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SUPPLEMENTARY INFORMATION:

Background

This document contains amendments to the Income Tax Regulations (26 CFR part 1) to provide rules relating to consumer protection with respect to qualified long-term care insurance contracts and relating to events that will result in the loss of grandfathered status for long-term care insurance contracts issued prior to January 1, 1997.

A notice of proposed rulemaking (REG-109333-97, 1998-9 I.R.B. 9) under section 7702B of the Code was published in the **Federal Register** on January 2, 1998 (63 F.R. 35). Written comments were received from the public, and a public hearing was held on May 13, 1998. After consideration of all the comments, the regulations proposed by REG-109333-97 are adopted as revised by this Treasury decision.

Explanation of Statutory Provisions

The Health Insurance Portability and Accountability Act of 1996 (Public Law 104-191, 110 Stat. 1936, 2054 and 2063)(HIPAA) added section 7702B to the Internal Revenue Code of 1986 (the Code). Section 7702B establishes the tax treatment for qualified long-term care insurance contracts. Section 7702B(a)(1) and (3) of the Code 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) of the Code provides that amounts (other than policyholder dividends and premium refunds) 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) of the Code was amended by section 322 of HIPAA to provide that eligible long-term care insurance premiums, as defined in section 213(d)(10) of the Code, are medical care expenses.

Section 7702B.—Treatment of Qualified Long-Term Care Insurance

26 CFR 1.7702N-1: Consumer protection provisions.

T.D. 8792

DEPARTMENT OF THE TREASURY Internal Revenue Service 26 CFR Part 1

Qualified Long-Term Care Insurance Contracts

AGENCY: Internal Revenue Service (IRS), Treasury.

ACTION: Final regulations.

SUMMARY: This document contains final Income Tax Regulations relating to consumer protection with respect to qualified long-term care insurance contracts and relating to events that will result in the loss of grandfathered status for 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: *Effective date.* These regulations are effective December 10, 1998.

Applicability date. Section 1.7702B-1 (concerning consumer protection provisions) of the regulations applies with respect to contracts issued after December 10, 1999. Section 1.7702B-2 (concerning special rules for pre-1997 contracts) of the regulations is applicable January 1, 1999.

Under section 7702B(b)(1)(F) of the Code, a qualified long-term care insurance contract must meet the consumer protection provisions of section 7702B(g) of the Code. In addition, section 4980C of the Code 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 insurance 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 final 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 final regulations are based on safe harbors that were originally

set forth in Notice 97–31 (1997-1 C.B. 417), and in the regulations proposed in REG–109333–97.

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 of the Code, 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) 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 final regulations reflect the standards that were set forth in Notice 97–31

and in the regulations proposed in REG–109333–97. 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.

Commentators generally approved of the consumer protection provisions of the proposed regulations. Some commentators suggested that the provisions should be applied on a prospective basis, such as for long-term care insurance contracts issued more than one year after publication of the final regulations. Consistent with this suggestion, the final regulations apply to contracts issued after December 10, 1999.

Commentators suggested that if any State has adopted a Model Act or Model Regulation requirement, such State’s interpretation of that requirement should be considered probative but not controlling of the meaning of the analogous requirements for purposes of applying sections 7702B(g) and 4980C of the Code to a contract situated in another State. This suggestion was not adopted. If a particular State has adopted a Model Act or Model Regulation requirement, that State’s interpretation should apply to determine whether the contract meets that State’s requirement. If a State has not adopted a particular requirement, the determination of what interpretation should apply for purposes of section 7702B(g) and 4980C of the Code is more appropriately made on a case-by-case basis.

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 final 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 com-

pany. 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 generally the date the contract becomes effective. For purposes of applying the grandfather rule of section 321(f)(2) of HIPAA 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.

