TITLE II- PUBLIC HEALTH INITIATIVES

SUBTITLE A - MEDICARE OUTPATIENT PRESCRIPTION DRUG BENEFITS (H.R. 3600 and S. 1757 p. 343)

Section 2001. Coverage of Outpatient Prescription Drugs. (a) This section amends section 1861(s) of the Social Security Act (relating to the definition of covered medical and other health services) to add covered outpatient drugs, and amends section 1861(t) (defining outpatient drugs and biologicals) to define covered outpatient drugs and biologicals used for a medically accepted indication to include the following items:

(A) A drug which may be dispensed only upon prescription and

(i) which is approved as safe and effective under section 505 or 507 of the Federal Food, Drug, and Cosmetic Act or is approved under section 505(j) of such Act;

(ii) which was commercially used or sold in the United States before enactment of the Drug Amendments of 1962 or which is identical, similar or related to such a drug and which has not been the subject of a final determination by the Secretary that it is a "new drug" (within the meaning of section 201(p) of the Federal Food Drug and Cosmetic Act) or an action brought by the Secretary under the Act to enforce the Act; or

(iii) which is described under section 107(c)(3) of the Drug Amendments of 1962 and for which the Secretary determines there is a compelling justification for its medical need, or is identical, similar or related to such a drug, and for which the Secretary has not issued a notice of hearing under the Federal Food, Drug, and Cosmetic Act on a proposed order of the Secretary to withdraw approval of an application for such drug on the grounds that it is less than effective for all prescribed, suggested or recommended uses.

(B) A biological product which may only be dispensed upon prescription, is licensed under section 351 of the Public Health Service Act and is produced at a federally licensed establishment under the Act; and

(C) Insulin certified under the Federal Food, Drug, and Cosmetic Act.

The term "covered outpatient drug" does not include any product which is:

(A) administered through infusion in a home setting unless it is a covered home infusion drug;

(B) furnished as part of, or incident to, any other item or service;

(C) which is an excludable drug under Medicaid and which the Secretary elects to exclude under Medicare (other than benzodiazepines and barbiturates).

The term "medically accepted indication" with respect to outpatient drugs includes any use which has been approved by the FDA for the drug and includes another use of the drug if:

(A) the drug has been approved by the FDA; and

(B) such use is supported by one or more citations which are included (or approved for inclusion) in the following compendia: the American Hospital Formulary Service-Drug Information, the American Medical Association Drug Evaluations, the United States Pharmacopoeia-Drug Information, and other authoritative compendia identified by the Secretary (unless the Secretary has determined that the use is not medically appropriate or that the identified use is not indicated), or the carrier determines under guidance by the Secretary that the use is accepted based on supportive clinical evidence in peer reviewed medical literature.

The Secretary may revise the list of compendia that have been designated as appropriate under this section.

The term "covered home infusion drug" is a covered outpatient drug or an external or parenteral nutrient dispensed to an individual that is administered intravenously, subcutaneously, epidurally or through other means determined by the Secretary, using an access device that is inserted into the body and an infusion device to control the drug flow rate, that is administered in the individual's home (including an institution used as a home) and is an antibiotic or other drug that can be administered safely and effectively in a home setting. The Secretary shall publish a list of covered home infusion drugs by January 1, 1996.

(c) Sections 1861 and 1881 are amended to make additional conforming amendments.

Section 2002. Payment Rules and Related Requirements for Covered Outpatient Drugs. Section 1834 (relating to special payment rules for specific services) is amended to add a new subsection governing payment for covered outpatient drugs.

(1) Payment shall be made for covered outpatient drugs only after the individual has satisfied the annual drug deductible of $250 in 1996, and in succeeding years, an amount that the Secretary estimates will ensure that the percentage of individuals satisfying the deductible will remain the same as in prior years (excluding beneficiaries enrolled in Medicare managed care plans). The Secretary shall promulgate deductible amounts for 1997 and each successive year by September of the previous year. In setting the deductible, the Secretary shall not take into account expenditures on drugs that exceed approved payment levels.

(2) The amount payable for covered drugs shall be equal to 80 percent of the payment basis for individuals who have satisfied their deductible for the year and 100 percent of the payment basis for individuals who have satisfied both the deductible and out-of-pocket requirement.

The annual out-of-pocket limit is $1000 in 1996 and in succeeding years, an amount determined by the Secretary that is estimated to ensure that the average percent of persons receiving covered benefits will remain the same as in the previous year (excluding beneficiaries enrolled in Medicare managed care plans). The

Secretary shall promulgate out-of-pocket limits for 1997 and each succeeding year by September of the previous year.

In determining the amount of expenses incurred the Secretary shall not take into account amounts paid beyond the payment basis for a drug.

(3) The "payment basis" is the lesser of the actual amount charged for a drug or the applicable payment limit.

(4) The applicable payment limit for drugs is as follows:

(A) For single source drugs or multiple source drugs with restrictive prescriptions the payment limit for a calculation period is the lesser of the 90th percentile of the actual charge (computed on a geographic basis) during the second previous calculation payment period or the amount of administrative allowance plus the product of the number of dosage units dispensed and the per unit estimated acquisition cost for the drug product.

(B) For multiple source drugs with non-restrictive prescriptions the payment limit equals the amount of administrative allowance plus the product of the number of dosage units dispensed and the unweighted median of the unit estimated acquisition cost.

(C) The Secretary shall determine the estimated acquisition cost for a drug during a calculation period. The cost may not exceed 93 percent of the average wholesale price during the period. The Secretary shall impose civil money penalties against wholesalers who refuse to provide price information, following the procedures under section 1128A of the Social Security Act. Information shall not be disclosed except as prescribed by the Secretary.

(5) The administrative allowance is $5.00 for 1996, and for each succeeding year, the amount adjusted by the percentage change in the consumer price index for all urban consumers for the 12-month period ending with June of the preceding year. The Secretary may reduce the amount of administrative allowance for mail order pharmacies after consulting with pharmacists, Medicare beneficiaries, and private insurers.

(6) The Secretary shall establish a program to identify (and educate physicians and pharmacists regarding) patterns and instances of inappropriate dispensing or prescribing, instances of substandard care, potential adverse reactions, and appropriate uses of generic drugs. The Secretary may require advance approval for an outpatient drug which the Secretary finds is subject to misuse or inappropriate use, is not cost effective, is a multiple source drug with restrictive prescription or is subject to rebate negotiation. The Secretary must ensure that prior approval procedures do not restrict patients' timely access to medically necessary drugs, assure prompt determinations of approval or disapproval and provide an appeal mechanism.

The Secretary may provide for a drug use review program with respect to covered

outpatient drugs to assure that prescriptions are medically necessary, appropriate, and are not likely to result in adverse medical reaction.

(7) The Secretary shall adopt a standard claims form for outpatient drugs consistent with Title V of the Health Security Act.

(8) Pharmacies may not receive payment for covered drugs unless pharmacy agrees to answer beneficiaries' questions about appropriate use, potential interactions and other matters.

(9) Under this section:

(A) the terms "multiple and single source drugs" have the same meaning as under section 1927(k)(7) of the Social Security Act;

(B) the term "restrictive prescription" means that the prescription indicates an appropriate restriction recognized by the Secretary in the prescriber's handwriting such as "brand medically necessary". In the case of a telephone prescription the prescriber must state that a particular drug must be dispensed and follows up with an appropriate hand-written confirmation within 30 days.

(C) The term "payment calculation period" means the 6-month period beginning with each January and July.

(b) Section 1848 (g)(4) (relating to limitations on beneficiary liability) is amended to require that pharmacies submit claims within 90 days in the case of prescribed outpatient drugs.

(c) Section 1842 (relating to use of carriers) is amended to permit the Secretary to enter into contracts with regional carriers and may determine an appropriate method of payment. The Secretary may also contract with any other qualified entity. to carry out these functions. The Secretary must use Railroad Retirement Act carriers to carry out functions for Retirement Act beneficiaries.

(d) Actions taken before 1996 that affect claims processing functions are not subject to section 111 of the Federal Property and Administrative Services Act and shall not be subject to administrative or judicial review.

(e) Adds conforming amendments to section 1833, section 1866 and section 1842.

Section 2003. Medicare Rebates for Covered Outpatient Drugs. (a) In order for payment to be available under this part for a covered outpatient drug on or after January 1, 1996, the manufacturer must enter into and have in effect a rebate agreement with the Secretary that meets the requirements of this section and must give equal access to discounts in accordance with this section. The following terms apply to rebate agreements:

(1) Each calendar quarter, within 30 days of receiving specified information, the manufacturer must pay the Secretary a specified rebate for all covered outpatient drugs. Drugs subject to the rebate are those drugs dispensed to beneficiaries (other than beneficiaries enrolled in Medicare managed care plans or state alliances) by pharmacies during the quarter.

(2) Within 60 days after the end of each quarter the Secretary shall inform the manufacturer of the total number of units, dosage strength and package size of each covered drug dispensed based on data furnished to the Secretary. The Comptroller General may audit the data to assure accuracy.

(3) Each manufacturer shall inform the Secretary within 30 days after the end of each calendar quarter the average manufacturer's retail and non-retail price for each dosage form and strength of each of its covered outpatient drugs. Each manufacturer must also inform the Secretary of its base quarter average manufacturer retail prices (within 30 days of entering into an agreement) of each dosage price for each dosage form and strength. The Secretary may inspect manufacturers' records to verify the average manufacturer retail and non-retail price and may impose civil money penalties in accordance with the provisions of section 1128A of the Social Security Act on manufacturers who provide false information or who refuse to furnish information. Manufacturers that do not provide timely information (within 90 days of the deadline imposed) may be suspended .

(4) Agreements may not be in effect for less than 1 year and shall be automatically renewed unless terminated. The Secretary may terminate for good cause, and the termination shall take effect 60 days after notice. The manufacturer may request a hearing, but the termination shall not be delayed pending the outcome of the hearing. A manufacturer may terminate for any reason, in which case the termination is effective on the first day of the first calendar quarter occurring at least 60 days after such notice is given. Terminations do not affect rebates due on or before the date of the termination. The Secretary must notify pharmacies and physician organizations of a termination no less than 30 days before the actual termination date.

