109TH CONGRESS
1ST SESSION

S. 1602

To amend title XIX of the Social Security Act to require States to disregard benefits paid under long-term care insurance for purposes of determining medicaid eligibility, to expand long-term care insurance partnerships between States and insurers, to amend the Internal Revenue Code of 1986 to allow individuals a deduction for qualified long-term care insurance premiums, the use of such insurance under cafeteria plans and flexible spending arrangements, and a credit for individuals with long-term care needs, to establish home and community-based services as an optional medicaid benefit, and for other purposes.

IN THE SENATE OF THE UNITED STATES

JULY 29, 2005

Mr. GRASSLEY (for himself, Mr. BAYH, and Mrs. CLINTON) introduced the following bill; which was read twice and referred to the Committee on Finance

---

A BILL

To amend title XIX of the Social Security Act to require States to disregard benefits paid under long-term care insurance for purposes of determining medicaid eligibility, to expand long-term care insurance partnerships between States and insurers, to amend the Internal Revenue Code of 1986 to allow individuals a deduction for qualified long-term care insurance premiums, the use of such insurance under cafeteria plans and flexible spending arrangements, and a credit for individuals with long-term care needs, to establish home and community-

based services as an optional medicaid benefit, and for other purposes.

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

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the ''Improving Long-Term Care Choices Act of 2005''.

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

SEC. 2. FINDINGS.

Congress finds that—

(1) The Medicaid program is designed to assist low-income individuals with few resources obtain health care, including long-term care.

(2) The average daily cost of a private room in a nursing home in the United States is more than $70,000 per year, with an average length of stay of 2.4 years.

(3) Many individuals deplete their savings and resources paying for long-term care or qualifying for Medicaid in order to receive that care.

(4) Encouraging individuals to purchase private long-term care insurance that meets minimum Federal standards would help ensure that Medicaid is able to continue to offer long-term care to low-income individuals who cannot afford that insurance.

(5) Requiring consumer protections and standards for long-term care insurance will help ensure that Federal, State, and individual resources are used to purchase high-quality long-term care coverage that meets individual needs.

(6) In 1999, the United States Supreme Court, in Olmstead v. L.C. (527 U.S. 581) held that the medically unnecessary institutionalization of individuals with disabilities constitutes discrimination in

violation of the provisions of the Americans with Disabilities Act of 1990 (ADA).

(7) The Olmstead decision has had the effect of broadening State efforts to revise their Medicaid plans to develop alternatives to institutional care, but certain limitations in Medicaid's structure constrain these efforts, in particular, the lack of certain coverage and benefit options related to community care, which in turn force States to rely on a more cumbersome Federal waiver process.

(8) Based on preliminary 2002 data, total Medicaid expenditures for that year for long-term care services were $92,800,000,000 ($66,100,000,000 for services in institutions and $26,700,000,000 for services provided in home and community-based settings).

(9) Nationally, only 33 percent of public long-term care spending is spent for home and community-based services and supports. Among the elderly, over 84 percent of long-term care funding is spent for nursing facility and other institutional care.

(10) In order to live independently, individuals with disabilities need access to home and community-based services and supports.

(11) Most Americans would prefer to receive long-term care services in their homes and communities.

(12) States are currently operating a complicated system of over 261 different home and community-based waivers.

(13) There is a need to build upon the progress made by the New Freedom Initiative, which was announced in 2001, and is a continuing nationwide effort to remove barriers to community living for people of all ages with disabilities and long-term illnesses.

TITLE I—LONG-TERM CARE INSURANCE

Subtitle A—Consumer Protections

SEC. 101. DISREGARD OF BENEFITS PAID UNDER LONG-TERM CARE INSURANCE FOR PURPOSES OF DETERMINING MEDICAID ELIGIBILITY.

(a) MEDICAID STATE PLAN REQUIREMENT.—Section 1902(a) of the Social Security Act (42 U.S.C. 1396a(a)) is amended—

(1) in paragraph (66), by striking ''and'' at the end;

(2) in paragraph (67), by striking the period at the end and inserting ''; and''; and

(3) by inserting after paragraph (67), the following:

''(68) provide that, with respect to benefits (including assigned benefits) paid under any insurance contract for coverage of qualified long-term care services (as defined in in section 7702B(c) of the Internal Revenue Code of 1986), the State does not treat such benefits as income for purposes of determining an individual's eligibility for medical assistance under the State plan.''.

(b) CONSUMER EDUCATION.—Not later than January 1, 2009, the Secretary of Health and Human Services shall establish a program for educating consumers regarding—

(1) the advisability of obtaining a qualified long-term care insurance contract (as defined in section 7702B(b) of the Internal Revenue Code of 1986); and

(2) the potential interaction between coverage under such an insurance contract and coverage of long-term care under Federal and State health insurance programs, (including under a long-term care partnership under section 1917(b)(1)(C)(ii) of the Social Security Act (42 U.S.C. 1396p(b)(1)(C)(ii)).

SEC. 102. ADDITIONAL CONSUMER PROTECTIONS FOR LONG-TERM CARE INSURANCE.

(a) ADDITIONAL PROTECTIONS APPLICABLE TO LONG-TERM CARE INSURANCE.—Subparagraphs (A) and (B) of section 7702B(g)(2) of the Internal Revenue Code of 1986 (relating to requirements of model regulation and Act) are amended to read as follows:

''(A) IN GENERAL.—The requirements of this paragraph are met with respect to any contract if such contract meets—

''(i) MODEL REGULATION.—The following requirements of the model regulation:

''(I) Section 6A (relating to guaranteed renewal or noncancellability), other than paragraph (5) thereof, and the requirements of section 6B of the model Act relating to such section 6A.

''(II) Section 6B (relating to prohibitions on limitations and exclusions) other than paragraph (7) thereof.

