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NOTE

RECONCILING THE PRINCIPLE OF INDEMNITY IN DIMINISHED VALUE AUTOMOBILE INSURANCE CLAIMS

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I. INTRODUCTION

The allowance of diminished value payments on automobile repair claims to compensate the vehicle owner for loss of *potential* resale value plus the cost to repair is a broad solution for an indeterminate problem. The solution must be addressed differently for liability claims against an insured, which are governed by tort law for compensation, in contrast to collision claims by the insured, which are governed largely by contract law that looks to the insurance policy provision. The principle of indemnity, inherent in all insurance losses, should be reconciled with these payment schemes, and doing so results in different conclusions.

The principle of indemnity, that insurance should make the insured whole after a loss but not better,[1] is a basic principle of insurance law often overlooked in the controversy for diminished value payments under the first-party collision coverage. We contend that the assertion for diminished value in first-party losses often relies, incorrectly, on using the tort-based liability compensation scheme. Where the owner actually sells the damaged vehicle, then paying the actual reduction in sale price due to the accident is justified to make the insured whole. Where the owner never actually sells the vehicle during any "reasonable period" after the collision, then paying a diminished value amount violates the principle of indemnity because it pays for an unrealized and non-existent loss. Further, the vehicle's value naturally declines to nominal value due to age and obsolescence. Even classifying the diminished value as an unrealized capital loss is a fiction, in part because hardly anyone has a personal balance sheet to reflect the change in one's financial position.

We propose that the diminished value payments controversy on first-party claims can be partially reconciled with the principle of indemnity using a narrower solution that also fits with insurer claims practicalities: payment of diminished value on leased vehicles where this results in an actual cost

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[1] "The goal and purpose of indemnity is to reimburse the insured for the insured's actual property loss sustained (restoration, dollar for dollar) but generally no more. The objective of indemnity is to put an insured in the same (but not better) position the insured would have occupied had no loss occurred." 15-111 APPLEMAN ON INSURANCE LAW & PRACTICE ARCHIVE § 111.1 (2d ed. 2011). *Accord* Koppers Co., Inc. v. Aetna Cas. & Sur. Co., 98 F.3d 1440, 1452 (3d Cir. 1996) ("a fundamental principle of insurance law which prohibits insurance contracts from conferring a benefit greater than the insured's loss (i.e., a 'double recovery').").

assessment on the lessee and on vehicles sold within one year of the repair.[2] We also think that the standard Insurance Services Office ("ISO") personal automobile insurance form can be improved upon to solve the differing interpretations, but that does not affect the principle of indemnity issue that has been mostly ignored in the controversy for diminished value compensation for first-party losses.

II. COVERAGE UNDER THE ISO PERSONAL AUTOMOBILE POLICY

Insurance coverage for damage to vehicles under the standard ISO personal automobile policy, 00 01 09 18, provides different definitions for damage to vehicles depending on whether the claim for damages is from a third-party alleging liability by the insured, or for damage from the insured under the collision or comprehensive coverage.[3] This is a starting point to analyze the disputes over coverage; these differences are a matter of contract, not anything inherent in vehicle losses, and contract terms can be changed. The contractual differences still fail to address the fundamental indemnity principle that guides our proposition.

A. ISO COVERAGE FOR LIABILITY LOSSES

The liability coverage under the standard ISO personal automobile policy, 00 01 09 18, states: "We will pay damages for 'bodily injury' or 'property damage' for which any 'insured' becomes legally responsible because of an auto accident."[4] The policy defines "property damage" as "physical injury to, destruction of or loss of use of tangible property."[5] That definition confines any loss payment to actual damage, *or* loss of use (The "*or* loss of use" phrase seems in practice to be conjunctive not disjunctive for what insurers pay on these claims—not exactly what the contract says).

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[2] Our discussion here is limited to automobile claims, which are depreciating assets. We ignore the issue in property loss (i.e., buildings) claims where there is a separate line of pertinent case law. Buildings are different: they are generally appreciating assets when maintained and improvements are made to increase their value, which compels a different analysis than for the depreciating assets of automobiles, although most courts overlook that important distinction. Another category ignored in this paper is collector automobiles, because these are generally insured with a valued policy.

[3] *Personal Auto Policy PP 00 01 09 18*, INS. SERVS. OFF. (2017) [hereinafter *ISO Personal Automobile Policy*].

[4] *Id.* at Liability Coverage Insuring Agreement (A).

[5] *Id.* at Definitions (H).

Those restrictions in payment are what the insurer will pay, even if the insured might be legally liable for more damages, such as for diminished *potential* resale value. Under tort law (as we discuss below), damages can exceed the physical damage repair cost.

There are few cases dealing with diminished value in liability claims. A Massachusetts case addressed this side of the problem, dealing with a different policy as mandated by Massachusetts law, which also required payment for "property damage," but with a broader definition. The approved Massachusetts policy provision in *McGilloway v. Safety Insurance Co.* provided:

> Under this Part, we will pay damages to someone else whose auto or other property is damaged in an accident. The damages we will pay are the amounts that person is legally entitled to collect for property damage through a court judgment or settlement. . . . Damages include any applicable sales tax and the costs resulting from the loss of use of the damaged property.[6]

The *McGilloway* court wrote that '"the term property damage . . . can include intangible damage such as the diminution in value of tangible property."'[7] The court reasoned that tort damages are intended to compensate the injured party for a loss and to put the plaintiff "as nearly as possible equivalent to his [or her] position before the tort."[8]

> Because the plain language of part 4 of the standard policy [cited above] does not limit recovery to merely repair or replacement costs, such recovery must compensate a claimant for any loss of value the claimant incurred as a result of a collision, offset by the increase in value that may occur from repairs to the vehicle. In short, if a third-party claimant's vehicle suffers IDV (inherent diminished valued) even after it is fully repaired, then under part 4 of the standard policy, the insurer may be liable to the claimant for IDV damages so that he or she may be "made whole" once again.[9]

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[6] McGilloway v. Safety Ins. Co., 174 N.E.3d 1191, 1195 (Mass. 2021).
[7] *Id.* at 1196.
[8] *Id.* at 1197.
[9] *Id.* at 1197.

Although the ISO policy limits what it means by property damage, the Massachusetts decision is, to our minds, a fair approach because the property damage is the result of a tort. The insurance covers the tort, the tort damages are to restore the plaintiff, the insurance provides for payment for property damages and thus, restoring the plaintiff should (or can) include diminished value (what the Massachusetts called "inherent diminished value"). This is consistent with the *Restatement of the Law – Torts* § 928:

> Where a person is entitled to a judgment for harm to chattels not amounting to a total destruction in value, the damages include compensation for
>
> > (a) the difference between the value of the chattel before the harm and the value after the harm or, at the plaintiff's election, the reasonable cost of repair or restoration where feasible, with due allowance for any difference between the original value and the value after repairs, and (b) the loss of use.[10]

The *Restatement (Second) of the Law – Torts*, is similar.[11]

Thus, under tort law, the controlling source of law when making claims against another driver, the compensation owed is to make the plaintiff whole in all ways and can thus include diminishment of damages.[12] A New Jersey case analogized the stigma to a scarlet letter:

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[10] RESTATEMENT OF TORTS § 928 (AM. L. INST. 1934).

[11] RESTATEMENT (SECOND) OF TORTS § 928 (AM. L. INST. 1979) ("When one is entitled to a judgment for harm to chattels not amounting to a total destruction in value, the damages include compensation for (a) the difference between the value of the chattel before the harm and the value after the harm or, at his election in an appropriate case, the reasonable cost of repair or restoration, with due allowance for any difference between the original value and the value after repairs, and (b) the loss of use.").

[12] *See* Copelan v. Infinity Ins. Co., 728 Fed. App'x. 724, 725 (9th Cir. 2018) ("Although diminution in value is not itself a form of physical damage, it is an accepted way of measuring damage."); *see also* Windham at Carmel Mountain Ranch Ass'n. v. Superior Ct., 135 Cal. Rptr. 2d 834, 844 (Cal. Ct. App. 2003) ("In its common usage, 'damage' includes harm, loss, injury, detriment, or diminution in value."). *See generally* ROBERT H. JERRY, II & DOUGLAS R. RICHMOND, UNDERSTANDING INSURANCE LAW 556–59 (6th ed. 2018).

> With the advent of databases such as CarFax, the consuming public now has the ability to learn whether a vehicle wears the "scarlet letter" of an accident history. Because the claims at hand rely on this newly-available source of information doesn't mean the information should be excluded when fixing damages in such a case. To the contrary, we hold that the damage caused by such a "scarlet letter" is just another factor that bears on value and is recoverable if supported by sufficient proof. . . . An award based on this "scarlet letter" or "stigma" is not speculative but is consistent with our past recognition that damages may include such intangible concepts. . . . The "scarlet letter" or "stigma" for which plaintiffs here seek redress fits well within a proper calculus of damage to a motor vehicle.[13]

While the ISO policy form for liability losses does not really embrace such breadth, the insurer probably is responsible for such losses because the insurance policy is approved by the state insurance commissioner and is expected to comply with state law. Where an insurance policy expressly excludes diminishment damages in a liability loss, courts have enforced that restriction.[14] That exclusion leaves the insured to pay that extra liability loss, as uncovered damages.

B. ISO COVERAGE FOR FIRST-PARTY LOSSES

The collision and comprehensive coverage for damages to the insured's own vehicle is defined differently than the liability coverage. Here the ISO insuring agreement in the Personal Automobile Policy states: "We will pay for direct and accidental loss to 'your covered auto' or any 'non-owned auto', including its equipment, minus any applicable deductible

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[13] Fin. Servs. Vehicle Tr. v. Panter, 458 N.J. Super. 244, 250–51 (N.J. Super. Ct. App. Div. 2019).

[14] *See* Hennessy v. Infinity Ins. Co., 358 F. Supp. 3d 1074, 1079 (C.D. Cal. 2019), *appeal dismissed*, Hennessy v. Infinity Ins. Co., No. 19-55266, 2019 WL 2383347 (9th Cir. 2019) ("The policy provides coverage for 'property damage,' meaning 'physical damage to tangible property,' and it clearly and specifically excludes from coverage 'loss . . . [t]o the insured auto for diminution of value,' also known as 'stigma damages.'").

shown in the Declarations."[15] Rather than define "loss" in this section, the policy instead has a "Limit of Liability" section later on that reads:

> A. Our limit of liability for loss will be the lesser of the:
>
> 1. Actual cash value of the stolen or damaged property; or
>
> 2. Amount necessary to repair or replace the property with other property of like kind and quality.
>
> . . .
>
> B. An adjustment for depreciation and physical condition will be made in determining actual cash value in the event of a total loss.[16]

Note that these claims do not involve torts subject to principles of compensatory damages. Instead these claims are solely subject to the insurance contract, as some early cases accurately note.[17] Sometimes, of course, the damage to the insured's vehicle may result from a tort by another driver, and thus, the insured could make that additional claim against the other motorist's auto policy, and absent sufficient coverage there, trigger the uninsured motorist coverage part of the policy.[18] Case law in some jurisdictions interpreting this section, dealing with the repair provision, has re-interpreted this compensation to include the diminishment of value. The reasoning of these cases is that:

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[15] *ISO Personal Automobile Policy*, *supra* note 3, at Insuring Agreement (A).

[16] *Id.* at Limit of Liability (A) & (B).

[17] *See generally* Haussler v. Indem. Co., 227 Ill. App. 504, 508–09 (Ill. App. Ct. 1923); U.S. Fid. & Guar. Co. v. Corbett, 35 Ga. App. 606, 610 (Ga. Ct. App. 1926); Gen. Accident. v. Judd., 400 S.W.2d 685, 687 (Ky. Ct. App. 1966).

[18] *See e.g.*, Noteboom v. Farmers Texas Cty. Mut. Ins. Co., 406 S.W.3d 381, 384 (Tex. Ct. App. 2013); Dunn v. Meridian Mut. Ins. Co., 836 N.E.2d 249, 255 (Ind. 2005) ("If an insured incurs damages recoverable from an uninsured motorist beyond the insured's collision coverage, there are 'damages' in addition to the 'loss' that is 'payable' under the Part D collision coverage."); Ibrahim v. AIU Ins. Co., 177 Wash. App. 504, 512 (Wash. Ct. App. 2013); Culhane v. W. Nat'l Mut. Ins. Co., 704 N.W.2d 287, 296–97 (S.D. 2005) ("[T]he contractual indemnification obligation is not governed by Culhane's post-loss feeling of what should be reasonably or rationally covered. Furthermore, Culhane's entitlement to recovery for the 'entire loss' is only applicable under the '[r]ules . . . [of] recovery in tort[, but those rules] do not apply to an action on a contract of insurance.'").

> [T]he term "repair" means restoration of the vehicle to substantially the same condition and value as existed before the damage occurred, so that the correct measure of loss caused by collision is the difference in market value of the automobile immediately before the collision and the combined amount of its market value immediately after being repaired, plus the deductible.[19]

A Washington court distinguished diminution in value damages where the vehicle cannot be restored to its pre-loss condition from stigma damages where the vehicle is restored but bears a "taint."[20] The distinction, however, is not important for this paper. Georgia courts have been especially noteworthy in holding this position, asserting that "repair" includes the amount necessary to restore the vehicle, or more accurately the owner's interest, to the value that preceded the damage. *State Farm Mutual Automobile Insurance Co. v. Mabry* is the most prominent Georgia case on this point:

> [T]he insurance policy, drafted by the insurer, promises to pay for the insured's loss; what is lost when physical damage occurs is both utility and value; therefore, the insurer's obligation to pay for the loss includes paying for any lost value. That interpretation has stood for 75 years in Georgia and has become, therefore, part of the agreement between the parties when they enter into a contract of insurance which includes the promise to pay for the insured's loss.[21]

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[19] 12A STEVEN PLITT ET AL., COUCH ON INSURANCE § 177:19 (3d ed. 2022).

[20] *See Ibrahim*, 177 Wash. App. at 1001–02 ("'Diminished value' damages are available where a vehicle "sustains physical damage in an accident, but due to the nature of the damage, it cannot be fully restored to its preloss condition.'") (citation omitted). "One example of this is where weakened metal cannot be repaired. …[U]nlike 'diminished value' damages, stigma damages "occur when the vehicle has been fully restored to its preloss condition, but it carries an intangible taint due to its having been involved in an accident.'" *Id.* (citation omitted). "Put somewhat differently, 'diminished value' damages may be available when the vehicle cannot be fully restored to its preloss condition, whereas stigma damages may be available when the vehicle can be fully restored to its preloss physical condition, but is perceived as being less valuable due to the accident.'" *Id.*

[21] State Farm Mut. Auto. Ins. Co. v. Mabry, 274 Ga. 498, 508 (Ga. 2001).

Well, not quite. First, the policy does not agree to pay for loss. Second, the *Mabry* decision cited 75 years of Georgia cases that have required payment of loss of value in addition to the repair costs.[22] That overstates the foundation of the *Mabry* decision. The first case *Mabry* relied on was *U.S. Fidelity & Guaranty Co. v. Corbett*, which was about technical pleading practices to assert a defense of whether the loss of value was properly before the court following an "appraisement" where the insurer did not properly seek to assert the limitation of liability.[23] The second case *Mabry* relied on was *Dependable Insurance Co. v. Gibbs*,[24] which was about an insurer that completed inadequate repairs on the vehicle. Apparently, insurers historically handled the repairs rather than now only paying for them, as is required by law or regulation in many states.[25] The third case was *Simmons v. State Farm* where the court said that the amount the insurer tendered to repair the damaged car seemed to have "the ring of a money settlement rather than an election to repair."[26]

> If the draft on presentation required the payee's signature to a release of all claims, this would be the only possible result, but, in any event, the communications from the insurer show that it intended for the insured to rely on the guarantee of the repairman, but failed to show that such a guarantee had in fact been made.[27]

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[22] *Id.* at 503–06.

[23] *See* U.S. Fid. & Guar. Co. v. Corbett, 134 S.E. 336, 338 (Ga. Ct. App. 1926) ("under the provisions of the policy now under consideration, the undertaking of the company to insure the owner against 'actual loss or damage' must be taken as the primary obligation, under which the measure of the liability would be the difference between the value of the property immediately before the injury and its value immediately afterwards [citation omitted] and the stipulation that the liability should not exceed the cost of repair or replacement must be construed as a subordinate provision, limiting or abating the primary liability, *to be pleaded defensively if the insurer would diminish or limit the amount of recovery by reason thereof.*") (citation omitted) (emphasis added). Since the insurer had failed to do so at the appraisement, it could not then assert it in the lawsuit. *Id.*

[24] *See* Dependable Ins. Co., Inc. v. Gibbs, 127 S.E.2d 454, 460 (Ga. 1962).

[25] *See e.g.*, CAL. CODE REGS. tit. 10, § 2695.85(c) (2022); CONN. GEN. STAT. § 38a-354 (2022); GA. CODE ANN. § 33-34-6(b) (West 2022).

[26] *See* Simmons v. State Farm Mut. Auto. Ins. Co., 143 S.E.2d 55, 58 (Ga. Ct. App. 1965).

[27] *Id.*

Regardless of the distortion, the *Mabry* decision, and some cases from the 1970s and 1980s that were cited by *Mabry*, established that in Georgia, the repair option includes the diminishment in value condition.

The Washington Court of Appeals has also allowed for diminishment of value damages, explaining in *Moeller v. Farmers Insurance Co*. that:

> A vehicle suffers diminished value when it sustains physical damage in an accident, but due to the nature of the damage, it cannot be fully restored to its pre-loss condition. Weakened metal that cannot be repaired is one such example. In contrast, 'stigma damages' occur when the vehicle has been fully restored to its pre-loss condition, but it carries an intangible taint due to its having been involved in an accident.[28]

Moeller agreed with the policyholder that '"like kind and quality"' in the policy means "a restoration of *appearance*, *function*, and *value*" and thus, includes diminishment of value.[29]

Many states reject this interpretation and (to our mind) stick with a proper and conventional interpretation of the contract language. The Delaware Supreme Court in *O'Brien v. Progressive Northern Insurance Co*. rejected the claimant's approach (and by extension, the Georgia approach) that "repair" includes "financial detriment."[30]

> [T]he claimed loss cannot be interpreted without an accompanying examination of all of the policies' limits on liability, which were contracted to by all of the involved parties . . . the policies in question give the insurer the option

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[28] Moeller v. Farmers Ins. Co., 229 P.3d 857, 861 (Wash. App. Div. 2 2010), *aff'd*, 267 P.3d 998 (Wash. 2011). The court's contention is not accurate. If the metal is weakened, then the structural integrity is deficient and it should be repaired to replace the weak metal, and if that cannot be done—such as having to replace the chassis—then the vehicle should be junked. This seems to be the view of the few cases that have allowed diminished value damages where repairs were inadequate or there was a delay in repair. *See* Campbell v. Calvert Fire Ins. Co., 109 S.E.2d 572 (S.C. 1959); Venable v. Import Volkswagen, 519 P.2d 67 (Kan. 1974); Pierce v. Am. Fid. Fire Ins. Co., 83 S.E.2d 493 (N.C. 1954).

[29] *Moeller*, 229 P.3d at 863.

[30] *See* O'Brien v. Progressive N. Ins. Co., 785 A.2d 281, 287 (Del. 2001).

> of either reimbursing the claimant for the entire value of the damaged automobile or of repairing or replacing its parts, depending on which will cost the insurer less. A reading of the policy language as Appellants suggest would render this "choice" meaningless.[31]

A California court explained that, "'[p]re-loss condition' means the 'preaccident safe, mechanical and cosmetic condition' of the covered vehicle."[32] The court continued, "an insurer's election to repair is conclusive 'provided the repair places the automobile substantially in its preaccident condition.'"[33] If it does not, then the automobile is deemed a total loss, and

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[31] *Id.* at 287. Noteworthy is the court's rebuke of the claimant's typical contention that a split of authority among the states is evidence of ambiguity of a contract provision.

> Appellants argue that the mere fact that a number of courts nationwide have reached different and contradictory conclusions about the meaning of policy terms nearly identical to those before us in this case creates an ambiguity. This contention, while seductive, is without merit. … The duty of the courts is to examine solely the language of the contractual provisions in question to determine whether the disputed terms are capable of two or more reasonable interpretations. In so doing, Delaware courts are obligated to confine themselves to the language of the document and not to look to extrinsic evidence to find ambiguity. A mere split in the case law concerning the meaning of a term does not render that meaning ambiguous in the Delaware courts.
>
> This Court would place itself in an untenable position if it were to recognize every split in judicial authority as *prima facie* evidence of ambiguity. In the context of interpreting insurance agreements, an adoption of this policy would unduly restrict the power of the Delaware courts to render decisions independent of our sister courts. . . . If this Court were to allow an insured to demonstrate ambiguity by providing evidence of a split in authority, *contra proferentem* would preclude us from even addressing the contract language or the merits of the case.

Id. at 289.

[32] Carson v. Mercury Ins. Co., 210 Cal. App. 4th 409, 420 (Cal. Ct. App. 2012).

[33] *Id.* at 421.

the insurer is liable for the preaccident value of the car."[34] An earlier case was more explicit, stating that there is no requirement "to repair the automobile to both its pre-accident condition *and* market value."[35]

Several treatises set out the arguments for and against allowing for diminishment in value compensation, citing to case law, in trying to interpret what "repair" and "quality" mean in the standard policy and the standard fallback of the insured's reasonable expectation as to what these might mean.[36] An insured's idea of reasonable expectations is itself subject to debate, controversy, and legal fiction given that insureds seem to expect everything from an insurance policy whenever there is a loss—despite having no understanding of insurance and never reading an insurance policy.[37] Whether an insured who never reads a policy, falls within the large category of financially illiterate consumers, and buys solely on price not

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[34] *Id.* at 421 (citing Ray v. Farmers Ins. Exch., 200 Cal. App. 3d 1411 (Cal. Ct. App. 1988)).

[35] *See* Ray v. Farmers Ins. Exch., 200 Cal. App. 3d 1411, 1417 (Cal. Ct. App. 1988).

[36] *See generally* JEFFREY W. STEMPEL & ERIK S. KNUTSEN, STEMPLE AND KNUTSEN ON INSURANCE § 27.08 (2020); STEVEN PLITT ET. AL., 12A COUCH ON INSURANCE 3D § 177:19 (2022); 16 WILLISTON ON CONTRACTS § 49:20 (4th ed. 2022); Thomas O. Farrish, *"Diminished Value" in Automobile Insurance: The Controversy and its Lessons*, 12 CONN. INS. L.J. 39, 57–59 (2005).

[37] A credible attack on the concept is in Susan M. Popik & Carol D. Quackenbos, *Reasonable Expectations After Thirty Years: A Failed Doctrine*, 5 CONN. INS. L.J. 425, 426 (1998). An earlier summary of the evolution of the doctrine, adoption, and criticism of reasonable expectations is in Roger C. Henderson, *The Doctrine of Reasonable Expectations in Insurance Law After Two Decades*, 51 OHIO ST. L.J. 823, 826–27 (1990). As Henderson notes, "reasonable expectations" is not necessary to the core idea of construing ambiguities against the drafter of the contract, *contra proferentem*. *Id.* Of course, an insurance policy that provides unusually restricted coverage from what might be called an industry standard policy, where that distinction is not brought to the attention of the insured, warrants protection. This was the case in C & J Fertilizer, Inc. v. Allied Mut. Ins. Co., 227 N.W.2d 169, 169 (Iowa 1975), where the burglary cause of loss had the uncommon restriction that there must be evidence of visible marks of entry on the exterior. Henderson notes that this provision was in other policies to deal with employee dishonesty losses. Henderson, *supra*, at 845–49. On the duty to read, and failure thereof, see 16 WILLISTON ON CONTRACTS § 49:21 (4th ed. 2022) and Harold Weston, *Insured's Duty to Read Insurance Policy as Affirmative Defense in Claims Against Insurance Agents and Brokers*, 8 AM. L. REP'S 6th 549 (2005).

content can even be said to have a reasonable expectation is a separate and much longer debate not germane to this article.[38]

Unusual facts may require both repair and compensation, such as where the car is stolen and considerable mileage is added to the vehicle although the actual repairs are nominal.[39] The table below shows the general breakdown of jurisdictions that allow or reject diminished value claims for vehicle damage and split between third-party (liability) claims and first-party (collision and comprehensive) claims. The table is not necessarily complete, and many additional cases can be listed beyond the few collected here.[40]

[38] Likewise not germane here is an analysis of the distinctions between personal lines insurance policies from other consumer contracts and the need for consumer protection. The articles about insureds not reading their policies are too long to even begin to list a few here.

[39] *See* Ciresi v. Globe & Rutgers Fire Ins. Co., 244 N.W. 688, 689 (Minn. 1932); Superior Pontiac Co. v. Queen Ins. Co., 434 S.W.2d 340, 340 (Tex. 1968); Ray v. Farmers Ins. Exch., 200 Cal. App. 3d 1411, 1420 (Cal. Ct. App. 1988); Edwards v. Md. Motorcar Ins. Co., 204 A.D. 174, 175 (N.Y. App. Div. 1922); Fanfarillo v. E. End Motor Co., 411 A.2d 1167, 1169 (N.J. Super. Ct. App. Div. 1980).

[40] *See e.g.*, STEMPEL & KNUTSEN, *supra* note 36; L.S. Tellier, Annotation, *Measure of Recovery by Insured Under Automobile Collision Insurance Policy*, 43 A.L.R. 327 (1955); J. Randolph Evans et al., *Insurance Coverage for Post-Repair Diminution in Value: Trends in Automobile and Real Property Claims* (Lexis 2011).

	States that allow for diminished value in auto claims	**State that disallow for diminished value in auto claims**
3d party liability	District of Columbia; Oklahoma; Massachusetts; West Virginia.[41]	Massachusetts; Oregon.[42]
1st party collision & comprehensive	Georgia; Mississippi; Oregon; Rhode Island; Washington[43]	California; Florida; Illinois; Louisiana, although in this case, the insurer's policy expressly excluded diminution in value; Kentucky; Ohio; Maine; Massachusetts; Michigan; Mississippi; Missouri; New Jersey; New Mexico; South Carolina; South Dakota; Tennessee; Texas; Virginia.[44]

[41] Am. Serv. Ctr. Assocs. v. Helton, 867 A.2d 235, 243 (D.C. 2005) (citing to the Restatement); McGilloway v. Safety Ins. Co., 174 N.E.3d 1191, 1196 (Mass. 2021); Brennen v. Aston, 84 P.3d 99, 102 (Okla. 2003); Ellis v. King, 400 S.E.2d 235, 239 (W. Va. 1990).

[42] Martins v. Vt. Mut. Ins. Co., 411 F. Supp. 3d 166, 172 (D. Mass. 2019) (predicting Massachusetts law). *See also* Dunmire Motor Co. v. Or. Mut. Fire Ins. Co. 114 P.2d 1005, 1009 (Or. 1941).

[43] Calvert Fire Ins. Co. v. Newman, 124 So. 2d 686 (Miss. 1960); Gonzales v. Farmers Ins. Co., 196 P.3d 1 (Or. 2008); Pawtucket Mut. Ins. Co. v. Gay, 786 A.2d 383 (R.I. 2001); Moeller v. Farmers Ins. Co., 229 P.3d 857, 861 (Wash. App. Div. 2 2010), *aff'd*, 267 P.3d 998 (Wash. 2011).

[44] Copelan v. Infinity Ins. Co., 728 Fed. App'x 724 (2018); Baldwin v. AAA N. Cal., Nev. & Utah Ins. Exch., 204 Cal. Rptr. 3d (Cal. Ct. App. 2016); Ray v. Farmers Ins. Exch., 246 Cal. Rptr. 593 (Cal. Ct. App. 1988); Hennessy v. Infinity Ins. Co.,

The ISO form seems clear enough on what the contract says, though it could do better by defining the damage to be paid (repair or actual cash value) rather than splitting this idea in a separate section on limitation of liability.[45] Debating the point further here will not advance the debate nor resolve the question. Courts that reject or distort the contract provision for first-party coverage can impose (as a matter of public policy but not as honest contract interpretation) an additional compensation. Our goal is not to provide a solid matrix on jurisdictional outcomes but to address these outcomes under the principle of indemnity, which we do in the next section.

III. THE PRINCIPLE OF INDEMNITY IN INSURANCE

The principle of indemnity is fundamental to insurance,[46] it '"is the basis and foundation of all insurance law,"'[47] though not stated within actual contracts. "This legal principle operates independently of any agreement between the parties."[48] It is "the concept that insurance contracts shall confer

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358 F. Supp. 3d 1074, 1079 (C.D. Cal. 2019) (policy excluded diminished value as damages); Siegle v. Progressive Consumers Ins. Co., 788 So. 2d 355 (Fla. Dist. Ct. App. 2001), *decision approved*, 819 So. 2d 732 (Fla. 2002); Sims v. Allstate Ins. Co., 851 N.E.2d 701 (Ill. App. Ct. 2006); Gen. Accident Fire & Like Assurance Corp. v. Judd, 400 S.W.2d 685 (Ky. 1966); Sandoz v. Bourgeois, 64 So. 3d 322 (La. Ct. App. 2011); Gehrisch v. Chubb Grp. of Ins. Cos., 645 Fed. App'x 488 (6th Cir. 2016); Hall v. Acadia Ins. Co., 801 A.2d 993 (Me. 2002); Given v. Com. Ins. Co., 796 N.E.2d 1275 (Mass. 2003); Driscoll v. State Farm Mut. Auto. Ins. Co., 227 F. Supp. 2d 696 (E.D. Mich. 2002); Blakely v. State Farm Mut. Auto. Ins. Co., 406 F.3d 747, 753 (5th Cir. 2005) (distinguishing earlier cases with different policy language); Lupo v. Shelter Mut. Ins. Co., 70 S.W.3d 16 (Mo. Ct. App. 2002); Kieffer v. High Point Ins. Co., 25 A.3d 1206 (N.J. Super. Ct. App. Div. 2011); Davis v. Farmers Ins. Co., 142 P.3d 17 (N.M. Ct. App. 2006); Schulmeyer v. State Farm Fire & Cas. Co., 579 S.E.2d 132 (S.C. 2003); Culhane v. W. Nat'l Mut. Ins. Co., 704 N.W.2d 287 (S.D. 2005); Black v. State Farm Mut. Auto. Ins. Co., 101 S.W.3d 427 (Tenn. Ct. App. 2002); Am. Mfrs. Mut. Ins. Co. v. Schaefer, 124 S.W.3d 154 (Tex. 2003). *See also* State & Cnty. Mut. Fire Ins. Co. v. Macias, 133 S.W.3d 271 (Tex. 2004); Bickel v. Nationwide Mut. Ins. Co., 143 S.E.2d 903 (Va. 1965).

[45] *See generally ISO Personal Automobile Policy*, *supra* note 3.

[46] *See* Koppers Co., Inc. v. Aetna Cas. & Sur. Co., 98 F.3d 1440, 1452 (3d Cir. 1996).

[47] Rochester Am. Ins. Co. v. Short, 252 P.2d 490, 493 (Okla. 1953) (quoting McAnarney v. Newark Fire Ins. Co., 159 N.E. 902, 904 (N.Y. 1928)).

[48] Letoha v. Nationwide Ins. Co., No. 06-CV-1009, 2007 WL 4557864, at *1 (S.D. Miss. Dec. 20, 2007).

a benefit no greater in value than the loss suffered by an insured."[49] The principles of adverse selection and moral hazard are not stated in insurance contracts either, but they, along with indemnity, underpin and suffuse the business and commitment of insurance to restore the insured to a position similar to but no better than had the loss not occurred—provided that the insurance policies cover such losses. The principle of indemnity can help resolve the contention for loss of value because it will force open the question of whether the loss of value is realized or unrealized (to use accounting terminology).

Robert H. Jerry, II in *New Appleman on Insurance* explains the principle of indemnity:

> In its simplest usage in insurance, the term "indemnity" refers to the compensation necessary to reimburse the insured's loss. One goal of an insurance transaction is to transfer the insured's risk of loss to the insurer. When the insured suffers a loss, the insurer pays proceeds, a benefit, to the insured in an amount that offsets the loss. This arrangement is based upon the assumption that the value of the benefit paid the insured will not exceed the amount of the loss; that is, insurance aims to reimburse and to do nothing more. It is consistent with the *principle of indemnity* to pay the insured a benefit *less than* the loss, but the *principle of indemnity* is violated if the insured is paid a benefit greater than the loss.
>
> Property insurance is fundamentally a contract of indemnity. Property values are relatively easy to measure, and property insurance is oriented toward reimbursing the impairment of a property's value.[50]

As Jerry notes, replacement cost coverage in building losses seems to violate the principle of indemnity "because the insured has an improvement through use of new materials," which leads to a repair

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[49] Teague-Strebeck Motors, Inc. v. Chrysler Ins. Co., 985 P.2d 1183, 1193 (N.M. Ct. App. 1999), *overruled on other grounds by*, Sloan v. State Farm Mut. Auto. Ins. Co., 85 P.3d 230 (N.M. 2004).

[50] ROBERT H. JERRY, II, 1 NEW APPLEMAN ON INSURANCE LAW LIBRARY EDITION § 1.05 (2021) (emphasis in the original). *See also* Gossett v. Farmers Ins. Co. of Wash., 948 P.2d 1264, 1271 (Wash. 1997) (further explaining indemnity).

"indemnified in a functional way."[51] This is always a challenge to the idea of replacement cost and repair, because it replaces new for old of similar kind and quality.[52] More accurately, that often means removing the depreciation of labor and materials from the actual cash value calculation,[53] and in some respects, it is not feasible to replace with exactly the same old materials: imagine trying to find 15-year-old roof shingles in a junkyard, lumber from a demolition site to do the basic frame carpentry, and an old dingy carpet to match what the policyholder had.

The same problem occurs in automobile repair cases. Old parts are replaced with new ones. The radiator that was developing rust and thin spots is now new, the fogged headlamps are now new, and so on and will last much longer than the original worn parts. Yet still the market value for a vehicle repaired from an accident is lower. As Thomas Farrish notes, "appellate courts seem almost ready to take judicial notice of the proposition that cars lose value regardless of how well the repairs might have been performed."[54]

James Athearn in his treatise on insurance gives a different definition:

> Insurance is a contract of indemnity. The insurer agrees to pay for loss suffered by the insured, and no more. The purpose of the contract is to shift the burden of risk from the insured to the insurer. The insured is to be restored to the same economic position he occupied prior to the loss. In no event is his position to be improved as a result of the loss and his agreement with the insurer. Indemnity agreements have

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[51] JERRY, *supra* note 50, at n.71.

[52] ALLAN D. WINDT, INSURANCE CLAIMS AN DISPUTES § 11:35 (6th ed. 2013) ("Replacement cost coverage, therefore, in contravention of the general rule that an insured cannot profit through insurance, results in the insured being better off than he or she was prior to the loss, since the insured ends up with a more valuable property.").

[53] *See e.g.*, Arnold v. State Farm Fire & Cas. Co., 268 F. Supp. 3d 1297, 1305 (S.D. Ala. 2017); Shelter Mut. Ins. Co. v. Goodner, 477 S.W.3d 512, 515 (Ark. 2015); Sproull v. State Farm Fire & Cas. Co., 184 N.E.3d 203, 210–16 (Ill. 2021) (collecting cases for and against depreciating labor); Wilcox v. State Farm Fire & Cas. Co., 874 N.W.2d 780, 785 (Minn. 2016) ("When a homeowner's insurance policy does not define the term 'actual cash value' or otherwise state whether embedded labor costs are depreciable for the purpose of calculating actual cash value, the trier of fact may consider embedded-labor-cost depreciation when such evidence logically tends to establish the actual cash value of a covered loss.").

[54] Farrish, *supra* note 36, at 50.

> practical significance for the insurer and for society as a whole. If the insured could gain by having a loss, many would be tempted to cause losses. . . . Any contract of insurance that makes it possible for the insured to profit is contrary to public policy and poor business for the insurer.[55]

This definition would embrace both the actual cost to repair the vehicle, and the economic loss that diminishment of value damages allow—except we are back to the question whether that extra compensation makes the insured better off than he or she would be. Indisputably, replacing new for old parts is an improvement, but that is the cost to repair and, as Jerry notes above, insurers have accommodated themselves to the reality that replacing new for old is part of the deal to restore the insured to the pre-loss condition.[56] Extra money, however, is not old for new.[57] Taking Athearn at his word, restoring the insured to the economic position he or she was in pre-loss would require only payment of the amount of that was the fair market value of the vehicle seconds before the impact.

Engaging the principle of indemnity to analyze this problem of compensable loss brings to the surface several features of the problem of diminished value in automobile claims: whether the insured has actually suffered a loss by the drop in value that can comply with the principle of indemnity.

A. DOES THE INSURED SUFFER A COMPENSABLE LOSS CONSISTENT WITH THE PRINCIPLE OF INDEMNITY?

Disregard the insuring agreements for first-party losses to deal here with a principle, not policy language; besides, the policy language can be changed. One answer is yes, there is a compensable loss, which is allowed under *tort* law, but that moves this back to a liability loss. These diminished value cases to compensate an insured arise from the indemnity principle, not from tort law. A vehicle that was in a collision and was repaired has a stigma and results in a lower resale value, which *can* be a compensable loss. The real question at the core is whether there *is* a loss if the insured does not sell the vehicle. This raises several points: What are the accounting rules for recognizing changes in value of damaged, and repaired, assets? When should an unrealized capital loss be recognized for a consumer? Is this an economic loss or a property loss?