The manufacturer shall rebate to the Secretary in accordance with the following rules:

(1) a basic rebate for each calendar quarter equal to the product of the total number of units subject to the rebate and the greater of (i) the difference between the average manufacturer retail price and the average manufacturer non-retail price; or (ii) 17 percent of the average manufacturer price;

(2) an additional rebate equal to the product of the number of dosage units subject to the rebate and the amount by which the average manufacturer retail price for the quarter in question exceed the average manufacturer retail price for the base

quarter increased by the percentage increase in the CPI for urban consumers from the end of the base quarter to the month before the beginning of each calendar quarter;

(3) the Secretary may negotiate a rebate amount for a new drug first marketed after June, 1993, which is not marketed in any country named in section 802(b)(4) of the Federal Food, Drug, and Cosmetic Act and which the Secretary believes may be excessively priced or which is marketed in one or more of the countries named in section 802 at a significantly lower price. In the case of drugs that are marketed in other countries, the rebate may equal the difference between the average manufacturer retail price in the U.S. and the price available to wholesalers in those countries. In determining if a price is excessive, the Secretary shall take into account the prices of other drugs in the same therapeutic class, other cost and pricing information, special manufacturing requirements, prices abroad, and other relevant factors. The Secretary may exclude a drug for which an acceptable rebate agreement cannot be negotiated. The effective date for an exclusion shall be 6 months after the effective date of marketing approval (but no earlier than July 1,1996) or the date the manufacturer terminates rebate negotiations;

(4) no rebates are imposed for outpatient drugs that are generic (i.e., neither single source drugs or an innovator multiple source drugs).

The Secretary may not disclose information under this part except to the degree necessary to administer the program or to permit review by the Comptroller General or the Director of the Congressional Budget Office.

Manufacturers must offer substantially the same terms to each purchaser of covered outpatient drugs. Equal access is determined in terms of prompt payment, cash payment, volume purchase, single site delivery, the use of formularies by purchasers and any other terms effectively reducing the manufacturer's costs. In determining compliance with this part, terms given to public programs, the Department of Defense and the Department of Veterans Affairs shall not be taken into account.

The following terms are defined:

(1) the term "average manufacturer retail price" means the average price paid to the manufacturer for drugs distributed through retail pharmacies, including discounts, prompt payment, volume purchases and rebates.

(2) the term " average manufacturer non-retail price" means the weighted average price (including discounts, prompt payment, volume purchases and rebates) paid to the manufacturer by hospitals and other institutional purchasers that purchase drugs for institutional use and not for resale.

(3) the term "base quarter" means the calendar quarter beginning April 1,

1993, or if later, the first full calendar quarter that a drug was marketed in the U.S.

(4) the term "covered drug" includes each innovator multiple source drug and each single source drug, as defined under section 1927(k)(7) of the Social Security Act.

(5) the term "manufacturer" means the entity whose National Drug Code number appears on the label or the individual named in the license or human drug application to the FDA.

(b) Amends section 1862 to exclude from coverage outpatient drugs for which there is no rebate agreement or drugs that are excluded because no rebate amount has been agreed to.

Section 2004. Extension of 25 Percent Rule for Portion of Premium Attributable to Covered Outpatient Drugs. Section 1839 (relating to Part B premiums) is amended to specify that the portion of the premium attributable to outpatient drugs shall equal 25 percent of Medicare program costs for outpatient drugs. This provision takes effect after December, 1998.

Section 2005. Coverage of Home Infusion Drug Therapy. (a) Section 1832(a)(2) is amended to add coverage of home infusion drug therapy services.

(b) Section 1861 is amended to add a definition of home infusion drug therapy services, which are defined as items and services furnished to an individual under the care of a physician in a residence used as the individual's home by a qualified home infusion drug therapy provider or by others under arrangements with the provider and under a plan established and periodically reviewed by the physician. Home infusion therapy items and services include nursing, pharmacy and related services including medical supplies, intravenous fluids, delivery and equipment as are necessary to carry out a home infusion regimen safely and effectively.

A qualified home infusion therapy provider is an entity that is capable of providing or arranging for items and services needed for home infusion, maintains clinical records on all patients, adheres to written protocols and policies, makes services available 7 days a week, 24 hours a day, coordinates all services with the patient's physician, conducts quality assessment activities, assures that only trained individuals provide home infusion, assumes responsibility for the quality of services and is appropriately licensed or approved by a state agency as required under state law.

(c) Section 1833 and 1834 (relating to payment for services) are amended to specify payment rules for home infusion therapy services as the lesser of the actual charge or the fee schedule established under this section. The Secretary is required to establish a per diem fee schedule before the beginning of 1996 and to update it annually.

Section 1877 (relating to physician referrals) is amended to prohibit physician referrals for home infusion services.

(d) Section 1835 is amended to require certification of the need for home infusion therapy, the provision of services in accordance with a written plan, and that the individual is under the care of a physician.

(e) Section 1861 is amended to provide that home infusion therapy providers shall be treated as part A providers and section 1864 is amended to require the Secretary to use state agencies to determine compliance.

Section 1846 (relating to intermediate sanctions for providers or suppliers of clinical laboratory services) is amended by adding home infusion drug therapy services and by permitting intermediate sanctions for providers no longer substantially in compliance (including plans of corrections, civil money penalties, payment for the cost of on-site monitoring and suspension of payments).

(f) Section 1816 (relating to the use of intermediaries) is amended to provide that the Secretary may use regional intermediaries to carry out this section.

(g) Section 1861 is amended to add coverage of enteral and parenteral nutrients, supplies and equipment.

Section 2006. Conforming Amendments to the Medicaid Program. (a) Section 1927 (relating to drug rebates) is amended to prohibit contracts between state Medicaid agencies and manufacturers that do not have Medicare rebate agreements in effect. Also provides that covered drugs furnished to dually eligible enrollees shall not be included in the determination of units of outpatient drugs subject to Medicaid rebates.

(b) The effective date is quarters beginning on or after January 1, 1996.

Section 2007. Effective Date. The amendments made by subtitle A shall take effect on or after January 1, 1996.

SUBTITLE B - LONG-TERM CARE
(H.R. 3600 and S. 1757 p. 389)

Subtitle B establishes a new source of to Federal funds for home- and community-based services and related activities for individuals with disabilities. It sets forth the conditions of state participation and also establishes basic eligibility criteria for individuals with disabilities. The subtitle includes a defined Federal budget allocation for the new services and the methodology for determining a state's allocation of that total.

PART 1. STATE PROGRAMS FOR HOME AND COMMUNITY-BASED SERVICES FOR INDIVIDUALS WITH DISABILITIES

Section 2101. State Programs for Home and Community-based Services for Individuals with Disabilities. Creates a new state entitlement to Federal payments for home- and community-based services and related activities for individuals with disabilities. The section entitles every state to Federal payments under section 2108 if a state has a plan for the home- and community-based services that has been approved by the Secretary.

The benefits conferred by this part do not constitute an entitlement for individuals, nor are states with approved plans required to spend the full amount of Federal funds to which they are entitled in any year.

Section 2102. State Plans. (a) State plans under this part must meet the following conditions for approval:

(1) Subject to the amount of state and Federal funding available, the plan must make covered services available to individuals in the state with disabilities (as defined in section 2103(a).

The plan must provide for initial screening of potentially eligible individuals.

The plan may not restrict the eligibility of individuals on the basis of income, age, geography, the nature, severity or category of disability, residential setting (other than institutional setting), or other grounds specified by the Secretary.

The plan must also provide assurances that the state will continue to make available under this plan, the state's Medicaid plan or otherwise, an appropriate level of assistance for home and community-based services for individuals who are receiving assistance for these services under the state Medicaid plan at the time of enactment of this Act. Such an individual's post-enactment level of assistance, under the state plan, must take into account the level of aid the individual was receiving on the date of enactment, and the individual's need for the services.

(2) Consistent with section 2104 (coverage of services), a state plan must specify the services and the extent and manner of allocation and availability of the

services available under the plan. It must specify how services under the state plan are to be coordinated with each other and with health and long-term care services otherwise available to individuals with disabilities. Subject to the coverage limitations in section 2104, services may be delivered in an individual's home, a range of community residential arrangements, or outside the home.

The state plan must also specify how it will allocate services among individuals with disabilities both during and after a phase-in period over 7 fiscal years, beginning in fiscal year 1996. The state plan may not allocate the services on the basis of income or other financial resources of the individuals.

The state may not require consumer-directed providers of personal assistance services to be licensed, certified or meet other requirements that the Secretary finds not necessary for the health and safety of individuals with disabilities. ("Consumer-directed" services, defined at the end of this section, are services provided by an individual who is selected and managed (and may also be trained) by the individual receiving the services).

To the extent possible, an individual with disabilities (and the individual's family) must be permitted to choose the type and provider of covered services.

The state plan must assure the number of low-income individuals with disabilities who receive home and community-based services under the plan, the state's Medicaid plan, or both, is proportional to the number of low-income individuals in the state.

(3) Cost-sharing under a state plan may not exceed the levels allowed under section 2105.

(4) A state plan must specify the types of providers that are eligible to participate in the program under the plan, including consumer-directed providers, and must also specify conditions of provider participation.

(5) A state plan must specify how the state will manage the Federal and state funds available under the plan to serve all categories of individuals with disabilities and otherwise satisfy state plan requirements. This information must be provided for disposition of funds available for each fiscal-year, beginning with fiscal year 1996 running through fiscal year 2003 and for each five fiscal-year period thereafter.

(6) A state plan must specify the methods that will be used to reimburse providers for services provided under the plan. The 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 a combination of these methods. If a plan uses cash or vouchers, it must specify how the plan will assure compliance with applicable employment tax provisions.

A state plan must also specify the methods and criteria to be used to set rates of payment for plan services (including rates for cash payments or vouchers).

The plan must limit payments to providers to those who agree to accept, as

full payment for covered services, payment at rates established under the plan (including any cost-sharing that may be imposed).

(7) The plan must provide for quality assurance and safeguards for people applying to and in the plan, in accordance with section 2106.

(8) A state plan must assure that the state advisory group required under section 2107(b) will be established and maintained.

(9) The plan must designate one or more state agencies responsible for administering or supervising administration of the plan. The plan must include assurances that administrative expenditures under the plan will not be more than 10 percent of total expenditures, beginning in fiscal year 2003.

The state also must specify how the plan will be integrated with specified public programs and with health plans. The public programs with which a state plan must be integrated are: the state Medicaid plan, titles V (maternal and child health) and XX of the Social Security Act; programs under the Older Americans Act of 1965, the Developmental Disabilities Assistance and Bill of Rights Act, the Individuals with Disabilities Education Act, and other Federal or state programs providing services or assistance targeted on individuals with disabilities.

