§ 7702B. Treatment of qualified long-term care insurance

(a) In general

For purposes of this title—

(1) a qualified long-term care insurance contract shall be treated as an accident and health insurance contract,

(2) amounts (other than policyholder dividends, as defined in section 808, or premium refunds) received under a qualified long-term care insurance contract shall be treated as amounts received for personal injuries and sickness and shall be treated as reimbursement for expenses actually incurred for medical care (as defined in section 213(d)),

(3) any plan of an employer providing coverage under a qualified long-term care insurance contract shall be treated as an accident and health plan with respect to such coverage,

(4) except as provided in subsection (e)(3), amounts paid for a qualified long-term care insurance contract providing the benefits described in subsection (b)(2)(A) shall be treated as payments made for insurance for purposes of section 213(d)(1)(D), and

(5) a qualified long-term care insurance contract shall be treated as a guaranteed renewable contract subject to the rules of section 816(e).

(b) Qualified long-term care insurance contract

For purposes of this title—

(1) In general

The term ''qualified long-term care insurance contract'' means any insurance contract if—

(A) the only insurance protection provided under such contract is coverage of qualified long-term care services,

(B) such contract does not pay or reimburse expenses incurred for services or items to the extent that such expenses are reimbursable under title XVIII of the Social Security Act or would be so reimbursable but for the application of a deductible or coinsurance amount,

(C) such contract is guaranteed renewable,

(D) such contract does not provide for a cash surrender value or other money that can be—

(i) paid, assigned, or pledged as collateral for a loan, or

(ii) borrowed,

other than as provided in subparagraph (E) or paragraph (2)(C),

(E) all refunds of premiums, and all policyholder dividends or similar amounts, under such contract are to be applied as a reduction in future premiums or to increase future benefits, and

(F) such contract meets the requirements of subsection (g).

(2) Special rules

(A) Per diem, etc. payments permitted

A contract shall not fail to be described in subparagraph (A) or (B) of paragraph (1) by reason of payments being made on a per diem or other periodic basis without regard to the expenses incurred during the period to which the payments relate.

(B) Special rules relating to medicare

(i) Paragraph (1)(B) shall not apply to expenses which are reimbursable under title XVIII of the Social Security Act only as a secondary payor.

(ii) No provision of law shall be construed or applied so as to prohibit the offering of a qualified long-term care insurance contract on the basis that the contract coordinates its benefits with those provided under such title.

(C) Refunds of premiums

Paragraph (1)(E) shall not apply to any refund on the death of the insured, or on a complete surrender or cancellation of the contract, which cannot exceed the aggregate premiums paid under the contract. Any refund on a complete surrender or cancellation of the contract shall be includible in gross income to the extent that any deduction or exclusion was allowable with respect to the premiums.

(c) Qualified long-term care services

For purposes of this section—

(1) In general

The term ''qualified long-term care services'' means necessary diagnostic, preventive, therapeutic, curing, treating, mitigating, and rehabilitative services, and maintenance or personal care services, which—

(A) are required by a chronically ill individual, and

(B) are provided pursuant to a plan of care prescribed by a licensed health care practitioner.

(2) Chronically ill individual

(A) In general

The term ''chronically ill individual'' means any individual who has been certified by a licensed health care practitioner as—

(i) being unable to perform (without substantial assistance from another individual) at least 2 activities of daily living for a period of at least 90 days due to a loss of functional capacity,

(ii) having a level of disability similar (as determined under regulations prescribed by the Secretary in consultation with the Secretary of Health and Human Services) to the level of disability described in clause (i), or

(iii) requiring substantial supervision to protect such individual from threats to health and safety due to severe cognitive impairment.

Such term shall not include any individual otherwise meeting the requirements of the preceding sentence unless within the preceding 12-month period a licensed health care practitioner has certified that such individual meets such requirements.

(B) Activities of daily living

For purposes of subparagraph (A), each of the following is an activity of daily living:

(i) Eating.
(ii) Toileting.
(iii) Transferring.
(iv) Bathing.
(v) Dressing.
(vi) Continence.

A contract shall not be treated as a qualified long-term care insurance contract unless the determination of whether an individual is a chronically ill individual described in subparagraph (A)(i) takes into account at least 5 of such activities.

(3) Maintenance or personal care services

The term ''maintenance or personal care services'' means any care the primary purpose of which is the provision of needed assistance with any of the disabilities as a result of which the individual is a chronically ill individual (including the protection from threats to health and safety due to severe cognitive impairment).

(4) Licensed health care practitioner

The term ''licensed health care practitioner'' means any physician (as defined in section 1861(r)(1) of the Social Security Act) and any registered professional nurse, licensed social worker, or other individual who meets such requirements as may be prescribed by the Secretary.

