# PART V: LONG-TERM CARE INSURANCE

## In General

### 424. What is a qualified long-term care insurance contract?

A long-term care insurance policy issued after 1996 is a qualified long-term care insurance contract under IRC Section 7702B(b) if:

(1) The only insurance protection provided under the contract is coverage of qualified long-term care services (Q 428);

(2) The contract does not pay or reimburse expenses incurred for services that are reimbursable under Title XVIII of the Social Security Act or that would be reimbursable but for the application of a deductible or coinsurance amount;

(3) The contract is guaranteed renewable[1];

(4) The contract does not provide for a cash surrender value or other money that can be paid, assigned, or pledged as collateral for a loan or borrowed; and

(5) All premium refunds and dividends under the contract are to be applied as a reduction in future premiums or to increase future benefits. An exception to this rule is for a refund made on the death of an insured or on a complete surrender or cancellation of a contract that cannot exceed the aggregate premiums paid. Any refund given on cancellation or complete surrender of a policy will be includable in income to the extent that any deduction or exclusion was allowable with respect to the premiums.[2]

In addition, a contract must satisfy certain consumer protection provisions concerning model regulation and model act provisions, disclosure, and nonforfeitability.[3]

A policy will be considered to meet the disclosure requirements if the issuer of the policy discloses in the policy and in the required outline of coverage that the policy is intended to be a qualified long-term care insurance contract under IRC Section 7702B(b).[4]

The nonforfeiture requirement is met for any level premium contract if the issuer of the contract offers to the policyholder, including any group policyholder, a non-forfeiture provision that:

1. Notably, the requirement for "guaranteed renewable" under (3) above requires only that the insurer is obligated to continue the coverage as long as premiums are paid; in other words, it only guarantees that the insurer cannot cancel the coverage, but doesn't that premiums will remain level. Although premiums cannot be altered on an individual basis, they can be raised for an entire class of insured individuals (e.g., all those for a certain company's policy issued in a certain year for insureds of a certain age), and if the policyowner happens to fit that class, premiums can increase.
2. IRC Sec. 7702B(b)(2)(C).
3. See IRC Sec. 7702B(g).
4. IRC Sec. 4980C(d).



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(1) Is appropriately captioned;

(2) Provides for a benefit available in the event of a default in the payment of any premiums and the amount of the benefit may be adjusted only as necessary to reflect changes in claims, persistency, and interest as reflected in changes in rates for premium paying contracts approved for the same contract form; and

(3) Provides for at least one of reduced paid-up insurance, extended term insurance, shortened benefit period, or other similar approved offerings.[1]

A qualified long-term care insurance contract that is approved must be delivered to a policyholder within 30 days of the approval date.[2] If a claim under a qualified long-term care insurance contract is denied, the issuer must provide a written explanation of the reasons for the denial and make available all information relating to the denial within 60 days of a written request from a policyholder.[3]

The penalty for not meeting the disclosure and issuer responsibility requirements is a tax equal to $100 per insured for each day that any of these requirements are not met for each qualified long-term care insurance contract.[4] If a failure is due to reasonable cause and not willful neglect, part or all of the penalty tax may be waived if paying the tax would be excessive in relation to the failure.[5]

For the treatment of long-term care insurance contracts issued before 1997, see Q 429.

## 425. Can a life insurance policy or annuity contract be used to provide long-term care coverage?

A life insurance or annuity policy may be issued as a "hybrid" policy providing long-term care insurance benefits as well. Any long-term care insurance coverage, qualified or otherwise, that is provided by a rider or as part of a life insurance or annuity contract will be treated as a separate contract for purposes of the treatment of long-term care benefits paid, which allows long-term care benefits to be paid tax-free, regardless of the treatment that would have otherwise applied to a withdrawal of the underlying life or annuity contract (Q 434).[6]

