/* Part two of Section 2 of the proposed Health Security Act follows. */

Section 2109 TOTAL FEDERAL BUDGET; ALLOTMENTS TO STATES.

(a) Total Federal Budget.

(1) Fiscal years 1996 through 2003. Subject to paragraph (5)(C), for purposes of this part, the total Federal budget for State plans under this part for each of fiscal years 1996 through 2003 is the following:

(A) For fiscal year 1996, $4.5 billion.

(B) For fiscal year 1997, $7.8 billion.

(C) For fiscal year 1998, $11.0 billion.

(D) For fiscal year 1999, $14.7 billion.

(E) For fiscal year 2000, $18.7 billion.

(F) For fiscal year 2001, $26.7 billion.

(G) For fiscal year 2002, $35.5 billion.

(H) For fiscal year 2003, $38.3 billion.

(2) Subsequent fiscal years.For purposes of this part, the total Federal budget for State plans under this part for each fiscal year after fiscal year 2003 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 home and community-based services provided disabled individuals under this part, 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 part. 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 part 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 part.

(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 part.

(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 2108(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 2108(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 150 percent of the poverty level, to

(B) the percentage of the population of the United States that has income below 150 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 part 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).

Part 2 MEDICAID NURSING HOME IMPROVEMENTS

Section 2201 REFERENCE TO AMENDMENTS.

For amendments to the medicaid program under title XIX of the Social Security Act to improve nursing home benefits under such program, see part 2 of subtitle C of title IV.

Part 3 PRIVATE LONG-TERM CARE INSURANCE

Subpart A General Provisions

Section 2301 FEDERAL REGULATIONS; PRIOR APPLICATION OR CERTAIN REQUIREMENTS.

(a) In General. The Secretary, with the advice and assistance of the Advisory Council, as appropriate, shall promulgate regulations as necessary to implement the provisions of this part, 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 a majority of the members are first appointed to the Advisory Council pursuant to section 2302, the Secretary shall publish in the Federal Register a notice setting forth the projected timetable for promulgation of regulations required under this part. Such timetable shall indicate which regulations are proposed to be published by the end of the first, second, and third years after appointment of the Advisory Council.

(2) Final deadline. All regulations required under this part shall be published by the end of the third year after appointment of the Advisory Council.

(c) Provisions Effective Without Regard to Promulgation of Regulations.

(1) In general. Notwithstanding any other provision of this part, 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 part:

(A) Section 2321(c) (standard outline of coverage);

(B) Section 2321(d) (reporting to State insurance commissioners);

(C) Section 2322(b) (preexisting condition exclusions);

(D) Section 2322(c) (limiting conditions on benefits);

(E) Section 2322(d) (inflation protection);

(F) Section 2324 (sales practices);

(G) Section 2325 (continuation, renewal, replacement, conversion,

and cancellation of policies); and

(H) Section 2326 (payment of benefits).

(2) Interim requirements. Before the effective date of applicable regulations promulgated by the Secretary implementing requirements of this part as specified below, such requirements will be considered to be met

(A) in the case of section 2321(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 2321(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 2322(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 2322(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 2322(d) (concerning inflation protection), if the insurer meets the requirements of section 12 of the NAIC Model Regulation;

(F) in the case of section 2324(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 2324(d) (concerning compensation for the sale of policies), if the insurer meets the requirements of the optional regulation entitled "Permitted Compensation Arrangements" included in the NAIC Model Regulation;

(H) in the case of section 2324(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;

(I) in the case of section 2324(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

(J) in the case of section 2325(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.

Section 2302 NATIONAL LONG-TERM CARE INSURANCE ADVISORY COUNCIL.

(a) Appointment. The Secretary shall appoint an advisory board to be known as the National Long-Term Care Insurance Advisory Council.

(b) Composition.

