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OFFICE OF
INSURANCE COMMISSIONER

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September 22, 2011

VIA hand delivery and e-mail

Kelly Cairns
Hearings Unit, Office of Insurance Commissioner
Insurance 5000 Building
P.O. Box 40255
Olympia, Washington 98504-0255

Hearings Unit, DIC
Patricia D. Petersen
Chief Hearing Officer

Re: Ability Insurance Company
Case/Docket No. 11-0088 and 11-0089

Dear Ms. Cairns:

The OIC's Supplemental Hearing Brief filed on Monday September the 19th contained typographical errors, some of which I would like to please correct. In sum:

- Page 25 line 10: "But the 5-month period applies to the presentation of proof, [...]" is wrong; should read "But the 5-month period does not apply to the presentation of proof, [...]"
- Page 25 line 21: "[...] loss of functional" and "[...]" is incomplete; should read "[...] loss of functional capacity" and "[...]"
- Page 26 line 10-11: "all simply determine" should read "all simply to determine"
- Page 27 line 3-4: ", but since then [...]" should read "But since then [...]"
- Page 36 line 20-21: "[...] that WAC 284-54-253 is not binding [...]" should read "[...] that WAC 284-83-025 is not binding [...]"

Enclosed are copies of pages 25, 26, 27, and 36 reflecting the above corrections.

Also, at footnote 28, the brief referenced certain attachments. Those, too, are enclosed.

Thank you.

Very truly yours,

A handwritten signature in black ink, appearing to read "Alan Michael Singer".

Alan Michael Singer
Staff Attorney
Legal Affairs Division

cc: Christopher Howard, counsel for Respondent (w/enc via US mail and email)

1 **C. The Company wrongfully denied reinstatement on the spurious ground that**
2 **the insured had not presented adequate proof of cognitive impairment or loss**
3 **of functional capacity.**

4 A year after denying coverage to the insured, the Company first asserted that it had
5 another reason for its denial: that the insured did not timely present enough proof to satisfy
6 the Company that she was cognitively impaired enough, or had enough loss of functional
7 capacity, so as to qualify for coverage. *See* OIC Exh. 26. At the hearing, the Company
8 claimed that the proof not only needed to be presented to it, to its satisfaction, within the 5-
9 month period, it also made vague allusions to various federal law, such as “HIPPA” and tax
10 laws, which prevented the Company from applying any more stringent consumer protection
11 definitions than the ones included in the Company’s policy, which were put there to meet tax-
12 qualification requirements. But the 5-month period does not apply to the presentation of
13 proof, nor does any federal law preempt the Company from imposing more stringent
14 consumer protection standards, such as looking to the WAC 284-54-040(3)(a) and (5)(a) to
15 guide whether the consumer has a “loss of functional capacity” under WASC 284-54-253(2).
16 The Company’s delay in bringing out these asserted reasons for its conduct not only
17 constitutes a failure to “promptly provide a reasonable explanation of the basis in the
18 insurance contract in relation to the facts or applicable law for denial of a claims” not only
19 violated WAC 284-54-800(9), but on all counts, the Company is wrong.

20 **1. WAC 284-54-253 does not require proof of cognitive impairment be**
21 **presented within 5 months, only a request for reinstatement.**

22 The Company incorrectly claims the insured needed to have presented proof of
23 cognitive impairment or loss of functional capacity within 5 months. WAC 284-54-253(2)
only requires that the insurer be provided (1) “proof of the insured’s cognitive impairment or
loss of functional capacity” and (2) a request for reinstatement “within the five months after
the policy lapsed or terminated due to nonpayment of premium.” Under this, the only thing
that needs to be given to the insurer within 5 months of the WAC 284-54-253(1)(a)’s lapse

1 date is a request for reinstatement of coverage or a claim for coverage. That occurred here.
2 Indeed, even the Company's policy (*see* OIC Exh. 1 at page 9) says someone "will have 5
3 months to request reinstatement of the policy." While OIC staff believe this language isn't
4 ambiguous, the Company believes WAC 284-54-253(2) has a different meaning, that the five
5 months should apply to both the request and the proof of infirmity. But in the case of any
6 ambiguity, such language must be construed in favor of coverage. *Kaplan v. Northwest*
Mutual Life Ins. Co., 115 Wn. App. 791, 804-05, 65 P.3d 16 (2003).

7 The reason why the 5 months do not apply to the presentation of proof makes sense,
8 too. A designee is a stranger to the contract, and may likely not be an expert in insurance,
9 law, or medicine. They may need time to consult with family members, doctors, insurance
10 expert, and lawyers to evaluate the facts, weigh the insured's needs and resources, and find
11 ways to acquire premium funds, all simply to determine whether the request should be made.
12 The designee may require time to gather proof. But it also makes sense because it would be
13 absurd to suggest that a designee will fail to secure reinstatement even if they timely request
14 reinstatement in month four, but then fail to gather enough "proof" until two days after the
15 fifth month. "The court should not construe a regulation in a manner that is strained or leads
16 to absurd results." *City of Seattle v. Allison*, 148 Wn.2d 75, 81, 59 P.3d 85 (2002), *citing*
State v. Burke, 92 Wn.2d 474, 478, 598 P.2d 395 (1979).

17 **2. The insured had a cognitive impairment and loss of functional capacity,
and the Company's claims to the contrary are meritless.**

18 The evidence presented included testimony and documents showing that clearly, the
19 insured had a cognitive impairment and a loss of functional capacity. This was obvious from
20 the testimony of the witnesses, the letter and certification of Dr. Mihali, and the records
21 admitted.

22 The Company erroneously claims that the standards for reinstatement are, as they
23 supposedly must be, more strict and more difficult to meet than what WAC 284-54 *et seq*
otherwise provides, because the Company feels that certain federal laws simply require it.

1 For example, at the hearing Mr. Lawler testified that a “certificate” was needed to satisfy the
2 Company under these more strict standards, and that the testimony and other evidence
3 presented to that point was simply not enough to meet this exceedingly high standard of
4 proof. At the time, no such certificate was in evidence. But since then, one has been offered.
5 This certificate, from Dr. Mihali, obviates any concern over whether the insured meets even
6 the more strict standards that the Company claims apply.

