

[4830-01-u]

DEPARTMENT OF THE TREASURY

Internal Revenue Service

26 CFR Part 1

[REG-109333-97]

RIN 1545-AV56

Qualified Long-Term Care Insurance Contracts

AGENCY: Internal Revenue Service (IRS), Treasury.

ACTION: Notice of proposed rulemaking and notice of public hearing.

SUMMARY: This document contains proposed regulations relating to consumer protection with respect to qualified long-term care insurance contracts and relating to events that will be considered material changes with respect to long-term care insurance contracts issued prior to January 1, 1997. Changes to the applicable law were made by the Health Insurance Portability and Accountability Act of 1996. The regulations affect issuers of long-term care insurance contracts and individuals entitled to receive payments under these contracts. The regulations are necessary to provide these taxpayers with guidance needed to comply with these changes.

DATES: Written comments must be received by April 2, 1998.

Outlines of topics to be discussed at the public hearing scheduled for May 13, 1998, must be received by April 2, 1998.

ADDRESSES: Send submissions to: CC:DOM:CORP:R (REG-109333-97), room 5226, Internal Revenue Service, POB 7604, Ben Franklin Station, Washington, DC 20044. Submissions may be hand delivered between the hours of 8 a.m. and 5 p.m. to CC:DOM:CORP:R (REG-109333-97), Courier's Desk, Internal Revenue Service, 1111 Constitution Avenue NW, Washington, DC. Alternatively, taxpayers may also submit comments electronically via the Internet by selecting the "Tax Regs" option on the IRS Home Page, or by submitting comments directly to the IRS Internet site at http://www.irs.ustreas.gov/prod/tax_regs/comments.html. The public hearing will be held in room 2615, Internal Revenue Building, 1111 Constitution Avenue NW, Washington, DC.

FOR FURTHER INFORMATION CONTACT: Concerning the regulations, Katherine A. Hossofsky, (202) 622-3477; concerning submissions and the hearing, LaNita VanDyke, (202) 622-7190 (not toll-free numbers).

SUPPLEMENTARY INFORMATION:

Background

This document contains proposed amendments to the Income Tax Regulations (26 CFR part 1) to provide rules under section 7702B of the Internal Revenue Code of 1986 (the "Code"). Section 7702B was added by sections 321 and 325 of the Health Insurance Portability and Accountability Act of 1996 (Pub. L. 104-191, 110 Stat. 1936, 2054 and 110 Stat. at 2063)("HIPAA"). Notice 97-31, 1997-21 I.R.B. 5 (May 6, 1997), provides interim guidance on certain provisions of section 7702B and other provisions of the Code added or amended by HIPAA.

Explanation of Statutory Provisions

Section 7702B establishes the tax treatment for qualified long-term care insurance contracts. Sections 7702B(a)(1) and (3) provide that a qualified long-term care insurance contract is treated as an accident and health insurance contract and that any employer plan providing coverage under a qualified long-term care insurance contract is treated as an accident or health plan with respect to that coverage.

Section 7702B(a)(2) provides that amounts (other than policyholder dividends and premium dividends) received under a qualified long-term care insurance contract are generally excludable from gross income as amounts received for personal injuries and sickness.

Section 213(d)(1)(D) was amended by section 322 of HIPAA to provide that eligible long-term care premiums as defined in section 213(d)(10) are deductible medical expenses.

Under section 7702B(b)(1)(F), a qualified long-term care insurance contract must meet the consumer protection provisions of section 7702B(g). In addition, section 4980C imposes an excise tax on issuers of qualified long-term care insurance contracts that do not provide further consumer protections.