Concerning the application of IRC Section 7702 for life insurance, the guideline premium limit generally will be increased by the sum of any charges, but not premium payments, against the life insurance contract's cash surrender value within the meaning of IRC Section 7702(f)(2)(A) for that coverage made to that date less any charges that reduce the premiums paid for the contract within the meaning of IRC Section 7702(f)(1) (Q 64).[7]

1. IRC Sec. 7702B(g)(4).
2. IRC Sec. 4980C(c)(2).
3. IRC Sec. 4980C(c)(3).
4. IRC Sec. 4980C(b)(1).
5. IRC Sec. 4980C(b)(2).
6. IRC Sec. 7702B(e)(1).
7. IRC Sec. 7702B(e)(2).



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There is no medical deduction permitted under IRC Section 213(a) for charges against a life insurance or annuity contract's cash surrender value unless the charges are includable in income as a result of the application of IRC Section 72(e)(10), which deals with modified endowment contracts, and the rider is a qualified long-term care insurance contract.[1] In addition to the fact that charges for long-term care insurance premiums against the cash value are not deductible, any such charges will be applied as a reduction in the investment in the contract (i.e., cost basis) of the insurance or annuity policy. [2]

These provisions for combination life/long-term care or annuity/long-term care policies will not apply to any of the following:

(1) A tax-exempt trust described in IRC Section 401(a) (Q 3758);

(2) A contract purchased by a tax-exempt trust described in IRC Section 401(a);

(3) A contract purchased as part of a plan under IRC Section 403(a);

(4) A contract described in IRC Section 403(b) (Q 3907);

(5) A contract provided for employees of a life insurance company under IRC Section 818(a)(3);

(6) A contract from an IRA (Q 3602); or

(7) A contract purchased by an employer for the benefit of an employee or an employee's spouse.

## 426. Can long-term care insurance be provided under a cafeteria plan or through the use of a health savings account or flexible spending arrangement?

Any product that is advertised, marketed, or offered as long-term care insurance is not a qualified benefit under a cafeteria plan (Q 3501).[3] Long-term care insurance premiums may be paid through a health savings account included in a cafeteria plan (Q 380).

### Flexible Spending Arrangements

Employer-provided coverage for qualified long-term care services provided through a flexible spending arrangement ("FSA") is includable in an employee's gross income.[4] For purposes of this rule, an FSA is a benefit program that provides employees with coverage under which specified incurred expenses may be reimbursed and the maximum amount of reimbursement that reasonably is available to a participant for the coverage is less than 500 percent of the value

1. IRC Sec. 7702B(e)(3).
2. IRC Sec. 72(e)(11).
3. IRC Sec. 125(f).
4. IRC Sec. 106(c)(1).



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of the coverage. For an insured plan, the maximum amount reasonably available is determined on the basis of the underlying coverage (Q 3501).[1]

## 427. Do the COBRA continuation coverage requirements apply to long-term care insurance?

No they do not. The COBRA continuation coverage requirements applicable to group health plans do not apply to plans under which substantially all of the coverage is for long-term care services.[2] This provision is effective for contracts issued after 1996.[3] A plan may use any reasonable method to determine whether substantially all of the coverage under the plan is for qualified long-term care services (Q 335).[4]

## 428. What are qualified long-term care services?

Qualified long-term care services are any necessary diagnostic, preventive, therapeutic, curing, treating, mitigating, and rehabilitative services, and maintenance or personal care services that are required by a chronically ill individual and that are provided under a plan of care set forth by a licensed health care practitioner.[5]

A chronically ill individual is a person who has been certified by a licensed health care practitioner as being unable to perform, without substantial assistance, at least two activities of daily living ("ADLs") for at least ninety days or a person with a similar level of disability; this is known as the ADL benefit trigger. The term substantial assistance means hands-on assistance or standby assistance. Hands-on assistance is the physical assistance of another person without which an individual would not be able to complete an ADL. Standby assistance means the presence of another individual that is needed to prevent an individual from injury while performing an ADL.[6]