(10) The state plan must provide that the state will make reports and cooperate with audits on the state's administration of its plan (including claims processing) as the Secretary determines are needed. The plan must also provide data required by the Secretary.

(11) The state plan must include assurances that Federal funds will not be used to pay the state's share of expenditures under the plan. The Section also incorporates the provisions of section 1903(w) of the Social Security Act (related to prohibited uses of provider taxes and donations under the Medicaid act).

(b) The Secretary shall approve a state's plan if the Secretary determines that the plan was developed in consultation with individuals with disabilities and their representatives, and meets all the foregoing requirements for elements of a state plan. The Secretary is required to monitor plans' compliance with the eligibility requirements of section 2103, is authorized to monitor other requirements of the subpart, and must promulgate timely regulations. Approvals take effect on the first day of the first fiscal year following approval, except that approvals made before January 1,1996, shall take effect on January 1. The Secretary may establish submission deadlines.

Section 2103. Individuals with Disabilities Defined. (a). An individual in one or more of the following four categories is an "individual with disabilities," for purposes of eligibility under this part.

(1) Individuals requiring help with daily living. These are individuals who need, and who are expected to need for at least 100 days, specified types of assistance to perform three or more activities of daily living. The specified types of assistance are hands-on, standby, supervision or cueing. "Activities of daily living," (ADLs) mean eating, toileting, dressing, bathing, and transferring in and out of bed.

(2) Individuals with severe cognitive or mental impairments. These are individuals of any age who satisfy the following criteria:

(A) the individual's scores on a standard mental status protocol that is appropriate for the person's condition (as specified by the Secretary), indicate severe cognitive or mental impairment or both;

(B) the individual requires hands-on or standby assistance, supervision of cueing with one or more ADLs, or requires assistance or cueing with one or more cognitive-related instrumental activities of daily living (IADLs)(as specified by the Secretary), or displays symptoms of one or more serious behavioral problems that create a need for supervision to prevent harm to self or others; and

(C) The individual is expected to meet these requirements for at least 100 days.

(3) Individuals with severe or profound mental retardation. This means an individual with severe or profound mental retardation, as determined by a protocol specified by the Secretary.

(4) Severely disabled children. These are children under 6 years of age who have a severe disability or chronic medical condition and who would need to be institutionalized in a hospital, nursing facility or intermediate care facility for the mentally retarded if personal assistance, or other "additional services" described in section 2104 were not provided. The individual must also be expected to have the disability or condition, and to require the services for at least 100 days.

(b) Disability must be determine by persons or entities specified under the state plan and using protocols that include an initial screening and assessment specified by the Secretary. A state may also collect additional information for purposes of assessing an individual's need for care and for developing a plan of care for the individual, as required under section 2104.

A state must establish a fair hearing process for appeals of eligibility determinations. An individual's eligibility, as an "individual with disabilities," is effective under a state plan for no longer than 12 months but may be effective for a longer period if a significant change in an individual's condition affecting eligibility is unlikely. If there is such a significant change, the individual's eligibility must be reassessed.

Section 2104. Home and Community-Based Services Covered Under State Plan.

(a) A state plan must specify the home- and community-based services that will be available under the plan to individuals or categories of individuals with disabilities, and must also specify limits applicable to such services. Services must be specified in a manner that permits sufficient flexibility for providers to meet individuals' needs in a cost-effective manner.

Services may be delivered in an individual's home, a range of community residential arrangements or outside the home, except (under an exclusion in a provision below), the services may not be delivered in a hospital, nursing facility, intermediate care facility for the mentally retarded or other institutional setting specified by the secretary.

(b) A state plan may provide services to an individual only if a comprehensive assessment of need has been made (regardless of whether all needed services are available under the state plan) and for whom an individualized plan of care, based on the assessment, has been developed. Only services consistent with the plan of care may be provided.

The individualized plan of care must be developed by qualified individuals in close consultation with the individual with disabilities and the individual's family. The care plan must be approved by the individual (or the individual's representative), and must be reviewed and updated at least every six months. The care plan must specify which of the services in the plan will be provided under the state plan and identify (to the extent possible) how an individual will obtain services that are not provided under the state plan. The care plan must also specify how the services provided to the individual under the state plan will be coordinated with the provision of other health care to the individual.

A state must make reasonable efforts to identify and arrange for those services in the care plan that are not provided under the state plan. Nothing in this section shall be interpreted to require the state to provide all the services in the care plan, either under the state plan or otherwise.

(c) A state plan must include in the array of services made available to each category of individuals with disabilities agency-administered and consumer-directed personal assistance services.

(d) Additional services that states may cover are case management; homemaker and chore assistance; home modifications; respite services; assistive devices; adult day services; habilitation and rehabilitation; supported employment; home health services; and any other care or assistive services approved by the Secretary that the state determines will help individuals with disabilities to stay in their homes.

The state plan must specify the methods and standards used to determine the types and amount, duration and scope of services covered for each category of individuals with disabilities, as well as how the state's coverage rules meet the needs of each of the 4 categories of individuals with disabilities.

(e) The exclusions and limitations that apply to services under a state plan are the following:

(1) A state plan may not provide for coverage of room and board, nor for services provided in a hospital, nursing facility, intermediate care facility for the mentally retarded, or other institutional setting specified by the Secretary. The plan may not provide for items and services to the extent that these are covered for the individual under a health plan or Medicare.

(2)In determining the amount or types of services to be made available to individuals with disability, a state plan may take into account the availability of informal care.

(f) A state plan may provide the following methods of paying for services: vouchers; direct cash payments for individuals with disabilities; payments per capita to health plans; and payments to providers.

(g) Personal assistance services, in this section, means services that a state plan specifies as personal assistance. Whether the personal assistance services are delivered by an agency or by a consumer-directed provider, they must include at least the following: hands on services and stand-by assistance, supervision, and cueing with activities of daily living. "Consumer-directed" means services provided by an individual who is selected and managed by the individual receiving the services, and if he or she chooses, also trained by the individual receiving the services. "Agency-directed" means services that are not consumer-directed.

Section 2105. Cost Sharing. (a) A state plan may not require more than nominal cost sharing for individuals whose income is less than 150 percent of the poverty level (as defined in section 1902(25) of the Act) applicable to a family of the size involved.

(b) A state plan must require cost sharing in the form of coinsurance, based on the amount paid under a state plan for a service, subject to the following sliding scale:

(1) The rate of coinsurance is 10 percent for individuals with disabilities whose income is more than 150 percent but is less than 200 percent of the poverty level applicable to a family of the size involved.

(2) The rate of coinsurance is 20 percent for individuals whose income is more than 200 percent but less than 250 percent of the poverty level applicable to a family of the size involved.

(3) The rate of coinsurance is 25 percent for individuals whose income is equal to or above 250 percent of the poverty level applicable to a family of the size involved.

(c) A state plan must specify a process that is consistent with standards specified by the Secretary for determining the income of an individual with disabilities for purposes of this section.

Section 2106. Quality Assurance and Safeguards. (a) A state plan must specify how the state will ensure and monitor the quality of services, including:

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

(2) minimum standards for agency providers, and how these standards will be enforced;

(3) minimum competency requirements for employees of agency providers who provide direct services, and how the competency of such employees will be enforced;

(4) obtaining meaningful input from consumers (including consumer surveys) that measure both the extent to which participants get the services described in their care plans, and their satisfaction with the services;

(5) participation by the state in quality assurance activities; and

(6) the role of the long-term care ombudsman (under the Older Americans Act of 1965), and the Advocacy Agency (under the Developmental Disabilities Assistance and Bill of Rights Act), in assuring the quality of services, and protecting the rights of individuals with disabilities.

(b) A state plan must also provide confidentiality and abuse safeguards. These safeguards must:

(1) restrict the use or disclosure of information about applicants and beneficiaries to purposes directly connected with administering a state plan;

(2) guard against physical, emotional or financial abuse or exploitation. Appropriate safeguards for individuals receiving program benefits in the form of direct cash payments or vouchers must be included.

Section 2107. Advisory Groups. (a) The Secretary must establish an advisory group to advise the Secretary and states on all aspects of the home and community-based services program. A majority of the advisory group must be individuals with disabilities and their representatives; the group must also include providers, Federal and state officials, and local community implementing agencies.

(b) Each state plan must also provide for establishing and maintaining an advisory group, appointed by the governor (or other state chief executive officer), to advise the state on all aspects of the state plan for the program. A majority of the advisory group must be individuals with disabilities and their representatives; the group must also include providers, state officials, and local community implementing agencies. Each state must establish a procedure through which all residents of the state, including individuals with disabilities, may nominate individuals to serve on the advisory group.

The state advisory group must:

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

(B) meet regularly with the involved state officials while they are developing the plan, to review and comment on all aspects of it;

(C) participate in public hearings to make sure that public comments

are addressed to the extent practicable;

(D) document differences between the group's recommendations and the state plan;

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

(F) meet regularly with officials of the designated state agency(ies) to advise on all aspects of implementing and evaluating the plan.

Section 2108. Payments to States. (a) Subject to the limitation for administrative costs (section 2102), the Secretary must make quarterly payments to a state with an approved plan from the state's allotment under the Federal budget (under section 2109). The amount paid to a state must be the total of the following:

(1) the Federal matching percentage (defined below) of the amount the state spent during the quarter for home and community-based services under the plan, for individuals with disabilities (as proven by state claims); plus

(2) 90 percent of the amount that the state spent during the quarter for determining eligibility (including preliminary screenings) and assessing individual needs; plus

(3) 90 percent of the amount spent during the quarter to design, develop and install mechanical claims processing systems and for information retrieval (but 75 percent of the costs beginning with quarters in fiscal year 2003); plus

(4) 50 percent of the remainder that a state spent during the quarter that are necessary for proper and efficient administration of the state plan (as found by the Secretary).

(b) The "Federal matching percentage" for a state, is the reference percentage (100 percent minus the state percentage) increased by 28 percentage points. The reference percentage can be no less than 50 percent and no more than 83 percent. The Federal matching percentage can be no less than 78 percent, and may not be more than 95 percent. The reference percentage must be 50 percent for Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa.

The "state percentage" is that percentage which bears the same ratio to 45 percent as the square of the state's per capita income bears to the square of the per capita income of the continental United States (including Alaska) and Hawaii.

(c) States shall receive their payment on a quarterly basis, computed and made as follows:

(1) Prior to the beginning of each quarter, the Secretary must estimate the amount to be paid to the state from its allotment for the quarter, on the basis of a state's report estimating the total amount to be spent in the quarter, and other information as the Secretary finds necessary.