(1) Number and qualifications of members. The Advisory Council shall consist of 5 members, each of whom has substantial expertise in matters relating to the provision and regulation of long-term care insurance. At least one member shall have experience as a State insurance commissioner or legislator with expertise in policy development with respect to, and regulation of, long-term care insurance.

(2) Terms of Office.

(A) In general. Except as otherwise provided in this subsection, members shall be appointed for terms of office of 5 years.

(B) Initial members. Of the initial members of the Council, one shall be appointed for a term of 5 years, one for 4 years, one for 3 years, one for 2 years, and one for 1 year.

(C) Two-term limit. No member shall be eligible to serve in excess of two consecutive terms, but may continue to serve until such member's successor is appointed.

(3) Vacancies. Any member appointed to fill a vacancy occurring before the expiration of the term of such member's predecessor shall be appointed for the remainder of such term.

(4) Removal. No member may be removed during the member's term of office except for just and sufficient cause.

(c) Chairperson. The Secretary shall appoint a Chairperson from among the members.

(d) Compensation.

(1) In general. Except as provided in paragraph (3), members of the Advisory Council, while serving on business of the Advisory Council, shall be entitled to receive compensation at a rate not to exceed the daily equivalent of the rate specified for level V of the Executive Schedule under section 5316 of title 5, United States Code.

(2) Travel. Except as provided in paragraph (3), members of the Advisory Council, while serving on business of the Advisory Council away from their homes or regular places of business, may be allowed travel expenses (including per diem in lieu of subsistence) as authorized by section 5703(b) of title 5, United States Code, for persons in the Government service employed intermittently.

(3) Restriction. A member of the Advisory Council may not be compensated under this section if the member is receiving compensation or travel expenses from another source while serving on business of the Advisory Council.

(e) Meetings. The Advisory Council shall meet not less often than 2 times a year at the direction of the Chairperson.

(f) Staff and Support.

(1) In general. The Advisory Council shall have a salaried executive director appointed by the Chairperson, and staff appointed by the executive director with the approval of the Chairperson.

(2) Federal entities. The head of each Federal department and agency shall make available to the Advisory Council such information and other assistance as it may require to carry out its responsibilities.

(g) General Responsibilities. The Advisory Council shall

(1) provide advice, recommendations, and assistance to the Secretary on matters relating to long-term care insurance as specified in this part and as otherwise required by the Secretary;

(2) collect, analyze, and disseminate information relating to long-term care insurance in order to increase the understanding of insurers, providers, consumers, and regulatory bodies of the issues relating to, and to facilitate improvements in, such insurance;

(3) develop for the Secretary's consideration proposed models, standards, requirements, and procedures relating to long-term care

insurance, as appropriate, with respect to the content and format of insurance policies, agent and insurer practices concerning the sale and servicing of such policies, and regulatory activities; and

(4) monitor the development of the long-term care insurance market (including policies, marketing practices, pricing, eligibility and benefit preconditions, and claims payment procedures) and advise the Secretary concerning the need for regulatory changes.

(h) Specific Matters for Consideration. The Advisory Council shall consider, and provide views and recommendations to the Secretary concerning, the following matters relating to long-term care insurance:

(1) Uniform terms, definitions, and formats.The Advisory Council shall develop and propose to the Secretary uniform terminology, definitions, and formats for use in long-term care insurance policies.

(2) Standard outline of coverage. The Advisory Council shall develop and propose to the Secretary a standard format for use by all insurers offering long-term care policies for the outline of coverage required pursuant to section 2321(c).

(3) Premiums. The Advisory Council shall consider, and make recommendations to the Secretary concerning I24 (A) whether Federal standards should be established governing the amounts of and rates of increase in premiums in long-term care policies, and I24 (B) if so, what factors should be taken into account (and whether such factors should include the age of the insured, actuarial information, cost of care, lapse rates, financial reserve requirements, insurer solvency, and tax treatment of premiums, and benefits.

