California Department of Insurance
Eight-Hour Mandatory Long-Term Care Course
Topics to be Included in the Course Outline

OVERVIEW
The following outline is a listing of the topics that must be addressed as part of all eight-hour long term care (LTC) insurance courses designed to meet the requirements of the Section 10234.93(a) (4) (A) (B), and (C) of the California Insurance Code (CIC) which reads in part, "…Licensees shall complete the initial training requirements of this Section prior to being authorized to solicit individual consumers for the sale of long-term care insurance…" Additionally, licensees who sell life insurance products that contain riders for long-term care are subject to the training requirements.

EDUCATION OBJECTIVES
Each topic must be developed in its entirety and should explain (not merely recite) chaptered legislation and pertinent regulations. Each topic should *include an explanation* of why each topic is significant to the agent and client. The subjects do not need to be presented in this outline order. However, each topic must be cross referenced to the material submitted to the Commissioner before the material can be approved. In addition, the topics need to be developed in a clear and meaningful manner so that the student derives a clear understanding of the pertinent issues and implications. It is expected that any viable long-term care (LTC) course proposed should be eight hours in length so as to cover adequately all the required topics. A course on LTC product knowledge only does not qualify for LTC continuing education credit. **NOTE:** All statistical information (dollar amounts, charts and tables) and points of fact must be referenced to the original source data. In addition, these sources must be California specific where available.

Course providers are encouraged to use examples that illustrate points and concepts.

For contact courses, the topics need to be articulated in writing to the extent that the student can relate the words of the instructor to the course material in a meaningful way. For correspondence courses, each topic must be developed in full so that the reader can get an understanding of the material as if he or she was in a contact course.

Discussion of topics must be handled in a neutral manner. These courses may ***NOT***:

- Use the opportunity to persuade;
- Indoctrinate or enlighten agents on a particular philosophy or a political or public policy position;
- Offer opinions about state or federal legislation or forecast the success or failure of legislation;
- Offer company specific sales presentations or similar information;
    - Absolutely no marketing information is allowed in long-term care courses;
- Use copyright material inserted or attached to the course material without proper references;
- Use attachments to the course material that contain the information noted in the above bulleted items; and,
- Substitute Insurance Code Sections for explanatory text.

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Course providers are required to do the following:

- Provide a detailed understanding of all the topic areas;
- Show continuity of explanations in the course textbook, examples, references, and citations;
- Provide easy to read text. Rather than seemingly unrelated pieces of data, the text should have a narrative explanation of why or how parts fit together;
- State conclusions (i.e. why is this topic important and what does it mean for the policyholder);
- Substantiate information with material presented;
- Focus course material on needs of consumers and the problems and solutions associated with long-term care and long-term care insurance;
- Include California Department of Insurance (CDI)-required attachments; and,
- Include any additional attachments.

Contact Course
(Interactive)

Credit Hours for Contact Courses: Our guideline for assigning credit hours to contact courses is based on a 50-minute hour of classroom instruction. No credit is given for breaks. The student can receive credit for only eight hours or 480 minutes of instruction per day. This equates to nine hours of classroom credit per day (partial hours are not given credit). The student is required to be attentive and participate. It is the instructor's discretion or judgment to determine if the student should receive credit based on his attention and participation. Additionally, the instructor may give credit if the student participates in at least 80 percent of class instruction. No credit is given for review. Credit is given for examinations only if it is mandatory to pass the examination to receive credit for the course.

Non-Contact Course
(Non-Interactive)

Credit Hours for Non-Contact Courses: One credit hour is approved for 4,600 words. For the examination, 10 to 15 percent of the approved credit hour(s) is added to arrive at the total credit hours for the non-contact course. The examination must have a minimum of three questions for each credit hour approved. Partial credit hours will not be awarded and will be rounded down to the nearest whole credit hour.

Disclaimer –The California Department of Insurance is released of responsibility for approved course materials that may have a copyright infringement. In addition, no course approved for either prelicensing or continuing education hours or any designation resulting from completion of such courses should be construed to be endorsed by the Commissioner.

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INTRODUCTION TO LONG-TERM CARE (THE LONG-TERM CARE CRISIS)

With the aid of technology and today's advanced healthcare systems, more people are living to age 80, 90 or beyond. This reflects the truth behind the marketing phrase "60 is the new 40". Now, with on-going scientific programs beginning to offer hope of truly understanding the genetics of aging, we may soon see additional increases in life expectancy. Longer life expectancy increases a person's need to plan for long-term care.

What is long-term care? Essentially, it is the inability to care for oneself due to a chronic (long-term) medical condition. Every day more than 5,000 people in this country turn 65. More than 2.5 million are 85 or older. And the likelihood of chronic illness increases with age. The chance of a person currently age 65 being confined to a nursing home at some time in the future is now one in three. According to the U.S. Census Bureau, the over-85 population is the fastest growing segment of the U.S. population, and one out of four people in that age group today lives in a nursing home. Approximately 75 percent of nursing home residents are women.

The programs that many believe cover chronic long-term care events are not necessarily designed to do so. Medicare and Medicare Supplements primarily pay for the costs associated with acute (as opposed to chronic) medical conditions. And, while Medi-Cal (Medicaid) does provide long-term care benefits for many senior citizens, they must first exhaust most of their income and assets to qualify. It is no secret that many seniors are paying a growing proportion of their income in out-of-pocket costs for health care and long-term care services at home due to limited or no insurance coverage. Every day people move into Medi-Cal/Medicaid facilities because they have run out of money from paying these out-of-pocket expenses for home health care or assisted living facility care.

The long-term care problem is made even more complex by the ever-rising cost of services. A study conducted by Genworth Financial and published in March 2013 noted that the semi-private nursing facility cost of long-term care in the U.S. is $207 per day or $75,555 per year and the median cost for "hands-off" homemaker services is $18 per hour. Are Americans planning for the costs associated with long-term care? In 2010 Gerontologist Ken Dychtwald (www.agewave.com) conducted focus groups that discovered the following:

- *Uninsured medical expenses (including long-term care) are the top financial worry among men and women age 55 and older.*
- *People are over five times more worried about being a burden on their family than dying.*

- *Almost two-thirds of people will actually require some long-term care, such as home care, assisted living or nursing home care after they reach age 65, but only 35 percent of people believe they will need such care.*
- *People greatly underestimate the financial, social and lifestyle impact of caregiving responsibilities.*
- *When someone needs long-term care, a wide circle of primary caregivers, secondary caregivers, other family, friends and community members often provide the care and are impacted by the responsibilities.*

The answer is that consumers are concerned about long-term care issues and are looking for credible guidance from insurance agents, financial advisors and other sources.

