

103^D CONGRESS
2^D SESSION

H. R. 4516

To amend the Internal Revenue Code of 1986 and other laws to improve and promote the provision of long-term care in the United States.

IN THE HOUSE OF REPRESENTATIVES

MAY 26, 1994

Mrs. KENNELLY (for herself and Mrs. JOHNSON of Connecticut) introduced the following bill; which was referred jointly to the Committees on Energy and Commerce and Ways and Means

A BILL

To amend the Internal Revenue Code of 1986 and other laws to improve and promote the provision of long-term care in the United States.

1 *Be it enacted by the Senate and House of Representa-*
2 *tives of the United States of America in Congress assembled,*

3 **SECTION 1. SHORT TITLE; TABLE OF CONTENTS.**

4 (a) SHORT TITLE.—This Act may be cited as the
5 “Long-Term Care Act of 1994”.

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

Sec. 1. Short title; table of contents.

TITLE I—ESTABLISHMENT OF FEDERAL STANDARDS FOR LONG-
TERM CARE INSURANCE

Sec. 101. Establishment of Federal standards for long-term care insurance.

“TITLE XXVII—LONG-TERM CARE INSURANCE STANDARDS

“PART A—PROMULGATION OF STANDARDS AND MODEL BENEFITS

“Sec. 2701. Standards.

“PART B—ESTABLISHMENT AND IMPLEMENTATION OF LONG-TERM CARE
INSURANCE POLICY STANDARDS

“Sec. 2711. Implementation of policy standards.

“Sec. 2712. Regulation of sales practices.

“Sec. 2713. Additional responsibilities for carriers.

“Sec. 2714. Renewability standards for issuance, and basis for cancellation
of policies.

“Sec. 2715. Benefit standards.

“Sec. 2716. Option to purchase nonforfeiture benefits.

“Sec. 2717. Limit of period of contestability and right to return.

“Sec. 2718. Civil money penalty.

“PART C—LONG-TERM CARE INSURANCE POLICIES, DEFINITION AND
ENDORSEMENTS

“Sec. 2721. Long-term care insurance policy defined.

“Sec. 2722. Code of conduct with respect to endorsements.

“PART D—MISCELLANEOUS PROVISIONS

“Sec. 2731. Funding for long-term care insurance information, counseling,
and assistance.

“Sec. 2732. Definitions.”

TITLE II—TAX TREATMENT

Subtitle A—Long-Term Care Insurance

Sec. 201. Qualified long-term care insurance defined and treated as accident or
health insurance.

Sec. 202. Qualified long-term care insurance treated as accident and health in-
surance for purposes of exclusion for benefits received under
such insurance and for employer contributions for such insur-
ance.

Sec. 203. Early distribution penalty tax not to apply to amounts withdrawn
from qualified plans, individual retirement plans, etc. for quali-
fied long-term insurance.

Sec. 204. Deduction of expenses relating to qualified long-term care.

Sec. 205. Treatment of prefunded long-term care benefits.

Sec. 206. Qualified long-term care insurance permitted to be offered in cafe-
teria plans.

Subtitle B—Payments under Life Insurance Contracts to Terminally Ill
Individuals

Sec. 211. Tax treatment of payments to terminally ill individuals under life in-
surance contracts.

Sec. 212. Tax treatment of companies issuing qualified terminal illness riders.

TITLE III—ELIMINATION OF MEDICAID RESTRICTION ON STATE ASSET PROTECTION PROGRAMS

- Sec. 301. Elimination of medicaid restriction on State asset protection programs.
- Sec. 302. Protection of assets through use of qualified long-term care insurance.

TITLE IV—STATE PROGRAMS FOR HOME AND COMMUNITY-BASED SERVICES FOR INDIVIDUALS WITH DISABILITIES

- Sec. 401. State programs for home and community-based services for individuals with disabilities.
- Sec. 402. State plans.
- Sec. 403. Individuals with disabilities defined.
- Sec. 404. Home and community-based services covered under State plan.
- Sec. 405. Cost sharing.
- Sec. 406. Quality assurance and safeguards.
- Sec. 407. Advisory groups.
- Sec. 408. Payments to States.
- Sec. 409. Total Federal budget; allotments to States.

TITLE V—REBASING MEDICARE PAYMENT RATES

Subtitle A—Rehabilitation Hospitals

- Sec. 501. Definition of rehabilitation hospitals.
- Sec. 502. Payment rules.
- Sec. 503. Payment for operating costs of rehabilitation hospitals.

Subtitle B—Long-Term Hospitals

- Sec. 511. Payment rules.

1 **TITLE I—ESTABLISHMENT OF**
 2 **FEDERAL STANDARDS FOR**
 3 **LONG-TERM CARE INSUR-**
 4 **ANCE**

5 **SEC. 101. ESTABLISHMENT OF FEDERAL STANDARDS FOR**
 6 **LONG-TERM CARE INSURANCE.**

7 (a) IN GENERAL.—The Public Health Service Act is
 8 amended—

- 9 (1) by redesignating title XXVII (42 U.S.C.
- 10 300cc et seq.) as title XXVIII; and

1 (2) by inserting after title XXVI the following
2 new title:

3 **“TITLE XXVII—LONG-TERM CARE**
4 **INSURANCE STANDARDS**

5 “PART A—PROMULGATION OF STANDARDS AND MODEL
6 BENEFITS

7 **“SEC. 2701. STANDARDS.**

8 “(a) APPLICATION OF STANDARDS.—

9 “(1) NAIC.—The Secretary shall request that
10 the National Association of Insurance Commis-
11 sioners (hereinafter in this title referred to as the
12 ‘NAIC’)—

13 “(A) develop specific standards that incor-
14 porate the requirements of this title; and

15 “(B) report to the Secretary on such
16 standards,

17 by not later than 12 months after enactment of this
18 title. If the NAIC develops such model standards
19 that incorporate the requirements of this title within
20 such period and the Secretary finds that such stand-
21 ards implement the requirements of this title, such
22 standards shall be the standards applied under this
23 title.

24 “(2) DEFAULT.—If the NAIC does not promul-
25 gate the model standards under paragraph (1) by

1 the deadline established in that paragraph, the Sec-
2 retary shall promulgate, within 12 months after such
3 deadline, a regulation that provides standards that
4 incorporate the requirements of this title and such
5 standards shall apply as provided for in this title.

6 “(3) RELATION TO STATE LAW.—Nothing in
7 this title shall be construed as preventing a State
8 from applying standards if—

9 “(A) the standards provide greater protec-
10 tion to policyholders of long-term care insur-
11 ance policies than the standards promulgated
12 under this title, except that such State stand-
13 ards may not be inconsistent or in conflict with
14 any of the requirements of this title; or

15 “(B) the Secretary finds that the stand-
16 ards do not unduly burden interstate commerce,
17 or adversely impact the quality and availability
18 of affordable long-term care insurance.

19 “(b) DEADLINE FOR APPLICATION OF STAND-
20 ARDS.—

21 “(1) IN GENERAL.—Subject to paragraph (2),
22 the date specified in this subsection for a State is—

23 “(A) the date the State adopts the stand-
24 ards established under subsection (a)(1); or

1 “(B) the date that is 1 year after the first
2 day of the first regular legislative session that
3 begins after the date such standards are first
4 established under subsection (a)(2);
5 whichever is earlier.

6 “(2) STATE REQUIRING LEGISLATION.—In the
7 case of a State which the Secretary identifies, in
8 consultation with the NAIC, as—

9 “(A) requiring State legislation (other than
10 legislation appropriating funds) in order for the
11 standards established under subsection (a) to be
12 applied; but

13 “(B) having a legislature which is not
14 scheduled to meet within 1 year following the
15 beginning of the next regular legislative session
16 in which such legislation may be considered;

17 the date specified in this subsection is the first day
18 of the first calendar quarter beginning after the
19 close of the first legislative session of the State legis-
20 lature that begins on or after January 1, 1994. For
21 purposes of the previous sentence, in the case of a
22 State that has a 2-year legislative session, each year
23 of such session shall be deemed to be a separate reg-
24 ular session of the State legislature.

1 “(c) ITEMS INCLUDED IN STANDARDS.—The stand-
2 ards promulgated under subsection (a) shall include—

3 “(1) minimum Federal standards for long-term
4 care insurance consistent with the provisions of this
5 title;

6 “(2) standards for the enhanced protection of
7 consumers with long-term care insurance;

8 “(3) procedures for the modification of the
9 standards established under paragraph (1) in a
10 manner consistent with future laws to expand exist-
11 ing Federal or State long-term care benefits or es-
12 tablish a comprehensive Federal or State long-term
13 care benefit program; and

14 “(4) other activities determined appropriate by
15 Congress.

16 “(d) CONSULTATION.—In establishing standards and
17 models of benefits under this section, the Secretary shall
18 provide for and consult with an advisory committee to be
19 chosen by the Secretary, and composed of—

20 “(1) three individuals who are representatives
21 of carriers;

22 “(2) three individuals who are representatives
23 of consumer groups;

24 “(3) three representatives who are representa-
25 tives of providers of long-term care services;

1 “(4) three other individuals who are not rep-
2 representatives of carriers or of providers of long-term
3 care services and who have expertise in the delivery
4 and financing of such services; and

5 “(5) the Secretary of Veterans Affairs.

6 “(e) DUTIES.—The advisory committee established
7 under subsection (d) shall—

8 “(1) recommend the appropriate inflationary
9 index to be used with respect to the inflation protec-
10 tion benefit portion of the standards;

11 “(2) recommend the uniform needs assessment
12 mechanism to be used in determining the eligibility
13 of individuals for benefits under a policy;

14 “(3) recommend appropriate standards for ben-
15 efits under section 2715(c); and

16 “(4) perform such other activities as deter-
17 mined appropriate by the Secretary.

18 “(f) ADMINISTRATIVE PROVISIONS.—The following
19 provisions of section 1886(e)(6) of the Social Security Act
20 shall apply to the advisory committee chosen under sub-
21 section (d) in the same manner as such provisions apply
22 under such section:

23 “(1) Subparagraph (C) (relating to staffing and
24 administration).

1 “(2) Subparagraph (D) (relating to compensa-
2 tion of members).

3 “(3) Subparagraph (F) (relating to access to
4 information).

5 “(4) Subparagraph (G) (relating to use of
6 funds).

7 “(5) Subparagraph (H) (relating to periodic
8 GAO audits).

9 “(6) Subparagraph (J) (relating to requests for
10 appropriations).

11 “PART B—ESTABLISHMENT AND IMPLEMENTATION OF
12 LONG-TERM CARE INSURANCE POLICY STANDARDS

13 “**SEC. 2711. IMPLEMENTATION OF POLICY STANDARDS.**

14 “(a) IN GENERAL.—

15 “(1) REGULATORY PROGRAM.—No long-term
16 care policy (as defined in section (2721)) may be is-
17 sued, sold, or offered for sale as a long-term care in-
18 surance policy in a State on or after the date speci-
19 fied in section 2701(b) unless—

20 “(A) the Secretary determines that the
21 State has established a regulatory program
22 that—

23 “(i) provides for the application and
24 enforcement of the standards established
25 under section 2701(a); and

1 “(ii) complies with the requirements
2 of subsection (b);
3 by the date specified in section 2701(b), and
4 the policy has been approved by the State com-
5 missioner or superintendent of insurance under
6 such program; or

7 “(B) if the State has not established such
8 a program, or if the State’s regulatory program
9 has been decertified, the policy has been cer-
10 tified by the Secretary (in accordance with such
11 procedures as the Secretary may establish) as
12 meeting the standards established under section
13 2701(a) by the date specified in section
14 2701(b).

15 For purposes of this subsection, the advertising or
16 soliciting with respect to a policy, directly or indi-
17 rectly, shall be deemed the offering for sale of the
18 policy.

19 “(2) REVIEW OF STATE REGULATORY PRO-
20 GRAMS.—The Secretary periodically shall review reg-
21 ulatory programs described in paragraph (1)(A) to
22 determine if they continue to provide for the applica-
23 tion and enforcement of the standards and proce-
24 dures established under section 2701(a) and (b). If
25 the Secretary determines that a State regulatory

1 program no longer meets such standards and re-
2 quirements, before making a final determination, the
3 Secretary shall provide the State an opportunity to
4 adopt such a plan of correction as would permit the
5 program to continue to meet such standards and re-
6 quirements. If the Secretary makes a final deter-
7 mination that the State regulatory program, after
8 such an opportunity, fails to meet such standards
9 and requirements, the Secretary shall assume re-
10 sponsibility under paragraph (1)(B) with respect to
11 certifying policies in the State and shall exercise full
12 authority under section 2701 for carriers, agents, or
13 associations or its subsidiary in the State plans in
14 the State.

15 “(b) ADDITIONAL REQUIREMENTS FOR APPROVAL
16 OF STATE REGULATORY PROGRAMS.—For purposes of
17 subsection (a)(1)(A)(ii), the requirements of this sub-
18 section for a State regulatory program are as follows:

19 “(1) ENFORCEMENT.—The enforcement under
20 the program—

21 “(A) shall be designed in a manner so as
22 to secure compliance with the standards within
23 30 days after the date of a finding of non-
24 compliance with such standards; and

1 “(B) shall provide for notice in the annual
2 report required under paragraph (5) to the Sec-
3 retary of cases where such compliance is not se-
4 cured within such 30-day period.

5 “(2) PROCESS.—The enforcement process
6 under each State regulatory program shall provide
7 for—

8 “(A) procedures for individuals and enti-
9 ties to file written, signed complaints respecting
10 alleged violations of the standards;

11 “(B) responding on a timely basis to such
12 complaints;

13 “(C) the investigation of—

14 “(i) those complaints which have a
15 reasonable probability of validity, and

16 “(ii) such other alleged violations of
17 the standards as the program finds appro-
18 priate; and

19 “(D) the imposition of appropriate sanc-
20 tions (which include, in appropriate cases, the
21 imposition of a civil money penalty as provided
22 for in section 2718) in the case of a carrier,
23 agent, or association or its subsidiary deter-
24 mined to have violated the standards.

1 “(3) CONSUMER ACCESS TO COMPLIANCE IN-
2 FORMATION.—

3 “(A) IN GENERAL.—A State regulatory
4 program must provide for consumer access to
5 complaints filed with the State commissioner or
6 superintendent of insurance with respect to
7 long-term care insurance policies.

8 “(B) CONFIDENTIALITY.—The access pro-
9 vided under subparagraph (A) shall be limited
10 to the extent required to protect the confiden-
11 tiality of the identity of individual policyholders
12 and certificate holders.

13 “(4) PROCESS FOR APPROVAL OF PREMIUMS.—

14 “(A) IN GENERAL.—Each State regulatory
15 program shall—

16 “(i) provide for a process for approv-
17 ing or disapproving proposed premium in-
18 creases or decreases with respect to long-
19 term care insurance policies; and

20 “(ii) establish a policy for receipt and
21 consideration of public comments before
22 approving such a premium increase or de-
23 crease.

24 “(B) CONDITIONS FOR APPROVAL.—No
25 premium increase shall be approved (or deemed

1 approved) under subparagraph (A) unless the
2 proposed increase is accompanied by an actuarial
3 memorandum which—

4 “(i) includes a description of the as-
5 sumptions that justify the increase;

6 “(ii) contains such information as
7 may be required under the Standards; and

8 “(iii) is made available to the public.

9 “(C) APPLICATION.—Except as provided in
10 subparagraph (D), this paragraph shall not
11 apply to a group long-term care insurance pol-
12 icy issued to a group described in section
13 4(E)(1) of the NAIC Long Term Care Insur-
14 ance Model Act (effective January 1991), ex-
15 cept that such group policy shall, pursuant to
16 guidelines developed by the NAIC, provide no-
17 tice to policyholders and certificate holders of
18 any premium change under such group policy.

19 “(D) EXCEPTION.—Subparagraph (C)
20 shall not apply to—

21 “(i) group conversion policies;

22 “(ii) the group continuation feature of
23 a group policy if the insurer separately
24 rates employee and continuation coverages;
25 and

1 “(iii) group policies where the func-
2 tion of the employer is limited solely to col-
3 lecting premiums (through payroll deduc-
4 tions or dues checkoff) and remitting them
5 to the insurer.

6 “(E) CONSTRUCTION.—Nothing in this
7 paragraph shall be construed as preventing the
8 NAIC from promulgating standards, or a State
9 from enacting and enforcing laws, with respect
10 to premium rates or loss ratios for all, including
11 group, long-term care insurance policies.