''(III) Section 6C (relating to extension of benefits).

''(IV) Section 6D (relating to continuation or conversion of coverage).

''(V) Section 6E (relating to discontinuance and replacement of policies).

''(VI) Section 7 (relating to unintentional lapse).

''(VII) Section 8 (relating to disclosure), other than sections 8F, 8G, 8H, and 8I thereof.

''(VIII) Section 11 (relating to prohibitions against post-claims underwriting).

''(IX) Section 12 (relating to minimum standards).

''(X) Section 13 (relating to requirement to offer inflation protection).

''(XI) Section 25 (relating to prohibition against preexisting conditions and probationary periods in replacement policies or certificates).

''(XII) The provisions of section 26 relating to contingent nonforfeiture

benefits, if the policyholder declines the offer of a nonforfeiture provision described in paragraph (4).

''(ii) MODEL ACT.—The following requirements of the model Act:

''(I) Section 6C (relating to preexisting conditions).

''(II) Section 6D (relating to prior hospitalization).

''(III) The provisions of section 8 relating to contingent nonforfeiture benefits, if the policyholder declines the offer of a nonforfeiture provision described in paragraph (4).

''(B) DEFINITIONS.—For purposes of this paragraph—

''(i) MODEL PROVISIONS.—The terms 'model regulation' and 'model Act' mean the long-term care insurance model regulation, and the long-term care insurance model Act, respectively, promulgated by the National Association of Insurance Commissioners (as adopted as of October 2000).

''(ii) COORDINATION.—Any provision of the model regulation or model Act listed under clause (i) or (ii) of subparagraph (A) shall be treated as including any other provision of such regulation or Act necessary to implement the provision.

''(iii) DETERMINATION.—For purposes of this section and section 4980C, the determination of whether any requirement of a model regulation or the model Act has been met shall be made by the Secretary.''.

(b) EXCISE TAX.—Paragraph (1) of section 4980C(c) of the Internal Revenue Code of 1986 (relating to requirements of model provisions) is amended to read as follows:

''(1) REQUIREMENTS OF MODEL PROVISIONS.—

''(A) MODEL REGULATION.—The following requirements of the model regulation must be met:

''(i) Section 9 (relating to required disclosure of rating practices to consumer).

''(ii) Section 14 (relating to application forms and replacement coverage).

"(iii) Section 15 (relating to reporting requirements).

"(iv) Section 22 (relating to filing requirements for marketing).

"(v) Section 23 (relating to standards for marketing), including inaccurate completion of medical histories, other than paragraphs (1), (6), and (9) of section 23C.

"(vi) Section 24 (relating to suitability).

"(vii) Section 29 (relating to standard format outline of coverage).

"(viii) Section 30 (relating to requirement to deliver shopper's guide).

The requirements referred to in clause (vi) shall not include those portions of the personal worksheet described in Appendix B relating to consumer protection requirements not imposed by section 4980C or 7702B.

"(B) MODEL ACT.—The following requirements of the model Act must be met:

"(i) Section 6F (relating to right to return).

"(ii) Section 6G (relating to outline of coverage).

"(iii) Section 6H (relating to requirements for certificates under group plans).

"(iv) Section 6J (relating to policy summary).

"(v) Section 6K (relating to monthly reports on accelerated death benefits).

"(vi) Section 7 (relating to incontestability period).

"(C) DEFINITIONS.—For purposes of this paragraph, the terms 'model regulation' and 'model Act' have the meanings given such terms by section 7702B(g)(2)(B).".

(C) EFFECTIVE DATE.—The amendments made by this section shall apply to policies issued more than 1 year after the date of enactment of this Act.

SEC. 103. EXPANSION OF STATE LONG-TERM CARE PARTNERSHIPS.

(a) IN GENERAL.—Section 1917(b)(1)(C)(ii) of the Social Security Act (42 U.S.C. 1396p(b)(1)(C)(ii)) is amended to read as follows:

"(ii) Clause (i) shall not apply in the case of an individual who received medical assistance under—

''(I) a Qualified State Long-Term Care Insurance Partnership (as defined in paragraph (6)); or

''(II) under a State plan of a State which—

''(aa) had a State plan amendment approved as of May 14, 1993, which provided for the disregard of any assets or resources to the extent that payments are made under a long-term care insurance policy or because an individual has received (or is entitled to receive) benefits under a long-term care insurance policy; and

''(bb) has a State plan amendment which satisfies the requirements of subparagraphs (B) through (F) of paragraph (6).''.

(b) SATISFACTION OF MINIMUM FEDERAL STANDARDS, TAX-QUALIFICATIONS, INFLATION PROTECTION, AND OTHER REQUIREMENTS FOR LONG-TERM CARE INSURANCE PARTNERSHIPS.—Section 1917(e) of the Social Security Act (42 U.S.C. 1396p(e)) is amended by inserting at the end the following:

''(6) The term 'Qualified State Long-Term Care Insurance Partnership' means a State with an

approved State plan amendment that provides for the following:

"(A) The disregard of any assets or resources in an amount equal to the amount of payments made to, or on behalf of, an individual who is a beneficiary under any long-term care insurance policy (including a certificate issued under a group insurance contract) sold under such plan amendment.

"(B) A requirement that the State will treat benefits paid under any long-term care insurance policy (including a certificate issued under a group insurance contract) sold under a plan amendment of a State that maintains a Qualified Long-Term Care Insurance Partnership or is described in subsection (b)(1)(C)(ii)(II) the same as the State treats benefits paid under such a policy sold under the State's plan amendment.

"(C) A requirement that any long-term care insurance policy (including a certificate issued under a group insurance contract) sold under such plan amendment be a qualified long-term care insurance contract within the mean-

ing of section 7702B(b) of the Internal Revenue Code of 1986.

