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

(b) *Coordination with State requirements*—(1) *Contracts issued in a State that imposes more stringent requirements.* If a State imposes a requirement that is more stringent than the analogous requirement imposed by section 7702B(g) or 4980C, then, under section 4980C(f), compliance with the more stringent requirement of State law is considered compliance with the parallel requirement of section 7702B(g) or 4980C. The principles of paragraph (b)(3) of this section apply to any case in which a State imposes a requirement that is more stringent than the analogous requirement imposed by section 7702B(g) or 4980C (as described in this paragraph (b)(1)), but in which there has been a failure to comply with that State requirement.

(2) *Contracts issued in a State that has adopted the model provisions.* If a State imposes a requirement that is the same as the parallel requirement imposed by section 7702B(g) or 4980C, compliance with that requirement of State law is considered compliance with the parallel requirement of section 7702B(g) or 4980C, and failure to comply with that requirement of State law is considered failure to comply with the parallel requirement of section 7702B(g) or 4980C.

(3) *Contracts issued in a State that has not adopted the model provisions or more stringent requirements.* If a State has not adopted the Model Act, the Model Regulation, or a requirement that is the same as or more stringent than the analogous requirement imposed by section 7702B(g) or 4980C, then the language, caption, format, and content requirements imposed by sections 7702B(g) and 4980C with respect to contracts, applications, outlines of coverage, policy summaries, and notices will be considered satisfied for a contract subject to the law of that State if the language, caption, format, and content are substantially similar to those required under the parallel provision of the Model Act or Model Regulation. Only nonsubstantive deviations are permitted in order for language, caption, format, and content to be considered substantially similar to the requirements of the Model Act or Model Regulation.

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

[T.D. 8792, 63 FR 68186, Dec. 10, 1998]

§ 1.7702B–2 Special rules for pre-1997 long-term care insurance contracts.

(a) *Scope.* The definitions and special provisions of this section apply solely for purposes of determining whether an insurance contract (other than a qualified long-term care insurance contract described in section 7702B(b) and any regulations issued thereunder) is treated as a qualified long-term care insurance contract for purposes of the Internal Revenue Code under section 321(f)(2) of the Health Insurance Portability and Accountability Act of 1996 (Public Law 104–191).

(b) *Pre-1997 long-term care insurance contracts*—(1) *In general.* A pre-1997 long-term care insurance contract is treated as a qualified long-term care insurance contract, regardless of whether the contract satisfies section 7702B(b) and any regulations issued thereunder.

(2) *Pre-1997 long-term care insurance contract defined.* A pre-1997 long-term care insurance contract is any insurance contract with an issue date before January 1, 1997, that met the long-term care insurance requirements of the State in which the contract was

sitused on the issue date. For this purpose, the long-term care insurance requirements of the State are the State laws (including statutory and administrative law) that are intended to regulate insurance coverage that constitutes ''long-term care insurance'' (as defined in section 4 of the National Association of Insurance Commissioners (NAIC) Long-Term Care Insurance Model Act, as in effect on August 21, 1996), regardless of the terminology used by the State in describing the insurance coverage.

(3) *Issue date of a contract*—(i) *In general.* Except as otherwise provided in this paragraph (b)(3), the issue date of a contract is the issue date assigned to the contract by the insurance company. In no event is the issue date earlier than the date the policyholder submitted a signed application for coverage to the insurance company. If the period between the date the signed application is submitted to the insurance company and the date coverage under which the contract actually becomes effective is substantially longer than under the insurance company's usual business practice, then the issue date is the later of the date coverage under which the contract becomes effective or the issue date assigned to the contract by the insurance company. A policyholder's right to return a contract within a free-look period following delivery for a full refund of any premiums paid is not taken into account in determining the contract's issue date.

(ii) *Special rule for group contracts.* The issue date of a group contract (including any certificate issued thereunder) is the date on which coverage under the group contract becomes effective.

