

THE DEFINITION OF LIFE INSURANCE  
UNDER SECTION 7702 OF THE INTERNAL REVENUE CODE

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A BRIEF HISTORY

*Early Cases and Rulings*

Since 1913, the Internal Revenue Code has excluded the death proceeds of life insurance policies from the taxable income of the beneficiary. This treatment, currently found in Section 101(a)(1), has been carried forward with relatively little change for nearly 75 years.

In defining life insurance for federal tax purposes, early cases and rulings focused on the shifting and distribution of risk and not on the extent or sufficiency of that risk. The criteria most often applied were the characterization of the contract for state law purposes and the presence of insurance risk in terms of the relationship of the face amount to the cash value.

The principal court case dealing with the definition of life insurance is *Helvering v. LeGierse* [1], a Supreme Court case that denied the exclusion of life insurance proceeds from an insured's gross estate where, one month prior to the death of the insured, a single premium life insurance policy and an annuity contract had been purchased simultaneously. The Internal Revenue Service (IRS) argued, and the Court agreed, that the sale had eliminated any meaningful risk on the part of the insurer and that the arrangement was not eligible for treatment as life insurance.

Other cases and rulings prior to 1980 dealt principally with the presence or absence of insurance risk. For example, a series of cases and rulings addressing the risk element in retirement income plans concluded that a retirement income plan was no longer life insurance once the cash value exceeded the face amount [2], a change from prior law, which required that risk need only be present at the inception of the contract.

*The Hutton Life Rulings and Their Aftermath*

The proliferation of new plans of insurance in the late 1970s and early 1980s resulted in numerous requests to the IRS for rulings on the tax status of these products. This culminated in a series of rulings issued in 1980 and 1981.

In August 1980, a term and annuity combination was found not to be eligible for life insurance treatment, even though it was sold as a single policy, all premiums were credited to the annuity, and the term premiums were deducted as partial withdrawals [3]. In January and February of 1981, the Hutton Life rulings were issued, granting favorable tax treatment to the death proceeds of a universal life plan [4]. In February of 1981, a favorable ruling was issued on variable life, and in May, a similar result was reached on an interest-sensitive whole life plan [5].

As in the earlier cases and rulings, the primary focus of these rulings was the presence of risk and the form of the plans under state law.

In the spring of 1981, the ruling position of the IRS on universal life came under attack, with the critics focusing on the degree of risk required under universal life and similar plans. Under the products then available in the marketplace, a large amount of cash value could accumulate with a relatively small risk amount [6]. If the Hutton Life rulings were followed, it was argued, these plans would qualify for the favorable treatment under Section 101(a) with only minimal required risk amounts.

Although ruling requests for several universal life plans were pending after the Hutton rulings, the IRS issued no further rulings and began a review of its prior position. This review culminated in the issuance of General Counsel's Memorandum (GCM) 38934 in July of 1982 (released to the public in December 1982) [7]. It recommended that a universal life policy be treated as term insurance and a savings element and not an integrated contract of life insurance as provided in the Hutton rulings. Only the pure amounts at risk would qualify as life proceeds, and the cash value would be treated as an annuity. This position raised, but did not resolve, what some commentators believed was the principal issue—the risk element necessary to qualify the entire contract as life insurance.

The recommendations of the GCM were never translated into a ruling on universal life. Recognizing the potential that the Hutton rulings (and thereby the viability of universal life) was threatened, a group of life insurance companies issuing universal life lobbied Congress for the addition of Section 101(f) to the Internal Revenue Code under TEFRA, the Tax Equity and Fiscal Responsibility Act of 1982.

### *Section 101(f)*

Section 101(f) provided statutory rules for the taxation of the proceeds of flexible premium contracts—the first definition of life insurance to appear

in the Internal Revenue Code. Compliance with the Section 101(f) rules provided a full exclusion for proceeds of contracts written prior to January 1, 1984 and was made retroactive as a response to the IRS “cloud” over the Hutton Life rulings.

Section 101(f) was adopted as a temporary measure to resolve the immediate problem of universal life and limited its application to flexible premium products, defined as plans that:

1. had one or more premiums not fixed by the insurer as to both timing and amount; and
2. were treated as integrated contracts of life insurance under state law.

As a result, Section 101(f) applied principally to universal life plans and certain adjustable life products. As a part of the stopgap provisions of TEFRA, Section 101(f) covered only those plans issued on or before December 31, 1983. (Under the transition rules later adopted as a part of the Deficit Reduction Act of 1984, the Section 101(f) rules were extended to December 31, 1984.)

Two alternative tests were provided under Section 101(f). The first test was a guideline premium and corridor test; the second was a cash value test that established a limit based on an attained age net single premium per thousand of death benefit. These tests were similar in concept to the tests currently found in Section 7702, but were more limited in their application.

Section 101(f) was included in TEFRA as a temporary measure to solve the immediate problem of the tax treatment of universal life death benefits. It was a pragmatic and political solution that gave the IRS legislative guidance and resolved industry concerns over the Service’s rulings position as outlined in GCM 38934. Although a temporary expedient, it also served as a model for future legislation.

With the passage of Section 101(f), tax policy concerns at Treasury and the IRS about potential abuse in products other than universal life were not answered. The continued uncertainty of the IRS over non-universal life products became clear in April of 1983, when a private letter ruling was issued, apparently granting life insurance status to a single premium increasing whole life plan with Section 101(f)-style corridor percentages. A short time later, in June, the ruling was revoked and a “no ruling” position was adopted [8].



*Section 7702*

As a part of the industrywide discussions in 1983 concerning the comprehensive revision of the federal income taxation of life insurance companies, the need for a new statute defining life insurance was anticipated by both the insurance industry and the government. The principal policy concerns were:

1. The expiration of Section 101(f) at the end of 1983;
2. The continued need to deal with forms of life insurance other than universal life, most notably single premium plans;
3. The absence of rules for variable life; and
4. The perception by some of the need to strengthen the Section 101(f) rules.

As a result, a provision defining life insurance was incorporated into the so-called Stark-Moore proposal (HR 4170) to revise life insurance company taxation. It employed a two-test format quite similar to that of Section 101(f). The first alternative test, a cash value accumulation test, limited contract values to those of a ten-payment policy maturing at age 95, with an exception for “reasonable” paid-up additions. The second test, a guideline premium and corridor test, limited premiums to the greater of the sum of the premiums for a ten-payment contract or the sum of the premiums for a level premium contract.

The proposal also significantly expanded the applicability of the tests from Section 101(f), which applied only to flexible premium plans, to a definition governing life insurance for all purposes of the Internal Revenue Code.

As initially proposed, the definition of life insurance would have virtually eliminated life insurance tax treatment for all single premium plans. It also would have limited the calculation of allowable values for all plans to a level death benefit basis by eliminating the prefunding of increasing death benefits. Limited payment plans with fewer than ten annual premiums and endowments maturing prior to age 95 for the full face amount also would be disqualified.

After additional considerations, a final version of Section 7702 was added to the Deficit Reduction Act of 1984 with several important changes from the initial proposal. Specifically, the ten-payment test was removed and a single premium test was substituted; the corridor requirements were adjusted to a level higher than the levels in Section 101(f); the treatment of qualified additional benefits was liberalized; and specific rules were proposed for variable life insurance. A provision permitting the level premium funding of a (universal life) increasing death benefit plan also was included.



In July 1984, Section 7702 of the Internal Revenue Code was enacted into law as a part of the Deficit Reduction Act of 1984.

#### SECTION 7702 — THE BASIC TESTS

Under Section 7702 of the Internal Revenue Code an insurance contract qualifies as life insurance if it is considered a life insurance contract according to applicable state law and satisfies either the cash value accumulation test under 7702(a)(1) or the guideline premium/cash value corridor test under 7702(a)(2).

Section 7702 defines the term life insurance contract for all sections of the Internal Revenue Code and therefore applies equally to both policyholder and life insurance company provisions. Thus, a contract that fails to meet the definitional requirements of Section 7702 is not a life insurance contract not only with respect to the treatment of death benefits and the deferral of income on cash value increases for individual taxpayers, but also with respect to the treatment of the reserves for life insurance company corporate taxation.

#### *Cash Value Accumulation Test*

The cash value accumulation test, as explained under Section 7702(b)(1), is met if, by the terms of the contract, the cash surrender value does not at any time exceed the net single premium required to fund future guaranteed contract benefits, subject to the limitation imposed by Section 7702 for allowable interest patterns, endowments, and death benefit patterns.

The term “cash surrender value” is defined in Section 7702(f)(2) as the cash value of the contract exclusive of any surrender charges, policy loans, or reasonable termination dividends. In the legislative history for Section 7702, as summarized in the Blue Book for the Deficit Reduction Act of 1984 [9], the term “cash surrender value” is further defined as the amount to which the policyholder is entitled upon surrender and against which the policyholder may borrow. Finally, a termination dividend is considered “reasonable” if it does not exceed \$35 per thousand [10].

The cash value accumulation test has its roots in the cash value test originated under Section 101(f), which applied to certain flexible premium contracts issued prior to January 1, 1985 [11]. According to the Blue Book, the cash value accumulation test is intended to allow “traditional life insurance policies, with cash values that accumulate at reasonable interest rates, to continue to qualify as life insurance” [12]. As a result, compliance with the

cash value accumulation test must be guaranteed “by the terms of the contract.” The cash value accumulation is a prospective test that must be met at all times. Thus, a contract that would not meet the cash value accumulation test at some future date will be considered to have failed at issue.

### *The Guideline Premium/Cash Value Corridor Test*

An alternative to the cash value accumulation test is the guideline premium test found in Section 7702(c)(1). The guideline premium test is met if the total of the premiums paid under the contract at any time does not exceed the guideline premium limitation at that time *and* if the cash value corridor requirement is satisfied. The guideline premium limit at any time equals the greater of the guideline single premium or the sum of the guideline level premiums to that date (the guideline level premium multiplied by the years since issue).

The guideline single premium is the single premium at issue with respect to future benefits under the contract based on guaranteed interest, mortality, and expense, subject to the Section 7702(c)(3) statutory limits. The guideline level premium is the level annual equivalent of the guideline single premium payable over a period extending at least until the insured attains age 95, except that the minimum rate of interest is 4 percent, rather than the 6 percent minimum rate mandated for the guideline single premium.

The cash value corridor is satisfied if the death benefit at any time is not less than the applicable percentage of the cash surrender value set forth in the statute [13]. The actual corridor percentages were the subject of intense lobbying during the writing of Section 7702 and, as a result, do not follow a smooth progression from age to age. They are, however, intended to be less than the ratio of death benefit to cash value found under the cash value accumulation test.

The corridor percentages, which are found in Section 7702(d)(2), are given on the next page. (Note that the corridor percentages apply to the attained age of the insured at the beginning of the year.)

CORRIDOR PERCENTAGES  
(ATTAINED AGES AT THE BEGINNING OF THE CONTRACT YEAR)

Age	%	Age	%	Age	%	Age	%
0-40	250%	50	185%	60	130%	70	115%
41	243	51	178	61	128	71	113
42	236	52	171	62	126	72	111
43	229	53	164	63	124	73	109
44	222	54	157	64	122	74	107
45	215	55	150	65	120	75-90	105
46	209	56	146	66	119	91	104
47	203	57	142	67	118	92	103
48	197	58	138	68	117	93	102
49	191	59	134	69	116	94	101
						95+	100

According to the House Committee Report [14], the corridor is intended to regulate the buildup of cash value relative to the insurance risk present, although to a lesser degree than the cash value accumulation test because of the limitation on premiums under the guideline premium/cash value corridor test [15]. It should be noted that the lower minimum interest rate under the cash value accumulation test (4 percent as compared with 6 percent in the guideline premium test) results in a lower initial amount at risk under that test, but later amounts at risk are higher than under the guideline premium test, particularly when the death benefit is determined by the corridor percentages.

Unlike the cash value accumulation test, the guideline premium test is a retrospective “fact” test under which a contract is assumed to be in compliance until an actual failure occurs. Thus, a guideline premium contract will initially be in compliance even though by its terms it will ultimately fail. In addition, a contract can actually fail and later be brought into compliance. The prospective nature of the cash value accumulation test, and the corresponding retrospective nature of the guideline test, is a basic difference that is generally ignored in determining which test applies to a particular plan. It would appear to operate to make correction of contract design errors somewhat simpler under the guideline test, however.

The determination of the premiums paid under a life insurance contract is important both in terms of measuring compliance with Section 7702 and in terms of determining the taxable gain on surrender or maturity under Section 72. The term “premiums paid” may have different meanings, however, depending on the context in which it is used.

For purposes of the guideline premium test, premiums paid are generally defined as the sum of:

1. the premiums paid under the contract, less
2. withdrawals that are not taxable (as return of basis) under Section 72(e), less
3. withdrawals that are taxable but are considered as return premiums under Section 7702.

This amount may be different from the “premiums paid,” which are used in determining a taxable gain under Section 72(e).