Long-Term Care Insurance (LTCi) is a category of coverage designed to address these growing problems. Obviously, the ideal time to purchase long-term care insurance would be the day before you need it, but as we know, life doesn't work that way. A 2012 study by the Life Insurance Marketing Research Association (LIMRA) indicated that the number one reason people purchase long-term care insurance is for asset and income protection in retirement. Policyholders also obtain peace of mind, secure their independence and preserve their assets by having coverage.

The concepts of long-term care and long-term care insurance are presented in this outline in basic terms as we unfold a story that is important to consumers, insurance agents and financial advisors as well as employers. The reality is that long-term care has become one of the greatest health-care issues for older persons and their families and one of the most common catastrophic health-care expenses.

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III. Federal Legislation and Long-Term Care

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- C. Tax Treatment of Pre-1997 Long-Term Care Insurance Policies
- D. Long-Term Care Insurance Premium Deductibility
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Eight-Hour Mandatory Long-Term Care Course
Topics to be Included in the Course Outline

I. Long-Term Care (LTC)

A. Introduction *(See Introduction to Long-Term Care within Overview)*
   1. What is long-term care?
   2. Why is long-term care important?
   3. Why is long-term care a problem?

B. Risk Factors Associated with Long-Term Care
   1. Gender
   2. Age
   3. Marital/domestic partner status
   4. Availability of family caregivers
   5. Medical history
   6. Financial factors

C. Long-Term Care Services and Facilities that Provide Care
   1. Long-term care services
      a. home care and community-based services
         i. home health care
         ii. adult day care
         iii. personal care
         iv. homemaker services
         v. hospice services
         vi. respite care
      b. public programs
         i. multipurpose senior service program (MSSP)
         ii. in-home supportive services (IHSS)
         iii. program of all-inclusive care for the elderly (PACE)
   2. Facilities that provide care
      a. formal care
         i. nursing homes
         ii. residential care facilities for the elderly (RCFE)
         iii. continuing care retirement communities (CCRC)
         iv. adult day care setting
      b. alternative living settings/arrangements
         i. retirement home living arrangement
         ii. life care communities
         iii. fraternal, religious and union sponsored living arrangements
         iv. family care

D. Locating Information on Services and Facilities that Provide Long-Term Care
   1. Where to obtain information on long-term care services and facilities
   2. How services are provided and funded

II. Potential Resources for Paying for Long-Term Care Expenses

A. Financing/Paying for Long-Term Care
   1. Funding mechanisms for long-term care
      a. personal savings
      b. home equity
         i. residential reverse mortgages insured by HUD
      c. life settlements
         i. viatical settlements
   2. Insurance products that contain long-term care benefit options
      a. stand-alone long-term care insurance products
      b. policies and annuities with long-term care benefits
      c. accelerated death benefits, riders and annuities
      d. other catastrophic benefits
   3. Medi-Cal *(See Attachment I – Medi-Cal Requirements)*
      a. Medi-Cal eligibility
         i. income and asset limits
         ii. hardship exception
         iii. look-back periods
         iv. agents should be aware that the purchase of a long-term care policy will not necessarily ensure that someone will avoid Medi-Cal when they need long term care

B. How Medicare Interrelates with Paying for Long-Term Care Expenses
   1. Medicare
   2. Medicare supplements
      a. traditional Medicare supplements (A-K)
      b. Medicare advantage

III. Federal Legislation and Long-Term Care *(See Attachment II – Tax Treatment of Long-Term Care Insurance and Expenses)*

A. Health Insurance Portability and Accountability Act (HIPAA) Definitions that Apply to Long-Term Care Expenses and Insurance
   1. Qualified long-term care services/chronically ill individual
   2. Licensed health care practitioner
   3. 90-day certification for activities of daily living
   4. Substantial assistance
      a. severe cognitive impairment and substantial supervision

B. Tax Qualified Long-Term Care Insurance
   1. Benefits
   2. Required consumer protection
   3. IRS reporting mechanism

C. Tax Treatment of Pre-1997 Long-Term Care Insurance Policies
   1. Definition of “material change”

D. Long-Term Care Insurance Premium Deductibility
   1. Health savings accounts (medical IRA account)
   2. Individual deductibility
   3. Deductibility for the self-employed
   4. Deductibility in closely-held C-corporation

E. Pension Protection Act of 2006

F. New Trends: Long-Term Care Insurance, Life Insurance, Annuities and Benefit Riders

IV. Long-Term Care Insurance (LTCi)

A. Types of Products
   1. Stand-alone long-term care products
   2. Products with long-term care riders
      a. life insurance
      b. annuity
      c. disability insurance
      d. critical illness insurance
      e. accelerated death benefit
      f. other products as they become available in the marketplace
   3. Hybrid long-term care policies
      a. life/long-term care
      b. annuity/long-term care
      c. other hybrid products as they become available in the marketplace

B. Group Coverage (Section 10231.6 of the CIC)
   1. Employer sponsored plan
      a. true group
      b. multi-life individual
   2. Trade/association/discretionary sponsored plan
      a. true group
      b. multi-life individual
   3. Group policies issued outside California (Section 10232 of the CIC)

C. Common Policy Benefits
   1. Coverage for care in a nursing facility (Section 10232.95 of the CIC)
   2. Coverage for care in a residential care facility for the elderly (RCFE) (Section 10232.92(a) of the CIC)
      a. minimum benefit – 70 percent of institutional confinement benefit (Section 10232.92(b) of the CIC)

b. all long-term care expenses incurred by insured must be covered up to (but not to exceed) daily maximum (Section 10232.92(c) of the CIC)

3. Coverage for home and community care (Sections 10232.9(a) through (c) of the CIC)
   a. services provided
      i. home health care
      ii. adult day care
      iii. personal care
      iv. homemaker services
      v. hospice services
      vi. respite care
   b. minimum benefits (Section 10232.9(d) of the CIC)
4. Benefit eligibility triggers and definitions
   a. tax qualified (Sections 10232.8(b) and (f) of the CIC)
      i. impairment in two out of six activities of daily living (ADLs) which include eating, bathing, continence, dressing, toileting and transferring
      ii. impairment of cognitive ability
      iii. assessment and plan of care
         (A) definition of a licensed health care practitioner (LHP) (Section 10232.8(c) of the CIC)
            (1) independent of the insurer
   b. non-tax qualified (Sections 10232.8(a) and (g) of the CIC)
      i. impairment in two out of seven activities of daily living (ADLs) which include eating, bathing, dressing, ambulating, transferring, toileting and continence
      ii. impairment of cognitive ability
      iii. other criteria at commissioner's discretion
   c. flexible benefit mandated
      i. policy lifetime maximum must be stated in single dollar amount (Section 10232.93 of the CIC)
   d. prohibited practices
      i. "usual and customary" standard (Section 10233.2(d) of the CIC)
      ii. medical necessity (Section 10232.9(c)(7) of the CIC)
      iii. prior hospital/institutional stay requirement (Section 10232.5 of the CIC)
   e. Insurers may verify necessity with any source of independent judgment (Section 10233 of the CIC)
5. Contractual methods of payment
   a. reimbursement
   b. indemnity
      i. cash