(4) Upgrades of coverage. The Advisory Council shall consider, and make recommendations to the Secretary concerning, whether Federal standards are needed governing the terms and conditions insurers may place on insured individuals' eligibility to obtain improved coverage (including any restrictions considered advisable with respect to premium increases, agent commissions, medical underwriting, and age rating).

(5) Threshold conditions for payment of benefits. The Advisory Council shall

(A) consider, and make recommendations to the Secretary concerning, the advisability of establishing standardized sets of threshold conditions (based on degrees of functional or cognitive impairment or on

other conditions) for payment of covered benefits;

(B) to the extent found appropriate, recommend to the Secretary specific sets of threshold conditions to be used for such purpose;

(C) develop and propose to the Secretary, with respect to assessments of insured individuals' levels of need for purposes of receipt of covered benefits

(i) professional qualification standards applicable to individuals making such determinations; and

(ii) uniform procedures and formats for use in performing and documenting such assessments.

(6) Dispute resolution. The Advisory Council shall consider, and make recommendations to the Secretary concerning, procedures that insurers and States should be required to implement to afford insured individuals a reasonable opportunity to dispute denial of benefits under a long-term care insurance policy.

(7) Sales and servicing of policies. The Advisory Council shall consider, and make recommendations to the Secretary concerning

(A) training and certification to be required of agents involved in selling or servicing long-term care insurance policies;

(B) appropriate limits on commissions or other compensation paid to agents for the sale or servicing of such policies;

(C) sales practices that should be prohibited or limited with respect to such policies (including any financial limits that should be applied concerning the individuals to whom such policies may be sold); and

(D) appropriate standards and requirements with respect to sales of such policies by or through employers and other entities, to employees, members, or affiliates of such entities.

(8) Continuing care retirement communities. The Advisory Council shall consider, and make recommendations to the Secretary concerning, the extent to which the long-term care insurance aspects of continuing care retirement community arrangements should be subject to regulation under this part (and the Secretary, in consultation with the Secretary of the Treasury, shall consider such recommendations and promulgate appropriate regulations).

(i) Activities. In order to carry out its responsibilities under this part, the Advisory Council is authorized to

(1) consult individuals and public and private entities with experience and expertise in matters relating to long-term care insurance (and shall consult the National Association of Insurance Commissioners);

(2) conduct meetings and hold hearings;

(3) conduct research (either directly or under grant or contract);

(4) collect, analyze, publish, and disseminate data and information (either directly or under grant or contract); and

(5) develop model formats and procedures for insurance policies and marketing materials; and develop proposed standards, rules, and procedures for regulatory programs.

(j) Authorization of Appropriations. There are authorized to be appropriated, for activities of the Advisory Council, $1,500,000 for fiscal year 1995, and $2,000,000 for each succeeding fiscal year.

Section 2303 RELATION TO STATE LAW.

Nothing in this part shall be construed as preventing a State from applying standards that provide greater protection to insured individuals under long-term care insurance policies than the standards promulgated under this part, except that such State standards may not be inconsistent with any of the requirements of this part or of regulations hereunder.

Section 2304 DEFINITIONS.

For purposes of this part:

(1) Activity of daily living. The term "activity of daily living" means any of the following: eating, toileting, dressing, bathing, and transferring.

(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) Advisory council. The term "Advisory Council" means the National Long-Term Care Insurance Advisory Council established pursuant to section

2302.

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

(5) 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.

(6) Designated representative. The term "designated representative" means the person designated by an insured individual (or, if such individual is incapacitated, pursuant to an appropriate administrative or judicial procedure) to communicate with the insurer on behalf of such individual in the event of such individual's incapacitation.

(7) 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.

(8) 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.

(9) 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.

(10) 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.

(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.

Subpart B Federal Standards and Requirements

Section 2321 REQUIREMENTS TO FACILITATE UNDERSTANDING AND COMPARISON OF BENEFITS.

(a) In General. The Secretary, after considering (where appropriate) recommendations of the Advisory Council, 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 Advisory Council.

