point, if an insurer intended to issue thousands of contracts using a contract form designed to comply with the CVAT, as noted above it would be critical that the terms of that contract form ensure that the appropriate relationship between the net single premium and the cash value is maintained "at any time" (meaning at all times) during the life of the contract. Thus, failure to account properly for post-age 100 circumstances could cause every one of those thousands of contracts to fail to comply with the CVAT. In contrast, the issues under *Le Gierse* and the constructive receipt doctrine apply, if at all, *only* once the NAR of a contract becomes very small or zero.

Very few of the thousands of insureds under the contracts in this example will survive to the deemed maturity date of section 7702, and thus any pertinent issues under *Le Gierse* and the constructive receipt doctrine are confined to a relatively small number of contracts. This is not to say that it is unimportant whether or how these authorities apply to contracts after the deemed maturity date. It is worthwhile that comments were requested on these subjects. However, safe harbor relief under sections 7702 and 7702A seemingly should not be tied to any independent questions arising in connection with these subjects.

COMMENTARY OF THE AGE 100 TESTING METHODOLOGIES PERTAINING TO CALCULATIONS UNDER SECTIONS 7702 AND 7702A

A hallmark of the Age 100 Testing Methodologies is that they confirm that the computational rule of section 7702(e)(1)(B), requiring use of a deemed maturity date no later than the insured's age 100, *must* be used in calculating guideline premiums, net single premiums, 7-pay premiums, and necessary premiums under sections 7702 and 7702A, even though a contract actually may mature at a later date. Section 3.02(a) of the Notice generally imposes this requirement, in stating that all determinations under sections 7702 and 7702A (other than the cash value corridor) must assume that the contract will mature by the date the insured attains age 100, notwithstanding a later contractual maturity date. This starting point for the proposed safe harbor is entirely appropriate, in that the statute clearly imposes this requirement. And indeed, the remaining requirements of the Age 100 Testing Methodologies generally reflect the controlling nature of the section 7702(e)(1)(B) computa-

tion rule. There are, however, a number of questions and comments that might be raised with respect to the specifics of some of these Methodologies, including the following:

- *Scope of proposed safe harbor.* One question regards the intended scope of the proposed safe harbor. In light of the 105 percent corridor requirement of section 3.02(i) of the Notice, we suspect that the proposed safe harbor would apply to very few, if any, life insurance contracts currently in force (unless they were amended). Also, while the Notice on its face is not limited to contracts with mortality guarantees based on the 2001 CSO Tables, it is somewhat unclear whether the Notice was intended to make safe harbor relief available for contracts based on predecessor tables.
- *Deemed maturity dates other than age 100.* As noted above, section 7702(e)(1)(B) permits use of a deemed maturity date on any date on or after the insured's age 95, but earlier than on or before the insured's age 100. However, a number of the Age 100 Testing Methodologies appear to preclude application of the proposed safe harbor where calculations have been performed using a deemed maturity date earlier than the insured's age 100, such as the insured's age 95. For example, section 3.02(b) of the Notice provides that net single premiums and necessary premiums must assume an endowment on the date the insured attains age 100. Similarly, section 3.02(c) of the Notice requires that guideline level premiums be determined assuming premium payments through the date the insured attains age 99. In contrast, section 3.02(a) of the Notice requires the assumption of a maturity date "by the date" the insured attains age 100 (seemingly meaning that an earlier date could be used, as long as it is consistent with section 7702(e)(1)(B)), and section 3.02(d) of the Notice requires that the sum of guideline level premiums increase through a date no earlier than the date the insured attains age 95 and no later than the date the insured attains age 99.⁷
- *Calculation of 7-pay premiums within seven years prior to age 100.* Section 3.02(e) of the Notice provides that, in the case of a contract issued or materially changed within fewer than seven years of the insured's attaining age 100, the net level premium under section 7702A(b) would be computed assuming level annual premium payments over the number of years between the date the contract is issued or materially changed and the date the insured attains age 100.⁸ Thus, for example, if there were a material change to



a contract at the insured's age 94, a 6-pay premium would be calculated (using age 100 as the deemed maturity date) rather than a 7-pay premium under this requirement of the Age 100 Testing Methodologies. At first glance, one might question the appropriateness of this result, since sections 7702A(b) and (c)(1) call for the calculation of "7 level annual premiums." A conundrum, however, exists due to the requirement of section 7702A(c)(1)(B) that the computational rules of section 7702(e), including the requirement of a deemed maturity date no later than the insured's age 100, be used in calculating the "7-pay" premium. Of necessity, one of the statutory provisions must take precedence, and for purposes of a safe harbor it is reasonable that the IRS viewed the computational rule as controlling, since as a general matter the computational rules operate to constrain how calculations under sections 7702 and 7702A are performed.⁹

- *Period of testing.* Section 3.02(d) of the Notice provides that testing under the guideline premium limitation would continue after an insured's age 100, even though the sum of guideline level premiums would have ceased accruing at the insured's age 100. Further, section 3.02(f) contemplates that, in the case of a "7-pay" premium calculated for a period of less than seven years (as just described), testing under the 7-pay test would continue for the entire 7-pay period, even though the sum of net level premiums under this test would have ceased accruing at the insured's age 100. This methodology mirrors the recommendations of the SOA Task Force. It appears to be based upon the notion that,

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while the computational rules may affect the calculation of a guideline premium, net single premium, or 7-pay premium, they should not be extended to limit the period during which testing is applied.¹⁰

- *Reduction in benefits rule of section 7702A(c)(2).* Similarly to the period of testing just described, section 3.02(g) of the Notice requires application of the reduction in benefits rule of section 7702A(c)(2) for the same period of time that generally would apply, even if that period extends beyond the insured's age 100. Thus, in the case of a contract covering a single life, if there were a material change on the date the insured attained age 94, the "7-pay" premium would be a 6-pay premium with the last net level premium accruing on the date the insured attains age 99; however, the reduction in benefits rule would apply for seven years from the date of that material change, *i.e.*, until the insured attains age 101. Likewise, in the case of a joint and survivor life insurance contract, the reduction in benefits rule would apply to reductions occurring at any time, including after one or both of the insureds attains age 100.¹¹
- *No adjustments or material changes after age 100.* Section 3.02(h) of the Notice provides that a change in benefits under (or in other terms of) a life insurance contract that occurs on or after the date the insured attains age 100 would not be treated as a material change for purposes of section 7702A(c)(3) or as an adjustment event for purposes of section 7702(f)(7). This provision reflects the recommendation made by the SOA Task Force and is intended to eliminate any problems with calculations

of guideline premiums, net single premiums, and 7-pay premiums that otherwise might arise from the fact that section 7702(e)(1)(B) requires use of a deemed maturity date no later than the insured's age 100 which, after that date, would of course be in the past. Thus, for example, the guideline premium limitation would continue to apply for the life of the contract, based on the limitation that exists as of the date the insured attains age 100. And under the CVAT, the Notice's treatment reflects a view that the net single premium for a \$1 of death benefit equals \$1 on and after the insured's age 100.¹²

CONSTRUCTIVE RECEIPT AND *LE GIERSE* CONSIDERATIONS

All but one of the Age 100 Testing Methodologies address the manner in which calculations under sections 7702 and 7702A should be performed, with particular focus on the effect of the computational rule of section 7702(e)(1)(B) that requires calculations to assume a maturity date no later than the insured's age 100. As previously noted, the final Age 100 Testing Methodology set forth in section 3.02(i) of the Notice, however, pertains to tax considerations that are independent of sections 7702 and 7702A. In particular, this provision states that "... a contract that remains in force would additionally be required to provide at all times a death benefit equal to or greater than 105 percent of the cash value."¹³ Based on the nature of this requirement and the IRS's prior discussion in the Notice, it appears that this 105 percent corridor requirement is being established in order to address concerns which might otherwise exist under the constructive receipt doctrine or *Le Gierse* and related authorities. Thus, it seems that the IRS has concern that, for example, if a contract had no NAR after the insured's age 100, a contract owner might be taxable on gain in the contract pursuant to one or both of these lines of authority.

There are a number of authorities and considerations that have a bearing on this question. Treas. Reg. section 1.451-2(a) sets forth the general rule for constructive receipt, stating that:

Income although not actually reduced to a taxpayer's possession is constructively received by him in the taxable year during which it is credited to his account, set apart for him, or otherwise made available so that he could have drawn upon it at any time.... However, income is not constructively received if the taxpayer's control of its receipt is subject to substantial limitations or restrictions.

Two key questions are 1) whether the constructive receipt doctrine has any application to a life insurance contract prior to its actual maturity or surrender in light of the rules of section 7702, comprehensively defining the term “life insurance contract” for tax purposes, and section 72, which governs the tax treatment of amounts received from a life insurance contract, and 2) if the constructive receipt doctrine has some application, what NAR and other factors might operate as “substantial limitations or restrictions” to preclude constructive receipt.

With respect to the applicability of the constructive receipt doctrine at all, Congress, in its enactment of section 7702, arguably has already decided how much NAR is required for a contract in order for it to be treated as life insurance for tax purposes. It seems relevant, for example, that in prescribing the cash value corridor requirement of section 7702(d) for contracts subject to the guideline premium limitation, Congress thought it acceptable for a declining NAR to apply to a contract that would reduce to 1 percent of the cash value beginning with the insured’s attained age 94 and then reduce to 0 percent of the cash value beginning with the insured’s attained age 95. (In contrast, the similar applicable percentage requirement of section 101(f)(1)(A)(ii) and (3)(C), a precursor to the cash value corridor, required an NAR equal to 5 percent of cash value beginning with the insured’s age 75, and this corridor requirement continued indefinitely thereafter.) The CVAT implicitly requires a minimum NAR as well, which reduces to 0 percent of cash value by the insured’s age 100. If Congress already has considered the question of permissible NARs in order to be treated as life insurance, should this targeted decision be bypassed through assertion of the applicability of more general tax law principles?¹⁴

With respect to whether the constructive receipt doctrine would apply by its own terms (if it were concluded to be applicable), it is important to remember that the application of the doctrine in any case depends on all the facts and circumstances. Thus, the NAR under a contract would be just one consideration, albeit an important one. It also would be important to examine other valuable rights that a contract owner would need to give up in order to receive a contract’s cash value, e.g., the ability to apply monies towards a settlement option in the life insurance contract based on annuity purchase rate guarantees under the contract.¹⁵

In addition, some of the authorities that would be relevant to the constructive receipt question include *Cohen v. Comm’r.*,¹⁶ which held that a requirement to surrender a life insurance contract to realize income constituted a “substantial restriction,” rendering the constructive receipt doctrine inapplicable, and *Nesbitt v. Comm’r.*,¹⁷ concluding that the constructive receipt doctrine was inapplicable where the taxpayer would have had to surrender dividend additions, i.e., paid-up life insurance, of \$24,898 to receive a cash payment of \$24,508.

Finally, and practically, we observe that section 101(g) provides that amounts received under a life insurance contract covering an individual who is terminally ill are treated as having been received by reason of the death of the insured, so that the exclusion from income under section 101(a) generally would apply. For this purpose, an individual will be considered terminally ill if he or she is certified by a physician as having an illness or physical condition that can reasonably be expected to result in death in 24 months or less. We suspect that a substantial percentage of insureds at age 100 would be able to be certified as terminally ill under this standard.¹⁸ For those insureds with an “illness or physical condition” that allows for such certification, questions which might be raised under *Le Gierse* or the constructive receipt doctrine would seem to be moot. Of course, a day may come when mortality greatly improves and section 101(g) would have less relevance. But that day has not yet arrived, at least based on the currently prevailing mortality table.

Thus, the NAR under a contract would be just one consideration, albeit an important one.

REQUEST FOR COMMENTS

In section 4 of Notice 2009-47, the IRS requests comments on the proposed safe harbor. The IRS also requests comments on other questions that can arise where a life insurance contract matures after the insured’s age 100. For example, the IRS asks about the treatment of a contract that is initially purchased after the insured’s age 100. The IRS also asks about the application of the constructive receipt doctrine where NAR is zero at age 100, and regarding the application of the section 101(a)(1) exclusion from income in such circumstances. The comments are requested to be filed with the IRS by Oct. 13, 2009.

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CONCLUSION

As the number of centenarians increases,¹⁹ the tax rules applicable to life insurance after an insured's age 100 correspondingly will become more important as well. It certainly would be troubling to have to explain to insureds or their beneficiaries that an excludable death benefit would have been provided

if death had occurred, say, at age 99, but that a substantial tax burden applies instead because the insured had the good fortune of living a little longer. The IRS is to be commended for the steps taken in Notice 2009-47 towards resolving open questions, including its request for comments on the tax questions arising in these circumstances. ◀

END NOTES

- ¹ Except as otherwise indicated, references to "section" are to sections of the Internal Revenue Code of 1986, as amended (the "Code").
- ² Pub. L. No. 98-369 (1984).
- ³ Specifically, the computational rule in section 7702(e)(1)(B) provides that for purposes of calculations under section 7702 "the maturity date [of a contract] ... shall be deemed to be no earlier than the day on which the insured attains age 95, and no later than the day on which the insured attains age 100." This computational rule also applies for purposes of calculating 7-pay premiums under section 7702A. See section 7702A(c)(1)(B). Prior to the issuance of Notice 2009-47, there has been little guidance on the application of this computational rule. See Treas. Reg. § 1.7702-2 (providing guidance on determining an insured's attained age); PLR 200910001 (September 8, 2008) (holding that the section 7702(e)(1)(B) computational rule must be used even if there is an expectation that a contract will not continue to the insured's age 95).
- ⁴ 2009-24 I.R.B. 1083.
- ⁵ See Letter from Laurie Lewis, Senior Vice President, Taxes & Ret. Sec., ACLI, to the IRS (Jan. 10, 2005) (submitting comments on Notice 2004-61, 2004-2 C.B. 96 and requesting guidance on the application of section 7702(e)(1)(B)).
- ⁶ 312 U.S. 531 (1941). The Notice also cites *Evans v. Comm'r.*, 56 T.C. 1142 (1971) (where the court characterized a contract as consisting of an annuity element and a life insurance element and concluded that, once the cash value exceeded the face amount of death benefit, the life insurance element had ceased and only the annuity remained). Cf. Rev. Rul. 66-322, 1966-2 C.B. 123 (regarding certain contracts purchased by an employer's qualified pension plan trust and stating that: "The contracts in question provided insurance protection and contained an element of risk for many years [and thus] were insurance contracts within the meaning of the *Le Gierse* holding at the time they were executed. The mere elimination of that risk when the reserve exceeded the face amount of the contract is not considered to be a conversion of the contract of insurance into an annuity contract for purposes of section 1.402(a)-1(a)(2) of the regulations"). The IRS has considered whether Rev. Rul. 66-322 should be revoked in light of *Evans*, but has not done so. See, e.g., GCM 38934 (July 9, 1982).
- ⁷ Consistency often is a necessary consideration in calculations under sections 7702 and 7702A. For example, if guideline level premiums were calculated assuming a deemed maturity date on the date the insured attains age 95, the sum of guideline level premiums only would accrue through the date that the insured attains age 94.
- ⁸ The statement in section 3.02(e) of the Notice that "the sum of the net level premiums would increase through attained age 100" appears to contemplate a deemed maturity date at attained age 100, with the last "7-pay" premium being paid on the date the insured attains age 99. (The SOA Task Force recommended an assumption of premium payments through the insured's attained age 99 in this instance.)
- ⁹ The SOA Task Force stated in its recommendations that "the computational rules of section 7702A(c)(1) provide that '[e]xcept as provided in this subsection, the determination under section (b) of the 7 level annual premiums shall be made...by applying the rules... of section 7702(e),' suggesting the need for a new seven pay premium. However, since section 7702(e)(1)(B) requires a maturity date of no later than the insured's attained age 100, it arguably overrides the computational rules of section 7702A(c)(1), and thus the calculations would end at age 100."
- ¹⁰ It is arguable, of course, that due to the deemed maturity date prescribed by sections 7702 and 7702A, Congress contemplated no testing of contracts after the deemed maturity date.
- ¹¹ Of course, under Treas. Reg. section 1.7702-2(c), the younger insured's life would be relevant for purposes of applying the computational rules under section 7702(e). (The language of section 3.02(g) of Notice 2009-47 may need a slight revision since in its current form it could be read as indicating that section 7702A(c)(6) concerns reductions in benefits during a 7-pay period rather than during the entire life of a contract.)
- ¹² While section 3.02(h) of the Notice on its face applies to changes in benefits or terms of a contract, it is also possible that receipt of a premium that exceeds the necessary premium limitation under section 7702A(c)(3)(B) may result in a material change. Presumably, it was intended that material changes for this reason also could not occur after the insured's age 100, since the deemed maturity date would precede the date on which the unnecessary premium is received.
- ¹³ The SOA Task Force's recommendations did not include any requirement similar to this 105 percent corridor. Rather, it stated that "Policies can remain in force after age 100 with a death benefit greater than or equal to the cash value."
- ¹⁴ We also note that, in GCM 38934 (1982), in considering the tax treatment of universal life insurance prior to the enactment of section 101(f), the IRS observed that, if the savings element of the contract were characterized as a deferred annuity, the "comprehensive rules of section 72 preclude the application of the doctrine of constructive receipt to amounts credited to the cash value of a deferred annuity." See also PLR 200742010 (July 19, 2007), PLR 200313016 (Dec. 20, 2002), and PLR 200151038 (Sept. 25, 2001), each noting that section 72 provides a comprehensive scheme for the taxation of life insurance. The regime established by sections 72 and 7702 also seems to address any concerns under *Le Gierse* and similar authorities in circumstances where other factors are not present (such as facts similar to those in *Le Gierse*, involving an integrated transaction that entailed the purchase of a non-refund life annuity together with a life insurance contract).
- ¹⁵ The Annuity 2000 Basic Table extends to an insured's age 115.
- ¹⁶ 39 T.C. 1055 (1963).
- ¹⁷ 43 T.C. 629 (1965).
- ¹⁸ It appears that, based on the 2001 CSO Tables, the average insured would have a life expectancy at age 100 of less than 3 years.
- ¹⁹ It is estimated that there were approximately 96,548 centenarians living in the U.S. as of November 1, 2008. See <http://www.census.gov/popest/national/asrh/2007-nat-res.html>.