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[55] JAMES L. ATHEARN, RISK AND INSURANCE 59 (1962).
[56] JERRY, *supra* note 50, at n.116.
[57] Farrish, *supra* note 36, at 70.

Basic accounting instructs that a loss is realized when the asset is sold (or disposed of) and the price is lower than the carrying cost, what it was valued at on the books and reflecting depreciation.[58] A loss is recognized when the event occurs, even if there is no sale of the asset (or receipt of cash for some asset or service).[59] Thus, a damaged vehicle would recognize a loss in the value of the asset, a repaired vehicle would cancel that out (if we are to make immediate accounting entries), and the diminished (stigma) fair market value would be recognized on the books if the asset is marked to market price even though the vehicle is not sold and no loss is realized.

Vehicles are depreciating assets, losing value due to time, wear, and mileage. A business owner can deduct the depreciation of the asset,[60] and there are specific tax depreciation schedules for various assets, including vehicles,[61] which can be different from Generally Accepted Accounting Principles (GAAP).

Most vehicles for consumers are purchased, operated, and maintained. Some people will "customize" a vehicle to improve the sound system, tires, rims, parts of the suspension, or engine with aftermarket parts, which, if significant, will raise the value. For consumers, these improvements create challenges in figuring out the right insurance limit and should increase any market value *if the vehicle is sold.* The vehicle, even at the higher value, then begins its decline in value. For consumers, unlike businesses, there is no *recognition* of any accounting event of this higher value for the balance sheet because there is almost never a consumer balance sheet (except when applying for a loan). For consumers, absent a sale, there is no loss or gain to *realize* the relevant market value against the carrying cost after depreciation plus any capital improvement to the asset.

Even if a consumer replaces an engine or transmission, which are expensive items, the event would in theory *recognize* a higher carrying value of the vehicle than what the vehicle was worth before the improvement, in part because this would be a capital replacement. In practice, consumers have no balance sheet on which to recognize this. This raises the insurance indemnity problem of what the right indemnity value is when an insurer replaces high-value items that increase the market price. Here, some policies allow an insurer to deduct the value of the betterment where it increases the value of the vehicle; thus, the example if an insurer replaces an engine

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[58] *Lesson 2: Realization vs Recognition*, ACCOUNT. BASICS (Sep. 3, 2014), https://accountingbasics.lifestylecpa.com/realization-vs-recognition/.

[59] *Id.*

[60] I.R.S. PUBL'N 946, HOW TO DEPRECIATE PROPERTY (2022).

[61] *Id.* at 59.

damaged by some covered peril (flood or collision, for example) that had 40,000 miles on it, now with a new engine, that new engine raises the market value of the car from the value with a 40,000 mile engine. That extra value may be deducted from the cost of repairs.[62]

Fair market value is the usual insurance equivalent of actual cash value.[63] This also reflects supply and demand for comparable vehicles regardless of ordinary depreciating value due to mileage, year, wear and tear, and any diminished or stigma value. This is a key point that in 2021 and 2022 raised the value of used cars due to the computer chip shortage for new cars.[64]

This connects the debate on whether the insured has a compensable loss or not. Where the insured does not sell the vehicle or have a balance sheet to reflect assets and consequent book value, there is a theoretical accounting loss only. Theoretical because in fact the insured has no accounting records or financial statements to display the value.

The absence of accounting records and financial statements is important but perhaps not definitive. Either the value exists regardless of whether a financial statement reflects it or the value does not exist, because there is no reason to record or reflect any such value. Consumers are generally aware of the values of their homes and the resale values of their cars. They do not need financial statements to know and to worry about those values. That does not mean, however, that they have a loss if those values decline. As Jeffrey Stempel observes:

> But accepting the idea that auto insurance should pay for diminished post-crash/post-repair market value runs counter to the social function of auto insurance. Auto collision

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[62] Andrew Janquitto, *The Insurer's Payment Obligation and Limitation*, *in* 6 NEW APPLEMAN ON INSURANCE LAW § 62.08 at 1, 12–13 (2022).

[63] *Id.* at § 62.08[b]. *See, e.g.*, Williams-Diggins v. Permanent Gen. Assurance Corp., 157 N.E.3d 220, 225 (Ohio Ct. App. 2020); Pannell v. Mo. Ins. Guar. Ass'n, 595 S.W.2d 339, 355 (Mo. Ct. App. 1980); Lowery v. Fid. Nat'l Prop. & Cas. Ins. Co., 805 F.3d 204, 210 (5th Cir. 2015). STEVEN PLITT ET AL., 12 COUCH ON INSURANCE § 175:24 (3d ed. 2022) ("Courts, in applying and interpreting the standard 'actual cash value' provision, have adopted several rules or tests in arriving at the extent of the insurer's liability, and it is the purpose of the subsequent sections to point out these various tests or rules.").

[64] *See* Matt Phillips, *Dealers Pay Record Prices for Used Cars, Reversing a Trend That Pointed to an Easing of Inflation*, N.Y. TIMES (Oct. 13, 2021), https://www.nytimes.com/2021/10/07/business/used-car-prices.html; Matt Phillips, *Wall Street Scans the Lots as Used Cars Prod Inflation*, N.Y. TIMES (Oct. 13, 2021), https://www.nytimes.com/2021/09/27/business/used-cars-inflation.html.

> insurance is designed to restore a damaged vehicle to its pre-accident condition. If, after a collision, the insurer pays for an adequate repair that restores the auto to its prior condition, the insurance policy has achieved its purpose.
>
> Imposing on the insurer the additional burden of paying for any loss of market value the car may have sustained, merely because it was in an accident, goes beyond the intended social purpose of collision insurance and turns auto insurance, designed to protect against the economic consequences of physical damage, into something of a price guarantee bond.[65]

A second feature that connects the diminished value question in first-party losses to the principle of indemnity is whether there is a property loss or an economic loss. A property loss can be fixed by repairs. The cause of the property loss is some damage either due to an insured peril as addressed by property insurance owned by the insured or property loss due to some negligent or intentional conduct by another party as addressed by the liability side of the insurance for that other party (leave aside the insured's own intentional destruction of the property and the exclusion in the insurance for that). A property loss requires repair or replacement of the damaged property. That is what the insurance contract agrees to do for the insured. The Texas court in *Carlton v. Trinity Universal Insurance Co.* noted this important distinction in rejecting diminution in value damages for damage to the insured's vehicle:

> [W]e do not consider what measure of recovery would make the insured whole after a loss or what would be fair and reasonable compensation for the loss he sustained, for we are not deciding a tort claim. Because the parties' rights and obligations are governed by the contract between them, we instead focus on the plain, unambiguous language of the insurance policy and the ordinary meaning of the words defining the parties' obligations.[66]

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[65] Jeffrey W. Stempel*, The Insurance Policy as Social Instrument and Social Institution*, 51 WM. & MARY L. REV. 1489, 1562–63 (2010).

[66] Carlton v. Trinity Universal Ins. Co., 32 S.W.3d 454, 464 (Tex. Ct. App. 2000).

Other courts have also adhered to the insurance contract and its limit of liability provision to reject reading into the word "repair" some extra value. For example, the court in *Schulmeyer v. State Farm Fire & Casualty Co.* stated: "In the context of an insurance contract the word 'replace' means the insurer will 'restore the insured's vehicle to a former place or position,' or 'take the place of . . . as a substitute or successor.'" [¶] There is no concept of value in the ordinary meaning of these words."[67] The court in *Driscoll v. State Farm Mutual Automobile Insurance Co.* stated:

> [T]he language of the provisions themselves expressly limit coverage to the *lesser* of the actual value or the cost of repair. This is not ambiguous language. The insured must pay for either the actual value of the car or the cost of repair, whichever is less. These are alternatives and do not include the addition of an obligation to pay for diminished value to the car. Reading into the cost of repair a requirement to also pay for diminished value would render the limitation provision meaningless, as the insurer would essentially always pay for the value of the car. [68]

That differs from the damages owed due to the tort when someone else is at fault, in third-party liability claims, where the claimant is entitled under tort law to recover all resulting damages, especially in cases where the repairs cannot restore the property to its pre-loss condition.[69] This is consistent with

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[67] Schulmeyer v. State Farm Fire & Cas. Co., 579 S.E.2d 132, 153 (S.C. 2003) (internal citations omitted). *See also* Culhane v. W. Nat'l Mut. Ins. Co., 704 N.W.2d 287, 291–92 (S.D. 2005).

[68] Driscoll v. State Farm Mut. Auto. Ins. Co., 227 F. Supp. 2d 696, 707 (E.D. Mich. 2002).

[69] *See* Merch. Shippers Ass'n v. Kellogg Express & Draying Co., 170 P.2d 923, 926 (Cal. 1946) (quoting Byrne v. W. Pipe & Steel Co., Cal. App. 270, 274 (Cal. Ct. App. 1927)) (concerning machinery that was damaged, stating that "'if the damaged property cannot be completely repaired, the measure of damages is the difference between its value before the injury and its value after the repairs have been made, plus the reasonable cost of making the repairs.'"). The court further noted that:

> It appears that the machine was a precision machine and that the repairs which were made did not restore it to its former state with no depreciation in its former value. There was evidence showing that the value of the machine after it was repaired was much less

the liability insurance side of the auto policy, which defines property damage "for which any 'insured' becomes legally responsible because of an auto accident."[70] That "*because of an auto accident*" phrase is not limiting, unlike the collision side of coverage that has a "limitation of liability" provision. That phrase embraces every aspect of the loss "because of an auto accident." Tort law reflects this, as discussed earlier.

An economic loss is different; it arises either from a breach of contract (not relevant in auto liability accident cases), or from some tort, such as another party's misrepresentation or falsehood or failure to perform. Both situations provide the remedy of benefit of the bargain damages or out-of-pocket damages.[71] Dodd describes these as "economic entitlement damages" in discussing common law and equitable torts, though the same principle applies in contract claims.[72] Dodd explains that where one party has misled another party as to the condition or value of a good or property, the plaintiff must "prove a loss" but does not also have to "realize a loss."[73] Moreover, "[t]hat is, they do not require the plaintiff to re-sell the purchased goods at a loss, to pay for repair or upgrading of the goods, or to suffer any kind of physical injury as a result of the item's poor qualities."[74] The Texas decision discussed above in *Carlton v. Trinity Universal Insurance Co.* also noted this and cited to a 1928 third-party case, *Milby Auto. Co. v. Kendrick*,[75] involving a tort claim for diminution in value in addition to the repairs made. The court recognized the potential for such recovery but disallowed the diminution part because the repairs restored the vehicle to its pre-accident market value.[76]

> than before the injury; that the repairs did not put it in such condition of working efficiency as would sustain a guarantee by the manufacturer; that the machine would still have to be completely overhauled and tested, preferably at the factory, before it would give satisfactory precision service in accordance with its design; that even when so overhauled and adjusted, it would nevertheless remain a secondhand machine on the market; and that this type of machine was 'slow moving' on the market because of the limited demand.

Merch. Shippers Ass'n, 170 P.2d at 927.

[70] *See ISO Personal Automobile Policy*, *supra* note 3.

[71] DAN B. DODD ET AL., THE LAW OF TORTS § 694 (2d ed. 2018).

[72] *Id. See also* Kieffer v. High Point Ins. Co., 422 N.J. Super. 38, 47–48 (N.J. Super. Ct. App. Div. 2011).

[73] DODD, ET AL., *supra* note 71.

[74] *Id.*

[75] Milby Auto. Co. v. Kendrick, 8 S.W.2d 743, 744 (Tex. Ct. App. 1928), *writ dismissed w.o.j.*, (Jan. 30, 1929).

[76] *Id.*

> [T]he amount paid by the appellee for repairs to his automobile was the reasonable necessary cost of restoring it to its condition immediately prior to its injury by appellant. It occurs to us that there could be no more accurate method of ascertaining the damage caused appellee by appellant's negligence than the reasonable necessary cost of restoring the injured automobile to its condition prior to its injury, thereby giving it the same value it possessed immediately before its injury. Such measure of damages conforms to the one fundamental rule, applicable in all cases of negligent injury, which entitles the injured party to fair and reasonable compensation for the loss sustained, and is not in conflict with the general rule that the measure of damage is the difference in the market value of the injured property before and after its injury. If the injured property is restored to its condition prior to its injury, its market value would ordinarily be restored, and the cost of such restoration would be identical with the difference between its market value before and after its injury.[77]

The problem with paying diminished value damages when the insured does not sell the vehicle is that he or she now has a cash payment for an unrealized and probably never-to-be-realized loss. That seems to violate the principle of indemnity in insurance and the fundamental concept of damages "that compensation, not enrichment, is the basis for the award of damages."[78] A Georgia court rejected a claim for loss of income in addition to the actual damages done to a telephone transmission line where there was no evidence for such loss of income, and stated that there was no evidence of any such loss to require compensation: "the purpose of damages is to put the aggrieved party in the position, as near as possible, as he or she would have been without the injury or damage."[79] Another Georgia court, being specific to automobile claims, allowed for damages to include "the value of

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[77] *Id.*
[78] MCI Commc'ns Servs., Inc. v. CMES, Inc., 291 Ga. 461, 463 (Ga. 2012).
[79] *Id.* at 464.

any permanent impairment."[80] Note that "permanent impairment" might be different from diminished value.

A fair argument against this payment even in liability cases is that the claimant does not sell the vehicle. Yet tort law does not require that the loss be realized in an accounting sense, only realized in a legal sense.

IV. RECONCILING THE PRINCIPLE OF INDEMNITY TO DIMINISHMENT OF VALUE IN AUTO CLAIMS.

If diminishment damages are to be allowed under the current policy language for first-party losses, then we think a better approach would be to consider what really makes the insured whole for a loss. If the insured actually sells the car within one year or returns the leased car whenever due and the lessor imposes a charge for damage against the policyholder, then the loss in value is real and being realized—the insured should be compensated for that. That actually makes the insured whole and is consistent with the principle of indemnity.[81] A Washington court addressing a property loss claim under a builder's risk policy, which loss was paid under an arbitration agreement with another party, said "[u]nder the indemnity principle of insurance, an insured receives only that amount that will indemnify actual loss, not an additional windfall above this amount."[82] To

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[80] T & T Transp. v. Duckworth, 864 S.E.2d 181, 183 (Ga. Ct. App. 2021), *reconsideration denied*, (Nov. 15, 2021). *See e.g.*, Sykes v. Sin, 493 S.E.2d 571, 574 (Ga. Ct. App. 1997).

[81] *See* Fernandez v. State Farm Mut. Auto. Ins. Co., 338 F. Supp. 3d 1193, 1199 (D. Nev. 2018) (requiring actual payment of benefits for a UIM clause to apply). *Cf.* Pan Pac. Retail Props., Inc. v. Gulf Ins. Co., 471 F.3d 961, 973–74 (9th Cir. 2006) ("[I]f Western was fully compensated by Pan Pacific's indemnification agreement and never made any payments itself, then Western should not obtain double recovery from Twin City based on its multiple agreements for indemnification. California case law states that an insurer may offset its contractual obligation to pay the insured against any previous payments made by other parties that have already compensated the insured for its loss").

[82] MKB Constructors v. Am. Zurich Ins. Co., 49 F. Supp. 3d 814, 826 (W.D. Wash. 2014). The point was developed in asbestos cases and other long-tailed toxic tort cases where multiple policies could be triggered to pay a loss; courts have limited the recovery to only the actual loss regardless of the number of policies. This is a complicated problem for how to allocate losses across multiple policies—all sums versus pro rata allocation—beyond the scope of this article. See Keene Corp. v. Ins. Co. of N. Am., 667 F.2d 1034 (D.C. Cir. 1981) and EnergyNorth Nat. Gas, Inc. v. Certain Underwriters at Lloyd's, 934 A.2d 517, 521–27 (N.H. 2007) for a

allow the insured there to recover both from the contracting party and the insurer "would be seeking a double recovery and a significant windfall, in violation of the most basic principle of insurance."[83] As noted earlier, replacement cost coverage can result in a benefit that improves the insured's position.[84] Consider too that collateral source payments by other parties can result in double recoveries.[85] A Texas case dealing with water damage to a home that was later sold emphasized the need for there to be an actual pecuniary loss reflected in the sale, not a hypothetical loss.

> [A]n insurer cannot be required to pay its insured more than the amount of his actual loss . . . there is no pecuniary loss when the loss has been made good out of a related transaction." . . . . In other words, courts should "analyze the reality of a loss" by '"look[ing] to the substance of the whole transaction rather than to seek a metaphysical hypothesis upon which to justify a loss that is no loss.'" In so doing, courts should aim to prevent windfall recoveries in which insureds who ultimately suffer no pecuniary loss are still entitled to recover under their insurance policies.[86]

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discussion of this problem. *See also* Eaton Corp. v. Westport Ins. Co., 567 F. Supp. 3d 1029, 1037 (E.D. Wis. 2021) ("under the all-sums allocation method, Eaton may select a policy year, allocate its covered losses to that year, and work its way up the coverage tower for that year. . . . If Eaton could allocate the same loss to multiple policy years, then Eaton would be recovering twice for the same loss. Yet the all-sums allocation method does not entitle Eaton to a double recovery").

[83] *MKB Constructors*, 49 F. Supp. 3d at 826–27. *See also* Koppers Co., Inc. v. Aetna Cas. & Sur. Co., 98 F.3d 1440, 1452 (3d Cir. 1996).

[84] *See supra* text accompanying notes 52–53.

[85] See Gustafson v. Cent. Iowa Mut. Ins. Ass'n, 277 N.W.2d 609, 612–14 (Iowa 1979), discussing the New York Rule versus the Wisconsin Rule, where the New York Rule imposes the obligation upon the happening of the insurable event, and thus, it does not allow an insurer to offset its payments under a property policy by what any third-party owes for a loss. The decision notes the many jurisdictions that have adopted either Rule. *See also* Montgomery v. First Nat'l Bank, 508 P.2d 428, 435 (Or. 1973) ("We would ignore the intentions of the parties to the insurance contract if we permitted the insurance company, or defendant bank, who can assert no greater rights than the insurance company, to claim the benefit of subsequent collateral events such as the repair of the building by the owner").

[86] Johnson v. Safeco Ins. Co., 240 F. Supp. 3d 555, 562 (N.D. Tex. 2017) (citations omitted).

If, however, the insured does not sell the car within one year, then the book value of the car is mostly irrelevant to the insured. To pay for the additional loss of value is a bonus and violates the principle of indemnity.

We recognize that our one-year cut-off is arbitrary. A cut-off must be arbitrary, and claims must be resolved and not left open for 5 years or whenever the insured actually sells the vehicle. One year to submit a supplemental claim for diminished value somewhat aligns with the insurer accounting principle of accident year when determining loss ratios. The sale must be arms-length. It is easy to imagine collusion occurring in a sale among some family member or friend, raising the cost of claims administration and insurance fraud investigations over a few hundred or maybe a few thousand dollars. This risk might be sufficient to compel an insurer to make a business decision to pay some extra compensation to close a file. We deal here, however, with the principle of indemnity not individual business decisions.

POLICYHOLDER MISREPRESENTATION IN INSURANCE CLAIMS

JAY M. FEINMAN *

Intentional misrepresentation by a policyholder in a proof of claim or a related claim document can provide an insurer with a defense against coverage under the policy—the "false swearing" rule.[1] This article summarizes the rule and situates it within the broader landscape of both the claims process and the range of responses to insurance fraud. It then suggests the proper contours of the rule and the applicable standard of proof: the false swearing rule should require reliance by the insurer and proof by clear and convincing evidence. This article also addresses the broader problem of agency and opportunism in insurance claims by both the insured and insurer,

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[1] There is a related problem of the negligent, but not intentional, provision of erroneous information by the insured that is not within the scope of this paper. On the broader issue, see George M. Cohen, *The Negligence-Opportunism Tradeoff in Contract Law*, 20 HOFSTRA L. REV. 941 (1992).

arguing that the insurer's conduct in asserting fraud should be evaluated by a reasonableness standard.

I. THE FALSE SWEARING RULE

Many insurance policies include an express provision declaring that fraud or other false statements permit the insurer to void the policy.[2] The first paragraph of the 1943 New York Standard Fire Insurance Policy—the "165 Lines" that became the basis for many standard, legislatively adopted policies—states such a provision:

> Concealment, Fraud
>
> This entire policy shall be void if, whether before or after a loss, the insured has willfully concealed or misrepresented any material fact or circumstance concerning this insurance or the subject thereof, or the interest of the insured therein, or in case of any fraud or false swearing by the insured relating thereto.[3]

More modern examples expand on the concept:

> Conditions
>
> R. Concealment Or Fraud
>
> We provide coverage to no "insureds" under this policy if, whether before or after a loss, an "insured" has:
>
> 1. Intentionally concealed or misrepresented any material fact or circumstance;
> 2. Engaged in fraudulent conduct; or
> 3. Made false statements;
>   a. relating to this insurance.[4]

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[2] 13A COUCH ON INSURANCE § 197:1 (3d ed. 2022).

[3] N.Y. INSURANCE LAW § 3404(e) (McKinney 2015).

[4] INS. SERVS. OFF., HOMEOWNERS 3 — SPECIAL FORM, HO 00 03 05 11, at 17 (2010) [hereinafter HO3].

Or, more simply:

> Concealment or Fraud: We do not provide coverage for any *insured* who has intentionally concealed or misrepresented any material fact or circumstance relating to this insurance.[5]

The doctrine that applies to these provisions is the "false swearing rule," often called the "false swearing defense" because it provides a defense to coverage.[6] An intentional misrepresentation by an insured in a proof of loss or other statement during the claim process violates the terms of the policy and enables the insurer to avoid paying a claim.[7] Indeed, in most jurisdictions a misrepresentation as to part of a loss enables the insurer to avoid paying for any of the loss, even portions that it otherwise would owe.[8] Despite the doctrine's name, the misrepresentation does not need to be sworn to defeat coverage.[9]

This simple statement of the doctrine conceals much complexity, of course. Courts vary in their approaches to the doctrine, and legislation in many states defines the rule. The Appleman treatise notes:

> The rules thus far set forth are generally accepted. A few cases apply them far more stringently than do the great majority of decisions. . . . The delineation line between the tests used by the various courts is narrow and wavering.[10]

Thus, a violation of the misrepresentation provision in the policy generally requires that the insured make a false statement regarding a material fact with an intent to deceive the insurer.[11] A broad, insurer-favorable version of the false swearing rule has generous standards for materiality and intent and no reliance or prejudice requirement,[12] but narrower versions of the rule require that the insurer relied on the

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[5] Longobardi v. Chubb Ins. Co., 582 A.2d 1257, 1259 (N.J. 1990).

[6] JEFFREY W. STEMPEL & ERIK S. KNUTSEN, STEMPEL AND KNUTSEN ON INSURANCE COVERAGE § 908[C] at 9-221 (4th ed. 2015).

[7] *Id. See also* ROBERT H. JERRY II & DOUGLAS R. RICHMOND, UNDERSTANDING INSURANCE LAW § 83 (5th ed. 2012).

[8] STEMPEL & KNUTSEN, *supra* note 6, at 9-221, 9-222.

[9] JERRY & RICHMOND, *supra* note 7, at 587.

[10] 5af-157f APPLEMAN ON INSURANCE LAW & PRACTICE ARCHIVE § 3587 (2d ed. 2011).

[11] 13A COUCH ON INSURANCE § 197:11 (3d ed. 2022).

[12] *Id.*

misrepresentation.[13] Innocent or innocuous misstatements are not sufficient to invoke the defense,[14] but where the insured asserts a valuation far in excess of the actual value of the loss, an inference of false swearing may be raised.[15] Generally, false swearing has the effect of avoiding the insurer's obligations under the policy altogether even if the misrepresentation related to only a portion of the loss; however, some courts hold that false swearing enables an insurer to avoid coverage only as to the portion of the claim that was misrepresented.[16]

II. THE BASIS FOR THE FALSE SWEARING RULE

The false swearing rule rests on four bases that span legal doctrine, morality, and public policy.

The first rationale for the false swearing rule is doctrinal. Part of the insured's contractual obligation with the insurer is to refrain from misrepresentation in the claim process. The obligation is clear and specific where the insurance policy contains a provision relating to misrepresentation after a loss, as in the ISO HO-3.[17] Even if the provision is less clear as to the conduct to which it applies, it reasonably is interpreted to apply to post-loss conduct as well as to misrepresentations in the course of applying for the insurance.[18] This element of the analysis is an instance of a fundamental principle of insurance law that the relation between insurer and insured is created and substantially defined by their agreement.[19] Indeed, even if an express provision was not included, the obligation to avoid misrepresentation would attach because of the general obligation of good faith, which is inherent in every contract.[20]

The second rationale provides an economic justification for the false swearing doctrine. An insured has an incentive to misrepresent or conceal information from its insurer during the claim process in order to maximize its recovery. This behavior runs a spectrum from the wrong, but not

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[13] *Id.* at § 197:18, 197:19.

[14] JERRY & RICHMOND, *supra* note 7, at 587.

[15] STEMPEL & KNUTSEN, *supra* note 6, at 9-221.

[16] STEMPEL & KNUTSEN, *supra* note 6, at § 908[C] at 9-221,222; 13 COUCH ON INSURANCE § 197:11 (3d ed. 2022).

[17] HO3, *supra* note 4.

[18] *Longobardi*, 582 A.2d at 1261.

[19] *See* Kenneth S. Abraham, *Four Conceptions of Insurance*, 161 U. PA. L. REV. 653, 658 (2013).

[20] *See* Jay M. Feinman, *The Law of Insurance Claim Practices: Beyond Bad Faith*, 47 TORT TRIAL & INS. PRAC. L.J. 693, 705–06 (2012).

depraved, in which the insured pads a claim to make up for an inadequacy of record-keeping or a careless decision to under-insure, to the callously deceitful, as the functional equivalent of stealing. As the New Jersey Supreme Court stated, "such misrepresentations strike at the heart of the insurer's ability to acquire the information necessary to determine its obligations and to protect itself from false claims."[21] Insurers, being aware of the potential for misrepresentation must invest resources to monitor insureds' behavior and to ferret out their fraud. The false swearing doctrine deters wrongful behavior by insureds and reduces the need for inefficient monitoring behavior by insurers.

The third rationale is moral: *fraus omnia corrumpit*—"fraud vitiates everything it touches" or "fraud corrupts and destroys the whole."[22] Davey and Richards describe this principle as "a broadly moral purpose consistent with judicial refusal to engage with those who commit fraud."[23] In the context of other types of contracts, the principle allows for the avoidance of a contract for fraud,[24] even in the presence of a merger clause that seems to require a contrary result.[25] The same result attaches in insurance claims where the court will not countenance or reward fraud of any type.[26]

The first three rationales focus on the two-party relation between insurer and insured. The fourth rationale treats the two-party relation as one among many similar relations. Baker colorfully expresses this as the merger of the story of the "immoral insured" with the story of the "depravity of those who threaten the public interest."[27]

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[21] *Longobardi*, 582 A.2d at 1261. *See also* James Davey & Katie Richards, *Deterrence, Human Rights and Illegality: The Forfeiture Rule in Insurance Contract Law*, LLOYD'S MAR. & COM. L.Q. 314, 318 (2015).

[22] Abry Partners V, L.P. v. F & W Acquisition LLC, 891 A.2d 1032, 1059 (Del. Ch. 2006) (see e.g., CORBIN ON CONTRACTS § 28.21); *Custom Data Solutions, Inc. v. Preferred Capital,* Inc., 733 N.W.2d 102, 105 (Mich. Ct. App. 2006) (quoting JOHN D. CALAMARI & JOSEPH M. PERILLO, THE LAW OF CONTRACTS § 9.21 340–41 (4th ed. 1998)).

[23] Davey & Richards, *supra* note 21, at 318.

[24] 7 JOSEPH M. PERILLO, CORBIN ON CONTRACTS § 28.22 (rev. ed. 2002).

[25] *Custom Data Solutions, Inc.,* 733 N.W.2d at 105 (observing that "[d]espite the existence of a merger clause, parol evidence is admissible for purposes of demonstrating that the agreement is void or voidable or for proving an action for deceit.") (citations omitted).

[26] STEMPEL & KNUTSEN, *supra* note 6; JERRY & RICHMOND, *supra* note 7.

[27] Tom Baker, *Constructing the Insurance Relationship: Sales Stories, Claims Stories, and Insurance Contract Damages*, 72 TEX. L. REV. 1395, 1411–12 (1994).

> The normally decent, law-abiding American . . . if left to his own devices, has a little larceny in his soul. . . . And really, people can't see it as anybody's money. The insurance company and the federal government—people like that—they are fair game where the public is concerned.[28]

Insurance fraud by false swearing cheats not only the individual insurer but also the pool of insureds that the insurer embodies. The same logic extends to the deterrence and efficiency rationales. The false swearing rule deters behavior and minimizes investigative costs, both of which ultimately are borne by all insureds—"substantial and unnecessary costs to the general public in the form of increased rates."[29]

III. AGENCY AND OPPORTUNISM

Much of the four-part rationale for the false swearing rule rests on the recognition of a potential problem in the insurance relation: the problem of agency and opportunism by the insured in filing a claim. In an agency relationship, one party has freedom to act in a way that affects the other party and has different incentives and access to different information that may shape its performance. This creates monitoring problems in which the party subject to the other's action either needs to incur costs in monitoring the performance or takes the risk of a disadvantageous performance. Agency is a particular problem in contractual relationships where one party may have the ability to control its performance in ways that defeat the other party's reasonable expectations. Opportunism—"self-interest seeking with guile"[30]—is an extreme form of agency in which the party with freedom to act exploits circumstances for selfish advantage without regard for a prior commitment such as a commitment to contractual performance. From this

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[28] *Id.* at 1411–12.

[29] Merin v. Maglaki, 599 A.2d 1256, 1259 (N.J. 1992) (referring to the purpose of the New Jersey Insurance Fraud Prevention Act, N.J.S.A. 17:33A-2). *See also* Versloot Dredging BV v. HDI Gerling Industrie Versicherung AG [2016] UKSC 45, [10] ("Fraudulent insurance claims are a serious problem, the cost of which ultimately falls on the general body of policy-holders in the form of increased premiums."). *Id.* at [55] ("if claims have to be investigated in detail and routinely verified by insurers, the cost of the systems necessary to do this will fall on policyholders generally through increased premiums, and good claims will be delayed alongside the bad.").

[30] Oliver E. Williamson, *Opportunism and Its Critics*, 14 MANAGERIAL & DECISION ECON. 97, 97 (1993). *See* Cohen, *supra* note 1, at 953–61.

perspective, the risk that an insured will conceal or misrepresent information in the claim process is an agency problem in which the insured may act opportunistically.

A. AGENCY AND OPPORTUNISM BY THE INSURED

The doctrinal rationale for false swearing recognizes that a fraud or concealment term in the policy is designed to check agency and opportunism by the insured and that the insurer's ability to avoid coverage is the necessary remedy. The rationale is based on "the asymmetrical positions of the parties to an insurance contract—the insurer being vulnerable on account of his dependence on the insured for information both at the formation of the contract and in the processing of claims."[31] The insured's agency in providing information about the cause of the loss and the amount of the loss enables it to act opportunistically by fabricating or exaggerating when filing a claim. In the absence of the false swearing doctrine, the insurer would need to respond by investing considerable costs in investigation; even then, in some cases, it will be unable to discover the presence or the full extent of the fraud and would therefore have to pay even in the absence of coverage.[32]

The moral and economic rationales for the false swearing rule similarly respond to potential agency and opportunism. The false swearing doctrine deters fraudulent breaches by the insured and reduces investigation costs by the insurer, both of which reduce their joint costs.[33] The rule's application to insurance is simply an example of the many settings in which fraud is the product of agency and opportunism, leading to the general principle that fraud corrupts all. The fourth rationale extends the economic logic to the pool of insureds. The efficient allocation of the risk of fraud and

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[31] *Versloot Dredging BV* [2016] UKSC 45 [9].

[32] Even in the absence of a policy term, the general obligation of good faith would prohibit fraud by the insured for the same reason. At least in the American context, the obligation of good faith is not an expression of the insurance law doctrine of *uberrima fides*, with its grand translation of "utmost good faith." *See* R. A. Hasson, *The Doctrine of* Uberrima Fides *in Insurance Law—A Critical Evaluation*, 32 MOD. L. REV. 615 (1969). *See also* Mkt. St. Assocs. v. Frey, 941 F.2d 588, 595 (7th Cir. 1991) (Judge Posner describing good faith as an "injection of moral principles into contract[,] . . . some newfangled bit of welfare-state paternalism[,] . . . [or] the sediment of an altruistic strain in contract law."); Jay M. Feinman, *Good Faith and Reasonable Expectations*, 67 ARK. L. REV. 525 (2014).

[33] Mkt. St. Assocs., 941 F.2d at 595.

the cost of preventing it in an individual transaction becomes the sum of all such individual transactions in considering the interests of the pool.[34]

B. AGENCY AND OPPORTUNISM BY THE INSURER

The four-part rationale for the false swearing rule embodies a certain vision of the relationship between insurer and insured, one in which the insured's freedom to act in an opportunistic way in the claim process must be checked by the rule. That vision is, at best, incomplete, and its incompleteness leads astray the formulation and application of the rule.

It is true that the insured and insurer are in an agency relationship in the claim process and that opportunism is a risk, but agency and opportunism run in both directions. The insurer, as well as the insured, possesses agency and has incentives to act opportunistically.

When a loss occurs, insurer agency arises because policy terms and the surrounding law that measure the company's performance are vague and difficult to enforce. Also, the insured usually is poorly situated to effectively monitor the company's performance in handling the claim. The insurance policy does not specify in much detail the insurer's duties in processing a claim. A typical HO-3 homeowners' policy, for example, only requires the company to pay claims within sixty days of agreement or adjudication and to participate in appraisal; otherwise, it delineates no duties concerning the processing of a claim.[35] Indeed, it is difficult to specify the insurer's duties because they necessarily rest on vague concepts such as promptness and reasonableness. As expressed in the Model Unfair Claims Settlement Practices Act, for example, a company must "adopt and implement reasonable standards for the prompt investigation and settlement of claims arising under its policies."[36] The vagueness of the company's defined responsibility, the substantial advantage in information, and the expertise that the insurer possesses create an inherent difficulty in monitoring the performance. Even if the insured can detect insurer opportunism, its ordinary

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[34] The moral rationale may speak more broadly about external norms of morality, but it seems to be at most a minor theme in the case law.

[35] HO3, *supra* note 4, at 15.

[36] Model Unfair Claims Settlement Practices Act § 4.C (Nat'l Ass'n of Ins. Comm'rs 1997). Even when a statute appears to narrowly specify a duty, the specification is usually qualified by a vague term. In Tennessee, for example, an insurer is subject to a statutory penalty if it fails to pay a claim within sixty days of a demand by the policyholder, but only if "the refusal to pay the loss was not in good faith." TENN. CODE ANN. § 56-7-105 (West 2008); *see also* GA. CODE ANN. § 33-4-6 (West 2016); LA. STAT. ANN. § 22:1892 (2021).

remedy is only to receive the benefits it already was entitled to under the policy; in most jurisdictions, broader remedies are available only if the insured can prove intentional or reckless misconduct.[37]

Moreover, the company has some incentive to act opportunistically and not pay a claim or pay less than it actually owes. The company that denies payment of a claim in whole or in part increases its profits. The company that only delays payment of a claim increases its investment income and thereby increases its profits. Market competition, reputational effects, and administrative regulation arguably fail to provide effective checks on opportunistic behavior.[38] A company that delays paying claims or denies valid claims in whole or in part conceivably could suffer a negative reputational effect, and reputation is an important element in consumer purchases of insurance. But claim practices are not a major determinant of satisfaction or purchasing behavior, particularly relative to price.[39]

The form of insurer opportunism in the claim process that is particularly relevant to the false swearing rule is the assertion of fraud by the insured as a reason for not paying a claim. The false swearing rule gives power to that assertion, and therefore, the rule itself potentially becomes a tool for opportunism. In many jurisdictions, the severe consequences of a finding of false swearing—denial of an entire claim for any nontrivial incidence of fraud—raise the stakes considerably. Therefore, with respect to false swearing in the claim process, agency and opportunism are present on both sides.

Each of the rationales for the false swearing doctrine also relates to insurer opportunism. Opportunism by insurers constitutes an egregious form of breach of the insurance contract not only of its express terms requiring payment of what is owed but also of the obligation of good faith. The risk of insurer opportunism imposes inefficient monitoring costs on insureds, costs that many insureds cannot bear at all. It violates moral and legal strictures, and insurer fraud imposes costs on members of the pool whose claims are not paid, just as the prevention of that kind of fraud benefits the entire pool by ensuring that the claim process works better for all claimants.

In a broader perspective, the false swearing doctrine is only a small part of a large-scale, public/private system designed to detect, punish, and deter fraud by insureds in the claim process.[40] The evils of insurance fraud

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[37] Feinman, *supra* note 20, at 704.

[38] Jay M. Feinman, *The Regulation of Insurance Claim Practices*, 5 U.C. IRVINE L. REV. 1319 (2015).

[39] Feinman, *supra* note 20, at 711 n.90.