The ninety day requirement for the ADL benefit trigger does not establish a waiting period before which benefits may be paid or before which services may constitute qualified long-term care services, but simply a duration over which the individual's health condition must be expected to persist.[7]

Activities of daily living are:

(1) eating;

(2) toileting;

(3) transferring in and out of bed;

(4) bathing;

1. IRC Sec. 106(c)(2).
2. IRC Sec. 4980B(g)(2).
3. HIPAA '96, Sec. 321(f)(1).
4. Treas. Reg. §54.4980B-2, A-1(e).
5. IRC Sec. 7702B(c)(1).
6. Notice 97-31, 1997-1 CB 417.
7. Notice 97-31, 1997-1 CB 417.



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(5) dressing; and

(6) continence.

To be considered a qualified long-term care insurance contract, a policy must take into account at least five of these ADLs in determining whether a person is a chronically ill individual unable to perform at least 2 ADLs under the ADL benefit trigger.[1]

In addition to the ADL benefit trigger, a person may be considered chronically ill if the person requires substantial supervision to protect himself or herself from threats to his or her health and safety due to severe cognitive impairment and this condition has been certified by a licensed health care practitioner within the previous twelve months; this is known as the cognitive impairment trigger.[2] Substantial supervision is continual supervision by another person that is needed to protect a severely cognitively impaired person from threats to his or her health or safety.[3]

For the cognitive impairment benefit trigger, there are several safe-harbor definitions that may be relied on. A severe cognitive impairment is a loss or deterioration in intellectual capacity that is similar to Alzheimer's disease and forms of irreversible dementia and is measured by clinical evidence and standardized tests that reliably measure impairment in short term memory, long-term memory, orientation to people, places or time, and deductive or abstract reasoning.

Some insurance contracts may provide for benefits under the ADL benefit trigger due not to a need for substantial assistance, but due to a loss of functional capacity. In addition, some insurance contracts may provide for benefits under the cognitive impairment trigger due not to a need for substantial supervision, but to protect the individual from threats to health and safety due to severe cognitive impairment. Such provisions may be used under a safe harbor provision, as long as the insurance company applies the same standards that it used to determine whether an individual was eligible under such terms for its pre-1997 contracts. [4]

## 429. How does the law treat long-term care contracts issued before 1997?

Any contract issued before January 1, 1997 that met the long-term care insurance requirements of the state in which it was issued will be treated for tax purposes as a qualified long-term care insurance contract and services provided under the contract or reimbursed by the contract will be treated as qualified long-term care services.[5]

Regulations provide that a pre-1997 long-term care insurance contract is treated as a qualified long-term care insurance contract, regardless of whether or not it otherwise satisfies the requirements of IRC Section 7702B(b).[6]

1. IRC Sec. 7702B(c)(2)(B).
2. IRC Sec. 7702B(c)(2)(A).
3. Notice 97-31, 1997-1 CB 417.
4. Notice 97-31, 1997-1 CB 417.
5. HIPAA '96 Sec. 321(f)(2).
6. Treas. Reg. §1.7702B-2(b)(1).



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The long-term care requirements of a state are the state laws that are intended to regulate insurance coverage that constitutes long-term care insurance, as defined in the NAIC Long Term Care Insurance Model Act on August 21, 1996.[1]

For this purpose, the issue date of a contract is the issue date assigned by the insurance company. The issue date cannot be earlier than the date on which the policyholder submitted an application for coverage. Further, if the period of time between the date an application is submitted and the date on which coverage becomes effective is substantially longer than under the insurance company's usual business practice, then the issue date is the date on which coverage becomes effective, assuming this date is later than the issue date assigned by the insurance company. The free-look period is not taken into account in determining a contract's issue date. The issue date of a group contract is the date on which coverage becomes effective.[2]

A contract issued in exchange for an existing contract after December 31, 1996, is considered a contract issued after this date and any change, as defined below, in a contract is treated as the issuance of a new contract with an issue date that cannot be earlier than the date that the change takes effect.

