Chapter 13: Elder Issues

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Corrections were made to this workbook through January of 2011. No subsequent modifications were made.

As clientele age, tax preparers are faced with issues other than the tax consequences of a specific transaction. The purpose of this chapter is to offer resources and insight into questions elder clients ask their tax preparers.

ANNUITIES

BACKGROUND

An annuity is a series of payments made at regular intervals over a period of more than one year. In addition, the term **annuity** is also often used to describe a contract between an investor and an issuer whereby the investor gives the issuer a sum of money in exchange for a promise to be paid a certain amount of money periodically beginning after some future date.

Annuities have grown in popularity in recent years. One appealing feature is that the earnings are tax deferred until distributions are received. In addition, many annuity contracts guarantee a minimum rate of return and also guarantee that the initial investment will not decrease in value. These guarantees are especially compelling to investors shaken by the volatile stock market and low interest rates of recent years.

Annuities are attractive to individuals who wish to save additional funds for retirement after they have contributed the maximum amount to their employer-sponsored plans and IRAs. Nonqualified annuities are also exempt from the required minimum distribution rules that apply to retirement funds after a taxpayer reaches age 70½.[1]

Unfortunately, economic circumstances have forced many taxpayers to withdraw funds from their commercial annuities. Although the Forms 1099-R issued by insurance companies are usually correct, knowing the general tax rules concerning annuities helps practitioners explain any tax consequences to their clients. This knowledge also helps practitioners provide planning guidance for those taxpayers who request advice before taking action.

Annuities have two phases: the accumulation phase and the annuitization phase. In the **accumulation phase**, a person invests money with an insurance or investment company either over a period of time or with a lump sum. The investment then produces income. Funds withdrawn during the accumulation phase are termed withdrawals and receive less favored tax treatment. In the **annuitization phase**, the annuity owner, annuitant, or beneficiary withdraws regular periodic payments from the contract until death or until a certain time period has elapsed.

An **immediate annuity** is one which is purchased with a single premium and requires distributions to begin within one year of the annuity's purchase. A **deferred annuity** does not have a predetermined date for payment distributions to begin. Money withdrawn during the annuitization phase is treated more favorably from a taxation standpoint.

1. IRC §4974.

PARTIES TO AN ANNUITY CONTRACT

There are three parties to an annuity contract: the owner, the annuitant, and the beneficiary. In many cases, the owner and annuitant are the same individual. These three parties are specified in the annuity contract or in related documents, such as employment agreements.

The owner is usually the purchaser of the annuity and has all the rights under the contract, except for the rights of any irrevocable beneficiary. The owner is responsible for income taxes on payments made from the annuity. If applicable, premature distribution penalties apply based on the owner's age. If the owner dies during the accumulation phase, there is a mandatory distribution of the death benefit for contracts issued after January 18, 1985. The distribution can take the form of:

1. An immediate lump-sum payment,
2. A complete withdrawal within five years of the date of death,[2] or
3. Payments over the life of the beneficiary (if one has been designated), beginning within one year of death.[3]

The sole exception to the mandatory distribution rule is that a spouse may elect to continue the contract.[4] If an owner dies after annuitization, payments continue to be made to the beneficiary based on the annuitant's life and the chosen payment plan.[5] An annuity owner may be a natural person or an entity that is not a natural person (e.g., corporations, partnerships, and trusts). With some exceptions, an annuity contract owned by an entity that is not a natural person does not receive tax-deferred treatment and the income is taxed annually as ordinary income received or accrued by the owner.[6] Exceptions include the following:

- A trust or other entity holding the annuity as an agent for a natural person,[7]
- Immediate annuities,
- Annuities acquired by an estate upon the death of the owner, and
- Annuities within a nonqualified deferred-compensation plan in which employers are nominal owners.

If the owner of an annuity is a grantor trust, the death of the grantor triggers a mandatory distribution.

The annuitant and beneficiary are named by the owner of the annuity contract. The **annuitant** must be a natural person because the amount and duration of payments made by the insurance company under the contract are based on the annuitant's expected life.

The **beneficiary** must be named in the contract. Frequently, the beneficiary is the spouse of the owner or annuitant. If the beneficiary is not named, a will or intestacy laws govern. The beneficiary designation may be revocable or irrevocable, with the revocability option being lost if the owner dies. The beneficiary receives any residual contract value upon the death of the annuitant. Annuities provide varying payments based on the age of the owner and beneficiary, and any term-certain survivorship established by the contract.

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2. IRC §72(s)(1)(B).
3. IRC §72(s)(2)(C).
4. IRC §72(s)(3).
5. IRC §72(s)(1(A).
6. IRC §72(u)(1).
7. Ibid.

THREE COMMON VARIETIES OF ANNUITIES

There are three types of annuities which differ in how money in the contract is invested:

1. **Fixed Annuities**. Fixed annuity payments are fixed for the entire life of the contract. In this regard, there is no risk to the owner. However, the payment amounts never increase.

2. **Variable Annuities**. While payments are guaranteed in variable annuities, the amount of the payment is not guaranteed. Payments vary depending on the rise or fall of the stock market. The money is placed in investment options known as subaccounts, which are similar to mutual funds. Each subaccount has its own degree of risk, ranging from aggressive growth funds to bond funds. Therefore, the annuity holder has the opportunity to make substantial gains, depending on the performance of the investment. However, the annuity holder can also lose money if the investments perform poorly. If the owner decides to transfer the money among subaccounts, there may be an associated fee. When annuitized, payments fluctuate depending on the performance of the investments. Some variable annuities allow **fixed annuitization,** in which the annuity holders receive fixed payments. The insurance or investment company recalculates payments each year based on the investments' performance.

3. **Equity-Indexed Annuities**. In this type of annuity, the money is invested in a fixed account, with a stated guaranteed return, and the investor may earn an additional return based on the performance of a particular stock index, such as the Standard and Poor's 500 Index, the Dow Jones Industrial Average, the NASDAQ Composite Index, or the Russell 2000 Index. Therefore, the owner receives both the opportunity to earn money based on stock performance and the stability of a fixed account. However, the investment is essentially a fixed annuity, and the gains made in the contract due to the performance of the stock index are fairly small. When annuitized, payments are fixed.

OTHER ANNUITY FEATURES

Annuity contracts can include riders. Riders are additional options available to investors of annuities. Riders usually have an additional charge associated with them.

For example, an annuity has a death benefit, although it is not like one found in a life insurance policy. If the annuity holder dies before the contract annuitizes, the beneficiary receives either the current value of the annuity or the amount paid into it, whichever is greater. If the annuity holder dies when the investments are performing poorly and the account value is less than what was contributed, the beneficiary receives the amount the annuity holder contributed.

Once an annuity holder begins to receive monthly payments, the death benefit no longer exists on the contract. For example, if the annuity holder begins receiving annuity payments at age 65 and dies at age 67, the insurance company retains the money held in the contract. However, one can buy **term-certain annuities,** which guarantee that either the annuity holder or the beneficiary will receive payments for a certain period of time, such as 10 to 15 years. For example, if the annuity owner died three years after beginning to receive payments from a 10-year term-certain annuity, the beneficiary would still receive payments for the next seven years. As the term-certain period increases, payments made under the contract decrease.

The money in an annuity grows tax deferred. Gains are taxed at ordinary income tax rates, a key disadvantage compared to investments whose gains are taxed at capital gain rates. If the annuity holder dies before payments begin, the beneficiary pays taxes on the gain from the death benefit. In either case, the person who receives the money (the annuity owner or beneficiary) is taxed at the ordinary income tax rate.

QUALIFIED VERSUS NONQUALIFIED ANNUITIES

Annuities may be qualified or nonqualified. If certain requirements are satisfied, contributions made to qualified annuities may be wholly or partially deductible from the taxable income of the individual or employer making the contributions. IRC §401(a) establishes these requirements. A **qualified annuity** is fully taxable when withdrawn, **unless nondeductible contributions** were made, such as to a nondeductible IRA. Annuities may be funded with IRA contributions or pension funds. Investment regulatory agencies discourage placing IRA contributions into annuities because the tax-deferred character of IRAs negates the advantage of annuities and the higher servicing costs of annuities erode growth of the investment. Annuities generally pay higher commissions than mutual funds. This may tempt salespersons to oversell them, rather than focusing on the suitability of the investment. Examples of common qualified annuity scenarios follow.

Example 1. Bob Jones retires after a 30-year career with the U.S. Park Service. His defined-benefit plan calls for a monthly $2,500 pension payment based on his tenure with the park service and his average salary over the last five years. To fulfill this obligation, the governmental agency buys an immediate annuity, which promises to pay Bob $2,500 per month for life in exchange for a single cash contribution. All of Bob's pension payments from the annuity are taxed as ordinary income.

Example 2. Lori makes IRA contributions that are invested into a qualified annuity for 20 years. At age 50, she withdraws $5,000. This distribution is fully taxable as ordinary income. Unless an exception applies, a 10% early withdrawal penalty is also imposed. All other IRA rules apply.

DETERMINING THE TAXABLE PORTION OF THE DISTRIBUTION

> **Caution.** The following rules only apply to annuities purchased on or after August 14, 1982. For annuities purchased before then, see IRS Pub. 575, *Pension and Annuity Income.*

The proper methods of calculating the taxable portion of the distribution depends on whether the distribution is:

1. Part of a series of payments over a period of more than one full year, or
2. A nonperiodic payment.

Periodic Distributions

The taxable portion of **nonqualified plan distributions** made as part of a series of payments is calculated using the General Rule.[8] Under the General Rule, the tax-free part of each annuity payment is based on the ratio of the cost of the contract to the total expected return. Expected return is the total amount expected to be received under the contract. If the expected return is not known, the total return must be determined using the actuarial tables prescribed by the IRS.[9]

8. IRS Pub. 575, *Pension and Annuity Income,* p. 11 (2009).
9. Ibid, p. 14.

Example 3. In 1990, Lola invested $15,000 in an annuity contract with Antioch Life Insurance. She never received any loans from the annuity. In 2010, when she turns 60, she starts receiving $5,000 annual payments. Based on the terms of the contract, she is guaranteed to receive a $5,000 annual payment for 10 years, then payments cease.

	Calculation	Result
Expected return	$5,000 × 10 years	$50,000
Ratio of investment to return	$15,000 ÷ 50,000	30%
Nontaxable return of principal	$5,000 × 30%	1,500
Annual taxable ordinary income	$5,000 − 1,500	3,500

Lola's 2010 Form 1099-R, *Distributions from Pensions, Annuities, Retirement or Profit-Sharing Plans, IRAs, Insurance Contracts, etc.*, from Antioch Insurance follows.

Note. In most cases, determining the total expected return is much more complicated. However, because the insurance company has all the required information, practitioners may request the information from the company.

☐ CORRECTED (if checked)

PAYER'S name, street address, city, state, and ZIP code	1 Gross distribution	OMB No. 1545-0119	Distributions From Pensions, Annuities, Retirement or Profit-Sharing Plans, IRAs, Insurance Contracts, etc.
ANTIOCH LIFE INSURANCE	$ 5000.00	2010	
	2a Taxable amount $ 3500.00	Form 1099-R	
	2b Taxable amount not determined ☐ Total distribution ☐		Copy B Report this income on your federal tax return. If this form shows federal income tax withheld in box 4, attach this copy to your return.
PAYER'S federal identification number: 37-1111111 / RECIPIENT'S identification number: 111-11-1111	3 Capital gain (included in box 2a) $	4 Federal income tax withheld $	
RECIPIENT'S name: LOLA	5 Employee contributions /Designated Roth contributions or insurance premiums $ 15000.00	6 Net unrealized appreciation in employer's securities $	
Street address (including apt. no.)	7 Distribution code(s) 7 / IRA/SEP/SIMPLE ☐	8 Other $ %	This information is being furnished to the Internal Revenue Service.
City, state, and ZIP code	9a Your percentage of total distribution %	9b Total employee contributions $	
1st year of desig. Roth contrib.	10 State tax withheld $ / $	11 State/Payer's state no.	12 State distribution $ / $
Account number (see instructions): WHIT1111-01	13 Local tax withheld $ / $	14 Name of locality	15 Local distribution $ / $

Form 1099-R — Department of the Treasury - Internal Revenue Service

13

Nonperiodic Distributions

Generally, the distribution is first allocated to earnings and then to the cost of the contract.[10] Therefore, the taxable portion of a nonperiodic distribution is considered to be withdrawn first.

