

**USING INDIVIDUAL LONG-TERM CARE
INSURANCE POLICIES AS PART OF
AN EMPLOYER SPONSORED PLAN**

ERISA AND TAX IMPLICATIONS

by

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**A Study Prepared for
THE NORTHWESTERN MUTUAL LIFE INSURANCE COMPANY**

FORWARD

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Printed in USA

ACKNOWLEDGMENTS

The authors wish to acknowledge Stanford A. Wynn, Assistant Director of Advanced Planning at Northwestern Mutual, for his many contributions to this work.

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USING INDIVIDUAL LONG-TERM CARE INSURANCE POLICIES AS PART OF AN EMPLOYER SPONSORED PLAN

ERISA AND TAX IMPLICATIONS¹

Introduction

Long-term care insurance is becoming a very popular employee benefit. Demographic shifts, medical innovation, and changing social expectations about long-term care have dramatically changed the need for and the delivery settings of long-term care. Budgetary pressures on the federal and state governments, the usual source of long-term care financing, will increasingly compel employers and individuals to look for long-term care financing alternatives. This Study discusses one of those options: the use of individual long-term care insurance policies as a part of an employer sponsored long-term care insurance plan. For purposes of this Study, an employer sponsored long-term care insurance plan is a plan that an employer sponsors or maintains by paying all or a portion of the premiums for individual long-term care insurance policies or by permitting employees to make after-tax payments of the entire premium.²

Part One provides a brief introduction of long-term care insurance. Part Two discusses the federal income tax consequences of offering and receiving employer sponsored long-term care insurance. Part Three provides an overview of the key plan design issues to be considered when implementing a long-term care insurance plan. Part Four discusses the application of the Employee Retirement Income Security Act of 1974 (“ERISA”) to employer sponsored long-term care insurance. Part Five touches upon certain collateral topics that should be considered when analyzing a long-term care insurance plan.³ Part Six provides case study examples. Finally, the Appendix provides certain sample forms designed to assist the practitioner in meeting the compliance requirements of ERISA when utilizing individual insurance policies as part of an employer sponsored long-term care insurance plan.

In this Study, when we use the terms “employer” and “employee,” we intend them to have a broad meaning, specifically including businesses and their owners, provided the owners regularly perform services for the business. As discussed more thoroughly in Part Two of the Study, some categories of business owners are treated as “self-employed individuals” for certain tax purposes, including the tax treatment of long-term care premiums paid on their behalf.⁴

¹ This is one in a series of studies on topics of special interest and importance prepared for The Northwestern Mutual Life Insurance Company by the law firm of Gray, Plant, Mooty, Mooty & Bennett, P.A., 3400 City Center, Minneapolis, Minnesota 55402. Individual long-term care insurance is offered through the Northwestern Long Term Care Insurance Company, a subsidiary of The Northwestern Mutual Life Insurance Company, Milwaukee, Wisconsin.

² When a minimum participation level of employees is reached for an employer sponsored plan, the individual long-term care insurance policies issued by an insurer may include a premium discount. The Northwestern Long Term Care Insurance Company’s program is called the Multi-Life Program.

³ An extensive discussion of each of these topics is outside the scope of this Study.

⁴ In this Study, when we wish to distinguish these business owners from other employees, we will refer to the business owners as “Self-Employed Owners,” and the other employees as “Employees.” For a definition of the terms “Self-Employed Owner” and “Employee,” as used in this Study, see Part Two, Section III.B.

PART ONE

BACKGROUND

I. WHAT IS LONG-TERM CARE INSURANCE?

Long-term care insurance generally provides an insured individual with reimbursement, up to a maximum daily and lifetime amount, for certain rehabilitation, maintenance and personal care services when the insured individual has a chronic illness or disability and needs care outside of an acute care setting such as a hospital. The most basic policy will pay a flat daily rate towards the cost of nursing home care. More comprehensive policies cover a broader range of sites of services such as in-home health care and assisted-living facilities.

Benefits that may be covered under a policy may include any necessary treating, mitigating and rehabilitative services and maintenance or personal care services. To be eligible for benefits, the insured individual must be “chronically ill” and the services required must be provided under a plan of care prescribed by a licensed health care practitioner. An insured individual is chronically ill if a licensed health care practitioner has certified within the preceding 12-month period that the insured individual is unable to perform at least two activities of daily living (“ADLs”) without substantial assistance from another individual for a period of at least 90 days. ADLs are eating, toileting, transferring (*e.g.*, moving from bed to chair), bathing, dressing and continence. A severe cognitive impairment comparable to and including Alzheimer’s disease will also trigger benefits.⁵

As noted above, a daily and lifetime cap generally limits the amount of reimbursement. Most long-term care insurers provide a selection of daily and lifetime maximum benefit levels. Under the policy, the insurer pays for charges incurred, up to the specified maximum, based on the site of care – with different rates for nursing home care and at-home care, for example.⁶

Premiums for long-term care insurance vary considerably, based upon age and plan design. Premiums are based on the age of the insured individual at the time of the application for the policy. The earlier the age at which the policy is purchased, the lower the premium. Premiums will also vary based on the types and level of benefits selected, such as the number of years benefits are available and the daily benefit amount selected.

Long-term care insurance policies may be purchased on a group, individual, or employer sponsored (multi-life) basis. A policy purchased on a multi-life basis is an employer sponsored individual policy purchased through an employer group. Most state insurance laws authorize discounts for individual policies sold as a part of an employer group (“franchise group insurance”). Thus, employees who purchase individual policies through an employer sponsored plan, even if the program is an employee-pay-all program, may be able to pay less for coverage when compared to policies they may purchase on their own.

⁵ For a definition of a “chronically ill individual” under I.R.C. § 7702B(c)(2), see *infra* note 78.

⁶ Long-Term Care Insurance: Hearing before the Subcomm. on Civil Service of the House Comm. on Government Reform and Oversight, Employee Benefit Research Institute, Mar. 26, 1998 (statement by Paul Fronstin, Ph.D.).

II. A BRIEF HISTORY OF THE TAXATION OF LONG-TERM CARE INSURANCE

Prior to the Health Insurance Portability and Accountability Act of 1996⁷ (“HIPAA”), the Internal Revenue Code⁸ did not provide explicit rules relating to the tax treatment of long-term care insurance contracts or long-term care services.⁹ Thus, the tax treatment of long-term care contracts and services was unclear. Because of this uncertainty, Congress in 1996 clarified the tax treatment of long-term care insurance premiums and benefits and ensured that certain consumer protection measures were in place for the sale and administration of those policies.

Under HIPAA, if a long-term care insurance policy satisfies certain requirements, it will be a “qualified long-term care insurance contract” (“QLTCIC”). For tax purposes, QLTCICs are treated as accident and health insurance. Premiums for QLTCICs are deductible on the same basis as premiums for accident and health coverage.¹⁰ Amounts received by the insured individual under a QLTCIC are treated as amounts received for personal injury and sickness and are treated as reimbursement of expenses actually incurred for medical care.¹¹ Any plan of an employer providing coverage under a QLTCIC is treated as an accident and health plan with respect to this coverage.¹²

As a result of this clarification in the tax laws, the variety of products offered by accident and health insurers and the interest in long-term care insurance have increased. This Study focuses on one element of the QLTCIC market, the use of individual policies in assisting employers to provide long-term care insurance benefits to their employees.

⁷ Pub. L. No. 104-191 (1996).

⁸ All references to the Internal Revenue Code or I.R.C. are to the Internal Revenue Code of 1986, as amended.

⁹ H.R. Conf. Rep. No. 104-736 (1996).

¹⁰ I.R.C. § 7702B(a)(1).

¹¹ I.R.C. § 7702B(a)(2).

¹² I.R.C. § 7702B(a)(3).

PART TWO

FEDERAL TAX CONSEQUENCES¹³

I. IN GENERAL

By enacting HIPAA, Congress established that certain long-term care insurance contracts (qualified long-term care insurance contracts or QLTCICs), would have a number of favorable tax attributes. Some of the favorable tax attributes of QLTCICs are:

1. An employer generally may deduct the premiums it pays for QLTCICs as a business expense;¹⁴
2. Employer-paid premiums are generally excluded from an employee's gross income;¹⁵ and
3. All or a portion of the amounts received under QLTCICs are generally excluded from the recipient's gross income.¹⁶

This section discusses the tax treatment and tax consequences of a QLTCIC in detail.

II. QUALIFIED LONG-TERM CARE INSURANCE CONTRACT ("QLTCIC")

A. Requirements

A long-term care insurance contract meeting the requirements of a "qualified long-term care insurance contract"¹⁷ will receive the favorable federal income tax treatment described above. A "qualified long-term care insurance contract" is one that:

1. Provides as its sole insurance protection the coverage of "qualified long-term care services";¹⁸
2. Does not pay or reimburse expenses that are either reimbursable under Medicare (Title XVIII of the Social Security Act) or that would be reimbursable under Medicare if they were not paid as part of a deductible or coinsurance payment;¹⁹
3. Is guaranteed renewable;²⁰

¹³ At the time of publication of this Study, legislation has been introduced in Congress that would alter some aspects of the tax treatment of long-term care, permitting a phased-in 100 percent above-the-line deduction for qualified long-term care insurance premiums, a \$3,000 tax credit for people with long-term care needs, and inclusion of long-term care coverage in employer cafeteria plans and flexible spending accounts. If this legislation is enacted, some of the discussion that follows will necessarily become outdated and/or obsolete. The practitioner should determine the status of this legislation before proceeding with a long-term care insurance plan.

¹⁴ I.R.C. § 162(a)(1).

¹⁵ I.R.C. § 7702B(a)(3); *see also* I.R.C. § 106(a), 26 C.F.R. § 1.106-1.

¹⁶ I.R.C. § 7702B(a)(2); *see also* I.R.C. §§ 105(b) and 104(a)(3).

¹⁷ I.R.C. §§ 7702B(a), (b)(1).

¹⁸ I.R.C. § 7702B(b)(1)(A).

¹⁹ I.R.C. § 7702B(b)(1)(B). A *per diem* policy, *i.e.*, one that pays a fixed amount for each day of needed service, may pay benefits in addition to Medicare benefits.

4. Does not provide (with certain exceptions) for a cash surrender value or other amounts that can be paid out to the policyholder or that the policyholder can borrow, assign, or pledge as collateral for a loan;²¹
5. Requires that all policyholder dividends, premium refunds, and similar amounts be applied to either reduce future premiums or increase future benefits;²²
6. Meets certain consumer protection requirements set forth in the January 1993 versions of the Long-Term Care Insurance Model Regulation and the Long-Term Care Insurance Model Act of the National Association of Insurance Commissioners;²³
7. Discloses that the policy is intended to be a qualified long-term care insurance contract;²⁴ and
8. Offers a nonforfeiture provision if the contract provides for level premiums.²⁵

Most policies offered by insurers today are intended to satisfy the requirements of the Internal Revenue Code such that they are deemed to be qualified contracts for federal income tax purposes. There are, however, a few issues of which the practitioner should be aware. These are discussed below.

B. Special Considerations

1. Pre-1997 Contracts

Long-term care insurance policies have been marketed by various insurers since the mid-1980s. Because of this, it is possible that a practitioner may encounter pre-HIPAA policies. Any long-term care contract with an issue date before January 1, 1997, that met the applicable state long-term care insurance requirements on its issue date, is treated as a QLTCIC, regardless of whether the contract satisfies all of the rules discussed above.²⁶

2. Exchanges and Changes to Pre-1997 Contracts

Certain changes in pre-1997 long-term care contracts (*e.g.*, a change that alters the amount or timing of an item payable or a change in the insured individual) are treated as the issuance of a new policy, and, if they occur after December 31, 1996, the “new” policy must meet the HIPAA QLTCIC standards to receive favorable tax status.²⁷ Any contract

²⁰ I.R.C. § 7702B(b)(1)(C).

²¹ I.R.C. § 7702B(b)(1)(D).

²² I.R.C. § 7702B(b)(1)(E).

²³ I.R.C. §§ 7702B(b)(1)(F), (g)(1)(A), (g)(2)(B)(i).

²⁴ I.R.C. §§ 7702B(b)(1)(F), (g)(1)(B), (g)(3), and § 4980C(d). Practitioners should note that a QLTCIC will state that it is “intended” to be a QLTCIC. The use of the word “intended” should not be viewed as ambiguity on the part of the insurer as to whether or not it views the policy as a QLTCIC. It simply is what the statute requires.

²⁵ I.R.C. §§ 7702B(b)(1)(F), and (g)(1)(C).

²⁶ 26 C.F.R. §§ 1.7702B-2(b)(1)-(3).

²⁷ 26 C.F.R. § 1.7702B-2(b)(4). See 26 C.F.R. § 1.7702B-2(b)(4)(ii) for specific exceptions.

issued in exchange for an existing contract after December 31, 1996, is treated as issued after that date.²⁸

3. Long-Term Care Insurance as Part of Life Insurance Contract

If long-term care insurance coverage is provided as a rider or as part of a life insurance contract, the QLTCIC rules will be applied as if the long-term care coverage is a separate contract from the life insurance contract.²⁹

III. FEDERAL INCOME TAX CONSEQUENCES TO EMPLOYER AND EMPLOYEE OF PREMIUM PAYMENTS FOR QLTCICs

A. Introduction

In an employer sponsored multi-life long-term care insurance plan, there are three options for paying the insurance premiums: (1) the employer may pay the entire premium (*i.e.*, an employer-pay-all approach); (2) the employee may pay the entire premium (*i.e.*, an employee-pay-all approach); or (3) a combination of both (*i.e.*, a contributory approach). As a general rule, employers are entitled to a deduction for the premiums that they pay on behalf of their employees for QLTCICs. Depending on their status as “Employees” (as defined below) or “Self-Employed Owners” (as defined below), and on who pays the premium (whether the employer or the employee), employees may be able to exclude or deduct from their income some or all of the premium payments made on their behalf.

B. “Employees” and “Self-Employed Owners” Defined

The tax rules applicable to QLTCICs (and certain other employee benefits) are somewhat different for employees who are considered to be “self-employed individuals” for tax purposes than for those who are not. A “self-employed individual” is one who earns income by carrying on a trade or business in which his or her personal services are a material income-producing factor.³⁰ Under the Internal Revenue Code, sole proprietors, partners in a general partnership or limited partnership, more than 2-percent shareholders³¹ of S Corporations, and owners of limited liability corporations (“LLCs”) and limited liability partnerships (“LLPs”) are all treated as “self-employed individuals” for purposes of certain employee benefits, including the tax rules applicable to QLTCICs.³² In this Study, these individuals will be referred to as “Self-Employed Owners.”

Employees who are not “Self-Employed Owners” include employees with no ownership interest in the employer at all, as well as shareholder employees in S Corporations who are not

²⁸ 26 C.F.R. § 1.7702B-2(b)(3)(iii).

²⁹ I.R.C. § 7702B(e)(1).

³⁰ See I.R.C. § 401(c)(1)(B).

³¹ “[T]he term ‘more than 2-percent shareholder’ means any person who owns (or is considered as owning within the meaning of the I.R.C. § 318 attribution rules) on any day during the taxable year of the S Corporation more than 2 percent of the outstanding stock of such corporation or stock possessing more than 2 percent of the total combined voting power of all stock of such corporation.” I.R.C. §1372(b).

³² I.R.C. §§ 707(c), 1372(a); Rev. Rul. 91-26, 1991-1 C.B. 184. In addition, a non-employee director of a corporation is considered to be self-employed with respect to the services he or she performs in this capacity. See the taxation discussion in Part Three, Section II.G of this Study for more information about the tax treatment of non-employee directors.

“more than 2-percent shareholders,” and shareholder employees in C Corporations, regardless of their level of ownership. In this Study, these workers will be referred to as “Employees.”³³

The reader should keep in mind that the terms “Self-Employed Owner” and “Employee” may not always be precisely descriptive of the categories of employees that fall within them. This is particularly true for more than 2-percent shareholders of S corporations. These individuals are treated as employees for both state law and employment tax (income tax withholding and FICA) purposes. Nevertheless, they are characterized as “self-employed individuals” for certain employee benefit purposes, including the tax treatment of long-term care insurance premiums. Accordingly, they are categorized as Self-Employed Owners in this Study. On the other hand, owner-employees of C corporations are generally treated as employees for all purposes, *i.e.*, state law, employment tax and employee benefits, regardless of their level of ownership in the corporation. Accordingly, an employee owning 100 percent of his or her C corporation employer would be characterized as an “Employee” and not a “Self-Employed Owner.” Partners in partnerships and owners of LLCs and LLPs who are employees of the organizations in which they have an ownership interest, and sole proprietors, are treated as self-employed for both employment tax and employee benefit purposes and are “Self-Employed Owners.” If there is any question about the status of an employee as a “Self-Employed Owner” or “Employee” as the reader proceeds through this Study, we encourage him or her to review the discussion above, as well as the following chart.

Chart A

**Self-Employed Owners and Employees Defined
(for purposes of the tax treatment of long-term care premiums)**

Self-Employed Owners	Employees
<ul style="list-style-type: none"> • All partners/owners in partnerships, LLPs or LLCs. • S corporation shareholders who own more than 2 percent of the shares. • Sole proprietors. 	<p>All other employees, including all non-owner employees, all shareholder-employees of C corporations (regardless of their level of ownership), and S corporation shareholders who own 2 percent or less of the shares.</p>

C. Employer-Paid Premiums $\frac{3}{4}$ Employer’s Deduction

QLTCICs are treated like accident and health insurance contracts for tax purposes. Therefore, an employer may deduct the premiums it pays under these contracts for its employees (including its Self-Employed Owners other than sole proprietors) on the same basis that it deducts the premiums it pays for health insurance for its employees. Accordingly, an employer³⁴ may deduct any premiums paid for a QLTCIC to the extent that the premium payments are not in excess of reasonable compensation for services actually rendered by the employee.³⁵ This deduction arises under the general rule allowing deductions as ordinary and necessary business

³³ The term “Employee” (with a capital “E”) is used to distinguish employees who are not Self-Employed Owners. When it is not necessary to differentiate between Self-Employed Owners and Employees, the Study will refer to both simply as “employees” (with a small “e”).

³⁴ “Employer” includes corporations (C and S), partnerships, limited liability companies, and sole proprietorships.

³⁵ I.R.C. § 162(a)(1); 26 C.F.R. § 1.162-10(a).

expenses for reasonable compensation paid to employees and not under any special rule pertaining specifically to long-term care insurance. The amount is deductible to the employer whether the premium is paid on behalf of an Employee or a Self-Employed Owner, as is more fully discussed below.

In the case of corporations (both C and S), the deduction is taken on the corporation's tax return. This generally is Form 1120 for a C corporation and Form 1120S for an S corporation. The deduction reduces the net income of the corporation, which, for an S corporation, reduces the income passed through to the shareholders.

In the case of a partnership (including LLPs and LLCs that are taxed as partnerships), the deduction is taken for its Employees on its partnership tax return, which is Form 1065. Payment of premiums for owners of a partnership, LLP or LLC for services rendered are treated as "guaranteed payments" under the partnership tax rules which are deductible to the entity on Form 1065.³⁶ The deduction reduces the income taxable to the partners/members.

A sole proprietor takes a deduction for premiums he or she makes on behalf of Employees on Form 1040, Schedule C. Since a sole proprietorship is not an entity separate from the owner, the sole proprietorship may not deduct premiums paid on behalf of the owner. Thus, the sole proprietor's ability to deduct the premium contributions made under a QLTCIC on his or her own behalf is subject to the limitations on deductions for Self-Employed Owners, as discussed below in Section III.D.2.

Although, as mentioned above, an employer is generally entitled to deduct as compensation the premiums that it pays for QLTCICs for its employees, the premium must be paid as compensation for services rendered. If the employee is also a shareholder of a corporation, a question may arise as to whether the premiums are being paid for services rendered or because the employee is a shareholder. If a corporation pays the premiums because the employee is a shareholder, the corporation's payment of the premiums are treated as a nondeductible dividend to the shareholder.³⁷

Because of this, practitioners need to be cautious when designing a plan that includes such owners. They need to take steps to ensure that the plan's eligibility requirements are based upon the services the owner provides to the organization so that the premium payments do not result in constructive distributions to the owners. In the remainder of this Study, we will assume that premiums paid by an employer on behalf of an individual who is an owner are based on the individual's services for the employer, not his or her ownership status, and that they are reasonable compensation for the services rendered.

The following example illustrates the deductions for employer-paid premiums. The tax consequences to an Employee and a Self-Employed Owner are described next in the text.

Example 1. In 2001, the POQ Corporation, a C corporation, decides to pay 100 percent of the annual premiums for individual qualified long-term care insurance for Mary, a non-shareholder employee, Sarah, a

³⁶ I.R.C. § 707(c).

³⁷ See, e.g., *Leidy v. Commissioner*, 34 T.C.M. (CCH) 1476 (1975), *aff'd per curiam*, 39 AFTR 2d 77-877 (4th Cir. 1976) (payments to shareholders from a health insurance plan that originally covered only shareholders and that always gave greater coverage to shareholders than other employees determined to be constructive dividends); *Larkin v. Commissioner*, 48 T.C. 629 (1967), *aff'd*, 394 F.2d 494 (1st Cir. 1968) ("[W]e think that the genesis of [the health insurance plan] was to benefit stockholders and their relatives and only incidentally and sporadically nonstockholder employees.")

Such inadvertent constructive dividends could have an adverse impact on an S corporation in another way. To qualify as an S corporation, a corporation must have only one class of stock. 26 C.F.R. § 1-1361-1(l). In general, a corporation is treated as having a single class of stock if all outstanding shares confer identical rights to distribution and liquidation proceeds. *Id.* Therefore, if the plan design results in constructive dividends to only certain shareholder employees, such selective distributions could jeopardize the corporation's S election if a principal purpose of the plan is to circumvent the one class of stock requirement. 26 C.F.R. § 1.361-1(l)(2)(i).

less than 2 percent shareholder employee, and Meredith, a 90 percent shareholder employee. The annual premium for this insurance is \$2,000. POQ pays the premiums directly to the insurance company.

For each employee, POQ Corporation may deduct the entire \$2,000 premium amount as an ordinary and necessary business expense on Form 1120. Note, if POQ were an S corporation, the deduction would appear on its Form 1120S, and the deduction would reduce the S corporation's taxable income allocated to its shareholders, including Sarah and Meredith.

D. Employer-Paid Premiums $\frac{3}{4}$ Tax Consequences to Employee and Self-Employed Owner

1. Employee's Exclusion from Taxable Income of Employer-Paid Premiums

As with premiums an employer pays on behalf of its employees for accident and health insurance, QLTCIC premiums paid by an employer for individual long-term care policies for its Employees (or the Employees' spouses or dependents) are excluded from the Employees' gross income.³⁸ Thus, an Employee pays no income tax on the premiums the employer pays on his or her behalf.