(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 Secretary on the basis of recommendations by the Advisory Council),

(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, and the portion of such premium attributable to each covered benefit,

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

(iii) any limit on annual premium increases,

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

(v) 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) Information on average costs (and variation in such costs) for nursing facility care (and such other care as the Secretary may specify) and information on the value of benefits relative to such costs.

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

(iii) 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;

(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.

(e) Comparison of Long-Term Care Coverage Alternatives. Each insurer shall be required to furnish to each individual before a long-term care insurance policy of the insurer is sold to the individual information on the conditions of eligibility for, and benefits under, each of the following:

(1) Policies offered by the insurer. The standard outline of coverage, and

such other information as the Secretary may specify, with respect to each long-term care insurance policy offered by the insurer.

(2) Comparison to other available private insurance. Information, in such format as may be required under this part, on

(A) benefits offered under long-term care insurance policies of the insurer (and the threshold conditions for receipt by an insured individual of each such benefit); and

(B) additional benefits available under policies offered by other private insurers (to the extent such information is made available by the State insurance commissioner).

(3) Public programs; regional alliances. Information furnished to the insurer, pursuant to section 2342(b)(2), by the State in which such individual resides, on conditions of eligibility for, and long-term care benefits (or the lack of such benefits) under

(A) each public long-term care program administered by the State,

(B) the Medicare programs under title XVIII of the Social Security Act; and

(C) each regional alliance operating in the State.

Section 2322 REQUIREMENTS RELATING TO COVERAGE.

(a) In General. The Secretary, after considering (where appropriate) recommendations of the Advisory Council, 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 evidence 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 provided in a setting other than a residential care facility

(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 subtitle; 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 on discrimination by diagnosis. A long-term care insurance policy may not provide for treatment of

(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, or

/* A non-discrimination provision related to AIDS. */

(D) HIV infection or AIDS, 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.

(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 (or such other rate of increase as may be determined by the Secretary to be adequate to offset increases in the costs of long-term care services for which coverage is provided under the policy).

(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.

Section 2323 REQUIREMENTS RELATING TO PREMIUMS.

(a) In General. The Secretary, after considering (where appropriate) recommendations of the Advisory Council, 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 Advisory Council, 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;

(2) limitations on the amount of initial premiums, or on the rate or amount of premium increases;

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

(4) the extent to which consumers should be entitled to participate or be represented in the rate-setting process and to have access to actuarial and other information relied on in setting rates.

Section 2324 REQUIREMENTS RELATING TO SALES PRACTICES.

(a) In General. The Secretary, after considering (where appropriate) recommendations of the Advisory Council, shall promulgate regulations establishing requirements applicable to the sale or offering for sale of long-term care insurance 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 Advisory Council.

(d) Compensation for Sale of Policies. Compensation by an insurer to an agent or agents for the sale of an original long-term care insurance policy, or for servicing or renewing such a policy, may not exceed amounts (or percentage shares of premiums or other reference amounts) specified by the Secretary in regulations, after considering recommendations of the Advisory Council.

(e) 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.

(f) 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).

(g) 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

(A) the insurer offering such policy shall not permit its marketing or sale through such entity unless the requirements of this subsection are met; and

(B) a membership entity that receives any compensation for such sale, marketing, or endorsement of such policy shall be considered the agent of the insurer for purposes of this part.

(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; 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.

Section 2325 CONTINUATION, RENEWAL, REPLACEMENT, CONVERSION, AND CANCELLATION OF POLICIES.

(a) In General. The Secretary, after considering (where appropriate) recommendations of the Advisory Council, 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 or loss of
functional capacity which could reasonably be expected to render the individual permanently or temporarily 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

(A) to require the insured individual, at the time of sale or issuance of a long-term care insurance policy

(i) 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, or

(ii) to complete a signed and dated statement declining to designate a representative, and

(B) to obtain from the insured individual, at the time of each premium payment (but in no event less often than once in each 12-month period) reconfirmation or revision of such designation or declination.