12 “(5) ANNUAL REPORTS.—Each State regu-
13 latory program shall provide for annual reports to be
14 submitted to the Secretary on the implementation
15 and enforcement of the standards in the State, in-
16 cluding information concerning violations in excess
17 of 30 days.

18 “(6) ACCESS TO OTHER INFORMATION.—The
19 State regulatory program must provide for consumer
20 access to actuarial memoranda provided under para-
21 graph (4).

22 “(7) DEFAULT.—In the case of a State without
23 a regulatory program approved under subsection (a),
24 the Secretary shall provide for the enforcement ac-
25 tivities described in subsection (c).

1 “(c) SECRETARIAL ENFORCEMENT AUTHORITY.—

2 “(1) IN GENERAL.—The Secretary shall exer-
3 cise authority under this section in the case of a
4 State that does not have a regulatory program ap-
5 proved under this section.

6 “(2) COMPLAINTS AND INVESTIGATIONS.—The
7 Secretary shall establish procedures—

8 “(A) for individuals and entities to file
9 written, signed complaints respecting alleged
10 violations of the requirements of this title;

11 “(B) for responding on a timely basis to
12 such complaints; and

13 “(C) for the investigation of—

14 “(i) those complaints that have a rea-
15 sonable probability of validity; and

16 “(ii) such other alleged violations of
17 the requirements of this title as the Sec-
18 retary determines to be appropriate.

19 In conducting investigations under this subsection,
20 agents of the Secretary shall have reasonable access
21 necessary to enable such agents to examine evidence
22 of any carrier, agent, or association or its subsidiary
23 being investigated.

24 “(3) HEARINGS.—

1 “(A) IN GENERAL.—Prior to imposing an
2 order described in paragraph (4) against a car-
3 rier, agent, or association or its subsidiary
4 under this section for a violation of the require-
5 ments of this title, the Secretary shall provide
6 the carrier, agent, association or subsidiary
7 with notice and, upon request made within a
8 reasonable time (of not less than 30 days, as
9 established by the Secretary by regulation) of
10 the date of the notice, a hearing respecting the
11 violation.

12 “(B) CONDUCT OF HEARING.—Any hear-
13 ing requested under subparagraph (A) shall be
14 conducted before an administrative law judge.
15 If no hearing is so requested, the Secretary’s
16 imposition of the order shall constitute a final
17 and unappealable order.

18 “(C) AUTHORITY IN HEARINGS.—In con-
19 ducting hearings under this paragraph—

20 “(i) agents of the Secretary and ad-
21 ministrative law judges shall have reason-
22 able access necessary to enable such agents
23 and judges to examine evidence of any car-
24 rier, agent, or association or its subsidiary
25 being investigated; and

1 “(ii) administrative law judges, may,
2 if necessary, compel by subpoena the at-
3 tendance of witnesses and the production
4 of evidence at any designated place or
5 hearing.

6 In case of contumacy or refusal to obey a sub-
7 poena lawfully issued under this subparagraph
8 and upon application of the Secretary, an ap-
9 propriate district court of the United States
10 may issue an order requiring compliance with
11 such subpoena and any failure to obey such
12 order may be punished by such court as a con-
13 tempt thereof.

14 “(D) ISSUANCE OF ORDERS.—If an admin-
15 istrative law judge determines in a hearing
16 under this paragraph, upon the preponderance
17 of the evidence received, that a carrier, agent,
18 or association or its subsidiary named in the
19 complaint has violated the requirements of this
20 title, the administrative law judge shall state
21 the findings of fact and issue and cause to be
22 served on such carrier, agent, association, or
23 subsidiary an order described in paragraph (4).

24 “(4) CEASE AND DESIST ORDER WITH CIVIL
25 MONEY PENALTY.—

1 “(A) IN GENERAL.—Subject to the provi-
2 sions of subparagraphs (B) through (F), an
3 order under this paragraph—

4 “(i) shall require the agent, associa-
5 tion or its subsidiary, or a carrier—

6 “(I) to cease and desist from
7 such violations; and

8 “(II) to pay a civil penalty in an
9 amount not to exceed \$15,000 in the
10 case of each agent, and not to exceed
11 \$25,000 for each association or its
12 subsidiary or a carrier for each such
13 violation; and

14 “(ii) may require the agent, associa-
15 tion or its subsidiary, or a carrier to take
16 such other remedial action as is appro-
17 priate.

18 “(B) CORRECTIONS WITHIN 30 DAYS.—No
19 order shall be imposed under this paragraph by
20 reason of any violation if the carrier, agent, or
21 association or its subsidiary establishes to the
22 satisfaction of the Secretary that—

23 “(i) such violation was due to reason-
24 able cause and was not intentional and was
25 not due to willful neglect; and

1 “(ii) such violation is corrected within
2 the 30-day period beginning on the earliest
3 date the carrier, agent, association, or sub-
4 sidiary knew, or exercising reasonable dili-
5 gence could have known, that such a viola-
6 tion was occurring.

7 “(C) WAIVER BY SECRETARY.—In the case
8 of a violation under this title that is due to rea-
9 sonable cause and not to willful neglect, the
10 Secretary may waive part or all of the civil
11 money penalty imposed under subparagraph
12 (A)(i)(II) to the extent that payment of such
13 penalty would be grossly excessive relative to
14 the violation involved and to the need for deter-
15 rence of violations.

16 “(D) ADMINISTRATIVE APPELLATE RE-
17 VIEW.—The decision and order of an adminis-
18 trative law judge under this paragraph shall be-
19 come the final agency decision and order of the
20 Secretary unless, within 30 days, the Secretary
21 modifies or vacates the decision and order, in
22 which case the decision and order of the Sec-
23 retary shall become a final order under this
24 paragraph.

1 “(E) JUDICIAL REVIEW.—A carrier, agent,
2 or association or its subsidiary or any other in-
3 dividual adversely affected by a final order is-
4 sued under this paragraph may, within 45 days
5 after the date the final order is issued, file a pe-
6 tition in the Court of Appeals for the appro-
7 priate circuit for review of the order.

8 “(F) ENFORCEMENT OF ORDERS.—If a
9 carrier, agent, or association or its subsidiary
10 fails to comply with a final order issued under
11 this paragraph against the carrier, agent, asso-
12 ciation or subsidiary after opportunity for judi-
13 cial review under subparagraph (E), the Sec-
14 retary shall file a suit to seek compliance with
15 the order in any appropriate district court of
16 the United States. In any such suit, the validity
17 and appropriateness of the final order shall not
18 be subject to review.

19 “(d) DEMONSTRATION GRANT PROGRAM.—

20 “(1) IN GENERAL.—The Secretary may award
21 grants to States for the establishment of demonstra-
22 tion programs to improve the enforcement within
23 such States of long-term care insurance standards
24 applicable under this title.

1 “(2) APPLICATION.—To be eligible to receive a
2 grant under paragraph (1), a State shall prepare
3 and submit to the Secretary an application at such
4 time, in such manner, and containing such informa-
5 tion as the Secretary may require, including a de-
6 scription of the program for which the State intends
7 to use the amounts provided under the grant.

8 “(3) MINIMUM AMOUNT OF GRANTS.—The
9 amount of a grant awarded under this subsection
10 shall not be less than \$100,000.

11 “(4) EVALUATION.—A State that receives a
12 grant under this subsection shall comply with such
13 evaluation procedures as the Secretary shall by regu-
14 lation establish. The Secretary shall utilize such
15 evaluations to conduct an overall evaluation of the
16 results of the demonstration programs established
17 under this section.

18 “(5) AUTHORIZATION OF APPROPRIATIONS.—
19 There are authorized to be appropriated to carry out
20 this subsection, \$5,000,000 for each of the fiscal
21 years 1993 through 1997.

22 **“SEC. 2712. REGULATION OF SALES PRACTICES.**

23 “(a) DUTY OF GOOD FAITH AND FAIR DEALING.—

24 “(1) IN GENERAL.—Each agent (as defined in
25 section 2733) or association that is selling or offer-

1 ing for sale a long-term care insurance policy has
2 the duty of good faith and fair dealing to the pur-
3 chaser or potential purchaser of such a policy.

4 “(2) PROHIBITED PRACTICES.—An agent or as-
5 sociation is considered to have violated paragraph
6 (1) if the agent or association engages in any of the
7 following practices:

8 “(A) TWISTING.—

9 “(i) IN GENERAL.—Knowingly making
10 any misleading representation (including
11 the inaccurate completion of medical his-
12 tories) or incomplete or fraudulent com-
13 parison of any long-term care insurance
14 policy or insurers for the purpose of induc-
15 ing, or tending to induce, any person to re-
16 tain or effect a change with respect to a
17 long-term care insurance policy.

18 “(ii) POLICY REPLACEMENT FORM.—

19 With respect to any person who elects to
20 replace or effect a change in a long-term
21 care insurance policy, the individual that is
22 selling such policy shall ensure that such
23 person completes a policy replacement
24 form developed by the NAIC. A copy of
25 such form shall be provided to such person

1 and additional copies shall be delivered by
2 the selling individual to the old policy is-
3 suer and the new issuer and kept on file
4 for inspection by the State regulatory
5 agency.

6 “(B) HIGH PRESSURE TACTICS.—Employ-
7 ing any method of marketing having the effect
8 of, or intending to, induce the purchase of a
9 long-term care insurance policy through force,
10 fright, threat or undue pressure, whether ex-
11 plicit or implicit.

12 “(C) COLD LEAD ADVERTISING.—Making
13 use directly or indirectly of any method of mar-
14 keting which fails to disclose in a conspicuous
15 manner that a purpose of the method of mar-
16 keting is solicitation of insurance and that con-
17 tact will be made by an insurance agent or in-
18 surance company.

19 “(D) OTHERS.—Engaging in such other
20 practices determined inappropriate under guide-
21 lines issued by the NAIC.

22 “(b) FINANCIAL STANDARDS.—The NAIC shall de-
23 velop recommended minimum financial standards (includ-
24 ing both income and asset criteria) for the purpose of ad-

1 vising individuals considering the purchase of a long-term
2 care insurance policy.

3 “(c) PROHIBITION OF SALE OR ISSUANCE TO MEDIC-
4 AID BENEFICIARIES.—An agent, an association, or a car-
5 rier may not knowingly sell or issue a long-term care in-
6 surance policy to an individual who is eligible for medical
7 assistance under title XIX of the Social Security Act.

8 “(d) PROHIBITION OF SALE OR ISSUANCE OF DUPLI-
9 CATE SERVICE BENEFIT POLICIES.—An agent, associa-
10 tion or its subsidiary, or a carrier may not sell or issue
11 a service-benefit long-term care insurance policy to an in-
12 dividual—

13 “(1) knowing that the policy provides for cov-
14 erage that duplicates coverage already provided in
15 another service-benefit long-term care insurance pol-
16 icy held by such individual (unless the policy is in-
17 tended to replace such other policy); or

18 “(2) for the benefit of an individual unless the
19 individual (or a representative of the individual) pro-
20 vides a written statement to the effect that the cov-
21 erage—

22 “(A) does not duplicate other coverage in
23 effect under a service-benefit long-term care in-
24 surance policy; or

1 “(B) will replace another service-benefit
2 long-term care insurance policy.

3 In this subsection, the term ‘service-benefit long-term care
4 insurance policy’ means a long-term care insurance policy
5 which provides for benefits based on the type and amount
6 of services furnished.

7 “(e) PROHIBITION BASED ON ELIGIBILITY FOR
8 OTHER BENEFITS.—A carrier may not sell or issue a
9 long-term care insurance policy that reduces, limits or co-
10 ordinates the benefits provided under the policy on the
11 basis that the policyholder has or is eligible for other long-
12 term care insurance coverage or benefits.

13 “(f) PROVISION OF OUTLINE OF COVERAGE.—No
14 agent, association or its subsidiary, or carrier may sell or
15 offer for a sale a long-term care insurance policy (or for
16 a certificate under a group long-term care insurance pol-
17 icy) without providing to the purchaser or potential pur-
18 chaser (or representative) an outline of coverage that com-
19 plies with the standards established under section
20 2701(a).

21 “(g) PENALTIES.—Any agent who sells, offers for
22 sale, or issues a long-term care insurance policy in viola-
23 tion of this section may be imprisoned not more than 5
24 years, or fined in accordance with title 18, United States
25 Code, and, in addition, is subject to a civil money penalty

1 of not to exceed \$15,000 for each such violation. Any asso-
2 ciation or its subsidiary or carrier that sells, offers for
3 sale, or issues a long-term care insurance policy in viola-
4 tion of this section may be fined in accordance with title
5 18, United States Code, and in addition, is subject to a
6 civil money penalty of not to exceed \$25,000 for each vio-
7 lation.

8 “(h) AGENT TRAINING AND CERTIFICATION RE-
9 QUIREMENTS.—The NAIC shall establish requirements
10 for long-term care insurance agent training and certifi-
11 cation that—

12 “(1) specify requirements for training insurance
13 agents who desire to sell or offer for sale long-term
14 care insurance policies; and

15 “(2) specify procedures for certifying agents
16 who have completed such training and who are as
17 qualified to sell or offer for sale long-term care in-
18 surance policies.

19 **“SEC. 2713. ADDITIONAL RESPONSIBILITIES FOR CAR-**
20 **RIERS.**

21 “(a) REFUND OF PREMIUMS.—If an application for
22 a long-term care insurance policy (or for a certificate
23 under a group long-term care insurance policy) is denied
24 or an applicant returns a policy or certificate within 30
25 days of the date of its issuance pursuant to subsection

1 2717, the carrier shall refund directly to the applicant,
2 or in the case of an employer to whomever remits the pre-
3 mium, and not by delivery by the agent, not later than
4 30 days after the date of the denial or return, any pre-
5 miums paid with respect to such a policy (or certificate).

6 “(b) MAILING OF POLICY.—If an application for a
7 long-term care insurance policy (or for a certificate under
8 a group long-term care insurance policy) is approved, the
9 carrier shall provide the applicant, or in the case of a
10 group plan the employer, the policy (or certificate) of in-
11 surance not later than 30 days after the date of the ap-
12 proval.

13 “(c) INFORMATION ON DENIALS OF CLAIMS.—If a
14 claim under a long-term care insurance policy is denied,
15 the carrier shall, within 30 days of the date of a written
16 request by the policyholder or certificate holder (or rep-
17 resentative)—

18 “(1) provide a written explanation of the rea-
19 sons for the denial; and

20 “(2) make available all medical and patient
21 records directly relating to such denial.

22 Except as provided in subsection (e) of section 2715, no
23 claim under such a policy may be denied on the basis of
24 a failure to disclose a condition at the time of issuance

1 of the policy if the application for the policy failed to re-
2 quest information respecting the condition.

3 “(d) REPORTING OF INFORMATION.—A carrier that
4 issues one or more long-term care insurance policies shall
5 periodically (not less often than annually) report, in a
6 form and in a manner determined by the NAIC, to the
7 Commissioner, superintendent or director of insurance of
8 each State in which the policy is delivered, and shall make
9 available to the Secretary, upon request, information in
10 a form and manner determined by the NAIC concerning—

11 “(1) the long-term care insurance policies of the
12 carrier that are in force;

13 “(2) the most recent premiums for such policies
14 and the premiums imposed for such policies since
15 their initial issuance;

16 “(3) the lapse rate, replacement rate, and re-
17 scission rates by policy;

18 “(4) the names of that 10 percent of its agents
19 that—

20 “(A) have the greatest lapse and replace-
21 ment rate; and

22 “(B) have produced at least \$50,000 of
23 long-term care insurance sales in the previous
24 year; and

1 “(5) the claims denied (expressed as a number
2 and as a percentage of claims submitted) by policy.
3 Information required under this subsection shall be re-
4 ported in a format specified in the standards established
5 under section 2701(a). For purposes of paragraph (3),
6 there shall be included (but reported separately) data con-
7 cerning lapses due to the death of the policyholder. For
8 purposes of paragraph (4), there shall not be included as
9 a claim any claim that is denied solely because of the fail-
10 ure to meet a deductible, waiting period, or exclusionary
11 period.

12 “(e) STANDARDS ON COMPENSATION FOR SALE OF
13 POLICIES.—

14 “(1) IN GENERAL.—A carrier that issues one or
15 more long-term care insurance policies may provide
16 a commission or other compensation to an agent or
17 other representative for the sale of such a policy only
18 if the first year commission or other first year com-
19 pensation to be paid does not exceed 200 percent of
20 the commission or other compensation paid for sell-
21 ing or servicing the policy in the second year, or if
22 the first year commission or other compensation to
23 be paid does not exceed 50 percent of the premium
24 paid on the first year policy, until the NAIC promul-

1 gates mandatory standards concerning compensation
2 for the sale of such policies.