Further, if a change described in the regulations occurs to some certificates under a group policy but not to others, the insurance coverage under the changed certificates is treated as coverage under a newly-issued group contract, that is, a group contract that is no longer grandfathered, while the insurance coverage provided under the unchanged certificates continues to be treated as covered under the original grandfathered contract.[3]

For this purpose, the following changes are treated as the issuance of a new contract:

(1) a change in the terms of a contract that alters the amount or timing of an item payable by a policyholder or certificate holder, an insured, or the insurance company;

(2) a substitution of the insured under an individual contract; or

(3) a material change in 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.[4]

The following items are not treated as the issuance of a new contract:

(1) a policyholder's exercise of any right provided under the contract in effect on December 31, 1996, or a right required by applicable state law to be provided to the policyholder;

(2) a change in premium payment mode;

1. Treas. Reg. §1.7702B-2(b)(2).
2. Treas. Reg. §1.7702B-2(b)(3).
3. Treas. Reg. §1.7702B-2(b)(3).
4. Treas. Reg. §1.7702B-2(b)(4).



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(3) a class-wide increase or decrease in premiums for a guaranteed renewable or noncancellable policy;

(4) a premium reduction due to the purchase of a long-term care insurance contract by a family member of the policyholder;

(5) a reduction in coverage requested by the policyholder;

(6) a reduction in premiums as a result of extending to a policyholder a discount applicable to similar categories of individuals pursuant to a premium rate structure that was in effect on December 31, 1996, for an issuer's pre-1997 long-term care insurance contracts of the same type;

(7) the addition of alternative benefit forms that a policyholder may choose without a premium increase;

(8) the addition of a rider to a pre-1997 long-term care insurance contract if the rider issued separately would be a qualified long-term care insurance contract under IRC Section 7702B and any regulations issued under this section;

(9) the deletion of a rider or contract provision that prohibited coordination of benefits with Medicare;

(10) the exercise of a continuation or a conversion right that is provided under a pre-1997 group contract and that, in accordance with the terms of the contract as in effect on December 31, 1996, provides for coverage under an individual contract following an individual's ineligibility for continued coverage under the group contract; and

(11) the substitution of one insurer for another insurer in an assumption reinsurance transaction.[1]

The regulations provide examples of the correct application of these rules.[2]

Treasury Regulation Section 1.7702B-2 is effective January 1, 1999 with respect to pre-1997 contracts.[3] For purposes of determining whether a change made before January 1, 1999 to a pre-1997 contract should have been treated as the issuance of a new contract, taxpayers may rely on Notice 97-31.[4] Further, a change made before January 1, 1999, to a pre-1997 contract will not be treated as the issuance of a new contract if the change would not be so treated under the final regulations. Taxpayers may not rely on Notice 97-31 with respect to changes made after 1998.

1. Treas. Reg. §1.7702B-2(b)(4).
2. Treas. Reg. §1.7702B-2(b)(5).
3. Treas. Reg. §1.7702B-2(c).
4. 1997-1 CB 417.



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## Premiums

### 430. Are premiums paid for a qualified long-term care insurance contract deductible as medical expenses?

Amounts paid for any qualified long-term care insurance contract or for qualified long-term care services generally are included in the definition of medical care and, thus, are eligible for income tax deduction, subject to certain limitations.[1] Amounts paid for the medical care of a taxpayer, the taxpayer's spouse, or the taxpayer's dependents are deductible subject to the 10 percent adjusted gross income floor. The 10 percent floor is effective for tax years beginning after 2012, but the 7.5 percent floor remains effective for senior citizens aged 65 and older (and their spouses) through 2016.[2]

The deduction for eligible long-term care premiums that are paid during any taxable year for a qualified long-term care insurance contract as defined in IRC Section 7702B(b) (Q 424) is subject to an additional dollar amount limit that increases with the age of the insured individual. In 2014, for persons age forty or less, the limit is $370. For ages forty-one through fifty, the limit is $700. For ages fifty-one through sixty, the limit is $1,400. For ages sixty-one through seventy, the limit is $3,720. For those over age seventy, the limit is $4,660.[3] The age is the individual's attained age before the close of the taxable year. The limits are indexed annually.[4]

