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Federal Legislation and Long-Term Care

A. Health Insurance Portability and Accountability Act (HIPAA)

Public policy is often served by providing economic relief to taxpayers or motivation for particular behavior. The1996 Health Insurance Portability & Accountability Act, more specifically referred to as HIPAA – Public Law 104-191, 110Stat. 1936, 2054 & 2063, is one of the most far-reaching laws passed by Congress in the latter part of the 20th century. The effects of HIPAA are so complex that federal and state governments continue to grapple with its legislative intent.

Federal Health Legislation passed in 1996 that allows, under specific conditions, long-term care insurance policies to be qualified for certain tax benefits. This Congress passed legislation became effective in 1997 and established the tax treatment of premiums paid for and the benefits paid by long-term care insurance policies that met certain federal standards. This legislation is formally called the Health Insurance Portability and Accountability Act or HIPAA.

While the HIPAA legislation was massive in the far reaching regulations applied to the health arena in our country, we specifically take a look here at the Federal health insurance legislation passed in 1996 that allows, under specified conditions, long-term care insurance policies to be qualified for certain tax benefits. We review the key issues surrounding long- term definitions, insurance, and process reform that were transformed, clarified, and expanded.

HIPAA's impact on the treatment of long-term care expenses and long-term care insurance is the focus of this section.

Congress attempted to fulfill a number of different public policy objectives in taking on long- term care. The key issues are

- Classifying long-term care costs as a medical expense thus providing taxpayers with some economic relief;
- Categorizing long-term care insurance as accident & health insurance thereby providing clarity as to the tax treatment of premiums and benefits; and
- Providing the general public an incentive to purchase long-term care insurance.

B. Definitions That Apply to Long-Term Care Expenses and Insurance

1. TQ Definitions

CIC §10232.8 (c)

ADLS Excludes Ambulating

HIPAA does not include ambulating as an activity of daily living. The inability to ambulate becomes more and more important as a person ages. Under HIPAA's qualified long term care plans, the ability to ambulate plays no part, which means benefits are not based on a person's inability to do so. The elimination of ambulation as an ADL in qualified LTC policies caused concern in California regulatory circles.

ADL Impairment

ADL impairment = “substantial assistance (either hands-on or standby) due to loss of functional capacity.”

Cognitive Impairment

Cognitive impairment = “needs substantial supervision due to severe cognitive impairment”

Impairment of Cognitive Ability

"Impairment of cognitive ability" means the insured needs substantial supervision due to severe cognitive impairment”

Plan of Care

Plan of Care = needs + type, frequency, providers, cost

"Plan of care means a written description of the insured's needs and a specification of the type, frequency, and providers of all formal and informal long-term care services required by the insured, and the cost, if any.”

Consumer Exchange Privileges

“In the event the federal Congress passes a law, or treasury rules on the taxation of benefits from non-tax qualified long term care insurance:

- **Exchange privileges made on a guaranteed issue basis:** Policyholders in California will have exchange privileges that must be made on a guaranteed issue basis at the policyholder’s original issue age.”
- **Insurers allowed to adjust premiums:** The insurers would be allowed to adjust premiums if there is a disparity between the old and the new policy.”
- **Exchange would be allowed to be facilitated:** The exchange would be allowed to be facilitated by a new policy or a rider attached to the original one.
- **Exchange not made if policyholder on claim:** The exchange would not be made if policyholder is on claim and receiving benefits. In this case, the original features and benefits of the original policy would continue to pay as promised until the person was no longer on claim. At that time, the policyholder would be granted an opportunity to exchange their policy, if desired.

California regulations address this issue in the following manner. “In the event a non-Medicaid national or state long-term care program is created through public funding that substantially duplicates benefits covered by the policy or certificate, the policyholder or certificate holder will be entitled to select either a reduction in future premiums or an increase in future benefits. An actuarial method for determining the premium reductions and increases in future benefits will be mutually agreed upon by the department and insurers. The amount of the premium reductions and future benefit increases to be made by each insurer will be based on the extent of the duplication of covered benefits, the amount of past premium payments, and claims experience. Each insurer's premium reduction and benefit increase plans must be filed and approved by the department.” CIC 10235.91

IRS Notice 97-31 TQ Definitions

Qualified Long-Term Care Services / Chronically Ill Individual

Qualified Long-Term Care Services

The IRS defines “qualified long-term care services” as

“Necessary diagnostic, preventative, therapeutic, curing, treating, mitigating, rehabilitative services and maintenance and personal care services required by a chronically ill individual pursuant to a plan of care prescribed by a licensed health care practitioner.”

Congress established a trigger basis for initiating benefits by tying services to a state of disability defined as a chronically ill individual to control when the cost of long-term care services could receive favorable tax treatment.

Chronically Ill Individual

The broad and expanding nature of long-term care expenses made it difficult to stipulate a “laundry list” of qualified services. The IRS defines “qualified long-term care services” as

Necessary diagnostic, preventative, therapeutic, curing, treating, mitigating, rehabilitative services and maintenance and personal care services required by a chronically ill individual pursuant to a plan of care prescribed by a licensed health care practitioner.

This overly broad universe of services could potentially be used by anyone at any time for services normally covered under healthcare insurance. To control when the cost of long-term care services could receive favorable tax treatment, Congress established a trigger basis for initiating benefits by tying services to a state of disability defined as a chronically ill individual.

A chronically ill individual must be certified by a **licensed health care practitioner** within the previous 12 months as one of the following:

1. The insured is unable, certified for at least 90 days, to perform at least two activities of daily living (ADL’s) without substantial assistance from another individual, due to loss of functional capacity. Activities of daily living are eating, toileting, transferring, bathing, dressing and continence.
2. The insured requires substantial supervision to be protected from threats to health and safety due to severe cognitive impairment.

The standardized definition of a chronically ill person cannot be altered in any way by state law, and it is the only definition allowed to receive the favorable tax treatment for the cost of long-term care services.

When Will Long-Term Care Insurance Begin Paying Benefits?

All long-term care policies require that your physical or mental abilities be limited to one of three standards before benefits will be paid. These standards are often called Benefit Triggers. Many policies also require that additional conditions be met before you will receive payment. These "conditions" are events that must occur (or documents you must submit) after you meet the "benefit triggers" and before benefits will be paid.