Example 2. In 2001, ABC Corporation, a C corporation, decides to pay 100 percent of the annual premiums for individual qualified long-term care insurance for Judy and Bill, both of whom are employees and 25 percent shareholders. The annual premium for this insurance is \$1,200. The premiums paid are an employee benefit excluded from Judy and Bill's income for federal income tax purposes.

If in *Example 2*, the ABC Corporation were an S corporation, sole proprietorship, partnership or LLC, that established a QLTCIC for its employees and owners, the Employees of ABC Corporation could exclude the employer-paid premiums from their federal gross income. However, any employee who is a Self-Employed Owner would have a different result, as discussed below.

2. Self-Employed Owner's Tax Deduction for Employer-Paid Premiums

Unlike Employees, Self-Employed Owners may not exclude from taxable income QLTCIC premiums their employers pay on their behalf.³⁹ Instead, Self-Employed Owners must include these premiums in gross income, but are permitted to take offsetting tax deductions for a portion of the premiums. The Self-Employed Owner is permitted a business deduction and may also be permitted a personal deduction, depending on several factors, as is more fully discussed below in a. and b.

³⁸ I.R.C. §§ 7702B(a)(3) and 106(a). 26 C.F.R. § 1.106-1 explicitly allows the exclusion of amounts paid for coverage of spouses and dependents. In general, dependents include any of the following individuals over half of whose support was received from the employee:

1. A son or daughter of the employee or descendant of either,
2. A stepson or stepdaughter of the employee,
3. A brother, sister, stepbrother, or stepsister of the employee,
4. The employee's father or mother or an ancestor of either,
5. The employee's stepfather or stepmother,
6. A niece or nephew of the employee,
7. An uncle or aunt of the employee,
8. A son-in-law, daughter-in-law, father-in-law, mother-in-law, brother-in-law, or sister-in-law of the employee, or
9. Any other individual (other than the employee's spouse) who has as his or her principal place of abode the home of the employee and who is a member of the employee's household.

I.R.C. § 152(a).

³⁹ See I.R.C. §§ 106 and 1372; Rev. Rul. 91-26, 1991-1 C.B. 184. Also see the discussion regarding non-employee corporate directors in Part Three, Section II.G.

a. Self-Employed Owner’s Business Deduction for Employer-Paid Premiums

A Self-Employed Owner may deduct as a business expense a percentage of “eligible long-term care premiums”⁴⁰ paid by the Self-Employed Owner’s employer for the Self-Employed Owner and his/her spouse and dependents,⁴¹ subject to a maximum limit.⁴² However, if the Self-Employed Owner is eligible to participate in any subsidized plan that provides coverage for qualified long-term care services that is maintained by any employer of the Self-Employed Owner or the Self-Employed Owner’s spouse, no business deduction is allowed.⁴³ The allowable percentage changes from year to year until 2003 as shown in the following chart.

Chart B

Allowable Percentage Deduction for Eligible Long-Term Care Insurance Premiums⁴⁴

Year	Allowable Percentage
Through 2001	60%
2002	70%
2003 and thereafter	100%

An “eligible long-term care premium” is a specific dollar amount of premiums that does not exceed the dollar limitations prescribed by the Internal Revenue Code during a taxable year for any QLTCIC.⁴⁵ These dollar limitations are based on age, *i.e.*, they increase with increasing age, and are inflation adjusted each year. They are announced in an annual revenue procedure. The limitations for 2001 are shown in the following chart.

⁴⁰ I.R.C. §§ 162(l)(1)(A), 162(l)(1)(B) and 162(l)(2)(C). See Chart B for the allowable percentage.

⁴¹ See I.R.C. § 152.

⁴² I.R.C. §§ 162(l)(2)(A) and 213(d)(10). In addition to the percentage limitation, an Owner’s deduction for QLTCIC premiums, when combined with deductions for other medical insurance costs, may not exceed his or her earned income derived from the business with respect to which the plan providing the coverage is established. “Earned income,” defined by reference to I.R.C. § 401(c)(2), means the net earnings from self-employment (as defined in I.R.C. § 1402(a)), with certain adjustments.

⁴³ I.R.C. § 162(l)(2)(B). Presumably, the reference to “subsidized plan” does not include a plan for a Self-Employed Owner where the amount the employer pays under the plan is treated as income to the Self-Employed Owner.

⁴⁴ I.R.C. § 162(l)(2)(C).

⁴⁵ I.R.C. § 162(l)(2)(C), § 213(d)(10). See Rev. Proc. 2001-13, 2001-3 IRB for 2001 limits.

Chart C

Eligible Long-Term Care Insurance Premiums 2001⁴⁶

Attained Age Before Close of Taxable Year	Applicable Eligible Premium Limitation for Year 2001
40 or less	\$230
Over 40, but not more than 50	\$430
Over 50, but not more than 60	\$860
Over 60, but not more than 70	\$2,290
Over 70	\$2,860

The Self-Employed Owner’s business deduction is taken on Form 1040, individual income tax return, as an adjustment to income in computing adjusted gross income.⁴⁷ As such, it is allowable whether or not the individual itemizes deductions. The following example illustrates a Self-Employed Owner’s business deduction.

Example 3. In 2001, QOE Corporation, an S corporation, decides to pay 100 percent of the annual premiums for individual qualified long-term care insurance for Lauren, an employee of QOE Corporation and its sole shareholder. Lauren has an adjusted gross income of \$55,000. She is 55 years old. The annual premium for this insurance is \$1,300.

Example 3. (continued) As shown in Chart C, the eligible premium limitation for Lauren for 2001 is \$860. A percentage of this \$860 will be deductible by Lauren on her federal income tax return as a deduction allowed “self-employed” persons. The allowable percentage is 60 percent. (See Chart B.) As a result, \$516 (\$860 X 60%) is deductible by Lauren as a business expense.

b. Self-Employed Owner’s Personal Deduction for Employer-Paid Premiums

Any portion of the “eligible long-term care premiums” paid by an employer for a Self-Employed Owner which may not be deducted under the above rules may still be deducted by the Self-Employed Owner as an unreimbursed medical expense to the extent that it and all other such medical expenses exceed 7.5 percent of the Self-Employed Owner’s adjusted gross income.⁴⁸ If premiums exceed the limitation on “eligible long-term care premiums” as described above, the excess amount is not deductible.⁴⁹

⁴⁶ Rev. Proc. 2001-13, 2001-3 I.R.B.

⁴⁷ Line 28 of 2000 Form 1040.

⁴⁸ I.R.C. § 213. Because this is an itemized deduction, this will produce a tax benefit only if the individual’s allowable itemized deductions exceeds the individual’s standard deduction. I.R.C. § 63. It is also subject to the general limitations on itemized deductions. I.R.C. § 68. For alternative minimum tax purposes, medical expenses are allowed as a deduction only to the extent the expenses exceed 10 percent of adjusted gross income. I.R.C. § 56(b)(1).

⁴⁹ The law is not entirely clear as to how IRC §§ 213(d)(10) and 162(l) interrelate. In this Study, we have assumed that in determining the amount of allowable itemized medical deductions for eligible long-term care premiums under I.R.C. § 213, the fixed dollar cap under I.R.C. § 213(d)(10) is first reduced by the amount allowable as a business deduction under I.R.C. § 162(l). See *Example 4*. Because the amount allowable under each provision is tied to the I.R.C. § 213(d)(10) cap, this interpretation applies that cap to the combined I.R.C. §§ 162(l) and 213 deductions. An alternative interpretation is that the I.R.C. § 213(d)(10) cap applies independently to the I.R.C. § 213 medical itemized deduction. This

Example 4. Assume the same facts as in *Example 3*. In addition to the business deduction, the remaining \$344 of the eligible premium amount (\$860 - \$516) may be deducted by Lauren on her federal income tax return as a personal, unreimbursed medical expense, provided that Lauren itemizes deductions and has total unreimbursed medical expenses for 2001 in excess of 7.5 percent of adjusted gross income. (Since 7.5 percent of Lauren’s adjusted gross income is \$4,125, Lauren would need to have other significant unreimbursed medical expenses for 2001 in order for the \$344 to be deductible.)

The remaining \$440 of the premium amount, which is the excess of the \$1,300 premium amount over the \$860 eligible premium limitation, is *not* deductible as either a business or personal expense.

E. Employee-Paid Premiums $\frac{3}{4}$ Tax Consequences to Employee and Self-Employed Owner

As mentioned above, there are three methods for payment of QLTCIC premiums. Sections C and D above focus on the employer-pay-all method, that is, where the employer pays the entire premium amount. The other two methods, where the employee pays the entire amount of the premium and where the employer pays a portion and the employee pays a portion, obviously entail some payment on the part of the employee. At the time of this Study,⁵⁰ no means exist by which an employee may pay QLTCIC premiums with pre-tax dollars.⁵¹ Accordingly, employees must pay for their portion of the premium on an after-tax basis, either through after-tax payroll deductions or by payment directly to the insurance company. To a limited extent, Employees may be entitled to a tax deduction for the premiums they pay. Self-Employed Owners are entitled to a tax deduction for the premiums they pay on the same basis as when the premiums are paid by the employer. These deductions are described below.

1. Employee’s Tax Deduction for Employee-Paid Premiums

As mentioned above, if an Employee pays some or all of the premiums for a QLTCIC, he or she must do so with after-tax dollars. Under certain circumstances, the Employee may be able to take a tax deduction under Internal Revenue Code § 213(a).⁵² The extent to which the Employee can take this deduction is subject to the limitations of both § 213(a) and § 213(d)(10). Internal Revenue Code § 213(a) permits an individual to take a deduction on his or her personal income tax return for unreimbursed medical expenses he or she incurs in excess of 7.5 percent of the individual’s adjusted gross income.⁵³ Section 213(d)(10) sets out the age-based limitation on “eligible long-term care premiums” described in Chart C in Section II.D.a, above. Thus, the Employee is entitled to a deduction on his or her personal income tax return for the portion of the premium that is an “eligible long-term care premium” to the extent that this amount, together with the Employee’s

alternative interpretation is based upon I.R.C. § 162(l)(4) which provides that amounts taken into account under I.R.C. § 162(l) shall not be taken into account in determining the amount deductible as an itemized medical deduction under I.R.C. § 213(a). Therefore, under this alternative interpretation, the amount allowed under I.R.C. § 162(l) is ignored in applying the I.R.C. § 213(d)(10) cap to determine the amount allowed as an itemized medical deduction under I.R.C. § 213(a). Under this alternative interpretation, in *Example 4*, Lauren could deduct all of the premium not deductible as a business expense (\$784) because it is less than the \$860 cap.

⁵⁰ At the time of this Study, legislation has been introduced to authorize the pre-tax payment of premiums through cafeteria plans. Practitioners should update this Study in this regard at the time of use. See Part Two, Section VI.A., regarding cafeteria plans.

⁵¹ I.R.C. § 106(c).

⁵² An Employee may not take a business deduction under I.R.C. § 162(l) for any portion of the premiums (as described above in Part Two, Section III.D.2.a) because the Employee is not considered to be a self-employed individual for this purpose.

⁵³ See *supra* note 48 and accompanying text regarding additional limitations on the medical deduction.

other unreimbursed medical expenses for the year, exceed 7.5 percent of the Employee's adjusted gross income.

This means that where an Employee pays the entire premium amount in an employer sponsored employee-pay-all arrangement, the tax effect to the Employee is the same as it would be if the Employee had purchased the insurance on his or her own. Even though this is the case, employee-pay-all arrangements have some advantages. These arrangements offer Employees convenience and, in some states, the multi-life discount mentioned above.

Example 5. In 2001, LMN Corporation, a C corporation, decides to sponsor an employee-pay-all tax-qualified long-term care insurance plan. LMN does not want to pay any of the premiums for the insurance, but is willing to bear the cost of administering the plan, including collecting amounts from payroll on an after-tax basis and forwarding them to the insurance company.

Several employees elect to participate. Two of these employees are Alex and Cindy. Their ages, adjusted gross income ("AGI"), premium amounts and eligible premium limitations are:

	<u>Age</u>	<u>AGI</u>	<u>Premium Amount</u>	<u>Eligible Premium Limitation</u>
Alex	45	\$40,000	\$600	\$430
Cindy	63	\$70,000	\$3,000	\$2,290

Alex and Cindy can include a portion (up to their eligible premium limitations) of their premium amounts in their unreimbursed medical expenses for 2001. Unreimbursed medical expenses that exceed 7.5 percent of AGI are deductible as an itemized deduction under I.R.C. § 213(a).

Assume that Alex has unreimbursed medical expenses, other than those for his long-term care premiums, of \$2,500 for 2001. In determining Alex's total unreimbursed medical expenses for 2001, he would add in the \$430 eligible premium amount (not the \$600 actual premium amount). Since Alex's unreimbursed medical expenses total less than \$3,000 (7.5% X \$40,000), he is not entitled to a deduction for any of his long-term care premiums.

Assume, though, that Cindy has significant unreimbursed medical expenses for 2001. Her unreimbursed medical expenses, before including her long-term care premiums, are \$4,000. In determining Cindy's total unreimbursed medical expenses, she would include her \$2,290 eligible premium amount. Since Cindy's total unreimbursed medical expenses for 2001 exceed \$5,250 (7.5% X \$70,000), Cindy can deduct \$1,040 (\$6,290 - \$5,250) of her premiums under I.R.C. § 213(a) as an itemized deduction on her personal income tax return for 2001. If this deduction, combined with her other itemized deductions, does not exceed Cindy's standard deduction, however, she will claim the standard deduction and receive no tax benefit from these medical expenses.

Note: The tax treatment of the long-term care premiums for Alex and Cindy are the same as if they had purchased the insurance on their own. However, they may be able to receive a lower premium rate because of the group participation and also pay for their insurance on a more convenient payroll deduction basis.

If an employer takes a contributory approach to providing long-term care insurance benefits, meaning that both the employer and the Employee pay a portion of the QLTCIC premium, the deductibility to the employer of the employer's contribution will follow the rules discussed in Section III.C, above, for employer contributions. The Employee will be permitted to exclude the employer's premiums payments from his or her gross income under the rules discussed in Section III.D, above, and will be entitled to deduct the Employee's contribution under the rules discussed above in this Section III.E.1 for after-tax employee contributions.

Example 6. Assume that the facts are the same as in *Example 5*, above, except that LMN Corporation wishes to pay 1/2 of the premium amount for each employee. In Alex's case, LMN Corporation pays \$300 and in Cindy's case \$1,500. These amounts are deductible by LMN and excludable from Alex's and Cindy's income. The portion that Alex and Cindy pay is treated in the same manner as described in *Example 5*. Again, Alex will not be entitled to any deduction under I.R.C. § 213(a). Cindy's I.R.C. § 213(a) deduction will be reduced. All of her \$1,500 premium payment may now be included in her unreimbursed medical expenses. Cindy's unreimbursed medical expenses will now total \$5,500, \$250 (\$5,500 - \$5,250) of which will be deductible under I.R.C. § 213(a).

2. Self-Employed Owner's Tax Deduction for Self-Employed Owner-Paid Premiums

The rules that apply to the deductibility by Self-Employed Owners of premiums for QLTCICs when they personally pay the premiums are the same as those that apply when the employer pays the premiums. In both cases, the premiums paid on behalf of the Self-Employed Owner, whether by the employer or by the Self-Employed Owner personally, are subject to the rules described in Section III.D.2, above.

Example 7. Assume that the facts are the same as in *Examples 3* and *4* above, except that Lauren, and not the S corporation, pays the entire premium amount. The tax result to Lauren is the same as in *Examples 3* and *4*, since she is a Self-Employed Owner.

Example 8. Assume that the facts are the same as in *Example 5*, above, except that LMN Corporation is an S corporation and Cindy is a 3 percent shareholder. Cindy must include the \$1,500 paid by the corporation for her QLTCIC into her taxable income. Cindy can deduct \$1,374 (60% X \$2,290) as a business expense. Cindy can include \$916 (\$2,290 - \$1,374) in her unreimbursed medical expenses for 2001.

IV. TAXATION OF BENEFITS

Amounts received under a QLTCIC (other than policyholder dividends or premium refunds) are treated as amounts received for personal injuries and sickness and are treated as reimbursement for expenses incurred for medical care as defined in Internal Revenue Code § 213(d).⁵⁴ All reimbursement amounts from an expense reimbursement policy are excluded from the recipient's gross income.⁵⁵ This is the tax result for reimbursement-type policies regardless of who makes the premium payment and whether the insured individual is an Employee or Self-Employed Owner.

With a *per diem* policy, however, only benefits up to a *per diem* limitation are excludable from gross income. The *per diem* limitation for any period is the greater of a prescribed dollar amount which is inflation-adjusted (\$200 per day for 2001) or the actual costs incurred for QLTCI services provided for the individual during such period, reduced by any reimbursements received for QLTCI services during such period.⁵⁶ This is the tax result for *per diem* type policies regardless of who makes the premium payment and whether the insured individual is an Employee or Self-Employed Owner. *Examples 9* and *10* illustrate the tax consequences of a *per diem* policy.⁵⁷

⁵⁴ I.R.C. § 7702B(a)(2).

⁵⁵ For personally paid insurance, I.R.C. § 104(a)(3) applies, and for employer-paid insurance, I.R.C. §§ 105(a) and (b) apply.

⁵⁶ I.R.C. §§ 7702B(d); Rev. Proc. 99-42, Sec. 3.27, 1999-46 I.R.B.

⁵⁷ Northwestern Long Term Care Insurance Company policies are not *per diem* policies.

Example 9. In 2001, Ruby was chronically ill for 12 months and received 12 monthly payments on a *per diem* basis from a QLTCIC. She was paid \$2,000 per month (\$24,000 total). Ruby’s actual cost for qualified long-term care services was \$100 per day (\$36,500). In addition, she received reimbursement under another policy of \$18,250.

The *per diem* limit is the greater of the prescribed dollar amount for 2001 multiplied by the number of days in the period (200×365 , or \$73,000) or the actual cost incurred for the period (\$36,500), less any reimbursed amounts. Thus, Ruby’s *per diem* limitation is \$54,750 ($\$73,000 - \$18,250$). Ruby’s QLTCIC *per diem* benefit of \$24,000 was less than the \$54,750 *per diem* limitation. Therefore, the entire \$24,000 benefit is excludable from Ruby’s gross income.

Example 10. Assuming the same facts as in *Example 9*, except that Ruby received a \$220 *per diem* benefit for 365 days, or \$80,300 ($\220×365) total in QLTCIC *per diem* benefits; her actual cost of qualified long-term care services was \$210 per day (\$76,650), and she received no other reimbursement of these expenses. Ruby’s *per diem* limitation is \$76,650 ($\$76,650 - \0); therefore, she would have \$3,650 ($\$80,300 - \$76,650$) in non-excludable income.

V. SUMMARY TAX CHART

The tax rules for QLTCICs⁵⁸ are briefly summarized in the chart below.

Chart D

Summary Tax Chart for Qualified Long-Term Care Insurance

	Type of Taxpayer Owning Qualified Long-Term Care Policy	
	Employee ⁵⁹	Self-Employed Owner ⁶⁰
1. Deductibility to employer of employer-paid premiums	Yes. Employer-paid premiums are deductible by the employer if the payment is reasonable compensation. I.R.C. § 162(a).	Yes. Employer-paid premiums are deductible by the employer if the payment is reasonable compensation (I.R.C. §§ 162(a), 707(c)), except for a sole proprietor’s payments for his or her own premiums, which are deductible under the rules described in 3, below.
2. Excludability of employer premium payments from employee’s income	Yes. Employer-paid premiums are excludable from the Employee’s taxable income if the payment is reasonable compensation. I.R.C. § 106(a).	Not applicable.

⁵⁸ A long-term care insurance policy that does not meet the QLTCIC standards spelled out in HIPAA has uncertain tax consequences.

⁵⁹ See Part Two, Section III.B for a discussion of which employees are considered “Employees.”

⁶⁰ See Part Two, Section III.B for a discussion of which employees are considered “Self-Employed Owners.”

Chart D (continued)

	Type of Taxpayer Owning Qualified Long-Term Care Policy	
	Employee	Self-Employed Owner
3. Deductibility to employee of employer-paid premium	Not applicable.	The “allowable percentage” ⁶¹ of the “eligible long-term care premium” ⁶² is deductible to the Self-Employed Owner as a business expense. Any additional “eligible long-term care premium” is deductible to the Self-Employed Owner as a personal unreimbursed medical itemized deduction to the extent it, along with other unreimbursed medical expenses, exceeds 7.5 percent of adjusted gross income. I.R.C. § 213(a). ⁶³
4. Deductibility to employee of employee-paid premiums	The “eligible long-term care premium” is deductible to the Employee as a personal unreimbursed medical itemized deduction to the extent it, along with other unreimbursed medical expenses, exceeds 7.5 percent of adjusted gross income. I.R.C. § 213(a). ⁶⁴	The same rules as in 3, above, apply to the deductibility of premiums personally paid by the Self-Employed Owner.
5. Taxability of benefits paid under policy⁶⁵	Reimbursement policy: No <i>Per diem</i> policy: Maybe	Reimbursement policy: No <i>Per diem</i> policy: Maybe

⁶¹ See Chart B.

⁶² See Chart C.

⁶³ See I.R.C. §§162(l)(1)(A), (1)(B) and (2)(C). Also, see Part Two, Section III.D.2 for an example of a tax calculation for Self-Employed Owners.

⁶⁴ See discussion in Part Two, Section III.E.1, regarding “Employee’s Tax Deduction for Employee-Paid Premiums.”

⁶⁵ See discussion in Part Two, Section IV, regarding “Taxation of Benefits.” The Northwestern Long Term Care Insurance Company policy is a reimbursement policy.

VI. OTHER TAX ISSUES

A. Cafeteria Plans

1. Long-Term Care Insurance Premiums

Cafeteria plans, also known as flexible benefits plans, offer certain pre-tax benefits to employees. These plans are governed by Internal Revenue Code § 125. In general, under Internal Revenue Code § 125, no amount is included in the gross income of a cafeteria plan participant solely because the participant may choose among the benefits of the plan.⁶⁶ To satisfy the requirements of Internal Revenue Code § 125, a plan must offer the employee the choice between cash and qualified benefits.⁶⁷ Long-term care insurance is specifically excluded from the Internal Revenue Code § 125 definition of a “qualified benefit” and, as a result, at this time⁶⁸ may not be offered on a pre-tax basis through a cafeteria plan.⁶⁹ This rule applies regardless of whether the policy is a qualified or non-qualified contract.⁷⁰

Employers may offer long-term care insurance through after-tax employee payroll deductions. Furthermore, employers may make long-term care insurance benefits available to employees in conjunction with a cafeteria plan to the extent of using combined election and enrollment forms and procedures. Benefits may not, however, be funded with salary reduction contributions or cafeteria plan credits, and should not be referred to in the cafeteria plan document or summary plan description.