(d) Aggregate payments in excess of limits

(1) In general

If the aggregate of—

(A) the periodic payments received for any period under all qualified long-term care insurance contracts which are treated as made for qualified long-term care services for an insured, and

(B) the periodic payments received for such period which are treated under section 101(g) as paid by reason of the death of such insured,

exceeds the per diem limitation for such period, such excess shall be includible in gross income without regard to section 72. A payment shall not be taken into account under subparagraph (B) if the insured is a terminally ill individual (as defined in section 101(g)) at the time the payment is received.

(2) Per diem limitation

For purposes of paragraph (1), the per diem limitation for any period is an amount equal to the excess (if any) of—

(A) the greater of—

(i) the dollar amount in effect for such period under paragraph (4), or

(ii) the costs incurred for qualified long-term care services provided for the insured for such period, over

(B) the aggregate payments received as reimbursements (through insurance or otherwise) for qualified long-term care services provided for the insured during such period.

(3) Aggregation rules

For purposes of this subsection—

(A) all persons receiving periodic payments described in paragraph (1) with respect to the same insured shall be treated as 1 person, and

(B) the per diem limitation determined under paragraph (2) shall be allocated first to the insured and any remaining limitation shall be allocated among the other such persons in such manner as the Secretary shall prescribe.

(4) Dollar amount

The dollar amount in effect under this subsection shall be $175 per day (or the equivalent amount in the case of payments on another periodic basis).

(5) Inflation adjustment

In the case of a calendar year after 1997, the dollar amount contained in paragraph (4) shall be increased at the same time and in the same manner as amounts are increased pursuant to section 213(d)(10).

(6) Periodic payments

For purposes of this subsection, the term ''periodic payment'' means any payment (whether on a periodic basis or otherwise) made without regard to the extent of the costs incurred by the payee for qualified long-term care services.

(e) Treatment of coverage provided as part of a life insurance or annuity contract

Except as otherwise provided in regulations prescribed by the Secretary, in the case of any long-term care insurance coverage (whether or not qualified) provided by a rider on or as part of a life insurance contract or an annuity contract—

(1) In general

This title shall apply as if the portion of the contract providing such coverage is a separate contract.

(2) Denial of deduction under section 213

No deduction shall be allowed under section 213(a) for any payment made for coverage under a qualified long-term care insurance contract if such payment is made as a charge against the cash surrender value of a life insurance contract or the cash value of an annuity contract.

(3) Portion defined

For purposes of this subsection, the term ''portion'' means only the terms and benefits under a life insurance contract or annuity contract that are in addition to the terms and benefits under the contract without regard to long-term care insurance coverage.

(4) Annuity contracts to which paragraph (1) does not apply

For purposes of this subsection, none of the following shall be treated as an annuity contract:

(A) A trust described in section 401(a) which is exempt from tax under section 501(a).

(B) A contract—

(i) purchased by a trust described in subparagraph (A),

(ii) purchased as part of a plan described in section 403(a),

(iii) described in section 403(b),

(iv) provided for employees of a life insurance company under a plan described in section 818(a)(3), or

(v) from an individual retirement account or an individual retirement annuity.

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

Any dividend described in section 404(k) which is received by a participant or beneficiary shall, for purposes of this paragraph, be treated as paid under a separate contract to which subparagraph (B)(i) applies.

(f) Treatment of certain State-maintained plans

(1) In general

If—

(A) an individual receives coverage for qualified long-term care services under a State long-term care plan, and

(B) the terms of such plan would satisfy the requirements of subsection (b) were such plan an insurance contract,

such plan shall be treated as a qualified long-term care insurance contract for purposes of this title.

(2) State long-term care plan

For purposes of paragraph (1), the term ''State long-term care plan'' means any plan—

(A) which is established and maintained by a State or an instrumentality of a State,

(B) which provides coverage only for qualified long-term care services, and

(C) under which such coverage is provided only to—

(i) employees and former employees of a State (or any political subdivision or instrumentality of a State),

(ii) the spouses of such employees, and

(iii) individuals bearing a relationship to such employees or spouses which is described in any of subparagraphs (A) through (G) of section 152(d)(2).

(g) Consumer protection provisions

(1) In general

The requirements of this subsection are met with respect to any contract if the contract meets—

(A) the requirements of the model regulation and model Act described in paragraph (2),

(B) the disclosure requirement of paragraph (3), and

(C) the requirements relating to nonforfeitability under paragraph (4).