3 “(2) SUBSEQUENT YEARS.—The commission or
4 other compensation provided for the sale of long-
5 term care insurance policies in years subsequent to
6 the first year of the policy shall be the same as that
7 provided in the second subsequent year and shall be
8 provided for no fewer than 5 subsequent years.

9 “(3) LIMITATION.—No carrier shall provide
10 compensation to its agents for the sale of a long-
11 term care insurance policy and no agent shall receive
12 compensation greater than the renewal compensation
13 payable by the replacing carrier on renewal policies
14 if an existing policy is replaced.

15 “(4) COMPENSATION DEFINED.—As used in
16 this subsection, the term ‘compensation’ includes pe-
17 cuniary or nonpecuniary remuneration of any kind
18 relating to the sale or renewal of the policy, includ-
19 ing but not limited to deferred compensation, bo-
20 nuses, gifts, prizes, awards, and finders fees.

21 **“SEC. 2714. RENEWABILITY STANDARDS FOR ISSUANCE,**
22 **AND BASIS FOR CANCELLATION OF POLICIES.**

23 “(a) IN GENERAL.—No long-term care insurance pol-
24 icy may be canceled or nonrenewed for any reason other

1 than nonpayment of premium, material misrepresentation
2 or fraud.

3 “(b) CONTINUATION AND CONVERSION RIGHTS FOR
4 GROUP POLICIES.—

5 “(1) IN GENERAL.—Each group long-term care
6 insurance policy shall provide covered individuals
7 with a basis for continuation or conversion in ac-
8 cordance with this subsection.

9 “(2) BASIS FOR CONTINUATION.—For purposes
10 of paragraph (1), a policy provides a basis for con-
11 tinuation of coverage if the policy maintains cov-
12 erage under the existing group policy when such cov-
13 erage would otherwise terminate and which is sub-
14 ject only to the continued timely payment of pre-
15 mium when due. A group policy which restricts pro-
16 vision of benefits and services to or contains incen-
17 tives to use certain providers or facility, may provide
18 continuation benefits which are substantially equiva-
19 lent to the benefits of the existing group policy.

20 “(3) BASIS FOR CONVERSION.—For purposes of
21 paragraph (1), a policy provides a basis for conver-
22 sion of coverage if the policy entitles each individ-
23 ual—

1 “(A) whose coverage under the group pol-
2 icy would otherwise be terminated for any rea-
3 son; and

4 “(B) who has been continuously insured
5 under the policy (or group policy which was re-
6 placed) for at least 6 months before the date of
7 the termination;

8 to issuance of a policy providing benefits identical to,
9 substantially equivalent to, or in excess of, those of
10 the policy being terminated, without evidence of in-
11 surability.

12 “(4) TREATMENT OF SUBSTANTIAL EQUIVA-
13 LENCE.—In determining under this subsection
14 whether benefits are substantially equivalent, consid-
15 eration should be given to the difference between
16 managed care and non-managed care plans.

17 “(5) GROUP REPLACEMENT OF POLICIES.—If a
18 group long-term care insurance policy is replaced by
19 another long-term care insurance policy purchased
20 by the same policyholder, the succeeding issuer shall
21 offer coverage to all persons covered under the old
22 group policy on its date of termination. Coverage
23 under the new group policy shall not result in any
24 exclusion for preexisting conditions that would have
25 been covered under the group policy being replaced.

1 “(c) STANDARDS FOR ISSUANCE.—

2 “(1) IN GENERAL.—

3 “(A) GUARANTEE.—An agent, association
4 or carrier that sells or issues long-term care in-
5 surance policies shall guarantee that such poli-
6 cies shall be sold or issued to an individual, or
7 eligible individual in the case of a group plan,
8 if such individual meets the minimum medical
9 underwriting requirements of such policy.

10 “(B) PREMIUM FOR CONVERTED POL-
11 ICY.—If a group policy from which conversion
12 is made is a replacement for a previous group
13 policy, the premium for the converted policy
14 shall be calculated on the basis of the insured’s
15 age at the inception of coverage under the
16 group policy from which conversion is made.
17 Where the group policy from which conversion
18 is made replaced previous group coverage, the
19 premium for the converted policy shall be cal-
20 culated on the basis of the insured’s age at in-
21 ception of coverage under the group policy re-
22 placed.

23 “(2) UPGRADE FOR CURRENT POLICIES.—The
24 NAIC shall establish standards, including those pro-
25 viding guidance on medical underwriting and age

1 rating, with respect to the access of individuals to
2 policies offering upgraded benefits.

3 “(d) EFFECT OF INCAPACITATION.—

4 “(1) IN GENERAL.—

5 “(A) PROHIBITION.—Except as provided
6 in paragraph (2), a long-term care insurance
7 policy in effect as of the effective date of the
8 standards established under section 2701(a)
9 may not be canceled for nonpayment if the pol-
10 icy holder is determined by a long-term care
11 provider, physician or other health care pro-
12 vider, independent of the issuer of the policy, to
13 be cognitively or mentally incapacitated so as to
14 not make payments in a timely manner.

15 “(B) REINSTATEMENT.—A long-term care
16 policy shall include a provision that provides for
17 the reinstatement of such coverage, in the event
18 of lapse, if the insurer is provided with proof of
19 cognitive or mental incapacitation. Such rein-
20 statement option shall remain available for a
21 period of not less than 5 months after termi-
22 nation and shall allow for the collection of past
23 due premium.

1 “(2) PERMITTED CANCELLATION.—A long-term
2 care insurance policy may be canceled under para-
3 graph (1) for nonpayment if—

4 “(A) the period of such nonpayment is in
5 excess of 30 days; and

6 “(B) notice of intent to cancel is provided
7 to the policyholder or designated representative
8 of the policy holder not less than 30 days prior
9 to such cancellation, except that notice may not
10 be provided until the expiration of 30 days after
11 a premium is due and unpaid.

12 Notice under this paragraph shall be deemed to have
13 been given as of 5 days after the mailing date.

14 **“SEC. 2715. BENEFIT STANDARDS.**

15 “(a) USE OF STANDARD DEFINITIONS AND TERMI-
16 NOLOGY, UNIFORM FORMAT, AND STANDARD BENE-
17 FITS.—Each long-term care insurance policy shall, with
18 respect to services, providers or facilities, pursuant to
19 standards established under section 2701(a)—

20 “(1) use uniform language and definitions, ex-
21 cept that such language and definitions may take
22 into account the differences between States with re-
23 spect to definitions and terminology used for long-
24 term care services and providers;

1 “(2) use a uniform format for presenting the
2 outline of coverage under such a policy; and

3 “(3) provide coverage for at least one standard
4 benefits package (of those developed by the NAIC);
5 as prescribed under guidelines issued by the NAIC and
6 periodically updated.

7 “(b) DISCLOSURE.—

8 “(1) OUTLINE OF COVERAGE.—

9 “(A) REQUIREMENT.—Each carrier that
10 sells or offers for sale a long-term care insur-
11 ance policy shall provide an outline of coverage
12 under such policy that meets the applicable
13 standards established pursuant to section
14 2701(a), complies with the requirements of sub-
15 paragraph (B), and is in a uniform format as
16 prescribed in guidelines issued by the NAIC
17 and periodically updated.

18 “(B) CONTENTS.—The outline of coverage
19 for each long-term care insurance policy shall
20 include at least the following:

21 “(i) A description of the principal
22 benefits and coverage under the policy.

23 “(ii) A statement of the principal ex-
24 clusions, reductions, and limitations con-
25 tained in the policy.

1 “(iii) A statement of the terms under
2 which the policy (or certificate) may be
3 continued in force or discontinued, the
4 terms for continuation or conversion, and
5 any reservation in the policy of a right to
6 change premiums.

7 “(iv) A statement, in bold face type
8 on the face of the document in language
9 that is understandable to an average indi-
10 vidual, that the outline of coverage is a
11 summary only, not a contract of insurance,
12 and that the policy (or master policy) con-
13 tains the contractual provisions that gov-
14 ern, except that such summary shall sub-
15 stantially and accurately reflect the con-
16 tents of the policy or the master policy.

17 “(v) A description of the terms, speci-
18 fied in section 2717, under which a policy
19 or certificate may be returned and pre-
20 mium refunded.

21 “(vi) Information on national average
22 costs for nursing facility and home health
23 care and information (in graphic form) on
24 the relationship of the value of the benefits
25 provided under the policy to such national

1 average costs and State average costs,
2 where available.

3 “(vii) A statement of the percentage
4 limit on annual premium increases that is
5 provided under the policy pursuant to this
6 section.

7 “(2) CERTIFICATES.—A certificate issued pur-
8 suant to a group long-term care insurance policy
9 shall include—

10 “(A) a description of the principal benefits
11 and coverage provided in the policy;

12 “(B) a statement of the principal exclu-
13 sions, reductions, and limitations contained in
14 the policy; and

15 “(C) a statement that the group master
16 policy determines governing contractual provi-
17 sions.

18 “(3) LONG-TERM CARE AS PART OF LIFE IN-
19 SURANCE.—In the case of a long-term care insur-
20 ance policy issued as a part of, or a rider on, a life
21 insurance policy, at the time of policy delivery there
22 shall be provided a policy summary that includes—

23 “(A) an explanation of how the long-term
24 care benefits interact with other components of

1 the policy (including deductions from death
2 benefits);

3 “(B) an illustration of the amount of bene-
4 fits, the length of benefit, and the guaranteed
5 lifetime benefits (if any) for each covered per-
6 son; and

7 “(C) any exclusions, reductions, and limi-
8 tations on benefits of long-term care.

9 “(4) ADDITIONAL INFORMATION.—The NAIC
10 shall develop recommendations with respect to in-
11 forming consumers of the long-term economic viabil-
12 ity of carriers issuing long-term care insurance poli-
13 cies.

14 “(c) LIMITING CONDITIONS ON BENEFITS; MINIMUM
15 BENEFITS.—

16 “(1) IN GENERAL.—A long-term care insurance
17 policy may not condition or limit eligibility—

18 “(A) for benefits for a type of services to
19 the need for or receipt of any other services;

20 “(B) for any benefit on the medical neces-
21 sity for such benefit;

22 “(C) for benefits furnished by licensed or
23 certified providers in compliance with conditions
24 which are in addition to those required for li-
25 censure or certification under State law, except

1 that if no State licensure or certification laws
2 exists, in compliance with qualifications devel-
3 oped by the NAIC; or

4 “(D) for residential care (if covered under
5 the policy) only—

6 “(i) to care provided in facilities
7 which provide a higher level of care; or

8 “(ii) to care provided in facilities
9 which provide for 24-hour or other nursing
10 care not required in order to be licensed by
11 the State.

12 “(2) HOME HEALTH CARE OR COMMUNITY-
13 BASED SERVICES.—If a long-term care insurance
14 policy provides benefits for the payment of specified
15 home health care or community-based services, the
16 policy—

17 “(A) may not limit such benefits to serv-
18 ices provided by registered nurses or licensed
19 practical nurses;

20 “(B) may not require benefits for such
21 services to be provided by a nurse or therapist
22 that can be provided by a home health aide or
23 licensed or certified home care worker, except
24 that if no State licensure or certification laws

1 exists, in compliance with qualifications devel-
2 oped by the NAIC;

3 “(C) may not limit such benefits to serv-
4 ices provided by agencies or providers certified
5 under title XVIII of the Social Security Act;
6 and

7 “(D) must provide, at a minimum, benefits
8 for personal care services (including home
9 health aide and home care worker services as
10 defined by the NAIC) home health services,
11 adult day care, and respite care in an individ-
12 ual’s home or in another setting in the commu-
13 nity, or any of these benefits on a respite care
14 basis.

15 “(3) NURSING FACILITY SERVICES.—If a long-
16 term care insurance policy provides benefits for the
17 payment of specified nursing facility services, the
18 policy must provide such benefits with respect to all
19 nursing facilities (as defined in section 1919(a) of
20 the Social Security Act or until such time as subse-
21 quently provided for by the NAIC in establishing
22 uniform language and definitions under section
23 2715(a)(1)) in the State.

24 “(4) PER DIEM POLICIES.—

1 “(A) DEFINITION.—For purposes of this
2 title, the term ‘per diem long-term care insur-
3 ance policy’ means a long-term care insurance
4 policy (or certificate under a group long-term
5 care insurance policy) that provides for benefit
6 payments on a periodic basis due to cognitive
7 impairment or loss of functional capacity with-
8 out regard to the expenses incurred or services
9 rendered during the period to which the pay-
10 ments relate.

11 “(B) LIMITATION.—No per diem long-term
12 care insurance policy (or certificate) may condi-
13 tion or otherwise exclude benefit payments
14 based on the receipt of any type of nursing fa-
15 cility, home health care or community-based
16 services.

17 “(d) PROHIBITION OF DISCRIMINATION.—A long-
18 term care insurance policy may not treat benefits under
19 the policy in the case of an individual with Alzheimer’s
20 disease, with any related progressive degenerative demen-
21 tia of an organic origin, with any organic or inorganic
22 mental illness, or with mental retardation or any other
23 cognitive or mental impairment differently from an indi-
24 vidual having another medical condition for which benefits
25 may be made available.

1 “(e) LIMITATION ON USE OF PREEXISTING CONDI-
2 TION LIMITS.—

3 “(1) INITIAL ISSUANCE.—

4 “(A) IN GENERAL.—Subject to subpara-
5 graph (B), a long-term care insurance policy
6 may not exclude or condition benefits based on
7 a medical condition for which the policyholder
8 received treatment or was otherwise diagnosed
9 before the issuance of the policy.

10 “(B) 6-MONTH LIMIT.—

11 “(i) IN GENERAL.—No long-term care
12 insurance policy or certificate issued under
13 this title shall utilize a definition of ‘pre-
14 existing condition’ that is more restrictive
15 than the following: The term ‘preexisting
16 condition’ means a condition for which
17 medical advice or treatment was rec-
18 ommended by, or received from a provider
19 of health care services, within 6 months
20 preceding the effective date of coverage of
21 an insured individual.

22 “(ii) PROHIBITION ON EXCLUSION OF
23 COVERAGE.—No long-term care insurance
24 policy or certificate may exclude coverage
25 for a loss or confinement that is the result

1 of a preexisting condition unless such loss
2 or confinement begins within 6 months fol-
3 lowing the effective date of the coverage of
4 the insured individual.

5 “(2) REPLACEMENT POLICIES.—If a long-term
6 care insurance policy replaces another long-term
7 care insurance policy, the issuer of the replacing pol-
8 icy shall waive any time periods applicable to pre-
9 existing conditions, waiting period, elimination peri-
10 ods and probationary periods in the new policy for
11 similar benefits to the extent such time was spent
12 under the original policy.

13 “(f) ELIGIBILITY FOR BENEFITS.—

14 “(1) LONG-TERM CARE POLICIES.—Each long-
15 term care insurance policy shall—

16 “(A) describe the level of benefits available
17 under the policy; and

18 “(B) specify in clear, understandable
19 terms, the level (or levels) of physical, cognitive,
20 or mental impairment required in order to re-
21 ceive benefits under the policy.

22 “(2) FUNCTIONAL ASSESSMENT.—In order to
23 submit a claim under any long-term care insurance
24 policy, each claimant shall have a professional func-
25 tional assessment of his or her physical, cognitive,

1 and mental abilities. Such initial assessment shall be
2 conducted by an individual or entity, meeting the
3 qualifications established by the NAIC to assure the
4 professional competence and credibility of such indi-
5 vidual or entity and that such individual meets any
6 applicable State licensure and certification require-
7 ments. The individual or entity conducting such as-
8 sessment may not control, or be controlled by, the
9 issuer of the policy. For purposes of this paragraph
10 and paragraph (4), the term ‘control’ means the di-
11 rect or indirect possession of the power to direct the
12 management and policies of a person. Control is pre-
13 sumed to exist, if any person directly or indirectly,
14 owns, controls, holds with the power to vote, or
15 holds proxies representing 10 percent of the voting
16 securities of another person.

17 “(3) CLAIMS REVIEW.—Except as provided in
18 paragraph (4), each long-term care insurance policy
19 shall be subject to final claims review by the carrier
20 pursuant to the terms of the long-term care insur-
21 ance policy.