Example 4. Art invested $15,000 in an annuity with Antioch Life Insurance in 1990. By 2010, when he is 70, the contract's cash value is $40,000. Art withdraws $20,000 to take his wife on her dream vacation through Europe. The entire $20,000 is taxable in 2010.

Example 5. Venita, age 65, invested $20,000 in an annuity with Northern Life Insurance in 2005. By 2010, the contract's cash value is $26,000. She withdraws $10,000 to publish her memoirs. Since the accumulated earnings are less than the distribution, only the earnings portion of $6,000 is taxable.

Venita's 2010 Form 1099-R from Northern Life Insurance is shown here.

☐ CORRECTED (if checked)

PAYER'S name, street address, city, state, and ZIP code	1 Gross distribution	OMB No. 1545-0119	Distributions From Pensions, Annuities, Retirement or Profit-Sharing Plans, IRAs, Insurance Contracts, etc.
NORTHERN LIFE INSURANCE	$ 10000.00	2010	
	2a Taxable amount $ 6000.00	Form 1099-R	
	2b Taxable amount not determined ☐ Total distribution ☐		Copy B Report this income on your federal tax return. If this form shows federal income tax withheld in box 4, attach this copy to your return.
PAYER'S federal identification number: 47-3333333 / RECIPIENT'S identification number: 333-33-3333	3 Capital gain (included in box 2a) $	4 Federal income tax withheld $ 600.00	
RECIPIENT'S name: VENITA	5 Employee contributions /Designated Roth contributions or insurance premiums $ 20000.00	6 Net unrealized appreciation in employer's securities $	
Street address (including apt. no.)	7 Distribution code(s): 7 / IRA/SEP/SIMPLE ☐	8 Other $ %	This information is being furnished to the Internal Revenue Service.
City, state, and ZIP code	9a Your percentage of total distribution %	9b Total employee contributions $	
1st year of desig. Roth contrib.	10 State tax withheld $ / $	11 State/Payer's state no.	12 State distribution $ / $
Account number (see instructions): KARC3333-01	13 Local tax withheld $ / $	14 Name of locality	15 Local distribution $ / $

Form 1099-R — Department of the Treasury - Internal Revenue Service

Note. Many practitioners compare the previous year's tax return entries to the current year's tax documents to determine if anything is missing. It can be confusing not having a tax statement if the taxpayer reports having received a distribution from an annuity in the previous year. However, this can be quickly resolved if the practitioner knows that the taxpayer receives nonperiodic distributions and that the prior year Form 1099-R for a commercial annuity reported that part of the distribution was not taxable.

10. Ibid, pp. 16–17.

An exception[11] to this treatment occurs when:

- The nonperiodic distribution is made after the periodic distributions begin, **and**
- Subsequent periodic payments will be reduced because of the nonperiodic distribution.

In this situation, the nontaxable portion of the distribution is calculated using the following formula:

$$\textbf{Nontaxable portion} = (\textbf{Cost of contract} - \textbf{Amounts previously recovered}) \times \frac{\textbf{Reduction in future payments}}{\textbf{Original amount of future payments}}$$

Example 6. Lola, from **Example 3,** takes an additional $2,000 in **2011** for a special gift to her granddaughter. At the time she withdraws the $2,000, she had already received the annual payment of $5,000. Previously, each $5,000 annual payment consisted of $1,500 nontaxable return of principal and $3,500 taxable earnings.

Lola's agent informs her that under the contract, her future payments will be reduced to $4,500 per year because of the extra $2,000 distribution in 2011.

Tax Result. Her current unrecovered cost of the contract is $12,000:

Original cost	$15,000
Less 2010 nontaxable portion of periodic distribution	(1,500)
Less 2011 nontaxable portion of periodic distribution	(1,500)
Unrecovered cost at time of nonperiodic distribution	$12,000

The proportionate amount of the unrecovered cost to be allocated to the nonperiodic distribution is 10% (($5,000 original annual distribution – $4,500 future distribution amount) ÷ $5,000 original annual distribution).

Her nontaxable portion of the $2,000 distribution is $1,200, the unrecovered cost of $12,000 × 10%. Her 2011 Form 1099-R is shown here.

☐ CORRECTED (if checked)

PAYER'S name, street address, city, state, and ZIP code	1 Gross distribution	OMB No. 1545-0119	Distributions From Pensions, Annuities, Retirement or Profit-Sharing Plans, IRAs, Insurance Contracts, etc.
ANTIOCH LIFE INSURANCE	$ 7000.00	2011	
	2a Taxable amount $ 4300.00	Form 1099-R	
	2b Taxable amount not determined ☐	Total distribution ☐	Copy B Report this income on your federal tax return. If this form shows federal income tax withheld in box 4, attach this copy to your return.
PAYER'S federal identification number: 37-1111111 / RECIPIENT'S identification number: 111-11-1111	3 Capital gain (included in box 2a) $	4 Federal income tax withheld $	
RECIPIENT'S name: LOLA	5 Employee contributions /Designated Roth contributions or insurance premiums $ 13500.00	6 Net unrealized appreciation in employer's securities $	
Street address (including apt. no.)	7 Distribution code(s): 7 / IRA/SEP/SIMPLE ☐	8 Other $ %	This information is being furnished to the Internal Revenue Service.
City, state, and ZIP code	9a Your percentage of total distribution %	9b Total employee contributions $	
1st year of desig. Roth contrib.	10 State tax withheld $ $	11 State/Payer's state no.	12 State distribution $ $
Account number (see instructions): WHIT1111-01	13 Local tax withheld $ $	14 Name of locality	15 Local distribution $ $

Form 1099-R — Department of the Treasury - Internal Revenue Service

[11] Ibid.

THE SIMPLIFIED METHOD FOR TAX COMPUTATIONS ON ANNUITY WITHDRAWALS

Employees who receive distributions from either **qualified employee plans** under IRC §401(a), employee annuities under §403(a), or annuity contracts under §403(b) must use a simplified method to compute the taxable and tax-exempt portion of the distributions. Under the simplified method, recipients recover their investment in the contract in equal amounts over the expected number of monthly payments determined from the tables in IRC §72(d)(1). If the taxpayer also receives a lump-sum distribution, the payment is taxed as if received before the annuity starting date.

Example 7. Arlo, age 59, began receiving annuity payments from his 401(k) retirement plan in 2010. He received 12 payments totaling $14,000 in 2010. Arlo has invested $31,000 of nondeductible money into the plan. The taxable amount that Arlo received in 2010 was $12,800. This was calculated by using the following worksheet from IRS Pub. 575, *Pension and Annuity Income.*

Worksheet A. **Simplified Method Worksheet** *Keep for Your Records*

1. Enter the total pension or annuity payments received this year. Also, add this amount to the total for Form 1040, line 16a; Form 1040A, line 12a; or Form 1040NR, line 17a	1.	14,000
2. Enter your cost in the plan (contract) at the annuity starting date plus any death benefit exclusion.* See *Cost (Investment in the Contract)* earlier. **Note.** If your annuity starting date was before this year and you completed this worksheet last year, skip line 3 and enter the amount from line 4 of last year's worksheet on line 4 below (even if the amount of your pension or annuity has changed). Otherwise, go to line 3.	2.	31,000
3. Enter the appropriate number from Table 1 below. But if your annuity starting date was after 1997 and the payments are for your life and that of your beneficiary, enter the appropriate number from Table 2 below	3.	310
4. Divide line 2 by the number on line 3	4.	100
5. Multiply line 4 by the number of months for which this year's payments were made. If your annuity starting date was before 1987, enter this amount on line 8 below and skip lines 6, 7, 10, and 11. Otherwise, go to line 6	5.	1,200
6. Enter any amount previously recovered tax free in years after 1986. This is the amount shown on line 10 of your worksheet for last year	6.	0
7. Subtract line 6 from line 2	7.	31,000
8. Enter the smaller of line 5 or line 7	8.	1,200
9. **Taxable amount for year.** Subtract line 8 from line 1. Enter the result, but not less than zero. Also, add this amount to the total for Form 1040, line 16b; Form 1040A, line 12b; or Form 1040NR, line 17b. **Note:** If your Form 1099-R shows a larger taxable amount, use the amount figured on this line instead. If you are a retired public safety officer, see *Insurance Premiums for Retired Public Safety Officers* earlier before entering an amount on your tax return	9.	12,800
10. Was your annuity starting date before 1987? ☐ Yes. **STOP.** Do not complete the rest of this worksheet. ☑ No. Add lines 6 and 8. This is the amount you have recovered tax free through 2009. You will need this number if you need to fill out this worksheet next year	10.	1,200
11. **Balance of cost to be recovered.** Subtract line 10 from line 2. If zero, you will not have to complete this worksheet next year. The payments you receive next year will generally be fully taxable	11.	29,800

* A death benefit exclusion (up to $5,000) applied to certain benefits received by employees who died before August 21, 1996.

Table 1 for Line 3 Above

IF the age at annuity starting date was...	AND your annuity starting date was— BEFORE November 19, 1996, enter on line 3...	AFTER November 18, 1996, enter on line 3...
55 or under	300	360
56-60	260	310
61-65	240	260
66-70	170	210
71 or older	120	160

Table 2 for Line 3 Above

IF the combined ages at annuity starting date were...	THEN enter on line 3...
110 or under	410
111-120	360
121-130	310
131-140	260
141 or older	210

The simplified method may not be used if the annuitant is over age 75 and there are five or more years of guaranteed payments under the annuity.[12] Instead, the regular annuity rules apply.

DISTRIBUTIONS BEFORE AGE 59½

Most annuity distributions made before the investor reaches age 59½ are subject to a 10% penalty in addition to the income taxes due on the taxable portion of the distribution. The penalty only applies to the taxable portion of the distribution.[13]

In many cases, the issuer of the Form 1099-R reports the distribution as an early distribution even though one of the exceptions applies. A code 1 in box 7 of Form 1099-R indicates that the payment is an early distribution with no known exception. If an exception does apply, the taxpayer must file Form 5329, *Additional Taxes on Qualified Plans (Including IRAs) and Other Tax-Favored Accounts.* This form allows the taxpayer to identify the applicable exception and quantify the amount of the distribution that qualifies.

> **Observation.** Determining that a code 1 distribution actually qualifies for an exception to the penalty can demonstrate to the taxpayer that using a tax professional is superior to using off-the-shelf software.

Under certain circumstances, a distribution from a commercial annuity is not subject to the additional 10% penalty. These exceptions are different from the exceptions related to distributions from qualified retirement plans and IRAs. If one of these conditions applies, the appropriate exception number from the Form 5329 instructions should be entered on the line across from line 2 on the form.

Exception codes and descriptions applicable to nonqualified annuities include the following:

02. A distribution is part of a series of substantially-equal periodic payments made over the life expectancy of the investor or the joint life expectancies of the investor and the beneficiary of the annuity.

03. The distribution is due to the disability of the contract holder.

04. The distribution is due to the death of the contract holder.

12. The portion of an early distribution which is allocable to investments made before August 14, 1982.

12. The annuity is part of a qualified personal injury settlement.

12. The annuity was purchased by the contract holder's employer upon termination of a qualified employee plan and held by the employer until the taxpayer's separation from service.