Section 7702B of the Code applies to contracts issued after December 31, 1996. Section 321(f)(2) of HIPAA treats a contract issued before January 1, 1997, as a qualified long-term care insurance contract under section 7702B(b) of the Code, and services provided or reimbursed under such a contract as qualified long-term care services under section 7702B(c) of the Code, provided the contract met the long-term care requirements of the State in which the contract was situated at the time the contract was issued. Section 321(f)(2) of HIPAA also provides that in the case of an individual covered on December 31, 1996, by a State long-term care plan under section 7702B(f) of the Code, the terms of the plan on that date are treated as a contract meeting the long-term care insurance requirements of that State.

Section 321(f)(4) of HIPAA provides that for purposes of applying sections 101(f), 7702, and 7702A of the Code, neither the issuance of a rider that is treated as a qualified long-term care insurance contract nor the addition of any provision required to conform any other long-term care rider to the requirements applicable to a qualified long-term care insurance contract is treated as a modification or material change of the contract.

Explanation of Provisions

The proposed regulations provide guidance concerning

- the consumer protection requirements that apply to qualified long-term care insurance contracts under sections 7702B(g), 7702B(b)(1)(F), and 4980C of the Code; and
- the grandfather provisions of section 321(f)(2) of HIPAA under which pre-1997 contracts are treated as qualified long-term care insurance contracts if certain conditions are met.

The standards in the proposed regulations are based on safe harbors that were originally set forth in Notice 97-31. They reflect comments made by consumer representatives, issuers of long-term care insurance, independent sales agents, State regulators of long-term care insurance, and others. The proposed regulations are intended to provide clear and workable rules to assist those who want to ensure that a contract issued before 1997 retains its status as a qualified long-term care insurance contract.

Notice 97-31

Notice 97-31 was issued to provide interim standards for taxpayers to use in interpreting the new long-term care provisions and to facilitate operation of the insurance market by avoiding the need to amend contracts. For example, Notice 97-31 includes interim guidance on the determination of whether an individual is a "chronically ill individual," including safe harbor definitions of the terms "substantial assistance," "hands-on assistance," "standby assistance," "severe cognitive impairment," and "substantial supervision." The standards contained in Notice 97-31 include interim guidance on both the consumer protection provisions and the scope of the statutory grandfather provisions that apply to long-term care insurance contracts issued before 1997.

Consumer Protection Requirements

Under sections 7702B(b)(1)(F), 7702B(g), and 4980C, qualified long-term care insurance contracts and issuers of those contracts are required to satisfy certain provisions of the model act and model regulation promulgated by the National Association of Insurance Commissioners (NAIC) for long-term care insurance as of January 1993. The requirements relate to guaranteed renewability, unintentional lapse, disclosure, prohibitions against post-claims underwriting, inflation protection, and prohibitions against pre-existing conditions exclusions and probationary periods. Section 4980C imposes an excise tax on an issuer of a qualified long-term care insurance contract if, after 1996, the issuer fails to satisfy certain requirements, including requirements relating to application forms, reporting, marketing, appropriateness of recommended purchase, standard format outline of coverage, delivery of a shopper's guide, right to return, outline of coverage, and incontestability. Most of these requirements are based on the NAIC model act and regulation.

The proposed regulations reflect the standards that were set forth in Notice 97-31. For example, the consumer protection requirements will be considered satisfied if a contract complies with State law in a State that has adopted the related NAIC model or a more stringent version of the model.

Pre-1997 Long-term Care Insurance Contracts

Section 321(f)(2) of HIPAA provides that a contract issued before January 1, 1997, is treated as a qualified long-term care insurance contract if the contract met the "long-term care insurance requirements of the State" in which the contract was situated at the time it was issued. Under the proposed regulations, the date on which a long-term care insurance contract other than a group long-term care insurance contract is issued is generally the date assigned to the contract by the insurance company. In no event is the issue date earlier than the date on which the policyholder submitted a signed application for coverage to the insurance company. In addition, if the period between the date of application and the date on which the long-term care insurance contract actually becomes effective is substantially longer than under the insurance company's usual business practice, then the issue date is the date the contract becomes effective. For purposes of applying the grandfather rule of section 321(f)(2) to a group long-term care insurance contract, the issue date of the contract is the date the group contract was issued. As a result, coverage for an individual who joins a grandfathered group long-term care insurance contract on or after January 1, 1997, is accorded the same treatment under section 321(f)(2) as is accorded coverage for those who joined the group before that date.