(e) Nonforfeiture.

(1) In general. The Secretary, after consideration of recommendations by the Advisory Council, shall by regulation require appropriate nonforfeiture benefits 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 nonforfeiture benefits shall increase proportionally with the
amount of premiums paid by a policyholder.

(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 part).

(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 part.

(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 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 substantially 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 Advisory Council, 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.

Section 2326 REQUIREMENTS RELATING TO PAYMENT OF BENEFITS.

(a) In General. The Secretary, after considering (where appropriate) recommendations of the Advisory Council, 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 Advisory Council on current practices of insurers concerning, and the appropriateness of standardizing, threshold conditions) may promulgate such regulations as the Secretary finds appropriate establishing 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 Advisory Council;

(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.

Subpart C Enforcement

Section 2342 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 subpart, the State must have in effect a program (including such laws and procedures as may be

necessary) for the regulation of long-term care insurance which the Secretary has determined

(1) includes the elements required under this subpart, 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 subpart B.

(b) Activities Under State Program. A State program approved under this subpart 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 part, 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 part.

(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 part (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) Information to insurers. Procedures for furnishing, to insurers selling or servicing any long-term care insurance policies in the State, information on conditions of eligibility for, and benefits under, each public long-term care program administered by the State, in order to enable them to comply with the requirement under section 2321(e)(3).

(3) 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 part, 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.

(4) Technical assistance to insurers. Provision of technical assistance to insurers to help them to understand and comply with the requirements of this part, 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 subpart 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 part.

(2) Plans of correction. Authority, in cases where the business practices of an insurer are determined not to comply with requirements under this part, 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 part, 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 violative act up to the greater of $10,000 or three times the amount of any commission involved

(A) for violations of subsections (d) (concerning compensation or sale of policies), (e) (concerning prohibited sales practices), and (f) (prohibition on sale of duplicate benefits) of section 2324,

(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 part.

(d) Records, Reports, and Audits. As a condition of approval of its program under this part, 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 part.

(e) Secretarial Responsibilities.

(1) Approval of state programs. The Secretary shall approve a State program meeting the requirements of this part.

(2) Information on medicare benefits. The Secretary shall furnish, to the official in each State with chief responsibility for the regulation of long-term care insurance, a description of the Medicare programs under title XVIII of the Social Security Act which makes clear the unavailability of long-term benefits under such programs, for distribution by such State official to insurers selling long-term care insurance in the State, in accordance with subsection (b)(2).

Section 2342 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 part, to remain available until expended.

Section 2343 ALLOTMENTS TO STATES.

The allotment for any fiscal year to a State with a program approved under this part 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.

Section 2344 PAYMENTS TO STATES.

(a) In General. Each State with a program approved under this part shall be entitled to payment under this title 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 subpart.

(c) Transfer and Deposit Requirements. The Secretary shall make payments under this section in accordance with section 6503 of title 31, United States Code.

Section 2345 FEDERAL OVERSIGHT OF STATE ENFORCEMENT.

(a) In General. The Secretary shall periodically review State regulatory programs approved under section 2341 to determine whether they continue to comply with the requirements of this part.

(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 part, 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 subsection (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 part by the date specified by the Secretary pursuant to subsection (c), the Secretary shall withdraw the approval of the State program pursuant to section 2341(e).

Section 2346 EFFECT OF FAILURE TO HAVE APPROVED STATE PROGRAM.

(a) Restriction on Sale of Long-Term Care Insurance.

(1) In general. No insurer may sell or offer for sale any long-term care insurance policy, on or after the date specified in subsection (c), in a State that does not have in effect a regulatory program approved under section 2341(e).

(2) Application of prohibition. For purposes of paragraph (1), an insurance policy shall not be considered to be sold or offered for sale in a State solely because it is sold or offered to a resident of such State.

(b) Civil Money Penalty.