[40] JAY M. FEINMAN, DELAY, DENY, DEFEND 167–88 (2010).

and the consequences for fraudsters are marketed to the public through social media, television advertisements, and promoted news reports.[41] Sophisticated predictive analytics trigger the identification of potentially fraudulent claims.[42] Insurance companies contain Special Investigation Units to which fraud claims are referred for a more aggressive investigation. Insurance regulators and prosecutors in most states have established distinct units to seek civil and criminal penalties for fraud, and legislation often requires insurers to report suspected cases of fraud to the authorities.[43] All states now recognize insurance fraud as a crime, with two-thirds of the states treating it as a felony.[44] This system embodies the potential for insurer opportunism.[45]

The essential point here is not that insurer-side fraud is commonplace or as great as insured-side fraud, but that the potential for insurer opportunism in the claim process and its manifestation in excessive claims of fraud is at least significant enough to enter into consideration of false swearing cases. The insurer's and the pool's interest in preventing fraudulent claims are legitimate but so are the insured's and the pool's interest in preventing fraudulent claims of fraud. Reconciling the possibility and effects of opportunism by the insured and by the insurer in formulating the boundaries of the false swearing rule requires consideration of the relative risk and severity of each form of opportunism. How likely are insureds to control relevant information and at what expense could insurers discover it? How likely are insurers to deny claims opportunistically? If an insurer asserts fraud, how likely will an insured effectively contest the insurer's position?

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[41] *Id. See e.g.*, *Video & Infographics*, COAL. AGAINST INS. FRAUD https://insurancefraud.org/videos-infographics/ (featuring a series of videos and infographics).

[42] FEINMAN, *supra* note 40, at 182–83.

[43] *See* Aviva Abramovsky, *An Unholy Alliance: Perceptions of Influence in Insurance Fraud Prosecutions and the Need for Real Safeguards*, 98 J. CRIM. L. & CRIMINOLOGY 363 (2008).

[44] *Id.*

[45] There is no doubt that insurance fraud is a problem, but it may not be as great of a problem as the system proclaims it to be. The most authoritative, quantitative study of insurance fraud concluded that the ratio of fraud alleged and reported by insurance companies to actual, provable fraud, was about 25 to 1. Richard A. Derrig, *Insurance Fraud*, 69 J. RISK & INS. 271, 275 (2002). *See also* James Davey, *A Smart(er) Approach to Insurance Fraud*, 27 CONN. INS. L.J. 34 (2020).

IV. RESPONSES TO OPPORTUNISM

The false swearing rule focuses on agency and opportunism by the insured. The presence, or at least the possibility, of insurer opportunism requires more balanced responses than the all-or-nothing consequences of a strict rule in at least three ways. The first response addresses the false swearing doctrine itself: to invoke the false swearing defense, an insurer should be required to establish both that the misrepresentation was material and that it relied on the misrepresentation. The second response is about the process of litigating cases: allegations of misrepresentation by the insured should require proof by clear and convincing evidence. In each of these first two responses there is a split among the states, and the suggested rule is better suited to achieving the objectives of the false swearing rule and to addressing the presence of opportunism on both sides of the insurance relation. The third response is collateral to the false swearing rule and addresses the issue of balancing insurer and insured opportunism: an insurer should be required to act reasonably in the claim process, and an insured who is injured by unreasonable claims processing should have an effective remedy.

A. DOCTRINE

A doctrinal response that balances the two forms of opportunism relates to the elements of materiality and reliance in the false swearing rule. The basic elements of false swearing are a false statement regarding a material fact and the intent to deceive the insurer. *Couch on Insurance* summarizes the materiality requirement which practically all cases use as follows:

> The requirement that a misrepresentation be material is satisfied, in the context of an insurer's post-loss investigation, if the false statement concerns a subject relevant and germane to the insurer's investigation as it was then proceeding. Accordingly, false answers are material if they might have affected the attitude and action of insurer, and they are equally material if they may be said to have been calculated either to discourage, mislead, or deflect company's investigation in any area that might seem to the company, at that time, a relevant or productive area to investigate.[46]

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[46] 13A COUCH ON INSURANCE § 197:18 (3d ed. 2022).

The materiality requirement is an objective element; a misrepresentation is material if it "concerns a subject relevant and germane to the insurer's investigation"[47] so that it might have deceived the insurer or impeded its investigation of the claim.

The states are divided on the related question, a subjective element of whether an element of false swearing is actual reliance by the insurer.[48] Some jurisdictions hold that materiality is sufficient, so reliance is not required; others conclude that the insurer must further prove that it relied on, and actually was misled or deceived, by the insured's misrepresentations.[49] The latter position is correct for two reasons.

First, the requirement of reliance is consistent with the way fraud is treated elsewhere in the law. Actual and justifiable reliance[50] are required where fraud in the inducement is used as a basis for avoidance of a contract[51] or as the basis for a tort cause of action independent of a contract.[52]

Second, the potential for insurer opportunism dictates the need for a reliance requirement. The more extreme rule that materiality is enough without reliance by the insurer purports to be based on the rationales for the false swearing doctrine generally. Courts may emphasize the presence of a concealment or fraud provision in the policy without a specific reliance requirement or the immorality of the fraudulent insured.[53] Most importantly, however, is the need to prevent insured opportunism.

> Moreover, if the law, out of some misgivings about forfeitures, were to require that the insurer demonstrate that it has been misled to its prejudice by the fraud, the policy provision would be virtually worthless and put a premium on dishonest dealings by the assured. . . . The mendacious assured, surveying the possibilities and contemplating

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[47] Fine v. Bellefonte Underwriters Ins. Co., 725 F.2d 179, 183 (2d Cir. 1984), *cert. denied*, 474 U.S. 826 (1985).

[48] 13A COUCH ON INSURANCE § 197:19 (3d ed. 2022).

[49] *Id.*

[50] Justifiable reliance in the law of fraud generally is the equivalent of the materiality requirement in the false swearing rule and is often stated in terms of materiality. DAN B. DOBBS, THE LAW OF TORTS 1359 (2000).

[51] E. ALLAN FARNSWORTH, FARNSWORTH ON CONTRACTS § 4.13 (1990).

[52] RESTATEMENT (THIRD) OF TORTS: LIABILITY FOR ECONOMIC HARM § 9 (AM. L. INST. 2020).

[53] Am. Diver's Supply & Mfg. Corp. v. Boltz, 482 F.2d 795, 797 (10th Cir. 1973).

> prospective tactics and strategy in the handling of his claim, would sense immediately that vis-a-vis himself and the underwriter, there would be no risk at all in his deceit. If it worked, he would have his money and, at worst, could be compelled to disgorge only by affirmative suit by the insurer if the fraud were discovered in time to be legally or practicably effective. If it didn't work–if, before consummation, fraud was detected–he would suffer no disadvantage whatsoever. *It would be an everything-to-win, nothing-to-lose proposition.*[54]

What this approach fails to recognize, of course, is the possibility of insurer opportunism, in either of two forms. An insurer has an incentive to use allegations of fraud as part of a broader scheme to deny payment of valid claims. Insurers could also make use of the non-reliance false swearing rule in a strategy that parallels post-claim underwriting. If an insurer discovers a misrepresentation during its investigation of a claim, it can use the misrepresentation as a basis for denying the claim, even if the misrepresentation played no part in its investigation, just as an insurer in past times could use a misrepresentation on the application, even if the misrepresentation played no role in its underwriting decision.[55]

Accordingly, a false swearing rule that includes a requirement of actual reliance better addresses the twin problems of opportunism by the insurer and the insured. Oregon law provides an example of the way in which the requirement of reliance works. Oregon originally enacted the fraud and concealment provision of the New York Standard Fire Policy and in 1985 added a requirement of reliance: "In order to use any representation by or on behalf of the insured in defense of a claim under the policy, the insurer must show that the representations are material and that the insurer relied on them."[56] The requirement in the statute "means ordinary reliance, which requires some evidence of a detrimental action or change in position."[57]

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[54] *Id.* (emphasis in original). *See also* Longobardi v. Chubb Ins. Co., 582 A.2d 1257, 1262 (N.J. 1990) ("[T]he better rule is one that induces insureds to answer truthfully questions about their losses.").

[55] *See* Thomas C. Cady & Georgia Lee Gates, *Post Claim Underwriting*, 102 W. VA. L. REV. 809 (2000).

[56] OR. REV. STAT. § 742.208(3) (West 2022).

[57] Eslamizar v. Am. States Ins. Co., 894 P.2d 1195 (Or. Ct. App. 1995). *See also* NEB. REV. STAT. § 44-358 (West 2022), applied to misrepresentations in the claim process in McCullough v. State Farm Fire & Cas. Co., 80 F.3d 269 (8th Cir. 1996);

Sufficient detrimental reliance arises if an insurer loses the opportunity to adequately investigate the cause of a loss or incurs time and expense in added investigation of a claim, such as being required to conduct a second Examination Under Oath;[58] processing the claim independently of the alleged misrepresentations does not itself constitute sufficient detrimental reliance.[59]

B. PROCESS

Most states use a preponderance of the evidence standard of proof for the elements of false swearing, while other states require that the elements be proven by clear and convincing evidence.[60] The former is the standard ordinarily applied in cases in which fraud is the basis for avoidance of a contract, and the latter is applied in cases involving the tort of fraud.[61] At a crude doctrinal level, one way of choosing the appropriate burden of proof is to decide whether false swearing is essentially a breach of a term of the contract, a failure of condition under the contract, or whether it is more akin to tortious misrepresentation. One line of authority, for example, distinguishes cases in which the insurer asserts that the insured has attempted to defraud the insurer from those in which the insurer asserts breach of a concealment clause as the basis for voiding the contract—but this makes no sense.[62] The typical policy provision bars both concealment and fraud, and in both cases, the gravamen of the insurer's claim and the consequences for the insured are the same.

Therefore, assigning a burden of proof requires further analysis. A canonical exposition of the differences among burdens of proof and the

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Bryant v. Nationwide Mut. Fire Ins. Co., 313 S.E.2d 803, 808 (N.C. Ct. App. 1984), *aff'd in part*, *rev'd in part*, 329 S.E.2d 333 (N.C. 1985).

[58] Allstate Ins. Co. v. Breeden, 410 Fed. Appx. 6, 8 (9th Cir. 2010); Leander Land & Livestock, Inc. v. Am. Econ. Ins. Co., No. 6:11-CV-06426-AA, 2013 WL 5940027, at *6 (D. Or., Nov. 1, 2013).

[59] Leavenworth v. State Farm Fire & Cas. Co., 297 Fed. Appx. 602 (9th Cir. 2008).

[60] 13A COUCH ON INSURANCE § 197:6 (3d ed. 2022); JERRY & RICHMOND, *supra* note 7, at 587.

[61] RESTATEMENT (THIRD) OF TORTS: LIABILITY FOR ECONOMIC HARM § 9 (AM. L. INST. 2020).

[62] Hall v. State Farm Fir & Cas. Co., 937 F.2d 210, 214 (5th Cir. 1991) (citing McGory v. Allstate Ins. Co., 527 So.2d 632, 637–38 (Miss. 1988)). *See also* McCord v. Gulf Guar. Life Ins. Co., 698 So.2d 89, 92 (Miss. 1997).

reasons for them are found in the United States Supreme Court's opinion in *Addington v. Texas*:

> The function of a standard of proof, as that concept is embodied in the Due Process Clause and in the realm of fact-finding, is to "instruct the factfinder concerning the degree of confidence our society thinks he should have in the correctness of factual conclusions for a particular type of adjudication." The standard serves to allocate the risk of error between the litigants and to indicate the relative importance attached to the ultimate decision. [63]

As the Court further noted, the lower preponderance of evidence standard is appropriate for "the typical civil case involving a monetary dispute between private parties."[64] Because "society has a minimal concern with the outcome of such private suits . . . the litigants thus share the risk of error in roughly equal fashion."[65] In criminal cases, "the interests of the defendant are of such magnitude that . . . they have been protected by standards of proof designed to exclude as nearly as possible the likelihood of an erroneous judgment"—that is, proof beyond a reasonable doubt.[66] In between lies the standard of clear and convincing evidence, in which "the interests at stake . . . are deemed to be more substantial than mere loss of money" such as "the risk to the defendant of having his reputation tarnished erroneously" through allegations of fraud or the like.[67] Other uses of the intermediate standard are those in which some public interest is at stake or the effect on the defendant is more severe than a money judgment. In public law, these uses include commitment to a mental institution and the termination of parental rights,[68] and in private law, suits on oral contracts to make a will and actions to reform written transactions.[69]

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[63] Addington v. Tex., 441 U.S. 418, 423 (1979) (citation omitted).
[64] *Id.*
[65] *Id.*
[66] *Id.*
[67] *Id.* at 424.
[68] 2 MICHAEL H. GRAHAM, HANDBOOK OF FEDERAL EVIDENCE § 301:5 (7th ed. 2015).
[69] 2 KENNETH S. BROUN ET AL., MCCORMICK ON EVIDENCE § 340 723–24 (7th ed. 2013).

The use of clear and convincing evidence in a fraud cause of action is well-established.[70] Indeed, the application of the standard is so well established that modern cases seldom specifically explain the court's logic in fraud cases, but it follows from the general rationale. Allegations of fraud are more serious than allegations of ordinary breach of contract, and "more evidence should be required to establish grave charges than to establish trifling or indifferent ones."[71]

Under this rationale, the false swearing defense should require proof by clear and convincing evidence. Indeed, false swearing in the insurance context is potentially a more serious matter than some other types of fraud. Insurance is about security for the insured, and the consequences for the insured in losing the security of its insurance policy are often severe or even catastrophic. Especially where insurer reliance on the misrepresentation is not required, the trier of fact needs to be more certain that the other elements are met, such as that the insured had made the misrepresentation intentionally, before attaching such drastic consequences, and more of the risk of error in fact-finding should be borne by the insurer. Finally, the threat of insurer opportunism in using allegations of fraud as a strategy to avoid paying claims—exploiting false claims of false swearing—suggests that courts ought to be cautious in enabling an insurer to use a claim of false swearing to entirely void its obligation under the policy and should assign the risk of error in fact-finding to the insurer.

C. OTHER RESPONSES

The best way to understand the false swearing doctrine is to situate it in the broader landscape of insurance claim practices. Doing so supports the approach to elements of the doctrine itself and the process by which it is applied in litigation described above—materiality and actual reliance proven by clear and convincing evidence. But it also suggests that the underlying issue should be addressed by other means as well.

From the insurer-side perspective, the fundamental problem addressed by the false swearing rule is the immoral insured seeking to defraud the insurer at the expense of the pool of policyholders. The appropriate response is a broad false swearing doctrine, an elaborate public/private structure for

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[70] 37 GEORGE BLUM ET AL., AMERICAN JURISPRUDENCE 2D FRAUD AND DECEIT § 479 (2022).

[71] Ziegler v. Hustisford Farmers Mut. Ins. Co., 298 N.W. 610, 612 (Wis. 1941) (quoting BURR. W. JONES, COMMENTARIES ON THE LAW OF EVIDENCE IN CIVIL CASES 1036 (2d ed. 1926)).

the investigation and sanctioning of insurance fraud, wide latitude for an insurer in invoking that structure, and insurer immunity from liability for reporting suspected fraud to civil and criminal authorities.[72] In litigation with an insured, an insurer should be subject to liability only for the most grievous errors in challenging a claim as fraudulent, perhaps where it intentionally or recklessly alleges fraud that does not exist. Today, in many states, an insurer is protected by such rules in both of these situations.

From the perspective that insurer-side opportunism also is a problem, however, the landscape looks much different and the responses to it should be different as well. The insurance fraud structure is far too elaborate for the scope of the problem and there is little in the way of a parallel structure for investigating and remedying insurer-side fraud in the wrongful delay or denial of claims.[73] One desirable response is to buttress the law of claim practices by requiring an insurer to observe reasonable standards of claim practices and making the insurer civilly liable to an insured where the insurer does not—that is, defining what is usually referred to as "bad faith" to be a negligence standard rather than intent or recklessness.[74] A negligence standard would provide a more effective deterrent for insurer opportunism, including opportunism through improper assertions of fraud by an insured while still enabling an insurer to deny a claim for false swearing where it is reasonable to do so.

V. CONCLUSION

The false swearing rule was developed to address the problems of agency and opportunism by an insured in the claim process. That problem is best understood within the insurance claim process with broad perspective, a perspective that recognizes the possibility of agency and opportunism by an insurer as well as by an insured. From that perspective, the rule needs to be properly defined, applied, and supplemented by other doctrines to balance the legitimate interests of insureds and insurers.

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[72] FEINMAN, *supra* note 40; Derrig, *supra* note 45; Davey, *supra* note 45.
[73] Feinman, *supra* note 38, at 1333–40.
[74] Feinman, *supra* note 20.

A MATTER OF HIGH INTEREST: HOW A QUIET CHANGE TO AN ACTUARIAL ASSUMPTION TURBOCHARGES THE LIFE INSURANCE TAX SHELTER

ANDREW GRANATO*

America's lengthy income tax code and financial regulations are notoriously full of special treatment for the politically favored. Academics and policymakers argue the relative merits of different approaches to tax and regulatory policy. Given the complexity of economic life, should the law attempt to be highly tailored and specific? Or does the exacting approach risk getting lost in the weeds? This Article will showcase the limits of a highly technical approach to policy with the first analysis of an almost completely unnoticed sea change in life insurance tax law, one that engorges a tax shelter at a moment of great attention to laws that enable the wealthiest members of society to face lower effective tax rates than their secretaries.

Life insurance has received extremely favorable tax treatment since the inception of the federal income tax. In the 1980s, in response to an increasing wave of policies smuggling traditional investment products into products calling themselves life insurance, Congress formalized a mathematical definition of life insurance policies directly into the Internal Revenue Code (§ 7702). Section 7702, a fully realized actuarial simulation, placed quantifiable limits on the degree to which policyholders could treat a life insurance policy like an investment (such as a mutual fund) rather than as insurance protection.

For decades, the provision was left alone. However, buried in the 2020 COVID-19 omnibus relief bill, Congress included—with essentially no public debate—a change to a key actuarial assumption of the § 7702 test. The result was that § 7702 was made substantially more permissive, giving policyholders much greater leeway to use life insurance policies as conduits for tax-exempt wealth accumulation, rather than mere protection of

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beneficiaries in the event of the worst. After over thirty years of near-total absence of analysis of Congress' life insurance definition in the legal literature, this paper resurrects the history, purpose, and structural limitations of § 7702 and the hyper-technical approach to tax policy it embodies. It further provides the first exhaustive analysis of the new world of life insurance after the stealth § 7702 amendment, one in which swathes of the industry are preparing to—as the Democratic Party eyes loophole crackdowns on the wealthy—leverage their extraordinary tax advantage into a new role at the center of high-end tax avoidance.

I. INTRODUCTION

The basic premise of insurance is that people are concerned about risk—risk of getting sick, of their home being damaged, of their car being broken into—and are therefore willing to pay to reduce it.[1] Life insurance policyholders pay premiums to a life insurance firm in exchange for the agreement that, should the policyholder die while the policy is in effect, the insurer will make a predetermined payment to the policyholder's beneficiary, such as their spouse. Life insurance markets are deep in the United States, with over $1 trillion in direct written premiums in 2020.[2] The primary reasons for most life insurance purchases are the coverage of burial and other death expenses, replacement of lost income and payment of mortgages, and the "transfer [of] wealth to [the] next generation."[3]

This Article is primarily interested in life insurance's role in something other than reducing risk for families: being a tax-advantaged vehicle for savings and investment. Since its inception, payouts from life insurance policies have been exempt from the federal income tax.[4] While the basic form of a life insurance policy is a simple "premiums for death benefit" exchange, there is also a general type of policy, cash value life insurance, that includes an additional savings component. Instead of putting money into a bank account or a mutual fund, a policyholder can put savings into a cash value life insurance policy, where money will be invested and earn returns but will be taxed like life insurance—in other words, not taxed. This differential tax treatment between cash value life insurance and normal investment vehicles creates an obvious arbitrage opportunity: why not simply take a normal investment contract, call it a life insurance policy, and enjoy a tax-free existence?

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[1] Ted O'Donoghue & Jason Somerville, *Modeling Risk Aversion in Economics*, 32 J. ECON. PERSPS. 91, 91 (2018) (stating that the topic of risk aversion is fundamental in economics, which generally treats individuals as being risk averse). *See also* Daniel Kahneman & Amos Tversky, *Prospect Theory: An Analysis of Decision Under Risk*, 47 ECONOMETRICA 263, 263 (1979) (articulating specific patterns of risk aversion such as loss aversion and prospect theory, where people generally weigh the prospect of losses relative to their original position more heavily than they do the prospect of equivalent gains).

[2] NAT'L ASS'N INS. COMM'RS, U.S. LIFE AND A&H INS. ANALYSIS REP. 1–2 (2021), https://content.naic.org/sites/default/files/inline-files/2020%20Life%20Annual%20Industry%20Commentary_0.pdf.

[3] ASHLEY DURHAM, 2015 INSURANCE BAROMETER STUDY 13 (2015).

[4] *See* discussion *infra* Section I.B.1.

For decades, under the Supreme Court's *Le Gierse* doctrine, the job fell to the courts to determine whether a contract would qualify for life insurance's tax-privileged status. However, in the 1980s, rising alarm about insurers pushing the limits of what most people would consider a life insurance policy brought the issue to a head, and the industry was forced to cut a deal.[5] The tax exemption would remain, but to qualify for it, a contract would have to a pass a new, highly mathematical test written directly into the tax code–§ 7702.[6] The new actuarial simulation required the use of deeply technical assumptions, little understood by those not deeply involved with the legislation or the insurance industry. The internal mechanics of § 7702 are so obscure that they have been almost completely out of view of critical scholarly literature since their inception.[7]

Recent events, however, must force renewed scrutiny of § 7702 and its key to unlocking access to some of the most favorable tax treatment of any contract. Hidden inside the 2020 coronavirus omnibus relief package was an almost completely unnoticed amendment to some of § 7702's technical interest rate assumptions, one that substantially relaxes the definition of "life insurance" and allows contracts that look much more like normal investment contracts to claim life insurance tax status.[8]

The § 7702 amendment comes at a time when the life insurance industry, battered by macroeconomic headwinds, has been abandoning "vanilla" life insurance products aimed at the working and middle classes and embracing a new identity as a tax shelter for the affluent. Middle-class families with modest savings are drawn to other places on the menu of tax-preferred investments, like 401(k) plans and Individual Retirement Accounts (IRAs). Life insurance companies, with huge fixed-income asset portfolios, are also disadvantaged by low interest rates, and so have been disadvantaged by the last decade of near-zero rates.[9] The industry is searching for new

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[5] *See* discussion *infra* Section I.B.2.

[6] *See* discussion *infra* Section II.A.

[7] The only law review article to principally engage with § 7702 was published in 1988. Andrew D. Pike, *Reflections on the Meaning of Life: An Analysis of Section 7702 and the Taxation of Cash Value Life Insurance*, 43 TAX L. REV. 491, 500–01 (1988). The major work done on life insurance policy taxation since the 1980s is a textbook written by actuaries and lawyers, first published in 2004. CHRISTIAN J. DESROCHERS, JOHN T. ADNEY, BRIAN G. KING & CRAIG R. SPRINGFIELD, LIFE INSURANCE & MODIFIED ENDOWMENTS UNDER INTERNAL REVENUE CODE SECTIONS 7702 AND 7702A (2d ed. 2015). The above, which are invaluable, represent almost the entire academic literature on the subject.

[8] *See* discussion *infra* Sections II.B, III.

[9] *See* discussion *infra* Section II.B.1.

avenues to profitability, and its greatest asset in doing so is its distinctive tax privilege, one that was meant for the purpose of expanding protection against the loss of a provider but has been adapted into a way to sell "insurance" with less and less actual insurance in it.

By constructing my own actuarial simulation per § 7702's requirements, I demonstrate that the § 7702 amendment as much as triples the amount of savings policyholders can shield from taxation in a given cash value policy, while correspondingly cutting the responsibility life insurers have to pay out death benefits.[10] The structure of the amendment, moreover, disproportionately rewards those who have the financial means to invest in high-value policies, creating a self-reinforcing cycle attracting the wealthy to the industry. The rise of private placement life insurance policies, marketed explicitly as a wrapper for tax-free investments into restricted asset classes like hedge funds, most directly showcases the new direction of the industry.[11]

While the initial impact of the § 7702 amendment on the federal budget is likely to be modest, it will rapidly swell,[12] and set up life insurance as the next central mechanism for tax avoidance. Recent proposals to tax the wealthy, such as a proposal by President Joe Biden to curb stepped-up basis, have neglected the ability of life insurers to step into the breach, putting the life insurance closer to a massive windfall of funds looking to escape the risk of taxation at death.[13]

How was this transformation accomplished without any prior media coverage, congressional debate, or intervention by public watchdogs?[14] While a variety of factors contributed, from insurer lobbying to the modern Congressional practice of concentrating legislation into gargantuan omnibus bills, the most important factor relates to the structure of § 7702 itself.[15] Section 7702's complexity requires its reader to have expertise in niche subfields like actuarial science, expertise that is overwhelmingly located in the insurance industry. The more mechanical and mathematical the subject, the more plausible neutral-seeming technical edits appear. Statutory structures like § 7702 thus pose problems for democratic accountability, and suggest that in low-salience policy areas, it is even more important to avoid intricate legislation that obscures the purported legislative policy goals.

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[10] *See* discussion *infra* Section III.A.1.
[11] *See* discussion *infra* Section III.A.2.
[12] *See* discussion *infra* Section III.B.1.
[13] *See* discussion *infra* Section III.B.2.
[14] *See* discussion *infra* Section III.C.1.
[15] *See* discussion *infra* Section III.C.2.

This paper revitalizes analysis of § 7702 and its impact on the life insurance sector since its enactment and offers the first investigation of the quiet sea change in cash value life insurance made possible by the 2020 amendment. It makes three arguments against the change: that it is an abuse of the life insurance exemption's intention, that it is a costly upside-down subsidy, and that it sets a template for interest groups to replicate rent extraction through mechanical legislative changes far from the public eye. Lastly, this paper argues that Congress should act to rectify its mistake—not by further obscure revisions to the § 7702 interest rate assumptions but by directly addressing the tax exemption from which the industry derives its comparative advantage as an investment product.[16]

This paper is organized into three Parts. Part I of this article gives an overview of the dynamics of life insurance policies and traces the history of their tax treatment through the adoption of § 7702, including the defensive insurer political coalition that created it. Part II lays out the statutory structure of § 7702 and its limits on abuse of the life insurance form as well as its 2020 amendment that loosened those limits. Part III traces the shift in the life insurance industry from being a mass-market product to one increasingly focused on tax planning for elites and demonstrates how the 2020 amendment's supposedly scientific edit embraces and doubles down on this move. Part III then details the structural flaws in the statutory construction of § 7702 that enabled this silent giveaway, including the inherent difficulty of legislating in the shadow of the "submerged state" and the cloaking effect of technical statutes, and ends with policy recommendations. Part IV concludes the Article.

II. THE STATE PROVIDES: LIFE INSURANCE PRINCIPLES, HISTORY, AND TAXATION BEFORE § 7702

A. BASIC TYPES AND FUNCTIONING OF LIFE INSURANCE POLICIES

Life insurance firms have developed several types of life insurance products over the years; this section will provide a brief overview of the most significant structures of such policies.

Term life insurance is the most basic form of life insurance: it is an exchange of premiums by the policyholder for a guaranteed death benefit paid to the policyholder's beneficiary if the policyholder dies during the

[16] *See* discussion *infra* Section III.D.

length of the contract.[17] For example, a forty-year-old man with a wife and child could take out a twenty-year term policy with his wife as the beneficiary. The man would pay the insurer a specified amount of money per month, and in return, if the man died during the next twenty years, his wife would receive a specified death benefit. The amount of premiums the man would have to pay would be based on a variety of factors, for example, his age.[18] Term insurance is sometimes called "pure"[19] life insurance, as the insurer is fully on the hook for the payout of the death benefit if the policyholder dies during the duration of the policy and the policy contains no features other than the death benefit and premium. Because term insurance is the simplest type of life insurance, it involves the lowest premium payments for a policyholder.

Term life insurance is by a significant margin the primary type of life insurance that Americans purchase and associate with the industry. Roughly half of American households own a term life insurance policy; while this represents the most widely purchased type of insurance, it is a modest decline from forty years ago, when about 58% of American households reported owning such a policy.[20]

In contrast to term life insurance, cash value life insurance includes the exchange of premiums for a death benefit to a beneficiary, but also permits the creation of a 'cash value' of savings that accumulates during a policyholder's life.[21] Policyholders pay more in premiums than they would if they were to purchase a simple term life policy (conditional on an equivalent death benefit), and while some of the payments go to insurer fees for expenses and policy maintenance as they would under term life, the remainder goes to developing a savings account inside of the insurance policy. This savings account will earn a return each year, just as if it was a

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[17] *Types of Life Insurance Policies*, N.Y. STATE DEP'T FIN. SERVS., https://www.dfs.ny.gov/consumers/life_insurance/types_of_policies.

[18] *Id*.

[19] Georgia Rose, *Term vs. Whole Life Insurance: Differences, Pros and Cons*, NERDWALLET (Apr. 20, 2022), https://www.nerdwallet.com/article/insurance/term-vs-whole-life-insurance.

[20] Daniel Hartley et al., *What Explains the Decline in Life Insurance Ownership?*, 41 FED. RSRV. BANK CHI.: ECON. PERSPS. 1 (2017) (basing calculations on survey data from the Survey of Consumer Finances, a triennial survey widely used in government statistics and economic and social science research most recently released in 2019).

[21] *Id.* at 3.

mutual fund account, and the process of this account accruing interest is known as "inside buildup."[22]

The term "cash value life insurance" is an umbrella term for various types of insurance products, including whole life insurance, universal life insurance, variable life insurance, and more. While each type of insurance sets different rules relating to what sorts of financial investment returns are guaranteed for the savings account portion of life insurance, the common thread among them is the presence of the savings account, created from the premium payments of the policyholder within the contractual entity of the life insurance policy. If the policyholder cancels the contract, it will receive the cash value accumulated back, but will likely have to pay fees to the insurer called "surrender charges."[23] The policyholder may also take out loans using the cash value as collateral. If the policyholder dies, the insurer will have to pay out the death benefit (the "face value"), which will include the accumulated cash value (so the insurer will have to pay out of its own coffers an amount equal to the death benefit minus the cash value, called the "net amount at risk").[24] Far fewer Americans own cash value policies than term life policies; only about a fifth of American households own such a policy, down from 37% in 1989.[25]

To illustrate the basic functioning of a cash value policy, this article employs a stylized example from whole life insurance, adapted from an example by tax scholar Andrew Pike.[26] Whole life insurance policies involve an essentially fixed death benefit and guarantee the policyholder a rate of return on the cash value[27] (for example, the insurer might contractually specify that the inside buildup will occur at a rate of 4%). A policyholder

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[22] DESROCHERS ET AL., *supra* note 7, at 13.

[23] *Id.* at 69.

[24] *Id.* at 345. Cash value life insurance contracts generally remain in effect until the policyholder hits a maturity date that is very advanced, such as age 95 or 100, at which point the contract will conclude and the insurer will return the accumulated cash value to the policyholder.

[25] Hartley et al., *supra* note 20.

[26] Pike, *supra* note 7, at 500–01. Pike's example draws from the mortality assumptions and charges found in the 1980 Commissioners' Standard Ordinary mortality table. From the example, I round the numbers used and conduct some simple recalculations, and then reformat the presentation of the results. Life insurance protection fees draw from common information and actuarial tables but vary by insurer, so it is difficult to directly demonstrate what someone's life insurance fees "should" be. I leverage Pike's example for ease of use.

[27] Stephen Michael Shepard, The Wolters Kluwer Bouvier Law Dictionary Desk Edition I (2012 CCH Inc.).

might pay for the policy through specified payments over time (level premium insurance; if the policyholder fails to make the payments, the policy lapses) or pay through a large payment upfront (single premium insurance). Consider the hypothetical example where a thirty-five-year-old policyholder, Steven, decides to purchase a $100,000 whole life policy from life insurance company Insurimax with the beneficiary being his wife, Amy. If Steven dies, Insurimax must pay Amy $100,000. Steven pays for the policy with a single premium of $25,000 that Insurimax specifies as the cost that Steven would have to pay based on the demographic and health information that he turns over to the company. (I use a single premium for simplicity; because of a provision to be explained later delineating a concept known as a "modified endowment contract," single premium policies are often avoided).

There are two basic factors that will guide what happens to the inside buildup of that $25,000 that Steven has paid: the fees paid to the insurer as a cost of insurance protection (for the cost to the insurer of the risk of having to pay out the policy) and the interest that will be credited to the policy. We will assume for this example that the contract between Steven and Insurimax specifies that there will be a 4% return on the cash value of the contract each year. The cost of insurance protection fees are derived from three main criteria: first, the likelihood that the policyholder will die in the next year; second, the payout that the insurer would have to make in the event that the policyholder dies (in general, the specified death benefit minus the accumulated cash value); and third, the income that the insurer expects to earn from its investment of the premium payments.[28] The cost of insurance protection fees are quite small relative to the policy as a whole, but the costs generally grow each year because of the increased actuarial risk that the policyholder will die, which will outweigh the lower cost the insurer would have to bear in the event of a payout (due to the increase in the policy's cash value).[29]

Assume that the cost of insurance protection to Steven is $150 in the policy's first year and increases by $15 a year for the first five years. The trajectory of the hypothetical policy during that initial period is as follows:

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[28] Pike, *supra* note 7, at 496–97.

[29] Pike, *supra* note 7, at 584–87. This long-term trend is visualized over the long term in Pike's Appendix.

Figure 1: Five Years of Steven's Single Premium Whole Life Policy (Hypothetical)					
Year of Policy	**1**	**2**	**3**	**4**	**5**
Face Value of Policy (amount of payout owed to Amy if Steven Dies)	$ 100,000	$ 100,000	$ 100,000	$ 100,000	$ 100,000
Premium Contributed by Steven	$ 25,000	$ -	$ -	$ -	$ -
Current Insurance Protection Fees	$ 150	$ 165	$ 180	$ 195	$ 210
Interest (guaranteed 4%, accrues on cash value minus fees paid)	$ 994	$ 1,027	$ 1,061	$ 1,096	$ 1,131
Cash Value	$ 25,844	$ 26,706	$ 27,587	$ 28,488	$ 29,409
Net Amount at Risk to Insurimax (amount of payout that would come out of Insurimax's own funds)	$ 74,156	$ 73,294	$ 72,413	$ 71,512	$ 70,591

The above hypothetical illustrates the general tenets of cash value life insurance, and although the different types of cash value insurance (whole life, universal life, variable life, etc.) differ in many respects, what is important for our purposes are the following observations.

First, cash value life insurance, despite its name, is only partially about insurance protection (the payment of a death benefit to a designated beneficiary by an outside party, the insurer, following the death of the policyholder). Cash value life insurance, as illustrated by the increase in the cash value each year (from the initial premium payment of $25,000 to $25,844 at the end of the first year, and to $29,409 by the end of the fifth year), is also about the accumulation of savings through the earning of returns on that cash value (minus the payment of fees to the insurer). As will be demonstrated later, for tax reasons, it is crucial that the buildup of these savings occurs within the life insurance contract.[30]

Second, because the cash value of a policy is included in the payout that flows to the beneficiary of the contract, the insurer is liable for less of that payout if the cash value of a policy increases. Because Steven paid for the policy in a single $25,000 premium, Insurimax would have to pay $100,000 - $25,000 = $75,000 of its own money, plus the $25,000 in cash value, to Amy if Steven died immediately afterwards (ignoring fees, etc.). After five years of inside buildup, because the cash value of Steven's policy has grown to $29,409, if Steven died, Insurimax would only have to pay Amy $100,000 - $29,409 = $70,591 from its general assets.

From these two observations, we can derive a general principle, one which will be fundamental to understanding why § 7702 was adopted: *the more cash value savings there are in a given cash value insurance policy, the less insurance protection there is from the insurer and the more like an investment vehicle the contract becomes.* The principal reason to structure

[30] *See* discussion *infra* Section I.B.1.

insurance in this manner from an insurance accessibility perspective is that, as a policyholder ages, the actuarial math of increasing probability of death means that term premiums will become more expensive for the policyholder. Packing in higher premiums that enable a cash value buildup early on will enable the policy to carry through the policyholder's full lifespan when it would otherwise be potentially infeasible for the insurer to offer such a policy that would be reasonably affordable to most people.[31] Fundamentally, the more quickly cash value accumulation is allowed, the faster the insurance company can get out of the business of providing actual costly insurance and get into the business of being an asset manager.

The structure of universal life insurance, which is a relatively new type of cash value insurance, is important because of its role in driving insurance tax policy.[32] Pioneered in the 1970s, universal life policies offer substantially more flexibility in both the premiums that policyholders contribute and the benefits that beneficiaries receive. Policyholders generally have the option of not only choosing a death benefit but also changing the death benefit mid-policy if they fulfill certain conditions.[33] If the policyholder misses a payment, the policy does not necessarily lapse, and the policy may permit partial withdrawals from the cash value. The insurer will specify a minimum annual interest rate for the policy. Essentially, universal life policies are a broader umbrella of cash value life insurance policies that are less subject to the relatively strict structure of whole life.