For purposes of applying section 321(f)(2) of HIPAA to long-term care insurance contracts issued before January 1, 1997, a material change in the contract generally is considered the issuance of a new contract. Notice 97-31 provides that a material change includes any change in the terms of the contract altering the amount or timing of any item payable by the policyholder (or certificate holder), the insured, or the insurance company. Notice 97-31 also provides that the exercise of an option or right granted to a policyholder under a qualified long-term care insurance contract as in effect on December 31, 1996, does not constitute a material change.

After Notice 97-31 was issued, commentators recommended that certain common practices should not cause long-term care insurance contracts issued before January 1, 1997, to lose their grandfathered status. In response to these comments, the proposed regulations provide additional exceptions to the general rule that a material change in a long-term care insurance contract issued before January 1, 1997, will be considered the issuance of a new contract.

- The proposed regulations provide that the exercise of any right provided to a policyholder (i.e., a right that can be exercised without the issuer's consent and without other conditions, such as underwriting) or the addition of any right that is required by State law to be provided to the policyholder will not be treated as a material change to a long-term care insurance contract.
- In addition, the proposed regulations provide that the following practices will not be treated as material changes for purposes of section 7702B: (1) any change in the mode of premium payment, such as a change from paying premiums

monthly to quarterly; (2) any classwide increase or decrease in premiums for contracts that have been issued on a guaranteed renewable basis; (3) a reduction in premiums due to the purchase of a long-term care insurance policy by a member of the policyholder's family; (4) any reduction in coverage (with correspondingly lower premiums) made at the request of a policyholder; (5) the addition, without an increase in premiums, of alternative forms of benefits that may be selected by the policyholder; (6) the purchase 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; (7) the deletion of a rider or provision of a contract (called an HHS rider) that prohibited coordination of benefits with Medicare; and (8) 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 proposed regulations include examples illustrating certain of these standards. The exceptions to the general rule that a material change results in the issuance of a new contract apply solely for purposes of determining whether a pre-1997 insurance contract is treated as a qualified long-term care insurance contract under section 7702B.

Comments are requested on these standards, including (1) whether the material change rules in the proposed regulations should be limited to pre-1997 long-term care insurance contracts that cannot have cash surrender value; (2) whether there are any conditions under which the expansion of coverage under a group long-term care insurance contract in connection with a corporate merger, acquisition or similar transaction should not constitute a material change; and (3) whether the extension of a group long-term care contract to a collective bargaining unit is a material change in all cases. For example, should the extension of a group long-term care contract to a bargaining unit after 1997 be treated as a material change if the bargaining agreement for the unit has not been renewed since before the group contract was first adopted?

Comments also are requested on what the effective date of the final regulations should be. It is intended that the regulations will not be effective until after the end of a specified period following adoption of the final regulations. Taxpayers may rely on these proposed regulations for guidance pending the issuance of final regulations. If, and to the extent, future guidance is more restrictive than the guidance in these proposed regulations, the future guidance will be applied without retroactive effect. In addition, until further notice, taxpayers may continue to rely on Notice 97-31.

Special Analyses

It has been determined that this notice of proposed rulemaking is not a significant regulatory action as defined in EO 12866. Therefore, a regulatory assessment is not required. It has also been determined that section 553(b) of the Administrative Procedure Act (5 U.S.C. chapter 5) does not apply

to these regulations, and because the regulations do not impose a collection of information on small entities, the Regulatory Flexibility Act (5 U.S.C. chapter 6) does not apply. Pursuant to section 7805(f) of the Internal Revenue Code, this notice of proposed rulemaking will be submitted to the Chief Counsel for Advocacy of the Small Business Administration for comment on its impact on small business.