2. Long-Term Care Services Under a Flexible Spending Account

Cafeteria plans may also include a flexible spending account (“FSA”) benefit for certain medical expenses.⁷¹ Under an FSA benefit arrangement, the employer offers a self-insured medical reimbursement plan, which is governed by Internal Revenue Code §§ 105 and 106, as well as Internal Revenue Code § 125.⁷² Typically, the employee elects a level of pre-tax salary reduction up to a plan-specified limit and receives reimbursement for expenses equal to the amount elected.⁷³ The FSA may reimburse medical expenses, generally as defined by Internal Revenue Code § 213 (which also relates to deductibility of medical expenses for income tax purposes).⁷⁴ These allowable expenses include many medical expenses associated with long-term care, such as certain nursing home costs, nursing care, therapies and prescription drugs.⁷⁵ HIPAA amended Internal Revenue Code § 213 to specifically include qualified long-term care services as allowable medical

⁶⁶ I.R.C. § 125(a).

⁶⁷ I.R.C. § 125(d)(1).

⁶⁸ At the time of this Study, legislation has been introduced into Congress that would authorize long-term care insurance to be offered through a cafeteria plan. Practitioners are advised to update this Study at the time of use. See *supra* note 13.

⁶⁹ I.R.C. § 125(f).

⁷⁰ For purposes of this exclusion, long-term care insurance includes “. . . any product which is advertised, marketed, or offered as long-term care insurance.” I.R.C. § 125(f).

⁷¹ Similar arrangements are possible for dependent care expenses under I.R.C. § 129 but are not discussed in this Study.

⁷² Prop. Treas. Reg. § 1.125-2, Q/A 7(a).

⁷³ See generally Prop. Treas. Reg. § 1.125-2, Q/A 7.

⁷⁴ Prop. Treas. Reg. § 1.125-2, Q/A 7 (b)(4). The FSA may not reimburse the participant for premiums paid for other health coverage. *Id.*

⁷⁵ IRS Publication 502 (2000) (listing specific medical expenses generally covered under I.R.C. § 213).

expenses.⁷⁶ Qualified long-term care services are necessary medical and personal services that are required by a “chronically ill individual” and provided pursuant to a plan of care prescribed by a licensed health care practitioner.⁷⁷ This amendment appears to expand the reimbursable expenses under an FSA to include certain personal care services for long-term care, provided the recipient is “chronically ill” as defined by the Internal Revenue Code and the services are provided under a licensed practitioner’s plan of care.⁷⁸ Thus, under this provision, employees seem to be able to obtain reimbursement of certain uninsured long-term care expenses from an FSA. Note that this conclusion applies only to out-of-pocket long-term care expenses, and an FSA may *not* reimburse for premiums paid for long-term care insurance.⁷⁹

HIPAA, however, also amended Internal Revenue Code § 106 to provide that employer-provided coverage for qualified long-term care services (as defined in Internal Revenue Code § 7702B(c)) provided through an FSA must be included in the employee’s gross taxable income.⁸⁰ The effect of this change appears to be that medical expenses that would otherwise be reimbursable on a nontaxable basis under an FSA are reimbursable only on a *taxable* basis if they are for qualified long-term care services.

B. Medical Savings Accounts (“MSA”)

Medical Savings Accounts or Archer MSAs (“MSAs”) were created to help self-employed individuals and employees of certain small employers pay for medical care costs. In summary, an MSA is a tax-exempt trust account with a financial institution (*e.g.*, a bank or insurance company) in which an individual may save money for future medical expenses. The individual may claim a tax deduction for contributions to the MSA, earnings on the account are tax free, and disbursements from the account for qualified medical expenses are not included in the

⁷⁶ I.R.C. § 213(d)(1)(C) (defining “medical care” to include qualified long-term care services as defined by I.R.C. § 7702B(c)).

⁷⁷ Qualified long-term care services are defined in I.R.C. § 7702B(c) as “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.”

⁷⁸ Under I.R.C. § 7702B(c)(2), “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 [eating, toileting, transferring, bathing, dressing, continence] 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.

⁷⁹ Prop. Treas. Reg. § 1.125-2(7)(b)(4).

⁸⁰ I.R.C. § 106(c). The gross income of an employee generally does not include employer-contributions (through premiums or through contributions to a fund) to a health plan. I.R.C. § 106(a); Reg. § 1.106-1.

individual's gross income. As of the date of this Study, premiums paid for a QLTCIC (as defined in Code § 7702B(b)) are qualified medical expenses under an MSA.⁸¹

To be eligible to establish an MSA, the individual generally must be self-employed or work for a small employer, and must have a High Deductible Health Plan (as defined in Internal Revenue Code § 220(c)(2)) and no other health plan. The individual's employer may make deductible contributions to the MSA, subject to restrictions.

The MSA is a pilot project, and the cut-off date to establish a new MSA is currently set at December 31, 2002.⁸² The rules relating to MSAs are somewhat complex and a complete discussion of the use of an MSA is beyond the scope of this Study. Please refer to Internal Revenue Code § 220, or I.R.S. Publ. 969 for more information.

C. Status of Long-Term Care Insurance Under COBRA

The Consolidated Omnibus Budget Reconciliation Act of 1986 ("COBRA") requires employers to provide employees and certain covered family members ("qualified beneficiaries") with the right to continue group health coverage at group rates for a limited period of time upon the occurrence of certain events ("qualifying events").⁸³ Many states have also enacted continuation laws that apply only to insured products offered in the state.

COBRA does not apply to qualified long-term care insurance plans.⁸⁴ In addition, a plan will not be treated as a group health plan for COBRA purposes if substantially all the coverage that is provided under the plan is for qualified long-term care services.⁸⁵ In determining whether a plan satisfies this exception, a plan may use any reasonable method.⁸⁶

The Internal Revenue Code and regulations specifically exclude plans for *qualified* long-term care benefits. Thus, a plan which offers non-qualified long-term care benefits and other benefits such that "substantially all" of the plan benefits are not for qualified long-term care services, would apparently be subject to COBRA. For example, a medical plan that covers certain long-term care expenses would remain subject to COBRA.

One advantage of using individual policies to fund employer sponsored long-term care benefits is the fact that the policy is portable, *i.e.*, the employee can take the policy with him or her on termination of employment. This feature, in essence, provides employees with continuation coverage without requiring employers to follow the COBRA requirements.

D. Tax Nondiscrimination Rules

As described above, employee-provided QLTCICs are treated as accident and health plans for federal tax purposes. Fully insured accident and health plans are not subject to any tax-based

⁸¹ I.R.C. § 220(d)(2)(B)(ii)(II). Medical Savings Accounts were renamed "Archer MSAs" for Rep. Bill Archer, sponsor of the bill extending MSAs. Consolidated Appropriations Act 2001, H.R. 4577, 106th Cong., § 201 (2000).

⁸² H.R. 4577, 106th Cong., § 201 (2000) (extending cut-off to December 31, 2002, except the program may end earlier if the number of participants exceeds 750,000).

⁸³ See generally I.R.C. § 4980B.

⁸⁴ I.R.C. § 4980B(g)(2); 26 C.F.R. § 54.4980B-2, Q&A 1(e).

⁸⁵ I.R.C. § 4980B(g)(2); 26 C.F.R. § 54.4980B-2, Q&A 1(e). Qualified Long-Term Care Insurance is defined in I.R.C. § 7702B(c).

⁸⁶ 26 C.F.R. § 54.4980B-2, Q&A 1(e).

nondiscrimination requirements.⁸⁷ These requirements generally limit deductions for employer contributions and exclusion of benefits received to plans that cover a certain percentage of nonhighly compensated employees.⁸⁸

As applied to QLTCICs, the lack of federal tax nondiscrimination requirements generally means that an employer may design its long-term care insurance plan to cover as many or as few of its employees as it wants. However, even though federal tax nondiscrimination requirements are not applicable, federal equal employment opportunity laws may require covering broader classes of employees.⁸⁹

E. Long-Term Care Payer Reporting of Benefits

A long-term care insurer must file a Form 1099-LTC with the Internal Revenue Service (“IRS”) and provide copies of that form to the policyholder and the insured individual when it pays long-term care benefits during any year. The information required to be shown on the 1099-LTC includes:

1. The insurer’s name, address, and telephone number;
2. The aggregate amount of long-term care benefits paid by the insurer to the individual during the calendar year;
3. Whether or not the long-term care benefits were paid on a *per diem* or other periodic basis without regard to the expenses incurred during the period to which the payments relate;
4. The name, address, and taxpayer identification number of the policyholder to whom the benefits were paid; and
5. The name, address, and social security number of the chronically ill individual on account of whose condition the benefits were paid.

Form 1099-LTC must be filed with the IRS each year by the end of February (or the first business day in April if the insurer files electronically) and must be provided to both the policyholder and the insured individual on or before January 31 of the year following the calendar year for which the return was filed.⁹⁰

F. Policyholder Reporting of Benefits Received

The Form 1099-LTC received by the policyholder should be used to determine whether or not any portion of benefits received are taxable as a result of excess reimbursement under a *per diem* policy.⁹¹ The IRS provides Form 8853 for this purpose.

⁸⁷ See generally I.R.C. §§ 104, 105 and 106 and the regulations issued thereunder, in particular Treas. Reg. § 1.105-5(a).

⁸⁸ See, e.g., I.R.C. § 105(h) relating to self-insured medical plans.

⁸⁹ See Part Five of this Study.

⁹⁰ I.R.C. § 6050Q.

⁹¹ Northwestern’s qualified long-term care policy is not a *per diem* policy; it is an expense reimbursement policy.

PART THREE

PLAN DESIGN AND IMPLEMENTATION

I. OVERVIEW

As with any other employee benefit plan, the plan sponsor and its advisors must make a number of plan design decisions in order to achieve the employer's human resources and benefits goals, ensure appropriate tax treatment, ensure appropriate ERISA treatment, formally adopt the plan, and communicate the plan to employees. This Part provides an overview of the key plan design issues and alternatives as well as describing the implementation process. The focus is on employers that have elected to use individual policies to fund an employer sponsored long-term care insurance plan. For specific examples of how long-term care insurance may be implemented for sole proprietorships, partnerships, C corporations and S corporations, see Part Six of the Study, entitled "Case Studies."

II. ELIGIBILITY

As noted in Part Two, Section VI.D, fully insured accident and health plans are not subject to any tax-based nondiscrimination requirements. Thus, from a tax perspective, an employer is generally free to establish whatever eligibility requirements it wants. The plan may cover just one employee (*e.g.*, the president), just key employees (*e.g.*, all officers), specific classes of employees (*e.g.*, all salaried employees), or all employees who work a specified number of hours each week. As a general rule, though, the broader the classification of employees covered, the less likely it will be that the employer will inadvertently stumble into other legal or human resources problems. Below is a discussion of several employee classifications and potential issues the practitioner may wish to consider.

A. Key Employees

It is becoming more common to provide a single key employee or class of key employees with long-term care coverage. If the class of key employees includes only owners of an entity and all of the owners are covered, the IRS could perceive this classification as simply a subterfuge to make distributions to owners. If so, the IRS could reclassify the entity's premium payments as constructive distributions with the result that the payments are nondeductible by the entity and taxable to the owner.⁹² In order to avoid this result, the practitioner should ensure that eligibility for this benefit is based on the services provided by the owner to the entity and not his or her ownership status.

Another issue to consider when limiting the class of eligible employees to key employees is whether the limitation could result in an equal employment claim. This could occur, for example, if the eligible class is composed of only males and all other employees are female. If this is the case, the practitioner will need to consider whether the plan's eligibility provisions implicate gender discrimination or other employment law questions. See Part Five of this Study for a brief discussion of potential employment law concerns.

⁹² See *supra* note 37 and the discussion in the text in Part Two, Section III.C.

B. Years of Service as an Eligibility Factor

Many employee benefit plans apply a length of service requirement as a condition to participating in the plan. Length of service requirements provide a number of potential advantages to the employer. First, they act as an incentive for employee retention by making a new benefit available to longer-term employees. Second, by requiring a minimum length of service before participation, the employer is relieved of the administrative burden of enrolling and perhaps dis-enrolling a short-term employee. If, however, the cost of the plan increases if participation is limited in this fashion, a length of service requirement could be a detriment.

Given the lack of tax-based nondiscrimination requirements, an employer may generally apply any length of service requirement it wishes. The practitioner needs to be cautious, however, to ensure that an objective length of service requirement does not create the potential for equal employment opportunity claims, by disproportionately excluding from participation the members of a protected class of employees. See Part Five, Section II of this Study for more information about non-discrimination laws.

C. Minimum Age Requirements

Long-term care insurance frequently is only of interest to individuals over a certain age. As a result, many employers inquire about the use of age as an eligibility criterion. As is noted in Part Five, both federal and state age discrimination laws will need to be analyzed before this type of eligibility criterion is used. Given that participation in the plan most likely will be voluntary, self-selection may eliminate the need for the employer to limit participation based on age.

D. Nominal Employees

On occasion, business owners inquire about adding a parent, friend, or other acquaintance to a plan by making that individual a “nominal” employee, *e.g.*, the individual may work one day a quarter in exchange for benefits. These types of arrangements need to be carefully analyzed. An employer’s federal tax deduction for employee compensation (including benefits) cannot exceed reasonable compensation for services actually rendered.⁹³ If the individual is not truly performing services for the employer, the anticipated tax consequences of providing and receiving the policy could be jeopardized. For example, the IRS could disallow the deduction to the extent the compensation exceeds what is reasonable, and the employer’s taxable income would then be increased by the amount of the disallowance. In addition, these “nominal employee” arrangements may be demoralizing to other employees if discovered, particularly if the benefit is not available to all classes of employees.

E. Dependents

Under Internal Revenue Code § 7702B(A)(3), any plan of an employer providing coverage under a QLTCIC is treated as an accident and health plan. Except for Self-Employed Owners,⁹⁴ Internal Revenue Code § 106, applicable to accident and health plans, explicitly allows the

⁹³ Code § 162(a)(1).

⁹⁴ See Part Two, Section III.B, for a definition of the term “Self-Employed Owner.” In the case of Self-Employed Owners, the tax rules described in Part Two, Sections III.D.2 and III.E.2, also apply to spouses and dependents of Self-Employed Owners. For illustrations of these rules, see *Examples 3, 7 and 8.*

exclusion of amounts paid for coverage for spouses and dependents.⁹⁵ Offering coverage under a plan to spouses and dependents should be considered. Advantages of offering such coverage include providing more attractive benefits than competitors, employee retention, and decreased absenteeism.

F. Retirees

Long-term care insurance needs continue and may become more important after retirement. Thus, employers may consider offering continued coverage through an employer sponsored long-term care plan to their retirees. Under long-standing IRS guidance applicable to accident and health insurance, employer contributions to accident and health plans for a retired employee (other than a Self-Employed Owner) are excludable from the retiree's income under Internal Revenue Code § 106 and the benefits received are nontaxable under Internal Revenue Code § 105 (assuming the coverage is attributable to the previous employment relationship).⁹⁶ Thus, it should be possible to offer continuing long-term care coverage to retirees and have the employer contributions and benefits excluded from the retiree's income. If, however, the plan is available only to retirees, or most participants are retirees, the tax treatment of the plan could be jeopardized.

Long-term care insurance may be included as one of the benefits in an early retirement package for employees. Such insurance could be purchased on an individual basis or multi-life basis depending on the size of the group. Some insurers offer single premium policies such that the employer can make a single lump sum premium payment to the insurer with no obligations to make any further premium payments. In the alternative, the employer could elect to pay the premiums for a fixed number of years, and then allow the retiree to personally continue the premium payments thereafter.

G. Directors

On occasion, business entities like to include non-employee directors in their employee benefit plans. Directors who are not employed by the entity on whose board they serve are considered self-employed. If an entity desires to include a non-employee director in a long-term care program and the entity desires to pay all or any portion of the premiums as a benefit for the director, the premiums are taxable to the director as non-employee income. Accordingly, the tax treatment to the director is the same whether the entity pays the premiums directly or pays cash to the director who then pays the premiums directly.

The rules applicable to Self-Employed Owners discussed in Part Two generally apply to directors. Thus, the director will be able to deduct a portion of the premium as a business expense under Internal Revenue Code § 162(l) limited by the amount of the director's "earned income" from his or her trade or business *as a director*. Any premium amount not deductible in

⁹⁵ 26 C.F.R. § 1.106-1. *See also, supra* note 38 regarding who can be classified as a dependent (*e.g.*, parents can be considered to be dependents under these rules, if over one half of the parent's support comes from the employee and certain other requirements are met).

⁹⁶ *See, e.g.*, Rev. Rul. 62-199, 1962-2 C.B. 38; Rev. Rul. 75-539, 1975-2 C.B. 45; Rev. Rul. 82-196, 1982-1 C.B. 53.

The revenue rulings interpreting I.R.C. § 106 have held that a retired employee is an "employee" within the meaning of § 106. The rationale underlying this position is that the retired employee has performed past services for the employer. G.C.M. 38917, 11/17/1982 (discussing Technical Study Project No. 78-35 which summarizes the rationale for this exclusion).

Coverage of retirees, as part of an employer multi-life group eligible for a discount, receives uneven treatment under state insurance laws; however, depending upon applicable state law, a group discount may be available to the retiree.

this manner could be included with the director's unreimbursed medical expenses (up to the eligible premium limitations for his or her age) and deductible as an itemized deduction under Internal Revenue Code § 213(a) to the extent the director's total unreimbursed medical expenses exceed 7.5 percent of adjusted gross income.

The director will likely not be able to take advantage of any multi-life discount, however, because most states do not specifically include corporate directors in their definition of "employee" under their franchise insurance laws.

H. Other Eligibility Factors and Concerns

See Part Five, entitled "Other Considerations," and in particular, Section II, entitled "Non-Discrimination Laws."

III. CONTRIBUTIONS

The second important plan design consideration is who will fund the program, *i.e.*, pay the premiums. As mentioned earlier in the Study, there are three funding methods: employer-pay-all, employee-pay-all, or a combination of the two, *i.e.*, a contributory plan. If the employer decides to pay all or a portion of the premium, the employer will need to determine its funding philosophy, *i.e.*, whether it wishes to fund the plan on a defined contribution or defined benefit basis. Finally, if employees will pay all or a portion of the premium, the employer will need to determine if the employees' contributions will be accomplished through payroll deduction or through payments made by the employees directly to the insurer. These plan design questions are discussed below.

A. Employer-Pay-All

As discussed in Part Two, any employer payment of premiums for Employees (as opposed to Self-Employed Owners) is generally fully excludable by the Employee from his or her income. This favorable tax treatment argues in favor of the employer fully paying the premiums for the QLTCICs. Since Self-Employed Owners are not permitted to exclude employer premium payments from income, the tax rules do not support the same conclusion for them.⁹⁷

Human resource goals for both Employees and Self-Employed Owners and budgeting constraints will generally dictate what, if any, employer contributions are made. Since long-term care insurance programs are not subject to tax nondiscrimination rules, the employer may elect to pay the entire premium for some classes of employees and not others.

B. Employee-Pay-All

An employee-pay-all program is one in which the employee pays the entire premium amount with after-tax dollars. While an Employee does not experience the same tax or compensation advantages that he or she would have if the employer paid the premium,⁹⁸ there may be some advantages to the Employee of participating in an employer sponsored employee-pay-all program. Employees may be able to benefit from a multi-life discount offered by insurance

⁹⁷ There is generally no tax difference to the Self-Employed Owner whether the employer or the Self-Employed Owner pays the premiums. In either case, the Self-Employed Owner is allowed a business deduction equal to a percentage of the premium payment up to the eligible premium limitation. See Part Two, Section III.

⁹⁸ See Part Two, Section III.E.1 for the application of the tax rules to Employees.

companies and the purchase of the policy may be more convenient for the Employee than if he or she bought it on an individual basis. The employer could allow Employees to purchase the insurance by payroll deduction, or, if permitted by the insurer, the Employee could pay the insurer directly without the need for any employer involvement. If payment is made through payroll deduction, the employer should consider whether solicitation of payroll deduction forms will be coordinated with the employer's cafeteria plan. See Part Two, Section VI.A for a discussion of this issue.

For Self-Employed Owners, there are no particular tax advantages of a program in which the employer pays all or some of the premium over a program in which the Self-Employed Owner pays all of the premiums. However, as with Employees, Self-Employed Owners may be able to take advantage of a multi-life discount and the purchase of the policy may be more convenient for the Self-Employed Owner if accomplished through an employer sponsored plan than if the Self-Employed Owner purchased the policy on his or her own.

C. Contributory Approach

Under a contributory approach, both the employer and the employee⁹⁹ pay a portion of the premium. Depending on how the employer designs the plan, the amount of the employee contribution could vary based on certain factors, such as years of service, or class of employee, or whether the participant is an employee or dependent of an employee (*e.g.*, the employer could pay 100 percent for employees and nothing for spouses). Normally, the employer will collect the employee's portion and pay the insurer the full amount.

D. Defined Benefit Versus Defined Contribution

Under a defined benefit approach to funding employee benefits, the focus is on the level of benefit employees will receive if and when benefits are paid out, not on the amount of periodic premiums paid. For example, under a defined benefit approach, the employer might purchase a basic policy offering \$100 per day nursing home coverage, a 50 percent home care benefit, a 91-day elimination period, and a 3-year maximum on benefits. Employees desiring more coverage would be able to purchase the additional coverage at their own expense. An employee could, for example, pay the additional premium amount for 100 percent home care and lifetime benefits. (Again, the employer would collect the employee's portion of the premiums and then remit the full premium amount to the insurer.)

Under a defined contribution approach to funding benefits, the employer defines its obligation to employees simply by the amount of premium that it pays. For example, under a defined contribution approach, the employer might agree to pay 75 percent of the employee premium and 25 percent of the spousal premium. (These rates could vary based on class of employee.)

The approach that is selected should be based on human resource goals and pricing issues. A defined benefit approach may, however, simplify concerns under the equal employment laws, as discussed in Part Five.

⁹⁹ *Id.*

IV. PLAN IMPLEMENTATION

The implementation of a long-term care plan is the same as the implementation of any other employer sponsored employee benefit program. The governing body of the employer should formally adopt the plan. A plan document may be required to be prepared and benefits need to be communicated to employees. All of these steps should be taken in the context of ERISA,¹⁰⁰ if applicable, and the Internal Revenue Code.¹⁰¹ This section discusses each of these steps and references sample documents contained in the Appendix.