Under the Section 72(e)(5) withdrawal provisions, amounts distributed under a life insurance contract are not taxable to the policyholder until they exceed the premiums paid in. An exception to this cost recovery rule is made when amounts are paid out under the Section 7702(f)(7) rules, in that taxable income can occur even though the premiums have not been recovered. In these instances, however, a portion of the taxable withdrawal may be considered as returned premiums under Section 7702 [16].

Under Section 7702(f)(1)(B) premiums paid also do not include amounts returned within 60 days of the end of the policy year in which they were paid, provided that they are returned with interest (which is taxable). In addition, a premium payment that causes the sum of the premiums paid to exceed the guideline limit will not result in disqualification of the contract, if the payment was necessary to prevent termination of the contract (without a cash value) on or before the end of the year.

### *Application of the Tests*

The notion of two equivalent tests, one for universal life plans and another for traditional products, was carried over into Section 7702 from the development of Section 101(f). It is assumed, but not required, that the cash value accumulation test will generally be applied to traditional permanent coverages and that the guideline premium test will be applied to universal life. The prospective focus of the cash value accumulation test was seen as more appropriate to traditional forms with fixed premiums and policy values, while the retrospective nature of the guideline test was seen as better suited to universal life and other flexible coverages, where the contract values are not fixed at issue. In determining that a contract need not refer to the specific test under which it qualifies, however, the Blue Book suggested that the choice of the test would be evident from the contract. The presumption is made that unless a contract passes the cash value accumulation test, it must be considered under the guideline premium/cash value corridor test [17].



It is important to note that Section 7702 is a consequence of the development of universal life and thus assumes that all life insurance products can easily be “unbundled” into interest, mortality, and expense components. This is a reason why universal life plans may appear to more readily and more easily qualify under Section 7702.

Although it is difficult in practice for a traditional plan to demonstrate compliance with the guideline premium test, many universal life plans have been designed to comply with the cash value accumulation test. There is nothing in Section 7702 that limits the choice of tests, and there are advantages and disadvantages to either approach. Once a contract has qualified under one test, however, it must continue to qualify under that test. An exception is mentioned in the Blue Book, permitting contracts using the guideline premium test to switch to the cash value accumulation test upon election of a nonforfeiture option [18].

As there is no provision made in Section 7702 for dividing a contract for purposes of applying the test, whatever test is chosen logically should be applied consistently to the entire contract. Thus, a paid-up addition under a participating contract is included in both the cash value and death benefit for purposes of applying Section 7702. Likewise, there is no apparent basis in the statute for applying the alternate death benefit rules (discussed below) to one part of a contract while applying the basic rules to other elements. A contract that measures compliance under a net level reserve method for the basic cash values, for example, could not under this interpretation apply a net single premium method to the cash value of paid-up additions as a means of demonstrating compliance.

A permanent cash value rider, such as a paid-up additions rider, raises an interesting definitional issue under Section 7702. If it is treated as a qualified additional benefit, the presence of a single premium or paid-up insurance rider will not increase either the guideline limitation or the net single premium (which anticipates that qualified additional benefits are in the nature of annual term insurance). In instances in which the basic contract qualifies on its own, the rider qualifies on its own, and the cash values are not combined, both policy and rider should logically qualify. This would not be the case, however, under a strict application of the qualified additional benefit rules to the rider.



## CALCULATION OF VALUES UNDER SECTION 7702

*The Test Plan Concept*

Calculation rules are provided by Section 7702(e). Along with the contract guarantees and Section 7702(b) and (c) statutory limits thereon, these rules provide the framework for the determination of allowable benefit patterns under both the cash value accumulation test and the guideline premium/cash value corridor test. The rules were designed to limit the prefunding of contract designs, which the framers of the statute believed were intended to manipulate the death benefits to produce contracts with substantial investment elements.

The calculation rules under Section 7702 effectively create a “test plan” that is used to determine the guideline premium and net single premium values under the statute. Under the test plan concept, these calculation rules do not directly limit the actual contract provisions but may restrict the values indirectly by limiting the allowable cash surrender values of premiums paid.

The test plan concept is consistent with the characterization of Section 7702 as a line-drawing exercise, which provides a somewhat arbitrary boundary for defining life insurance under the Internal Revenue Code. If the actual contract falls within the parameters for allowable premiums or cash values based on the test plan and the qualification basis used, the contract meets the Section 7702 requirements. If not, the contract fails.

*The Calculation Rules*

Four calculation rules are defined under Section 7702(e)(1), as follows:

1. 7702(e)(1)(A): The death benefit (and any qualified additional benefit) is deemed not to increase.
2. 7702(e)(1)(B): The maturity date is deemed to be no earlier than the date the insured attains age 95 and no later than the date on which the insured attains age 100.
3. 7702(e)(1)(C): Death benefits are deemed to be provided until the maturity date described under (B) above.
4. 7702(e)(1)(D): The amount of any endowment benefit is deemed not to exceed the least amount payable as a death benefit at any time under the contract.

Under the first calculation rule, the Blue Book suggests that the limit on increases in death benefit prohibits a contract from assuming a death benefit that decreases in earlier years and increases in later years in order to artificially increase the guideline limit [19].



Under the second and third calculation rules, the qualification limits for contracts maturing prior to age 95 can be measured by assuming that benefits continue to age 95. As a general rule, however, endowments for the full face amount prior to age 95 are not permitted, but partial endowments for less than the face amount are allowed. Effectively, a contract may endow at any time for an amount not in excess of the net single premium at that time for an endowment at age 95. Also, an actual contract may mature at an age over 100, although the premium or cash value limits must be based on an age that meets the calculational limit [20].

Under the fourth calculation rule, the endowment benefit (or sum of endowment benefits) cannot exceed the least amount payable as a death benefit at any time under the contract. For these purposes, the term endowment benefit also refers to the cash surrender value at the maturity date.

### *The Alternate Death Benefit Rules*

An exception to the death benefit rules is provided for certain types of increasing death benefit plans. In computing the guideline level premium, an increasing death benefit may be taken into account under Section 7702(e)(2)(A), but only to the extent necessary to prevent a decrease in the excess of the death benefit over the cash surrender value (that is, a decrease in the net amount at risk). According to the Blue Book [21], this modification to the computation rules is intended to permit guideline level premiums to be adequate to fund, on a guaranteed basis, a death benefit equal to the cash value plus a fixed amount of insurance benefit. Under the alternate death benefit rules, the guideline single premium would be calculated by using a level death benefit, while the guideline level premium would still be calculated assuming the increase was prefunded to the extent permitted.

In the cash value accumulation test under Section 7702(e)(2)(B), the increase described above can be taken into account, if the contract will meet the test at all times by using a net level reserve rather than a net single premium as the basis for qualification. The exception to the calculation rule for the cash value accumulation test indicates that the net level reserve is to be used as a complete substitute for the net single premium as it would be applied to a level benefit contract. In the early contract years, this is very restrictive in the sense that there is no analogue on the cash value accumulation test to the guideline single premium, so that the allowance provided for increasing benefit plans is significantly less than that for level benefit plans in the early durations [22].



The alternate death benefit exception overrides the computation rule under Section 7702(e)(1)(A), which otherwise prevents the death benefit from increasing, but does not provide relief from 7702(e)(1)(D), which limits the guaranteed funding for the endowment benefit, and thereby the cash value at maturity, to the least amount payable under the contract. Thus, if the test plan is an endowment, the modification to the calculation rule in (A) will result in a benefit that increases for a number of years, but later decreases to the least death benefit to satisfy the requirement of the fourth calculational rule.

Where test plan values are computed to the end of the mortality table, however, the final endowment benefit has no effect on the guideline premium or net level premium, because the present value of the endowment is zero. In this case, under a literal application of the calculation rule any pattern of increasing benefits would appear to be allowable so long as the net amount at risk under the contract does not increase. This approach would allow a constantly increasing pattern of death benefit with effectively no limit on the final endowment, so long as the benefit is funded on a level premium basis over the life of the insured.

The interpretation that the “least endowment” calculational rule is not applicable to whole life plans may not have been anticipated by the framers of Section 7702, and it does result in significantly higher guideline premiums and net level reserves than would be permissible if the actual maturity value were required to be the least amount payable under the contract. Although it can be argued that such a requirement on actual policy values would be inconsistent with the test plan concept, it appears to have been the intent of Congress that maturity values (or cash values at maturity) in excess of the least death benefit not be permitted in the determination of permissible values under Section 7702.

#### CONTRACT PROVISIONS AND GUARANTEES

Three sets of limits create the test plan values under Section 7702:

1. The actual contract provisions and guarantees;
2. The Section 7702(b) and (c) limits on interest, mortality, and expense; and
3. The Section 7702(e) calculational rules.

In general, all guarantees made under the contract should be given effect in determining the guideline premium or net single premium. For example, initial guarantees of interest, mortality, or expense should be recognized.

Calculations will generally follow the structure of the policy. For example, if the policy requires that mortality charges be deducted monthly, the policy value projection should reflect monthly mortality deductions. An annual calculation could presumably be made as an alternative if it produces lower guideline premiums and net single premiums. In addition, calculations of guideline premium and net single premium values are made by using the basic benefit structure or “main track” of the plan. Determinations may be based on either continuous or curtate functions, consistent with the manner in which cash values or reserves are determined under the policy.

The attained age to be used in calculating values is limited by the language in the Blue Book [23] to an age within 12 months of the insured’s actual age. Under this limit, age setbacks (which are conservative) are permitted, but age setforwards (as might be used for substandard ratings, for example) are not. Note that “within 12 months” may exclude values that are exactly 12 months apart.

The Blue Book also provides for “reasonable” approximations and rounding, limited to \$1.00 per \$1,000, in the calculation of net single premium and guideline premium values.

### *Interest*

The rate of interest assumed in calculations under Section 7702 is the only contract guarantee so limited by the specific terms of the statute. The interest rate is the greater of the rate or rates guaranteed on issuance of the contract or the statutory minimums:

1. Guideline Single Premium: 6 percent per annum (Section 7702(c)(3)(B)(iii))
2. Guideline Level Premium: 4 percent per annum (Section 7702(c)(4))
3. Net Single Premium: 4 percent per annum (Section 7702(b)(2)(A)).

According to the Blue Book, the rate or rates guaranteed on issuance are the interest rates reflected in the contract’s nonforfeiture values, “assuming the use of the method in the Standard Nonforfeiture Law” [24].

The reference to “the rate or rates guaranteed upon issuance” recognizes that the rate to be used is the guaranteed minimum rate or floor rate below which contractual rates may not fall. This would presumably cover any guarantee made at issue that was enforceable by the policyholder, whether made specifically in the contract or as an extracontractual guarantee. In addition, the reference to multiple rates indicates that the guarantee must be examined separately for each period in which a guarantee is made. Thus, the guaranteed rate for each duration is compared to the statutory minimum,

and the higher of the rates is chosen. Where an initial guarantee that is higher is made, the higher rate is to be used for the period of the initial guarantees.

A contract in which the minimum rate is set by an index would generally use the minimum guaranteed basis, except that the initial index value would be used if it is higher than the statutory and contractual minimum.

In some cases, the guaranteed rate applied to policy loans is higher than the minimum. This could occur, for example, under a contract having a so-called “zero net cost loan” tied to an 8 percent loan rate, so that the portion of the cash value representing loans is guaranteed an 8 percent accumulation. In this instance, an argument could be made to require that an 8 percent rate be applied in the determination of Section 7702 values, on the basis that the policyholder can exercise a guaranteed option to achieve an 8 percent credited rate. At the same time, however, it also can be argued that the recognition of a higher rate at issue is inconsistent with the notion that the rates are those used in the determination of the contract nonforfeiture values. The recognition of the higher guarantee as an adjustment to the floor interest rate, however, would not be inconsistent with the adjustment rules.

### *Mortality*

The basis for the guaranteed mortality is, according to Section 7702(c)(3)(B)(i), to be the mortality charges specified in the contract or, if no mortality charges are specified, the mortality charges used in the determination of the statutory reserves.

For accumulation contracts in which the mortality basis is explicitly stated, this rule is clear in its application. (For other plans, see the discussion on “Implied Guarantees,” below.) For traditional life insurance plans, the mortality table is generally specified, but the assumed mortality “charges” are not. This may cause technical compliance difficulties for plans, such as the unisex products issued to employee benefit plans under the *Norris* [25] decision, in which the cash values and reserves are on a different basis. For these plans, the cash values are on a blended table and are therefore identical for males and females. The reserves, however, under the current NAIC model regulation must be sex distinct. If mortality charges are not explicitly stated and mortality rates are imputed as being equal to the reserve basis, policies issued to females would not comply with a strict interpretation of the law.



Unlike the interest rates assumed, Section 7702 does not explicitly limit the mortality charges that may be applied in the determination of guideline premiums or net single premiums. The greater the mortality charges, the higher the allowable premiums or net single premium values. In practice, however, an insurer may not have absolute freedom in the actual rates to be applied. This concern was addressed in an article by John Adney and Jeffrey Hahn:

While the statute permits the specification and use of charges more conservative than those expected to be made at the time the contract is issued, the statute's framers expected that market forces would limit the size of the charges so specified and, hence, the amount of the increase in the guideline premium limit (or net single premium) attributable to their conservatism. It should be emphasized, however, that Section 7702(j) grants ample authority to limit the size of charges . . . considered excessive in that their sole apparent purpose is to increase the guideline premium limit (or net single premium) [26].