ii. per diem

6. Definitions of providers (licensed or not) (Sections 10232.9 and 10232.92 of the CIC)
7. Inflation protection
   a. requirement for offer (Section 10237.1 of the CIC)
   b. other methods of providing inflation protection
      i. compound inflation
      ii. simple inflation
      iii. consumer price index (CPI)
      iv. periodic increases
      v. defined number of years
      vi. defined age
8. Waiver of premium, elimination/waiting period
9. Benefit period
10. Restoration of benefits
11. Home modification and other ancillary benefits (Section 10233.2(f) of the CIC)
12. Survivor benefits
13. Return of premium
14. Nonforfeiture (Section 10235.30 of the CIC)

V. California Statutory Policy Provisions, Requirements and Terminology

A. Company Responsibilities and Prohibitions

1. Application and underwriting
   a. applications must ask "yes" or "no" health questions (Section 10232.3(a) of the CIC)
   b. warning on application that misstatements may result in rescission (Sections 10232.3(b) of the CIC)
   c. insurer must have, use and apply suitability standards (Section 10234.95(f) and (h) of the CIC)
   d. company must resolve all underwriting issues submitted on application – no post claim underwriting (Section 10232.3(d) of the CIC)
   e. every application shall include a checklist (Section 10232.3(c) of the CIC)
      i. important notice regarding policies available
      ii. outline of coverage (OOC) (Section 10233.5 of the CIC)
      iii. health insurance counseling and advocacy program (HICAP) notice (Section 10234.93(a)(8) of the CIC)
      iv. long-term care insurance shoppers guide (Taking Care of Tomorrow – provided by insurer) (Section 10234.93(a)(9) of the CIC)
      v. long-term care insurance personal worksheet (Section 10234.95(c)(4), (d) and (e) of the CIC)

- vi. notice to applicant regarding replacement of accident and sickness for long-term care insurance (Sections 10235.16 and 10235.18 of the CIC)

- f. definition of preexisting condition (Section 10232.4(a) of the CIC)
- g. no new preexisting conditions on replacement policies (Section 10235.18(a)(1) of the CIC)
- h. contestability period is two years (Section 10232.3(f) of the CIC)
- i. completed application must be delivered with policy (Section 10232.3(g) of the CIC)
- j. protection against unintentional lapse (Section 10235.40 of the CIC)
  - i. applicant may designate another to receive notice of lapse – the insurer must receive either:
    - (A) information on designee, or
    - (B) verbatim waiver signed and dated
  - ii. insurer must offer right to change designee no less often than once every two years
  - iii. insurer must mail notice 30 days before termination
  - iv. policy and certificate must include five-month reinstatement
- k. inflation protection
  - i. requirement for illustration (Section 10237.6 of the CIC)
  - ii. requirement for waiver (Section 10237.5 of the CIC)

2. Reporting requirements
   - a. insurers must file rescission annually (Section 10232.3(h) of the CIC)
   - b. insurers must report the number of replacement sales and lapses (Section 10234.86 of the CIC)
   - c. insurers must annually report the number of applicants who refused to complete the personal worksheet and the number that did not meet the suitability requirements (Section 10234.95(i) of the CIC)
   - d. insurers must file personal worksheet upon each rate increase (Section 10234.95(c)(4) of the CIC)
   - e. insurers must file commission structure for replacement coverage (Section 10234.97(c) of the CIC)
   - f. insurers must semiannually file all agents authorized to sell long-term care insurance (Section 10234.93(a)(3) of the CIC)
   - g. insurers must file initial premium rates (Section 10236.11 of the CIC)
   - h. insurers must file all rate increase requests for approval (Section 10236.13 of the CIC)
3. Required policy definitions
   - a. Medicare (Section 10235.2(a) of the CIC)
   - b. skilled nursing care (Section 10235.2(b) of the CIC)
   - c. intermediate care (Section 10235.2(b) of the CIC)
   - d. home care (Sections 10232.9(b)(1 through 6) of the CIC)
   - e. residential care facility for the elderly (RCFE) (Section 10232.92 of the CIC)

4. Consumer protection
   a. shortened benefit period (Section 10235.30 of the CIC)
   b. distinguish between groups and individual disclosure in certificates
   c. 30-day free look (Section 10232.7 of the CIC)
   d. right to reduce coverage and lower premiums (Section 10235.50 of the CIC)
   e. right to increase coverage (Section 10235.51 of the CIC)
      i. insurer may require insured to undergo new underwriting (Section 10235.51(c) of the CIC)
5. Policy replacement
   a. premium credits for replacement policies (Section 10234.87 of the CIC)
      i. five percent of prior annual premium (not to exceed 50 percent)
   b. replacement policy conversions (Section 10236.5 of the CIC)
   c. exchange from group non-tax qualified to tax qualified (Section 10232.2(d) of the CIC)
6. Long-term care personal worksheet with company-specific premium increase information (Section 10234.95(c)(4) of the CIC)
   a. in California
   b. filed in any other state
7. Option to increase coverage
   a. insurer must offer inflation protection (Section 10237.1 of the CIC)
      i. five percent compounded annually unless applicant signs rejection (Section 10237.5(a) of the CIC)
         (A) rejection statement must be verbatim (Section 10237.5(b) of the CIC)
   b. mandated offer goes to group policyholder (Section 10237.1(d) of the CIC)
   c. life insurance with accelerated benefits are exempt (Section 10237.3 of the CIC)
   d. no limits on inflation protection
      i. regardless of age, claim status, claim history or policy term (Section 10237.4(a) of the CIC)
      ii. no reduction of inflation benefit increases due to payment of claims (net of claims issues) (Section 10237.4(c) of the CIC)
   e. insurer must offer level premiums if offering automatic increases (Section 10237.4(b) of the CIC)
   f. outline of coverage must include:
      i. 20-year graph contrasting inflation protection with no inflation protection (Section 10237.6(a)(1) of the CIC)
      ii. expected premium increases to pay for inflation protection (Section 10237.6(a)(2) of the CIC)

iii. illustration must be reasonable (Section 10237.6(b) of the CIC)

g. other optional forms of inflation protection

i. automatic, simple and compound (USC)

ii. consumer price index (CPI)

iii. future purchase option (FPO)