12. The annuity is an immediate annuity contract. (An immediate annuity contract is one purchased with a single premium that provides substantially-equal payments starting within one year from the date of purchase. The payments must be made at least once per year to qualify.)

> **Caution.** If the substantially-equal-periodic-payment exception applies and the taxpayer subsequently makes changes to the payment stream, a recapture tax may apply. See IRS Pub. 575 for more information.

12. IRC §72(d)(1)(E).

13. IRS Pub. 575, *Pension and Annuity Income*, pp. 30–32 (2009).

Example 8. Kenny, age 35, is totally and permanently disabled as the result of being struck by an ambulance. In 2010, he takes a fully-taxable distribution of $7,000 from his commercial annuity. His 2010 Form 1099-R from the insurance company shows a code 1 in Box 7 because he was under age 59½.

His CPA, Wendy, prepares the following Form 5329 and submits it with his 2010 tax return. She enters code 03 on the line across from line 2 to indicate that Kenny is not subject to the 10% penalty because of his disability. This entry is circled on the following example for emphasis.

Form **5329**

Department of the Treasury
Internal Revenue Service (99)

Additional Taxes on Qualified Plans (Including IRAs) and Other Tax-Favored Accounts

▶ Attach to Form 1040 or Form 1040NR.

▶ See separate instructions.

OMB No. 1545-0074

2010

Attachment Sequence No. 29

Name of individual subject to additional tax. If married filing jointly, see instructions.	Your social security number
Kenny	345-66-6666

Fill in Your Address Only If You Are Filing This Form by Itself and Not With Your Tax Return

Home address (number and street), or P.O. box if mail is not delivered to your home	Apt. no.
City, town or post office, state, and ZIP code	If this is an amended return, check here ▶ ☐

If you **only** owe the additional 10% tax on early distributions, you may be able to report this tax directly on Form 1040, line 58, or Form 1040NR, line 56, without filing Form 5329. See the instructions for Form 1040, line 58, or for Form 1040NR, line 56.

Part I Additional Tax on Early Distributions

Complete this part if you took a taxable distribution before you reached age 59½ from a qualified retirement plan (including an IRA) or modified endowment contract (unless you are reporting this tax directly on Form 1040 or Form 1040NR—see above). You may also have to complete this part to indicate that you qualify for an exception to the additional tax on early distributions or for certain Roth IRA distributions (see instructions).

1	Early distributions included in income. For Roth IRA distributions, see instructions	1	7,000
2	Early distributions included on line 1 that are not subject to the additional tax (see instructions). Enter the appropriate exception number from the instructions: 03	2	7,000
3	Amount subject to additional tax. Subtract line 2 from line 1	3	0
4	**Additional tax.** Enter 10% (.10) of line 3. Include this amount on Form 1040, line 58, or Form 1040NR, line 56	4	

Caution: *If any part of the amount on line 3 was a distribution from a SIMPLE IRA, you may have to include 25% of that amount on line 4 instead of 10% (see instructions).*

Part II Additional Tax on Certain Distributions From Education Accounts

Complete this part if you included an amount [illegible] on Form 1040 or Form 1040NR [illegible] a Co[illegible]

FEDERAL INCOME TAX WITHHOLDING[14]

A recipient may specify the amount of taxes to withhold from an annuity distribution by giving the payer Form W-4P, *Withholding Certificate for Pension or Annuity Payments.* To be valid, the form must include the recipient's social security number (SSN). Absent a valid Form W-4P, the payer must withhold taxes from the taxable portion of any distribution.

For **periodic payments,** the default level of withholding is based on the withholding tables for wages. Tax is withheld as if the recipient were married and claiming three withholding allowances. However, if the recipient fails to provide a valid SSN, the taxpayer is assumed to be single with no allowances.

For **nonperiodic payments** the default level of withholding is 10% of the taxable distribution.

> **Observation.** The default levels of withholding are seldom appropriate for the taxpayer's situation. Practitioners may wish to provide clients with a completed Form W-4P to submit to their annuity providers.

14. Ibid, pp. 8–9.

Example 9. Kenny, from **Example 8**, has $700 withheld from the $7,000 distribution from his commercial annuity. Since he has no federal tax liability, Wendy recommends that he elect to have no taxes withheld from future distributions. She provides him with the following Form W-4P to sign and give to his annuity provider. The line 1 box is circled for emphasis.

---------- Cut here and give Form W-4P to the payer of your pension or annuity. Keep the top part for your records. ----------

Form **W-4P**
Department of the Treasury
Internal Revenue Service

Withholding Certificate for Pension or Annuity Payments
► For Privacy Act and Paperwork Reduction Act Notice, see page 4.

OMB No. 1545-0074
2011

Type or print your first name and middle initial.	Last name	Your social security number
KENNY		345 66 6666
Home address (number and street or rural route)		Claim or identification number (if any) of your pension or annuity contract
City or town, state, and ZIP code		SP-CJN 51

Complete the following applicable lines.

1 Check here if you **do not want any** federal income tax withheld from your pension or annuity. (Do not complete lines 2 or 3.) ► ☑

2 Total number of allowances and marital status you are claiming for withholding from each **periodic** pension or annuity payment. (You may also designate an additional dollar amount on line 3.) . . . . . ► _____ (Enter number of allowances.)

Marital status: ☐ Single ☐ Married ☐ Married, but withhold at higher "Single" rate

3 Additional amount, if any, you want withheld from each pension or annuity payment. (**Note.** *For periodic payments, you cannot enter an amount here without entering the number (including zero) of allowances on line 2.)* . . ► $

Your signature ► **Date** ►

Cat. No. 10225T Form **W-4P** (2010)

TAX CONSEQUENCES OF OWNERSHIP CHANGES

Annuity contracts may allow any of the following ownership changes:

- The addition or deletion of a joint owner
- A transfer to another individual or entity
- An assignment of the annuity

When one of the above transfers occurs, the earnings are subject to income tax. A 10% penalty and/or gift taxes may apply. Exceptions to the imposition of these taxes and penalties include the following:

- Transfers due to divorce
- Transfers between spouses
- Transfers between an individual and his/her grantor trust

SURRENDERING AN ANNUITY OR SWITCHING FROM ONE ANNUITY TO ANOTHER

If a person buys an annuity and then decides to get out of the contract, the annuity can be surrendered. Most companies charge a surrender fee if a person decides to get out of the annuity contract within the first seven to eight years of owning it. The shorter the length of time the annuity contract is held, the more the person pays in surrender fees. For example, if the annuity has a 7-year surrender period and a person surrenders the annuity in the first year, then 7% of the value of the investment might be surrendered to the company. Surrendering the annuity in the second year might cost the owner 6%, and so on.

A person can switch from one annuity contract to another without paying taxes. Exchanging one contract for another is known as a §1035 exchange. In a §1035 exchange, a person can make a nontaxable exchange of a life insurance policy for another life insurance policy, an annuity for another annuity, or a life insurance policy for an annuity. However, a person cannot exchange an annuity for a life insurance policy without paying taxes on the gains in the contract. To be eligible for tax-deferred treatment, the policies or annuities must be exchanged through the insurance companies. When the owner personally receives any money during the exchange, even if the intent is to apply it to a new policy, it is subject to income tax.

If a person needs to withdraw money before the surrender period, some insurers allow access to a small percentage (10 to 15%) of the investment. This may be allowed under special circumstances, such as serious illness or disability, or simply at the discretion of the owner. After the surrender period, a person can withdraw as much of the annuity as desired. However, if the person withdraws money before attaining age 59½, the withdrawal is subject to a 10% penalty on the taxable portion unless an exception applies.

ANNUITY SUITABILITY ISSUES

The ideal annuity buyer is age 55 or older. Annuities are less attractive to younger investors due to the 10% penalty for withdrawing money before reaching age 59½ for reasons other than death or disability. However, many people who are already retired and need income immediately opt for immediate annuities. These annuities skip the accumulation phase and begin issuing payments as soon as money is invested in the contract. The early withdrawal penalty may severely limit the liquidity of funds for a senior citizen who buys an annuity that is not the immediate type. For this reason, annuity purchases by older individuals are often discouraged by investment regulatory agencies unless the individual is purchasing an immediate annuity.

The ideal annuity buyer is also someone who contributed the maximum amount to an existing tax-deferred retirement plan, such as a 401(k) or 403(b) plan, or an IRA. This investor already has accumulated tax-deferred money in those plans, and the fees associated with those accounts usually are much lower than those for annuities. With the large increases to contribution limits to qualified plans and IRAs in the last decade, few taxpayers have extra funds remaining with which to purchase annuities after funding, for example, a solo 401(k) plan, in which up to $49,000 per person may be deferred in 2010.

CONCLUSION

Annuities have become increasingly popular and more complex because their features have expanded to meet perceived and actual consumer demands. The goal of a tax professional is to handle the tax treatment of these investments correctly and to understand them well enough to competently serve clients.

ANNUITY GLOSSARY

Accumulation Phase. This is the phase in which a person contributes money to the annuity. Individuals can either contribute a lump sum of money or make payments into the annuity over time.

Annuitization Phase. In this phase, a person receives monthly payments from the annuity.

Death Benefit. This term refers to the amount of money the beneficiary receives if the owner dies before beginning the annuitization phase. It is generally the value of the annuity or the invested amount, whichever sum is greater. The death benefit on the annuity is taxable to the beneficiary.

Nonqualified Annuity. This is an annuity that is funded with after-tax dollars.

Qualified Annuity. This is an annuity that is funded with pre-tax dollars.

Rider. This term refers to an annuity feature that provides an additional benefit. For example, a long-term care rider covers nursing-home costs. A bonus rider gives the owner an extra 1–5% of the investment upon buying the annuity.

Surrender. This term refers to the act of giving up the annuity. There is usually a fee for surrendering the annuity within the first seven or eight years of owning it. This fee is also known as a contingent deferred sales charge or a back-end sales load.

Tax Deferral. The money that accumulates in the annuity is not taxable until the owner begins receiving annuity payments. (Tax is deferred until the money is received.)

Term-Certain Annuity. This refers to an annuity that provides the owner with income payments for a specific period of time, such as 10 or 20 years, rather than a lifetime.

LONG-TERM CARE INSURANCE

The popularity of long-term care insurance is increasing, with 7 million policies in effect.[15] The reasons for this popularity include the following:

- The population is aging rapidly, with greater needs for both home and custodial care.
- The government is concerned about its ability to continue paying a majority of all nursing home costs and encourages people to consider other financing options.
- Many seniors do not want their nursing home options limited by Medicaid.
- Tax breaks make purchasing the insurance more affordable.
- Through the use of standardized language and benefit options, policies are becoming easier to compare.

TAX TREATMENT OF LONG-TERM CARE INSURANCE

To encourage taxpayers to purchase long-term care insurance, Congress generally treats premiums for these policies like health insurance premiums. IRS Pub. 502, *Medical and Dental Expenses*, explains specifications that long-term care contracts must meet in order to be tax-qualified under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). In brief, the contract must:

- Provide long-term care coverage only,
- Be guaranteed renewable,
- Not permit cash-surrender values,
- Not permit refunds except at death or cancellation of the policy, and
- Not pay or reimburse items that would be reimbursed under Medicare, except as a secondary payor.

Policies that meet these standards are eligible for similar tax treatment as health insurance premiums, including an adjustment to income for the self-employed. The premiums may also be deducted on Schedule A, *Itemized Deductions*, as a medical expense if they are paid by the individual. In addition, the premiums can be deducted if they are included as benefits in §§105 or 125 plans and are paid by either the employer or employee. For payroll purposes, neither employer nor employee contributions are subject to income or payroll taxes.