''(D) A requirement that any such policy sold under the State plan amendment shall provide for compound annual inflation protection.

''(E) A requirement that any individual who sells such a policy receive training, and demonstrate evidence of an understanding of, the policy and how the policy relates to other public and private coverage of long-term care.

''(F) A requirement that the issuer of any such policy report—

''(i) to the Secretary, such information or data as the Secretary may require; and

''(ii) to the State, the information or data reported to the Secretary (if any), the information or data required under the minimum reporting requirements developed under section 103(c)(1)(B) of the Improving Long-Term Care Choices Act of 2005, and such additional information or data as the State may require.

For purposes of applying this paragraph, if a long-term care insurance policy is exchanged for another

such policy, the date coverage became effective under the first policy shall determine when coverage first becomes effective.''.

(c) DEVELOPMENT OF RECIPROCITY AND UNIFORM DATA STANDARDS.—

(1) IN GENERAL.—Not later than 1 year after the date of enactment of this Act, the Secretary of Health and Human Services, in consultation with the National Association of Insurance Commissioners, issuers of long-term care insurance policies, States with experience with long-term care insurance partnership plans, and other States shall develop the following standards:

(A) RECIPROCITY.—Standards for ensuring that long-term care insurance policies issued under a State long-term care insurance partnership under section 1917(b)(1)(C)(ii) of the Social Security Act (42 U.S.C. 1396p(b)(1)(C)(ii)) (as amended by subsection (a)) are portable to other States with such a partnership.

(B) MINIMUM REPORTING REQUIREMENTS.—Standards for minimum reporting requirements for issuers of long-term care insurance policies under such State long-term care

insurance partnerships that shall specify the data and information that each such issuer shall report to the State with which it has such a partnership. The requirements developed in accordance with this subparagraph shall specify the type and format of the data and information to be reported and the frequency with which such reports are to be made.

(2) STATE REPORTING REQUIREMENTS.—Nothing in paragraph (1)(B) shall be construed as prohibiting a State from requiring an issuer of a long-term care insurance policy sold in the State (regardless of whether the policy is issued under a State long-term care insurance partnership under section 1917(b)(1)(C)(ii) of the Social Security Act) to require the issuer to report information or data to the State that is in addition to the information or data required under the minimum reporting requirements developed under that paragraph.

(d) ANNUAL REPORTS TO CONGRESS.—The Secretary of Health and Human Services shall annually report to Congress on the long-term care insurance partnerships established in accordance with section 1917(b)(1)(C)(ii) of the Social Security Act (42 U.S.C. 1396p(b)(1)(C)(ii))). Such reports shall include analyses

of the extent to which such partnerships expand or limit access of individuals to long-term care and the impact of such partnerships on Federal and State expenditures under the medicare and medicaid programs.

SEC. 104. NATIONAL CLEARINGHOUSE FOR LONG-TERM CARE INFORMATION.

(a) ESTABLISHMENT.—The Secretary of Health and Human Services shall establish, by grant, contract, or interagency agreement, a National Clearinghouse for Long-Term Care Information.

(b) DUTIES.—The National Clearinghouse for Long-Term Care Information shall—

(1) educate consumers regarding the extent to which Federal and State health insurance programs provide coverage for long-term care and options for financing long-term care;

(2) establish mechanisms for assisting consumers with the decisionmaking process for determining whether to purchase a long-term care insurance policy or pursue other options for financing long-term care; and

(3) establish an Internet website that allows consumers to compare qualified long-term care insurance contracts (as defined in section 7702B(b) of the Internal Revenue Code of 1986) with respect to

price, benefits provided, historical data on premium increases, and other information that would help a consumer determine whether such a policy would meet their needs.

(c) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated for purposes of carrying out this section, such sums as may be necessary for fiscal year 2006 and each fiscal year thereafter.

Subtitle B—Amendments to the Internal Revenue Code of 1986

SEC. 121. TREATMENT OF PREMIUMS ON QUALIFIED LONG-TERM CARE INSURANCE CONTRACTS.

(a) IN GENERAL.—Part VII of subchapter B of chapter 1 of the Internal Revenue Code of 1986 (relating to additional itemized deductions) is amended by redesignating section 224 as section 225 and by inserting after section 223 the following new section:

"SEC. 224. PREMIUMS ON QUALIFIED LONG-TERM CARE INSURANCE CONTRACTS.

''(a) IN GENERAL.—In the case of an individual, there shall be allowed as a deduction an amount equal to the applicable percentage of the amount of eligible long-term care premiums (as defined in section 213(d)(10)) paid during the taxable year for coverage for the taxpayer and the taxpayer's spouse and dependents under a quali-

fied long-term care insurance contract (as defined in section 7702B(b)).

''(b) APPLICABLE PERCENTAGE.—For purposes of subsection (a), the applicable percentage shall be determined in accordance with the following table:

''For taxable years beginning in calendar year—	**The applicable percentage is—**
2005, 2006, or 2007	25
2008	35
2009	65
2010 or thereafter	100.

''(c) COORDINATION WITH OTHER DEDUCTIONS.—Any amount paid by a taxpayer for any qualified long-term care insurance contract to which subsection (a) applies shall not be taken into account in computing the amount allowable to the taxpayer as a deduction under section 162(l) or 213(a).''.

(b) LONG-TERM CARE INSURANCE PERMITTED TO BE OFFERED UNDER CAFETERIA PLANS AND FLEXIBLE SPENDING ARRANGEMENTS.—

(1) CAFETERIA PLANS.—The last sentence of section 125(f) of such Code (defining qualified benefits) is amended by inserting before the period at the end ''; except that such term shall include the payment of premiums for any qualified long-term care insurance contract (as defined in section 7702B) to the extent the amount of such payment does not ex-

ceed the eligible long-term care premiums (as defined in section 213(d)(10)) for such contract''.