(2) Requirements of model regulation and Act

(A) In general

The requirements of this paragraph are met with respect to any contract if such contract meets—

(i) Model regulation

The following requirements of the model regulation:

(I) Section 7A (relating to guaranteed renewal or noncancellability), and the requirements of section 6B of the model Act relating to such section 7A.

(II) Section 7B (relating to prohibitions on limitations and exclusions).

(III) Section 7C (relating to extension of benefits).

(IV) Section 7D (relating to continuation or conversion of coverage).

(V) Section 7E (relating to discontinuance and replacement of policies).

(VI) Section 8 (relating to unintentional lapse).

(VII) Section 9 (relating to disclosure), other than section 9F thereof.

(VIII) Section 10 (relating to prohibitions against post-claims underwriting).

(IX) Section 11 (relating to minimum standards).

(X) Section 12 (relating to requirement to offer inflation protection), except that any requirement for a signature on a rejection of inflation protection shall permit the signature to be on an application or on a separate form.

(XI) Section 23 (relating to prohibition against preexisting conditions and probationary periods in replacement policies or certificates).

(ii) Model Act

The following requirements of the model Act:

(I) Section 6C (relating to preexisting conditions).

(II) Section 6D (relating to prior hospitalization).

(B) Definitions

For purposes of this paragraph—

(i) Model provisions

The terms ''model regulation'' and ''model Act'' mean the long-term care insurance model regulation, and the long-term care insurance model Act, respectively, promulgated by the National Association of Insurance Commissioners (as adopted as of January 1993).

(ii) Coordination

Any provision of the model regulation or model Act listed under clause (i) or (ii) of subparagraph (A) shall be treated as including any other provision of such regulation or Act necessary to implement the provision.

(iii) Determination

For purposes of this section and section 4980C, the determination of whether any requirement of a model regulation or the model Act has been met shall be made by the Secretary.

(3) Disclosure requirement

The requirement of this paragraph is met with respect to any contract if such contract meets the requirements of section 4980C(d).

(4) Nonforfeiture requirements

(A) In general

The requirements of this paragraph are met with respect to any level premium con-

tract, if the issuer of such contract offers to the policyholder, including any group policyholder, a nonforfeiture provision meeting the requirements of subparagraph (B).

(B) Requirements of provision

The nonforfeiture provision required under subparagraph (A) shall meet the following requirements:

(i) The nonforfeiture provision shall be appropriately captioned.

(ii) The nonforfeiture provision shall provide for a benefit available in the event of a default in the payment of any premiums and the amount of the benefit may be adjusted subsequent to being initially granted only as necessary to reflect changes in claims, persistency, and interest as reflected in changes in rates for premium paying contracts approved by the appropriate State regulatory agency for the same contract form.

(iii) The nonforfeiture provision shall provide at least one of the following:

(I) Reduced paid-up insurance.

(II) Extended term insurance.

(III) Shortened benefit period.

(IV) Other similar offerings approved by the appropriate State regulatory agency.

(5) Cross reference

For coordination of the requirements of this subsection with State requirements, see section 4980C(f).

(Added and amended Pub. L. 104–191, title III, §§ 321(a), 325, Aug. 21, 1996, 110 Stat. 2054, 2063; Pub. L. 105–34, title XVI, § 1602(b), (e), Aug. 5, 1997, 111 Stat. 1094; Pub. L. 105–206, title VI, § 6023(28), July 22, 1998, 112 Stat. 826; Pub. L. 108–311, title II, § 207(25), Oct. 4, 2004, 118 Stat. 1178; Pub. L. 109–280, title VIII, § 844(c), (f), Aug. 17, 2006, 120 Stat. 1011, 1013.)

INFLATION ADJUSTED ITEMS FOR CERTAIN YEARS

For inflation adjustment of certain items in this section, see Revenue Procedures listed in a table under section 1 of this title.

Editorial Notes

REFERENCES IN TEXT

The Social Security Act, referred to in subsec. (b)(1)(B), (2)(B)(i), is act Aug. 14, 1935, ch. 531, 49 Stat. 620. Title XVIII of the Act is classified generally to subchapter XVIII (§ 1395 et seq.) of chapter 7 of Title 42, The Public Health and Welfare. Section 1861(r)(1) of the Act is classified to section 1395x(r)(1) of Title 42. For complete classification of this Act to the Code, see section 1305 of Title 42 and Tables.

AMENDMENTS

2006—Subsec. (e). Pub. L. 109–280, § 844(c), amended subsec. (e) generally. Prior to amendment, subsec. (e) related to treatment of coverage provided as part of a life insurance contract.

Subsec. (e)(1). Pub. L. 109–280, § 844(f), substituted ''title'' for ''section''.