Comments and Public Hearing

Before these proposed regulations are adopted as final regulations, consideration will be given to any comments that are submitted timely to the IRS (a signed original and eight (8) copies). All comments will be available for public inspection and copying.

A public hearing has been scheduled for May 13, 1998, at 10 a.m., in room 2615, Internal Revenue Building, 1111 Constitution Avenue NW, Washington, DC. Because of access restrictions, visitors will not be admitted beyond the Internal Revenue Building lobby more than 15 minutes before the hearing starts.

The rules of 26 CFR 601.601(a)(3) apply to the hearing.

Persons that wish to present oral comments at the hearing must submit written comments by April 2, 1998 and submit an outline of the topics to be discussed and the time to be devoted to each topic by April 2, 1998.

A period of 10 minutes will be allotted to each person for making comments.

An agenda showing the scheduling of the speakers will be prepared after the deadline for receiving outlines has passed. Copies of the agenda will be available free of charge at the hearing.

Drafting Information

The principal author of these regulations is Katherine A. Hossofsky, Office of Assistant Chief Counsel (Financial Institutions & Products). However, other personnel from the IRS and Treasury Department participated in their development.

List of Subjects in 26 CFR Part 1

Income taxes, Reporting and recordkeeping requirements.
Proposed Amendments to the Regulations

Accordingly, 26 CFR part 1 is proposed to be amended as follows:

PART 1--INCOME TAXES

Paragraph 1. The authority citation for part 1 continues to read in part as follows:

Authority: 26 U.S.C. 7805 * * *

Par. 2. Sections 1.7702B-1 through 1.7702B-2 are added to read as follows:

§ 1.7702B-1 Consumer protection provisions.

(a) In general. Under sections 7702B(b)(1)(F), 7702B(g), and 4980C, qualified long-term care insurance contracts and issuers of those contracts are required to satisfy certain provisions of the Long-Term Care Insurance Model Act (Model Act) and Long-Term Care Insurance Model Regulation (Model Regulation) promulgated by the National Association of Insurance

Commissioners (NAIC), as adopted as of January 1993. The requirements for qualified long-term care insurance contracts under sections 7702B(b)(1)(F) and 7702B(g) relate to guaranteed renewal or noncancellability, prohibitions on limitations and exclusions, extension of benefits, continuation or conversion of coverage, discontinuance and replacement of policies, unintentional lapse, disclosure, prohibitions against post-claims underwriting, minimum standards, inflation protection, prohibitions against pre-existing conditions exclusions and probationary periods, and prior hospitalization. The requirements for qualified long-term care insurance contracts under section 4980C relate to application forms and replacement coverage, reporting requirements, filing requirements for marketing, standards for marketing, appropriateness of recommended purchase, standard format outline of coverage, delivery of a shopper's guide, right to return, outline of coverage, certificates under group plans, policy summary, monthly reports on accelerated death benefits, and incontestability period.

(b) Coordination with State requirements--(1) Contracts issued in a State that imposes more stringent requirements. If a State imposes a requirement that is more stringent than the analogous requirement imposed by section 7702B(g) or 4980C, then, under section 4980C(f), compliance with the more stringent requirement of State law is considered compliance with the parallel requirement of section 7702B(g) or 4980C. The principles of paragraph (b)(3) of this section apply to any case in which a State imposes a requirement that is more stringent than the analogous requirement imposed by section 7702B(g) or 4980C (as described in this paragraph (b)(1)), but in which there has been a failure to comply with that State requirement.

(2) Contracts issued in a State that has adopted the model provisions. If a State imposes a requirement that is the same as the parallel requirement imposed by section 7702B(g) or 4980C, compliance with that requirement of State law is considered compliance with the parallel requirement of section 7702B(g) or 4980C, and failure to comply with that requirement of State law is considered failure to comply with the parallel requirement of section 7702B(g) or 4980C.