For tax years beginning after 2009, an annuity contract, life insurance policy, or long-term care insurance policy, may be exchanged for another qualified long-term care insurance contract without taxation (Q 44, Q 495).[5]

An amount paid for qualified long-term care services as defined in IRC Section 7702B(c) (Q 424) will not be treated as paid for medical care if a service is provided by an individual's spouse or a relative unless the service is provided by a licensed professional. A relative generally is any individual who can be considered a dependent under the IRC.[6]

In addition, a service may not be provided by a corporation or partnership that is related to an individual within the meaning of IRC Sections 267(b) or 707(b).[7]

### 431. May a self-employed individual deduct premiums paid for a qualified long-term care insurance contract?

Yes, the individual may deduct premiums paid for a qualified long-term care insurance contract. Because amounts paid for qualified long-term care insurance contracts come within the definition of medical care, qualified long-term care insurance premiums are eligible for deduction from income by self-employed individuals.[8] The amount of eligible qualified long-term care

1. IRC Sec. 213(d)(1)(D).
2. IRC Sec. 213(a).
3. Rev. Proc. 2009-50, 2009-45 IRB 617, as modified by Rev Proc. 2010-24, 2010-25 IRB 764. Rev Proc. 2013-35, 2013-47 IRB 537.
4. IRC Sec. 213(d)(10); 2013-35.
5. IRC Sec. 1035(a)(3) & (a)(4).
6. IRC Secs. 152(a)(1) through (8).
7. IRC Sec. 213(d)(11).
8. IRC Secs. 162(l), 213(d).



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insurance premiums that may be deducted is subject to dollar amount limits (Q 430), and applies for sole proprietors, partners, and S corporation shareholders owning more than 2 percent of an S corporation's shares (Q 328).[1] The deduction is claimed as an "above-the-line" deduction and is not subject to the 10%-of-AGI floor for medical expenses.

The deduction is not available to a self-employed individual for any calendar month in which he or she is eligible to participate in any subsidized health plan maintained by his or her employer or by an employer of his or her spouse. This rule is applied separately to plans that include coverage for qualified long-term care services or that are qualified long-term care insurance contracts (Q 424) and to plans that do not include this coverage and are not long-term care insurance contracts.[2]

### 432. Are long-term care insurance premiums paid by an employer includable in employees' income?

No.

An employer's plan that provides coverage under a qualified long-term care insurance contract generally is treated as an accident and health plan with respect to that coverage.[3] Thus, premiums for long-term care insurance coverage paid by an employer are not includable in the gross income of employees.[4]

### 433. May an employer deduct as a business expense premiums paid for a qualified long-term care insurance contract for employees?

Yes.

An employer plan providing coverage under a qualified long-term care insurance contract is treated as an accident and health insurance plan with respect to this coverage.[5] An employer generally may deduct health insurance premiums paid for employees as a business expense (Q 313). Thus, premiums for a qualified long-term care insurance contract paid by an employer for employees are similarly deductible.

## Taxation of Benefits

### 434. Are benefits received under a qualified long-term care insurance contract taxable income?

No, they are not. A qualified long-term care insurance contract is treated as an accident and health insurance contract. See Q 424. Thus, amounts (other than dividends or premium refunds) received under such a contract are treated as amounts received for personal injuries and sickness and are treated as reimbursement for expenses actually incurred for medical

1. IRC Sec. 162(l)(2)(C).
2. IRC Sec. 162(l)(2)(B).
3. IRC Sec. 7702B(a)(3).
4. IRC Sec. 106(a); see House Comm. Report on Sec. 321 of HIPAA '96, P.L. 104-191.
5. IRC Sec. 7702B(a)(3).



