I

103D CONGRESS
2D SESSION

H. R. 4632

To establish a program to provide Federal payment to States for the operation of programs for long-term care services for needy individuals with disabilities, to amend the Internal Revenue Code of 1986 to revise the tax treatment of expenses for long-term care insurance and services, to reform standards for the long-term care insurance market, and for other purposes.

IN THE HOUSE OF REPRESENTATIVES

JUNE 22, 1994

Mr. PETERSON of Florida introduced the following bill; which was referred jointly to the Committees on Energy and Commerce and Ways and Means

---

A BILL

To establish a program to provide Federal payment to States for the operation of programs for long-term care services for needy individuals with disabilities, to amend the Internal Revenue Code of 1986 to revise the tax treatment of expenses for long-term care insurance and services, to reform standards for the long-term care insurance market, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the ''Comprehensive Long-Term Care Reform Act of 1994''.

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

TITLE I—STATE PROGRAMS FOR LONG-TERM CARE SERVICES FOR NEEDY INDIVIDUALS WITH DISABILITIES

Subtitle A—State Long-Term Care Programs

SEC. 101. STATE PROGRAMS FOR LONG-TERM CARE SERVICES FOR NEEDY INDIVIDUALS WITH DISABILITIES.

(a) IN GENERAL.—Each State that has a plan for the long-term care services to needy individuals with disabilities submitted to and approved by the Secretary under section 102(b) is entitled to payment in accordance with section 108.

(b) NO INDIVIDUAL ENTITLEMENT ESTABLISHED.—Nothing in this subtitle shall be construed to create an

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

(c) STATE DEFINED.—In this Act, the term ''State'' includes the District of Columbia, Puerto Rico, the Virgin Islands, Guam, American Samoa, and the Northern Mariana Islands.

SEC. 102. STATE PLANS.

(a) PLAN REQUIREMENTS.—In order to be approved under subsection (b), a State plan for long-term care services for needy individuals with disabilities must meet the following requirements:

(1) ELIGIBILITY.—

(A) IN GENERAL.—Within the amounts provided by the State (and under section 108) for such plan, the plan shall provide that services under the plan will be available to needy individuals with disabilities (as defined in section 103(a)) in the State.

(B) INITIAL SCREENING.—The plan shall provide a process for the initial screening of individuals who appear to have some reasonable likelihood of being an individual with disabilities.

(C) RESTRICTIONS.—The plan may not limit the eligibility of needy individuals with disabilities based on—

(i) age,

(ii) geography,

(iii) nature, severity, or category of disability,

(iv) residential setting (other than an institutional setting), or

(v) other grounds specified by the Secretary.

(D) MAINTENANCE OF EFFORT.—The plan must provide assurances that, in the case of an individual receiving medical assistance for home and community-based services under the State medicaid plan as of the date of the enactment of this Act, the State will continue to make available (either under this plan or otherwise) to such individual an appropriate level of assistance for home and community-based services, taking into account the level of assistance provided as of such date and the individual's need for home and community-based services.

(2) SERVICES.—

(A) SPECIFICATION.—Consistent with section 104, the plan shall specify—

(i) the services made available under the plan,

(ii) the extent and manner in which such services are allocated and made available to individuals with disabilities, and

(iii) the manner in which services under the plan are coordinated with each other and with health and long-term care services available outside the plan for individuals with disabilities.

(B) ALLOCATION.—The State plan—

(i) shall specify how it will allocate services under the plan, during and after the 4-fiscal-year phase-in period beginning with fiscal year 1996, among covered individuals with disabilities, and

(ii) may not allocate such services based on the income or other financial resources of such individuals.

(C) LIMITATION ON LICENSURE OR CERTIFICATION.—The State may not subject consumer-directed providers of personal assistance services to licensure, certification, or other

requirements which the Secretary finds not to be necessary for the health and safety of individuals with disabilities.

(D) CONSUMER CHOICE.—To the extent possible, the choice of an individual with disabilities (and that individual's family) regarding which covered services to receive and the providers who will provide such services shall be followed.

(3) COST SHARING.—The plan shall impose cost sharing with respect to covered services only in accordance with section 105.

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

(A) the types of service providers eligible to participate in the program under the plan, which shall include consumer-directed providers for home and community-based services, and

(B) any requirements for participation applicable to each type of service provider.

(5) BUDGET.—The plan shall specify how the State will manage Federal and State funds available under the plan for each fiscal year during the period beginning with fiscal year 1996 and ending with fiscal year 2000 and for each 5-fiscal-year periods

thereafter to serve all categories of individuals with disabilities and meet the requirements of this subsection. If the Secretary makes an adjustment under section 109(a)(5)(C) for a year, each State shall update the specifications under this paragraph to reflect the impact of such an adjustment.

(6) PROVIDER REIMBURSEMENT.—

(A) PAYMENT METHODS.—The plan shall specify the payment methods to be used to reimburse providers for services furnished under the plan. Such methods may include retrospective reimbursement on a fee-for-service basis, prepayment on a capitation basis, payment by cash or vouchers to individuals with disabilities, or any combination of these methods. In the case of the use of cash or vouchers, the plan shall specify how the plan will assure compliance with applicable employment tax provisions.

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

(C) PLAN PAYMENT AS PAYMENT IN FULL.—The plan shall restrict payment under

the plan for covered services to those providers that agree to accept the payment under the plan (at the rates established pursuant to subparagraph (B)) and any cost sharing permitted or provided for under section 105 as payment in full for services furnished under the plan.

(7) QUALITY ASSURANCE AND SAFEGUARDS.—The State plan shall provide for quality assurance and safeguards for applicants and beneficiaries in accordance with section 106.

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

(A) assure the establishment and maintenance of an advisory group under section 107(b), and

(B) include the documentation prepared by the group under section 107(b)(4).

(9) ADMINISTRATION.—

(A) STATE AGENCY.—The plan shall designate a State agency or agencies to administer (or to supervise the administration of) the plan.

(B) ADMINISTRATIVE EXPENDITURES.—Effective beginning with fiscal year 2003, the plan shall contain assurances that not more than 10 percent of expenditures under the plan

for all quarters in any fiscal year shall be for administrative costs.

(C) COORDINATION.—The plan shall specify how the plan—

(i) will be integrated with the State medicaid plan, titles V and XX of the Social Security Act, programs under the Older Americans Act of 1965, programs under the Developmental Disabilities Assistance and Bill of Rights Act, the Individuals with Disabilities Education Act, the Rehabilitation Act of 1973, and any other Federal or State programs that provide services or assistance targeted to individuals with disabilities, and

(ii) will be coordinated with health plans.

(10) REPORTS AND INFORMATION TO SECRETARY; AUDITS.—The plan shall provide that the State will furnish to the Secretary—

(A) such reports, and will cooperate with such audits, as the Secretary determines are needed concerning the State's administration of its plan under this subtitle, including the processing of claims under the plan, and

(B) such data and information as the Secretary may require in order to carry out the Secretary's responsibilities.

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

(b) APPROVAL OF PLANS.—The Secretary shall approve a plan submitted by a State if the Secretary determines that the plan—

(1) was developed by the State after consultation with individuals with disabilities and representatives of groups of such individuals, and

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

The approval of such a plan shall take effect as of the first day of the first fiscal year beginning after the date of such approval (except that any approval made before January 1, 1996, shall be effective as of January 1, 1996). In order to budget funds allotted under this subtitle, the Secretary may establish a deadline for the submission of such a plan before the beginning of a fiscal year as a condition of its approval effective with that fiscal year.

(c) MONITORING.—The Secretary shall monitor the compliance of State plans with the eligibility requirements

of section 103 and may monitor the compliance of such plans with other requirements of this subtitle.

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

SEC. 103. INDIVIDUALS WITH DISABILITIES AND NEEDY INDIVIDUAL DEFINED.

(a) IN GENERAL.—In this subtitle, for purposes of both home and community-based services and institutional services, the term ''individual with disabilities'' means any individual within one or more of the following 4 categories of individuals:

(1) INDIVIDUALS REQUIRING HELP WITH ACTIVITIES OF DAILY LIVING.—An individual of any age who—

(A) requires hands-on or standby assistance, supervision, or cueing (as defined in regulations) to perform—

(i) with respect to home and community-based services, two or more activities of daily living (as defined in subsection (c)), or

(ii) with respect to institutional services, three or more activities of daily living; and

(B) is expected to require such assistance, supervision, or cueing over a period of at least 120 days.

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

(A) whose score, on a standard mental status protocol (or protocols) appropriate for measuring the individual's particular condition specified by the Secretary, indicates either severe cognitive impairment or severe mental impairment, or both;

(B) who—

(i) requires hands-on or standby assistance, supervision, or cueing with one or more activities of daily living,

(ii) requires hands-on or standby assistance, supervision, or cueing with at least such instrumental activity (or activities) of daily living related to cognitive or mental impairment as the Secretary specifies, or

(iii) displays symptoms of one or more serious behavioral problems (that is on a list of such problems specified by the Sec-

retary) which create a need for supervision to prevent harm to self or others; and

(C) is expected to meet the requirements of subparagraphs (A) and (B) over a period of at least 100 days.

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

(4) SEVERELY DISABLED CHILDREN.—An individual under 6 years of age who—

(A) has a severe disability or chronic medical condition,

(B) but for receiving personal assistance services or any of the services described in section 104(d)(1), would require institutionalization in a hospital, nursing facility, or intermediate care facility for the mentally retarded, and

(C) is expected to have such disability or condition and require such services over a period of at least 100 days.

(b) DETERMINATION OF DISABILITY.—

(1) IN GENERAL.—The determination of whether an individual is an individual with disabilities

shall be made, by persons or entities specified under the State plan, using a uniform protocol consisting of an initial screening and assessment specified by the Secretary. A State may collect additional information, at the time of obtaining information to make such determination, in order to provide for the assessment and plan described in section 104(b) or for other purposes. The State shall establish a fair hearing process for appeals of such determinations.

(2) PERIODIC REASSESSMENT.—The determination that an individual is an individual with disabilities shall be considered to be effective under the State plan for a period of not more than 12 months (or for such longer period in such cases as a significant change in an individual's condition that may affect such determination is unlikely). A reassessment shall be made if there is a significant change in an individual's condition that may affect such determination.

(c) ACTIVITY OF DAILY LIVING DEFINED.—In this subtitle, the term ''activity of daily living'' means any of the following: eating, toileting, dressing, bathing, and transferring.

(d) NEEDY INDIVIDUAL DEFINED; DETERMINATION OF INCOME AND RESOURCES.—

(1) NEEDY INDIVIDUAL DEFINED.—In this title, the term ''needy individual'' means an individual—

(A) whose income (as determined under paragraph (2)) is less than 200 percent of the official poverty line (as defined by the Office of Management and Budget, and revised annually in accordance with section 673(2) of the Omnibus Budget Reconciliation Act of 1981) applicable to a family of the size involved, and

(B) whose resources (as determined under paragraph (3)(A)) are less than the amount specified by the State consistent with paragraph (3)(B).

(2) DETERMINATION OF INCOME.—

(A) IN GENERAL.—The State plan shall specify the methodology to be used to determine the income of an individual with disabilities for purposes of paragraph (1) and section 105 (relating to cost sharing).

(B) STANDARDS.—Such methodology shall be consistent with standards specified by the Secretary. Such standards shall be consistent with the methodology generally used by States

as of the date of the enactment of this Act and shall—

(i) provide for taking into account expenses incurred for medical care or other types of remedial care recognized under State law, and

(ii) be consistent with the provisions of section 105(a) and the rules provided under section 1924 of the Social Security Act (with respect to institutionalized spouses).

(3) DETERMINATION OF RESOURCES.—

(A) METHODLOGY.—

(i) IN GENERAL.—The State plan shall specify the methodology to be used to determine the resources of an individual with disabilities for purposes of paragraph (1) and section 105 (relating to cost sharing).

(ii) STANDARDS.—Such methodology shall be consistent with standards and methodology specified by the Secretary. Such standards and methodology shall—

(I) be based on the methodology used under the supplemental security income program, and

(II) take into account the provisions of section 105(a) and the rules provided under section 1924 of the Social Security Act (with respect to institutionalized spouses).

(B) RESOURCE LEVEL.—

(i) IN GENERAL.—The resource level specified in this subparagraph is—

(I) $5,000 for an individual who has no spouse with whom the individual is living, and

(II) $7,500 for an individual who has a spouse with whom the individual is living.

(ii) ADJUSTMENT.—A State may increase either or both of the levels specified under clause (i) to up to $12,000.

(4) SPECIAL RULE FOR CURRENT MEDICAID BENEFICIARIES.—In the case of an individual who as of January 1, 1996, was receiving medical assistance for long-term care services under a State plan under title XIX of the Social Security Act, the indi-

vidual shall be deemed to be a needy individual so long as the individual would have been eligible to receive such assistance under such plan (as in effect on such date), but for section 1931 of such Act (as added by section 121(a)).

(5) APPLICATION OF TRANSFER OF ASSET RULES.—Except as specifically provided, the State shall apply rules similar to the rules described in section 1917(c) of the Social Security Act with respect to the disposal of assets for less than fair market value.

SEC. 104. LONG-TERM CARE SERVICES COVERED UNDER STATE PLAN.