To summarize, while life insurance is most publicly associated with the pure insurance protection of term life, contemporary life insurers also often offer a plethora of cash value life policies, sold to a smaller number of consumers, that incorporate a savings account inside of the policy. Cash value life insurance policies may take the form of fixed-premium, fixed-death benefit policies (like whole life insurance), or its more flexible cousin, universal life insurance. Cash value life insurance, because it relies on policyholders contributing more in premiums up front to bring about inside buildup of the cash value, shifts the role of the insurer away from the provision of death benefits and towards being an asset manager, like a mutual fund. We will next explore how tax policy applies to life insurance policies

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[31] Randall L. Shaw, *Universal Life Insurance: How It Works*, 71 A.B.A. J. 68, 68 (1985).

[32] *See* discussion *infra* Section I.B.2. The first sale of a universal life policy, by a firm renamed to Hutton Life and eventually merged into Pacific Life, occurred in the U.S. in 1978, though policies sold prior to then contained various features of universal life. Paul J. Mason & Stephen E. Roth, *SEC Regulation of Life Insurance Products – On the Brink of the Universal*, 15 CONN. L. REV. 505, 551 n.186 (1983).

[33] *Id.* at 552.

and how inside buildup has enabled the industry to not only offer products that pool risk and provide security, but also become a facilitator of tax avoidance and sometimes outright tax fraud.

B. LIFE INSURANCE TAX TREATMENT AND THE ROAD TO § 7702

1. The Life Insurance Exclusion from Income

The acquisition of a life insurance policy has been among the most financially blessed of transactions by the federal income tax system, going all the way back to the inception of the modern tax. In 1913, Congress ratified the Sixteenth Amendment, giving the federal government the absolute power to "lay and collect taxes on incomes, from whatever source derived, without apportionment among the several States."[34] Congress swiftly passed the Revenue Act of 1913, imposing a small, progressive tax that began on individual incomes of over $3,000 a year.[35] In that Act, Congress specifically exempted from income "the proceeds of life insurance policies paid upon the death of the person insured or payments . . . upon the return thereof to the insured at the maturity of the term mentioned in the contract, or upon surrender of contract."[36] The great bulk of the life insurance exemption, where the death benefit is completely untaxed, has been protected in every change to the tax code ever since[37] (despite, by the count of an executive of the National Association of Insurance and Financial Advisors, at least 13 "serious" congressional attempts to place limitations on it).[38] The exemption is codified in I.R.C. § 101(a) for death benefits and I.R.C. § 72 for surrenders, where surrenders of cash value up to the amount

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[34] U.S. CONST. amend. XVI. A previous federal income tax, adopted in the 1870s, had been struck down by the Supreme Court in 1895 for being a "direct tax." Pollock v. Farmers' Loan & Tr. Co., 157 U.S. 429, 430 (1895). Following the Supreme Court's ruling in *Pollock*, a cross-party political movement emerged to restore Congress' ability to levy an income tax, culminating in the passage of the Sixteenth Amendment. *See generally* Sheldon D. Pollack, *Origins of the Modern Income Tax, 1894–1913*, 66 TAX LAW. 295, 296 (2013).

[35] Revenue Act of 1913, H.R. 3321, 63d Cong. § 2(A) (enacted).

[36] *Id.* at 167.

[37] Pike, *supra* note 7, at 493 n.1.

[38] Mark Maremont & Leslie Scism, *Shift to Wealthier Clientele Puts Life Insurers in a Bind*, WALL ST. J. (Oct. 3, 2010, 6:42 PM), https://www.wsj.com/articles/SB10001424052748703435104575421411449555240.

the policyholder has contributed (the "investment in the contract") are untaxed as well.[39]

The inside buildup on a cash value life insurance policy—the returns credited to the assets held inside of the life insurance cocoon—is also excluded from taxable income. This exclusion dates back to the Revenue Act of 1913, where floor debate of the bill made clear the intent to exempt such returns even though the law did not explicitly include such language.[40] Congress' view was that policyholders could not properly be seen as owning the interest income because "to receive that interest income they would have to give up the insurance protection or the annuity guarantees."[41] Congress has made some very modest efforts to put some limitations on this exemption for corporate-owned policies, but has not done so for individuals—indeed, Congress has explicitly rejected proposals to do so, as we will cover in the following section.[42] And despite concerns from commentators about the lack of a firm statutory foundation for this expansive view of tax exemption,[43] non-inclusion of inside buildup in income has long been blessed by the

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[39] I.R.C. § 72(e)(5).

[40] DESROCHERS ET AL., *supra* note 7, at 299 (citing 50 CONG. REC., as reported in JACOB S. SEIDMAN, SEIDMAN'S LEGISLATIVE HISTORY OF FEDERAL INCOME TAX LAWS, 1861–1938, at 989 (1938)). The main author of the Revenue Act, Representative Cordell Hull of Tennessee, told another representative, among other remarks, that "the proceeds of life-insurance policies paid on the death of the person insured, and also includes the return of any and all sums which a person invests in insurance and receives back at one time or at periodical times during his life" were included in the life insurance exemption. On another occasion during House floor debate, when asked if "a widow will be required to pay an income tax on the money secured as the result of her husband's death," Hull replied, "[i]t never was contemplated to tax the proceeds of life insurance policies." 50 CONG. REC. 508 (1913). *See also* CONG. RSCH. SERV., TAX EXPENDITURES: COMPENDIUM OF BACKGROUND MATERIAL ON INDIVIDUAL PROVISIONS, 112TH CONG., 2D SESSION, S. PRT. 112–45, at 323 (2012).

[41] CONG. RSCH. SERV., *supra* note 40, at 323–25.

[42] *Id.* at 323.

[43] *See* Pike, *supra* note 7, at 493 n.2 (arguing that "[t]he precise basis for this exclusion is obscure" and "has been questioned for some time"); Lawrence J. Macklin, *An Analysis of Proposals Using Life Insurance: What Works, What May Not Be as Effective as Promoted, and What Does Not Work*, 43 ESTS., GIFTS, & TRS. J. 123, 132 (2018) (noting that non-taxation of inside buildup "has not been expressly or directly codified in the code"). The Joint Committee on Taxation recently stopped formally considering the nontaxation of inside buildup to meet the definition of a tax expenditure because of this lack of statutory basis. *See infra* n.51.

courts[44] and the IRS.[45] Taxpayers may also take out loans using their cash value as collateral without losing this tax-exempt status.[46] The exemption of the death benefit and the inside buildup of money in cash value policies from federal income tax makes life insurance a valuable instrument for tax reduction purposes.

The tax preference for life insurance is so sufficiently strong that it has long been an object of experimentation for the commercially inventive. One signature example: in the famous case *Knetsch v. United States*, an entrepreneurial taxpayer undertook a tax arbitrage scheme by borrowing $4 million to purchase a deferred annuity life insurance product with tax-deferred inside buildup that was scheduled to start actually paying him money when he hit the age of 90.[47] Knetsch would have made back the money he had nominally put in to the policy, using debt financing with tax-deductible interest, in 2,325 years.[48] Knetsch's scheme allowed him to exclude income from his life insurance product (formally, an annuity) while deducting income from his nominal debt expense, or at least it did until the Supreme Court ruled that his transaction constituted a "sham" and his debt interest payments were non-deductible.[49]

Concerns about tax arbitrage schemes caused Congress to enact I.R.C. § 264 in 1954 to prevent tax double-dipping, and following *Knetsch*, Congress further amended § 264 to expand it.[50] Section 264 now provides that taxpayers may not deduct premiums for life insurance products if they are beneficiaries of the policy or deduct any amount accrued on debt undertaken to purchase a life insurance product, and allows for certain exceptions that are outside the scope of this paper. The key point is that while Congress, aided by the Supreme Court, has acted to prevent some of the most egregious tax gaming employing life insurance's tax attributes, it has not

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[44] Macklin, *supra* note 43, at 132 n.3 (citing Cohen v. Commissioner, 39 T.C. 1055 (1963), acq., 1964-1 C.B. 4.); David S. Miller, *Distinguishing Risk: The Disparate Tax Treatment of Insurance and Financial Contracts in a Converging Marketplace*, 55 TAX L. 481, 504 n.81 (2002) (citing *Cohen*, 39 T.C. and Nesbitt v. Commissioner, 43 T.C. 629 (1965)).

[45] Macklin, *supra* note 43, at 132 n.2 (citing I.R.S. Tech. Adv. Mem. 200213010, at 6 (2002) (stating that "taxpayers may defer tax on their policy's inside buildup").

[46] Pike, *supra* note 7, at 503 n.53.

[47] *See* Knetsch v. United States, 364 U.S. 361, 364 (1960).

[48] Daniel N. Shaviro, *The Story of Knetsch: Judicial Doctrines Combating Tax Avoidance, in* TAX STORIES: AN IN-DEPTH LOOK AT TEN LEADING FEDERAL INCOME TAX CASES 313, 314 (Paul L. Caron ed., 2003).

[49] *See* Knetsch, 364 U.S. at 366; *id.* at 370.

[50] I.R.S. Tech. Adv. Mem. 200213010, 6 (Mar. 29, 2002).

done so in a way that takes aim at the core tax preference that privileges the life insurance sector in non-"sham" transactions.

To review, life insurance death benefits are not taxable. The return of accumulated cash value to a policyholder at the end of a life insurance contract is not taxable. Cash value surrenders are not taxable up to the policyholder's investment in the contract. Cash value inside buildup is tax-deferred (and, unless surrendered, above the investment in the contract, will fall into a non-taxable bucket). And loans against cash value, which provide liquidity to policyholders, do not interfere with this tax status. The collective drain of tax revenue due to the I.R.C. treatment of life insurance policies is quite substantial, estimated to total about $370 billion from 2016 to 2025.[51] The multibillion-dollar question, then, if life insurance is to be subject to such favorable tax treatment, is: what actually demarcates life insurance policies from other contracts?

2. Defining Life Insurance: From Common Law to Statutory Compromise

Wrangling over a definition of life insurance, previously a job delegated to the courts, has become a matter of political dealmaking.

Prior to the 1980s enactment of § 7702, whether a contract was considered life insurance or not fell to an amorphous test prescribed by the Supreme Court in its 1941 case, *Helvering v. Le Gierse*.[52] The Court did not apply a technical definition, but instead, drawing on the fact that "[h]istorically and commonly insurance involves risk-shifting and risk-distributing," merely stated that "the amounts [the insurer receives] must be received as the result of a transaction which involved actual 'insurance risk'

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[51] U.S. DEP'T TREASURY OFF. TAX. ANALYSIS, THE TAX EXPENDITURE FOR LIFE INSURANCE INSIDE BUILDUP 1 n.2 (2016) (citing U.S. OFF. MGMT. BUDGET, BUDGET OF THE U.S. GOV'T, FISCAL YEAR 2017, ANALYTICAL PERSPS., Table 14-3). The deduction for premiums to employer-provided group term life insurance is a separate tax expenditure that totals another $28 billion over that ten-year span, bringing the total size of the tax expenditure to about $400 billion for the period. I use the set of numbers beginning in 2016 because the Joint Committee on Taxation stopped formally designating the nontaxation of inside buildup of cash value policies as a tax expenditure around this time because of the lack of a formal statutory exclusion, making measurement of the total tax loss more complex in subsequent years. The Office of Tax Analysis report describes this decision, and its counterargument that the tax expenditure designation should continue, on page 2 of its report.

[52] Helvering v. Le Gierse, 312 U.S. 531, 537–40 (1941).

at the time the transaction was executed."[53] In the subsequent decades, new subtypes of life insurance products proliferated, such as extraordinary life, adjustable whole life, combinations of term insurance and annuities, nonguaranteed premium whole life, universal life, and more, to which the IRS generally issued rulings signing off on tax exemption.[54]

The *Le Gierse* test, with its minimalist standard of only requiring non-zero risk shifting by the policyholder and risk distribution by the policy issuer, ran into political headwinds by the 1980s. Public attention to court-enabled tax shelters was cresting and both the IRS and Congress sprang into action to curb many of the most egregious tax base erosions.[55] If the standard for qualifying as a life insurance contract was so lenient that financial institutions could get access to § 101 and § 72 tax treatment by including a bare amount of risk shifting and distributing, then *Le Gierse*, interpreted sufficiently loosely, presented an appetizing opportunity for almost any contract made by knowledgeable lawyers to undergo a modest makeover and call itself life insurance. The IRS, which had blessed universal life contracts by the firm E.F. Hutton Life[56] in 1981 rulings that seemed to expand the definition of life insurance even further, began having second thoughts and issued a memorandum a year later recommending that its Hutton Life rulings be "reconsidered."[57] A crackdown on *Le Gierse* seemed imminent.

The life insurance industry, a perennial heavy lifter in D.C., stepped in to ward off the storm. Life insurers have been highly attentive to their policyholders' tax treatment since the inception of the income tax. During Senate discussion on ongoing lobbying over the Revenue Act of 1913, Mississippi Senator John Williams remarked, ". . . great and rich and powerful life insurance companies of the country have sent broadcast all over the country printed slips, to be signed by every policyholder whom they

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[53] *Id.* at 539.

[54] DESROCHERS ET AL., *supra* note 7, at 309–10.

[55] MICHAEL J. GRAETZ ET AL., FEDERAL INCOME TAXATION 402 (8th ed. 2018) (discussing a variety of tax shelters, "typically involv[ing] a mismatching of deductions and income to produce net losses that offset unrelated income," that taxpayers employed). The Congressional crackdown on such devices culminated in three bills passed in 1982, 1984, and 1986, which ultimately, in the Tax Reform Act of 1986, brought about § 469, a provision that limited losses from "passive activities" in a year to gains from such activities. *Id*. at 424.

[56] E.F. Hutton Life was the first insurer to sell universal life policies. Mason & Roth, *supra* note 32, at 551 n.186.

[57] DESROCHERS ET AL., *supra* note 7, at 311–12 (citing PLR 8116073 (January 23, 1981); PLR 8121074 (February 26, 1981); General Counsel Memorandum 38934 (July 1982)).

have, asking them in another circular to sign and date the same and send it to their Senators and their Representative."[58] Seventy years later, the industry moved to cut off the most adventurous wildcats in its midst in order to preserve the overall exemption, lobbying Congress to pass a stricter set of criteria for universal life policies to receive preferential tax treatment than *Le Gierse* required. Tensions between large, incumbent life insurance providers (many of whom were "mutual" life insurance companies owned by policyholders) and upstarts (often stock companies who specialized in newer types of insurance) had flared for years.[59] Rather than risk an IRS crackdown on universal life policies and face uneasy relationships with the traditional, relatively conservative mutual insurers, universal life providers went to Congress to lobby for the addition of § 101(f) to the I.R.C.[60] Section 101(f), passed in the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA),[61] was a stopgap provision that provided two alternative tests for flexible premium life insurance contracts to become eligible for tax exemption: a cash value accumulation test and a guideline premium and cash value corridor test.[62] These tests will be described in more detail in the next section, as though they were initially temporary measures applying to only flexible premium policies issued prior to 1983,[63] they became the basis for the permanent codification of the definition of life insurance for federal tax purposes.

Following the addition of makeshift § 101(f) to the tax code, the life insurance industry spent years in the political trenches. Democrat Pete Stark

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[58] 50 CONG. REC. 1807 (1913).

[59] In the late 1970s, major insurance firms fought life insurance annuity providers over the tax treatment of investment annuity products. The American Council of Life Insurers (ACLI), the major life insurance trade association, moved to ally with the Carter administration's push to oppose annuities' tax-deferred status. When small insurers that disproportionately sold annuities objected, the ACLI retreated to only object to tax-deferred status for "abuses." Nancy L. Ross, *Annuities Tax Shift*, WASH. POST (April 30, 1978), https://www.washingtonpost.com/archive/business/1978/04/30/annuities-tax-shift/e7ba2436-2906-41cb-8f06-39c1541dc146/. Some mutual companies lobbied for adverse IRS rulings against universal life products in the early 1980s as well. Rex P. Cornelison III, *Federal Income Taxation of Life Insurance Products After the Tax Reform Act of 1984*, GA. STATE UNIV. L. REV. 237, 248 (1985).

[60] DESROCHERS ET AL., *supra* note 7, at 312.

[61] Tax Equity and Fiscal Responsibility Act of 1982, Pub. L. No. 97-248, §§ 266(a)(B).

[62] §§ 266(a)(B).

[63] DESROCHERS ET AL., *supra* note 7, at 313.

of California, the Chairman of the Subcommittee on Select Revenue Measures on the powerful House Ways and Means Committee, suggested in April 1983 that inside buildup of cash value policies should no longer receive an exemption.[64] William B. Harman, a lawyer who served as the Executive Vice President of the American Council of Life Insurers (ACLI) in the 1970s, wrote a tax journal article in 1992 reflecting on the past two decades of life insurance tax reform; the journal described him as being "directly involved in almost all of those changes in one capacity or another."[65] Harman, evaluating the push to tax inside buildup from government and commentators, conceded, "[u]nfortunately, to a degree their argument was bolstered by some elements within the insurance industry that aggressively developed overly investment-oriented life insurance products and marketed them by stressing the beneficial tax treatment available."[66]

Now playing defense, the life insurance sector pushed to intervene, and made a more limited case for exemption preservation in May 1983 hearings before Stark's Select Revenue Measures subcommittee.[67] At the hearings, Stark—who noted they occurred "basically as a result of intense lobbying on the part of both the stock and mutual companies"[68]—opened the discussion with a call for "a complete reexamination of the taxation of life insurance companies and their products."[69] Displaying the bipartisan nature of the discontent with the laxity of the tax regime, the Reagan administration weighed in to agree that things had gone too far and that Congress needed to take action on a life insurance definition.[70]

For the hearing, mutual insurers banded together and were represented by a fourteen company Mutual Company Executive

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[64] William B. Harman Jr., *Two Decades of Insurance Tax Reform*, INS. TAX REV. 1089, n.14 (1992).

[65] *Id.*

[66] *Id.* at 1090.

[67] *See generally Tax Treatment of Life Insurance: Hearings Before the Subcomm. on Select Revenue Measures of the H. Comm. On Ways & Means,* 98th Cong., 1st Sess. (1983) [hereinafter 1983 Hearings].

[68] *Id.* at 5.

[69] *Id.* at 2.

[70] John Chapoton, the Treasury Assistant Secretary for Tax Policy, testified that "[i]n extreme cases . . . the [life insurance] policy differs little from an investment account in the name of the policyholder with the insurance company." *Id.* at 26. Chapoton noted support for a Congressional life insurance definition. *See id.* at 60.

Committee,[71] which declared its support for life insurance tax exemptions only applying to "policies whose predominant purpose is the provision of life insurance protection."[72] Specifically, the Executive Committee recommended a definition requiring that life insurance contracts provide death benefits and have cash values that cannot exceed the net single premium for the policy.[73] However, the industry held the line against taxation of inside buildup, and the congressional proposal that followed the hearings, by Stark and Republican Henson Moore, represented a compromise: there would be no taxation of inside buildup, but an adapted version of the TEFRA mathematical cash value and guideline premium tests would become permanent and apply to all life insurance.[74] Senate hearings on the proposal, along many of the same lines, followed six months later.[75] For the price of accepting some mathematically defined limitations on how much a life insurance contract could resemble a straightforward asset management contract, the industry's tax treatment would now have congressionally stamped security.

III. CONGRESS DECIDES: § 7702 AND ITS AMENDMENTS

Part I of this article introduced the history and political economy of the life insurance industry in 20th century America, including the bargaining that led up to the enactment of a statutory definition of life insurance for federal income tax purposes, § 7702. Part II will articulate what, specifically, § 7702 does to limit firms from simply offering investment management

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[71] The members of Executive Committee were Empire State Mutual Life Insurance Company, Equitable Life Assurance Society of the United States, Guarantee Mutual Life Company, The Guardian Life Insurance Company, John Hancock Mutual Life Insurance Company, Massachusetts Mutual Life Insurance Company, Metropolitan Life Insurance Company, Minnesota Mutual Life Insurance Company, Mutual Benefit Life Insurance Company, Northwestern Mutual Life Insurance Company, Phoenix Mutual Life Insurance Company, The Prudential Life Insurance Company of America, and Security Benefit Life Insurance Company. In total, 53 mutual companies said they supported the statement. *See id.* at 163–65.

[72] *Id.* at 156 (the Executive Committee made sure to criticize "that there are products in the marketplace that are primarily short-term investment vehicles masquerading as life insurance" as well).

[73] *Id.*

[74] Harman, *supra* note 64, at n.14.

[75] *Tax Treatment of Life Insurance Products and Policyholders: Hearing Before the Comm. on Finance*, 98th Cong., 2d Sess. (1984).

services under the tax-preferred guise of life insurance, as well as explain why its 2020 amendment substantially weakens this hard-fought balance.

A. THE GRAND BARGAIN: ENACTMENT AND IMPACT OF § 7702

The amended Stark-Moore proposal was passed in the Deficit Reduction Act of 1984 (DEFRA),[76] making the life insurance industry's bargain, codified in I.R.C. § 7702, the law of the land. The law works as follows: first, to be eligible for federal income tax exemptions as a life insurance contract, a contract must first be considered life insurance "under the applicable law,"[77] meaning the state law of the state where the policy was issued.[78] Second, the contract must pass one of two standards, chosen at the inception of the policy: the cash value accumulation test or the guideline premium and cash value corridor tests.[79] The two standards are strictly mathematical simulations, directly writing actuarial calculations into the tax code so as to place concrete bounds on the level of investment orientation a policy can have. An important point to underscore, before looking into the specifics, is that each test functions as a simulation, such that regardless of the actually existing provisions of a specific life insurance contract, that contract will pass the test if its simulated version passes the test. If a contract fails its test, the policyholder will lose the tax treatment accorded to life insurance policies.[80] The main features of each test will be examined in

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[76] Deficit Reduction Act of 1984, Pub. L. No. 98-369, § 221, 98 Stat. 494, 767 (codified as amended at 26 U.S.C. § 7702).

[77] I.R.C. § 7702(a) (2020).

[78] DESROCHERS ET AL., *supra* note 7, at 338.

[79] § 7702(a).

[80] Formally, per § 7702(f) and (g), if a contract ever fails its test, the "income on the contract" that occurs in a given year (the "increase in the net surrender value" plus the "cost of life insurance protection" minus the "premiums paid" in that year) will be considered taxable income. *See* § 7702(f)(1); *see also* § 7702(g)(1)(A)–(B). Additionally, per § 7702(g)(2), if a contract that has failed to meet § 7702 pays out a death benefit, the "net surrender value of the contract" that is paid out will also be considered taxable income; only the remaining portion of the death benefit that is paid directly by the insurer will retain its tax exemption. Per § 7702(f)(2)(B), the "net surrender value" of a contract is the amount of money that a policyholder would receive if they surrendered their policy while they were still alive, taking into account the surrender charges specified in the contract, but not taking into account policy loans.

turn.[81] Section II.A.3 will summarize the main features of the test as a flowchart.

1. Placing Limits on Whole Life: The Cash Value Accumulation Test

a. structuring cash value accumulation limits

The cash value accumulation test (CVAT) is the main test for whole life insurance policies, allowing for relatively more cash value accumulation in early years but relatively less in later years.[82] A contract passes the CVAT if its "cash surrender value" never exceeds "the net single premium which would have to be paid at such time to fund future benefits under the contract."[83] The "net single premium" is the amount of money required today to generate the contract's arranged future cash values (remember that the insurer is guaranteeing the policyholder a certain annual return) and to pay for the actuarial mortality costs associated with the contract's death benefit. Essentially, the CVAT restricts the amount of money that can be stuffed into a policy with a given death benefit to the actual amount necessary to support that death benefit. If there were no cash value accumulation restriction whatsoever, a whole life policy could theoretically be written with a $100,000 death benefit where the policyholder simply handed over $100,000 immediately to the insurer. That structure would mean that the life insurer would effectively manage a tax-preferred investment account for the policyholder's $100,000 savings instead of the policyholder going to a mutual fund. The CVAT prevents life insurers from issuing whole life policies in which they would not actually risk having to pay out death benefits because of their having a very high ratio of cash value to death benefit.

In general, to perform the mathematical calculations necessary to determine if a contract passes the CVAT, four main variables are required: the age of the policyholder, the policy benefits (mainly the death benefit), the year's maximal insurance protection fees, and the guaranteed rate at which interest is credited to the cash value (the amount of inside buildup that

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[81] Because of the substantial density of the law and the mathematical calculations that undergird it, the overview of the § 7702 statute is relatively high-level. For a more granular treatment of the statute, see generally DESROCHERS ET AL., *supra* note 7; *see also* Pike, *supra* note 7.

[82] Pike, *supra* note 7, at 508.

[83] § 7702(b)(1).

the insurer guarantees will occur each year).[84] Two of these variables, the age of the policyholder and the policy benefits, are easily observable from the policyholder and contract, and are uncontroversial in the statute. The other two require further analysis because of their susceptibility to manipulation by insurance providers seeking to push the limits of the CVAT.

b. simulating mortality and insurance protection rates

I examine insurance protection charges first. Insurance protection charges, as covered in Section I.A, in theory reflect the actuarial cost to the insurer of providing the policy. In a given year there is a certain probability that the policyholder will die, meaning that the life insurer would have to pay out the death benefit, costing it an amount of money equal to the death benefit minus the contract's accumulated cash value. The money charged to the policyholder for providing this service is represented by this charge. However, it is impossible to truly know if a given person will die within a given year, and the insurance protection charge is at the discretion of the insurer. To game the CVAT, an insurer could nominally record very pessimistic probabilities of a person's survival each year, thereby mechanically increasing the reported amount of insurance protection charges to the policyholder and enabling the policyholder to contribute additional premiums to the policy when doing so would otherwise have failed the CVAT. Intuitively, if projections for survival are pessimistic, then the actuarial cost to an insurer for providing the policy increases. Thus, the amount of money that would have to be paid to fund the contract increases, so the net single premium increases.

DEFRA initially did not regulate insurers' use of actuarial assumptions because its authors initially preferred to rely on market competition to discipline unrealistic modeling.[85] After the passage of DEFRA and the Tax Reform Act of 1986, life insurers even ran ads claiming to be the "last remaining tax shelter" and that their single premium policies were "too good to be true;"[86] Congress added further teeth to § 7702 in the

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[84] Pike, *supra* note 7, at 511 (citing KENNETH BLACK, JR. & HAROLD D. SKIPPER, JR., LIFE INSURANCE (11th ed.1987)).

[85] DESROCHERS ET AL., *supra* note 7, at 318 n.121.

[86] DESROCHERS ET AL., *supra* note 7, at 315.

Technical and Miscellaneous Revenue Act of 1988 (TAMRA).[87] Mortality charges are now required to be "reasonable," with a safe harbor given to charges that do not exceed the charges specified in the "prevailing commissioner standard tables."[88] These tables are set by the National Association of Insurance Commissioners (NAIC),[89] an organization of state insurance regulators, meaning that insurers must adhere to standardized tables for calculation of mortality fees to remain in the safe harbor of CVAT compliance. So, no matter how life insurers internally calculate insurance protection charges in their existing contracts, for the purposes of the CVAT, each contract will be evaluated on a specified mathematical simulation of itself in which the mortality tables used are uniform and trusted.

c. simulating interest crediting rates

This article now turns to the treatment of the rate at which interest is credited to a policy's cash value—the inside buildup. It is this aspect of the CVAT (and, as we will see, the guideline premium and cash value corridor tests) that has been the subject of recent change. In whole life policies and other types of insurance, the insurer will credit interest to the cash value of a policy each year (the inside buildup). For example, if the policyholder has $100 in cash value and the insurer credits 7%, the policyholder will then have $107 in cash value. Many policies provide for a minimum annual inside buildup, with the possibility of a larger one (for example, a policy could specify that at least 4.5% a year would be credited). However, similar to the insurance protection fees and mortality charges discussed above, insurers face an incentive to manipulate the guaranteed inside buildup. If the rate of interest used in the calculation is lower, then it will require more in policyholder contributions for the policy to grow towards the same amount of money, so the net single premium increases. By default, when calculating the net single premium, the CVAT employs the "rate or rates guaranteed on issuance of the contract."[90] Therefore, if an insurer were to decrease the guaranteed rate of interest crediting while changing nothing else, the insurer would be able to allow the policyholder to stuff the policy with substantially more cash value and thus reduce the insurer's net amount at risk on the

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[87] Technical and Miscellaneous Revenue Act of 1988, Pub. L. No. 100-647, § 5011, 102 Stat. 3342, 3660 (codified as emended at 26 U.S.C. § 7702) [hereinafter TAMRA].

[88] TAMRA, §5011(a), 102 Stat. 3342, 3660 (amending I.R.C. § 7702(c)(3)(B)).

[89] I.R.C. § 7702(f)(10).

[90] § 7702(b)(2)(A).

policy, while permitting the policyholder to receive the preferential tax treatment.

To guard against such manipulations, § 7702 (until 2020) specified that regardless of the actual guaranteed interest crediting rate of a policy, the interest rate to be used in the CVAT calculations would be subject to a lower bound of 4%.[91] To reiterate, if the contractually guaranteed rate of interest crediting to the cash value of a contract was less than 4% (for example, the a policy could guarantee inside buildup of 1% annually), when such a policy would be tested for § 7702 compliance, the policy would be evaluated as if it guaranteed 4%.

The interest rate used in the § 7702 formula has a significant impact on the amount of cash value that can be put into a life insurance contract. For example, in the case of a newly issued whole life insurance policy with a face value of $225,000 to a 25-year-old nonsmoking male, if the interest rate used in the calculation was 6%, the net single premium for that policy (the amount of savings that can be put into that policy) would be about $9,900.[92] If the rate was 4%, the net single premium would be about $25,300—more than doubling capacity to absorb policyholder savings.

DEFRA's 4% lower bound on the interest rate to be used for the CVAT was written directly into the statute, which raises the question: why specifically 4%? Why not 3%? Or 5%? There is no strictly mathematical reason that the simulated lower bound of the interest credited was written to

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[91] Deficit Reduction Act of 1984, Pub. L. No. 98-369 § 221(a), 98 Stat. 767 (adding § 7702(b)(2)(A), which has been since amended).

[92] For this calculation, I use the 2017 Unloaded Commissioners Standard Ordinary Male Nonsmoker ANB Mortality Rates and calculate the net single premium for a newly issued whole life insurance policy with a level face amount. I add no load to the premium (do not factor in expenses or profits) for simplicity, following the recommendation employed in Pike, *supra* note 7, at n.39. I employ the Basic Actuarial Principles net single premium calculation approach for such a policy delineated in DESROCHERS ET AL., *supra* note 7, at 59. The net single premium, for this type of policy, can be calculated as the face value of the policy times product of an interest rate discount with the probability that the policyholder survives to an age 45+t and the probability that the policyholder dies at the age of 45+t, summed over the ages of 45 to 120. The data tables and calculations performed are available online. I checked my calculations with two actuaries to verify their accuracy; I thank Reggie Mazyck and Patrick Nolan in the acknowledgments and here as well for serving as resources. The numbers presented in the text are rounded to the nearest hundred. Online Data and Calculations Appendix https://docs.google.com/spreadsheets/d/11IJ6yAih3cQAQ-ByPjzWJ2_qZx75PqymoRiABWD7C2E/edit#gid=1896335209 (link directs to a Google Sheet with calculations I authored).

be 4%. Section 7702 was a political compromise between the life insurance industry and policymakers who were concerned that the industry was selling products that did not have much insurance in them at all. As Harman, the former Executive Vice President of the ACLI, wrote in 1992, though the statutory limits on insurance risk "involved drawing a somewhat arbitrary line, this was necessary to ensure that [life insurance] contracts did not permit too great an investment orientation."[93]

2. Placing Limits on Universal Life: The Guideline Premium and Cash Value Corridor Tests

The guideline premium test (GPT) and cash value corridor test (CVCT) comprise the main test for universal life insurance policies, allowing for relatively less cash value accumulation in early years but relatively more in later years. To reiterate from an earlier explanation, universal life policies are substantially more flexible cash value policies than traditional whole life, in which policyholders receive discretion to choose the initial premium quantities as well as the death benefit, and may choose to make alterations mid-policy.[94] Many of the concepts employed in the CVAT, including the use of prescribed mortality rate tables and floor restrictions on the interest credited, are employed in the GPT and CVCT for analogous reasons.

a. The Guideline Premium Test

The GPT sets a cap on the cumulative amount of premiums that a policyholder may contribute to a policy in a manner that roughly matches the implicit premium limitations placed by the CVAT.[95] The GPT sets up two standards: the guideline single premium (GSP), which is the premium that would be required to pay up front to support the future benefits of the contract if the payment was made all at once,[96] and the guideline level premium (GLP), which is the annual premium that would be required to be paid to support the future benefits of the contract.[97] The GLP is the greater of the two,[98] and the GPT states that the sum of the premiums that a

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[93] Harman, *supra* note 64, at 902. Harman's quote is directly referring to the statutory limits applied in TEFRA to flexible premium contracts, but also refers to Congress' use of TEFRA's principles to develop § 7702 two years later.

[94] *See supra* Section I.A.

[95] Pike, *supra* note 7, at 519.

[96] I.R.C. § 7702(c)(2)(A).

[97] I.R.C. § 7702(c)(2)(B).

[98] I.R.C. § 7702(c)(2).

policyholder has paid under the life insurance contract cannot exceed the guideline premium limitation, which is the greater of the GSP and sum of GLP premiums paid up to that date.[99] The GPT therefore puts an upper bound on the amount of premiums that a policyholder can contribute to a policy so as to hinder policyholders' ability to accumulate a great deal of rapid cash value while the insurer rapidly reduces its own risk, similar to the structure of the CVAT.

Also in a way that is comparable to the CVAT, the GPT includes several conditions that are in place to stop insurers from gaming the simulation. The GLP must be calculated in a manner that reflects what the required premium would be if premiums were paid each year until the insured "attains age 95."[100] The two main actuarial limitations present in the CVAT, the mortality charges and rate of crediting interest, are present in the GPT as well. Just as in the CVAT, the GPT requires (after the passage of TAMRA) that the GSP and GLP be computed using "reasonable mortality charges" and offers the NAIC-set "prevailing commissioner standard tables" as a safe harbor.[101] Without this restriction on the simulated version of the contract, a universal life insurer could employ excessively pessimistic mortality assumptions to enable additional early premium contributions and corresponding reductions in insurer net amount at risk.

With regard to crediting interest on the policy, the GPT, like the CVAT, provides for a floor on the guaranteed rate of interest credited in the simulated policy subjected to the test to prevent insurers from allowing premium stuffing through artificially low interest. DEFRA prescribed that the rate of interest to be used in calculating the GLP was to be the rate guaranteed on the issuance of the contract, but with a minimal rate of 4%,[102] consistent with the 4% floor employed in the CVAT. This mirroring of the annual interest crediting standard ensures equal tax treatment of otherwise functionally equivalent level-premium policies across whole and universal life. DEFRA prescribed that the minimal rate of interest to be used in calculating the GSP, on the other hand, was to be 6%,[103] or two percentage points higher.[104] Similarly to the 4% lower bound rate of the CVAT, the 4%

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[99] I.R.C. § 7702(c)(1).

[100] I.R.C. § 7702(c)(4).

[101] I.R.C. § 7702(c)(3)(B)(i).

[102] Deficit Reduction Act of 1984, Pub. L. No. 98-369, §221(a), 98 Stat. 767 (adding I.R.C. § 7702(c)(4), which has since been amended).

[103] *Id.* (adding I.R.C. § 7702(c)(3)(B)(iii), which has since been amended).

[104] The reason for the higher floor rate for guideline single premiums relative to guideline level premiums may be due to that the relatively strict 6% floor may be

and 6% lower bounds of the GPT are not selected due to any exacting mathematical reason, but are political compromises designed to limit the ability of life insurers to offer essentially untaxed mutual funds.[105]

I re-emphasize here that the 4% (6%) minimum applies to the simulated policy being examined for tax purposes, while the corresponding actual contract is not legally required to credit 4% (6%) or more to the policyholder in that year. Life insurers may execute contracts, such as ones that guarantee returns of less than 4%, on whatever terms they please. If insurers wish for the contract to receive preferential tax treatment, their obligation is to make sure that the contract, once the actuarial simulation of § 7702 is applied, passes the relevant test.

b. The Cash Value Corridor Test

The Cash Value Corridor Test (CVCT), which is to be applied alongside the GPT, is an additional limitation that limits the amount of cash value that can be placed inside of a policy relative to the policy's death benefit. The CVCT gradually relaxes this limit, called the cash value corridor, as the policyholder ages. Formally, the CVCT sets a maximal ratio of the "cash surrender value" (the cash value "determined without regard to any surrender charge, policy loan, or reasonable termination dividends")[106] to the death benefit and specifies a table in the statute for the corresponding maximal ratios for each year.[107] Translated for the reader's ease, the cash value corridor reads:

balanced by the relatively lenient cash value corridor or that arguably a 6% rate of return is, over the long term, a more justified figure for the market rate. Pike, *supra* note 7, at 521 n.156.

[105] Harman, *supra* note 64.

[106] I.R.C. § 7702(f)(2)(A).

[107] I.R.C. § 7702(d)(2).