7 But while the Company seems to claim that some yet unrevealed federal laws preempt
8 and/or mandate that the Company must require insureds to satisfy stricter and more difficult
9 to meet standards for reinstatement, the opposite is true here. According to the legislative
10 materials underlying two such federal laws Mr. Lawler alluded to in his testimony, states like
11 Washington are specifically allowed to require more stringent consumer protection standards
12 without the policies losing their tax-qualified status or otherwise running afoul of any law.
13 For example, the HIPPA conference report states that “a Federal standard” was “not
14 intended,” and that “applicable or appropriate state standards” which may be more stringent
15 than the federal law, are expressly permissible. This was contemplated when the laws were
16 being written:

17 [...] an otherwise qualified long-term care insurance contract will not fail to be a
18 qualified long-term care insurance contract, and will not be treated as failing to meet
19 the analogous requirement under the conference agreement, solely because it satisfies
20 a consumer protection standard imposed under applicable State law that is more
21 stringent than the analogous standard provided in the bill. The conference agreement
22 does not preclude States from enacting more stringent consumer protection provisions
23 than the analogous standards under the bill.

See attached excerpts of the HIPPA Conference Report.²⁸ Likewise, this remained the case
after the enactment of HIPPA:

HIPPA provides that an otherwise qualified long-term care insurance contract will not
fail to be a qualified long-term care insurance contract, and will not be treated as
failing to meet the analogous requirement under HIPA, solely because it satisfies a
consumer protection standard imposed under applicable State law that is more

²⁸ Attached to this brief are copies of excerpts from the Conference Report and Joint Committee on Taxation
explanation of HIPPA and a copy of IRS Notice 97-31.

1 policy becomes a part of the contract as though expressly written therein, and a policy
2 must be considered to contain those requirements. [...] The parties are chargeable
3 with knowledge of statutes and with the fact that insurance policies cannot be issued in
4 conflict with them. And thus missing terms required by statute will be read into the
5 policy and terms in conflict with statute will be amended to conform to them, and this
6 is the result even though increased liability not reflected in original premium is the
7 consequence.

8 4-22 Appleman on Insurance § 22.1.

9 **Must an insurance policy comply only at renewal, and how is renewal defined?**

10 The answer depends. As was touched upon in the *Bushnell* case, whose opinion was
11 published and is now final, when renewal occurs depends on the language in the policy and
12 the language in any pertinent statute or regulation. OIC staff believes that, occasionally, the
13 Legislature or OIC may have intended requirements to take place upon renewal, or only upon
14 original issuance only, or some combination, and will endeavor to provide further explanation
15 in its subsequent briefing.

16 **In a guaranteed renewable policy such as Ability's policy with Ms. White herein**
17 **(Ability's policy), is there a renewal date upon which the policy must comply? [For**
18 **example, in this case the Health Insurance Portability and Accountability Act of 1996**
19 **(HIPPA), P.L. 104-191, was enacted after WAC 284-54-253 (eff. 10/12/95).**

20 No, the policy does not appear to set forth a "renewal date." The analysis in the
21 *Bushnell* case would appear helpful in the resolution of this question. Both the policy in the
22 *Bushnell* case and OIC Exh. 1 here appear to contain certain identical provisions, but the
23 absence of the reservation of the right to not renew in OIC Exh. 1 would appear relevant to
this analysis. As to HIPPA, as indicated, it and other federal laws expressly allow any more
stringent consumer protection provisions contained in such provisions as WAC 284-54-253,
so HIOPPA's enactment is, in OIC staff's view, irrelevant to this matter.

How is WAC 284-54-253 (eff. 10/12/95) to be properly interpreted in light of
WAC 284-83-025 ((eff. 12/25/08) and HIPAA?

OIC staff respectfully submits that WAC 284-83-025 is not binding on how WAC
284-54-253 should be interpreted. WAC 284-83-025 is functionally identical in all or nearly
all material respects when compared with WAC 284-54-253. The only difference, as alluded
to above, is that WAC 284-83-025 appears to have adopted the Model's 5-day notice deeming

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY
ACT OF 1996

JULY 31, 1996.—Ordered to be printed

Mr. HASTERT, from the committee of conference,
submitted the following

CONFERENCE REPORT

[To accompany H.R. 3103]

The committee of conference on the disagreeing votes of the two Houses on the amendment of the Senate to the bill (H.R. 3103), to amend the Internal Revenue Code of 1986 to improve portability and continuity of health insurance coverage in the group and individual markets, to combat waste, fraud, and abuse in health insurance and health care delivery, to promote the use of medical savings accounts, to improve access to long-term care services and coverage, to simplify the administration of health insurance, and for other purposes, having met, after full and free conference, and agreed to recommend and do recommend to their respective Houses as follows:

That the House recede from its disagreement to the amendment of the Senate and agree to the same with an amendment as follows:

In lieu of the matter proposed to be inserted by the Senate amendment, insert the following:

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

(a) **SHORT TITLE.**—This Act may be cited as the "Health Insurance Portability and Accountability Act of 1996".

(b) **TABLE OF CONTENTS.**—The table of contents of this Act is as follows:

Sec. 1. Short title; table of contents.

TITLE I—HEALTH CARE ACCESS, PORTABILITY, AND RENEWABILITY

Subtitle A—Group Market Rules

PART I—PORTABILITY, ACCESS, AND RENEWABILITY REQUIREMENTS

Sec. 101. Through the Employee Retirement Income Security Act of 1974.

JOINT EXPLANATORY STATEMENT OF THE COMMITTEE OF CONFERENCE

The managers on the part of the House and the Senate at the conference on the disagreeing votes of the two Houses on the amendment of the Senate to the bill (H.R. 3103) to amend the Internal Revenue Code of 1986 to improve portability and continuity of health insurance coverage in the group and individual markets, to combat waste, fraud, and abuse in health insurance and health care delivery, to promote the use of medical savings accounts, to improve access to long-term care services and coverage, to simplify the administration of health insurance, and for other purposes, submit the following joint statement to the House and the Senate in explanation of the effect of the action agreed upon by the managers and recommended in the accompanying conference report:

The Senate amendment struck all of the House bill after the enacting clause and inserted a substitute text.

The House recedes from its disagreement to the amendment of the Senate with an amendment that is a substitute for the House bill and the Senate amendment. The differences between the House bill, the Senate amendment, and the substitute agreed to in conference are noted below, except for clerical corrections, conforming changes made necessary by agreements reached by the conferees, and minor drafting and clerical changes.