The three benefit triggers permitted in long-term care insurance policies in California are

- Impairment in activities of daily living (ADLS);
- Impairment in cognitive ability (or cognitive impairment); or

- Medical necessity.

Impairment in Activities of Daily Living (ADLs).

"Activities of Daily Living" (ADLs) are used to measure your physical abilities to determine if you qualify for benefits. The law requires tax-qualified policies to pay benefits if you are impaired in 2 out of the following 6 ADLs: bathing, dressing, transferring, eating, toileting and continence. For non-tax qualified policies, the requirement is for 2 out of the following 7 ADLs: ambulating, bathing, dressing, transferring, eating, toileting and continence. Note that the additional ADL for non- tax qualified policies is ambulating, which means walking or moving around inside or outside the home regardless of the use of a cane, crutches, or braces.

“Only two ADLs can be required before benefits will be paid for nursing home care, RCFE care, or home care in policies sold after October 1, 2001.”

“Impairment" means that you need human assistance or continual supervision to perform an Activity of Daily Living. Policies that trigger benefits when you only have to meet one of the ADLs may begin paying benefits earlier in your disability than if you have to meet two. However, your premiums will be higher and the policy will not be tax qualified.”

Impairment in Cognitive Ability (or Cognitive Impairment

"Impairment in Cognitive Ability" that would require the need for continual supervision to protect oneself or others due to the deterioration or loss of intellectual capacity due to organic mental disease, including Alzheimer's disease or related illnesses.”

Medical Necessity

“Medical Necessity" usually means your doctor has certified that your medical condition will deteriorate if you do not receive the care recommended. However, under California law, an insurer is not allowed to require that your benefits also be "medically necessary" before the company will pay. Federal law prohibits the use of a medical necessity trigger in tax-qualified long-term care insurance policies.” A Guide to Long-Term Care Insurance-CA

TQ “Licensed Health Care Practitioner” Independent of Insurer

CIC §10232.8(C)

Licensed Health Care Practitioner

The Internal Revenue Service defines the licensed health care practitioner (LHP) in very general terms. They can include doctors, nurses, social workers, chiropractors, Christian Science practitioners, mental health professionals, and other licensed therapists. Agents can find an expanded source of information on this in IRS Publication 502 which includes an extensive list of licensed health care practitioners. California Insurance Code Section 10232.8(c) narrows the list by specifying the role of the LHP in the certification, assessment, and plan of care of the insured for the purposes of the claims process. The LHP must be independent of the insurance company and “shall not be compensated in any manner that is linked to the outcome of the certification” CIC 10232.8(c). “Federal and State law requires the certification of the insured’s assessment be renewed every 12 months.” CIC §10232.8(c)

Licensed Health Care Practitioner

"Licensed Health Care Practitioner = MD, RN or LSW" licensed health care practitioner" means a physician, registered nurse, licensed social worker, or other individual whom the United States Secretary of the Treasury may prescribe by regulation;"

90-Day Certification for Activities of Daily Living

"The 90-day certification by a LHP is not a requirement for qualification under the cognitive impairment trigger. Similar to the ADL qualification however, the insured must be re- certified every 12 months to ensure that they still qualify for benefits.

Taxpayers and tax preparers must document an ADL or cognitive impairment consistent with HIPAA rules in order to deduct long-term care expenses as a medical expense. Many tax preparers miss this point and it could be a critical matter during a tax audit.

Impairment in activities of daily living means the insured needs "substantial assistance" either in the form of "hands-on assistance" or "standby assistance," due to a loss of functional capacity to perform the activity.

Substantial Assistance

For the purposes of the activities of daily living, IRS Notice 97-31 (1997) allows substantial assistance to be defined to mean both hands-on assistance and standby assistance.

- **Hands-On Assistance:** means the physical assistance of another person without which the individual would be unable to perform the ADL.
- **Stand-By Assistance:** means the presence of another person within arm's reach of the individual that is necessary to prevent, by physical intervention, injury to the individual while the individual is performing the ADL (such as being ready to catch the individual if the individual falls while getting into or out of the bathtub or shower as part of bathing, or being ready to remove food from the individual's throat if the individual chokes while eating)."

Impairment of Cognitive Ability

"Impairment of cognitive ability" means the insured needs substantial supervision due to severe cognitive impairment."

As an additional note, **Medical Necessity,** if applicable, a third trigger beyond those listed previously usually means one's doctor has certified that their medical condition will deteriorate if they do not receive the care recommended. However, under California law, "an insurer is not allowed to require that your benefits also be 'medically necessary' before the company will pay. Federal law prohibits the use of a medical necessity trigger in tax- qualified long-term care insurance policies."

Severe Cognitive Impairments and Substantial Supervision

"Severe cognitive impairment" means a loss or deterioration in intellectual capacity that is

- Comparable to (and includes) Alzheimer's disease and similar forms of irreversible dementia, and
- Measured by clinical evidence and standardized tests that reliably measure impairment in the individual's
  - Short-term or long-term memory,
  - Orientation as to people, places, or time, and
  - Deductive or abstract reasoning."

"Substantial supervision" means continual supervision (which may include cuing by verbal prompting, gestures, or other demonstrations) by another person that is necessary to protect the severely cognitively impaired individual from threats to his or her health or safety (such as may result from wandering)."

C. Tax-Qualified Long-Term Care Insurance

1. TQ Definitions of the Six ADLs

- **Eating**, which shall mean feeding oneself by getting food in the body from a receptacle (such as a plate, cup, or table) or by a feeding tube or intravenously.
- **Bathing**, which shall mean washing oneself by sponge bath or in either a tub or shower, including the act of getting into or out of a tub or shower.
- **Continence**, which shall mean the ability to maintain control of bowel and bladder function; or when unable to maintain control of bowel or bladder function, the ability to perform associated personal hygiene (including caring for a catheter or colostomy bag).
- **Dressing**, which shall mean putting on and taking off all items of clothing and any necessary braces, fasteners, or artificial limbs.
- **Toileting**, which shall mean getting to and from the toilet, getting on or off the toilet, and performing associated personal hygiene.
- **Transferring**, which shall mean the ability to move into or out of bed, a chair or wheelchair. Transferring may include ambulating activities.