Cash Value Corridor		
Age of the Insured as of the Beginning of the Contract Year:	**Death Benefit Must Be At Least This Much Larger Than the Cash Surrender Value (ratio decreases by a ratable portion for each year)**	
	From:	**To:**
0-40	2.5x	2.5x
41-45	2.5x	2.15x
46-50	2.15x	1.85x
51-55	1.85x	1.5x
56-60	1.5x	1.3x
61-65	1.3x	1.2x
66-70	1.2x	1.15x
71-75	1.15x	1.05x
76-90	1.05x	1.05x
91-95	1.05x	1x

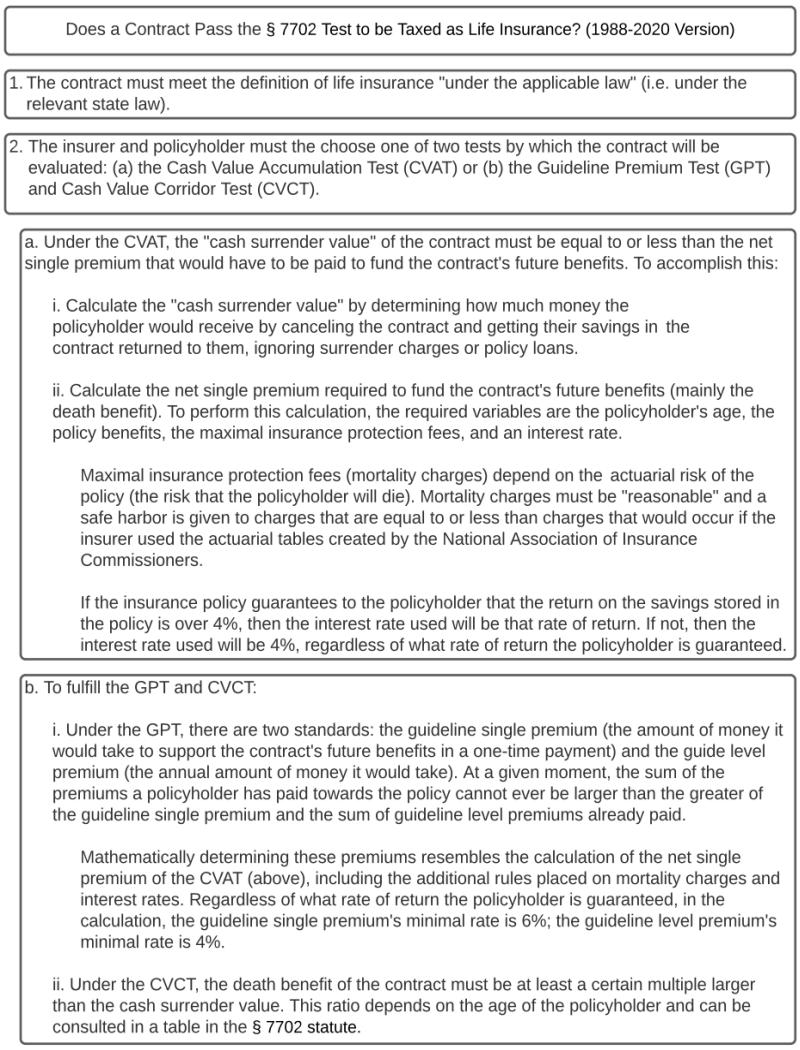
For relatively young policyholders, as can be seen from the table, the death benefit must be at least two and a half times the size of the "cash surrender value," and as the policyholder reaches age 95, the ratio is gradually relaxed until the "cash surrender value" is eventually allowed to reach the death benefit. The effect of the CVCT, when used in conjunction with the GPT, is that policyholders' inside buildup is held within certain bounds, with the dual structure working to ensure that creative insurance entrepreneurs do not find loopholes around its structure.

3. Summary of § 7702 Mechanics

To condense the above discussion in subparts II.A.1 and II.A.2, the political compromise of § 7702 requires that, in order to get access to life insurance tax exemptions, a contract must first meet the definition of life insurance under the relevant state law. Then, the contract must pass either the cash value accumulation test (CVAT), generally for whole life policies, or the guideline premium test (GPT) and cash value corridor test (CVCT), generally for universal life policies. These tests are designed to limit the degree of orientation the policy has towards being an investment fund rather than a pure term insurance policy. Life insurers can write their policies how they please, but regardless of how they write them, to pass § 7702, a

simulated version of the policy that employs certain mandated actuarial assumptions (the use of NAIC mortality tables and certain minimums on credited rates of interest) must pass one of the available tests. These actuarial assumptions are, on some level, arbitrary but are employed to prevent life insurers from writing policies where, by use of excessively pessimistic mortality tables and excessively low minimum crediting of interest on inside buildup, the insurers may greatly reduce their net value at risk on a given policy through policyholder stuffing of cash value.

The following infographic provides a walkthrough of if a policy passes § 7702:



4. Aftermath: § 7702 as 30-Year Peace

For the life insurance industry, § 7702 was a worthy compromise. As discussed above, while President Ronald Reagan struck a reputation as a tax cutter, he also pushed for reforms to get rid of tax shelters, a major political issue.[108] Among the signature legislation of Reagan's two terms in office was the Tax Reform Act of 1986 (TRA),[109] which reduced general rates of taxation and closed some loopholes; twenty years later, the author of a book on the passage of the Act called it "the broadest revision of the federal income tax in history.[110] Reagan's original proposal for the TRA, announced in May 1985—a year after the passage of § 7702—included four separate proposals for new taxes on life insurance policies and companies, including taxation of inside buildup of cash value policies.[111]

Reagan slammed the nontaxation of inside buildup as going only to "individuals with excess disposable income that allows them to save, and particularly people in high tax brackets," while being unavailable to purchasers of term life insurance and being distortionary for channeling savings into the life insurance industry rather than other financial institutions.[112] But Reagan's life insurance proposals did not survive to the final bill "for a variety of reasons, not the least of which was that Congress had only recently considered and resolved the issue, albeit with the different result," wrote former Executive Vice President of the ACLI William Harman in his retrospective.[113] Section 7702 had fulfilled its purpose. By cutting loose its most extreme elements, the life insurance industry had preserved its most important tax exemptions.

All that remained was some clean-up. As referenced above, in 1988 Congress passed an additional tax reform act, TAMRA, to make various mechanical alterations to recent changes in the tax code.[114] In TAMRA,

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[108] GRAETZ ET AL., *supra* note 55, at 424.

[109] Tax Reform Act of 1986, Pub. L. No. 99-514, 100 Stat. 2085.

[110] Jeffrey H. Birnbaum, *Taxing Lessons, 20 Years In the Making*, WASH. POST (Oct. 22, 2006), https://www.washingtonpost.com/wp-dyn/content/article/2006/10/20/AR2006102001255.html.

[111] WHITE HOUSE, THE PRESIDENT'S TAX PROPOSALS TO THE CONGRESS FOR FAIRNESS, GROWTH, AND SIMPLICITY 253–64 (1985).

[112] *Id.* at 255–56.

[113] Harman, *supra* note 64, at n.21. Harman also cites insufficient revenue from the tax and an argument from the industry that subjecting inside buildup to tax would "effectively destroy the market for the products" as the other principal reasons why the tax was removed from the bill.

[114] TAMRA, *supra* note 87.

Congress added to § 7702 the requirement that mortality charges be "reasonable"[115] to prevent improper cash value stuffing. Congress also responded to post-TRA concerns about the use of single premium cash value contracts by enacting additional restrictions on a subset of life insurance policies subject to early cash value stuffing called "modified endowment contract[s]."[116] After that, § 7702 went completely unmodified for decades (until 2020), with the sole cosmetic change being that the citation to the "prevailing commissioners' standard tables" was moved from a different section of the I.R.C. into § 7702 itself.[117]

This section has told the story of the enactment of § 7702 with the following emphasis: § 7702 is a political equilibrium between (1) Congress, an executive, and a public suspicious that the life insurance industry was playing fast and loose, and (2) a life insurance industry willing (eager, even) to jettison its wayward nephews to preserve its political capital and privileged tax status. This equilibrium was hard-won, the result of extensive political maneuvering, congressional hearings, and four separate major pieces of legislation in seven years (TEFRA in 1982, DEFRA in 1984, TRA in 1986, and TAMRA in 1988). The treaty of § 7702 then lasted for over thirty years, before being quietly and abruptly overhauled with essentially no public discussion or negotiation in 2020, in the midst of the COVID-19 pandemic.

B. THE RETREAT: THE 2020 AMENDMENT TO § 7702

This section will first cover changes in the life insurance sector since the 1980s and how those changes laid the foundation for the 2020 § 7702 amendment, and then it will cover the specifics of that amendment.

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[115] TAMRA, §5011(a), 102 Stat. 3342, 3660 (amending I.R.C. § 7702(c)(3)(B)).

[116] *See generally* I.R.C. § 7702A(b) (the modified endowment contract (MEC) definition and its implications are highly technical, but the basic structure is that an MEC is a contract that passes § 7702 but that fails the "7-pay" test, which means the policyholder contributed more in premiums to the contract within the first seven years than "the sum of the net level premiums which would have been paid on or before such time if the contract provided for paid-up future benefits after the payment of 7 level annual premiums" (essentially, if the policyholder paid enough in the first seven years for the policy's necessary premiums to be fulfilled)). *See also* I.R.C. §§ 72(e)(10) & 72(v)(1) (if a policy receives MEC designation, withdrawals from the cash value and loans against the cash value will be automatically treated as taxable income and will also carry a 10% penalty).

[117] Budget Fiscal Year 2018, Pub. L. No. 115–97, 131 Stat. 2054, title I, § 13517(a)(4) (2017).

1. The Slow Decline of Life Insurance and the End of the People's Investment Vehicle

Despite the continuation of highly tax-favored treatment of life insurance policies, from 1989 to 2013, the percentage of American households that owned a term life insurance policy dropped from 58% to 50%. For cash value policies, the drop was from 37% to 19%.[118]

The reasons for the waning percentages are varied. Insurance economics papers point to the decline of fees in mutual funds;[119] the rise of the internet (enabling more substantial price shopping);[120] the decline of the traditional model of life insurance sales via salesmen;[121] the 1990s introduction of additional tax-advantaged savings vehicles such as Roth IRAs, 529 education plans, and Coverdell Education Savings Accounts;[122] and the decline of interest rates.[123]

The decline of interest rates is of particular concern to the business model of life insurance.[124] Life insurers derive revenue from two main sources: the premiums policyholders pay them and the financial investments that insurers make with those premiums.[125] From the premiums, life insurers invest a gargantuan amount of assets, totaling over $6 trillion in their general accounts.[126] Insurers must invest their assets in a portfolio consistent with

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[118] Hartley et al., *supra* note 20.

[119] *Id.* The authors also find that the decline in life insurance ownership was overwhelmingly not driven by demographic changes in the U.S. (such as the changing incomes, age composition, racial composition, or educational attainment of Americans during the period).

[120] *See generally* Austan Goolsbee & Jeffrey R. Brown, *Does the Internet Make Markets More Competitive? Evidence from the Life Insurance Industry*, 110 J. POL. ECON. 481, 481–505 (2002).

[121] Barry Mulholland, et al., *Understanding the Shift in Demand for Cash Value Life Insurance*, 19 RISK MGMT. & INS. REV. 7, 32 (2015).

[122] *Id.* at 31.

[123] Hartley et al., *supra* note 20.

[124] *See generally* Elia Berdin & Helmut Gründl, *The Effects of a Low Interest Rate Environment on Life Insurers*, 40 GENEVA PAPERS RISK & INS. – ISSUES & PRAC. 385 (2015).

[125] JOINT COMM. TAX'N, REVENUE ESTIMATING, https://www.jct.gov/operations/revenue-estimating/ (last visited Nov. 7, 2022).

[126] *Life Insurance Companies, General Accounts; Total Financial Assets, Level*, FRED, https://fred.stlouisfed.org/series/BOGZ1FL544090075Q (last visited Nov. 7, 2022). Some life insurers also have "separate accounts," which hold

their liability risk. In other words, insurers must invest so that they minimize the risk that they will not be able to make payouts related to death benefits and surrenders. Life insurer investment portfolios are therefore notably conservative, with a full three-quarters of general account assets invested in bonds, mostly in corporate bonds.[127]

Because life insurer general account investment portfolios are highly concentrated in fixed-income assets (bonds) rather than equities, their investment returns flag when interest rates are lower.[128] Life insurers' financials suffer if interest rates decline greatly for extended periods of time, as they must still credit interest to policyholders at rates that were guaranteed when promises of higher minimum returns were much more feasible, while being able to offer new policyholders less favorable interest guarantees.[129] In the 1980s, when § 7702 was enacted, the United States federal funds rate was at an all-time high.[130] The rate, and corporate bond yields along with it, have collapsed since then:

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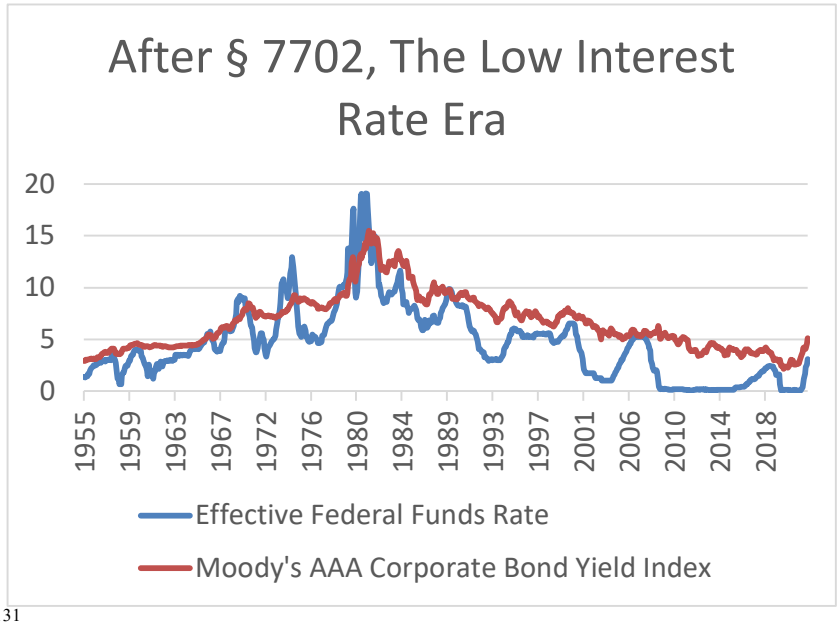
variable annuity-affiliated investments in which the policyholder is bearing the risk.

[127] Robert McMenamin, et al., *What Do Life Insurers Invest In?*, CHI. FED. LETTER (2013).

[128] *Id.*

[129] In countries like Germany, the situation is more extreme. *See generally* Berdin & Gründl, *supra* note 124. *See also* Leslie Scism, *Universal Life Insurance, a 1980s Sensation, Has Backfired*, WALL ST. J. (Sept. 19, 2018, 10:54 AM ET), https://www.wsj.com/articles/universal-life-insurance-a-1980s-sensation-has-backfired-1537368656. The low interest rate era has also increased the financial fragility of insurers due to increased interest risk exposure, particularly among insurers with relatively higher business concentration in products with return guarantees. Ralph S. J. Koijen & Motohiro Yogo, *Global Life Insurers during a Low Interest Rate Environment*, 112 AEA PAPERS AND PROCEEDINGS 503, 503 (2022).

[130] Kate Davidson & Sudeep Reddy, *Paul Volcker, Who Guided U.S. Monetary Policy and Finance for Nearly Three Decades, Is Dead*, WALL ST. J. (Dec. 9, 2019, 7:45 PM), https://www.wsj.com/articles/paul-volcker-who-guided-u-s-monetary-policy-and-finance-for-nearly-three-decades-is-dead-11575901675.



[131]

Some insurers have been selling their traditional life insurance businesses entirely, often to private equity firms.[132] The NAIC has tracked the decline of insurer portfolio yields as well as the decline of the contractually guaranteed rates offered to policyholders.[133]

The problem is deep, and the industry has responded: despite the long-term decline in the reach of life insurance to the American public and

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[131] *Federal Funds Effective Rate*, FRED, https://fred.stlouisfed.org/series/FEDFUNDS (last visited Nov. 7, 2022); *Moody's Seasoned Aaa Corporate Bond Yield*, FRED, https://fred.stlouisfed.org/series/AAA#0 (last visited Nov. 7, 2022). Data used is the monthly series for each index; the last data point available on the date of download was October 1, 2022. AAA bonds are the highest-rated (considered to be the most safe) corporate bonds.

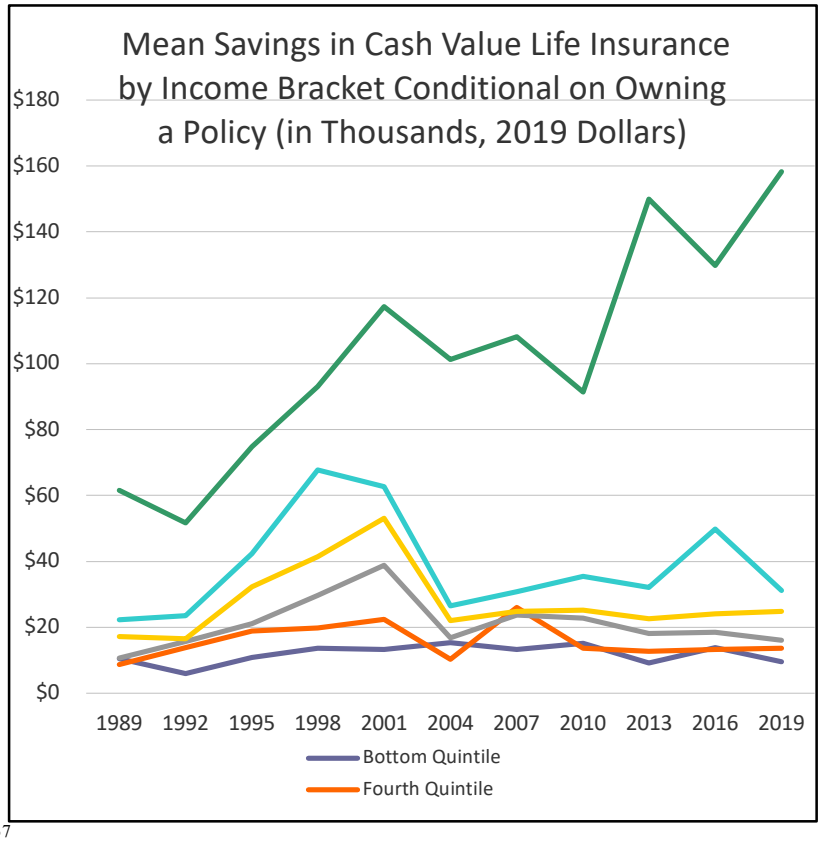
[132] Alwyn Scott, Nivedita Balu & David French, *AIG to Sell Life and Retirement Unit Stake to Blackstone, Another with IPO*, REUTERS (July 15, 2021, 4:03 PM), https://www.reuters.com/business/aig-sell-10-stake-life-retirement-business-blackstone-2021-07-14/.

[133] *Low Interest Rates*, NAIC, https://content.naic.org/cipr_topics/topic_low_interest_rates.htm (last visited Nov. 7, 2022).

decline in insurer returns on investment, total assets owned in the general accounts of the life insurance industry still hit all-time highs nearly every year.[134]

This seemingly paradoxical development is possible because of the increasing amount of premiums and assets flowing into the decreasing number of life insurance policies that remain. From 1989 to 2013, the average face value of term life insurance policies in force increased from $156,000 to $353,000, and the average face value of cash value insurance policies in force increased from $158,000 to $226,000.[135] The average value of the savings inside cash value policies increased by a much higher percentage than the face values did, going from an average of $20,000 to $36,000.[136] (Figures are in 2013 dollars to adjust for inflation). These averages do not tell the full story. Delving into the Survey of Consumer Finances and updating the data to 2019, it becomes apparent that the top decile of incomes has driven almost the entire growth of the average amount of cash value since the 1980s, among policies that remain in force:

[134] FRED, *supra* note 126.
[135] Hartley et al., *supra* note 20.
[136] *Id.*



[137]

A team of economists, confirming the increasing link between policyholder affluence and cash value ownership, also found that even after controlling for wealth, proxies for financial sophistication predict increased cash value ownership during this period.[138] But most shockingly, during this

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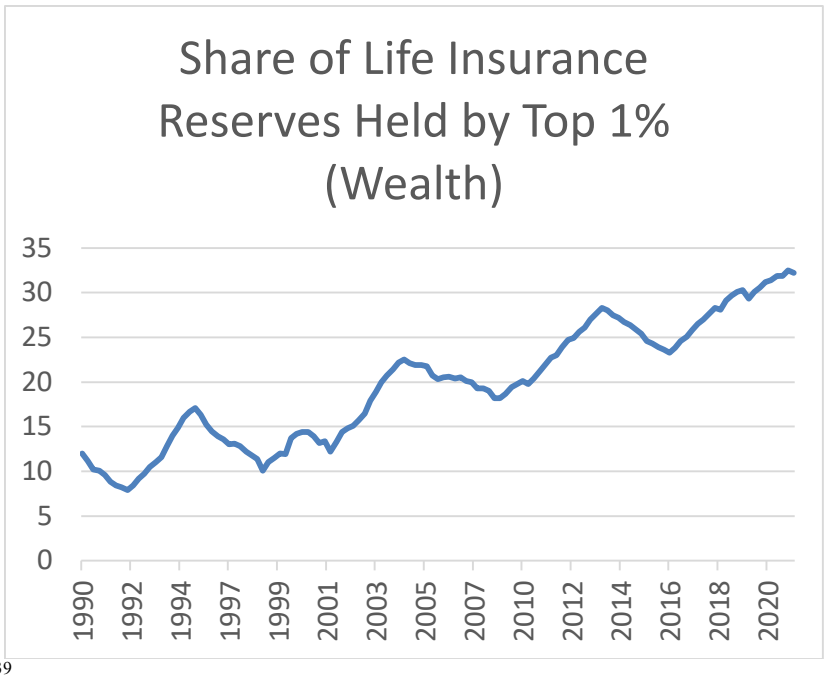
[137] *Survey of Consumer Finances, 1989-2019*, BD. GOVERNORS. FED. RSRV. SYS., https://www.federalreserve.gov/econres/scf/dataviz/scf/chart/#series:Cash_Value_Life_Insurance;demographic:nwcat;population:all;units:mean;range:1989,2019 (last visited Nov. 7, 2022).

[138] Proxies used, from the Survey of Consumer Finances, were "(1) willingness of the respondent to accept some financial risk, (2) whether the respondent revolves more than 50 percent of their credit card limit, (3) stock

same period, the share of life insurance reserves held by individuals in the top 1% of the wealth distribution skyrocketed from 13% at the end of the 1980s to an all-time high of 32% today.



[139]

In 2010, when the share of reserves held by the top 1% of the wealth distribution was at a then all-time-high of 22%, an article appeared in the Wall Street Journal covering nervousness in some insurance circles about the increasingly upscale nature of the industry once known for providing a safety net for working class and immigrant communities.[140] Multiple current and former insurance executives told reporters that they were concerned Congress would take another look at scaling back the industry's tax preferences, as it had considered doing in the 1980s, and that the industry

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ownership, and (4) the SCF interviewer's assessment of the respondent's understanding of personal finance." Mulholland et al., *supra* note 121.

[139] *Share of Life Insurance Reserves Held by the Top 1% (99th to 100th Wealth Percentiles)*, FRED, https://fred.stlouisfed.org/series/WFRBST01123 (last visited Nov. 7, 2022).

[140] Maremont & Scism, *supra* note 38.

would have less political clout to fight back.[141] As it turned out, the opposite would happen. The industry, now more financially dependent on elite customers shopping for maximally tax-efficient savings instruments, would have increased financial incentive to expand the scope of the life insurance tax exemption, and Congress would acquiesce without a fight.[142]

2. § 7702 Amended and the New Landscape of Cash Value Life

The 2020 amendment to § 7702 was passed in the omnibus Consolidated Appropriations Act of 2021 (CAA) on December 27, 2020.[143] The amendment was as follows: the 4% floor threshold for the simulated interest crediting rate used in the cash value accumulation test (CVAT) and guideline level premium (GLP) of the guideline premium test (GPT) was replaced by a new rate called the "applicable accumulation test minimum rate" (AATMA).[144] The 6% floor threshold of the guideline single premium (GSP) of the GPT was also replaced by a new rate called the "applicable guideline premium minimum rate" (AGPMR).[145] The AGPMR is simply the AATMA plus two percentage points,[146] so the difference between the GSP minimum simulated interest crediting rate and the corresponding rate for the CVAT and GLP remains the same as before. The significant change comes from replacing the previous 4% lower bound with the AATMA.

The statutory construction of the new AATMA is convoluted (a summary infographic of AATMA computation is at the end of this Section for simplicity), but its general structure is as follows. While previously, the interest crediting rate to be used in the CVAT and GLP was the rate guaranteed on issuance of the contract with a lower bound at 4%, as amended, the lower bound of the interest crediting rate used in the simulation is based on a formula involving a calculation of long-duration life insurance

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[141] *Id.*

[142] *See* discussion *infra* Sections II.B.2, III.C.

[143] Consolidated Appropriations Act of 2021, Pub. L. No. 116-260, § 205, 134 Stat. 1182 (2020) (amending I.R.C. § 7702). The legislative language of the amendment first appears in the proposed Health and Economic Recovery Omnibus Emergency Solutions Act (HEROES Act), which was formally introduced in the House on May 12, 2020. H.R. 6800, 116th Cong. § 40308 (2020). The language used in the HEROES Act and CAA is identical.

[144] § 205(a)(1), 134 Stat. (amending I.R.C. § 7702(b)(2)(A)); § 205(c)(1), 134 Stat. (amending I.R.C. § 7702(c)(4)).

[145] § 205(b)(1), 134 Stat. (amending I.R.C. § 7702(c)(3)(B)(iii)).

[146] *Id.* at § 205(b)(2) (amending I.R.C. § 7702(c)(3)(E)).

valuation interest rates and U.S. Treasury bond yields which maxes out at 4%.[147] The new formulation thus guarantees that the new minimum interest crediting rate for § 7702 simulation purposes will be at least as low as it was under the old formulation and will be substantially lower in low-interest-rate periods. The mechanical result of the change is that insurers will be able to sell life insurance products with a greater investment orientation and less net amount at risk in low-interest rate periods than they were under the previous § 7702 formulation.

The AATMA is defined as the lesser of "an annual effective rate of 4%" (the floor under the old calculation) and another new concept called the "insurance interest rate."[148] The insurance interest rate, in turn, is defined as the lesser of the "section 7702 valuation interest rate" for the year and the "section 7702 applicable Federal interest rate" for the year.[149]

The § 7702 valuation interest rate for a given year is "the prescribed U.S. valuation interest rate for life insurance with guaranteed durations of more than 20 years," as defined by the NAIC.[150] The valuation interest rate in this context is an assumption about the rate of return on investment of assets purchased with premiums for long-duration life insurance.[151] The NAIC, in an effort to help standardize reserve calculations, puts out a Valuation Manual, and its most recent update came out in 2021.[152] The valuation interest rate the NAIC employs is the output of a formula based on the recent monthly averages of the Moody's AAA (seasoned) corporate bond yield index.[153] As interest rates have declined, the relevant valuation interest rate has declined as well, to 3%.[154] The following infographic presents the calculation of the valuation interest rate: [155]

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[147] *Id.* at § 205(d) (adding I.R.C. § 7702(f)(11)).

[148] *Id.* at § 205(a)(3) (amending I.R.C. § 7702(b)(3)).

[149] *Id.* at § 205(d) (adding I.R.C. § 7702(f)(11)(A)).

[150] *Id.* at § 205(d) (adding I.R.C. § 7702(f)(11)(B)).

[151] AM. ACAD. OF ACTUARIES, ANNUITY RSRV. WORK GRP., REPORT OF THE ANNUITY RESERVE WORK GROUP TO THE NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS' LIFE AND HEALTH ACTUARIAL TASK FORCE 4 (2009).

[152] *See generally* NAT'L ASS'N INS. COMM'RS, VALUATION MANUAL (2021) [hereinafter Valuation Manual].

[153] WILLIS TOWERS WATSON, PRESCRIBED U.S. STATUTORY AND TAX INTEREST RATES FOR THE VALUATION OF LIFE INSURANCE AND ANNUITY PRODUCTS 4 (2020).

[154] *Id.* at 2.

[155] *See* Valuation Manual, *supra* note 152, at 20-13, 20-14.

Calculating the Valuation Interest Rate:

1. Per NAIC instructions, calculate, for each year:
   a. Valuation Interest Rate = .03 + W*(R1 - .03) + (W/2)*(R2 - .09).
      i. W = a weighting factor (.5 if guaranteed coverage duration is ten or less years, .45 if ten to twenty years, .35 if greater than twenty years).
      ii. R1 = the lesser of R and .09.
      iii. R2 = the greater of R and .09.
      iv. R = the lesser of the monthly average of the last 36 months of the Moody's AAA corporate bond index, ending on June 30 of the prior year, and the last 12 months of the same metric.
2. Round the result in each year to the nearest .25.
3. If the valuation interest rate for a year is only .25 different than that of the previous year, then the rate does not change from the previous year.

It should be noted that because the NAIC is an association of regulators tasked with the stability and preservation of the insurance system, its valuation methods, by its own description, are risk-averse and conservative.[156] In the 1980s, the NAIC's valuation interest rate formula produced a rate of only 6%—at a time when the Moody's AAA corporate bond yield index, on the conservative side of an insurer's general account investment portfolio, was about 9%. When corporate bond yields are below 9%, as they have been in every decade except the 1980s (using a data source that begins in the 1950s),[157] the valuation interest rate formula for long-duration polices simplifies to a quite low number, [.0195 + (the lesser of two averages of recent AAA yield rates * .35)], which does not even reach the actual AAA yield rate until the AAA yield rate hits 3%.[158] The choice of a formula employed elsewhere as highly cautious guidance to avoid future insurer insolvencies outwardly suggests seriousness and prudence but, in fact, encourages the development of policies that the industry feared were too feral in the 1980s.

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[156] *See* Valuation Manual, *supra* note 152, at 5 (explaining that "[r]eserve requirements prescribed in the Valuation Manual are intended to support a statutory objective conservative valuation to provide protection to policyholders and promote solvency of companies against adverse fluctuations in financial condition or operating results").

[157] FRED, *supra* note 131.

[158] Valuation Manual, *supra* note 152. As I = .03 + W*(R1 - .03) + (W/2) * (R2 - .09), when R < .09 the latter term in the formula goes to 0 and drops out (because R2 is the greater of R and .09). That leaves I = .03 + W*(R1 - .03) where R1=R and W=.35. Rearranging, the formula simplifies to I = .0195 + .35*R. To solve for the R where I = R, set I = R in I = .0195 + .35*R and simplify algebraically.

Turning to the other prong of the AATMA, the § 7702 applicable federal interest rate is the average, rounded to the nearest whole percentage point, of the "Federal mid-term rates" as of the beginning of the most recent 60 months ending the most recent year in which NAIC revises its valuation interest rate.[159] Federal mid-term rates are the yields of U.S. Treasuries with maturities of three to nine years, officially published every month by the I.R.S.

Again, as in the § 7702 valuation interest rate, the § 7702 applicable federal interest rate formula is structured to produce quite a small numerical outcome. Federal mid-term rates, which decrease in times of expansionary monetary policy, have been less than 4% since January 2008, bottoming out at 0.35% in September 2020.[160] Indeed, interest rates on government debts broadly, but particularly for U.S. Treasuries, have been at record lows (with some ebbs and flows) over the past two decades, with many economists theorizing that a "global savings glut" in countries like China has created a naturally lower equilibrium level of interest.[161]

It should be noted that this article was mainly written in the 2021 period of rock-bottom interest rates, but final edits to this article are being made in early November of 2022, a year that has seen substantial rate hikes (though the federal funds rate remains below already-low mid-2000s rates).[162] If rates continue to spike, because the § 7702 applicable federal interest rate will only update following a year in which the NAIC valuation interest rate changes, there will be a built-in lag for insurers to continue issuing policies using the lower floor. Since 2000, the NAIC has only changed its valuation rate three times (in 2006, 2013, and 2021)[163] because its formula has a built-in delay provision that requires a significant change

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[159] § 205(d), 134 Stat. (adding I.R.C. § 7702(f)(11)(C)).

[160] Rev. Rul. 2008-04, Table 1 I.R.B. 246; Rev. Rul. 2020-16, Table 1 I.R.B. 660; Rev. Rul. 2022-3, Table 1 I.R.B. 449. The federal mid-term rates for each month since January 2000 are available at https://www.irs.gov/applicable-federal-rates.

[161] *See generally* Ben Bernanke, The Global Saving Glut and the U.S. Current Account Deficit (2005), *in* FED. RSRV. BD.; Lawrence Summers, *U.S. Economic Prospects: Secular Stagnation, Hysteresis, and the Zero Lower Bound*, 49 BUS. ECONS. 65, 70–71 (2014).

[162] Jeff Cox, *Fed Approves .75-Point Hike to Take Rates to Highest Since 2008 and Hints at Change in Policy Ahead*, CNBC (Nov. 2, 2022), https://www.cnbc.com/2022/11/02/fed-hikes-by-another-three-quarters-of-a-point-taking-rates-to-the-highest-level-since-january-2008.html.

[163] WILLIS TOWERS WATSON, *supra* note 153, at 14.

in the Moody's AAA bond index before performing a recalculation.[164] Additionally, to reiterate, when the valuation rate does change, the recalculation of the § 7702 applicable federal interest rate will be computed using an average of the most recent five years ending in the December prior to the year of the change, giving the prior low interest rate period great ballast in weighing down the average in a period of rising rates. As with the § 7702 valuation interest rate, the § 7702 applicable federal interest rate ties itself to a common and relevant economic indicator that drives its outcome variable lower and enables the selling of life insurance with less actual insurance in it.

The new rules for § 7702 apply in full beginning in 2022; policies issued in 2021 used a bridge insurance interest rate of 2%.[165]

The following figure demonstrates what the AATMA would have been over the past fifteen years had it been enacted in 2006, as well as what the AATMA is in 2022:

[164] *See* Valuation Manual, *supra* note 152. To restate: the valuation interest rate is rounded to the nearest .25, and if the rate in the next year rounds to being only .25 away from the prior year's rate, then the valuation interest rate does not change. Thus, the new rate must be two units of .25 away in order for the rate to change.

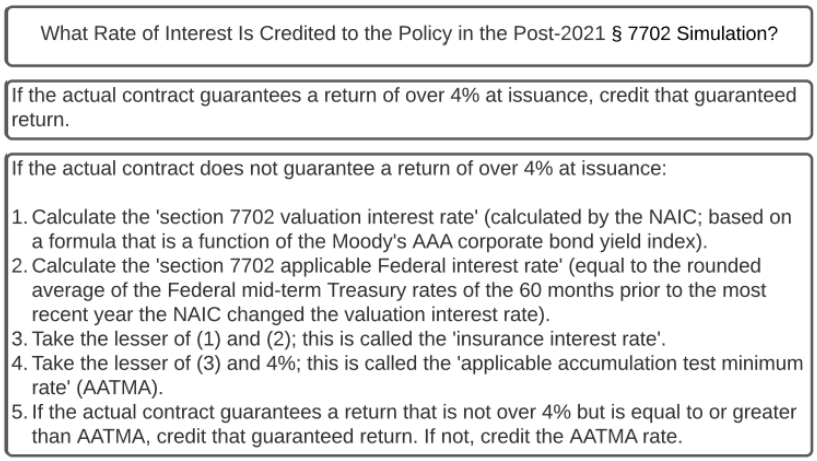
[165] Consolidated Appropriations Act of 2021, Pub. L. No. 116-260, § 205(d), 134 Stat. 1182 (2020) (adding I.R.C. § 7702(f)(11)(E)).

Minimum Allowed Interest Crediting Simulated Rate (CVAT, GLP)				
Year	Under Old 7702 Rule	Section 7702 Valuation Interest Rate	Section 7702 Applicable Federal Interest Rate	Applicable Accumulation Test Minimum Rate (under New 7702 rule)
2006	4%	4%	4%	4%
2007	4%	4%	4%	4%
2008	4%	4%	4%	4%
2009	4%	4%	4%	4%
2010	4%	4%	4%	4%
2011	4%	4%	4%	4%
2012	4%	4%	4%	4%
2013	4%	3.5%	2%	2%
2014	4%	3.5%	2%	2%
2015	4%	3.5%	2%	2%
2015	4%	3.5%	2%	2%
2016	4%	3.5%	2%	2%
2017	4%	3.5%	2%	2%
2018	4%	3.5%	2%	2%
2019	4%	3.5%	2%	2%
2020	4%	3.5%	2%	2%
2021	4%	3%	2%	2%
2022	4%	3%	2%	2%

As the above graphic illustrates, when the NAIC's valuation interest rate decreased by enough in 2013 to warrant a change in the § 7702 valuation interest rate, the resulting change in the § 7702 applicable federal interest rate would have been enough to cut the AATMA in half. Up until the actual enactment of the amendment, the AATMA would have remained at 2%, where it remains as of this writing in November 2022, substantially below the 4% minimum rate prescribed by the old § 7702 statute. The AGPMR, defined to be the AATMA plus two percentage points,[166] would have declined to 4% from 6%, and so would have been reduced by a third.