8. Requirement to make specimen policy available on website and by request (Section 10237.93(a)(10) of the CIC)
9. Insurer must retain records for each agent for replacement sales and lapses (Section 10234.86(a) of the CIC)
10. Insurer must retain auditable procedures for compliance (Section 10234.93(a)(7) of the CIC)
11. Additional insurer obligations (Section 10232.65 of the CIC)
12. California Life and Health Insurance Guarantee Association (CLHIGA) (Sections 1067.02(a)(1) and 1067.02(b)(1) of the CIC)

B. Agent Responsibilities and Prohibitions

1. Duty of honesty, good faith, fair dealing (Section 10234.8 of the CIC)
2. Long-term care training (Section 10234.93 of the CIC)
    a. licensees must meet eight-hour mandatory long-term care training requirement (Section 10234.93(a)(A)(B) of the CIC)
    b. non-resident agents must meet eight-hour mandatory long-term care training requirement (Section 10234.93(a)(C) of the CIC)
3. Suitability (Section 10234.95 of the CIC)
    a. agents must use company suitability standards
        i. ability to pay
        ii. applicant's goals or needs
        iii. value, benefits and costs of the applicant's existing insurance
    b. personal worksheet
        i. consumer may decline to provide information (Section 10234.95(h) of the CIC)
4. Replacement
    a. replacement coverage (Section 10234.97 of the CIC)
        i. definition
        ii. basis on improvement of insured's position
        iii. applicability
        iv. restriction on replacement sales commission
    b. replacement of existing insurance notice (Section 10235.16 of the CIC)
5. Consumer protection
    a. insurers/agents must provide "Taking Care of Tomorrow" to applicant – which can be accessed on the Department of Aging's website at www.aging.ca.gov (Section 10234.93(a)(9) of the CIC)

- b. California Department of Insurance's (CDI) toll free consumer services 1-800-927-HELP
- c. agents required to provide local HICAP program name, location and telephone number and statewide HICAP telephone number 1-800-434-0222 (Section 10234.93(a)(8) of the CIC)
- d. HICAP notice on outline of coverage (Section 10232.3(c)(3) of the CIC)
- e. rights to reduce, add or purchase new coverage (Sections 10235.50-10235.52 of the CIC)
- f. right to choose a paid up benefit (contingent benefit upon lapse) following a rate increase (Sections 10235.35 and 10236.13(e)(3) of the CIC)
- g. right to request and receive sample policy (Section 10234.93(a)(10) of the CIC)
- h. right to appeal contract language (Section 10235.94 of the CIC)

6. Replacement of long-term care insurance unnecessarily (Section 10234.85 of the CIC)
7. Agent retention of records for five years (Section 10508.5 of the CIC)
8. Long-term care rate & history guide – www.insurance.ca.gov (Section 10234.6 of the CIC)

C. Statutory Rate Stabilization Requirements
1. Importance of rate stability in long-term care insurance
2. Company responsibilities
   - a. submission of new business premiums (Section 10236.11 of the CIC)
   - b. rate revisions filed on or after January 1, 2010 (Section 10236.1 of the CIC)
   - c. rate increase subject to CDI approval (Sections 10236.13 through 10236.15 of the CIC)
   - d. explain what rates are stabilized
   - e. contingent non-forfeiture

VI. Administration and Enforcement

A. Authority to Bring Actions and Assess Penalties (Section 10234.2 of the CIC)
1. authorizes private right of action
2. authorizes actions by district attorneys, attorney general and city attorneys
3. orders reasonable attorney fees and costs to prevailing party

B. Violations and Penalties *(See Attachment III)*

C. Notice and Hearing (Section 10234.5 of the CIC)

VII. Advertising Guidelines and Marketing Practices

A. Advertising Guidelines
   1. Advertisements must be filed (Section 10234.9 of the CIC)
      a. provide copy of advertisement to the commissioner 30 days before dissemination
         i. advertisement must comply with all laws in California
         ii. insurer will retain advertisement for at least three years (Section 10508 of the CIC)
      b. advertisement designed to produce leads must contain specific language
         i. "an insurance agent will contact you" if that is the case
      c. information generated by a cold lead device must be immediately disclosed to the consumer
   2. Identify the rules regarding Internet advertisements (Section 1726 of the CIC)

B. Marketing Practices (Section 10234.93 of the CIC)
   1. Insurer responsibilities
      a. establish marketing procedures for agents
      b. submit to the commissioner a list of long-term care insurance agents, updated every six months
      c. provide continuing education training
      d. notice on page one of the policy: "this policy may not cover all costs associated with long-term care incurred by the buying during the period of coverage"
      e. written notice identifying local HICAP
      f. establish auditable procedures
   2. Agent responsibilities
      a. fair and accurate comparisons
      b. no excessive insurance
      c. determine applicant's existing coverage
      d. provide California Department of Aging shoppers guide prior to application

VIII. California Partnership for Long-Term Care

A. Introduction to the Partnership (www.dhcs.ca.gov/services/ltc/pages/cpltc.aspx)
   1. Partnership product allows dollar-for-dollar offset of benefit with Medi-Cal spend-down recovery
   ~~2. Partnership product is only appropriate for a narrow segment of individuals who fit a certain income and asset profile~~
   2~~3~~. Special Partnership certification is required in order to sell Partnership product

IX. Attachments

A. Medi-Cal Requirements – Attachment I

B. Tax Treatment of Long-Term Care Insurance & Expenses – Attachment II
   1. Provide sample of 1099 LTC form and instructions
   2. Provide copy of tax form 8853

C. Applicable Laws & Penalties – Attachment III

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Attachment I

Medi-Cal Requirements[1]

When to Apply for Medi-Cal

Medi-Cal eligibility is not automatic. You must apply for Medi-Cal to become eligible for public assistance. To become eligible for Medi-Cal, you must:

- Be aged, blind, or disabled;
- Be a citizen or have satisfactory immigration status; and
- Meet the Medi-Cal property and asset requirements.

Once your eligibility has been determined, you may be required to pay, from your income, a monthly "share of cost" for your care.

Once accepted by Medi-Cal, you are eligible for all services that Medi-Cal covers. Medi-Cal services may be different than those you received under your private long-term care insurance. For example, Medi-Cal has no limits on the number of days covered, if they are medically necessary. **However, Medi-Cal will not pay for your stay in a Residential Care Facility.** Medi-Cal will pay for some nursing services in the home, including services in a Residential Care Facility, if that is where you live, and if you are temporarily or permanently unable to leave your home. For example, if you are recently discharged from a hospital, Medi-Cal will pay for follow-up care which can be provided in your home.