(a) SPECIFICATION.—

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

(A) the long-term care services available under the plan to individuals with disabilities (or to such categories of such individuals), and

(B) any limits with respect to such services.

(2) FLEXIBILITY IN MEETING INDIVIDUAL NEEDS.—The services shall be specified in a manner that permits sufficient flexibility for providers to

meet the needs of individuals with disabilities in a cost effective manner consistent with the individualized plan of care. Subject to subsection (e)(1)(B), such services may be delivered in an individual's home, a range of community residential arrangements, or outside the home.

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

(1) IN GENERAL.—The State plan shall provide for long-term care services to an individual with disabilities only if—

(A) a comprehensive assessment of the individual's need for long-term care services (regardless of whether all needed services are available under the plan) has been made by a care manager (who meets qualifications specified in the State plan),

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

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

(2) INVOLVEMENT OF INDIVIDUALS.—The individualized plan of care under paragraph (1)(B) for an individual with disabilities shall—

(A) be developed by the care manager who performed the comprehensive assessment,

(B) be developed and implemented in close consultation with the individual and the individual's family,

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

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

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

(A) specify which services specified under the individual plan will be provided under the State plan under this subtitle,

(B) identify (to the extent possible) how the individual will be provided any services specified under the plan of care and not provided under the State plan, and

(C) specify how the provision of services to the individual under the plan will be coordinated with the provision of other health care services to the individual.

The State shall make reasonable efforts to identify and arrange for services described in subparagraph (B). Nothing in this subsection shall be construed as

requiring a State (under the State plan or otherwise) to provide all the services specified in such a plan.

(c) LONG-TERM CARE SERVICES DEFINED.—

(1) IN GENERAL.—In this title, the term ''long-term care services'' means—

(A) home and community-based services (as defined in subsection (d)), and

(B) institutional services (as defined in section (e)).

(2) SECONDARY PAYER TO MEDICARE AND OTHER HEALTH PLANS.—A State plan may not provide for coverage of any items and services to the extent coverage is provided for the individual under a health plan or the medicare program.

(d) HOME AND COMMUNITY-BASED SERVICES.—

(1) IN GENERAL.—In this subtitle, the term ''home and community-based services''—

(A) includes, for all categories of individuals with disabilities, both agency-administered and consumer-directed personal assistance services (as defined in paragraph (3)); and

(B) subject to paragraph (4), includes any (or all) of the following:

(i) Case management.

(ii) Homemaker and chore assistance.

(iii) Home modifications.

(iv) Respite services.

(v) Assistive devices.

(vi) Adult day services.

(vii) Habilitation and rehabilitation.

(viii) Supported employment.

(ix) Home health services.

(x) Hospice services.

(xi) Care or assisted services provided in an assisted living facility, continuing care retirement community or other residential care facility, excluding room and board.

(xii) Any other care or assistive services (approved by the Secretary) that the State determines will help individuals with disabilities to remain in their homes and communities.

(2) CRITERIA FOR SELECTION OF SERVICES.—The State plan shall specify—

(A) the methods and standards used to select the types, and the amount, duration, and scope, of home and community-based services described in paragraph (1)(B) to be covered

under the plan and to be available to each category of individuals with disabilities, and

(B) how the types, and the amount, duration, and scope, of such services specified meet the needs of individuals within each of the 4 categories of individuals with disabilities.

(3) PERSONAL ASSISTANCE SERVICES.—

(A) IN GENERAL.—In this section, the term ''personal assistance services'' means those services specified under the State plan as personal assistance services and shall include at least hands-on and standby assistance, supervision, and cueing with activities of daily living, whether agency-administered or consumer-directed (as defined in subparagraph (B)).

(B) CONSUMER-DIRECTED; AGENCY-ADMINISTERED.—In this subtitle:

(i) The term ''consumer-directed'' means, with reference to personal assistance services or the provider of such services, services that are provided by an individual who is selected and managed (and, at the individual's option, trained) by the individual receiving the services.

(ii) The term ''agency-administered'' means, with respect to such services, services that are not consumer-directed.

(4) EXCLUSIONS AND LIMITATIONS.—

(A) IN GENERAL.—A State plan may not provide for coverage as home and community-based services of—

(i) room and board, or

(ii) services furnished in a hospital, nursing facility, intermediate care facility for the mentally retarded, or other institutional setting specified by the Secretary.

(B) TAKING INTO ACCOUNT INFORMAL CARE.—A State plan may take into account, in determining the amount and array of home and community-based services made available to covered individuals with disabilities, the availability of informal care.

(e) INSTITUTIONAL SERVICES DEFINED.—In this subtitle, the term ''institutional services'' means services furnished in a nursing facility, intermediate care facility for the mentally retarded, or any other institutional facility (at the approval of the Secretary) that the State determines will assist individuals with disabilities.

(f) PAYMENT FOR SERVICES.—A State plan may provide for the use of—

(1) vouchers,

(2) capitation payments to health plans, and

(3) payment to providers,

to pay for covered services.

SEC. 105. COST SHARING.

(a) HOME AND COMMUNITY-BASED SERVICES.—With respect to home and community-based services provided under the State plan—

(1) NO OR NOMINAL COST SHARING FOR POOREST.—The State plan may not impose any cost sharing (other than nominal cost sharing) for individuals with income (as determined under section 103(d)(2)) less than 100 percent of the official poverty line (referred to in section 103(d)(1)(A)) applicable to a family of the size involved.

(2) SLIDING SCALE FOR REMAINDER.—The State plan shall impose cost sharing in the form of coinsurance (based on the amount paid under the State plan for a service)—

(A) at a rate of 5 percent for individuals with disabilities with income not less than 100 percent, and less than 150 percent, of such official poverty line (as so applied); and

(B) at a rate of 10 percent for such individuals with income not less than 150 percent, and less than 200 percent, of such official poverty line (as so applied).

(b) INSTITUTIONAL SERVICES.—

(1) IN GENERAL.—With respect to institutional services provided under the State plan, the cost sharing shall be the amount of income, other than the allowances provided under paragraph (2).

(2) ALLOWANCES.—The allowances under this paragraph are as follows:

(A) PERSONAL NEEDS ALLOWANCE.—A personal needs allowance of $66 per month for an institutionalized individual and $132 per month for an institutionalized couple (if both are aged, blind, or disabled, and their incomes are considered available to each other in determining eligibility).

(B) COMMUNITY SPOUSE ALLOWANCE.—In the case of an individual with a community spouse (as defined in section 1924 of the Social Security Act), an amount of income equivalent to the amount of income that would be protected under section 1924 of the Social Security

Act (determined without regard to subsection (d)(1)(A) thereof).

(3) RULES FOR DETERMINATION OF INCOME OF INSTITUTIONALIZED SPOUSES.—In determining income of an institutionalized spouse for purposes of this subsection, the State shall apply rules similar to the rules described in section 1924 of the Social Security Act consistent with paragraph (2).

(4) INSTITUTIONALIZED AND COMMUNITY SPOUSE DEFINED.—In this subsection, the terms ''institutionalized spouse'' and ''community spouse'' have the meanings given such terms in section 1924(h) of the Social Security Act.

SEC. 106. QUALITY ASSURANCE AND SAFEGUARDS.

(a) QUALITY ASSURANCE.—The State plan shall specify how the State will ensure and monitor the quality of services (including both home and community-based services and institutional services), including—

(1) safeguarding the health and safety of individuals with disabilities,

(2) the minimum standards for agency providers and how such standards will be enforced,

(3) the minimum competency requirements for agency provider employees who provide direct serv-

ices under this subtitle and how the competency of such employees will be enforced,

(4) obtaining meaningful consumer input, including consumer surveys that measure the extent to which participants receive the services described in the plan of care and participant satisfaction with such services,

(5) participation in quality assurance activities, and

(6) specifying the role of the long-term care ombudsman (under the Older Americans Act of 1965), the Protection and Advocacy Agency (under the Developmental Disabilities Assistance and Bill of Rights Act), and the State advocacy agency for the mentally ill (under the Protection and Advocacy for Mentally Ill Individuals Act of 1986) in assuring quality of services and protecting the rights of individuals with disabilities.

(b) SAFEGUARDS.—

(1) CONFIDENTIALITY.—The State plan shall provide safeguards which restrict the use or disclosure of information concerning applicants and beneficiaries to purposes directly connected with the administration of the plan (including performance reviews under section 2602).

(2) SAFEGUARDS AGAINST ABUSE.—The State plans shall provide safeguards against physical, emotional, or financial abuse or exploitation (specifically including appropriate safeguards in cases where payment for program benefits is made by cash payments or vouchers given directly to individuals with disabilities).

SEC. 107. ADVISORY GROUPS.

(a) FEDERAL ADVISORY GROUP.—

(1) ESTABLISHMENT.—The Secretary shall establish an advisory group, to advise the Secretary and States on all aspects of the program under this subtitle.

(2) COMPOSITION.—The group shall be composed of individuals with disabilities and their representatives, providers, Federal and State officials, and local community implementing agencies. A majority of its members shall be individuals with disabilities and their representatives.

(b) STATE ADVISORY GROUPS.—

(1) IN GENERAL.—Each State plan shall provide for the establishment and maintenance of an advisory group to advise the State on all aspects of the State plan under this subtitle.

(2) COMPOSITION.—Members of each advisory group shall be appointed by the Governor (or other chief executive officer of the State) and shall include individuals with disabilities and their representatives, providers, State officials, and local community implementing agencies. A majority of its members shall be individuals with disabilities and their representatives.

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

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

(A) before the State plan is developed, advise the State on guiding principles and values, policy directions, and specific components of the plan,

(B) meet regularly with State officials involved in developing the plan, during the development phase, to review and comment on all aspects of the plan,

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

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

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

(F) meet regularly with officials of the designated State agency (or agencies) to provide advice on all aspects of implementation and evaluation of the plan.

SEC. 108. PAYMENTS TO STATES.

(a) IN GENERAL.—Subject to section 102(a)(9)(B) (relating to limitation on payment for administrative costs), the Secretary, in accordance with the Cash Management Improvement Act, shall authorize payment to each State with a plan approved under this subtitle, for each quarter (beginning on or after January 1, 1996), from its allotment under section 109(b), an amount equal to—

(1) the Federal matching percentage (as defined in subsection (b)) of the amount demonstrated by State claims to have been expended during the quarter for long-term care services under the plan for individuals with disabilities; plus

(2) an amount equal to 90 percent of the amount expended during the quarter under the plan for activities (including preliminary screening) relating to determination of eligibility and performance of needs assessment; plus

(3) an amount equal to 90 percent (or, beginning with quarters in fiscal year 2003, 75 percent) of the amount expended during the quarter for the design, development, and installation of mechanical claims processing systems and for information retrieval; plus

(4) an amount equal to 50 percent of the remainder of the amounts expended during the quarter as found necessary by the Secretary for the proper and efficient administration of the State plan.

(b) FEDERAL MATCHING PERCENTAGE.—

(1) STATES AND THE DISTRICT OF COLUMBIA.—

(A) IN GENERAL.—In subsection (a), except as provided in paragraph (3), the term ''Federal matching percentage'' means, for each of the 50 States and the District of Columbia, 100 percent reduced by the product of the budget neutrality percentage (as defined in subparagraph (B)) and the ratio of—

(i)(I) for each of the 50 States, the total taxable resources ratio (as defined in subparagraph (C)) of the State, or

(II) for the District of Columbia, the per capita income ratio (as defined in subparagraph (D)), to—

(ii) the disabled population in poverty ratio (as defined in subparagraph (E)) of the State or District.

(B) BUDGET NEUTRALITY PERCENTAGE DEFINED.—For purposes of this subsection, the term ''budget neutrality percentage'' means a percentage estimated by the Secretary with the advice of the General Accounting Office that, when applied under subparagraph (A), would result (taking into account paragraph (2)) in an amount of aggregate payments under this title for the fiscal year involved equal to the total Federal budget amount under section 109(a).

(C) TOTAL TAXABLE RESOURCES RATIO DEFINED.—For purposes of this subsection, the term ''total taxable resources ratio'' means—

(i) an amount equal to the most recent 3-year average of the total taxable re-

sources of the State, as determined by the Secretary of the Treasury, divided by

(ii) an amount equal to the sum of the 3-year averages determined under clause (i) for each of the 50 States.

(D) PER CAPITA INCOME RATIO DEFINED.—For purposes of this subsection, the term ''per capita income ratio'' means—

(i) an amount equal to the most recent 3-year average of the total personal income of the District of Columbia, as determined in accordance with the provisions of section 1101(a)(8)(B) of the Social Security Act, divided by

(ii) an amount equal to the total personal income of the continental United States (including Alaska) and Hawaii, as determined under section 1101(a)(8)(B) of such Act.

(E) DISABLED POPULATION IN POVERTY RATIO DEFINED.—For purposes of this subsection, the term ''disabled population in poverty ratio'' means—

(i) an amount equal to the 3-year-average of the number of individuals with

disabilities in the State (or the District of Columbia) whose family income is below 200 percent of the income official poverty line (as defined by the Office of Management and Budget and revised annually in accordance with section 673(2) of the Omnibus Budget Reconciliation Act of 1981), divided by

(ii) an amount equal to the sum of the averages determined under clause (i) for the 50 States.

(2) TERRITORIES.—The Federal matching percentage for Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa shall be 40 percent.