TITLE I—HEALTH CARE ACCESS, PORTABILITY, AND RENEWABILITY

I. STRUCTURE

House bill

The House bill would amend the Internal Revenue Code (IRC) and the Employee Retirement Income Security Act of 1974 (ERISA), and includes free-standing provisions.

Senate amendment

The Senate amendment includes free-standing provisions.

Conference agreement

The conference agreement adds new provisions to the Employee Retirement Income Security Act of 1974 (ERISA), the Public Health Services (PHS) Act, and the Internal Revenue Code (IRC).

II. AVAILABILITY AND PORTABILITY OF GROUP HEALTH PLANS

Current law

Current federal law does not impose any requirements on employers to provide or contribute toward the health insurance coverage of their employees or their employees' dependents. However,

Conference agreement

The conference agreement increases the deduction for health insurance of self-employed individuals as follows: the deduction would be 40 percent in 1997; 45 percent in 1998 through 2002; 50 percent in 2003; 60 percent in 2004; 70 percent in 2005; and 80 percent in 2006 and thereafter.

The conference agreement also provides that payments for personal injury or sickness through an arrangement having the effect of accident or health insurance (and that are not merely reimbursement arrangements) are excludable from income. In order for the exclusion to apply, the arrangement must be insurance (e.g., there must be adequate risk shifting). This provision equalizes the treatment of payments under commercial insurance and arrangements other than commercial insurance that have the effect of insurance. Under this provision, a self-employed individual who receives payments from such an arrangement could exclude the payments from income.

Effective date.—The provision is effective for taxable years beginning after December 31, 1996. No inference is intended with respect to the excludability of payments under arrangements having the effect of accident or health insurance under present law.

* C. TREATMENT OF LONG-TERM CARE INSURANCE AND SERVICES

(Secs. 321–323 and 325–328 of the House bill and secs. 411–415 and 421–424 of the Senate amendment.)

*Present law**In general*

Present law generally does not provide explicit rules relating to the tax treatment of long-term care insurance contracts or long-term care services. Thus, the treatment of long-term care contracts and services is unclear. Present law does provide rules relating to medical expenses and accident or health insurance.

Itemized deduction for medical expenses

In determining taxable income for Federal income tax purposes, a taxpayer is allowed an itemized deduction for unreimbursed expenses that are paid by the taxpayer during the taxable year for medical care of the taxpayer, the taxpayer's spouse, or a dependent of the taxpayer, to the extent that such expenses exceed 7.5 percent of the adjusted gross income of the taxpayer for such year (sec. 213). For this purpose, expenses paid for medical care generally are defined as amounts paid: (1) for the diagnosis, cure, mitigation, treatment, or prevention of disease (including prescription medicines or drugs and insulin), or for the purpose of affecting any structure or function of the body (other than cosmetic surgery not related to disease, deformity, or accident); (2) for transportation primarily for, and essential to, medical care referred to in (1); or (3) for insurance (including Part B Medicare premiums) covering medical care referred to in (1) and (2).

number of the chronically ill individual on account of whose condition such amounts are paid, and whether the contract under which the amount is paid is a per diem-type contract.

A grandfather rule is provided under the conference agreement in the case of a per diem type contract issued to a policyholder on or before July 31, 1996. Under the grandfather rule, the amount of the dollar cap with respect to such a per diem contract is calculated without any reduction for reimbursements for qualified long-term care services under any other contract issued with respect to the same insured on or before July 31, 1996. The other provisions of the dollar cap are not affected by the grandfather rule. The grandfather rule ceases to apply as of the time that any of the contracts issued on or before July 31, 1996, with respect to the insured are exchanged, or benefits are increased.

Life insurance company reserves

The conference agreement includes the Senate amendment provision with respect to life insurance reserves. Thus, under the conference agreement, in determining reserves for insurance company tax purposes, the Senate amendment provides that the Federal income tax reserve method applicable for a long-term care insurance contract is the method prescribed by the NAIC (or, if no reserve method has been so prescribed, a method consistent with the tax reserve method for life insurance, annuity or noncancellable accident and health insurance contracts, whichever is most appropriate). As under present law, in no event may the tax reserve for a contract as of any time exceed the amount which would be taken into account with respect to the contract as of such time in determining statutory reserves.

* *Consumer protection provisions* *

The conference agreement clarifies and modifies the category of contracts to which the consumer protection provisions apply. The conference agreement clarifies that the consumer protection provisions that apply with respect to the terms of the contract apply only for purposes of determining whether a contract is a qualified long-term care insurance contract (within the meaning of the bill).

The conference agreement provides that, for purposes of both the requirements as to contract terms and the requirements relating to issuers of contracts, the determination of whether any requirement of a model regulation or model Act has been met is made by the Secretary of the Treasury. It is not intended that the Secretary create a Federal standard, but rather, look to applicable or appropriate State standards or to those provided specifically in the model regulation or model Act.

The conference agreement modifies the \$100-per-day tax on failure to satisfy the requirements for issuers of contracts, to provide that the amount of the tax imposed is \$100 per insured per day. The conference agreement provides that the consumer protection requirements for issuers of contracts apply with respect to contracts that are qualified long-term care insurance contracts (within the meaning of the bill).

The conference agreement modifies the rule relating to State establishment of standards relating to contract terms or issuers of

contracts. The conference agreement provides that an otherwise qualified long-term care insurance contract will not fail to be a qualified long-term care insurance contract, and will not be treated as failing to meet the analogous requirement under the conference agreement, solely because it satisfies a consumer protection standard imposed under applicable State law that is more stringent than the analogous standard provided in the bill. The conference agreement does not preclude States from enacting more stringent consumer protection provisions than the analogous standards under the bill.

Effective date

The conference agreement follows the Senate amendment with respect to the effective date of the provision treating long-term care services as a medical expense. Thus, under the conference agreement, this provision is effective for taxable years beginning after December 31, 1996.

The conference agreement provides that the provision relating to life insurance company reserves is effective for contracts issued after December 31, 1997.

D. TREATMENT OF ACCELERATED DEATH BENEFITS UNDER LIFE INSURANCE CONTRACTS

(Secs. 331-332 of the House bill and secs. 431-432 of the Senate amendment).