In reflecting substandard mortality, a reasonable rule is that the mortality charges should be consistent with the underwriting practices underlying the plan and should bear some relationship to the actual rates being charged.

In some early discussions of the Section 7702 tests, concern was expressed with respect to the use of substandard mortality in connection with the cash value accumulation test, in that the use of a substandard net single premium was not consistent with prevailing industry practice in the determination of reserves and cash values under traditional life insurance plans. This does not apply to the guideline premium test, because the use of substandard mortality charges is common in universal life and similar plans. Section 7702 does not differentiate between the tests in defining the permissible assumptions, so the interpretation has no direct support in the statute, but this is another reason to approach the subject of substandard mortality with caution. It also is another indication of the universal life orientation of Section 7702.

In light of the Blue Book assumption that the cash value accumulation test ultimately has a higher ratio of insurance protection to cash value than does the guideline premium/cash value corridor test, a highly substandard net single premium (in which this relationship no longer held) also would be a cause for concern, especially if it was not strictly supported by the underwriting basis.



### *Expense Charges*

Under Section 7702(c)(3)(B)(ii), any charges other than mortality charges (either for expenses or qualified additional benefits) that are specified in the contract may be recognized in the determination of values under the guideline premium test. Expense charges, other than those for qualified additional benefits, may not be used in the determination of values under the cash value accumulation test. Charges assessed upon surrender may not be recognized in either the cash value accumulation test or the guideline premium test.

As is the case for mortality charges, the level of expense charges is not specifically limited by the statute [27]. The Adney and Hahn commentary on the appropriate levels of mortality charges is equally applicable to expense charges to the extent that the contractual expense charges must bear some relationship to the actual economics of the contract and must not be specified simply to increase the allowable values.

Expense charges typically have consisted of per policy, per thousand of face amount, and percentage of premium elements. Although asset-based charges have been present in variable life contracts for some time, percentage of accumulation value charges have come into increased use for fixed contracts, particularly single premium plans. When these charges are used in the determination of guideline single premium values, they have the effect of reducing the effective interest rate at which the single premium values are determined. Thus, a 2 percent of accumulation value expense charge applied to a 6 percent guideline single premium would be equivalent to computing the guideline single premium at an effective rate, net of expense charges, of 4 percent.

Asset-based expense charges raise the issue of whether the statutory minimum rates are “net” rates. With respect to expense charges, this is certainly the case under the cash value accumulation test. Under the guideline premium test, however, expense charges can be recognized and are not limited in form, so it would seem appropriate to reflect any type of expense charge set forth in the contract. In using asset-based charges, care should be taken that the rate used can be shown to be consistent with the contract economics. One approach that may be defensible would be to apply only the portion of an asset-based charge that is attributable to expense and profit elements, under the assumption that mortality-related costs are adequately covered by the policy mortality guarantees. At the same time, an argument could be made that an asset-based mortality risk charge is in the nature of a mortality



charge. In that case, the “net” rate applicable to both the cash value accumulation and guideline premium tests would be reduced by the amount of the mortality risk charge.

### *Implied Guarantees*

A concept developed in the Committee Reports on Section 7702 may be called the principle of implied guarantees [28]. This approach is intended to limit the permissible level of prefunding under Section 7702 to level face amount single premium plans. The need to recognize the so-called implied guarantees is based on the qualification “assuming the use of the method in the Standard Nonforfeiture Law” on the applicability of the cash value interest rate to the determination of values under Section 7702.

This was directed at contracts under which cash values are determined on a nonstandard basis, such as a plan under which the guaranteed values are an accumulation of premiums at interest. In this instance, the Blue Book states that a company will not be considered to guarantee a lower interest rate by failing to state a mortality charge. It prescribes a procedure by which the interest rate is redetermined as the rate at which cash values would accumulate assuming that a mortality charge based on the reserve mortality were actually applied.

As a general rule, where one or more policy guarantees may be implicit, the guaranteed interest is used as a balancing item in a year-by-year comparison of the contract values to standard cash values.

Although there is no basis specified for making the required calculations, one approach would be to assume that the net premium is applied to the accumulation value each year and to solve for the effective interest rate that connects successive cash values. This is accomplished by solving the following equation for  $i_t$ :

$$AV_t = [(AV_{t-1} + NP_t) \times (1 + i_t) - DB_t \times q_{x+t-1}] / p_{x+t-1}$$

where  $AV_t$  = accumulation value at the end of year  $t$ ,  $NP_t$  = net premium paid during year  $t$ , and  $DB_t$  = death benefit at the end of year  $t$ .

The rate used in determining the guideline premiums or net single premiums would be the greater of the “guaranteed” rate so determined or the statutory minimum rate.



### *Secondary Guarantees*

Any so-called secondary guarantees present in a contract should be considered in selecting the appropriate policy guarantees of interest, mortality, and expense to be recognized in the determination of values under Section 7702. Secondary guarantees typically occur in fixed premium universal life contracts that have cash value scales based on the greater of an accumulation value less a surrender charge and a minimum nonforfeiture value.

These plans were the subject of clarification during the preparation of the Blue Book to arrive at an appropriate treatment under Section 7702. Under the method stated, both the accumulation guarantee and the secondary guarantee are to be considered prospectively in applying the Section 7702 tests. If the contract cash values are projected forward, one of three results generally occurs:

1. The projected accumulation value can exceed the secondary guarantee in all durations;
2. The accumulation value and the secondary guarantee can meet at maturity; or
3. The accumulation value is not sufficient to mature the contract, and the values meet prior to maturity.

Under a contract as described in nos. 1 and 2, the factors used for the accumulation values would be used in all durations in the determination of Section 7702 values. Under no. 3, the accumulation assumptions would be used until the secondary guarantees became the determining values. At that point, calculations would be based on the secondary guarantee assumptions for mortality, interest, and expense. If more than one “crossover” (where the minimum value exceeds the accumulation basis value) occurs, then the values that actually determine the guaranteed cash value for a particular contract duration will be used.

Under the guideline premium test, this method may be applied in practice by specifically identifying in the contract as an expense charge the difference between the accumulation basis guideline premium and the nonforfeiture adjusted premium. Thus, whatever guarantee basis is used, the resulting guideline premiums will always be equal.

Under both the cash value accumulation test and the guideline premium test, charges for qualified additional benefits are to be treated as a future benefit under the contract, thereby increasing the net single premium or the guideline premium based on the discounted amount of the charges for the benefits [29].

### *Qualified Additional Benefits*

Qualified additional benefits are expressly defined to include the following:

1. guaranteed insurability,
2. accidental death and disability [30],
3. family term coverage [31],
4. disability waiver, and
5. other benefits set by regulation.

The method of recognizing qualified additional benefits was first discussed in the Blue Book for TEFRA [32], which provided that qualified additional benefits are taken into account by reflecting the interaction of their cost in the base policy cash value. For computational purposes, this means that the effect of qualified additional benefits differs for level face amount universal life plans and face amount plus cash value plans. Level death benefit plans effectively are discounted by using interest and mortality, while increasing death benefits are discounted at interest only.

Both the TEFRA Blue Book and the Committee Reports on Section 7702 indicate that, in determining guideline level premiums, the guideline premiums should reflect the charges over the period for which they are incurred, thus avoiding post-funding of the benefits. Although the “bilevel” funding results in a higher initial guideline limitation, it does result in a lower overall guideline limit [33]. As a result, an approach of funding qualified additional benefits over the lifetime of the insured is not only contrary to the legislative history, but also results in a higher guideline limit.

The treatment of an additional benefit that does not fall within the list of qualified benefits also is prescribed. In the case of an additional benefit that is not qualified and not prefunded (by withdrawals or subtractions from the policy cash value), neither the benefit nor the charge is taken into account in determining the net single premium, the guideline premium limit, or the sum of the premiums paid. In this case the benefits are ignored, both in calculating the applicable limit and in measuring compliance.

If, however, the qualified additional benefit is prefunded in the cash value, the charges are included in determining the premiums paid, even though they may not be recognized in determining future benefits under either test. Further, compliance with the cash value accumulation test would be based on the entire cash value, including that created by the prefunding. In this case, the benefits are not used in determining the applicable limit but are recognized in measuring compliance.



## ADJUSTMENTS

*Adjustable Events*

Adjustments are required for a change in future benefits, qualified additional benefit, or other contract terms that are not reflected in a previous determination of the definitional limits. Adjustments differ in their requirements, depending on the nature of the adjustable event and the test used for qualification.

Adjustments are required under both the guideline premium/cash value corridor test and the cash value accumulation test for any of the following:

1. Changes in death or endowment benefits made at the request of the policyowner;
2. Changes in death or endowment benefits that result from the operation of the contract and that have not previously been reflected in the calculation of the limits (presumably because of the calculation rules);
3. The addition or termination of a qualified additional benefit;
4. A change between a level and increasing death benefit pattern; and
5. Changes to basic interest and mortality guarantees.

Under the guideline test, the limits are recomputed in two instances: (1) if the policyholder initiates the change, and (2) if a scheduled change is not reflected because of the calculation limits. Changes that do not trigger adjustments include changes initiated by the company or changes resulting from the growth of the cash surrender value (whether by the crediting of excess interest or the payment of guideline premiums) [34]. The rule that excess interest (as well as reductions in mortality charges) is not reflected is consistent with the approach used in Section 101(f):

aside from taking into account initial guarantees that are different from generally applicable charges and interest rates assumed under the contract, the Act (Section 101(f)) does not require that any “excess interest” or any reduction in mortality charges be taken into account [35].

Unlike the guideline premium test, the cash value accumulation requires that all changes be taken into account and that the net single premium be recalculated based on the attained age of the insured at the time of the change.

Adjustments may occur in some unexpected ways. Consider, for example, a contract under which the death benefit option is changed from “level” to “increasing” when a disability waiver of premium is in effect. In some instances, this results in the guideline limit being reduced by the disability of the insured as a consequence of the application of the adjustment rules.

### *Guideline Premium Test*

Different approaches are prescribed for reflecting changes under the guideline premium/cash value corridor test and the cash value accumulation test. Under the guideline test, the increase is treated separately from the basic guideline values. This is done by using the so-called Dole-Bentsen colloquy, or attained age decrement approach of “before and after” calculations based on the attained age of the insured at the time of the change.

Under the Dole-Bentsen method, attained age layers of guideline premium values are added to the existing guideline single and guideline level premiums. In symbols:

$$\text{Incremental Guideline Single Premium}_{x+t} = \text{GSP(AFTER)}_{x+t} - \text{GSP(BEFORE)}_{x+t}$$

$$\text{Incremental Guideline Level Premium}_{x+t} = \text{GLP(AFTER)}_{x+t} - \text{GLP(BEFORE)}_{x+t}$$

This method first appeared in a Senate floor colloquy related to Section 101(f), appearing in the *Congressional Record* for August 19, 1982. In the discussion, Senator Dole stated that the adjustment would be computed in the same manner as the original guideline premiums, but based on the change in amount or benefit pattern and the attained age of the insured at the time of the change.

In an example prepared for the TEFRA Blue Book [36], post-issue changes that increased benefits were reflected by calculating a guideline premium adjustment, which was then added to the original guideline premium to produce the new limitation. In addition, the method as applied to reductions in benefits (in reference to a decrease under Section 7702(f)(7)(B)) appeared in the Committee Reports to the Tax Reform Act of 1986:

The guideline premium limitation shall be redetermined using an “attained age decrement” method. Under this method, when benefits under the contract are reduced, the guideline level and guideline single premium limitations are each adjusted and redetermined by subtracting from the original guideline premium limitation, a “negative guideline premium limitation” which is determined as of the date of the reduction in benefits and at the attained age of the insured on such date. The negative guideline premium limitation is the guideline premium limitation for an insurance contract that, when combined with the original insurance contract after the reduction in benefits, produces an insurance contract with the same benefit as the original contract before such reduction [37].



The use of the “attained age decrement” approach creates a number of calculational problems in the determination of the guideline limit. When future benefits decrease, attained age adjustments for the decrease in the face amount are deducted from the original guideline premiums. If the decrease is large enough, the guideline premium limitation can become negative, thus making compliance impossible. In many instances, the guideline single premium becomes negative immediately, but the contract can remain in force as the overall limit declines more slowly through the limitation of the annual premium.

Under a “face amount plus cash value” plan, the guideline single premium is limited by the calculation rules to the guideline single premium for a level death benefit. Under the adjustment rules, an increase in the guideline single premium could in theory be made for that portion of the death benefit increase attributable to the “guaranteed” cash value. (The increase attributable to excess interest and the “nonguaranteed” reduction in mortality charges is not eligible to be recognized under the limitations set forth in the Blue Book.)