Example 10. Doug purchased all the personal business property on the retail store owned by his family. Doug rents the real estate from his father Ed. Ed is semi-retired but still works every day in the store and is paid a monthly wage in cash or commodities. Doug has a §105 medical benefit plan in place that provides Ed with full medical coverage, including long-term care insurance premiums. In this manner, the real estate is protected and the premiums are paid by Doug, the person who stands to benefit the most.

15. [www.urban.org/publications/1001273.html] Accessed on Aug. 10, 2010.

Unlike health insurance premiums, deductibility limits exist for long-term care premiums. These limits are indexed for inflation. Per-person limits for 2009–2010 for deductible long-term care premiums are as follows:[16]

Age Range	2009	2010
Age 40 or under	$ 320	$ 330
Age 41 to 50	600	620
Age 51 to 60	1,190	1,230
Age 61 to 70	3,180	3,290
Age 71 or over	3,980	4,110

As a comparison to actual expenses, the National Clearinghouse for Long-Term Care Information gave average premium information for 2007, the latest year available, as follows:[17]

Age	Annual Average Premium
All ages	$2,207
Under age 40	881
Age 40–49	1,781
Age 50–59	1,982
Age 60–64	2,249
Age 65–69	2,539
Age 70 and older	3,026

The policies utilized for the above table provided on average a $160-per-day benefit, 4.8 years of coverage, and some form of automatic inflation protection. For younger people, the average premiums paid exceed the amounts that may be deducted but the tax savings still are significant.

Generally, periodic payments received under a per diem qualified long-term care contract are excluded from gross income, subject to an annual limit. The limit on the exclusion for payments made on a per diem or other periodic basis under a long-term care insurance contract is $290 per day for 2010.[18] The limit applies to the total of these payments and any accelerated death benefits made on a per diem or other periodic basis under a life insurance contract because the insured individual is chronically ill.

Under this limit, the excludable amount for any period is calculated by subtracting any reimbursement received (through insurance or otherwise) for the cost of qualified long-term care services from the larger of the following amounts:

- The cost of qualified long-term care services during the period
- The per diem dollar amount for the period

To claim this exclusion, taxpayers must file Form 8853, *Archer MSAs and Long-Term Care Insurance Contracts*, with their returns. There is no accountability requirement to match this per diem payment with actual costs of long-term care.

16. Rev. Proc. 2009-50, 2009-45 IRB 617, and Rev. Proc. 2008-66, 2008-45 IRB 1107.

17. [www.longtermcare.gov/LTC/Main_Site/Paying_LTC/Private_Programs/LTC_Insurance/index.aspx] Accessed on July 23, 2010.

18. Rev. Proc. 2009-50, 2009-45 IRB.

LONG-TERM CARE INSURANCE POLICIES

For individuals who either have insufficient funds to pay for their own nursing home expenses or too many assets to qualify for Medicaid, long-term care insurance is a viable alternative. Information included in this section is based on information found in a publication produced by the National Association of Insurance Commissioners.[19]

What Is Long-Term Care?

Long-term care involves a wide variety of services for people with prolonged physical illnesses, disabilities, or cognitive disorders, such as Alzheimer's disease. Long-term care is not one service. It is many different services aimed at helping people with chronic conditions compensate for limitations in their ability to function independently. Long-term care differs from traditional medical care because it is designed to help people maintain their level of functioning, as opposed to providing care or services that are designed to rehabilitate or correct certain medical problems. Long-term care services may include, but are not limited to, help with daily activities at home (bathing and dressing), respite care, home healthcare, adult daycare, and nursing home care.

Persons with physical illnesses or disabilities often need hands-on assistance with activities of daily living. Persons with cognitive impairments generally need supervision, protection, or verbal reminders to accomplish everyday activities.

The delivery mechanisms for long-term care services are changing very rapidly; however, **skilled care** and **personal care** remain the most common terms used to describe long-term care and the level of care a person may need.

Skilled care is generally needed for medical conditions that require care by skilled medical personnel, such as registered nurses or professional therapists. This care is usually provided 24 hours per day, is ordered by a physician, and involves a treatment plan. Skilled care is generally provided in a nursing home; however, it may also be provided in other settings such as the patient's home by visiting nurses or therapists.

Personal care (also known as custodial care) helps a person perform activities of daily living (ADL), which include assistance with bathing, eating, dressing, toileting, and transferring. It is less intensive or complicated than skilled care and can be provided in many settings, including nursing homes, adult daycare centers, or at home.

There are different types of providers of long-term care and various places where a person can receive this care. State laws governing the providers of long-term care vary widely as do terms used to describe these providers. Individuals investigating long-term care insurance options will become familiar with services provided by nursing homes, adult daycare centers, assisted-living facilities, and home care agencies.

Long-Term Care Costs

Long-term care can be expensive, depending upon the amount and type of care needed and the setting in which it is provided. In 2010, the median cost of one year in a semi-private nursing home in Illinois was $55,489.[20] This cost represents an average and varies widely across the country, with California costing an average of $86,870 and Connecticut costing an average of $125,925.[21] If a person receives skilled nursing care in the home and is visited by a home health aide three times per week for the entire year, the bill would equal about $18,000, based on national averages.[22]

19. *Shoppers Guide to Long-Term Care* can be ordered at www.naic.org/index_ltc_section.htm.

20. *Compare Cost of Care across the U.S.* Genworth Financial. [www.genworth.com/content/products/long_term_care/long_term_care/cost_of_care.html] Accessed on Aug. 2, 2010.

21. [www.longtermcare.gov/LTC/Main_Site/Paying_LTC/Costs_Of_Care/Costs_Of_Care.aspx] Accessed on July 24, 2010.

22. Ibid.

Paying for Long-Term Care

Nationally, one-third of all nursing home expenses are paid out of pocket by individuals and their families, and about half are paid by state Medicaid programs. Long-term care expenses are generally not paid by Medicare, Medicare supplemental insurance, or the major-medical health insurance provided by most employers. Medicare covers the cost of some skilled care in approved nursing homes or in the home but only in certain situations. Furthermore, Medicare's skilled nursing facility (SNF) benefit does not cover general nursing home care. The SNF benefit is a post-hospital benefit which only covers a relatively intensive level of skilled care furnished during a brief convalescent period after an acute care stay in a hospital. Medicare does not cover homemaker services.

Medicare does not pay for custodial care provided by home health aides unless the individual is also receiving skilled care such as nursing or therapy and the custodial care is related to the treatment of the illness or injury. However, there are limits on the number of days and hours of care an individual can receive in any week.

Medicare supplemental insurance is private insurance designed to help pay for some of the gaps in Medicare coverage, such as hospital deductibles and excess physicians' charges. These policies do not cover long-term care expenses. However, of the standardized Medicare supplement policies, Plans D, G, I, and J do contain an at-home recovery benefit that may pay up to $1,600 per year for short-term, at-home assistance with ADLs for those recovering from an illness, injury, or surgery.

In the United States, Medicaid[23] pays for nearly half of all nursing home care.[24] Medicaid may also pay for community-based services. To receive Medicaid assistance, a person must meet federal poverty guidelines for income and assets. Some assets, such as a person's home, are not taken into consideration when determining Medicaid eligibility. Many people who need nursing home care begin by paying out of pocket and eventually utilize most of their financial resources before they qualify for Medicaid. At that point, Medicaid begins to pay part or all of their nursing home expenses.

State laws differ as to how much money and assets a person is allowed to keep in order to become eligible for Medicaid. Individuals should contact their state Medicaid office, office on aging, state department of social service, or local Social Security Administration office to learn about the rules in their state. In most states, the health insurance counseling and assistance program also may provide some Medicaid information.

Who Should Buy Long-Term Care Insurance?

Not everyone should buy a long-term care insurance policy. For some, a long-term care policy is an affordable and attractive form of insurance. For others, the cost is too great, or the affordable benefits are insufficient. A long-term care policy is not a good option if it would cause financial hardship and make the buyer forgo other more pressing financial needs. Individuals, in consultation with their family members, tax adviser, and financial adviser should carefully examine their needs and resources to decide whether long-term care insurance is appropriate.

The need for long-term care can arise gradually as a person needs more and more assistance with ADLs, such as bathing and dressing. The need can surface suddenly following a major illness, such as a stroke or a heart attack.

Some people who have acute illnesses may need nursing home or home healthcare for only short periods of time. Others may need these services for many months or years.

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23. Medicaid is a state and federal government program that pays for certain long-term care services for older people with low incomes and limited assets. Income limits and services covered vary depending on the state. See [www.medicare.gov/longtermcare/static/home.asp] Accessed on Aug. 2, 2010.

24. National Clearinghouse for Long-Term Care Information. [www.longtermcare.gov/LTC/Main_Site/Paying_LTC/Costs_Of_Care/Costs_Of_Care.aspx#Who] Accessed on Aug. 2, 2010.

It is difficult to predict who will need long-term care. Studies provide information on the likelihood of needing such care. For example, one national source projects that approximately 9 million Americans over age 65 will need long-term care services this year. They predict this will increase to 12 million by 2020. Forty percent of people currently receiving long-term care are between 18 and 64 years old. They also predict about 70% of individuals over age 65 will need some type of long-term care services during their lifetimes.[25]

Men usually need care for shorter periods of time than women. Men need care for an average of 2.2 years compared to 3.7 years for women. Approximately 30% of the population over 65 years of age will never need long-term care.[26]

The chances of needing home healthcare are substantially greater than needing nursing home care. Each individual should assess the odds of needing coverage, analyze reasons for and against obtaining a policy, and determine how to pay for it.

Whether a person should buy a policy depends on age, health status, overall retirement objectives, and income. For instance, if the only source of income is a social security benefit or supplemental security income, long-term care insurance should probably not be purchased. Individuals who have trouble stretching their income to meet other financial obligations — such as paying for utilities, food, or medicine — should probably not purchase long-term care insurance policies.

On the other hand, people with significant assets may or may not need to consider buying a long-term care policy in order to save these assets. Many people buy a long-term care insurance policy because they want to pay for their own care and not burden their children or the government with nursing home bills. However, individuals who cannot afford the premiums or cannot reasonably predict whether they will be able to pay the premiums in the future should probably not buy policies.

People who have existing health problems that are likely to result in the need for long-term care, like Alzheimer's disease or Parkinson's disease, will probably not be eligible to buy a policy. Insurance companies have medical underwriting standards in place to keep the cost of long-term care insurance affordable. In the absence of such standards, most people would not buy coverage until they needed long-term care services.

TYPES OF POLICIES

Today, long-term care insurance policies are not standardized like Medicare supplemental insurance. Companies sell policies with various combinations of benefits and coverage. A person may acquire a policy in a variety of ways, such as:

- Individually,
- Through an employer,
- Through a spouse's employer,
- Through a child's employer,
- Through membership in an association, or
- Through a life insurance policy.

25. [www.longtermcare.gov/LTC/Main_Site/Understanding_Long_Term_Care/Basics/Basics.aspx] Accessed on July 24, 2010.
26. Ibid.

Individual Policies

Most of the policies sold today are sold to individuals. Many of these policies are sold through insurance agents, and some are sold through mail solicitations or direct telemarketing. Individual policies offer a wide variety of coverage; however, not all companies offer the same coverage. In order to find a policy that best meets an individual's needs, shopping among various companies and agents is highly recommended.

Joint Policies

Most long-term care insurance companies offer an option to cover two individuals with a defined total set of benefits. These policies allow either of the covered parties to use any or all of the benefits as they qualify. Any unused benefits remaining after the first-covered individual remain available to the second covered individual.

In essence, two individuals are pooling benefits and risks, which usually results in significant premium savings.

Employer Policies

An employer may allow employees to enroll in a group long-term care insurance plan. The coverage provided by these employer-group policies may be similar to what could be purchased individually from an agent or through direct-mail solicitation. Employer-sponsored policies usually give employees a choice of benefit periods, maximum payments, and elimination periods. Insurers may allow employees to keep the coverage after they leave the company. This is done by offering continuation of coverage or conversion options.