22 “(4) APPEALS PROCESS.—

23 “(A) IN GENERAL.—Each long-term care
24 insurance policy shall provide for a timely and
25 independent appeals process, meeting standards

1 established by the NAIC, for individuals who
2 dispute the results of the claims review, con-
3 ducted under paragraph (3), of the claimant’s
4 functional assessment, conducted under para-
5 graph (2).

6 “(B) INDEPENDENT ASSESSMENT.—An
7 appeals process under this paragraph shall in-
8 clude, at the request of the claimant, an inde-
9 pendent assessment of the claimant’s physical,
10 cognitive or mental abilities.

11 “(C) CONDUCT.—An independent assess-
12 ment under subparagraph (B) shall be con-
13 ducted by an individual or entity meeting the
14 qualifications established by the NAIC to as-
15 sure the professional competence and credibility
16 of such individual or entity and any applicable
17 State licensure and certification requirements
18 and may not be conducted—

19 “(i) by an individual who has a direct
20 or indirect significant or controlling inter-
21 est in, or direct affiliation or relationship
22 with, the issuer of the policy;

23 “(ii) by an entity that provides serv-
24 ices to the policyholder or certificateholder

1 for which benefits are available under the
2 long-term care insurance policy; or

3 “(iii) by an individual or entity in con-
4 trol of, or controlled by, the issuer of the
5 policy.

6 “(5) STANDARD ASSESSMENTS.—Not later than
7 2 years after the date of enactment of this title, the
8 advisory committee established under section
9 2701(d) shall recommend uniform needs assessment
10 mechanisms for the determination of eligibility for
11 benefits under such assessments.

12 “(g) INFLATION PROTECTION.—

13 “(1) OPTION TO PURCHASE.—A carrier may
14 not offer a long-term care insurance policy unless
15 the carrier also offers to the proposed policyholder,
16 including each group policyholder, the option to pur-
17 chase a policy that provides for increases in benefit
18 levels, with benefit maximums or reasonable dura-
19 tions that are meaningful, to account for reasonably
20 anticipated increases in the costs of long-term care
21 services covered by the policy. A carrier may not
22 offer to a policyholder an inflation protection feature
23 that is less favorable to the policyholder than one of
24 the following:

1 “(A) With respect to policies that provide
2 for automatic periodic increases in benefits, the
3 policy provides for an annual increase in bene-
4 fits in a manner so that such increases are
5 computed annually at a rate of not less than 5
6 percent.

7 “(B) With respect to policies that provide
8 for periodic opportunities to elect an increase in
9 benefits, the policy guarantees that the insured
10 individual will have the right to periodically in-
11 crease the benefit levels under the policy with-
12 out providing evidence of insurability or health
13 status so long as the option for the previous pe-
14 riod was not declined. The amount of any such
15 additional benefit may not be less than the dif-
16 ference between—

17 “(i) the existing policy benefit; and

18 “(ii) such existing benefit compounded
19 annually at a rate of at least 5 percent for
20 the period beginning on the date on which
21 the existing benefit is purchased and ex-
22 tending until the year in which the offer of
23 increase is made.

24 “(C) With respect to service benefit poli-
25 cies, the policy covers a specified percentage of

1 the actual or reasonable charges and does not
2 include a maximum specified indemnity amount
3 or limit.

4 “(2) EXCEPTION.—The requirements of para-
5 graph (1) shall not apply to life insurance policies or
6 riders containing accelerated long-term care benefits.

7 “(3) REQUIRED INFORMATION.—Carriers shall
8 include the following information in or together with
9 the outline of coverage provided under this title:

10 “(A) A graphic comparison of the benefit
11 levels of a policy that increases benefits over the
12 policy period with a policy that does not in-
13 crease benefits. Such comparison shall show
14 benefit levels over not less than a 20-year pe-
15 riod.

16 “(B) Any expected premium increases or
17 additional premiums required to pay for any
18 automatic or optional benefit increases, whether
19 the individual who purchases the policy obtains
20 the inflation protection initially or whether such
21 individual delays purchasing such protection
22 until a future time.

23 “(4) CONTINUATION OF PROTECTION.—Infla-
24 tion protection benefit increases under this sub-
25 section under a policy that contains such protection

1 shall continue without regard to an insured's age,
2 claim status or claim history, or the length of time
3 the individual has been insured under the policy.

4 “(5) CONSTANT PREMIUM.—An offer of infla-
5 tion protection under this subsection that provides
6 for automatic benefit increases shall include an offer
7 of a premium that the carrier expects to remain con-
8 stant. Such offer shall disclose in a conspicuous
9 manner that the premium may change in the future
10 unless the premium is guaranteed to remain con-
11 stant.

12 “(6) REJECTION.—Inflation protection under
13 this subsection shall be included in a long-term care
14 insurance policy unless a carrier obtains a written
15 rejection of such protection signed by the policy-
16 holder.

17 **“SEC. 2716. OPTION TO PURCHASE NONFORFEITURE BENE-**
18 **FITS.**

19 “A carrier may not offer a long-term care insurance
20 policy unless the carrier also offers to the proposed policy-
21 holder, including each group policyholder, the option to
22 purchase a policy that provides that if the policy lapses
23 after the policy has been in effect for a specified minimum
24 period, the policy will provide, without payment of any ad-
25 ditional premiums, nonforfeiture benefits which—

1 “(1) are not less favorable to the policyholder
2 than the benefits specified under the standards
3 under section 2701(a), and

4 “(2) provide that the percentage or amount of
5 benefits increase based upon the policyholder’s eq-
6 uity in the policy.

7 “(b) ESTABLISHMENT OF STANDARDS.—The stand-
8 ards under section 2701(a) shall provide that the percent-
9 age or amount of benefits under subsection (a) must in-
10 crease based upon the policyholder’s equity in the policy.

11 **“SEC. 2717. LIMIT OF PERIOD OF CONTESTABILITY AND**
12 **RIGHT TO RETURN.**

13 “(a) CONTESTABILITY.—A carrier may not cancel or
14 renew a long-term care insurance policy or deny a claim
15 under the policy based on fraud or material misrepresenta-
16 tion relating to the issuance of the policy unless notice
17 of such fraud or material misrepresentation is provided
18 within a time period to be determined by the NAIC.

19 “(b) RIGHT TO RETURN.—Each applicant for a long-
20 term care insurance policy shall have the right to return
21 the policy (or certificates) within 30 days of the date of
22 its delivery (and to have the premium refunded) if, after
23 examination of the policy or certificate, the applicant is
24 not satisfied for any reason.

1 **“SEC. 2718. CIVIL MONEY PENALTY.**

2 “(a) CARRIER.—Any carrier, association or its sub-
3 sidiary that sells or offers for sale a long-term care insur-
4 ance policy and that—

5 “(1) fails to make a refund in accordance with
6 section 2713(a);

7 “(2) fails to transmit a policy in accordance
8 with section 2713(b);

9 “(3) fails to provide, make available, or report
10 information in accordance with subsections (c) or (d)
11 of section 2713;

12 “(4) provides a commission or compensation in
13 violation of section 2713(e);

14 “(5) fails to provide an outline of coverage in
15 violation of section 2715(b)(1); or

16 “(6) issues a policy without obtaining certain
17 information in violation of section 2715(f);

18 is subject to a civil money penalty of not to exceed \$25,000
19 for each such violation.

20 “(b) AGENTS.—Any agent that sells or offers for sale
21 a long-term care insurance policy and that—

22 “(1) fails to make a refund in accordance with
23 section 2713(a);

24 “(2) fails to transmit a policy in accordance
25 with section 2713(b);

1 “(3) fails to provide, make available, or report
2 information in accordance with subsections (c) or (d)
3 of section 2713;

4 “(4) fails to provide an outline of coverage in
5 violation of section 2715(b)(1); or

6 “(5) issues a policy without obtaining certain
7 information in violation of section 2715(f);

8 is subject to a civil money penalty of not to exceed \$15,000
9 for each such violation.

10 “PART C—LONG-TERM CARE INSURANCE POLICIES,

11 DEFINITION AND ENDORSEMENTS

12 “**SEC. 2721. LONG-TERM CARE INSURANCE POLICY DE-**

13 **FINED.**

14 “(a) IN GENERAL.—As used in this section, the term
15 ‘long-term care insurance policy’ means any insurance pol-
16 icy, rider or certificate advertised, marketed, offered or de-
17 signed to provide coverage for not less than 12 consecutive
18 months for each covered person on an expense incurred,
19 indemnity prepaid or other basis, for one or more nec-
20 essary diagnostic, preventive, therapeutic, rehabilitative,
21 maintenance or personal care services, provided in a set-
22 ting other than an acute care unit of a hospital. Such term
23 includes—

24 “(1) group and individual annuities and life in-
25 surance policies, riders or certificates that provide

1 directly, or that supplement long-term care insur-
2 ance; and

3 “(2) a policy, rider or certificates that provides
4 for payment of benefits based on cognitive impair-
5 ment or the loss of functional capacity.

6 “(b) ISSUANCE.—Long-term care insurance policies
7 may be issued by—

8 “(1) carriers;

9 “(2) fraternal benefit societies;

10 “(3) nonprofit health, hospital, and medical
11 service corporations;

12 “(4) prepaid health plans;

13 “(5) health maintenance organizations; or

14 “(6) any similar organization to the extent they
15 are otherwise authorized to issue life or health insur-
16 ance.

17 “(c) POLICIES EXCLUDED.—The term ‘long-term
18 care insurance policy’ shall not include any insurance pol-
19 icy, rider or certificate that is offered primarily to provide
20 basic Medicare supplement coverage, basic hospital ex-
21 pense coverage, basic medical-surgical expense coverage,
22 hospital confinement indemnity coverage, major medical
23 expense coverage, disability income or related asset-protec-
24 tion coverage, accident only coverage, specified disease or
25 specified accident coverage, or limited benefit health cov-

1 erage. With respect to life insurance, such term shall not
2 include life insurance policies, riders or certificates that
3 accelerate the death benefit specifically for one or more
4 of the qualifying events of terminal illness, medical condi-
5 tions requiring extraordinary medical intervention, or per-
6 manent institutional confinement, and that provide the op-
7 tion of a lump-sum payment for those benefits and in
8 which neither the benefits nor the eligibility for the bene-
9 fits is conditioned upon the receipt of long-term care.

10 “(d) APPLICATIONS.—Notwithstanding any other
11 provision of this title, this title shall apply to any product
12 advertised, marketed or offered as a long-term insurance
13 policy, rider or certificate.

14 **“SEC. 2722. CODE OF CONDUCT WITH RESPECT TO EN-**
15 **DORSEMENTS.**

16 “Not later than 1 year after the date of enactment
17 of this title the NAIC shall issue guidelines that shall
18 apply to organizations and associations, other than em-
19 ployers and labor organizations that do not accept com-
20 pensation, and their subsidiaries that provide endorse-
21 ments of long-term care insurance policies, or that permit
22 such policies to be offered for sale through the organiza-
23 tion or association. Such guidelines shall include at mini-
24 mum the following:

1 “(1) In endorsing or selling long-term care in-
2 surance policies, the primary responsibility of an or-
3 ganization or association shall be to educate their
4 members concerning such policies and assist such
5 members in making informed decisions. Such organi-
6 zations and associations may not function primarily
7 as sales agents for insurance companies.

8 “(2) Organizations and associations shall pro-
9 vide objective information regarding long-term care
10 insurance policies sold or endorsed by such organiza-
11 tions and associations to ensure that members of
12 such organizations and associations have a balanced
13 and complete understanding of both the strengths
14 and weaknesses of the policies that are being en-
15 dorsed or sold.

16 “(3) Organizations and associations selling or
17 endorsing long-term care insurance policies shall dis-
18 close in marketing literature provided to their mem-
19 bers concerning such policies the manner in which
20 such policies and the insurance company issuing
21 such policies were selected. If the organization or as-
22 sociation and the insurance company have interlock-
23 ing directorates, the organization or association shall
24 disclose such fact to their members.

1 “(4) Organizations and associations selling or
2 endorsing long-term care insurance policies shall dis-
3 close in marketing literature provided to their mem-
4 bers concerning such policies the nature and amount
5 of the compensation arrangements (including all
6 fees, commissions, administrative fees and other
7 forms of financial support that the organization or
8 association receives) from the endorsement or sale of
9 the policy to its members.

10 “(5) The Boards of Directors of organizations
11 and associations selling or endorsing long-term care
12 insurance policies, if such organizations and associa-
13 tions have a Board of Directors, shall review and ap-
14 prove such insurance policies, the compensation ar-
15 rangements and the marketing materials used to
16 promote sales of such policies.

17 “PART D—MISCELLANEOUS PROVISIONS

18 **“SEC. 2731. FUNDING FOR LONG-TERM CARE INSURANCE**
19 **INFORMATION, COUNSELING, AND ASSIST-**
20 **ANCE.**

21 “(a) IN GENERAL.—The Secretary, acting through
22 the Public Health Service, may award grants to States,
23 and national organizations with demonstrated experience
24 in long-term care insurance, for the establishment of pro-
25 grams to provide information, counseling, and assistance

1 relating to the procurement of adequate and appropriate
2 long-term care insurance.

3 “(b) APPLICATION.—To be eligible to receive a grant
4 under subsection (a), a State or national organization
5 shall prepare and submit to the Secretary an application
6 at such time, in such manner, and containing such infor-
7 mation as the Secretary may require, including a descrip-
8 tion of the program for which the State or organization
9 intends to use the amounts provided under the grant.

10 “(c) AUTHORIZATION OF APPROPRIATIONS.—

11 “(1) IN GENERAL.—There are authorized to be
12 appropriate for grants to States under subsection
13 (a), \$10,000,000 for each of the fiscal years 1994
14 through 1996.

15 “(2) NATIONAL ORGANIZATIONS.—There are
16 authorized to be appropriate for grants to national
17 organizations under subsection (a), \$1,000,000 for
18 each of the fiscal years 1994 through 1996.

19 **“SEC. 2732. DEFINITIONS.**

20 “As used in this title:

21 “(1) AGENT.—The term ‘agent’ means—

22 “(A) prior to 2 years after the date of en-
23 actment of this Act, an individual who sells or
24 offers for sale a long-term care insurance policy
25 subject to the requirements of this title and is

1 licensed or required to be licensed under State
2 law for such purpose; and

3 “(B) after the date referred to in subpara-
4 graph (A), an individual who meets the training
5 and certification requirements established under
6 section 2712(f).

7 “(2) ASSOCIATION.—The term ‘association’ in-
8 cludes the association and its subsidiaries.

9 “(3) CARRIER.—The term ‘carrier’ means any
10 person that offers a health benefit plan, whether
11 through insurance or otherwise, including a licensed
12 insurance company, a prepaid hospital or medical
13 service plan, a health maintenance organization, a
14 self-insured carrier, a reinsurance carrier, and a
15 multiple employer welfare arrangement (a combina-
16 tion of employers associated for the purpose of pro-
17 viding health benefit plan coverage for their employ-
18 ees).”.

19 (b) CONFORMING AMENDMENTS.—

20 (1) Sections 2701 through 2714 of the Public
21 Health Service Act (42 U.S.C. 300cc through
22 300cc–15) are redesignated as sections 2801
23 through 2814, respectively.

24 (2) Sections 465(f) and 497 of such Act (42
25 U.S.C. 286(f) and 289(f)) are amended by striking

1 out “2701” each place that such appears and insert-
2 ing in lieu thereof “2801”.

3 **TITLE II—TAX TREATMENT**
4 **Subtitle A—Long-Term Care**
5 **Insurance**

6 **SEC. 201. QUALIFIED LONG-TERM CARE INSURANCE DE-**
7 **FINED AND TREATED AS ACCIDENT OR**
8 **HEALTH INSURANCE.**

9 (a) IN GENERAL.—Section 818 of the Internal Reve-
10 nue Code of 1986 (relating to definitions) is amended by
11 adding at the end thereof the following new subsection:

12 “(g) QUALIFIED LONG-TERM CARE INSURANCE
13 TREATED AS ACCIDENT OR HEALTH INSURANCE.—For
14 purposes of this subchapter:

15 “(1) IN GENERAL.—Any reference to
16 noncancellable accident or health insurance contracts
17 shall be treated as including a reference to qualified
18 long-term care insurance.