The following infographic summarizes the navigation of the 2020 § 7702 amendment for the CVAT and GLP tests:

[166] *Id.*



IV. § 7702 GOING FORWARD: FALLOUT AND IMPLICATIONS

This Article has contextualized the adoption of § 7702 as a political compromise made necessary by the economics and tax treatment of cash value life insurance. It has also covered the events that have taken place since then: the slow decline of the life insurance industry from near-universal prominence and the corresponding turn towards a role as a tax shelter for the affluent, and the significant amendment to § 7702 that was enacted in December 2020. But why was this amendment so consequential to § 7702 and (some) life insurance policyholders, and what does its passage illustrate about the new reality of the life insurance industry? Part III will cover the political economy implications of the 2020 amendment and why it crystallizes the industry's turn towards elite service. It will examine the impact that the 2020 amendment may have on future federal budget revenues, and why a Joint Committee on Taxation ten-year projection likely heavily understates its long-term impact. It will also examine the contrast between the passage of the original § 7702, which was a years-long public brawl, and the almost completely unnoticed nature of its amendment, which carries great implications for future design of legislation so as to avoid industry capture. Lastly, it will evaluate the amendment to § 7702 in the public policy context for life insurance's preferential tax treatment and conclude with policy recommendations to address the situation.

A. OPENING THE FLOODGATES: HOW § 7702'S AMENDMENT PUTS LIFE INSURANCE CLOSER TO CENTER STAGE OF TAX AVOIDANCE FOR THE WELL-OFF

1. The Impact of § 7702's Amendment on Cash Value Life Insurance as a Tax Shelter

a. expanding premium stuffing capability

How much less insurance is there required to be in a cash value insurance policy as a result of the change? As of this writing (November 7, 2022), the AATMA remains at 2%. The amount of cash value that a 45-year-old nonsmoking male could put into a whole life policy with a $225,000 face value, as measured by the net single premium, increases from $49,500 at an assumed 4% interest rate to $102,400 at an assumed 2% rate—more than doubling it.[167] (I use a $225,000 face value for the example because it is roughly the face value of the average life insurance policy; I will discuss later in this article that it is much higher face value policies owned by a small subset of policyholders that are likely to take full advantage of the policy change.)[168] For younger policyholders, the difference is even more dramatic, as the increase in net single premiums for a 25-year-old policyholder is from $25,300 to $72,100, nearly tripling the investment capacity of the policy.[169] My direct calculations match the estimates made by industry professionals; policies evaluated under the GP and CVCT tests experience increases in investment capacity only modestly less in magnitude.[170]

The following infographics illustrate the impact of the new 2% floor on net single premiums (and, therefore, on the amount of cash surrender value permitted by the CVAT) on a policy with a face value of $225,000 (a fairly typical policy) and a policy with a face value of $5,000,000 (an atypical policy owned by a wealthy policyholder):

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[167] Online Data and Calculations Appendix, *supra* note 92. Numbers are rounded to the nearest hundred.

[168] Hartley et al., *supra* note 20.

[169] *Id*.

[170] Phil Ferrari, et al., Product Tax and Company Tax Update, Society of Actuaries 2020 Virtual Annual Meeting & Exhibit 15 (2020); Alan Jadhe, *The New IRC 7702 Rules – Did Congress Make Life Insurance More Affordable?*, INVS. PREFERRED (Jan. 14, 2021), https://www.investorspreferred.com/irc7702rules; Michael Liebeskind & Bryan Bloom, *New Law Changes Interest Rate Assumptions for Life Insurance*, WEALTH MGMT., https://www.wealthmanagement.com/high-net-worth/new-law-changes-interest-rate-assumptions-life-insurance.

Impact of a 2% Assumed Interest Rate on Net Single Premiums

Employing the 2017 Commissioners Standard Ordinary unloaded mortality tables associated with a male nonsmoker, the net single premium for a newly issued whole life, policy with a level face amount of $225,000 is:

	If the policyholder is 25:	If the policyholder is 45:	If the policyholder is 65:
If the interest rate used is 6%:	$9,900	$25,500	$64,200
If the interest rate used is 4%:	$25,300	$49,500	$94,500
If the interest rate used is 2%:	$72,100	$102,400	$143,600

Impact of a 2% Assumed Interest Rate on Net Single Premiums

Employing the 2017 Commissioners Standard Ordinary unloaded mortality tables associated with a male nonsmoker, the net single premium for a newly issued whole life, policy with a level face amount of $5,000,000 is:

	If the policyholder is 25:	If the policyholder is 45:	If the policyholder is 65:
If the interest rate used is 6%:	$220,100	$567,200	$1,425,600
If the interest rate used is 4%:	$562,200	$1,100,400	$2,100,100
If the interest rate used is 2%:	$1,602,400	$2,276,200	$3,190,100

171

[171] Online Data and Calculations Appendix, *supra* note 92. Numbers are rounded to the nearest hundred.

An increase in investment capacity, because it increases as a ratio of the original capacity, delivers much higher absolute dollar increases of investment capacity to insurance policies with higher face values. As shown above, when dropping the assumed interest rate from 4% to 2%, the 25-year-old male nonsmoker who owns a $225,000 whole life policy will gain about $45,000 in cash value investment capacity, but the one who owns a $5,000,000 policy gains over a million dollars in such capacity. Therefore, the more a person chooses to invest in life insurance, the more valuable the 2020 amendment is to that person. The structure of the amendment creates a self-reinforcing cycle to attract very high net worth individuals to the insurance sector.

The main data source for tracking estimates of the amount of actual cash value people have in cash value life insurance is the Survey of Consumer Finances.[172] The survey is performed every three years and is next scheduled to be released in 2023,[173] at which point policymakers will be able to observe more directly the level of shift into cash value policies that results from the change. Fairly broad insurance sales data from 2021 reports record-breaking sales of new policies,[174] including "a 6.2% increase in the number of whole life policies . . . making the first positive result since 2016" and a 17.1% increase in the "aggregate amount of insurance issued under whole life policies and endowments . . . which stands as the highest year-over-year rate of expansion since 1997."[175] More time and more detailed data will be required to thoroughly evaluate the causal impact of the amendment on sales of the § 7702 change, especially in light of the COVID-19 pandemic, but preliminary evidence suggests a cash value life surge.

b. a conceptual note on premium stuffing

A skeptical observer may ask here, following the previous subsection on the impact of the new rules permitting more cash value to be

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[172] Hartley et al., *supra* note 20 (employing data from this survey).

[173] BD. GOVERNORS FED. RSRV. SYS., FR 3059; OMB No. 7100-0287, SUPPORTING STATEMENT FOR THE SURVEY OF CONSUMER FINANCES (2021).

[174] *LIMRA: First Quarter U.S. Life Insurance Policy Sales Highest Since 1983*, LIMRA (May 27, 2021), https://www.limra.com/en/newsroom/news-releases/2021/limra-first-quarter-u.s.-life-insurance-policy-sales-highest-since-1983/.

[175] Tim Zawacki, *Historic 2021 US individual life, annuity premium growth a tough act to follow*, S&P GLOB. MKT. IINTEL. (Mar. 22, 2022), https://www.spglobal.com/marketintelligence/en/news-insights/research/historic-2021-us-individual-life-annuity-premium-growth-a-tough-act-to-follow.

put inside of a given policy, why would that matter to a wealthy person seeking to minimize taxes? If an affluent policyholder wants to increase the amount of cash value it owns, which is subject to highly favorable tax treatment, why couldn't the policyholder simply purchase a larger policy, one where the death benefit would be sufficiently large so as to enable the desired amount of premiums to fit within the § 7702 rules? After all, § 7702's restrictions are relative to "the future benefits under the contract,"[176] and it is true that a person with sufficient resources could afford to purchase a life insurance policy with an extremely high death benefit.[177]

Simply ratcheting up the death benefit of the policy so as to allow for additional premiums and investment capacity, however, is costly.[178] As covered in the explanation of cash value life, insurers charge policyholders fees that correspond to the actuarial cost of the policy, which in turn corresponds to the returns the life insurer is receiving on its investments, the risk that the insurer will have to make a death benefit payout, and the amount of payout that the insurer would have to make.[179] For a given death benefit, when the cash value inside of a policy increases, the net value at risk to the insurer decreases, translating into an (all else equal) lower fee to the policyholder. But when a policy has a higher death benefit, the net value at risk to the insurer increases, requiring higher fees to sustain the policy.

Because the 2020 § 7702 change allows for more premiums to be placed into the policy when AATMA is below 4%, that structure increases the relative attractiveness of cash value policies because the policyholder may make those tax-advantaged contributions while actually lowering the net value at risk to the insurer. This dynamic results in lower fees, which in turn results in faster cash value accumulation *on top of* the higher permitted premium contribution.

In sum, the § 7702 amendment enables insurers to claim favorable tax treatment for products that have moved substantially closer to simply being a mutual fund rather than a term life insurance policy. Policyholders cannot replicate the effect of the amendment by simply purchasing a cash value policy with a higher death benefit alone.

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[176] I.R.C. § 7702(b)(1); I.R.C. § 7702(c)(3)(A).

[177] The Guinness Book of World Records reports that the most valuable life insurance policy in the world has a face value of $201 million. *Mystery Billionaire Takes Out Historic $201 Million Life Insurance Policy*, GUINNESS WORLD RECS. (Mar. 13, 2014), https://www.guinnessworldrecords.com/news/2014/3/mystery-billionaire-takes-out-historic-$201-million-life-insurance-policy-56096.

[178] *See supra* Section I.A.

[179] Pike, *supra* note 7, at 497.

2. The New Political Economy of the Life Insurance Industry

This article has covered the empirical evidence of the increasing reliance of the life insurance industry on elite clientele[180] and the § 7702 amendment's bearing on making cash value an increasing suitable product for tax avoidance.[181] This section on the life insurance industry's ongoing transformation into a more unambiguous vehicle for tax avoidance by the affluent includes with three remarks: first, an analysis of the life insurance industry's argument for the amendment; second, an illustration of the industry's embrace of explicitly patrician private placement life insurance; and third, a contrast with the insurance industry's behavior during the 1980s.

a. industry justification for the § 7702 change

To the extent that the industry has offered a public justification for the § 7702 amendment in the months after its passage, it has argued that the decrease of the required interest crediting rates for § 7702 testing purposes is a technical change made necessary by the collapse in interest rates. ACLI Senior Vice President of Policy Development Paul Graham told the Wall Street Journal that insurer yields "dropped to the point they were bumping up against their ability to pay that 4% interest rate on their policies," and that without the amendment, "whole life as we knew it would be severely compromised and may no longer exist."[182] An ACLI talking points list on the amendment criticizes the "hard-coded interest rates" of the old test, which it emphasizes were written, "when interest rates were 10 percent and higher."[183]

While it is true that life insurer financials have taken a beating from the low interest rate era, this explanation performs a slight of hand. As covered earlier, the previous 4% and 6% § 7702 interest rate floors were not restrictions on actual insurance policies, but were actuarial guardrails solely used for § 7702 simulation testing purposes to make sure that a policy did not have an excessive orientation towards investment rather than actual

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[180] *See supra* Section II.B.1.

[181] *See supra* Section III.A.1.

[182] Leslie Scism, *A Small Tax Change Is a Boon for Permanent Life Insurance*, WALL ST. J. (Jan. 10, 2021), https://www.wsj.com/articles/a-small-tax-change-is-a-boon-for-permanent-life-insurance-11610283602.

[183] AM. COUNCIL LIFE INSURERS, CONSOLIDATED APPROPRIATIONS ACT UPDATES TO INTERNAL REVENUE CODE SECTION 7702, at 1–2 (2021) [hereinafter ACLI Talking Points].

insurance.[184] At no point did § 7702 mandate that a life insurance policy offer any specific minimum return to a policyholder, at 4% or any other threshold. The previous 4% floor was a political compromise to mechanically cap the level of investment orientation rather than insurance orientation that a cash value policy could have.[185]

The ACLI's talking points sheet also argues that "the changes will benefit all consumers by ensuring appropriate and actuarially sound relationships between cash value and premium limits to death benefits in very low interest rate environments."[186] Again, this point is incomplete and misleading. The § 7702 amendment impacts all cash value policies, but the ACLI knows that cash value insurance has already become a product line strongly weighted towards the wealthy, that few middle-and-lower income households purchase cash value policies, and that the middle-and-lower income households who do have them have relatively little savings stored in those policies.[187] Middle and upper-middle class households tend to put more savings into other tax-advantaged vehicles like IRAs and 401(k) plans, which roughly half of American households use.[188] Policyholders of term life insurance, who represent a broader cross-section of the American public,[189] are unaffected by the amendment. Lastly, the structure of the amendment, because it increases cash value investment capacity as a ratio of the prior capacity, offers augmented rewards to very high net worth policyholders who have the means to purchase policies with even higher face values.[190]

Lastly, the ACLI talking points include an argument that the cash value corridor, because it remains unchanged, "safeguards the integrity of life insurance from being used as an investment product."[191] However, the cash value corridor only applies to policies evaluated under the GPT and CVCT dual test, not the CVAT test.[192] Additionally, while it is true that the cash value corridor sets an age-based maximum ratio of accumulated cash value to death benefit for a policy, it is the GPT that sets limits on policyholders' ability under the dual test to take advantage of the flexibility in premium payments of universal life to simply contribute the maximum

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[184] *See supra* Section II.A.

[185] Harman, *supra* note 64.

[186] ACLI Talking Points, *supra* note 183, at 2.

[187] *See supra* Section II.B.1.

[188] CHERYL R. COOPER & ZHE LI, CONG. RSCH. SERV., RL 46441, SAVING FOR RETIREMENT: HOUSEHOLD DECISIONMAKING AND POLICY OPTIONS 5 (2020).

[189] Hartley et al., *supra* note 20.

[190] *See supra* Section III.A.1.a.

[191] ACLI Talking Points, *supra* note 183, at 2.

[192] I.R.C. § 7702(a).

amount of money the CVCT allows up front and let interest take the wheel.[193] The CVCT is still enforced, but the changes to the GPT permit policyholders substantially more freedom to reach those outer limits, as industry members acknowledge.[194]

The villain for life insurers in this story is the low interest rate environment, which, unlike the old rules of § 7702, poses genuine difficulty for policyholders and providers. In a prolonged low interest rate period, to sustain a policy, policyholders will be required to contribute additional premiums so that the premiums can support the contractual death benefit. The requirement to put in additional money to sustain the same policy, or to be told up front that more payments will be required in order to establish a contract, reduces the appeal of cash value life.[195] One might feel sympathy for businesses put in this position, where their profitability depends substantially on interest rates that are out of their control and that have presented significant difficulty for years, but it does not follow that the appropriate policy response is to permit the insurance industry to sell tax-advantaged products with less insurance in them.

b. private placement life insurance and the turn towards elite professional service

The impact of the § 7702 amendment will likely be seen most starkly in the areas of insurance that exemplify the industry's trend away from mass-market policies and towards tax-aggressive products aimed at the wealthy. Private placement life insurance (PPLI) is a prominent example. PPLI, a subtype of variable universal life insurance (a type of universal life in which the bulk of the premiums are invested in insurer-approved asset classes and the policyholder assumes more risk), requires individualized negotiation with an insurance provider.[196] The distinguishing feature of PPLI is that

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[193] *See supra* Section II.A.2.

[194] Stu Kwassman, *Recent Change to IRC § 7702 Interest Rates and Impact on Life Insurance Products*, SOC'Y ACTUARIES (Feb. 2021), https://www.soa.org/sections/product-dev/product-dev-newsletter/2021/february/pm-2021-02-kwassman/.

[195] Scism, *supra* note 182.

[196] PPLI should not be confused with private placements as a whole, as the general term "private placement" usually only refers to a sale of securities in a manner that is exempt from registration with the Securities and Exchange Commission. *Private Placements Under Regulation D*, SEC, https://www.sec.gov/oiea/investor-alerts-bulletins/ib_privateplacements (June 10, 2022).

while most variable universal life policies have a fairly limited selection of assets and funds in which the policyholder can invest, PPLI enables policyholders to invest in highly specialized asset classes, most notably hedge funds.[197]

The main restriction on PPLI is that, under the "investor control doctrine," the assets of a life insurance policy are required to be considered owned by the insurer, not the policyholder, for life insurance tax treatment to apply.[198] A PPLI policyholder cannot therefore have full control over the asset allocation of the policy, though the exact degree of control possible has been contested and the policyholder may select the investment manager, and make initial asset allocations.[199] A PPLI policy must also meet certain investment diversification requirements under I.R.C. § 817.[200]

PPLI providers have long been quite open about the fact that the industry is aimed at eliminating the capital gains taxation of wealthy clients by letting them invest in hedge funds and other specialty investments tax-free. For example, PPLI provider Cohn Financial Group says on its website, "PPLI is designed as a tax efficient instrument, with the death benefit being secondary."[201] Purchasers of PPLI must meet the definitions of "qualified purchaser" and "accredited investor" under federal securities law (essentially, be a multimillionaire)[202] and are generally limited to policyholders who pay over $1 million in premiums.[203]

Information about the scale of the PPLI industry is very limited. In 2006, when the industry was still navigating relatively recent I.R.S. rulings

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[197] Scott A. Bowman & Nathan R. Brown, *A Primer on Private Placement Life Insurance*, 88 FLA. BAR J. 52, 52 (2014).

[198] *See* Rev. Rul. 77-85, 1977-1 C.B. 12; *Christoffersen v. United States*, 749 F.2d 513 (8th Cir. 1985); *Webber v. C.I.R.*, 144 T.C. 324, 325–26 (2015).

[199] Bowman & Brown, *supra* note 197 (citing Rev. Rul. 2003-92; 2003-2 CB 350; Rev. Rul. 2003-91; 2003-2 CB 347; I.R.S. Priv. Ltr. Rul. 200244001; I.R.S. Priv. Ltr. Rul. 9752061).

[200] I.R.C. § 817(h); Treas. Reg. § 1.817-5(a)(1).

[201] *Private Placement Investing*, COHN FIN. GRP., https://cfgllc.com/our-expertise/private-placement-investing/ (last visited Nov. 7, 2022).

[202] Bowman & Brown, *supra* note 197. The definition of an "accredited investor" is complex, but an individual may qualify by having a net worth of over $1 million or an income of over $200,000 a year for the past two years. 17 C.F.R. § 230.501 (2020). An individual can clear the definition of a "qualified investor" by owning $5 million in investments. 15 U.S.C. § 80a-2(a)(51)(A).

[203] Rachel E. Silverman, *Insuring Against Hedge Fund Taxes*, WALL ST. J. (Oct. 18, 2006, 12:01 AM), https://www.wsj.com/articles/SB116113678252396059.

that finally clarified the nature of the investor control doctrine,[204] "industry watchers" estimated to the Wall Street Journal that the size of the onshore PPLI market was a relatively small $4-5 billion.[205] Though small in 2006, PPLI was already attracting the attention of insurance giants like AIG, which offered forty PPLI investment options (called insurance dedicated funds, or IDFs).[206] Today, though individual information on PPLI administration is quite difficult to find publicly, there is evidence that it is increasingly widespread, and not just among niche firms.[207] One PPLI firm boasts that it administers IDFs attached to policies at heavyweights like John Hancock, Mass Mutual, Nationwide, New York Life, Pacific Life, and more.[208] Other major insurers like Prudential and Zurich offer PPLI products as well.[209]

While likely still a relatively small portion of the market (there are only so many people who can clear the securities regulation hurdles for entry), it is also likely that PPLI and structures like it will be the biggest winners of the § 7702 amendment. Six months after its passage, the chief life actuary of Zurich North America told insurance credit rating agency AM Best that his firm "is very active in the high net worth market, where signs point to the changes having the biggest effect."[210]

c. The New Life Insurance Political Normal

This Article emphasized, in my retelling of the enactment of § 7702, the role of respected life insurance firms in persuading Congress that life insurance's favored tax treatment should be kept in favor of casting out the most investment-oriented policies.[211] It was the major life insurance incumbents, after all, that had lobbied Congress to pass the precursor to §

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[204] Bowman & Brown, *supra* note 197.

[205] Silverman, *supra* note 203.

[206] *Id.*

[207] Heather Perlberg & Ben Steverman, *Blackstone's Tax-Free Hedge Fund Pitch Woos More Clients,* BLOOMBERG BUS. NEWS (May 29, 2018, 10:08 AM), https://www.bloomberg.com/news/articles/2018-05-29/blackstone-s-tax-free-hedge-fund-pitch-woos-even-more-clients.

[208] *Insurance Companies*, SALI FUND SERVS., https://www.sali.com/insurance-companies/ (last visited Nov. 7, 2021).

[209] Perlberg & Steverman, *supra* note 207; Robert D. Colvin & Michael B. Liebeskind, Introduction to Private Placement Life Insurance (PPLI) (2017).

[210] Terrence Dopp, *US Tax Changes Could Make Life Insurance More Popular*, BEST'S REV. (June 2021), https://news.ambest.com/articlecontent.aspx?refnum=308709&altsrc=2.

[211] *See supra* notes 58–75 and accompanying text.

7702 in the first place, and that had told Congress that some of their brethren had gone too far with offering policies with excessive investment orientations.[212]

Circa 2022, the coalition of the 1980s has shifted dramatically. At least three of the surviving firms that were on the Mutual Company Executive Committee that was so crucial at the 1983 Congressional hearings now offer PPLI.[213] The low interest rate period and transition away from the mass market and towards niche client services for the wealthy has left the industry with little appetite for the defensive political maneuvering of the § 7702 enactment era. And the industry is willing to spend. Per data from the Senate Office of Public Records, in 2020 the life insurance industry spent over $68 million in formally disclosed lobbying, making it one of the most donation-heavy sectors.[214] While it is difficult to discern what fraction of that spending was specifically done on § 7702 (many disclosure reports on specific lobbying issues employ phrases like "tax issues of importance to company" or "issues related to tax reform," which are unclear), it is immediately clear that the § 7702 reform was a focal point for the sector. One insurer, New York Life, spent $2.74 million alone in 2020 on "issues related to section 7702 of the Internal Revenue Code."[215] The ACLI does not fully disaggregate its spending and lobbies on a variety of issues, but it reports spending $3.7 million in total in 2020 on matters including § 7702 and the HEROES Act.[216]

The industry is emboldened by a supportive audience. The Chair of the House and Ways Committee and Chair of the Joint Committee on Taxation during 2020 was Democrat Richard Neal of Massachusetts (as of November 7, 2022, Neal remains in those positions). Neal, whose district

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[212] 1983 Hearings, *supra* note 67.

[213] John Hancock, Massachusetts Mutual, and Prudential.

[214] *Summary: Top Contributors, 2021-2022*, OPEN SECRETS, https://www.opensecrets.org/industries/indus.php?ind=F09 (last visited Nov. 7, 2022). Lobbying reports made to the Senate Office of Public Records filed pursuant to the Lobbying Disclosure Act of 1995 are most easily available via Open Secrets. The "Insurance" industry is listed as making $154 million in contributions in 2020, but this category also includes property & casualty and health insurance firms and lobbying organizations. To calculate the $68 million figure, I manually went through the Open Secrets list of insurance organizations that donated over $1 million in 2020 and separated out insurers that have a life insurance line of business and lobbying groups that include life insurance firms, agents, or brokers.

[215] *Id.* New York Life spent $1.25 million on the issue in 2020Q1, $540,000 in Q2, $370,000 in Q3, and $580,000 in Q4.

[216] *Id.*

includes the headquarters of Massachusetts Mutual, has received more contributions from the insurance sector than any other industry for decades.[217] Neal, also the co-chair of the House Financial Security and Life Insurance Caucus, co-won the 2016 Financial Security & Life Insurance Champion Award from the ACLI.[218] Seven months before the § 7702 amendment was formally proposed, Neal attracted controversy for presiding over a "centennial congressional reception" for the 100th anniversary of life insurer and 2008 congressional bailout recipient AIG, hosted in the hearing room of the Ways and Means Committee.[219]

Given current congressional leadership, there seems to be little congressional pressure to halt the life insurance sector's slow transition away from its cautious 1980s attitude. The economic factors that have eroded traditional mass-market life insurance business lines and pushed the sector towards high-net-worth tax planning, as well as political actors who are disinclined to interfere, have resulted in an ever-more aggressive embrace by the industry of its new role.

B. THE IMPACT OF THE § 7702 AMENDMENT ON FEDERAL TAX REVENUES

1. In the Long Run, We Are All Dead

The § 7702 amendment is likely to deprive the Treasury of billions of dollars in revenue each year, but its full financial impact is likely understated by existing analysis. When the text of the § 7702 amendment first appeared, it did so in the Health and Economic Recovery Omnibus Emergency Solutions Act (HEROES Act)—a House Democratic-supported bill—before being passed into law by the CAA.[220] The Joint Committee on

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[217] *Richard E Neal: Summary*, OPEN SECRETS, https://www.opensecrets.org/members-of-congress/richard-e-neal/summary?cid=N00000153&cycle=2020&type=C (last visited Nov. 7, 2022).

[218] *Reps. Tiberi, Neal Receive Financial Security and Life Insurance Champion Award*, ACLI (January 31, 2017), https://neal.house.gov/media-center/in-the-news/reps-tiberi-neal-receive-financial-security-and-life-insurance-champion (last visited Nov. 7, 2022).

[219] Zachary Warmbrodt, *A Decade After Massive Bailout, AIG Celebrated on Capitol Hill*, POLITICO (Oct. 28, 2019), https://www.politico.com/news/2019/10/28/a-decade-after-massive-bailout-aig-celebrated-on-capitol-hill-060851.

[220] H.R. 6800, 116th Cong. § 40308 (2020). The HEROES Act was sponsored by former Representative Nita Lowey (D-MA).

Taxation (JCT) released an analysis[221] that projected that the passage of the amendment would reduce federal income tax revenues by $3.3 billion over ten years,[222] a small additional amount relative to the hundreds of billions in tax subsidy to the industry in previously existing policy.[223] This Article will argue here that this figure, if viewed in the proper context, does not actually demonstrate that the impact of the amendment will be quite modest, at least for the numerically small clientele who are best positioned to take advantage of it.

A ten-year budget window is likely to give a misleading impression of the long-term impact of a provision like the 2020 § 7702 amendment. The amendment is a change to actuarial assumptions used in interest rates, enabling increased premium stuffing into tax-exempt cash value policies. This means that in each year following the passage of the amendment, the budgetary impact of the passage of the law will be in the taxes not collected on the additional amount of premiums going into cash value policies that would otherwise have produced taxable income.

Life insurance policies are not structured to deliver the bulk of their tax savings up front. Single premium policies are highly discouraged because, as covered above, they would be subject to modified endowment contract restrictions and not receive the full tax benefits of life insurance.[224] Flexible, rising, or level premium policies, which are the norm in cash value insurance, are structures in which payments are made over the course of many years. The tax savings from the credit interest are savings that will

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[221] The JCT is a Congressional committee made up of an equal number of House and Senate members and has a nonpartisan staff. The staff conducts analysis of the budgetary impact of proposed legislation and is required to do so over a ten-year budget window. JCT estimates proceed on the assumptions that Gross National Product is fixed and that all other law remains the same, and take into account likely taxpayer behavioral reactions to the proposed laws. *Revenue Estimating*, J. COMM. TAX'N, https://www.jct.gov/operations/revenue-estimating/ (last visited Nov. 7, 2022).

[222] J. Comm. on Tax'n, 116th Cong., JCX-16-20, at 4 (2020) (referencing the "minimum rate of interest for certain determinations related to life insurance contracts"). The JCT additionally released an analysis of the cost of a subsequent version of the bill and of the CAA that had an essentially identical analysis of the provision. J. Comm. on Tax'n, 116th Cong., JCX-21-20 (2020); J. Comm. on Tax'n, 116th Cong. JCX-24-20 (2020).

[223] U.S. DEP'T TREASURY OFF. TAX ANALYSIS, *supra* note 51, at 1 n.2 (2016).

[224] I.R.C. § 7702A. *See supra* text accompanying note 116.

come from compounding, which are small for quite a while before growing to become massive.[225]

Additionally, during each year of the policy that the policyholder is alive, the tax savings correspond only to the tax savings on the inside buildup. It is, of course, when the policyholder dies that the untaxed death benefit is bestowed (or, if the policyholder hits an age such as 95, the untaxed cash value is returned).[226] The death benefit is a payout far larger than any year of inside buildup, but the median age of a life insurance policyholder is about 48,[227] and the percentage of current policyholders who will die during the next decade is relatively small. Reduced revenues from an increasing number of tax-exempt death benefits will take a long time.

Lastly, as covered earlier, older cash value policyholders also gain relatively little from the § 7702 amendment—it is the youngest generations, policyholders under 40, who are most enabled to open the floodgates with premium stuffing.[228]

While the JCT report does not contain an explanation of its calculations, this trend can also be seen in the year-by-year breakdown it provides. The JCT projected the § 7702 amendment to only cost $8 million in 2021, but each year it increases steadily until 2030 (the final year analyzed), when JCT projects the amendment to cost $791 million.[229] That number will only grow with each passing year. While it is true that the deficit impact of the amendment will be blunted because the principal benefits of the change flow to only the few with the resources to buy very high face value policies, there is also a possible policy change that will open the floodgates into life insurance: repeal of stepped-up basis.

2. Stepped-Up Basis Reform and the Life Insurance Escape Hatch

Stepped-up basis functions as follows. Because capital gains on taxable assets are not considered income until the asset is sold or exchanged,[230] and because the tax basis of property (the starting point from which capital gain is measured) resets to the fair market value when the

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[225] Daniel Hemel, *Tax 101: The Problem of Life Insurance*, SUBSTANCE OVER FORM (May 3, 2021), https://substanceoverform.substack.com/p/tax-101-the-problem-of-life-insurance.

[226] *See* DESROCHERS ET AL., *supra* note 7, at 69.

[227] Hartley et al., *supra* note 20.

[228] *See supra* Section III.A.1.a.

[229] Joint Comm. On Tax'n, 116th Cong., JCX-16-20, at 4 (2020).

[230] I.R.C. § 1001(a)–(b).

owner dies and the property is transferred to its new owner (the "stepped-up basis"),[231] holding on to assets for life and then passing them on through inheritance is highly tax-advantaged. Consequently, many wealthy people employ a tax-minimization strategy with the shorthand "buy, borrow, die."[232] This strategy of relying on loans (with tax-deductible interest) backed by high levels of assets (which lowers the interest payments) instead of selling the assets for liquid cash has proven to be spectacularly successful at helping the extremely affluent cut tax rates, often to single-digits or flatly zero.[233]

In 2021, President Biden proposed a tax plan that would increase long-term capital gains tax rates to ordinary income rates and functionally eliminate stepped-up basis on individuals who earn more than $1 million a year, a severe threat to the "buy, borrow, die" strategy.[234] The threat of ending stepped-up basis is of huge benefit to the life insurance industry because assets delivered by a death benefit from a life insurance policy would be unaffected by such a change: life insurance payouts are untaxed transfers of cash and/or assets to a beneficiary that occur upon death, so they can be thought of as having a de facto step-up in basis, independent of the stepped-up basis provision of the tax code.[235] As tax treatment on most investments would become harsher by ending the formal step-up in basis, life insurance would become much more attractive as a vehicle for passing on wealth. While stepped-up basis repeal was dropped from Biden's plan in Congress,[236] the mere raising of the issue represents a significant new policy

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[231] I.R.C. § 1014(a).

[232] *See generally* Edward McCaffery, *Taxing Wealth Seriously*, 70 TAX L. REV. 305, 306 (2017); Rachel L. Ensign & Richard Rubin, *Buy, Borrow, Die: How Rich Americans Live Off Their Paper Wealth*, WALL ST. J. (July 13, 2021), https://www.wsj.com/articles/buy-borrow-die-how-rich-americans-live-off-their-paper-wealth-11625909583.

[233] Jesse Eisinger, et al., *The Secret IRS Files: Trove of Never-Before-Seen Records Reveal How the Wealthiest Avoid Income Tax*, PROPUBLICA (June 8, 2021), https://www.propublica.org/article/the-secret-irs-files-trove-of-never-before-seen-records-reveal-how-the-wealthiest-avoid-income-tax.

[234] DEP'T TREAS., GENERAL EXPLANATIONS OF THE ADMINISTRATION'S FISCAL YEAR 2022 REVENUE PROPOSALS 62 (2021), https://home.treasury.gov/system/files/131/General-Explanations-FY2022.pdf.

[235] Hemel, *supra* note 225. *See also* Trevor J. Hamilton, *Private Placement Life Insurance: A Potential Tool for Tax Efficiency and Wealth Transfer*, BESSEMER TR. 2–3 (2019), https://www.bessemertrust.com/sites/default/files/2019-04/04_30_19_BT_CL_PrivatePlacementLifeInsurance.pdf.

[236] Kate Dore, *House Democrats' plan drops repeal of a tax provision for inheritances*, CNBC (Sept. 13, 2021 3:46 PM),

direction, and should a future administration succeed in pursuing it, the sky is the limit as to how much money will come pouring in to cash value policies.

C. STATUTORY ASSEMBLY AND THE STRUCTURAL FLAWS OF § 7702

The adoption of § 7702 followed years of public debate, a two-year stopgap bill, and multiple congressional hearings.[237] The 2020 amendment to § 7702, by contrast, involved essentially no public debate or public advance notice. This article argues that the manner in which the amendment was passed showcases a weakness in § 7702's structure: the statutory provision exists at the nexus of several issues, including statutory complexity and the submerged state, that makes it extremely vulnerable to legislative capture. Further, the article argues that almost total lack of controversy about the amendment's successful passage unfortunately presents special interests with a powerful playbook for achieving their agendas.

1. In the Dead of Night: Amending § 7702 Without Anyone Noticing

The § 7702 amendment was originally introduced in the House in May 2020 in the anthology COVID-19 aid package proposal, the Health and Economic Recovery Omnibus Emergency Solutions (HEROES) Act,[238] and later signed into law in the omnibus CAA on December 27, 2020.[239] Other than the text of the bills, there is no mention of the proposed change in the congressional record, including floor debates.[240]

A search on Google News for news articles including the text strings "7702" and "life insurance" published between January 1, 2020 and

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https://www.cnbc.com/2021/09/13/house-democrats-plan-drops-repeal-of-a-tax-provision-for-inheritances.html.

[237] *See supra* Section I.B.2.

[238] Health and Economic Recovery Omnibus Emergency Solutions Act, H.R. 6800, 166th Cong. § 40308 (2020).

[239] Consolidated Appropriations Act of 2021, Pub. L. No. 116-260, § 205, 134 Stat. 1182 (2020) (enacted) (adding to I.R.C. § 7702).

[240] CONGRESS.GOV, https://www.congress.gov/search?q=%7B%22source%22%3A%22congrecord%22%2C%22search%22%3A%227702%22%2C%22congress%22%3A%5B%22116%22%2C117%5D%7D (last visited Nov. 7, 2022).

December 26, 2020[241] yields only *two* results with any reference to an amendment,[242] both of which were published on December 22—the day after the bill cleared both houses of Congress.[243] Neither was in a newspaper. The first (and, as of this writing, only) time any reference to the change appears in the Wall Street Journal, the flagship paper of corporate America, is on January 10, 2021, weeks after the law was passed.[244] As of November 7, 2022, no article in the New York Times mentions the change at all.[245] The few other scattered mentions of the possibility of a change that can be found online at all from 2020 are brief mentions by insurance services firms and organizations,[246] the text of the bills themselves, and the JCT financial analysis of the HEROES Act.[247]

As far as anyone who was not specifically working on the change and a few members of the industry knew, there was no reason to suspect an impending substantive change to a provision that had been the subject of a

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[241] GOOGLE, https://www.google.com/search?q=%227702%22+%22life+insurance%22&tbs=cdr:1,cd_min:1/1/2020,cd_max:12/26/2020&tbm=nws&ei=Db8YYZOmOtXctQapt6i4Bw&start=0&sa=N&ved=2ahUKEwjT4IrKvbLyAhVVbs0KHakbCnc4ChDx0wN6BAgHEDQ&biw=1440&bih=720&dpr=1, (last visited Nov. 7, 2022).

[242] Allison Bell, *CAA 2021 Package Includes Life Insurance Interest Rate Provision*, THINKADVISOR (Dec. 22, 2020, 5:44 PM), https://www.thinkadvisor.com/2020/12/22/cca-2021-package-includes-life-insurance-interest-rate-provision/; Alistair M. Nevius, *Many Tax Provisions Appear in Year-End Coronavirus Relief Bill*, J. ACCOUNTANCY, https://www.journalofaccountancy.com/news/2020/dec/tax-provisions-in-covid-19-relief-bill-ppp-and-business-meal-deductibility.html (Dec. 27, 2020).

[243] § 205, 134 Stat. 1182.

[244] Scism, *supra* note 182.

[245] N.Y. TIMES, https://www.nytimes.com/search?dropmab=false&endDate=20221107&query=%22life%20insurance%22%20%22tax%22&sort=best&startDate=20200101(last visited Nov. 7, 2022).

[246] Howard Bard, et al., *ACLI Update*, TAXING TIMES (June 2020), https://sections.soa.org/publication/?m=59625&i=664796&view=articleBrowser&article_id=3705178; *House Democrats unveil HEROES Act coronavirus bill*, EY (May 13, 2020), https://taxnews.ey.com/news/2020-1277-house-democrats-unveil-heroes-act-coronavirus-bill; Ferrari et al., *supra* note 170; Alex Brosseau, et al., *House OKs smaller recovery package as Pelosi-Mnuchin Talks Falter*, DELOITTE TAX LLP (Oct. 2, 2020), https://web.archive.org/web/20220121112505/https://newsletters.usdbriefs.com/2020/Tax/TNV/201002_1.html.