2. Impact and Implications for Trigger Differences

Agents should be able to reflect the impact and implications of these definitions as they relate to TQ vs. NTQ and benefit eligibility in California. The State of California has seven activities of daily living for non-qualified policies, whereas federal law contains six for tax- qualified policies. At first glance, it would appear that federal ADL's are easier to trigger, but this is not necessarily true. Federal ADL's are more restrictive in that they require the policyholder to need assistance for 90 days or longer before benefits are paid, whereas California's does not require this.

A point to emphasize is that federal law does not allow a less restrictive requirement for the inability to perform two of the ADL's if tax-qualification is desired. Federal law will also not allow anything other than severe cognitive impairment as an alternative trigger to the two ADL's requirement. In addition, a licensed health care professional must prepare a new certified plan of care every 12 months.

In contrast, California non-qualified policies do not have the 90 day requirement. Activities of daily living are easier to meet, as well.

NOTE: HIPAA left the door open for a third definition that has yet to be determined.

If Federal Government Expands Its Triggers

"If the federal government expands its triggers in the future the California Insurance Department will issue emergency regulations to bring their regulations into compliance and to clarify the California issues to the extent they are impacted by the Federal changes or expansion, department must issue emergency regulations.

In California, if federal law or regulations allow other types of disability to be used, the commissioner will promulgate emergency regulations to add those other criteria as a third threshold to establish eligibility for benefits. Insurers must submit policies for approval within 60 days of the effective date of the regulations.

With respect to policies previously approved, the department is authorized to review only the changes made to the policy. All new policies approved and certificates issued

after the effective date of the regulation must include the third criterion. No policy can be sold that does not include the third criterion after one year beyond the effective date of the regulations. An insured meeting this third criterion shall be eligible for benefits regardless of whether the individual meets the impairment requirements regarding activities of daily living and cognitive ability."

3. Written Plan of Care, 12-Month Renewal, and Not From Benefit Maximum

"A licensed health care practitioner must develop a written plan of care after personally examining the insured. The written certification must be renewed every 12 months. The costs to have a licensed health care practitioner certify that an insured meets, or continues to meet, the definition of "chronically ill individual," or to prepare written plans of care cannot count against the lifetime maximum of the policy or certificate."

4. Shall Apply Only to TQ Policies

"The above requirements apply only to a policy or certificate intended to be a federally qualified long-term care insurance contract."

D. Benefits

1. Benefit Eligibility for TQ and Non-TQ

Agents should be able to reflect the impact and implications of these definitions as they relate to TQ vs. NTQ and benefit eligibility in California. The State of California has seven activities of daily living for non-qualified policies, whereas federal law contains six for tax- qualified policies. At first glance, it would appear that federal ADL's are easier to trigger, but this is not necessarily true. Federal ADL's are more restrictive in that they require the policyholder to need assistance for 90 days or longer before benefits are paid, whereas California's does not require this.

A point to emphasize is that federal law does not allow a less restrictive requirement for the inability to perform two of the ADL's if tax-qualification is desired. Federal law will also not allow anything other than severe cognitive impairment as an alternative trigger to the two ADL's requirement. In addition, a licensed health care professional must prepare a new certified plan of care every 12 months.

In contrast, California non-qualified policies do not have the 90 day requirement. Activities of daily living are easier to meet, as well.

If the Federal Government expands their benefit triggers requirements in any way, the California Department of Insurance must issue emergency regulations.

NOTE: "It is extremely important for agents to understand the difference between federal and state benefit triggers so as to be able to explain to the client. If the client does not understand these differences, he or she will be unable to make a decision as to which policy best suites his or her needs."

Despite fewer ADL's by the federal government, they are more restrictive and difficult to meet than California's ADL requirements.

"An example is Jennifer who qualified with the state's definition of ADL's, but not with the federal definition. The reason was that when eating she was able to grasp a cup, but could not drink because her hands were shaking so badly. The liquid would spill before it reached her mouth. The federal definition speaks only of "feeding" oneself, not grasping a cup or plate."

An agent advising her on what policy to buy would recommend the “easier to qualify for” State of California ADL’s; especially because she did not need tax protection due to her low income.

“Charlie had cognitive impairment, but it was not “severe” by federal definition. He was able to walk, feed and toilet himself, but he could not bathe alone because he could not get in and out of the bathtub by himself. On occasion, he also forgot where he lived. Henry would not have qualified for federal ADLs.”

2. Required Consumer Protection

Disclosure, TQ or Not TQ, on Policy, OOC and Application

There are 3 types of long-term care policies that can be offered for sale in California. Since they have specific areas of coverage as their focus, issuers of this coverage must make it clear to consumers and purchasers what type each one is and make it clear on all documents that are part of the sales process.

“Each policy must be clearly labeled on the policy, the OOC–Outline of Coverage, and on the application.” *CIC §10232.25*

Products Must Be Called "Nursing Facility and Residential Care Facility"

Three Categories of Long-Term Care Insurance Policies

Nursing Facility and Residential Care Facility Only

These policies cover skilled, intermediate, or custodial care in a nursing home or similar facility. These policies also pay for assisted living care in a Residential Care Facility for the Elderly (RCFE) but Home Care is not covered.

Home Care Only

These policies are required to pay for: Home Health Care, Adult Day Care, Personal Care, Homemaker Services, Hospice Services and Respite Care but care in a facility is not covered.