RECENT GUIDANCE INVOLVING THE TAXATION OF LIFE SETTLEMENT TRANSACTIONS

By Frederic J. Gelfond and Yvonne S. Fujimoto

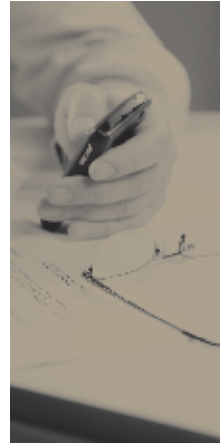
*IF YOU GIVE A MOUSE A COOKIE,
HE'S GOING TO ASK FOR A GLASS OF MILK.
WHEN YOU GIVE HIM THE MILK,
HE'LL PROBABLY ASK FOR . . .¹*

As the life settlement industry continues to take deeper root, arguably the first seeds of tax guidance have only recently been planted for sellers and investors in existing life insurance contracts. In May 2009, the Internal Revenue Service (Service or IRS) released two revenue rulings—Revenue Ruling 2009-13 and Revenue Ruling 2009-14 (the Rulings)—that provide their answers to some of the questions raised by taxpayers involved in the secondary market for life insurance contracts. Many of the questions revolving around the taxation of life settlement transactions were identified in a February 2009 article in *TAXING TIMES* (the February 2009 Article).² That article centered on the complexities involved in, and anomalies resulting from, the application of current life insurance tax guidance to life settlement transactions, as it appears that the current tax laws and existing guidance did not contemplate the development of a secondary market for life insurance contracts.

ANSWERS THAT BEGET EVEN MORE QUESTIONS

The questions identified in the February 2009 article touch upon what one might think are basic concepts that would have been resolved decades ago with respect to the purchase, sale and a purchaser's holding of an existing life insurance contract. The questions involved issues around how to determine basis in a life insurance contract, how to measure gains and losses associated with a sale of a contract, assuming one can recognize a loss on a life insurance contract, and whether income or, potentially, loss that is recognized should be characterized as ordinary or capital.

The Rulings each describe three scenarios that the Service uses to provide answers to many of these questions. But, because the rulings are specific to their facts and provide only limited analyses of some issues, they leave many questions unanswered, and cause many others to be asked.



The February 2009 article also mentioned questions regarding the application of various anti-abuse provisions in the Internal Revenue Code,³ such as those involving the deductibility of interest on debt incurred with respect to an insurance policy. Neither of the Rulings directly address those types of issues, though an argument can be made that Revenue Ruling 2009-14 might provide some limited assistance in that area.

In light of all the uncertainty regarding the IRS view of this evolving industry, it is helpful that they have at least made their positions on some key questions known.

REVENUE RULING 2009-13: SURRENDER OR SALE BY ORIGINAL, INDIVIDUAL OWNER/INSURED

Revenue Ruling 2009-13, applies to an individual taxpayer who is the original policyholder and insured under a life insurance contract. In each of the three scenarios presented in the ruling, the individual either surrenders or sells the policy. In Situation 1, the holder surrenders the contract to the insurance company for its cash surrender value. In Situation 2, the holder sells the policy to an unrelated party for an amount in excess of its cash value. Situation 3 also involves a sale, but the contract is a term policy that does not have a cash value associated with it.

An Initial Matter

As an initial matter, because the ruling specifically states that it applies to an individual, it is unclear as to whether the principles it sets forth are intended to be similarly applicable in a situation involving a nonindividual taxpayer. In contrast, the facts set forth in Revenue Ruling 2009-14, establish that the ruling applies to a "U.S. person," which can be an individual or nonindividual taxpayer.

Even though the ruling cites cases involving nonindividual taxpayers in its analyses, the failure to specifically address nonindividual taxpayers in Revenue Ruling 2009-13 is an important omission. Many original owners of life insurance contracts that are sold on the secondary market are businesses that no longer need their policies; for example a business with a key-man policy purchased on an employee who subsequently

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leaves the firm, or a corporation that disposes of a corporate-owned life insurance (COLI) program.

This leaves a big question mark with respect to one of the key distinctions between the IRS position on the treatment of an original policyholder in Revenue Ruling 2009-13 and that of an investor in an existing policy, which is the subject of Revenue Ruling 2009-14. As discussed below, that key distinction is the IRS view that an original policyholder must reduce its basis upon its sale of a contract by cost of insurance charges, whereas the investor of an existing policy does not need to. The rationale provided in the ruling is that a secondary purchaser views a policy as a purely financial investment; unlike an original purchaser who the ruling asserts purchases a policy for protection against economic loss in the event of the insured's death.

While not using the terms insurable interest, it appears that the Rulings are suggesting that the existence of an insurable interest is determinative of a policyholder's motivation for acquiring a policy; and is thus, the distinguishing factor for tax purposes, between an original and secondary purchaser.

Similar to secondary investors, however, corporate taxpayers who are original purchasers also frequently purchase contracts as financial investments; for example, those who enter into COLI programs that serve as aggregate funding mechanisms for various employee benefit programs. Moreover, one could also envision many situations in which an individual, original purchaser is predominantly interested in the investment aspects of a policy, rather than protection against economic loss.

Regardless of whether one agrees whether it is appropriate for any taxpayer to reduce basis by cost of insurance charges, it is curious that the rulings base a technical distinction in the tax treatment solely on a policyholder's rationale for buying a policy. For example, one would think that if a distinction in the treatment is necessary, the rulings might have supplemented the reasoning by basing such distinction on the fact that Congress treats original purchasers and secondary owners differently by virtue of the transfer for value rules.⁴ That is, unlike original owners, secondary purchasers generally do not receive tax free treatment upon the receipt of death benefits. While that has nothing directly to do with the basis question, it does perhaps provide a more solid foundation for potentially distinguishing between the treatment of original

and secondary owners when looking at the tax treatment of life settlement transactions more globally.

Basic Tax Treatment of Original Holders of Life Insurance Contracts

Under the general tax rules for holding a life insurance contract, death benefits are excluded from taxable income.⁵ Premiums paid for a life insurance contract by a direct or indirect beneficiary under the contract are not deductible.⁶

If a policyholder surrenders its contract to the insurance company, and receives an amount reflective of an associated cash value account, the policyholder will be subject to tax to the extent that the amount received upon surrender exceeds the policyholder's "investment in the contract." The investment in the contract is the total amount of premiums or other amounts paid for the contract less any amounts that might have been previously distributed under the contract that were excluded from income.

In effect, Congress has determined that the "basis" to be used in measuring the amount of gain attributable to cash value build-up upon the surrender of a contract includes the total amount of premiums and other amounts paid for the contract.

Typically, an insurance company will impose mortality, expense, and other charges on a policyholder in exchange for providing insurance coverage. A portion of each premium paid will go towards paying these mortality and other charges. This mortality charge, or the amount of explicitly identified mortality charges will differ, depending on how a given insurance company markets its policies. In fact, some companies offer "no-load" policies that purportedly involve no mortality charges at all, or front-end loaded policies in which the insurance company takes out a greater percentage of such charges earlier in the life of a policy, or back-end loaded policies in which the charges are taken out later.

A mortality charge is different from an insurance company's cost of insurance. A cost of insurance reflects what the insurance company actually incurs in providing death benefits to beneficiaries of matured policies. To simplify this concept, one might analogize an insurance company's cost of insurance to an automobile manufacturer's cost of goods sold in building and selling a car. When a purchaser of an automobile determines its basis in the vehicle, it does not consider the manufacturer's cost of goods sold.

Congress is fully aware of these mortality charge and cost of insurance concepts. In fact, they are considered in the definition of life insurance contract under section 7702, as well as the limits set forth in section 7702A dealing with modified endowment contracts.

Even though a policyholder receives protection during the life of a contract, and hence, arguably incurs or “expends” these costs, Congress nevertheless determined that the basis of a contract for purposes of determining gain upon a surrender is not reduced for costs of insurance incurred by the issuer or for mortality charges set forth in a life insurance contract.

Nevertheless, as discussed below, one of the fundamental questions addressed in the Rulings is whether in determining basis in the case of a sale of a life insurance contract the seller must reduce basis by some form of cost of insurance charges. Revenue Ruling 2009-13 suggests that it is necessary to do so in the case of an original, individual seller of a contract. In doing so, it cites three judicial authorities issued in the 1930s. There are, however, judicial and other authorities that were released subsequent to those 1930s cases that indicate that one need not determine gain upon a sale by reducing for cost of insurance charges. Some of these cases are cited in Revenue Ruling 2009-13 with respect to issues other than the basis question, but the ruling does not distinguish them for purposes of its analysis regarding a policyholder’s basis.

SITUATION 1

In the first of the three scenarios presented in the ruling, the individual surrenders the life insurance contract for its cash surrender value of \$78,000 after having paid \$64,000 in premiums throughout the life of the contract. The \$78,000 cash surrender value reflected the subtraction of \$10,000 in cost-of-insurance charges collected by the insurance company during the period of coverage prior to the surrender. The ruling concludes that, upon the surrender, the individual must recognize income of \$14,000, the amount by which the cash surrender value of \$78,000 exceeds the “investment in the contract” of \$64,000.⁷ This is a simple application of the general rule that gain upon the surrender of a life insurance contract is equal to the excess of the proceeds received upon surrender—generally, the cash surrender value—over the policyholder’s investment in the contract.

Character on Surrender

The ruling next concludes that the income received upon a surrender of a contract should be treated as ordinary income. In reaching this conclusion, the ruling recognizes that the Code provisions governing the measurement of income upon surrender do not provide guidance on how such income should be characterized. Accordingly, the ruling first looks to the definition of capital gain in the Code, which defines that term as gain from the “sale or exchange of a capital asset.”⁸ Continuing its analysis, the ruling confirmed that a life insurance contract is a capital asset,⁹ but also stated that the surrender of a contract does not produce a capital gain.

In reaching this conclusion, it cites Revenue Ruling 64-51 which noted that “the proceeds received by an insured upon the surrender of, or at the maturity of, a life insurance policy constitutes ordinary income to the extent such proceeds exceed the cost of the policy.” In doing so, Revenue Ruling 2009-13 appears to rely solely on that summary statement contained in Revenue Ruling 64-51. In other words, Revenue Ruling 2009-13 stops short of actually making the further statement in the analysis under Situation 2 that a surrender does not result in a capital gain for the additional reason that a surrender is not a “sale or exchange.”

The likely response to this is that such a finding is inherent in the ruling. Arguably supporting that, is the analysis under Situation 2, which involves a sale of a contract, rather than a surrender. Contained in that discussion is a statement that, “Section 72 has no bearing on the determination of the basis of a life insurance contract that is sold, because section 72 applies only to amounts received under the contract.”

The above conclusions regarding the measurement of income upon a surrender, reflect the application of section 72; and hence, consider the amounts received upon a surrender to be amounts received under a contract. It would thus appear to logically follow that the IRS view is that a surrender is not a sale or exchange. As noted below, under the discussion of Situation 2, the characterization of whether amounts are received pursuant to a sale or exchange, or under a contract, is important for several reasons. Among such reasons are

Continuing its analysis, the ruling confirmed that a life insurance contract is a capital asset, but also stated that the surrender of a contract does not produce a capital gain.

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the sourcing and other international tax provisions that are mentioned, but not fully analyzed in Revenue Ruling 2009-14.

The conclusion the ruling reaches as to the amount of income to be recognized upon a surrender, as well as the fact that such income should be treated as ordinary is neither surprising nor controversial. Nevertheless, it is interesting that the ruling takes the time to present the legal definitions of a capital gain and capital asset, but does not specifically state why a surrender transaction falls outside of those rules, choosing instead to cite to a summary conclusion in a prior ruling.

Although it is useful for the ruling to mention those rules, this ruling also presented an opportunity to provide further useful guidance. For example, the ruling further states that section 1234A “does not change this result.” That section treats gain or loss attributable to the cancellation, lapse, expiration or other termination of a right or obligation with respect to a capital asset as gain or loss from the sale of a capital asset, except in the case of the retirement of a debt instrument. The ruling does not state, however, why that section does not change the result.

Again, it would be helpful to know the IRS’ views on this, as questions frequently arise as to what it means to surrender a life insurance contract. For example, is it a cancellation or termination of a right? Or perhaps, is it an exercise of a right? Is it a statement that neither a “surrender,” a “redemption,” nor a “maturity,” the operative terms under section 72, constitute a cancellation, lapse, expiration, or other termination of a right or obligation referred to in section 1234A?

Further, it is not uncommon for questions to arise as to whether a life insurance contract, or, more frequently, an annuity contract, is a form of debt instrument. Is that why section 1234A does not change the result?

Alternatively, is such conclusion reached out of a concern that section 1234A would provide a taxpayer a basis upon which to claim a loss under a life insurance policy? Neither of the Rulings presents a scenario in which a policy is surrendered or sold for a loss. That is a topic that has been the subject of considerable public discussion, and is particularly relevant given today’s current economic environment in which many policyholders are holding, for example, variable policies that have significantly reduced cash value accounts. Guidance in that area would have been helpful as well.

SITUATION 2

In the second scenario described in the ruling, the facts are the same as in Situation 1, except that the individual owner/insured sells the existing life insurance policy to an unrelated person for \$80,000, instead of surrendering it to the insurance company. As noted above, the ruling also states that the cash surrender value of \$78,000 reflects a \$10,000 subtraction for “cost-of-insurance” charges collected by the insurance company for periods ending prior to the sale. The ruling concludes that the transaction is governed by section 1001(a), which provides that the gain realized from the sale or other disposition of property is the excess of the amount realized over the adjusted basis. The ruling then concluded that the policyholder’s basis in the life insurance contract is \$54,000, which is equal to the \$64,000 of premiums paid reduced by the \$10,000 of cost-of-insurance charges, and the resulting gain on sale is \$26,000, or \$80,000 less \$54,000.

As pointed out in the ruling, “adjusted basis for determining gain or loss is generally the cost of the property.” Under a section 72 “investment in the contract” theory, Congress mandated that the “cost” to be subtracted from the amount received in determining gain upon the surrender of a contract, is generally the amount of premiums paid under the contract, less any amounts that may have been returned to the policyholder on a tax-free basis.

Revenue Ruling 2009-13 distinguishes between an amount received upon a surrender of a contract, and that is hence, governed by section 72, and an amount that is received upon a sale of a contract. As noted:

Section 72 has no bearing on the determination of the basis of a life insurance contract that is sold, because section 72 applies only to amounts received under the contract.

Instead, the IRS looks to various cases from the 1930s,¹⁰ involving situations in which taxpayers were seeking to claim a loss upon a sale or surrender of a life insurance contract. These cases indicated a view that basis in a life insurance contract should be reduced for amounts that were reflective of amounts paid for insurance coverage prior to the time the contracts were sold or surrendered. The rulings, however, fail to also address in this context, subsequent cases that actually applied an investment in the contract theory for determining basis in a life insurance contract, and numerous legislative and judicial authorities that have specifically analogized the terms “investment in the contract” and “basis.”

See, for example, *Gallun v. Commissioner*,¹¹ which is cited in Revenue Ruling 2009-13 solely for the proposition that a gain on sale is partially ordinary income. The ruling does not seek to distinguish the fact that the amount of gain recognized by the selling policyholder in that case was determined based on the premiums paid for the subject contracts, with no reduction for cost of insurance charges. Cost of insurance charges were clearly considered by the court in that case, as it mentioned the impact of various expenses and charges in reducing the contracts' total cash surrender value.

Given the divergent authorities on this issue, it is likely to be an area of continuing conversation among practitioners. On one side of the debate will be those who point to the fact that a policyholder receives insurance coverage for the period that it holds the policy, and hence, must have incurred charges during that time period. On the other side will be those who focus on the fact that premiums paid are for coverage during the whole of the life of the insured or the entire term of coverage; and that the magnitude of the benefits that are made available during the entire period are a function of all the premiums paid during the life of the contract. Even in the case of a term policy for a number of years, there is an interrelationship between the premiums paid in all years to the benefits that are made available throughout the life of the contract.

Others might point to the fact that, from the policyholder's standpoint, there is no substantive difference between a sale and a surrender. That is, in both cases, the policyholder is giving up all rights under a contract. In the case of a surrender, Congress deemed it appropriate to give the policyholder "basis" credit for the entire amount paid for the contract.

Similarly, in a situation involving the transfer for value rules described below, the purchaser is given credit for all amounts paid for a contract, unreduced by cost of insurance charges.

Even if there was full agreement that it is appropriate to reduce basis by cost of insurance charges, there are likely to be several practical issues as to how to determine what those cost of insurance charges should be. Is it the mortality charge stated in the contract or otherwise collected by the insurance company? Is it the insurance company's cost of insurance? If it is the former, how can one determine such charges if they are not explicitly stated in the contract? Further, how might one figure into this



calculation, the extent to which a return of cost of insurance charges are inherent in a policyholder dividend that is paid in a subsequent year, or that is effected through some other form of policy crediting? That is, should there not be an increase in basis to the extent that an insurance company credits favorable mortality experience back to its policy holders. Will the result of all this be a lack of uniformity in terms of how taxpayers compute these charges?

Character on Sale

Even though the rulings recognize that life insurance contracts are capital assets, and the transaction in Situation 2 is a sale or exchange, the ruling nevertheless treats at least a portion of the gain on the sale as ordinary income. More precisely, the ruling concludes that the portion of the \$26,000 gain that reflected the amount of income the policyholder would have been required to recognize upon a surrender of the contract (\$14,000, equal to the \$78,000 cash surrender value less the \$64,000 investment in the contract) should be treated as ordinary income, and the remainder of the gain (\$12,000, equal to \$26,000 total gain less \$14,000 of ordinary income) should be treated as capital.

In doing so, the ruling followed a "substitute for ordinary income" theory discussed in a long line of cases involving insurance and other capital assets that were treated as capital, but that also were deemed to generate ordinary income that increased the value of the asset, but was not previously recognized by the seller. Essentially, those courts examined, "whether the gain realized thereon represented an appreciation of the capital asset itself, or rather represented income produced by such asset."¹² Those courts sought to prevent gains that they deemed to be reflective of ordinary income from being converted to capital gain by a sale or

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exchange. With respect to insurance contracts, those courts analyzed the character of the gain attributable to the inside buildup in terms of how that gain would have been treated had the contract been surrendered.

There is a good deal of authority to support this approach.¹³ It is interesting, however, that in the discussion of cost of insurance charges noted above, the rationale that the Rulings provide for treating an original purchaser and an investor in the secondary market differently from a basis perspective, is because the original purchaser acquires a policy for protection against loss in the event of death, not for the investment aspects of a policy. If that is the case, then it would seem that ruling would have recognized that the accretion to value of the policy in the ruling is attributable to the increasing value of the death benefit, not because of the inside buildup in the policy. In fact, in the secondary market, the value of the policy is based on a determination as to the present value of the death benefit. A large cash value is commonly deemed to be a hindrance towards the efficient administration of the contract once acquired, and is typically reduced to the extent possible without terminating the policy. As such, one might view the cited cases as being not fully consistent with the common fact pattern in a life settlement transaction. That is, the value of a policy is not based on its cash surrender value, it is based on the expected date of death of the insured.

Another interesting aspect to this is that by virtue of the manner in which this calculation is performed, the ruling would at least mathematically convert a cost of insurance expenditure into a capital gain upon a sale of the associated contract.