Many employers allow retirees, spouses, parents, and parents-in-law to buy coverage. Typically, employee spouses and relatives must pass the company's medical screening to qualify for coverage. Employees, however, may not be required to pass any medical examination. If an employer offers such coverage, it is advisable to consider it carefully. An employer-group policy may offer options that employees will not find if they try to buy policies independently.

Association Policies

Many associations allow insurance companies and agents to offer long-term care insurance to their members. These policies are similar to other types of long-term care insurance policies. Like employer-sponsored policies, association policies usually give their members many choices. Association policies may offer nonforfeiture benefits and inflation protection. In most states, association policies must allow members to keep their coverage after they leave the association. However, a person should be cautious about joining an association for the sole purpose of purchasing any insurance coverage, especially long-term care coverage.

Whether offered through an employer or an association, individuals should take time to compare different policies before making a decision.

Life Insurance Policies

Some life insurance companies offer access to the life insurance death benefit and cash value under certain specified conditions prior to death, such as terminal illness, permanent confinement in a nursing home, or for long-term care. This is often referred to as an **accelerated benefit** provision. Long-term care benefits can be offered as a feature of an individual or group life insurance policy. Under these arrangements, a portion of the policy's death benefit is paid on a periodic basis when the insured individual needs long-term care services. Policies may pay up to 100% of the death benefit for long-term care, and some companies offer the option to purchase additional long-term care coverage beyond the death benefit amount.

It is important to remember that the amounts used under this type of care reduce the amount of death benefit the beneficiary will receive, as well as the cash value of the life policy. For example, if a person purchases a policy with a $100,000 death benefit and uses $60,000 for long-term care, the death benefit of the policy is reduced to $40,000. If a person purchases life insurance to provide a benefit upon death for a specific need but uses this option for long-term care needs, the benefit upon death may not cover the original need. If a person never uses the long-term care benefit, the full death benefit stated in the life insurance policy is paid to the beneficiary.

Annuities Policies

Recently, some insurance companies have offered riders to their annuity policies which allow for increased annuity payments when a long-term care event is triggered. For instance, if an individual is admitted to a nursing home for 60 or more days or loses two or more of their six ADLs, then the monthly annuity might increase by 50% or even 100%. The specific coverage differs between companies, but the result is that this hybrid approach to coverage is often a more attractive option to an individual than no coverage or the all-or-nothing coverage of a traditional long-term care policy.

Partnership Programs

Some states have programs designed to assist individuals with the financial consequences of spending down their assets in order to qualify for Medicaid. These programs, generally called partnerships, allow individuals to purchase certain qualified long-term care insurance policies and receive full or partial protection against the normal Medicaid spend-down of assets. Individuals should check with their state insurance department or counseling program to see whether this type of program is available in their state.

Keep in mind that partnership programs are specific to a particular state, and the individual must be a resident of that state once the policy benefits are exhausted and they are ready to apply for Medicaid assistance. These programs were initially available in only a few states but were were expanded nationwide with 2006 legislation. Individual states must pass enabling legislation and regulations, and many have already done so. The impact of these policies is to allow a person to protect an amount of assets in their estate equal to the coverage provided by the long-term care policy. For example, if the policy provides $500,000 of coverage, the person would be able to spend down to this level rather than the normal $2,000–$3,000 needed for Medicaid eligibility. A map showing the states that have adopted these plans is found at **www.dehpg.net/ltcpartnership/map.aspx.** Only eight states have not adopted these plans.

HOW DO POLICIES WORK?

Covered Services

People who buy long-term care policies must understand the coverage for the variety of long-term care services available. Some policies cover only stays in nursing homes. Others cover only home care services. Still others cover both nursing home and home care. In addition, many policies also cover services provided in adult daycare centers or other community facilities.

Many long-term care policies only pay for care provided in licensed nursing facilities. Most policies on the market today do not distinguish among the types of nursing home care or level of care that is provided. They pay for any care needed, as long as long-term care is required and other eligibility requirements contained in the policy are met.

Home care coverage varies. Some policies pay home care benefits only for services performed in a person's home by registered nurses; licensed practical nurses; and occupational, speech, or physical therapists. Many policies offer a broader range of home care benefits. For instance, the services of home health aides employed by licensed home care agencies may be covered. These aides have less training than nurses who perform skilled care, and they generally help patients with personal care. A person may find a policy that pays for homemaker or chore worker services. This type of policy, though rare, pays for someone to come to the home to cook meals and run errands. Generally speaking, adding home care benefits to the policy increases the cost.

> **Note:** Most policies do not pay benefits to family members who perform home care services.

How Benefits Are Paid

Insurance companies generally pay benefits using two different methods: the expense incurred method, and the indemnity method.

In the **expense incurred method**, when an eligible person submits claims, the insurance company either pays the insured or the provider up to the limits contained in the policy. The policy or certificate pays benefits only when eligible services are received.

The second type of benefit payment is the **indemnity method.** Under this method, once a person is eligible for benefits, the insurance company pays the insured person directly in the amount specified in the policy, without regard to the specific services received.

It is important to read the literature that accompanies the policy or certificate. Most recently purchased policies pay benefits by the expense incurred method. Expense incurred policies tend to be less expensive and may provide benefits for a longer period of time.

Where Is Service Covered?

With a long-term care policy, it is not enough to know what services are covered, it is also important to know **where** services are covered. If the insured individual is not in the right type of facility, the insurance company may refuse to pay. Some policies cover care provided in any state-licensed facility. Others may limit the kinds of facilities where a person can receive care.

For example, many will not cover personal care unless it is provided in a licensed nursing facility. Other policies list the kinds of facilities that will not be covered. These often include homes for the aged, rest homes, personal care homes, and assisted-living facilities, although many states license these facilities to provide personal care. Some policies may explicitly define the kinds of facilities they will cover. Some may require the facility to care for a certain number of patients or require a certain kind of nursing supervision. It is important to check these requirements very carefully and pay particular attention to the types of facilities that provide services near the person's locale. It is also important to contact the insurance company before entering the healthcare facility to determine whether the stay will be covered.

Exclusions and Limitations

Insurance companies generally do not pay benefits if services are needed for a person who has:

- A mental or nervous disorder or disease, other than Alzheimer's disease;
- An alcohol or drug addiction;
- An illness or injury caused by an act of war;
- Received treatment that was already paid for by the government; or
- Attempted suicide or intentionally self-inflicted injuries.

Note: Insurance carriers cannot exclude coverage for Alzheimer's disease in states that have adopted the NAIC's Long-Term Care Insurance Model Regulation. Individuals should contact their state's department of insurance to find out whether this applies in their state. Virtually all policies specifically say they will cover Alzheimer's disease. Individuals also should be aware of the connection between Alzheimer's disease and eligibility for benefits discussed below.

Scope of Coverage

The amount of coverage provided by a policy or certificate is expressed in different ways:

1. **Lifetime Maximum Benefits.** Most plans have a total maximum benefit payable over the policy's duration. The maximum benefit limit is generally expressed in language such as "total lifetime benefit," "maximum lifetime benefit," or "total plan benefit." When examining a policy or certificate, carefully consider the total amount of coverage available. A few plans offer unlimited lifetime benefits. Often, these benefits are expressed in the marketing materials as benefit periods of one, two, three, or more years, or as the total dollar amount available. When considering which is better — a longer or a shorter benefit period — keep in mind that most nursing home stays are short and last three months or less. However, some illnesses last for several years, necessitating very long stays. A person must decide whether they want to be protected for such catastrophic events, bearing in mind that policies with longer benefit periods tend to be more expensive.

2. **Daily/Monthly Benefit Amounts.** Benefits are often payable on a daily, weekly, monthly, annual, or other periodic basis. For example, in an expense incurred plan, a nursing home benefit might be paid on a daily basis in an amount up to $100 per day, while the nursing home might cost $300 per day. A policy might contain inflation protection for these amounts. These policies usually involve a higher premium payment.

A person should understand the amount of coverage furnished by the policy or certificate. The type of service received will dictate the amount of coverage.

CLASS PROGRAM

The Patient Protection and Affordable Care Act (PPACA) establishes a new long-term care insurance option, which is expected to be available in October 2012. The Community Living Assistance Services and Supports (CLASS) program is a national voluntary insurance program for the purchase of community living services (long-term care) and for payment of institutional long-term care services. The purposes of this program are the following:

- Provide tools to individuals with functional limitations in order to allow them to maintain their personal and financial independence
- Establish an infrastructure to help address community living assistance services and support needs
- Alleviate burdens on family caregivers
- Address institutional bias by providing a financing mechanism that supports personal choice and independent community living[27]

Working adults can participate through an employment-based program. Spouses of workers can participate if they meet eligibility criteria. Self-employed individuals and individuals whose employers do not offer the CLASS program, can participate through an alternate sign-up method.

CLASS will be financed by voluntary payroll deductions or direct payments from individuals. At this point, premiums are expected to average approximately $120 per month.[28] Employees working for a participating employer will be automatically enrolled in the program unless they opt out.

27. PPACA Sec. 8001, adding Sec. 3203 to the Public Health Service Act.

28. [http://web.extension.illinois.edu/countrysidecenter/blogs/eb141/20100713_3814.html] Accessed on July 30, 2010.

Benefits are expected to average about $75 per day,[29] with the exact amount of benefit payments depending on the degree of loss of physical or mental function. Cash benefits will be paid to the participant according to the level of impairment. Participants are not eligible for benefits until they have contributed to the program for five years. Thus, the CLASS program is not designed to help people who are currently disabled and unable to work, or those who are already retired.

> **Note.** Many of the details of the CLASS program have yet to be developed by the HHS but are expected to be announced by October 2012.

TAXATION OF LONG-TERM CARE (LTC) BENEFITS

When the taxpayer receives benefits from a LTC contract, the benefits are not taxable as long as they do not exceed a maximum dollar limit. The limit is indexed for inflation and is $290 per day for 2010[30] when the contract payout is using an **indemnity method**. If the contract pays using the **expense incurred method**, the benefits are not taxable as long as the taxpayer has incurred the specified amount of qualified expense.

If the taxpayer receives benefits, Form 1099-LTC, *Long-Term Care and Accelerated Death Benefits*, is issued at yearend. The taxpayer files Form 8853, *Archer MSAs and Long-Term Care Insurance Contracts*, with Form 1040.

Example 11. Bessie purchased a LTC contract in 1997. On July 1, 2010, she moves into a nursing home because she had a disabling stroke. She pays $50,200 to the nursing home in 2010.

The LTC contract pays her $250 per day for the 184 days of confinement, or $46,000 for the year. Because this is less than the $290-per-day limit, the proceeds are not taxable.

Bessie's Form 1099-LTC and page 2 of Form 8853 follow.

☐ CORRECTED (if checked)

PAYER'S name, street address, city, state, ZIP code, and telephone no.	1 Gross long-term care benefits paid	OMB No. 1545-1519	
Care Insurance LTD **1 Broadway** **New York City, NY 11111**	$ **46000.00**	**2010**	**Long-Term Care and Accelerated Death Benefits**
	2 Accelerated death benefits paid $	Form **1099-LTC**	

PAYER'S federal identification number	POLICYHOLDER'S identification number	3 ■ Per diem ☐ Reimbursed amount	INSURED'S social security no.	**Copy B** **For Policyholder**
11-1234567	**111-22-3333**		**111-22-3333**	This is important tax information and is being furnished to the Internal Revenue Service. If you are required to file a return, a negligence penalty or other sanction may be imposed on you if this item is required to be reported and the IRS determines that it has not been reported.