Comprehensive Long-Term Care

These policies pay for nursing facility care, assisted living care in a RCFE, and home and community care. These policies must include at least 8 benefits: a nursing home benefit, a RCFE benefit for assisted living, and the 6 home care benefits: Home Health Care, Adult Day Care, Personal Care, Homemaker Services, Hospice Service and Respite Care. A Comprehensive Long-Term Care policy must have the maximum benefit payment for home care that is at least 50 percent of maximum benefit payment for institutional care. CA Long- term care Rate Guide-A Guide to Long-Term Care

In California, every policy that is intended to be a qualified long-term care insurance contract as provided by Public Law 104-191 must be identified by prominently displaying and printing on page one of the policy form and the outline of coverage and in the application the following words:

"This contract for long-term care insurance is intended to be a federally qualified long-term care insurance contract and may qualify you for federal and state tax benefits." CIC §10232.92

Every policy that is not intended to be a qualified long-term care insurance contract as provided by Public Law 104-191 must be identified by prominently displaying and

printing on page one of the policy form and the outline of coverage and in the application the following words:

"This contract for long-term care insurance is not intended to be a federally qualified long-term care insurance contract." CIC §10232.92

Products Must Be Called "Nursing Facility and Residential Care Facility"

“Any policy or certificate in which benefits are limited to the provision of institutional care shall be called a "nursing facility and residential care facility only" policy or certificate and the words "Nursing Facility and Residential Care Facility Only" must be prominently displayed on page one of the form and the outline of coverage. The commissioner may approve alternative wording if it is more descriptive of the benefits.” CIC §10232.92

Products Must Be Called "Home Care Only"

“Any policy or certificate in which benefits are limited to the provision of home care services, including community-based services, must be called a "home care only" policy or certificate and the words "Home Care Only" must be prominently displayed on page one of the form and the outline of coverage. The commissioner may approve alternative wording if it is more descriptive of the benefits.”

May Be Called "Comprehensive Long-Term Care" If Both Are Included

“Only those policies or certificates providing benefits for both institutional care and home care may be called "comprehensive long-term care" insurance.”

3. Required Consumer Protection - NAIC

NAIC Consumer Protection Required for TQ LTCI by HIPAA

Qualified long-term care insurance policies are required to meet specific consumer protection guidelines of the 1993 National Association of Insurance Commissioners Model Act and Regulations for Long-term Care Insurance. Many of the consumer protections in the NAIC Models had already been adopted in California with the passage of Senate Bill 1943, Chapter 1132, Statutes of 1992, that included protections related to the following: guaranteed renewal or non-cancellation of the policy; prohibitions on exclusions and limitations; extension of benefits and conversions; replacement; unintentional lapse; post-claim underwriting; requirement to offer inflation protection and rejection by consumer; restrictions on preexisting conditions and probationary periods; disclosure; and, non-forfeiture provisions.

4. IRS Reporting Mechanism

Reporting of Tax-Qualified Long-Term Care Benefits

HIPAA also establishes a reporting mechanism for benefits received under all long-term care insurance policies. Similar to disability insurance, if a policyholder receives benefits from a long- term care insurance policy, they will receive an IRS 1099 LTC Form issued by the carrier.

Benefits reported on the 1099 must also be reported on IRS Form 8853. The 1099 form must identify the method of benefit payment (reimbursement or per diem) but does not need to determine the tax qualified status of the actual long-term care insurance policy from which the benefits were paid. Form 8853, which contains the medical savings and the IRS 1099 information, adds additional questions to the taxation of non-qualified benefits because it provides a vehicle for these benefits to

be taxed. Despite continuing confusion, neither the Department of the Treasury nor Congress has clarified this matter.

The insurance carrier is required to report to the IRS on Form 1099-LTC on how much the amount paid for long-term care benefits for the year that the payment was made. Both the tax code and the federal government through HIPAA are silent on how benefit payments made under a non-federally qualified policy should be reported. It is not possible to give an absolutely correct answer at this time on benefit taxation. Agents should refer their clients to their accountants or other qualified advisors in how they should view tax benefits for their particular situation. Only Congress, the Internal Revenue Service, or a tax court can give the ultimate answer.

It may be easier to qualify for benefits from non-tax qualified policies that use the standards established by California. Policies sold as federally tax qualified long-term care insurance use a standard of eligibility for benefits that may be stricter than the standards established in California for non-qualified policies. Their long-term care insurance agent can advise them if one has questions about the tax status of a policy they own or one they are considering buying. They should talk to their tax advisor to see how it will affect their individual taxes if they have specific questions pertaining to how the purchase of tax qualified long-term care insurance will impact the deductions they take or the taxes they pay. CA Long-term care Rate Guide-A Guide to Long-Term Care

Insurers May Give Applicant a Time of Solicitation Verbatim TQ Comparison Chart

This chart included below in the material and is the most current). CIC §10232.25

“When solicitation of a long-term care product is made, a verbatim tax qualified comparison chart must be given to the consumer. This chart must be the most current chart available.”

A. Tax-Qualified Eligibility for Benefits	A. Non-Tax-Qualified Eligibility for Benefits
You will not be paid for any home care services you need until: You are unable to do 2 out of 6 ADLs (Activities of Daily Living) which include • Bathing • Dressing • Continence • Toileting • Transferring • Eating OR You need help due to Severe Cognitive Impairment (Please see the outline of coverage for a definition of ADL)	You will not be paid for any home care services you need until: You are unable to do 2 out of 7 ADLs (Activities of Daily Living) which include • Bathing • Dressing • Continence • Toileting • Transferring • Eating or • Ambulating (this added ADL may make it easier to qualify for home care benefits) OR You need help due to Cognitive Impairment.
A health care practitioner must certify that the insured will need assistance with	No 90-day certification requirement. Some policies may provide benefits for serious illnesses of less than 90 days.

Activities of Daily Living for at least a period of 90 days.	(Please see the outline of coverage for your policy provisions.)
In general, no policy benefits can be paid for services covered by Medicare or be applied to pay for Medicare deductibles or co- payments.	In general, there are no limitations regarding the use of policy benefits for Medicare- related services.
B. Tax-Qualified Federal and State Tax Treatment	**B. Non-Tax-Qualified Federal and State Tax Treatment**
Premiums are intended to be deductible as a medical expense if you itemize deductions on your tax returns. Medical expenses must exceed 7.5% of your adjusted gross income. The amount you can deduct is capped, based on your age and adjusted gross income.	Premiums are not intended to be deductible on your tax returns.
Benefits paid under the policy are not intended to be taxed as income.	Benefits paid under the policy may or may not be taxed as income. Should the IRS treat these benefits as taxable income, the costs you pay for care may or may not be eligible as an offsetting tax deduction. Neither federal law, nor the IRS, has taken a position on these issues.

If you have further questions regarding your choice of policies, you may wish to contact your local Health Insurance Counseling and Advocacy Program (HICAP) office which provides long-term care insurance counseling free of charge. Your insurance agent or insurer is required to provide you with the name, address, and telephone number of your local HICAP office. The statewide HICAP telephone number is 1-800-434-0222.