2004—Subsec. (f)(2)(C)(iii). Pub. L. 108–311 substituted ''subparagraphs (A) through (G) of section 152(d)(2)'' for ''paragraphs (1) through (8) of section 152(a)''.

1998—Subsec. (e)(2). Pub. L. 105–206 inserted ''section'' after ''Application of'' in heading.

1997—Subsec. (c)(2)(B). Pub. L. 105–34, § 1602(b), inserted ''described in subparagraph (A)(i)'' after ''chronically ill individual'' in concluding provisions.

Subsec. (g)(4)(B)(ii), (iii)(IV). Pub. L. 105–34, § 1602(e), substituted ''appropriate State regulatory agency'' for ''Secretary''.

1996—Subsec. (g). Pub. L. 104–191, § 325, added subsec. (g).

Statutory Notes and Related Subsidiaries

EFFECTIVE DATE OF 2006 AMENDMENT

Amendment by Pub. L. 109–280 applicable to contracts issued after Dec. 31, 1996, but only with respect to taxable years beginning after Dec. 31, 2009, except as otherwise provided, see section 844(g)(1) of Pub. L. 109–280, set out as a note under section 72 of this title.

Amendment by section 844(f) of Pub. L. 109–280 effective as if included in section 321(a) of Pub. L. 104–191, see section 844(g)(5) of Pub. L. 109–280, set out as a note under section 72 of this title.

EFFECTIVE DATE OF 2004 AMENDMENT

Amendment by Pub. L. 108–311 applicable to taxable years beginning after Dec. 31, 2004, see section 208 of Pub. L. 108–311, set out as a note under section 2 of this title.

EFFECTIVE DATE OF 1997 AMENDMENT

Amendment by Pub. L. 105–34 effective as if included in the provisions of the Health Insurance Portability and Accountability Act of 1996, Pub. L. 104–191, to which such amendment relates, see section 1602(i) of Pub. L. 105–34, set out as a note under section 26 of this title.

EFFECTIVE DATE OF 1996 AMENDMENT

Amendment by section 325 of Pub. L. 104–191 applicable to contracts issued after Dec. 31, 1996, with provisions of section 321(f) of Pub. L. 104–191, set out as an Effective Date note below, applicable to such contracts, see section 327 of Pub. L. 104–191, set out as an Effective Date note under section 4980C of this title.

EFFECTIVE DATE

Pub. L. 104–191, title III, § 321(f), Aug. 21, 1996, 110 Stat. 2059, provided that:

''(1) GENERAL EFFECTIVE DATE.—

''(A) IN GENERAL.—Except as provided in subparagraph (B), the amendments made by this section [enacting this section and amending sections 106, 125, 807, and 4980B of this title, section 1167 of Title 29, Labor, and section 300bb–8 of Title 42, The Public Health and Welfare] shall apply to contracts issued after December 31, 1996.

''(B) RESERVE METHOD.—The amendment made by subsection (b) [amending section 807 of this title] shall apply to contracts issued after December 31, 1997.

''(2) CONTINUATION OF EXISTING POLICIES.—In the case of any contract issued before January 1, 1997, which met the long-term care insurance requirements of the State in which the contract was situsted [sic] at the time the contract was issued—

''(A) such contract shall be treated for purposes of the Internal Revenue Code of 1986 as a qualified long-term care insurance contract (as defined in section 7702B(b) of such Code), and

''(B) services provided under, or reimbursed by, such contract shall be treated for such purposes as qualified long-term care services (as defined in section 7702B(c) of such Code).

In the case of an individual who is covered on December 31, 1996, under a State long-term care plan (as defined in section 7702B(f)(2) of such Code), the terms of such plan on such date shall be treated for purposes of the preceding sentence as a contract issued on such date which met the long-term care insurance requirements of such State.

''(3) EXCHANGES OF EXISTING POLICIES.—If, after the date of enactment of this Act [Aug. 21, 1996] and before

January 1, 1998, a contract providing for long-term care insurance coverage is exchanged solely for a qualified long-term care insurance contract (as defined in section 7702B(b) of such Code), no gain or loss shall be recognized on the exchange. If, in addition to a qualified long-term care insurance contract, money or other property is received in the exchange, then any gain shall be recognized to the extent of the sum of the money and the fair market value of the other property received. For purposes of this paragraph, the cancellation of a contract providing for long-term care insurance coverage and reinvestment of the cancellation proceeds in a qualified long-term care insurance contract within 60 days thereafter shall be treated as an exchange.