SITUATION 3

Situation 3 involves the sale, for \$20,000, of a term life insurance contract that has no cash value. Because the policy has no cash value, the full amount of the premium, or \$500 per month, is considered to be cost of insurance. The seller paid premiums on the policy at the beginning of each month for 90 months, for a total of \$45,000 in premium payments over that term. The policyholder sold the policy in the middle of the 90th month. In accordance with the approach it set forth in Situation 2, the ruling concludes that the policyholder's basis in the contract is \$250 (\$45,000 of total premiums less \$44,750 cost of insurance deemed to have been incurred after 89.5 months), and that the policyholder would be required to recognize a gain on sale of \$19,750. Because the contract was held for more than one year, the gain is deemed to be a long-term capital gain.

In selling the contract at this time, the policyholder is giving up its rights to continuing insurance coverage for the remaining seven and a half years of insurance coverage. The policyholder is ascribed no basis in those rights that it is giving up.

The ruling does not state whether the death benefit remains the same through the life of contract. As such, it is not clear whether the premiums paid in the expired years include amounts that are at least in part, reflective of costs of coverage for the later years. In fact, the ruling states, "absent other proof," the cost of insurance charge each month is equal to the entire monthly premium of \$500. It is uncertain whether it was appropriate to reduce the policyholder's basis by the full \$500 premium paid each month, assuming the ruling is correct in its conclusion that it is proper to reduce for costs of insurance in the first instance. Everything else aside, the suggestion that the conclusion is being made "absent further proof," is perhaps foreshadowing the fact that policyholders are likely to have a significant burden to overcome in substantiating basis in this area.

EFFECTIVE DATE

Perhaps recognizing that the positions set forth in this ruling reflect a change in how many taxpayers have been calculating and characterizing income relative to their life settlement transactions, the ruling indicates that the holdings relative to Situations 2 and 3 will not be applied adversely to sales occurring before August 26, 2009.

REVENUE RULING 2009-14: SECONDARY MARKET PURCHASER'S TAX TREATMENT

Revenue Ruling 2009-14, offers tax guidance to an investor in a life insurance contract in the secondary market; *i.e.*, a purchaser¹⁴ of an existing life insurance contract. Similar to Revenue Ruling 2009-13, Revenue Ruling 2009-14 presents three scenarios that illustrate the IRS positions on the amount and character of income the purchaser should recognize with respect to certain life settlement transactions. In two of the three scenarios, the purchaser is a U.S. person—*i.e.*, an individual or an entity—who buys a term life insurance contract from a U.S. individual and either receives the death benefit on the contract or sells the contract to an unrelated purchaser while the insured is still alive. The third scenario involves a foreign purchaser of an existing contract who holds the policy until receipt of the death benefit.

The ruling uses a general fact pattern that steers clear of many of the questions that have been raised in the life settlement

area. In particular, none of the scenarios involve the transfer of a policy that has a cash value, or that is a whole life policy. None of the scenarios involve the use of indebtedness, which is a common feature of many life settlement structures. The rulings provide citations to various Code sections implicated by each of the scenarios, but it provides virtually no analyses with respect to the associated conclusions.

As discussed above, among the general rules governing the purchase, holding and maturity of a life insurance contract are that premiums paid by a direct or indirect beneficiary under the contract are not deductible, and amounts received upon the death of the insured are excludable from income. The latter rule does not apply, however, in the case of a contract that has been acquired in a transfer for value; *e.g.*, as occurs in a life settlement transaction. In a circumstance involving a transfer for value, only the portion of the death benefit that reflects the “cost” of the contract to the policyholder would be excluded from taxable income.

The amount that is excluded is the value of the consideration paid for the contract plus premiums and other amounts subsequently paid by the transferee. The “other amounts” include interest payments that are disallowed as a deduction pursuant to section 264(a)(4).

The interest deduction limitation rules set forth in section 264 are designed to prevent perceived abuses relative to the original purchase and ownership of life insurance policies by individuals and businesses that are generally able to defer or otherwise exclude income from their contracts. In general, these rules reflect an attempt by Congress to limit taxpayers’ ability to deduct amounts incurred in connection with the generation of tax-deferred or tax-free income. Yet, it is questionable how, if not whether, many of these rules should be applied in the context of a business operating in a secondary market in which the income from death benefits is generally subject to tax; *i.e.*, they do not involve the same opportunities for arbitrage as may exist with respect to policies held by their original owners.

The ruling refers to the application of section 264 as it relates to its limitation on the deductibility of premiums by a direct or indirect beneficiary. The fact patterns in the ruling, however, do not involve the use of debt or a policy with a cash value. As such, it does not address some of the more significant questions involved in a typical life settlement structure. Because of the magnitude of this issue, uncertainty around the application of the interest deductibility limitations in

particular is one of the largest drivers of life settlement structures being set up in offshore jurisdictions.

On the other hand, the transfer for value rule, referred to above, permits the policyholder to include in the cost of the policy that may be excluded from income, interest expense that was otherwise disallowed as a current deduction. In effect, the policyholder may capitalize, rather than currently deduct, this otherwise disallowed interest expense for the purpose of measuring the taxable portion of death proceeds. It is uncertain, however, whether such disallowed interest would be permitted to be capitalized in the case of a sale of a contract by the secondary market investor. The ruling answers this question in the context of premium deductions disallowed under section 264, permitting such amounts to be capitalized, but it does not address the question as it relates to disallowed interest deduction amounts.

SITUATION 1

In the first scenario, the purchaser pays \$20,000 for a level premium 15-year term life insurance contract without cash surrender value and names itself as beneficiary. The contract is underwritten by a domestic insurance company on the life of a U.S. citizen residing in the United States. The purchaser buys the policy from the insured solely for the purpose of making a profit, has no insurable interest in the life of the insured, and has no relationship to the insured.

The insured dies and the purchaser/beneficiary receives a \$100,000 death benefit. Prior to the insured’s death, the purchaser paid the monthly premiums totaling \$9,000 to keep the contract in force. The ruling concluded that as a transfer for valuable consideration, section 101(a)(2) provides that the death benefit is included in taxable income in an amount equal to the amount received upon the death of the insured less the sum of the consideration paid for the contract and the premiums and other amounts subsequently paid. The purchaser will include \$71,000 of the death benefit in gross income, which is equal to the \$100,000 death benefit received less \$29,000 (\$20,000 purchase price from original owner plus \$9,000 in monthly premiums).

This conclusion reflects a straightforward application of the transfer for value rules. Most secondary market transactions

The ruling refers to the application of section 264 as it relates to its limitation on the deductibility of premiums by a direct or indirect beneficiary.

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involve a number of other fees or amounts paid in connection with the acquisition of a contract beyond the purchase price paid to the seller and the additional premiums paid to the insurance company. It will be interesting to observe what other items might be included in the “other amounts” paid that may be excluded from income.

Character of Death Benefits

Similar to Revenue Ruling 2009-13, this ruling concludes that a life insurance contract is a capital asset. Despite this characterization however, the IRS determines that “neither the surrender of a life insurance or annuity contract nor the receipt of a death benefit from the issuer under the terms of the contract produces a capital gain” and declares that the \$71,000 is ordinary income. Although not unexpected, the ruling provides no explanation for this conclusion; something that would have been helpful given the frequency with which this question is raised by taxpayers.

SITUATION 2

The second scenario in Revenue Ruling 2009-14 is similar to the first scenario except that the secondary owner resold the policy prior to the death of the original insured, to a purchaser unrelated to either the original or the secondary owner. The sales price received for the contract was \$30,000.

Similar to the sale transaction in Revenue Ruling 2009-13, the ruling concluded that this transaction is governed by the rules dealing with sales or other dispositions of property. For purposes of determining basis, the ruling found that the transfer for value rules are not relevant, as those provisions apply only to amounts received by reason of the death of the insured. The analysis does not mention the investment in the contract rules.

Instead, similar to Revenue Ruling 2009-13, it analyzes the cost of the life insurance policy. The similarity to that ruling ends there, however, as Revenue Ruling 2009-14 applies regulations relating to capitalization of amounts paid to acquire intangible assets.¹⁵ Accordingly, it determined that the cost of the life insurance policy included the \$20,000 purchase price paid to the original owner plus the additional \$9,000 in premiums paid before the resale. The ruling stated that the additional premiums should be capitalized even though such amounts are disallowed as a deduction under section 264. It reasoned that the premiums paid by a secondary market purchaser on a term insurance contract serves “to create or enhance a future benefit for which capitalization is appropriate.”

Revenue Ruling 2009-14 concludes that a secondary purchaser is not required to reduce the premium amounts paid by cost of insurance charges collected by the insurance company during the time the secondary owner held the contract. It reasoned that the purchaser did not buy the life insurance contract for protection against any economic loss upon the insured’s death. It found that instead, the secondary market purchaser acquired the contract solely with a view towards profit and that it paid the additional premiums to prevent the lapse of its purely financial investment in the contract.

While the ruling ends up with what is arguably the correct result, for the reasons set forth in the above discussion of Revenue Ruling 2009-13, the rationale it provides would seem to be equally applicable to many original purchasers of life insurance contracts, individual and nonindividual owners alike.

Character of Gain on Sale

The gain of \$1,000 (*i.e.*, \$30,000 sales proceeds less the \$29,000 original purchase price and additional premiums paid) is treated as a long-term capital gain because the contract is a capital asset under section 1221 and was held for more than one year.

As an interesting note, the ruling expressly states that the “Service will not challenge the capitalization of such premiums paid or incurred prior to the issuance of this ruling.” This may reassure some investors that purchased life insurance contracts prior to this ruling as to the IRS’s view of calculating basis.

SITUATION 3

The third and final situation presented in the ruling is similar to that in Situation 1, but involves a foreign corporation as the purchaser of the level premium 15-year term life insurance contract. The foreign corporation is not engaged in a trade or business within the United States (including the trade or business of purchasing, or taking assignments of, life insurance contracts). This information is given as a fact but it would have been helpful to see the process of determining whether or not a foreign corporation is engaged in a U.S. trade or business. Whether a life settlement structure may be a trade or business is a key question in determining the tax treatment of a foreign investor. It will have an impact on determining where the income is sourced, as well as whether amounts paid to the entity will be subject to withholding. The mere fact, however, that the ruling acknowledges that investing in life settlements can be a trade or business—as opposed to an investment—is itself, a key piece of guidance.

Fixed or Determinable Annual or Periodical Income?

The ruling states that the amount of income recognized from the death benefit is the same \$71,000 as under situation one and is “fixed or determinable annual or periodical income” (FDAP) within the meaning of section 881(a)(1). The IRS references various pieces of guidance as support for the treatment of the death benefit as FDAP, including regulation section 1.1441-2(b), Revenue Ruling 64-51, and Revenue Ruling 2004-75. The regulation and rulings, however, do not specifically mention death benefits.

For example, Revenue Ruling 2004-75 concludes that income received by a nonresident alien individual under life and annuity contracts issued by a foreign branch of a U.S. life insurance company is U.S. source FDAP income. The ruling does not address death benefit payments. Instead, it compares the income received under a life insurance or annuity contract as it relates to an investment return on the cash value of the contract to interest on a debt obligation or dividends on a stock.

The second ruling cited in support of its conclusion that death benefits are FDAP is Revenue Ruling 64-51. Revenue Ruling 64-51 cites regulation 1.1441-2(a), which has been amended since the time of the 1964 ruling, and which states that “income is determinable whenever there is a basis of calculation by which the amount to be paid may be ascertained.” The 1964 ruling concludes:

Generally, the company issuing the life insurance policy can predetermine and has a basis of calculation to ascertain the amounts to be paid to and the income to be included in the cash surrender value or the maturity value of such a policy. Therefore, the income realized upon the surrender or maturity of a life insurance policy comes within the definition of the term “fixed or determinable annual or periodical income.”

Based on this language, it would appear that death benefits, which for a term life insurance contract would represent the maturity of the contract, could arguably be considered FDAP. Absent the above citations, however, Revenue Ruling 2009-14 does not provide any analysis in furtherance of its conclusion that a death benefit paid by a U.S. insurer to a foreign corporation on a U.S. insured is FDAP.

Doing so would have been helpful given the existence of authorities that potentially conflict with the 1964 ruling.

As discussed in the February 2009 article, the regulations provide a description of items of income that are not FDAP. More precisely, regulation section 1.1441-2(b)((2) states that “[g]ains derived from the sale of property” are not FDAP. That is, one could envision an argument that the payment of a death benefit is a disposition, similar to a sale, and that such income would fall under the FDAP exclusion for gains derived from the sale of property.

Source of Income

For purposes of determining the source of the death benefit as either U.S. or foreign, the ruling finds that when the source of income is not specified by statute or regulation, the courts have determined the source of the item by comparison and analogy to other classes of income specified in the statute. The ruling mentions to section 861(a)(1) and (7). Section 861(a)(1) provides that interest received from a domestic corporation is generally from sources within the U.S. Comparison to section 861(a)(1) would arguably seem reasonable when attempting to source payments made under a life insurance contract related to earnings reflected in the cash value of the contract. The comparison with respect to the source of death benefits, however, does not seem nearly as relevant. Section 861(a)(7) provides that amounts received as underwriting income from the issuing of insurance or annuity contracts on the lives of U.S. residents would be considered gross income from sources within the United States. The ruling does not explain how this type of income compares, or may be analogized to a death benefit.

The IRS also makes a single-sentence reference to section 865, which provides that the source of income from the sale of personal property is generally sourced to the residence of the taxpayer. No further discussion is given regarding section 865.

Life insurance has long been recognized as personal property.¹⁶ Section 865(i)(2), as discussed in the February 2009 Article, defines the term “sale” to include “an exchange, or any other disposition.” It would seem from this language that a sale of a life insurance contract by the foreign corporation would be considered foreign source income. The ruling, however, does not include a sale of a life insurance contract by a foreign purchaser as one of the scenarios discussed. The third situation involves a death benefit payment to a foreign corporation which arguably could be viewed as an “other disposition” under section 865(i)(2). If that were the case, the source of the death benefit would be foreign, not U.S.¹⁷

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As previously mentioned, the ruling does not fully describe its analysis of section 865 and simply concludes that the foreign purchaser will recognize \$71,000 of ordinary income from sources within the United States that will apparently be subject to withholding tax under section 881(a)(1). Further discussion of its analysis with respect to the third scenario would have been helpful to taxpayers trying to structure their transactions in accordance with the very complex regime in place for taxing foreign investors, and for ensuring that domestic entities with payment obligations act in accordance with the various withholding requirements.

CONCLUSION

Anyone, whether an individual or a corporation, with a life insurance contract that they may no longer need, or who is in greater need of the cash that the contract represents than the insurance coverage it offers, or an investor in the life settlements business is appreciative of whatever tax guidance the IRS can offer with respect to the sale, purchase, and holding of a life insurance contract. Both of the revenue rulings discussed herein are helpful in providing insight into their positions relative to calculating basis, the amount of income to be recognized, and the character of that income. In some instances, taxpayers may

have questions as to the appropriateness of the answers or may still have questions that remain unanswered. As stated at the outset of this article, those participating in the life settlements business have been looking for answers. Some answers have now been provided, but the life settlements industry participants are looking for more. *If you give a mouse a cookie...*

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END NOTES

¹ *If You Give a Mouse a Cookie*, by Laura Joffe Numeroff.

² Frederic J. Gelfond, "Selected Insurance and International Tax Considerations for Investors in Life Settlement Businesses," *TAXING TIMES*, February 2009, Vol. 5, Issue 1.

³ Internal Revenue Code of 1986, as amended (Code). Unless otherwise indicated, all section references are to the Code.

⁴ Section 101(a)(2).

⁵ Section 101(a)(1).

⁶ Section 264(a)(1).

⁷ See section 72(e).

⁸ Section 1223(3).

⁹ Per section 1221(a), a capital asset is property held by a taxpayer that is not one of the items listed in section 1221(a)(1)-(8).

¹⁰ *Century Wood Preserving Co. v. Commissioner*, 69 F.2d 967 (3rd Cir. 1934); *Keystone Consolidated Publishing v. Commissioner*, 26 B.T.A. 1210 (1932); *London Shoe Co. v. Commissioner*, 80 F.2d 230, 231 (2nd Cir. 1935).

¹¹ *Gallun v. Commissioner*, 327 F.2d 809 (7th Cir. 1964).

¹² *First National Bank of Kansas City v. Commissioner*, 309 F.2d 587 (8th Cir. 1962), at 588.

¹³ *Commissioner v. Phillips*, 275 F.2d 33 (4th Cir. 1960); *First National Bank of Kansas City v. Commissioner*, 309 F.2d 587 (8th Cir. 1962); *Gallun v. Commissioner*, 327 F.2d 809 (7th Cir. 1964).

¹⁴ Purchaser is a United States person as defined in section 7701(a)(30).

¹⁵ Essentially, it applies the rules under regulation section 1.263(a)-4(c)(1)(iv).

¹⁶ See, e.g., *Lucas v. Alexander*, 279 U.S. 573 (1929).

¹⁷ Section 865(e)(2) provides that if a foreign entity maintains an office or other fixed place of business in the United States, the income from the sale of personal property attributable to such office or other fixed place of business shall be sourced in the United States.

GUIDANCE RELEASED ON COLI BEST PRACTICES RULES

By John T. Adney, Bryan W. Keene, and Joel W. Mann

On May 22, 2009, the Internal Revenue Service (“IRS”) released Notice 2009-48 (the “IRS Notice”), which provides significant clarification in question-and-answer format on several provisions of the corporate-owned life insurance (“COLI”) “best practices” rules that were codified in section 101(j)¹ by the Pension Protection Act of 2006 (the “PPA”).² The IRS Notice became effective June 15, 2009, but it states that the IRS will not challenge a taxpayer who made a good faith effort to comply with section 101(j) based on a reasonable interpretation of that section before the effective date. The IRS released the new guidance at least in part in response to a request by the American Council of Life Insurers (“ACLI”) in 2007. In its request for guidance, the ACLI brought to the Treasury Department’s (“Treasury”) attention several areas of uncertainty regarding section 101(j). Agreeing that these areas merited further clarification, Treasury and the IRS placed the matter on their combined 2008-2009 Priority Guidance Plan and subsequently released the IRS Notice. This article provides a brief review of the rules of section 101(j) and then summarizes the guidance contained in the IRS Notice.