(iii) *Exchange of contract or certain changes in a contract treated as a new issuance.* For purposes of this paragraph (b)(3)—

(A) A contract issued in exchange for an existing contract after December 31, 1996, is considered a contract issued after that date;

(B) Any change described in paragraph (b)(4) of this section is treated as the issuance of a new contract with an issue date no earlier than the date the change goes into effect; and

(C) If a change described in paragraph (b)(4) of this section occurs with regard to one or more, but fewer than all, of the certificates evidencing coverage under a group contract, then the insurance coverage under the changed certificates is treated as coverage under a newly issued group contract (and the insurance coverage provided by any unchanged certificate continues to be treated as coverage under the original group contract).

(4) *Changes treated as the issuance of a new contract*—(i) *In general.* For purposes of paragraph (b)(3) of this section, except as provided in paragraph (b)(4)(ii) of this section, the following changes are treated as the issuance of a new contract—

(A) A change in the terms of a contract that alters the amount or timing of an item payable by either the policyholder (or certificate holder), the insured, or the insurance company;

(B) A substitution of the insured under an individual contract; or

(C) A change (other than an immaterial change) in the contractual terms, or in the plan under which the contract was issued, relating to eligibility for membership in the group covered under a group contract.

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

(A) A policyholder's exercise of any right provided under the terms of the contract as in effect on December 31, 1996, or a right required by applicable State law to be provided to the policyholder;

(B) A change in the mode of premium payment (for example, a change from monthly to quarterly premiums);

(C) In the case of a policy that is guaranteed renewable or noncancellable, a classwide increase or decrease in premiums;

(D) A reduction in premiums due to the purchase of a long-term care insurance contract by a family member of the policyholder;

(E) A reduction in coverage (with a corresponding reduction in premiums) made at the request of a policyholder;

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

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

(H) The addition of a rider (including any similarly identifiable amendment) to a pre-1997 long-term care insurance contract in any case in which the rider, if issued as a separate contract of insurance, would itself be a qualified long-term care insurance contract under section 7702B and any regulations issued thereunder (including the consumer protection provisions in section 7702B(g) to the extent applicable to the addition of a rider);

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

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

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

(5) *Examples.* The following examples illustrate the principles of this paragraph (b):

Example 1. (i) On December 3, 1996, A, an individual, submits a signed application to an insurance company to purchase a nursing home contract that meets the long-term care insurance requirements of the State in which the contract is situsued. The insurance company decides on December 20, 1996, that it will issue the contract, and assigns December 20, 1996, as the issue date for the contract. Under the terms of the contract, A's insurance coverage becomes effective on January 1, 1997. The company delivers the contract to A on January 3, 1997. A has the right to return the contract within 15 days following delivery for a refund of all premiums paid.

(ii) Under paragraph (b)(3)(i) of this section, the issue date of the contract is December 20, 1996. Thus, the contract is a pre-1997 long-term care insurance contract that is treated as a qualified long-term care insurance contract.

Example 2. (i) The facts are the same as in *Example 1,* except that the insurance coverage under the contract does not become effective until March 1, 1997. Under the insurance company's usual business practice, the period between the date of the application and the date the contract becomes effective is 30 days or less.

(ii) Under paragraph (b)(3)(i) of this section, the issue date of the contract is March 1, 1997. Thus, the contract is not a pre-1997 long-term care insurance contract, and, accordingly, the contract must meet the requirements of section 7702B(b) and any regulations issued thereunder to be a qualified long-term care insurance contract.

Example 3. (i) B, an individual, is the policyholder under a long-term care insurance contract purchased in 1995. On June 15, 2000, the insurance coverage and premiums under the contract are increased by agreement between B and the insurance company.

(ii) Under paragraph (b)(4)(i)(A) of this section, a change in the terms of a contract that alters the amount or timing of an item payable by the policyholder or the insurance company is treated as the issuance of a new contract. Thus, B's coverage is treated as coverage under a contract issued on June 15, 2000, and, accordingly, the contract must meet the requirements of section 7702B(b) and any regulations issued thereunder in order to be a qualified long-term care insurance contract.

