Company Sponsored Group Long-Term Care Insurance Today

Long-term care insurance (LTCI) continues to be a relatively common voluntary benefit made available to employees on a group basis. According to the U.S. Dept. of Health and Human Services, nearly 70% of Americans over age 65 will require some form of long-term care (LTC) before they die—but only about 10% will purchase LTCI. Just over 7.25 million Americans have LTCI today, up from 4.5 million in 2000, according to Morningstar. In 2017, LTCI companies paid or reimbursed LTC benefits to 295,000 individuals at a cost of $9.2 billion according to the American Association of Long Term Care Insurance (AALTCI). Meanwhile, the number of LTC insurers continues to decrease, largely due to the increased costs of care, longer life expectancies, and the challenges in setting appropriate premiums.

Our most recent informal survey of companies where Ayco provides financial counseling or financial education services indicates that 201 companies, representing around 50% of the companies in our database, offer a group LTCI voluntary benefit to eligible employees. However, at 25 companies the program is frozen, meaning that those with coverage can maintain it, but new enrollments are not being accepted. Of the 302 companies that participated in our 2017 Executive Benefits Survey, 37% reported currently offering group long-term care insurance as a voluntary benefit to eligible employees.

- What Are Long-Term Care Benefits?
  Long-term care refers to services provided to individuals who are no longer able to care for themselves. These services can be delivered in a nursing home, assisted living facility, adult day care center, or even in the person’s own home. These expenses are not covered by most health insurance plans. LTCI allows individuals to protect themselves and their family against the financial burdens of a long-term illness or injury. Thus, it is not just for retirees or older Americans.

Under group programs sponsored by employers, LTC coverage typically is offered to employees, their spouses, parents, parents-in-law, grandparents, grandparents-in-law, and sometimes also to retirees. Employees may enroll during an open enrollment period without providing evidence of good health. In contrast, eligible family members and retirees generally may enroll only upon meeting underwriting standards, which are expanding as insurers adjust to the risks and costs involved. Coverage is portable so that once enrolled, a participant may continue coverage by paying the ongoing annual cost even if the employee has retired or terminated employment. Generally, even when a company freezes its LTCI program, those who have coverage may continue to maintain it by paying the required premiums.

- Who Should Consider Purchasing LTC Insurance?
  Long-term care planning for most Americans begins between ages 50 and 64. The AARP Public Policy Institute also has estimated that 70% of those over age 65 will need some level of long-term care in their lifetime. However, more than a third of those with LTCI at age 65 will have the insurance lapse before they need it, according to the Center for Retirement Research at Boston College. This is primarily due to the failure to pay often increasing premiums.
Many Americans believe incorrectly that Medicare or their private health insurance will pay for their LTC needs. In fact, Medicare will pay only a portion for the first 100 days in a skilled nursing home, and it pays very limited amounts for home health care, which does not include personal care. State-based Medicaid may also provide a very limited amount of coverage. In fact, Medicaid currently pays about 40% of all nursing home expenses in the U.S.

**Nursing Homes** - One in three people who live until age 65 will reside in a nursing home at some point, according to the Kaiser Family Foundation. The Health Insurance Association of American (HIAA) estimates that a person who reaches age 65 faces a 43% chance of entering a nursing home, and has a 23% chance of remaining there for more than one year. However, half of all nursing home stays are for a period of three months or less, and the average stay is estimated to be 3.3 years. A study of LTC claims revealed that a majority were for care which lasted less than two years and only about 5% of claims exceed six years.

**Company-Sponsored Group Policies** - Perhaps, not surprisingly, purchasers of group policies are likely to be financially better-off than the average senior. Economists have concluded that buying LTCI may be unnecessary for some and economically inadvisable for low-income workers eligible for Medicaid coverage. According to a recent study conducted by the American Association for Long-Term Care Insurance (AALTCI), a trade association, buyers of group policies tend to be younger, select longer coverage, and make claims against their policies at younger ages. The average age for individual purchases is 57.

Long-term care insurance should be viewed as protection of an employee’s retirement savings. For this reason, employees eligible for group programs need to consider whether coverage should be purchased not only for themselves, but for parents or parents-in-law if the employee may be faced withshouldering the costs of care for these family members. But, group coverage may not always be more comprehensive, or even cheaper than individually acquired coverage, according to the AALTCI. Employer-sponsored group coverage is almost always the best deal for an individual with health issues. There are various websites available to compare individual and group coverage offered by top-rated carriers.