Medi-Cal Property and Asset Limitations

There are property/asset limits for the Medi-Cal program. If your property/assets are over the Medi-Cal property limit, you will not get Medi-Cal unless you lower them according to the program rules.

The county looks at how much you and your family have each month. If your property/assets are below the limit at any time during that month, you will get Medi-Cal, if otherwise eligible. If you have more than the limit for a whole month, you will be discontinued until you are once again below the limits.

The home you live in, furnishings, personal items, and one motor vehicle are not counted.

A single person is allowed to keep $2,000 in property/assets, the limit is higher if you are married or have a family.

For more information, please ask your county welfare office (usually the Department of Social Services) for a form called "Medi-Cal General Property Limitations for all Medi-Cal Applicants" (MC Information Notice 007).

Medi-Cal Property and Asset Limitations for Married Couples When One Spouse is in a Nursing Home

If one spouse (husband or wife) goes into a nursing home, and the other spouse is still at home, the spouse at home may keep up to $115,920 while the institutionalized spouse may keep $2,000 (this is the amount allowed in 2013; the amount is adjusted by the annual increase of the Consumer Price Index).

[1] Data reproduced from the 2013 Before You Buy guide, with the approval of the California Partnership for Long-Term Care.

In 2013, the spouse at home may keep all of the couple's income he/she receives in his/her own name. If this amount is under $2,898 per month, a monthly allocation may be made from the institutionalized spouse to the at-home spouse to bring the at-home spouse's income up to at least $2,898 per month. This is referred to as the at-home spouse's "monthly maintenance needs allowance." (This amount is also adjusted annually by the cost of living increase.)

The at-home spouse may retain additional income or assets through a "fair hearing," or by court order. The spouse in the nursing home is permitted to keep $35 a month for personal needs.

Medi-Cal Share of Cost

If you are on Medi-Cal, you may need to use some portion of your monthly income from Social Security, a pension, etc. to pay for your health and long-term care expenses. Your income will probably not be enough to pay the entire bill, so Medi-Cal will pay the rest of your nursing home bill or any other medical expenses you may have.

You will be allowed to keep a certain amount of your income each month. In 2013, you may keep the following "Maintenance of Need" amount:

- If you are living in the community, an individual may keep $600*, a married couple $934*; or
- If you are in a nursing home, an individual may keep $35 for personal needs. If he or she has a spouse at home, the at-home spouse may keep all of the couple's income he/she receives in his/her name. If this amount is under $2,898 per month, a monthly allocation may be made from the institutionalized spouse to the at-home spouse to bring the at-home spouse's income up to at least $2,898 per month.

In determining your share of cost, Medi-Cal will calculate the applicant's/institutionalized spouse's total monthly income. This figure is your net income. The county will subtract the allocation to the at-home spouse, if applicable. Then the "Maintenance of Need" amount is subtracted from your net income. The remaining amount is your monthly share of cost – the amount you would have to spend on medical or long-term care before Medi-Cal begins payment.

For more detailed information on how the Medi-Cal share-of-cost is calculated, contact your county Department of Social or Human Services (also known as the county welfare office).

*There may be other adjustments allowed based on individual circumstances.

California Department of Insurance
Eight-Hour Mandatory Long-Term Care Course
Attachment II

Tax Treatment of Long-Term Care Insurance & Expenses

Introduction

Federal and state tax codes have a purpose beyond raising revenue. Public policy is often served by providing economic relief to taxpayers or motivation for particular behavior. The 1996 Health Insurance Portability and Accountability Act (HIPAA – Public Law 104-191, 110 Stat. 1936, 2054 and 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 as well as the insurance and health care industry continue to grapple with it.

By including long-term care insurance in HIPAA, Congress attempted to fulfill a number of different public policy objectives including: (1) classifying long-term care costs as a medical expense thus providing taxpayers with some economic relief; (2) categorizing long-term care insurance as accident and health insurance thereby providing clarity as to the tax treatment of premiums and benefits; and (3) providing the general public an incentive to purchase private long-term care insurance.

In addition, as Federal and State governments recognized that long-term care expenses were having a significant financial impact on state Medicaid (Medi-Cal) budgets, Congress was attempting to shift the financial burden of Medicaid to the private sector by providing general tax incentives to purchase long-term care insurance in anticipation of the huge number of baby boomers who may need care in the future.

Note: ***The information provided in this treatise gives a broad description of the tax issues related to long-term care and 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 insured's about their specific tax situation and circumstances. Agents should always refer clients to a tax advisor for the final analysis of tax impact of long-term care insurance and expenses. Additionally, there are several examples provided in this Attachment that should be included in the course.***

HIPAA Definitions That Apply to Long-Term Care Expenses and Insurance

Introduction

The Internal Revenue Code (IRC) allows deductions for medical and dental expenses under certain circumstances (IRC Sec. 213d). Prior to the passage of HIPAA, a broad range of long-term care expenses were generally not deductible. Part of Congress' intent in enacting HIPAA was to provide tax relief to individuals and families that were incurring long-term care costs. However, part of the challenge facing legislators was determining which expenses would qualify.

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Qualified Long-Term Care Services/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 is a wide-ranging universe of potential services. To control when the cost of long-term care services could receive favorable tax treatment, Congress established a threshold 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 meeting one of the following tests:

- The individual is unable, 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. (See Internal Revenue Service Notice 97-31, issued May 6, 1997 or California Insurance Code (CIC) section 10232.8(e)(1 – 6) for the definitions of the ADL's.)

- The individual requires substantial supervision to be protected from threats to health and safety due to severe cognitive impairment.

Federal and State laws require the certification of the insured's status as a "chronically ill individual" to be renewed annually. It is only when an insured meets this definition that favorable tax treatment for the cost of long-term care services will be granted.

Licensed Health Care Practitioner
The Internal Revenue Service defines licensed health care practitioner (LHP) in very general terms. It may include doctors, nurses, social workers, chiropractors, Christian Science practitioners, mental health professionals, and other licensed therapists. IRS Publication 502 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".

90-Day Certification for Activities of Daily Living
Congress intended to limit long-term care costs to those associated with chronic illness. A clinical definition of chronic illness is one that is expected to last 90 days or more. Some expenses for acute or short term illnesses were already deductible as a medical expense. If policy makers had ignored the distinction between acute and chronic, it could have had the unintended consequence of allowing taxpayers to deduct expenses associated with short-term disabilities due to the broad nature of the definition of qualified *long-term care service.*

Therefore, a taxpayer who wishes to deduct qualified long-term care expenses using the ADL definition must have a licensed health care practitioner certify that the insured is likely to need substantial assistance for at least 90 days. Keep in mind, the requirement concerns the likelihood of needing care, not the actual receipt of care. In fact, there is no requirement that the person actually receives the full 90 days of care. The insured must be recertified by the LHP (licensed health professional) at least annually.