Notice 97-31 and the proposed regulations use the term *material change* to identify those changes to pre-1997 long-term care insurance contracts that are treated as the issuance of a new contract and, therefore, result in the loss of grandfathered status under section 7702B. The use of the term *material* may have caused some confusion in light of the bright line standards that the regulations are generally intended to provide. For this reason, the final regulations do not use the term *material* in this context. No substantive change is intended by this modification.

The final regulations generally adopt the standards set forth in the proposed regulations for purposes of determining whether a change to a pre-1997 long-term care insurance contract is considered the issuance of a new contract.¹ For example, the final regulations provide that the exercise of any right provided to a policyholder or the addition of any right that is required by State law to be provided to the policyholder will not be treated as the issuance of a new contract. Thus, as illustrated in an example in the regulations, the exercise of a right set forth in a pre-1997 contract, without underwriting, does not result in the loss of grandfathered status.

¹ These standards are different from those that apply for purposes of determining the grandfathered status of other types of insurance contracts under the Code (including sections 7702, 7702A, 101(f), and 264). Those other provisions limit the tax benefits associated with the purchase of insurance products that, unlike pre-1997 long-term care insurance contracts, have a substantial investment orientation.

The final regulations also provide that the following practices will not be treated as the issuance of a new contract for purposes of the grandfathering provision of section 321(f)(2) of HIPAA: (1) a change in the mode of premium payment, such as a change from paying premiums monthly to quarterly; (2) a 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) a reduction in coverage (with correspondingly lower premiums) made at the request of a policyholder; (5) 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 when a policyholder becomes a member of a group entitled to a group discount, or changes from smoker to nonsmoker status); (6) the addition, without an increase in premiums, of alternative forms of benefits that may be selected by the policyholder; (7) 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; (8) 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; (9) 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; and (10) the substitution of one insurer for another in an assumption reinsurance transaction. These exceptions are generally similar to those listed in the proposed regulations. In response to comments, however, the exceptions have been broadened to permit certain premium reductions and to clarify that a change in insurer pursuant to an assumption reinsurance transaction is not treated as the issuance of a new contract (assuming that the contract would not otherwise be treated as newly issued, such as by reason of a change in the amount or timing of benefits or premiums).

Some commentators suggested that the regulations include a parenthetical to the effect that some changes in the amount or timing of items (such as de minimis changes in premiums) are not treated as

the issuance of a new contract, even if no specific exception applies under the regulation. An important purpose of these regulations is to provide certainty as to the qualification of pre-1997 long-term care insurance contracts, and the exceptions enumerated in the proposed regulations provide broad relief from treatment as the issuance of a new contract resulting in the loss of grandfathered status. Accordingly, the final regulations do not contain this additional parenthetical.

Some commentators identified additional circumstances under which expansion of coverage under a group long-term care insurance contract should not be treated as the issuance of a new contract. For example, some requested that the addition of a spouse, dependent children, or others should not be treated as the issuance of a new contract. Other commentators suggested that no loss of grandfathering should result from the expansion of coverage under a group contract by reason of a corporate merger or acquisition, or the extension of coverage to collectively bargained employees, or the addition of former employees. The final regulations clarify that such expansion is not treated as the issuance of a new contract, provided that the addition is without underwriting and is pursuant to the terms of the contract and the plan under which the contract was issued as in effect on December 31, 1996. Thus, the addition of a business's assets and related employees by a company with a pre-1997 group contract is not treated as the issuance of a new contract if, as of December 31, 1996, the contract and the plan under which it was issued provided that new employees automatically are eligible to participate in the group contract. If, however, a new subsidiary is acquired by the company and the company's pre-1997 group contract or plan requires that a subsidiary be designated by the company in order for its employees to be eligible to participate, then the designation of the new subsidiary would be a change in the terms of the contract or in the plan relating to eligibility. Although the final regulations were not modified to accommodate further expansion, a new qualified long-term care insurance contract could be entered into to expand coverage under these circumstances. Alternatively, the final regulations permit coverage under the pre-1997

contract to be expanded by a rider to the pre-1997 contract if the rider would constitute a qualified long-term care insurance contract if it were issued as a separate contract.²

Finally, it was suggested that the grandfather provisions of the final regulations should be effective immediately. The final regulations with respect to contracts issued before 1997 are effective January 1, 1999.