**Customization & Use** - Individually acquired coverage and increasingly, some group programs, can allow a purchaser to customize coverage to their needs and may lead to reduced costs for coverage. For example, an individual may be able to select among:

- different “elimination periods” (the time before benefits begin to be paid) – often 30, 60, 90 or even 180 days; the longer the period, the lower the premium;
- different maximum benefit periods (the number of years of coverage after the elimination period; often now a limited period of 3-5 years);
- plan riders, such as: inflation protection, automatic purchase benefit, waiver of premiums when benefits begin, death benefits or partial return of premiums if benefits are not payable prior to death.

As to who actually uses the insurance, a report by the AALTCI revealed that two-thirds of those receiving LTC benefits were women and one-third were men. Genworth, the largest LTC insurance company, has paid 71% of its claims for women. These statistics should not surprise anyone who has visited a nursing home or assisted living facility. Women face a double whammy, as pointed out by an article entitled “Americans Unprepared for Long-Term Care.” They typically are the primary caregivers and also the more likely recipients. The average age of an assisted living facility resident is now estimated to be 86.9 years old. Payments for nursing home care accounted for 45% of group LTCI claims, with homecare representing 38% of claims and care in assisted living facilities representing 17% of claims. Around 15% of claims made to Genworth were for services that lasted longer than five years.

**Cost of Long-Term Care Services**

The Genworth 2017 Cost of Care Survey calculated the national median annual cost for a private room in a nursing home room last year at $97,455. The median annual cost for a semi-private room was slightly less at around $85,775. The average median costs of LTC services increased an average of 4.5% from 2016 to 2017, the second highest year-over-year increase in nearly 15 years. The largest increase was for a home health aide, where median cost of coverage went up 6.2%. However, the cost of care varies considerably based on location and the quality of the nursing home facility. The most costly state for a private room in a nursing home? Alaska (by far) followed by Connecticut, Hawaii and Massachusetts; in contrast, the states with the lowest median nursing home costs include Oklahoma, Missouri and Louisiana.
More retirees hope and expect to remain in their own home rather than moving into a nursing home. The annual median cost of home health aide services nationwide was $49,192, according to the Genworth 2017 survey. The states with the lowest median costs were Louisiana and West Virginia, while the states with the highest annual median costs for LTC provided at home were North Dakota, Minnesota, Massachusetts, and Rhode Island.

One in four who are over age 65 will face at least $50,000 in out-of-pocket LTC expenses, according to the U.S. Dept. of Health and Human Services.

According to the Genworth 2017 Survey, the median rates for various long-term care services nationwide as of last year were:

- $235/day for a semi-private room in a nursing home
- $267/day for a private room in a nursing home
- $3,750/month for care in an Assisted Living Facility
- $21.50/hour for a Home Health Aide
- $21/hour for a Homemaker service
- $70/day for care in an Adult Day Health Care Center

However, an individual’s actual costs can vary considerably from these median rates. A recent study on non-recurring healthcare expenses reported by the Employee Benefit Research Institute indicated that single-person households average over twice the total expense compared with couple households. One reason could be because one person acts as a caregiver. Over 75% of caregivers are women.

**The Cost of LTC Insurance**

What does a policy cost? It really depends on the features selected and the age of the enrollee when the policy is first purchased. The National Association of Insurance Commissioners recommends that individuals spend no more than 5% of their income on a LTC policy. They publish a guide comparing costs at naic.org. Inflation protection can add 25% to 40% to the annual premium. Limiting coverage to a defined period – say, three years, can save nearly 40% in premium costs. Premiums can range from around $1,000 to $5,000 (or more) per year, depending on the age, sex and health of the purchaser, as well as the features of coverage. Insurers also have become more careful in issuing new policies. There are tougher underwriting standards in place and health issues now result in 30-40% denial rates for new applications of individual policies. This actually can make group programs more attractive.

Many carriers have begun charging women higher premiums than men of the same age. In fact, the National Women’s Law Center has sued four insurers on the grounds that gender-based pricing violates the Affordable Care Act’s prohibition against sex discrimination in health care. However, many employer-sponsored programs have unisex pricing. Single women considering purchasing coverage should look back at any employer’s plan since insurer’s have been charging single women up to 50% more than single men.