(3) Contracts issued in a State that has not adopted the model provisions or more stringent requirements. If a State has not adopted the Model Act, the Model Regulation, or a requirement that is the same as or more stringent than the analogous requirement imposed by section 7702B(g) or 4980C, then the language, caption, format, and content requirements imposed by sections 7702B(g) and 4980C with respect to contracts, applications, outlines of coverage, policy summaries, and notices will be considered satisfied for a contract subject to the law of that State if the language, caption, format, and content are substantially similar to those required under the parallel provision of the Model Act or Model Regulation. Only nonsubstantive deviations are permitted in order for language, caption, format, and content to be considered substantially similar to the requirements of the Model Act or Model Regulation.

§1.7702B-2 Special rules for pre-1997 long-term care insurance contracts.

(a) Scope. The definitions and special provisions of this section apply solely for purposes of determining whether an insurance contract (other than a qualified long-term care insurance contract described in section 7702B(b) and any regulations issued thereunder) is treated as a qualified long-term care insurance contract for purposes of the Internal Revenue Code.

(b) Pre-1997 long-term care insurance contracts.--(1) In general. A pre-1997 long-term care insurance contract is treated as a qualified long-term care insurance contract, regardless of whether the contract satisfies section 7702B(b) and any regulations issued thereunder.

(2) Pre-1997 long-term care insurance contract defined. A pre-1997 long-term care insurance contract is any insurance contract with an issue date before January 1, 1997, that met the long-term care insurance requirements of the State in which the contract was situated on the issue date. For this purpose, the long-term care insurance requirements of the State are the State laws (including statutory and administrative law) that are intended to regulate insurance coverage that constitutes "long-term care insurance" (as defined in section 4 of the National Association of Insurance Commissioners (NAIC) Long-Term Care Insurance Model Act, as in effect on August 21, 1996), regardless of the terminology used by the State in describing the insurance coverage.

(3) Issue date of a contract. (i) In general. The issue date of a contract is the issue date assigned to the contract by the insurance company, but in no event is the issue date earlier than the date the policyholder submitted a signed application for coverage to the insurance company. However, if the period between the date the signed application is submitted to the insurance company and the date coverage under the contract actually becomes effective is substantially longer than under the insurance company's usual business practice, then the issue date is the date coverage under the contract becomes effective (if this is later than the issue date assigned to the contract by the insurance company). A policyholder's right to return a contract within a "free-look" period following delivery for a full refund of any premiums paid is not taken into account in determining the contract's issue date.

(ii) Special rule for group contracts. The issue date of a group contract (including any certificate issued thereunder) is the date on which coverage under the group contract becomes effective.

(iii) Exchange of contract or material change in a contract treated as a new issuance. For purposes of this paragraph

(b)(3)--

(A) A contract issued in exchange for an existing contract after December 31, 1996, is considered a contract issued after that date;

(B) Any material change (as defined in paragraph (b)(4) of this section) in a contract is treated as the issuance of a new

contract with an issue date no earlier than the date the material change goes into effect; and

(C) If a material change occurs with regard to one or more, but fewer than all, of the certificates evidencing coverage under a group contract, then the insurance coverage under the changed certificates is treated as coverage under a newly issued group contract (and the insurance coverage provided by any unchanged certificate continues to be treated as coverage under the original group contract).

(4) Material change. (i) In general. For purposes of paragraph (b)(3) of this section, except as provided in paragraph (b)(4)(ii) of this section, a material change means--

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

(B) A substitution of the insured under an individual contract; or

(C) A change (other than an immaterial change) in the eligibility for membership in the group covered under a group contract.