Example 4. (i) C, an individual, is the policyholder under a long-term care insurance contract purchased in 1994. At that time and through December 31, 1996, the contract met the long-term care insurance requirements of the State in which the contract was situsued. In 1996, the policy was amended to add a provision requiring the policyholder to be offered the right to increase dollar limits for inflation every three years (without the policyholder being required to pass a physical or satisfy any other underwriting requirements). During 2002, C elects to increase the amount of insurance coverage (with a resulting premium increase) pursuant to the inflation provision.

(ii) Under paragraph (b)(4)(ii)(A) of this section, an increase in the amount of insurance coverage at the election of the policyholder (without the insurance company's consent and without underwriting or other limitations on the policyholder's rights) pursuant to a pre-1997 inflation provision is not treated as the issuance of a new contract. Thus, C's contract continues to be a pre-1997

long-term care insurance contract that is treated as a qualified long-term care insurance contract.

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

[T.D. 8792, 63 FR 68187, Dec. 10, 1998]

§ 1.7703–1 Determination of marital status.

(a) *General rule.* The determination of whether an individual is married shall be made as of the close of his taxable year unless his spouse dies during his taxable year, in which case such determination shall be made as of the time of such death; and, except as provided in paragraph (b) of this section, an individual shall be considered as married even though living apart from his spouse unless legally separated under a decree of divorce or separate maintenance. The provisions of this paragraph may be illustrated by the following examples:

Example 1. Taxpayer A and his wife B both make their returns on a calendar year basis. In July 1954, they enter into a separation agreement and thereafter live apart, but no decree of divorce or separate maintenance is issued until March 1955. If A itemizes and claims his actual deductions on his return for the calendar year 1954, B may not elect the standard deduction on her return since B is considered as married to A (although permanently separated by agreement) on the last day of 1954.

Example 2. Taxpayer A makes his returns on the basis of a fiscal year ending June 30. His wife B makes her returns on the calendar year basis. A died in October 1954. In such case, since A and B were married as of the date of death, B may not elect the standard deduction for the calendar year 1954 if the income of A for the short taxable year ending with the date of his death is determined without regard to the standard deduction.

(b) *Certain married individuals living apart.* (1) For purposes of Part IV of Subchapter B of Chapter 1 of the Code, an individual is not considered as married for taxable years beginning after December 31, 1969, if (i) such individual is married (within the meaning of paragraph (a) of this section) but files a separate return; (ii) such individual maintains as his home a household which constitutes for more than one-half of the taxable year the principal place of abode of a dependent (*a*) who (within the meaning of section 152 and the regulations thereunder) is a son, stepson, daughter, or stepdaughter of the individual, and (*b*) with respect to whom such individual is entitled to a deduction for the taxable year under section 151; (iii) such individual furnishes over half of the cost of maintaining such household during the taxable year; and (iv) during the entire taxable year such individual's spouse is not a member of such household.

(2) For purposes of subparagraph (1)(ii)(*a*) of this paragraph, a legally adopted son or daughter of an individual, a child (described in paragraph (c)(2) of §1.152–2) who is a member of an individual's household if placed with such individual by an authorized placement agency (as defined in paragraph (c)(2) of §1.152–2) for legal adoption by such individual, or a foster child (described in paragraph (c)(4) of §1.152–2) of an individual if such child satisfies the requirements of section 152(a)(9) of the Code and paragraph (b) of §1.152–1 with respect to such individual, shall be treated as a son or daughter of such individual by blood.

(3) For purposes of subparagraph (1)(ii) of this paragraph, the household must actually constitute the home of the individual for his taxable year. However, a physical change in the location of such home will not prevent an individual from qualifying for the treatment provided in subparagraph (1) of this paragraph. It is not sufficient that the individual maintain the household without being its occupant. The individual and the dependent described in subparagraph (1)(ii)(*a*) of this paragraph must occupy the household for more than one-half of the taxable year of the individual. However, the fact that such dependent is born or dies within the taxable year will not prevent an individual from qualifying for such treatment if the household constitutes the principal place of abode of such dependent for the remaining or preceding part of such taxable year. The individual and such dependent will be considered as occupying the household during temporary absences from the household due to special circumstances. A nonpermanent failure to occupy the common abode by reason of illness, education, business, vacation,