''(4) ISSUANCE OF CERTAIN RIDERS PERMITTED.—For purposes of applying sections 101(f), 7702, and 7702A of the Internal Revenue Code of 1986 to any contract—

''(A) the issuance of a rider which is treated as a qualified long-term care insurance contract under section 7702B, and

''(B) the addition of any provision required to conform any other long-term care rider to be so treated,

shall not be treated as a modification or material change of such contract.

''(5) APPLICATION OF PER DIEM LIMITATION TO EXISTING CONTRACTS.—The amount of per diem payments made under a contract issued on or before July 31, 1996, with respect to an insured which are excludable from gross income by reason of section 7702B of the Internal Revenue Code of 1986 (as added by this section) shall not be reduced under subsection (d)(2)(B) thereof by reason of reimbursements received under a contract issued on or before such date. The preceding sentence shall cease to apply as of the date (after July 31, 1996) such contract is exchanged or there is any contract modification which results in an increase in the amount of such per diem payments or the amount of such reimbursements.''

LONG-TERM CARE STUDY REQUEST

Pub. L. 104–191, title III, §321(g), Aug. 21, 1996, 110 Stat. 2060, related to a study of the marketing and other effects of per diem limits on certain types of long-term care policies, and provided that if the National Association of Insurance Commissioners agreed to the study request by Congress, the Association would report the results of the study not later than 2 years after accepting the request.

§ 7703. Determination of marital status

(a) General rule

For purposes of part V of subchapter B of chapter 1 and those provisions of this title which refer to this subsection—

(1) the determination of whether an individual is married shall be made as of the close of his taxable year; except that if his spouse dies during his taxable year such determination shall be made as of the time of such death; and

(2) an individual legally separated from his spouse under a decree of divorce or of separate maintenance shall not be considered as married.

(b) Certain married individuals living apart

For purposes of those provisions of this title which refer to this subsection, if—

(1) an individual who is married (within the meaning of subsection (a)) and who files a separate return maintains as his home a household which constitutes for more than one-half of the taxable year the principal place of abode of a child (within the meaning of section 152(f)(1)) with respect to whom such individual is entitled to a deduction for the taxable year under section 151 (or would be so entitled but for section 152(e)),

(2) such individual furnishes over one-half of the cost of maintaining such household during the taxable year, and

(3) during the last 6 months of the taxable year, such individual's spouse is not a member of such household,

such individual shall not be considered as married.

(Added Pub. L. 99–514, title XIII, §1301(j)(2)(A), Oct. 22, 1986, 100 Stat. 2657; amended Pub. L. 100–647, title I, §1018(u)(41), Nov. 10, 1988, 102 Stat. 3592; Pub. L. 108–311, title II, §207(26), Oct. 4, 2004, 118 Stat. 1178.)

Editorial Notes

PRIOR PROVISIONS

Provisions relating to determination of marital status were formerly contained in section 143 of this title, prior to enactment of this section by Pub. L. 99–514.

AMENDMENTS

2004—Subsec. (b)(1). Pub. L. 108–311 substituted ''152(f)(1)'' for ''151(c)(3)'' and struck out ''paragraph (2) or (4) of'' before ''section 152(e)),''.

1988—Subsec. (b)(1). Pub. L. 100–647 substituted ''section 151(c)(3)'' for ''section 151(e)(3)''.

Statutory Notes and Related Subsidiaries

EFFECTIVE DATE OF 2004 AMENDMENT

Amendment by Pub. L. 108–311 applicable to taxable years beginning after Dec. 31, 2004, see section 208 of Pub. L. 108–311, set out as a note under section 2 of this title.

EFFECTIVE DATE OF 1988 AMENDMENT

Amendment by Pub. L. 100–647 effective, except as otherwise provided, as if included in the provision of the Tax Reform Act of 1986, Pub. L. 99–514, to which such amendment relates, see section 1019(a) of Pub. L. 100–647, set out as a note under section 1 of this title.

EFFECTIVE DATE

Section applicable to bonds issued after Aug. 15, 1986, except as otherwise provided, see sections 1311 to 1318 of Pub. L. 99–514, set out as an Effective Date; Transitional Rules note under section 141 of this title.

§ 7704. Certain publicly traded partnerships treated as corporations

(a) General rule

For purposes of this title, except as provided in subsection (c), a publicly traded partnership shall be treated as a corporation.

(b) Publicly traded partnership

For purposes of this section, the term ''publicly traded partnership'' means any partnership if—

(1) interests in such partnership are traded on an established securities market, or

(2) interests in such partnership are readily tradable on a secondary market (or the substantial equivalent thereof).

(c) Exception for partnerships with passive-type income

(1) In general

Subsection (a) shall not apply to any publicly traded partnership for any taxable year if