Some states regulate LTCI premium increases and 16 states, including CA, FL, and NY have unisex pricing rules for LTC insurance. Group plan discounts often can save a buyer 5%-15% of the cost compared to an individual contract.

Premiums on LTC policies have increased significantly over the past decade, although they decreased slightly within the past year. Rates also will vary by state, terms of the contract, who is covered, and when the payment of premiums will begin.

Here is the 2018 National Long-Term Care Insurance Price Index released by the AALTCI estimating annual premiums at different ages (assuming an initial benefit of $150 per day with a 90-day elimination period, 3-year maximum benefit term and 3% annual inflation factor):

<table>
<thead>
<tr>
<th>Age</th>
<th>Single Male</th>
<th>Single Female</th>
<th>Couple (of same age)*</th>
</tr>
</thead>
<tbody>
<tr>
<td>55</td>
<td>$1,870</td>
<td>$2,965</td>
<td>$3,000</td>
</tr>
<tr>
<td>60</td>
<td>$2,010</td>
<td>$3,475</td>
<td>$3,490</td>
</tr>
<tr>
<td>65</td>
<td>$2,460</td>
<td>$4,270</td>
<td>$4,675</td>
</tr>
</tbody>
</table>

*reflects marital discount when a couple elects joint coverage

A policy with coverage for 3 years will cost about 36% less than one providing lifetime benefits; a policy with a 90-day waiting period for coverage costs about 30% less than one with a 30-day waiting period. Data shows that premium costs are rising by 15% to 20% annually. But the decision by the Federal Reserve to raise short-term interest rates last quarter could have a positive impact on LTCI companies and the cost of products they offer, according to the AALTCI. Higher interest rates will enable insurers to avoid increasing rates at the same pace on new policies. According to AALTCI data, a 1% increase in long-term interest rates can translate into a 10-15% decline in policy premium costs, which should tamper future premium increases.
Insurance Carriers
While there currently are several insurance companies that market long-term care insurance to individual buyers, the largest insurers for the group programs are confined to a few well-known companies including Genworth Financial, John Hancock, Mass Mutual, and Mutual of Omaha. Meanwhile, several insurance carriers have left the business for selling new individual contracts, group policies, or both. The New York Times reported that only 14 companies currently sell LTCI compared with over 125 companies in 2000. In 2010, MetLife, one of the largest providers of LTC insurance, announced that it would discontinue the sale of both individual and group policies. CNA and Berkshire stopped selling LTC in 2011. Prudential stopped selling individuals policies to focus on group policies, and UNUM stopped selling group and individual policies in 2012.

Some of the current insurance carriers have stopped selling new policies in certain states, due primarily to state’s insurance regulators turning down proposed rate increases. As an example, Genworth is no longer selling new policies in MA and MedAmerica has ceased sales of its FlexCare product in CA. But because existing contracts generally are guaranteed renewable, they continue in force, as long as premiums are paid on a timely basis. Approximately 15% of the companies in our survey group have frozen eligibility for their group LTC insurance.

LTC as Part of Life Insurance Policy
A number of life insurance companies (including John Hancock, Lincoln Financial and Pacific Life) now can include long-term care riders to certain life insurance policies and annuity contracts. These are sometimes called “combination products.” The rider allows the insured to receive payment from the cash value to pay for designated long-term care needs. Individuals also may pay LTC insurance premiums with the cash value of life insurance or annuities without paying tax on the gain through what is called a Section 1035 exchange.

Certain cash value life insurance policies have an accelerated death benefit feature. This can allow the insured to have access a portion of the death benefits to pay for LTC expenses also with no tax consequences.

Tax Treatment
Individuals who purchase “qualified” LTCI may be able to deduct the premiums as a medical expense on their tax returns subject to age-based limits (medical expenses are deductible to the extent that they exceed 7.5% of adjusted gross income (AGI) for 2017 and 2018; thereafter, this threshold increases to 10% of income). State tax deduction rules vary considerably with 24 states allowing a deduction or tax credit.