Present law

Treatment of amounts received under a life insurance contract

If a contract meets the definition of a life insurance contract, gross income does not include insurance proceeds that are paid pursuant to the contract by reason of the death of the insured (sec. 101(a)). In addition, the undistributed investment income ("inside buildup") earned on premiums credited under the contract is not subject to current taxation to the owner of the contract. The exclusion under section 101 applies regardless of whether the death benefits are paid as a lump sum or otherwise.

Amounts received under a life insurance contract (other than a modified endowment contract) prior to the death of the insured are includible in the gross income of the recipient to the extent that the amount received constitutes cash value in excess of the taxpayer's investment in the contract (generally, the investment in the contract is the aggregate amount of premiums paid less amounts previously received that were excluded from gross income).

If a contract fails to be treated as a life insurance contract under section 7702(a), inside buildup on the contract is generally subject to tax (sec. 7702(g)).

Requirements for a life insurance contract

To qualify as a life insurance contract for Federal income tax purposes, a contract must be a life insurance contract under the applicable State or foreign law and must satisfy either of two alternative tests: (1) cash value accumulation test or (2) a test consist-

[JOINT COMMITTEE PRINT]

**GENERAL EXPLANATION OF
TAX LEGISLATION
ENACTED IN THE 104TH CONGRESS**

PREPARED BY THE STAFF
OF THE
JOINT COMMITTEE ON TAXATION



DECEMBER 18, 1996

U.S. GOVERNMENT PRINTING OFFICE

WASHINGTON : 1996

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million in 2001, \$320 million in 2004, \$378 million

Health Insurance Expenses of 11 of HIPA and sec. 162(1)

Prior Law

Individuals were entitled to deduct health insurance for the individual's spouse and dependent. The deduction for health insurance is not available for individuals who are not able to participate in a self-insured plan of the taxpayer or employer of the taxpayer or available in the case of self-insured plans. The self-insured plan must be appropriate risk arrangement. Expenses can exclude from income health insurance.

Change

Change to increase the deduction for health insurance for individuals in order to help make health insurance more affordable for individuals.

Provision

Health insurance of self-employment is 40 percent in 1997; 50 percent in 2003; 60 percent in 2006 and thereafter. Expenses for personal injury or sickness (including accident or health insurance) are excluded from gross income. To apply the exclusion, the arrangement must be adequate risk arrangement of payments under other than commercial insurance. Under this provision, payments from such an arrangement are excluded from gross income.

Beginning after December 31, 1995, the exclusion applies to the extent of the employee's contribution for the 1995 increase in

deductibility of payments under arrangements having the effect of accident or health insurance under prior law.

Revenue Effect

The provision is estimated to reduce Federal fiscal year budget receipts by \$64 million in 1997, \$238 million in 1998, \$340 million in 1999, \$377 million in 2000, \$410 million in 2001, \$445 million in 2002, \$537 million in 2003, \$524 million in 2004, \$1,290 million in 2005, and \$1,827 million in 2006.

C. Treatment of Long-Term Care Insurance and Services (secs. 321-327 of HIPA and secs. 106, 125, 213, 4980B, 4980C, 6050Q, and 7702B of the Code)

Present and Prior Law

In general

Prior law generally did not provide explicit rules relating to the tax treatment of long-term care insurance contracts or long-term care services. Thus, the treatment of long-term care contracts and services was unclear. Prior and present law do provide rules relating to medical expenses and accident or health insurance.

Itemized deduction for medical expenses

In determining taxable income for Federal income tax purposes, a taxpayer is allowed an itemized deduction for unreimbursed expenses that are paid by the taxpayer during the taxable year for medical care of the taxpayer, the taxpayer's spouse, or a dependent of the taxpayer, to the extent that such expenses exceed 7.5 percent of the adjusted gross income of the taxpayer for such year (sec. 213). For this purpose, expenses paid for medical care generally are defined as amounts paid: (1) for the diagnosis, cure, mitigation, treatment, or prevention of disease (including prescription medicines or drugs and insulin), or for the purpose of affecting any structure or function of the body (other than cosmetic surgery not related to disease, deformity, or accident); (2) for transportation primarily for, and essential to, medical care referred to in (1); or (3) for insurance (including Part B Medicare premiums) covering medical care referred to in (1) and (2).

Exclusion for amounts received under accident or health insurance

Amounts received by a taxpayer under accident or health insurance for personal injuries or sickness generally are excluded from gross income to the extent that the amounts received are not attributable to medical expenses that were allowed as a deduction for a prior taxable year (sec. 104).

Treatment of accident or health plans maintained by employers

Contributions of an employer to an accident or health plan that provides compensation (through insurance or otherwise) to an employee for personal injuries or sickness of the employee, the employee's spouse, or a dependent of the employee, are excluded from

in the case of a person on or before July 31, 1996, the amount of the dollar cap calculated without any long-term care services to the same insured persons of the dollar cap. The grandfather rule for contracts issued on or before July 31, 1996, is not applied to contracts issued after that date.

The legislation imposes a limit on the amount of excludable benefits in certain circumstances. It suggests a preference for the grandfather rule advantage to one type of long-term care contract.

Ways and Means and the Joint Committee on Taxation jointly to request that the Secretary of the Treasury conduct a study to determine the impact of the dollar cap on certain types of long-term care contracts. Such a study, if requested, shall be completed by no later than 180 days after the date of enactment of the bill.

On or after 1997 for inflation-adjusted consumer price index. The Secretary shall develop a more appropriate method for adjusting the limit. Such an adjustment shall be made in skilled nursing facilities. The Treasury shall determine the amount of the limit as of 1997.

For this purpose to include, marketed or offered, to report to the IRS the name of any individual during the year and taxpayer identification number, a payor is required to provide a classification number of those conditions such as a long-term care contract under which the individual is receiving care. A copy of the report shall be filed following the year of the aggregate amount of the long-term care provided in the calendar year. Failure to comply is subject to the same penalties as for the failure to provide similar information.

Life insurance company reserves

In determining reserves for insurance company tax purposes, HIPA provides that the Federal income tax reserve method applicable for a long-term care insurance contract issued after December 31, 1996, is the method prescribed by the NAIC (or, if no reserve method has been so prescribed, a method consistent with the tax reserve method for life insurance, annuity or noncancellable accident and health insurance contracts, whichever is most appropriate). The method currently prescribed by the NAIC for long-term care insurance contracts is the one-year full preliminary term method. As under prior and present law, however, in no event may the tax reserve for a contract as of any time exceed the amount which would be taken into account with respect to the contract as of such time in determining statutory reserves.