IRS Publication 502 stipulates that the 90-day certification period is not a deductible period for people who have long-term care insurance. Long-term care insurance can still pay benefits following the deductible period of the policy, if any, as long as the certification stipulates that the person is likely to need qualified long-term care services for at least 90 days. The certification may also be done retroactively in the event a claim is not filed until after the deductible period in the policy has been met.

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.

Severe Cognitive Impairment and Substantial Supervision

Notice 97-31 defines a *severe cognitive impairment* "as a loss or deterioration in intellectual capacity that is similar to Alzheimer's disease and like forms of irreversible dementia and is measured by clinical evidence and standardized tests that reliably measure impairment in short-term and long-term memory, orientation to people, places or time and deductive or abstract reasoning." Note that 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 recertified 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.

Tax Qualified Long-Term Care Insurance

Introduction

Prior to HIPAA, neither long-term care insurance premiums nor benefits were addressed in the Federal tax code. There was uncertainty as to whether LTC insurance would be classified as accident and health insurance or disability insurance for the purposes of both the deductibility of premiums and the taxation of the benefits. However, the common belief was that as long as premiums were paid with after-tax dollars, benefits would be tax free.

HIPAA requires that long-term care insurance policies comply with its guidelines to be considered "qualified" long-term care insurance. As such, qualified long-term care insurance policies are accident and health policies and the tax treatment or their benefits are generally the same as other A & H plans.

Policies that do not meet these requirements are considered to be non-qualified long-term care insurance policies. Premiums paid for a non-qualified policy are not presumed to be deductible as accident and health insurance. However, HIPAA was silent as to the tax treatment of benefits received from non-qualified policies issued after January 1, 1997. To date, the Department of the Treasury has not issued an opinion on this conflict and Congress has not taken the matter up again leading to continued speculation about the tax implications of these benefits.

Benefits

Congress created a generalized structure to which qualified LTCi products must adhere. For purposes of HIPAA, a qualified long-term care insurance policy must pay benefits using no less than 5 or no more than 6 of the following activities of daily living: eating; toileting; transferring; bathing; dressing; and/or continence.

Tax qualified long-term care insurance is generally treated the same as an accident and health insurance policy. Some of the rules include:

1. Reimbursement method long-term care insurance benefits pass tax-free
2. Per diem and cash method policy benefits received are subject to an annually adjusted limit amount of $320/day in 2013 (indexed upwards annually by approximately 5 percent)
3. Premiums are generally deductible
4. Premiums paid by an employer for an employee are 100 percent deductible and do not count as income to the employee
5. Certain tax deductibility limitations apply to individuals, sole proprietors, owners of S-corporations, and LLP's
6. Individuals with Health savings accounts can utilize these funds to pay for qualified long-term care insurance subject to limitations discussed below
7. Qualified long-term care insurance cannot be included in a Section 125 Cafeteria Plan or flexible spending arrangement
8. Qualified long-term care insurance policies may not use "medical necessity" as a benefit trigger and must coordinate benefit payment with Medicare

Required Consumer Protection

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.

IRS Reporting Mechanism

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 disclosed on IRS Form 8853. The 1099 form must identify the method of benefit payment (reimbursement or per diem) but does indicate 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.

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

Introduction

Policies issued prior to January 1, 1997, created a challenge under 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.

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.

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.***

Long-Term Care Insurance Premium Deductibility

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) and subsequent Department of the Treasury rulings have created four primary deductibility scenarios for tax qualified long-term care insurance. They are: health savings accounts; individual deductibility; deductibility for the self-employed, owners of S-corporations, limited liability partnerships (LLP) and limited liability corporations (LLC); and, deductibility for employee/owners of C-corporations. The tax incentives that allow for premium deductibility may help the self-employed and employees of companies that provide employer-paid long-term care insurance. To a lesser extent, some individual taxpayers, who are not self-employed may benefit from the premium deductibility allowed by HIPAA.

Health Savings Accounts (Medical IRA Account)

Health Savings Accounts (HSA) and their predecessor MSA's, 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 2013) $3,250 (individual) or $6,450 (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.

HSA's 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. HSA's represent an opportunity for some consumers to tailor their medical insurance and long-term care insurance priorities in a cost and tax-efficient manner.

Individual Deductibility

Taxpayers who itemize their deductions may benefit from the deductibility of qualified long-term care insurance premiums. Based on the taxpayer's age, only a portion of the long-term care insurance premium is deductible. Taxpayers over age 60 with above average income and assets may be interested in long-term care insurance. These individuals may itemize their deductions because they own property and the standard deduction is not in their best interest. Expenses for medical care and insurance premiums are deductible to the extent that they exceed 10% of adjusted gross income. Prior to HIPAA, most taxpayers in this circumstance would not exceed 10% of their adjusted gross income in unreimbursed medical expenses. However, with the inclusion of qualified long-term care insurance as an accident and health insurance policy, some taxpayers may benefit.

HIPAA states that premiums for tax qualified long-term care insurance are deductible as an accident and health insurance policy. However, unlike other accident and health insurance premiums, the amount of qualified long-term care insurance premiums is limited by a stipulated age to the amount that can be deducted. In 2013, the age "banded" amounts that may be applied towards the taxpayer's un-reimbursed medical expenses are:

Banded Age Limits	Individuals/Couples
➢ Under Age 40	$ 360/$720
➢ Ages 41 - 50	$ 680/$1,360
➢ Ages 51 - 60	$1,310/$2,620
➢ Ages 61 - 70	$3,640/$7,280
➢ Ages 71 +	$4,370/$8,740

Individual taxpayers under age 61 who itemize their deductions may not get much of a tax relief by including the allowable long-term care insurance premium amount in their unreimbursed medical expenses. However, someone age 61+ may benefit. Individual taxpayers, who itemize their deductions, may include the cost of tax qualified long-term care insurance as an accident and health insurance premium. The deductible premium amount allowed is limited by the age-banded amount in that tax year.

The following is a thumbnail example of how this may work for a hypothetical husband and wife, both ages 65, who are considering purchasing a qualified long-term care insurance policy with a joint annual premium of $9,000. Assume, for the purposes of this example, that this couple has an adjusted gross

income of $100,000 therefore they must exceed $10,000 of un-reimbursed medical expenses before they receive any type of tax relief from these types of deductions.