In practice, this increase in the guideline single premium is not recognized, for two reasons: (1) the difficulty in identifying the appropriate increase amount, and (2) the difficulties of applying the decrease rule when the cash value is reduced for any reason. Under this approach, if the “model plan” concept is used to determine when an adjustment is required, a partial withdrawal from this type of plan would not trigger an adjustment to the guideline single premium. It is not as clear that an adjustment to the guideline level premium is not required in this instance, but in practice no rules have been set for determining when an adjustable decrease (attributable to the guaranteed cash value) occurs.

A second consequence of not continually increasing the guideline single premium is that a change from an “increasing” to a “level” death benefit generally results in an increased guideline premium limit, a result thought to be contrary to the understanding of the framers of the statute, as this type of change was cited as one reason behind the enactment of Section 7702(f)(7)(B) [38]. The limitation increases because the guideline single premium is not adjusted by incremental changes in the cash value until the option change occurs. Under Section 101(f), the guideline single premium was allowed to prefund the face amount plus the cash value, and as a result, the guideline limit generally decreased for this type of contract adjustment.

For changes in contract benefits subsequent to issue, an increase may create a lower limitation than if two contracts were purchased separately.



This occurs because the guideline single and guideline level premiums are increased separately. For a mature contract, the guideline limit is likely to be based on the sum of the guideline level premiums. If the result of the increase is to move the contract to the guideline single premium as the applicable limit, the effect of the increase would be smaller than if the two contracts had been purchased separately.

Increases in face amount resulting from the operation of the corridor do not create corresponding increases in the guideline limit. An increase of the same amount elected in anticipation of (or subsequent to) the corridor increase would result in an increase in the guideline limit, however.

### *Cash Value Accumulation Test*

Adjustments under the cash value accumulation test are considerably simpler than those under the guideline premium/cash value corridor. An increase under the cash value test is computed by treating the date of the change as a new issue date for measuring compliance, so that in the absence of a change in contract guarantees, the net single premium limitation is simply to be measured against the new face amount.

Because the cash value test is always applied as an attained age net single premium, increases and decreases are handled automatically, thus avoiding some of the problems found in the guideline premium test. The simplicity of adjustments is one reason the cash value accumulation test has been applied to universal life and other accumulation plans. However, the assumption that the cash value test is continuously applied to any change in the cash value would imply that the net single premiums should always reflect any outstanding (current) contract guarantees as to interest and mortality charges. Thus, if a one-year guarantee of current interest and (or) mortality is made, the net single premium should always reflect one year of current values.

### TAXATION OF WITHDRAWALS UNDER SECTION 7702(f)(7)(B)

The general rule for taxation of a surrender or partial withdrawal under a life insurance contract is found in Section 72(e), which provides that proceeds are taxable only to the extent that they exceed the premiums paid [39]. The provisions of Section 7702(f)(7)(B) define a narrow set of circumstances in which the normal rules do not apply, and the amounts distributed are taxed on an income-first basis.

The Section 7702(f)(7)(B) rules were added to Section 7702 by the Technical Corrections Bill to the Deficit Reduction Act of 1984. As it was originally enacted, Section 7702(f)(7)(B) provided that a change to a contract that reduced the future benefits would be treated as an exchange of contracts.

The House Committee Report for the Deficit Reduction Act noted that the change should be treated as an exchange of contracts under Section 1035 of the Internal Revenue Code. Further, the provision was specifically intended to deal with a change in benefit option from an increasing pattern of death benefits to a level pattern [40]. Under the Section 1031(b) rules, if the adjustment to the contract resulted in a distribution of cash, the payment would be taxable to the extent there was a gain in the contract.

After the enactment of Section 7702, it became clear that little agreement existed among insurance industry and government representatives as to the precise meaning of the (f)(7)(B) provisions. At one extreme, the provisions were viewed as affecting only a change in death benefit option as outlined in the Committee Reports. At the other extreme, they were viewed as a significant change to the Section 72 ordering rules that would create taxable income under a wide variety of circumstances, including the surrender of a paid-up addition under a fully paid-up traditional participating contract.

The current rules were put in place as a result of negotiations between insurance industry representatives and Treasury staff. Under the current (f)(7)(B) rules, taxable income to the policyholder may be recognized in connection with a change in contract values if *all* of the following conditions are met:

1. The change reduces the future benefits under the contract;
2. The change occurs within 15 years of the original issue date;
3. Cash is distributed from the contract as a part of or consequence of the change;
4. The recapture ceiling, as defined in the statute, is exceeded; and
5. There is a gain in the contract (the cash surrender value exceeds the policyholder's basis) [41].

Taxable income is to be recognized on the cash distributed, up to the gain in the contract, to the extent of the recapture ceiling.

For purposes of determining the recapture ceiling, the contract is divided into two distinct periods: policy years one through five, and policy years six through fifteen. In years one through five, the recapture ceiling is equal to the distribution required under Section 7702(f)(7)(A) to maintain the contract in compliance with Section 7702. This will differ for contracts under the cash value accumulation test and those under the guideline premium/cash



value corridor test. In policy years one through five, the limitations are as follows:

1. Recapture ceiling I (cash value accumulation test) equals the cash surrender value immediately prior to the withdrawal less the net single premium for the new face amount immediately after the withdrawal.
2. Recapture ceiling I (guideline premium/cash value corridor test) equals the greater of (I) or (II), where:
  - (I) equals the premiums paid under the contract minus the guideline premium limitation after the withdrawal; and
  - (II) equals the cash surrender value immediately prior to the withdrawal minus the face amount immediately after the change divided by the applicable corridor percentage.

In policy years six through fifteen, a single rule applies to both tests:

3. Recapture ceiling II equals (II), above [42].

During the first five contract years, the recapture ceiling results in a recognition of income to the extent that amounts are “forced out” of a contract under the Section 7702(f)(7)(A) adjustment rules. The recapture ceiling during years six to fifteen uses only the cash value corridor found in the guideline premium test as a measure of a “force out.” This effectively creates a maximum cash value per thousand of face amount which may be present in a contract for a partial withdrawal to be entirely tax free. Under the rule, the allowable tax free withdrawal becomes smaller as the amount of cash value per thousand increases.

A consequence of the operation of the three-part rule is that there are significant differences in the tax treatment of withdrawals during the transitional years. For example, a withdrawal that would be taxed if it occurred at the end of policy year five could be subject to substantially less tax at the beginning of policy year six. A withdrawal that occurs at the end of policy year fifteen can incur a tax, while one made at the beginning of policy year sixteen may be entirely tax-free.

The application of the Section 7702(d) corridor percentages during years six to fifteen to contracts under the cash value accumulation test also means that taxable income is less likely to result under a cash value accumulation test plan, unless the cash value accumulation test mortality charges are highly substandard or a large withdrawal is made.

One proposed response to the tax on withdrawals is the use of a so-called underwritten partial withdrawal. Under most universal life plans, a reduction in future benefits occurs as a result of operation of the partial withdrawal



provision, in which the face amount is reduced by the amount of the withdrawal, so that the net amount at risk is the same before and after the withdrawal, thus controlling antiselection through the withdrawal process. By securing evidence of insurability, or by underwriting a systematic withdrawal program at issue, it is possible that the reduction in face amount, and thereby the application of the Section (f)(7)(B) rules, can be avoided. Note also that under current tax law, the use of policy loans as an alternative to withdrawals would avoid the Section (f)(7)(B) rules.

#### FAILED CONTRACTS

Specific procedures are given in Section 7702(f)(8) and (g) for dealing with errors and contracts that fail to qualify.

If a contract fails to meet the Section 7702 tests due to “reasonable error,” the failure may be waived by the Secretary of the Treasury if it can be demonstrated that reasonable steps are being taken to correct the error. (It is anticipated that this procedure will be developed further through the rulings process.)

For contracts that cease to meet the definitional tests, the income for all prior taxable years is treated as received or accrued in the year in which the disqualification occurs. The income on the contract is defined as the excess of:

1. the sum of (I) and (II), where (I) equals the increase in the net cash surrender value [43] and (II) is the cost of insurance protection provided during the year, over
2. the premiums paid during the taxable year.

The cost of protection is based on the lesser of the contract mortality charges and a uniform table to be specified by regulations.

The taxable income for any year can be shown to be equivalent to the interest credited to the contract plus any reduction in surrender charge, less any expense charges deducted.

For a life insurance company, the reserves under failed contracts are no longer considered as life insurance reserves but must be reported as 807(c)(4) reserves.

#### SPECIFIC APPLICATIONS AND PROBLEMS

##### *Variable Life*

For variable life plans, as defined under Section 817 of the Internal Revenue Code, special rules are provided in Section 7702(f)(9). These plans must be tested for compliance with either the cash value accumulation test

or the guideline premium test (corridor) whenever the death benefits change. In any event, the determination must not be made less frequently than once in each 12-month period. The Blue Book indicates that if the contract is checked for compliance once per year, the determination must be made at the same time each year [44].

In determining the net single premium under the cash value accumulation test, a 4 percent interest rate is to be used if no nonforfeiture interest rate is provided. Similarly, for the guideline premium test, a 6 percent rate applies in the determination of the guideline single premium.

For a guideline premium product, the effective interest rate (net of expense charges) at which the calculations are made can be reduced by any percentage of asset charges specified in the contract. Note, however, that this is limited to charges actually specified in the variable life contract and may not be extended to charges levied by separate accounts or unit investment trusts that are not specifically set by the contract. It is also important to note that expense charges may not be recognized in the determination of the net single premium under the cash value accumulation test.

Because Section 7702(f)(9) specifically cross-references Section 817, a related issue for variable life plans that is not addressed by Section 7702 is the wraparound issue, dealing with ownership of the assets underlying the variable life plan. Life insurance status could be denied unless the separate account funding vehicle meets the IRS standards on asset diversification, even though the technical requirements of Section 7702 were met.

### *Reducing Face Amount Plans*

Section 7702 is unclear as to the recognition of scheduled decreases in coverage, except for the calculation rule in Section 7702(e)(1)(D). This rule provides that the least amount payable as a death benefit must be recognized in computing the endowment element of a guideline premium net single premium.

The four calculation rules that are applied in the determination of future contract benefits are *deemed* to apply in determining Section 7702 test plan values. The first rule does not permit death benefits to increase and is intended to prohibit either a pattern of increasing benefits or a pattern of decreasing and later increasing benefits to be used. Note that the rule does not mandate that benefits be decreased to follow contractual benefits — only that, once they are decreased, they cannot subsequently be increased.

For plans under which the face amount decreases subsequent to issue, it does not appear to be inconsistent with the Section 7702 rules either to recognize the scheduled decreases at issue or, alternatively, to assume a level death benefit pattern and recognize the decreases as they occur as adjustments under Section 7702(f)(7)(A).

Under one view of the third calculation rule, it could be argued that a contractual pattern of decreasing benefits should be followed if it is a part of the contract guarantee structure. This interpretation is based on the theory that the purpose of the rule in Section 7702(e)(1)(C) is only to permit partial endowments and the otherwise the contract structure should be followed. It raises the question, however, of why it is appropriate to “deem” a level death benefit where no benefits are provided, but it is not appropriate to use level benefits where some coverage is provided.

The second and third calculation rules permit the test plan to be an endowment at 95, or a whole life coverage, even if the actual contract terminates prior to that time. Continuation of the initial level of benefits is not inconsistent with these rules. Under these rules, it is well-established that benefits are assumed to continue to the deemed maturity date for a contract that terminates prior to 95, so the continuation of level benefits to the deemed maturity date also would seem to be permissible.

The fourth calculation rule limits the final endowment value to the least amount payable as a death benefit under the contract. This would have an effect on the calculation of values under a reducing face amount contract, in that the maximum allowable single premium is for an endowment at 95 with the endowment value equal to the smallest death benefit. This would not present a problem for a whole life plan, because the value of the final endowment is zero.

### *Cash Value Bonus Plans*

Some universal life contracts have been issued that provide, on a guaranteed basis, increases in the cash value if the contract is in force at a specified policy duration. It is appropriate to recognize these guaranteed increases in policy values in the determination of Section 7702 test plan values.

Calculations under Section 7702 are made by using contract values and methods, subject to the statutory limits on assumptions and calculation rules. Assuming that a contract was structured so that it is consistent with the statutory requirements, it is anticipated that the guideline premiums or net

single premium at issue would be the amount required to mature the contract under guaranteed assumptions.

A provision increasing the cash value would reduce both the required guideline premiums and net single premium from the comparable values required under a contract without such a provision. As a consequence, it can be argued that the statute requires the recognition of such a provision. This is consistent with the notion that policy mechanics are to be used in the determination of values. In addition, it is consistent with the tax policy objective to avoid overfunding of contracts on a guaranteed basis.

The additional contract interest could be recognized as it occurs by amount and duration in the calculation of guideline premiums and net single premium. For example, it could be incorporated into the calculation as a negative expense charge or could be recognized as an additional interest guarantee.

A cash value bonus would not need to be recognized in this way if it were provided on a nonguaranteed basis and would be treated in the same manner as any dividend or excess interest payment.

### *Joint Life Plans*

There is no direct limitation in Section 7702 regulating the form of insurance that may be provided in terms of the number of lives. There is also little guidance available in terms of the calculation rules or other effects of the statute. In instances where a separate charge is made for term coverage for an additional insured, it is clear that the additional benefit rules apply. It not at all clear, however, as to how a joint life or a last-to-die function would be handled.