(2) FLEXIBLE SPENDING ARRANGEMENTS.—Section 106 of such Code (relating to contributions by an employer to accident and health plans) is amended by striking subsection (c) and redesignating subsection (d) as subsection (c).

(c) CONFORMING AMENDMENTS.—

(1) Section 62(a) of such Code is amended by inserting before the last sentence at the end the following new paragraph:

''(21) PREMIUMS ON QUALIFIED LONG-TERM CARE INSURANCE CONTRACTS.—The deduction allowed by section 224.''.

(2) Sections 223(b)(4)(B), 223(d)(4)(C), 223(f)(3)(B), 3231(e)(11), 3306(b)(18), 3401(a)(22), 4973(g)(1), and 4973(g)(2)(B)(i) of such Code are each amended by striking ''section 106(d)'' and inserting ''section 106(c)''.

(3) Section 6041 of such Code is amended—

(A) in subsection (f)(1) by striking ''(as defined in section 106(c)(2))'', and

(B) by adding at the end the following new subsection:

''(h) FLEXIBLE SPENDING ARRANGEMENT DEFINED.—For purposes of this section, a flexible spending arrangement is a benefit program which provides employees with coverage under which—

''(1) specified incurred expenses may be reimbursed (subject to reimbursement maximums and other reasonable conditions), and

''(2) the maximum amount of reimbursement which is reasonably available to a participant for such coverage is less than 500 percent of the value of such coverage.

In the case of an insured plan, the maximum amount reasonably available shall be determined on the basis of the underlying coverage.''.

(4) The table of sections for part VII of subchapter B of chapter 1 of such Code is amended by striking the last item and inserting the following new items:

''Sec. 224. Premiums on qualified long-term care insurance contracts.
''Sec. 225. Cross reference.''.

(d) EFFECTIVE DATES.—

(1) IN GENERAL.—Except as provided in paragraph (2), the amendments made by this section shall apply to taxable years beginning after December 31, 2005.

(2) CAFETERIA PLANS AND FLEXIBLE SPENDING ARRANGEMENTS.—The amendments made by subsection (b) shall apply to taxable years beginning after December 31, 2007.

SEC. 122. CREDIT FOR TAXPAYERS WITH LONG-TERM CARE NEEDS.

(a) IN GENERAL.—Subpart A of part IV of subchapter A of chapter 1 of the Internal Revenue Code of 1986 (relating to nonrefundable personal credits), as amended by the Energy Tax Incentives Act of 2005, is amended by inserting after section 25D the following new section:

"SEC. 25E. CREDIT FOR TAXPAYERS WITH LONG-TERM CARE NEEDS.

''(a) ALLOWANCE OF CREDIT.—

''(1) IN GENERAL.—There shall be allowed as a credit against the tax imposed by this chapter for the taxable year an amount equal to the applicable credit amount multiplied by the number of applicable individuals with respect to whom the taxpayer is an eligible caregiver for the taxable year.

''(2) APPLICABLE CREDIT AMOUNT.—For purposes of paragraph (1), the applicable credit amount shall be determined in accordance with the following table:

"For taxable years beginning in calendar year—	The applicable credit amount is—
2005	$1,000
2006	1,500
2007	2,000
2008	2,500
2009 or thereafter	3,000.

''(b) LIMITATION BASED ON ADJUSTED GROSS INCOME.—

''(1) IN GENERAL.—The amount of the credit allowable under subsection (a) shall be reduced (but not below zero) by $100 for each $1,000 (or fraction thereof) by which the taxpayer's modified adjusted gross income exceeds the threshold amount. For purposes of the preceding sentence, the term 'modified adjusted gross income' means adjusted gross income increased by any amount excluded from gross income under section 911, 931, or 933.

''(2) THRESHOLD AMOUNT.—For purposes of paragraph (1), the term 'threshold amount' means—

''(A) $150,000 in the case of a joint return, and

''(B) $75,000 in any other case.

''(3) INDEXING.—In the case of any taxable year beginning in a calendar year after 2005, each dollar amount contained in paragraph (2) shall be increased by an amount equal to the product of—

''(A) such dollar amount, and

''(B) the medical care cost adjustment determined under section 213(d)(10)(B)(ii) for the calendar year in which the taxable year begins, determined by substituting 'August 2004' for 'August 1996' in subclause (II) thereof.

If any increase determined under the preceding sentence is not a multiple of $50, such increase shall be rounded to the next lowest multiple of $50.

''(c) DEFINITIONS.—For purposes of this section—

''(1) APPLICABLE INDIVIDUAL.—

''(A) IN GENERAL.—The term 'applicable individual' means, with respect to any taxable year, any individual who has been certified, before the due date for filing the return of tax for the taxable year (without extensions), by a physician (as defined in section 1861(r)(1) of the Social Security Act) as being an individual with long-term care needs described in subparagraph (B) for a period—

''(i) which is at least 180 consecutive days, and

''(ii) a portion of which occurs within the taxable year.

Notwithstanding the preceding sentence, a certification shall not be treated as valid unless it

is made within the 39½ month period ending on such due date (or such other period as the Secretary prescribes).

''(B) INDIVIDUALS WITH LONG-TERM CARE NEEDS.—An individual is described in this subparagraph if the individual meets any of the following requirements:

''(i) The individual is at least 6 years of age and—

''(I) is unable to perform (without substantial assistance from another individual) at least 3 activities of daily living (as defined in section 7702B(c)(2)(B)) due to a loss of functional capacity, or

''(II) requires substantial supervision to protect such individual from threats to health and safety due to severe cognitive impairment and is unable to perform, without reminding or cuing assistance, at least 1 activity of daily living (as so defined) or to the extent provided in regulations prescribed by the Secretary (in consultation with the Secretary of Health and

Human Services), is unable to engage in age appropriate activities.