[247] H.R. Rep., 116th Cong., JCX-16-20, at 4.

maelstrom to get enacted. Andrew Pike, the scholar and author of the definitive law review article on § 7702 after it was enacted in the 1980s, had not been informed that there was an amendment in the works, let alone that it had passed, until I emailed him, asking to discuss his article.

2. Uncontroversial: Why Was There No Noise about the § 7702 Amendment?

The passage of the 2020 § 7702 amendment is at the intersection of many different strands of law and political science that focus on legislative viability and resiliency. Several factors led to the invisibility of this highly consequential change, and from these factors emerges a playbook that any interest group could attempt to use.

First, the provision was a drop in the bucket compared to the aggregate legislation in which it was placed. The original HEROES Act was over 1,800 pages long[248] and the § 7702 change took up only five of them. The CAA, in which the change became law, was over 2,100 pages.[249] Additionally, the final text of the CAA only became available to members for a few hours before the vote was taken, making a thorough read of the final bill essentially impossible.[250] These factors are commonly bemoaned for letting surprise provisions slip through to benefit special interests in a variety of contexts.

Second, to reiterate from III.A.3.b, the life insurance industry has a remarkable lobbying apparatus and close supporters in Congress, most importantly the current Chair of the Ways and Means Committee and the Joint Committee on Taxation. This political influence goes back a century, all the way to its tax exemption in the first income tax bill following the Sixteenth Amendment.[251] The HEROES Act summary, the one document where Congress has provided any explanation of the change, almost completely follows the life insurance industry's preferred explanation,

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[248] Health and Economic Recovery Omnibus Emergency Solutions Act, H.R. 6800, 116th Cong. § 40308 (2020).

[249] § 205, 134 Stat. 1182.

[250] Luke Broadwater, et al., *Buried in the Pandemic Aid Bill: Billions to Soothe the Richest*, N.Y. TIMES (Dec. 22, 2020), https://www.nytimes.com/2020/12/22/us/politics/whats-in-the-covid-relief-bill.html.

[251] 50 CONG. REC. 1807 (1903).

saying that the change "updates section 7702 to reflect the interest rate environment that has been exacerbated by the current crisis."[252]

Third, provisions like the § 7702 amendment pose a classic collective action problem, that of concentrated benefits and diffuse costs.[253] The beneficiaries of the amendment are specific: cash value life insurance providers and policyholders. The costs of the amendment are most directly seen in foregone revenue to the state, not to any particular constituency. This forgone revenue is likely to be relatively insignificant in the short run (but only the short run),[254] further diluting the urgency of the costs. Additionally, while in one sense other asset managers are also losers in this amendment because they compete with cash value life for savings allocation, products like private placements demonstrate that the increasing appeal of cash value life is not necessarily a zero-sum game for both basic investments like corporate bond indexes as well as specialty asset classes like hedge funds. There is therefore scarce activist constituency to oppose the plan.

The fourth and fifth factors work in tandem and, combined, are what makes § 7702 and its 2020 amendment distinctive. The fourth factor is that the provision, instead of a direct cash outlay, employed an economically identical but much less politically salient tax expenditure. Tax expenditures are tax revenue losses due to exclusions or deductions from base rates, as opposed to a direct spending outlay.[255] Across surveys, many Americans indicate that they simply do not consider tax expenditures to be equivalent to government spending; this concept is known as the "submerged state" because spending done through tax expenditures, rather than cash transfers, is simply much less recognized.[256] For example, many people who use tax deductions, such as the home mortgage interest deduction, will answer "no" in polls to questions about if they have "ever used a government social program."[257] The life insurance tax exclusion and § 7702, like the home mortgage interest deduction, are part of the submerged state. Section 7702

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[252] H. APPROPRIATIONS COMM., 116TH CONGRESS, H.R. 6800, THE HEROES ACT TITLE-BY-TITLE SUMMARY § 308, at 34.

[253] *See* MANCUR OLSON, THE LOGIC OF COLLECTIVE ACTION: PUBLIC GOODS AND THE THEORY OF GROUPS 9–16 (1965).

[254] H.R. REP., 116TH CONG., JCX-16-20, at 4.

[255] U.S. DEP'T TREASURY, https://home.treasury.gov/policy-issues/tax-policy/tax-expenditures (last visited Nov. 7, 2022).

[256] *See generally* SUZANNE METTLER, THE SUBMERGED STATE: HOW INVISIBLE GOVERNMENT POLICIES UNDERMINE AMERICAN DEMOCRACY (2011).

[257] Suzanne Mettler, *Our Hidden Government Benefits*, N.Y. TIMES (Sept. 19, 2011), https://www.nytimes.com/2011/09/20/opinion/our-hidden-government-benefits.html.

does not work by cutting a check to holders of qualifying policies each year, but instead works through delineating access to an income exemption located in two other separate tax code provisions, § 101 and § 72. This structure suppresses the public prominence of the significant taxpayer subsidy.

The fifth factor is the sheer inaccessibility of § 7702. Section 7702 and its 2020 amendment are extraordinarily technical and statutorily complex, requiring specialized knowledge about the economics of cash value life insurance, interest calculations, and actuarial principles. The topic of cash value life is already niche, and most Americans cannot pass basic financial literacy tests,[258] let alone evaluate the merits of an actuarial simulator.

Section 7702 is designed such that only a very small subset of people will ever become remotely familiar with the actual details, and while this is true of legislation generally, it becomes a particularly strong impairment to public understanding when the technical barriers are sufficient to inhibit understanding by policymakers who are ordinarily charged with safeguarding legislation's integrity. When a statute or regulation becomes complex enough that the institutional knowledge of its inner workings shifts to the industry it impacts, institutional capture by that industry against overburdened gatekeepers becomes inevitable. This is a chronic problem in financial regulation, where legislation in the hundreds of pages (and accompanying regulations in the thousands) is recurring, resulting in regulatory debacles where deadlines are missed by years and attempts at

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[258] Annamaria Lusardi & Olivia Mitchell, *The Economic Importance of Financial Literacy: Theory and Evidence*, 52 J. ECON. LITERATURE 1, 9 (2014). Lusardi and Mitchell use a simple three-question survey to test for basic financial knowledge: (1) "Suppose you had $100 in a savings account and the interest rate was 2 percent per year. After 5 years, how much do you think you would have in the account if you left the money to grow: [more than $102; exactly $102; less than $102; do not know; refuse to answer.]"; (2) "Imagine that the interest rate on your savings account was 1 percent per year and inflation was 2 percent per year. After 1 year, would you be able to buy: [more than, exactly the same as, or less than today with the money in this account; do not know; refuse to answer.]"; and (3) "Do you think that the following statement is true or false? 'Buying a single company stock usually provides a safer return than a stock mutual fund.' [true; false; do not know; refuse to answer]." In the United States, only 30% of people in their study could answer all three questions correctly. (The answers are (1) more than $102; (2) less than today; and (3) false.)

clarity become muddled in post-passage chaos.[259] When the purported justification for undebated legislative action is simply the talking points of the affected well-connected industry on niche legislation,[260] the tipping point has passed and the industry is in the driver's seat for the topics over which it has the advantage of insider knowledge.

Not only was § 7702 already far too complex for non-specialists to grasp, but the 2020 amendment makes the situation even worse. Compared to the old version's "4%," its replacement requires two nested "lesser than" statements to change the standard to one that sometimes is identical to the old one but at other times is a floating rate, drawing on two separate data series that each require their own separate explanation and calculation.[261] This further convolution, however, does align with the industry's stated narrative for the change: if the problem is that the required § 7702 rate is too high because interest rates are now too low, shouldn't the rate be able to adjust with the times, so the argument goes. When only four members of the House of Representatives are still serving from when § 7702 was enacted,[262] and the institutional knowledge of the debate at the time has therefore disappeared, the level of deference to a technical explanation offered by an outsider will be substantially higher.

Bringing together these fourth and fifth factors, the § 7702 amendment is a caricature of the submerged state. The amendment changed the lower bound of an actuarial assumption in a simulated cash value life insurance policy from 4% to the lesser of 4% and a metric that is the lesser of a data series dependent upon the Moody's AAA corporate bond yield index and the last several months of medium-term U.S. Treasury yields. This amendment was done in order to set different bounds for the exact types of cash value policies would be eligible for a series of tax benefits, including nontaxation of inside buildup and nontaxation of the death benefit, while plausibly seeming at first glance to comply with the general spirit of the low interest rate era. The test that was relatively accessible, the CVCT, was unchanged. It is not surprising that no one cared about the amendment!

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[259] Roberta Romano, *Regulating in the Dark and a Postscript Assessment of the Iron Law of Financial Regulation*, 43 HOFSTRA L. REV. 25, 26, 57, 68 (2014). A particularly notable example of this process is the Dodd-Frank "Volcker Rule" that attempts to mostly ban banks from performing proprietary trading with their accounts. *Id*. at 69–75.

[260] THE HEROES ACT TITLE-BY-TITLE SUMMARY § 308, *supra* note 252.

[261] I.R.C. § 7702(f)(11).

[262] *Terms of Service for Members of the House of Representatives in the 117th Congress*, CLERK, https://clerk.house.gov/member_info/Terms_of_Service.pdf (last visited Nov. 7, 2022).

Even within the context of the submerged state, if someone had proposed giving cash value life a tax credit, or set up a relatively simple test, that might have gotten some degree of attention. But when the law is structured to be as intricate as possible, that vacuum will be filled by attention to the tangible, such as the months-long controversy over which businesses got to receive Paycheck Protection Program loans.[263] The more a proposal is submerged into the lowest-salience form possible, and the lower the visibility and higher the technicality, the greater the potential for capture.

D. SUMMARY OF OBJECTIONS AND POLICY RECOMMENDATION

To conclude, this Article sums up three objections to the 2020 § 7702 amendment, and offers a policy recommendation and additional observations consistent with those objections.

First, the amendment is an abuse of the life insurance tax exemption, which, if it should exist at all, should have the aim of aiding in the protection of policyholders and their beneficiaries from the worst. The amendment shifts the locus of the § 101 exemption away from actual protection in the event of death and towards products that are simply normal investment policies, draining the exemption of moral content it could have previously at least tried to claim.[264] The amendment reduces the amount of actual insurance protection (net amount at risk to the insurer), but delivers to the policyholder greater tax savings at the cost of federal revenue. This dynamic turns the idea of an "insurance exemption" on its head. Indeed, the changing profile of life insurance ownership and the § 7702 amendment weaken the general case for an inside buildup exemption.

Second, the amendment, with a cost to the federal tax coffers likely to grow into the billions of dollars each year,[265] is an amplification of an upside-down subsidy. Cash value life was always skewed towards the affluent, but this aspect of the insurance industry has become particularly pronounced in the past two decades.[266] The cash value policies that are most able to take advantage of this change are also not the ones that have a relatively small amount of savings with inside buildup, but the minority of

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[263] Emily Stewart, *The PPP worked how it was supposed to. That's the problem*, VOX (July 13, 2020, 8:00 AM), https://www.vox.com/recode/2020/7/13/21320179/ppp-loans-sba-paycheck-protection-program-polling-kanye-west.

[264] Maremont & Scism, *supra* note 38.

[265] *See supra* Section III.B.1.

[266] *Survey of Consumer Finances*, *supra* note 137.

extremely flush policies specifically structured as savings vehicles. Furthering premium stuffing doubles down on a policy that overwhelmingly benefits the affluent more and more, and may do so in a particularly egregious manner if stepped-up basis reform passes.[267]

Third, the amendment rewards a legislative process that minimizes public understanding of the law and accountability for government capture.[268] Members of the community should not be able to extract public rents based on their ability to obscure and confuse policymakers and the public, and legislation should be structured as to maximize the ability for the legislative body to maintain a mastery over its content.

The effort to write actuarial principles into the I.R.C., while admirable, has demonstrated that it is not a sustainable equilibrium. While life insurance providers face legitimate difficulty in selling traditional products in the low interest rate era, the solution cannot be to implicitly sanction the industry's move away from the very products that were the reason for the subsidy in the first place. Unfortunately, given the tenor of Congress,[269] comprehensive reform seems unlikely.

It should be noted that, despite its deep problems, the highly technical approach of § 7702 does have one significant advantage: legislative clarity about which contracts will receive the life insurance tax exemption. Recall that under the old standard for delineating access to the exemption, the *Le Gierse* test, was judicial discretion to decide whether the contract contained sufficient risk shifting.[270] Since the passage of § 7702, there has been almost no litigation over if a policy is or is not in compliance with the provision.[271]

Keeping in mind the advantages and disadvantages of § 7702 in its current state, as a first-best policy proposal, Congress should eliminate the

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[267] *See supra* Section III.B.2.

[268] *See supra* Section III.C.1.

[269] Warmbrodt, *supra* note 219.

[270] *Le Gierse*, 312 U.S. at 537–40.

[271] In a search of cases that reference § 7702 and life insurance on Westlaw, in only two cases did parties disagree on contract compliance under federal tax law. In Buck v. Am. Gen. Life Ins. Co., plaintiffs alleged that faulty procedures by the insurer caused a policy to fall out of § 7702 compliance. No. 117CV13278NLHKMW, 2021 WL 733809 (D.N.J. Feb. 25, 2021). In Muffin Trust v. Mony Life Insurance Company of America, parties disagreed on the requirements of the guideline premium limit. No. SUCV201801106BLS2, 2019 WL 7753754 (Mass. Super. Dec. 31, 2019). There has also been litigation over whether policies that fulfilled § 7702's requirements nonetheless constituted "shams". *See, e.g.*, Winn-Dixie Stores, Inc. v. Comm'r, 254 F.3d 1313 (11th Cir. 2001).

income tax exemption of inside buildup. Given the difficult political circumstances, this Article recommends a proposal of a hard numerical cap, perhaps of $100,000,[272] on the amount of inside buildup that will receive the § 101 exemption. This policy has the virtues of being easy to explain to policymakers and the public and being easy to write into the statute, thus avoiding wading into an actuarial quagmire. It would reduce the regressivity of the subsidy and ensure that a greater fraction of the dollars exempted from tax under § 101 were for insurance protection, while being perhaps more achievable than full inside buildup taxation. The cap would also forestall the possible future scenario of a tsunami of capital from other asset classes into life insurance in an attempt to get around a repeal of stepped-up basis. Attempts to modify the cap in the future would have to modify a statute written in straightforward language, so it would be more resilient, or at least would not go unnoticed. The cap would not interfere with the ability of anyone to provide for their loved ones in the event of their death. In short, it would be a simple but effective way to regain some control of a tax exemption and associated legislative process.

Additionally, though this is not a federal policy recommendation, the structure of § 7702 enables other participants to act to blunt the amendment's impact. Most notably, though the bulk of § 7702 requirements pertain to the actuarial calculations covered at length in this article, § 7702 also requires that to get preferential tax treatment the insurance policy must meet the applicable state law definition of a life insurance policy.[273] So, for example, life insurance policies in New York must abide by New York state law pertaining to life insurance, and in New York flexible premium policies, the policyholder must receive a sixty-one day grace period after making the first payment to pay sufficient premiums to keep the policy in force if the insurer determines that the policy's net cash surrender value is not sufficient to pay the insurance charges.[274]

If a state was concerned about the weakening of § 7702, it could require that any life insurance policy in its state meet the old requirements of the actuarial test for recognition under its law, which would then trigger § 7702's applicable law requirement. A state government could, in effect,

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[272] For the distribution of the amount of cash value policyholders have in cash value policies, conditional on having a cash value policy. *See* Online Data and Calculations Appendix *supra* note 92. The mean amount of cash value in the cash value policy of a policyholder in the 80th–89.9th percentile of income is about $31,000, while for the 90th–100th percentile of income it is about $158,000.

[273] DESROCHERS ET AL., *supra* note 7, at 338.

[274] N.Y. Ins. Law. § 3203 (McKinney 2013).

reinstate the old statutory language for federal tax exemption, though only to policies under its jurisdiction. State governments could go further and impose stricter limits on private placement life insurance, such as increasing investment diversification requirements, stripping the policyholder of control of initial asset allocations, or banning PPLI entirely. State-by-state policy is susceptible to geographic gaming by the industry, but the federalism embedded within the § 7702 statute does enable experimentation.

V. CONCLUSION

The life insurance sector forged the Internal Revenue Code § 7702 bargain in the 1980s when overly aggressive new products and marketing by new companies threatened to bring congressional scrutiny to the favorable tax treatment the industry enjoyed. Section 7702's limitations on the amount of pure investment that could be deposited into tax-exempt cash value life insurance policies were carefully constructed to incorporate actuarial science, as well as hard-fought political compromises, into the tax code. After thirty years of declining interest rates and concentrating wealth, it is now the incumbents of life insurance who are aggressively pushing boundaries in the form of new policy design and advocacy for even more lavish tax treatment. Their successful (and almost entirely unnoticed) push to amend § 7702 in 2020 showcases the limitations of such a highly technical and obscure approach. The new § 7702 relies on an even more intricate and inscrutable statute but structures its new formula to enlarge permissible investment orientation, sometimes almost tripling the amount of savings that can be stored into a given policy to avoid taxes. Furthermore, those willing to purchase the highest-value policies are in the best position to benefit from this new legislative world.

The life insurance sector, which has been suffering in the low interest rate era, is leaving behind ordinary Americans and reinventing itself as an investment product for elites, including embracing openly blue-blooded products like private placement insurance. To some degree, the economics of the situation may make this trend inevitable. However, it does not follow that American taxpayers should bless increasingly arcane and top-heavy products with a more expansive definition of "life insurance" that extends a tax loophole to policies that have less actual insurance. Doing so costs the federal budget tax revenue, subsidizes inequality, harms the integrity of the legislative process, and reinforces a template for special interests to disguise special treatment as technical sophistication.

WORKERS' COMPENSATION RECOVERY FOR INJURED UNIVERSITY STUDENT ATHLETES: THE IMPACT OF RECENT LEGAL DEVELOPMENTS

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I. INTRODUCTION

Scholars have long debated the entitlement of university[1] student-athletes to workers' compensation recovery for injuries arising out of the athletes' participation in university athletic activities.[2] Despite the scholarly arguments in favor of granting workers' compensation recovery to student-athletes, a majority of the caselaw in recent decades suggests that courts are not receptive to student-athletes' attempts to recover workers' compensation from their universities.[3] However, recent developments indicate that courts may become more receptive to these claims than they have been in the past. Specifically, three recent developments, taken together, foreshadow a sea-change in workers' compensation recovery for student-athletes: (1) the Supreme Court's opinion in *Alston v. NCAA*;[4] (2) the Eastern District of Pennsylvania's decision in *Johnson v. NCAA*;[5] and (3) the September 29, 2021, National Labor Relations Board ("NLRB") General Counsel's memo titled "Statutory Rights of Players at Academic Institutions (Student-Athletes) Under the National Labor Relations Act" ("NLRB Memo").[6]

This essay will begin by briefly explaining the existing framework for workers' compensation recovery.[7] Then, it will discuss the historical application of the workers' compensation framework to cases brought by student-athletes.[8] It will next detail each of these recent developments in turn and the impact of these developments on the workers' compensation analysis

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[1] This note uses the term "university" to refer generally to all institutions of higher education as defined by the Higher Education Act. *See* 20 U.S.C. § 1001 (2012).

[2] *See generally* Frank P. Tiscione, *College Athletics and Workers' Compensation: Why the Courts Get it Wrong in Denying Student-Athletes Workers' Compensation Benefits When They Get Injured*, 14 SPORTS L.J. 137 (2007); Timothy Davis, *Intercollegiate Athletics: Competing Models and Conflicting Realities*, 25 RUTGERS L.J. 269 (1994); Shaun Loughlin, *Workers' Compensation and Student-Athletes: Protecting Unpaid Talent in the Profit-Making Enterprise of Collegiate Athletics*, 48 CONN. L. REV. 1737 (2016).

[3] *See infra* Section II.2.b.

[4] NCAA v. Alston, 141 S. Ct. 2141 (2021).

[5] Johnson v. NCAA, 561 F. Supp. 3d 490 (E.D. Pa. 2021).

[6] Memorandum from Jennifer A. Abruzzo, Off. Gen. Couns., NLRB, to the Reg'l Dirs., Officers-in-Charge & Resident Officers, NLRB (Sept. 29, 2021) [hereinafter NLRB Memo].

[7] *See infra* Section II.A.

[8] *See infra* Section II.B.

as applied to student-athletes.[9] Lastly, this essay will examine the potential systematic implications of administering workers' compensation benefits to injured university student-athletes.[10]

II. BACKGROUND

A. EXISTING FRAMEWORK FOR WORKERS' COMPENSATION RECOVERY

At its core, workers' compensation is the system through which an employee receives medical and financial benefits to compensate the employee for loss of earning potential resulting from work-related injuries.[11] Although workers' compensation is a creature of state law, most jurisdictions require that an injury must (1) arise out of the employment, and (2) occur within the course of employment in order for the injured worker to receive workers' compensation benefits.[12] An injury arises out of employment when there is a causal connection between the injury and the employment.[13] An

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[9] *See infra* Section III.A.

[10] *See infra* Section III.B.

[11] *See* 1 LARSON'S WORKERS' COMPENSATION LAW § 1.03(1) (Matthew Bender Elite Prods. 2022) ("The right to compensation benefits depends on one simple test: Was there a work-connected injury? . . . In compensation, unlike tort, the only injuries compensated for are those which either actually or presumptively produce disability and thereby presumably affect earning power.").

[12] *See* Leckie v. H.D. Foote Lumber Co., 40 So. 2d 249, 251 (La. Ct. App. 1948) ("[I]n determining whether an accident arises out of the employment, it is necessary to consider only two questions. First, was the employee then engaged about his employer's business *and not merely* pursuing his own business or pleasure and second, did the necessity of the employer's business reasonably require that the employee be at the place of the accident at the time the accident occurred." (emphasis in original)). *See generally* 1 LARSON'S WORKERS' COMPENSATION LAW § 3 (Matthew Bender Elite Prods. 2022) (explaining the historical development and current application of the arising out of employment element); 2 LARSON'S WORKERS' COMPENSATION LAW § 12 (Matthew Bender Elite Prods. 2022) (explaining the historical development and current application of the course of employment element).

[13] 1 LARSON'S WORKERS' COMPENSATION LAW § 3.syn (Matthew Bender Elite Prods. 2022) ("[T]he 'arising out of' test is primarily concerned with causal connection. Most courts in the past have interpreted "arising out of employment" to require a showing that the injury was caused by an increased risk to which claimant, as distinct from the general public, was subjected by his or her employment. A substantial number have now modified this to accept a showing merely that the risk,

injury occurs within the course of employment when the injury "takes place within the period of the employment, at a place where the employee reasonably may be, and while the employee is fulfilling work duties or [is] engaged in doing something incidental thereto."[14] As these elements imply, courts must answer a threshold question in the affirmative to uphold a grant of workers' compensation to a claimant: is the claimant an employee of the respondent?[15] In other words, a court must determine that an employment contract exists between the claimant and the respondent.

While courts in different states may use a variety of tests to determine whether an employment contract exists, the most common tests are: (1) the right to control test,[16] (2) the nature of the work test,[17] and (3) the

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even if common to the public, was actually a risk of this employment. An important and growing group of jurisdictions has adopted the positional-risk test, under which an injury is compensable if it would not have happened but for the fact that the conditions or obligations of the employment put claimant in the position where he or she was injured.").

[14] 2 LARSON'S WORKERS' COMPENSATION LAW § 12.syn (Matthew Bender Elite Prods. 2022). *See also* Perez v. RadioShack, 2008 Colo. Workers' Comp. LEXIS 85, 3–4 (2008) (finding that an employee injured during a golf trip that the employee took at the behest of a supervisor was within the course of employment because "[t]he supervisor proposed the golf outing and rescheduled . . . [t]he golf outing occurred during work hours on a day that the claimant was to have off . . . [and the employee's] evaluation and a possible promotion were both discussed while golfing").

[15] *See id.*

[16] *See, e.g.*, Hanson v. Transp. Gen., 716 A.2d 857, 861 (Conn. 1998) ("The 'right to control' test determines the [employment] relationship by asking whether the putative employer has 'the right to control the means and methods' used by the worker in the performance of his or her job." (citing Hunte v. Blumenthal, 680 A.2d 1231, 1235 (Conn. 1996); Silverberg v. Great Southwest Fire Ins. Co., 573 A.2d 724, 727 (Conn. 1990))).

[17] *See, e.g.*, Hammermill Paper Co. v. Rust Eng'g Co., 243 A.2d 389, 392 (Pa. 1968) ("While no hard and fast rule exists to determine whether a particular relationship is that of employer-employee or owner-independent contractor, certain guidelines have been established and certain factors are required to be taken into consideration: 'Control of manner work is to be done; responsibility for result only; terms of agreement between the parties; the nature of the work or occupation; skill required for performance; whether one is engaged in a distinct occupation or business; which party supplied the tools; whether payment is by the time or by the

economic realities test.[18] Each of these tests focuses on whether the facts of a particular case demonstrate that a legally binding contractual relationship was formed such that the claimant can be fairly categorized as an employee of the respondent for purposes of a workers' compensation claim.[19]

All in all, in order to succeed in a workers' compensation claim, an injured worker must prove that they were employed by the employer from which they seek recovery and that the worker's injury arose out of and occurred within the course of such employment.

B. HISTORICAL APPLICATION OF THE WORKERS' COMPENSATION FRAMEWORK TO STUDENT-ATHLETES

Courts apply the aforementioned framework to examine whether student-athletes are entitled to workers' compensation recovery for injuries arising out of their participation in university athletic activities. To understand the significance of the *Alston* and *Johnson* decisions and the NLRB memo, it is important to place these recent developments in the context of the courts' historical application of the workers' compensation framework as applied to university student-athletes. As mentioned above, to succeed in a workers' compensation claim, the athlete must prove that they were an employee of the university and that their injury (1) arose out of the employment and (2) occurred within the course of employment.[20] Case law applying this framework to student-athletes can be described in two distinct categories: pre-1980s cases, mostly allowing recovery in discrete claims of workers' compensation by student-athletes against universities,[21] and the

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job; whether work is part of the regular business of the employer, and also the right to terminate the employment at any time.'" (quoting Stepp v. Renn, 135 A.2d 794, 796 (1957))).

[18] Kidder v. Miller-Davis Co., 564 N.W.2d 872, 880 (Mich. 1997) ("The relationship must still be evaluated under the economic reality test . . . this standard examines a number of criteria including control, payment of wages, hiring, firing, the maintenance of discipline, and common objective. These factors are viewed together in their entirety under a totality of the circumstances test. We repeat: No one factor is controlling.").

[19] *See, e.g.*, Johnson v. City of Albia, 212 N.W. 419, 421 (Iowa 1927) ("The question at once, the, in the case, is whether or not the appellee at the time of the injury, to wit, on November 16, had a contract of employment, express or implied, with the appellant.").

[20] *See supra* Section II.A.

[21] *See infra* Section II.B.1.

1980s-to-present cases, categorically denying workers' compensation recovery for student-athletes.[22]

As will be discussed, the recent cases denying workers' compensation recovery have almost entirely relied on the reasoning that the student-athlete claimants failed to prove that they were employees of the university.[23] In other words, the recent case law demonstrates that courts deny student-athletes the right to recover workers' compensation from universities by holding that student-athletes are not employees of their universities and, consequently, dispense with the claim before analyzing whether the athlete's injury arose out of university athletic participation and occurred during the course of the university's athletic program.[24] It is against this backdrop of the 1980s-to-present caselaw that the *Alston* and *Johnson* decisions and the NLRB Memo stand out as suggestive of a significant sea-change in courts' treatment of student athletes' claims for workers' compensation recovery.[25]

1. The Pre-1980s Cases

In the early days of college athletics, courts upheld grants of workers' compensation to injured university student-athletes at a more frequent rate than in recent years. For example, in *Van Horn v. Industrial Accident Commission*, a California court of appeals annulled an administrative denial of workers' compensation in the form of death benefits from the state's industrial accident commission to the widow and children of a college athlete killed in a plane accident on his way back from an intercollegiate football game.[26] The *Van Horn* court reasoned that the Commission's finding that the deceased athlete was not "rendering services" for the university within the meaning of the relevant Workmen's Compensation Act was erroneous.[27] The court further found that the

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[22] *See infra* Section II.B.2.

[23] *See id.*

[24] *See id.*

[25] *See infra* Section III.

[26] *See* Van Horn v. Indus. Accident Comm'n, 219 Cal. App. 2d 457, 460 (Cal. Dist. Ct. App. 1963).

[27] *See id.* at 465 ("As we have stated, the commission concluded that by playing football for the college the decedent was not 'rendering services' within the meaning of the Workmen's Compensation Act. While the case is one of first impression in this jurisdiction, there is authority for the proposition that one who participates for

deceased athlete's scholarship for his participation on the football team was evidence of an employment contract.[28]

Similarly, in *University of Denver v. Nemeth*, the Supreme Court of Colorado upheld the industrial commission's grant of compensation to a student-athlete who injured his back during a university football practice.[29] The *Nemeth* court pointed to evidence that the student athlete's part-time employment with the university in exchange for reduced room and board expenses was offered to him, particularly because he was a student-athlete.[30] The court reasoned that because the university conditioned the student athlete's part-time employment on the student athlete's participation in university athletic programs, the student was an employee of the university, injured during the course of the student's employment, and the injury was causally connected to the university athletic program.[31]

The Supreme Court of Colorado overturned *Nemeth* in *State Compensation Insurance Fund v. Industrial Accident Commission*.[32] The *State Compensation Insurance Fund* court examined whether an employment relationship existed between the student-athlete and the university by examining whether the student-athlete's participation in athletic activities provided value to the university.[33] The court reasoned that no employment agreement existed between a university and a student-athlete because the university did not receive a direct benefit from the student-

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compensation as a member of an athletic team may be an employee within the statutory scheme of the Workmen's Compensation Act. (Metro. Cas. Ins. Co. v. Huhn, 142 S.E. 121 (Ga. 1928) [professional baseball player]; Univ. of Denver v. Nemeth, 257 P.2d 423 (Colo. 1953) [state college football player].) The fact that academic credit is given for participation in the activity is immaterial.") (internal citations altered).

[28] *Id.* at 464.

[29] Univ. of Denver v. Nemeth, 257 P.2d 423, 427 (Colo. 1953).

[30] *See id.* at 426–27, 430.

[31] *Id.* at 430 ("The obligation to compensate Nemeth arises solely because of the nature of the contract, its incidents and the responsibilities which Nemeth assumed in order not only to earn his remuneration but to retain his job. He apparently had the physical ability and aptitude for football, and the University hired him to perform work on the campus and, as an incident of this work, to have him engage in football.").

[32] State Comp. Ins. Fund v. Indus. Accident Comm'n, 314 P.2d 288 (Colo. 1957).

[33] *See id.* at 289–90.

athlete's participation in the university's athletic program.[34] The *State Compensation Insurance Fund* court's reasoning foreshadows the reasoning of courts analyzing student athletes' entitlement to workers' compensation recovery in recent decades.

2. The 1980s-to-Present Cases

During the 1980s, courts began consistently holding against granting workers' compensation to university student-athletes. In *Rensing v. Indiana State University Board of Trustees*, a student-athlete on the Indiana State football team suffered a back injury leaving them permanently disabled.[35] The Supreme Court of Indiana held that the student athlete's permanent disability was not a covered injury under the state workers' compensation statute because no employer-employee relationship existed between the student and the university.[36] The court reasoned that since the student's scholarship was not considered income by the National Collegiate Athletic Association ("NCAA") rules or the Internal Revenue Service ("IRS"), the student-athlete was not an employee of the university.[37] The court specifically referred to the NCAA's policy, which described the scholarship money as a "grant in aid of athletic participation," *not* a payment for athletic

[34] *See id.* ("Since the evidence does not disclose any contractual obligation to play football, then the employer-employee relationship does not exist and there is no contract which would support a claim for compensation under the Act. A review of the evidence disclosed that none of the benefits he received could, in any way, be claimed as consideration to play football, and there is nothing in the evidence that is indicative of the fact that the contract of hire by the college was dependent upon his playing football, that such employment would have been changed had deceased not engaged in the football activities.").

[35] Rensing v. Ind. State Univ. Bd. of Trs., 44 N.E.2d 1170, 1172 (Ind. 1983).

[36] *Id.* at 1173.

[37] *See id.* ("[T]here is evidence that the financial aid which Rensing received was not considered by the parties involved to be pay or income. Rensing was given free tuition, room, board, laboratory fees and a book allowance. These benefits were not considered to be 'pay' by the University or by the NCAA since they did not affect Rensing's or the University's eligibility status under NCAA rules. Rensing did not consider the benefits as income as he did not report them for income tax purposes. The Internal Revenue Service has ruled that scholarship recipients are not taxed on their scholarship proceeds and there is no distinction made between athletic and academic scholarships.").

participation in support of its finding that the student-athlete was not an employee.[38]

Additionally, in *Coleman v. Western Michigan University*, a university student-athlete suffered a disabling injury that prevented him from playing football.[39] Western Michigan University reduced the student athlete's scholarship as a result of him no longer being able to participate in football.[40] The *Coleman* court found that the university student-athlete's scholarship was a wage but ultimately held that the economic realities of the relationship between the student-athlete and Western Michigan University did not demonstrate an employment relationship and, consequently, the university student-athlete was not entitled to workers' compensation recovery.[41]

Similarly, in *Cheatham v. Workers' Compensation Appeals Board*, the court denied workers' compensation coverage to an injured college wrestler, reasoning that the university was providing service in the form of educational benefits to the student-athlete and no economic benefit for the university existed in its wrestling program.[42] In other words, the *Cheatham* court found that the injured student-athlete was not an employee of the university because his participation in the university's athletic program did not provide a service of value to the university, but instead, the defining characteristic of the relationship was that the university was providing education to the student-athlete.[43]

Further, in *Waldrep v. Texas Employers Insurance Association*, [44] a student-athlete that suffered a football injury, leaving him with quadriplegia, was denied workers' compensation coverage. The *Waldrep* court reasoned that no employment relationship existed between the student-athlete and the university because the student-athlete and the university never intended for

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[38] *See id.*

[39] Coleman v. W. Mich. Univ., 336 N.W.2d 224, 226 (Mich. Ct. App. 1983).

[40] *See id.* at 227.

[41] *Id.* at 227 ("In summary, the first and second factors of the 'economic reality' test demonstrate that defendant had at least some right to control the activities of the plaintiff and to discipline the plaintiff for nonperformance, but these rights were substantially limited. The third factor, *i.e.*, the 'payment of wages,' favors the finding of an employment relationship. The fourth factor, concerning whether the employee's duties were integral to the employer's business, however, weighs heavily against the finding of an employment relationship.").

[42] Cheatham v. Workers Comp. Apps. Bd., 49 Cal. Comp. Cases 54, 55, 58 (Cal. Ct. App. 1984).

[43] *See id.*

[44] Waldrep v. Tex. Emps. Ins. Ass'n, 21 S.W.3d 629 (Tex. App. 2000).

student-athletes to be considered professional athletes.[45] In furtherance of its reasoning, the court cited the NCAA's rules distinguishing college athletes as amateurs.[46]

III. ANALYSIS

A. RECENT DEVELOPMENTS IMPACTING WORKERS' COMPENSATION FOR STUDENT-ATHLETES

1. *Alston*

The Supreme Court's recent decision in *Alston v. NCAA* did not take up workers' compensation directly. Instead, *Alston* was an antitrust case against the NCAA.[47] In *Alston*, the plaintiffs (Division I basketball and football players) successfully argued that the NCAA's grant-in-aid cap—which limited the dollar amount of educational benefits a university may provide student-athletes—was an unreasonable restraint on trade in violation of the Sherman Antitrust Act.[48] Consequently, the Supreme Court upheld an injunction against the NCAA enforcing its grant-in-aid cap on educational benefits.[49] Although the *Alston* decision did not take up the issue of workers' compensation for university student-athletes, the Supreme Court's opinion provided a particularly relevant lengthy discussion of the history of compensation for student-athletes.[50] The *Alston* court's discussion of university student-athlete compensation is significant to workers' compensation because it detailed the development of the NCAA as the story of an organization with two juxtaposed purposes: (1) limiting compensation for student-athletes and (2) expanding its share in the market for commercializing university sports.[51] The *Alston* court's description of the

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[45] *See id.* at 700.

[46] *See id.* at 700–02.

[47] NCAA v. Alston, 141 S. Ct. 2141, 2151 (2021).

[48] *Id.* at 2151, 2165.

[49] *Id.* at 2165 ("Under the current decree, the NCAA is free to forbid in-kind benefits unrelated to a student's actual education; . . .").

[50] *See id.* at 2148–52.