A. Adoption of the Plan

As a matter of good business practice, the governing body of the employer should formally adopt the plan. The governing body may be a Board of Directors (as is the case in most S and C corporations), a Board of Trustees (as may be the case in a tax-exempt, nonprofit corporation), a Board of Governors (as may be the case in an LLC or LLP), or an action by the partners (in the case of a partnership). Adoption of the resolution should also help to establish the basis for any deductions for Self-Employed Owners and can be used to formalize the employer's communication to employees.

The preamble to the resolutions usually tells the story of the employer's desire to establish the plan, to provide benefits to the class or classes of employees to be covered, and states who will pay for the plan. The preamble also often recites that the board members have reviewed the plan. The actual resolutions formally adopt the plan as of a date certain and clearly delegate to certain officers the obligation to implement and administer the plan.

Form 1 in the Appendix provides the practitioner with a sample adoption resolution. While this form is designed for corporate-type entities, other entities may use this form as well.

B. The Plan Document

Part Four of this Study discusses the ERISA implications of using individual QLTCIC as part of an employer sponsored long-term care insurance plan. Whether or not the practitioner determines that ERISA applies to the arrangement, it is usually good policy to have employee benefit arrangements documented in proper form simply to ensure that the employer's promises to employees are clear and well considered.

Form 2 in the Appendix provides a sample ERISA plan document that uses individual QLTCICs as the funding vehicle.

C. The Summary Plan Description

ERISA requires that each participant of an employee benefit plan be provided with a summary plan description ("SPD"). Part Four of this Study discusses ERISA's SPD requirements and potential exceptions. As with the plan document, even if the practitioner determines that

¹⁰⁰ See Part Four of this Study for a detailed discussion of ERISA requirements.

¹⁰¹ See Part Two of this Study for a detailed discussion of the taxation of long-term care under an employer sponsored arrangement. Note: the Internal Revenue Code does not have any specific requirement for a written plan document, but it is helpful to have such a document so that the employer and employees understand their rights and obligations. If the arrangement is subject to ERISA, written documentation is required. ERISA § 402(a)(1). See Part Four, Section III.E.2, entitled "Plan Document," for a discussion of the ERISA plan document requirement.

ERISA does not apply to the long-term care insurance plan offered by a particular employer,¹⁰² it is good practice to offer an SPD-type document to participants to ensure that the plan is fully understood. Also, as discussed later, under ERISA it is permissible to have separate SPDs for different employee groups covered by the plan. There may be an advantage to having separate SPDs if the benefits offered to the different groups vary.

Form 3 in the Appendix provides an annotated SPD for an ERISA plan that uses individual QLTCICs as the funding vehicle.

¹⁰² See Part Four, Section II, entitled “Potential Exemptions from ERISA.”

PART FOUR

APPLICATION OF ERISA

I. IS LONG-TERM CARE INSURANCE COVERED BY ERISA

ERISA¹⁰³ applies to employee benefit plans established or maintained by any employer engaged in commerce or in any industry or activity affecting commerce.¹⁰⁴ Employee benefit plans subject to ERISA are generally divided into two categories, pension benefit plans and welfare benefit plans. At the time of this Study, no explicit guidance exists classifying long-term care insurance as either type of plan, but given ERISA's definition of a welfare benefit plan, it seems likely that it would fall within this category. An employee welfare benefit plan is defined, in relevant part, in ERISA § 3(1) as:

. . . any plan, fund, or program which was heretofore or is hereafter established or maintained by an employer or by an employee organization, or by both, to the extent that such plan, fund, or program was established or is maintained for the purpose of providing for its participants or their beneficiaries, through the purchase of insurance or otherwise, [. . .] medical, surgical, or hospital care or benefits, or benefits in the event of sickness, accident, disability, death or unemployment . . .¹⁰⁵

As noted above, ERISA covers any plan providing benefits in the event of sickness, accident or disability. Thus, it is reasonable to assume that employer provided long-term care insurance will be considered a welfare benefit plan subject to ERISA if it is provided under a program established or maintained by the employer for the benefit of its employees.¹⁰⁶ With regard to individual policies offered through an employer, the courts that have addressed the issue have generally taken the position that ERISA can apply to individual policies under the right combination of circumstances.¹⁰⁷

This Part assumes that an employer's use of individual policies to provide long-term care insurance to employees creates an ERISA plan and discusses the applicable ERISA exceptions, exemptions and requirements. For the reader who desires a more detailed discussion of ERISA, Northwestern Mutual's

¹⁰³ Employee Retirement Income Security Act of 1974, Pub. L. No. 93-406.

¹⁰⁴ ERISA § 4(a). Although not specifically discussed in this Study, ERISA similarly applies to employee benefit plans established by any employee organization representing employees engaged in commerce or in any industry or activity affecting commerce. *Id.*

¹⁰⁵ ERISA § 3(1).

¹⁰⁶ Practitioners who desire additional information on whether a program is subject to ERISA should see *Donovan v. Dillingham*, 688 F.2d 1367 (11th Cir. 1982) and its progeny. Factors relevant to a determination of whether a plan or program is "established or maintained" by an employer are also discussed in the ERISA group or group-type insurance programs safe harbor at 29 C.F.R. § 2510.3-1(j). See Part Four, Section II.C of this Study.

A benefit arrangement will not be considered to be an ERISA plan, however, unless that arrangement requires some ongoing administrative scheme to meet the employer's obligations. *Fort Halifax Packing Company, Inc. v. Coyne*, 482 U.S.1, 12 (1987); but see *Peckham v. Gem State Mutual of Utah*, 964 F.2d 1043, 1048 (10th Cir. 1992) (concluding that *Fort Halifax* does not specifically require that the employer exercise control over eligibility or claims, *i.e.*, "play the role of insurer").

¹⁰⁷ *Agrawal v. Paul Revere Life Ins. Co.*, 205 F.3d. 297, 301 (6th Cir. 2000) ("[C]ourts have recognized that an employee welfare benefit plan may be funded by group or individual policies"); *O'Brien v. Mutual of Omaha Inc. Co.*, 99 F.Supp.2d 744 (E.D. La. 1999) (finding that the individual medical policy fit within the meaning of an ERISA "plan") (dicta); *Burrill v. Leco Corp.*, No. 5:97-CV-21, 1998 U.S. Dist. Lexis 8178, at *9 (W.D.Mich. May 11, 1998) (individual health insurance policies subject to ERISA); *Massachusetts Casualty Ins. Co. v. Reynolds*, 113 F.3d 1450, 1453 (6th Cir. 1997) (acknowledging that an ERISA plan can consist of individual disability policies covering each of the employer's employees rather than a group policy); *Madonia v. Blue Cross & Blue Shield*, 11 F.3d 444 (4th Cir. 1993) (individual health insurance policies subject to ERISA), *cert. denied*, 511 U.S. 1019 (1994); *Collins v. Strategic Health Care Mgmt. Serv., Inc.*, No. 91 C 7469, 1992 U.S. Dist. Lexis 6075, at *6 (N.D.Ill. Apr. 28, 1992) (same). But see *New England Mut. Life Ins. Co., Inc. v. Baig*, 166 F.3d 1 (1st Cir. 1999) (finding an individual disability insurance policy not subject to ERISA).

special study entitled “The Employee Retirement Income Security Act and Nonqualified Employee Benefit Plans” is available.¹⁰⁸

While many employers may be fearful of ERISA, it should be noted that for welfare benefit plans provided by small employers, the ERISA requirements are minimal due to a number of exceptions and exemptions. In any event, much of what is required by ERISA reflects good business practice.

II. POTENTIAL EXEMPTIONS FROM ERISA

As an initial step, the practitioner should ensure that the employer is the type of employer subject to ERISA. As noted above, ERISA generally applies to any employer engaged in commerce.¹⁰⁹ ERISA does, however, exclude certain types of employers and certain types of plans.

A. Governmental and Church Plans

Specifically excluded from ERISA are governmental plans,¹¹⁰ defined to mean plans established and maintained by the federal government, a state government or any political subdivision.¹¹¹ Cities, counties, villages, towns and school districts generally are considered to be “political subdivisions” and should fall within this exemption.

ERISA also does not apply to church plans,¹¹² generally defined to mean plans established or maintained by a church recognized as such under Internal Revenue Code § 501.¹¹³ The definition of a church plan is technical and should be thoroughly reviewed before relying on the church plan exemption from ERISA.

If a plan is either a governmental plan or a church plan, ERISA does not apply and the remainder of this section may be skipped.

B. Plans Covering No Employees

Department of Labor (“DOL”) regulations exclude from the definition of “employee benefit plan,” a plan, fund, or program under which no employees are participants.¹¹⁴ For these purposes, the following individuals are not employees:

- Individual and spouse with respect to a trade or business, whether or not incorporated, which is wholly owned by the individual and his or her spouse.¹¹⁵
- Partner in a partnership and his or her spouse.¹¹⁶

¹⁰⁸ This 1995 study (F.O. 22-3901) was authored by Richard A. Hackett, J.D. and Virginia S. Schubert, J.D. of the law firm of Gray, Plant, Mooty, Mooty & Bennett, P.A., Minneapolis, Minnesota.

¹⁰⁹ ERISA § 4(a).

¹¹⁰ ERISA § 4(b)(1).

¹¹¹ ERISA § 3(32).

¹¹² ERISA § 4(b)(2).

¹¹³ ERISA § 3(33).

¹¹⁴ 29 C.F.R § 2510.3-3(b).

¹¹⁵ According to ERISA Op. Ltr. 76-67 (May 21, 1976), the exemption applies only where all of the stock of an entity is owned by one shareholder and his or her spouse and the shareholder and/or the spouse are the only participants in the plan. However, not all courts agree with this reading of the regulations. In *In re Kaplan*, 189 B.R. 882 (E.D. Pa. 1995), a Pennsylvania district court held that two *unmarried* joint owners of an S corporation were not employees for purposes of determining whether the corporation’s pension plan covered any employees.

Under this rule, plans using individual policies to provide long-term care insurance only for sole proprietors, partners or 100 percent shareholders of corporations would be exempt from ERISA because such plans would cover no employees (within the meaning of this ERISA exemption). If any other employee of the employer is also covered under the plan, though, the exemption is not available.

C. Group or Group-Type Insurance Programs Exception

Department of Labor regulations also provide a “safe harbor” exception under which certain types of insurance programs offered by an insurer to a group of employees are not considered to be welfare benefit plans under ERISA. In order to qualify for this safe harbor, a number of conditions that strictly limit the involvement of the employer in the program must be met. These safe harbor conditions are

- (1) No contributions are made by an employer;
- (2) Participation in the program is completely voluntary for employees;
- (3) The sole functions of the employer with respect to the program are, without endorsing the program, to permit the insurer to publicize the program to employees or members, to collect premiums through payroll deductions or dues checkoffs and to remit them to the insurer; and
- (4) The employer receives no consideration in the form of cash or otherwise in connection with the program, other than reasonable compensation, excluding any profit, for administrative services actually rendered in connection with payroll deductions or dues checkoffs.¹¹⁷

Since employee-pay-all plans require no employer contributions, one might be inclined to believe that they would fall within the safe harbor, particularly if the employer’s involvement in the plan is limited. This may, in fact, be the case with a pure payroll deduction plan, *i.e.*, a plan in which the employer merely makes payroll deductions available to employees to purchase individually owned insurance, does not pay any portion of the premiums, does not select the insurer, and does not endorse the program in any manner.

However, it does not take very much employer involvement to violate the requirements of the exception. If the employer states it has “arranged for” a group program, this along with other employer activities may lead employees to conclude that the plan is one “established or

¹¹⁶ At the time of this writing, the DOL has not provided any guidance with regard to the treatment of LLC members. LLC members are treated as partners for tax purposes, and an argument could be made that they should be treated analogously for purposes of ERISA. Thus LLC members would not be employees for the purposes of this ERISA exemption. If this is the case, and an LLC limits plan participation to its members, the plan would cover no employees and would not be subject to ERISA.

¹¹⁷ 29 C.F.R. § 2510.3-1(j). *See also* *Schneider v. UNUM Life Ins. Co.*, No. 00-CV-1838, LEXIS 6455 (E.D. Pa., May 17, 2001) (applying the safe harbor analysis in the context of long term care insurance policies).

This exception is very narrow and most employer-sponsored programs will not fall within it because the employer’s involvement exceeds the limitations. A program that fails to satisfy the safe harbor provision is not automatically deemed to have been “established or maintained” by the employer, but, rather, is subject to further evaluation. *Johnson v. Watts Regulator Co.*, 63 F.3d 1129, 1133 (1st Cir. 1995). *But see* *Stuart v. UNUM Life Ins. Co.*, 217 F.3d 1145, 1150-53 (9th Cir. 2000) (holding that an employer’s failure to satisfy any one of the four requirements of the safe harbor conclusively demonstrates that the plan is subject to ERISA, and concluding that *Johnson* also so holds).

maintained by the employer” so that the safe harbor would not be applicable.¹¹⁸ Furthermore, the DOL has stated that suggestions by an employer to the insurer regarding plan design and structure would represent direct involvement in the plan in excess of the minimal neutral involvement contemplated by the safe harbor regulation.¹¹⁹

Accordingly, if the employer performs ongoing administrative tasks, selects the insurer, establishes eligibility requirements, or if the employer restricts the employee’s rights, it is likely that the arrangement will be considered an employee benefit plan subject to ERISA (absent some other ERISA exception). In analyzing the applicability of this exception, the employer’s actions, not its intentions, would be examined from the viewpoint of the employee, in light of all the surrounding facts and circumstances. Small differences in the facts can produce different results.

Given the limited degree of ERISA compliance that will be required at the present time for most welfare benefit arrangements, we believe it is better to adopt the more conservative approach and, if there is any doubt, assume that the individual policy arrangement is an employee welfare benefit plan subject to ERISA.

III. REQUIREMENTS OF ERISA TITLE I

A. Scope Of Discussion

Title I of ERISA imposes requirements on welfare benefit plans in three separate areas: (1) reporting to the DOL and disclosure of information to participants; (2) compliance with fiduciary obligations; and (3) establishment of a claims procedure.¹²⁰ There are a number of exemptions under ERISA that narrow the scope of these requirements for certain plans, *e.g.*, plans sponsored by small employers and plans maintained for a select group of management or highly compensated employees. The chart below provides a summary of the requirements and exemptions. They will be discussed in greater detail in the text that follows.

¹¹⁸ DOL Advisory Opinions 94-22A, 94-23A, and 94-24A (concerning the employer’s life, accident/sickness and accidental death/dismemberment benefits, respectively).

¹¹⁹ DOL Advisory Opinions 94-22A, 94-23A, and 94-24A. Nevertheless, in *Johnson v. Watts Regulator*, a group insurance program was found not to be an ERISA plan, despite the employer recommending enrollment, characterizing the arrangement as “a plan,” and assisting with distribution of materials and with claim documentation. *Johnson v. Watts Regulator*, 63 F.3d 1129 (1st Cir. 1995). The court followed the approach taken by the DOL – that an employer is said to have endorsed the plan if “in light of all the surrounding facts and circumstances, an objectively reasonable employee would conclude on the basis of the employer’s actions that the employer had not merely facilitated the program’s availability but exercised control over it and made it appear to be part and parcel of the company’s own benefit package.” *Id.* at 1135. The court concluded that although the company had made its employees aware of the program, it stopped short of endorsing it. The company’s letter encouraging participation specifically stated that the decision to participate was entirely up to the employee. Finally, the court concluded that the company performed only administrative tasks, taking no role in substantive tasks, such as drafting or designing the plan, determining eligibility, interpreting policy language, investigating, allowing or disallowing claims, or negotiating settlements. *Id.* at 1136.

¹²⁰ ERISA also imposes standards for participation and vesting and funding of benefits. Because these provisions do not apply to welfare plans, they will not be considered in these materials.

Chart E
ERISA Title I Requirements
Insured Welfare Plans Summary Chart
For Plans Subject to ERISA

	<u>LARGE</u> <u>EMPLOYER</u> 100 or more Participants	<u>SMALL</u> <u>EMPLOYER</u> Fewer than 100 Participants	<u>EXECUTIVE</u> <u>ONLY</u> Noncontributory Select Management or Highly Paid
<u>Reporting & Disclosure:</u>			
Annual Report	Yes	No	No
Summary Annual Report	Yes	No	No
Summary Plan Description	Yes	Yes	No
Summary of Material Modifications <i>(See discussion in Part Four, III.D)</i>	Yes	Yes	No
<u>Fiduciary Responsibilities:</u>			
Plan Document	Yes	Yes	Yes
Named fiduciary	Yes	Yes	Yes
Funding policy	Yes	Yes	Yes
Allocation of fiduciary responsibility	Yes	Yes	Yes
Amendment procedure	Yes	Yes	Yes
Basis for payments	Yes	Yes	Yes
Trust Requirement	No	No	No
Fidelity Bonding <i>(See discussion in Part Four, III.E)</i>	No	No	No
<u>Claims Procedure:</u> <i>(See discussion in Part Four, III.F.1)</i>	Yes	Yes	Yes

The following discussion focuses on the available DOL exemptions in each area for employer sponsored long-term care plans and indicates those requirements to which employers utilizing this type of arrangement would most likely be subject.

B. The Small Employer Exemption $\frac{3}{4}$ Fewer Than 100 Participants

Under DOL regulations, if a plan qualifies as a “small employer” welfare benefit plan, it is exempt from all reporting and disclosure requirements except the obligation to deliver a Summary Plan Description (“SPD”) to participants and to make certain documents available to the DOL on request.¹²¹ Thus, most small benefit plans are not required to file annual reports with the DOL or to deliver summary annual reports to participants provided that any employee contributions are remitted to the insurer promptly.

¹²¹ 29 C.F.R. § 2520.104-20. The plan is *not* exempt from the fiduciary obligations and claims procedure requirements, however. Furthermore, although a plan may be exempt from the ERISA requirement to file an annual report with the DOL, if the plan meets the definition of a “specified fringe benefit plan” under I.R.C. § 6039D, the plan administrator may still be required to file an annual information return with the IRS (through the DOL). “Specified fringe benefit plan” means any plan under I.R.C. §§ 79, 105, 106, 120, 125, 127, 129 or 137.

A welfare benefit plan qualifies as a small welfare benefit plan if it:

- (1) has fewer than 100 participants at the beginning of the plan year;
- (2) provides benefits only out of either
 - (a) general assets of the employer;¹²²
 - (b) insurance contracts or policies for which premiums are paid out of general assets of the employer or partly from its general assets and partly from contributions by employees (provided such contributions are remitted to the insurer promptly and always within three months of collection); or
 - (c) both; and
- (3) if applicable, provides that refunds from insurers to which participants are entitled are returned to them within three months of receipt and informs participants of the refund policy upon entry into the plan.¹²³

This exemption should apply to most employers seeking to use individual policies to fund long-term care insurance, because these plans are likely to be small (fewer than 100 participants) and offering the benefit through insurance contracts.

C. The Executive Only Exemption $\frac{3}{4}$ Noncontributory Plan for Select Management or Highly Compensated Employees

The DOL has also established reporting and disclosure exemptions for employee welfare plans maintained by employers for a select group of its management or highly compensated employees.¹²⁴ The DOL advisory opinions and court decisions indicate that plans generally will not be considered to be established for a “select group of management or highly compensated employees” unless coverage is limited to a small percentage of employees who are much more highly compensated than other employees and are at the very highest level of management in the

¹²² The DOL published the plan assets-participant contribution regulation at 29 C.F.R. § 2510.3-102 in 1988 describing when participant contributions to an employee benefit plan become plan assets. This regulation put the availability of the Small Employer Exemption in jeopardy by stating that participant contributions held by a plan are plan assets. The plan assets-participant contribution regulation provides that such contributions become plan assets as of the earliest date they can reasonably be segregated from the employer’s general assets, but in no event later than 90 days from receipt by the employer.

The DOL then issued ERISA Technical Release 92-01, which stated that the DOL would not assert a violation in any enforcement proceeding against (a) a cafeteria plan for failure to hold participant contributions in trust, or (b) a contributory welfare plan with respect to which participant contributions are applied only to pay insurance premiums in a manner consistent with § 2520.104-20(b)(ii) or (iii) solely because of a failure to hold participant contributions in trust. ERISA Tech. Rel. 92-01, 57 F.R. 23272 (June 2, 1992). If a trust is not established, in reliance on Tech. Rel. 92-01, the small welfare plan reporting exemption continues to be available, provided participant contributions are used to pay premiums within three months of receipt.

Technical Release 92-01, by its terms, was originally to expire as of the earlier of December 31, 1993, or the adoption of final regulations providing relief with respect to the application of the plan asset regulations. In 1993, the DOL extended the relief by deleting the December 31, 1993 expiration date, stating that the non-enforcement policy of Tech. Rel. 62-01 will continue until the DOL issues final regulations in the matter. 53 F.R. 45359 (Aug. 27, 1993). The DOL provided further assurances in 1996 that Tech. Rel. 92-01 remains in effect until further notice. 61 Fed. Reg. 41220 (Aug. 7, 1996). To date, no further notice or regulation has been issued and the non-enforcement policy of Tech. Rel. 92-01 remains in effect.

¹²³ 29 C.F.R. § 2520.104-20(b).

¹²⁴ 29 C.F.R. § 2520.104-24.

company.¹²⁵ Welfare plans in this category are exempt from all reporting and disclosure requirements, except the obligation to provide plan documents to the DOL upon request, if benefits under the plan are:

- (1) paid as needed solely out of the general assets of the employer;
- (2) provided exclusively through insurance contracts for which all premiums are paid directly by the employer out of its general assets; or
- (3) both.¹²⁶

It should be noted that this exemption does not permit employee contributions as does the small employer welfare plan exemption. Therefore, it will not apply to an employee-pay-all or contributory plan.¹²⁷ Accordingly, this exemption will be limited to long-term care plans for a select group of management or highly compensated employees where the employer pays the entire premium. If participation in the plan is extended to employees who fall outside this group, this exemption will not apply (although the small employer exemption may apply).

D. Reporting and Disclosure

1. Statutory Requirements

An employee benefit plan not subject to the small employer exemption or the executive only exemption must file an annual report with the DOL¹²⁸ and must provide copies of portions of each annual report (the “Summary Annual Report”) to each participant.¹²⁹

An employee benefit plan not subject to the executive only exemption must provide to each participant a summary plan description (“SPD”), and if changes are made, a summary of material modifications to the plan (“SMM”).¹³⁰ In addition, other documents related to the plan must be made available for examination and copying by participants.

See Chart E in Section III.A for a summary of these reporting and disclosure requirements.