''(ii) The individual is at least 2 but not 6 years of age and is unable due to a loss of functional capacity to perform (without substantial assistance from another individual) at least 2 of the following activities: eating, transferring, or mobility.

''(iii) The individual is under 2 years of age and requires specific durable medical equipment by reason of a severe health condition or requires a skilled practitioner trained to address the individual's condition to be available if the individual's parents or guardians are absent.

''(2) ELIGIBLE CAREGIVER.—

''(A) IN GENERAL.—A taxpayer shall be treated as an eligible caregiver for any taxable year with respect to the following individuals:

''(i) The taxpayer.

''(ii) The taxpayer's spouse.

''(iii) An individual with respect to whom the taxpayer is allowed a deduction under section 151(c) for the taxable year.

"(iv) An individual who would be described in clause (iii) for the taxable year if section 151(c) were applied by substituting for the exemption amount an amount equal to the sum of the exemption amount, the standard deduction under section 63(c)(2)(C), and any additional standard deduction under section 63(c)(3) which would be applicable to the individual if clause (iii) applied.

"(v) An individual who would be described in clause (iii) for the taxable year if—

"(I) the requirements of clause (iv) are met with respect to the individual, and

"(II) the requirements of subparagraph (B) are met with respect to the individual in lieu of the support test under subsection (c)(1)(D) or (d)(1)(C) of section 152.

"(B) RESIDENCY TEST.—The requirements of this subparagraph are met if an individual has as his principal place of abode the home of the taxpayer and—

''(i) in the case of an individual who is an ancestor or descendant of the taxpayer or the taxpayer's spouse, is a member of the taxpayer's household for over half the taxable year, or

''(ii) in the case of any other individual, is a member of the taxpayer's household for the entire taxable year.

''(C) SPECIAL RULES WHERE MORE THAN 1 ELIGIBLE CAREGIVER.—

''(i) IN GENERAL.—If more than 1 individual is an eligible caregiver with respect to the same applicable individual for taxable years ending with or within the same calendar year, a taxpayer shall be treated as the eligible caregiver if each such individual (other than the taxpayer) files a written declaration (in such form and manner as the Secretary may prescribe) that such individual will not claim such applicable individual for the credit under this section.

''(ii) NO AGREEMENT.—If each individual required under clause (i) to file a written declaration under clause (i) does

not do so, the individual with the highest adjusted gross income shall be treated as the eligible caregiver.

''(iii) MARRIED INDIVIDUALS FILING SEPARATELY.—In the case of married individuals filing separately, the determination under this subparagraph as to whether the husband or wife is the eligible caregiver shall be made under the rules of clause (ii) (whether or not one of them has filed a written declaration under clause (i)).

''(d) IDENTIFICATION REQUIREMENT.—No credit shall be allowed under this section to a taxpayer with respect to any applicable individual unless the taxpayer includes the name and taxpayer identification number of such individual, and the identification number of the physician certifying such individual, on the return of tax for the taxable year.

''(e) TAXABLE YEAR MUST BE FULL TAXABLE YEAR.—Except in the case of a taxable year closed by reason of the death of the taxpayer, no credit shall be allowable under this section in the case of a taxable year covering a period of less than 12 months.''.

(b) CONFORMING AMENDMENTS.—

(1) Section 6213(g)(2) of such Code is amended by striking ''and'' at the end of subparagraph (L), by striking the period at the end of subparagraph (M) and inserting '', and'', and by inserting after subparagraph (M) the following new subparagraph:

''(N) an omission of a correct TIN or physician identification required under section 25E(d) (relating to credit for taxpayers with long-term care needs) to be included on a return.''.

(2) The table of sections for subpart A of part IV of subchapter A of chapter 1 of such Code is amended by inserting after the item relating to section 25D the following new item:

''Sec. 25E. Credit for taxpayers with long-term care needs.''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 2005.

SEC. 123. TREATMENT OF EXCHANGES OF LONG-TERM CARE INSURANCE CONTRACTS.

(a) IN GENERAL.—Subsection (a) of section 1035 of the Internal Revenue Code of 1986 (relating to exchanges of insurance policies) is amended by striking the period at the end of paragraph (3) and inserting ''; or'' and by adding at the end the following new paragraph:

''(4) a qualified long-term care insurance contract for another qualified long-term care insurance contract.''.

(b) QUALIFIED LONG-TERM CARE INSURANCE CONTRACT.—Subsection (b) of section 1035 of such Code (relating to definitions) is amended by adding at the end the following new paragraph:

''(4) QUALIFIED LONG-TERM CARE INSURANCE CONTRACT.—The term 'qualified long-term care insurance contract' means—

''(A) any qualified long-term care insurance contract (as defined in section 7702B), and

''(B) any contract which is treated as such by section 321(f)(2) of the Health Insurance Portability and Accountability Act of 1996.''.

(c) EFFECTIVE DATE.—

(1) IN GENERAL.—The amendments made by this section shall apply to exchanges after December 31, 1997.

(2) WAIVER OF LIMITATIONS.—If the credit or refund of any overpayment of tax with respect to a taxable year ending before the date of the enactment of this Act resulting from the application of section 1035(a)(4) of the Internal Revenue Code of 1986, as

added by this section, is prevented at any time by the operation of any law or rule of law (including res judicata), such credit or refund may nevertheless be allowed or made if the claim therefor is filed before the close of the 1-year period beginning on the date of the enactment of this Act.

TITLE II—MEDICAID HOME AND COMMUNITY-BASED SERVICES OPTIONAL BENEFIT

SEC. 201. MEDICAID HOME AND COMMUNITY-BASED SERVICES OPTIONAL BENEFIT.