- Amount Allowed For TQ-LTCi $7,820
- Medicare Supplement Premiums $5,000
- Medicare Part B Premiums $3,000
- Other Allowable Medical Expenses $3,000
    - (Rx, eyeglasses, dental)
        - ***Total*** ***$18,820***

In this example, the taxpayers would be allowed to deduct $8,820 ($18,820 minus their $10,000 threshold) of un-reimbursed medical expenses. If they are in a combined federal and state income tax bracket of 35%, their tax savings would equal $3,087 ($8,820 x 35%). This would amount to an approximately 35% premiums savings ($3,087 ÷ $9,000). The deductible amount allowed for long-term care insurance premiums is not enough to trigger a deduction for these taxpayers; neither are the stand-alone deductions for the other unreimbursed medical expenses. However, the combination of all of them provides this hypothetical couple with a savings. It is important to note that most agents are not qualified tax advisors and as such need to be cautious in their recommendations. Clearly, if the agent inquires as to the unreimbursed expenses illustrated above they may spot a potential tax savings for the consumer and refer them to their tax advisor.

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

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 age 55 who are considering purchasing a tax qualified long-term care insurance policy with a joint annual premium of $6,000 per year. They would be allowed to deduct $2,620. If they are in the combined Federal and State tax bracket of 35% their tax savings would be $917 or approximately 15% 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 this Attachment that should be 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 stockholder 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.

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

The Pension Protection Act of 2006 (PPA), like HIPAA, is a significant 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. 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 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 ($320 in 2013 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--if it looks like qualified long-term care insurance, it is qualified long-term care insurance.

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.

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, or Life-Only Agent (only if it is a LTC rider on a full life policy).
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.

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 agents 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 insured's about their specific tax situation and circumstances. Agents should always refer clients to insured's tax advisor for the final analysis of the tax impact of long-term care insurance and expenses.

California Department of Insurance
Eight-Hour Mandatory Long-Term Care Course
Attachment III

Applicable Laws & Penalties

INSURANCE		
Long-Term Care Insurance **Sections 10230-10237.6**	**§10233.3; §10234.85; §10234.86; §10234.87; §10234.97** Various requirements for the replacement of LTC policies. **§10234.95** All sales of LTC insurance shall meet the "suitability" standards.	*All violations of Chapter 2.6 subject to the following penalties in addition to court penalties, attorney's fees and costs per §10234.2.:* • **§10234.3(a):** Penalty of not less than $250 for each 1st violation; not less than $1,000 and not more than $25,000 for each subsequent or knowing violation; for inappropriate replacement of LTC coverage, penalty not more than $5,000 for each violation. • **§10234.4(a):** Suspend or revoke license. • **§10234.4(c):** Ordered to cease marketing LTC insurance in California.

GENERAL PROVISIONS		
Misrepresentation of Policies **Section 780** **Twisting** **Section 781**	**§780** Prohibited statements re: terms, benefits, privileges or future dividends of policy. **§781(a)** Twisting: prohibited statement known to be a misrepresentation to induce person to take out a policy, refuse a policy and take out another, let lapse, forfeit of surrender policy. **§781(b)** Prohibited misleading statement or comparison of insurers or policies to induce person to let insurance lapse, forfeit, change or surrender policy.	**Section 782:** Any person who violates section 780 or 781 is punishable by fine not to exceed $25,000, or if victim loss exceeds $10,000, the fine not to exceed 3 times the loss suffered by the victim, by imprisonment not to exceed 1 year or by both a fine and imprisonment. Restitution to victim pursuant to Section 1202.4 of the Penal Code shall be satisfied before any fine imposed by this section is collected. **Section 783:** Any insurance agent, broker or solicitor who knowingly violates section 780 or 781 may have their license suspended for up to three years after a hearing.
Unfair Practices **Sections 790-790.15**	**§790.01** Applies to insurers, agents, etc. and "all other persons engaged in the business of insurance". **§790.02** Prohibits use of unfair trade practices or unfair method of competition or deceptive act or practice in the business of insurance. **§790.03** Lists in detail prohibited acts such as: misrepresentations about the terms of any policy issued or the benefits or advantages promised; prohibits making, disseminating, causing to be made or disseminated in any manner any known or reasonably should be known,	*All violations of Article 6.5 subject to penalties as follows*: • **§790.035(a):** Civil penalty of NTE $5,000.00 for each act. If act or practice is willful, civil penalty NTE $10,000.00 for each act. • **§790.05:** Cease and Desist Order; subsequent violations license may be suspended/revoked for up to one year. • **§790.06:** Prosecution of acts not defined in §790.03-Cease and Desist Order. • **§790.07:** Violation of Cease and Desist

	untrue, deceptive, misleading statement. **§790.037** Unfair practice selling health care products; cold lead advertising; appointments; Medicare products restrictions on sales discussions.	Order; penalty NTE $5,000; if willful, penalty NTE $55,000 plus penalty under §790.05. • **§790.08**: Provides that the penalties in this Article are in addition to any other powers of the Commissioner to enforce the laws.
OTHER RELEVANT INSURANCE CODE SECTIONS		
Insurance Information & Privacy Protection Act **Sections 791-791.28**	**§791.03** Prohibits the use of "pretext interviews" to obtain information in connection with an insurance transaction (i.e. "free lunch" seminars).	*All violations of Article 6.6 subject to penalties as follows*: • **§791.17:** Cease and desist order issued. • **§791.19:** Violation of Cease & Desist order: Penalty of not more than $10,000 for each violation; or not more than $50,000 if frequent violations constitute general business practice. Suspension & revocation of license for knowing violation.
Medicare Supplement Insurance **Sections 10192.1-10192.24**	**§10192.18** Application forms require certain questions to determine if applicant already has a policy or certificate; must be signed by applicant and agent. **§10192.21(b)** Prohibits sale of a Medicare supplement policy or certificate if individual already has one. **§10192.23** States time periods for replacement of policies.	*All violations of Article 6 subject to the following penalties:* • **§10192.165(a) & (c):** Court penalties including damages & restitution. • **§10192.165(b)(1):** Penalty of no less than $250 for first violation by agent, broker, other person/entity engaged in business of insurance. • **§10192.165(b)(2):** Penalty of no less than $1,000 and no more than $25,000 for each second, subsequent or knowing violation. • **§10192.165(d):** Order to cease marketing any Medicare supplement policy or certificate. • **§10192.165(e):** Any person who knowingly or intentionally violates this Article is punishable by imprisonment in county jail NTE one year, or by imprisonment per Penal Code §1170 or a fine NTE $10,000 or both.

OTHER RELEVANT INSURANCE CODE SECTIONS

Welfare & Institutions Code §15610.27
"Elder" means any person residing in this state, 65 years of age or older.