¹²⁵ See DOL Advisory Opinion 85-37A (October 25, 1985); DOL Advisory Opinion 90-14A (May 8, 1990); *Belka v. Rowe Furniture Corporation*, 571 F. Supp. 1249 (D. Md. 1983); *Darden v. Nationwide Mutual Insurance Company*, 717 F. Supp. 388 (E.D.N.C. 1989), *aff’d on other grounds*, 922 F.2d 203 (4th Cir. 1991), *rev’d on other grounds*, 112 S. Ct. 1344 (1992); *Loffland Bros. Co. v. Overstreet*, 758 P.2d 813 (Okla. 1988); *Pane v. RCA Corporation*, 868 F.2d 631 (3rd Cir. 1989). *But see Demery v. Extebank Deferred Compensation Plan(B)*, 216 F.3d 283 (2nd Cir. 2000) (holding that a plan offered to 15.34 percent of a bank’s employees was established for a “select group” because all the plan participants were officers of the bank, in management positions, and highly compensated in comparison to the bank’s employees as a whole).

The DOL advisory opinions and court decisions concerning this matter generally have addressed the pension plan exemptions to ERISA that apply to a “select group of management or highly compensated employees,” rather than the welfare plan exemptions. Since the exemptions for both types of plans use identical language to describe the group of employees under consideration, we assume that the same analysis applies in determining who falls within the group.

¹²⁶ 29 C.F.R. § 2520.104-24. The plan is *not* exempt from the fiduciary obligations and claims procedure requirements, however.

¹²⁷ Any employer-pay-all plan is, we believe, noncontributory even if a portion of the cost is taxed to the employee.

¹²⁸ ERISA §§ 101, 103, 104.

¹²⁹ ERISA § 104(b).

¹³⁰ ERISA §§ 102, 104(a) and (b).

2. The Annual Report

The annual report is a financial statement and contains a statement of assets and liabilities, changes in fund balance, and changes in financial position.¹³¹ Welfare plans generally do not have to complete the full form. The instructions to the Form 5500 detail which questions to answer.

If an annual report is required, it is filed on IRS Form 5500 and must be filed within seven months of the end of the plan year.¹³² ERISA defines the plan year as any calendar, policy or fiscal year selected for recordkeeping purposes.¹³³ Most employers select the employer's fiscal year to coordinate tax filings.

Plan administrators who fail to file or refuse to file an annual report within the required time may be assessed a civil penalty by the DOL.¹³⁴ The DOL is authorized to impose a penalty of up to \$1,000 per day, but the penalty actually imposed is rarely this high. In determining the amount of the penalty, the DOL takes into consideration the degree and willfulness of the failure to file.¹³⁵ The DOL has established a voluntary filing program called the Delinquent Filer Voluntary Compliance ("DFVC") Program under which plan administrators that have not filed the Form 5500 as required may reduce the penalties the DOL would otherwise assess. The program is open to eligible plan administrators and requires filing with both the IRS and DOL.¹³⁶

3. Summary Annual Report (SAR)

If an annual report is required, each plan participant must be furnished a summary annual report within nine months after the end of the plan year.¹³⁷ The Summary Annual Report conveys in plain language the salient features of the financial statements contained in the annual report. DOL regulations provide a format for plan administrators to use.¹³⁸

4. Summary Plan Description (SPD)

ERISA § 101(a) requires a plan administrator to furnish an SPD to each plan participant and beneficiary.¹³⁹ The SPD must include certain designated information and

¹³¹ ERISA § 103(b)(1); 29 C.F.R. § 2520.103-1.

¹³² 29 C.F.R. § 2520.104a-5. For example, a calendar year plan must file its annual report on or before July 31 of the next year. Effective February 2, 2000, a new form 5500 was adopted, with a single 5500 form to be used by all filers and 13 schedules focused on specific subjects and filing requirements. A new computerized filing system, EFAST, was also implemented.

¹³³ ERISA § 3(39).

¹³⁴ ERISA § 502(c)(2).

¹³⁵ 29 C.F.R. § 2560.502c-2.

¹³⁶ 60 Fed. Reg. 20874 (1995).

¹³⁷ 29 C.F.R. § 2520.104b-10(c).

¹³⁸ 29 C.F.R. § 2520.104b-10(d)(4).

¹³⁹ As described in Part Four, Section III.C, the SPD requirement does not apply to Executive Only Plans (*i.e.*, noncontributory plans for a select group of management or highly compensated employees).

Although ERISA § 101(a) speaks of furnishing an SPD to both a participant and a "beneficiary who is receiving benefits under the plan," distribution of the SPD to a beneficiary is not required under a welfare plan (as contrasted with a pension plan), unless the beneficiary requests one. Moreover, long-term care insurance policies typically do not have beneficiaries. Therefore, with regard to such a long-term care insurance policy, the SPD needs to be furnished only to the employee.

must be written in a manner calculated to be understood by the average plan participant and be sufficiently accurate and comprehensive to reasonably apprise participants and beneficiaries of their rights and obligations under the plan.¹⁴⁰ *Form 3* in the Appendix provides a sample format that is intended to comply with ERISA. Below is a general discussion of the content, format and distribution rules applicable to SPDs.

a. Content of the SPD

The following is a list of the information that must be included in the SPD:¹⁴¹

- (1) the name of the plan and, if different, the name by which the plan is commonly known by its participants and beneficiaries;
- (2) the name and address of the employer whose employees are covered by the plan;
- (3) the employer identification number assigned by the IRS to the plan sponsor, and the plan number assigned by the plan sponsor to the plan;¹⁴²
- (4) the type of plan, *e.g.*, long-term care insurance plan;
- (5) the type of administration, *e.g.*, insurer administration;
- (6) the name, business address, and business telephone number of the plan administrator (usually the employer/plan sponsor);¹⁴³
- (7) the name of the person designated as agent for service of legal process and the address at which process may be served on such person, and, in addition, a statement that service may be made upon the plan trustee or the plan administrator;
- (8) if the plan is maintained pursuant to one or more collective bargaining agreements, a statement that the plan is so maintained and that a copy of any such agreement may be obtained by participants and beneficiaries upon written request to the plan administrator and is available for examination by participants and beneficiaries;
- (9) the plan's requirement respecting eligibility for participation and benefits;

¹⁴⁰ ERISA § 102(a); 29 C.F.R. § 2520.102-2(a).

¹⁴¹ ERISA § 102(b); 29 C.F.R. § 2520.102-3 (as revised Nov. 21, 2000, and effective on the first day of the second plan year after January 22, 2001, except as otherwise stated in the regulation).

¹⁴² For further information, see "Identification Numbers Under ERISA" (Publ. 1004), published jointly by the DOL, IRS and Pension Benefit Guaranty Corporation ("PBGC").

¹⁴³ The plan administrator, as defined in ERISA § 3(16)(A), is "(i) the person specifically so designated by the terms of the instrument under which the plan is operated; (ii) if an administrator is not so designated, the plan sponsor; or (iii) in the case of a plan for which an administrator is not designated and a plan sponsor cannot be identified, such other person as the Secretary may by regulation prescribe." In the case of an employee benefit plan established or maintained by a single employer, the term "plan sponsor" means the employer. ERISA § 3(16)(B).

- (10) a description or summary of the benefits;¹⁴⁴
- (11) a statement clearly identifying the circumstances which may result in disqualification, ineligibility, denial, loss, forfeiture, or suspension, offset, reduction or recovery (*e.g.*, by exercise of subrogation or reimbursement rights) of any benefits that a participant or beneficiary might reasonably expect the plan to provide on the basis of the description of benefits;
- (12) a summary of any plan provisions governing the plan sponsor's authority to amend or terminate the plan, and any resulting rights or obligations of participants and beneficiaries;
- (13) a summary of any provisions that may result in the imposition of a fee or charge on a participant or beneficiary, the payment of which is a condition to receipt of benefits under the plan;
- (14) the source of contributions to the plan; *e.g.*, employer and/or employee, and the method by which the amount of contribution is calculated;
- (15) the identity of any funding medium through which benefits are provided;¹⁴⁵
- (16) the date of the end of the plan year;
- (17) certain specified information regarding the procedures to be followed in presenting claims for benefits, and appeals of adverse determinations;¹⁴⁶ and
- (18) the statement of ERISA rights.

The foregoing information must be accurate as of a date not earlier than 120 days prior to the date the SPD is disclosed.¹⁴⁷ In other words, the SPD need not reflect changes in the plan made within 120 days of the distribution of the SPD but must reflect all changes prior to that date.

¹⁴⁴ For any plan that is a "group health plan" providing "medical care" as defined by ERISA § 733(a), this SPD description of benefits must include information about deductibles, copayments and other cost-sharing provisions; annual and lifetime limits; coverage for preventive care; drug coverage; coverage for medical tests, devices and procedures; provisions governing the use of network providers; gatekeeper provisions; preauthorization and utilization review procedures. 29 C.F.R. § 2520.102-3(j)(3); 65 Fed. Reg. 70226 (Nov. 21, 2000). For purposes of this Study, we have assumed that a long-term care insurance plan is not a group health plan as defined in ERISA § 733(a). See *Form 3, Note 3*, in the Appendix of this Study for additional discussion of this issue.

¹⁴⁵ The SPD must identify the insurance company, if any, through which benefits are provided; indicating (a) the name and address of the insurance company, (b) whether and to what extent benefits under the plan are guaranteed under a contract or policy of insurance, and (c) the nature of any administrative services (*e.g.*, payment of claims) provided by the insurance company.

¹⁴⁶ The claims and appeals procedures vary, based on the type of claim. 29 C.F.R. § 2560.503-1. Stricter requirements, with regard to time periods, apply to group health plans and disability plans. For purposes of this Study, we have assumed that a long-term care insurance plan is neither a group health plan nor a disability plan. See *Form 3, Note 3*, in the Appendix to this Study for additional discussion of this issue.

¹⁴⁷ 29 C.F.R. § 2520.102-3.

b. Style and Format of the SPD

The regulations dealing with the style and format of the SPD¹⁴⁸ are based on the assumption that the basic purpose of the SPD – to inform participants and beneficiaries of their rights and obligations – will only be served if the information is presented in terms that are as clear and simple as possible. To that end, the use of technical terms and complex sentences is discouraged and the use of examples, illustrations, a table of contents and clear cross-references is encouraged. The standard set out is that the SPD must be geared to the level of comprehension and education of “typical” participants and the plan administrator is to “exercise considered judgment and discretion” in determining whether the SPD is sufficiently understandable and comprehensive.¹⁴⁹

Whatever format is selected, it must result in a balanced presentation of plan terms. Exceptions, limitations, reductions in benefits and other restrictions must be accorded the same prominence as benefits, without attempting to minimize the former or emphasize the latter.¹⁵⁰ In essence, negative material may not be “in the fine print,” although restrictions need not appear in close conjunction with benefits so long as the presentation of benefits refers to the page where restrictions are described.

c. Distribution of the SPD

The SPD must be distributed to participants within 90 days after they become participants, or, if later, 120 days after the plan becomes subject to Part 1 of Title I of ERISA.¹⁵¹ In addition, the plan administrator upon written request must furnish copies of the latest updated SPD to plan participants, but the participant may be charged a reasonable amount for the expenses involved.¹⁵²

Employers must furnish SPDs to the DOL upon request.¹⁵³

d. Manner of Distribution

The basic guideline in selecting a method for distributing SPDs is that it must be “likely to result in full distribution.”¹⁵⁴ Hand delivery to each required

¹⁴⁸ 29 C.F.R. § 2520.102-2.

¹⁴⁹ 29 C.F.R. § 2520.102-2(a). The style and format requirements also require plans to provide foreign language assistance to participants who are literate only in a language other than English if: (1) the plan has fewer than 100 participants and 25 percent or more are literate only in the same non-English language; or (2) the plan has 100 participants or more and the lesser of (a) 500 or more participants or (b) 10 percent of all participants, are literate only in the same non-English language. 29 C.F.R. § 2520.102-2(c). The assistance required need not be in writing, so long as the SPD contains a prominent notice in the relevant non-English language that assistance is available and instructions for obtaining it. 29 C.F.R. § 2520.102-2(c).

¹⁵⁰ 29 C.F.R. § 2520.102-2(b).

¹⁵¹ ERISA § 104(b).

¹⁵² ERISA § 104 (b)(4).

¹⁵³ ERISA § 104(a)(6). *See also* Taxpayer Relief Act of 1997, Pub. L. No. 105-34 (Aug. 5 1997).

¹⁵⁴ 29 C.F.R. § 2520.104b-1(b)

recipient is specifically authorized, as is delivery by mail. Simply leaving copies in locations frequented by participants is specifically prohibited, and mailing by second or third class mail is acceptable only if return and forwarding postage is guaranteed and address corrections requested. For small employers, hand delivery will probably be both the safest and least expensive method of reaching participants; otherwise, first-class mail is recommended.¹⁵⁵

e. Different SPDs for Different Employee Groups

In some cases, a plan may provide different benefits for different classes of participants and beneficiaries. In such cases, the plan administrator may fulfill the SPD requirements by furnishing to each member of each class of participants and beneficiaries (if applicable)¹⁵⁶ a copy of an SPD appropriate to that class.¹⁵⁷ Each SPD so prepared must satisfy the above requirements. It should clearly indicate on the first page of the text the class of participants for which it has been prepared and also list the other classes covered by the plan.¹⁵⁸ This alternative is very useful when an employer has different levels of benefits or contributions for different classes of employees.

f. Updated SPDs

The SPD must be updated and redistributed every five years if there have been amendments or changes in the plan, or every 10 years if there have been no changes.¹⁵⁹

5. Summary of Material Modifications (SMM)

Where there is a “material modification” in the plan or a change affecting information which must be included in the SPD, a summary description of the modification or change must be distributed not more than 210 days after the end of the plan year during which the change is adopted.¹⁶⁰

E. Fiduciary Responsibilities

1. Duties of Fiduciaries

ERISA requires that individuals or entities considered to be “fiduciaries” of an employee benefit plan perform certain duties. A fiduciary is defined in general terms as anyone who exercises any discretionary authority or control with respect to the management of a plan or its assets.¹⁶¹ An employer is a fiduciary with respect to the plan

¹⁵⁵ Group health plans may also distribute SPDs and SMMs through electronic media for participants who can access those electronic documents at work and readily convert them to paper form free of charge. 29 C.F.R. § 2520.104b-1(c). Proposed regulations issued in 1999 would extend this approach to all ERISA plans and to other documents, including summary annual reports. 64 Fed. Reg. 4506 (1999).

¹⁵⁶ For long-term care insurance policies that do not have beneficiaries, distribution of the SPD will be to the participant only.

¹⁵⁷ 29 C.F.R. § 2520.102-4.

¹⁵⁸ *Id.*

¹⁵⁹ ERISA § 104(b)(1).

¹⁶⁰ ERISA § 104(b)(1)(B).

¹⁶¹ *See* ERISA § 3(21)(A).

because it normally bears ultimate responsibility for plan administration. Plan administration responsibilities which generally involve exercise of fiduciary duties include decisions regarding the selection of an insurer and the negotiation of any contractual agreement obligating the plan.¹⁶² The employer has a fiduciary duty to exercise reasonable care in selecting an insurance carrier.¹⁶³

Many of the responsibilities of a fiduciary may be delegated, *e.g.*, to an insurer. In the context of a fully insured long-term care plan where an insurer makes claim determinations, the remaining fiduciary obligations for the employer may be fairly limited once the selection of insurer has been made.

2. Plan Document

Under ERISA § 402, every employee benefit plan must be established and maintained pursuant to a written instrument.¹⁶⁴ The writing requirement is intended to allow employees to determine their rights and obligations under the plan and to let employees know who is responsible for operating the plan.¹⁶⁵ Attached as *Form 2* in the Appendix is a sample plan document intended to satisfy both the ERISA requirements mentioned below and to wrap around the individual policies to be issued to the employee.

To satisfy ERISA, a plan must contain the following:

- (a) the name of one or more fiduciaries responsible for managing and controlling the operation and administration of the plan;
- (b) a procedure for establishing and carrying out a funding policy and method consistent with the objectives of the plan and the requirements of ERISA;
- (c) a description of any procedures under the plan for allocating responsibility for the operation and administration of the plan;
- (d) procedures for amending the plan and for identifying the persons who have the authority to amend the plan;¹⁶⁶ and
- (e) a description of the basis on which payments are made to or from the plan.¹⁶⁷

¹⁶² See ERISA Op. Ltr. 93-11A (Jan. 5, 1993); ERISA Interpretive Bulletin 95-1 (Mar. 6, 1995) (with regard to selecting annuities).

¹⁶³ See *Nidiffer v. Clinchfield R. Co.*, 600 S.W.2d 242 (Tenn. App. 1980).

¹⁶⁴ ERISA § 402(a)(1).

¹⁶⁵ H.R. Conf. Rep. No. 93-1280, at 297 (1974).

¹⁶⁶ In *Curtiss-Wright Corporation v. Schoonejongen*, 514 U. S. 73 (1995), the Supreme Court held that the employer's (Curtiss-Wright's) general reservation clause, which provided that the Company reserves the right to modify or amend, in whole or in part, any provisions of the plan, constituted a valid amendment provision under ERISA. According to the Court, the primary purpose of § 402(b)(3) of ERISA (paragraph (d) in the text, above) is functional, to ensure that every plan has a workable amendment procedure, not to enable participants to learn their rights and obligations. Further, naming the employer as the entity vested with authority to amend the plan satisfied § 402(b)(3)'s requirement that there be a procedure for identifying persons who have authority to amend the plan, because the employer was governed in its operations by state corporate law. Although an elaborate amendment procedure is not required, it is critical that an amendment be adopted in accordance with whatever procedure the plan specifies.

¹⁶⁷ ERISA § 402(a).

3. Trust Requirement

Under ERISA § 403, all assets of an employee benefit plan must be held in trust by one or more trustees.¹⁶⁸ Such trustee(s) must generally have exclusive authority and discretion to manage and control the assets of the plan, except to the extent (a) the plan expressly provides that the trustee is subject to the direction of a named fiduciary, or (b) a plan fiduciary appoints an investment manager for any plan asset.¹⁶⁹

One significant exception to the trust requirement applies to any assets of a plan that consist of insurance contracts or policies issued by an insurance company qualified to do business in a state.¹⁷⁰ Under this exception, fully insured employee welfare plans, such as a plans using only individual long-term care policies to fund them, do not need a trust because the only assets of the plan are the insurance contracts.

4. Fidelity Bonding

The fidelity bonding requirement in ERISA § 412 requires that all fiduciaries of employee benefit plans and anyone else handling funds or other property of the plan be bonded. Funds are not considered “handled,” for purposes of the bonding requirement, if the funds used to pay insurance premiums are not segregated from the employer’s general assets prior to payment of such premiums, and benefits from the insurance policy do not belong to the plan but rather to the employee.¹⁷¹ Under this exception, no bonding should be required with regard to the long-term care insurance policies paid through the employer’s general assets, where the policy proceeds are paid directly to the employee.

F. Administration and Enforcement

1. Claim Procedures

ERISA requires that every employee benefit plan establish and maintain reasonable claims procedures.¹⁷² An employer may delegate most of the responsibility for the processing and reviewing of claims for benefits under insured plans to the insurance company. However, the claims review and appeals processes of the insurer is subject to the same time limitations and other procedural requirements as apply to the employer.¹⁷³ The sample plan document and SPD contained in *Forms 2* and *3*, respectively, in the Appendix to this Study delegate the responsibility for claims procedures for insured benefits to the insurance company issuing the policy. (Claims procedures for other claims under the plan, if any, remain the responsibility of the employer.) To the extent the insurance company

¹⁶⁸ ERISA § 403(a). Such trustee or trustees are either named in the trust instrument or plan document, or may be appointed by a person who is a named fiduciary. *Id.* But see ERISA Tech. Rel. 92-01 regarding current DOL non-enforcement policy with regard to the trust requirement in certain situations. See also *supra* note 122.

¹⁶⁹ ERISA § 403(a).

¹⁷⁰ ERISA § 403(b)(1).

¹⁷¹ 29 C.F.R. § 2580.412-6(b)(7).

¹⁷² 29 C.F.R. § 2560.503-1(b). Note: This discussion reflects the requirements of the new claims regulations, published November 21, 2000, and effective for all claims filed on or after January 1, 2002. Until January 1, 2002, the prior claims regulations will continue to apply. For purposes of this discussion, it is assumed that a long-term care insurance plan is not a “group health plan” within the meaning of ERISA § 733(a). Additional discussion of this issue may be found in the Appendix, *Form 3, Note 3*.

¹⁷³ 63 Fed. Reg. 48392 (preamble to the proposed claims regulations, Sept. 9, 1998).

makes the final claim determinations under the plan, it will likely be deemed an ERISA fiduciary.¹⁷⁴

The claims procedures must contain administrative processes and safeguards designed to ensure and verify that benefit claim determinations are made in accordance with the plan, and that plan provisions are applied consistently for similarly situated claimants.¹⁷⁵ Furthermore, the claims procedures must not contain any provision or be administered in any way that unduly inhibits or hampers the initiation of, or processing of, claims.¹⁷⁶

2. Enforcement

ERISA contains criminal and civil sanctions for failure to comply with its requirements.¹⁷⁷ While willful failure to comply is a criminal offense subject to fine, imprisonment, or both, the more likely risk of noncompliance with regard to a welfare plan is that the plan is exposed to suit by participants. ERISA § 502(g) authorizes courts to award reasonable attorneys' fees and costs to either party.

¹⁷⁴ See 63 Fed. Reg. 48392, note 5 (preamble to the proposed claims regulations, Sept. 9, 1998)

¹⁷⁵ 29 C.F.R. § 2560.503-1(b)(5).

¹⁷⁶ 29 C.F.R. § 2560.503-1(b)(3).

¹⁷⁷ The criminal penalties are set forth in § 501 and civil enforcement in § 502.

PART FIVE

OTHER CONSIDERATIONS

I. FEDERAL PRE-EMPTION

One of the goals of ERISA is to establish a uniform federal law applicable to employee benefits. To achieve this goal, ERISA § 514 pre-empts any state law which “relates to” employee benefit plans. The scope of federal pre-emption under ERISA continues to evolve through a series of cases addressing this issue. Early court decisions adopted a broad interpretation of what it means for a state law to “relate to” employee benefit plans. In general, a law was deemed to “relate to employee benefit plans” if it had a “connection with” or “reference to” such plans.¹⁷⁸ Since 1995, and the U.S. Supreme Court’s decision in *New York State Conference of Blue Cross & Blue Shield Plans*,¹⁷⁹ courts have continued to limit the previously expansive scope of ERISA pre-emption, but have yet to define a clear standard.¹⁸⁰

There is one important exception to the broad scope of federal pre-emption. ERISA excepts from pre-emption any state laws dealing with insurance, banking, securities or criminal matters.¹⁸¹ Since long-term care insurance is insurance, a state may indirectly regulate long-term care insurance plans, whether funded with individual policies or group policies, through their powers to regulate the insurance industry and the underlying insurance policy.¹⁸²

II. NON-DISCRIMINATION LAWS

A long-term care plan will be subject to federal (and potentially state) equal employment opportunity laws. These laws need to be examined when establishing the plan, most particularly when determining eligibility for benefits and any required contributions. A detailed and complete discussion of these laws is beyond the scope of this Study. This section is intended to highlight the general rules, discuss potential exemptions and provide the practitioner with guidance as it applies to individual long-term care insurance where such guidance is available.