REVIEW OF SECTION 101(J)

Subject to certain transition rules, section 101(j) generally denies the exclusion from income under section 101(a)(1) for death benefits under an “employer-owned life insurance contract” to the extent they exceed the premiums and other amounts paid for the contract. An employer-owned life insurance contract is a life insurance contract that 1) is owned by a trade or business, 2) directly or indirectly designates that trade or business as the beneficiary, 3) covers the life of an insured who is an employee of the “applicable policyholder” when the contract is issued, and 4) is issued or “materially changed” after Aug. 17, 2006. An applicable policyholder is a person who engages in a trade or business and owns an employer-owned life insurance contract, or is a related person.³

Several exceptions to the general exclusion disallowance rule are available. One set of exceptions is based on whether amounts are paid to the insured’s heirs.⁴ The other set is based on the insured’s status with the applicable policyholder,

namely, insureds who were employees within 12 months of their death and insureds who were directors or “highly compensated” at the time the contract was issued.⁵ None of the exceptions applies unless the employer, before the contract is issued, 1) notifies the insured in writing that the employer intends to procure the coverage, including the maximum face value for which the person could be insured; 2) obtains the insured’s written consent to the coverage and to the possible continuation of the coverage after the insured terminates employment; and 3) informs the insured in writing that the employer will be the contract beneficiary.⁶

GUIDANCE ON NOTICE AND CONSENT REQUIREMENTS

One of the concerns that the ACLI raised in its request for guidance was the lack of any mechanism to correct inadvertent “foot faults” made in attempting to comply with the notice and consent requirements before a contract was issued. The IRS Notice provides, in response, that the IRS will not challenge an inadvertent failure to satisfy those requirements if 1) the employer made a good faith effort to satisfy them, 2) the failure was inadvertent, and 3) the employer corrects the error by the due date of its tax return for the year the contract was issued.⁷ This “self-help” correction mechanism gives employers acting in good faith considerable leeway and should alleviate concerns that innocent and inevitable human errors would have harsh consequences. The key to effective utilization of this self-help mechanism is prompt discovery and correction of the error. In the absence of prompt action, there is no means under section 101(j) of correcting an inadvertent failure to comply with the notice and consent requirements. Hence, in the case of a failure discovered beyond the timeframe permitted under the IRS Notice, the only recourse would seem to be surrender of the affected contracts or, possibly, seeking a closing agreement with the IRS coupled with belated compliance with the statute’s requirements.

Another question that arose when taxpayers began implementing the notice and consent requirements was how long an employee’s consent remains valid. In other words, could



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an otherwise valid consent become “stale” if there was some delay in issuing the contract after the consent was obtained? This could occur, for example, if outside events delayed the plan moving forward after consents were obtained, or if a plan was implemented in multiple steps. With regard to the latter possibility, a related question became whether a single consent with respect to a given face amount could be used to purchase two or more smaller contracts that totaled to the amount for which the consent was given. The IRS Notice answers both of these questions. It provides that consent remains valid up to one year from when it was obtained, or up to the date the employment relationship ends—whichever occurs earlier.⁸ It also provides that a single consent may apply to multiple contracts covering the life of the same insured, so long as the maximum face value to which the employee consented is not surpassed.⁹ Taken together, these two rules suggest that if an employer plans to purchase multiple contracts based on a single consent, it should do so within a year of the consent or else the consent will expire. (The stale consent issue is discussed further below.)

Still another question that arose soon after section 101(j) was added to the Code was whether the “written” notice and consent requirements could be met *via* electronic means. The IRS Notice clarifies that they can, as long as the electronic notification and consent system has elements in place similar to the administrative requirements in the case of electronically filed Forms W-4.¹⁰ It is our understanding that some employers have already been providing notice and obtaining consent electronically, based in part on the general applicability of the federal “E-SIGN” statute.¹¹ Those employers will likely want to review the IRS Notice to ensure that their current electronic system complies with the new guidance.

In addition to the foregoing, the IRS Notice also clarifies that 1) notice and consent is required of an owner-employee of a wholly-owned corporation; 2) notice and consent is not required with regard to an existing life insurance contract that an employee irrevocably transfers to an employer, because the transfer itself is sufficient to satisfy the notice and consent requirements; and 3) the notification to the employee of the maximum face amount for which the employee could be insured must be satisfied by using either a dollar amount or a multiple of salary, and not a general statement such as “the maximum face amount for which you can be insured.”¹²

GUIDANCE ON THE ISSUE DATE OF A CONTRACT

There also has been general concern over what date a contract will be considered “issued” for purposes of section 101(j). The concern arises because the new rules apply only to contracts “issued” after Aug. 17, 2006, and because the notice and consent requirements must be met before the contract is “issued.” For example, it is common for large purchases of employer-owned life insurance to be accomplished using a binding premium receipt, which provides immediate coverage for a specific amount of time, such as until the underwriting process is complete. If a contract was deemed “issued” before this binding premium receipt became effective, notice and consent would not be timely if accomplished after that time, which would often be the case.

The IRS Notice provides a reasonable and flexible response to this type of concern by clarifying that a contract’s “issue” date is the latest of 1) the date of application for coverage, 2) the effective date of coverage, or 3) the formal issuance of the contract.¹³ Thus, for example, the fact that a binder is effective before notice and consent are obtained will not necessarily cause a violation. As discussed below, this definition of “issue” date also has implications for the transition rules governing section 101(j)’s application and for determining the insured’s status as a director or as “highly compensated.”

GUIDANCE ON TRANSITION RULES

Section 101(j) applies only to contracts issued after Aug. 17, 2006, “except for a contract issued after such date pursuant to an exchange described in section 1035 ... for a contract issued on or prior to that date.”¹⁴ For this purpose, “any material increase in the death benefit or other material change shall cause the contract to be treated as a new contract.”¹⁵ While it is common for statutory enactments to treat a material change to a life insurance contract as giving rise to a new contract,¹⁶ the

exception for contracts exchanged pursuant to section 1035 was somewhat novel. This novelty has created confusion over the interaction between the two provisions.

The confusion stems from the appearance that the two rules, taken together, suggest that a deemed exchange resulting from a material change will trigger the rule's effective date, whereas an actual exchange of contracts will not—*i.e.*, the section 1035 exchange rule could be read to “swallow” the material change rule. The IRS Notice interprets these rules by retaining some meaning for each, stating that an actual exchange “that results in a material increase in death benefit or other material change (*other than a change in issuer*) is treated as the issuance of a new contract.”¹⁷ In effect, this interpretation adds a change in the identity of the contract's issuer to the list of items that will not be considered a “material change” for purposes of the transition rules.

In that regard, the IRS Notice also lists specific changes that are not treated as material for purposes of the transition rules. These largely track a similar list that was set forth in the only legislative history for section 101(j).¹⁸ They are: 1) increases in death benefit due to the operation of section 7702 or the terms of the contract (provided the insurer's consent is not required); 2) administrative changes; 3) changes from general to separate account or from separate to general account (the latter being somewhat of an expansion, given that the legislative history referred only to changes from general account to separate account); and 4) changes as a result of an option or a right under the contract as originally issued.¹⁹ With respect to contracts already subject to section 101(j), the IRS Notice also provides that a material change to the contract—whether through a modification to the contract or an actual exchange—will require a new notice and consent unless one remains in effect under the “expiration” provisions summarized above (*e.g.*, the change occurs within a year of the original notice and consent).²⁰

Although this guidance on the perennially thorny issue of material changes is quite helpful, some questions are bound to remain. By way of example, as noted above the IRS Notice provides that a section 1035 exchange which also results in a material change, other than a change in the issuer of the contract, gives rise to a new contract for section 101(j) purposes. State law generally requires contracts issued after 2008, including those issued in an exchange, to base their mortality charge guarantees on the 2001 CSO mortality tables rather than the 1980 CSO tables. Normally, a change to a life insur-

ance contract's guaranteed mortality charges is treated as a material change for tax purposes.²¹ While the IRS Notice does not speak directly to this point, it may not be correct to read it as voiding the section 101(j) grandfather in this instance, for to do so could seem to swallow the section 1035 exchange relief Congress provided in the transition rule.

OTHER GUIDANCE

In its 2007 request for guidance, the ACLI noted that significant uncertainty existed with respect to the application of section 101(j) to various traditional insurance arrangements. The IRS Notice responds by clarifying whether 101(j) applies in several circumstances. First, it states that a contract is an employer-owned life insurance contract only if it is owned by a person who engages in a trade or business, and not when it is owned by a person who does not engage in one.²² The IRS Notice gives the example of a life insurance contract owned by a qualified plan or VEBA that is sponsored by a business, and notes that such an arrangement is not subject to section 101(j).²³ Second, the IRS Notice states that a contract involved in a split-dollar arrangement can constitute an employer-owned life insurance contract, but any death benefits received under the contract that are paid to a family member or designated beneficiary of the insured are excluded from income due to section 101(j)(2)(B).²⁴ Finally, the IRS Notice provides that a life insurance contract owned by a partnership or sole proprietorship may still constitute an employer-owned life insurance contract, but not if the contract is owned by a sole proprietor and covers his or her own life.²⁵

In addition to the foregoing, the IRS Notice provides several other clarifications. First, it specifies that for purposes of section 101(j), the term “employee” is not limited to common law employees. Second, the IRS Notice provides that in order to qualify for the exception in section 101(j)(2)(B)(ii) that allows death benefits to remain tax free when they are used to purchase an equity (or capital or profits) interest in the employer (technically, the applicable policyholder) from family members or designated beneficiaries of the insured, the death benefits must be so used by the due date, including extensions, of the tax return for the taxable year in which the employer is treated as receiving them under the contract.²⁶

Although this guidance on the perennially thorny issue of material changes is quite helpful, some questions are bound to remain.

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The final item on which the IRS Notice provides guidance is the information reporting requirements of section 6039I, which was also added to the Code by the PPA, and Form 8925, which is the IRS form used to implement the reporting requirements. Section 6039I and Form 8925 require each applicable policyholder owning one or more employer-owned life insurance contracts issued after Aug. 17, 2006, to provide certain information to the IRS. The ACLI had inquired in its request for guidance whether multiple taxpayers could be required to file Form 8925 by reason of the same employer-owned life insurance contract, since an “applicable policyholder” could possibly include both owners of the contracts and other related parties. The IRS Notice responds by saying that only the applicable policyholder that owns one or more

employer-owned life insurance contracts is required to file the information return.²⁷

CONCLUSION

The IRS Notice responds to the concerns of the ACLI and others in the industry quite thoroughly, and should be commended. The correction mechanism for inadvertent failures to satisfy the notice and consent requirements is particularly favorable to taxpayers. Despite the thoroughness of the IRS Notice, however, no doubt other questions will arise in the future. In light of the comprehensive guidance provided under the Notice, such remaining questions likely can be answered adequately through the private letter ruling process. ◀

END NOTES

- ¹ All references to “section” are to sections of the Internal Revenue Code of 1986, as amended (the “Code”).
- ² Pub. L. No. 109-280, 120 Stat. 780 (2006).
- ³ See sections 267(b) and 707(b)(1).
- ⁴ See section 101(j)(2)(B). This includes an amount paid to purchase an equity (or capital or profits) interest in the applicable policyholder from the insured’s family members or certain others.
- ⁵ See section 101(j)(2)(A).
- ⁶ See section 101(j)(4).
- ⁷ See Q&A-13 of Notice 2009-48.
- ⁸ See Q&A-9 of Notice 2009-48.
- ⁹ See Q&A-10 of Notice 2009-48.
- ¹⁰ See Q&A-11 of Notice 2009-48; Treas. Reg. § 31.3402(f)(5)-1(c)(2).
- ¹¹ E-SIGN stands for the Electronic Signatures in Global and National Commerce Act, Pub. L. No. 106-229 (2004), which generally facilitates the use of electronic signatures in various instances where federal law requires a signature or communication to be “in writing.”
- ¹² See Q&A-7, -8, and -12 of Notice 2009-48, respectively.
- ¹³ See Q&A-4 of Notice 2009-48.
- ¹⁴ Pub. L. No. 109-280 § 863(d).
- ¹⁵ *Id.*
- ¹⁶ See S. Pt. No. 98-169, at 579 (1984) (discussing the treatment of exchanged contracts as new contracts for purposes of the effective date of section 7702).
- ¹⁷ See Q&A-15 of Notice 2009-48 (emphasis added).
- ¹⁸ See Staff of J. Comm. on Tax’n, 109th Cong., 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 August 3, 2006, at 212–13 (J. Comm. Print 2006).
- ¹⁹ See Q&A-14 of Notice 2009-48.
- ²⁰ See Q&A-16 of Notice 2009-48.
- ²¹ See, e.g., S. Pt. No. 98-169, at 579 (1984); H.R. Conf. Rep. No. 98-861, at 1076 (1984) (stating that the conference report follows the Senate report); Staff of J. Comm. on Tax’n, 98th Cong., General Explanation of the Revenue Provisions of the Deficit Reduction Act of 1984, at 656 (J. Comm. Print 1984).
- ²² See Q&A-1 of Notice 2009-48.
- ²³ However, a contract owned by a grantor trust, the assets of which are treated as assets of a grantor that is engaged in a trade or business, constitutes an employer-owned life insurance contract and is subject to section 101(j).
- ²⁴ See Q&A-2 of Notice 2009-48. The statement in the IRS Notice is true, of course, only if the statute’s notice and consent requirements are met.
- ²⁵ See Q&A-3 of Notice 2009-48.
- ²⁶ See Q&A-5 and -6 of Notice 2009-48, respectively.
- ²⁷ See Q&A-17 of Notice 2009-48.

PLR 200906001— A CONSERVATIVE TAXPAYER OR A VERY SUBTLE MESSAGE FROM THE IRS?

By Joseph F. McKeever, III and Daniela Stoia

Life insurance companies seek private letter rulings from the Internal Revenue Service (the “Service”) for various reasons. For example, they may seek private letter rulings where the law is unclear¹ or they may seek to extend the application of the law beyond established authorities by obtaining a private letter ruling that “pushes the envelope.”² Alternatively, insurers may seek a private letter ruling to level the playing field, *i.e.*, eliminate an advantage competitors may have gained by taking a questionable position. But, in contrast, it is unusual for insurers to seek a private letter ruling sanctioning a practice that seemingly is more conservative than both industry practice and the requirements of the Code. This, however, is what appears to have happened in PLR 200906001,³ released on Feb. 6, 2009.

PLR 200906001 (the “PLR”) addresses the “reasonable mortality charges” requirement of section 7702(c)(3)(B)(i). The PLR holds that life insurance contracts will not fail to satisfy the requirements of section 7702 or the 7-pay test of section 7702A(b) solely because a declaration of a discount to the current cost of insurance charges (“COIs” or “mortality charges”) or the crediting of a discount to the current COIs pursuant to the terms of a “Wellness Rider” is not treated as an “adjustment event” under section 7702(f)(7)(A) or a “material change” under section 7702A(c)(3), provided that the mortality charges used in the initial section 7702 and 7702A calculations reflect the anticipated, but nonguaranteed, mortality discount provided under the Wellness Rider. As discussed below, the law seems quite clear that such reductions need not be reflected in the initial calculations under these Code sections, nor do they give rise to an adjustment or a material change. As a result, this PLR has left the authors, and others, wondering whether there is more to the PLR than meets the eye. Before speculating on what the PLR means, however, some more background on the PLR is in order.

THE WELLNESS RIDER

The PLR addresses a Wellness Rider that an affiliated group of life insurance companies proposed to offer on a prospective basis with newly issued life insurance contracts. The contracts would be offered under both the “cash value accumulation test”⁴ and the “guideline premium test.”⁵ The



companies did not propose to make the Wellness Rider available on their existing life insurance contracts. As a result, it is likely that the life insurance contracts to be issued with the Wellness Rider would be subject to the 2001 Commissioners’ Standard Ordinary mortality tables (“2001 CSO” or “2001 CSO tables”).

The Wellness Rider provides, in relevant part, a discount on the current COI charges (the “COI Discount”) for individuals who periodically satisfy certain wellness qualification criteria (the “Wellness Rewards Benefit”). Specifically, in order to be eligible for the COI Discount under the Wellness Rewards Benefit, insureds must 1) complete a routine physical examination by a licensed physician, and 2) maintain a weight within a range established when the contract is issued as part of the initial underwriting process (the “Wellness Qualification Criteria”). If an insured satisfies the Wellness Qualification Criteria, then the contract covering the insured is allowed to participate in any COI Discount declared under the Wellness Rewards Benefit for the next two contract years.

It is quite clear from the facts described in the PLR that the COI Discount would not be guaranteed and that the mortality guarantees in the contracts issued with the Wellness Rider would not change by virtue of an insured satisfying the Wellness Qualification Criteria. In this regard, the PLR states that the companies expected the COI Discount to be declared annually, but that whether the COI Discount in fact would be provided was not guaranteed. Rather, the COI Discount would be set at the discretion of the companies, depending upon, for example, their future expectations of mortality and persistency for the cohort of insureds that satisfied and were expected to continue to satisfy the Wellness Qualification Criteria. If declared, the COI Discount would be applied to reduce the current mortality charges otherwise declared under the life insurance contracts issued with the Wellness Rider. However, even if a COI Discount was declared by the companies for a particular year, the discount (similar to the current mortality charges imposed under the contracts issued with the Wellness Rider) would not be guaranteed. In fact, the companies reserved the right to increase, reduce, or

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discontinue the COI Discount provided under the Wellness Rewards Benefit at any time.

For purposes of calculating the “guideline single premium”⁶ (the “GSP”), the “guideline level premium”⁷ (the “GLP”), the “net single premium”⁸ (the “NSP”), and the “7-pay premiums,”⁹ the companies proposed to reduce the COI charges otherwise taken into account under Notice 2006-95¹⁰ by the amount of the anticipated COI Discount (*i.e.*, the amount by which the anticipated current mortality charges exceed the anticipated discounted mortality charges for the pool of contracts expected to qualify for the Wellness Rewards Benefit based on the companies’ actuarial best estimates at contract issuance (the “Reduction Methodology”). Finally, the companies proposed not to treat the declaration of a discount to the current COIs or the crediting of a discount to the current COIs pursuant to the terms of the Wellness Rider as an adjustment event under section 7702(f)(7)(A) or a material change under section 7702A(c)(3).¹¹

THE SERVICE’S ANALYSIS

The Reasonable Mortality Charge Rule

In calculating the NSP, GSP, GLP and 7-pay premiums, life insurers must follow the reasonable mortality charge rule of section 7702(c)(3)(B)(i). Thus, those calculations must reflect “reasonable mortality charges which meet the requirements (if any) prescribed in regulations and which (except as provided in regulations) do not exceed the mortality charges specified in the prevailing commissioners’ standard tables (as defined in section 807(d)(5)) as of the time the contract is issued.”¹²

In addition, the Service has issued interim safe harbor guidance regarding the reasonable mortality charge rule, most recently in Notice 2006-95. In relevant part, Notice 2006-95

provides that a mortality charge will satisfy the requirements of section 7702(c)(3)(B)(i) if 1) the mortality charge does not exceed 100 percent of the applicable mortality charge set forth in the 2001 CSO tables; 2) the mortality charge does not exceed the mortality charge specified in the contract at issuance; and 3) either (a) the contract is issued after Dec. 31, 2008, or (b) the contract is issued before Jan. 1, 2009, in a state that permits or requires the use of the 2001 CSO tables at the time the contract is issued (the “2001 CSO Safe Harbor”).¹³ For the reasons noted above, the 2001 CSO Safe Harbor likely applies to the contracts to be issued with the Wellness Rider.