(3) PERMISSIBLE RANGE.—The Federal matching percentage shall in no case be less than 40 percent or more than 75 percent.

(c) PAYMENTS ON ESTIMATES WITH RETROSPECTIVE ADJUSTMENTS.—The method of computing and making payments under this section shall be as follows:

(1) The Secretary shall, prior to the beginning of each quarter, estimate the amount to be paid to the State under subsection (a) for such quarter, based on a report filed by the State containing its

estimate of the total sum to be expended in such quarter, and such other information as the Secretary may find necessary.

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

(d) APPLICATION OF RULES REGARDING LIMITATIONS ON PROVIDER-RELATED DONATIONS AND HEALTH CARE RELATED TAXES.—The provisions of section 1903(w) of the Social Security Act shall apply to payments to States under this section in the same manner as they apply to payments to States under section 1903(a) of such Act .

SEC. 109. TOTAL FEDERAL BUDGET; ALLOTMENTS TO STATES.

(a) TOTAL FEDERAL BUDGET.—

(1) FISCAL YEAR 1996—Subject to paragraph (5)(C), for purposes of this subtitle, the total Federal budget for State plans under this subtitle for fiscal year 1996 is $46.74 billion.

(2) SUBSEQUENT FISCAL YEARS.—For purposes of this subtitle, the total Federal budget for State plans under this subtitle for each fiscal year after fiscal year 1996 is the total Federal budget under this subsection for the preceding fiscal year multiplied by—

(A) a factor (described in paragraph (3)) reflecting the change in the CPI for the fiscal year, and

(B) a factor (described in paragraph (4)) reflecting the change in the number of individuals with disabilities for the fiscal year.

(3) CPI INCREASE FACTOR.—For purposes of paragraph (2)(A), the factor described in this paragraph for a fiscal year is the ratio of—

(A) the annual average index of the consumer price index for the preceding fiscal year, to—

(B) such index, as so measured, for the second preceding fiscal year.

(4) DISABLED POPULATION FACTOR.—For purposes of paragraph (2)(B), the factor described in this paragraph for a fiscal year is 100 percent plus (or minus) the percentage increase (or decrease) change in the disabled population of the United

States (as determined for purposes of the most recent update under subsection (b)(3)(D)).

(5) ADDITIONAL FUNDS DUE TO MEDICAID OFFSETS.—

(A) IN GENERAL.—Each participating State must provide the Secretary with information concerning offsets and reductions in the medicaid program resulting from long-term care services provided individuals with disabilities under this subtitle, that would have been paid for such individuals under the State medicaid plan but for the provision of similar services under the program under this subtitle. At the time a State first submits its plan under this title and before each subsequent fiscal year (through fiscal year 2003), the State also must provide the Secretary with such budgetary information (for each fiscal year through fiscal year 2003), as the Secretary determines to be necessary to carry out this paragraph.

(B) REPORTS.—Each State with a program under this subtitle shall submit such reports to the Secretary as the Secretary may require in order to monitor compliance with subparagraph (A).

(C) ADJUSTMENTS TO FEDERAL BUDGET.—

(i) IN GENERAL.—For each fiscal year (beginning with fiscal year 1996 and ending with fiscal year 2003) and based on a review of information submitted under subparagraph (A), the Secretary shall determine the amount by which the total Federal budget under subsection (a) will increase. The amount of such increase for a fiscal year shall be limited to the reduction in Federal expenditures of medical assistance (as determined by Secretary) that would have been made under title XIX of the Social Security Act for home and community based services for disabled individuals but for the provision of similar services under the program under this subtitle.

(ii) ANNUAL PUBLICATION.—The Secretary shall publish before the beginning of such fiscal year, the revised total Federal budget under this subsection for such fiscal year (and succeeding fiscal years before fiscal year 2003).

(D) NO DUPLICATE PAYMENT.—No payment may be made to a State under this section for any services to the extent that the State received payment for such services under section 1903(a) of the Social Security Act.

(E) CONSTRUCTION.—Nothing in this subsection shall be construed as requiring States to determine eligibility for medical assistance under the State medicaid plan on behalf of individuals receiving assistance under this subtitle.

(b) ALLOTMENTS TO STATES.—

(1) IN GENERAL.—The Secretary shall allot to each State for each fiscal year an amount that bears the same ratio to the total Federal budget for the fiscal year (specified under paragraph (1) or (2) of subsection (a)) as the State allotment factor (under paragraph (2) for the State for the fiscal year) bears to the sum of such factors for all States for that fiscal year.

(2) STATE ALLOTMENT FACTOR.—

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

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

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

for the State for the fiscal year.

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

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

(ii) 80 PERCENT OF THE NATIONAL PER CAPITA BUDGET.—80 percent of the national average per capita budget amount (determined under paragraph (4)) for the fiscal year.

(iii) WAGE ADJUSTMENT FACTOR.—The wage adjustment factor (determined under paragraph (5)) for the State for the fiscal year.

(iv) FEDERAL MATCHING RATE.—The Federal matching rate (determined under section 108(b)) for the fiscal year.

(C) LOW INCOME ALLOTMENT FACTOR.—The low income allotment factor, specified in

this subparagraph, for a State for a fiscal year is equal to the product of the following:

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

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

(iii) WAGE ADJUSTMENT FACTOR.—The wage adjustment factor (determined under paragraph (5)) for the State for the fiscal year.

(iv) FEDERAL MATCHING RATE.—The Federal matching rate (determined under section 108(b)) for the fiscal year.

(v) LOW INCOME INDEX.—The low income index (determined under paragraph (6)) for the State for the preceding fiscal year.

(3) NUMBER OF INDIVIDUALS WITH DISABILITIES.—The number of individuals with disabilities

in a State for a fiscal year shall be determined as follows:

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

(B) DISABILITY PREVALENCE LEVEL BY POPULATION CATEGORY.—The Secretary shall determine, for each such age, sex, and income category, the national average proportion of the population of such category that represents individuals with disabilities. The Secretary may conduct periodic surveys in order to determine such proportions.

(C) BASE DISABLED POPULATION IN A STATE.—The number of individuals with disabilities in a State in 1994 is equal to the sum of the products, for such each age, sex, and income category, of—

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

(ii) the national average proportion for such category (determined under subparagraph (B)).

(D) UPDATE.—The Secretary shall determine the number of individuals with disabilities in a State in a fiscal year equal to the number determined under subparagraph (C) for the State increased (or decreased) by the percentage increase (or decrease) in the disabled population of the State as determined under the current population survey from 1994 to the year before the fiscal year involved.

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

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

(B) the sum, for the fiscal year, of the numbers of individuals with disabilities (determined under paragraph (3)) for all the States for the fiscal year.

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

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

(B) the national average hourly wages for service workers (other than household or protective services).

The hourly wages shall be determined under this paragraph based on data from the most recent decennial census for which such data are available.

(6) LOW INCOME INDEX.—The low income index for each State for a fiscal year is the ratio, determined for the preceding fiscal year, of—

(A) the percentage of the State's population that has income below 200 percent of the poverty level, to

(B) the percentage of the population of the United States that has income below 200 percent of the poverty level.

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

(c) STATE ENTITLEMENT.—This subtitle constitutes budget authority in advance of appropriations Acts, and

represents the obligation of the Federal Government to provide for the payment to States of amounts described in subsection (a).

Subtitle B—Increase in SSI Personal Needs Allowance

SEC. 111. INCREASE IN SSI PERSONAL NEEDS ALLOWANCE.

(a) IN GENERAL.—Section 1611(e)(1)(B) of the Social Security Act (42 U.S.C. 1382(e)(1)(B)) is amended—

(1) in clauses (i) and (ii)(I), by striking ''$360'' and inserting ''$800''; and

(2) in clause (iii), by striking ''$720'' and inserting ''$1,600''.

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall apply with respect to months beginning with January 1996.

Subtitle C—Repeal of Coverage Under the Medicaid Program of Long-Term Care Services

SEC. 121. REPEAL OF COVERAGE UNDER THE MEDICAID PROGRAM OF LONG-TERM CARE SERVICES COVERED UNDER STATE PLAN.

(a) IN GENERAL.—Title XIX of the Social Security Act is amended by redesignating section 1931 as section 1932 and by inserting after section 1930 the following new section:

''TREATMENT OF LONG-TERM CARE SERVICES COVERED UNDER STATE PROGRAMS FOR NEEDY INDIVIDUALS WITH DISABILITIES

''SEC. 1931. (a) NO COVERAGE OF SERVICES REQUIRED.—Notwithstanding any other provision of this title, the State plan under this title is not required to provide medical assistance consisting of payment for any long-term care services for needy individuals with disabilities for which coverage is provided under a State plan under subtitle A of title I of the Comprehensive Long-Term Care Act of 1994.

''(b) DEFINITIONS.—In this section—

''(1) the term 'needy individual with a disability' means an individual with a disability (as defined in section 103(a) of the Comprehensive Long-Term Care Act of 1994) who is a needy individual (as defined in section 103(d) of such Act); and

''(2) the term 'long-term care services' has the meaning given such term in section 104(c) of the Comprehensive Long-Term Care Act of 1994.''.

(b) NO FEDERAL FINANCIAL PARTICIPATION.—Section 1903(i) of the Social Security Act (42 U.S.C. 1396b(i)) is amended—

(1) by striking ''or'' at the end of paragraph (14),

(2) by striking the period at the end of paragraph (15) and inserting ''; or'', and

(3) by inserting after paragraph (15) the following new paragraph:

''(16) with respect to long-term care services (as defined in section 1931(b)(2)) for needy individuals with disabilities (as defined in section 1931(b)(1)) for which coverage is provided under a State plan under subtitle A of title I of the Comprehensive Long-Term Care Act of 1994.''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply with respect to services furnished in a State on or after January 1, 1996.

TITLE II—TAX TREATMENT OF LONG-TERM CARE INSURANCE AND SERVICES

SEC. 201. AMENDMENT OF 1986 CODE.

Except as otherwise expressly provided, whenever in this title an amendment or repeal is expressed in terms of an amendment to, or repeal of, a section or other provision, the reference shall be considered to be made to a section or other provision of the Internal Revenue Code of 1986.

SEC. 202. QUALIFIED LONG-TERM CARE SERVICES TREATED AS MEDICAL CARE.

(a) GENERAL RULE.—Paragraph (1) of section 213(d) (defining medical care) is amended by striking ''or'' at the end of subparagraph (B), by redesignating subparagraph (C) as subparagraph (D), and by inserting after subparagraph (B) the following new subparagraph:

''(C) for qualified long-term care services (as defined in subsection (g)), or''.

(b) ADJUSTED GROSS INCOME THRESHOLD NOT TO APPLY TO AMOUNTS PAID FOR LONG-TERM CARE.—Subsection (a) of section 213 (relating to medical, dental, etc., expenses) is amended to read as follows:

''(a) ALLOWANCE OF DEDUCTION.—There shall be allowed as a deduction the following amounts, not compensated for by insurance or otherwise—

''(1) the amount by which the amount of the expenses paid during the taxable year (reduced by any amount deductible under paragraph (2)) for medical care of the taxpayer, his spouse, or a dependent exceeds 7.5 percent of adjusted gross income, and

''(2) the amounts paid during the taxable year for—

''(A) a qualified long-term care insurance policy which constitutes medical care for the taxpayer, his spouse, or a dependent, and

''(B) for qualified long-term care services for the taxpayer, his spouse, or a dependent.

For purposes of this subsection, the term 'dependent' has the meaning given such term by section 152.''

(c) QUALIFIED LONG-TERM CARE SERVICES DEFINED.—Section 213 (relating to the deduction for medical, dental, etc., expenses) is amended by adding at the end thereof the following new subsection:

''(g) QUALIFIED LONG-TERM CARE SERVICES.—For purposes of this section—

''(1) IN GENERAL.—The term 'qualified long-term care services' means necessary diagnostic, curing, mitigating, treating, preventive, therapeutic, and rehabilitative services, and maintenance and personal care services (whether performed in a residential or nonresidential setting) which—

''(A) are required by an individual during any period the individual is an incapacitated individual (as defined in paragraph (2)),

''(B) have as their primary purpose—

''(i) the provision of needed assistance with 1 or more activities of daily living (as defined in paragraph (3)), or

''(ii) protection from threats to health and safety due to severe cognitive impairment, and

''(C) are provided pursuant to a continuing plan of care prescribed by a licensed professional (as defined in paragraph (4)).

''(2) INCAPACITATED INDIVIDUAL.—The term 'incapacitated individual' means any individual who—

''(A) is unable to perform, without substantial assistance from another individual (including assistance involving cueing or substantial supervision), at least 2 activities of daily living selected under paragraph (3)(B), or

''(B) has severe cognitive impairment as defined by the Secretary in consultation with the Secretary of Health and Human Services.

Such term shall not include any individual otherwise meeting the requirements of the preceding sentence unless a licensed professional within the preceding 12-month period has certified that such individual meets such requirements.

''(3) ACTIVITIES OF DAILY LIVING.—

''(A) IN GENERAL.—Subject to subparagraph (B), each of the following is an activity of daily living:

''(i) Eating.

''(ii) Toileting.

''(iii) Transferring.

''(iv) Bathing.

''(v) Dressing.

''(vi) Continence.