Consumer protection provisions

Under HIPA, long-term care insurance contracts, and issuers of such contracts, are required to satisfy certain provisions of the long-term care insurance model Act and model regulations promulgated by the NAIC (as adopted as of January 1993).

The contract requirements relate to disclosure, nonforfeitability, guaranteed renewal or noncancellability, prohibitions on limitations and exclusions, extension of benefits, continuation or conversion of coverage, discontinuance and replacement of policies, unintentional lapse, post-claims underwriting, minimum standards, inflation protection, preexisting conditions, and prior hospitalization. HIPA also provides disclosure and nonforfeiture requirements. The nonforfeiture provision gives consumers the option of selecting reduced paid-up insurance, extended term insurance, or a shortened benefit period in the event a policyholder who elects a nonforfeiture provision is unable to continue to pay premiums.²⁴² The requirement that insurers offer policyholders a nonforfeiture benefit does not preclude the imposition of a reasonable delay period. The consumer protection provisions that apply with respect to the terms of the contract apply only for purposes of determining whether a contract is a qualified long-term care insurance contract (within the meaning of HIPA).

The requirements for issuers of long-term care insurance contracts relate to application forms, reporting requirements, marketing, appropriateness of purchase, format, delivering a shopper's guide, right to return, outline of coverage, group plans, policy summary, monthly reports on accelerated death benefits, and incontestability period. A tax is imposed equal to \$100 per insured per day for failure to satisfy these requirements. The consumer protection requirements for issuers of contracts apply with respect to contracts that are qualified long-term care insurance contracts (within the meaning of HIPA).

²⁴² The nonforfeiture provision shall provide for a benefit available in the event of a default in the payment of any premium and the amount of the benefit may be adjusted subsequent to being initially granted only as necessary to reflect changes in claims, persistency, and interest as reflected in changes in rates for premium paying policies approved by the appropriate State regulatory authority for the same contract form. A technical correction may be necessary so that the statute reflects this intent.

HIPA provides that, for purposes of both the requirements as to contract terms and the requirements relating to issuers of contracts, the determination of whether any requirement of a model regulation or model Act has been met is made by the Secretary of the Treasury. It was not intended that the Secretary create a Federal standard, but rather, look to applicable or appropriate State standards or to those provided specifically in the model regulation or model Act.

HIPA provides that an otherwise qualified long-term care insurance contract will not fail to be a qualified long-term care insurance contract, and will not be treated as failing to meet the analogous requirement under HIPA, solely because it satisfies a consumer protection standard imposed under applicable State law that is more stringent than the analogous standard provided in HIPA. HIPA does not preclude States from enacting more stringent consumer protection provisions than the analogous standards under HIPA.

Effective Date

The provisions defining long-term care insurance contracts and qualified long-term care services apply to contracts issued after December 31, 1996. Any contract issued before January 1, 1997, that met the long-term care insurance requirements of the State in which the contract was situated at the time it was issued is treated as a qualified long-term care insurance contract, and services provided under or reimbursed by the contract are treated as qualified long-term care services. Solely for purposes of this grandfather rule, and not for other purposes, it is intended that in the case of a group contract that was issued before January 1, 1997, the contract will not cease to be treated as issued before January 1, 1997, solely by reason of the addition after December 31, 1996, of individuals to the coverage (as of December 31, 1996) under the contract. It is intended that a contract be treated as meeting the long-term care insurance requirements of the State, if it meets the insurance requirements of the State with respect to insurance contracts covering types of long-term care services (such as only nursing home care, or only home health care), even though such State requirements are separate from long-term care insurance requirements, or prohibit the contract from being labeled a long-term care contract. Similarly, a State waiver of a long-term care insurance requirement (such as the loss ratio requirement) in the case of a long-term care rider or provision under a life insurance contract is not intended to cause the contract to be treated as not meeting the long-term care insurance requirements of the State.

A contract providing for long-term care insurance may be exchanged for a long-term care insurance contract (or the former canceled and the proceeds reinvested in the latter within 60 days) tax free between the date of enactment and January 1, 1998. Taxable gain would be recognized to the extent money or other property is received in the exchange.

The issuance or conformance of a rider to a life insurance contract providing long-term care insurance coverage is not treated as a modification or a material change for purposes of applying sections 101(f), 7702 and 7702A of the Code.

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Requirements

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the requirements as to relating to issuers of contracts. The requirement of a model made by the Secretary of the Secretary create a Federal or appropriate State in the model regulation

long-term care insured long-term care insurance to meet the analog because it satisfies a State law as standard provided in enacting more stringent analogues standards

insurance contracts and contracts issued after December 31, 1996, that provisions of the State in it issued is treated and services provided are treated as qualified services of this grandfathered that in the case of January 1, 1997, the before January 1, 1997, December 31, 1996, of individuals meeting the long-term if it meets the insurance insurance contracts which as only nursing home through such State requirements, or long-term care contract care insurance requirements the case of a long-term insurance contract is not in as not meeting the long-term.

insurance may be contract (or the former contract within 60 days) tax January 1, 1998. Taxable property or other property is

to a life insurance coverage is not treated as imposes of applying such

The provisions relating to treatment of eligible long-term care premiums and long-term care services as a medical expense generally are effective for taxable years beginning after December 31, 1996.

The provisions relating to the maximum exclusion for certain long-term care benefits and reporting are effective for taxable years beginning after December 31, 1996. Thus, the initial year in which reports will be filed with the IRS and copies provided to the payee will be 1998, with respect to long-term care benefits paid in 1997.

The provision relating to life insurance company reserves is effective for contracts issued after December 31, 1997.

Revenue Effect

The provisions are estimated to reduce Federal fiscal year budget receipts by \$108 million in 1997, \$667 million in 1998, \$645 million in 1999, \$663 million in 2000, \$743 million in 2001, \$827 million in 2002, \$905 million in 2003, \$1,009 million in 2004, \$1,103 million in 2005, and \$1,205 million in 2006.

D. Treatment of Accelerated Death Benefits Under Life Insurance Contracts (secs. 331-332 of HIPA and secs. 101(g), 818(g), 6050Q, and 7702B of the Code)

Present and Prior Law

Treatment of amounts received under a life insurance contract

If a contract meets the definition of a life insurance contract, gross income does not include insurance proceeds that are paid pursuant to the contract by reason of the death of the insured (sec. 101(a)). In addition, the undistributed investment income ("inside buildup") earned on premiums credited under the contract is not subject to current taxation to the owner of the contract. The exclusion under section 101 applies regardless of whether the death benefits are paid as a lump sum or otherwise.