After reviewing the reasonable mortality charge rule and the safe harbors set forth in Notice 2006-95, the Service stated that the companies requesting the PLR could use 100 percent of the mortality charges specified in the applicable CSO mortality tables (*e.g.*, 100 percent of 2001 CSO) in their section 7702 and 7702A computations for contracts issued with the Wellness Rider, without taking into account the COI Discounts provided under the Wellness Rider. This statement is consistent with the 2001 CSO Safe Harbor and is not surprising because both the availability and the amount of the COI Discount under the Wellness Rider would be wholly within the companies’ discretion and would not be guaranteed or specified in the contracts with which the Wellness Rider would be issued. Thus, absent a mortality charge guarantee less than 2001 CSO,¹⁴ the companies would be free to reflect in their initial section 7702 and 7702A calculations mortality charges that do not exceed 100 percent of the applicable mortality charges set forth in the 2001 CSO tables.

Nevertheless, according to the facts of the PLR, the companies proposed to reflect in their initial section 7702 and 7702A calculations mortality charges determined by reducing 100 percent of the mortality charges specified in the applicable CSO mortality tables (*i.e.*, the mortality charges in fact guaranteed under the contracts to be issued with the Wellness Rider) by the amount of anticipated COI Discounts. The Service observed that the guaranteed rates would not exceed 100 percent of the applicable CSO table charges and then stated that the companies’ reflection of the reduced mortality charges complied with “the reasonable mortality charge requirement of § 7702(c)(3)(B)(i), as implemented by Notice 2006-95 and Notice 88-128.”

Adjustments and Material Changes

Section 7702(f)(7)(A) requires “proper adjustments in future determinations” made under section 7702 if “there is a change in the benefits under (or in other terms of) the

contract which was not reflected in any previous determination or adjustment made under [section 7702].” Similarly, section 7702A(c)(3)(A) provides that “[i]f there is a material change in the benefits under (or in other terms of) the contract which was not reflected in any previous determination under [section 7702A],” the contract must be treated as a newly issued contract as of the date of the change and appropriate adjustments must be made in determining whether the contract meets the 7-pay test to take into account the cash surrender value under the contract.

In the PLR, the Service further elaborated on the adjustment and material change rules by stating that *any* change in a mortality guarantee would be a change in the terms of a life insurance contract that gives rise to an adjustment event under section 7702(f)(7)(A) and a material change under section 7702A(c)(3)(A).¹⁵ However, the PLR then observes, as discussed above, that the declaration of a COI Discount pursuant to the Wellness Rider would not change the mortality guarantees under a contract. Thus, the Service stated, a periodic declaration by the companies over the life of a contract that results in the discounting of current mortality charges would not result in either an adjustment event under section 7702(f)(7)(A) or a material change under section 7702A(c)(3)(A).

Rulings

Based on the foregoing, the Service ruled as follows:

- 1) A contract designed to satisfy the cash value accumulation test, which is issued with the Wellness Rider, “will not fail to satisfy [that] test solely because” the companies do not perform an adjustment under section 7702(f)(7)(A) or treat the contract as a newly issued contract each time the companies declare or credit a COI Discount due to the contract holder’s satisfaction of the Wellness Qualification Criteria, provided that the companies use the Reduction Methodology upon contract issuance in calculating the NSP.
- 2) A contract designed to satisfy the guideline premium test, which is issued with the Wellness Rider, “will not fail to satisfy the guideline premium limitation solely because” the companies do not perform an adjustment under section 7702(f)(7)(A) or treat the contract as a newly issued contract each time the companies declare or credit a COI Discount due to the contract holder’s satisfaction of the Wellness Qualification Criteria, provided that the companies use the Reduction Methodology upon contract issuance in calculating the GSP and GLP.
- 3) A contract issued with the Wellness Rider “will not fail to satisfy the 7-pay test set forth in § 7702A(b) solely because” the companies do not treat the contract as having undergone a material change within the meaning of section 7702A(c)(3) or otherwise as a newly issued or entered into contract each time the companies declare or credit a COI Discount due to the contract holder’s satisfaction of the Wellness Qualification Criteria, provided that the companies use the Reduction Methodology upon contract issuance in calculating the 7-pay premiums.

SO WHAT IS GOING ON HERE?

Perhaps what is most intriguing about this PLR is why the companies requested it in the first instance. Based on the facts as set forth in the PLR, there do not appear to have been any issues relating to whether the declaration of the COI Discounts could be characterized as giving rise to guarantees that reduced the otherwise applicable mortality guarantees under the contracts issued with the Wellness Rider. As a result, it is unclear why the companies proposed to adopt the Reduction Methodology in their calculations of the NSP, GSP, GLP, and 7-pay premiums. It is equally unclear why the companies were concerned that the declaration of the COI Discounts could give rise to adjustment events under section 7702(f)(7)(A) and material changes under section 7702A(c)(3)(A).

In considering the reasons the companies may have had for seeking the PLR, two possibilities come to mind. First, the Wellness Rider is somewhat novel and the companies may have wanted comfort from the Service that this novel benefit did not present any section 7702 or 7702A compliance issues. Even though the companies apparently requested rulings only on the issues discussed above, insurers sometimes use the ruling process as a means of identifying other issues that the Service may believe exist. Second, because similar benefits seem to be gaining in popularity in the industry, the companies may have concluded that having a PLR on the treatment of the benefit under sections 7702 and 7702A would provide a marketing advantage vis à vis their competitors. Neither of these two possibilities explain, however, why the companies would adopt such a conservative position.

This leads one to wonder whether the companies did not originally propose to perform their calculations in the manner

Perhaps what is most intriguing about this PLR is why the companies requested it in the first instance.

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described in the PLR. Perhaps the companies requested rulings that 1) they did not need to take the anticipated mortality discount into account at issue, and 2) they did not need to treat the granting of the discount as an adjustment event or material change, but decided to change their proposal based on discussions with the Service. This is mere speculation on the authors' part, but it is not unusual for insurers to modify PLR requests based on Service feedback.

In this regard, while the rulings in the PLR seem more conservative than necessary under the 2001 CSO Safe Harbor, they do appear to reflect the philosophy embodied in the interim rule for reasonable mortality charges that accompanied the enactment of the reasonable mortality charge rule in the Technical and Miscellaneous Revenue Act of 1988 ("TAMRA").¹⁶ The interim rule applies prior to the issuance of final regulations and states that section 7702(c)(3)(B)(i) will be deemed to be satisfied by "mortality charges which do not differ materially from the charges actually expected to be imposed by the company (taking into

account any relevant characteristic of the insured of which the company is aware)."¹⁷ What is puzzling is what applicability the TAMRA interim rule would have in light of the existence of the safe harbors set forth in Notice 2006-95.

CONCLUSION

It will be interesting to see what further statements, if any, the Service makes on the issues involved in the PLR. Pending additional guidance, however, it would seem that other insurers offering such non-guaranteed mortality charge discounts should not be constrained by the practices reflected in the PLR. Specifically, absent a mortality charge guarantee less than 2001 CSO, insurers should be free to reflect in their initial section 7702 and 7702A calculations mortality charges that do not exceed 100 percent of the applicable mortality charges set forth in the 2001 CSO tables. Likewise, again assuming that any wellness type discount provided to a policyholder is not guaranteed, insurers should not need to treat the temporary provision of such a benefit, *e.g.*, for one year, as an adjustment event or a material change. ◀

END NOTES

- ¹ See, *e.g.*, PLR 9519023 (Feb. 8, 1995); PLR 9513015 (Dec. 30, 1994). In both of these private letter rulings the Service concluded that term rider coverage on the insured generally should be viewed as a qualified additional benefit (or "QAB") under section 7702, but as a death benefit and not a QAB under section 7702A(b). Unless otherwise indicated, all references to "section" are to sections of the Internal Revenue Code of 1986, as amended (the "Code").
- ² See, *e.g.*, PLR 9741046 (July 16, 1997) (concluding that if a term rider on the primary insured continues until age 95 or later, then it is treated as a death benefit under both sections 7702 and 7702A).
- ³ Oct. 17, 2008. A private letter ruling is issued to a particular taxpayer and can be relied upon only by that taxpayer. See section 6110(k)(3). However, given the paucity of published guidance under sections 7702 and 7702A, insurers and their advisors tend to study private letter rulings issued under these sections in the same manner CIA analysts used to study photographs of the way the Kremlin leadership arranged itself on the May Day parade reviewing stand in the 1950s.
- ⁴ See section 7702(a)(1) and (b) (setting forth the requirements of the "cash value accumulation test").
- ⁵ In order for a life insurance contract that is treated as such under state law to satisfy the "guideline premium test" it must both meet the "guideline premium requirements" set forth in section 7702(a)(2)(A) and (c) and fall within the "cash value corridor" of section 7702(a)(2)(B) and (d).
- ⁶ See section 7702(c)(3) (defining the "guideline single premium").
- ⁷ See section 7702(c)(4) (defining the "guideline level premium").
- ⁸ See section 7702(b)(1) and (2) (describing the "net single premium").
- ⁹ See section 7702A(b) and (c) (describing the "7-pay test" and the "7 level annual premiums," referred to herein as "7-pay premiums").
- ¹⁰ 2006-2 C.B. 848, supplementing Notice 88-128, 1988-2 C.B. 540, and modifying and superseding Notice 2004-61, 2004-2 C.B. 596.
- ¹¹ The companies also proposed to treat the Wellness Rider under section 7702(f)(5)(C) as an "additional benefit which is not a qualified additional benefit." Thus, the companies proposed not to reflect the charges imposed for the Wellness Rider in calculating the GSP, GLP, NSP, and 7-pay premiums.
- ¹² In 1991, the Service issued proposed regulations regarding the reasonable mortality charge rule, although such regulations have not been finalized and thus are not effective. See Prop. Treas. Reg. § 1.7702-1(a)-(c).
- ¹³ See Notice 2006-95 section 4.03.
- ¹⁴ The PLR states "[t]he current mortality charges against which the COI discount will be applied will also not be guaranteed or specified in such contracts."
- ¹⁵ Cf. PLR 199929028 (Apr. 27, 1999) (holding that temporary guarantees for up to one year are properly treated as dividends rather than as changes in the benefits under (or in other terms of) a contract that should be treated as adjustment events under section 7702(f)(7)(A); CHRISTIAN J. DESROCHERS, JOHN T. ADNEY, DOUGLAS N. HERTZ & BRIAN G. KING, LIFE INSURANCE & MODIFIED ENDOWMENTS: UNDER INTERNAL REVENUE CODE SECTIONS 7702 AND 7702A, 94 (1st ed. 2004) (stating that "[t]emporary guarantees for up to one year are properly treated as dividends; longer guarantees may be dividends, but at some unspecified point the character of a temporary guarantee would change and an adjustment event or deemed exchange would occur").
- ¹⁶ Pub. L. No. 100-647.
- ¹⁷ TAMRA section 5011(c)(2).

HAPPY 25TH ANNIVERSARY DEFRA— A RETROSPECTIVE

In 1984, Congress enacted the Deficit Reduction Act of 1984 known as DEFRA. This legislation greatly altered the tax landscape of insurance companies and their products. Now with the 25th anniversary of DEFRA upon us, the editorial board of *TAXING TIMES* in conjunction with the SOA Taxation Section Council felt this was a good opportunity to have a look back at the DEFRA legislation. Going back to several of the active participants who were involved in the creation of the legislation and providing them with some questions to help with their reflection, we asked for their thoughts on what occurred 25 years ago, the impact it had on our industry and the things that could have been done differently. Their thoughts are compiled in this article. This retrospective from the key players that were there 25 years ago should provide the readers of *TAXING TIMES* with an extremely interesting perspective on this important piece of tax legislation.

GENERAL OBSERVATIONS

The 1984 legislation that revised life insurance taxation was part of a Deficit Reduction Act (DEFRA 1984), which as its name implied was intended to reduce the deficit. It followed two-year temporary legislation (TEFRA 1982). If DEFRA 1984 had not been enacted, life insurance companies would have been taxed under laws enacted in 1959, and as a result, life insurance company taxes would have been greater if Congress had not enacted this legislation. The legislation was initially adopted by a subcommittee of the Ways and Means Committee chaired by Democrat Pete Stark and senior minority member Henson Moore. This legislation was notable in several respects. The legislative process involved two major hearings and numerous staff meetings with tax committee staff and Congressmen Stark and Moore. The procedure was judicious and Congressional fund-raising was prodigious. In several respects, the legislation was an improvement over the 1959 Act. It eliminated a three-phase system for life insurance companies and taxed stock life insurance companies on their corporate earnings without deductions for noneconomic expenditures.

—Theodore Groom, principal, Groom Law Group

As I think about it, my view of what happened with the enactment of the Deficit Reduction Act of 1984 (the 1984 Act) may



be somewhat different than that of other government staff who worked on the legislation. Unlike most of the others, I came to the task with more than six years technical tax experience in the Interpretative Division of the IRS Chief Counsel's Office, specializing in the taxation of insurance companies and their products. Also, unlike most of the government staff assigned to the Stark-Moore life insurance project, I have continued with the same technical tax specialty for the last 25 years. So, my first response to the editorial board's statement that the 1984 Act "greatly altered the tax landscape" for life insurance companies and their products is, at least with respect to company taxation: "Not so much."

—Susan Hotine, partner, Scribner, Hall & Thompson, LLP

Given the perspective of time, 25 years since the enactment of DEFRA, if there was an opportunity for one "do-over" concerning this legislation, what would it be? Why?

I believe that if we did anything wrong, it was that the reserve methodology was too formulaic and dependent on the NAIC standards. I recall someone once told me, "One mistake that we made in the 1984 Act was that we assumed you actuaries know how to compute reserves." In retrospect, particularly given the issues surrounding principle-based reserves, we may have been better off following more like the PC approach to reserves, which provides more flexibility on assumptions. In the context of the times, there was a strongly held view in the government that life reserves were far too conservative. As a result, the use of the state-mandated minimum standards seemed to be a reasonable approach. However, the limitation on the reserve method as of the issue date of a contract may be overly restrictive and does not appear to have a strong tax policy justification. Removing that limitation would provide some needed flexibility today, particularly as the industry faces the transition to principle-based reserves.

—Christian DesRochers, senior managing director, SMART Business Advisory and Consulting, LLC

Probably, the single largest error of the 1984 legislation was the imposition of an additional tax on mutual life insurance companies on imputed corporate earnings under section 809.

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Not only did section 809 excessively tax mutual companies, but it did so in a way that provided an incentive for mutual companies to reduce capital and surplus. It was clear within three to five years after its enactment that section 809 was seriously flawed, and while section 809 was eventually repealed, it took about 20 years to do so. In the meantime, 20 of the largest mutual companies demutualized.

The limitation of reserve deductions based on a new and arbitrary federal standard was a mistake also as it provided an incentive for companies to reduce reserves to conform to the tax reserve standard. The use of mechanical rules to limit cash rich life insurance and other financial products made it more difficult for consumers to save and created a system that has been cumbersome to administer. Finally, the later enactment of the DAC tax had its origin in the stock-mutual wars of 1984 and its aftermath.

—Theodore Groom, principal, Groom Law Group

For those of us who worked with and are familiar with the 1959 Act, the 1984 Act simplified the structure for taxing life insurance companies by eliminating the Phase I taxable investment base and cutting off the Phase III policyholder surplus account, but resulted in a single-tax base for life insurance companies conceptually modeled on the Phase II gain from operations base. Coming to the legislative process from the technical tax administrative perspective, my personal goal (perhaps not communicated to the rest of the staff) was to resolve as many technical tax issues as possible. One such issue was the question of whether a life insurance reserve had to be “properly computed” in order for the company to get the tax benefit of the reserve. I went to some lengths to have the 1984 Act clarify that proper computation was not a prerequisite for deducting life insurance reserves; that is, the company is entitled to a reserve deduction based on the federally prescribed rules whether or not such reserve is properly computed on the annual statement or the tax return. Thus, the legislative history explains that the issue of proper computation only applies in the context of statutory reserves used for the life company qualification fraction. If I had one “do-over,” I would have recommended that we change the statute to provide that proper computation is not necessary for qualification either; rather, the numerator of the qualification fraction should have been amended to include any statutory amounts held for unaccrued liabilities that reasonably can be computed or estimated based on an assumed interest rate and

mortality and morbidity tables (regardless of whether they are so computed on the annual statement).

—Susan Hotine, partner, Scribner, Hall & Thompson, LLP

Overall DEFRA was an excellent outcome given the difficulty of the task. In my opinion, section 809 had the biggest flaws, primary the socialized nature of the calculation of the differential earnings rate and the establishment of the starting pegged rate (16.5 percent) at the wrong level. This is of course a stock company perspective – no doubt the mutual company perspective is that the entire concept was flawed.

—John Palmer, vice chairman, Ohio National Financial

What was the biggest hurdle that the life insurance industry faced in light of the legislative activity taking place back in 1984? How did the industry respond to this hurdle?

The 1984 Act was clearly revenue-driven. As a result of the use of reinsurance under section 820, as well as the effects of the approximate reserve revaluation under section 818(c), there was a widely held, and largely accurate, view that the life insurance industry was lightly taxed in the early 1980s, based both on the absolute amount of tax revenue as well as the industry effective tax rates. Combined with the disagreements between the stock and mutual segments of the industry, Congress set goals not only for industry, but also for “segment balance,” the amount paid by stocks and mutuals. The industry response was to engage the Congress in conversations about revenue, and the effects of various proposals, which carried forth for a number of years after the 1984 Act.

—Christian DesRochers, senior managing director, SMART Business Advisory and Consulting, LLC

The biggest hurdle the industry faced during the enactment process for the 1984 Act was a self-inflicted handicap: We were hopelessly divided over the taxation of mutual life insurers. Stock companies insisted that there must be a special provision increasing mutual company income tax to reflect the fact that mutuals would otherwise recognize no ownership profits in their tax reporting. Mutuals, naturally, resisted. The resulting fight had spillover effects everywhere, including the definition of life insurance, the reserves allowed in income measurement and proration.

The sad fact is that with 20-20 hindsight we can see the industry divide was unnecessary. Section 809 was enacted, but, if I

recall correctly, it raised a noticeable amount of revenue in only two or three years of its 20-year history. The insignificant impact of section 809 proved to be no barrier to the stocks' survival and success. Some mutuals have remained mutual and continue to thrive, but I doubt that anyone today believes the stock side of the industry needs (or needed back then, based on the historical evidence) any special protection in the tax law. I can't view this as a "do-over" because no one back then knew for sure what we know now from the result of the section 809 experiment. The fight was a great boost to some career paths on both sides, but the industry effect was a pure negative. In the early eighties we just couldn't see any way to avoid an ultimately pointless, but costly, fight.