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care.[1] Since amounts received for personal injuries and sickness are generally not includable in gross income, benefits received under qualified long-term care insurance are generally not taxable.[2] See Q 324.

But there is a limit on the amount of qualified long-term care benefits that may be excluded from income. Generally, if the total periodic payments received under all qualified long-term care insurance contracts (and any periodic payments received as an accelerated death benefit under IRC Section 101(g) (see Q 54)) exceed a per diem limitation, the excess must be included in income (without regard to IRC Section 72). If the insured is terminally ill when a payment treated under IRC Section 101(g) is received, the payment is not taken into account for this purpose.[3]

If payments exceed the greater of $330 per day (in 2014; $320 for 2013 and $310 for 2012, adjusted annually for inflation[4]) or the actual amount of qualified long-term care expenses incurred, the excess payment amounts are taxable as income when benefits are paid. Notably, this "per diem" rule will not apply, regardless of payment size, if the payments are fully allocable to the reimbursement of the insured's long-term care insurance expenses. However, payments in excess of reimbursements may become taxable to the extent they exceed the per diem limitation as calculated above.

## Non-Qualified Long-Term Care Insurance Contract

### 435. How is a long-term care insurance policy taxed when it is not a qualified long-term care insurance contract?

Policies that do not meet the definition of a qualified long-term care insurance contract under IRC Section 7702B(b) generally are referred to as nonqualified long-term care policies (Q 424). The IRC does not address the income taxation of premiums paid for or benefits received from nonqualified policies. The fact that Congress enacted favorable income tax treatment specifically for qualified long-term care insurance contracts in IRC Section 7702B may be interpreted as an indication that nonqualified policies will not receive favorable treatment (i.e., that benefits will be taxable when received).

Any contract issued before January 1, 1997 that met the long-term care insurance requirements of the state in which the contract was issued will be treated for tax purposes as a qualified long-term care insurance contract, regardless of whether the provisions of the contract would have otherwise been eligible. Services provided under such a contract or reimbursed by such a contract will be treated as qualified long-term care services (Q 424) and payments will be tax-free.[5]

1. IRC Sec. 7702B(a).
2. IRC Secs. 104(a)(3), 105(b).
3. IRC Sec. 7702B(d).
4. IRC Secs. 7702B(d)(4), 7702B(d)(5); Rev. Proc. 2013-35, 2013-47 IRB 537.
5. HIPAA '96, Sec. 321(f)(2). See also Treas. Reg. §1.7702B-2.



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## Reporting Requirements

### 436. What reporting requirements are applicable to long-term care benefits?

Long-term care insurance companies paying long-term care benefits must file a return that sets forth:

(1) the aggregate amount of long-term care benefits paid to any individual during a calendar year;

(2) whether or not benefits are paid, either fully or partially, on a per diem or other periodic basis without regard to expenses incurred during the period;

(3) the name, address, and taxpayer identification number ("TIN") of the individual; and

(4) the name, address, and TIN of the chronically ill or terminally ill individual for whom the benefits are paid.[1]

In addition, any company required to file a return must provide a written statement to each individual whose name is reported under the above requirement. The statement must show the name, address, and phone number of the information contact of the company making the payments and the aggregate amount of long-term care benefits paid to the individual shown on the above-mentioned return. This written statement must reach the individual on or before January 31 of the year following the calendar year for which the return was required.[2]

The IRS has prescribed Form 1099-LTC[3] to meet both filing requirements.

For purposes of these reporting requirements, a long-term care benefit is any payment under a product that is advertised, marketed, or offered as long-term care insurance and any payment that is excludable from gross income as an accelerated death benefit under IRC Section 101(g).[4]

1. IRC Sec. 6050Q(a).
2. IRC Sec. 6050Q(b).
3. http://www.irs.gov/pub/irs-pdf/i1099ltc.pdf (last accessed February 17, 2014).
4. IRC Sec. 6050Q(c).



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