[51] *Id.* at 2149 ("To some, [NCAA rules] sought to substitute a consistent, above-board compensation system for the varying under-the-table schemes that had long proliferated. To others, [NCAA rules] marked the beginning of the NCAA behaving

NCAA's development suggested that the NCAA's ever-expanding share in the market for commercializing university sports may have become large enough, at least in regard to Division I athletic programming, and that the university student-athletes are providing a service of value to their universities.[52]

Furthermore, the Supreme Court's classification of scholarships and educational benefits as compensation for student-athlete labor provides student-athletes with support for the contention that their educational benefits should also be considered compensation under the workers' compensation framework.[53] Arguably, the *Alston* court's discussion of the NCAA's development established that college athletics is an industry and that the scholarships, travel expenses, tutors, and other benefits that student athletes receive is compensation for their contribution to the profit-making goal of college athletics.[54] Accordingly, the *Alston* court provides a foundation on which student-athletes may successfully argue that they are employees of their universities because of their participation in their university's athletic programs.[55] Particularly regarding workers' compensation claims, courts have barred student-athletes from recovering workers' compensation from universities because scholarships and educational benefits did not count as a direct benefit paid to the student-athlete as an employee of the university.[56]

Historically, courts have reasoned that universities are not employers of student-athletes because universities provide the service of

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as an effective cartel, by enabling its member schools to set and enforce rules that limit the price they have to pay for their inputs." (internal quotation marks omitted)).

[52] *Id.* at 2150 ("At the center of this thicket of associations and rules sits a massive business. The NCAA's current broadcast contract for the March Madness basketball tournament is worth $1.1 billion annually.").

[53] *See id.* at 2166 ("[T]his case involves only a narrow subset of the NCAA's compensation rules—namely, the rules restricting the *education-related* benefits that student athletes may receive, such as post-eligibility scholarships at graduate or vocational schools.") (emphasis in original).

[54] *Id.* at 2150.

[55] *Compare id.* at 2166, *with* Rensing v. Ind. State Univ. Bd. of Trs., 44 N.E.2d 1170, 1173 (Ind. 1983) ("[T]here is evidence that the financial aid which Rensing received was not considered by the parties involved to be pay or income. Rensing was given free tuition, room, board, laboratory fees and a book allowance. These benefits were not considered to be 'pay' by the University or by the NCAA[.]").

[56] *See* State Comp. Ins. Fund v. Indus. Accident Comm'n, 314 P.2d 288, 289–90 (Colo. 1957); Rensing v. Ind. State Univ. Bd. of Trs., 444 N.E.2d, 1172, 1173 (Ind. 1983).

education to students. Consequently, universities' business objectives are tied to the institutions' educational services to students, not profit-making athletic programming.[57] The *Alston* decision dispenses with this argument by classifying educational benefits as compensation and describing competition among schools to recruit student-athletes as ensuring "[s]tudent-athletes would receive offers that would more closely match the value of their athletic services."[58] Consequently, the *Alston* decision provides injured university student-athletes, especially those in Division I programs, with support for a claim that they are entitled to workers' compensation as employees of their universities, given that their participation in athletic programming provides universities with valuable revenue.

2. *Johnson*

Like the Supreme Court's *Alston* decision, the Eastern District of Pennsylvania's decision in *Johnson v. NCAA*[59] did not directly consider the question of a university student-athlete's entitlement to workers' compensation benefits. Instead, the *Johnson* court held that the plaintiffs, also Division I student athletes, survived a 12(b)(6) motion to dismiss the plaintiffs' claims that they were employees of the NCAA and their universities.[60] The *Johnson* court held that the plaintiff university student athletes plausibly pled that they were employees of their universities under the Fair Labor Standards Act ("FLSA") and various state minimum wage acts and, consequently, were entitled to payment of wages for the time they spent participating in their universities' athletic programs.[61] Therefore, the court denied the defendant NCAA and member institutions' motion to dismiss for failure to state a claim.[62]

In reaching its conclusion, the *Johnson* court addressed the defendants' three arguments in turn: (1) that the student athletes were amateurs, not professional athletes and, therefore, not employees, (2) that the Department of Labor ("DOL") does not consider student-athletes as

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[57] *See* Coleman v. W. Mich. Univ., 336 N.W.2d 224, 225 (Mich. Ct. App. 1983); Cheatham v. Workers Comp. Apps. Bd., 49 Cal. Comp. 54, 58 (Cal. Ct. App. 1984); Waldrep v. Tex. Emps. Ins. Ass'n, 21 S.W.3d 692, 698 (Tex. App. 2000).

[58] NCAA v. Alston, 141 S. Ct. 2141, 2151 (2021).

[59] Johnson v. NCAA, 561 F. Supp. 3d 490 (E.D. Pa. 2021).

[60] *Id.* at 493, 507.

[61] *Id.* at 497–508.

[62] *Id.* at 507.

employees under the FLSA, and (3) that the plaintiffs did not plausibly allege that the economic realities of the relationship between the plaintiffs and defendants demonstrated an employment relationship.[63]

First, the *Johnson* court cited *Alston* to support its finding that the argument that the plaintiff university student-athletes were not employees of their universities because they were amateurs necessarily failed as "circular reasoning."[64] Second, the court found that although the DOL's Field Operations Handbook provided that programs "conducted primarily for the benefit of the participants as a part of the educational opportunities provided by the school or institutions are not work of the kind contemplated by [the FLSA]," the *Johnson* plaintiffs' participation in NCAA Division I athletic programing was not for the primary benefit of the plaintiff student-athletes, but instead for the benefit of the defendant universities.[65] Third, the court applied the seven factor *Glatt* test to analyze the economic realities of the relationship between the plaintiffs and the defendants, "based on the whole relationship between the parties."[66]

The seven *Glatt* factors required the court to analyze the extent to which (1) both parties had no expectation of compensation; (2) the training provided was educational; (3) the plaintiff's participation in the athletic program structurally resembled an academic program; (4) the athletic program accommodated the plaintiff's academic requirements; (5) the athletic program duration was limited to the duration for which the program would benefit the plaintiff's learning; (6) the plaintiffs' participation in athletics complimented, rather than displaced, the plaintiffs' education; and (7) the parties understood that the program was to be conducted without pay.[67] The *Johnson* court found that the first and seventh factors weighed in

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[63] *Id.* at 503, 505.

[64] Johnson v. NCAA, 556 F. Supp. 3d 491, 501 ("[T]he [defendants] engage in the circular reasoning that they should not be required to pay Plaintiffs a minimum wage under the FLSA because Plaintiffs are amateurs, and that Plaintiffs are amateurs because the [defendants] and other NCAA member schools have a long history of not paying student athletes like the Plaintiffs.") .

[65] *Id* at 504 n.8; *see also id.* at 506 ("[T]he Complaint plausibly alleges that the NCAA D1 interscholastic athletics are not part of the educational opportunities provided to the student athletes by the colleges and universities that they attend but, rather, interfere with the student athletes' abilities to participate in and get the maximum benefit from the academic opportunities offered by their colleges and universities.").

[66] *Id.* at 504–05.

[67] *Id.* at 505–06.

favor of the defendants, the second and fifth factors were neutral, and the third, fourth, and sixth factors weighed in favor of the plaintiffs.[68]

Much like how student-athletes can argue that the *Alston* decision supports a finding that they are employees of their universities,[69] they can also find support by pointing to the *Johnson* court's finding that student-athletes are plausibly employees—considering the economic realities of the relationship between Division I student-athletes, the NCAA, and the students' universities.[70] The *Johnson* court not only cites *Alston* in dispensing with the defendants' amateurism argument,[71] but also extensively analyzes the economic realities of the relationship between Division I student-athletes and their universities.[72] The *Johnson* court's reasoning directly addresses the workers' compensation threshold question of whether student-athletes are employees by using a test that has been applied to analyze claimants' entitlement to workers' compensation recovery in other contexts.[73] Therefore, an injured university student-athlete may cite *Johnson* in pursuing workers' compensation benefits as support for the contention that the economic realities of the relationship between university student-athletes and their universities demonstrates that they are in fact employees of their universities.

3. NLRB Memo

While the *Alston* and *Johnson* decisions alone provide evidence of a change in how courts view university student-athlete's legal status in relation to their universities, the NLRB Memo provides evidence that signals a shift in the treatment of student-athletes by the legal community more broadly. On September 29, 2021, the General Counsel of the NLRB published the NLRB Memo, titled "Statutory Rights of Players at Academic Institutions (Student-Athletes) Under the National Labor Relations Act."[74] The NLRB memo reinstated a 2015 NLRB decision titled *Northwestern University and College Athletes Players Association (CAPA)* that had been repealed by the

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[68] *Id.* at 508.

[69] *See supra* Section III.A.1.

[70] *See generally* Johnson v. NCAA, 561 F. Supp 3d 490 (E.D. Pa. 2021).

[71] *See id.* at 499.

[72] *See id.* at 502.

[73] *Compare id., with* Kidder v. Miller-Davis Co., 564 N.W.2d 872, 880 (Mich. 1997).

[74] NLRB Memo, *supra* note 6.

Trump-era NLRB.[75] The 2015 NLRB decision provided, in relevant part, that Northwestern University Division I football players who were fighting for their right to unionize were employees under the National Labor Relations Act ("NLRA"), and, therefore, entitled to engage in collective bargaining.[76] The NLRB Memo also articulated the NLRB General Counsel's position on university student-athletes more generally: "the football players at issue in *Northwestern University*, and similarly situated Players at Academic Institutions, are employees under [the NLRA]."[77]

Although the NLRB Memo, like the *Alston* and *Johnson* decisions, did not specifically take up the question of student athletes' entitlement to workers' compensation benefits, it provides support for the argument that university student-athletes should be legally categorized as employees of their universities, which would increase the likelihood that such student-athletes would succeed in accessing workers' compensation benefits when injured during university athletic programs.[78] Illustratively, the NLRB General Counsel specifically cited the Supreme Court's *Alston* decision as "a precursor to more changes to come in college athletics . . . as courts continue to chip away at NCAA restrictions on benefits to student-athletes, more compensation that is untethered to academics brings student-athletes more fully within employee status under the law."[79] In other words, the NLRB Memo frames the *Alston* decision as suggestive of a judicial trend toward allowing more compensation of university student-athletes, which in turn allows more university student-athletes to take on the characteristics consistent with the legal definition of an employee.[80]

Further, the NLRB Memo specifically makes a point of calling student-athletes "Players" because the General Counsel claimed that the term student-athlete "was created to deprive those individuals of workplace protections . . . . [the] NCAA's president and lawyers coined the term 'student athlete' in 1950s to avoid paying workers' compensation claims to injured athletes[.]"[81] Arguably, if the NLRB General Counsel's claims are presented to and accepted by courts deciding whether university student-

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[75] *See id.*

[76] *See id.* at 2. *See also* Northwestern Univ. 362 N.L.R.B. no. 167, 1364 (2015) ("In sum, based on the entire record in this case, I find that the Employer's football players who receive scholarships fall squarely within the Act's broad definition of 'employee' when one considers the common law definition of 'employee.'").

[77] *See* NLRB Memo, *supra* note 6.

[78] *Id.*

[79] *See id.* at 5 (internal quotation marks omitted).

[80] *See id.*

[81] *Id.* at 1 n.1.

athletes are entitled to workers' compensation recovery, these courts will likely be increasingly wary of defendant universities' arguments that university student-athletes are in a separate legal category from professional athletes that are entitled to workers' compensation recovery.[82]

All in all, the *Alston* and *Johnson* decisions and the NLRB Memo suggest that the legal classification of university student-athletes as non-employees is eroding.[83] At minimum, these recent developments in the legal classification of university student-athletes provide injured university student-athletes with legal precedent in support of the argument that they are employees of their universities.[84] Once student-athletes are no longer considered non-employees of universities by courts, courts will consider a given student-athlete's claim for workers' compensation recovery by analyzing the two elements of a workers' compensation claim: (1) whether the injury arose out of the employment, and (2) whether the injury occurred during the course of employment.[85] Given that university athletic programs are physically strenuous and dangerous activities, student-athlete claimants will likely succeed in making a case for workers' compensation recovery because athletes are likely to suffer injuries caused by their participation in athletic programs (arising out of employment) and at the time and place of such athletic programming (course of employment).[86] Therefore, the *Alston* and *Johnson* decisions and the NLRB Memo are significant in that they provide support for student athletes overcoming their biggest hurdle to

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[82] *Compare id., and* Johnson v. NCAA, 556 F. Supp. 3d 491, 501 (E.D. Pa. 2021) ("[T]he [defendants] engage in the circular reasoning that they should not be required to pay Plaintiffs a minimum wage under the FLSA because Plaintiffs are amateurs, and that Plaintiffs are amateurs because the [defendants] and other NCAA member schools have a long history of not paying student athletes like the Plaintiffs."), *with* Coleman v. W. Mich. Univ., 336 N.W.2d 224, 226, 227–28 (Mich. Ct. App. 1983) ("[W]hether the employee's duties were integral to the employer's business, however, weighs heavily against the finding of an employment relationship.").

[83] *See supra* Section III.A.

[84] *See id.*

[85] *See supra* Section II.A.

[86] Zachary Y. Kerr, et al., *College Sports-Related Injuries—United States, 2009–10 Through 2013–14 Academic Years,* CTRS. DISEASE CONTROL & PREVENTION (Dec. 11, 2015), https://www.cdc.gov/mmwr/preview/mmwrhtml/mm6448a2.htm.

workers' compensation recovery: the existence of an employment relationship between the university and the student athlete.

B. POTENTIAL SYSTEMATIC IMPLICATIONS OF WORKERS' COMPENSATION FOR STUDENT-ATHLETES

As the history of workers' compensation caselaw demonstrates, the largest hurdle to workers' compensation recovery for student-athletes has been the courts' decision not to classify them as employees.[87] As discussed above, the recent developments of the *Alston* and *Johnson* decisions and the NLRB Memo suggest that a sea-change is occurring in the legal classification of student-athletes, making it more likely that student-athletes will be considered employees of their universities in the future.[88] Given the inherent dangers of university athletics, it is very likely that opening the door to student-athletes becoming classified as employees will also open the flood gates to student-athletes' workers' compensation recovery because it is highly likely that student-athletes' injuries will both arise out of and occur during the course of their participation in university athletic programs.[89]

Therefore, the three recent developments of *Alston*, *Johnson*, and the NLRB Memo are significant catalysts to workers' compensation recovery for university student-athletes. These developments provide precedent for courts to allow student-athletes to recover workers' compensation benefits using the traditional workers' compensation framework, but coming to a different result than courts have since the 1980s on the threshold question of whether an employment relationship exists.

Given that the *Alston* and *Johnson* decisions and the NLRB Memo suggest that courts will more readily classify student-athletes as employees, and the fact that student-athlete plaintiffs will meet the other elements of a workers' compensation claim with ease, these recent developments merit a closer look at the administrative realities of a workers' compensation system for student-athletes. Specifically, these recent developments merit a closer examination of four considerations: (1) the source of funds for student-athlete workers' compensation recovery and the potential financial burden of such claims; (2) the implication of the exclusivity of remedy doctrine; (3) the impact on other legal systems affecting student athletes; and (4) the impact on other student workers.

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[87] *See supra* Section II.B.
[88] *See supra* Section III.A.
[89] *See* Kerr et al., *supra* note 86.

1. The Potential Financial Burden and the Source of Funding

If, as this essay predicts, workers' compensation recovery becomes more common for student-athletes, it is helpful to analyze the financial risk faced by universities and conferences by examining the possible recovery for the most extreme case as an orienting analysis. At first glance, one may think that workers' compensation recovery for a permanently disabled university student-athlete may be astronomical. Given the athlete's young age and the potential (albeit exceedingly rare) that they may become a high-earning professional athlete.[90] However, it is unlikely that workers' compensation is the system by which student athletes will find such windfall recovery.

Workers' compensation benefits in most states are set by an average weekly wage schedule.[91] Therefore, even professional athletes who obtain workers' compensation for their injuries tend to only receive workers' compensation recovery in amounts set by state average weekly wage schedules, which almost always fall far below what the professional athlete would have made had they been able to continue competing at the professional level.[92] The fact that courts in many jurisdictions apply scheduling to calculate the amount of workers' compensation recovery for injured professional athletes suggests that courts are not likely to provide

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[90] *NCAA Recruiting Facts*, NCAA (August 2014), https://www.nfhs.org/media/886012/recruiting-fact-sheet-web.pdf ("Fewer than 2 percent of NCAA student-athletes go on to be professional athletes.").

[91] 8 LARSON'S WORKERS' COMPENSATION LAW § 93.01(1)(a) (Matthew Bender Elite Prods. 2022) ("The beginning point in calculating the amount of benefits is the 'average weekly wage.' This, when the fixed statutory percentage—usually two-thirds—has been applied to it, becomes the unit of benefit by which practically all compensation except disfigurement allowances, medical payments, and occasional special enhancements is measured, subject to maximum and minimum limits.").

[92] Dan Churney, *Life After the Chicago Bears: Ex-Players Have Collected $13M in Workers' Comp Since 2000*, FORBES (Mar. 20, 2018, 10:47 AM), https://www.forbes.com/sites/legalnewsline/2018/03/20/life-after-the-chicago-bears-ex-players-have-collected-13m-in-workers-comp/?sh=5b220bfd97e1 (summarizing workers compensation settlements for various professional athletes valued at $550,000, $220,000, and $400,000); Marc Lifsher, *Athletes Cash in on California's Workers' Comp*, LA TIMES (Feb. 23, 2013, 12:00 AM), https://www.latimes.com/sports/la-xpm-2013-feb-23-la-fi-proathletes-workers-comp-20130223-story.html (detailing a $199,000 workers compensation settlement for a professional athlete).

workers' compensation recovery equal to the university student-athlete's potential professional earning capacity but for the injury. A court is unlikely to speculate as to the amount earned in a university student-athlete's potential professional career if courts do not make a special exception to the wage scheduling for the calculation of recovery for a professional athlete, who has already been making a professional athlete's salary and, therefore, whose earning potential is much less speculative than that of a university student-athlete.

Although the amount of recovery may not be crippling to a university or a conference in response to each discrete claim of workers' compensation by a university student-athlete, university athletics is a dangerous undertaking and, consequently, the probability of multiple student athletes seeking workers' compensation is high.[93] Therefore, it remains important to consider the source of funding for student-athlete workers' compensation recovery. Most universities are not-for-profit institutions.[94] The main funding for universities comes from tuition, fundraising, and governmental grants.[95] One other source of funding of note in this context is the broadcasting and spectator revenue from particularly popular university athletic events.[96] Further, universities insure against financial risks posed by

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[93] Kerr et al., *supra* note 86 ("The 1,053,370 injuries estimated during the 5 academic years studied represented an average of 210,674 total injuries per year[.]").

[94] Josh Moody, *A Guide to the Changing Number of U.S. Universities*, U.S. NEWS & WORLD REP. (April 27, 2021 9:30 AM) https://www.usnews.com/education/best-colleges/articles/how-many-universities-are-in-the-us-and-why-that-number-is-changing#:~:text=Private%20Colleges,profit%20schools%20in%20fall%202019.

[95] *See Current Revenue Sources for Public Research Universities*, AM. ACAD. ARTS & SCI., https://www.amacad.org/publication/public-research-universities-understanding-financial-model/section/2#:~:text=As%20state%20appropriations%20for%20higher,and%20endowment%20and%20investment%20income (last visited Nov. 25, 2021); *IPEDS ANALYTICS: Delta Cost Project Database, National Center for Education Statistics*, NAT'L CTR. EDUC. STAT., https://nces.ed.gov/ipeds/deltacostproject/ (last visited Nov. 25, 2021).

[96] *See* NCAA v. Alston, 141 S. Ct. 2141, 2150–51 (2021) ("At the center of this thicket of associations and rules sits a massive business. The NCAA's current broadcast contract for the March Madness basketball tournament is worth $1.1 billion annually. Its television deal for the FBS conference's College Football Playoff is worth approximately $470 million per year. Beyond these sums, the Division I conferences earn substantial revenue from regular-season games. For example, the Southeastern Conference (SEC) made more than $409 million in

lawsuits, including workers' compensation for individuals traditionally considered employees of the university.[97] Arguably, the most efficient way for student-athlete workers' compensation recovery to be funded is through insurance coverage that mirrors the coverage already in place for typical employees.[98] Although it remains to be seen how much financial risk universities face from student-athlete workers' compensation claims, the typical employee workers' compensation insurance deductible provides a good baseline metric until enough of these cases are processed to provide a representative dataset for future cost predictions for student-athlete-specific workers' compensation recovery.[99]

2. The Implications of the Exclusive Remedy Doctrine

A fundamental characteristic of workers' compensation is the exclusivity of remedy doctrine. Exclusivity of remedy provides that employees entitled to workers' compensation recovery are not able to pursue another cause of action against their employers to compensate them for an

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revenues from television contracts alone in 2017, with its total conference revenues exceeding $650 million that year. All these amounts have increased consistently over the years." (internal quotations and citations omitted)).

[97] *See, e.g.*, *Workers Compensation*, PA. ST. UNIV., https://hr.psu.edu/workers-compensation (last visited Nov. 25, 2021); Risk *Management and Insurance*, COLO. ST. UNIV. http://rmi.prep.colostate.edu/workers-compensation/ (last visited Nov. 25, 2021); *Workers' Compensation*, UNIV. OF MO. SYS., https://www.umsystem.edu/ums/fa/management/risk/insurancecoverages-workerscompensation (last visited Nov. 25, 2021).

[98] *See* Jennifer Berrier et al., *2020 Pennsylvania Workers' Compensation and Workplace Safety Annual Report*, PA. DEP'T LAB. & INDUS. (July 2021), https://www.dli.pa.gov/Individuals/Workers-Compensation/publications/Documents/2020%20WC%20Annual%20Report.pdf ("For new self-insurers starting self-insurance after Oct. 30, 1993, the assessment is 0.5 percent of their modified premium for the 12 months immediately preceding the start of self-insurance. Existing and former self-insurers with runoff claims may be assessed on an as-needed basis at the rate of up to 1 percent of compensation paid annually. For fiscal year 2019-20, the amount assessed was $33,478 and represented 0.5 percent of the annual modified premium of employers starting self-insurance.").

[99] *See id.*

injury covered by workers' compensation.[100] In other words, workers' compensation recovery is the exclusive remedy provided to injured workers for compensation of a workplace injury.[101] One justification for exclusivity of remedy is that in workers' compensation cases, claimants have a lower evidentiary burden. Workers' compensation claimants are not required to show fault on behalf of the employer, whereas in tort cases, plaintiffs are required to prove a breach of duty, which requires proof of negligence on the part of the employer.[102] Given the centrality of exclusivity of remedy to the workers' compensation system, in assessing the implications of allowing workers' compensation recovery for student-athletes, it is important to assess the risks and benefits of foregoing other potential tort claims that student-athletes may currently bring against their university.[103]

In order to hold the university liable for negligence arising out of the student-athlete's injury during an athletic activity, the student-athlete would need to prove that the university had a duty to prevent such an injury; that the university breached such duty; that the university's breach caused the injury; and that the injury was legally cognizable.[104] Arguably, one benefit

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[100] *See, e.g.*, Hyett v. Nw. Hosp. for Women & Children, 180 N.W. 552, 553 (Minn. 1920) ("That the remedy so given and provided is exclusive of all others seems to be the prevailing opinion of the courts where the question has received attention. . . . With the opportunity presented, the discovery of negligence in some respect contributing to a particular injury, would not be difficult, and thus the employer exposed to a second suit in which recovery could be had for pain and suffering, disfigurement of person, in addition to a recovery of compensation for actual disability under the compensation act." (internal citations omitted)).

[101] *See id.*

[102] *See* 9 LARSON'S WORKERS' COMPENSATION LAW § 100.01(1) (Matthew Bender Elite Prods. 2022) ("Once a workers' compensation act has become applicable either through compulsion or election, it affords the exclusive remedy for the injury by the employee or the employee's dependents against the employer, including a borrowing employer, and insurance carrier. This is part of the *quid pro quo* in which the sacrifices and gains of employees and employers are to some extent put in balance, for, while the employer assumes a new liability without fault, it is relieved of the prospect of large damage verdicts.").

[103] *See, e.g.*, Ryan Boysen, *Ex-Players Sue UCLA, Coaches, NCAA For Injuries, Abuse*, LAW360 (May 31, 2019, 10:38 PM) https://www.law360.com/articles/1164791/ex-players-sue-ucla-coaches-ncaa-for-injuries-abuse.

[104] RESTATEMENT (SECOND) OF TORTS § 281 ("The actor is liable for an invasion of an interest of another, if: (a) the interest invaded is protected against unintentional invasion, and (b) the conduct of the actor is negligent with respect to such interest

of a workers' compensation system is that the student-athlete would only need to prove that the they were an employee of the university and that the injury arose out of and was in the course of the their employment, which is a comparably lower evidence.[105]

However, one potential downside of allowing workers' compensation recovery for student-athletes is that the recovery will be limited by schedules determined by state workers' compensation statutes.[106] Whereas with tort claims, the student-athlete's damages would not be limited in such a manner.[107] Therefore, exclusivity of remedy could prevent injured student-athletes from receiving a monetary award equal to the amount that they would be entitled to if the university was being held liable for negligence. Given that workers' compensation law limits the amount of benefits that a student-athlete may recover, and exclusivity of remedy bars an injured university student-athlete from bringing a concurrent tort claim, the university's incentive to rectify the dangerous condition that led to the injury of the plaintiff may be lessened by allowing workers' compensation recovery instead of tort claims.

3. The Impact on Other Relevant Legal Systems

As mentioned above, workers' compensation claims by injured university student-athletes have not been successful in courts since the 1980s.[108] Since the 1980s, much has changed in the world of higher education law. Some legal developments in the recent decades may pose

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or any other similar interest of the other which is protected against unintentional invasion, and (c) the actor's conduct is a legal cause of the invasion, and (d) the other has not so conducted himself as to disable himself from bringing an action for such invasion.").

[105] *See supra* Section II.A.

[106] *See* 7 LARSON'S WORKERS' COMPENSATION LAW § 86.01 (Matthew Bender Elite Prods. 2022) ("Schedule benefits for permanent partial disability are authorized by the statutes of all American jurisdictions except Florida, Kentucky, and Nevada.").

[107] *See* RESTATEMENT (THIRD) OF TORTS § 901 (AM. L. INST. 2000) ("The rules for determining the measure of damages in tort are based upon the purposes for which actions of tort are maintainable. These purposes are: (a) to give compensation, indemnity or restitution for harms; (b) to settle disputes as to rights; (c) to punish wrongdoers.").

[108] *See supra* Section II.B.2.

particular challenges to the administration of a workers' compensation system for university student-athletes.[109] Specifically, Title IX, which prevents discrimination on the basis of sex in educational programs receiving federal funding,[110] and Title IV, which regulates the administration of federal financial assistance that students receive for university attendance.

Title IX was interpreted by the Department of Education to require a federally funded university "which operates or sponsors interscholastic, intercollegiate, club, or intramural athletics shall provide equal athletic opportunity for members of both sexes."[111] In other words, Title IX requires the equal distribution of university resources for university athletic teams that are designated by gender (historically men's and women's teams).[112] Given that the *Alston* and *Johnson* decisions, as well as the NLRB memo, include an analysis of the employment relationship between universities and student-athletes with a particular focus on Division I football, it is unclear whether the same analysis finding that particular university student-athletes were employees would likewise apply to other teams.[113] This legal context presents a challenge to university efforts to comply with Title IX because if only athletes from particular teams are designated as "Men's Teams" (such as football) and considered employees eligible for workers' compensation benefits, then a university could be liable under Title IX for discriminatorily allocating resources to teams with players of a certain gender. In other words,

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[109] 20 U.S.C. § 1070 (2009).

[110] § 1681(a) (1986).

[111] 45 C.F.R. § 86.41(c) (1979); 10 C.F.R. § 5.450(c) (2009).

[112] *See id.*

[113] *See* NCAA v. Alston, 141 S. Ct. 2141, 2150–51 (2021) ("The NCAA divides Division I football into the Football Bowl Subdivision (FBS) and the Football Championship Subdivision, with the FBS generally featuring the best teams. . . . Its television deal for the FBS conference's College Football Playoff is worth approximately $470 million per year."); Johnson v. NCAA, 556 F. Supp. 3d 491, 497 (E.D. Pa. 2021) ("In their 2016 fiscal year, NCAA D1 schools in the football power five subdivision had median total revenues related to NCAA sports of $97,276,000; schools in the football bowl subdivision reported median total revenues related to NCAA sports of $33,470,000; schools in the football championship subdivision had median total revenues related to NCAA sports of $17,409,000[.]"); NLRB Memo, *supra* note 6 ("[T]he athletes play football (perform a service) for the university and the NCAA, thereby generating tens of millions of dollars in profit and providing an immeasurable positive impact on the university's reputation, which in turn boosts student applications and alumni financial donations; the football players received significant compensation, including up to $76,000 per year, covering their tuition, fees, room, board, and books, and a stipend covering additional expenses such as travel and childcare[.]").

universities could violate Title IX because traditionally male football student athletes would be entitled to workers' compensation recovery, whereas teams typically designated as "Women's Teams" would not.[114] In order to address this potential Title IX compliance risk, universities may need to designate a fund for medical and disability benefits that mirrors the amount of workers' compensation benefits that may be recovered by university student-athletes on teams typically designated as "Men's Teams." This fund would then provide those benefits to injured student athletes on teams typically designated as "Women's Teams," despite the fact that those athletes may not succeed in pursuing workers' compensation recovery through traditional channels.[115]

Title IV includes nine provisions that all relate to students' receipt of federal funds to support their education.[116] Title IV is important to consider in the context of workers' compensation recovery for injured university student-athletes because, as the *Alston* and *Johnson* decisions demonstrate, courts are beginning to find that student-athletes receive compensation from universities in the form of athletic scholarships and other educational benefits.[117] Given that the majority of student-athletes do not receive the full cost of attendance from their universities in exchange for their participation in athletic programs and the majority of undergraduates receive federal student aid,[118] the impact of workers' compensation recovery on student athletes' financial aid eligibility under Title IV is important to consider.

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[114] *See* 45 C.F.R. § 86.41(c) ("A recipient which operates or sponsors interscholastic, intercollegiate, club, or intramural athletics shall provide equal athletic opportunity for members of both sexes. In determining whether equal opportunities are available the Director will consider, among other factors: . . . [p]rovision of medical and training facilities and services [and] [p]rovision of housing and dining facilities and services[.]").

[115] *See supra* Section II.

[116] 20 U.S.C. § 1070 (2009).

[117] *See Alston*, 141 S. Ct. at 2164; *Johnso*n, 556 F. Supp. 3d at 507.

[118] *NCAA Recruiting Facts*, NCAA (August 2014), https://www.nfhs.org/media/886012/recruiting-fact-sheet-web.pdf (finding that 53% of Division I student athletes receive some level of athletic scholarship).

On one hand, workers' compensation recovery is typically federally tax-exempt,[119] which suggests that workers' compensation recovery would not be considered in a Title IV analysis of the student-athlete's federal student aid eligibility.[120] On the other hand, if the purpose of workers' compensation benefits is to compensate an injured worker for their loss of earning capacity, and the earnings of a student-athlete are scholarship dollars, then an athlete may receive a windfall by receiving workers' compensation benefits without also having such benefits accounted for as deductions from the athlete's eligibility for federal student aid under Title IV.[121] Therefore, if workers' compensation recovery becomes commonplace for injured university student-athletes, Title IV may need to be amended or further guidance may need to be issued to address whether workers' compensation benefits will be included in future calculations of student-athletes' eligibility for federal student aid.

4. The Impact on Other Student Workers

If, as this essay argues, the *Alston* and *Johnson* decisions and the NLRB memo do signal a sea-change in the legal classification of student athletes as employees and such a sea-change will also lead to increased workers' compensation recovery for student-athletes,[122] it is important to consider what this change would mean for other student workers who have typically not been legally considered employees of their universities.[123]

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[119] *See* I.R.S. Notice 15047D, 19 (2021) ("Amounts you receive as workers' compensation for an occupational sickness or injury are fully exempt from tax if they're paid under a workers' compensation act or a statute in the nature of a workers' compensation act.").

[120] 20 U.S.C. § 1070(a)(2) (2009). ("[T]he term 'adjusted gross income' means- (i) in the case of a dependent student, the adjusted gross income (as defined in section 62 of title 26) of the student's parents in the second tax year preceding the academic year; and (ii) in the case of an independent student, the adjusted gross income (as defined in section 62 of title 26) of the student (and the student's spouse, if applicable) in the second tax year preceding the academic year[.]").

[121] *See* 1 LARSON'S WORKERS' COMPENSATION LAW § 1.03(4) (Matthew Bender Elite Prods. 2022) ("In compensation, unlike tort, the only injuries compensated for are those which either actually or presumptively produce disability and thereby presumably affect earning power.").

[122] *See supra* Section III.A.

[123] *See, e.g.*, Lyons v. Chittenden Cent. Supervisory Union, 185 A.3d 551, 564 (Vt. 2018) ("As in this case, the student's program included both classroom work and an apprenticeship to allow the participants to apply their classroom knowledge

Arguably, student-athletes are not the only students that engage in work that creates value for the university. There are also student interns and student teachers working in a variety of other settings including classrooms, university hospitals, labs, and administrative offices. Non-athlete student-workers also present similar questions to courts—of whether they are employees of the university. Illustratively, the *Glatt* factors used by the *Johnson* court to examine the economic realities of the relationship between student-athletes and their universities were developed in order to test if a student intern should be considered an employee.[124] Specifically, the distinction between a student—frequently not categorized by workers' compensation statutes as an employee—and an apprentice—frequently categorized as an employee under workers' compensation statutes—can affect whether an injured student-teacher, intern, or other student-worker can recover workers' compensation from the student's institution for an injury that the student sustained while working.[125]

Arguably, if student athletes continue to be legally categorized as employees of their universities and are allowed to recover for athletic injuries, those findings would provide other students working for their universities with support for the argument that they too are employees. Particularly, the *Alston* and *Johnson* decisions found that the student athletes' academic scholarships were compensation for the value that the

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in a hospital setting. . . . In concluding that the student was an 'apprentice' under the state workers' compensation statute, the court emphasized that, although he was not paid monetarily, the student 'received the benefits of acquiring the practical skills required in accomplishing the tasks a respiratory therapist must perform.'"); Walls v. N. Miss. Med. Ctr., 568 So. 2d 712, 717–18 (Miss. 1990) ("The job status of apprentice medical-related personnel is highly problematic and usually must be determined not only on a case-by-case basis but also with special regard to relevant statutory provisions. Though possibly and seemingly incongruous, a lab technician trainee could be considered a student for some purposes and an employee for others. . . . we are concerned with coverage under the Workmen's Compensation Act of trainees who learn primarily from work in a hospital affiliated with a technical school the practical and technical skills required for employment in their training specialty. We find these trainees not to be primarily students, but rather to be apprenticeship employees within the meaning of the Workmen's Compensation Act.").

[124] *See* Johnson v. NCAA, 561 F. Supp. 3d 490, 505–06 (E.D. Pa. 2021).

[125] *See supra* note 123.

student athletes brought to the university.[126] A student-worker could make a similar argument that participation in a university internship program or work-study was in fact the student adding value to the university and not the student receiving educational services from the university.[127] Whether or not student-workers succeed with such an argument, courts that allow workers' compensation recovery for injured student-athletes will need to engage in difficult and fact-specific, line-drawing analyses to define the type of work or athletic activity that counts as employment under the relevant workers' compensation laws of each state. In doing so, courts will need to engage in the task of analyzing what type of student-work creates value for the university, which is a highly subjective task with important public policy implications.

IV. CONCLUSION

The recent developments of the *Alston* and *Johnson* decisions, as well as the NLRB memo, suggest that student athletes will succeed more frequently in workers' compensation claims because these developments provide a framework for which courts may more readily hold that student-athletes are employees. Courts applying such reasoning are likely to hold in favor of workers' compensation recovery for student-athletes because the other elements of workers' compensation claims will be easily met, given the inherently dangerous nature of college athletics. Therefore, it is important to consider the administrative realities of a workers' compensation system for student-athletes, since such recovery is more likely in light of *Alston*,

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[126] *See* NCAA v. Alston, 141 S. Ct. at 2150–51 (2021); *Johnson*, 561 F. Supp. 3d at 495–96.

[127] *See, e.g.*, *Alston*, 141 S. Ct. at 2166 ("By permitting colleges and universities to offer enhanced education-related benefits, [the injunction against the cap on educational benefits] may encourage scholastic achievement and allow student-athletes a measure of compensation more consistent with the value they bring to their schools."); Memorandum at 18, Johnson v. NCAA, No. 19-5230 (E.D. Pa. Aug. 25, 2021) ("[W]e find that the Complaint plausibly alleges that NCAA D1 interscholastic athletics are not conducted primarily for the benefit of the student athletes who participate in them, but for the monetary benefit of the NCAA and the colleges and universities that those student athletes attend. We further find that the Complaint plausibly alleges that the NCAA D1 interscholastic athletics are not part of the educational opportunities provided to the student athletes by the colleges and universities that they attend but, rather, interfere with the student athletes' abilities to participate in and get the maximum benefit from the academic opportunities offered by their colleges and universities.").

Johnson, and the NLRB memo. Specifically, courts should consider the implications of allowing injured university student-athletes to recover workers' compensation benefits on: (1) the source of funds for student-athlete-workers' compensation recovery and the potential financial burden of such claims; (2) the implications of the exclusivity of remedy doctrine; (3) the impact on other legal systems affecting student athletes; and (4) the impact on other student workers.