(a) HOME AND COMMUNITY-BASED SERVICES AS AN OPTIONAL BENEFIT FOR INDIVIDUALS ELIGIBLE FOR MEDICAL ASSISTANCE.—Title XIX of the Social Security Act (42 U.S.C. 1396 et seq.) is amended—

(1) in section 1905(a)—

(A) in paragraph (27), by striking ''and'' at the end;

(B) by redesignating paragraph (28) as paragraph (29); and

(C) by inserting after paragraph (27), the following:

''(28) subject to section 1930A, such home and community-based services (as defined in subsections (c)(4)(B) and (d)(5)(C)(i) of section 1915 (not in-

cluding payment for room and board but including, in the case of services described in section 1915(c)(4)(B), any other services requested by a State and approved by the Secretary under such section)) as the State shall specify in a State plan amendment; and''; and

(2) by inserting after section 1930, the following:

''HOME AND COMMUNITY-BASED SERVICES

''SEC. 1930A. (a) IN GENERAL.—A State may provide through a State plan amendment for the provision of such home and community-based services under section 1905(a)(28) as the State shall specify for individuals eligible for medical assistance under the State plan (without determining that but for the provision of such services the individuals would require the level of care provided in a hospital or a nursing facility or intermediate care facility for the mentally retarded), but only if the State meets the following requirements:

''(1) NEEDS-BASED CRITERIA FOR ELIGIBILITY FOR, AND RECEIPT OF, HOME AND COMMUNITY-BASED SERVICES.—The State establishes needs-based criteria for determining an individual's eligibility under the State plan for medical assistance for such home and community-based services, and if the individual is eligible for such services, the specific

home and community-based services that the individual will receive.

''(2) ESTABLISHMENT OF MORE STRINGENT NEEDS-BASED ELIGIBILITY CRITERIA FOR INSTITUTIONALIZED CARE.—The State establishes needs-based criteria for determining whether an individual requires the level of care provided in a hospital, a nursing facility, or an intermediate care facility for the mentally retarded under the State plan or under any waiver of such plan that are more stringent than the needs-based criteria established under paragraph (1) for determining eligibility for home and community-based services.

''(3) PROJECTION OF NUMBER OF INDIVIDUALS TO BE PROVIDED HOME AND COMMUNITY-BASED SERVICES.—The State submits to the Secretary, in such form and manner, and upon such frequency as the Secretary shall specify, the projected number of individuals to be provided home and community-based services.

''(4) CRITERIA BASED ON INDIVIDUAL ASSESSMENT.—

''(A) IN GENERAL.—The criteria established by the State for purposes of paragraphs (1) and (2) requires an assessment of an indi-

vidual's support needs and capabilities, and may take into account the inability of the individual to perform 1 or more activities of daily living (as defined in section 7702B(c)(2)(B) of the Internal Revenue Code of 1986) or the need for significant assistance to perform such activities, and such other risk factors as the State determines to be appropriate.

"(B) ADJUSTMENT AUTHORITY.—The State plan amendment provides for modification of the criteria established under paragraph (1) (without having to obtain prior approval from the Secretary) in the event that the enrollment of individuals eligible for home and community-based services exceeds the projected enrollment submitted for purposes of paragraph (3), but only if—

"(i) the State provides at least 60 days notice to the Secretary and the public of the proposed modification;

"(ii) the State deems an individual receiving home and community-based services on the basis of the most recent version of the criteria in effect prior to the effective date of the modification to continue to

be eligible for such services after the effective date of the modification and until such time as the individual no longer meets the standard for receipt of such services under such pre-modified criteria; and

''(iii) after the effective date of such modification, the State applies the criteria for determining whether an individual requires the level of care provided in a hospital, a nursing facility, or an intermediate care facility for the mentally retarded under the State plan or under any waiver of such plan which applied prior to the application of the more stringent criteria developed under paragraph (2).

''(5) INDEPENDENT EVALUATION AND ASSESSMENT.—

''(A) ELIGIBILITY DETERMINATION.—The State uses an independent evaluation for making the determinations described in paragraphs (1) and (2).

''(B) ASSESSMENT.—In the case of an individual who is determined to be eligible for home and community-based services, the State

uses an independent assessment, based on the needs of the individual to—

"(i) determine a necessary level of services and supports to be provided, consistent with an individual's physical and mental capacity,

"(ii) prevent the provision of unnecessary or inappropriate care; and

"(iii) establish an individualized care plan for the individual in accordance with paragraph (7).

"(6) ASSESSMENT.—The independent assessment required under paragraph (5)(B) shall include the following:

"(A) An objective evaluation of an individual's inability of the individual to perform 1 or more activities of daily living (as defined in section 7702B(c)(2)(B) of the Internal Revenue Code of 1986) or the need for significant assistance to perform such activities, and of the individual's ability to engage in major life activities such as walking, seeing, hearing, breathing, speaking, working, performing manual tasks, learning, thinking, concentrating, interacting

with others, sleeping, and any other appropriate activities.

''(B) A face-to-face evaluation of the individual by an individual trained in the assessment and evaluation of individuals whose physical or mental conditions trigger a potential need for home and community-based services.

''(C) Where appropriate, consultation with the individual's family, spouse, guardian, or other responsible individual.

''(D) Consultation with appropriate treating and consulting health and support professionals caring for the individual.

''(E) An examination of the individual's relevant history, medical records, and care and support needs, guided by best practices and research on effective strategies that result in improved health and quality of life outcomes.

''(F) If the State offers individuals the option to self-direct the purchase of, or control the receipt of, home and community-based service, an evaluation of the ability of the individual or the individual's representative to self-direct the purchase of, or control the receipt of, such services if the individual so elects.