POLICYHOLDER'S name	INSURED'S name
Bessie	**Bessie**
Street address (including apt. no.) **101 Smith Road**	Street address (including apt. no.) **101 Smith Road**
City, state, and ZIP code **Anytown, MN 11111**	City, state, and ZIP code **Anytown, MN 11111**

Account number (see instructions)	4 ☐ Qualified contract (optional)	5 (optional) ☐ Chronically ill ☐ Terminally ill	Date certified

Form **1099-LTC** (keep for your records) Department of the Treasury - Internal Revenue Service

29. Ibid.

30. Rev. Proc. 2009-50, 2009-45 IRB (Oct. 15, 2009).

For Example 11

Form 8853 (2010) Attachment Sequence No. 39 Page 2

Name of policyholder (as shown on Form 1040): Bessie

Social security number of policyholder ▶ 111-22-3333

Section C. Long-Term Care (LTC) Insurance Contracts. See **Filing Requirements for Section C** on page 6 of the instructions before completing this section.

If more than one Section C is attached, check here . . . . . ▶ ☐

14a Name of insured ▶ **Bessie** b Social security number of insured ▶ **111-22-3333**

15 In 2010, did anyone other than you receive payments on a per diem or other periodic basis under a qualified LTC insurance contract covering the insured or receive accelerated death benefits under a life insurance policy covering the insured? . . . . . ☐ Yes ☑ No

16 Was the insured a terminally ill individual? . . . . . ☐ Yes ☑ No

Note: *If "Yes" and the **only** payments you received in 2010 were accelerated death benefits that were paid to you because the insured was terminally ill, skip lines 17 through 25 and enter -0- on line 26.*

17	Gross LTC payments received on a per diem or other periodic basis. Enter the total of the amounts from box 1 of all Forms 1099-LTC you received with respect to the insured on which the "Per diem" box in box 3 is checked		17	46,000
	Caution: ***Do not*** *use lines 18 through 26 to figure the taxable amount of benefits paid under an LTC insurance contract that is not a **qualified** LTC insurance contract. Instead, if the benefits are not excludable from your income (for example, if the benefits are not paid for personal injuries or sickness through accident or health insurance), report the amount not excludable as income on Form 1040, line 21.*			
18	Enter the part of the amount on line 17 that is from **qualified** LTC insurance contracts		18	46,000
19	Accelerated death benefits received on a per diem or other periodic basis. Do not include any amounts you received because the insured was terminally ill (see page 7 of the instructions)		19	0
20	Add lines 18 and 19		20	46,000
	Note: *If you checked "Yes" on line 15 above, see **Multiple Payees** on page 7 of the instructions before completing lines 21 through 25.*			
21	Multiply $290 by the number of days in the LTC period	21 53,360		
22	Costs incurred for qualified LTC services provided for the insured during the LTC period (see page 7 of the instructions)	22		
23	Enter the **larger** of line 21 or line 22	23 53,360		
24	Reimbursements for qualified LTC services provided for the insured during the LTC period	24 0		
	Caution: *If you received any reimbursements from LTC contracts issued before August 1, 1996, see page 7 of the instructions.*			
25	Per diem limitation. Subtract line 24 from line 23		25	53,360
26	**Taxable payments.** Subtract line 25 from line 20. If zero or less, enter -0-. Also include this amount in the total on Form 1040, line 21. On the dotted line next to line 21, enter "LTC" and the amount		26	0

Form **8853** (2010)

In this example, the actual amount of long-term care expenses does not change the result. If the actual expenses had exceeded $53,360, the limitations on lines 23 and 25 would be higher.

Note. For per diem-based payments, the amount in box 1 of Form 1099-LTC is reported on line 17 of Form 8853. For reimbursement-based payments, it is reported on line 24. The amount **must not** be reported on both lines.

CONCLUSION

LTC insurance will become increasingly common as baby boomers reach retirement. Therefore, professionals must be knowledgeable in this area to properly advise clients. The decision to purchase any LTC product is a personal one based on family and personal health histories, individual risk factors, one's financial situation, family stage, and risk tolerance. Social security and nursing home planning are areas of strategic importance that may allow some individuals to save on insurance costs.

PAYROLL TAX ISSUES FOR HOME CARE

As the population ages, the need for elder care of all types will increase. This includes home healthcare, which has been encouraged by favorable payment provisions passed by Congress in the last decade. Confusion exists as to the payroll tax issues associated with home healthcare workers. This section explains the rules regarding which home healthcare workers are subject to domestic employment rules and outlines the steps that must be taken in order to comply with the law. IRS Pub. 926, *Household Employer's Tax Guide*, provides the following definition of a household employee:

> ***Do You Have a Household Employee?***
>
> *You have a household employee if you hired someone to do household work and that worker is your employee. The worker is your employee if you can control not only what work is done, but how it is done. If the worker is your employee, it does not matter whether the work is full time or part time or that you hired the worker through an agency or from a list provided by an agency or association. It also does not matter whether you pay the worker on an hourly, daily, or weekly basis, or by the job.*
>
> **Example 12.** Emma is single. She recently had heart surgery. She pays Betty to come into her home to cook, care for her, and do light housework 25 hours per week. Betty follows Emma's specific instructions about household and cooking duties. Emma provides the household equipment and supplies that Betty needs to do her work. Betty is Emma's household employee.

Household work is defined as work that is done in or around a home. Some examples of persons who do household work are the following:

- Babysitters
- Caretakers
- Cleaning people
- Domestic workers
- Drivers
- Health aides
- Housekeepers
- Maids
- Nannies
- Private nurses
- Yard workers

IRS Pub. 926 also provides guidance on who may **not** be considered household employees:

> ***Workers who are not your employees.*** *If only the worker can control how the work is done, the worker is not your employee but is self-employed. A self-employed worker usually provides his or her own tools and offers services to the general public in an independent business.*
>
> *A worker who performs child care services for you in his or her home generally is not your employee. If an agency provides the worker and controls what work is done and how it is done, the worker is not your employee.*[31]

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31. IRS Pub. 926, *Household Employer's Tax Guide*.

Example 13. Arnold is single. He recently had hip-replacement surgery and needs some assistance while he recuperates at home. Arnold contacted Horizon Health to arrange for his care at home. Horizon Health runs a home healthcare business and offers their services to the general public. They provide their own supplies and hire and pay any helpers that are needed. Neither Horizon Health nor their helpers are Arnold's household employees.

Horizon Health issues Forms W-2 to its employees; submits reimbursement requests for its charges to Medicare, Medicaid, or insurance providers; and generally does everything that a business would do in providing services to the public.

The deciding factors used to determine whether a household employment situation exists include the following:

- **Where Duties are Performed.** If services are provided in the senior citizen's home, the worker may be a household worker if the worker is not employed by an agency.
- **Who Controls the Hours and Terms of the Care.** If an agency establishes the hours, schedules the workers, and pays them, then the workers are not considered household workers.
- **Whether the Worker Is Hired by Multiple Senior Clients.** If the worker is hired by several senior clients, then the worker probably owns a business, advertises for clients, and runs a 1-person home health operation.

REPORTING REQUIREMENTS FOR HOME CARE EMPLOYEES

The payroll reporting requirements for domestic workers must be fulfilled as specified in IRS Pub. 926, *Household Employer's Tax Guide*. The following table, found in this publication, explains when individuals must pay social security and Medicare taxes (FICA) and when they must pay unemployment taxes (FUTA).

Table 1. **Do You Need To Pay Employment Taxes?**

IF you ...		THEN you need to ...
A–	Pay cash wages of $1,700 or more in 2010 to any one household employee. Do not count wages you pay to— • Your spouse, • Your child under the age of 21, • Your parent (see page 4 for an exception), or • Any employee under the age of 18 at any time in 2010 (see page 4 for an exception).	Withhold and pay social security and Medicare taxes. • The taxes are 15.3% of cash wages. • Your employee's share is 7.65%. (You can choose to pay it yourself and not withhold it.) • Your share is a matching 7.65%.
B–	Pay total cash wages of $1,000 or more in any calendar quarter of 2009 or 2010 to household employees. Do not count wages you pay to— • Your spouse, • Your child under the age of 21, or • Your parent.	Pay federal unemployment tax. • The tax is usually 0.8% of cash wages. • Wages over $7,000 a year per employee are not taxed. • You also may owe state unemployment tax.
Note. If neither A nor B above applies, you do not need to pay any federal employment taxes. But you may still need to pay state employment taxes.		

Note. Liability for state employment taxes and workers compensation may exist even though a person is not required to pay FICA or FUTA taxes.

SUPPLEMENTAL HEALTH INSURANCE FOR MEDICARE RECIPIENTS

For almost all Americans reaching age 65, Medicare becomes the primary health insurance. In many cases, seniors choose to purchase a supplemental health insurance policy, sometimes known as a Medigap policy. This section examines the coverage provided by Medicare Parts A, B, and D and discusses what coverage may be available through supplemental health insurance policies.

MEDICARE PART A — INPATIENT OR SKILLED NURSING CARE

Medicare Part A covers the following:

1. **Hospital Coverage.** Except for a $1,100 deductible (2010), Medicare pays all hospital costs for the first 60 days of a patient's stay. This deductible is adjusted each year on January 1. If the patient remains in the hospital for 61 through 90 days, there is a daily copay ($275 in 2010, adjusted annually). After 90 days, coverage lapses, except that up to 60 additional "reserve" days may be used during a patient's lifetime with a per-day copay of $550 (2010).
2. **Skilled Nursing Home Coverage.** Medicare also serves as a short-term funding source for nursing home stays. If a person has sufficient quarters to be covered by Medicare and is over age 65, blind, or disabled, the coverage is triggered by a hospital stay that involves at least three consecutive nights. The nursing home must be a Medicare-certified skilled nursing facility, and the patient must be receiving "daily skilled nursing services." If these qualifications are met, the patient is entitled to the following benefits:
   a. Full payment of charges for board, room, and skilled nursing care for the first 20 days. If the patient has a shorter stay than 20 days, the remaining eligibility may be used during a later stay in the nursing home, provided the other qualifications are met.
   b. For days 21 to 100, Medicare pays charges over the daily copay, which in 2010 is $137.50. This copay is subject to an annual cost-of-living adjustment.

   This coverage frequently comes into play when a nursing home is used as an after-surgery therapy provider for joint replacements, colostomies, and other medical conditions with significant recovery times. The patient is often sent home after a recovery period, and Medicare serves as a funding source for these temporary stays. The $4,263-per-month copay after the first 20 days may still be prohibitive for some patients; however, they will likely be covered by Medicaid if their resources and income are low enough.

Caution. Not all nursing homes accept Medicaid since Medicaid funding levels are significantly lower. A tactic these institutions can use after a 20-day stay is to declare that the patient is "no longer making progress."

In this case, the facility may begin billing the patient at private-pay rates, which can be $5,000 per month or more, or force the patient to move to another nursing home that accepts Medicaid. If these actions are not acceptable outcomes, provisions are available to block these moves while an appeal is pending.

It is important to know that signing a form giving the facility permission to stop billing Medicare leaves the patient with no avenue of appeal. Patients in this situation are placed on private-pay rates or are forced to move.

If done properly, the guardian or patient may ensure that the nursing home continues to bill Medicare for the reason that therapy is needed to maintain the patient's present level of functioning. If this request is made within 24 hours of the facility's declaration of "no longer making progress," the patient can maintain benefits during appeal.

The action used to accomplish this delay is to write the following phrase in the blank space provided on the form requesting permission to stop billing: "Patient needs daily skilled nursing services or therapy to maintain present level of functioning." This gives the patient or guardian the right to an automatic review by the Medicare intermediary and appeal rights with an administrative law judge.

3. **Psychiatric Hospital Coverage.** Medicare Part A covers up to 190 days of inpatient care in a psychiatric hospital or psychiatric unit of a general hospital. This is a lifetime limitation. Coverage limits are reduced by any days spent in an inpatient psychiatric hospital during the 150-day period before Medicare coverage begins.