As noted above, long-term care benefits paid under policies that meet California standards but that are not intended to qualify for tax benefits may or may not be taxable as income. If the U.S. Congress or the IRS resolves this issue, you will be provided a one-time opportunity to EXCHANGE POLICIES. If this issue is resolved, you will be notified by your insurer that you may exchange your policy regardless of whether you purchased a policy intended to qualify for tax benefits or one that is not intended to qualify for tax benefits. The exchanged policy will be issued without any additional evidence of insurability and the new policy premium (which may be lower or higher) will be based on your age at the time you were issued the original policy. However, you will not be allowed to exchange policies if you are receiving long term care benefits under your policy at the time of the notice, or if the exchange would make you immediately eligible to receive benefits.

If you have questions about the potential tax impacts of these two types of policies, you may wish to consult a TAX ADVISER before deciding which type of policy you wish to purchase.

Your agent or insurer is required by law to provide you with this form which displays the major differences between these two types of policies. Before signing this disclosure form and your application, please discuss with your agent or insurer the above side-by-side comparison information regarding these two types of policies.

Applicant: _____ Agent or Insurer: _____

Date: _____

Date:_____

A copy of this form is to be provided to the applicant.

5. Employers Comparison Notice

Tax-qualified and non-tax qualified comparisons must also be given by Employers to their Employees and the Employee's dependents. This chart aids in that process. Employees must be able to make an informed decision.

E. Tax Treatment of Pre-1997 Long-Term Care Insurance Policies

Insurer must disclose possible tax consequences if pre-1997 insured requests "material modification" CIC §10232.96

"When a policy or certificate holder of an insurance contract issued prior to December 31, 1996, requests a material modification to the contract as defined by federal law or regulations, the insurer, prior to approving such a request, shall provide written notice to the policy or certificate holder that the contract change requested may constitute a material modification that jeopardizes the federal tax status of the contract and appropriate tax advice should therefore be sought. "

1. Grandfathered Status of Policies Issued Prior to January 1, 1997

Congress realized that there were many long-term care insurance policies issued prior to January 1, 1997, that would not comply with HIPAA. Either their benefit structures or payment mechanisms were inferior to its guidelines or, in the case of California, the benefit triggers were considered too generous. Legislators left it to the Department of the Treasury to establish guidelines for "grandfathered" policies. In its interim directive on tax qualified long-term care insurance (Notice 97-31, May 1997), the Department of the Treasury indicated that long-term care insurance policies issued prior to January 1, 1997, meeting "long-term care insurance requirements of the State in which the contract was issued" would be grandfathered in for the purposes of tax qualification unless the policyholder made a "material change" to the policy."

2. Eligibility for Benefits

What may make it easier to qualify for benefits in pre-1997 policies than required triggers in TQ policies are eligibility triggers?

"If the insured meets one or two following criteria, this is possible (a) inability to perform two activities of daily living, or (b) impairment of cognitive ability. The policy or certificate may provide for the lesser eligibility criteria. The commissioner can also approve other criteria if the insurer shows that the insured is better served." (Source: AB 1483, Sec. 4, 10232.8).

"All insurers that offers policies or certificates that are intended to be federally qualified long-term care insurance contracts, including riders of life insurance contracts providing long-term care coverage, must fairly and concurrently offer and

market long-term care insurance policies or certificates that are not intended to be federally qualified.

Every long-term care insurance contract, including riders to life insurance contracts providing long-term care coverage, approved after January 1, must meet all of the following:

- Until January 1, 1999, or 90 days after approval of contracts submitted for approval, whichever comes first, insurers were allowed to continue to offer and market previously approved long-term care insurance contracts.
- Group policies issued prior to January 1, 1997, must be allowed to remain in force and not be required to meet the requirements of this chapter, as amended during the 1997 portion of the 1997-98 Regular Session, unless those policies cease to be treated as federally qualified long-term care insurance contracts. If such a policy or certificate issued on such a group policy ceases to be a federally qualified long-term care insurance contract under the grandfather rules. The insurer must offer the policy and certificate holders the option to convert, on a guaranteed-issue basis, to a policy or certificate that is federally tax qualified if the insurer sells tax-qualified policies.
- Until October 1, 2001, insurers could continue to offer and market previously approved long-term care insurance contracts.
- Group policies issued prior to January 1, 1997, must be allowed to remain in force and not be required to meet the current requirements, unless those policies cease to be treated as federally qualified long-term care insurance contracts.
- If a policy or certificate issued on a group policy of that type ceases to be a federally qualified long-term care insurance contract under the grandfather rules, the insurer must offer the policy and certificate holders the option to convert, on a guaranteed- issue basis, to a policy or certificate that is federally tax qualified if the insurer sells tax-qualified policies."

3. Tax Consequences of Making "Material Modifications" to Existing Policies

CIC §10232.96

4. Department of Treasury, Material Modification Rules, Interim Guidance

Favorable Tax Treatment Can Be Retained

"If the insurance contract specifically allows for the change in benefits requested by a policyholder, i.e. add a non-forfeiture rider, favorable tax treatment can be retained in pre 1/1/97 policies."

Favorable Tax Treatment Can Be Lost

If the change materially modifies the existing contract, favorable tax treatment can be lost.

"For policies issued prior to December 31, 1996, when a policy or certificate holder of an insurance contract, requests a material modification to the contract as defined by federal law or regulations, the insurer, prior to approving such a request, shall provide written notice to the policy or certificate holder that the contract change requested may constitute a material modification that jeopardizes the federal tax status of the contract and appropriate tax advice should therefore be sought."

5. Definition of "Material Change"

Although the interim directive did not define "material change", the final regulations issued in December 1998 identified criteria for which a "material change" would result in a policy losing its tax qualified status. The following are treated as "material

changes" and considered issuance of a new contract with the resulting loss of tax qualified status:

- "A change in terms of a contract that alters the amount or timing of an item payable by either the policyholder, the insured or insurance company;
- A substitution of the insured under an individual contract;
- A change (other than a non-material change) in the contractual terms or in the plan under which the contract was issued relating to eligibility for membership in the group covered under a group contract."