(1) In general. An insurer shall be subject to a civil money penalty, in an amount up to the greater of $10,000 or three times any commission involved, for each incident in which the insurer sells, or offers to sell, an insurance policy to an individual in violation of subsection (a).

(2) Enforcement procedure. The Secretary shall enforce the provisions of this subsection in accordance with the procedures provided under section 5412 of this Act.

(c) Effective Date.

(1) In general. The date specified in this subsection, for purposes of subsection (a), with respect to any requirement under this part, is the date one year after the date the Secretary first promulgates regulations with respect to such requirement.

(2) Exception. To the extent that a State demonstrates to the Secretary that State legislation is required to meet any such requirement, the State shall not be regarded as failing to have in effect a program in compliance with this part solely on the basis of its failure to comply with such requirement before the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature that begins after the promulgation of the regulation imposing such requirement. For purposes of the preceding sentence, in the case of a State that has a 2-year legislative session, each year of such session shall be deemed to be a separate regular session of the State legislature.

Subpart D Consumer Education Grants

Section 2361 GRANTS FOR CONSUMER EDUCATION.

(a) Grant Program Authorized. The Secretary is authorized to make grants

(1) to States,

(2) to regional alliances (at the option of States within which such Alliances are located), and

(3) to national organizations representing insurance consumers, long-term care providers, and insurers, for the development and implementation of long-term care information, counseling, and other programs.

(b) Applications.

(1) In general. Each State or organization seeking a grant under this section shall submit to the Secretary an application, in such format and containing such information as the Secretary may require.

(2) Goals. Programs under this section shall be directed at 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. An application for a grant under this section shall indicate the activities the State or organization would carry out under such grant, which activities may include

(A) coordination of the activities of State agencies and private entities as necessary to carry out the State's program under this section;

(B) collection, analysis, publication, and dissemination of information,

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

(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, and

(E) other appropriate activities.

(4) Priority for innovation. In awarding grants under this section, the Secretary shall give priority to applications proposing to use innovative approaches to providing information, counseling, and other assistance to individuals who might benefit from, or are considering the purchase of, long-term care insurance.

(c) Period of Grants. Grants under this section shall be for not longer than 3 years.

(d) Evaluations and Reports.

(1) By grantees to the secretary. Each recipient of a grant under this section shall annually evaluate the effectiveness of its program under such grant, and report its conclusions to the Secretary.

(2) By the secretary to the congress. The Secretary shall annually evaluate, and report to the Congress on, the effectiveness of programs under this section, on the basis of reports received under paragraph (1) and such independent evaluation as the Secretary finds necessary.

(e) Authorization of Appropriations. There are authorized to be appropriated, for grants under this section

(1) $10,000,000 for each of fiscal years 1995 through 1997 for grants to States, and

(2) $1,000,000 for each of fiscal years 1995 through 1997, for grants to eligible organizations.

Part 4 TAX TREATMENT OF LONG-TERM CARE INSURANCE AND SERVICES

Section 2401 REFERENCE TO TAX PROVISIONS.

For amendments to the Internal Revenue Code of 1986 relating to the treatment of long-term care insurance and services, see subtitle G of title VII.

Part 5 TAX INCENTIVES FOR INDIVIDUALS WITH DISABILITIES WHO WORK

Section 2501 REFERENCE TO TAX PROVISION.

For amendment to the Internal Revenue Code of 1986 providing for a tax credit for cost of personal assistance services required by employed individuals, see section 7901.

Part 6 DEMONSTRATION AND EVALUATION

Section 2601 DEMONSTRATION ON ACUTE AND LONG-TERM CARE INTEGRATION.

(a) Program Authorized. The Secretary of Health and Human Services shall conduct a demonstration program to test the effectiveness of various approaches to financing and providing integrated acute and long-term care services described in subsection (b) for the chronically ill and disabled who meet eligibility criteria under subsection (c).

(b) Services and Benefits.