''(B) SELECTION OF 5 ACTIVITIES OF DAILY LIVING.—The insurance company issuing a long-term care insurance policy shall select 5 of the 6 activities of daily living which shall be included within the policy.

''(4) LICENSED PROFESSIONAL.—The term 'licensed professional' means—

''(A) a physician or registered professional nurse, or

''(B) any other individual who meets such requirements as may be prescribed by the Secretary after consultation with the Secretary of Health and Human Services.

''(5) CERTAIN SERVICES NOT INCLUDED.—The term 'qualified long-term care services' shall not include any services provided to an individual—

''(A) by a relative (directly or through a partnership, corporation, or other entity) unless the relative is a licensed professional with respect to such services, or

''(B) by a corporation or partnership which is related (within the meaning of section 267(b) or 707(b)) to the individual.

For purposes of this paragraph, the term 'relative' means an individual bearing a relationship to the individual which is described in paragraphs (1) through (8) of section 152(a).''

(d) TECHNICAL AMENDMENTS.—

(1) Subparagraph (D) of section 213(d)(1) (as redesignated by subsection (a)) is amended to read as follows:

''(D) for insurance (including amounts paid as premiums under part B of title XVIII of the Social Security Act, relating to supplementary medical insurance for the aged) covering medical care referred to in—

''(i) subparagraphs (A) and (B), or

''(ii) subparagraph (C), but only if such insurance is provided under a qualified long-term care insurance policy (as defined in section 7702B(b)) and the amount paid for such insurance is not disallowed under section 7702B(d)(4).''

(2) Paragraph (6) of section 213(d) is amended—

(A) by striking ''subparagraphs (A) and (B)'' and inserting ''subparagraph (A), (B), and (C)'', and

(B) by striking ''paragraph (1)(C)'' in subparagraph (A) and inserting ''paragraph (1)(D)''.

(e) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 1995.

SEC. 203. TREATMENT OF LONG-TERM CARE INSURANCE.

(a) GENERAL RULE.—Chapter 79 (relating to definitions) is amended by inserting after section 7702A the following new section:

''SEC. 7702B. TREATMENT OF LONG-TERM CARE INSURANCE.

''(a) IN GENERAL.—For purposes of this title—

''(1) a qualified long-term care insurance policy (as defined in subsection (b)) shall be treated as an accident and health insurance contract,

''(2) amounts (other than policyholder dividends (as defined in section 808) or premium refunds) received under a qualified long-term care insurance policy shall be treated as amounts received for personal injuries and sickness and shall be treated as reimbursement for expenses actually incurred for medical care (as defined in section 213(d)),

''(3) any plan of an employer providing coverage under a qualified long-term care insurance policy shall be treated as an accident and health plan with respect to such coverage,

''(4) amounts paid for a qualified long-term care insurance policy providing the benefits described in subsection (b)(6)(B) shall be treated as payments made for insurance for purposes of section 213(d)(1)(D), and

''(5) a qualified long-term care insurance policy shall be treated as a guaranteed renewable contract subject to the rules of section 816(e).

''(b) QUALIFIED LONG-TERM CARE INSURANCE POLICY.—For purposes of this title—

''(1) IN GENERAL.—The term 'qualified long-term care insurance policy' means any long-term care insurance policy (as defined in section 302(9) of the Comprehensive Long-Term Care Reform Act of 1994) that—

''(A) satisfies the requirements of title III of such Act,

''(B) limits benefits under such policy to individuals who are certified by a licensed professional (as defined in section 213(g)(4)) within the preceding 12-month period as being unable to perform, without substantial assistance from another individual (including assistance involving cueing or substantial supervision), 2 or more activities of daily living (of those selected under section 213(g)(3)(B)), or who have a severe cognitive impairment (as defined in section 213(g)(2)(B)), and

''(C) satisfies the requirements of paragraphs (2), (3), (4), (5), and (6).

''(2) PREMIUM REQUIREMENTS.—The requirements of this paragraph are met with respect to a policy if such policy provides that premium payments may not be made earlier than the date such payments would have been made if the contract pro-

vided for level annual payments over the life expectancy of the insured. A policy shall not be treated as failing to meet the requirements of the preceding sentence solely by reason of a provision in the policy providing for a waiver of premiums if the insured becomes an individual certified in accordance with paragraph (1)(B).

''(3) PROHIBITION OF CASH VALUE.—The requirements of this paragraph are met if the policy does not provide for a cash value or other money that can be paid, assigned, pledged as collateral for a loan, or borrowed, other than as provided in paragraph (4).

''(4) REFUNDS OF PREMIUMS AND DIVIDENDS.—The requirements of this paragraph are met with respect to a policy if such policy provides that—

''(A) policyholder dividends are required to be applied as a reduction in future premiums or, to the extent permitted under paragraph (6), to increase benefits described in subsection (a)(2), and

''(B) refunds of premiums upon a partial surrender or a partial cancellation are required

to be applied as a reduction in future premiums, and

''(C) any refund on the death of the insured, or on a complete surrender or cancellation of the policy, cannot exceed the aggregate premiums paid under the contract.

Any refund on a complete surrender or cancellation of the policy shall be includible in gross income to the extent that any deduction or exclusion was allowable with respect to the premiums.

''(5) COORDINATION WITH OTHER ENTITLEMENTS.—The requirements of this paragraph are met with respect to a policy if such policy does not cover expenses incurred to the extent that such expenses are covered under the health coverage described in section 322 of the Comprehensive Long-Term Care Reform Act of 1994.

''(6) MAXIMUM BENEFIT.—

''(A) IN GENERAL.—The requirements of this paragraph are met if the benefits payable under the policy for any period (whether on a periodic basis or otherwise) shall not exceed the dollar amount in effect for such period.

''(B) NONREIMBURSEMENT PAYMENTS PERMITTED.—Benefits shall include all pay-

ments described in subsection (a)(2) to or on behalf of an insured individual without regard to the expenses incurred during the period to which the payments relate. For purposes of section 213(a), such payments shall be treated as compensation for expenses paid for medical care.

''(C) DOLLAR AMOUNT.—The dollar amount in effect under this paragraph shall be $150 per day (or the equivalent amount within the calendar year in the case of payments on other than a per diem basis).

''(D) ADJUSTMENTS FOR INCREASED COSTS.—

''(i) IN GENERAL.—In the case of any calendar year after 1996, the dollar amount in effect under subparagraph (C) for any period or portion thereof occurring during such calendar year shall be equal to the sum of—

''(I) the amount in effect under subparagraph (C) for the preceding calendar year (after application of this subparagraph), plus

''(II) the product of the amount referred to in subclause (I) multiplied by the cost-of-living adjustment for the calendar year of the amount under subclause (I).

''(ii) COST-OF-LIVING ADJUSTMENT.—For purposes of clause (i), the cost-of-living adjustment for any calendar year is the percentage (if any) by which the cost index under clause (iii) for the preceding calendar year exceeds such index for the second preceding calendar year.

''(iii) COST INDEX.—The Secretary, in consultation with the Secretary of Health and Human Services, shall before January 1, 1997, establish a cost index to measure increases in costs of nursing home and similar facilities. The Secretary may from time to time revise such index to the extent necessary to accurately measure increases or decreases in such costs.

''(iv) SPECIAL RULE FOR CALENDAR YEAR 1997.—Notwithstanding clause (ii), for purposes of clause (i), the cost-of-living adjustment for calendar year 1997 is the

sum of 1½ percent plus the percentage by which the CPI for calendar year 1996 (as defined in section 1(f)(4)) exceeds the CPI for calendar year 1995 (as so defined).

''(E) PERIOD.—For purposes of this paragraph, a period begins on the date that an individual has a condition which would qualify for certification under subsection (b)(1)(B) and ends on the earlier of the date upon which—

''(i) such individual has not been so certified within the preceding 12-months, or

''(ii) the individual's condition ceases to be such as to qualify for certification under subsection (b)(1)(B).

''(F) AGGREGATION RULE.—For purposes of this paragraph, all policies issued with respect to the same insured shall be treated as one policy.

''(c) TREATMENT OF LONG-TERM CARE INSURANCE POLICIES.—For purposes of this title, any amount received or coverage provided under a long-term care insurance policy that is not a qualified long-term care insurance policy shall not be treated as an amount received for personal injuries or sickness or provided under an accident

and health plan and shall not be treated as excludible from gross income under any provision of this title.

''(d) TREATMENT OF COVERAGE PROVIDED AS PART OF A LIFE INSURANCE CONTRACT.—Except as otherwise provided in regulations prescribed by the Secretary, in the case of any long-term care insurance coverage (whether or not qualified) provided by rider on a life insurance contract—

''(1) IN GENERAL.—This section shall apply as if the portion of the contract providing such coverage is a separate contract or policy.

''(2) PREMIUMS AND CHARGES FOR LONG-TERM CARE COVERAGE.—Premium payments for coverage under a long-term care insurance policy and charges against the life insurance contract's cash surrender value (within the meaning of section 7702(f)(2)(A)) for such coverage shall be treated as premiums for purposes of subsection (b)(2).

''(3) APPLICATION OF 7702.—Section 7702(c)(2) (relating to the guideline premium limitation) shall be applied by increasing the guideline premium limitation with respect to a life insurance contract, as of any date—

''(A) by the sum of any charges (but not premium payments) described in paragraph (2) made to that date under the contract, less

''(B) any such charges the imposition of which reduces the premiums paid for the contract (within the meaning of section 7702(f)(1)).

''(4) APPLICATION OF SECTION 213.—No deduction shall be allowed under section 213(a) for charges against the life insurance contract's cash surrender value described in paragraph (2), unless such charges are includible in income as a result of the application of section 72(e)(10) and the coverage provided by the rider is a qualified long-term care insurance policy under subsection (b).

For purposes of this subsection, the term 'portion' means only the terms and benefits under a life insurance contract that are in addition to the terms and benefits under the contract without regard to the coverage under a long-term care insurance policy.

''(e) PROHIBITION OF DISCRIMINATION.—

''(1) IN GENERAL.—Notwithstanding subsection (a)(3), any plan of an employer providing coverage under a qualified long-term care insurance policy

shall qualify as an accident and health plan with respect to such coverage only if—

''(A) the plan allows all employees, except as provided in paragraph (2), to participate, and

''(B) the benefits provided under the plan are identical for all employees that choose to participate.

''(2) EXCLUSION OF CERTAIN EMPLOYEES.—For purposes of paragraph (1), there may be excluded from consideration—

''(A) employees who have not completed 3 years of service;

''(B) employees who have not attained age 25;

''(C) part-time or seasonal employees; and

''(D) employees who are nonresident aliens and who receive no earned income (within the meaning of section 911(d)(2)) from the employer which constitutes income from sources within the United States (within the meaning of section 861(a)(3)).

''(f) REGULATIONS.—The Secretary shall prescribe such regulations as may be necessary to carry out the requirements of this section, including regulations to prevent

the avoidance of this section by providing long-term care insurance coverage under a life insurance contract and to provide for the proper allocation of amounts between the long-term care and life insurance portions of a contract.''.

(b) CLERICAL AMENDMENT.—The table of sections for chapter 79 is amended by inserting after the item relating to section 7702A the following new item:

''Sec. 7702B. Treatment of long-term care insurance.''.

(c) EFFECTIVE DATE.—

(1) IN GENERAL.—The amendments made by this section shall apply to policies issued after December 31, 1995. Solely for purposes of the preceding sentence, a policy issued prior to January 1, 1996, that satisfies the requirements of a qualified long-term care insurance policy as set forth in section 7702B(b) or the requirements of model laws and regulations of the National Association of Insurance Commissioners (relating to long-term care insurance policies) as of the date the policy was issued, shall, on and after January 1, 1996, be treated as being issued after December 31, 1995.

(2) TRANSITION RULE.—If, after the date of enactment of this Act and before January 1, 1996, a policy providing for long-term care insurance coverage is exchanged solely for a qualified long-term care insurance policy (as defined in section

7702B(b)), no gain or loss shall be recognized on the exchange. If, in addition to a qualified long-term care insurance policy, money or other property is received in the exchange, then any gain shall be recognized to the extent of the sum of the money and the fair market value of the other property received. For purposes of this paragraph, the cancellation of a policy providing for long-term care insurance coverage and reinvestment of the cancellation proceeds in a qualified long-term care insurance policy within 60 days thereafter shall be treated as an exchange.

(3) ISSUANCE OF CERTAIN RIDERS PERMITTED.—For purposes of determining whether section 7702 or 7702A of the Internal Revenue Code of 1986 applies to any contract, the issuance, whether before, on, or after December 31, 1995, of a rider on a life insurance contract providing long-term care insurance coverage shall not be treated as a modification or material change of such contract.

SEC. 204. TAX TREATMENT OF ACCELERATED DEATH BENEFITS UNDER LIFE INSURANCE CONTRACTS.

(a) GENERAL RULE.—Section 101 (relating to certain death benefits) is amended by adding at the end thereof the following new subsection:

''(g) TREATMENT OF CERTAIN ACCELERATED DEATH BENEFITS.—

''(1) IN GENERAL.—For purposes of this section, any amount distributed to an individual under a life insurance contract on the life of an insured who is a terminally ill individual (as defined in paragraph (3)) shall be treated as an amount paid by reason of the death of such insured.