To be “qualified”, any policies issued after 1996 must adhere to certain requirements and offer inflation protection and non-forfeiture. For 2018, the maximum amount of LTC premiums that may be treated as medical expenses are:

<table>
<thead>
<tr>
<th>Age</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>40 or less</td>
<td>$420</td>
</tr>
<tr>
<td>41 – 50</td>
<td>$780</td>
</tr>
<tr>
<td>51 – 60</td>
<td>$1,560</td>
</tr>
<tr>
<td>61 – 70</td>
<td>$4,160</td>
</tr>
<tr>
<td>71 or over</td>
<td>$5,200</td>
</tr>
</tbody>
</table>

Benefits received from a “qualified” LTC insurance policy may be excluded from income – and almost all group plans are IRS qualified. For any year in which benefits are paid, a Form 1099-LTC will be provided to the policyholder indicating the amount of benefits paid. For a nonqualified contract, some or all of the benefits paid will be taxable.

If an employer pays any portion of the employee’s premiums for LTCI, it need not impute that amount to the employee and may deduct such contributions as a business expense. In our survey group, we saw nine employers that pay for a portion or all of LTCI on behalf of all or certain employees. Amounts withdrawn from a health savings account (HSA) are tax-free to the individual if used to pay for LTC premiums or LTC expenses. However, such premiums cannot be paid from a health FSA.

Conclusion
Companies making LTCI available as a voluntary benefit generally can expect about a 5-7% participation rate by eligible employees. However, LTCI can be an important piece in an employee’s overall financial plan and a hedge to protect retirement savings. Purchasing LTCI with the obligation to make sometimes significant premium payments for many years that extend beyond employment is clearly not appropriate for everyone. Wealthier employees can be better off by self-insuring this risk. But at some point, individuals should assess whether coverage, either through an individual contract, group contract or combination product, makes economic sense for themselves and their family. Any financial planning solution should be based on each family’s needs and other resources.
Some of the potential benefits to an employer who offers LTCI include:

- A retention tool and possible morale booster with relatively little cost to the company;
- Voluntary benefit that can be valuable to some employees, as well as their parents;
- Helps productivity for those employees caring for older relatives;
- Could provide discounts in pricing compared to individual policies for those with health issues;
- Could have less stringent underwriting requirements; and
- Any payment of premiums by employer are tax-free.

### Tax Consequences of International Tax Equalization Program

Many, if not most, large U.S. companies have employees who work full-time or part-time outside of the U.S. This generally means that any such employee who is a U.S. taxpayer will have to file and usually pay taxes in all countries in which services were performed. Many companies offer a tax equalization program to their expat employees, as well as foreigners who may be working in the U.S. This program may include tax preparation services. The IRS recently released guidance in the form of an Office of Chief Council Memorandum (OCCM-201810007) explaining the IRS position on the tax consequences to the employee who receives tax preparation services as part of the employer’s international tax equalization program.

The large American company in question (which was not named in the guidance) employs thousands of U.S. citizens and residents of many countries around the world. The company also frequently would transfer employees from country to country. In order to facilitate these transfers and assist employees, the company offered a tax equalization policy. The intent of this program was that individuals would end up paying only the amount of income tax as he/she would have paid if they worked full-time in the U.S. A CPA firm was engaged to prepare the tax returns for employees. Under the tax equalization process, an employee’s “hypothetical income tax” would be estimated before the beginning of each tax year. This would be an estimation of what the individual’s overall tax liability for the upcoming year would be if the individual were to remain in the U.S. The employee’s salary or agreed upon remuneration for the upcoming year would be reduced by an amount equal to the approximate hypothetical tax. The employer would then pay all taxes owed by the employee to both the countries in which the employee worked as well as their country of citizenship, without deducting any taxes from the employee’s compensation. The employer’s payment of these taxes on behalf of the employee would result in additional compensation to the employee, but the employer would then gross-up the amount of imputed income related to paying the employee’s taxes.

At the end of the year, a calculation would be made of the exact amount of taxes that the employee would have owed had he/she remained in the U.S. (this was characterized as the “actual hypothetical tax” as opposed to the “approximate hypothetical tax”). If the approximate tax was too high, the company would pay the employee an amount equal to the difference between the actual hypothetical tax and the approximate hypothetical tax (that previously was deducted from salary). If the approximate tax was too low, the employee would be required to repay a portion of their compensation to the employer.