19 “(2) QUALIFIED LONG-TERM CARE INSUR-
20 ANCE.—For purposes of this subsection:

21 “(A) IN GENERAL.—Subject to subpara-
22 graphs (B) and (C), the term ‘qualified long-
23 term care insurance’ means insurance under a
24 policy or rider, issued by a qualified issuer, to

1 be advertised, marketed, offered, or designed to
2 provide coverage—

3 “(i) for not less than 12 consecutive
4 months for each covered person,

5 “(ii) on an expense incurred, indem-
6 nity, prepaid or other basis,

7 “(iii) for 1 or more necessary or medi-
8 cally necessary diagnostic services, preven-
9 tive services, therapeutic services, rehabili-
10 tation services, maintenance services, or
11 personal care services,

12 “(iv) for the loss of functional capac-
13 ity, and

14 “(v) provided in a setting other than
15 an acute care unit of a hospital.

16 “(B) QUALIFIED ISSUER.—For purposes
17 of subparagraph (A), the term ‘qualified issuer’
18 means any of the following provided they are
19 subject to the jurisdiction and regulation of at
20 least one State insurance department:

21 “(i) Private insurance company.

22 “(ii) Fraternal benefit society.

23 “(iii) Nonprofit health corporation.

24 “(iv) Nonprofit hospital corporation.

1 “(v) Nonprofit medical service cor-
2 poration.

3 “(vi) Prepaid health plan.”

4 (b) EFFECTIVE DATE.—The amendment made by
5 subsection (a) shall apply to taxable years beginning after
6 December 31, 1994.

7 **SEC. 202. QUALIFIED LONG-TERM CARE INSURANCE TREAT-**
8 **ED AS ACCIDENT AND HEALTH INSURANCE**
9 **FOR PURPOSES OF EXCLUSION FOR BENE-**
10 **FITS RECEIVED UNDER SUCH INSURANCE**
11 **AND FOR EMPLOYER CONTRIBUTIONS FOR**
12 **SUCH INSURANCE.**

13 (a) IN GENERAL.—Section 105 of the Internal Reve-
14 nue Code of 1986 (relating to amounts received under ac-
15 cident and health plans) is amended by adding at the end
16 thereof the following new subsection:

17 “(j) SPECIAL RULES RELATING TO QUALIFIED
18 LONG-TERM CARE INSURANCE.—For purposes of section
19 104, this section, and section 106:

20 “(1) BENEFITS TREATED AS PAYABLE FOR
21 SICKNESS, ETC.—Any benefit received through quali-
22 fied long-term care insurance (as defined in section
23 818(g)) shall be treated as amounts received
24 through accident or health insurance for personal in-
25 juries or sickness.

1 “(2) EXPENSES FOR WHICH REIMBURSEMENT
2 PROVIDED UNDER QUALIFIED LONG-TERM CARE IN-
3 SURANCE TREATED AS INCURRED FOR MEDICAL
4 CARE OR FUNCTIONAL LOSS.—Expenses incurred by
5 an individual to the extent of benefits paid under
6 qualified long-term care insurance (as defined in sec-
7 tion 818(g)) shall be treated for purposes of sub-
8 section (b) as incurred for medical care (as defined
9 in section 213(d)) and for purposes of subsection (c)
10 as payment for the permanent loss or loss of use of
11 a member or function of the body or the permanent
12 disfigurement of the taxpayer, his spouse, any de-
13 pendent of the taxpayer, or any parent of the tax-
14 payer of his spouse.

15 “(3) REFERENCES TO ACCIDENT AND HEALTH
16 PLANS.—Any reference to an accident or health plan
17 shall be treated as including a reference to a plan
18 providing qualified long-term care insurance (as de-
19 fined in section 818(g)).”

20 (b) CURRENT DEDUCTION FOR EMPLOYER PRE-
21 MIUMS FOR LONG-TERM CARE POLICIES.—Subparagraph
22 (B) of section 404(b)(2) of such Code (relating to plans
23 providing certain deferred benefits) is amended by striking
24 “or” at the end of clause (i), by striking the period at

1 the end of clause (ii) and inserting “, or”, and by adding
2 at the end thereof the following new clause:

3 “(iii) any benefit provided under a
4 policy of qualified long-term care insurance
5 (as defined in section 818(g)) through the
6 payment (in whole or in part) of premiums
7 by an employer pursuant to a plan for its
8 active or retired employees, but only if any
9 refund of premiums is applied to reduce
10 the future costs of the plan or increase
11 benefits under the plan.”

12 (c) EFFECTIVE DATE.—The amendments made by
13 this section shall apply to taxable years beginning after
14 December 31, 1994.

15 **SEC. 203. EARLY DISTRIBUTION PENALTY TAX NOT TO**
16 **APPLY TO AMOUNTS WITHDRAWN FROM**
17 **QUALIFIED PLANS, INDIVIDUAL RETIREMENT**
18 **PLANS, ETC. FOR QUALIFIED LONG-TERM IN-**
19 **SURANCE.**

20 (a) IN GENERAL.—Paragraph (1) of section 72(t) of
21 the Internal Revenue Code of 1986 (relating to 10-percent
22 additional tax on early distributions from qualified retire-
23 ment plans) is amended by adding at the end thereof the
24 following new subparagraph:

1 “(C) for those services described in section
2 818(g)(2)(A)(iii) (relating to services provided
3 under qualified long-term care insurance), or”.

4 (b) DEDUCTION FOR LONG-TERM CARE EXPENSES
5 FOR PARENT OR GRANDPARENT.—Section 213 of such
6 Code (relating to deduction for medical expenses) is
7 amended by adding at the end the following new sub-
8 section:

9 “(g) SPECIAL RULE FOR CERTAIN LONG-TERM CARE
10 EXPENSES.—For purposes of subsection (a), the term ‘de-
11 pendent’ shall include any parent or grandparent of the
12 taxpayer for whom the taxpayer has expenses for long-
13 term care services described in section 818(g)(2)(A)(iii),
14 but only to the extent of such expenses.”

15 (c) TECHNICAL AMENDMENTS.—

16 (1) Subparagraph (D) of section 213(d)(1) of
17 such Code, as redesignated by subsection (a), is
18 amended by striking “subparagraphs (A) and (B)”
19 and inserting “subparagraphs (A), (B), and (C)”.

20 (2) Paragraph (6) of section 213(d) of such
21 Code is amended—

22 (A) by striking “subparagraphs (A) and
23 (B)” and inserting “subparagraphs (A), (B),
24 and (C)”, and

1 (B) by striking “paragraph (1)(C)” and in-
2 serting “paragraph (1)(D)”.

3 (3) Paragraph (7) of section 213(d) of such
4 Code is amended by striking “subparagraphs (A)
5 and (B)” and inserting “subparagraphs (A), (B),
6 and (C)”.

7 (d) EFFECTIVE DATE.—The amendments made by
8 this section shall apply to taxable years beginning after
9 December 31, 1994.

10 **SEC. 205. TREATMENT OF PREFUNDED LONG-TERM CARE**

11 **BENEFITS.**

12 (a) IN GENERAL.—

13 (1) Paragraph (2) of section 419A(c) of the In-
14 ternal Revenue Code of 1986 (relating to additional
15 reserve for post-retirement medical and life insur-
16 ance benefits) is amended by striking “or” at the
17 end of subparagraph (A), by striking the period at
18 the end of subparagraph (B) and inserting “, or”,
19 and by adding at the end thereof the following new
20 subparagraph:

21 “(C) post-retirement long-term care bene-
22 fits (as defined in section 818(g)) to be pro-
23 vided to covered employees.”

1 (2) The paragraph heading for such paragraph
2 (2) is amended by inserting “, LONG-TERM CARE,”
3 after “MEDICAL”.

4 (b) RESERVE FOR LONG-TERM CARE BENEFITS
5 MUST BE NONDISCRIMINATORY.—

6 (1) Paragraph (1) of section 419A(e) of such
7 Code (relating to special limitations on reserves for
8 medical benefits or life insurance benefits provided
9 to retired employees) is amended by inserting “,
10 long-term care benefits,” after “medical benefits”
11 each place it appears.

12 (2) The subsection heading for section 419A(e)
13 of such Code is amended by inserting “, LONG-TERM
14 CARE BENEFITS,” after “MEDICAL BENEFITS”.

15 (c) EFFECTIVE DATE.—The amendments made by
16 this section shall apply to taxable years beginning after
17 December 31, 1994.

18 **SEC. 206. QUALIFIED LONG-TERM CARE INSURANCE PER-**
19 **MITTED TO BE OFFERED IN CAFETERIA**
20 **PLANS.**

21 (a) IN GENERAL.—Paragraph (2) of section 125(c)
22 of the Internal Revenue Code of 1986 (relating to the ex-
23 clusion of deferred compensation) is amended by adding
24 at the end thereof the following new subparagraph:

1 “(D) EXCEPTION FOR LONG-TERM CARE
2 INSURANCE.—For purposes of subparagraph
3 (A), a plan shall not be treated as providing de-
4 ferred compensation by reason of providing
5 qualified long-term care insurance (as defined
6 in section 818(g)) if—

7 “(i) the employee may not surrender
8 such insurance for cash, and

9 “(ii) the terms of the plan permits,
10 the employee may elect to continue the in-
11 surance upon cessation of participation in
12 the plan.”

13 (b) LONG-TERM CARE INSURANCE INCLUDED AS
14 QUALIFIED BENEFIT.—Paragraph (2) of section 125(e)
15 of such Code (defining qualified benefits) is amended by
16 striking “and” at the end of subparagraph (A), by striking
17 the period at the end of subparagraph (B) and inserting
18 “, and”, and by adding at the end thereof the following
19 new subparagraph:

20 “(C) qualified long-term care insurance (as
21 defined in section 818(g)).”

22 (c) EFFECTIVE DATE.—The amendments made by
23 this section shall apply to taxable years beginning after
24 December 31, 1994.

1 **Subtitle B—Payments under Life**
2 **Insurance Contracts to Termi-**
3 **nally Ill Individuals**

4 **SEC. 211. TAX TREATMENT OF PAYMENTS TO TERMINALLY**
5 **ILL INDIVIDUALS UNDER LIFE INSURANCE**
6 **CONTRACTS.**

7 (a) GENERAL RULE.—Section 101 of the Internal
8 Revenue Code of 1986 (relating to certain death benefits)
9 is amended by adding at the end thereof the following
10 new subsection:

11 “(g) TREATMENT OF AMOUNTS PAID TO TERMI-
12 NALLY ILL INDIVIDUALS.—

13 “(1) IN GENERAL.—For purposes of this sec-
14 tion, any amount paid under a life insurance con-
15 tract to an insured who is a terminally ill individual
16 shall be treated as an amount paid by reason of the
17 death of such insured.

18 “(2) TERMINALLY ILL INDIVIDUAL.—For pur-
19 poses of this subsection, the term ‘terminally ill indi-
20 vidual’ means an individual who has been certified
21 by a physician, licensed under State law, as having
22 an illness or physical condition which can reasonably
23 be expected to result in death in 12 months or less.”

1 (b) EFFECTIVE DATE.—The amendment made by
2 subsection (a) shall apply to taxable years beginning after
3 December 31, 1994.

4 **SEC. 212. TAX TREATMENT OF COMPANIES ISSUING QUALI-**
5 **FIED TERMINAL ILLNESS RIDERS.**

6 (a) QUALIFIED TERMINAL ILLNESS RIDER TREATED
7 AS LIFE INSURANCE.—Section 818 of the Internal Reve-
8 nue Code of 1986 (relating to other definitions and special
9 rules), as amended by section 201(a), is further amended
10 by adding at the end thereof the following new subsection:

11 “(h) QUALIFIED TERMINAL ILLNESS RIDER TREAT-
12 ED AS LIFE INSURANCE.—For purposes of this part:

13 “(1) IN GENERAL.—Any reference to life insur-
14 ance shall be treated as including a reference to a
15 qualified terminal illness rider.

16 “(2) QUALIFIED TERMINAL ILLNESS RIDER.—
17 For purposes of this subsection, the term ‘qualified
18 terminal illness rider’ means any rider on a life in-
19 surance contract which provides for payments to an
20 insured upon such insured becoming a terminally ill
21 individual (as defined in section 101(g)(2)).”

22 (b) DEFINITIONS OF LIFE INSURANCE AND MODI-
23 FIED ENDOWMENT CONTRACTS.—

24 (1) RIDER TREATED AS QUALIFIED ADDI-
25 TIONAL BENEFIT.—Paragraph (5)(A) of section

1 7702(f) of such Code is amended by striking “or”
2 at the end of clause (iv), by redesignating clause (v)
3 as clause (vi), and by inserting after clause (iv) the
4 following new clause:

5 “(v) any qualified terminal illness
6 rider (as defined in section 818(h)(2)),
7 or”.

8 (2) TRANSITIONAL RULE.—For purposes of ap-
9 plying section 7702 or 7702A of the Internal Reve-
10 nue Code of 1986 to any contract (or determining
11 whether either such section applies to such con-
12 tract), the issuance of a qualified terminal illness
13 rider (as defined in section 818(h)(2) of such Code)
14 with respect to any contract shall not be treated as
15 a modification or material change of such contract.

16 (c) EFFECTIVE DATE.—The amendments made by
17 this section shall apply to taxable years beginning after
18 December 31, 1994.

1 **TITLE III—ELIMINATION OF**
2 **MEDICAID RESTRICTION ON**
3 **STATE ASSET PROTECTION**
4 **PROGRAMS**

5 **SEC. 301. ELIMINATION OF MEDICAID RESTRICTION ON**
6 **STATE ASSET PROTECTION PROGRAMS.**

7 (a) IN GENERAL.—Section 1917(b) of the Social Se-
8 curity Act (42 U.S.C. 1396p(b)), as amended by section
9 13612 of the Omnibus Budget Reconciliation Act of 1993,
10 is amended—

11 (1) in paragraph (1), by striking subparagraph
12 (C),

13 (2) in paragraph (3), by striking “(other than
14 paragraph (1)(C))”, and

15 (3) in paragraph (4), by striking all that follows
16 “deceased individual” and inserting “shall include
17 all real and personal property and other assets in-
18 cluded within the individual’s estate, as defined for
19 purposes of State probate law”.

20 (b) EFFECTIVE DATE.—The amendments made by
21 subsection (a) shall apply to calendar quarters beginning
22 on or after October 1, 1993.

1 **SEC. 302. PROTECTION OF ASSETS THROUGH USE OF**
2 **QUALIFIED LONG-TERM CARE INSURANCE.**

3 (a) IN GENERAL.—Title XIX of the Social Security
4 Act is amended by adding at the end the following new
5 section:

6 “SPECIAL RULES FOR ASSET DISREGARD IN THE CASE OF
7 QUALIFIED LONG-TERM CARE INSURANCE CONTRACTS

8 “SEC. 1931. (a) IN GENERAL.—Each State plan
9 under this title, as a condition for the receipt of payment
10 under section 1903(a) with respect to long-term care serv-
11 ices (as defined in subsection (c)(1)), shall provide that
12 in determining the eligibility of an individual for medical
13 assistance under the plan with respect to such services
14 there shall be disregarded some or all of the individual’s
15 assets which are attributable (as determined under sub-
16 section (c)(2)) to coverage under a qualified long-term
17 care insurance contract (as defined in subsection (b)).

18 “(b) QUALIFIED LONG-TERM CARE INSURANCE
19 CONTRACT DEFINED.—In this section, the term ‘qualified
20 long-term care insurance contract’ means, with respect to
21 a State, a long-term care insurance contract (as defined
22 in section 818A(b) of the Internal Revenue Code of 1986)
23 which—

24 “(1) provides such protection against the costs
25 of receiving long-term care services as the State may
26 require by law;

1 “(2) provides that benefits under the contract
2 shall be paid without regard to eligibility for medical
3 assistance under this title; and

4 “(3) meets such other requirements (such as re-
5 quirements relating to premiums, disclosure, mini-
6 mum benefits, rights of conversion, and standards
7 for claims processing) as the State may determine to
8 be appropriate.

9 “(c) OTHER DEFINITIONS.—In this section:

10 “(1) LONG-TERM CARE SERVICES.—The term
11 ‘long-term care services’ means nursing facility serv-
12 ices, home health care services, and home and com-
13 munity-based services, and includes such other simi-
14 lar items and services described in section 1905(a)
15 as a State may specify.