''(2) NECESSARY CONDITIONS.—

''(A) Paragraph (1) shall not apply to any distribution unless—

''(i) the distribution is not less than the present value (determined under subparagraph (B)) of the reduction in the death benefit otherwise payable in the event of the death of the insured, and

''(ii) the percentage derived from dividing the cash surrender value of the contract, if any, immediately after the distribution by the cash surrender value of the contract immediately before the distribution is equal to or greater than the percentage derived by dividing the death benefit immediately after the distribution

by the death benefit immediately before the distribution.

''(B) The present value of the reduction in the death benefit occurring on the distribution must be determined by—

''(i) using as the discount rate a rate not to exceed the highest rate set forth in subparagraph (C), and

''(ii) assuming that the death benefit (or the portion thereof) would have been paid at the end of a period that is no more than the insured's life expectancy from the date of the distribution or 12 months, whichever is shorter.

''(C) RATES.—The rates set forth in this subparagraph are the following:

''(i) the 90-day Treasury bill yield,

''(ii) the rate described as Moody's Corporate Bond Yield Average-Monthly Average Corporates as published by Moody's Investors Service, Inc., or any successor thereto for the calendar month ending 2 months before the date on which the rate is determined,

''(iii) the rate used to compute the cash surrender values under the contract during the applicable period plus 1 percent per annum, and

''(iv) the maximum permissible interest rate applicable to policy loans under the contract.

''(3) TERMINALLY ILL INDIVIDUAL.—For purposes of this subsection, the term 'terminally ill individual' means an individual who the insurer has determined, after receipt of an acceptable certification by a licensed physician, has an illness or physical condition which can reasonably be expected to result in death within 12 months of the date of certification.

''(4) APPLICATION OF SECTION 72(e)(10).—For purposes of section 72(e)(10) (relating to the treatment of modified endowment contracts), section 72(e)(4)(A)(i) shall not apply to distributions described in paragraph (1).''

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

SEC. 205. TAX TREATMENT OF COMPANIES ISSUING QUALIFIED ACCELERATED DEATH BENEFIT RIDERS.

(a) QUALIFIED ACCELERATED DEATH BENEFIT RIDERS TREATED AS LIFE INSURANCE.—Section 818 (relating to other definitions and special rules) is amended by adding at the end thereof the following new subsection:

''(g) QUALIFIED ACCELERATED DEATH BENEFIT RIDERS TREATED AS LIFE INSURANCE.—For purposes of this part—

''(1) IN GENERAL.—Any reference to a life insurance contract shall be treated as including a reference to a qualified accelerated death benefit rider on such contract.

''(2) QUALIFIED ACCELERATED DEATH BENEFIT RIDERS.—For purposes of this subsection, the term 'qualified accelerated death benefit rider' means any rider on a life insurance contract which provides for a distribution to an individual upon the insured becoming a terminally ill individual (as defined in section 101(g)(3)).''

(b) DEFINITIONS OF LIFE INSURANCE AND MODIFIED ENDOWMENT CONTRACTS.—Paragraph (5)(A) of section 7702(f) is amended by striking ''or'' at the end of clause (iv), by redesignating clause (v) as clause (vi), and by inserting after clause (iv) the following new clause:

''(v) any qualified accelerated death benefit rider (as defined in section 818(g)), or''.

(c) EFFECTIVE DATE.—

(1) IN GENERAL.—The amendments made by this section shall apply to contracts issued after December 31, 1994.

(2) TRANSITIONAL RULE.—For purposes of determining whether section 7702 or 7702A of the Internal Revenue Code of 1986 applies to any contract, the issuance, whether before, on, or after December 31, 1994, of a rider on a life insurance contract permitting the acceleration of death benefits (as described in section 101(g) of such Code) shall not be treated as a modification or material change of such contract.

SEC. 206. EXCLUSION FROM GROSS INCOME FOR AMOUNTS WITHDRAWN FROM CERTAIN PLANS TO PAY QUALIFIED LONG-TERM CARE INSURANCE PREMIUMS.

(a) IN GENERAL.—Part III of subchapter B of chapter 1 of the Internal Revenue Code of 1986 (relating to items specifically excluded from gross income) is amended by redesignating section 137 as section 138 and by inserting after section 136 the following new section:

''SEC. 137. AMOUNTS WITHDRAWN FROM CERTAIN PLANS TO PAY QUALIFIED LONG-TERM CARE INSURANCE PREMIUMS.

''The gross income of an individual shall not include any distribution from an individual retirement plan, or from amounts attributable to employer contributions made pursuant to elective deferrals described in subparagraph (A) or (C) of section 402(g)(3) or section 501(c)(18)(D)(iii), if—

''(1) such individual has attained age 59½ before the date of such distribution, and

''(2) such distribution is used by such individual (before the close of the 60th day after the day on which such distribution is received) to pay premiums on any qualified long-term care insurance policy (as defined in section 7702B) covering such individual or the spouse of such individual.''

(b) CLERICAL AMENDMENT.—The table of sections for such part III is amended by striking the last item and inserting the following new items:

''Sec. 137. Amounts withdrawn from certain plans to pay qualified long-term care insurance premiums.
''Sec. 138. Cross references to other Acts.''

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to distributions after December 31, 1994, in taxable years ending after such date.

SEC. 207. NONRECOGNITION OF GAIN ON SALE OF PRINCIPAL RESIDENCE TO EXTENT PROCEEDS USED FOR ENTRANCE INTO CONTINUING CARE RETIREMENT COMMUNITY.

(a) IN GENERAL.—Section 1034 of the Internal Revenue Code of 1986 (relating to rollover of gain of sale of principal residence) is amended by redesignating subsection (l) as subsection (m) and by inserting after subsection (k) the following new subsection:

''(l) NONRECOGNITION OF GAIN IF NEW RESIDENCE IS QUALIFIED CONTINUING CARE RETIREMENT COMMUNITY.—

''(1) IN GENERAL.—Gross income shall not include gain from the sale of the principal residence of the taxpayer if—

''(A) the taxpayer attained age 55 before the date of such sale, and

''(B) within the 2-year period beginning on such date, the taxpayer has as his principal residence a qualified continuing care retirement community.

''(2) LIMITATION.—The amount excluded from gross income under paragraph (1) shall not exceed the amount paid by the taxpayer during such 2-year period to such retirement community as an entrance

fee in order for the taxpayer or his spouse (or both) to reside in such community.

''(3) RECAPTURE IN CERTAIN CASES.—If the taxpayer ceases to have as his principal residence (other than by reason of death) a qualified continuing care retirement community at any time during the 2-year period beginning on the date such community began being the taxpayer's principal residence, the amount excluded from gross income under paragraph (1) shall be included in the taxpayer's gross income (as long-term capital gain) for the taxable year in which such cessation occurs.

''(4) SPECIAL RULES FOR MARRIED INDIVIDUALS.—In the case of a husband and wife who file a joint return for the taxable year which includes the date of the sale of the old residence—

''(A) the age requirement of paragraph (1)(A) shall be treated as met if either spouse meets such requirement, and

''(B) paragraph (3) shall be applied by taking into account one-half of the gain with respect to each spouse if such spouses do not file a joint return for the taxable year in which the cessation referred to in paragraph (3) occurs.

''(5) QUALIFIED CONTINUING CARE RETIREMENT COMMUNITY.—For purposes of this subsection, the term 'qualified continuing care retirement community' has the meaning given such term by section 7872(g).''

(b) EFFECTIVE DATE.—The amendments made by this section shall apply to old residences sold after December 31, 1994.

TITLE III—LONG-TERM CARE INSURANCE REFORM

Subtitle A—General Provisions

SEC. 301. FEDERAL REGULATIONS; PRIOR APPLICATION OR CERTAIN REQUIREMENTS.

(a) IN GENERAL.—The Secretary, with the advice and assistance of the National Association of Insurance Commissioners, as appropriate, shall promulgate regulations as necessary to implement the provisions of this title, in accordance with the timetable specified in subsection (b).

(b) TIMETABLE FOR PUBLICATION OF REGULATIONS.—

(1) FEDERAL REGISTER NOTICE.—Within 120 days after the date of the enactment of this Act, the Secretary shall publish in the Federal Register a notice setting forth the projected timetable for promul-

gation of regulations required under this title. Such timetable shall indicate which regulations are proposed to be published by the end of the first, second, and third years after the date of the enactment of this Act.

(2) FINAL DEADLINE.—All regulations required under this title shall be published by the end of the third year after the date of the enactment of this Act.

(3) REVISION OF REGULATIONS.—The Secretary may periodically revise and update the regulations published under this title. However, any such revisions shall not become effective until States have been provided an adequate period of time in which to implement such revisions.

(4) CONGRESSIONAL DISAPPROVAL.—A regulation, or revision or update of a regulation, under this section shall take effect unless—

(A) the regulation, revision, or update is submitted to Congress, and

(B) a joint resolution or Act disapproving such regulation, revision, or update is enacted before the end of the 60-day period beginning on the date on which such regulation, revision, or update is submitted.

(c) PROVISIONS EFFECTIVE WITHOUT REGARD TO PROMULGATION OF REGULATIONS.—

(1) IN GENERAL.—Notwithstanding any other provision of this title, insurers shall be required, not later than 6 months after the enactment of this Act, regardless of whether final implementing regulations have been promulgated by the Secretary, to comply with the following provisions of this title:

(A) Section 321(c) (standard outline of coverage);

(B) Section 321(d) (reporting to State insurance commissioners);

(C) Section 322(b) (preexisting condition exclusions);

(D) Section 322(c) (limiting conditions on benefits);

(E) Section 322(d) (inflation protection);

(F) Section 324 (sales practices);

(G) Section 325 (continuation, renewal, replacement, conversion, and cancellation of policies); and

(H) Section 326 (payment of benefits).

(2) INTERIM REQUIREMENTS.—Before the effective date of applicable regulations promulgated by the Secretary implementing requirements of this title

as specified below, such requirements will be considered to be met—

(A) in the case of section 321(c) (requiring a standard outline of coverage), if the long-term care insurance policy meets the requirements of section 6.G.(2) of the NAIC Model Act and of section 24 of the NAIC Model Regulation;

(B) in the case of section 321(d) (requiring reporting to the State insurance commissioner), if the insurer meets the requirements of section 14 of the NAIC Model Regulation;

(C) in the case of section 322(c)(1) (general requirements concerning limiting conditions on benefits), if such policy meets the requirements of section 6.D. of the NAIC Model Act;

(D) in the case of section 322(c)(2) (limiting conditions on home health care or community-based services) if such policy meets the requirements of section 11 of the NAIC Model Regulations;

(E) in the case of section 322(d) (concerning inflation protection), if the insurer meets the requirements of section 12 of the NAIC Model Regulation;

(F) in the case of section 324(b) (concerning applications for the purchase of insurance), if the insurer meets the requirements of section 10 of the NAIC Model Regulation;

(G) in the case of section 324(g) (concerning sales through employers or membership organizations), if the insurer and the membership organization meet the requirements of section 21.C. of the NAIC Model Regulation;

(H) in the case of section 324(h) (concerning interstate sales of group policies), if the insurer and the policy meet the requirements of section 5 of the NAIC Model Act; and

(I) in the case of section 325(f) (concerning continuation, renewal, replacement, and conversion of policies), if the insurer and the policy meet the requirements of section 7 of the NAIC Model Regulation.

SEC. 302. DEFINITIONS.

For purposes of this title:

(1) ACTIVITY OF DAILY LIVING.—The term ''activity of daily living'' means any of the following: eating, toileting, dressing, bathing, transferring, and continence.

(2) ADULT DAY CARE.—The term ''adult day care'' means a program providing social and health-related services during the day to six or more adults with disabilities (or such smaller number as the Secretary may specify in regulations) in a community group setting outside the home.

(3) CERTIFICATE.—The term ''certificate'' means a document issued to an individual as evidence of such individual's coverage under a group insurance policy.

(4) CONTINUING CARE RETIREMENT COMMUNITY.—The term ''continuing care retirement community'' means a residential community operated by a private entity that enters into contractual agreements with residents under which such entity guarantees, in consideration for residents' purchase of or periodic payment for membership in the community, to provide for such residents' future long-term care needs.

(5) DESIGNATED REPRESENTATIVE.—The term ''designated representative'' means the person (if any) designated by an insured individual (or, if such individual is incapacitated, pursuant to an appropriate administrative or judicial procedure) to com-

municate with the insurer on behalf of such individual in the event of such individual's incapacitation.

(6) HOME HEALTH CARE.—The term ''home health care'' means medical and nonmedical services including such services as homemaker services, assistance with activities of daily living, and respite care provided to individuals in their residences.

(7) INSURED INDIVIDUAL.—The term ''insured individual'' means, with respect to a long-term care insurance policy, any individual who has coverage of benefits under such policy.

(8) INSURER.—The term ''insurer'' means any person that offers or sells an individual or group long-term care insurance policy under which such person is at risk for all or part of the cost of benefits under the policy, and includes any agent of such person.

(9) LONG-TERM CARE INSURANCE POLICY.—The term ''long-term care insurance policy'' has the meaning given that term in section 4 of the NAIC Model Act, except that the last sentence of such section shall not apply.

(10) NAIC.—The term ''NAIC'' means the National Association of Insurance Commissioners.