Under prior law, amounts received under a life insurance contract (other than a modified endowment contract) prior to the death of the insured were includible in the gross income of the recipient to the extent that the amount received constitutes cash value in excess of the taxpayer's investment in the contract. Generally, the investment in the contract is the aggregate amount of premiums paid less amounts previously received that were excluded from gross income.

If a contract fails to be treated as a life insurance contract under section 7702(a), inside buildup on the contract is generally subject to tax (sec. 7702(g)).

Requirements for a life insurance contract

To qualify as a life insurance contract for Federal income tax purposes, a contract must be a life insurance contract under the applicable State or foreign law and must satisfy either of two alternative tests: (1) a cash value accumulation test or (2) a test consisting of a guideline premium requirement and a cash value corridor requirement (sec. 7702(a)). A contract satisfies the cash value accu-

Long-Term Care Services and Insurance

Notice 97-31

This notice provides interim guidance relating to qualified long-term care services and qualified long-term care insurance contracts under §§ 213, 7702B, and 4980C of the Internal Revenue Code. It is effective pending the publication of proposed regulations or other guidance.

SUMMARY

The notice includes interim guidance concerning the definition of a "chronically ill individual," including safe-harbor definitions of the terms "substantial assistance," "hands-on assistance," "standby assistance," "severe cognitive impairment," and "substantial supervision." Under the long-term care provisions added to the Internal Revenue Code in 1996, certain payments received on account of a chronically ill individual from a qualified long-term care insurance contract are excluded from income. In addition, certain expenditures incurred for qualified long-term care services required by a chronically ill individual are deductible as medical care expenses.

The notice also includes an interim safe harbor that allows key provisions in qualified long-term care insurance contracts to be interpreted by an insurance company using the same standards that the company used before 1997 to determine whether an individual is unable to perform activities of daily living or is cognitively impaired. In addition, the notice provides interim guidance on the scope of the statutory grandfather provisions that apply to individual and group long-term care insurance contracts issued before 1997.

The safe harbors are designed to provide standards for taxpayers to use in interpreting the new long-term care provisions and to provide interim guidance to facilitate operation of the insurance market without the need for interim amendment of contracts.

The guidance takes into account comments and information provided by State insurance regulators (including the National Association of Insurance Commissioners), insurance companies offering long-term care insurance, consumer representatives, groups representing individuals with chronic disabilities, the De-

partment of Health and Human Services, health professionals expert in the care and rehabilitation of individuals with chronic illnesses, and others. The notice addresses certain issues identified as those for which interim guidance would be most helpful. The Internal Revenue Service and Treasury Department are continuing to consider these and other issues and welcome further comments.

STATUTORY CHANGES

Sections 7702B and 4980C, added by §§ 321 and 326 of the Health Insurance Portability and Accountability Act of 1996 (Pub. L. 104-191, 110 Stat. 1936, 2054 and 110 Stat. at 2065)(HIPAA), establish requirements for qualified long-term care insurance contracts and issuers of those contracts. Section 7702B(b)(1)(A) requires a qualified long-term care insurance contract to provide insurance protection only for qualified long-term care services. Generally, § 7702B applies to contracts issued after December 31, 1996, and § 4980C applies to actions taken after December 31, 1996. See HIPAA §§ 321(f)(1) and 327.

Section 7702B(c)(1) defines "qualified long-term care services" as necessary diagnostic, preventive, therapeutic, curing, treating, mitigating, and rehabilitative services, and maintenance or personal care services that are required by a chronically ill individual, and provided pursuant to a plan of care prescribed by a licensed health care practitioner.

Section 7702B(c)(2)(A) defines a "chronically ill individual" as 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 out of 6 activities of daily living listed in § 7702B(c)(2)(B) (ADLs) for a period of at least 90 days due to a loss of functional capacity (the ADL Trigger);

(ii) having a level of disability similar to the level of disability described in the ADL Trigger as determined under regulations prescribed by the Secretary of the Treasury in consultation with the Secretary of Health and Human Services (the Similar Level Trigger); or

(iii) requiring substantial supervision to protect the individual from threats to health and safety due to severe

cognitive impairment (the Cognitive Impairment Trigger).

The 6 ADLs listed in § 7702B(c)(2)(B) are eating, toileting, transferring, bathing, dressing, and continence. Section 7702B(c)(2)(B) further provides that a contract is not a qualified long-term care insurance contract unless it takes into account at least 5 of these 6 activities in determining whether an individual is a chronically ill individual.

In addition, § 322 of HIPAA amended § 213 of the Code. For taxpayers who itemize deductions, § 213 generally allows a deduction for expenses paid during the taxable year, not compensated for by insurance or otherwise, for medical care of the taxpayer, his or her spouse, and dependents, to the extent that the expenses exceed 7.5 percent of the taxpayer's adjusted gross income. As amended by HIPAA, § 213(d) provides that the term "medical care" includes (1) eligible premiums paid for any qualified long-term care insurance contract (as defined in § 7702B(b)) and (2) amounts paid for qualified long-term care services (as defined in § 7702B(c)).

INTERIM GUIDANCE

I. CHRONICALLY ILL INDIVIDUAL

This section of the notice provides interim guidance including safe harbors relating to the determination of whether an individual is a "chronically ill individual" under § 7702B(c)(2). Taxpayers (including uninsured individuals, insurance companies, employers, policyholders, and certificate holders) may rely on this interim guidance to determine whether an individual is a chronically ill individual under the ADL Trigger or the Cognitive Impairment Trigger for purposes of the definitions of "qualified long-term care services" in § 7702B(c) and "medical care" in § 213(d).

ADL Trigger. For purposes of the ADL Trigger, taxpayers may rely on all or any of the following safe-harbor definitions —

(1) "Substantial assistance" means hands-on assistance and standby assistance.

(2) "Hands-on assistance" means the physical assistance of another person without which the individual would be unable to perform the ADL.

(3) "Standby assistance" means the presence of another person within arm's reach of the individual that is necessary

to prevent, by physical intervention, injury to the individual while the individual is performing the ADL (such as being ready to catch the individual if the individual falls while getting into or out of the bathtub or shower as part of bathing, or being ready to remove food from the individual's throat if the individual chokes while eating).