16 “(2) ATTRIBUTION RULES.—An individual’s as-
17 sets are considered to be ‘attributable’ to a qualified
18 long-term care insurance contract to the extent spec-
19 ified under the State plan. Such a plan shall provide
20 for at least one of the following:

21 “(A) All assets are considered attributable
22 if the insurance contract provides coverage for
23 at least a period of coverage (of not less than
24 1 year and of not more than 6 years) for long-
25 term care services specified in the contract.

1 “(B) An amount of assets, up to the dollar
2 limitation on benefits for long-term care serv-
3 ices under the contract, is considered attrib-
4 utable to the contract.”.

5 (b) CONFORMING AMENDMENT.—Section
6 1902(a)(17)(A) of such Act (42 U.S.C. 1396a(a)(17)(A))
7 is amended by inserting “and section 1931” after “objec-
8 tives of this title”.

9 (c) EFFECTIVE DATE.—

10 (1) IN GENERAL.—The amendments made by
11 this section shall apply (except as provided under
12 paragraph (2)) to payments to States under title
13 XIX of the Social Security Act for calendar quarters
14 beginning on or after one year after the date of the
15 enactment of this Act, without regard to whether
16 regulations to implement such amendment are pro-
17 mulgated by such date.

18 (2) DELAY PERMITTED IF STATE LEGISLATION
19 REQUIRED.—In the case of a State plan for medical
20 assistance under title XIX of the Social Security Act
21 which the Secretary of Health and Human Services
22 determines requires State legislation (other than leg-
23 islation authorizing or appropriating funds) in order
24 for the plan to meet the additional requirements im-
25 posed by the amendments made by this section, the

1 State plan shall not be regarded as failing to comply
2 with the requirements of such title solely on the
3 basis of its failure to meet these additional require-
4 ments before the first day of the first calendar quar-
5 ter beginning after the close of the first regular ses-
6 sion of the State legislature that begins after the
7 date of the enactment of this Act. For purposes of
8 the previous sentence, in the case of a State that has
9 a 2-year legislative session, each year of such session
10 shall be deemed to be a separate regular session of
11 the State legislature.

12 **TITLE IV—STATE PROGRAMS**
13 **FOR HOME AND COMMUNITY-**
14 **BASED SERVICES FOR INDI-**
15 **VIDUALS WITH DISABILITIES**

16 **SEC. 401. STATE PROGRAMS FOR HOME AND COMMUNITY-**
17 **BASED SERVICES FOR INDIVIDUALS WITH**
18 **DISABILITIES.**

19 (a) IN GENERAL.—Each State that has a plan for
20 the home and community-based services to individuals
21 with disabilities submitted to and approved by the Sec-
22 retary under section 402(b) is entitled to payment in ac-
23 cordance with section 408.

24 (b) NO INDIVIDUAL ENTITLEMENT ESTABLISHED.—
25 Nothing in this title shall be construed to create an entitle-

1 ment for individuals or a requirement that a State with
2 such an approved plan expend the entire amount of funds
3 to which it is entitled in any year.

4 **SEC. 402. STATE PLANS.**

5 (a) PLAN REQUIREMENTS.—In order to be approved
6 under subsection (b), a State plan for home and commu-
7 nity-based services for individuals with disabilities must
8 meet the following requirements:

9 (1) ELIGIBILITY.—

10 (A) IN GENERAL.—Within the amounts
11 provided by the State (and under section 408)
12 for such plan, the plan shall provide that serv-
13 ices under the plan will be available to individ-
14 uals with disabilities (as defined in section
15 403(a)) in the State who meet the income
16 standard described in subparagraph (E).

17 (B) INITIAL SCREENING.—The plan shall
18 provide a process for the initial screening of in-
19 dividuals who appear to have some reasonable
20 likelihood of being an individual with disabil-
21 ities.

22 (C) RESTRICTIONS.—The plan may not
23 limit the eligibility of individuals with disabil-
24 ities based on—

- 1 (i) income (except as provided in sub-
2 paragraph (E)),
3 (ii) age,
4 (iii) geography,
5 (iv) nature, severity, or category of
6 disability,
7 (v) residential setting (other than an
8 institutional setting), or
9 (vi) other grounds specified by the
10 Secretary.

11 (D) MAINTENANCE OF EFFORT.—The plan
12 must provide assurances that, in the case of an
13 individual receiving medical assistance for home
14 and community-based services under the State
15 medicaid plan as of the date of the enactment
16 of this Act, the State will continue to make
17 available (either under this plan, under the
18 State medicaid plan, or otherwise) to such indi-
19 vidual an appropriate level of assistance for
20 home and community-based services, taking
21 into account the level of assistance provided as
22 of such date and the individual's need for home
23 and community-based services.

24 (E) INCOME LIMITATION.—No individual
25 shall be provided services under the plan unless

1 the individual is determined to have income
2 below 250 percent of the official poverty line
3 (as defined by the Office of Management and
4 Budget, and revised annually in accordance
5 with section 673(2) of the Omnibus Budget
6 Reconciliation Act of 1981) applicable to a fam-
7 ily of the size involved.

8 (2) SERVICES.—

9 (A) SPECIFICATION.—Consistent with sec-
10 tion 404, the plan shall specify—

11 (i) the services made available under
12 the plan,

13 (ii) the extent and manner in which
14 such services are allocated and made avail-
15 able to individuals with disabilities, and

16 (iii) the manner in which services
17 under the plan are coordinated with each
18 other and with health and long-term care
19 services available outside the plan for indi-
20 viduals with disabilities.

21 (B) ALLOCATION.—The State plan—

22 (i) shall specify how it will allocate
23 services under the plan, during and after
24 the 7-fiscal-year phase-in period beginning

1 with fiscal year 1996, among covered indi-
2 viduals with disabilities, and

3 (ii) may not allocate such services
4 based on the income or other financial re-
5 sources of such individuals.

6 (C) LIMITATION ON LICENSURE OR CER-
7 TIFICATION.—The State may not subject
8 consumer-directed providers of personal assist-
9 ance services to licensure, certification, or other
10 requirements which the Secretary finds not to
11 be necessary for the health and safety of indi-
12 viduals with disabilities.

13 (D) CONSUMER CHOICE.—To the extent
14 possible, the choice of an individual with dis-
15 abilities (and that individual's family) regarding
16 which covered services to receive and the pro-
17 viders who will provide such services shall be
18 followed.

19 (E) REQUIREMENT TO SERVE LOW-INCOME
20 INDIVIDUALS.—The plan shall assure that—

21 (i) the proportion of the population of
22 low-income individuals with disabilities in
23 the State that represents individuals with
24 disabilities who are provided home and
25 community-based services either under the

1 plan, under the State medicaid plan, or
2 under both, is not less than

3 (ii) the proportion of the population of
4 the State that represents individuals who
5 are low-income individuals.

6 (3) COST SHARING.—The plan shall impose cost
7 sharing with respect to covered services only in ac-
8 cordance with section 405.

9 (4) TYPES OF PROVIDERS AND REQUIREMENTS
10 FOR PARTICIPATION.—The plan shall specify—

11 (A) the types of service providers eligible
12 to participate in the program under the plan,
13 which shall include consumer-directed providers,
14 and

15 (B) any requirements for participation ap-
16 plicable to each type of service provider.

17 (5) BUDGET.—The plan shall specify how the
18 State will manage Federal and State funds available
19 under the plan for each fiscal year during the period
20 beginning with fiscal year 1996 and ending with fis-
21 cal year 2003 and for each 5-fiscal-year periods
22 thereafter to serve all categories of individuals with
23 disabilities and meet the requirements of this sub-
24 section.

25 (6) PROVIDER REIMBURSEMENT.—

1 (A) PAYMENT METHODS.—The plan shall
2 specify the payment methods to be used to re-
3 imburse providers for services furnished under
4 the plan. Such methods may include retrospec-
5 tive reimbursement on a fee-for-service basis,
6 prepayment on a capitation basis, payment by
7 cash or vouchers to individuals with disabilities,
8 or any combination of these methods. In the
9 case of the use of cash or vouchers, the plan
10 shall specify how the plan will assure compli-
11 ance with applicable employment tax provisions.

12 (B) PAYMENT RATES.—The plan shall
13 specify the methods and criteria to be used to
14 set payment rates for services furnished under
15 the plan (including rates for cash payments or
16 vouchers to individuals with disabilities).

17 (C) PLAN PAYMENT AS PAYMENT IN
18 FULL.—The plan shall restrict payment under
19 the plan for covered services to those providers
20 that agree to accept the payment under the
21 plan (at the rates established pursuant to sub-
22 paragraph (B)) and any cost sharing permitted
23 or provided for under section 405 as payment
24 in full for services furnished under the plan.

1 (7) QUALITY ASSURANCE AND SAFEGUARDS.—
2 The State plan shall provide for quality assurance
3 and safeguards for applicants and beneficiaries in
4 accordance with section 406.

5 (8) ADVISORY GROUP.—The State plan shall—

6 (A) assure the establishment and mainte-
7 nance of an advisory group under section
8 407(b), and

9 (B) include the documentation prepared by
10 the group under section 407(b)(4).

11 (9) ADMINISTRATION.—

12 (A) STATE AGENCY.—The plan shall des-
13 ignate a State agency or agencies to administer
14 (or to supervise the administration of) the plan.

15 (B) ADMINISTRATIVE EXPENDITURES.—
16 Effective beginning with fiscal year 2003, the
17 plan shall contain assurances that not more
18 than 10 percent of expenditures under the plan
19 for all quarters in any fiscal year shall be for
20 administrative costs.

21 (C) COORDINATION.—The plan shall speci-
22 fy how the plan—

23 (i) will be integrated with the State
24 medicaid plan, titles V and XX of the So-
25 cial Security Act, programs under the

1 Older Americans Act of 1965, programs
2 under the Developmental Disabilities As-
3 sistance and Bill of Rights Act, the Indi-
4 viduals with Disabilities Education Act,
5 and any other Federal or State programs
6 that provide services or assistance targeted
7 to individuals with disabilities, and

8 (ii) will be coordinated with health
9 plans.

10 (10) REPORTS AND INFORMATION TO SEC-
11 RETARY; AUDITS.—The plan shall provide that the
12 State will furnish to the Secretary—

13 (A) such reports, and will cooperate with
14 such audits, as the Secretary determines are
15 needed concerning the State’s administration of
16 its plan under this title, including the process-
17 ing of claims under the plan, and

18 (B) such data and information as the Sec-
19 retary may require in order to carry out the
20 Secretary’s responsibilities.

21 (11) USE OF STATE FUNDS FOR MATCHING.—
22 The plan shall provide assurances that Federal
23 funds will not be used to provide for the State share
24 of expenditures under this title.

1 (b) APPROVAL OF PLANS.—The Secretary shall ap-
2 prove a plan submitted by a State if the Secretary deter-
3 mines that the plan—

4 (1) was developed by the State after consulta-
5 tion with individuals with disabilities and representa-
6 tives of groups of such individuals, and

7 (2) meets the requirements of subsection (a).

8 The approval of such a plan shall take effect as of the
9 first day of the first fiscal year beginning after the date
10 of such approval (except that any approval made before
11 January 1, 1996, shall be effective as of January 1, 1996).
12 In order to budget funds allotted under this title, the Sec-
13 retary may establish a deadline for the submission of such
14 a plan before the beginning of a fiscal year as a condition
15 of its approval effective with that fiscal year.

16 (c) MONITORING.—The Secretary shall monitor the
17 compliance of State plans with the eligibility requirements
18 of section 403 and may monitor the compliance of such
19 plans with other requirements of this title.

20 (d) REGULATIONS.—The Secretary shall issue such
21 regulations as may be appropriate to carry out this title
22 on a timely basis.

1 **SEC. 403. INDIVIDUALS WITH DISABILITIES DEFINED.**

2 (a) IN GENERAL.—In this title, the term “individual
3 with disabilities” means any individual within one or more
4 of the following 4 categories of individuals:

5 (1) INDIVIDUALS REQUIRING HELP WITH AC-
6 TIVITIES OF DAILY LIVING.—An individual of any
7 age who—

8 (A) requires hands-on or standby assist-
9 ance, supervision, or cueing (as defined in regu-
10 lations) to perform three or more activities of
11 daily living (as defined in subsection (c)), and

12 (B) is expected to require such assistance,
13 supervision, or cueing over a period of at least
14 100 days.

15 (2) INDIVIDUALS WITH SEVERE COGNITIVE OR
16 MENTAL IMPAIRMENT.—An individual of any age—

17 (A) whose score, on a standard mental sta-
18 tus protocol (or protocols) appropriate for
19 measuring the individual’s particular condition
20 specified by the Secretary, indicates either se-
21 vere cognitive impairment or severe mental im-
22 pairment, or both;

23 (B) who—

24 (i) requires hands-on or standby as-
25 sistance, supervision, or cueing with one or
26 more activities of daily living,

1 (ii) requires hands-on or standby as-
2 sistance, supervision, or cueing with at
3 least such instrumental activity (or activi-
4 ties) of daily living related to cognitive or
5 mental impairment as the Secretary speci-
6 fies, or

7 (iii) displays symptoms of one or more
8 serious behavioral problems (that is on a
9 list of such problems specified by the Sec-
10 retary) which create a need for supervision
11 to prevent harm to self or others; and

12 (C) whose is expected to meet the require-
13 ments of subparagraphs (A) and (B) over a pe-
14 riod of at least 100 days.

15 (3) INDIVIDUALS WITH SEVERE OR PROFOUND
16 MENTAL RETARDATION.—An individual of any age
17 who has severe or profound mental retardation (as
18 determined according to a protocol specified by the
19 Secretary).

20 (4) SEVERELY DISABLED CHILDREN.—An indi-
21 vidual under 6 years of age who—

22 (A) has a severe disability or chronic medi-
23 cal condition,

24 (B) but for receiving personal assistance
25 services or any of the services described in sec-

1 tion 404(d)(1), would require institutionaliza-
2 tion in a hospital, nursing facility, or intermedi-
3 ate care facility for the mentally retarded, and

4 (C) is expected to have such disability or
5 condition and require such services over a pe-
6 riod of at least 100 days.

7 (b) DETERMINATION.—

8 (1) IN GENERAL.—The determination of wheth-
9 er an individual is an individual with disabilities
10 shall be made, by persons or entities specified under
11 the State plan, using a uniform protocol consisting
12 of an initial screening and assessment specified by
13 the Secretary. A State may collect additional infor-
14 mation, at the time of obtaining information to
15 make such determination, in order to provide for the
16 assessment and plan described in section 404(b) or
17 for other purposes. The State shall establish a fair
18 hearing process for appeals of such determinations.

19 (2) PERIODIC REASSESSMENT.—The determina-
20 tion that an individual is an individual with disabil-
21 ities shall be considered to be effective under the
22 State plan for a period of not more than 12 months
23 (or for such longer period in such cases as a signifi-
24 cant change in an individual's condition that may af-
25 fect such determination is unlikely). A reassessment

1 shall be made if there is a significant change in an
2 individual's condition that may affect such deter-
3 mination.

4 (c) ACTIVITY OF DAILY LIVING DEFINED.—In this
5 title, the term “activity of daily living” means any of the
6 following: eating, toileting, dressing, bathing, and trans-
7 ferring.

8 **SEC. 404. HOME AND COMMUNITY-BASED SERVICES COV-**
9 **ERED UNDER STATE PLAN.**

10 (a) SPECIFICATION.—

11 (1) IN GENERAL.—Subject to the succeeding
12 provisions of this section, the State plan under this
13 title shall specify—

14 (A) the home and community-based serv-
15 ices available under the plan to individuals with
16 disabilities (or to such categories of such indi-
17 viduals), and

18 (B) any limits with respect to such serv-
19 ices.

20 (2) FLEXIBILITY IN MEETING INDIVIDUAL
21 NEEDS.—The services shall be specified in a manner
22 that permits sufficient flexibility for providers to
23 meet the needs of individuals with disabilities in a
24 cost effective manner. Subject to subsection
25 (e)(1)(B), such services may be delivered in an indi-

1 vidual’s home, a range of community residential ar-
2 rangements, or outside the home.

3 (b) REQUIREMENT FOR NEEDS ASSESSMENT AND
4 PLAN OF CARE.—

5 (1) IN GENERAL.—The State plan shall provide
6 for home and community-based services to an indi-
7 vidual with disabilities only if—

8 (A) a comprehensive assessment of the in-
9 dividual’s need for home and community-based
10 services (regardless of whether all needed serv-
11 ices are available under the plan) has been
12 made,

13 (B) an individualized plan of care based on
14 such assessment is developed, and

15 (C) such services are provided consistent
16 with such plan of care.