The following, however, are actions that are not considered "material changes" and will not jeopardize the policy's grandfathered status:

- "Regarding premiums: a change in the mode of premium payment; an increase or decrease in premiums for all contracts that have been issued on a guaranteed renewable basis; a reduction in premiums due to the purchase of a long-term care insurance policy by a member of the policyholder's family; a reduction in premium due to a reduction in coverage made at the request of a policyholder; a reduction in premiums that occurs because the policyholder becomes entitled to a discount under the issuer's pre-1997 premium rate structure (such as a group or association discount or change from smoker to non-smoker status); the addition, without an increase in premiums, of alternative forms of benefits that may be selected by the policyholder.
- Regarding riders: the addition of a rider to increase benefits under a pre-1997 contract if the rider would constitute a qualified long-term care insurance contract if it were a separate contract; the deletion of a rider or provision of a contract (called an HHS – Health and Human Services – rider) that prohibited coordination of benefits with Medicare.
- Other actions include: the effectuation of a continuation or conversion of coverage right under a group contract following an individual's ineligibility for continued coverage under the group contract; the substitution of one insurer for another in an assumption reinsurance transaction; the expansion of coverage under a group contract caused by corporate merger or acquisition; the extension of coverage to collectively bargained employees; the addition of former employees."

Legal Consequences of Making Material Modifications

CIC §10232.96

Almost any change, as it stands currently, will be considered to be a material modification, which would jeopardize the grandfathered tax qualified status of their policy, California's SB 1052 added legislation to protect consumers. It requires the insurance company to "notify the policy or certificate holder of any policy issued prior to December 31st, 1996 that by requesting a change they could cause the loss of their tax preferred status." This has to be done "when the policyholder or certificate holder makes a request for modification. The company notice must be sent prior to any change actually being made. This precludes insurers from making changes without notifying policy holder that such changes may jeopardize federal tax treatment."

Note: The critical message for consumers is that anytime a consumer considers replacing a policy issued prior to January 1, 1997, great caution must be exercised. A pre-HIPAA policy may contain provisions that might make it easier to qualify for benefits: for example, 2 out of 7 activities of daily living instead of the 2 out of 6 required by HIPAA; a medical necessity benefit trigger that is prohibited in HIPAA; no HIPAA 90-day certification requirement; the benefits of a pre-HIPAA policy do not require coordination with Medicare, which increases the amount available to pay for long-term care.

F. Long-Term Care Insurance Premium Deductibility

Long-term care policies that use the federal standards to pay benefits are labeled as "Federally Tax Qualified." Some or all of the premiums for these federally tax qualified policies may be deductible as a medical expense on one's federal and California income tax returns (depending on one's age and the amount of annual premium).

1. Health Savings Accounts (Medical IRA Account)

Health Savings Accounts (HSAs), and their predecessor MSAs, were established under HIPAA and more recent reforms. Those consumers under age 65, who are willing to take on the responsibility of a larger medical insurance deductible in favor of lower premiums, are provided a tax incentive to do so.

Simply stated, the consumer purchases a qualified high deductible medical insurance plan. They are then allowed to make a pre-tax contribution to their HSA account not to exceed (in 2015) $3,350 (individual) or $6,650 (family). "Catch-Up" contribution provisions allow HSA holders to add an additional $1,000 to their account if they are age 55 or older. The money placed in the HSA account grows tax deferred, similar to an IRA or other qualified retirement plan. The funds accumulated can be used to pay for unreimbursed medical expense allowed by IRC Sec. 213(d), deductibles and co-insurance. The money in the HSA can also be used to pay the premiums on a tax qualified long-term care insurance policy up to the age banded limits listed below.

HSAs are achieving acceptance in individual and group health insurance markets. Their applicability depends on the regional make-up of the medical care delivery system, the availability of medical insurance plans in an area, and the pricing disparity between conventional "low-deductible" plans and the "high-deductible" plans that qualify for the HSA program. HSAs represent an opportunity for some consumers to tailor their medical insurance and long-term care insurance priorities in a cost and tax-efficient manner.

2. Individual Deductibility

The HIPAA of 1996 contained a change in the tax law for long-term care insurance contracts that meet certain federal standards. Basically, it treats certain "qualified" long-term care contracts the same as health insurance for tax purposes. The premiums are deductible in part or whole from the insured's personal income. Up to $330 per day (2015), or $120,450 per year, of payments from long-term care policies would not be included in personal income. This also applies to life insurance riders designed to provide long-term care benefits. The un- reimbursed cost of qualified long-term care services is deductible as a medical expense.

Currently taxpayers can deduct regular medical expenses if they exceed 10% (7.5% if over 65 until 2016) of their adjusted gross income. For long-term care insurance, the maximum deduction a taxpayer can take for premiums is limited according to their age. See the table below for those amounts and ages:

How Much Can Be Deducted? (2015)	
Age:	**Maximum Deduction:**
40 or younger	$360
41-50	$680
51-60	$1,360
61-70	$3,640
71 or older	$4,550

These amounts represent individual figures. On a joint return, each person can deduct the individual amount shown in the table.

Depending on what tax bracket an individual ultimately is in during a taxable year will determine what the specific dollar savings would be for them. *For example,* a 15% tax bracket on a $2,000 premium for a 70 year old would be $300. For a 40 year old with a

$2,000 premium, the 15% could only be applied toward $200 of the premium for a $30 tax savings. The tax savings potential might not be significant enough for the 40 year old to choose the more stringent rules of eligibility in a tax qualified policy. It depends on the individual and their overall suitability issues taken together.

A long-term care policy with substantial coverage can be bought within these limits shown in the table above. These savings are "potential." There are limitations on the amount of the deduction that will prevent some policyholders from claiming the deduction or even a part of it.

Only those who itemize their deductions on their tax return will be able to deduct all or a portion of the cost of their premium. Most taxpayers take advantage of the standard deduction allowed by the IRS. Less than 30 percent of all taxpayers itemize their deductions on their tax return. Even less of senior citizens itemize their deductions on their income tax forms. This is probably due to the fact that few seniors enough significant interest and expenses. Generally, it is not to their advantage to itemize.