(11) NAIC MODEL ACT.—The term ''NAIC Model Act'' means the Long-Term Care Insurance Model Act published by the NAIC, as amended through January 1993.

(12) NAIC model regulation.—The term ''NAIC Model Regulation'' means the Long-Term Care Insurance Model Regulation published by the NAIC, as amended through January 1993.

(13) NURSING FACILITY.—The term ''nursing facility'' means a facility licensed by the State to provide to residents—

(A) skilled nursing care and related services for residents who require medical or nursing care;

(B) rehabilitation services for the rehabilitation of injured, disabled, or sick individuals, or

(C) on a regular basis, health-related care and services to individuals who because of their mental or physical condition require care and services (above the level of room and board) which can be made available to them only through institutional facilities.

(14) POLICYHOLDER.—The term ''policyholder'' means the entity which is the holder of record of a group long-term care insurance policy.

(15) RESIDENTIAL CARE FACILITY.—The term ''residential care facility'' means a facility (including a nursing facility) that—

(A) provides to residents medical or personal care services (including at a minimum assistance with activities of daily living) in a setting other than an individual or single-family home, and

(B) does not provide services of a higher level than can be provided by a nursing facility.

(16) RESPITE CARE.—The term ''respite care'' means the temporary provision of care (including assistance with activities of daily living) to an individual, in the individual's home or another setting in the community, for the purpose of affording such individual's unpaid caregiver a respite from the responsibilities of such care.

(17) STATE INSURANCE COMMISSIONER.—The term ''State insurance commissioner'' means the State official bearing such title, or, in the case of a jurisdiction where such title is not used, the State

official with primary responsibility for the regulation of insurance.

Subtitle B—Federal Standards and Requirements

SEC. 321. REQUIREMENTS TO FACILITATE UNDERSTANDING AND COMPARISON OF BENEFITS.

(a) IN GENERAL.—The Secretary, after considering (where appropriate) recommendations of the NAIC, shall promulgate regulations designed to standardize formats and terminology used in long-term care insurance policies, to require insurers to provide to customers and beneficiaries information on the range of public and private long-term care coverage available, and to establish such other requirements as may be appropriate to promote consumer understanding and facilitate comparison of benefits, which shall include at a minimum the requirements specified in this section.

(b) UNIFORM TERMS, DEFINITIONS, AND FORMATS.—Insurers shall be required to use, in long-term care insurance policies, uniform terminology, definitions of terms, and formats, in accordance with regulations promulgated by the Secretary, after considering recommendations of the NAIC.

(c) STANDARD OUTLINE OF COVERAGE.—

(1) IN GENERAL.—Insurers shall be required to develop for each long-term care insurance policy offered or sold, to include as a part of each such policy, and to make available to each potential purchaser and furnish to each insured individual and policyholder, an outline of coverage under such policy that—

(A) includes the elements specified in paragraph (2),

(B) is in a uniform format (as prescribed by the Secretary on the basis of recommendations by the NAIC),

(C) accurately and clearly reflects the contents of the policy, and

(D) is updated periodically on such timetable as may be required by the Secretary (or more frequently as necessary to reflect significant changes in outlined information).

(2) CONTENTS OF OUTLINE.—The outline of coverage for each long-term care insurance policy shall include at least the following:

(A) BENEFITS.—A description of—

(i) the principal benefits covered, including the extent of—

(I) benefits for services furnished in residential care facilities, and

(II) other benefits,

(ii) the principal exclusions from and limitations on coverage,

(iii) the terms and conditions, if any, upon which the insured individual may obtain upgraded benefits, and

(iv) the threshold conditions for entitlement to receive benefits.

(B) CONTINUATION, RENEWAL, AND CONVERSION.—A statement of the terms under which a policy may be—

(i) returned (and premium refunded) during an initial examination period,

(ii) continued in force or renewed,

(iii) converted to an individual policy (in the case of coverage under a group policy),

(C) CANCELLATION.—A statement of the circumstances in which a policy may be terminated, and the refund or nonforfeitures benefits (if any) applicable in each such circumstance, including—

(i) death of the insured individual,

(ii) nonpayment of premiums,

(iii) election by the insured individual not to renew,

(iv) any other circumstance.

(D) PREMIUM.—A statement of—

(i) the total annual premium,

(ii) any reservation by the insurer of a right to change premiums,

(iii) any expected premium increases associated with automatic or optional benefit increases (including inflation protection), and

(iv) any circumstances under which payment of premium is waived.

(E) DECLARATION CONCERNING SUMMARY.—A statement, in bold face type on the face of the document in language understandable to the average individual, that the outline of coverage is a summary only, not a contract of insurance, and that the policy contains the contractual provisions that govern.

(F) COST/VALUE COMPARISON.—

(i) A comparison of benefits, over a period of at least 20 years, for policies with and without inflation protection.

(ii) A declaration as to whether the amount of benefits will increase over time, and, if so, a statement of the type and amount of, any limitations on, and any premium increases for, such benefit increases.

(G) TAX TREATMENT.—A statement of the Federal income tax treatment of premiums and benefits under the policy, as determined by the Secretary of the Treasury.

(H) OTHER.—Such other information as the Secretary may require.

(d) REPORTING TO STATE INSURANCE COMMISSIONER.—Each insurer shall be required to report at least annually, to the State insurance commissioner of each State in which any long-term care insurance policy of the insurer is sold, such information, in such format, as the Secretary may specify with respect to each such policy, including—

(1) the standard outline of coverage required pursuant to subsection (c);

(2) lapse rates and replacement rates for such policies (including, by percentage, the reasons for the lapse);

(3) the ratio of premiums collected to benefits paid;

(4) reserves;

(5) written materials used in sale or promotion of such policy; and

(6) any other information the Secretary may require.

SEC. 322. REQUIREMENTS RELATING TO COVERAGE.

(a) IN GENERAL.—The Secretary, after considering (where appropriate) recommendations of the NAIC, shall promulgate regulations establishing requirements with respect to the terms of and benefits under long-term care insurance policies, which shall include at a minimum the requirements specified in this section.

(b) LIMITATIONS ON PREEXISTING CONDITION EXCLUSIONS.—

(1) INITIAL POLICIES.—A long-term care insurance policy may not exclude or limit coverage for any service or benefit, the need for which is the result of a medical condition or disability because an insured individual received medical treatment for, or was diagnosed as having, such condition before the issuance of the policy, unless—

(A) the insurer, prior to issuance of the policy, determines and documents (with evi-

dence including written evidence that such condition has been treated or diagnosed by a qualified health care professional) that the insured individual had such condition during the 6-month period (or such longer period as the Secretary may specify) ending on the effective date of the policy; and

(B) the need or such service or benefit begins within 6 months (or such longer period as the Secretary may specify) following the effective date of the policy.

(2) REPLACEMENT POLICIES.—Solely for purposes of the requirements of paragraph (1), with respect to an insured individual, the effective date of a long-term care insurance policy issued to replace a previous policy, with respect to benefits which are the same as or substantially equivalent to benefits under such previous policy, shall be considered to be the effective date of such previous policy with respect to such individual.

(c) LIMITING CONDITIONS ON BENEFITS.—

(1) IN GENERAL.—A long-term care insurance policy may not—

(A) condition eligibility for benefits for a type of service on the need for or receipt of any

other type of service (such as prior hospitalization or institutionalization, or a higher level of care than the care for which benefits are covered);

(B) condition eligibility for any benefit (where the need for such benefit has been established by an independent assessment of impairment) on any particular medical diagnosis (including any acute condition) or on one of a group of diagnoses;

(C) condition eligibility for benefits furnished by licensed or certified providers on compliance by such providers with conditions not required under Federal or State law; or

(D) condition coverage of any service on provision of such service by a provider, or in a setting, providing a higher level of care than that required by an insured individual.

(2) HOME CARE OR COMMUNITY-BASED SERVICES.—A long-term care insurance policy that provides benefits for any home care or community-based services—

(A) may not limit such benefits to services provided by registered nurses or licensed practical nurses;

(B) may not limit such benefits to services furnished by persons or entities participating in programs under titles XVIII and XIX of the Social Security Act and in part 1 of this title; and

(C) must provide, at a minimum, benefits for personal assistance with activities of daily living, home health care, adult day care, and respite care.

(3) NURSING FACILITY SERVICES.—A long-term care insurance policy that provides benefits for any nursing facility services—

(A) must provide benefits for such services provided by all types of nursing facilities licensed by the State, and

(B) may provide benefits for care in other residential facilities.

(4) PROHIBITION OF DISCRIMINATION BY DIAGNOSIS.—A long-term care insurance policy may not provide for treatment of any of the following medical conditions different from the treatment of any other medical condition for purposes of determining whether threshold conditions for the receipt of benefits have been met, or the amount of benefits under the policy:

(A) Alzheimer's disease or any other progressive degenerative dementia of an organic origin.

(B) Any organic or inorganic mental illness.

(C) Mental retardation or any other cognitive or mental impairment.

(D) HIV infection or AIDS.

(d) INFLATION PROTECTION.—

(1) REQUIREMENT TO OFFER.—An insurer offering for sale any long-term care insurance policy shall be required to afford the purchaser the option to obtain coverage under such policy (upon payment of increased premiums) of annual increases in benefits at rates in accordance with paragraph (2).

(2) RATE INCREASE IN BENEFITS.—For purposes of paragraph (1), the benefits under a policy for each year shall be increased by a percentage of the full value of benefits under the policy for the previous year, which shall be not less than 5 percent of such value.

(3) REQUIREMENT OF WRITTEN REJECTION.—Inflation protection in accordance with paragraph (1) may be excluded from the coverage under a policy only if the insured individual (or, if different, the

person responsible for payment of premiums) has rejected in writing the option to obtain such coverage.

SEC. 323. REQUIREMENTS RELATING TO PREMIUMS.

(a) IN GENERAL.—The Secretary, after considering (where appropriate) recommendations of the NAIC, shall promulgate regulations establishing requirements applicable to premiums for long-term care insurance policies, which shall include at a minimum the requirements specified in this section.

(b) LIMITATIONS ON RATES AND INCREASES.—The Secretary, after considering recommendations of the NAIC, may establish by regulation such standards and requirements as may be determined appropriate with respect to—

(1) mandatory or optional State procedures for review and approval of premium rates and rate increases or decreases; and

(2) the factors to be taken into consideration by an insurer in proposing, and by a State in approving or disapproving, premium rates and increases.

SEC. 324. REQUIREMENTS RELATING TO SALES PRACTICES.

(a) IN GENERAL.—The Secretary, after considering (where appropriate) recommendations of the NAIC, shall promulgate regulations establishing requirements applicable to the sale or offering for sale of long-term care insur-

ance policies, which shall include at a minimum the requirements specified in this section.

(b) APPLICATIONS.—Any insurer that offers any long-term care insurance policy (including any group policy) shall be required to meet such requirements with respect to the content, format, and use of application forms for long-term care insurance as the Secretary may require by regulation.

(c) AGENT TRAINING AND CERTIFICATION.—An insurer may not sell or offer for sale a long-term care insurance policy through an agent who does not comply with minimum standards with respect to training and certification established by the Secretary after consideration of recommendations by the NAIC.

(d) PROHIBITED SALES PRACTICES.—The following practices by insurers shall be prohibited with respect to the sale or offer for sale of long-term care insurance policies:

(1) FALSE AND MISLEADING REPRESENTATIONS.—Making any statement or representation—

(A) which the insurer knows or should know is false or misleading (including the inaccurate, incomplete, or misleading comparison of long-term care insurance policies or insurers), and

(B) which is intended, or would be likely, to induce any person to purchase, retain, terminate, forfeit, permit to lapse, pledge, assign, borrow against, convert, or effect a change with respect to, any long-term care insurance policy.

(2) INACCURATE COMPLETION OF MEDICAL HISTORY.—Making or causing to be made (by any means including failure to inquire about or to record information relating to preexisting conditions) statements or omissions, in records detailing the medical history of an applicant for insurance, which the insurer knows or should know render such records false, incomplete, or misleading in any way material to such applicant's eligibility for or coverage under a long-term care insurance policy.

(3) UNDUE PRESSURE.—Employing force, fright, threat, or other undue pressure, whether explicit or implicit, which is intended, or would be likely, to induce the purchase of a long-term care insurance policy.

(4) COLD LEAD ADVERTISING.—Using, directly or indirectly, any method of contacting consumers (including any method designed to induce consumers to contact the insurer or agent) for the purpose of inducing the purchase of long-term care insurance

(regardless of whether such purpose is the sole or primary purpose of the contact) without conspicuously disclosing such purpose.

(e) PROHIBITION ON SALE OF DUPLICATE BENEFITS.—An insurer or agent may not sell or issue to an individual a long-term care insurance policy that the insurer or agent knows or should know provides for coverage that duplicates coverage already provided in another long-term care insurance policy held by such individual (unless the policy is intended to replace such other policy.

(f) SALES THROUGH EMPLOYERS OR MEMBERSHIP ORGANIZATIONS.—

(1) REQUIREMENTS CONCERNING SUCH ARRANGEMENTS.—In any case where an employer, organization, association, or other entity (referred to as a ''membership entity'') endorses a long-term care insurance policy to, or such policy is marketed or sold through such membership entity to, employees, members, or other individuals affiliated with such membership entity, the insurer offering such policy shall not permit its marketing or sale through such entity unless the requirements of this subsection are met.