— Doug Hertz, senior manager & actuary,
SMART Business Advisory and Consulting, LLC

The biggest hurdle that the life industry faced in the legislative process 25 years ago was the very first version of the Stark-Moore proposal that would have imposed a company tax structure that resulted in cash value life insurance products essentially being taxed as term insurance plus a deposit (that is the way Congressman Pete Stark, ex-banker, looked at it). The next biggest legislative problem for the industry was itself and the ever ongoing stock-mutual battle. The industry managed to avoid the original Stark-Moore proposal which would have been an indirect tax on product inside buildup, but the industry did get tax rules reducing deductions and limiting company flexibility for life insurance reserve computations, as well as tax definitional rules that restricted the inside build-up of life insurance contracts¹ and the deferral benefit afforded to annuity contracts.

— Susan Hotine, partner, Scribner, Hall & Thompson, LLP

There were two major hurdles. The first was the extraordinarily complex technical nature of the issues, both company and policyholder; the second was the stock/mutual split in the industry. With respect to the first, the industry certainly made comprehensive and unrelenting efforts to deal with the issues, but success really depended on the truly admirable efforts of Treasury and Congressional staffs to understand and deal intelligently with these arcane issues. With respect to the second, while the industry never surmounted the split a generally fair compromise outcome was achieved.

— John Palmer, vice chairman, Ohio National Financial

DEFRA instituted a number of changes and accomplished a number of objectives. From your perspective, did DEFRA fully accomplish its tax policy purpose? Are there additional legislative changes still needed?

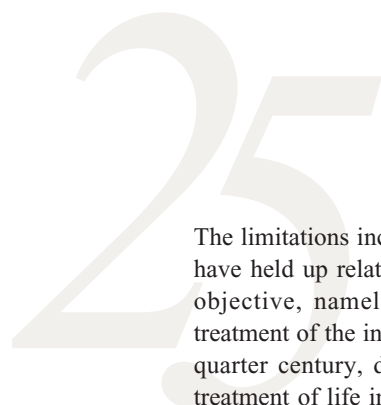
DEFRA's revision of the life insurance tax rules accomplished the goals of placing all life insurers on a "total income" tax base while generally simplifying the rules of part I of subchapter L. Some complexity remains, of course, but some is necessary in undertaking the annual measurement of the net income of life insurers, which are numbered among the world's most complex institutions. Over the past 25 years, interestingly, two of the more complicated features of the 1984 Act have fallen away: the section 809 limit on mutual companies' dividend deductions has been repealed, and the section 815 "phase III" tax on stock companies carried over from the 1959 Act has been suspended into oblivion. In fact, only one other left-over from the 1959 Act era, the section 1503(c) limits on life-nonlife consolidation, represents legislative business unfinished from the 1984 revision. As my partners and I argued in our 2001 article, "The Taxes on Starlight: A Case for the Repeal of Sections 809, 815, and 1503(c) of the Internal Revenue Code" (20 *Insurance Tax Review* 31), those limits were imposed in reaction to the three-phase tax base that applied to companies prior to 1984 and that DEFRA replaced with the current formula. Sound tax policy warrants their repeal.

— John Adney, partner,
Davis & Harman

Overall, DEFRA was well-constructed from a technical perspective. Some of this can be attributed to significant industry input, as well as the willingness of Congressional staff at the time to give serious consideration to input from the industry. With respect to life company tax, the 1984 Act was considerably simpler than the three-phase system of the 1959 Act that it replaced. With the 1984 Act, the taxation of life insurance companies was more consistent with corporations generally, with the obvious exception of the reserve deduction, which is a distinguishing characteristic of insurance taxation. The subsequent changes in 1986, to change the reserve interest rates, as well as the addition of the DAC in 1990 were arguably more about raising revenue than correcting any shortcomings in the original 1984 legislation.

The industry managed to avoid the original Stark-Moore proposal which would have been an indirect tax on product inside buildup. ...

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The limitations included in the definition of life insurance have held up relatively well for 25 years. The key policy objective, namely preservation of the traditional tax treatment of the inside buildup, has held up during the last quarter century, despite some efforts to modify the tax treatment of life insurance generally. However, one could argue that the failure to index the interest rates in the definitional limitations was shortsighted. While the rates appeared to be very conservative given prevailing interest rates in the early 1980s, the industry might have been better served by an indexed interest rate, perhaps tied to the reserve or nonforfeiture rates.

— *Christian DesRochers, senior managing director, SMART Business Advisory and Consulting, LLC*

Even though no tax (or other) law is entirely satisfactory, DEFRA did an admirable job of establishing a stable tax regime in the areas it addressed. The large number and significance of company tax issues of the previous two decades largely vanished, and the opportunities for manipulation were greatly reduced. The policyholder tax structure has set a principle-based limit on possible investment orientation that has functioned with no meaningful abuse in the past 25 years. It did leave a significant number of ambiguities and provided much opportunity for controversy, but however they are resolved they do not generally have any meaningful effect on a contract's investment orientation.

— *John Palmer, vice chairman, Ohio National Financial*

The worldwide movement toward fair value and principle-based reserves is a move to a more “active” valuation system. ...

There remain a number of interpretive questions that have not been conclusively addressed by the Service, yet there have been 25 years of well-established company practice that implicitly answer these questions. Do any of these questions still need to be answered or is it sufficient to let the current state of play continue?

The fundamental issue that may increasingly cause difficulties between the Service and the industry is that of the appropriate tax reserves. Reserves affect both the balance sheet and the income statement. Historically, both statutory and tax reserves have been based on a “passive” reserve methodology in which reserve assumptions are set at issue and are generally unchanged over the life of the policies.

In the past, this has satisfied both regulatory solvency concerns and allowed for an emergence of taxable income which is relatively stable year by year. The worldwide movement toward fair value and principle-based reserves is a move to a more “active” valuation system, which, as discussions between the industry and the government over VACARVM have shown, is becoming increasingly difficult for the Service to deal with, particularly given the historical application of a less volatile passive reserve system. It is still a matter of debate as to what “authority” Congress actually placed on the NAIC to set reserve methodologies. That debate is likely to continue.

— *Christian DesRochers, senior managing director, SMART Business Advisory and Consulting, LLC*

The 1984 legislation reflected a serious effort by the Congress to get it right, and the failures to completely do so show how difficult the tax legislative process is in a political context where members are understandably more concerned with constituent company interests than with neutral, fair and economic concepts of taxing income. All the more reason that companies should be reluctant to revisit the legislative process in the current environment.

— *Theodore Groom, principal, Groom Law Group*

The tax policies of retaining the benefit of inside buildup for the policyholder, as well as simplifying the tax structure for life insurance companies and making it more like that used for general corporations, were accomplished. Also, the narrower tax policy of leveling the playing field between high-surplus and low-surplus companies was accomplished by prescribing rules for computing life insurance reserves for tax purposes. I thought that the legislative history of the 1984 Act set forth fairly comprehensive explanations of the provisions and made the tax policy adopted by Congress pretty clear. In fact, a large number of the audit and litigating issues of prior law were eliminated under the 1984 Act, greatly reducing the number of subchapter L disputes. The question of whether additional changes are needed, at this point is more a question of whether the operative tax policy has or should be changed. As a general observation, I would say that many “unanswered” interpretative questions seem to arise today because the questioner merely disagrees with (and refuses to acknowledge) the tax policy underlying the applicable Code provision in arriving at the answer to the question.

— *Susan Hotine, partner, Scribner, Hall & Thompson, LLP*

There is no pragmatic reason to do so. As noted above, the overall goal of the original legislation has been achieved: Company tax manipulative possibilities have been mostly eliminated and investment orientation of insurance products has been tightly circumscribed. Further specificity will tend to conflict in minor ways with well-established practices, the correction of which will create labor, confusion and expense to no useful end.

— John Palmer, vice chairman, Ohio National Financial

Oftentimes it helps to look back before looking forward. That was the intent of this retrospective. The opinions of several of the players present for the 1984 Act, offer an interesting perspective on the legislation, its successes and its shortcomings. Although they differ in some of their opinions, many of the observations hold common themes—the futility of the Stock/Mutual fight, the simplification in eliminating the

three-phase system for taxing life insurance companies which existed under the 1959 Act.

Looking forward ... we are currently faced with a growing deficit, economic turmoil and an Administration looking for ways to generate revenue to support their spending. Insurance companies and their products are not immune to new tax initiatives. Hopefully, this insight from the past better prepares us going forward. At the very least, it sets us to thinking about tax legislation aimed at our industry. ◀

END NOTES

¹ I also recognize that some in the industry favored having a definition of a life insurance contract as a means to assure the treatment of universal life as whole life insurance.

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COMMON MYTHS IN INTERPRETING THE COMPANY TAX PROVISIONS OF THE 1984 ACT

By Peter H. Winslow

When I joined our law firm in 1979 to specialize in insurance taxation, the Life Insurance Company Income Act of 1959 was already 20 years old and seemed well-entrenched. Many participants in the drafting of the 1959 Act were still around and there was a detailed legislative history that made interpretation of the basic structure and purpose of the statutory provisions relatively straightforward. Yes, the three-phase system was complex and, yes, there was a lot of litigation. But, Congress' underlying tax policy was not really in dispute particularly after 1961 when comprehensive regulations were promulgated with extensive industry input and comments.

I cannot say the same thing about the Tax Reform Act of 1984. It is now 25 years old and we seem to be debating fundamental principles about what Congress had in mind and what the statute really says. There are a few of us still around who were there at the 1984 Act genesis. We think we know what was intended and are frequently frustrated by revisionist interpretations. So, as my contribution to the 25th anniversary of the 1984 Act, here are some common myths about Congress' tax policy underlying the 1984 Act that I would like to debunk.

MYTH 1 – IN THE 1984 ACT, CONGRESS ENACTED A COMPLETELY NEW TAX REGIME FOR LIFE INSURANCE COMPANIES.

NOT TRUE.

By the early 1980s, the 1959 Act's three-phase system had become broken. The Menge Formula incorporated into taxable investment income (Phase I) was out-of-date and the phase system could be gamed to reduce tax liability, particularly with reinsurance. So, Congress wanted to eliminate the primary source of the problem—the three-phase system—in favor of a single phase based on gain from operations. If we were to compare the 1984 Act gain from operations with its predecessor in the 1959 Act, there is remarkably little difference. The changes made basically fall within three categories: 1) special deductions were eliminated as part of the repeal of Phase III; 2) life

insurance reserves went from a net level premium basis to a preliminary term basis through the repeal of former section 818(c) and the adoption of section 807(d); and 3) simplification and clarification changes were made in an attempt to avoid much of the litigation that had occurred under the 1959 Act. Thus, for example, the definition of net investment income was simplified for proration in section 812 and premium recognition was placed on an accrual basis (thereby eliminating recognition of deferred and uncollected premiums). So, when we look at gain from operations in the 1984 Act, we are really just seeing a stream-lined version of the 1959 Act. That is why the legislative history tells us in effect: In reading the 1984 Act, do not try to reinvent the wheel; if the 1984 Act did not make a specific change, you should just go back to the 1959 Act for guidance. The basic point here is that most of the statutory provisions under the 1984 Act are carried over from the 1959 Act and the original well-established tax policy underlying those provisions did not change.

MYTH 2 – CONGRESS' PRIMARY GOAL IN THE 1984 ACT WAS TO RAISE REVENUE.

NOT TRUE.

The late 1970s and early 1980s were a period of great change in the life insurance industry. The advancements in computer technology gave insurers the ability to unbundle their contracts and make mortality charges and interest credits transparent. Universal life was born and policyholders were given flexibility within the contract to determine the level of premiums they would pay and the amount of death benefits they desired. The popularity of universal life, which credited excess interest and adjusted mortality charges for favorable experience, prompted stock companies to issue contracts that had many of the same economic benefits of participating whole life insurance issued by mutual companies. Mutual companies responded by offering their own universal life contracts so that their products would have the unbundled transparency that the marketplace was demanding.

The convergence of product offerings, coupled with a broken and out-of-date three-phase tax system, called for a legislative solution. How should the tax law be changed to ensure a level playing field in light of the rapidly changing and converging marketplace? Mutual and stock companies disagreed bitterly for many years whether the 1984 Act achieved its goal of fairness among segments of the industry and, thankfully, the repeal of section 809 has put an end to that corrosive debate. But, in interpreting the 1984 Act, the fundamental point to remember is that the changes in law were primarily driven by a Congressional desire to provide a level playing field among segments of the industry.

MYTH 3 – BY THE ENACTMENT OF SECTION 807(d), CONGRESS INTENDED THAT LIFE INSURANCE COMPANIES WOULD BE ALLOWED A DEDUCTION FOR THE SMALLEST AMOUNT OF LIFE INSURANCE RESERVES PERMITTED BY STATE REGULATORS.

NOT TRUE.

Congress did intend that the deduction for life insurance reserves would be reduced under the 1984 Act. In the 1959 Act, statutory reserves were the basis of computing the deductions for life insurance reserves. These could be determined on a net level premium basis and, if they were not, section 818(c) permitted an election to convert preliminary term reserves to net level premium reserves either exactly or by a crude, and sometimes overly generous, formula. In the 1984 Act, Congress changed this by limiting all companies to preliminary term reserves (CRVM) regardless of the statutory reserve method used.

Once this basic change was made, the driving force behind most of the other adjustments to life insurance reserves in the 1984 Act was a desire for a level playing field. Thus, mortality tables and interest rates were to be the same for all companies by reference to a 26-state rule and the reserve method would be determined by the National Association of Insurance Commissioners (NAIC) regardless of whether

a particular state permitted smaller or higher reserves. These uniform reserve standards were adopted recognizing that the minimum reserve levels required by the majority of states and the NAIC were conservative. It was not until 1987 that Congress attempted to address the conservatism in tax reserves and, then, only in one factor – the assumed discount rate.

MYTH 4 – STATUTORY RESERVES HAVE LITTLE RELEVANCE IN COMPUTING TAX RESERVES UNDER THE 1984 ACT.

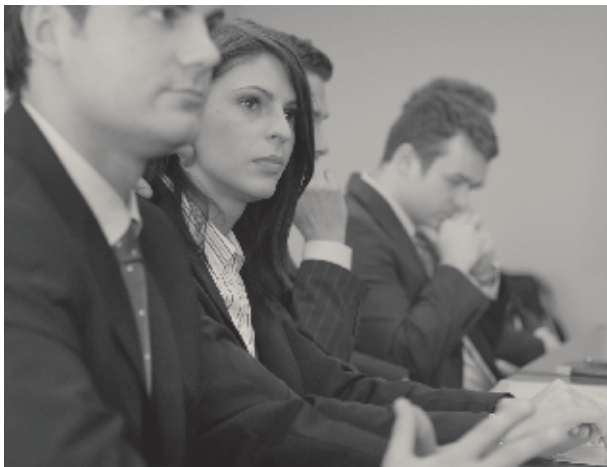
NOT TRUE.

Life insurance company tax practitioners generally know that, under the 1984 Act, statutory reserves are still important in determining life insurance company qualification, the cap on deductible insurance reserves, certain reserves for supplemental benefits and several non-life insurance reserves under section 807(c). But, the importance of statutory reserve assumptions in federally prescribed reserves is often overlooked. Although NAIC actuarial guidelines have provided greater uniformity in interpretations of CRVM and CARVM, much uncertainty and divergence of practices remain. State regulators frequently permit actuaries the flexibility to adopt one of several permissible interpretations. In these circumstances, the legislative history says that the assumptions used for statutory reserves should govern for tax purposes. So, despite Congress' goal for a level playing field, the amount of tax reserves can differ between companies depending on their statutory reserve assumptions.

Where there are several permissible interpretations of CRVM or CARVM, the 1984 Act sometimes has been misinterpreted to require the lowest reserve assumption permitted by 26 states. This is not what the 1984 Act

The convergence of product offerings, coupled with a broken and out-of-date three-phase tax system, called for a legislative solution.

CONTINUED ON PAGE 52



provides. The legislative history says that if the NAIC has not prescribed a specific interpretation of CRVM or CARVM, then the interpretation of 26 states will govern before resorting to the assumptions made for statutory reserves. The apparent rationale for this legislative history is that, where 26 states have adopted a specific interpretation, the NAIC tacitly has adopted a rule by the actions of a majority of its members. The legislative history does not suggest that a single 26-state interpretation has been adopted where a majority of states permit several permissible interpretations one of which may consistently yield lower reserves. In such cases, the permissible assumption used for statutory reserves properly governs even if it yields higher reserves, just as it would if the NAIC were to issue a guideline that permits several interpretations of CRVM or CARVM. The 1984 Act only requires tax reserves to be the lowest reserve permissible by 26 states when the NAIC specifies that method or when 26 states specify that method as the only proper interpretation of CRVM or CARVM.

MYTH 5 – FOR PURPOSES OF THE STATUTORY CAP, STATUTORY RESERVES ARE LIMITED TO SECTION 807(c) RESERVES.

NOT TRUE.

Under the 1984 Act, statutory reserves as defined in what is now section 807(d)(6) served two functions. The excess of statutory reserves over tax reserves served to increase a mutual company's equity base, and thereby taxable income, in the now-repealed "add-on tax" imposed by section 809.

Statutory reserves also served—and continue to serve—as a limitation on the amount of deductible tax reserves. For these purposes, statutory reserves were defined broadly to include all reserves reported on the annual statement "with respect to" reserve items described in section 807(c). This definition incorporates two important concepts. On the one hand, the reserves do not have to qualify as section 807(c) insurance reserves to be included in statutory reserves, but, on the other hand, there must be a factual nexus between the reserve and an insurance reserve described in section 807(c). This "with respect to" wording of the statute was intentional and served the tax policy goals underlying both sections 809 and 807. For the "add-on" tax, the equity base started with statutory surplus and capital and was increased by, among other items, any excess of statutory reserves over tax reserves. Congress was concerned that mutual companies would artificially reduce their equity base by reporting a portion of what otherwise could be section 807(c) reserve items as some other type of liability on the annual statement. The broader "with respect to" language ensured that all reserves for the contract would be taken into account to the extent they exceeded reserves described in section 807(c), wherever they appeared on the annual statement.

For the statutory reserve cap, a broad definition of statutory reserves served the tax policy objective of a level playing field. Congress' goal was that all life companies obtain comparable tax reserve deductions for the same products, but only if the company did not hold smaller reserves on its annual statement. But, to prevent an unfair result, statutory reserves were broadly defined so that the cap would come into play only where the company does not have sufficient reserves on the annual statement for the contract wherever those reserves might be reported.

A good example of the practical effect of Congress' tax policy is the treatment of deficiency reserves. Although deficiency reserves were not deductible under the 1959 Act, an actual disallowance was rare. The reason was that statutory reserve interest rate and mortality assumptions could be adjusted to increase basic deductible reserves and eliminate the need for deficiency reserves. The 1984 Act eliminates this tax planning opportunity when dealing with the statutory reserve cap. The level-playing-field objective is served by including deficiency reserves within the statutory reserve cap whether or not a company

adjusts statutory reserve assumptions to avoid deficiency reserves. Because deficiency reserves are part of basic CRVM reserves as defined in the Standard Valuation Law by the NAIC, they are reserves held “with respect to” section 807(c)(1) life insurance reserves and included in statutory reserves. The legislative history reconfirms that Congress intended deficiency reserves to be included in statutory reserves for purposes of the statutory reserves cap.