(2) The allotment paid must be reduced or increased by any amount (not previously adjusted) by which the estimate for the amount to be paid to the state for

any previous period of time was more, or less, than what should have been paid.

(d) Section 1903(w) of the Social Security Act (prohibiting the use of provider donations and taxes except under certain circumstances, applies to state expenditures under this part.

Section 2109. Total Federal Budget; Allotments to States. (a)(1) The total Federal budget, stated in this section, for the state plans for home and community-based services is as follows for fiscal years 1996 through 2003:

(A) Fiscal 1996, $4.5 billion;
(B) Fiscal 1997, $7.8 billion;
(C) Fiscal 1998, $11.0 billion;
(D) Fiscal 1999, $14.7 billion;
(E) Fiscal 2000, $18.7 billion;
(F) Fiscal 2001, $26.7 billion;
(G) Fiscal 2002, $35.5 billion;
(H) Fiscal 2003, $38.3 billion.

(2) For each fiscal year after fiscal 2003, the total Federal budget for the state plans is the amount of the total budget for the preceding fiscal year, multiplied by two factors, reflecting changes for the fiscal year in the consumer price index ("CPI increase factor") and changes in the number of individuals with disabilities ("disabled population factor").

(3) The CPI increase factor for a fiscal year is the ratio of the annual average index of the CPI for the preceding fiscal year to the same index for the year preceding that (the second preceding fiscal year).

(4) The disabled increase factor is the difference between 100 percent and 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).

(5) States must inform the Secretary of offsets and reductions in the funds that would have been paid under Medicaid for similar services to individuals with disabilities who instead receive services under the home and community-based services program. States must report this information as the Secretary may require for purposes of monitoring state compliance.

The Secretary must review the state reports and increase the total Federal budget for state plans by the amount that Federal expenditures for home and community-based services under Medicaid are reduced. States may not receive payments under this section for any services for which the state received payment under section 1903(a) of the Social Security Act. Nothing in this part shall be construed as requiring states to determine Medicaid eligibility for individuals receiving services under this program.

(b)(1) From the total amount allotted under this section , the Secretary must allot to each state, for each fiscal year an amount that bears the same ratio to the total Federal budget for that fiscal year as the state allotment factor for the fiscal year (defined below) bears to the total of such factors for all states for that fiscal year.

(2) The Secretary must compute the "state allotment factor" referred to above for each state, for each year, using the following method. A state's annual allotment factor is to equal the sum of its base allotment factor and a low-income allotment factor for each fiscal year.

The base allotment factor is calculated by multiplying the following four elements: the number of individuals with disabilities in the state; 80 percent of the national average per capita budget amount for the fiscal year; the wage adjustment factor for the state; and the Federal matching rate.

The low-income allotment factor is calculated by multiplying the following five elements: the number of individuals with disabilities in the state; 10 percent of the national average per capita budget amount; the wage adjustment factor for the state; the Federal matching rate; and the low income index for the state for the preceding year.

(3) The number of individuals with disabilities is determined as follows: on the basis of the 1990 census, adjusted as appropriate by the March 1994 current population survey, the Secretary must determine the number of individuals in the state by age, sex and income category. The Secretary must also 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 determine such proportions by periodic surveys.

Based on these determinations, the Secretary must establish a 1994 "base disabled population" in each state by multiplying the state's population of individuals with disabilities in each age, sex, and income category by the national average proportion for such population and adding the results. For any fiscal year, the Secretary must determine the number of individuals with disabilities in a state on the basis of the base disabled population, increased or decreased by the percentage increase or decrease in the disabled population of the state (as determined by the current population survey from 1994 to the year before the fiscal year involved.

(4) The national per capita budget amount is determined as follows: the numbers of individuals with disabilities in all the states for the involved fiscal year (determined as above), are added together, and the Federal budget specified for home and community-based services for the year is divided by the total (national) number of individuals with disabilities.

(5) The wage adjustment factor for a state for a fiscal year, referred to above, is the ratio of the average hourly wages for service workers in the state to the national hourly wages for service workers. (The state and national average hourly wages

exclude those of household or protective service workers.) The hourly wages used in the foregoing determination must be based on data from the most recent census that are available.

(6) The low income index for each state for a fiscal year is the ratio, determined for the preceding fiscal year, of the percentage of the state's population with income below 150 percent of poverty to the percentage of the U.S. population with income below 150 percent of poverty. Percentages shall be calculated from the decennial census and updated through the most recent current population survey.

(c) This part of the Act constitutes budget authority in advance of appropriations Acts, and represents the obligation of the Federal government to provide payments to states of the amounts described above (section 2109).

PART 2 - MEDICAID NURSING HOME IMPROVEMENTS

Section 2201. Reference to amendments. See Title IV Subtitle C.

PART 3 -- PRIVATE LONG-TERM CARE INSURANCE

SUBPART A -- GENERAL PROVISIONS

Section 2301. Federal Regulations' Prior Application or Certain Requirements.
(a) The Secretary must issue regulations needed to implement this part, in consultation with the Advisory Council established in section 2302.

(b) Within 120 days after a majority of Council members are appointed, the Secretary must publish a timetable of the regulations to be published subsequently, at the end of the first, second and third years after the appointment of the Council. All regulations must be published at the end of the third year after appointment of the Council.

(c)(1) Notwithstanding the regulatory timetable, within 6 months after enactment of the Act, insurers must 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 (preexisting condition exclusion);
(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);
(H) section 2326 (payment of benefits).

(2) Insurers will be considered as having met the requirements of these sections prior to the effective date of regulations if on an interim basis they adopt the following applicable provisions of the NAIC Model Act and Regulation.

(A) section 6.G(2) of the Model Act and section 24 of the Model Regulation in the case of standard outline of coverage (section 2321(c));

(B) section 14 of the Model Regulation in the case of reporting to state insurance commissioners (section 2321(d));

(C) section 6.D of the Model Act in the case of preexisting condition exclusions (section 2322(c)(1));

(D) section 2322(c) and section 11 of the Model Act in the case of limiting conditions on benefits (2322(c)(2));

(E) section 12 of the Model Regulation in the case of inflation protection (section 2322(d));

(F) section 10 of the Model Regulation in the case of applications for the purchase of insurance (section 2324(b);

(G) Permitted Compensation Arrangements in the Model Regulation in the case of compensation for the sale of policies (section 2324(d));

(H) section 21.C of the Model Regulation in the case of sales through employers or membership organizations (section 2324(g));

(I) section 5 of the NAIC Model Act, in the case of interstate sales of group policies (section 2324(h));

(J) section 7 of the NAIC Model Act in the case of continuation, conversion, replacement and renewal of policies (section 2325(f)).

Section 2302. National Long-Term Care Insurance Advisory Council. (a) The Secretary must appoint a National Long-Term Care Insurance Advisory Council made up of five members.

(b) The Council's 5 members each must have substantial expertise with regard to providing and regulating long-term care insurance. At least one member must have experience as a state insurance commissioner or legislator with expertise in developing policy for and regulating long-term care insurance. Members of the council serve for no more than two successive terms of five years each, with shorter, staggered terms for the first appointees. Members may removed from the council only for cause.

(c) The Secretary of HHS shall appoint a chair from among the members.

(d) The Council must be provided with travel compensation and expenses,

(e) The Council must meet at least twice a year.

(f) The Council must have a salaried executive director and staff. The Council is to be provided with information and assistance from Federal agencies to carry out its duties.

(g) The responsibilities of the Council are to:

(1) advise and assist the Secretary on long-term care insurance;

(2) collect, analyze and disseminate information on long-term care insurance to insurers, providers, consumers and regulatory bodies;

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

(4) monitor the long-term care insurance market and advise the Secretary on any needed regulatory changes.

(h) The Council must also make recommendations to the Secretary on:

(1) uniform terminology, definitions and formats for use in long-term care insurance policies;

(2) a standard format, to be used in long-term care policies, for the outline of coverage required under section 2321(c);

(3) whether Federal standards should be established for the amounts of premiums for long-term care policies and rates of premium increases and if so, on what factors should the standards be based;

(4) whether Federal standards are needed regarding the conditions insurers may place on an insured person to improve his or her coverage;

(5) whether "threshold conditions" for payment of covered benefits (i.e. the degree of impairment required before a benefit will be paid) should be standardized, and related matters;

(6) what procedures for resolving benefit disputes should be required of insurers and states;

(7) standards relating to sales and servicing of long-term care policies, including mandatory training and certification of agents, limitations on insurance agents' commissions or other compensation, sales practices that should be prohibited or limited, and standards for sales of policies by or through employers and other entities.

(8) the extent to which the long-term care insurance aspects of continuing care retirement community arrangements should be subject to regulation (the Secretary must consider these recommendations and promulgate resulting regulations with the Secretary of the Treasury.

(h) In carrying out its responsibilities, the Council may consult broadly, conduct meetings, hearings and research, collect, analyze and disseminate information, develop model formats and procedures for insurance policies and marketing materials and develop proposed regulatory standards, rules and procedures.

(i) For the Council's activities, $1,500,000 is authorized for fiscal year 1995 and $2,000,000 for each succeeding fiscal year.

Section 2303. Relation to State Law. This part may not be interpreted to prevent a state from imposing standards for long-term care insurance policies that are more

protective of individuals, except that state standards may not be inconsistent with this part or regulations issued under the part.

Section 2304. Definitions. For purposes of this part:

(1) "activity of daily living" means eating, toileting, dressing, bathing and/or transferring in and out of bed;

(2) "adult day care" means a program providing social and health-related services to six or more adults during the day, in a community setting;

(3) "advisory council" refers to the national council established under section 2302;

(4) "certificate" means a document showing an individual's coverage under a group insurance policy;

(5) "continuing care retirement community" means a privately-operated residential community that contracts with its residents to provide for their future long-term care;

(6) "designated representative" means the person who represents an incapacitated insured individual to the insurer (the representative is chosen by the insured or by administrative or judicial procedure for an incapacitated individual);

(7) "home health care" means medical and such nonmedical services as homemaker service, assistance with activities of daily living and respite care;

(8) "insured individual" with respect to a long-term care insurance policy means the individual covered by the policy;

(9) "insurer" means a person (including an agent) offering or selling a long-term care insurance policy under which the person is at risk for all or part of the cost of benefits under the policy;

(10) "long-term care insurance policy" has the meaning given the term in section 4 of the NAIC Model Act except that the last sentence of that section does not apply;

(11) "NAIC Model Act" means the model act as amended through January 1993;

(12) "NAIC Model Regulation" means the model regulation as amended through January 1993;

(13) "nursing facility" means a state-licensed facility providing skilled nursing care, rehabilitation services and health-related care and services for individuals requiring these types of care;

(14) "policyholder" means the entity that is the holder of record of a group long-term care insurance policy;

(15) "residential care facility" means a facility (including a nursing facility) providing residents with medical or personal care services in a setting other than an individual or single-family home, and does not provide services at a higher level of care than can be provided by a nursing facility;

(16) "respite care" means temporarily providing care to an individual, in his or her home, to relieve individual's unpaid caregiver for a period of time;

(17) "state insurance commissioner" means the state official with that title or,

absent the title, with primary responsibility for regulating insurance.