(2) DISCLOSURE AND INFORMATION REQUIREMENTS.—A membership entity that endorses a long-

term care insurance policy, or through which such policy is sold, to individuals affiliated with such entity, shall—

(A) disclose prominently, in a form and manner designed to ensure that each such individual who receives information concerning any such policy through such entity is aware of and understands such disclosure—

(i) the manner in which the insurer and policy were selected;

(ii) the extent (if any) to which a person independent of the insurer with expertise in long-term care insurance analyzed the advantages and disadvantages of such policy from the standpoint of such individuals (including such matters as the merits of the policy compared to other available benefit packages, and the financial stability of the insurer), and the results of any such analysis;

(iii) any organizational or financial ties between the entity (or a related entity) and the insurer (or a related entity);

(iv) the nature of compensation arrangements (if any) and the amount of

compensation (including all fees, commissions, and other forms of financial support) for the endorsement or sale of such policy (which amount may be stated as a percental of the total annual premiums earned); and

(B) make available to such individuals, either directly or through referrals, appropriate counseling to assist such individuals to make educated and informed decisions concerning the purchase of such policies.

SEC. 325. CONTINUATION, RENEWAL, REPLACEMENT, CONVERSION, AND CANCELLATION OF POLICIES.

(a) IN GENERAL.—The Secretary, after considering (where appropriate) recommendations of the NAIC, shall promulgate regulations establishing requirements applicable to the renewal, replacement, conversion, and cancellation of long-term care insurance policies, which shall include at a minimum the requirements specified in this section.

(b) INSURED'S RIGHT TO CANCEL DURING EXAMINATION PERIOD.—Each individual insured (or, if different, each individual liable for payment of premiums) under a long-term care insurance policy shall have the unconditional right to return the policy within 30 days after

the date of its issuance and delivery, and to obtain a full refund of any premium paid.

(c) INSURER'S RIGHT TO CANCEL (OR DENY BENEFITS) BASED ON FRAUD OR NONDISCLOSURE.—An insurer shall have the right to cancel a long-term care insurance policy, or to refuse to pay a claim for benefits, based on evidence that the insured falsely represented or failed to disclose information material to the determination of eligibility to purchase such insurance, but only if—

(1) the insurer presents written documentation, developed at the time the insured applied for such insurance, of the insurer's request for the information thus withheld or misrepresented, and the insured individual's response to such request;

(2) the insurer presents medical records or other evidence showing that the insured individual knew or should have known that such response was false, incomplete, or misleading;

(3) notice of cancellation is furnished to the insured individual before the date 3 years after the effective date of the policy (or such earlier date as the Secretary may specify in regulations); and

(4) the insured individual is afforded the opportunity to review and refute the evidence presented by the insurer pursuant to paragraphs (1) and (2).

(d) INSURER'S RIGHT TO CANCEL FOR NONPAYMENT OF PREMIUMS.—

(1) IN GENERAL.—Insurers shall have the right to cancel long-term care insurance policies for nonpayment of premiums, subject to the provisions of this subsection and subsection (e) (relating to nonforfeiture).

(2) NOTICE AND ACKNOWLEDGEMENT.—

(A) IN GENERAL.—The insurer may not cancel coverage of an insured individual until—

(i) the insurer, not earlier than the date when such payment is 30 days past due, has given written notice to the insured individual (by registered letter or the equivalent) of such intent, and

(ii) 30 days have elapsed since the insurer obtained written acknowledgment of receipt of such notice from the insured individual (or the designated representative, at the insured individual's option or in the case of an insured individual determined to be incapacitated in accordance with paragraph (4)).

(B) ADDITIONAL REQUIREMENT FOR GROUP POLICIES.—In the case of a group long-

term care insurance policy, the notice and acknowledgement requirements of subparagraph (A) apply with respect to the policyholder and to each insured individual.

(3) REINSTATEMENT OF COVERAGE OF INCAPACITATED INDIVIDUALS.—In any case where the coverage of an individual under a long-term care insurance policy has been canceled pursuant to paragraph (2), the insurer shall be required to reinstate full coverage of such individual under such policy, retroactive to the effective date of cancellation, if the insurer receives from such individual (or the designated representative of such individual), within 5 months after such date—

(A) evidence of a determination of such individual's incapacitation in accordance with paragraph (4) (whether made before or after such date), and

(B) payment of all premiums due and past due, and all charges for late payment.

(4) DETERMINATION OF INCAPACITATION.—For purposes of this subsection, the term ''determination of incapacitation'' means a determination by a qualified health professional (in accordance with such requirements as the Secretary may specify), that an

insured individual has suffered a cognitive impairment which could reasonably be expected to render the individual permanently unable to deal with business or financial matters. The standard used to make such determination shall not be more stringent than the threshold conditions for the receipt of covered benefits.

(5) DESIGNATION OF REPRESENTATIVE.—The insurer shall be required to notify the insured individual, at the time of sale or issuance of a long-term care insurance policy, of the individual's right to designate a representative for purposes of communication with the insurer concerning premium payments in the event the insured individual cannot be located or is incapacitated.

(e) NONFORFEITURE.—

(1) IN GENERAL.—The Secretary, after consideration of recommendations by the NAIC, shall by regulation require appropriate nonforfeiture benefits to be offered with respect to each long-term care insurance policy that lapses for any reason (including nonpayment of premiums, cancellation, or failure to renew, but excluding lapses due to death) after remaining in effect beyond a specified minimum period.

(2) NONFORFEITURE BENEFITS.—The standards established under this subsection shall require that the amount or percentage of any such nonforfeiture benefits shall increase proportionally with the amount of premiums paid by a policyholder, but shall not be required to exceed the asset share remaining in the policy.

(f) CONTINUATION, RENEWAL, REPLACEMENT, AND CONVERSION OF POLICIES.—

(1) IN GENERAL.—Insurers shall not be permitted to cancel, or refuse to renew (or replace with a substantial equivalent), any long-term care insurance policy for any reason other than for fraud or material misrepresentation (as provided in subsection (c)) or for nonpayment of premium (as provided in subsection (d)).

(2) DURATION AND RENEWAL OF POLICIES.—Each long-term care insurance policy shall contain a provision that clearly states—

(A) the duration of the policy,

(B) the right of the insured individual (or policyholder) to renewal (or to replacement with a substantial equivalent),

(C) the date by which, and the manner in which, the option to renew must be exercised, and

(D) any applicable restrictions or limitations (which may not be inconsistent with the requirements of this title).

(3) REPLACEMENT OF POLICIES.—

(A) IN GENERAL.—Except as provided in subparagraph (B), an insurer shall not be permitted to sell any long-term care insurance policy as a replacement for another such policy unless coverage under such replacement policy is available to an individual insured for benefits covered under the previous policy to the same extent as under such previous policy (including every individual insured under a group policy) on the date of termination of such previous policy, without exclusions or limitations that did not apply under such previous policy.

(B) INSURED'S OPTION TO REDUCE COVERAGE.—In any case where an insured individual covered under a long-term care insurance policy knowingly and voluntarily elects to substitute for such policy a policy that provides less

coverage, substitute policy shall be considered a replacement policy for purposes of this title.

(3) CONTINUATION AND CONVERSION RIGHTS WITH RESPECT TO GROUP POLICIES.—

(A) IN GENERAL.—Insurers shall be required to include in each group long-term care insurance policy, a provision affording to each insured individual, when such policy would otherwise terminate, the opportunity (at the insurer's option, subject to approval of the State insurance commissioner) either to continue or to convert coverage under such policy in accordance with this paragraph.

(B) RIGHTS OF RELATED INDIVIDUALS.—In the case of any insured individual whose eligibility for coverage under a group policy is based on relationship to another individual, the insurer shall be required to continue such coverage upon termination of the relationship due to divorce or death.

(C) CONTINUATION OF COVERAGE.—A group policy shall be considered to meet the requirements of this paragraph with respect to rights of an insured individual to continuation of coverage if coverage of the same (or substan-

tially equivalent) benefits for such individual under such policy is maintained, subject only to timely payment of premiums.

(D) CONVERSION OF COVERAGE.—A group policy shall be considered to meet the requirements of this paragraph with respect to conversion if it entitles each individual who has been continuously covered under the policy for at least 6 months before the date of the termination to issuance of a replacement policy providing benefits identical to, substantially equivalent to, or in excess of, the benefits under such terminated group policy—

(i) without requiring evidence of insurability with respect to benefits covered under such previous policy, and

(ii) at premium rates no higher than would apply if the insured individual had initially obtained coverage under such replacement policy on the date such insured individual initially obtained coverage under such group policy.

(4) TREATMENT OF SUBSTANTIAL EQUIVALENCE.—

(A) UNDER SECRETARY'S GUIDELINES.—The Secretary, after considering recommendations by the NAIC, shall develop guidelines for comparing long-term care insurance policies for the purpose of determining whether benefits under such policies are substantially equivalent.

(B) BEFORE EFFECTIVE DATE OF SECRETARY'S GUIDELINES.—During the period prior to the effective date of guidelines published by the Secretary under this paragraph, insurers shall comply with standards for determinations of substantial equivalence established by State insurance commissioners.

(5) ADDITIONAL REQUIREMENTS.—Insurers shall comply with such other requirements relating to continuation, renewal, replacement, and conversion of long-term care insurance policies as the Secretary may establish.

SEC. 326. REQUIREMENTS RELATING TO PAYMENT OF BENEFITS.

(a) IN GENERAL.—The Secretary, after considering (where appropriate) recommendations of the NAIC, shall promulgate regulations establishing requirements with respect to claims for and payment of benefits under long-

term care insurance policies, which shall include at a minimum the requirements specified in this section.

(b) STANDARDS RELATING TO THRESHOLD CONDITIONS FOR RECEIPT OF COVERED BENEFITS.—Each long-term care insurance policy shall meet the following requirements with respect to identification of, and determination of whether an insured individual meets, the threshold conditions for receipt of benefits covered under such policy:

(1) DECLARATION OF THRESHOLD CONDITIONS.—

(A) IN GENERAL.—The policy shall specify the level (or levels) of functional or cognitive mental impairment (or combination of impairments) required as a threshold condition of entitlement to receive benefits under the policy (which threshold condition or conditions shall be consistent with any regulations promulgated by the Secretary pursuant to subsection (B)).

(B) SECRETARIAL RESPONSIBILITY.—The Secretary (after considering the views of the NAIC on current practices of insurers concerning, and the appropriateness of standardizing, threshold conditions) may promulgate such regulations as the Secretary finds appropriate es-

tablishing standardized thresholds to be used under such policies as preconditions for varying levels of benefits.

(2) INDEPENDENT PROFESSIONAL ASSESSMENT.—The policy shall provide for a procedure for determining whether the threshold conditions specified under paragraph (1) have been met with respect to an insured individual which—

(A) applies such uniform assessment standards, procedures, and formats as the Secretary may specify, after consideration of recommendations by the NAIC;

(B) permits an initial evaluation (or, if the initial evaluation was performed by a qualified independent assessor selected by the insurer, a reevaluation) to be made by a qualified independent assessor selected by the insured individual (or designated representative) as to whether the threshold conditions for receipt of benefits have been met;

(C) permits the insurer the option to obtain a reevaluation by a qualified independent assessor selected and reimbursed by the insurer;

(D) provides that the insurer will consider that the threshold conditions have been met in any case where—

(i) the assessment under subparagraph (B) concluded that such conditions had been met, and the insurer declined the option under subparagraph (C), or

(ii) assessments under both subparagraphs (B) and (C) concluded that such conditions had been met; and

(E) provides for final resolution of the question by a State agency or other impartial third party in any case where assessments under subparagraphs (B) and (C) reach inconsistent conclusions.

(3) QUALIFIED INDEPENDENT ASSESSOR.—For purposes of paragraph (2), the term ''qualified independent assessor'' means a licensed or certified professional, as appropriate, who—

(A) meets such standards with respect to professional qualifications as may be established by the Secretary, after consulting with the Secretary of the Treasury, and

(B) has no significant or controlling financial interest in, is not an employee of, and does

not derive more than 5 percent of gross income from, the insurer (or any provider of services for which benefits are available under the policy and in which the insurer has a significant or controlling financial interest).

(c) REQUIREMENTS RELATING TO CLAIMS FOR BENEFITS.—Insurers shall be required—

(1) to promptly pay or deny claims for benefits submitted by (or on behalf of) insured individuals who have been determined pursuant to subsection (b) to meet the threshold conditions for payment of benefits;

(2) to provide an explanation in writing of the reasons for payment, partial payment, or denial of each such claim; and

(3) to provide an administrative procedure under which an insured individual may appeal the denial of any claim.

Subtitle C—Enforcement

SEC. 341. STATE PROGRAMS FOR ENFORCEMENT OF STANDARDS.

(a) REQUIREMENT FOR STATE PROGRAMS IMPLEMENTING FEDERAL STANDARDS.—In order for a State to be eligible for grants under this subtitle, the State must have in effect a program (including such laws and proce-

dures as may be necessary) for the regulation of long-term care insurance which the Secretary has determined—

(1) includes the elements required under this title, and

(2) is designed to ensure the compliance of long-term care insurance policies sold in the State, and insurers offering such policies and their agents, with the requirements established pursuant to subtitle B.