The company’s tax equalization policy provided that the following services would be performed by the CPA firm engaged for this purpose:

- Preparation of U.S. federal and state tax returns and any required foreign returns;
- Computation and payment of the approximate and actual hypothetical tax and the tax equalization settlements;
- Respond to inquiries from any tax authorities;
- Provide advice and instruction to the company’s payroll department with regard to how to report and withhold taxes appropriately.

The company imputed the value of the U.S. federal and state tax preparation services provided, but imputed no income relating to the foreign tax return preparation services. In addition, the employer concluded that any additional benefits provided in connection with the tax equalization policy were primarily provided for the employer’s benefit and, therefore, was properly excludible from the employee’s reported wages. The question posed to the IRS Office of Chief Counsel was whether this position was correct. The answer was – not exactly.

In determining the value of the federal and state tax return preparation services, the employer relied, in part on a survey conducted by the National Society of Accountants regarding the average tax preparation fees for an itemized Form 1040 and a state tax return, as well as guidance from the Treasury Department which estimated the average time
and cost of preparing a Form 1040. The amount actually paid to the CPA firm for the tax preparation services exceeded the averages referenced. Some of this was attributable to the non-tax preparation services, which included the tax equalization and hypothetical tax calculations. One question posed by the employer was whether any portion of these fees could be considered an excludable working condition fringe benefit. Under IRC §132(d), this could include property or services provided to an employee to the extent that if the employee paid for the service, this payment would be allowable as a deduction under IRC §162 or §167. So, here is what the IRS concluded in this memorandum:

The value of the tax preparation services provided a direct and personal benefit to the employee. It also will not qualify as a working condition fringe benefit inasmuch as the value of the services cannot be deducted by the employee under either IRC §162 or §167. Such expenses can be deductible by an employee only under IRC §212(3).

As far as the amount that should be reported as taxable, Treasury Regulations provide that an individual must include in gross income the fair market value of services provided. Neither the employee’s subjective perception of the value of the benefit, nor the employer’s cost in providing the benefit, are determinative of its fair market value. Instead, the fair market value is the amount an individual would have to pay for the particular benefit in an arm’s length transaction. There were discounts in the amount being charged by the CPA firm for the number of individuals eligible for the service. While the employer’s cost is not, by itself, determinative of the benefit’s fair market value, the IRS concluded that the facts and circumstances of this case indicate that it is reasonable to use the amounts the employer paid for the tax preparation services as the best indicator of the fair market value. Thus, that was the amount that should be reported as additional wages to the employee. This would also be the value for FICA tax purposes and for tax withholding. Depending on the country in which the employee worked, as well as their period of service during the year, there could be a totalization agreement between the U.S. and that country which would determine the Social Security taxation of the tax prep services.

As far as federal tax withholding, under IRC §3401(a), the value of the services performed constitutes wages subject to federal income tax withholding, unless an exception applies. Thus, employers should be withholding on the imputed income unless the value is excludible from the employee’s gross income under IRC §911. That Code section provides an exclusion from income for foreign earned income (up to a maximum of $104,100 for 2018), as well as a foreign housing exclusion. It is only available to an individual who meets the following criteria:

- A U.S. citizen who is a bona fide resident of a foreign country or countries for an uninterrupted period that includes an entire tax year;
- A U.S. resident alien who is a citizen or national of a country with which the United States has an income tax treaty in effect and who is a bona fide resident of a foreign country or countries for an uninterrupted period that includes an entire tax year; or
- A U.S. citizen or a U.S. resident alien who is physically present in a foreign country or countries for at least 330 full days during any period of 12 consecutive months.

Inasmuch as the company in question had employees stationed in many different countries throughout the world, the company may have had to withhold taxes in some foreign countries based on the value of the tax preparation services.

This guidance should be reviewed closely by any companies which provide a tax equalization service or international tax preparation service.

**DOL Fiduciary Rule Now in Limbo**

ERISA, enacted in 1974, established new rules for employee benefit plans. It also conferred on the Department of Labor (DOL) regulatory authority over employer-sponsored welfare benefit and retirement plans. One year later in 1975, the DOL issued guidance as to who would be considered to be a fiduciary under its investment advice rules. Under these rules, a fiduciary is subject to a statutory duty of loyalty and prudence. Penalties may be imposed on those who violate these rules.