A. Age Discrimination

The federal Age Discrimination in Employment Act (“ADEA”)¹⁸³ prohibits discrimination in employment based on age. Individuals in the age group of 40 and older are protected under the ADEA.¹⁸⁴ If an individual falls within this protected group, the ADEA forbids employers from making hiring or firing decisions based on age or discriminating as to compensation or other terms or conditions of employment. The ADEA applies to private employers engaged in an

¹⁷⁸ *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724 (1985).

¹⁷⁹ 514 U.S. 645 (1995).

¹⁸⁰ *See, e.g., DeBuono v. NYSA-ILA Medical & Clinical Services Fund*, 520 U.S. 806 (1997); *Boggs v. Boggs*, 520 U.S. 833 (1997); *California Div. of Labor Standards Enforcement v. Dillingham Construction, N.A., Inc.*, 519 U.S. 316 (1997).

¹⁸¹ ERISA §§ 514(b)(2)(A) and 514(b)(4).

¹⁸² *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724 (1985).

¹⁸³ 29 U.S.C. §§ 623(a)(1) and 631(a).

¹⁸⁴ 29 U.S.C. § 631.

activity affecting commerce that have at least 20 employees on each working day during 20 weeks per year.¹⁸⁵ Thus, very small employers are generally not subject to this law.

If the law applies, the ADEA provides an exception for employers who observe the terms of a bona fide employee benefit plan that is not a subterfuge to avoid the purposes of the ADEA. A plan is considered bona fide if its terms have been accurately described in writing to all employees and if it actually provides benefits in accordance with the terms of the plan.¹⁸⁶

Congress strengthened the ADEA in 1990 by passage of the Older Workers Benefit Protection Act (“OWBPA”).¹⁸⁷ The OWBPA amended the ADEA to include coverage of benefit programs by codifying “equal benefit or equal cost” principles developed by the Equal Employment Opportunity Commission (“EEOC”). This principle essentially says that older workers must receive benefits equal to benefits received by younger workers, unless the reduction is justified by a greater cost. To date, no definitive guidance is available relative to the application of the ADEA to age-weighted individual long-term care insurance policies offered through an employer plan. According to EEOC regulations, however, an employee in the protected age group may be required, as a condition of participation in a voluntary plan, to make a greater contribution than a younger employee only if the older employee is not thereby required to bear a greater proportion of the total premium.¹⁸⁸

Based upon this guidance, using age-weighted individual policies should not create an ADEA issue if: (1) the premiums are fully paid by the employer; (2) the premiums are fully paid by the employee; (3) the employer pays the same percentage of the premiums for all employees regardless of age; or (4) the employer provides the same benefits to all employees eligible to participate irrespective of age. This last technique can be implemented by taking a defined benefit approach to planning.

B. Sex Discrimination

Sex discrimination in the workplace is prohibited under three separate acts of Congress: the Equal Pay Act, the Civil Rights Act¹⁸⁹ and the Pregnancy Discrimination Act. In general, if eligibility for benefits and benefit levels are not gender-rated, plans will survive legal scrutiny. The practitioner should ensure, however, that the employer’s eligibility classifications do not, in fact, result in sex discrimination.

¹⁸⁵ 29 U.S.C. § 630(b).

¹⁸⁶ 29 U.S.C. § 623(f); 29 C.F.R. § 1625.10.

¹⁸⁷ Pub. L. No. 101-433 (1990).

¹⁸⁸ 29 C.F.R. § 1625.10. To date, only one court has applied the EEOC’s equal benefit/equal cost safe harbor. *Erie County Retirees Assn. v. County of Erie*, 140 F.Supp.2d 466 (W.D.Pa. 2001), *on remand from* 220 F.3d 193 (3rd Cir. 2000).

The ADEA regulations do not specifically address the application of the ADEA to retiree health plans and many practitioners believe that the ADEA does not apply to such plans. Recently, this position has been called into question by the Third Circuit Court of Appeals, which held in *Erie County Retirees Assn. v. County of Erie* that the ADEA does apply to retirees and retiree health plans. *Erie County Retirees Assn. v. County of Erie*, 220 F.3d 193 (3rd Cir. 2000), *cert. denied*, 121 S.Ct. 1247 (2001).

¹⁸⁹ The Civil Rights Act also prohibits discrimination based upon race, religion, national origin, creed and certain other protected class status. Practitioners should be aware of these requirements and a plan should not discriminate on any of these bases.

1. Equal Pay Act

The Federal Equal Pay Act requires that men and women receive equal compensation for work that requires equal skill, effort and responsibility.¹⁹⁰ There are exceptions, however, where differences in wages result from a seniority or merit system, a system measuring compensation on the basis of number or quality of units produced, or systems other than those based on sex. Any violation of the Equal Pay Act is also a violation of Title VII of the Civil Rights Act (discussed in the text that follows).¹⁹¹

2. Civil Rights Act

Title VII of the Civil Rights Act prohibits discrimination in hiring and firing employees as well as discrimination in the conditions or privileges of employment.¹⁹² Title VII applies to private or governmental (other than federal) employers engaged in an activity affecting interstate commerce, if it has at least 15 employees each day for 20 weeks per year.¹⁹³ Regulations issued by the EEOC, the agency charged with enforcing Title VII, provide, in relevant part, that it is unlawful for an employer to

- (a) discriminate between men and women as to fringe benefits, including insurance and other employee benefit plans;
- (b) condition benefits on an employee's status in the family, *e.g.*, "head of household"; or
- (c) provide for different benefits to the dependents of men and women employees.

3. Pregnancy Discrimination Act

The Pregnancy Discrimination Act ("PDA"),¹⁹⁴ an amendment to Title VII of the Civil Rights Act, elaborates on Title VII's prohibitions against sex discrimination. It provides that discrimination based on pregnancy, childbirth or a related medical condition is considered sex discrimination.¹⁹⁵ Under the PDA, pregnancy, childbirth and related medical conditions are to be treated in the same way as other temporary disabilities.

Under all three of these laws, employers are potentially subject to a claim of sex discrimination. Most employers can avoid this claim by simply not taking gender into account in plan design.

¹⁹⁰ 29 U.S.C. § 206(d).

¹⁹¹ 29 C.F.R. § 1620.27.

¹⁹² 42 U.S.C. § 2000e-2(a).

¹⁹³ 42 U.S.C. §§ 2000e(b) and (h).

¹⁹⁴ Pub. L. No. 95-555, 92 Stat. 2076 (1978), adding subsection (k) to 42 U.S.C. § 2000e.

¹⁹⁵ *Id.*

C. Americans with Disabilities Act

Under the Americans with Disabilities Act (“ADA”)¹⁹⁶ it is unlawful for an employer to discriminate with respect to the fringe benefits it offers to its employees on the basis of disability.¹⁹⁷ Generally any employer employing 15 or more employees for each working day in each of 20 or more calendar months is a subject to the ADA.¹⁹⁸ The ADA also prohibits an employer from entering into contractual arrangements such as insurance contracts that have the effect of discriminating on the basis of disability. Under the language of the ADA and regulations issued by the DOL, an insurer that administers benefit plans may underwrite, classify and administer risks that are not inconsistent with state law. Also, an employer may sponsor and administer the terms of a bona fide plan that are based on underwriting risks, classifying risks or administering risks if they are not inconsistent with state law and are not a subterfuge to evade the purposes of the ADA.¹⁹⁹

Because underwriting for long-term care coverage must look to an individual’s functional status (*i.e.*, the ability to perform certain activities of daily living), potential ADA issues could arise if an employee is denied coverage. Under interim EEOC guidance addressing the interrelationship of the ADA and health insurance, insurance distinctions that are not based on disabilities and apply equally to all employees are permissible.²⁰⁰ For example, an employer may underwrite for those who smoke because this status is at least potentially applicable to all employees. On the other hand, according to the EEOC, underwriting distinctions that are based on disability status (*e.g.*, individuals who have cancer) may violate the ADA. At this time, it is not clear whether the DOL believes its guidance for health plans applies to long-term care insurance. This is an evolving issue that will need to be examined when a program is implemented and monitored as case law and regulatory guidance become available. Practitioners should understand the underwriting criteria used for the individual policies and assess their status under the ADA.

D. State Non-Discrimination Laws

ERISA § 514 generally preempts state laws governing age and sex discrimination as they relate to employee benefit plans.²⁰¹ ERISA does not, however, pre-empt federal law relating to discrimination. In *Shaw v. Delta Air Lines, Inc.*, the U.S. Supreme Court held that ERISA also does not preempt state civil rights laws that relate, directly or indirectly, to employee benefit plans, to the extent the state law duplicates protection provided under federal civil rights law.²⁰² These state laws, the Court reasoned, form an important part of the enforcement scheme of the federal law. However, if the state laws provide greater rights and protections than the federal laws, they no longer support the federal law and, as a result, may be pre-empted by ERISA.²⁰³

¹⁹⁶ 42 U.S.C. § 12101 *et seq.*

¹⁹⁷ 29 C.F.R. § 1630.4(f).

¹⁹⁸ Note that the 15-employee test for coverage under the ADA has many special rules (*e.g.*, rules governing employers having common management or ownership with other employers) and one should assume that most employers are covered by the ADA or may be covered in the near future.

¹⁹⁹ 29 C.F.R. § 1630.16(f).

²⁰⁰ EEOC Interim Guidance on Application of ADA the Health Insurance (June 8, 1993), *reprinted in* Bureau of National Affairs (BNA), EEOC Compliance Manual, N:2301, N:2303.

²⁰¹ ERISA § 514(d).

²⁰² *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 102 (1986).

²⁰³ *Id.* at 103.

While *Shaw* concerned claims of sex discrimination (based on pregnancy), other courts have extended this reasoning to other types of discrimination.²⁰⁴

III. FAMILY AND MEDICAL LEAVE ACT

Under the Family and Medical Leave Act of 1993 (“FMLA”),²⁰⁵ employers must make available to eligible employees unpaid leave for up to 12 weeks per year in connection with the birth or adoption of a child, because of the employee’s serious health condition, or to allow the employee to care for a child, spouse or parent with a serious health condition. FMLA applies to private-sector employers with 50 or more full or part-time employees for each working day during each of 20 calendar work weeks in the current or preceding calendar year. Thus many small employers using individual long-term care policies will be exempt from the FMLA.²⁰⁶

Under the FMLA, employers must maintain “group health plan” coverage in effect at the time a FMLA leave commences. The employer may require the employee to pay for this coverage at active employee rates. Group health plan coverage is defined to mean, in relevant part, a plan of or contributed to by an employer (including a self-employed person) to provide health care to employees and others.²⁰⁷

There is a question regarding whether the FMLA health continuation rules apply to long-term care plans funded by individual policies. There are three arguments that it does not. First, long-term care benefits, while treated as accident and health plans for Internal Revenue Code §§ 105 and 106 purposes, are not the type of “health benefits” contemplated by Internal Revenue Code § 5000. Therefore they should not be considered “group health plans” under the FMLA.

Second, the COBRA continuation requirements under Internal Revenue Code § 4980B specifically utilize the Internal Revenue Code § 5000 definition of “group health plan.” Under COBRA,²⁰⁸ long-term care insurance is specifically excluded from the definition of a group health plan under Internal Revenue Code § 5000. Arguably a similar exclusion should apply for FMLA purposes.

Finally, an argument can be made that long-term care insurance is not a “group health plan” within the meaning of the FMLA regulations themselves. The FMLA regulations provide that the term “group health plan” does not include an insurance program providing health coverage under which employees purchase individual policies from insurers provided that:

- (1) no contributions are made by the employer;
- (2) participation in the program is completely voluntary for employees;

²⁰⁴ See, e.g., *Tompkins v. United Healthcare of New England, Inc.*, 203 F.3d 90 (1st Cir. 2000) (applying *Shaw* to discrimination claims under the ADA).

²⁰⁵ Pub. L. No. 103-3, 107 Stat. 6 (1993), codified at 29 U.S.C. §§ 2601 *et seq.*

²⁰⁶ 29 C.F.R. § 825.104(a). FMLA also applies to state and local government employees, federal government employees, and congressional employees. 29 C.F.R. § 825.109. Public agencies are covered employers without regard to the number of employees. 29 C.F.R. § 825.104(a); see 29 C.F.R. § 825.108 for the definition of a public agency. Private elementary and secondary school employers are also covered without regard to the number of employees. 29 C.F.R. § 825.104(a). Also, some states have their own version of a family and medical leave law, which may apply to smaller employers or impose additional requirements as compared to the federal FMLA. Legal counsel should be consulted regarding the application of state law.

²⁰⁷ 29 U.S.C. § 2614(c); I.R.C. § 5000.

²⁰⁸ I.R.C. § 4980B(g)(2).

- (3) the sole functions of the employer with respect to the program are, without endorsing the program, to permit the insurer to publicize the program to employees, to collect premiums through payroll deductions and to remit them to the insurer;
- (4) the employer receives no consideration in the form of cash or otherwise in connection with the program, other than reasonable compensation, excluding any profit, for administrative services actually rendered in connection with payroll deduction; and
- (5) the premium charged with respect to such coverage does not increase in the event the employment relationship terminates.²⁰⁹

This third argument may not be a particularly strong one because it is unlikely that most employer sponsored long-term care plans using individual policies have the requisite level of employer neutrality to satisfy the exemption,²¹⁰ but each practitioner will need to make this determination for his or her own client.

The most conservative approach would be to assume that FMLA applies and have the employer continue to collect premiums from employees for the policies either through advance payments before the leave, on a pay-as-you-go basis during the leave, or through catch-up contributions once the employee returns.

Under FMLA, when an employee returns to work, the employer must reinstate him or her to the coverage on the same terms as existed prior to the leave. No waiting period or elimination period may be imposed; no physical examination may be required, and pre-existing conditions exclusions may not be imposed.²¹¹ These are restrictions on the employer, not on any insurer of the relevant coverage. Thus, if an employee does not pay for the coverage during the leave, the employer may have to pay for the coverage during the leave to ensure continued coverage on return to work. However, any amounts so paid may be collected from the employee as long as the employer follows the rules set out in the FMLA for collecting these amounts.

IV. STATE INSURANCE LAWS

States have the authority to regulate insurance. Since most long-term care insurance plans are insured plans, state regulation has a significant impact on the coverage available, eligibility requirements and other plan provisions. The National Association of Insurance Commissioners (“NAIC”) has developed a Model Act and Model Regulations governing long-term care for chronically ill individuals. Many states have adopted legislation based on the NAIC model; however, each state has the option of varying the provisions of the Model Act and Model Regulations. All states have adopted at least a portion of the Model Act. Some have adopted legislation or regulations that go beyond the requirements of the Model Act while others fall short of having all the sections. In addition, states may adopt legislation independent of the NAIC model or none at all. As noted previously, many states have also adopted laws that permit the offering of individual discounted policies to eligible employees and their dependents as “franchise group insurance.” An examination of the state laws affecting long-term care insurance in all 50 states is beyond the scope of this Study.

²⁰⁹ 29 C.F.R. § 825.209(a) and (b).

²¹⁰ See the discussion in Part Four, Section II.C.

²¹¹ 29 C.F.R. § 825.209(e).

PART SIX

CASE STUDIES

A. Introduction

The following case studies are intended to provide the reader with a further understanding of the tax and ERISA implications of an employer's establishment of a long-term care insurance plan. (For additional information regarding the tax and ERISA implications of establishing a long-term care insurance plan, see Part Two, entitled "Federal Tax Consequences," and Part Four, entitled "Application of ERISA.")

B. Sole Proprietors

CASE 1: Assume a 45-year-old sole proprietor that employs one other individual as a common law employee. The sole proprietor desires to purchase tax-qualified individual expense reimbursement-type long-term care policies for himself and his spouse who is also 45.

Analysis: Because there are no tax nondiscrimination rules that apply to long-term care insurance plans, the sole proprietor may establish a program that covers only him. Under Internal Revenue Code § 162, he may also cover his spouse using business assets. As a result, he may purchase the policy through his business as a business expense. In 2001, he will be entitled to deduct 60 percent of \$430 (the maximum amount of "eligible long-term care premiums")²¹² or \$258 for himself and the same amount for his spouse. He also may include \$172 (\$430 - \$258) for himself and the same for his spouse towards the 7.5 percent limit on unreimbursed personal medical expenses on their joint tax return. Any premiums in excess of \$430 may not be deducted. As they age, the eligible premium increases and they will be able to deduct a higher premium amount. Any benefits paid to either him or his spouse will not be subject to tax.

As discussed in Part Four, the program will not be subject to ERISA because the plan does not cover any employees. (Neither the sole proprietor nor his spouse is considered an employee for this purpose.)

While it would be prudent to have the sole proprietor document the establishment of a program for himself, this is not required. A plan document and SPD are also not required.

CASE 2: Assume the same facts as above, but the sole proprietor also wishes to purchase tax-qualified coverage for his employee, who is 45 years old.

Analysis: The tax consequences for the owner and his spouse remain the same as in Case 1. The sole proprietor will be able to deduct on his tax return the entire amount of the premiums he pays for the *employee* as a business expense. The employee will not be taxed on the value of the premiums. In addition, any benefits the employee may receive under the policy will be tax-free to her.

The sole proprietor has now established an employee welfare benefit plan subject to ERISA. Even though he has covered only one employee, the exception for plans without employees would not apply.

²¹² See *supra* note 45 and accompanying text for a definition of "eligible long-term care premiums."

However, the small employer exception under ERISA would apply, and as a result he would be relieved of certain ERISA requirements, such as those requiring the completion of an annual report.

To adopt the plan, the sole proprietor should take some action documenting the adoption. He should also prepare a plan document as required by ERISA. Since the exemption for plans without employees no longer applies, the proprietor and the employee would *both* be participants in the plan. Accordingly, assuming that the proprietor and the employee are not both members of a select group of management or highly-compensated employees (*i.e.*, the plan is not eligible for the SPD exemption described at Part Four, Section III.C), the sole proprietor would prepare an SPD for distribution to both the sole proprietor and the employee.

C. Partnerships

CASE 3: Assume an 11-person law firm with 3 partners, 4 associates and 4 support staff. The partners desire to purchase individual tax-qualified long-term care policies for themselves and their spouses.

Analysis: The partnership may deduct the premiums paid as a guaranteed payment and the amount of the premium for a partner will be income to the partner. The same analysis as set forth in Case 1 applies in determining the deductibility of such amount by the partner.

CASE 4: Assume the same facts as in Case 3, but the partners also want to purchase policies for the associates but not their spouses.

Analysis: The partnership and the partners will receive the same tax treatment as described in Case 3 with respect to premiums paid to partners. The partnership may cover the associates and exclude the associates' spouses. The partnership will be able to deduct the premiums paid for the associates as a business expense. The associates, who are employees, will not be taxed on the value of the premiums or on any benefits received. The partnership will have established an ERISA plan because the plan now covers employees. The partnership should document the adoption of the plan, have a written plan document and distribute an SPD to all participants (including the partners and the associates) in a manner consistent with ERISA's small employer exception (described in Part Four, Section III.B). If the partnership is concerned about associates knowing that the partners' spouses are covered, separate SPDs could be drafted for each group.

CASE 5: Assume the same facts as in Case 4, but the partnership desires to offer tax-qualified coverage to the support staff, but only if the support staff pays the entire premium.

Analysis: For the partners and associates, the analysis described in Case 4 applies. The support staff, if they elect to take the coverage, may pay through after-tax employee contributions or direct pay to the insurance company. In this case, the "eligible long-term care premiums" will be tax-deductible as an itemized deduction by support staff only to the extent those premiums together with other unreimbursed medical expenses exceed 7.5 percent of the staff person's adjusted gross income. If a support staff person does not itemize deductions (because this deduction, together with other allowable itemized deductions does not exceed the individual's standard deduction) the individual will receive no tax benefit from the premium payment. There are no direct tax benefits to the staff person of participating in the employer program (as opposed to obtaining insurance on an individual basis). The staff person may, however, receive a discount on the premium from the insurer because the long-term care insurance is purchased on an employer sponsored basis.

This is an ERISA plan. In this case, because of the difference in the premium payments and plan design for different categories of participants, it may be worthwhile to have separate SPDs for each category.

D. C Corporations

CASE 6: Assume a C corporation with 25 employees, two of whom are owners. The corporation desires to purchase individual tax-qualified long-term care insurance for “key employees,” *i.e.*, the shareholder-employees, as well as their spouses.

Analysis: Because the corporation is a C corporation, the shareholder-employees are considered “Employees” for tax purposes rather than Self-Employed Owners. Therefore, the premiums will not be taxed to them (assuming the premiums are considered reasonable compensation). Any benefits received will be tax-free. The corporation will be able to deduct the entire amount of premiums paid (assuming again that the premiums are reasonable compensation). In order avoid any question regarding whether the premiums are constructive dividends to the shareholder-employees, the practitioner should ensure (and document) that the insurance is being provided to them because of their status as employees, and not because of their status as shareholders.

Because the plan participants are common law employees, and the no-employee ERISA exemption does not apply,²¹³ the plan is subject to ERISA. The ERISA executive only exemption (*i.e.*, the exemption for plans maintained for a “select group of management or highly compensated employees”) may apply however. Assuming the shareholder-employees fall within this category, the ERISA requirements are minimal. The employer need only adopt a plan (including a claims procedure). The practitioner will need to examine the impact of collateral laws such as Title VII and the Americans with Disability Act on the program, as discussed in Part Five.

CASE 7: A C corporation with 100 employees takes a defined benefit approach to long-term care benefits under which all employees with the title of President, Vice President or Manager are provided with a basic tax-qualified long-term care policy that is paid for by the employer. Eligible employees may purchase enhanced benefits under the policy on an after-tax basis through payroll deduction.

Analysis: The tax analysis is the same as in Case 6 for the employer contributions. An employee electing enhanced benefits is entitled to deduct as an itemized deduction his or her after-tax premiums up to the “eligible long-term care premium” limitation to the extent they, together with any other unreimbursed medical expenses, exceed 7.5 percent of the employee’s adjusted gross income.