(1) In general. Except as provided in paragraph (2), the following services and benefits shall be provided under each demonstration approved under this section:

(A) Comprehensive benefit package. All benefits included in the comprehensive benefit package under title I of this Act.

(B) Transitional benefits. Specialized benefits relating to the transition from acute to long-term care, including

(i) assessment and consultation,

(ii) inpatient transitional care,

(iii) medical rehabilitation,

(iv) home health care and home care,

(v) caregiver support, and

(vi) self-help technology.

(C) Long-term care benefits. Long-term care benefits, including

(i) adult day care,

(ii) personal assistance services,

(iii) homemaker services and chore services;

(iv) home-delivered meals;

(v) respite services;

(vi) nursing facility services in specialized care units;

(vii) services in other residential settings including community supported living arrangements and assisted living facilities; and

(viii) assistive devices and environmental modifications.

(D) Habilitation services. Specialized habilitation services for participants with developmental disabilities.

(2) Variations in minimum benefits.

(A) In general. Subject to the requirement of subparagraph (B), demonstrations may omit specified services listed under subparagraphs (C)

and (D) of paragraph (1), or provide additional services, as found appropriate by the Secretary in the case of a particular demonstration, taking into consideration factors such as

(i) the needs of a specialized group of eligible beneficiaries;

(ii) the availability of the omitted benefits under other programs in the service area; and

(iii) the geographic availability of service providers.

(B) Breadth requirement. In approving variant demonstrations pursuant to subparagraph (A), the Secretary shall ensure that demonstrations under this section, taken as a group, adequately test financing and delivery models covering the entire array of services and benefits described in paragraph (1).

(c) Eligibility Criteria. The Secretary shall establish eligibility criteria for individuals who may receive services under demonstrations under this section. Under such criteria, any of the following may be found to be eligible populations for such demonstrations:

(1) Individuals with disabilities who are entitled to services and benefits under a State program under part 1 of this subtitle.

(2) Individuals who are entitled to benefits under parts A and B of title XVIII of the Social Security Act.

(3) Individuals who are entitled to medical assistance under a State plan under title XIX of the Social Security Act, and are also

(A) individuals described in paragraph (2), or

(B) individuals eligible for supplemental security income under title XVI of that Act.

(d) Application.

(1) In general. Each entity seeking to participate in a demonstration under this section shall submit an application, in such format and containing such information as the Secretary may require, including the information specified in this subsection.

(2) Service delivery. The application shall state the services to be provided under the demonstration (either directly by the applicant or under

other arrangements approved by the Secretary), which shall include services specified pursuant to subsection (b) and

(A) enrollment services;

(B) client assessment and care planning;

(C) simplified access to needed services;

(D) integrated management of acute and chronic care, including measures to ensure continuity of care across settings and services;

(E) quality assurance, grievance, and appeals mechanisms; and

(F) such other services as the Secretary may require.

(3) Consumer protection and participation. The applicant shall provide evidence of consumer participation

(A) in the planning of the demonstration (including a showing of support from community agencies or consumer interest groups); and

(B) in the conduct of the demonstration, including descriptions of methods and procedures to be used

(i) to make available to individuals enrolled in the demonstration information on self-help, health promotion and disability prevention practices, and enrollees' contributions to the costs of care;

(ii) to ensure participation by such enrollees (or their designated representatives, where appropriate) in care planning and in decisions concerning treatment;

(iii) to handle and resolve client grievances and appeals;

(iv) to take enrollee views into account in quality assurance and provider contracting procedures; and

(v) to evaluate enrollee satisfaction with the program.

(4) Applicant qualifications. Applicants for grants under this section shall meet eligibility criteria established by the Secretary, including requirements relating to

(A) adequate financial controls to monitor administrative and service

costs,

(B) demonstrated commitment of the Board of Directors or comparable governing body to the goals of demonstration,

(C) information systems adequate to pay service providers, to collect required utilization and cost data, and to provide data adequate to permit evaluation of program performance, and

(D) compliance with applicable State laws.