Also, in order to be deductible, the cost of the qualified long-term care insurance premium, plus other qualifying medical expenses, must exceed 10% (7.5% if over 65 until 2016) of the taxpayer's adjusted gross income. To begin with, many taxpayers do not have enough non- reimbursed medical expenses to reach the 10% (7.5% if over 65 until 2016) mark. Unless the 10% (7.5% if over 65 until 2016) threshold is exceeded, no deduction can be claimed. Only the portion of medical expenses that exceed 10% (7.5% if over 65 until 2016) percent is deductible. All policies certified by the California Partnership for Long-Term Care are tax qualified.

Non-qualified long-term care insurance premiums are not deductible. There are no tax benefits from these premiums.

In addition, when a policyholder files a claim for long-term care benefits from their qualified policy, under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the tax treatment of these benefit payments received are not considered to be taxable income. They are not subject to income tax except for certain per diem type reimbursements, then only if the per diem rate exceeds certain amounts ($330 per day in 2015).

Both the tax code and the federal government through HIPAA are silent on how benefit payments made under a non-federally qualified policy should be reported. The insurance carrier is required to report to the IRS on Form 1099-LTC on how much the amount paid for long-term care benefits for the year that the payment was made. It is not possible to give an absolutely correct answer at this time on benefit taxation. Only Congress, the Internal Revenue Service, or a tax court can give the ultimate answer. Agents should refer their clients to their accountants or other qualified advisors in how they should view tax benefits for their particular situation.

Policies sold as federally tax qualified long-term care insurance use a standard of eligibility for benefits that may be stricter than the standards established in California

for non-qualified policies. It may be easier to qualify for benefits from non-tax qualified policies that use the standards established by California.

If one has questions about the tax status of a policy they own or one they are considering buying, their long-term care insurance agent can advise them. If they have specific questions pertaining to how the purchase of tax qualified long-term care insurance will impact the deductions they take or the taxes they pay, they should talk to their tax advisor to see how it will affect their individual taxes. CA Long-term care Rate Guide-A Guide to Long-Term Care.

Deductibility for the Self-Employed

Premiums for qualified long-term care insurance paid by an employer on behalf of an employee are deductible to the employer as an accident and health insurance premium. That being said, if the employee is an owner of the business entity some limitations apply.

For the purposes of this discussion, self-employed individuals include sole proprietors, partners and owners of S-corporations, limited liability partnerships ("LLP") and limited liability corporations ("LLC"). An owner is defined as any individual who owns 2% or more of the business entity. While these types of business entities can have a separate tax identification number for the reporting of income, the tax return that is filed is informational in nature only. The profit or loss from the business entity is passed through to the owners pursuant to their share of ownership. Typically, in sole proprietorships and partnerships, spouses are not considered owners. If they are on the payroll, they would be considered employees. Spouses of owners of S-corporations, LLP's and LLC's are considered owners regardless of their direct or indirect participation in the business' activities. With respect to accident and health insurance coverage purchased by one of these entities for a non-owner- employee, premiums are fully deductible. There is no imputed income to the employee of premiums and the benefits pass tax free at the time of the claim.

Beginning in 2003 premiums for accident and health insurance are 100% deductible for owners of these entities. It is not necessary for these taxpayers to exceed 10% of adjusted gross income to benefit from the tax code for these expenses. Tax qualified long-term care insurance (considered accident and health insurance for these purposes), falls into this general rule and the 10% AGI threshold does not come into play. The amount allowable for deduction is limited by the previously discussed age-related schedule.

Consider a self-employed husband and wife, both ages 55 who are considering purchasing a tax qualified long-term care insurance policy with a joint annual premium of $4,000 per year. They would be allowed to deduct $2,380 ($1,190 x 2). If they are in the combined Federal and State tax bracket of 35% their tax savings would be $833 or approximately 21% of premium.

Additionally, they may save on their self-employment taxes because the premium amount paid by the business entity would be received not as income, but as an employee benefit. This may save this self-employed couple an additional 15% of the premium paid. Individually or combined, these tax savings provides incentives to owners of these entities to purchase qualified long-term care insurance through their businesses.

Agents should always refer clients to insured's tax advisor for the final analysis of tax impact of long-term care insurance and expenses. Additionally, there are several

examples provided in Attachment II that is included in the course.

Deductibility in Closely Held C-Corporation

The fine-line difference between owners of business entities discussed in the previous section and employee owners of closely-held C-corporations is that for the purposes of paying taxes they are considered employees, not owners. Therefore, premiums paid by the C-corporation for tax qualified long-term care insurance (a.k.a. accident and health insurance) for stockholder employees is deductible to the corporation. There is no imputed income to the employee stock-holder for premiums paid and the benefits will pass tax-free at time of claim. Some believe that this tax treatment of accident and health insurance premiums and benefits means that every employee in the company must receive “like” benefits. Others go to the other extreme and tell consumers that they can discriminate as to who receives such benefits. Both are incorrect. The Internal Revenue Code section 105 clearly indicates that accident and health insurance specifically provided to stockholder employees on a selective basis, without creating a distinguishable class of employees who are eligible for the benefit, is not allowed. The class must be based on employment status. It cannot be based on stock ownership. A class of employees such as “officer employees” can be created for the corporation who are eligible for a specific accident and health insurance benefit. However, they must be employees, not just officers or stockholders.

Court decisions on this matter go back to 1968. If the closely-held corporation cannot validate a clear class of employees who are eligible for the benefit then the premiums could be treated as dividends to the stockholder-employee and the premiums are not deductible to the corporation. It is therefore incumbent upon agents and tax advisors to be judicious in recommending and establishing classes eligible for coverage. It is also important for the corporation to establish the plan in their Minutes and to clearly identify the classes of employees that are eligible for benefits. Again, once a bona fide class of employees is established, tax qualified long-term care insurance premiums are deductible to the corporation. There is no income imputed to the employee and the benefits pass tax free at time of claim; however it is important to consult with a tax advisor.

G. Pension Protection Act of 2006

The Pension Protection Act of 2006 (PPA), like HIPAA, is an enormous piece of legislation that addresses hundreds of disparate issues. Also like HIPAA, a very small portion (section 844) deals with long-term care insurance and riders that are part of life insurance or annuity contracts. The PPA not only provides tax clarification of long term care insurance (LTCI) combination policies, but also the ability to pay LTCI premiums in a tax-advantaged way using life insurance or annuity cash values.