In addition, a number of methods are used in the calculation of multiple life values, which are often approximated by the use of uniform seniority tables. This can result in a wider variation in practice in the determination of premium values under joint life than is likely to occur under comparable single life calculations.

Attained age is defined in the Blue Book as the age determined by reference to contract anniversaries, so long as the age assumed under the contract is within 12 months of the actual age [45]. The definition of attained age is not clear when two insureds are involved, but one approach that has been used under the guideline premium test is to assume that the age of the younger insured is the appropriate age, although this seems highly restrictive and may cause difficulties in meeting the limitation on final maturity date. Other plans have defined values based on joint life status, under which the

precise meaning of “attained age” has yet to be determined. Aside from the “12 month” problem, the limiting age of 100 also causes definitional problems in applying Section 7702 to joint life plans, unless the joint insureds’ ages are within five years, and the contract can then be assumed to endow between ages 95 and 100.

A reference to joint contracts (not directly related to Section 7702) appears in the legislative reports to the Omnibus Budget Reconciliation Act of 1987 (H.R. 3545) [46] dealing with the allocation of deductible policy loan interest among two insureds. This discussion of joint life is significant in that it gives credibility to the notion that Congress did not intend to eliminate joint plans under Section 7702, as it is the first mention of joint contracts since Section 7702.

### *Contract Modifications*

Section 7702 subjects contracts issued after December 31, 1984 to the definitional requirements, but most contracts issued prior to that date are exempt. There are certain instances, however, in which changes to existing contracts may subject pre-Section 7702 contracts to the definitional limits.

The Blue Book provides that contracts issued in exchange for existing contracts after December 31, 1984 must meet the requirements of Section 7702. Thus, a pre-Section 7702 contract will lose its grandfathered status as the result of a Section 1035 exchange, even though the basis of the old contract is carried over to the new contract for determining the taxable gain upon surrender [47].

Unlike an exchange, the exercise of an option or right granted under a contract as originally issued, such as the exercise of a conversion right, will not result in a new contract and therefore does not constitute a new issue subject to the Section 7702 rules. Note, however, that a complying contract would be required, unless the conversion privilege specifically required that a noncomplying contract be issued.

According to the Blue Book, a substitution of insured rider issued under a binding contractual obligation is not a new contract, so that the grandfather is not lost. A substitution of insured under a contract subject to Section 7702 contract will require some adjustment, however. If the Blue Book is followed and it is not treated as a new contract, it will likely follow the adjustment rules, with the adjustment based on the attained ages of the insureds at the time of the substitution. Some taxable income may result if the amounts of insurance are determined on a basis other than the attained age of the new insured [48].



A change to a contract issued prior to January 1, 1985 may serve to bring the contract within Section 7702. According to the Blue Book [49], the grandfather is preserved only if the terms of the resulting contract (amount or pattern of death benefits, rate or rates guaranteed on issuance, mortality and expense charges, etc.) are fundamentally unchanged. One implication is that an increase in coverage under a pre-Section 7702 plan could be interpreted as bringing the contract under Section 7702, unless the right to increase coverage is specifically granted by the contract.

#### EXAMPLES

##### *Sample Plan Illustrations*

Sample calculations are provided in Tables 1 through 6 to illustrate the mechanics of determining values under Section 7702. The plan illustrated is identical to the plan illustrated in the TEFRA Blue Book, with appropriate modifications for the changes incorporated into Section 7702 from those found under Section 101(f). The data in the tables illustrate a number of policy events, as follows:

1. Basic values: level death benefit
2. Basic values: increasing death benefit
3. Decrease in face amount: level death benefit
4. Change in death benefit option: increasing to level death benefit
5. Section 7702(f)(7)(B): withdrawal of the single premium (guideline premium)
6. Section 7702(f)(7)(B): withdrawal of the single premium (cash value accumulation test).

##### *Plan Assumptions*

The assumptions underlying the sample plan are as given below:

1. Mortality: 75 percent of 1958 CSO, male, ALB in policy year 1 and 100 percent thereafter.
2. Interest: guaranteed interest is equal to 10 percent in year 1 and 4 percent thereafter.
3. Expense charges: 10 percent of premium plus \$3.00 per \$1,000 of insurance in year 1 and 10 percent of premium thereafter.
4. Withdrawals, when illustrated, occur at the end of policy years. Withdrawals reduce the face amount by the amount of the withdrawal.
5. All values are per \$1,000 of face amount unless otherwise noted.
6. Net single premium values are calculated by assuming that no guarantees of interest and mortality charges are made subsequent to issue.

7. All guideline premium and net single premium values are calculated on an annual basis.
8. The single premium plan illustrated in Tables 5 and 6 assumes that current cash values accumulate without a mortality charge.

### Formulas

1. Guideline Single Premium ( $GSP_x$ ) =

$$(E_1 + A_{x:\overline{95-x}|(6\%)}) \div (1 - E\%)$$

2. Guideline Level Premium – Level Death Benefit ( $GLPI_x$ ) =

$$(E^1 + A_{x:\overline{95-x}|(4\%)}) \div (1 - E\%) \ddot{a}_{x:\overline{95-x}|}$$

3. Guideline Level Premium – Increasing Death Benefit ( $GLPII_x$ ) =

$$(E^1 + A_{x:\overline{95-x}|(4\%)}) \div [(1 - E\%) \ddot{a}_{95-x}|]$$

$$\text{where } A_{x:\overline{95-x}|} = \sum v^{t+1} q_{x+t} + v^{95-x}$$

(For a development of formulas for a face amount plus cash value plan, see Franklin C. Smith, “A General Treatment of Insurance for Face Amount plus Reserve or Cash Value,” *TSA XVI* (1964): 218–28.)

4. Guideline Premium Limitation: Maximum of ( $t \times GLP$ ,  $GSP$ )
5. Net Single Premium ( $NSP_{x+t}$ ) =  $A_{x+t:\overline{95-x+t}|(4\%)}$
6. Net Single Premium “Corridor” ( $NSPC_{x+t}$ ) =  $1 \div NSP_{x+t}$
7. Net Level Reserve ( $NLR_{x+t}$ ) =
 
$$A'_{x+t:\overline{95-x-t}|} - P'_x \ddot{a}_{95-x-t}|$$
 where  $P'_x = A'_{x:\overline{95-x}|} \div \ddot{a}_{95-x}|$
8. Net Level Reserve “Corridor” ( $NLRC_{x+t}$ ) =
 
$$(1 + NLR_{x+t}) \div NLR_{x+t}$$
9. Adjustment in Death Benefit: Guideline Single Premium ( $GSP_{x+t}$ ) =
 
$$GSP_x + GSP_{x+t}(\text{AFTER}) - GSP_{x+t}(\text{BEFORE})$$
10. Adjustment in Death Benefit: Guideline Level Premium ( $GLP_{x+t}$ ) =
 
$$GLP_x + GLP_{x+t}(\text{AFTER}) - GLP_{x+t}(\text{BEFORE})$$

## 11. Adjustment in Death Benefit: Cash Value Accumulation Test

$$(\text{NSP}_{x+t}) = \text{NSP}_{x+t}(\text{AFTER})$$

12. Section 7702(f)(7)(B): Guideline Premium Test, Recapture Ceiling I  
Premiums Paid – Maximum of

$$[\text{GSP}_x + \text{GSP}_{x+t}(\text{AFTER}) - \text{GSP}_{x+t}(\text{BEFORE})]$$

and

$$[t \times \text{GLP}_x + \text{GLP}_{x+t}(\text{AFTER}) - \text{GLP}_{x+t}(\text{BEFORE})]$$

## 13. Section 7702(f)(7)(B): Cash Value Accumulation Test, Recapture Ceiling I

$$\text{CV}_{x+t}(\text{BEFORE}) - [\text{Face Amount (AFTER)} - \text{Withdrawal}] \div \text{NSP}_{x+t}$$

## 14. Section 7702(f)(7)(B): Recapture Ceiling II

$$\text{CV}_{x+t}(\text{BEFORE}) - [\text{Face Amount (AFTER)} - \text{Withdrawal}] \div \text{CVC}_{x+t}$$

where  $\text{CVC}_{x+t}$  is equal to the Section 7702(d) corridor values.



TABLE 1  
SECTION 7702 BASIC VALUES: LEVEL DEATH BENEFIT

Age	Guideline Level Premium (GLPI)	Guideline Single Premium (GSP)	Cash Value Corridor Percentage (CVC)	Guideline Premium Limitation	Net Single Premium (NSP)	NSP Corridor Percentage (NSPC)
35	15.90	172.19	250%	172.19	254.772	392.5%
36			250	172.19	278.857	358.6
37			250	172.19	288.075	347.1
38			250	172.19	297.557	336.1
39			250	172.19	307.291	325.4
40			250	172.19	317.268	315.2
41			243	172.19	327.481	305.4
42			236	172.19	337.928	295.9
43			229	172.19	348.612	286.9
44			222	172.19	359.531	278.1
45			215	174.91	370.681	269.8
46			209	190.81	382.054	261.7
47			203	206.71	393.642	254.0
48			197	222.61	405.413	246.7
49			191	238.52	417.411	239.6
50			185	254.42	429.567	232.8
51			178	270.32	441.887	226.3
52			171	286.22	454.361	220.1
53			164	302.12	466.980	214.1
54			157	318.02	479.732	208.4
55			150	333.92	492.605	203.0
56			146	349.82	505.585	197.8
57			142	365.72	518.651	192.8
58			138	381.63	531.782	188.0
59			134	397.53	544.959	183.5
60			130	413.43	558.161	179.2
61			128	429.33	571.366	175.0
62			126	445.23	584.556	171.1
63			124	461.13	597.710	167.3
64			122	477.03	610.803	163.7
65			120	492.93	623.808	160.3
66			119	508.83	636.691	157.1
67			118	524.73	649.411	154.0
68			117	540.64	661.924	151.1
69			116	556.54	674.194	148.3

TABLE 1 — Continued

Age	Guideline Level Premium (GLPI)	Guideline Single Premium (GSP)	Cash Value Corridor Percentage (CVC)	Guideline Premium Limitation	Net Single Premium (NSP)	NSP Corridor Percentage (NSPC)
70			115	572.44	686.210	145.7
71			113	588.34	697.979	143.3
72			111	604.24	709.534	140.9
73			109	620.14	720.924	138.7
74			107	636.04	732.190	136.6
75			105	651.94	743.344	134.5
76			105	667.84	754.370	132.6
77			105	683.74	765.221	130.7
78			105	699.65	775.804	128.9
79			105	715.55	786.134	127.2
80			105	731.45	796.098	125.6
81			105	747.35	805.718	124.1
82			105	763.25	815.019	122.7
83			105	779.15	824.057	121.4
84			105	795.05	832.908	120.1
85			105	810.95	841.663	118.8
86			105	826.85	850.731	117.5
87			105	842.76	859.359	116.4
88			105	858.66	868.641	115.1
89			105	874.56	878.539	113.8
90			105	890.46	889.423	112.4
91			104	906.36	901.856	110.9
92			103	922.26	916.748	109.1
93			102	938.16	935.676	106.9
94			101	954.06	961.538	104.0

Sample calculations:

Policy year 1: Guideline Single Premium =  $(151.96938 + 3.00)/0.9 = 172.188$ .  
 Guideline Level Premium =  $(254.77232 + 3.00)/(0.9 \times 18.01305) = 15.900$ .  
 Net Single Premium = 254.77232.