17 (2) INVOLVEMENT OF INDIVIDUALS.—The indi-
18 vidualized plan of care under paragraph (1)(B) for
19 an individual with disabilities shall—

20 (A) be developed by qualified individuals
21 (specified under the State plan),

22 (B) be developed and implemented in close
23 consultation with the individual and the individ-
24 ual’s family,

1 (C) be approved by the individual (or the
2 individual's representative), and

3 (D) be reviewed and updated not less often
4 than every 6 months.

5 (3) PLAN OF CARE.—The plan of care under
6 paragraph (1)(B) shall—

7 (A) specify which services specified under
8 the individual plan will be provided under the
9 State plan under this title,

10 (B) identify (to the extent possible) how
11 the individual will be provided any services
12 specified under the plan of care and not pro-
13 vided under the State plan, and

14 (C) specify how the provision of services to
15 the individual under the plan will be coordi-
16 nated with the provision of other health care
17 services to the individual.

18 The State shall make reasonable efforts to identify
19 and arrange for services described in subparagraph
20 (B). Nothing in this subsection shall be construed as
21 requiring a State (under the State plan or other-
22 wise) to provide all the services specified in such a
23 plan.

24 (c) MANDATORY COVERAGE OF PERSONAL ASSIST-
25 ANCE SERVICES.—The State plan shall include, in the

1 array of services made available to each category of indi-
2 viduals with disabilities, both agency-administered and
3 consumer-directed personal assistance services (as defined
4 in subsection (g)).

5 (d) ADDITIONAL SERVICES.—

6 (1) TYPES OF SERVICES.—Subject to subsection
7 (e), services available under a State plan under this
8 title shall include any (or all) of the following:

9 (A) Case management.

10 (B) Homemaker and chore assistance.

11 (C) Home modifications.

12 (D) Respite services.

13 (E) Assistive devices.

14 (F) Adult day services.

15 (G) Habilitation and rehabilitation.

16 (H) Supported employment.

17 (I) Home health services.

18 (J) Any other care or assistive services
19 (approved by the Secretary) that the State de-
20 termines will help individuals with disabilities to
21 remain in their homes and communities.

22 (2) CRITERIA FOR SELECTION OF SERVICES.—

23 The State plan shall specify—

24 (A) the methods and standards used to se-
25 lect the types, and the amount, duration, and

1 scope, of services to be covered under the plan
2 and to be available to each category of individ-
3 uals with disabilities, and

4 (B) how the types, and the amount, dura-
5 tion, and scope, of services specified meet the
6 needs of individuals within each of the 4 cat-
7 egories of individuals with disabilities.

8 (e) EXCLUSIONS AND LIMITATIONS.—

9 (1) IN GENERAL.—A State plan may not pro-
10 vide for coverage of—

11 (A) room and board,

12 (B) services furnished in a hospital, nurs-
13 ing facility, intermediate care facility for the
14 mentally retarded, or other institutional setting
15 specified by the Secretary, or

16 (C) items and services to the extent cov-
17 erage is provided for the individual under a
18 health plan or the medicare program.

19 (2) TAKING INTO ACCOUNT INFORMAL CARE.—

20 A State plan may take into account, in determining
21 the amount and array of services made available to
22 covered individuals with disability, the availability of
23 informal care.

24 (f) PAYMENT FOR SERVICES.—A State plan may pro-
25 vide for the use of—

- 1 (1) vouchers,
- 2 (2) cash payments directly to individuals with
- 3 disabilities,
- 4 (3) capitation payments to health plans, and
- 5 (4) payment to providers,
- 6 to pay for covered services.

7 (g) PERSONAL ASSISTANCE SERVICES.—

8 (1) IN GENERAL.—In this section, the term
9 “personal assistance services” means those services
10 specified under the State plan as personal assistance
11 services and shall include at least hands-on and
12 standby assistance, supervision, and cueing with ac-
13 tivities of daily living, whether agency-administered
14 or consumer-directed (as defined in paragraph (2)).

15 (2) CONSUMER-DIRECTED; AGENCY-ADMINIS-
16 TERED.—In this title:

17 (A) The term “consumer-directed” means,
18 with reference to personal assistance services or
19 the provider of such services, services that are
20 provided by an individual who is selected and
21 managed (and, at the individual’s option,
22 trained) by the individual receiving the services.

23 (B) The term “agency-administered”
24 means, with respect to such services, services
25 that are not consumer-directed.

1 **SEC. 405. COST SHARING.**

2 (a) NO OR NOMINAL COST SHARING FOR POOR-
3 EST.—The State plan may not impose any cost sharing
4 (other than nominal cost sharing) for individuals with in-
5 come (as determined under subsection (c)) less than 150
6 percent of the official poverty line (referred to in section
7 402(a)(1)(E)) applicable to a family of the size involved.

8 (b) SLIDING SCALE FOR REMAINDER.—The State
9 plan shall impose cost sharing in the form of coinsurance
10 (based on the amount paid under the State plan for a serv-
11 ice)—

12 (1) at a rate of 10 percent for individuals with
13 disabilities with income not less than 150 percent,
14 and less than 200 percent, of such official poverty
15 line (as so applied); and

16 (2) at a rate of 20 percent for such individuals
17 with income not less than 200 percent, and less than
18 250 percent, of such official poverty line (as so ap-
19 plied).

20 (c) DETERMINATION OF INCOME FOR PURPOSES OF
21 COST SHARING.—The State plan shall specify the process
22 to be used to determine the income of an individual with
23 disabilities for purposes of this section. Such process shall
24 be consistent with standards specified by the Secretary.

1 **SEC. 406. QUALITY ASSURANCE AND SAFEGUARDS.**

2 (a) QUALITY ASSURANCE.—The State plan shall
3 specify how the State will ensure and monitor the quality
4 of services, including—

5 (1) safeguarding the health and safety of indi-
6 viduals with disabilities,

7 (2) the minimum standards for agency provid-
8 ers and how such standards will be enforced,

9 (3) the minimum competency requirements for
10 agency provider employees who provide direct serv-
11 ices under this title and how the competency of such
12 employees will be enforced,

13 (4) obtaining meaningful consumer input, in-
14 cluding consumer surveys that measure the extent to
15 which participants receive the services described in
16 the plan of care and participant satisfaction with
17 such services,

18 (5) participation in quality assurance activities,
19 and

20 (6) specifying the role of the long-term care om-
21 budsman (under the Older Americans Act of 1965)
22 and the Protection and Advocacy Agency (under the
23 Developmental Disabilities Assistance and Bill of
24 Rights Act) in assuring quality of services and pro-
25 tecting the rights of individuals with disabilities.

26 (b) SAFEGUARDS.—

1 (1) CONFIDENTIALITY.—The State plan shall
2 provide safeguards which restrict the use or disclo-
3 sure of information concerning applicants and bene-
4 ficiaries to purposes directly connected with the ad-
5 ministration of the plan.

6 (2) SAFEGUARDS AGAINST ABUSE.—The State
7 plans shall provide safeguards against physical, emo-
8 tional, or financial abuse or exploitation (specifically
9 including appropriate safeguards in cases where pay-
10 ment for program benefits is made by cash pay-
11 ments or vouchers given directly to individuals with
12 disabilities).

13 **SEC. 407. ADVISORY GROUPS.**

14 (a) FEDERAL ADVISORY GROUP.—

15 (1) ESTABLISHMENT.—The Secretary shall es-
16 tablish an advisory group, to advise the Secretary
17 and States on all aspects of the program under this
18 title.

19 (2) COMPOSITION.—The group shall be com-
20 posed of individuals with disabilities and their rep-
21 resentatives, providers, Federal and State officials,
22 and local community implementing agencies. A ma-
23 jority of its members shall be individuals with dis-
24 abilities and their representatives.

25 (b) STATE ADVISORY GROUPS.—

1 (1) IN GENERAL.—Each State plan shall pro-
2 vide for the establishment and maintenance of an
3 advisory group to advise the State on all aspects of
4 the State plan under this title.

5 (2) COMPOSITION.—Members of each advisory
6 group shall be appointed by the Governor (or other
7 chief executive officer of the State) and shall include
8 individuals with disabilities and their representa-
9 tives, providers, State officials, and local community
10 implementing agencies. A majority of its members
11 shall be individuals with disabilities and their rep-
12 resentatives.

13 (3) SELECTION OF MEMBERS.—Each State
14 shall establish a process whereby all residents of the
15 State, including individuals with disabilities and
16 their representatives, shall be given the opportunity
17 to nominate members to the advisory group.

18 (4) PARTICULAR CONCERNS.—Each advisory
19 group shall—

20 (A) before the State plan is developed, ad-
21 vise the State on guiding principles and values,
22 policy directions, and specific components of the
23 plan,

24 (B) meet regularly with State officials in-
25 volved in developing the plan, during the devel-

1 opment phase, to review and comment on all as-
2 pects of the plan,

3 (C) participate in the public hearings to
4 help assure that public comments are addressed
5 to the extent practicable,

6 (D) document any differences between the
7 group's recommendations and the plan,

8 (E) document specifically the degree to
9 which the plan is consumer-directed, and

10 (F) meet regularly with officials of the des-
11 ignated State agency (or agencies) to provide
12 advice on all aspects of implementation and
13 evaluation of the plan.

14 **SEC. 408. PAYMENTS TO STATES.**

15 (a) IN GENERAL.—Subject to section 402(a)(9)(B)
16 (relating to limitation on payment for administrative
17 costs), the Secretary, in accordance with the Cash Man-
18 agement Improvement Act, shall authorize payment to
19 each State with a plan approved under this title, for each
20 quarter (beginning on or after January 1, 1996), from its
21 allotment under section 409(b), an amount equal to—

22 (1) the Federal matching percentage (as de-
23 fined in subsection (b)) of amount demonstrated by
24 State claims to have been expended during the quar-

1 ter for home and community-based services under
2 the plan for individuals with disabilities; plus

3 (2) an amount equal to 90 percent of amount
4 expended during the quarter under the plan for ac-
5 tivities (including preliminary screening) relating to
6 determination of eligibility and performance of needs
7 assessment; plus

8 (3) an amount equal to 90 percent (or, begin-
9 ning with quarters in fiscal year 2003, 75 percent)
10 of the amount expended during the quarter for the
11 design, development, and installation of mechanical
12 claims processing systems and for information re-
13 trieval; plus

14 (4) an amount equal to 50 percent of the re-
15 mainder of the amounts expended during the quar-
16 ter as found necessary by the Secretary for the prop-
17 er and efficient administration of the State plan.

18 (b) FEDERAL MATCHING PERCENTAGE.—

19 (1) IN GENERAL.—In subsection (a), the term
20 “Federal matching percentage” means, with respect
21 to a State, the reference percentage specified in
22 paragraph (2) increased by 20 percentage points, ex-
23 cept that the Federal matching percentage shall in
24 no case be less than 70 percent or more than 88
25 percent.

1 (2) REFERENCE PERCENTAGE.—

2 (A) IN GENERAL.—The reference percent-
3 age specified in this paragraph is 100 percent
4 less the State percentage specified in subpara-
5 graph (B), except that—

6 (i) the percentage under this para-
7 graph shall in no case be less than 50 per-
8 cent or more than 83 percent, and

9 (ii) the percentage for Puerto Rico,
10 the Virgin Islands, Guam, the Northern
11 Mariana Islands, and American Samoa
12 shall be 50 percent.

13 (B) STATE PERCENTAGE.—The State per-
14 centage specified in this subparagraph is that
15 percentage which bears the same ratio to 45
16 percent as the square of the per capita income
17 of such State bears to the square of the per
18 capita income of the continental United States
19 (including Alaska) and Hawaii.

20 (c) PAYMENTS ON ESTIMATES WITH RETROSPEC-
21 TIVE ADJUSTMENTS.—The method of computing and
22 making payments under this section shall be as follows:

23 (1) The Secretary shall, prior to the beginning
24 of each quarter, estimate the amount to be paid to
25 the State under subsection (a) for such quarter,

1 based on a report filed by the State containing its
2 estimate of the total sum to be expended in such
3 quarter, and such other information as the Secretary
4 may find necessary.

5 (2) From the allotment available therefore, the
6 Secretary shall provide for payment of the amount
7 so estimated, reduced or increased, as the case may
8 be, by any sum (not previously adjusted under this
9 section) by which the Secretary finds that the esti-
10 mate of the amount to be paid the State for any
11 prior period under this section was greater or less
12 than the amount which should have been paid.

13 (d) APPLICATION OF RULES REGARDING LIMITA-
14 TIONS ON PROVIDER-RELATED DONATIONS AND HEALTH
15 CARE-RELATED TAXES.—The provisions of section
16 1903(w) of the Social Security Act shall apply to pay-
17 ments to States under this section in the same manner
18 as they apply to payments to States under section 1903(a)
19 of such Act .

20 **SEC. 409. TOTAL FEDERAL BUDGET; ALLOTMENTS TO**
21 **STATES.**

22 (a) TOTAL FEDERAL BUDGET.—

23 (1) FISCAL YEAR 1996.—For purposes of this
24 title, the total Federal budget for State plans under
25 this title for fiscal year 1996 is \$11.0 billion.

1 (2) SUBSEQUENT YEARS.—For purposes of this
2 title, the total Federal budget for State plans under
3 this title for each fiscal year after fiscal year 1996
4 is the total Federal budget under this subsection for
5 the preceding fiscal year increased by the percentage
6 increase (as estimated by the Secretary) in Federal
7 expenditures under title XVIII of the Social Security
8 Act from the previous fiscal year to the fiscal year
9 involved.

10 (3) CONSTRUCTIONS.—

11 (A) NO DUPLICATE PAYMENT.—No pay-
12 ment may be made to a State under this section
13 for any services to the extent that the State re-
14 ceived payment for such services under section
15 1903(a) of the Social Security Act.

16 (B) CONSTRUCTION.—Nothing in this sub-
17 section shall be construed as requiring States to
18 determine eligibility for medical assistance
19 under the State medicaid plan on behalf of indi-
20 viduals receiving assistance under this title.

21 (b) ALLOTMENTS TO STATES.—

22 (1) IN GENERAL.—The Secretary shall allot to
23 each State for each fiscal year an amount that bears
24 the same ratio to the total Federal budget for the
25 fiscal year (specified under paragraph (1) or (2) of

1 subsection (a)) as the State allotment factor (under
2 paragraph (2) for the State for the fiscal year) bears
3 to the sum of such factors for all States for that fis-
4 cal year.

5 (2) STATE ALLOTMENT FACTOR.—

6 (A) IN GENERAL.—For each State for each
7 fiscal year, the Secretary shall compute a State
8 allotment factor equal to the sum of—

9 (i) the base allotment factor (specified
10 in subparagraph (B)), and

11 (ii) the low income allotment factor
12 (specified in subparagraph (C)),

13 for the State for the fiscal year.

14 (B) BASE ALLOTMENT FACTOR.—The base
15 allotment factor, specified in this subparagraph,
16 for a State for a fiscal year is equal to the
17 product of the following:

18 (i) NUMBER OF INDIVIDUALS WITH
19 DISABILITIES.—The number of individuals
20 with disabilities in the State (determined
21 under paragraph (3)) for the fiscal year.

22 (ii) 80 PERCENT OF THE NATIONAL
23 PER CAPITA BUDGET.—80 percent of the
24 national average per capita budget amount

1 (determined under paragraph (4)) for the
2 fiscal year.

3 (iii) WAGE ADJUSTMENT FACTOR.—

4 The wage adjustment factor (determined
5 under paragraph (5)) for the State for the
6 fiscal year.

7 (iv) FEDERAL MATCHING RATE.—The
8 Federal matching rate (determined under
9 section 408(b)) for the fiscal year.

10 (C) LOW INCOME ALLOTMENT FACTOR.—

11 The low income allotment factor, specified in
12 this subparagraph, for a State for a fiscal year
13 is equal to the product of the following:

14 (i) NUMBER OF INDIVIDUALS WITH
15 DISABILITIES.—The number of individuals
16 with disabilities in the State (determined
17 under paragraph (3)) for the fiscal year.

18 (ii) 10 PERCENT OF THE NATIONAL
19 PER CAPITA BUDGET.—10 percent of the
20 national average per capita budget amount
21 (determined under paragraph (4)) for the
22 fiscal year.

23 (iii) WAGE ADJUSTMENT FACTOR.—

24 The wage adjustment factor (determined

1 under paragraph (5)) for the State for the
2 fiscal year.