''(7) INDIVIDUALIZED CARE PLAN.—

''(A) IN GENERAL.—In the case of an individual who is determined to be eligible for home and community-based services, the State uses the independent assessment required under paragraph (5)(B) to establish a written individualized care plan for the individual.

''(B) PLAN REQUIREMENTS.—The State ensures that the individualized care plan for an individual—

''(i) is developed—

''(I) in consultation with the individual, the individual's treating physician, health care or support professional, or other appropriate individuals, as defined by the State, and, where appropriate the individual's family, caregiver, or representative; and

''(II) taking into account the extent of, and need for, any family or other supports for the individual;

''(ii) identifies the necessary home and community-based services to be furnished to the individual (or, if the individual elects

to self-direct the purchase of, or control the receipt of, such services, funded for the individual); and

''(iii) is reviewed at least annually and as needed when there is a significant change in the individual's circumstances.

''(C) STATE OPTION TO OFFER ELECTION FOR SELF-DIRECTED SERVICES.—

''(i) INDIVIDUAL CHOICE.—At the option of the State, the State may allow an individual or the individual's representative to elect to receive self-directed home and community-based services in a manner which gives them the most control over such services consistent with the individual's abilities and the requirements of clause (ii).

''(ii) SELF-DIRECTED SERVICES.—The term 'self-directed' means, with respect to the home and community-based services offered under the State plan amendment, such services for the individual which are planned and purchased under the direction and control of such individual or the individual's authorized representative, includ-

ing the amount, duration, scope, provider, and location of such services, under the State plan consistent with the following requirements:

"(I) ASSESSMENT.—There is an assessment of the needs, capabilities, and preferences of the individual with respect to such services.

"(II) SERVICE PLAN.—Based on such assessment, there is developed jointly with such individual or the individual's authorized representative a plan for such services for such individual that is approved by the State and that—

"(aa) specifies those services which the individual or the individual's authorized representative would be responsible for directing;

"(bb) identifies the methods by which the individual or the individual's authorized representative will select, manage, and dismiss providers of such services;

"(cc) specifies the role of family members and others whose participation is sought by the individual or the individual's authorized representative with respect to such services;

"(dd) is developed through a person-centered process that is directed by the individual or the individual's authorized representative, builds upon the individual's capacity to engage in activities that promote community life and that respects the individual's preferences, choices, and abilities, and involves families, friends, and professionals as desired or required by the individual or the individual's authorized representative;

"(ee) includes appropriate risk management techniques that recognize the roles and sharing of responsibilities in obtaining services in a self-directed manner and

assure the appropriateness of such plan based upon the resources and capabilities of the individual or the individual's authorized representative; and

''(ff) may include an individualized budget which identifies the dollar value of the services and supports under the control and direction of the individual or the individual's authorized representative.

''(III) BUDGET PROCESS.—With respect to individualized budgets described in subclause (II)(ff), the State plan amendment—

''(aa) describes the method for calculating the dollar values in such budgets based on reliable costs and service utilization;

''(bb) defines a process for making adjustments in such dollar values to reflect changes in individual assessments and service plans; and

"(cc) provides a procedure to evaluate expenditures under such budgets.

"(8) QUALITY ASSURANCE; CONFLICT OF INTEREST STANDARDS.—

"(A) QUALITY ASSURANCE.—The State ensures that the provision of home and community-based services meets Federal and State guidelines for quality assurance.

"(B) CONFLICT OF INTEREST STANDARDS.—The State establishes standards for the conduct of the independent evaluation and the independent assessment to safeguard against conflicts of interest.

"(9) REDETERMINATIONS AND APPEALS.—The State allows for at least annual redeterminations of eligibility, and appeals in accordance with the frequency of, and manner in which, redeterminations and appeals of eligibility are made under the State plan.

"(10) PRESUMPTIVE ELIGIBILITY FOR ASSESSMENT.—

"(A) IN GENERAL.—The State, at its option, elects to provide for a period of presumptive eligibility for an individual that is limited

to medical assistance for carrying out the independent evaluation and assessment under paragraph (5) to determine an individual's eligibility for home and community-based services, and if the individual is eligible for such services, the specific home and community-based services that the individual will receive.

"(B) APPLICATION OF EXISTING RULES.—In the case of a State that makes such an election, the State provides for a period of presumptive eligibility in the same manner as the State may provide for such a period under section 1920B (except that subsection (d)(2) of that section is applied by substituting 'section 1903' for 'clause (4) of the first sentence of section 1905(b)').

"(b) DEFINITION OF INDIVIDUAL'S REPRESENTATIVE.—In this section, the term 'individual's representative' means, with respect to an individual, a parent, a family member, or a guardian of the individual, an advocate for the individual, or any other individual who is authorized to represent the individual.

"(c) NO EFFECT ON 1915 OR 1115 WAIVERS.—Nothing in this section shall be construed as effecting the option of a State to offer home and community-based serv-

ices under a waiver under subsections (c) or (d) of section 1915 or under section 1115.''.

(2) CONFORMING AMENDMENT.—Section 1902(a)(10)(C)(iv) of such Act (42 U.S.C. 1396a(a)(10)(C)(iv)) is amended by inserting ''or (28)'' after ''(24)''.

(b) STATE OPTION TO EXPAND HOME AND COMMUNITY-BASED SERVICES TO ADDITIONAL AT-RISK INDIVIDUALS.—

(1) IN GENERAL.—Section 1930A of the Social Security Act (42 U.S.C. 1396d(y)) (as added by subsection (a)) is amended—

(A) by redesignating subsection (b) as subsection (c); and

(B) by inserting after subsection (a) the following:

''(b) HOME AND COMMUNITY-BASED SERVICES FOR AT-RISK INDIVIDUALS.—

''(1) IN GENERAL.—If a State elects to offer under the State plan medical assistance for home and community-based services in accordance with section 1905(a)(28) and subsection (a), the State may elect, subject to paragraph (3), to offer such services to an individual described in paragraph (2) who is determined on the basis of an independent

evaluation to meet the criteria established under subsection (a)(1) for eligibility for, and receipt of, such services.