An individual is a chronically ill individual under the ADL Trigger only if a licensed health care practitioner has certified that the individual is unable to perform (without substantial assistance from another individual) at least 2 ADLs for a period of at least 90 days due to a loss of functional capacity. This 90-day requirement does not establish a waiting period before which benefits may be paid or before which services may constitute qualified long-term care services.

Cognitive Impairment Trigger. For purposes of the Cognitive Impairment Trigger, taxpayers may rely on either or both of the following safe-harbor definitions—

(1) "Severe cognitive impairment" means a loss or deterioration in intellectual capacity that is (a) comparable to (and includes) Alzheimer's disease and similar forms of irreversible dementia, and (b) measured by clinical evidence and standardized tests that reliably measure impairment in the individual's (i) short-term or long-term memory, (ii) orientation as to people, places, or time, and (iii) deductive or abstract reasoning.

(2) "Substantial supervision" means continual supervision (which may include cuing by verbal prompting, gestures, or other demonstrations) by another person that is necessary to protect the severely cognitively impaired individual from threats to his or her health or safety (such as may result from wandering).

Under the Cognitive Impairment Trigger, unlike the ADL Trigger, a qualified long-term care insurance contract is not required to take any ADL into account for purposes of determining whether an individual is a chronically ill individual.

Safe-Harbor for Continuation of Pre-1997 Insurance Standards. This safe harbor applies to post-1996 long-term care insurance contracts (including any pre-1997 contracts not grandfathered under § 321(f)(2) and the grandfather rules in this notice for certain pre-1997 insurance contracts) issued by an insurance company with outstanding pre-1997 long-term care insurance contracts that base eligibility for payments upon the inability to perform any of the ADLs

(eating, toileting, transferring, bathing, dressing, and continence) or cognitive impairment. Insurance companies, policyholders, and certificate holders may rely on this safe harbor (as well as the safe-harbor definitions above for the ADL and Cognitive Impairment Triggers) to determine whether an individual is a chronically ill individual under both or either the ADL Trigger and the Cognitive Impairment Trigger for purposes of the definition of a "qualified long-term care insurance contract," whether or not the post-1996 contracts generally incorporate the provisions of § 7702B(c)(2). In order to rely on any of these safe harbors for federal tax purposes, contracts are not required to incorporate or refer to the safe harbors.

In applying the ADL Trigger to its post-1996 contracts, an insurance company is permitted to use the same standards that it uses to determine whether an individual is unable to perform an ADL for purposes of eligibility for benefit payments under its pre-1997 contracts ("pre-1997 ADL standards"). If the insurance company makes determinations regarding an individual's inability to perform an ADL under a post-1996 contract using its pre-1997 ADL standards, the contract will be deemed to satisfy the requirement under the ADL Trigger that an individual is unable to perform (without substantial assistance from another person) that ADL due to a loss of functional capacity. For example, if an insurance company has outstanding pre-1997 long-term care insurance contracts that provide for benefit payments if the insured is unable to perform at least 2 ADLs (whether or not the contracts refer to substantial assistance), the company may interpret "substantial assistance" for purposes of the ADL Trigger as requiring the same assistance as the company requires under its pre-1997 contracts.

In applying the Cognitive Impairment Trigger to its post-1996 contracts, an insurance company is permitted to use the same standards that it uses to determine whether an individual qualifies for benefits due to cognitive impairment under its pre-1997 contracts ("pre-1997 cognitive impairment standards"). If the insurance company makes determinations regarding an individual's cognitive impairment under a post-1996 contract using its pre-1997 cognitive impairment standards, the contract will be deemed to satisfy the requirement under the Cognitive Impairment Trigger that an

individual requires substantial supervision to protect the individual from threats to health and safety due to severe cognitive impairment.

This safe harbor for continuation of pre-1997 insurance standards applies only for purposes of determining whether an individual (1) is unable to perform (without substantial assistance from another person) an ADL due to a loss of functional capacity or (2) requires substantial supervision to protect the individual from threats to health and safety due to severe cognitive impairment. This safe harbor does not apply for purposes of the other statutory requirements of § 7702B(c)(2), such as (1) the requirement that an individual's loss of functional capacity apply to at least 2 of 5 or 6 ADLs, (2) the requirement for a certification by a licensed health care practitioner, and (3) the 90-day requirement. These statutory requirements must be satisfied in order for the individual to be a "chronically ill individual" under the ADL or Cognitive Impairment Trigger, whether or not similar requirements are imposed under the insurance company's pre-1997 contracts.

II. QUALIFIED LONG-TERM CARE INSURANCE

This section of the notice addresses certain issues relating to the consumer protection provisions of §§ 7702B(b), 7702B(g), and 4980C, rules for adjustments to nonforfeiture benefits under § 7702B(g)(4), and the grandfather rules for certain pre-1997 insurance contracts. Taxpayers (including insurance companies, employers, policyholders, and certificate holders) may rely on this interim guidance for purposes of the definition of "qualified long-term care insurance contract" in § 7702B(b) and the requirements of § 4980C.

Consumer Protections Applicable to Long-Term Care Insurance. Under §§ 7702B(b)(1)(F), 7702B(g), and 4980C, qualified long-term care insurance contracts and issuers of those contracts are required to satisfy certain requirements of the Long-Term Care Insurance Model Act (Model Act) and Long-Term Care Insurance Model Regulation (Model Regulation) promulgated by the National Association of Insurance Commissioners (NAIC), as adopted as of January 1993. The requirements for qualified long-term care insurance contracts under §§ 7702B(b)(1)(F) and 7702B(g) relate to guaranteed renewal or noncancellability, prohibitions on

limitations and exclusions, extension of benefits, continuation or conversion of coverage, discontinuance and replacement of policies, unintentional lapse, disclosure, prohibitions against post-claims underwriting, minimum standards, inflation protection, prohibitions against preexisting conditions and probationary periods, and prior hospitalization. The requirements for qualified long-term care insurance contracts under § 4980C relate to application forms and replacement coverage, reporting requirements, filing requirements for marketing, standards for marketing, appropriateness of recommended purchase, standard format outline of coverage, delivery of a shopper's guide, right to return, outline of coverage, certificates under group plans, policy summary, monthly reports on accelerated death benefits, and incontestability period.

