

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.

California Department of Insurance

Eight-Hour Mandatory Long-Term Care Course

Attachment II

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*.

California Department of Insurance

Eight-Hour Mandatory Long-Term Care Course

Attachment II

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.

California Department of Insurance

Eight-Hour Mandatory Long-Term Care Course

Attachment II

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-

California Department of Insurance

Eight-Hour Mandatory Long-Term Care Course

Attachment II

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

California Department of Insurance

Eight-Hour Mandatory Long-Term Care Course

Attachment II

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

California Department of Insurance

Eight-Hour Mandatory Long-Term Care Course

Attachment II

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 unreimbursed medical expenses are:

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

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

California Department of Insurance

Eight-Hour Mandatory Long-Term Care Course

Attachment II

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.

California Department of Insurance

Eight-Hour Mandatory Long-Term Care Course

Attachment II

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

California Department of Insurance

Eight-Hour Mandatory Long-Term Care Course

Attachment II

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

California Department of Insurance

Eight-Hour Mandatory Long-Term Care Course

Attachment II

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.