From an ERISA perspective, the plan automatically fails the executive only exemption because it is contributory, *i.e.*, it permits employee contributions.²¹⁴ The small plan exception will, however, apply. That exception applies if there are fewer than 100 participants in the plan. Under this exemption, the plan will be subject to many ERISA requirements, but not the requirement to file an annual report. In order to comply with ERISA, the corporation will need to formally adopt the plan, prepare a plan document and prepare and distribute SPDs to all participants.

²¹³ The corporation is not owned by just one person (or just one person and his or her spouse).

²¹⁴ Depending on the number of employee eligible to participate and their compensation and responsibilities within the corporation, it may be that the category of eligible employees has expanded too much to be considered a “select group of management or highly-compensated employees,” so that the plan also fails to satisfy the exemption for this reason. Ultimately, of course, this is a factual determination.

CASE 8: Assume the same facts as in Case 7, but all other employees are entitled to participate if they pay any required premiums on an after-tax basis.

Analysis. The tax analysis is the same as in Case 7. An employee participating only through after-tax contributions is entitled to deduct, as an itemized deduction, his or her long-term care premiums up to the “eligible long-term care premiums” limitation to the extent that they, along with the employee’s other unreimbursed medical expenses, exceed 7.5 percent of adjusted gross income.

If all 100 employees participate at the beginning of the plan year, the employer will lose the benefit of the small employer exception and, in addition to satisfying the other ERISA requirements described in Case 7, the employer must file an annual report and distribute a summary annual report on forms prescribed by the IRS and the DOL. Because of the differences in the benefits provided to the two categories of employees, the employer will want to consider separate SPDs.

E. S Corporations

CASE 9: Assume an S corporation with 25 employees. The corporation desires to purchase individual long-term care insurance for shareholder-employees, each of whom owns more than 2 percent of the corporation, and their spouses. The corporation will pay all of the premiums.

Analysis: The tax consequences are the same as in Case 3, *i.e.*, the corporation may deduct the premiums and the shareholder-employees must include the premium payments made by the corporation into their taxable income. The shareholder-employees may deduct 60 percent (through 2001) of “eligible long-term care premiums” as a business deduction. Any excess “eligible long-term care premiums” may be added in with the shareholder-employees’ other unreimbursed medical expenses for the year and deducted as a personal medical itemized deduction to the extent that they exceed 7.5 percent of the shareholder-employees’ adjusted gross income.

While these shareholder-employees are treated like the partners in Case 3 (and not employees) for tax purposes, the same is not true under ERISA. As a result, the non-employee exemption is not available. The executive only exemption may be available, but once again this will be a factual determination. The employer should formally adopt the plan, and, unless the executive only exemption is available, prepare SPDs for all plan participants.

CASE 10: Assume the same facts as in Case 7, but the entity is an S corporation. Some of the eligible employees are shareholder-employees owning more than 2 percent of the corporation and some are not.

Analysis: The tax analysis is the same as in Case 9 for the more than 2 percent shareholder-employees. That is, these individuals must include the corporation’s premium payments into their taxable income. They may take a business deduction for a portion of the corporation’s premium payments, as well as their own premium payments if they elect enhanced coverage. They may take a business deduction equal to 60 percent (through 2001) of “eligible long-term care premiums.” Any excess “eligible long-term care premiums” may be added in with their other unreimbursed medical expenses for the year and deducted as a personal medical itemized deduction to the extent they exceed 7.5 percent of the shareholder’s adjusted gross income. As for the other employees participating in the arrangement, the employer contribution will be excluded from their income. The employees’ after-tax contributions used to purchase enhanced benefits (up to the “eligible long-term care premium” limitation) may be added together with other unreimbursed medical expenses and deducted as an

itemized deduction to the extent total unreimbursed medical expenses exceed 7.5 percent of adjusted gross income.

The ERISA analysis is the same as described in Case 7. The same plan implementation process should be followed.

CASE 11: Same facts as in Case 8, but the entity is an S corporation.

Analysis: The tax analysis for the more than 2 percent shareholder-employees and the other key employees is the same as in Case 10. For other employees participating through after-tax contributions only, their itemized medical deduction will be limited by the “eligible long-term care premiums” limitation and by the 7.5 percent of adjusted gross income threshold.

The plan will be subject to ERISA. If all employees actually participate at the beginning of the plan year, the small employer exception will not apply. The same plan implementation process as set forth in Case 8 should be followed. As in Case 8, this may be an appropriate circumstance to consider separate SPDs for different categories of employees.

PART SEVEN

CONCLUSIONS

Long-term care insurance is a popular and valuable employee benefit that can be provided through individual long-term care insurance policies. When arranged for or offered by an employer, whether or not paid for by the employer, these policies may provide an economical way for an employer to attract and retain employees and protect the employee and his or her family members from unneeded financial strain.

When the employer helps fund this coverage for its employees, the tax benefits may be considerable. If structured well, the sponsorship of these plans should not create any unnecessary burdens to the employer under ERISA or ancillary laws.

APPENDIX

The Appendix provides annotated sample forms to assist employers and their attorneys in adopting an employer sponsored long-term care insurance plan using individual policies. As noted on each form, the forms are intended for the use of legal counsel only. Counsel is in a position to assess their application to the circumstances of a particular employer and make necessary modifications.

Form 1 is a sample board resolution adopting the long-term care insurance plan.

Form 2 is a sample plan document.

Form 3 is a sample summary plan description.

Each form is preceded by an explanation of its application.

Explanation of Form 1

BOARD RESOLUTION ADOPTING LONG-TERM CARE INSURANCE PLAN

PURPOSE: To document the formal adoption of an employer sponsored long-term care insurance plan using individual policies as a funding vehicle.

- NOTES:**
- (1) The drafter will need to ascertain the proper name of the entity's governing body. For corporations, it is usually a Board of Directors. For LLC's, it may be a Board of Governors. For partnerships, a Resolution of Partners may be required.
 - (2) The drafter should identify if dependents or others are to be covered under the plan. If not, all references to dependents should be deleted.
 - (3) The Company should designate a plan administrator. In most cases this will be the Company and the secretary of the organization is assumed to hold all plan related documents unless otherwise specified.
 - (4) The Sample Plan Document (*Form 2*) authorizes the indemnification of plan fiduciaries. This is permitted by ERISA and 29 C.F.R. § 2509.75-4. Most fiduciaries desire this type of protection. Insurance also may be purchased for this purpose. The validity and scope of indemnification will depend on local law as determined by the Company and its counsel. If no indemnification or lesser indemnification is desired, the plan's indemnification section will need to be revised. If limited indemnification is desired, the Board resolution should clarify who will be indemnified, for what, and to what extent.

**Form 1
Sample Resolution**

¾ For the Use of Legal Counsel Only ¾

**RESOLUTION ADOPTED
BY THE
BOARD OF [DIRECTORS] [_____]^(NOTE 1) OF [INSERT EMPLOYER
NAME] ADOPTING THE [INSERT EMPLOYER NAME]
LONG-TERM CARE INSURANCE PLAN**

WHEREAS, the Board considers it desirable and in the best interests of [insert company name] (the “Company”) and [its] [certain of its] employees that it provide [its] [certain of its] employees with long-term care insurance under an employer sponsored long-term care insurance plan.

WHEREAS, the [insert name of Company] Long-Term Care Insurance Plan (the “Plan”), a plan designed to provide benefits to [certain of the] employees of the Company [and their spouses] [dependents],^(NOTE 2) has been presented to [the Board] for its review.

WHEREAS, the Board has reviewed the terms of the Plan and found it to be satisfactory in all respects.

NOW, THEREFORE, BE IT RESOLVED, that the [insert name of Company] Long-Term Care Insurance Plan as presented to the Board of Directors is hereby approved and adopted in all respects as an employee benefit plan of the Company, effective as of _____, 20__, and the President of the Company is hereby authorized to execute the Plan on behalf of the Company.

FURTHER RESOLVED, that the [Vice President of Human Resources] of the Company is hereby authorized and directed to take all necessary or appropriate steps to implement the Plan.

FURTHER RESOLVED, that the [Company]^(NOTE 3) is hereby designated as the Plan Administrator of the Plan and the [Secretary] is directed to maintain a copy of the Plan with the permanent records of the Company and to make duplicates thereof available to participating employees upon request.^(NOTE 4)

Explanation of Form 2

PLAN DOCUMENT

PURPOSE: To satisfy ERISA’s plan document requirements and to provide an administrative structure for the Plan.

- NOTES:**
- (1) See definition in Section 2.1(c) of the Document.
 - (2) If an amendment and restatement, add the following language: “This Plan replaces and supersedes any and all similar plans or programs sponsored or maintained by the Company, in whole or in part, for the benefit of Eligible Individuals.”
 - (3) If dependents are not offered coverage under the Plan, delete all reference to Dependents. See discussion regarding dependents in Part Three, Section II.E, entitled “Dependents.”
 - (4) If this is not intended to be an ERISA plan, delete references to ERISA but not to the Internal Revenue Code. See Part Four of this Study.
 - (5) Insert a description of the class of eligible individuals here. See Parts Three and Five of the Study for issues that may arise in determining the eligible class.

The term “Eligible Individual” should be defined in the Plan to include partners and other owners, as appropriate. Independent contractors or others should be specifically excluded, as appropriate.

- (6) This generally should be the Company’s fiscal year. This date will determine when annual reports, if required, for the Plan are due. See Part Four, Section III.D.2 entitled, “The Annual Report.”
- (7) Delete if the plan is paid by employer contributions only.
- (8) Describe how employee contributions are paid, *e.g.*, after-tax payroll deductions.
- (9) The summary claims procedures described herein are based on the claims procedures regulations issued November 21, 2000, and effective for claims filed on or after January 1, 2002. 65 Fed. Reg. 70246. The claims requirements differ according to the type of plan, with additional requirements and shorter timeframes applying to group health plans and disability plans. For purposes of this Study, we have assumed that the long-term care insurance plan is *not* a group health plan or disability plan. See *Form 3*, Notes 3 and 10 for more information regarding this issue.

For plans that are exempt from the requirement that an SPD be provided (see Part Four, Section III.C of the Study), this claims section of the Plan may be copied and provided to employees upon request.

- (10) The named fiduciary may be an individual designated by name or office held (*e.g.*, President, Human Resources Director, etc.) or may be the Company or its Board of Directors. This form assumes that the Company is designated as the named fiduciary.
- (11) As discussed in the Board Resolution comments, the validity and scope of indemnification will depend on local law and will have to be determined by the employer's legal counsel. Indemnification is permitted under ERISA. 29 C.F.R. § 2509.75-4.
- (12) It may be useful to delegate amendment authority to an officer to avoid the need to have all amendments brought to the Board.

Comment: See Part Three entitled "Plan Design and Implementation" for additional background.

Form 2
Annotated Sample Plan Document

*This plan document assumes the plan is subject to ERISA.
See Part Four for a full explanation
of the ERISA plan document requirement.*

¾ For the Use of Legal Counsel Only ¾

[COMPANY NAME]
LONG-TERM CARE INSURANCE PLAN

[Effective _____, 20__]
[Amended and Restated _____, 20__]

Article I. Establishment and Interpretation of the Plan

Section 1.1 Establishment. _____ (the “Company”)^(NOTE 1) hereby [adopts][amends and restates],^(NOTE 2) effective as of _____, 20__, the _____ Long-Term Care Insurance Plan (the “Plan”) which is a welfare benefit plan providing long-term care insurance for the exclusive benefit of Eligible Individuals [and Dependents]^(NOTE 3) of the Company.

Section 1.2 Purpose. The purpose of the Plan is to provide to Participants and [their Dependents] certain welfare benefits described herein. The Plan is intended to meet all applicable requirements of the Employee Retirement Income Security Act of 1974, as amended (“ERISA”) and the Internal Revenue Code of 1986, as amended (“I.R.C.”), as well as rulings and regulations issued or promulgated thereunder.^(NOTE 4)

Article II. Definitions, Gender and Number

Section 2.1 Definitions. Whenever used in the Plan, the following words and phrases shall have the meanings set forth below unless the context plainly requires a different meaning, and when the defined meaning is intended, the term is capitalized:

- (a) “Board” means the Board of _____ of the Company as constituted at the relevant time.
- (b) “Internal Revenue Code” or “Code” means the Internal Revenue Code of 1986, as amended from time to time, and any successor statute. References to an Internal Revenue Code section shall be deemed to be that section or to any successor to that section.
- (c) “Company” means [insert name], and its successors.
- (d) “Effective Date” means _____, 20__.
- (e) “Dependent” means an individual who qualifies as a dependent under the terms of Code § 152.

(f) “Eligible Individual” means _____^(NOTE 5).

Comment: This section 2.1(f) should refer to the group of persons the employer intends to cover. Selected Options, from most restrictive to least restrictive, are as follows:

Option 1: Select Group – by the Individuals’ Names

“Eligible Individual” means an individual providing services to the Company whose name appears on Appendix A. [If this option is used, add an appendix to this document.]

Option 2: Select Group by Class

“Eligible Individual” means an employee of the Company who is classified as the President or a Vice President.

Option 3: Larger Classes

“Eligible Individual” means all individuals providing services to the Company and classified by the Company as [Partners][Associates] [Define terms.]

Option 4: All Full-Time Employees

“Eligible Individual” means all employees who are regularly scheduled to work ____ hours per week for the Company.

(g) “ERISA” means the Employee Retirement Income Security Act of 1974, as amended from time to time.

(h) “Insurer” means the insurance company issuing the policy or policies providing benefits under the Plan.

(i) “Participant” means an Eligible Individual [or Dependent] who has satisfied the participation requirements of Article III.

(j) “Plan” means the _____ Long-Term Care Insurance Plan, as set forth herein and as may be amended or restated from time to time.

(k) “Plan Administrator” means the Company, unless another entity or person is appointed by the Company to administer the Plan pursuant to Section 7.4.

(l) “Plan Year” means the twelve (12) consecutive month period ending each _____^(NOTE 6).

(m) “Policy” means a long-term care insurance policy issued by the Insurer and providing benefits to Participants.

Section 2.2 Gender and Number. Pronoun references in the Plan shall be deemed to be of any gender relevant to the context, and words used in the singular may also include the plural.

Article III. Eligibility and Participation

Section 3.1 **Commencement of Participation.** An Eligible Individual shall become a Participant in the Plan as of [their date of hire] [or, specify elimination period, if applicable, *e.g.*, first day of the month after [one month] [one year] of employment] provided the Eligible Individual [or Dependent] satisfies all the conditions set forth in Section 3.2.

Section 3.2 **Participation Conditions.** As a condition to participation and receipt of benefits under the Plan, an Eligible Individual [or Dependent] agrees to:

- (a) Furnish to the Insurer any required application to participate provided for in Section 3.3 within [thirty (30)] days of becoming an Eligible Individual;
- (b) Observe all rules and regulations implementing the Plan and satisfy any requirements of an Insurer, including any underwriting criteria, as a condition of issuing the Policy;
- (c) Consent to inquiries by the Insurer as provided under the Policy;
- (d) Submit to the Company or such other agents as the Company may designate, all reports, bills and other information which the Company may reasonably require[; and] [.]
- [(e) Agree to make required contributions to the Plan as described in Section 4.1.]^(NOTE 7)

Section 3.3 **Application to Participate.** Each Eligible Individual [or Dependent] shall execute and deliver to the Insurer, a written application by which the Eligible Individual [or Dependent] applies to participate in the Plan and supplies any other pertinent information that the Insurer reasonably requires.

Section 3.4 **Termination of Participation.** In the event a Participant terminates employment for whatever reason, or otherwise ceases to be an Eligible Individual, the Participant shall cease to be a Participant in the Plan as of that date consistent with the Policy. The former Participant may continue to receive long-term care coverage by paying any required premium directly to the Insurer.

Article IV. Funding and Benefits

Comment: Select and customize these alternatives based upon plan design decisions.^(NOTE 8)

Option 1: Employer Pay All

Section 4.1 **Company Contributions.** The Company pays the entire cost of coverage under the Plan. Participant contributions are neither required nor accepted.

Option 2: Employee Pay All

Section 4.1 **Participant Contributions.** The Participant pays the entire cost of coverage under the Plan through [direct payment to the Insurer] [after-tax payroll deductions].

Option 3: Contributory Approach

Section 4.1 **Contributions.**

(a) **Participant Contributions.** The Participant pays the cost of coverage under the Plan to the extent not paid for by the Company.

(b) **Company Contributions.** The Company may, in its discretion, pay all or a portion of the premiums for coverage under the Plan. As of the Effective Date, the Company shall pay [describe percentage of premium or dollar amount]. This amount may be changed at any time by action of the Company provided that the Company provides written notice to all Participants.

Section 4.2 **Funding.** The Plan is funded by [Participant] [and] [Company] contributions. Benefits are provided exclusively through individual qualified long-term care insurance policies. [The Company shall pay to the Insurer when due all premiums required to maintain such insurance in force.] [The Participant shall pay to the Insurer when due all premiums required to maintain such insurance in force.] [The Company shall pay to the Insurer when due all premiums required to maintain such insurance in force for those Participants who have made any required Participant contributions]. Nothing herein requires the Company or the Plan Administrator to contribute to the Plan, or to maintain any fund or segregate any amount for the benefit of any Participant, except to the extent specifically required hereunder. No Participant shall have any right to, or interest in, the assets of the Company.

Article V. Benefits

The Plan provides for long-term care benefits as described in the Policy provided to the Participant which Policy is incorporated herein by reference and made a part hereof. Benefits to be provided hereunder will be provided solely under such Policy. All benefits are subject to the terms and conditions of the Policy.

Article VI. Claims Procedure^(NOTE 9)

Section 6.1 **Written Claim for Insured Benefits.** No benefit shall be paid until the Insurer has received a claim for benefits that satisfies all requirements set forth in the Policy.

Section 6.2 **Claims Procedure for Insured Benefits (Policy Claims).** The claims procedure and appeals procedure for insured benefits shall be as set forth in the Policy. The Insurer shall decide the claim within a reasonable period of time after it is received. If the Insurer denies the claim, in whole or in part, a written notification will be provided, setting forth the reason(s) for the denial. If a claim is denied, the Participant may appeal to the Insurer for a review of the denied claim, in accordance with the procedures and within the time period set forth in the Policy. Refer to the Policy for complete information on the claims and appeals processes. In the event of an adverse determination on appeal, the claimant may pursue other remedies as provided for under ERISA § 502.

Section 6.3 **Other Claims Under the Plan (Non-Policy Claims).** For other claims under the Plan (other than for benefits under the Policy), the Participant must make a claim by delivering a written request to the Plan Administrator. Upon receipt of such request the Plan Administrator may require the Participant to complete such forms and provide such additional information as may be reasonably necessary to establish the Participant's rights under the Plan.

If a claim is wholly or partially denied, the Plan Administrator shall furnish to the Participant a notice of the decision, within ninety (90) days after receipt of the claim by the Plan. If special circumstances require more than ninety (90) days to process the claim, this period may be extended for up to an additional ninety (90) days by giving written notice to the Participant before the end of the initial 90-day period stating the special circumstances requiring the extension and the date by which a final decision is expected. Failure to provide a

notice of decision in the time specified shall constitute a denial of the claim and the Participant shall be entitled to require a review of the denial under the review procedures.

The notice to be provided to every Participant who is denied a claim shall be in writing and shall set forth, in a manner calculated to be understood by the Participant, the following:

- (1) The specific reason(s) for the adverse determination;
- (2) Reference to the specific Plan provision(s) on which the denial is based;
- (3) A description of any additional material or information necessary for the Participant to perfect the claim and an explanation of why such material or information is necessary; and
- (4) An explanation of the Plan's claim review procedure describing the steps to be taken by a Participant who wishes to submit his or her claim for review.

The purpose of the review procedure is to provide a procedure by which a Participant may have a reasonable opportunity to appeal a denial of a claim to the Plan Administrator for a full and fair review. To accomplish that purpose, the Participant or his or her duly authorized representative:

- (1) May request a review upon written application to the Plan Administrator;
- (2) May review and obtain copies of relevant Plan documents, upon request and free of charge; and
- (3) May submit for consideration: written comments, documents, records and other information related to the claim.

A Participant (or his duly authorized representative) shall request a review by filing a written application for review with the Plan Administrator at any time within sixty (60) days after receipt by the Participant of written notice of the denial of his or her claim.

The decision on review of a denied claim shall be made in the following manner:

- (1) The decision on review shall be made by the Plan Administrator, who may in his or her discretion hold a hearing on the denied claim. The Plan Administrator shall make a decision promptly, which shall ordinarily be not later than sixty (60) days after the Plan's receipt of the request for review, unless special circumstances (such as the need to hold a hearing) require an extension of time for processing. In that case a decision shall be rendered as soon as possible, but not later than one hundred twenty (120) days after receipt of the request for review. If an extension of time is required due to special circumstances, written notice of the extension shall be furnished to the Participant prior to the time the extension commences.
- (2) The decision on review shall be in writing and shall include specific reason(s) for the decisions, written in a manner calculated to be understood by the Participant, as well as reference to the specific plan provisions on which the decision is based.
- (3) The Participant may review and obtain copies of relevant Plan documents, upon request and free of charge.

- (4) In the event the decision on review is not furnished to the Participant within the time required, the claim shall be deemed denied on review.

In the event of an adverse determination on appeal, the Participant may pursue other remedies as provided for under ERISA § 502.

Article VII. Administration and Finances

Section 7.1 **Named Fiduciary.** The Company shall be the named fiduciary of the Plan. ^(NOTE 10)

Section 7.2 **Administration.** The Company shall be the Plan Administrator, and, as such, has total and complete discretionary authority to determine conclusively for all parties all questions arising in the administration of the Plan and all relevant facts, except where such authority may have been delegated to another individual or entity pursuant to Section 7.4. It is understood that the Insurer has total and complete discretionary authority to determine conclusively for all parties all questions arising in the administration of the Policy and all relevant facts.

Section 7.3 **Powers of the Company.** The Company, or any agent to whom it has delegated its authority, shall have all powers necessary to administer the Plan, including, without limitation, powers:

- (a) to interpret the provisions of the Plan;
- (b) to establish rules for the administration of the Plan and to prescribe any forms required to administer the Plan; and
- (c) to change plans, contracts or policies and/or insurers or other providers of benefits described Article V of the Plan.

Section 7.4 **Delegation.** The Company shall have the power, by resolution of the Board, to delegate specific duties and responsibilities. Any delegation by the Company, if specifically stated, may allow further delegations by such individual or entity to whom the delegation has been made. The Company may rescind any delegation at any time. Each person or entity to whom a duty or responsibility has been delegated shall be responsible for the exercise of those duties or responsibilities and shall not be responsible for any act or failure to act of any other individual or entity.