SUBPART B -- FEDERAL STANDARDS AND REQUIREMENTS

Section 2321. Requirements to Facilitate Understanding and Comparison of Benefits. (a) The Secretary, after considering advisory council recommendations, must issue regulations to standardize the formats and terminology of long-term care insurance policies, to require insurers to provide customers and beneficiaries with information on available public and private long-term care coverage, and to establish other requirements to promote consumer understanding and facilitate comparisons of benefits. The "other requirements" must at least include the following requirements in this section.

(b) The Secretary must require insurers to use uniform terminology, definitions of terms, and formats in long-term care insurance policies.

(c) The Secretary must require insurers to provide an outline of coverage under a long-term care insurance policy as part of each policy, to make such an outline available to each potential purchaser and provide such an outline to each insured individual and policyholder. The outline must be in the uniform format prescribed by the Secretary, must reflect the contents of the policy clearly and accurately, must be periodically updated, and must include at least the following elements:

(A) a description of principal benefits covered including services in residential care facilities, terms for obtaining upgraded benefits, benefit "triggers" and principal exclusions from and limitations on coverage;

(B) a statement of terms under which a policy may be returned with a refund during a period for initial examination (of the policy), continued in force or renewed, or converted from group to individual coverage;

(C) a statement of circumstances in which a policy may be terminated and if applicable, a refund obtained including the death of the insured, nonpayment of premiums, decision by the insured not to renew, and any other circumstance;

(D) a statement of the total annual premium, any right reserved by the insurer to change premiums, any limitation on annual premium increases, any expected premium increases, and circumstances for waiver of premiums payment;

(E) a readily understandable statement in boldface type, on the face of the document, that the outline is a summary, not the contract of insurance.

(F) information on average costs for nursing facility and other types of care as specified by the Secretary; information on the value of the policy benefits relative to such care costs, and a comparison of policies, for a period of 20 years or more, of policies with and without protection for inflation. The outline must also declare whether the amount of benefits will increase over time and any limitations on and premium increases for the benefit increases;

(G) 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 information required by the Secretary of HHS.

(d) The Secretary of HHS must require each insurer to report specified information each year to each state insurance commissioner in which the insurer sells a long-term care insurance policy. Information that must be reported includes the standard outline of coverage (above), rates of policy lapses and replacements; the ratio of premiums collected to benefits paid; reserves; written materials used in selling or promoting the policy; and other information required by the Secretary.

(e) The Secretary must require each insurer to provide to each individual, before he or she buys a long-term insurance policy from the insurer, information on eligibility and benefits under the insurer's policy, and on additional benefits available under policies of other private insurers, and information on eligibility and benefits under each public long-term care program administered by the state, Medicare programs, and each regional alliance in the state. The insurer is obligated to provide the above information to the extent that it is available from the state insurance commissioner.

Section 2322. Requirements Relating to Coverage. (a) The Secretary, after considering advisory council recommendations, must issue regulations on requirements for terms of and benefits under long-term care insurance policies. The regulations must include at least the following requirements in this section.

(b)(1) A long-term care insurance policy may not exclude or limit coverage for a condition or disability because the insured was treated for or diagnosed with the condition before the policy was issued; however, an insurer may so exclude or limit coverage if

(A) the insurer determines before issuing the policy that the insured had the condition during the six months before the effective date of the policy or

(B) the need for or the service benefit begins within six months after the effective date of the policy.

(2) The effective date of a replacement policy, for purposes of these exclusion and limitation rules, is the effective date of the policy being replaced.

(c)(1) A long-term care insurance policy may not condition an insured's eligibility for benefits on:

(A) a requirement for prior hospitalization or the need for any other type of service;

(B) a particular medical diagnosis or group of diagnoses;

(C) compliance by licensed or certified providers of the benefits sought with any conditions not required by Federal or state law;

(D) the benefits being provided at a higher level of care than is needed by the insured.

(2) A long-term care insurance policy that provides benefits for home or community-based services at some other site than a residential care facility

(A) may not limit the benefits to services of registered or licensed practical nurses;

(B) may not limit benefits to persons or entities participating in Medicaid, Medicare, or part 1 of this subtitle; and

(C) must at least cover personal assistance with activities of daily living and home health, adult day and respite care.

(3) A long term care insurance policy that provides benefits for any nursing facility services:

(A) must cover such services provided by all types of nursing facilities licensed in the state; and

(B) may cover care in other residential facilities.

(4) A long-term care insurance policy may not discriminate against certain medical conditions with respect to the "threshold" conditions that determine whether an insured will receive benefits and in the amount of benefits. The conditions for which such different treatment is prohibited are:

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

(B) any organic or inorganic mental illness;

(C) mental retardation or any other cognitive or mental impairment; and

(D) HIV infection or AIDS.

(d)(1)An insurer selling a long-term care insurance policy must offer the purchaser the option of inflation protection (annual increases in benefits) if the purchaser pays higher premiums.

(2) The increases for each year must reflect a percentage of the full value of benefits for the previous year, but no less than 5 percent of that value (or the rate of increase determined by the Secretary to be adequate).

(3) The inflation protection described above may be excluded from an individual's coverage only if the individual objects to it in writing.

Section 2323. Requirements Relating to Premiums. (a) The Secretary, after considering advisory council recommendations, must issue regulations on requirements for premiums for long-term care insurance coverage. The regulations must include at least the requirements in this section.

(b) The Secretary, after considering advisory council recommendations, may establish by regulation appropriate standards and requirements for

(1) mandatory or optional state procedures for reviewing and approving premium rates and increases or decreases in such rates;

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

(3) the factors to be considered by an insurer in proposing and a state in approving or rejecting rates and increases of premiums;

(4) the extent of consumer participation or representation in rate-setting, and consumer access to information used in setting rates.

Section 2324. Requirements Relating to Sales Practices. (a) The Secretary, after considering advisory council recommendations, must issue regulations on requirements for the selling and offering for sale long-term care insurance policies. The regulations must include at least the requirements in this section.

(b) An insurer offering a long-term care insurance policy must meet requirements established by regulation for the content, format and use of application forms for the policies.

(c) An insurer may not sell or offer a long-term care insurance policy through an agency who fails to comply with minimum training and certification standards established by the Secretary.

(d) An insurer may not pay more in compensation to agent(s) for sales or servicing or renewing long-term care insurance policies than the maximum specified by the Secretary in regulations.

(e) The following practices are prohibited in the sale or offering of long-term care insurance policies:

(1) false and misleading representations;

(2) inaccurate completion of medical history of an applicant for insurance;

(3) using force, fright or other undue pressure to induce the purchase of a policy;

(4) "cold lead advertising," which means any method of inducing an individual to contact an insurer or agent for the purpose of inducing the individual to buy insurance, if that purpose is not disclosed conspicuously;

(f) An insurer or agent may not sell or issue a long-term care insurance policy that the insurer or agent knows (or should know) duplicates coverage that the purchaser already has (except to replace a duplicative policy).

(g)(1) In sales of long-term care insurance endorsed by or sold through an employer, organization, association or other entity,

(A) the insurer must not sell through the entity unless certain requirements are met; and

(B) the entity receiving compensation for the sale or marketing shall be

considered the insurer's agent.

(2) The entity that endorses a long-term care insurance product must:

(A) disclose prominently to individuals receiving insurance policy information: the manner in which the entity selected the insurer and the policy; the extent to which the policy was evaluated by an experienced, independent analyst; organizational or financial connections between the entity and the insurer (or a related entity or insurer); and the nature and amount of any compensation for the endorsement or sale of the policy.

(B) make counseling available, directly or through referrals, to potential purchasers of the policy.

Section 2325. Continuation, Renewal, Replacement, Conversion, and Cancellation of Policies. (a) The Secretary, after considering Advisory Council recommendations, must issue regulations on requirements for renewal, replacement, conversion and cancellation of long-term care insurance policies. The regulations must include at least the requirements in this section.

(b) Each insured individual must have an unconditional right to return a policy within 30 days after it is issued and delivered and to receive a full refund of the premium he or she has paid.

(c) An insurer has the right to cancel a long-term care insurance policy, or to refuse to pay a claim, on the basis of evidence that the insured falsified or failed to disclose information material to eligibility for coverage but only if

(1) the insurer produces written documentation at the time of application that the insurer requested the information that was withheld and the individual's response;

(2) the insurer produces medical records of evidence showing that the insured knew or should have known that information furnished was false, misleading or incomplete;

(3) the notice of cancellation is provided within three years of the policy's effective date; and

(4) the insured has an opportunity to refute the insurer's evidence.

(d)(1) Insurers have the right to cancel long-term care insurance policies for nonpayment of premiums, subject to certain requirements:

(2) the requirements are as follows:

(A) the insurer must give written notice not earlier than the date on which the payment is 30 days past due and 30 days must elapse to permit the insured to respond to the notice;

(B) the notice requirement in the case of group policies applies to each insured individual.

(3) the insurer must reinstate the individual retroactively to the date of cancellation if the insurer receives within 5 months of the date of cancellation evidence that the individual was incapacitated and all premiums due and late charges

are paid.

(4) incapacitation is defined as a determination of incapacitation by a qualified health professional of 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.

(5) the insurer must permit an individual to designate a representative at the time of sale for purposes of communication concerning premium payments or to complete a signed and dated statement declining such representation.

(e) The Secretary, after considering advisory council recommendations, must by regulation require appropriate nonforfeiture benefits in any long-term care insurance policy that lapses for any reason (including non-payment, cancellation or failure to renew but excluding lapses due to death) after it has been in effect for a specified minimum period of time. The percentage of non-forfeiture benefits must increase with the amount of premiums paid.