Sections 7702B and 4980C reference NAIC model provisions that specify exact language (including punctuation), captions, format, and content that must be included in long-term care insurance contracts, applications, outlines of coverage, policy summaries, and notices. See, e.g., §§ 10, 13, and 24 of the Model Regulation.

In the case of a State that has adopted all or any portion of the Model Act or Model Regulation, compliance with the applicable requirement of State law is considered compliance with the parallel Model Act or Model Regulation requirement specified in § 7702B(g) or § 4980C, and failure to comply with that requirement of State law is considered failure to comply with the parallel Model Act or Model Regulation requirement in § 7702B(g) or § 4980C. For example, if a particular State has adopted Section 6C of the Model Act (relating to preexisting conditions), then, for a contract that is subject to that State's insurance laws, compliance with that State law is considered compliance with § 7702B(g)(2)(A)(ii)(I) and failure to comply with that State law is considered failure to comply with § 7702B(g)(2)(A)(ii)(I). In accordance with § 4980C(f), in the case of a State that imposes a requirement that is more stringent than the analogous requirement imposed by § 7702B(g) or § 4980C, compliance with the applicable requirement of State law is considered compliance with the parallel Model Act or Model Regulation requirement in § 7702B(g) or § 4980C.

If a State has not adopted a provision of the Model Act or Model Regulation

that is specified in § 7702B(g) or § 4980C (and has not adopted a requirement that is more stringent than the requirement imposed by that provision), the language, caption, format, and content requirements imposed by the Model Act or Model Regulation provision with respect to contracts, applications, outlines of coverage, policy summaries, and notices will be considered satisfied for a contract subject to the law of that State if the language, captions, format, and content are substantially identical in all material respects to those required under that Model Act or Model Regulation provision.

Adjustments to Nonforfeiture Benefits Under Insurance Contracts. Section 7702B(g)(4)(B)(ii) provides that the amount of a nonforfeiture benefit available in the event of a default in premium payments may be subsequently adjusted only as necessary to reflect changes in claims, persistency, and interest that have been taken into account in a change in the premium rates for contracts issued on the same contract form if the contract form has been approved by the Secretary of the Treasury. Solely for the purpose of making such adjustments, approval by the State insurance commissioner or other applicable State authority will be treated as approval by the Secretary of the Treasury.

Grandfather Rules for Certain Pre-1997 Insurance Contracts. Section 321(f)(2) of HIPAA provides that a contract issued before January 1, 1997, is treated as a qualified long-term care insurance contract if the contract met the "long-term care insurance requirements of the State" in which the contract was situated at the time it was issued. For this purpose, the "long-term care insurance requirements of the State" means the State laws (including statutory and administrative law) that are intended to regulate insurance coverage that constitutes "long-term care insurance" (as defined in § 4 of the Long-Term Care Insurance Model Act as adopted by the NAIC in December, 1995), regardless of the terminology used by the State in describing the insurance coverage.

For purposes of applying the grandfather rule of § 321(f)(2) to a contract other than a group contract, the issue date of a contract is generally the date assigned to the contract by the insurance company, but in no event earlier than the date the application is signed. How-

ever, if the period between the date of application and the date on which the contract is actually placed in force is substantially longer than under the insurance company's usual business practice, then the issue date is the date the contract is placed in force.

For purposes of applying the grandfather rule of § 321(f)(2) to a group contract, the issue date of the contract is the date the group contract was issued. Thus, insurance coverage under certificates evidencing the addition, on or after January 1, 1997, of individuals to the coverage available under a grandfathered group contract is accorded the same grandfather treatment under § 321(f)(2) as the preexisting coverage under the grandfathered group contract.

A policyholder's right to return a long-term care insurance contract within a "free-look" period following delivery (with a refund of any premiums that have been paid) is not taken into account in determining the issue date of the contract.

For purposes of applying the grandfather rule of § 321(f)(2), any material change in a contract will be considered the issuance of a new contract. This includes any change in the terms of the contract altering the amount or timing of any item payable by the policyholder (or certificate holder), the insured, or the insurance company. For example, for purposes of § 321(f)(2), any change in the terms of a contract altering the amount or timing of benefits (including nonforfeiture benefits) or premiums constitutes a material change that will be considered the issuance of a new contract. A substitution of the insured under an individual contract, or a change (other than an immaterial change) in the eligibility for membership in the group covered by a group contract, also constitutes a material change that will be considered the issuance of a new contract. However, the unilateral exercise of an option or right granted to a policyholder under the contract as in effect on December 31, 1996, will not constitute a material change. For this purpose, a unilateral exercise includes only a change that becomes effective without any consent or other non-ministerial action by the issuer of the contract. A contract issued in an exchange after December 31, 1996, for an existing contract is considered a contract issued after that date.

COMMENTS REQUESTED

The Internal Revenue Service and Treasury Department invite comments concerning the application of new §§ 7702B and 4980C, the amendments made to § 213, and other federal income tax provisions relating to long-term care as enacted under HIPAA §§ 321 through 326, including the standards and definitions in this notice. Comments are particularly requested on: (1) whether the relief provided for insurance contracts complying with the interim guidance provided in this notice needs to be extended beyond the effective date of more definitive guidance; and (2) the types of disability that should be included in any regulations that may be prescribed under the Similar Level Trigger. Comments should be submitted by August 4, 1997. Written comments should be sent to: Internal Revenue Service, P.O. Box 7604, Ben Franklin Station, Attn: CC:CORP:T:R, Room 5228, Washington, DC 20044. Alternatively, submissions may be hand delivered between the hours of 8 a.m. and 5 p.m. to: CC:DOM:CORP:R (Notice 97-31), Courier's Desk, Internal Revenue Service, 1111 Constitution Avenue, NW, Washington, DC. Finally, taxpayers may submit comments electronically via the Internal Revenue Service INTERNET site at: http://www.irs.ustreas.gov/prod/tax_regs/comments.html. All submitted comments will be available for public inspection and copying.

FURTHER INFORMATION

For further information, contact Ms. A. Kathie Jacob Kiss at (202) 622-4920 regarding section I of this notice and Ms. Katherine A. Hossofsky at (202) 622-3970 regarding section II of this notice (not toll-free calls).

PROCEDURAL INFORMATION

This document serves as an "administrative pronouncement" as that term is defined in § 1.6661-3(b)(2) of the Income Tax Regulations and may be relied upon to the same extent as a revenue ruling or a revenue procedure.