In the decades that followed, there developed a distinction between (1) investment advisors who could be considered fiduciaries if they furnished regular services that were the “primary basis” for a client’s investment decisions, and (2) a broker-dealer whose advice was incidental to the conduct of business. Under common law definitions, which pre-dates ERISA, fiduciary status depends on the existence of a relationship of trust and confidence between the parties.
As retirement accounts, including 401(k) plans and IRAs, expanded significantly in the decades that followed, the DOL concluded that it needed to clarify its fiduciary rules. As a result, in 2016, the DOL proposed a number of significant changes in its investment advice fiduciary rules. It also created a Best Interest Contract Exemption (BICE) which could allow a fiduciary to avoid prohibited transaction penalties. These rules were expected to be effective this year. However, last month, the 5th Circuit Federal Court of Appeals issued a 2:1 decision which, if upheld, would unequivocally eliminate the DOL’s proposed rule (Chamber of Commerce of USA et. al vs. U.S. Department of Labor).

The federal court concluded that the DOL’s fiduciary rule conflicts with ERISA statutory language which assigns fiduciary status to persons who render investment advice for a fee or other compensation or have any authority or responsibility to do so. According to the court’s decision, the DOL expanded the universe of those who should be considered a fiduciary. The court majority concluded that this was not a reasonable interpretation of ERISA.

While ERISA impacts employer-sponsored plans, there is a different regime for IRAs and similar individual retirement accounts. Under general rules prior to when the DOL issued its proposed new rules, a recommendation to take a distribution from a qualified employer plan (e.g., 401(k) or pension) and roll it into an IRA was, in most cases, not a fiduciary act. However, under the DOL’s proposed new rules, such a recommendation would be considered a fiduciary act and would need to be based on a prudent analysis of the individual’s need and a comparison of the plans. Unless the BIC Exemption were met, it would be a prohibited transaction for an investment advisor, broker, or planner to make more money due to the rollover as opposed to remaining in the current plan. Thus, the 5th Circuit Court of Appeals vacated the DOL fiduciary rule. So what comes next?

Despite the court’s decision, the DOL proposed rule remains in effect, at least temporarily. The DOL has 45 days to petition the court for a re-hearing, so the earliest that the court can issue a mandate vacating the rule will be May 7, 2018, assuming the DOL does not seek a re-hearing. It is also possible, but unlikely, that the DOL or a third party could appeal the 5th Circuit’s decision to the U.S. Supreme Court. Two days before the 5th Circuit decision, a different federal appeals court upheld key parts of the fiduciary rule and there are pending decisions in other federal courts.

The DOL has announced that it will not enforce the proposed fiduciary rule “pending further review”. Meanwhile, the Securities and Exchange Commission (SEC) has indicated that it expects to propose its own fiduciary rules later this year.

While this may mean uncertainty as to the status of the DOL’s fiduciary rules, it is unlikely to have an immediate or significant impact for most employers with 401(k) plans or other retirement plans. Several broker-dealers and registered investment advisors have altered their services, as well as fees and whether they will accept IRA rollovers. Whether the pre-fiduciary rules will be resuscitated or new rules issued, remains to be seen. It appears we are in a “wait-and-see” environment.
Did You Know...

- Four states (IL, OR, MD, VT) passed laws requiring all health plans to provide male contraception or sterilization services with little or no cost-sharing. However, the IRS has indicated that a high deductible health plan (HDHP) cannot pay for vasectomy costs in that situation. This has created a dilemma (VT already has reversed its law) and even the IRS has recognized the problem this has created for employers with employees in those states. The IRS has now provided transitional relief until 2020. Individuals in HDHPs will not lose their ability to fund a HSA just because the plan provides for male contraceptives or a vasectomy before the plan’s deductible is satisfied.

- According to the Centers for Medicare and Medicaid Services final report on 2018 enrollment in the Healthcare Marketplace (federal and state exchanges), about 11.8 million Americans enrolled for 2018. This was a slight reduction from 2017. A large majority qualified for a tax credit. An estimated 180 million Americans receive health coverage through their or a family member’s employer.

- The U.S. General Accounting Office (GAO) recently issued GAO-18-19 recommending that the IRS clarify exactly how taxpayers are to report any participation in foreign retirement plans. Also recommended was a tax law change that would allow tax-deferred transfers among foreign plans.

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