''(2) INDIVIDUAL DESCRIBED.—For purposes of paragraph (1), an individual described in this paragraph is an individual whose income (as determined under section 1612, but without regard to subsection (b) thereof) does not exceed such percent of the supplemental security income benefit rate established by section 1611(b)(1) as the State may establish (but not to exceed 300 percent).

''(3) APPLICATION OF RULES FOR OFFERING HOME AND COMMUNITY-BASED SERVICES AS AN OPTIONAL BENEFIT.—The requirements of subsection (a) shall apply to the provision of home and community-based services to eligible individuals under this subsection.''.

(2) CONFORMING AMENDMENT.—Section 1903(f)(4) of such Act (42 U.S.C. 1396b(f)(4)) is amended in the matter preceding subparagraph (A), by inserting ''1930A(b)'' after ''1905(p)(1)''.

(c) QUALITY OF CARE MEASURES.—

(1) IN GENERAL.—The Secretary of Health and Human Services (in this subsection referred to as the ''Secretary''), acting through the Director of the

Agency for Healthcare Research and Quality, shall consult with consumers, health and social service providers and other professionals knowledgeable about long-term care services and supports to develop program performance indicators, client function indicators, and measures of client satisfaction with respect to home and community-based services offered under State medicaid programs (under a waiver approved under section 1115 or 1915 of the Social Security Act or under section 1930A of such Act (as added by subsections (a) and (b))).

(2) BEST PRACTICES.—The Secretary shall—

(A) use the indicators and measures developed under paragraph (1) to assess such home and community-based services, the outcomes associated with the receipt of such services (particularly with respect to the health and welfare of the recipient of the services), and the overall system for providing home and community-based services under the medicaid program under title XIX of the Social Security Act; and

(B) make publicly available the best practices identified through such assessment and a comparative analyses of the system features of each State.

TITLE III—INTEGRATED ACUTE AND LONG-TERM CARE SERVICES FOR DUALLY ELIGIBLE INDIVIDUALS.

SEC. 301. REMOVAL OF BARRIERS TO INTEGRATED ACUTE AND LONG-TERM CARE SERVICES FOR DUALLY ELIGIBLE INDIVIDUALS.

(a) REGULATIONS AND LEGISLATIVE RECOMMENDATIONS.—Not later than January 1, 2007, the Secretary of Health and Human Services, in consultation with directors of State medicaid programs under title XIX of the Social Security Act, health care insurers, managed care entities (as defined in section 1932(a)(1)(B) of the Social Security Act (42 U.S.C. 1396u–2(a)(1)(B)), entities offering Medicare Advantage plans under part C of title XVIII of such Act (42 U.S.C. 1395w–21 et seq.) (including specialized MA plans for special needs individuals (as defined in section 1859(b)(6) of such Act), PACE providers (as defined in section 1934(a)(3) of the Social Security Act (42 U.S.C. 1396u–4(a)(3)), and representatives of individuals who are dually eligible for the medicare and medicaid programs, shall do the following:

(1) REMOVAL OF ADMINISTRATIVE BARRIERS TO INTEGRATED CARE.—Issue regulations removing administrative barriers under the medicare and med-

icaid programs that impede the offering of integrated acute and long-term care services which combine acute, home and community-based, nursing facility, and mental health services, and, to the extent consistent with an enrollee's coverage for such services under part D of title XVIII of the Social Security Act, coverage for prescribed drugs, into a single model of care for individuals who are dually eligible for such programs. Such regulations shall address conflicting requirements under such programs for managed care entities (as defined in section 1932(a)(1)(B) of the Social Security Act (42 U.S.C. 1396u–2(a)(1)(B)), entities offering Medicare Advantage plans under part C of title XVIII of such Act (42 U.S.C. 1395w–21 et seq.) (including specialized MA plans for special needs individuals (as defined in section 1859(b)(6) of such Act), and PACE providers (as defined in section 1934(a)(3) of the Social Security Act (42 U.S.C. 1396u–4(a)(3)) with respect to identification cards, marketing requirements, and such other requirements as the Secretary shall identify.

(2) SUBMISSION OF RECOMMENDATIONS FOR REMOVAL OF STATUTORY BARRIERS TO INTEGRATED CARE.—Submit to Congress recommendations for re-

moval of such statutory barriers to the offering of such integrated services to individuals dually eligible under the medicare and medicaid programs as the Secretary shall identify.

(b) MEDPAC COMMENTS.—Not later than February 1, 2007, the Medicare Payment Advisory Commission shall submit to Congress comments on the recommendations submitted by the Secretary of Health and Human Services under subsection (a)(2).

TITLE IV—EFFECTIVE DATE

SEC. 401. EFFECTIVE DATE.

(a) IN GENERAL.—Except as otherwise provided in this Act, this Act and the amendments made by this Act take effect on October 1, 2005.

(b) EXTENSION OF EFFECTIVE DATE FOR STATE LAW AMENDMENT.—In the case of a State plan under title XIX of the Social Security Act which the Secretary of Health and Human Services determines requires State legislation in order for the plan to meet the additional requirements imposed by the amendments made by a provision of this Act, the State plan shall not be regarded as failing to comply with the requirements of this Act solely on the basis of its failure to meet these additional requirements before the first day of the first calendar quarter beginning after the close of the first regular session of the

State legislature that begins after the date of enactment of this Act. For purposes of the previous sentence, in the case of a State that has a 2-year legislative session, each year of the session shall be considered to be a separate regular session of the State legislature.

○