(ii) Exceptions. For purposes of this paragraph (b)(4), the following changes are not treated as a material change:

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

(B) A change in the mode of premium payment (for example, a change from monthly to quarterly premiums);

(C) In the case of a policy that is guaranteed renewable or noncancellable, a classwide increase or decrease in premiums;

(D) A reduction in premiums due to the purchase of a long-term care insurance contract by a family member of the policyholder;

(E) A reduction in coverage (with a corresponding reduction in premiums) made at the request of a policyholder;

(F) The addition, without an increase in premiums, of alternative forms of benefits that may be selected by the policyholder;

(G) The addition of a rider (including any similarly identifiable amendment) to a pre-1997 long-term care insurance contract in any case in which the rider, if issued as a separate contract of insurance, would itself be a qualified long-term care insurance contract under section 7702B and any regulations issued thereunder (including the consumer protection provisions in section 7702B(g) to the extent applicable to the addition of a rider);

(H) The deletion of a rider or provision of a contract (often referred to as an HHS rider) that prohibited coordination of benefits with Medicare; and

(I) The effectuation of a continuation or conversion of coverage right provided under a group contract following an individual's ineligibility for continued coverage under the group contract.

(5) Examples. The following examples illustrate the

principles of this paragraph (b):

Example 1. (i) On December 3, 1996, A, an individual, submits a signed application to an insurance company to purchase a nursing home contract that meets the long-term care insurance requirements of the State in which the contract is situated. The insurance company decides on December 20, 1996, that it will issue the contract, and assigns December 20, 1996, as the issue date for the contract. Under the terms of the contract, A's insurance coverage becomes effective on January 1, 1997. The company delivers the contract to A on January 3, 1997. A has the right to return the contract within 15 days following delivery for a refund of all premiums paid.

(ii) Under paragraph (b)(3)(i) of this section, the issue date of the contract is December 20, 1996. Thus, the contract is a pre-1997 long-term care insurance contract that is treated as a qualified long-term care insurance contract.

Example 2. (i) The facts are the same as in Example 1, except that the insurance coverage under the contract does not become effective until March 1, 1997. Under the insurance company's usual business practice, the period between the date of the application and the date the contract becomes effective is 30 days or less.

(ii) Under paragraph (b)(3)(i) of this section, the issue date of the contract is March 1, 1997. Thus, the contract is not a pre-1997 long-term care insurance contract, and, accordingly, the contract must meet the requirements of section 7702B(b) and any regulations issued thereunder to be a qualified long-term care insurance contract.

Example 3. (i) B, an individual, is the policyholder under a long-term care insurance contract purchased in 1995. On June 15, 2000, the insurance coverage and premiums under the contract are increased by agreement between B and the insurance company.

(ii) Under paragraph (b)(4)(i)(A) of this section, a change in the terms of a contract that alters the amount or timing of an item payable by the policyholder or the insurance company is a material change in the contract. Thus, B's coverage is treated as coverage under a contract issued on June 15, 2000, and, accordingly, the contract must meet the requirements of section 7702B(b) and any regulations issued thereunder in order to be a qualified long-term care insurance contract.

Example 4. (i) C, an individual, is the policyholder under a long-term care insurance contract purchased in 1994. At that time and through December 31, 1996, the contract met the long-term care insurance requirements of the State in which the contract was situated. In 1996, the policy was amended to add a provision requiring the policyholder to be offered the right to increase dollar limits for inflation every three years (without the policyholder being required to pass a physical or satisfy any

other underwriting requirements). During 2002, C elects to increase the amount of insurance coverage (with a resulting premium increase) pursuant to the inflation protection provision.

(ii) Under paragraph (b)(4)(ii)(A) of this section, an increase in the amount of insurance coverage at the election of the policyholder (without the insurance company's consent and

without underwriting or other limitations on the policyholder's rights) pursuant to a pre-1997 inflation protection provision does not constitute a material change in the contract. Thus, C's contract continues to be a pre-1997 long-term care insurance contract that is treated as a qualified long-term care insurance contract.

Deputy Commissioner of Internal Revenue