(f)(1) Insurers may not cancel or refuse to renew or replace a long-term care insurance policy for any reason other than fraud or material misrepresentation or for nonpayment of premiums.

(2) Each policy must clearly state its duration, the insured's rights and conditions for renewal, the date and manner by which an option to renew must be exercised, and any applicable restrictions or limitations consistent with this part.

(3) An insurer may not sell a replacement policy to an individual or group that reduces any individual's coverage as a replacement for his or her more generous policy. Individuals may knowingly and willfully elect to substitute a less generous policy as a replacement policy.

(4)(A) Each group long-term care policy must permit each insured policyholder at the insurer's option to continue or convert coverage with equivalent coverage (as determined by guidelines issued by the Secretary). Insurers must comply with other requirements for continuation, renewal, replacement or conversion of long-term care insurance policies that are established by the Secretary.

(B) Insurers must allow continuation in cases in which the relationship of related individuals covered jointly is terminated by death or divorce.

(C) Insurance policies meet continuation requirements if the same benefits are maintained, subject only to timely payment requirements.

(D) Insurance policies meet conversion requirements if each previously covered individual is entitled to a replacement policy with benefits at least identical or substantially the same without requiring evidence of insurability and at premium rates no higher than the initial group policy rate.

(5) The Secretary must develop long term care comparison guidelines for the purpose of determining whether policy benefits are substantially equivalent. Prior to the effective date of Federal guidelines, state insurance commission guidelines for substantial equivalence shall apply.

(6) The Secretary may establish other requirements for cancellation,

continuation, conversion, renewal and replacement.

Section 2326. Requirements Relating to Payment of Benefits. (a) The Secretary, after considering advisory council recommendations, must issue regulations establishing requirements for claims for and payment of benefits under long-term care policies. The regulations must include at least the requirements in this section.

(b) Each long-term care insurance policy must meet certain requirements with respect to identifying and determining if an insured person meets threshold coverage conditions:

(1) the policy must specify the level of functional or cognitive impairment needed (the "threshold conditions") to receive benefits under the policy. The Secretary may require the use of standardized thresholds. Each policy must provide a procedure for determining whether the threshold conditions have been met for an insured individual.

(2) Each policy must apply uniform procedures for determining whether threshold conditions have been met which:

(A) apply uniform standards, procedures and formats if specified by the Secretary;

(B) permit an initial evaluation by a qualified independent assessor (selected by the individual or a representative) of whether the threshold conditions have been met;

(C) permit the insurer to obtain a reevaluation by an evaluator chosen and paid for by the insurer;

(D) provide that the insurer will consider the threshold conditions as having been met in cases in which the insurer does not reevaluate or where both the initial evaluation and the reevaluation conclude that the conditions are met.

(E) provide for a final resolution by a state agency where the initial and reevaluation reach inconsistent conclusions.

(3) a qualified independent assessor means a licensed or certified professional who meets standards established by the Secretary after consulting with the Secretary of the Treasury, who has no significant or controlling financial interest in the insurer or is not an employee of the insurer.

(c) Insurers must be required to promptly pay or deny claims for benefits by individuals meeting threshold conditions, provide written explanations for their actions on claims, and provide an administrative procedure for appealing a denial of a claim.

SUBPART C - ENFORCEMENT

Section 2342. State Programs for Enforcement of Standards. (a) A state is eligible for enforcement grants under this subpart, if the state has a program that meets certain conditions under rules of the Secretary.

(1) the program must include the elements required under this subpart; and

(2) the program must be designed to ensure compliance with the requirements established under subpart B, both for long-term care insurance policies sold in the state and for insurers offering such policies and their agents.

(b) A state program must provide for:

(1) monitoring compliance of insurers doing business in the state and of long-term care insurance policies sold in the state with requirements under this part. The state program must provide for review, certification and annual recertification of each such policy sold in the state, annual reporting by insurers needed to ensure compliance, data collection from insurers, service providers, insured individuals and others, and oversight of insurers' marketing practices, and procedures for monitoring insurers' administration of benefits including determination of eligibility and actions on claims for payment;

(2) procedures for providing insurers with information on eligibility and benefits under public long-term care programs administered by the state, so that insurers can comply with the consumer-information requirements of section 2321(e)(3);

(3) procedures for investigating and resolving consumer complaints and disputes with regard to long-term care insurance conduct under this law or other applicable laws including disputes over eligibility, amounts payable and other issues involving the rights and responsibilities of insurers and insured persons;

(4) technical assistance to insurers to help insurers comply with requirements of this part and other relevant state laws.

(c) A state program must ensure that the state insurance commissioner (or other appropriate authority) has the authority to:

(1) prohibit the sale or marketing of any long-term care insurance policy that does not comply with requirements of this part;

(2) require an insurer to develop, submit for state approval and carry out in less than one year a correction plan for practices that do not comply with requirements of this part as a condition of continuing to do business in the state;

(3) direct an insurer out of compliance with requirements of this part (subject to appropriate due process) to eliminate the noncompliance within 30 days;

(4) assess civil money penalties for each violation up to the greater of $10,000 or three times the amount of the commission involved, for violations of requirements concerning compensation or sale of policies, prohibited sales practices, and prohibition on sale of duplicate benefits, for such other violative acts as the Secretary specifies in regulation and other cases as the state finds appropriate; and

(5) other authority that the state finds appropriate or necessary for enforcing requirements under this part.

(d) A state must maintain the records, make the reports, and cooperate with the audits that the Secretary finds necessary to determine compliance with this part.

(e)(1) The Secretary must approve a state program meeting the requirements of this part.

(2) the Secretary must also provide the state official chiefly responsible for regulating long term care insurance with a description of the Medicare programs, making clear the unavailability of long-term care under the programs, for distribution to insurers selling long-term care insurance in the state.

Section 2342. Authorization of Appropriations for State Programs. For states with programs meeting the requirements of this part, the following amounts are authorized: $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 1999 and each fiscal year thereafter. These funds are available until spent.

Section 2343. Allotments to States. A state's allotment for its long-term care insurance program (if the program is approved under this part) is an amount determined by the Secretary, taking into account the numbers of policies for such insurance sold in the state, the number of its elderly residents, and other factors.

Section 2344. Payments to States. A state with an approved program is entitled to an annual payment of its allotted funds, for up to fifty percent of the cost of the program's activities. A state may not use funds from any Federal source to pay its share of program costs under this subpart.

Section 2345. Federal Oversight of State Enforcement. (a) The Secretary must periodically review state regulatory programs approved under 2341 for compliance with requirements of this part.

(b) If the Secretary determines that a state program is not in compliance, the Secretary must notify the state specifically of the problem and permit the state a reasonable opportunity to correct the problem (including time to develop and secure the Secretary's approval of a correction plan). The Secretary must withdraw approval of the state program if it fails to eliminate the problem by the date set by the Secretary.

(c) Where a correction plan is needed, the Secretary may permit a state reasonable time after notice to develop a correction plan for the Secretary's approval and permit the state reasonable time to eliminate the cause for non-compliance.

(d) The Secretary must withdraw approval in the case of states that fail to cure the non-compliance problem by the specified date.

Section 2346. Effect of Failure to Have Approved State Program. (a) No insurer may sell or market any long-term care insurance policy in a state without an approved regulatory program. A policy shall not be considered sold or offered for sale solely because it is sold or offered to a resident of the state.

(b) An insurer is subject to a civil money penalty of up to the greater of $10,000 or three times any commission involved for each instance in which the insurer sells or markets a long-term care insurance policy in violation of subsection (a). The Secretary shall enforce this provision in accordance with civil money penalty procedures under section 5412 of the Health Security Act.

(c) The prohibition on sales and marketing in subsection (a) takes effect one year after the date that the Secretary first promulgates regulations on the prohibition. However, if a state requires state legislative action to comply, it will not be considered to be out of compliance until the first day of the first calendar quarter that begins after the first regular session of the state legislature following promulgation of the regulation.

SUBPART D -- CONSUMER EDUCATION GRANTS

Section 2361. (a) The Secretary may make grants for developing and implementing long-term care insurance information, counseling and other programs; the grants may be made to states, regional alliances (at the option of the state in which an alliance is located) and national organizations representing insurance consumers, long-term care providers and insurers.

(b) Applications for grants must be in the format and include information required by the Secretary. The goals of programs under this section are to increase consumer understanding and awareness of their long-term care options with regard to risks of needing long-term care and costs of these services, shortfalls in long-term care coverage under Medicare, supplementary Medicare ("medigap"), policies, standard private health insurance and state programs; availability, variations in coverage and common features of private long-term care insurance and pitfalls to avoid when purchasing such insurance.

Grants under this section may fund appropriate activities including coordination of public and private entities to carry out a grant-funded program; collection, analysis, publication and dissemination of information; consumer education, outreach and information programs; consumer counseling and consultation programs and other appropriate activities. Grants proposing innovative approaches to assisting individuals who might benefit from or are considering buying long-term care insurance must be given priority.

(c) Grants may not be longer than 3 years.

(d) Each grantee must annually evaluate its program effectiveness and report on it to the Secretary and the Secretary must report annually to Congress on program effectiveness.

(e) The following amounts are authorized for grants under this section: for grants to states, $10,000,000 for each year in fiscal years 1995 through 1997; for grants to eligible organizations, $1,000,000 for each of fiscal years 1995 through 1997.

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 VI.

PART 5 - TAX INCENTIVES FOR INDIVIDUALS WITH DISABILITIES WHO WORK

Section 2501. Reference to tax provision. For amendment to 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) The Secretary must establish a demonstration program to test the effectiveness of various approaches to financing and providing integrated acute and long-term care services for chronically ill or disabled persons who meet the eligibility criteria in this part.

(b)(1) Except as permitted by the Secretary, each demonstration approved under this section must offer the following services and benefits:

(A) the comprehensive benefit package under Title I of the Health Security Act;

(B) benefits relating to the transition from acute to long-term care including: assessment and consultation; medical rehabilitation; inpatient transitional care; home health care and home care; caregiver support and self-help technology;

(C) long-term care benefits, including adult day care; personal assistance services; homemaker and chore services; home-delivered meals; respite services; nursing facility services in specialized care units and in other residential settings; and assistive devices and environmental modifications; and

(D) specialized habilitation services (for participants with developmental disabilities).