(b) ACTIVITIES UNDER STATE PROGRAM.—A State program approved under this subtitle shall provide for the following procedures and activities:

(1) MONITORING OF INSURERS AND POLICIES.—Procedures for ongoing monitoring of the compliance of insurers doing business in the State, and of long-term care insurance policies sold in the State, with requirements under this subtitle, including at least the following:

(A) POLICY REVIEW AND CERTIFICATION.—A program for review and certification (and annual recertification) of each such policy sold in the State.

(B) REPORTING BY INSURERS.—Requirements of annual reporting by insurers selling or servicing long-term care insurance policies in

the State, in such form and containing such information as the State may require to determine whether the insurer (and policies) are in compliance with requirements under this subtitle.

(C) DATA COLLECTION.—Procedures for collection, from insurers, service providers, insured individuals, and others, of information required by the State for purposes of carrying out its responsibilities under this subtitle (including authority to compel compliance of insurers with requests for such information).

(D) MARKETING OVERSIGHT.—Procedures for monitoring (through sampling or other appropriate procedures) the sales practices of insurers and agents, including review of marketing literature.

(E) OVERSIGHT OF ADMINISTRATION OF BENEFITS.—Procedures for monitoring (through sampling or other appropriate procedures) insurers' administration of benefits, including monitoring of—

(i) determinations of insured individuals' eligibility to receive benefits, and

(ii) disposition of claims for payment.

(2) CONSUMER COMPLAINTS AND DISPUTE RESOLUTION.—Administrative procedures for the investigation and resolution of complaints by consumers, and disputes between consumers and insurers, with respect to long-term care insurance, including—

(A) procedures for the filing, investigation, and adjudication of consumer complaints with respect to the compliance of insurers and policies with requirements under this subtitle, or other requirements under State law; and

(B) procedures for resolution of disputes between insured individuals and insurers concerning eligibility for, or the amount of, benefits payable under such policies, and other issues with respect to the rights and responsibilities of insurers and insured individuals under such policies.

(3) TECHNICAL ASSISTANCE TO INSURERS.—Provision of technical assistance to insurers to help them to understand and comply with the requirements of this subtitle, and other State laws, concerning long-term care insurance policies and business practices.

(c) STATE ENFORCEMENT AUTHORITIES.—A State program meeting the requirements of this subtitle shall

ensure that the State insurance commissioner (or other appropriate official or agency) has the following authority with respect to long-term care insurers and policies:

(1) PROHIBITION OF SALE.—Authority to prohibit the sale, or offering for sale, of any long-term care insurance policy that fails to comply with all applicable requirements under this subtitle.

(2) PLANS OF CORRECTION.—Authority, in cases where the business practices of an insurer are determined not to comply with requirements under this subtitle, to require the insurer to develop, submit for State approval, and implement a plan of correction which must be fulfilled within the shortest period possible (not to exceed a year) as a condition of continuing to do business in the State.

(3) CORRECTIVE ACTION ORDERS.—Authority, in cases where an insurer is determined to have failed to comply with requirements of this subtitle, or with the terms of a policy, with respect to a consumer or insured individual, to direct the insurer (subject to appropriate due process) to eliminate such noncompliance within 30 days.

(4) CIVIL MONEY PENALTIES.—Authority to assess civil money penalties, in amounts for each viola-

tive act up to the greater of $10,000 or three times the amount of any commission involved—

(A) for violations of subsections (d) (concerning prohibited sales practices) and (e) (prohibition on sale of duplicate benefits) of section 324,

(B) for such other violative acts as the Secretary may specify in regulations, and

(C) in such other cases as the State finds appropriate.

(5) OTHER AUTHORITIES.—Such other authorities as the State finds necessary or appropriate to enforce requirements under this subtitle.

(d) RECORDS, REPORTS, AND AUDITS.—As a condition of approval of its program under this subtitle, a State must agree to maintain such records, make such reports (including expenditure reports), and cooperate with such audits, as the Secretary finds necessary to determine the compliance of such State program (and insurers and policies regulated under such program) with the requirements of this subtitle.

(e) SECRETARIAL RESPONSIBILITY FOR APPROVAL OF STATE PROGRAMS.—The Secretary shall approve a State program meeting the requirements of this subtitle.

SEC. 342. AUTHORIZATION OF APPROPRIATIONS FOR STATE PROGRAMS.

There are authorized to be appropriated $10,000,000 for fiscal year 1996, $10,000,000 for fiscal year 1997, $7,500,000 for fiscal year 1998, and $5,000,000 for fiscal year 1999 and each succeeding fiscal year, for grants to States with programs meeting the requirements of this subtitle, to remain available until expended.

SEC. 343. ALLOTMENTS TO STATES.

The allotment for any fiscal year to a State with a program approved under this subtitle shall be an amount determined by the Secretary, taking into account the numbers of long-term care insurance policies sold, and of elderly individuals residing, in the State, and such other factors as the Secretary finds appropriate.

SEC. 344. PAYMENTS TO STATES.

(a) IN GENERAL.—Each State with a program approved under this subtitle shall be entitled to payment under this subtitle for each fiscal year in an amount equal to its allotment for such fiscal year, for expenditure by such State for up to 50 percent of the cost of activities under such program.

(b) STATE SHARE OF PROGRAM EXPENDITURES.—No Federal funds from any source may be used as any part of the non-Federal share of expenditures under the State program under this subtitle.

(c) TRANSFER AND DEPOSIT REQUIREMENTS.—The Secretary shall make payments under this section in accordance with section 6503 of title 31, United States Code.

SEC. 345. FEDERAL OVERSIGHT OF STATE ENFORCEMENT.

(a) IN GENERAL.—The Secretary shall periodically review State regulatory programs approved under section 341 to determine whether they continue to comply with the requirements of this subtitle.

(b) NOTICE OF DETERMINATION OF NONCOMPLIANCE.—The Secretary shall promptly notify the State of a determination that a State program fails to comply with this subtitle, specifying the requirement or requirements not met and the elements of the State program requiring correction.

(c) OPPORTUNITY FOR CORRECTION.—

(1) IN GENERAL.—The Secretary shall afford a State notified of noncompliance pursuant to subsection (b) a reasonable opportunity to eliminate such noncompliance.

(2) CORRECTION PLANS.—In a case where substantial corrections are needed to eliminate noncompliance of a State program, the Secretary may—

(A) permit the State a reasonable time after the date of the notice pursuant to sub-

section (b) to develop and obtain the Secretary's approval of a correction plan, and

(B) permit the State a reasonable time after the date of approval of such plan to eliminate the noncompliance.

(d) WITHDRAWAL OF PROGRAM APPROVAL.—In the case of a State that fails to eliminate noncompliance with requirements under this subtitle by the date specified by the Secretary pursuant to subsection (c), the Secretary shall withdraw the approval of the State program pursuant to section 341(e).

Subtitle D—Recommendations for Consumer Education Program

SEC. 361. RECOMMENDATIONS FOR CONSUMER EDUCATION PROGRAM.

(a) DESIGN.—

(1) IN GENERAL.—The Secretary shall design programs for educating consumers concerning long-term care and long-term care insurance.

(2) GOALS.—The programs shall be designed to achieve the goals of increasing consumers' understanding and awareness of options available to them with respect to long-term care insurance (and alternatives, such as public long-term care programs), including—

(A) the risk of needing long-term care;

(B) the costs associated with long-term care services;

(C) the lack of long-term care coverage under the Medicare program, Medicare supplemental (Medigap) policies, and standard private health insurance;

(D) the limitations on (and conditions of eligibility for) long-term care coverage under State programs;

(E) the availability, and variations in coverage and cost, of private long-term care insurance;

(F) features common to many private long-term care insurance policies; and

(G) pitfalls to avoid when purchasing a long-term care insurance policy.

(3) ACTIVITIES.—The program may include—

(A) improving coordination of the activities of State agencies and private entities;

(B) collecting, analyzing, publishing, and disseminating information,

(C) conducting or sponsoring of consumer education, outreach, and information programs, and

(D) providing (directly or through referral) counseling and consultation services to consumers to assist them in choosing long-term care insurance coverage appropriate to their circumstances.

(b) REPORT TO CONGRESS.—The Secretary shall submit to Congress a specific legislative proposal to provide for the authorization of appropriations of Federal funds to support the program design completed under subsection (a).

TITLE IV—FINANCING

SEC. 401. PHASE IN OF 24-CENT/PACK INCREASE IN EXCISE TAXES ON CIGARETTES.

(a) CIGARETTES.—Subsection (b) of section 5701 of the Internal Revenue Code of 1986 is amended—

(1) by striking ''$12 per thousand ($10 per thousand on cigarettes removed during 1991 or 1992)'' in paragraph (1) and inserting ''$24 per thousand ($20 per thousand on cigarettes removed during 1997, $16 per thousand on cigarettes removed during 1996)'', and

(2) by striking ''$25.20 per thousand ($21 per thousand on cigarettes removed during 1991 or 1992)'' in paragraph (2) and inserting ''$50.40 per thousand ($42 per thousand on cigarettes removed

during 1997, $33.60 per thousand on cigarettes removed during 1996)''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to cigarettes removed after December 31, 1995.

(c) FLOOR STOCKS TAXES.—

(1) IMPOSITION OF TAX.—On cigarettes manufactured in or imported into the United States which are removed before any tax-increase date and held on such date for sale by any person, there shall be imposed the following taxes:

(A) SMALL CIGARETTES.—On cigarettes, weighing not more than 3 pounds per thousand, $4 per thousand.

(B) LARGE CIGARETTES.—On cigarettes weighing more than 3 pounds per thousand, $8.40 per thousand; except that, if more than 6½ inches in length, they shall be taxable at the rate prescribed for cigarettes weighing not more than 3 pounds per thousand, counting each 2¾ inches, or fraction thereof, of the length of each as one cigarette.

(2) EXCEPTION FOR CERTAIN AMOUNTS OF CIGARETTES.—

(A) IN GENERAL.—No tax shall be imposed by paragraph (1) on cigarettes held on any tax-increase date by any person if—

(i) the aggregate number of cigarettes held by such person on such date does not exceed 30,000, and

(ii) such person submits to the Secretary (at the time and in the manner required by the Secretary) such information as the Secretary shall require for purposes of this subparagraph.

For purposes of this subparagraph, in the case of cigarettes measuring more than 6½ inches in length, each 2¾ inches (or fraction thereof) of the length of each shall be counted as one cigarette.

(B) AUTHORITY TO EXEMPT CIGARETTES HELD IN VENDING MACHINES.—To the extent provided in regulations prescribed by the Secretary, no tax shall be imposed by paragraph (1) on cigarettes held for retail sale on any tax-increase date by any person in any vending machine. If the Secretary provides such a benefit with respect to any person, the Secretary may reduce the 30,000 amount in subparagraph (A)

and the $60 amount in paragraph (3) with respect to such person.

(3) CREDIT AGAINST TAX.—Each person shall be allowed as a credit against the taxes imposed by paragraph (1) an amount equal to $60. Such credit shall not exceed the amount of taxes imposed by paragraph (1) for which such person is liable.

(4) LIABILITY FOR TAX AND METHOD OF PAYMENT.—

(A) LIABILITY FOR TAX.—A person holding cigarettes on any tax-increase date to which any tax imposed by paragraph (1) applies shall be liable for such tax.

(B) METHOD OF PAYMENT.—The tax imposed by paragraph (1) shall be paid in such manner as the Secretary shall prescribe by regulations.

(C) TIME FOR PAYMENT.—The tax imposed by paragraph (1) shall be paid on or before the 1st June 30 following the tax-increase date.

(5) DEFINITIONS.—For purposes of this subsection—

(A) TAX-INCREASE DATE.—The term ''tax-increase date'' means January 1, 1996, January 1, 1997, and January 1, 1998.

(B) OTHER DEFINITIONS.—Terms used in this subsection which are also used in section 5702 of the Internal Revenue Code of 1986 shall have the respective meanings such terms have in such section.

(C) SECRETARY.—The term ''Secretary'' means the Secretary of the Treasury or his delegate.

(6) CONTROLLED GROUPS.—Rules similar to the rules of section 5061(e)(3) of such Code shall apply for purposes of this subsection.

(7) ARTICLES IN FOREIGN TRADE ZONES.—Notwithstanding the Act of June 18, 1934 (48 Stat. 998, 19 U.S.C. 81a) and any other provision of law, any article which is located in a foreign trade zone on a tax-increase date shall be subject to the tax imposed by paragraph (1) if—

(A) internal revenue taxes have been determined, or customs duties liquidated, with respect to such article before such date pursuant to a request made under the 1st proviso of section 3(a) of such Act, or

(B) such article is held on such date under the supervision of a customs officer pursuant to the 2d proviso of such section 3(a).

(8) OTHER LAWS APPLICABLE.—All provisions of law, including penalties, applicable with respect to the taxes imposed by section 5701 of such Code shall, insofar as applicable and not inconsistent with the provisions of this subsection, apply to the floor stocks taxes imposed by paragraph (1), to the same extent as if such taxes were imposed by such section 5701.

○

HR 4632 IH——2

HR 4632 IH——3

HR 4632 IH——4

HR 4632 IH——5

HR 4632 IH——6

HR 4632 IH——7

HR 4632 IH——8

HR 4632 IH——9