3 (iv) FEDERAL MATCHING RATE.—The
4 Federal matching rate (determined under
5 section 408(b)) for the fiscal year.

6 (v) LOW INCOME INDEX.—The low in-
7 come index (determined under paragraph
8 (6)) for the State for the preceding fiscal
9 year.

10 (3) NUMBER OF INDIVIDUALS WITH DISABIL-
11 ITIES.—The number of individuals with disabilities
12 in a State for a fiscal year shall be determined as
13 follows:

14 (A) BASE.—The Secretary shall determine
15 the number of individuals in the State by age,
16 sex, and income category, based on the 1990
17 decennial census, adjusted (as appropriate) by
18 the March 1994 current population survey.

19 (B) DISABILITY PREVALENCE LEVEL BY
20 POPULATION CATEGORY.—The Secretary shall
21 determine, for each such age, sex, and income
22 category, the national average proportion of the
23 population of such category that represents in-
24 dividuals with disabilities. The Secretary may

1 conduct periodic surveys in order to determine
2 such proportions.

3 (C) BASE DISABLED POPULATION IN A
4 STATE.—The number of individuals with dis-
5 abilities in a State in 1994 is equal to the sum
6 of the products, for such age, sex, and income
7 category, of—

8 (i) the population of individuals in the
9 State in the category (determined under
10 subparagraph (A)), and

11 (ii) the national average proportion
12 for such category (determined under sub-
13 paragraph (B)).

14 (D) UPDATE.—The Secretary shall deter-
15 mine the number of individuals with disabilities
16 in a State in a fiscal year equal to the number
17 determined under subparagraph (C) for the
18 State increased (or decreased) by the percent-
19 age increase (or decrease) in the disabled popu-
20 lation of the State as determined under the cur-
21 rent population survey from 1994 to the year
22 before the fiscal year involved.

23 (4) NATIONAL PER CAPITA BUDGET AMOUNT.—
24 The national average per capita budget amount, for
25 a fiscal year, is—

1 (A) the total Federal budget specified
2 under subsection (a) for the fiscal year; divided
3 by

4 (B) the sum, for the fiscal year, of the
5 numbers of individuals with disabilities (deter-
6 mined under paragraph (3)) for all the States
7 for the fiscal year.

8 (5) WAGE ADJUSTMENT FACTOR.—The wage
9 adjustment factor, for a State for a fiscal year, is
10 equal to the ratio of—

11 (A) the average hourly wages for service
12 workers (other than household or protective
13 services) in the State, to

14 (B) the national average hourly wages for
15 service workers (other than household or protec-
16 tive services).

17 The hourly wages shall be determined under this
18 paragraph based on data from the most recent de-
19 cennial census for which such data are available.

20 (6) LOW INCOME INDEX.—The low income
21 index for each State for a fiscal year is the ratio, de-
22 termined for the preceding fiscal year, of—

23 (A) the percentage of the State's popu-
24 lation that has income below 150 percent of the
25 poverty level, to

1 (B) the percentage of the population of the
2 United States that has income below 150 per-
3 cent of the poverty level.

4 Such percentages shall be based on data from the
5 most recent decennial census for which such data
6 are available, adjusted by data from the most recent
7 current population survey as determined appropriate
8 by the Secretary.

9 (c) STATE ENTITLEMENT.—This title constitutes
10 budget authority in advance of appropriations Acts, and
11 represents the obligation of the Federal Government to
12 provide for the payment to States of amounts described
13 in subsection (a).

14 **TITLE V—REBASING MEDICARE**
15 **PAYMENT RATES**
16 **Subtitle A—Rehabilitation**
17 **Hospitals**

18 **SEC. 501. DEFINITION OF REHABILITATION HOSPITALS.**

19 (a) IN GENERAL.—Clause (ii) of section
20 1886(d)(1)(B) of the Social Security Act (42 U.S.C.
21 1395ww(d)(1)(B)) is amended to read as follows:

22 “(ii) a rehabilitation hospital (as de-
23 fined by the Secretary) and including a
24 hospital that provides rehabilitation serv-
25 ices to patients at least 75 percent of

1 whom in any cost reporting period are de-
2 termined to require rehabilitation as a re-
3 sult of any of the following: stroke, spinal
4 cord injury, congenital deformity, amputa-
5 tion, major multiple trauma, fracture of
6 femur, brain injury, polyarthritis (includ-
7 ing rheumatoid arthritis), neurological dis-
8 orders, burns, chronic pain, cardiac condi-
9 tions, pulmonary conditions, or oncology,”.

10 (b) EFFECTIVE DATE.—The amendment made by
11 subsection (a) shall take effect October 1, 1994.

12 **SEC. 502. PAYMENT RULES.**

13 (a) IN GENERAL.—Section 1886(b)(3) of the Social
14 Security Act (42 U.S.C. 1395ww(b)(3)) is amended—

15 (1) in subparagraphs (A) and (B)(ii), by strik-
16 ing “and (E)” and inserting “(E), and (F)”, and

17 (2) by adding at the end the following new sub-
18 paragraph:

19 “(F) Notwithstanding any other provision of this
20 title, for cost reporting periods beginning on and after Oc-
21 tober 1, 1994, in the case of a hospital described in clause
22 (ii) or (iv) of subsection (d)(1)(B) and not described in
23 subparagraph (G)(ii), and a rehabilitation unit as de-
24 scribed in such subsection, the term ‘target amount’
25 means—

1 “(i) in the case of a hospital or distinct part
2 unit that is subject to a target amount in the first
3 such period, the allowable operating costs of inpa-
4 tient hospital services (as defined in subsection
5 (a)(4) for its cost reporting period ending on or be-
6 fore December 31, 1991 (in this subparagraph re-
7 ferred to as ‘the new base year’), increased by the
8 applicable percentage increases prescribed by sub-
9 section (b)(3)(B), except that (I) in no case shall
10 such target amount for any hospital or distinct part
11 unit be less than 70 percent of the national averages
12 for all such hospitals and distinct part units (as de-
13 termined by the Secretary) and (II) in no case shall
14 payment per discharge to a hospital in a cost report-
15 ing period beginning on or after October 1, 1994, be
16 less than the amount paid per discharge in the new
17 base year (including any payments pursuant to para-
18 graph (1)(A)) multiplied by the applicable percent-
19 age increase prescribed by subparagraph (B); and

20 “(ii) in the case of a hospital or distinct part
21 unit that is not subject to a target amount in the
22 first such period, the allowable operating costs of in-
23 patient hospital services (as defined in subsection
24 (a)(4)) in the 12-month cost reporting period imme-
25 diately preceding the first period subject to a target

1 amount shall be increased by the applicable percent-
2 age increase prescribed by subparagraph (B), except
3 that in no case shall such target amount for any
4 hospital or unit be not less than 70 percent of the
5 national average for all such hospitals or distinct
6 part units (as determined by the Secretary) of the
7 type of hospital or distinct part unit for which it was
8 granted approval to participate under this title (as
9 determined by the Secretary).”.

10 (b) EFFECTIVE DATE.—The amendments made by
11 subsection (a) shall apply to cost reporting periods begin-
12 ning on or after October 1, 1994.

13 **SEC. 503. PAYMENT FOR OPERATING COSTS OF REHABILI-**
14 **TATION HOSPITALS.**

15 (a) IN GENERAL.—Section 1886(d) of the Social Se-
16 curity Act (42 U.S.C. 1395ww(d)) is amended by adding
17 at the end the following new paragraph:

18 “(11)(A) Notwithstanding section 1814(b), but sub-
19 ject to the provision of section 1813, the amount of the
20 payment with respect to the operating costs of inpatient
21 hospital services of a rehabilitation hospital or a distinct
22 part rehabilitation unit (in this paragraph referred to as
23 a ‘rehabilitation center’), as defined in subparagraph (B),
24 in cost reporting periods beginning on and after October

1 1, 1996, shall be determined in accordance with this para-
2 graph.

3 “(B)(i) The Secretary—

4 “(I) shall establish a classification of inpatient
5 hospital discharges of rehabilitation centers by func-
6 tional-related groups (in this paragraph referred to
7 as ‘FRGs’) to include impairment, age and func-
8 tional capability and such other factors as the Sec-
9 retary deems appropriate; and

10 “(II) shall establish a methodology for
11 classifying specific discharges from a rehabilitation
12 center within these groups.

13 “(ii) For each such functional-related group the Sec-
14 retary shall assign an appropriate weighting factor which
15 reflects the relative hospital resources used with respect
16 to discharges classified within that group compared to dis-
17 charges classified within other groups.

18 “(iii) The Secretary shall, from time to time, adjust
19 the classifications and weighting factors established under
20 this clause as appropriate to reflect changes in treatment
21 patterns, technology and other factors which may change
22 the relative use of resources, except that any such adjust-
23 ments shall be made in a manner that assures that the
24 aggregate payments under this paragraph for discharges
25 in the fiscal year are not greater or less than those that

1 would have been made for discharges in the year without
2 such adjustment.

3 “(C) The Secretary shall determine an FRG payment
4 rate for each rehabilitation center discharge for which
5 such rehabilitation center is entitled to receive payment
6 under this title. Such payment rate for cost reporting peri-
7 ods beginning on and after October 1, 1996, shall be the
8 average payment per discharge under this title for inpa-
9 tient operating costs of rehabilitation centers in the fiscal
10 year ending September 30, 1996, as estimated by the Sec-
11 retary, adjusted by—

12 “(i) updating such per-discharge amount by the
13 applicable percentage increase provided by sub-
14 section (b)(3)(B)(iv)(IV),

15 “(ii) variations among hospitals by area in the
16 average hospital wage index (as described in sub-
17 paragraph (H)),

18 “(iii) the FRG weighting factor (as defined in
19 subparagraph (B)), and

20 “(iv) for any hospital or distinct part unit that
21 serves a disproportionate number of low-income pa-
22 tients (as defined in paragraph (5)(F)(v), a factor
23 determined in accordance with subparagraph (F).

24 “(D) The Secretary shall provide for an additional
25 payment to a rehabilitation center for any discharges in

1 a functional-related group, the length of stay of which ex-
2 ceeded the mean length of stay for discharges within that
3 group by a fixed number of days or exceeds such mean
4 length of stay by some fixed number of deviations, which-
5 ever is the fewer number of days.

6 “(E) For cases which are not included in subpara-
7 graph (D), a rehabilitation center may request additional
8 payments in any case where charges, adjusted to cost, ex-
9 ceed a fixed multiple of the applicable FRG prospective
10 payment rate, or exceed such other fixed dollar amount,
11 whichever is greater, or exceed the FRG prospective pay-
12 ment rate plus a fixed dollar amount determined by the
13 Secretary.

14 “(F) The Secretary may provide for such adjust-
15 ments to the payment amounts under this paragraph as
16 the Secretary deems appropriate to take into account the
17 unique circumstances of rehabilitation facilities located in
18 Alaska and Hawaii.

19 “(G) The Secretary shall provide for publication in
20 the Federal Register, on or before September 1 before
21 each fiscal year (beginning with fiscal year 1996), of the
22 FRG weighting factors for such fiscal year and a descrip-
23 tion of the methodology and data used in computing the
24 adjusted FRG prospective payment rates under this para-
25 graph.

1 “(H) The Secretary shall adjust the proportion (as
2 estimated by the Secretary from time-to-time) of rehabili-
3 tation centers’ costs which are attributable to wages and
4 wage-related costs, of the FRG prospective payment rates
5 computed under subparagraph (C) for area differences in
6 hospital wage levels by a factor (established by the Sec-
7 retary) reflecting the relative hospital wage level in the
8 geographic area of the rehabilitation center compared to
9 the national average hospital wage level. Not later than
10 October 1, 1997 (and at least every 12 months thereafter),
11 the Secretary shall update the factor under the preceding
12 sentence on the basis of a survey conducted by the Sec-
13 retary (and updated as appropriate) of the wages and
14 wage-related costs incurred in furnishing hospital services.
15 Any adjustments or updates made under this subpara-
16 graph for a fiscal year shall be made in a manner that
17 assures that the aggregated payments under this para-
18 graph in the fiscal year are not greater or less than those
19 that would have been made in the year without such ad-
20 justment.

21 “(I) The determinations required by this paragraph
22 shall be made in a manner that assures that the aggre-
23 gated payments under this paragraph in the fiscal year
24 beginning October 1, 1996, and subsequent fiscal years
25 are not greater or less than those that would have been

1 made in any such year had this paragraph not been en-
2 acted.

3 “(J) The Secretary also shall provide for an addi-
4 tional payment amount for rehabilitation centers with in-
5 direct costs of medical education in an amount computed
6 in the same manner as is such additional payment com-
7 puted for subsection (d) hospitals under paragraph
8 (5)(B).”.

9 (b) EFFECTIVE DATE.—The amendment made by
10 subsection (a) shall apply to cost reporting periods begin-
11 ning on or after October 1, 1996.

12 **Subtitle B—Long-Term Hospitals**

13 **SEC. 511. PAYMENT RULES.**

14 (a) ASSIGNMENT OF NEW BASE YEAR FOR CER-
15 TIFIED LONG-STAY HOSPITALS SERVING A SIGNIFICANT
16 PROPORTION OF LOW-INCOME PATIENTS.—Section
17 1886(b)(3) of the Social Security Act (42 U.S.C.
18 1395ww(b)(3)), as amended by section 502(a), is amend-
19 ed—

20 (1) in subparagraphs (A) and (B)(ii), by strik-
21 ing “and (F)” and inserting “(F), and (G)”, and

22 (2) by adding at the end the following new sub-
23 paragraph:

24 “(G)(i) In the case of a hospital described in clause
25 (ii), the term ‘target amount’ means—

1 “(I) with respect to the first 12-month cost re-
2 porting period in which this subparagraph is applied
3 to the hospital, the allowable operating costs of inpa-
4 tient hospital services (as defined in subsection
5 (a)(4)) recognized under this title for the hospital’s
6 fiscal year 1991 cost reporting period increased (in
7 a compound manner) by the sum of the applicable
8 percentage increases applied to such hospital under
9 this paragraph for cost reporting periods after the
10 hospital’s fiscal year 1991 cost reporting period and
11 up to and including such first 12-month cost report-
12 ing period; or

13 “(II) with respect to a later cost reporting pe-
14 riod, subject to clause (iii), the target amount for
15 the preceding 12-month cost reporting period, in-
16 creased by the applicable percentage increase under
17 subparagraph (B)(ii) for the cost reporting period.

18 “(ii) A hospital described in this clause is a hos-
19 pital—

20 “(I) which is described in clause (iv) of sub-
21 section (d)(1)(B);

22 “(II) which has not received the additional pay-
23 ment amount described in paragraph (1)(A) for at
24 least 2 consecutive years; and

1 “(III) for which the sum of the amounts de-
2 scribed in subclauses (I) and (II) of subsection
3 (d)(5)(F)(vi) in the period described in clause (i) ex-
4 ceeds 25 percent.

5 “(iii) Notwithstanding clause (i)(II), if, after July 1,
6 1995, a hospital is still described in clause (ii), there shall
7 be substituted for the base cost reporting period described
8 in clause (i)(I) a subsequent reporting period chosen by
9 the Secretary which shall be one of the fiscal years de-
10 scribed in clause (ii)(II) of the hospital, but only if such
11 substitution results in an increase in the target amount
12 for the hospital.

13 “(iv) In making available to the hospital the pay-
14 ments described in section 1815(e)(2), the Secretary shall
15 take into account the enactment of this subparagraph,
16 and, effective as of the date of the enactment of this sub-
17 paragraph, shall increase such payments as if the target
18 amount of the hospital had been established pursuant to
19 this subparagraph as of such date.”.

20 (b) EFFECTIVE DATE.—

21 (1) IN GENERAL.—The amendments made by
22 subsection (a) shall be effective with respect to cost
23 reporting periods beginning on or after July 1,
24 1993.

1 (2) SPECIAL RULE FOR HOSPITALS WITH EX-
2 CEPTION OR ADJUSTMENT REQUESTS PENDING.—In
3 the case of a hospital described in clause (iv) or (v)
4 of section 1886(d)(1)(B) of the Social Security Act
5 and that has filed a request for an exception or ad-
6 justment pursuant to section 1886(b)(4) of such Act
7 on or after October 1, 1990, and before June 1,
8 1993, the provisions of this section shall, at the op-
9 tion of the hospital, apply to the hospital for cost re-
10 porting periods during which and after such request
11 was filed.

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