MYTH 6 – NAIC ACTUARIAL GUIDELINES HAVE NO RETROACTIVE EFFECT.

NOT TRUE.

Section 807(d) provides that life insurance reserves generally are required to be computed using the tax reserve method prescribed by the NAIC as of the date the contract was issued. Because of this basic rule, it is frequently asserted that actuarial guidelines have no retroactive effect on contracts issued prior to the actual date the guideline is adopted. But, this assertion is almost always wrong, which is why life insurance companies are currently challenging this position in litigation.

It is true that an actuarial guideline adopted in a year after a contract is issued may not represent the NAIC’s express interpretation of CRVM or CARVM prior to its adoption. However, an actuarial guideline may represent one of several permissible interpretations of the Standard Valuation Law even before it is adopted by the NAIC. And, rarely does an actuarial guideline overrule a single interpretation of CRVM or CARVM previously adopted by 26 states. In these circumstances, where an actuarial guideline represents one of several permissible interpretations of the Standard Valuation Law at the time the contract was issued, as a practical matter, it becomes the method that should be used for tax purposes. At such time, the basic rule that statutory reserve assumptions must be followed takes over because at the time the contract was issued there was no definitive NAIC or 26-state interpretation.

So, as a general rule, almost every actuarial guideline has retroactive effect when statutory reserves are changed to comply with the guideline (subject, of course, to the possible application of the ten-year spread rule of section 807(f)). A notable exception from this general rule will be Actuarial Guideline 43 which supersedes two previous guidelines.

For variable annuity contracts issued prior to the adoption of Actuarial Guideline 43, the NAIC had prescribed Actuarial Guidelines 34 and 39 which should continue to apply to previously-issued contracts.

CONCLUSION

There was a great deal of litigation over the complex provisions of the 1959 Act. These disputes rarely involved a disagreement about Congress’ tax policy, but instead usually concerned whether a particular item met the Code’s technical definition. The 1984 Act successfully eliminated most of these disputes by repealing the three-phase system and making many technical amendments. But, for some reason, after 25 years, we are still arguing about Congress’ basic tax policy objectives in the 1984 Act. But, if we go back and examine what Congress was trying to accomplish, most of these disputes should go away. When interpreting the company tax provisions of the 1984 Act, ask yourself: Will this interpretation promote a level playing field and will it be consistent with how gain from operations was interpreted under the 1959 Act? Divergence from these two basic principles in interpreting the 1984 Act provisions should have clear support in the statute or legislative history. ◀

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ACLI UPDATE COLUMN

By Bill Elwell and Mandana Parsazad

ADMINISTRATION'S FISCAL YEAR 2010 REVENUE PROPOSALS

On May 11, 2009, the Administration announced its Fiscal Year 2010 Revenue Proposals to raise revenue for health care reform. Among these are four proposals that directly affect the taxation of life insurance companies and products. The Administration included three of the proposals in a section entitled "Make reforms to close tax loopholes." The proposals would:

1. Expand the pro rata interest expense disallowance for corporate-owned life insurance (COLI) contracts;
2. Modify the dividends-received deduction (DRD) for life insurance company separate accounts; and
3. Modify rules that apply to sales of life insurance contracts.

The fourth proposal, included in a section entitled "Reduce the tax gap," would require information reporting on private separate accounts. The most recent revenue estimates by the Joint Committee on Taxation for these four proposals totals \$11.7 billion over 10 years.¹

1) Proposal to expand the pro rata interest disallowance for COLI, effective after the date of enactment.²

This proposal would disallow an interest deduction to a company to the extent of the cash value of its COLI policies on the lives of all except for 20-percent owners of the company or business, thus repealing the exception to the interest disallowance rule for COLI policies on the lives of individuals who are officers, directors or employees. The net impact of this proposal would be to eliminate the benefits of inside buildup on policies on the lives of officers, directors or employees. This proposal was previously considered and rejected in 1998. Since that time, Congress has addressed outstanding questions about broad-based COLI, and in 2006 imposed further conditions on the associated tax benefits.

The Administration's proposal increases taxes and restrictions on businesses that purchase life insurance. Businesses

often purchase life insurance to protect against financial loss from the deaths of key employees and to facilitate business continuation after the death of a business owner. Many businesses purchase life insurance to fund the cost of employee and retirement benefits and to serve as a valuable risk-management tool. In 2006, Congress reformed the tax laws governing COLI to effectively limit coverage to highly-compensated employees or directors of a business and to require written and informed consent of the insured. No additional limitations are needed or appropriate.

2) Proposal to modify the DRD for life insurance company separate accounts, effective after Dec. 31, 2010.³

This proposal generally describes a change to the formula for measuring required interest, which is used to determine the company's share of the DRD. The tax code mitigates the double taxation of corporate earnings through the DRD. All corporate taxpayers are allowed the DRD, which generally provides corporate shareholders with a partial exclusion (70 percent) of the dividend amount from income tax. Life insurance companies have been subject to a set of rules that further limit the DRD for separate accounts for many years. The Administration's proposal is based on a misguided notion that life insurers' DRD under current law represents more than the insurers' interest in the dividends.

The separate account DRD is an integral element in an overall tax system that taxes life insurance companies. Life insurance companies' tax rules are part of a complex and well-reasoned mechanism based on sound tax policies that has worked well for many years. Indeed, life insurance companies pay material amounts of tax on variable annuity and variable life policies through deferred acquisition costs (DAC) and reductions in the reserve deduction. A legislative change that singles out one particular segment of that mechanism for review would be misguided and detrimental to this overall method of taxation.

The Administration's proposal would reduce life insurance companies' DRD by changing the calculations for DRD on separate accounts, which underlie

variable life insurance and variable annuity contracts—important products for financial and retirement security.

The proposal is an inappropriate attempt to further reduce life insurers' DRD, thus increasing taxes and making variable life insurance and variable annuity products more expensive.

3) Proposal to modify rules that apply to sales of life insurance contracts, effective after Dec. 31, 2010.⁴

Most notably, this proposal would require anyone who purchases an interest in an existing life insurance contract with a death benefit equal to or greater than \$1 million to report information on the sale to IRS, the insurance company and the seller. Upon payment of the death benefit under the affected policy, the proposal would require the insurer to issue an IRS Form 1099 to the payee.

The Administration's description provides little detail, but suggests that modifying the exceptions to the transfer-for-value rules in section 101(a)(2) to prevent the application of these exceptions to sales of life insurance policies.

4) Proposal to require information reporting on private separate accounts, effective after Dec. 31, 2010.⁵

This proposal would require life insurance companies to report to IRS, for each contract whose cash value is partially or wholly invested in a private separate account for any portion of the taxable year, detailed information on the policy and the policyholder's financial interest in the account. The

proposal defined a private separate account as any account with respect to which a related group of persons owned policies whose cash values, in the aggregate, represented at least 10 percent of the value of the separate account.

The Administration's description provides little detail, but suggests that increased reporting of investments in private separate accounts would help IRS prevent tax avoidance and to assist in the classification of variable insurance contracts as insurance contracts.

ACLI has actively opposed the proposals on COLI and DRD because the current rules are based on sound tax policy and should not be changed. We are exploring the implication of these proposals on our member companies and are seeking clarification on the proposals that require reporting on life settlement transactions and private separate accounts. The COLI and DRD proposals were characterized as "loopholes"—they represent long-standing rules and practices and are not loopholes. Moreover, changing the tax treatment of life insurers' COLI and DRD would make the products that provide financial and retirement security more expensive for families and businesses alike.

Defending the industry against inappropriate changes to the taxation of life insurance companies and their products remains a top priority for ACLI as the Administration and Congress work toward health care reform and possible tax reform amidst a continuing need for revenue in these challenging financial times. ◀

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END NOTES

¹ Joint Committee on Taxation (JCT), *Estimated Budget Effects of the Revenue Provisions Contained in the President's Fiscal Year 2010 Budget Proposal* (June 11, 2009).

The Office of Management & Budget's *Analytical Perspectives* of the Administration's FY 2010 Budget originally estimated these proposals at 12.7 billion over 10 years.

² This proposal is estimated to raise \$8.41 billion over 10 years. JCT *Estimated Budget Effects*, *supra* at note 1. The OMB's *Analytical Perspectives* originally estimated this proposal at \$8.47 billion over 10 years. *Supra* at note 1.

³ This proposal is estimated to raise \$2.63 billion over 10 years. JCT *Estimated Budget Effects*, *supra* at note 1. The OMB's *Analytical Perspectives* originally estimated this proposal at \$3.44 billion over 10 years. *Supra* at note 1.

⁴ This proposal is estimated to raise \$626 million over 10 years. JCT *Estimated Budget Effects*, *supra* at note 1. The OMB's *Analytical Perspectives* originally estimated this proposal at \$812 million over 10 years. *Supra* at note 1.

⁵ This proposal is estimated to raise less than \$500,000 over 10 years. JCT *Estimated Budget Effects*, *supra* at note 1. The OMB's *Analytical Perspectives* originally estimated this proposal at \$20 million over 10 years. *Supra* at note 1.

T³: TAXING TIMES TIDBITS

IRS PRIVATE LETTER RULINGS ON "COMBINATION" INSURANCE PRODUCTS

By Craig R. Springfield and Mark E. Griffin

In two recently issued private letter rulings, the Internal Revenue Service ("IRS") addressed federal tax issues pertaining to so-called "combination" insurance products. The first ruling, PLR 200903001 (Oct. 14, 2008), involved a critical illness insurance rider to a life insurance contract, and the second ruling, PLR 200919011 (Feb. 2, 2009), is the first private letter ruling to be issued regarding combinations of long-term care ("LTC") insurance with an annuity contract, which were authorized by the Pension Protection Act of 2006 ("PPA").

PLR 200903001— Critical Illness Rider to Life Insurance Contract

In PLR 200903001, a critical illness rider (the "Rider") to a life insurance contract provided for an acceleration of the life insurance contract's death benefit upon the insured's critical illness. More specifically, the accelerated death benefit (referred to as the "Rider Benefit") was payable when the insured was diagnosed by a physician as having one of a number of qualifying covered conditions, which in turn were defined by the Rider.

The underlying life insurance contract was an individual, nonparticipating, flexible premium adjustable life insurance contract and generally was designed to comply with the requirements of section 7702 (defining "life insurance contract" for federal tax purposes) by meeting the guideline premium limitation/cash value corridor test of section 7702(a)(2), (c) and (d). The ruling notes, however, that certain of the contracts would be issued with an endorsement that would ensure their compliance with the cash value accumulation test of section 7702(a)(1) and (b). The taxpayer represented that the contract and critical illness rider were purchased with after-tax monies and that the critical illness rider was not a "qualified additional benefit" under section 7702(f)(5)(A).

Because the triggering event for benefits was the insured's critical illness, the Rider is not governed by section 101(g), which addresses certain accelerated death benefits payable upon an insured's terminal illness or chronic illness, nor is the Rider governed by section 7702B, which also can apply to certain accelerated death benefits payable upon an insured's chronic illness.

The IRS ruled that the critical illness rider was accident or health insurance and that benefits received under the rider would be excludable from the recipient's gross income under section 104(a)(3). (Section 104(a)(3) generally excludes from income amounts received through accident or health insurance for personal injuries or sickness.) The ruling also notes that a request for ruling had been withdrawn under section 7702(f).

The IRS's conclusion in this private letter ruling is consistent with its prior rulings under section 104(a)(3). *See, e.g.*, PLR 200339015 (June 17, 2003) and PLR 200339016 (June 17, 2003), both involving critical illness riders to cash value life insurance contracts, and PLR 200627014 (March 6, 2006), involving a critical illness rider to a term life insurance contract.

PLR 200919011—LTC-Annuity Rider

In PLR 200919011, a life insurance company intended to add an LTC insurance rider (the "Rider") to a deferred annuity contract. For tax years after 2009, the Rider was designed to comply with the definition of a "qualified long-term care insurance contract" under section 7702B(b). The Rider provides for monthly LTC benefit payments (not to exceed the per diem limitation of section 7702B(d)(2)) upon the insured's chronic illness. The Rider is funded through an annual charge assessed against the annuity contract's cash value. This charge is at an arms-length rate for the Rider coverage and is determined in accordance with widely accepted actuarial principles based on the insurer's good faith expectation for the claims experience it will incur.

Prior to the annuity starting date, LTC benefits are comprised of two components: i) a “Linked Component” that reduces the annuity contract’s cash value on a dollar-for-dollar basis, and ii) an “Unlinked Component” that is paid from net amount at risk. If the insured is chronically ill and LTC benefits are being paid on the scheduled annuity starting date, LTC benefits continue until the contract’s cash surrender value is reduced to zero. If the contract owner is not receiving LTC benefits on the scheduled annuity starting date, the Rider generally terminates unless the contract owner elects to continue LTC coverage.

If the annuity contract is annuitized on the annuity starting date, the contract owner elects to continue LTC coverage after this date, and the insured then meets the eligibility requirements for payment of LTC benefits, LTC benefits will replace the annuity payments being made from the contract. The monthly LTC benefits in this circumstance equal the sum of the annuity payments that would have been made plus the monthly Unlinked Component immediately prior to the annuity starting date, subject to certain maximums.

In the first requested ruling, the insurer had asked the IRS to rule that the LTC portion of the annuity-LTC contract met the definition of a “qualified long-term care insurance contract” under section 7702B(b). In this regard, the insurer represented that, if the LTC portion of the contract constituted an “insurance contract,” all of the requirements to be a qualified long-term care insurance contract under section 7702B(b)(1) would be satisfied for tax years beginning after Dec. 31, 2009. Thus, the question before the IRS was whether the LTC “portion” of the annuity-LTC contract, as defined by section 7702B(e), constituted an “insurance contract.”

The IRS ruled that the “insurance contract” requirement was met, citing *Helvering v. Le Gierse*, 312 U.S. 531 (1941) and related authorities. Under these authorities, the IRS observed that risk shifting and risk distribu-

tion must be present, and the arrangement must constitute insurance in the commonly accepted sense based on all the facts surrounding the case. The ruling noted that courts had identified several nonexclusive factors bearing on this, including the treatment of the arrangement under state law, premiums priced at arm’s length, and the language of the operative agreements and the method of resolving claims.

From the disclosed facts of the ruling, it is unclear how large the Unlinked Component of LTC benefits was (*i.e.*, the amount paid from net amount at risk) relative to the Linked Component (*i.e.*, the amount paid from the annuity cash value or from annuity payments). Also, the ruling otherwise largely focuses only on the facts presented, which is typical for private letter rulings. Thus, even though the PPA appears to offer considerable flexibility with respect to designs for annuity-LTC products, the ruling provides little indication of how the IRS will address design alternatives, apart from it being clear that the LTC portion of a contract must constitute an “insurance contract.”

In the second requested ruling, the insurer had asked the IRS to rule that LTC benefits (including both the Linked and Unlinked Components) would be excludable from gross income to the extent not in excess of the per diem limitation of section 7702B(d)(2). The IRS agreed with the insurer and ruled favorably. In describing the applicable law, the ruling stated that, under section 7702B(a)(1) and (2), LTC insurance benefits received under a qualified long-term care insurance contract are treated as amounts received for personal injuries and sickness under accident or health insurance, subject to limits with respect to per diem LTC benefits under section 7702B(d).

In addition, the ruling stated that the LTC “portion” of a contract means only the terms and benefits under an annuity contract that are in addition to the terms and benefits under the contract without regard to LTC insurance coverage. In this regard, the ruling cited the Joint Committee on Taxation’s “Bluebook” explanation of the PPA, which states that—

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... 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 life insurance contract's death benefit or cash surrender value or in the annuity contract's cash value.¹

In the third requested ruling, the insurer had asked the IRS to rule that payment of LTC benefits did not reduce the "investment in the contract" of the annuity contract for purposes of section 72. The IRS disagreed with the insurer and ruled that "investment in the contract" was reduced by "the payment of LTC Benefits under the Rider."

The definition of "investment in the contract" in section 72(e)(6) provides that this term means, as of any date, "(A) the aggregate amount of premiums or other consideration paid for the contract before such date, minus (B) the aggregate amount received under the contract before such date, to the extent that such amount was excludable from gross income...." While the IRS's rationale for the third ruling is not expressly stated, it appears to be based on the view that LTC benefits that are excludable from income constitute amounts within the scope of section 72(e)(6)(B). The IRS does not address the interaction between section 72(e)(6)(B) and section 7702B(e), which treats the LTC portion of the contract as a separate contract for purposes of the entire Internal Revenue Code. Given the separate contract treatment under section 7702B(e), seemingly the LTC benefits should be treated as having been received under the qualified long-term care insurance portion of the contract (as the IRS so held in the second ruling), and correspondingly no part of the LTC benefits should be treated as having been received from the annuity "portion" of the contract. Since section 72(e)(6)(B) only accounts for amounts received "under the contract" (and not amounts received under a separate LTC insurance contract), it is not clear why the IRS concluded that "investment in the contract" is reduced by LTC benefits.

It is also pertinent that section 72(e)(11) (as amended by the PPA) excludes from income LTC rider charges that are assessed against an annuity contract's cash value, but then further provides that such charges reduce "investment in the contract" under section 72(e)(6). Implicitly, this rule recognizes that imposition of LTC rider charges results in deemed distributions from the annuity contract that then are paid into the rider. Section 72(e)(11) is entirely consistent with

section 7702B(e), *i.e.*, one reflects and the other dictates separate contract treatment for the LTC portion of a contract. What is inconsistent, however, is the ruling's rejection of separate contract treatment when LTC benefits are paid. It seems very unlikely that Congress would have intended for "investment in the contract" to be reduced by the deemed distributions arising from charges for an LTC rider, but then to disregard the separate contract treatment prescribed by section 7702B(e) and further reduce "investment in the contract" when LTC benefits are paid.

Even if such a result were somehow justified, it also seems incorrect to reduce "investment in the contract" by the net amount at risk portion of LTC benefits, since the effect of this would be to create additional income on the contract that would not have existed absent the LTC coverage.

As the Jan. 1, 2010, effective date for the new annuity-LTC rules enacted as part of the PPA draws nearer, it will be interesting to watch the development of both products and IRS guidance on this subject. ◀

END NOTES

¹ Staff of the J. Comm. on Tax'n, 109th Cong., 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 August 3, 2006, at 195 (J. Comm. Print.).