**TABLE 2**  
**SECTION 7702 BASIC VALUES: INCREASING DEATH BENEFIT**

Age	Guideline Level Premium (GLPII)	Guideline Single Premium (GSP)	Cash Value Corridor Percentage (CVC)	Guideline Premium Limitation	Net Level Reserve (NLR)	Corridor Percentage (NLRC)
35	38.55	172.19	250%	172.19	33.488	3086.1%
36			250	172.19	68.170	1566.9
37			250	172.19	104.055	1061.0
38			250	172.19	141.150	808.5
39			250	192.77	179.469	657.2
40			250	231.33	219.025	556.6
41			243	269.88	259.844	484.8
42			236	308.44	301.951	431.2
43			229	346.99	345.368	389.5
44			222	385.55	390.111	356.3
45			215	424.10	436.190	329.3
46			209	462.66	483.606	306.8
47			203	501.21	532.359	287.8
48			197	539.77	582.442	271.7
49			191	578.32	633.844	257.8
50			185	616.88	686.547	245.7
51			178	655.43	740.539	235.0
52			171	693.99	795.801	225.7
53			164	732.54	852.304	217.3
54			157	771.10	910.012	209.9
55			150	809.65	968.874	203.2
56			146	848.21	1,028.822	197.2
57			142	886.76	1,089.773	191.8
58			138	925.31	1,151.640	186.8
59			134	963.87	1,214.311	182.4
60			130	1,002.42	1,277.666	178.3
61			128	1,040.98	1,341.572	174.5
62			126	1,079.53	1,405.872	171.1
63			124	1,118.09	1,470.382	168.0
64			122	1,156.64	1,534.886	165.2
65			120	1,195.20	1,599.123	162.5
66			119	1,233.75	1,662.790	160.1
67			118	1,272.31	1,725.539	158.0
68			117	1,310.86	1,787.024	156.0
69			116	1,349.42	1,846.913	154.1

TABLE 2 — Continued

Age	Guideline Level Premium (GLPII)	Guideline Single Premium (GSP)	Cash Value Corridor Percentage (CVC)	Guideline Premium Limitation	Net Level Reserve (NLR)	Corridor Percentage (NLRC)
70			115%	1,387.97	1,904.938	152.5%
71			113	1,426.53	1,960.862	151.0
72			111	1,465.08	2,014.474	149.6
73			109	1,503.64	2,065.506	148.4
74			107	1,542.19	2,113.537	147.3
75			105	1,580.75	2,157.977	146.3
76			105	1,619.30	2,198.054	145.5
77			105	1,657.86	2,232.836	144.8
78			105	1,696.41	2,261.272	144.2
79			105	1,734.96	2,282.435	143.8
80			105	1,773.52	2,295.403	143.6
81			105	1,812.07	2,299.334	143.5
82			105	1,850.63	2,293.448	143.6
83			105	1,889.18	2,276.951	143.9
84			105	1,927.74	2,248.968	144.5
85			105	1,966.29	2,208.522	145.3
86			105	2,004.85	2,154.534	146.4
87			105	2,043.40	2,085.758	147.9
88			105	2,081.96	2,000.678	150.0
89			105	2,120.51	1,897.400	152.7
90			105	2,159.07	1,773.537	156.4
91			104	2,197.62	1,626.104	161.5
92			103	2,236.18	1,451.389	168.9
93			102	2,274.73	1,244.839	180.3
94			101	2,313.29	1,000.000	200.0

Sample calculations:

Policy year 1: Guideline Single Premium =  $(151.96938 + 3.00)/0.9 = 172.188$ .

Guideline Level Premium =  $(770.78067 + 3.00)/0.9 \times 22.29960 = 38.5549$ .

**TABLE 3**  
**DECREASE IN FACE AMOUNT: LEVEL DEATH BENEFIT**  
**(REDUCTION TO \$500 AT AGE 45)**

Age	Guideline Level Premium (GLPI)	Guideline Single Premium (GSP)	Cash Value Corridor Percentage (CVC)	Guideline Premium Limitation	Net Single Premium (NSP)	NSP Corridor Percentage (NSPC)
35	15.90	172.19	250%	172.19	254.772	392.5%
36			250	172.19	278.857	358.6
37			250	172.19	288.075	347.1
38			250	172.19	297.557	336.1
39			250	172.19	307.291	325.4
40			250	172.19	317.268	315.2
41			243	172.19	327.481	305.4
42			236	172.19	337.928	295.9
43			229	172.19	348.612	286.9
44			222	172.19	359.531	278.1
45	-12.59	-131.34	215	162.33	185.341	269.8
46			209	165.64	191.027	261.7
47			203	168.96	196.821	254.0
48			197	172.27	202.707	246.7
49			191	175.59	208.706	239.6
50			185	178.90	214.784	232.8
51			178	182.22	220.944	226.3
52			171	185.53	227.181	220.1
53			164	188.85	233.490	214.1
54			157	192.16	239.866	208.4
55			150	195.48	246.303	203.0
56			146	198.79	252.793	197.8
57			142	202.11	259.326	192.8
58			138	205.42	265.891	188.0
59			134	208.74	272.480	183.5
60			130	212.05	279.081	179.2
61			128	215.37	285.683	175.0
62			126	218.68	292.278	171.1
63			124	222.00	298.855	167.3
64			122	225.31	305.402	163.7
65			120	228.63	311.904	160.3
66			119	231.94	318.346	157.1
67			118	235.26	324.706	154.0
68			117	238.57	330.962	151.1
69			116	241.89	337.097	148.3

TABLE 3 — Continued

Age	Guideline Level Premium (GLPI)	Guideline Single Premium (GSP)	Cash Value Corridor Percentage (CVC)	Guideline Premium Limitation	Net Single Premium (NSP)	NSP Corridor Percentage (NSPC)
70			115%	245.20	343.105	145.7%
71			113	248.52	348.990	143.3
72			111	251.83	354.767	140.9
73			109	255.15	360.462	138.7
74			107	258.47	366.095	136.6
75			105	261.78	371.672	134.5
76			105	265.10	377.185	132.6
77			105	268.41	382.611	130.7
78			105	271.73	387.902	128.9
79			105	275.04	393.067	127.2
80			105	278.36	398.049	125.6
81			105	281.67	402.859	124.1
82			105	284.99	407.510	122.7
83			105	288.30	412.029	121.4
84			105	291.62	416.454	120.1
85			105	294.93	420.832	118.8
86			105	298.25	425.366	117.5
87			105	301.56	429.680	116.4
88			105	304.88	434.321	115.1
89			105	308.19	439.270	113.8
90			105	311.51	444.712	112.4
91			104	314.82	450.928	110.9
92			103	318.14	458.374	109.1
93			102	321.45	467.838	106.9
94			101	324.77	480.769	104.0

Sample calculations: Reduction to \$500 at age 45:

$$\text{Policy year 11: Guideline Single Premium Change} = (500-1,000) \times 246.4036 / (0.9 \times 1,000) = -136.891.$$

$$\text{Guideline Level Premium Change} = (500-1,000) \times 22.6546 / (0.9 \times 1,000) = -12.586.$$

$$\text{Net Single Premium} = 370.681 \times 500 / 1,000 = 185.341.$$

**TABLE 4**  
**CHANGE IN DEATH BENEFIT OPTION: INCREASING TO LEVEL DEATH BENEFIT**  
**(CHANGE TO \$1,436.19 LEVEL FACE AT AGE 45)**

Age	Guideline Level Premium (GLPII)	Guideline Single Premium (GSP)	Cash Value Corridor Percentage (CVC)	Guideline Premium Limitation	Net Level Reserve (NLR)	Corridor Percentage (NLRC)
35	38.55	172.19	250%	172.19	33.488	3086.1%
36			250	172.19	68.170	1566.9
37			250	172.19	104.055	1061.0
38			250	172.19	141.150	808.5
39			250	192.77	179.469	657.2
40			250	231.33	219.025	556.6
41			243	269.88	259.844	484.8
42			236	308.44	301.951	431.2
43			229	346.99	345.368	389.5
44			222	385.55	390.111	356.3
45	-20.98	119.42	215	403.12	532.368	269.8
46			209	420.70	548.702	261.7
47			203	438.27	565.345	254.0
48			197	455.85	582.250	246.7
49			191	473.42	599.482	239.6
50			185	491.00	616.940	232.8
51			178	508.57	634.634	226.3
52			171	526.15	652.549	220.1
53			164	543.72	670.672	214.1
54			157	561.30	688.986	208.4
55			150	578.87	707.474	203.0
56			146	596.45	726.116	197.8
57			142	614.02	744.881	192.8
58			138	631.59	763.740	188.0
59			134	649.17	782.665	183.5
60			130	666.74	801.625	179.2
61			128	684.32	820.590	175.0
62			126	701.89	839.533	171.1
63			124	719.47	858.425	167.3
64			122	737.04	877.229	163.7
65			120	754.62	895.907	160.3
66			119	772.19	914.409	157.1
67			118	789.77	932.678	154.0
68			117	807.34	950.649	151.1
69			116	824.92	968.271	148.3

TABLE 4 — Continued

Age	Guideline Level Premium (GLPII)	guideline Single Premium (GSP)	Cash Value Corridor Percentage (CVC)	Guideline Premium Limitation	Net Level Reserve (NLR)	Corridor Percentage (NLRC)
70			115%	842.49	985.528	145.7%
71			113	860.07	1,002.430	143.3
72			111	877.64	1,019.026	140.9
73			109	895.22	1,035.384	138.7
74			107	912.79	1,051.564	136.6
75			105	930.37	1,067.583	134.5
76			105	947.94	1,083.419	132.6
77			105	965.52	1,099.003	130.7
78			105	983.09	1,114.202	128.9
79			105	1,000.66	1,129.038	127.2
80			105	1,018.24	1,143.348	125.6
81			105	1,035.81	1,157.164	124.1
82			105	1,053.39	1,170.522	122.7
83			105	1,070.96	1,183.502	121.4
84			105	1,088.54	1,196.214	120.1
85			105	1,106.11	1,208.788	118.8
86			105	1,123.69	1,221.811	117.5
87			105	1,141.26	1,234.203	116.4
88			105	1,158.84	1,247.534	115.1
89			105	1,176.41	1,261.749	113.8
90			105	1,193.99	1,277.380	112.4
91			104	1,211.56	1,295.237	110.9
92			103	1,229.14	1,316.624	109.1
93			102	1,246.71	1,343.809	106.9
94			101	1,264.29	1,380.951	104.0

Sample calculations: Option change to a \$1,436.19 level face at age 45:

Policy year 11: Guideline Single Premium Change =  $(1,436.19 - 1,000) \times 246.4036 / (0.9 \times 1,000) = 119.421$ .

Guideline Level Premium Change =  $[(1,436.19 \times 22.6546) - 1,000 \times 51.418] / (0.9 \times 1,000) = -20.98$ .

TABLE 5  
 WITHDRAWAL OF THE SINGLE PREMIUM UNDER SECTION 7702(f)(7)(B)  
 FROM A GUIDELINE PREMIUM TEST PLAN

Age	Yr	Guideline Single Premium (GSP)	Cash Value Corridor Percentage (CVC)	Cash Value	Face Amount	Recapture Ceiling I	Recapture Ceiling II	Taxable Income	Taxable % Withdrawal
35	1	172.19	250%	167	1,000	29.65	0.00	- 4.69	0.0%
36	2	176.69	250	184	1,000	30.42	0.00	12.06	7.0
37	3	184.89	250	203	1,000	31.84	0.00	30.48	17.7
38	4	193.43	250	223	1,000	33.31	0.00	33.31	19.3
39	5	202.31	250	245	1,000	34.84	0.00	34.84	20.2
40	6		250	270	1,000		0.00	0.00	0.0
41	7		243	297	1,000		0.00	0.00	0.0
42	8		236	326	1,000		0.00	0.00	0.0
43	9		229	359	1,000		0.00	0.00	0.0
44	10		222	395	1,000		22.06	22.06	12.8
45	11		215	434	1,000		49.41	49.41	28.7
46	12		209	478	1,000		81.80	81.80	47.5
47	13		203	526	1,067		84.82	84.82	49.3
48	14		197	578	1,139		87.41	87.41	50.8
49	15		191	636	1,215		90.15	90.15	52.4
50	16		185	700	1,294				
51	17		178	770	1,370				
52	18		171	847	1,448				
53	19		164	934	1,527				
54	20		157	1,024	1,608				

Sample calculations:

Policy year 5: Recapture Ceiling I =  $172.19 - \{172.19 + [202.31 \times (1,000 - 172.19) / 1,000] - 202.31\}$

=  $202.31 \times 172.19 / 1,000 = 34.84.$

Recapture Ceiling II =  $[245 - (1,000 - 172.19) / 2.5] = -86.12 = 0.$

**TABLE 6**  
**WITHDRAWAL OF THE SINGLE PREMIUM UNDER SECTION 7702(f)(7)(B)**  
**FROM A CASH VALUE ACCUMULATION TEST PLAN**

Age	Yr	Net Single Premium (NSP)	Cash Value Corridor Percentage (CVC)	Cash Value	Face Amount	Recapture Ceiling I	Recapture Ceiling II	Taxable Income	Taxable % Withdrawal
35	1	254.772	250%	280	1,100	64.91	0.00	-6.16	0.0%
36	2	278.857	250	308	1,105	71.04	0.00	21.86	8.6
37	3	288.075	250	339	1,177	73.39	0.00	52.69	20.7
38	4	297.557	250	373	1,254	75.81	0.00	75.81	29.8
39	5	307.291	250	410	1,335	78.29	0.00	78.29	30.7
40	6	317.268	250	451	1,423		0.00	0	0.0
41	7	327.481	243	496	1,516		0.00	0	0.0
42	8	337.928	236	546	1,616		0.00	0	0.0
43	9	348.612	229	601	1,723		0.00	0	0.0
44	10	359.531	222	661	1,838		0.00	0	0.0
45	11	370.681	215	727	1,961		0.00	0	0.0
46	12	382.054	209	800	2,093		0.00	0	0.0
47	13	393.642	203	880	2,234		0.00	0	0.0
48	14	405.413	197	967	2,386		0.00	0	0.0
49	15	417.411	191	1,064	2,550		0.00	0	0.0
50	16	429.567	185	1,171	2,725		0.00	0	
51	17	441.887	178	1,288	2,914		0.00	0	
52	18	454.361	171	1,417	3,118		0.00	0	
53	19	466.980	164	1,558	3,337		0.00	0	
54	20	479.732	157	1,714	3,573		0.00	0	

Sample calculations:

Policy year 5: Recapture Ceiling I =  $410.31 - [(1,335.26 - 254.772) \times 0.307921]$   
= 78.29.  
Recapture Ceiling II =  $410.31 - [(1,335.26 - 254.772)/2.5]$   
= -21.89 = 0.