(2) The Secretary may allow a demonstration to omit long-term care services and specialized habilitation services under sub-paragraphs (C) and (D) or to provide additional services if the Secretary determines this appropriate, taking into consideration such factors as the needs of a specialized group of beneficiaries, the availability of the omitted services under other programs, and the geographic availability of services. The Secretary must assure that in approving demonstrations that vary from the benefit list under paragraph (1), the demonstrations as a group will adequately test financing and delivery models for all of the required services.

(c) The Secretary must establish eligibility criteria for individuals receiving benefits in the demonstrations. The following groups of individuals may be eligible under the criteria:

(1) individuals with disabilities who are entitled to services and benefits from a state program under part 1 of this subtitle (home and community care);

(2) individuals entitled to benefits under parts A and B of Medicare (title XVIII of the Social Security Act);

(3) individuals entitled to Medicare who are also medical assistance recipients or SSI beneficiaries.

(d)(1) Applications by entities to participate in a demonstration must be in the format and contain the information required by the Secretary.

(2) An application must state the services to be provided (either directly or through participation agreements); 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 assure continuity of care;

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

(F) other services that the Secretary may require.

(3) The applicant must provide evidence of consumer participation in planning and conducting the demonstration (including aspects of the demonstration such as information on self-help, health promotion and disability prevention practices, enrollee contributions to the cost of care, care planning and decisions concerning treatment, grievance resolution and appeals procedures, quality assurance and provider contracting, and consumer satisfaction evaluation).

(4) Applicants must meet eligibility criteria established by the Secretary, including the existence of adequate financial controls, a demonstrated commitment to the goal of the demonstration, adequate information systems, and compliance with applicable state laws.

(e) An entity conducting a demonstration is entitled to receive, for each period of services for each enrollee, such payment amounts as the Secretary provides. These amounts may include risk-based and non-risk-based payments by government programs, third parties, program enrollees or any combination of such payments. Amounts paid by the Secretary may vary by project and by enrollee.

(f) The Secretary must publish a request for applications under this section no later than a year after the Act is enacted, and must authorize no more than 25 demonstrations, each to last for 7 years from the date of the award.

(g) The Secretary must evaluate the demonstration projects and make interim and final reports to Congress. The final report must contain recommendations regarding whether to include some or all of the tested models for integrated services in the benefit package of

title I of the Act or in Medicare.

(h) The following amounts are authorized for costs of the demonstration authorized in this section (including costs of technical assistance and research and evaluation): $7,000,000 for fiscal year 1996 and $4,500,000 for each of the six fiscal years thereafter. Authorized funds are available until spent.

Of the total authorized above, no less than $1,000,000 must be made available for studies of the feasibility of systems to provide integrated care for non-aged populations).

Funds are also authorized for costs of benefits for which no public or private program or entity is legally obligated to pay. The amounts authorized for this purpose are $50,000,000 for the first fiscal year in which grants are awarded under the section and in each of the four following years.

Section 2602. Performance Review of the Long-term Care Programs. (a) The Secretary must make interim and final reports to Congress on the effectiveness of programs established under this subtitle. The interim report must be made no later than the end of the seventh full calendar year that begins after enactment of the Act, and the final report by two years later.

(b) Evaluations must address at least states' effectiveness in delivering services, access to and quality of services, the performance of the private sector in offering affordable and adequate long-term care insurance, costs of insurance, and the effectiveness of the programs to integrate long-term, and acute care and social services.

TITLE III - PUBLIC HEALTH INITIATIVES

SUBTITLE A - WORKFORCE PRIORITIES UNDER FEDERAL PAYMENTS (H.R. 3600 and S. 1757 p. 504)

PART 1 - INSTITUTIONAL COSTS OF GRADUATE MEDICAL EDUCATION; WORKFORCE PRIORITIES

SUBPART A - NATIONAL COUNCIL REGARDING WORKFORCE PRIORITIES

Section 3001. National Council on Graduate Medical Education. (a) Establishes the Council on Graduate Medical Education within the Department of Health and Human Services.

(b) Requires the Secretary to carry out Subpart B (dealing with the allocation of residency positions among specialties and programs) through the Council.

(c) Specifies the following categories of private sector individuals to be included in the membership of the Council:consumers; medical school faculty; physicians in private practice; officers or employees of health alliances; officers or employees of health plans; others determined to be appropriate by the Secretary. Also authorizes appointment of Federal officers or employees as ex officio members of the Council.

(d) Requires the Secretary to designate one member as Chair.

(e) Defines "medical school" as a school of medicine or of osteopathic medicine, referencing section 799 of the Public Health Service Act.

SUBPART B--AUTHORIZED POSITIONS IN SPECIALITY TRAINING

Section 3011. Cooperation Regarding Approved Physician Training Programs. (a) With respect to funding under section 3031 (Subpart C), requires that approved physician training programs enter into agreements that the number of enrollees in their programs will be in accordance with this subpart.

(b) Defines an "approved physician training program" as any postgraduate physician training program participation in which may count toward specialty certification. Includes programs based in ambulatory settings whether or not they also provide inpatient hospital services. Defines "eligible program" as an approved physician training program receiving funding under Subpart C,. Includes all medical, surgical and other physician specialties and subspecialties within the term "medical specialty."

Section 3012. Annual Authorization of Number of Specialty Positions;

Requirements Regarding Primary Health Care. (a) Requires the National Council to designate for each academic year the number of individuals who are authorized to be enrolled in eligible programs.

(b) Requires that at least 55 percent of individuals completing eligible programs nationwide be in primary care, beginning with the class entering training in the year 1998-99.

(c) Requires the National Council to designate the number of positions in each specialty for three academic years at a time, beginning with 1998-99 through 2000-01.

(d) Specifies that the need for additional practitioners in the specialty be included among the factors considered by the National Council in designating specialty positions. Requires the National Council to consider the recommendations of organizations representing physicians in particular specialties and of organizations representing consumers of the services of such physicians. Requires the National Council to ensure that the total number of residency positions nationwide bears a relationship to the number of graduates of U.S. medical schools consistent with the purpose of this subpart, beginning with academic year 1998-99, and is reduced between the years 1998-99 through 2002-03.

(e) Defines "primary health care" as family medicine, general internal medicine, general pediatrics, and obstetrics and gynecology.

Section 3013. Allocations Among Specialties and Programs. (a) Requires the National Council to allocate the designated annual number of specialty positions nationwide among eligible programs.

(b) Requires that the allocations among programs be done for three years at a time, with at least one year advance notice to programs, with the first allocations beginning in academic year 1998-99.

(c) Requires that the historical distribution of specialty positions among different areas of the country and the quality of each of the programs be included among the factors considered in making allocations among programs. Requires that the following be included among the factors considered by the National Council in making an allocation for an eligible program: the extent to which the program includes training participants who are members of racial or ethnic minority groups and the extent to which such group is underrepresented in the field of medicine or its specialties. Requires that the National Council consider recommendations of organizations representing physicians in particular specialties and of organizations representing consumers of the services of such physicians in making allocations among programs.

SUBPART C -- INSTITUTIONAL COSTS OF GRADUATE MEDICAL EDUCATION

Section 3031. Federal Formula Payments to Approved Physician Training Programs. Requires the Secretary to make payments for the operation of approved physician training programs that submit applications (in accordance with section 3032), beginning in calendar year 1996.

Section 3032. Application for Payments. (a) Requires that applications for payment be submitted on a timely basis; contain the described funding agreements and provide assurances of compliance with those agreements that are satisfactory to the Secretary; are in the form and manner and contain information required by the Secretary; and contain agreements by the institution within which the program operates that payments will be made directly to the program by the Secretary.

(b) Institutions operating residency programs must meet these requirements as a condition of participation as providers in alliance health plans.

Section 3033. Availability of Funds for Payments; Annual Amount of Payments. (a) Establishes an annual health professions workforce account to contain amounts determined by the Secretary to be necessary for making payments to operate eligible programs and to make transitional payments to programs (under section 3051, dealing with programs that lose residency positions), within the following limitations for specified calendar years: $3,200,000,000 in 1996; $3,550,000,000 in 1997; $4,800,000,000 in 1998; $5,800,000,000 in 1999; $5,800,000,000 in 2000; and in subsequent years, $5,800,000,000 increased by the general health care inflation factor (as defined in section 6001(a)(3)) for each year.

(b) Payments to each eligible program shall equal the full-time-equivalent number of residents in the program multiplied by the national average of the costs of training residents (as determined for the academic year 1992-93, trended forward by the consumer price index for each year, and adjusted to reflect regional differences in wage and wage-related costs).

(c) Payments in any year will be pro-rated if necessary on the basis of available funds. Under section 4051, payments under Medicare for direct graduate medical education costs are terminated for cost reporting periods beginning on or after October 1, 1995.

Section 3034. Additional Funding Provisions. Funds for the annual health professions workforce account are to come from three sources: Medicare, corporate alliances, and regional alliances.

Under section 4051, Medicare is required to make transfers from the Part A and Part B Trust Funds at the rate at which payments for the direct costs of graduate medical education would have been made, in the amount of $1,500,000,000 in fiscal year 1996 and $1,600,000,000 for fiscal years 1997 and 1998, and for years beyond 1998 at the 1998 rate increased by the consumer price index.

After the level of Medicare payments is determined, corporate and regional alliances pay the balance needed in the annual health professions workforce account, with such payments coming from the 1 percent corporate alliance assessment (under section 7121) and the 1.5% regional alliance assessment (under section 1353). For 1996 and 1997, one-half of such regional alliance payments are available for the annual health professions workforce account, with the remainder made available from payments by corporate alliances. In subsequent years, payments into the annual health professions workforce account are made in proportion to the total payments to corporate and regional health plans by corporate and regional alliances, respectively.

Beginning in 1996 an additional transfer of funds is made equal to 50 percent of the amount made available for graduate nurse education under section 3063(b),.

SUBPART E - TRANSITIONAL PAYMENTS

Section 3051. Transitional Payments to Institutions. The Secretary must make payments to institutions that operate programs that lose specialty training positions as a result of allocations by the National Council. Applications for payment must be submitted on a timely basis; contain the described funding agreements and provide assurances of compliance with those agreements that are satisfactory to the Secretary; and be in the form and manner and contain information required by the Secretary. The institution requesting payment must have cooperated with the programs in permitting payments to be made directly to the programs by the Secretary.