Standards before the Effective Date of the Final Regulations

The consumer protection provisions in the final regulations apply with respect to contracts issued after December 10, 1999. Taxpayers may continue to rely on Notice 97-31 with respect to contracts issued on or before that date. In addition, a contract issued on or before December 10, 1999, will not be treated as failing to satisfy the consumer protection requirements of section 7702B(g) or 4980C of the Code if the contract satisfies the requirements of the final regulations. Taxpayers may not rely on Notice 97-31 with respect to contracts issued after December 10, 1999.

The final regulations are effective January 1, 1999, with respect to pre-1997 long-term care insurance contracts. Taxpayers may continue to rely on Notice 97-31 for the purpose of determining whether a change made before January 1, 1999, to a pre-1997 contract is treated as the issuance of a new contract. In addition, a change made before that date to a pre-1997 contract will not be treated as the issuance of a new contract if the change is not treated as the issuance of a new contract under the final regulations. Taxpayers may not rely on Notice 97-31 with respect to changes made on or after January 1, 1999.

Special Analyses

It has been determined that this Treasury decision is not a significant regula-

² As was indicated in the preamble to the proposed regulations, certain of the consumer protection requirements would not apply to such a rider. Specifically, sections 7702B(g)(2)(A)(i)(III), 7702B(g)(2)(A)(i)(V), 7702B(g)(2)(A)(i)(VII) (other than section 9B of the NAIC Model regulation), 7702B(g)(2)(A)(i)(X), 7702B(g)(3), 7702B(g)(4), 4980C(c)(1)(A)(I), and 4980C(c)(2) of the Internal Revenue Code would apply only the first time a contract is purchased, and would not apply to the purchase of a rider.

tory 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, the notice of proposed rulemaking preceding these regulations was submitted to the Chief Counsel for Advocacy of the Small Business Administration for comment on its impact on small business.

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.

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Adoption of Amendments to the Regulations

Accordingly, 26 CFR part 1 is 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 and 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 section 7702B(b)(1)(F) and (g) relate to guaranteed renewal or noncancellability, prohibitions on limitations and exclusions, ex-

tension 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 re-

quirement 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.

(c) *Effective date.* This section applies with respect to contracts issued after December 10, 1999.

§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 under section 321(f)(2) of the Health Insurance Portability and Accountability Act of 1996 (Public Law 104-191).

(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 ef-

fect 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.* Except as otherwise provided in this paragraph (b)(3), the issue date of a contract is the issue date assigned to the contract by the insurance company. In no event is the issue date earlier than the date the policyholder submitted a signed application for coverage to the insurance company. 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 later of the date coverage under the contract becomes effective or 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 certain changes 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 change described in paragraph (b)(4) of this section is treated as the issuance of a new contract with an issue date no earlier than the date the change goes into effect; and

(C) If a change described in paragraph (b)(4) of this section 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) *Changes treated as the issuance of a new contract—(i) In general.* For purposes of paragraph (b)(3) of this section,

except as provided in paragraph (b)(4)(ii) of this section, the following changes are treated as the issuance of a new contract—

(A) A change in the terms of a contract that alters the amount or timing of an item payable by either 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 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.

(ii) *Exceptions.* For purposes of this paragraph (b)(4), the following changes are not treated as the issuance of a new contract—

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

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

(H) 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);

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

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

(K) The substitution of one insurer for another insurer in an assumption reinsurance transaction.

(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 treated as the issuance of a new 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 De-

ember 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 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 provision is not treated as the issuance of a new 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.

(c) *Effective date.* This section is effective January 1, 1999.

David A. Mader,
*Acting Deputy Commissioner of
Internal Revenue.*

Approved November 24, 1998.

Donald C. Lubick,
*Assistant Secretary of
the Treasury.*

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