Section 7.5 **Reports and Records.** The Company and those to whom the Company has delegated duties and authority under the Plan shall keep records of all their proceedings and actions, and shall maintain all books of account, records, and other data necessary for the proper administration of the Plan and for compliance with applicable laws.

Section 7.6 **Actions of the Company.** The Company (including any person or persons to whom the Company has delegated duties), has discretionary authority to interpret and construe the terms of the Plan and to determine all questions of eligibility and status of employees, Participants, and beneficiaries under the Plan and their respective interests. All determinations, interpretations, rules and decisions of the Company (including those made or established by any person or persons to whom the Company has delegated duties) are conclusive and binding upon all persons having or claiming to have any interest or right under the Plan.

Section 7.7 **Costs.** Except as provided to the contrary, the costs of administering the Plan shall be borne by the Company.

Section 7.8 Indemnification. To the extent permitted by law, the Company shall indemnify the members of the Company's Board, and others to whom the Company has delegated duties and authority pursuant to Section 7.4 who are either employees, officers, or directors of the Company against any and all claims, losses, damages, expenses, and liabilities, arising from their responsibilities in connection with the Plan which are not covered by insurance (without recourse) paid for by the Company, unless due to gross negligence or intentional misconduct. ^(NOTE 11)

Article VIII. Amendments and Termination

Section 8.1 Amendments. The Company shall have the right at any time and from time to time, by resolution of the Board, to amend the Plan, in full or in part, including changing eligibility requirements and the amount of any Participant contributions, such amendment to be effective at the time stated therein. ^(NOTE 12)

Section 8.2 Benefits Provided through Third Parties. In the case of any benefit provided pursuant to an insurance policy or other contract with a third party, the Company may amend the Plan by changing insurers, policies, or contracts without changing the language of the Plan, provided that copies of the contracts or policies are filed with the Plan documents and the Participants are informed of the effects of any changes.

Section 8.3 Termination. The Company expects the Plan to remain in force, but necessarily must, and hereby does, reserve the right to terminate the Plan at any time. Upon termination of the Plan, all Participant and Company contributions will cease and no future Participant or Company contributions will be made. Any such termination shall be evidenced by a resolution of the Board or by action of such other person(s) to whom such action has been delegated by the Board pursuant to Sections 7.4. Neither the Company nor any of its respective officers, directors or employees shall have any further financial obligations under the Plan from and after termination of the Plan except those that have accrued up to the date of termination and have not been satisfied.

Article IX. Miscellaneous

Section 9.1 No Guaranty of Employment. The adoption and maintenance of the Plan shall not be deemed to be a contract of employment between the Company and any Participant. Nothing contained herein shall give any Participant the right to be retained in the employ of the Company or to interfere with the right of the Company to discharge any Participant at any time, nor shall it give the Company the right to require any Participant to remain in its employ or to interfere with the Participant's right to terminate his or her employment at any time.

Section 9.2 Limitation on Liability. The Company does not guarantee benefits payable under any Policy, and any benefits payable thereunder shall be the exclusive responsibility of the Insurer that is obligated under the Policy.

Section 9.3 Nonalienation. No benefit payable at any time under the Plan shall be subject in any manner to alienation, sale, transfer, assignment, pledge, levy, attachment, or encumbrance of any kind by any Participant or beneficiary.

Section 9.4 Applicable Law. The Plan and all rights under it shall be governed by and construed according to the laws of the State of _____, except to the extent those laws are preempted by the laws of the United States of America.

Section 9.5 Benefits Provided Through Insurer. In the case of any benefit provided under a Policy, if there is any conflict or inconsistency between the description of benefits contained in the Plan and the Policy, the terms of the Policy shall control.

Section 9.6 Captions. Article and section headings and captions are provided for purposes of reference and convenience only and shall not be relied upon in any way to construe, define, modify, limit, or extend the scope of any provision of the Plan.

IN WITNESS WHEREOF, the Company has caused this Plan to be executed by its duly authorized [officers][partners] effective as of the ____ day of _____, 200__.

COMPANY:

By: _____

Its: _____

Explanation of Form 3

SUMMARY PLAN DESCRIPTION

PURPOSE: To satisfy ERISA’s SPD requirements.

- NOTES:**
- (1) Describe eligible class. See *Form 2*, Note 5. If dependents are not to be offered coverage, delete all references to dependents.
 - (2) Either the employer or the insurer may impose these eligibility requirements. The general eligibility requirements, such as hours worked per week, classification restrictions, active-at-work condition, and waiting periods, should be stated. In addition, include any applicable special eligibility provisions, such as provisions related to retiree coverage.
 - (3) Detailed benefit information must be provided, but may be provided by reference to a separate schedule or description of benefits, which is available to the participant upon request and at no charge. 29 C.F.R. § 2520.102-3(j)(2). This requirement is satisfied by a reference in the SPD to the Policy, which contains the details of the long term care benefits. Benefit details may also be provided in a document attached to the SPD (which could be the Policy or a benefit schedule). Additional disclosure requirements apply if the plan is a “group health plan,” as defined in ERISA § 733(a). 29 C.F.R. § 2520.102-3(j)(3); *see also* 65 Fed. Reg. 70226 (Nov. 21, 2000).

At the time of this Study, there is limited guidance as to whether a long-term care insurance plan would be classified as a “group health plan” under ERISA. On November 21, 2000, the DOL issued regulations revising the minimum requirements for claims procedures of employee benefit plans. 65 Fed. Reg. 70246. In the preamble to these regulations, the DOL considered the issue of whether a long-term care insurance plan is a “group health plan.” The DOL analyzed a long-term care plan which provided benefits designed to provide assistance in the tasks of daily living to individuals with disabilities or chronic conditions. Benefit eligibility was based solely on the individual being unable to perform a requisite number of ADLs due to a loss of functional capacity or requiring substantial supervision due to severe cognitive impairment. Benefits under that plan included respite care, coverage for home modifications for the disabled, nursing home care, and payment for family care givers, all directed toward meeting the routine needs of daily life, but did not include “medical care” within the meaning of ERISA § 733(a)(2). The DOL opined that provision of the benefits described would not, in and of itself, cause the plan to be treated as a group health plan for purposes of the regulation. 65 Fed. Reg. 70247.

We have assumed, for purposes of this Study, that the long-term care insurance plan is *not* a group health plan. The reader is cautioned to review the current state of the law at the time he or she implements the plan to determine if additional guidance has been issued classifying long-term care plans as group health plans for ERISA purposes. If so, modifications will need to be made to the SPD to conform to the requirements for group health plans.

- (4) There are three sources of contributions to employee benefit plans sponsored by employers: (1) the employer, (2) the employee, and (3) the employer and employee together. Any required employee contributions should be clearly identified and the consequences of failure to contribute stated.
- (5) If the employer pays a portion of the cost, indicate how contributions are shared. Since the regulations refer only to the source and the method of calculation, not the amount, some practitioners believe it is not necessary to include the dollar amount the participant must contribute. Nevertheless, it may make sense to include that information here. Consideration should be given to providing different SPDs to different employees if different contribution levels are required. See Part Four, Section III.D.4.e, entitled “Different SPDs for Different Employee Groups.”
- (6) This Sample Plan assumes that employees may maintain coverage under their individual policies even if they cease to be Eligible Individuals, but if the employee’s individual policy lapses, coverage will terminate. Modify as required by policy terms — *e.g.*, if policy has a nonforfeiture provision.
- (7) If the Plan is maintained pursuant to one or more collective bargaining agreements, include a statement that the Plan is so maintained and that a copy of any such agreement may be obtained by participants and beneficiaries upon written request to the Plan Administrator and is available for examination by participants and beneficiaries.
- (8) In most insured welfare plans, both the employer and the insurance company take part in the administration of the plan. The employer, through the plan administrator, may set up eligibility rules, determine qualification and file forms with the Insurer. The employer may be involved in premium administration. The insurance company will be involved in such matters as determining insurability, establishing benefit schedules, and processing claims. In disclosing the type of administration under these circumstances, the SPD should reflect this joint responsibility and describe, at least in general terms, the matters over which each party exercises control.
- (9) For insured welfare plans, the applicability of this item will be limited to identifying the insurance policies used to provide any insured benefits. Under the regulations, this will include the name and address of the insurance company and the type of policy or policies used, not just the fact that insurance is part of the plan. However, it should not be necessary to identify specific policies by number, date of issue, etc.
- (10) At the time of this Study, new regulations have been issued regarding the minimum requirements for claims procedures. 65 Fed. Reg. 70246 (Nov. 21, 2000). These requirements apply to claims filed on or after January 1, 2002. The claims procedures in this sample SPD reflect these new requirements.

The claims requirements differ according to the type of plan, with additional requirements and shorter timeframes applying to group health plans and disability plans. For purposes of this Study, we have assumed that the long-term care insurance plan is not a group health plan or a disability plan within the meaning of ERISA. *See Note 3 for a discussion of this issue.*

- (11) Note: Most claims under the Plan will be Policy Claims.

Complete information regarding claim procedures must be provided either in the SPD, or in a separate document (*e.g.*, an insurance policy). If provided as a separate document: (a) that document must “accompany” the SPD (see below), and satisfy the style and format requirements of 29 C.F.R. § 2520.102-2 (see Part Four, Section III.D.4.b); and (b) the SPD must contain a statement that the plan’s claims procedures are furnished automatically, without charge, as a separate document. 29 C.F.R. § 2520.102-3(s) (Nov. 21, 2000).

The claims procedures regulations do not define what it means for a separate document to “accompany” the SPD. It does not, however, appear to mean that the document must be attached to the SPD, or even, necessarily, that the two documents be provided contemporaneously. Practitioners should be alert to further guidance concerning this requirement.

The Policy’s claims procedure must provide an explanation of the procedures governing claims for benefits, procedures for filing claim forms, providing notifications of benefit determinations, and reviewing denied claims. The claims review process of the insurer is subject to the same time limitations and other procedural requirements as apply to the employer under the claims regulations, at 29 C.F.R. § 2560.503-1.

In this *Form 3*, the claims procedures for Policy Claims are being provided in a separate document (the Policy), and the SPD contains the necessary statements in this regard. The claims procedures for Non-Policy Claims are not provided as a separate document; therefore, they must be stated in full in the SPD.

- (12) All welfare plans need to be assigned a 3-digit plan number that begins with the number 5. Practitioners should determine the next sequential number based on the number of plans the employer is already sponsoring.

Comment: See Part Three entitled “Plan Design and Implementation” and Part Four entitled “Application of ERISA” for additional information regarding the SPD requirements for long-term care insurance plans.

Form 3
Annotated Sample Summary Plan Description (SPD)

*This SPD assumes the plan is subject to ERISA.
 See Part Four for a full explanation
 of the ERISA SPD requirements.*

¾ For the Use of Legal Counsel Only ¾

[COMPANY NAME]
LONG-TERM CARE INSURANCE PLAN
SUMMARY PLAN DESCRIPTION

This Summary Plan Description is intended to explain the [Company Name] Long-Term Care Insurance Plan in a manner that you can easily understand. If you have any questions after reading this Summary Plan Description, please call [the Human Resources Department] at () _____. [If different SPDs are used, add “This Summary Plan Description describes benefits for your class of participants. Other classes of participants who receive benefits under the Plan are _____.”]

WHAT IS THE PURPOSE OF THE PLAN?

To provide individual qualified long-term care insurance policies to you [and your dependents].

WHEN AM I ELIGIBLE FOR COVERAGE?^(NOTE 1)

Comment: This Section must coordinate with the eligibility provisions of the Plan document (see Notes 3 and 5 of “Explanation of Form 2”). The following is suggested language based on the options set forth in the Sample Plan Document (Form 2). Modify these options based on your unique circumstances.

You are eligible to participate in the Plan if _____. [See options below]

Note: If you are electing Option 1 or 2, you may be exempt from the ERISA SPD requirement. The SPD requirement does not apply to certain noncontributory plans covering only select management or highly compensated employees. Refer to Part Four, Section III.C of the Study.

Option 1: Select Group by the Individuals’ Names

You are eligible to participate in the Plan if your name appears on the list set forth in the Appendix.

Option 2: Select Group by Class

You are eligible to participate in the Plan if you are a President or a Vice President.

Option 3: Larger Classes

You are eligible to participate in the Plan if you are classified as a Partner or an Associate.

Option 4: All Full-Time Employees

You are eligible to participate in the Plan if you are an employee regularly scheduled to work at least ____ hours per week.

Eligibility begins as of _____ [insert participation commencement date such as first day of the month after completing one month, one year of service] provided you have completed and given to _____ your written application for coverage[, including the authority for the Company to deduct premium payments from your pay].

The Insurer requires evidence of insurability. If you [or your dependent] fail to satisfy this requirement, coverage may be denied by the Insurer. In the event coverage is denied, the plan sponsor is not responsible for providing the denied coverage.^(NOTE 2)

WHAT ARE THE BENEFITS UNDER THE PLAN?

Your long-term care insurance policy (“Policy”) describes in detail the long-term care benefits you may receive.^(NOTE 3)

WHAT IS THE SOURCE OF FUNDING FOR THE PLAN?

The Plan is funded by individual qualified long-term care insurance policies. These policies are paid for by [participant] [and] [Company] contributions.^(NOTE 4)

WHAT IS THE COST OF THE PLAN TO ME?^(NOTE 5)

Comment: *This provision needs to coordinate with the terms of the Plan (see Note 8 of “Explanation of Form 2”). The following is suggested language based on the three options set forth in the Sample Plan Document (Form 2):*

Option 1: Employer Pay All

The Company pays the entire cost of the Plan. You pay nothing.

Option 2: Employee Pay All

You pay the entire cost of the Plan. The Company pays nothing.

Option 3: Contributory Approach

The Company will pay [__%] [\$_____] [for your [and your dependent’s] coverage] [for the basic Policy] towards the cost of coverage under the Plan. You will need to pay [any remaining premium amount] [for dependent coverage] [for any enhanced benefits you elect]. These amounts will be paid by you [through after-tax payroll deductions] [directly to the Insurer].

IN WHAT CIRCUMSTANCES MAY I BE DISQUALIFIED, LOSE, FORFEIT OR BE DENIED MY BENEFITS UNDER THE PLAN OR POLICY?

Under the Plan

Your participation in the Plan will terminate on the earliest of:

- (a) The date you or the Company stop paying any required premiums for the Plan, or the last day of the last period for which premiums were paid;
- (b) The date on which the plan terminates or is amended to exclude you or your class of employees from participating in the Plan; or
- (c) The date on which you are no longer an eligible individual.

However, please be aware that:

- (a) If the Company pays any portion of the premiums under the Plan, it may discontinue these premium payments at any time in its sole discretion;
- (b) The Company may discontinue the Plan or may change the eligibility requirements at any time in its sole discretion; and
- (c) If you terminate employment or otherwise cease to be an Eligible Individual, you may continue your coverage by paying the premiums directly to the Insurer.)^(NOTE 6)

Under the Policy

Coverage under the Policy may terminate in certain circumstances as described in the Policy. Such circumstances include (but are not limited to) the following:

- (a) The Policy will terminate if the premium is not paid within the time period specified in the Policy;
- (b) A material misstatement on the application may result in a denial of a claim or rescission of the Policy; and
- (c) Policy coverage will end when you have exhausted your limits under the Policy or upon your death.

Your entitlement to benefits under the Policy is solely governed by the terms of the Policy as administered by the Insurer. Please refer to your Policy for more information.

WHEN IS THE END OF THE PLAN YEAR?

The end of the Plan Year is _____.

WHAT HAPPENS IF THE PLAN IS AMENDED, TERMINATED OR DISCONTINUED?

The Company reserves the right to amend or change the Plan at any time.

WHO IS THE PLAN SPONSOR?

The Plan Sponsor is the Company:

[Company Name]
[Address]
[Telephone]^(NOTE 7)

WHO IS DESIGNATED AS THE PLAN ADMINISTRATOR?

The Company is the Plan Administrator and may be contacted at:

[Company's Name]
[Address]
[Telephone]

WHAT IS THE TYPE OF PLAN ADMINISTRATION?

Benefits are provided through individual insurance Policies issued by the Insurer. The Company administers the Plan. As the administrator, the Company has the discretionary authority to interpret and construe any terms of the Plan, to make eligibility and benefit determinations, and to delegate such determinations. The Company has delegated certain of its authority to the Insurer. The Company's role under the Plan is limited to determining eligibility to participate and administer premium payments. The Insurer administers the Policies. Claims for benefits are sent to the Insurer. The Insurer, not the Company, is responsible for determining eligibility for and the amount of any benefits payable under the Policies.^(NOTE 8)

WHAT IS THE FUNDING MEDIUM OF THE PLAN?

The Plan is a fully insured long-term care insurance plan consisting of individual policies issued to participants.^(NOTE 9) The Insurer provides all benefits. The Insurer is:

[Insurer's Name]
[Address]
[Telephone]

WHAT IS THE CLAIMS PROCEDURE FOR BENEFITS?^(NOTE 10)

Policy Claims^(NOTE 11)

Benefit payments will not be made under the Policy until the Insurer has received a claim for benefits that satisfies all requirements of the Plan. The claims procedure and appeals procedure are described in your Policy. This information regarding claims and appeal procedures is furnished to you automatically and without charge.

The Insurer will decide the claim within a reasonable period of time after it is received. If the Insurer denies the claim, in whole or in part, you will receive a written notification, stating the reason(s) for the denial. If a claim is denied, you (or your duly authorized representative) may appeal to the Insurer for a review of the denied claim, in accordance with the procedures and within the time period set forth in the Policy. In the event of an adverse determination on appeal, you (or your duly authorized representative) may pursue other remedies as provided for under ERISA § 502.

Please refer to the Policy for complete information regarding the claims and appeals procedures.

Non-Policy Claims

For other claims under the Plan (other than for benefits under the Policy), the participant must make a claim by delivering a written request to the Plan Administrator. Upon receipt of such request the Plan Administrator may require the participant to complete such forms and provide such additional information as may be reasonably necessary to establish the participant's rights under the Plan.

If a claim is wholly or partially denied, the Plan Administrator shall furnish to the participant a notice of the decision, within ninety (90) days after receipt of the claim by the Plan. If special circumstances require more than ninety (90) days to process the claim, this period may be extended for up to an additional ninety (90) days by giving written notice to the participant before the end of the initial 90-day period stating the special circumstances requiring the extension and the date by which a final decision is expected. Failure to provide a notice of decision in the time specified shall constitute a denial of the claim and the participant shall be entitled to require a review of the denial under the review procedures.

The notice to be provided to every participant who is denied a claim shall be in writing and shall set forth, in a manner calculated to be understood by the participant, the following:

- (1) The specific reason(s) for the adverse determination;
- (2) Reference to the specific Plan provision(s) on which the denial is based;
- (3) A description of any additional material or information necessary for the participant to perfect the claim and an explanation of why such material or information is necessary; and
- (4) An explanation of the Plan's claim review procedure describing the steps to be taken by a participant who wishes to submit his or her claim for review.

The purpose of the review procedure is to provide a procedure by which a participant may have a reasonable opportunity to appeal a denial of a claim to the Plan Administrator for a full and fair review. To accomplish that purpose, the participant or his or her duly authorized representative:

- (1) May request a review upon written application to the Plan Administrator;
- (2) May review and obtain copies of relevant Plan documents, upon request and free of charge; and
- (3) May submit for consideration: written comments, documents, records and other information related to the claim.

A participant (or his duly authorized representative) shall request a review by filing a written application for review with the Plan Administrator at any time within sixty (60) days after receipt by the participant of written notice of the denial of his or her claim.

The decision on review of a denied claim shall be made in the following manner:

- (1) The decision on review shall be made by the Plan Administrator, who may in his or her discretion hold a hearing on the denied claim. The Plan Administrator shall make a decision promptly, which shall ordinarily be not later than sixty (60) days after the Plan's receipt of

the request for review, unless special circumstances (such as the need to hold a hearing) require an extension of time for processing. In that case a decision shall be rendered as soon as possible, but not later than one hundred twenty (120) days after receipt of the request for review. If an extension of time is required due to special circumstances, written notice of the extension shall be furnished to the participant prior to the time the extension commences.

- (2) The decision on review shall be in writing and shall include specific reason(s) for the decisions, written in a manner calculated to be understood by the participant, as well as reference to the specific plan provisions on which the decision is based.
- (3) The participant may review and obtain copies of relevant Plan documents, upon request and free of charge.
- (4) In the event the decision on review is not furnished to the participant within the time required, the claim shall be deemed denied on review.

In the event of an adverse determination on appeal, the participant may pursue other remedies as provided for under ERISA § 502.

WHAT ARE THE PLAN NAME, PLAN NUMBER AND EMPLOYER IDENTIFICATION NUMBER?

The Plan Name is “_____ Long-Term Care Insurance Plan.” The Plan Number assigned to the Plan by the Company is [501].^(NOTE 12) The Employer Identification Number assigned to the Company is __ - _____.

WHAT ARE MY RIGHTS UNDER ERISA?

As a participant in the Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA) described below.

ERISA provides that all participants of ERISA plans are entitled to:

Receive Information about Your Plan and Benefits

Examine, without charge, at the Plan Administrator’s office and at other specified locations, all documents governing the Plan, including insurance contracts, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Pension and Welfare Benefit Administration.

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500) and updated summary plan description. The Plan Administrator may make a reasonable charge for the copies.

Receive a summary of the Plan’s annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan participants ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your Plan, called “fiduciaries” of the

Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your employer, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office of the Pension and Welfare Benefits Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquires, Pension and Welfare Benefits Administration, U.S. Department of Labor, 200 Constitution Avenue NW, Washington, DC 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Pension and Welfare Benefits Administration.

WHAT IF I NEED MORE INFORMATION?

If you have questions about eligibility to participate or general questions about the Plan, please contact the Plan Administrator. If you have questions about eligibility for or the amount of any benefit payable under the Policy, please contact the Insurer.

This document is just a summary of the actual terms of the Plan. You may examine a copy of the actual Plan at _____ at any time during regular working hours. You may also obtain a copy of the Plan by furnishing a written request for a copy to _____, at _____. There may be a charge for the expense of copying the Plan document. Since this document is only considered to be a summary, in case of any inconsistencies between this summary and the Plan, the Plan will control.

Also, certain information concerning the Plan is filed with the Treasury Department and the Department of Labor. Should you wish to correspond with either agency about this Plan, you must refer to Employer Identification Number _____ and Plan Number _____.

WHO IS THE AGENT FOR SERVICE OF LEGAL PROCESS?

The Company's _____ has been designated as agent for purpose of service of legal process. Also, legal process may be served on the Plan Administrator. The address of the agent for service of process is the address of the Plan Administrator as shown on page ___.

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