PPA affirms HIPAA as it pertains to life insurance contracts and accelerated benefit riders (ABRs). Over the years, accelerated benefit riders have appeared in various life insurance policies with a promise to pay part of the death benefit (generally 2% to 4% monthly) if a qualifying event other than death occurs; e.g. disability, critical illness, cancer, terminal or chronic illness.

Section 1035 of the PPA 2006 amended the Code to allow for tax-free exchanges of life insurance contracts, annuity contracts, and endowment contracts for qualified LTC contracts

Section 101(g)(1) of the Internal Revenue Code governs the accelerated payment of death proceeds on the life of a terminally or chronically ill insured. HIPAA added

section 7702B to the IRC which specified the definition of "chronic illness." Essentially, if the qualifying event for benefits matches the chronic illness definition established by HIPAA, the early payout of the death benefit for long-term care expenses will not be taxed as income. However, the payments cannot exceed the per diem limits ($330 in 2015) and must comply with other provisions of the NAIC Model for long-term care insurance.

Per PPA, the premiums (or charges) for this coverage can be deducted from the internal growth of the annuity without a taxable event (income) to the annuitant. In addition, if the annuitant qualifies for care, the long-term care benefits payments from the annuity will be received income tax free. One of the central points is that the long-term care benefits must be consistent with the HIPAA. Of it looks like qualified long-term care insurance, it is qualified long-term care insurance.

President George W. Bush, on Aug. 17, 2006, signed a bill that could permanently change the way long term care insurance is sold. The Pension Protection Act of 2006 (PPA) became law more than a decade ago and took effect Jan. 1, 2010.

H. Insurers May Offer Non-TQ if They Offer TQ Products

While there have been different requirements concerning this issuer requirement since the HIPAA introduction in 1996, currently issuers of long-term care insurance policies may offer either or both types of policies, upon state approval, in California.

There was a point in time where issuers had to offer non-qualified policies if they issued tax-qualified policies. This is no longer a requirement.

(Automatic repeal if CA policies become TQ under federal law) (Otherwise sunsets 7-1-2001, SB 527). All certificates and riders must comply with this chapter.

1. New Trends: LTC Insurance, Life Insurance, Annuities and Benefit Riders

A typical product design for a single premium deferred annuity (SPDA/LTCI) combo product will provide a long-term care benefit that is generally a multiple of the annuity account value. The payout will be delivered over a certain number of months, 24, 36 or 48. While examples will vary by insurance carrier, age and health conditions, let's say that the insured wants $6,000 per month of benefit for 48 months ($6,000 X's 48 = $288,000). To get that $288,000 benefit, the policy holder may have to place $100,000 into the SPDA combo product. A risk charge will be taken from the accumulation of the product to provide the additional $188,000 of coverage. The first money out of the SPDA to pay the long-term care benefit will be the insured's initial premium to the plan. If the policyholder dies before their contribution is exhausted a beneficiary will receive the difference. Once benefits are paid beyond the initial premium the insurance company will continue to pay benefits until they are exhausted. The risk charge for the benefit beyond the premium will generally be between one-half to 1.25 basis points. In other words, if a typical SPDA was paying a return of 5.5%, the combo plan may only pay 4.5%. Again, since the long-term care benefit under the program qualifies under IRC section 7702B, the cost of the long-term care benefit will not be a taxable event to the insured.

Long-term care benefit payments will reduce the basis of the annuity for income tax purposes. This may create a larger tax burden on heirs of the annuity owner after death. Due to the legislation included in the Pension Protection Act of 2006, owners of new, specially designed annuities, can take cash withdrawals from annuity contract

values for qualifying long-term care expenses that are. tax free regardless of the cost basis up to daily benefit cap prescribed in HIPAA.

Here are some key points for agents to think about when discussing “combo products” with consumers:

1. How insurance agents and financial advisors who have been working primarily in their narrow specialties will be able to help clients navigate this new world of long- term care planning choices. Benefits available with life and annuity/LTCI combos are likely to be limited as to benefits paid at time of claim.
2. Long-term care benefit qualification must be consistent with HIPAA in order for the combo plan to fall under the PPA guidelines. In order to solicit/sell long-term care insurance in California, Agents need to hold a current license as: Life Agent, Accident and Health Insurance Agent, Life-Only Agent (only if it is a LTC rider on a full life policy), or Fire and Casualty Broker-Agent.
3. What sorts of long-term care expenses will the life or annuity combo pay for--nursing home only, assisted living, home care, or all of the above? Will the plan reimburse for incurred cost or provide some sort of indemnity (per diem) benefit based on a day of service incurred? What sorts of assessments and plans of care will the claims process require?
4. Underwriting criteria will lead to choices of deferral periods based on insured’s health issues. This will be a special challenge to life insurance agents selling annuities, marketers and wholesalers not attuned to underwriting issues in the current SPDA environment.
5. 1035 exchange opportunities are likely to occur (moving cash values from life insurance and annuity contracts to those with LTCI benefits).
6. Which type of life insurance product, SPDA, fixed, indexed or variable, will be best suited to specific clients? What if they do not perform as anticipated? Will consumers who purchase a combo plan be faced with a lower level of benefits if the underlying life insurance or annuity contract pays the guaranteed rate as opposed to the current rate? Will there be “true-up” provisions which give the insured an ability to “reinforce” their long-term care pay-out in the event that product investment performance doesn’t reach expectations.

I. Conclusion

This complex area of law and especially the advent of “combo products” (life and annuity) raise many new questions regarding how agents discuss long-term care needs and solutions with consumers. Full discussion of suitability of specific long-term care products and disclosure of all terms, conditions and protections will become even more important as will suggesting the correct and suitable solution.

Finally, all insurance producers should be keenly aware that the information provided in this treatise gives a broad description of the tax issues related to long-term care insurance. Since most agents are not Certified Public Accountants (CPA’s) or tax preparers they should be very cautious and understand their limitations in advising insureds about their specific tax situation and circumstances. Agents should always refer clients to insured’s tax advisor for the final analysis of tax impact of long-term care insurance and expenses.

Chapter Complete