Welfare & Institutions Code §15610.30
(a) "Financial abuse" of an elder or dependent adult occurs when a person or entity does any of the following:

(1) Takes, secretes, appropriates, obtains, or retains real or personal property of an elder or dependent adult for a wrongful use or with intent to defraud, or both.
(2) Assists in doing the above activities.
(3) Does or assists in the above activities by undue influence, as defined in Section 1575 of the Civil Code.
(b) A person or entity shall be deemed to have committed the above acts for a wrongful use if, among other things, the person or entity takes, secretes, appropriates, obtains, or retains the property and the person or entity knew or should have known that this conduct is likely to be harmful to the elder or dependent adult.
(c) For purposes of this section, a person or entity takes, secretes, appropriates, obtains, or retains real or personal property when an elder or dependent adult is deprived of any property right, including by means of an agreement, donative transfer, or testamentary bequest, regardless of whether the property is held directly or by a representative of an elder or dependent adult.
(d) For purposes of this section, "representative" means a person or entity that is either of the following:
  (1) A conservator, trustee, or other representative of the estate of an elder or dependent adult.
  (2) An attorney-in-fact of an elder or dependent adult who acts within the authority of the power of attorney.

California Penal Code §182 – Conspiracy
(a) If two or more persons conspire:

(1) To commit any crime.
(2) Falsely and maliciously to indict another for any crime, or to procure another to be charged or arrested for any crime.
(3) Falsely to move or maintain any suit, action, or proceeding.
(4) To cheat and defraud any person of any property, by any means which are in themselves criminal, or to obtain money or property by false pretenses or by false promises with fraudulent intent not to perform those promises.
(5) To commit any act injurious to the public health, to public morals, or to pervert or obstruct justice, or the due administration of the laws.
(6) To commit any crime against the person of the President or Vice President of the United States, the Governor of any state or territory, any United States justice or judge, or the secretary of any of the executive departments of the United States.

California Penal Code §368(d) – Financial Elder Abuse
Any person who is not a caretaker who violates any provision of law proscribing theft, embezzlement, forgery, or fraud, or who violates Section 530.5 proscribing identity theft, with respect to the property or personal identifying information of an elder or a dependent adult, and who knows or reasonably should know that the victim is an elder or a dependent adult is punishable as follows:

(1) By a fine not exceeding two thousand five hundred dollars ($2,500), or by imprisonment in a county jail not exceeding one year, or by both that fine and imprisonment, or by a fine not exceeding ten thousand dollars ($10,000), or by imprisonment pursuant to subdivision (h) of Section 1170 for two, three, or four years, or by both that fine and imprisonment, when the moneys, labor, goods, services, or real or personal property taken or obtained is of a value exceeding nine hundred fifty dollars ($950).

(2) By a fine not exceeding one thousand dollars ($1,000), by imprisonment in a county jail not exceeding one year, or by both that fine and imprisonment, when the moneys, labor, goods, services, or real or personal property taken or obtained is of a value not exceeding nine hundred fifty dollars ($950).

California Penal Code §459 - Burglary
Every person who enters any house, room, apartment, tenement, shop, warehouse, store, mill, barn, stable, outhouse or other building, tent, vessel, as defined in Section 21 of the Harbors and Navigation Code, floating home, as defined in subdivision (d) of Section 18075.55 of the Health and Safety Code, railroad car, locked or sealed cargo container, whether or not mounted on a vehicle, trailer coach, as defined in Section 635 of the Vehicle Code, any house car, as defined in Section 362 of the Vehicle Code, inhabited camper, as defined in Section 243 of the Vehicle Code, vehicle as defined by the Vehicle Code, when the doors are locked, aircraft as defined by Section 21012 of the Public Utilities Code, or mine or any underground portion thereof, with intent to commit grand or petit larceny or any felony is guilty of burglary. As used in this chapter, “inhabited" means currently being used for dwelling purposes, whether occupied or not. A house, trailer, vessel designed for habitation, or portion of a building is currently being used for dwelling purposes if, at the time of the burglary, it was not occupied solely because a natural or other disaster caused the occupants to leave the premises.

California Penal Code §470 – Forgery
Every person who, with the intent to defraud, knowing that he or she has no authority to do so, signs the name of another person or of a fictitious person to any of the items listed in subdivision (d) is guilty of forgery.

California Penal Code §487 – Grand Theft
When the money, labor, or real or personal property taken is of a value exceeding nine hundred fifty dollars ($950)

California Penal Code §502(c) – Computer Access Fraud
(c) any person who commits any of the following acts is guilty of a public offense:

(1) Knowingly accesses and without permission alters, damages, deletes, destroys, or otherwise uses any data, computer, computer system, or computer network in order to either (A) devise or execute any scheme or artifice to defraud, deceive, or extort, or (B) wrongfully control or obtain money, property, or data.
(2) Knowingly accesses and without permission takes, copies, or makes use of any data from a computer, computer system, or computer network, or takes or copies any supporting documentation, whether existing or residing internal or external to a computer, computer system, or computer network.

(3) Knowingly and without permission uses or causes to be used computer services.
(4) Knowingly accesses and without permission adds, alters, damages, deletes, or destroys any data, computer software, or computer programs which reside or exist internal or external to a computer, computer system, or computer network.
(5) Knowingly and without permission disrupts or causes the disruption of computer services or denies or causes the denial of computer services to an authorized user of a computer, computer system, or computer network.
(6) Knowingly and without permission provides or assists in providing a means of accessing a computer, computer system, or computer network in violation of this section.
(7) Knowingly and without permission accesses or causes to be accessed any computer, computer system, or computer network.
(8) Knowingly introduces any computer contaminant into any computer, computer system, or computer network.
(9) Knowingly and without permission uses the Internet domain name of another individual, corporation, or entity in connection with the sending of one or more electronic mail messages, and thereby damages or causes damage to a computer, computer system, or computer network.

California Penal Code §530 – Identity Theft
Every person who falsely personates another, in either his private or official capacity, and in such assumed character receives any money or property, knowing that it is intended to be delivered to the individual so personated, with intent to convert the same to his own use, or to that of another person, or to deprive the true owner thereof, is punishable in the same manner and to the same extent as for larceny of the money or property so received.

California Penal Code §532 – Theft by False Pretenses
Every person who knowingly and designedly, by any false or fraudulent representation or pretense, defrauds any other person of money, labor, or property, whether real or personal, or who causes or procures others to report falsely of his or her wealth or mercantile character, and by thus imposing upon any person obtains credit, and thereby fraudulently gets possession of money or property, or obtains the labor or service of another, is punishable in the same manner and to the same extent as for larceny of the money or property so obtained.