(e) Payments to Participants. An entity conducting a demonstration under this section shall be entitled to receive, with respect to each enrollee, for the period during which it is providing to such enrollee services under a demonstration under this section, such amounts as the Secretary shall provide, which amounts

(1) may include risk-based payments and non-risk based payments by governmental programs, by third parties, or by project enrollees, or any combination of such payments, and

(2) may vary by project and by enrollee.

(f) Number and Duration of Demonstration Projects.

(1) Request for applications. The Secretary shall publish a request for applications under this section not later than one year after enactment of this Act.

(2) Number and duration. The Secretary shall authorize not more than 25 demonstrations under this section, each of which shall run for 7 years from the date of the award.

(g) Evaluation and Reports. The Secretary shall evaluate the demonstration projects under this section, and shall submit to the Congress

(1) an interim report, by three years after enactment, describing the status of the demonstration and characteristics of the approved projects; and

(2) a final report, by one year after completion of such demonstration projects, evaluating their effectiveness (including cost-effectiveness), and discussing the advisability of including some or all of the integrated models tested in the demonstration as a benefit under the comprehensive benefit package under title I of this Act, or under the programs under title XVIII of the Social Security Act.

(h) Authorization of Appropriations.

(1) For secretarial responsibilities.

(A) In general. There are authorized to be appropriated $7,000,000 for fiscal year 1996, and $4,500,000 for each of the 6 succeeding fiscal years, for payment of costs of the Secretary in carrying out this section (including costs for technical assistance to potential service providers, and research and evaluation), which amounts shall remain available until expended.

(B) Set-aside for feasibility studies. Of the total amount authorized to be appropriated under subparagraph (A), not less than $1,000,000 shall be available for studies of the feasibility of systems to provide integrated care for nonaged populations (including physically disabled children and adults, the chronically mentally ill, and individuals with disabilities, and combinations of these groups).

(2) For covered benefits. There are authorized to be appropriated $50,000,000 for the first fiscal year for which grants are awarded under this section, and for each of the four succeeding fiscal years, for payment of costs of benefits for which no public or private program or entity is legally obligated to pay.

Section 2602 PERFORMANCE REVIEW OF THE LONG-TERM CARE PROGRAMS.

(a) In General.The Secretary of Health and Human Services shall prepare and submit to the Congress

(1) an interim report, not later than the end of the seventh full calendar year beginning after the date of the enactment of this Act, and

(2) a final report, not later than two years after the date of the interim report, evaluating the effectiveness of the programs established and amendments made by this subtitle (and including at a minimum the elements specified in subsection (b)).

(b) Elements of Assessment. The evaluations to be made, and included in the reports required pursuant to subsection (a), include at least the following:

(1) State service delivery programs. An evaluation of States' effectiveness in meeting the needs for home and community-based services

(including personal assistance services) of individuals with disabilities (including individuals who do, and who do not, meet the eligibility criteria for the service program under part 1, individuals of different ages, type and degree of disability, and income levels, members of minority groups, and individuals residing in rural areas).

(2) Service access. An evaluation of the degree of (and obstacles to) access of individuals with disabilities to needed home and community-based services and to inpatient services.

(3) Quality. An evaluation of the quality of long-term care services available.

(4) Private insurance. An evaluation of the performance of the private sector in offering affordable long-term care insurance that provides adequate protection against the costs of long-term care, and of the effectiveness of Federal standards and State enforcement, pursuant to part 3, in adequately protecting long-term care insurance consumers.

(5) Cost issues. An evaluation of the effectiveness of amendments made by this subtitle in containing the costs of long-term care, and in limiting the share of such costs borne by individuals with lower incomes.

(6) Service coordination and integration. An evaluation of the effectiveness of the programs established or amended under this subtitle in achieving coordination and integration of long-term care services, and of such services with acute care services and social services, and in ensuring provision of services in the least restrictive setting possible.