4. **Home Healthcare.** The government encourages the use of home healthcare by not requiring Medicare deductibles and by only requiring a 20% copay on durable equipment, such as wheelchairs, etc. A wide variety of services are covered. Agencies providing the care must be Medicare approved.

Part A Premiums

For those entitled to benefits, there are no Medicare Part A premium payments required. For those not covered, the Part A premium is $461 per month (2010), with an additional 10% surcharge for those who do not apply in the first 12 months of eligibility. To be eligible for free coverage, the person must receive or be eligible to receive social security or railroad retirement benefits, have earned 40 quarters (credits), or be qualified through a spouse, ex-spouse, or deceased spouse.[32]

MEDICARE PART B — MEDICAL COVERAGE

Medicare Part B covers:

- Outpatient services,
- Doctor bills for hospital or nonhospital visits,
- Medically-necessary ambulance services,
- Physical therapy,
- Chiropractic treatment,
- Optometrist services,
- Oral surgery treatment,
- Podiatrist services,
- Mental healthcare treatment and clinical psychologists,
- Administered drugs, and
- Medical equipment and supplies if prescribed by a doctor.

All of these services are, by definition, outpatient and have various restrictions as to what specifically is covered. Services that are not medically necessary are not covered. These include:

- Cosmetic surgery,
- Routine physicals,
- Eye and hearing exams,
- General dental work,
- Immunizations, and
- Drugs and medicines taken outside a hospital or doctor's office.

32. [www.ssa.gov/pubs/10043.html#part3] Accessed on Aug. 10, 2010.

Premiums, Deductibles, and Copayments

Each October 15, the annual Part B premium is announced for the following year. For 2010, this amount is $96.40 for most Medicare enrollees. For new enrollees or those not having the monthly premium deducted from their social security checks, the premium is $110.50.[33] The premium is typically deducted from the individual's monthly social security check or may be paid directly if the covered person is not receiving social security payments or is having an automatic deduction from another source. It is crucial to enroll in Medicare at age 65. If the senior is not working and covered by group medical insurance, premiums increase 10% for each year the receipt of benefits is delayed after age 65.

For Medicare Part B, a $155 deductible applies to eligible payments annually in 2010. After this deductible, a 20% copayment is required. Several deviations from this copayment exist, including the following:

- For hospital charges, the patient is liable for 20% of the actual charges, not 20% of the amount eligible for Medicare reimbursement.
- For mental health outpatient coverage, the deductible is 50%.

Medicare Part B is heavily subsidized by the federal government, with only approximately 25% of the cost being covered by premiums. The conference committee for the 1997 Taxpayer Relief Act eliminated a provision that would have placed premiums on a sliding scale based on income. The premiums could have gone as high as $180 per month for those with higher incomes. This concept resurfaced with the 2003 Medicare Reform Act, which phased out subsidized premiums for those whose modified adjusted gross incomes (MAGI) exceed $85,000.[34] For 2010, the Part B premiums are based on the MAGI from 2008.

Yearly Income in 2008		
Individual Filers	**Joint Filers**	**2010 Part B Premium**
$ 85,001–$107,000	$170,001–$214,000	$154.70
107,001– 160,000	214,001– 320,000	221.00
160,001– 214,000	320,001– 428,000	287.30
Above 214,000	Above 428,000	353.60

Medicare Part B recipients who file MFS pay the following premiums in 2010:[35]

Recipient's Yearly Income	Premium
Up to $ 85,000	$110.50
$ 85,001– 129,000	287.30
129,001 or more	353.60

33. [www.medicare.gov/Publications/Pubs/pdf/11444.pdf] Accessed on July 25, 2010.

34. Ibid.

35. [http://questions.medicare.gov/app/answers/detail/a_id/2261/related/1] Accessed on July 26, 2010.

MEDICARE PART D — DRUG COVERAGE

Starting in 2006, Medicare Part D drug coverage became available to seniors who enrolled in either Medicare Part A or Part B. In 2009, the coverage had an average monthly premium of $28 per month, and it increased to $30 per month in 2010.[36]

The drug benefit is defined in terms of the benefit structure, not the drugs covered. The benefit has an initial deductible. After that deductible is met, the recipient pays 25% of the cost of drugs up to an initial coverage limit.

Once the coverage limit is exceeded, the recipient must pay the entire cost of the drugs until the plateau is reached where "catastrophic coverage" begins. The gap where the recipient is required to pay the total cost is called the **coverage gap** or the **donut hole.**

> **Note.** The Patient Protection and Affordable Care Act of 2010 authorized one-time $250 rebate checks to help close the donut hole. Once the donut hole is reached by a Medicare recipient with Part D coverage, a $250 check will automatically be sent within 45 days. The rebate payment is tax exempt.

Each state has multiple providers of Medicare Part D coverage. Some providers often offer more than one option for coverage. Some states have 50 options or more to choose from, with premiums ranging from $20 to over $100 per month. For assistance in selecting the right plan, Medicare offers a section on their website entitled Medicare Prescription Drug Care Finder. This can be found at **http://plancompare.medicare.gov/pfdn/FormularyFinder/LocationSearch.**

Each fall, there is an open enrollment period. Seniors may switch plans during open enrollment.

Extra help is available for people on Medicare who have low income and limited assets. Federal poverty guidelines are as follows.[37]

2009–2010 HHS Poverty Guidelines

Persons in Family	48 Contiguous States and DC	Alaska	Hawaii
1	$10,830	$13,530	$12,460
2	14,570	18,210	16,760
3	18,310	22,890	21,060
4	22,050	27,570	25,360
5	25,790	32,250	29,660
6	29,530	36,930	33,960
7	33,270	41,610	38,260
8	37,010	46,290	42,560
For each additional person above 8	3,740	4,680	4,300

For those in the poverty groups,[38] the subsidies for 2010 are as shown in the following table.[39]

36. [http://us.select.mercer.com/xlink/550823/] Accessed on July 25, 2010.
37. [www.atdn.org/access/poverty.html] Accessed on July 25, 2010.
38. [www.liheap.ncat.org/profiles/povertytables/FY2010/popstate.htm] Accessed on Aug. 10, 2010.
39. [www.medicareadvocacy.org/InfoByTopic/PartDandPrescDrugs/PartDMain.htm] Accessed on July 25, 2010.

2010 Low-Income Subsidy Groups and Costs

	Standard Benefit	Group 1 Dual Eligibles	Group 2 MSP (QMB, SLMB,QI) SSI w/ Medicare but w/o Medicaid	Group 3 Income <135% FPL and Resources below: $8,100 for singles; $12,910 for couples	Group 4 Income <150% FPL and Resources below: $12,510 for singles; $25,010 for couples
Premium	$31.94/month	$0 up to "benchmark"	$0 up to "benchmark"	$0 up to "benchmark"	Sliding scale ($0–$28.00) based on income
Deductible	$310 per year	$0	$0	$0	$63
Cost Sharing[a]	Up to $4,550 out-of-pocket	Copay: **Institutionalized** $0 **< 100% FPL** $1.10 generic drugs; $3.30 brand name drugs **> 100% FPL** $2.50 generic drugs; $6.30 brand name drugs	Copay: $2.50 generic drugs $6.30 brand name drugs	Copay: $2.50 generic drugs $6.30 brand name drugs	15% coinsurance
Catastrophic Coverage	5% of actual cost or Copay: $2.50 generic drugs $6.30 brand name drugs	$0	$0	$0	Copay: $2.50 generic drugs $6.30 brand name drugs

[a] Individuals in these four groups do not have the "Donut Hole" gap in coverage.

MSP = Medicare Savings Program
QMB = Qualified Medicare Beneficiary
SLMB = Special Low-Income Medicare Beneficiary
QI = Qualified Individual
FPL = Federal Poverty Line

Individuals falling within the groups referred to in the previous table may have little incentive to purchase Medicare supplemental insurance because in most cases their medical expenses are already substantially covered. Medicaid usually is the principal program that covers these individuals' care. These individuals run the risk of being denied care by hospitals or other providers who do not accept Medicaid patients.

For those who are not eligible for subsidies, the following table of Part D benefits for 2006–2010 applies.[40]

40. Ibid.

Part D Standard Benefit 2006–2010

	2006	2007	2008	2009	2010
Annual Deductible Maximum	$250	$265	$275	$295	$310
Member Pays 25% of the Next . . .	**$2,000** (25% = $500)	**$2,135** (25% = $533.75)	**$2,235** (25% = $558.75)	**$2,405** (25% = $601.25)	**$2,520** (25% = $630)
Initial Benefit Period Maximum (what the member and the plan have spent)	**$2,250** ($250 + $2,000)	**$2,400** ($265 + $2,135)	**$2,510** ($275 + $2,235)	**$2,700** ($295 + $2,405)	**$2,830** ($310 + $2,520)
Donut Hole Member Pays 100% of the Next . . .	$2,850	$3,051.25	$3,216.25	$3,453.75	$3,610
Catastrophic Coverage Begins When Member **(not plan)** Has Spent a Total of . . .	**$3,600** ($250 + $500 + $2,850)	**$3,850** ($265 + $533.75 + $3,051.25)	**$4,050** ($275 + $558.75 + $3,216.25)	**$4,350** ($295 + $601.25 + $3,453.75)	**$4,550** ($310 + $630 + $3,610)
Cost Sharing during Catastrophic Coverage	The higher of: **1.** 5% of actual cost, or **2.** Copay of: $2 (generic) $5 (brand name)	The higher of: **1.** 5% of actual cost, or **2.** Copay of: $2.15 (generic) $5.35 (brand name)	The higher of: **1.** 5% of actual cost, or **2.** Copay of: $2.25 (generic) $5.60 (brand name)	The higher of: **1.** 5% of actual cost, or **2.** Copay of: $2.40 (generic) $6 (brand name)	The higher of: **1.** 5% of actual cost, or **2.** Copay of: $2.50 (generic) $6.30 (brand name)

Of the many plans offered by private companies providing Medicare Part D coverage, almost none match the provisions shown. In Minnesota, of the more than 20 insurers offering over 50 plans, most offer benefits that exceed the minimum requirements and charge premiums below the recommended level. The monthly premiums range from $20 to over $100.

Observation. Why are companies aggressively working to acquire this business?

The combination of premiums, copayments, and high profit margins, make this service lucrative. Some of the providers are owned by drug companies. The potential of cutting out local pharmacists and keeping more of the income from drug sales is a strong incentive.

Building a customer base now may mean larger profits later for providers because premiums, deductibles, coverage limits, and coverage gaps are projected to double in the next eight years, all of which will increase providers' profit levels.

The providers are eager to acquire their share of the country's largest drug market segment, which has tremendous growth potential. The HHS expects 29.3 million of the 43.4 million Medicare recipients to enroll in Medicare drug plans, with 10.9 million of the enrollees qualifying for low-income subsidies. The government pays full cost for all the drugs used by these individuals, as mandated by law.

The government heavily subsidizes the providers for their administrative expenses by paying health insurance agents for each senior enrolled.

MEDICARE SUPPLEMENTAL INSURANCE POLICIES

The following explanation of Medigap policies is found on the Medicare website:[41]

> *A Medigap policy is health insurance sold by private insurance companies to fill the "gaps" in Original Medicare Plan coverage. Medigap policies help pay some of the health care costs that the Original Medicare Plan does not cover. If a person is in the Original Medicare Plan and has a Medigap policy, Medicare and the Medigap policy will pay both their shares of covered health care costs.*

Insurance companies can only sell a standardized Medigap policy. All Medigap policies must have specific benefits to allow for easy comparison.

A person may be able to choose from up to 12 different standardized Medigap policies (Medigap Plans A through L). Medigap policies must follow federal and state laws which protect the consumer. A Medigap policy must be clearly identified on the cover as "Medicare Supplemental Insurance." Each plan, A through L, has a different set of basic and extra benefits.