Payments are equal to the number of full-time-equivalent specialty positions lost (equal to the difference between the positions for which payment will be made under section 3031 and the number of full-time-equivalent specialty positions at the institution for academic year 1993-94) multiplied by the national average salary of training participants (as determined for the academic year 1992-93, trended forward by the consumer price index for each year, and adjusted to reflect regional differences in wage and wage-related costs). Payments may begin in calendar year 1998 or the first year that the programs of the institution experience a net reduction in specialty positions because of the allocations by the Council. Such payments are to be made over a four year period. Payments in the first year are equal to the amount calculated above in the first year, but decline by 25 percent in each of the three succeeding years.

PART 2 - INSTITUTIONAL COSTS OF GRADUATE NURSING EDUCATION; WORKFORCE PRIORITIES

Section 3061. National Council; Authorized Graduate Nurse Training Positions; Institutional Costs. (a) Establishes a program with respect to graduate nurse training that parallels the program for approved physician training programs under part 1.

(b) Such programs are ones for advanced nurse education, nurse practitioners, nurse midwives, nurse anesthetists, and other training in clinical nurse specialties determined by the Secretary to require advanced education. Programs must meet the conditions defined in sections 821, 822, and 831 of the Public Health Service Act.

Section 3062. Applicability of Part 1 Provisions. (a) The provisions of part 1, , apply to the graduate nurse training program under section 3061 in the same extent and manner as they apply to the graduate physician training programs, except as they are modified in this part. (b) For the purposes of this program, the council is the National Council on Graduate Nurse Education. The council will make allocation of nurse training positions in the same way as the Council on Graduate Medical Education does for physician residencies.

Section 3063. Funding. The amount available for graduate nurse training programs under this part is $200,000,000 annually, provided as direct transfers from the Treasury under sections 3034, and 3104. Under section 4051, payments under Medicare for the costs of approved educational programs other than direct graduate medical education costs are specifically continued for cost reporting periods beginning on or after October 1, 1995.

PART 3 -- RELATED PROGRAMS

Section 3071. Programs of the Secretary of Health and Human Services. (a) Authorizes to be appropriated $400,000,000 for fiscal year 1994 and each year thereafter, for carrying out the programs described in this section, in addition to amounts otherwise authorized to be appropriated for such programs. Requires the Secretary of Health and Human Services to carry out the programs in this section.

(b) Establishes or expands existing programs with respect to training primary care physicians and physician assistants, including programs to train additional numbers of physicians and physician assistants; to retrain mid-career physicians previously certified in a nonprimary care specialty; to expand the supply of physicians with special training to serve in medically underserved areas; to expand service-linked educational networks for training in community settings; to provide training in managed care, practice management, and continuous quality improvement; and to enhance information on primary care workforce issues.

(c) Establishes or expands programs with respect to training of underrepresented minorities and disadvantaged persons, including programs to increase the number of such persons in the health professions through financial assistance, recruitment and retention, enhancing interest at the preprofessional level, and training of additional minority health professions faculty.

(d) Establishes or expands programs with respect to training of nurses, including training additional numbers of nurse practitioners and nurse midwives; baccalaureate nurses

for careers in teaching, community health service and specialized clinical care; nurse clinicians and nurse anesthetists; and, school-based community nurses; also programs to promote research on nursing workforce issues.

(e) Establishes a program to develop and encourage adoption of model practice statutes for advanced practice nurses and physician assistants, and other to support efforts to remove inappropriate barriers to practice by advanced practice nurses and physician assistants.

(f) Establishes or expands programs with respect to training health professionals and administrators in managed care, cost-effective practice management, continuous quality improvement practices, and provision of culturally sensitive care.

(g) Authorizes the Secretary to carry out these programs through existing programs in Titles VII and VIII of the Public Health Service Act.

Section 3072. Programs of the Secretary of Labor. (a) Authorizes to be appropriated $200,000,000, for fiscal year 1994 and each year thereafter, for carrying out the programs described in this section, in addition to amounts otherwise authorized to be appropriated for such programs. Requires the Secretary of Labor to carry out the programs in this section.

(b) Establishes programs to provide for skills upgrading and occupational retraining (including retraining health care workers as technicians, nurses, and physician assistants) and for quality and workforce improvement; to assist health care workers in career advancement; to develop health worker job banks; to provide for joint labor-management decision-making on workplace matters; and to facilitate the comprehensive workforce adjustment initiative.

(c) Requires the Secretary of Labor, in carrying out programs under this section, to provide for specific skill requirements, internal career movement opportunities, employment during retraining, evaluation and dissemination.

(d) Requires the Secretary, in carrying out programs under this section, to provide for joint labor-management implementation and administration and discussion and consultation.

Section 3073. National Institute for Health Care Workforce Development. (a) Requires the establishment of the National Institute for Health Care Workforce Development jointly by the Secretary of Health and Human Services and the Secretary of Labor.

(b) Authorizes the Secretary of Labor to carry out section 3073 through the Director of the Institute.

(c) Requires the Director of the Institute to make recommendations regarding health

care workforce needs of the system established under the Act and the impact of the new system on health care workers and the needs of such workers with respect to education, training and related career development.

(d) Establishes an advisory board for the Institute, including both Secretaries and representatives of health care workers, institutions, education and consumer organizations, and other appropriate individuals. Sunsets the Institute at the end of calendar year 2000.

Section 3074. Requirement for Certain Programs Regarding Redeployment of Health Care Workers. With respect to plans for State programs for home and community-based services under section 2102(a), and for mental health and substance abuse service integration under section 3511(a), requires negotiations with labor unions prior to implementation of such plans, and the inclusion of evidence concerning such negotiations in such plans.

SUBTITLE B - ACADEMIC HEALTH CENTERS
(H.R. 3600 and S. 1757 p. 548)

PART 1 - FORMULA PAYMENTS

Section 3101. Federal Formula Payments to Academic Health Centers. (a) Requires the Secretary to make payments to teaching hospitals and to academic health centers that operate teaching hospitals.

(b) The payments to the hospitals and health centers are to assist with specialized costs they incur that are not routinely incurred by other entities in providing health services.

(c) Defines an "academic health center" as an entity that operates a school of medicine or osteopathy, operates or is affiliated with other health professional training programs, and operates or is affiliated with a teaching hospital. Defines a teaching hospital as a hospital that operates an approved physician training program (as defined under section 3011).

Section 3102. Request for Payments. Requires that requests for payment be submitted on a timely basis; contain the described funding agreements; and be in the form and manner and contain such agreements, assurances, and information required by the Secretary. Requires that entities involved agree to maintain their status as a teaching hospital or as an academic health center.

Section 3103. Availability of Funds for Payments; Annual Amount of Payments. Establishes an annual academic health center account that provides for total payments in each calendar year of $3,100,000,000 in 1996; $3,200,000,000 in 1997; $3,200,000,000 in 1998; $3,700,000,000 in 1999; $3,800,000,000 in 2000; and in each subsequent year, $3,800,000,000 increased by the general health care inflation factor (as defined in section 6001(a)(3)) for such years.

(b) Provides for distribution of such funds among academic health centers in proportion to the product of their relative gross receipts for patient care and the indirect teaching adjustment factor (under section 1886(d)(5)(B)(ii) of the Social Security Act) applicable to patients discharged from the center in the preceding year or in 1997.

(c) Requires the Secretary to report to the Congress by July 1, 1996, with any recommendations for allocating funds among centers. Under section 4052, payments under Medicare for indirect graduate medical education costs are terminated for discharges occurring on or after October 1, 1995.

Section 3104. Additional Funding Provisions. Funds for the annual academic health center account are to come from three sources: Medicare, corporate alliances, and

regional alliances.

Under section 4052, Medicare is required to make transfers from the Part A Trust Fund at the rate at which payments for the indirect costs of graduate medical education would have been made, in the amount of $2,100,000,000 in fiscal year 1996 and $2,000,000,000 for fiscal years 1997 and 1998, and for years beyond 1998 at the 1998 rate increased by the consumer price index.

After the level of Medicare payments is determined, corporate and regional alliances pay the balance needed in the annual academic health center account, with such payments coming from the 1 percent corporate alliance assessment (under section 7121) and the 1.5 percent regional alliance assessment (under section 1353). For 1996 and 1997, one-half of such regional alliance payments are available for the annual academic health center account, with the remainder made available from payments by corporate alliances. In subsequent years, payments into the annual academic health center account are made in proportion to the total payments to corporate and regional health plans by corporate and regional alliances, respectively.

Beginning in 1996 an additional transfer of funds is made equal to 50 percent of the amount made available for graduate nurse education under section 3063(b).

PART 2 -- ACCESS OF PATIENTS TO ACADEMIC HEALTH CENTERS

Section 3131. Contracts for Ensuring Access to Centers. (a) Requires regional and corporate alliances to ensure that health plans have sufficient contracts with eligible centers to assure that their enrollees receive appropriate specialized treatment of such centers.

(b) Contracts are in compliance with this section if they provide for referrals to the centers of patients in the plans whose health conditions are within the specialized expertise of the centers.

(c) Specialized treatment expertise of academic health centers is expertise in treating rare diseases or unusually severe conditions, and providing other specialized health care.

Section 3132. Discretionary Grants Regarding Access to Centers. Authorizes grants to academic health centers for the establishment and operation of information and referral systems and other activities to provide services to rural health plans.

SUBTITLE C - HEALTH RESEARCH INITIATIVES
(H.R. 3600 and S. 1757 p. 560)

PART 1 - PROGRAMS FOR CERTAIN AGENCIES

Section 3201. Biomedical and Behavioral Research on Health Promotion and Disease Prevention. Amends the Public Health Service Act to require the Director of the National Institutes of Health, in collaboration with the Associate Director for Prevention and the heads of the agencies of NIH to conduct and support biomedical and behavioral research on promoting health and preventing disease, and establishes priorities for such research.

Section 3202. Health Services Research. Amends the Public Health Service Act to require the Administrator for Health Care Policy and Research to conduct and support research on the reform of the health care system, as directed by the National Board, and establishes priorities for such research.

PART 2 -- FUNDING FOR PROGRAMS

Section 3211. Authorizations of Appropriations. (a) Authorizes to be appropriated $400,000,000 for fiscal year 1995 and $500,000,000 for each fiscal year 1996 through 2000 for conducting and supporting biomedical and behavioral research on promoting health and preventing disease under section 3201.

(b) Authorizes to be appropriated $150,000,000 for fiscal year 1995, $400,000,000 for fiscal year 1996, $500,000,000 for fiscal year 1997, and $600,000,000 for each fiscal year 1998 through 2000 for conducting and supporting research on the reform of the health care system under section 3202.

(b) Both authorizations, are in addition to any other authorizations of appropriations available for those purposes.