## ENDNOTES

1. *Helvering v. LeGierse* 312 U.S. 531(1941).
2. See *Revenue Ruling 66-322* (1966-2 C.B. 123) and *A. Rolph Evans* 56 TC 1142 (1971).
3. *Private Letter Ruling 8047051*.
4. *Private Letter Rulings 8116073 and 8121034*.
5. *Private Letter Rulings 8120023 and 8132119*. *Private Letter Ruling 8120023* was preceded by a similar private letter on variable life in October 1978, which was later published as *Revenue Ruling 79-87* (1979-1 C.B. 73).
6. The Hutton Life design, for example, had a flat risk corridor of only \$5,000 to \$10,000 of amount at risk, and the example of \$1,000,000 cash value with a \$5,000 net amount at risk was often cited by the critics as an example of potential abuse.
7. Although not released to the public until after the enactment of Section 101(f), the significance of the GCM was in the shaping of the IRS position prior to the Tax Equity and Fiscal Responsibility Act of 1982, of which Section 101(f) was a part. Because of the intervention of TEFRA, the GCM had no impact on the tax treatment of universal life.
8. *Private Letter Ruling 8332021* and *Rev. Proc. 83-45*.
9. *General Explanation of the Revenue Provisions of the Deficit Reduction Act of 1984*, Joint Committee on Taxation, December 31, 1984, p. 647.
10. *Ibid.* Note that the term net cash surrender value is used in the Blue Book to refer to the cash value net of surrender charge.
11. The cash value test was added to Section 101(f) during the Conference Committee negotiations when it was discovered that in addition to universal life plans, Section 101(f) would also apply to the adjustable life plans sold by Minnesota Mutual and Bankers of Iowa and that compliance with the guideline test would be very difficult, if not impossible, for these products. As a result, there was very little legislative guidance available on this test prior to its inclusion in Section 7702.
12. *General Explanation DEFRA*, p. 647.
13. As in the cash value accumulation test, the cash value determined without regard to any surrender charge, loan, or reasonable termination dividend. This would generally be the accumulation value under an “unbundled” contract such as universal life.
14. *H.R. Report No. 98-432*, 98th Congress, 2nd session, 1984, p. 1445.
15. It is generally true that the corridor values are less than the corridors “implied” by the cash value accumulation test (face amount divided by net single premium). This may not be true in the case of a highly substandard plan, as the net single premiums under the cash value accumulation test become larger, while the cash value corridor remains static.
16. Amounts paid out in connection with Section 7702(f)(7)(B) do not reduce the Section 72 basis, however, so that the “premiums paid” may be different under Section 7702 from the policyholders basis under Section 72. A similar result occurs under a Section 1035 exchange where the premiums paid under the guideline test are based

on the contract premiums at the time the policy is exchanged, while the Section 72 basis relates to the original premiums.

17. *General Explanation DEFRA*, p. 646.
18. *Ibid.* p. 646.
19. *Ibid.* p. 646.
20. This is an example of the test plan concept, where the contract provisions are not limited by Section 7702, but the allowable values are.
21. *General Explanation DEFRA*, p. 653.
22. The Blue Book justifies this treatment in a footnote which states that the higher investment orientation allowed a guideline premium contract is attributable to the fact that "it is generally understood that the owner of a guideline premium contract is not able to leverage his investment through policy loans." Note that the deductibility of loans was substantially eliminated by the 1986 Tax Reform Act. See *General Explanation DEFRA*, p. 649.
23. *General Explanation DEFRA*, p. 651. The language in the *General Explanation to the Tax Equity and Fiscal Responsibility Act* (at p. 371) is somewhat clearer in this regard: "attained age can appropriately be read as meaning the insured's age determined by reference to contract anniversaries rather than individuals' actual birthdays. So long as the age assumed is within 12 months of the insured's actual age, then it is reasonable to use that age as the attained age."
24. *Ibid.* p. 649.
25. Arizona Governing Committee v. Norris, 103 S.Ct. 3492 (1983).
26. Adney and Hahn, "The New Federal Tax Definition of Life Insurance," *CLU Journal* (November 1984): 53. Section 7702(j) permits the Secretary of the Treasury to issue regulations as may be necessary or appropriate to carry out the provisions of Section 7702.
27. At one point in the development of Section 101(f), a standardized expense charge was discussed, but this was dropped in favor of the "marketplace limit" approach cited in the discussion of mortality charges.
28. *Senate Finance Committee Report 98-169*, 98th Congress, 2nd session, 1984, p. 574; *General Explanation DEFRA*, p. 649.
29. Section 7702(f)(5).
30. Accidental death and disability refers to AD&D coverages, not disability income riders.
31. Family members clearly include spouse and children; the applicability of the qualified additional benefit rules to other relatives is unclear at best.
32. *House Report (DEFRA)*, pp. 1445-1446; *General Explanation of the Tax Equity and Fiscal Responsibility Act of 1982*, Joint Committee on Taxation, December 31, 1982, p. 369.
33. *General Explanation DEFRA*, p. 654.
34. *General Explanation DEFRA*, p. 654.
35. *General Explanation TEFRA*, p. 370.

36. *General Explanation TEFRA*, p. 373.
37. *Senate Finance Committee Report 99-313*, 99th Congress, 2nd session, 1986, p. 989. In 1984, the Treasury was comfortable with the application of the attained age method to increase; by 1986, the Treasury had extended its acceptance of the approach to decreases as well.
38. An example of this calculation is given in Table 4.
39. Under H.R. 3441, introduced by Reps. Stark and Gradison on October 7, 1987, this treatment would be changed as the rules currently applicable to annuity distributions would also apply to life insurance.
40. *House Report DEFRA*, p. 1448.
41. Cash surrender value is defined elsewhere in Section 7702 to equal account value.
42. See Tables 5 and 6.
43. The net cash surrender value is equal to the surrender value without regard to policy loans but recognizing surrender charges.
44. *General Explanation DEFRA*, p. 647.
45. *Ibid.* p. 651.
46. *H.R. Report 100-391*, 100th Congress, 1st session, 1987, p. 1249.
47. *General Explanation DEFRA*, p. 656.
48. *Ibid.* p. 657.
49. *Ibid.* p. 657.

## DISCUSSION OF PRECEDING PAPER

PHILIP J. BIELUCH:

Mr. DesRochers has presented a practical primer on the intricacies of Internal Revenue Code Section 7702. This paper provides actuaries with help in designing life insurance products that will be taxed as life insurance.

As with anything as complicated as life insurance taxation, there is room for disagreement among practitioners in this area. The following paragraphs present areas worthy of further comment.

Mr. DesRochers discussed how a life insurance contract needs to have provisions to calculate the death benefit under the cash value corridor test. He points out that if the contract does not contractually meet the cash value test, the guideline premium test would apply. It is equally important to note that as a practical matter, contracts intended to qualify under the guideline premium test should contain provisions to ensure compliance with the test.

Mr. DesRochers leaves readers without guidance on which test to use for universal life. At one point he states, "The retrospective nature of the guideline test was seen as better suited to universal life and other flexible coverages." He later states, however, "Many universal life plans have been designed to comply with the cash value accumulation test." Finally, he notes, "An exception is mentioned in the Blue Book, permitting contracts using the guideline premium test to switch to the cash value accumulation test upon election of a nonforfeiture option." Note that switching to the cash value accumulation test could require a significant increase in the insurance amount upon selection of the nonforfeiture option and might not be practical.

When dealing with cash value tests on a universal life product, Mr. DesRochers neglects to note that a common interpretation is to have a monthly single premium reflecting the monthly accounting found in the universal life contract. This is in contrast to traditional annual net single premiums that can be used for traditional whole life insurance. This monthly net single premium significantly complicates universal life administration.

Under alternate death benefit rules, Mr. DesRochers does not specifically address the issue of adjustments under the cash value test for face plus cash value plans qualifying based on the net level reserve corridor. A straightforward application would require the attained age net level reserve "corridors" calculated at issue to continue for the life of the contract. Many practitioners assume, however, that each excess interest credit would have to buy a new face plus cash value policy at the then-attained age with a net level reserve for that attained age at issue.

Mr. DesRochers points out that under adjustments for face amount plus cash value plans, the adjustment to the guideline single premium resulting from “guaranteed” increases in death benefits is often ignored in practice. This brings to mind a potentially dangerous area for companies in calculating guideline premium limitations. It is often more practical to calculate guideline premiums on a “conservative” basis, rather than a theoretically exact basis. When decreases in benefits occur, however, if adjustments are made on this same “conservative” basis, the resulting guideline premium limitation may be overstated. In the face amount plus cash value case, the theoretically correct guideline single premium could fall below the guideline single premium as calculated under Mr. DesRochers’ method if partial withdrawals or other decreases in future benefits are made.

Mr. DesRochers’ quick dismissal of using the higher contractual cash value interest rate for those portions of the cash values backed by policy loans in the calculation of the death benefit corridor is not universally agreed with.

When Mr. DesRochers talks about nonqualified additional benefits, he does not mention the current controversy of whether payment for a non-qualified additional benefit from a universal life cash value would be a distribution within the meaning of Section 7702(f)(7).

Finally, the formula for the net level reserve “corridor” ( $NLCR_{x+t}$ ) can be reworked so that  $(NLCR_{x+t}) = 1/(NLR_{x+t}) + 1$ , compared with the net single premium “corridor” of  $(NSPC_{x+t}) = 1/(NSP_{x+t})$ .

On November 10, 1988, President Reagan signed into law the Technical and Miscellaneous Revenue Act (TAMRA). This law places limits on mortality for purposes of Section 7702 and limits expense charges for guideline premium products. The law also defines a new class of contracts that are taxed similarly to annuities. The calculation requires a 7-Pay premium to be calculated by using some of the calculation rules of the guideline single and level premium calculations, while having their own idiosyncracies. All this further complicates the testing necessary to preserve the tax treatment of life insurance. Quick estimates are that the 1988 law will cost \$100 million to administer.

#### J. PETER DURAN:

Mr. DesRochers’ paper is a welcome addition to the actuarial literature because it presents an actuarial view of a topic of great interest to the life insurance industry. However, many questions surrounding Section 7702 have

no clear-cut answers, and some of Mr. DesRochers' views on these matters are, in fact, interpretations rather than statements of fact.

The purpose of this discussion is to present contrary views on a number of these questions. There are companies that have adopted reasonable interpretations that are at odds with Mr. DesRochers' and that I believe are sustainable based on the language and history of Section 7702.

### *Guideline Single Premium*

The guideline single premium (GSP) is the single premium that funds future death and endowment benefits subject to the rules prescribed in the section. For a death benefit option 2 universal life plan (death benefit equals specified amount plus policy value), the initial death benefit is equal to the specified amount plus the initial policy value. One may therefore take this amount as both the death benefit and the endowment benefit in calculating the GSP. Page 373 of the TEFRA Blue Book corroborates the approach of using the initial death benefit, rather than the specified amount, as the death and endowment benefit for GSP calculation purposes. Although this issue is not discussed explicitly by Mr. DesRochers, his formulas take account of only the specified amount.

### *Adjustable Events*

I would agree with Mr. DesRochers that the first four events he lists are events requiring adjustments to the guideline premiums. However, I disagree that a change in the basic mortality or interest guarantee is necessarily an adjustable event. Section 7702(f)(7) states that adjustments are to be made when there is a "change in benefits under (or in other terms of) the contract" not previously reflected. As noted elsewhere, benefits are defined as death and endowment benefits. In general, a change in the contract guarantees does not change these benefits because of their "deemed" nature. Arguably, a change of this type is a change in "other terms" of the contract, but because there are no regulations, rulings or court cases on this matter, we cannot be sure.

Mr. DesRochers suggests that the device of an "underwritten partial withdrawal" might be used to avoid the application of the (f)(7)(B) rules. I doubt this would be effective unless the policy provisions were such that partial withdrawals were automatically accompanied by corresponding changes in specified amounts. More typically, the partial withdrawal provision and the policyholder-elected increase in specified amount provision are distinct. The

“underwritten partial withdrawal” in this case is a combination of two changes, one of which is a reduction in benefits falling under (f)(7)(B).

### *Adjustment Formulas*

The so-called Dole-Bentsen colloquy is quoted as support for the “attained age decrement” method for adjusting guideline premiums. This is fine as far as it goes. Unfortunately, one can construct examples in which the method of adjustment specified in the Committee Reports quoted by Mr. DesRochers and the language of Section 7702 are at odds. Subparagraph (f)(7)(A) refers to changes “not reflected in previous determinations or adjustments.” Therefore, the “base policy” against which the adjustment should be measured is not necessarily the policy as it existed immediately prior to the adjustable event, but rather the policy that was presumed to exist when the guideline premiums were last calculated. An example may help to illustrate the point.