It is important to compare Medigap policies because costs can vary. The benefits in any Medigap Plan are the same for any insurance company. Each insurance company decides which Medigap policies it wants to sell.

Generally, a person buying a Medigap policy must be enrolled in Medicare Part A and Part B. A person must pay the monthly Medicare Part B premium in addition to a premium for the Medigap insurance.

The consumer and spouse must buy separate Medigap policies. **A Medigap policy does not cover any healthcare costs for a person's spouse.**

Additional information on Medigap policies, including reasons to buy a Medigap policy and information about what Medigap policies cover, is contained in *Choosing a Medigap Policy: A Guide to Health Insurance for People with Medicare*. This 64-page publication is an excellent resource. It can be downloaded from **www.medicare.gov/Publications/Pubs/pdf/02110.pdf.**

41. [www.cms.gov/medigap] Accessed on July 25, 2010.

POWER OF ATTORNEY ISSUES

A power of attorney (POA) is a legal document which authorizes another person(s) to act on behalf of the individual who grants it. It may apply to medical, legal, or financial matters. The person authorizing another to act is the principal, grantor, or donor (of the power), and the one authorized to act is the attorney-in-fact.

A POA may generally be oral and, whether witnessed or not, will hold up in court just as if it were in writing. For some purposes, the law requires a POA to be in writing. In most states, in order for the POA to be recorded, it must be notarized. Many institutions, including the IRS, will only honor a written POA, and they will usually keep an original copy for their records. Unless the POA is irrevocable, the grantor may revoke the power of attorney by telling the attorney-in-fact it is revoked. However, if the principal does not inform third parties of the revocation and it is reasonable for third parties to rely upon the POA being in force, the principal may still be bound by the acts of the original attorney-in-fact. In such situations, the attorney-in-fact may also be liable for any unauthorized acts. Some states may require that a written revocation be recorded for the POA to be legally revoked.

TYPES OF POWERS OF ATTORNEY

A POA may be limited to one specified act or type of act, or it may be general. Whatever it defines as its scope is what a court enforces. In addition to a particular type of POA, the POA may be of a limited duration. Under common law, a POA becomes ineffective if its grantor dies or becomes **incapacitated.** The term **incapacitated** means the grantor is unable to grant such a power because of physical injury or mental incapacity. If a grantor wants to ensure that the POA does not become ineffective, the POA must specify that it will continue to be effective even if the grantor becomes incapacitated. This type of POA is called a **durable power of attorney.** Regardless of the language contained in a POA, it ends when the grantor dies.

A **healthcare power of attorney** is an advance directive which empowers the attorney-in-fact (proxy) to make healthcare decisions for the grantor. This can even include terminating care by "pulling the plug" on machines keeping a critically- and/or terminally-ill patient alive. Healthcare decisions include the power to consent, refuse consent, or withdraw consent to any type of medical care, treatment, service, or procedure. A living will is a written statement of a person's healthcare and medical wishes. It does not appoint another person to make healthcare decisions. In some jurisdictions, a durable POA can include healthcare directives as normally granted in a separate healthcare POA.

OPTIONS WITHIN THE POWER OF ATTORNEY

The POA document usually has a number of options that may be chosen or specified. These may include the following:

- A provision for successor attorneys-in-fact should the original attorney-in-fact predecease the grantor,
- Guidance on whether multiple attorneys-in-fact must act together or may act independently,
- A stipulation as to whether the attorney-in-fact can transfer real estate to him/herself,
- The requirement of an accounting by the attorney-in-fact,
- An expiration date or indefinite appointment,
- Durable provisions enabling the attorney-in-fact to continue if the grantor is incapacitated, and
- A variety of allowed acts or a general power of attorney which allows virtually any transaction to be performed by the attorney-in-fact.

WHY GRANT A POWER OF ATTORNEY?

POAs provide a method to address the potential problem of incapacitation and give those involved a description of the grantor's wishes. Property laws, medical practices, and virtually all legal provisions are based on the assumption that individuals will make decisions on their own behalf. A number of scenarios can arise in which this is no longer possible, such as:

- Physical or mental incapacity due to injury, mental deterioration, or any other reason;
- Absence from the location where some transaction needs to be completed; or
- Lack of expertise in certain matters, such as tax issues in an audit.

If some transaction or act needs to be performed and the grantor is no longer able to do so, having a valid POA in place may save taxes, legal expenses, or accomplish tasks that the grantor wanted to do but is no longer capable of doing.

DEALING WITH FAILING TAXPAYERS

Tax preparers normally operate on the assumption that clients are mentally able to provide the information required to prepare their returns and are able to sign the return or the electronic filing transmittal Form 8879, *IRS e-File Signature Authorization*, or its entity equivalent. Unfortunately, tax preparers encounter clients for whom this is no longer possible due to mental incompetency. Preparers must meet IRS regulations when this occurs.

As is the case with most government agencies, the IRS requires that any POA granted by a taxpayer be in writing. Additionally, the POA must address the actual tax matters in question. Form 2848, *Power of Attorney and Declaration of Representative*, does this.

A general POA may allow someone other than the taxpayer the legal right to sign a document. Signing a tax return can fall within this right. The POA expires when the taxpayer dies. After death, a court-appointed executor is entitled to sign tax returns on behalf of the decedent.

REVERSE MORTGAGES

Reverse mortgages are becoming a popular financial planning tool for many seniors. In the fiscal year that ended September 2008, the most popular reverse mortgage, the Federal Housing Administration (FHA) Home Equity Conversion Mortgage (HECM), set a record with 112,154 mortgages issued, up 4.3% from the prior year.[42]

> **Note.** For information about reverse mortgages, see Chapter 4, Tax Aspects of Home Ownership. Reverse mortgages were also covered in depth in Chapter 7, Elder Issues, in the 2007 *University of Illinois Federal Tax Workbook*. This can be found on the accompanying CD.

42. [www.seniorjournal.com/NEWS/ReverseMortgage/2008/20081015-ReverseMortgagesContinued.htm] Accessed on July 26, 2010.

GIFTING

Gifting is the process of transferring cash, real property, or other assets for no consideration or for less than fair market value. By definition, a gift is not deductible to the giver (donor) unless given to a qualified charity, and is not taxable to the recipient (donee). State and federal law limits gifting in order to keep individuals from completely avoiding income or estate taxes.

ANNUAL GIFT EXCLUSION

In 2010, any individual may gift $13,000 annually to any other individual without having to report it to the IRS. A married couple may jointly gift double this amount to a child. If the child is married, the gift may be as high as $52,000 annually from the parents to the married child and the child's spouse with no gift tax reporting. This annual exclusion from reporting is increased in $1,000 increments based on inflation; the annual exclusion has been $13,000 since 2008. No announcement has been made yet about the 2011 gifting limit.

The annual gifting exclusion does not apply to reporting for Medicaid purposes. In this case, nearly all gifts trigger penalties unless the gift is to a spouse, minor child, disabled person, or a qualifying trust. Gifts for Medicaid purposes have a 5-year look-back period. Gifts made within the five years trigger a penalty. The **penalty period** is computed by dividing the gift by the monthly private pay nursing home cost for the donor's state.[43] During the penalty period, the person transferring assets is ineligible for Medicaid.

> **Example 14.** Three years before she would otherwise be eligible for Medicaid, Bonnie gives $50,000 to a close friend. If the monthly nursing home cost in the state where Bonnie lives is $5,000, she is ineligible for Medicaid benefits for 10 months ($50,000 gift ÷ $5,000 monthly nursing home cost).

Both spouses' available resources count against Medicaid eligibility caps. In limited cases, a parent may transfer a home to a child without penalty.

Medicaid is a federal program administered by the states. This gives different states some latitude in what they allow in terms of gifting. Donors should check with a qualified elder law attorney in their state to determine eligibility requirements.

LIFETIME GIFT EXCLUSIONS

The federal lifetime exclusion is $1 million per person. States may have different limits. The lifetime exclusion is the amount that anyone can gift during their lifetime without the imposition of gift taxes. An individual may gift in conjunction with their spouse through gift splitting and thus effectively double the lifetime exclusion. An individual can deduct $13,000 from the annual total paid to each recipient (donee) or a couple can deduct $26,000 from their annual total per donee in determining the amount of the lifetime exclusion used by gifts during the year. The lifetime exclusion has been fixed at $1 million since 2001. This may change in 2011 with expected legislation producing modifications to estate tax provisions.

Money or property transferred from one spouse to the other during life or at death is not subject to gift or estate tax if certain conditions are met. The property must either be given outright or transferred to a qualifying trust. This is called the **unlimited marital deduction.** However, there is an exception for transfers to non-citizen spouses. A U.S. citizen can only gift a non-U.S.-citizen spouse (i.e., alien spouse) up to $134,000 in tax year 2010 without gift tax consequences. This number is indexed for inflation. Gifting to a spouse may not always be advisable because it may bring the spouse's estate over the threshold amount for estate taxes. Consultation with an attorney specializing in estate planning is advisable.

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43. [www.elderlawanswers.com/Elder_Info/Elder_Article.asp?id=2751] Accessed on July 26, 2010.

Gifting is a powerful tool in a farm or business transfer. Using annual gift exclusions or a larger gift may trigger a Form 709, *United States Gift (and Generation-Skipping Transfer) Tax Return*, but can save the donor of real estate or other assets thousands of dollars of income taxes. Other reasons to use gifting include the following:

- Assets that are likely to appreciate in value may be gifted, moving future appreciation to the donee.
- Gifts to charity have no dollar limit and they may provide income tax deductions as well as reducing the donor's estate.
- Gifting during a person's lifetime allows the donor to establish a legacy.
- Choosing to gift business assets may allow the donor to choose assets that carry the greatest tax liability.

Gifting may have drawbacks as well:

- Donors lose control of their accumulated wealth, limiting retirement flexibility.
- Retaining a life estate or other present interest may expose the property to indefinite look-back periods for Medicaid purposes.
- Donees do not receive a stepped-up basis on real estate, stocks, or other property.
- Gifting assets to children or others, if spent in the 5-year look-back period, may create a problem if the donor needs to enter a nursing home.

GENERATION-SKIPPING TRANSFER TAX

The generation-skipping transfer tax (GSTT) imposes a tax on both outright gifts and transfers in trust to or for the benefit of unrelated individuals more than 37½ years younger than the donor, or to related persons more than one generation younger than the donor (such as grandchildren). The GSTT is imposed only if the transfer avoids incurring a gift or estate tax at each generation level.

The current version of the GSTT no longer attempts to impose a tax equal to the estate or gift tax that was avoided. Instead, the GSTT is imposed at a flat rate equal to the highest marginal estate and gift bracket applicable at the time of the gift, bequest, transfer, or termination. That rate is currently 45%.

In 2009, each taxpayer had a $3.5 million exemption from the GSTT. Only aggregate gifts and bequests to grandchildren or younger beneficiaries in excess of $3.5 million ($7 million for a married couple) were subject to the GSTT. This exemption is currently unlimited for 2010. However, the law that increased the GSTT exemption, lowered the tax rate, and eliminated the GSTT in 2010 is set to expire in 2011. This means that the GSTT exemption amount will return to $1 million per individual in 2011 unless Congress makes additional changes.

ADVANTAGES OF USING EXEMPTIONS FROM THE TAX

Many parents who might otherwise leave their entire estates outright to their children use their generation-skipping exemptions to create a generation-skipping trust for their grandchildren, which can be funded with up to $7 million of cash or property.

Utilizing the GSTT exemption in this manner offers two important advantages:

- The trust escapes all transfer taxes and passes tax free to the grandchildren.
- The trust may be protected from the claims of creditors and, to some degree, from claims of ex-spouses. If the trust property were left to the children outright, the property would be subject to such claims.

In some states (e.g., Wisconsin), property acquired by gift or inheritance from a third party is not subject to division in divorce proceedings and is not subject to claims by an ex-spouse.