IRS APPLIES SECTION 845 TO DISALLOW REINSURANCE

By Biruta P. Kelly

Background
Section 845¹ contains two rules available for the IRS to use to adjust the federal income tax consequences of the parties to a reinsurance transaction—one for related party reinsurance and one for any reinsurance transaction, including reinsurance between unrelated parties. Section 845(a) applies only to related parties and, in general, allows the IRS to make necessary adjustments that reflect the "proper amount, source or character of the taxable income" of the parties to the agreement. The second rule, under section 845(b), in general, allows the IRS to make adjustments where the reinsurance contract has a "significant tax avoidance effect." Although Congress enacted section 845 as part of the Deficit Reduction Act of 1984,² section 845 had its genesis in the Tax Equity and

Fiscal Responsibility Act of 1982 (“TEFRA”),³ which repealed the special election for modco reinsurance. Unlike the substantial explanation of section 845 provided in the 1984 legislative history, Congress provided no guidance on the precursor to section 845 in 1982.⁴

During the 1990s, the IRS sought to apply section 845 in several instances.⁵ At that time it pursued litigation under both section 845(a)⁶ and section 845(b).⁷ The section 845(b) *Trans City* case⁸ was a significant loss for the IRS and to date is still the only case that analyzes the scope of IRS authority under section 845. After *Trans City*, the IRS spent many years reconsidering the application of section 845, but issued nothing definitively applying section 845, until FAA 20092101F (Feb. 4, 2009).⁹

FAA 20092101F

FAA 20092101F¹⁰ involves a reinsurance contract between a domestic corporation and a related section 953(d) insurance company that is a member of the same consolidated group. The FAA indicates that the section 953(d) company’s only insurance business is the insurance of a line of business (details are redacted) that had been profitable in the first year, but then experienced losses over the next five years, resulting in a build-up of net operating losses (“NOLs”). Under section 1503(d), a section 953(d) company is required to treat any losses as “dual consolidated losses” with the result that they can be used only by the section 953(d) company and cannot be used to offset or reduce taxable income of the parent or any other member of the affiliated group that includes the section 953(d) company.

In the FAA, therefore, the section 953(d) company’s NOLs could not have been used against the income of the ceding company, because of the application of section 1503(d). The reinsurance transaction in the FAA resulted in income for the section 953(d) company, against which the company attempted to use its NOLs. This tax effect was the determining factor for the FAA’s application of section 845(b).

The FAA provides a detailed explanation of section 845 and its legislative history. The FAA notes that although it could apply the section 845(a) related party rule, which is subject to a lower standard of proof, it opts for an application of section 845(b). Under section 845(b), the FAA notes that adjustments may be made only if the

transaction has a tax avoidance effect and the effect is significant. The FAA finds that the reinsurance contract has a tax avoidance effect because of the shifting of income between the two companies, which allowed the section 953(d) company to obviate the dual consolidated loss rule. Next, the FAA analyzes whether the tax avoidance effect is significant. The FAA notes that the legislative history for section 845 sets out seven factors for analyzing whether a tax avoidance effect is significant (“Conference Report”),¹¹ and that the *Trans City* case contains two more factors. Instead of analyzing these factors, however, the FAA asserts that they are largely irrelevant, “in part because the parties are related,” and the FAA finds only two factors are applicable—the relative tax positions of the parties and state determinations. The FAA states that the first factor weighs in favor of applying section 845(b), due to the shifting of the income to the loss corporation. The FAA finds that the fact that the state had approved the transaction to be a neutral factor and, therefore, concludes that the tax avoidance effect is significant based solely on the amount of tax that is avoided and disallows the reinsurance transaction under section 845(b). It is not stated in the FAA exactly what adjustments are to be made.

The FAA’s analysis is deficient. The key to “significant” tax avoidance effect is whether “the transaction is designed so that the tax benefits enjoyed by one or both parties to the contract are disproportionate to the risk transferred between the parties.” Conference Report at 1063. The Conference Report notes that the existence of tax benefits is only the beginning, not the end, of the analysis. The various factors provided in the Conference Report and *Trans City*, and perhaps others, need to be analyzed to make this determination. An appropriate weighing of the tax benefits against the factors giving the transaction substance is required. The FAA does not do this and, in particular, ignores the level of risk transfer. This disregard of the many factors to be considered in weighing the tax benefit against the non-tax effect to determine whether the tax avoidance is significant reflects an application of section 845 in a broad, result-oriented manner.¹²

In FAA 20092101F the IRS may be placing undue emphasis on the fact that the transaction is between related parties because it is attempting to apply section 845(b), which applies equally, and presumably similarly, to reinsurance between unrelated parties. Would the IRS invoke section 845(b) if the

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953(d) company with losses had assumed a profitable block of business from an unrelated company?

Future Litigation?

FAA 20092101F advocates the use of litigation: “The [section 845] adjustment is not merely appropriate, but absolutely necessary. Further, absent full concession by Company A, it should be litigated.” This statement expresses the views of the Associate Industry Counsel Property and Casualty Insurance of LMSB and is not a determination that the case is a designated litigating vehicle. The FAA provides guidance to revenue agents, but need not be followed by the Appeals Division, should the case ultimately be forwarded for Appeals Office consideration, unless and until IRS Chief Counsel designates the case for litigation.¹³ Nevertheless, the strong statements by LMSB in the FAA presage increased IRS section 845 activity, including perhaps litigation. ◀

END NOTES

¹ Unless otherwise specified, all references to a section are to a section of the Internal Revenue Code of 1986, as amended.

² Pub. L. No. 98-369.

³ Pub. L. No. 97-248.

⁴ Even the TEFRA blue book contains little guidance, merely that the “scope of authority granted under the provision is broader than that granted under existing law generally (Code section 482),” and that the provision may be applied to reinsurance involving a property/casualty or foreign company. Staff of the Jt. Comm. on Tax’n, *General Explanation of the Revenue Provisions of the Tax Equity and Fiscal Responsibility Act of 1982* 345.

⁵ See, e.g., Field Service Advice (“FSA”) 1812 (May 31, 1996); Technical Advice Memorandum (“TAM”) 9346004 (Aug. 10, 1993); TAM 9339001 (May 6, 1993); TAM 9308003 (Nov. 20, 1992).

⁶ FSA 1812 states that the IRS was seeking a litigating vehicle under section 845(a). A related-party section 845 case was docketed in the Tax Court, *Lone Star Life Ins. Co. v. Commissioner*, Tax Ct. Docket Nos. 14781-96 and 5898-97, but was resolved without a trial.

⁷ *Trans City v. Commissioner*, 106 T.C. 274 (1996).

⁸ The IRS nonacquiesced in *Trans City*, 1997-2 C.B. 1. In AOD 1997-011, the IRS specifies that its disagreement is with the following aspects of the case: The Service disagrees with the court’s factual finding of abuse of discretion in this case. The Service also disagrees with the court’s apparent characterization of the economic substance test of section 845(b), “risk transferred versus tax benefits derived,” as only a factor to be used in the determination of whether a significant tax-avoidance effect exists. The Service also disagrees with the court’s definition of “risk,” in the overriding economic substance test of section 845(b), in terms of the amount of risk, or the possibility of loss, rather than the amount at risk, or the probability of loss.

⁹ Several rulings issued by the IRS since 1996 note the potential for the application of section 845, but fail to apply it specifically. See, e.g., Notice 2002-70, 2002-2 C.B. 765; FSA 200027008 (Mar. 31, 2000); FSA 200026016 (Mar. 31, 2000).

¹⁰ The FAA, Field Attorney Advice, is a memorandum from the Associate Industry Counsel Property and Casualty Insurance of LMSB (Large & Mid-Size Business (“LMSB”)) to a supervisory revenue agent to guide the revenue agents examining the taxpayer’s return.

¹¹ H. R. Rep. 861, 98th Cong., 2d Sess. 1063.

¹² If the section 953(d) company could have assumed the same risks and accomplished the exact same results if it had written the reinsured business directly, did the reinsurance result in a significant tax avoidance effect? See Conference Report at 1063 (“There is no significant tax avoidance effect for a reinsurer, however, merely because a tax reduction arises from a loss on the reinsurance contract for a particular year, if the loss experienced was no greater than if the reinsurer had written the allocable portion of the reinsured business directly”).

¹³ Prop. Treas. Reg. § 601.106(a)(4)(viii) eliminates Appeals consideration of cases that are designated for litigation by IRS Chief Counsel.

PLR 200917002—IS THE IRS STILL IN THE BUSINESS OF ISSUING WAIVERS?

By Daniela Stoia

On April 24, 2009, the Internal Revenue Service (the “Service”) released PLR 200917002¹ (the “PLR”). The PLR provides a waiver, pursuant to section 7702(f)(8), for a number of contracts that failed to satisfy the requirements of section 7702 (the “Failed Contracts”) due to certain errors, described below. This article begins with a review of the PLR and the waiver that was issued. The article then summarizes the types of errors eligible for correction under Rev. Proc. 2008-42² and finishes with a discussion of what conclusions can be drawn, if any, about the status of the traditional the waiver request process based on the release of this PLR after the effective date of the Auto Waiver Procedure.

The PLR

In order for a taxpayer to receive a waiver pursuant to section 7702(f)(8), the taxpayer must demonstrate to the Service that the failure to satisfy the requirements of section 7702 was due to “reasonable error” and that “reasonable steps” are being taken to remedy the error.

Reasonable Errors

The PLR addressed Failed Contracts that were intended to satisfy the requirements of section 7702 by meeting the “guideline premium test” (the “GPT”).³ However, due to the five errors described below, the Failed Contracts did not satisfy the GPT.

- **Errors 1, 2, and 3 – Programming Errors.** The PLR describes three programming errors that caused certain of the Failed Contracts not to comply with the requirements of the GPT. The first programming error occurred during the conversion of some of the Failed Contracts to the taxpayer’s administration system, which also monitors the taxpayer’s contracts for compliance with the require-

ments of the GPT (the “GPT System”). As part of that process, the taxpayer’s programmers inadvertently converted the contracts in such a manner as to cause the GPT System to increase erroneously the guideline premium limitation used by the system to monitor the contracts’ compliance with the GPT. Effectively, the error prevented the GPT System from identifying premiums that were paid in excess of the correctly calculated guideline premium limitation. This programming error is similar to other programming errors relating to conversions that the Service has waived in the past.⁴ The second programming error was a failure of the taxpayer’s programmers to program the specifications developed for certain policy forms as related to the duration for which certain expense charges were expected to be imposed. This error is also consistent with other programming errors that the Service has waived relating to the implementation of specifications for a policy form.⁵ The third programming error was made by the taxpayer’s programmers when they modified the taxpayer’s GPT System to reflect a contract feature as an interest rate guarantee, which resulted in unintended consequences in the manner in which the system treated the contracts with this feature. This error is also consistent with prior waivers issued by the Service in the case of programming errors arising when modifications were made to a system to reflect a new product or a new product feature.⁶

- *Error 4 – Application of Reasonable Expense Charge Rule.* Although the precise nature of the fourth error addressed by the PLR is uncertain, it appears to have related to the assumptions that were made in reflecting certain expense charges in calculating guideline premiums. The reasonable expense charge rule of section 7702(c)(3)(B)(ii) provides that in calculating guideline premiums “any reasonable charges (other than mortality charges) which (on the basis of the company’s experience, if any, with respect to similar contracts) are reasonably expected to be actually paid” may be reflected. In this case, it appears that the assumptions that were made regarding the collection of certain expense charges were inconsistent with the requirements of the reasonable expense charge rule. Although very few waivers have been issued by the Service relating to the reasonable expense charge rule, this PLR is consistent with an earlier PLR issued by the Service in a circumstance where that taxpayer’s assumptions about its expense charges were inconsistent with the reasonable expense charge rule.⁷

- *Error 5 – Clerical Errors.* Like most insurers, the taxpayer seeking the PLR had in place procedures for its employees to follow in interacting with the GPT System. Nonetheless, the taxpayer discovered that its employees failed to follow these procedures, e.g., they overrode the guideline premiums calculated by the GPT System. Historically, such errors have been characterized as “clerical errors” and they are the classic types of errors that the Service has waived since waiver private letter rulings were first issued in the late 1980s.⁸ One could even go as far as to say that it was these types of clerical errors that were the impetus for the issuance of the Auto Waiver Procedure.

After evaluating each of the five errors described above, the Service concluded that the errors were “reasonable errors” within the meaning of section 7702(f)(8). This conclusion was not surprising because, as described above, the Service has issued waivers for similar errors in the past.

Reasonable Steps to Correct

The taxpayer took a number of steps to minimize the possibility that any of its life insurance contracts would fail to satisfy the requirements of the GPT in the future. For example, the taxpayer corrected the programming errors by recalculating guideline premiums in accordance with the requirements of section 7702, entering those amounts into its GPT System, and making the necessary modifications to the coding of the GPT System to correct the programming errors. The taxpayer also took certain additional steps to strengthen its procedures to minimize the possibility of further clerical errors causing compliance issues. In addition to the foregoing, the taxpayer also corrected the Failed Contracts by refunding excess premiums with interest to bring them back into compliance with the requirements of section 7702. After evaluating the taxpayer’s corrective actions, the Service concluded that the taxpayer’s actions satisfied the requirements of section 7702(f)(8).

In light of the foregoing, the Service granted the taxpayer a waiver because the errors causing the Failed Contracts were determined to be “reasonable errors” and the taxpayer’s corrective actions were determined to be “reasonable steps” to remedy the errors.

Eligible Reasonable Errors Addressed by Rev. Proc. 2008-42

In relevant part, Rev. Proc. 2008-42 applies to any issuer of a life insurance contract that fails to satisfy the requirements

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of section 7702 due to an “eligible reasonable error” if reasonable steps are taken to remedy the error.⁹ The revenue procedure specifically provides that an “eligible reasonable error” exists if three criteria are satisfied. First, the issuer has compliance procedures with specific, clearly articulated provisions that if followed would have prevented the contract from failing to satisfy the requirements of section 7702. Second, an employee or independent contractor of the issuer acted, or failed to act, in accordance with those procedures. Third, such act or failure to act was inadvertent, and was the sole reason that the contract failed to satisfy the requirements of section 7702.

The revenue procedure also provides some specific examples of errors causing failures under section 7702 that are not eligible for correction under the Auto Waiver Procedure. Specifically, neither a defective legal interpretation nor a computer programming error would be eligible reasonable errors under the Auto Waiver Procedure. This is because these errors would not satisfy the requirements of the revenue procedure that the issuer’s compliance procedures, if followed, would have prevented the error. Nonetheless, if a defective legal interpretation or a computer programming error is reasonable, the issuer may request a traditional waiver by private letter ruling under the procedures set forth in Rev. Proc. 2009-1.¹⁰ If such errors are not reasonable, an issuer may request a closing agreement under the procedures set forth in Rev. Proc. 2008-40¹¹ to correct any failures resulting from the error.

Conclusions to be Drawn from the PLR

As various individuals from the Service have said on countless occasions, it is dangerous to draw too many conclusions from private letter rulings because they are issued to address a taxpayer’s specific facts and the pertinent facts may be redacted in the version of the private letter rulings released to the public. In this case, taxpayers may quickly jump to the conclusion that this PLR indicates that the Service is as willing as it was prior to the release of the Auto Waiver Procedure to issue waivers pursuant to section 7702(f)(8). That conclusion may be premature in light of the fact that the request for the PLR may have predated the release of the Auto Waiver Procedure. In fact, one might speculate that the request for the PLR was submitted prior to the release of the Auto Waiver Procedure because one of the types of errors covered by the PLR—the clerical error—seems to be an example of an eligible reasonable error that the Auto

Waiver Procedure was intended to correct. However, that is not certain because the PLR primarily focuses on the types of errors that cannot be corrected under the Auto Waiver Procedure, *e.g.*, programming errors. Only time will tell if the number of waiver private letter rulings issued by the Service will decrease because more and more taxpayers will avail themselves of the Auto Waiver Procedure. This, in part, will depend on whether taxpayers find that errors causing section 7702 compliance failures satisfy the eligible reasonable error criteria of Rev. Proc. 2008-42. ◀

END NOTES

¹ Jan. 15, 2009. A private letter ruling is issued to a particular taxpayer and can be relied upon only by that taxpayer. See section 6110(k)(3). Unless otherwise indicated, all references to “section” are to sections of the Internal Revenue Code of 1986, as amended.

² 2008-29 I.R.B. 160, amplifying Rev. Rul. 91-17, 1991-1 C.B. 190. Rev. Proc. 2008-42 provides the procedures under which taxpayers may automatically obtain a waiver pursuant to section 7702(f)(8) for certain “eligible reasonable errors” (the “Auto Waiver Procedure”). The Auto Waiver Procedure became effective on July 21, 2008.

³ In order for a life insurance contract that is treated as such under state law to satisfy the GPT it must both meet the “guideline premium requirements” set forth in section 7702(a)(2)(A) and (c) and fall within the “cash value corridor” of section 7702(a)(2)(B) and (d).

⁴ See, *e.g.*, PLR 200044016 (Aug. 1, 2000) (waiving programmers’ inadvertent disabling of the code in the taxpayer’s administration system which indicated that the contracts should be monitored for compliance with the GPT during the conversion of contracts to the taxpayer’s administration system).

⁵ See, *e.g.*, PLR 200646002 (Aug. 3, 2006) (waiving a number of inadvertent errors by programmers, such as the failure to load the correct table of guaranteed mortality charges or to change a reference point to the correct table of guaranteed mortality charges); PLR 200027030 (Apr. 10, 2000) (waiving various programming and coding errors such as the incorrect coding of a plan as a 1958 CSO plan).

⁶ *Id.*

⁷ See, *e.g.*, PLR 9517042 (Jan. 31, 1995) (addressing the reasonable expense charge rule and stating: “None of the contracts issued as the result of intracompany exchanges, including the dd contracts here, were subject to the charges taken into account by Taxpayer in the calculation of the guideline premium limitation. The same charges were reasonably expected to be actually paid under all other contracts issued on the same policy forms. Contracts issued in intracompany exchanges are not ‘similar’ to contracts that are original issue or received in an intercompany exchange, if each class of contracts is treated differently for charge purposes. In the absence of regulations defining the term ‘similar contracts,’ however, we find that Taxpayer’s interpretation of the parenthetical phrase to include the company’s experience with respect to other contracts using the same policy form was a reasonable error.”).

⁸ See, *e.g.*, PLR 200749005 (Aug. 24, 2007) (waiving contract failures resulting from employees failing to follow the company’s procedures for addressing adjustment events and from employees “[m]anually overriding the system to backdate a premium to the date it was received rather than the date the system indicated was permissible”); PLR 200646002 (waiving contract failures resulting from employees failing to follow the company’s procedures for addressing adjustment events and from employees releasing premiums from a premium deposit account or other suspense arrangement and crediting those premiums when permitted by the GPT, but with an effective date that preceded the actual date on which the premiums were credited).

⁹ The Auto Waiver Procedure also applies to section 101(f) failures. See Rev. Proc. 2008-42 section 3.01.

¹⁰ 2009-1 I.R.B. 1.

¹¹ 2008-29 I.R.B. 151, superseding in part Rev. Rul. 91-17, 1991-1 C.B. 190, and superseding Notice 99-48, 1992-2 C.B. 429.

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