Suppose that a universal life policy is issued with death benefit option 2 and that the initial death benefit (policy value plus specified amount) is \$55,000. The guideline single premium calculation must assume a level death benefit because of the computational rules of 7702(e). Assume that at some later date actual premium payments, policy charges and policy credits have resulted in a death benefit of \$60,000 (\$50,000 of specified amount plus \$10,000 of policy value). The policyholder then elects to increase the specified amount to \$90,000 so that the total death benefit is \$100,000.

The guideline premiums have not been adjusted for the \$5,000 increase in death benefit since original issue of the policy. This is in accordance with the Senate Committee Report for the 1984 Tax Act, which states that “no adjustment shall be made if the change occurs automatically due, for example, to the growth of the cash surrender value.” This seems like a sensible interpretation; otherwise guideline premium adjustment would be required monthly in our example.

The question at hand is whether the adjustment calculation should reflect an increase of \$40,000 or \$45,000. I believe the better answer is \$45,000, as this is the amount that “was not reflected in any previous determination.” Here we are drawing a distinction between the event that triggered the adjustment calculation (namely, a policyholder-elected increase in specified amount of \$40,000) and the amount to be reflected in the adjustment calculation itself (\$45,000).

Another example of the same general ilk is an adjustment made to a universal life policy whose specified amount has been changed because of the workings of the cash value corridor provision. These examples share a common theme. Adjustments should reflect those benefits and only those benefits under the contract that were not reflected in previous guideline premium determinations.



How is “proper adjustment” to be made? The following method (which was not originally suggested by me) is actuarially sound and adheres strictly to the language of Section 7702(f)(7)(A). As of original issue of the policy, one can calculate a “guideline single (level) maturity fund.” This is the policy value that will build up if *all* the assumptions underlying the calculation of the guideline single (level) premium are realized. When an adjustment is to be made, the *total* guideline single (level) premium is recalculated based on the future benefits under the policy after the change *but assuming that* the guideline single (level) maturity fund previously calculated is available as the existing policy value. The guideline premium *adjustment* is then simply the difference between the total guideline premium so calculated and the original guideline premium.

This method can be extended to any adjustment. For each adjustment, one calculates and stores the string of future guideline maturity funds for use in the calculation of the next adjustment when and if that should happen.

This method has the following characteristics:

1. In the most common case of a change in specified amount under a death benefit option 1 universal life policy, it will yield the same result as the method described by Mr. DesRochers (provided the specified amount and policy guarantees have remained unchanged since the previous adjustment calculation).
2. Very often the difference between the changed policy and the original policy is not itself a “policy” (as the Committee Report language would imply). For example, if a death benefit option 1 policy is changed to option 2, the increase in benefits is not expressible as a separate, “free-standing” policy. This, however, will be irrelevant in this approach (as indeed it would in the approach described by Mr. DesRochers).
3. The approach is consistent with a literal reading of the Section 7702 provision that proper adjustment be made “if there is a change in the benefits under (or in other terms of) the contract which was not reflected in any previous determinations or adjustments.”
4. The approach is actuarially sound.

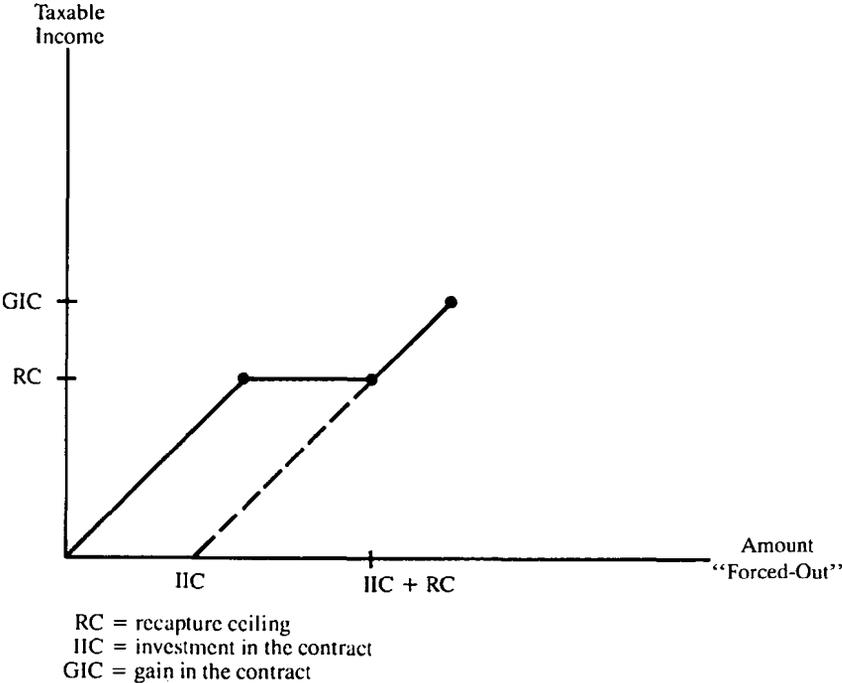
### *Taxability of Withdrawals*

Mr. DesRochers states that in order for taxable income to be recognized to the policyholder, the amount of the force out must exceed the recapture ceiling. This is not the case. Under Section 7702(f)(7)(B), any force-out amount up to the recapture ceiling would be taxed on a LIFO (that is, gain

first) basis. During the first five policy years, it can be shown that the force-out amount can *never* exceed the recapture ceiling. In this situation, therefore, the entire force-out amount would be taxable to the extent of the gain in the contract.

During years six through fifteen, the force-out amount could exceed the recapture ceiling. In this case the force-out amount must be treated in two pieces, namely, the amount of the recapture ceiling itself and the excess over the recapture ceiling. The recapture ceiling amount would be taxable to the extent it represented gain in the contract. If the gain in the contract is in fact greater than the recapture ceiling, a portion of the excess of the force-out amount over the recapture ceiling may be taxable to the extent it exceeds the investment in the contract. Note that if the excess of the force-out amount over the recapture ceiling exceeds the investment in the contract, the entire investment in the contract has been recovered tax-free and the

Taxability of "Force-Out" Amounts



force-out amount is effectively taxed on a FIFO basis. Thus, the most adverse tax treatment results up to the recapture ceiling. The taxable portion of the withdrawal grades from a LIFO to a FIFO basis between the recapture ceiling and the recapture ceiling plus the investment in the contract. This can be illustrated by the graph on page 260. The solid line represents the Section 7702(f)(7)(B) treatment of withdrawals, while the dotted line represents the Section 72(e)(5) treatment. For withdrawal amounts greater than the recapture ceiling plus the investment in the contract, the two lines coincide.

(AUTHOR'S REVIEW OF DISCUSSION)

CHRISTIAN J. DESROCHERS:

I would like to thank Messrs. Bieluch and Duran for their thoughtful comments on my paper.

With respect to the comments by Mr. Bieluch, I agree that as a practical matter, a contract will state the basis of compliance—certainly that has been the practice on universal life contracts from the inception of the Section 101(a) rules in 1982. In the legislative reports that accompanied 7702, the staff seemed to emphasize the point that compliance with the cash value accumulation test would be by the terms of the contract, and therefore any contract that could not comply by its terms would necessarily be subject to the guideline premium test. From a practical viewpoint, however, the basis of compliance is typically indicated.

The choice of a test is a matter of company practice and plan design. The guideline premium test has the advantages that contract expense charges may be recognized in determining the guideline premiums and that the ratio of death benefit to cash value is generally less in the later contract durations. Under the cash value test, the premiums are not limited, and the adjustment rules are easier to administer. Neither of the tests is clearly superior, so the choice depends on whichever seems to best fit the product need and the administrative capacity of the company writing it.

I agree with Mr. Bieluch's comment on the net single premium and the reflection of the contract dynamics.

The choice of an appropriate interest rate where the net credited rate applied to loaned values is higher than that credited to unloaned values raises the issue of the appropriate treatment of multiple track policies and the proper method to apply to contingent guarantees. One approach would be to always use the method that produced the most conservative result. I believe the most practical rule is to use the "main track" of the policy, although the net



result of this approach might be to require a contract adjustment upon the occurrence of the contingent event.

I agree with Mr. Duran that the methods suggested are subject to interpretation. As with any complex tax legislation, we can expect that some of the details will be filled in by regulation, additional legislation, and court cases. Until that time, however, there is room for disagreement among practitioners. Note, however, that one source of guidance on matters of interpretation is the reports of the tax-writing committees.

Mr. Duran argues that the initial death benefit to be recognized in the determination of the guideline single premium should include the initial cash value for plans that have a return of cash value death benefit. In the legislative history for Section 101(f), as Mr. Duran points out, the initial premium was recognized in the determination of the guideline single premium. I have chosen not to use this approach in my formulas, for two reasons: First, Section 101(f) provided different rules for the guideline single premium depending on the death benefit option; Section 7702 does not. Second, I believe that it is much more difficult to apply the adjustment rules if the method of computation suggested by Mr. Duran is followed. I would note, however, that some commentators agree with Mr. Duran's position.

For an underwritten partial withdrawal to be effective, it must be a part of the contract language to avoid the problem cited by Mr. Duran.

With regard to the method of adjustments and the Dole-Bentsen colloquy, the "attained-age increment" method dates back to Section 101(f). The method has appeared in the Blue Books for TEFRA, DEFRA, and the technical correction bill for DEFRA and is the only method cited in the legislative history. Although other methods may be actuarially sound, the issue is one of tax law and not of actuarial practice.

The method that is suggested by Mr. Duran can be shown to be mathematically equivalent to the attained age increment approach:

(1) Under the Dole-Bentsen method:

$$GLP_{x+t} = GLP_x + GLP_{x+t}(\text{AFTER}) - GLP_{x+t}(\text{BEFORE}).$$

(2) If we ignore expenses for simplicity, (1) is equivalent to:

$$GLP_{x+t} = GLP_x + (A_{x+t:\overline{n}|}^A - A_{x+t:\overline{n}|}^B) / (\ddot{a}_{x+t:\overline{n}|})$$

where  $A$  is after the change and  $B$  is before the change.

(3) Mr. Duran defined a policy value based on the guideline premium (guideline maturity fund). If we define this as  ${}_tGLF_x$ , then:

$${}_tGLF_x = A_{x+t:\overline{n-\eta}}^B - GLP_x \ddot{a}_{x+t:\overline{n-\eta}}.$$

(4) The restated formula would be that suggested by Mr. Duran:

$$GLP_{x+t} = (A_{x+t:\overline{n-\eta}}^A - {}_tGLF_x) / (\ddot{a}_{x+t:\overline{n-\eta}}).$$

In his discussions concerning the tax applied to “force outs,” Mr. Duran is correct in his analysis that a force out under Section 7702(f)(7) is taxable to the extent of the gain in the contract (as I also indicate on page 61). The statement referred to should have read:

“4. The recapture ceiling, as defined in the statute, is equaled or exceeded.”

The force-out amount would be equal to the recapture ceiling.

### *Section 7702A*

Mr. Bieluch referred to Section 7702A. Section 7702A was enacted as a part of the Technical and Miscellaneous Revenue Act of 1988 (TAMRA). Section 7702A specifically limits the permissible mortality and expense charges that can be recognized in the determination of guideline premiums and net single premiums and also creates a class of contracts known as modified endowments. Distributions under these contracts are to be taxed under rules similar to the current deferred annuity rules, rather than the rules generally applicable to life insurance plans.

The original provisions of Section 7702 permitted the use of contractual mortality charges in the determination of guideline premiums (under the guideline test) and net single premiums (under the cash value accumulation test). For contracts issued on and after October 21, 1988, the applicable mortality charges are limited to:

reasonable mortality charges which . . . 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.

Expense charges that may be used in the determination of guideline premiums are similarly limited to:

any reasonable charges (other than mortality charges) which (on the basis of the company’s experience) are reasonably expected to be actually paid.

The Treasury Department is directed to issue regulations by January 1, 1990 setting forth standards for determining the reasonableness of mortality

charges. In the interim, charges that do not materially differ from those actually expected to be imposed are considered reasonable.

The enactment of Section 7702A has defined a class of contracts known as modified endowments. These plans are considered life insurance under Section 7702, but are subject to distribution rules (for other than death benefit payments) that are based on the current rules for deferred annuities. For a contract classified as a modified endowment:

- (1) Amounts distributed are considered as income first to the extent of any gain in the contract (cash value in excess of premiums paid);
- (2) Policy loans (and dividends applied to pay policy loans) are considered as amounts distributed under (1) above; and,
- (3) Certain distributions are subject to a 10 percent penalty tax (amounts received prior to age 59-1/2 or not received as annuity payments or as the result of a disability).

A modified endowment is defined as a contract that meets the requirements of Section 7702, but fails to meet a 7-Pay test under Section 7702A. The 7-Pay test is applied by comparing the premiums paid under the contract with a 7-Pay limit determined in the same manner as the net single premium under the cash value accumulation test. A contract for which the premiums paid exceed the 7-Pay limit would be classified as a modified endowment.

The Section 7702A rules apply to contracts entered into on or after June 21, 1988, with special transition rules applicable to material changes made in contracts issued prior to that date.