

109<sup>TH</sup> CONGRESS  
2<sup>D</sup> SESSION

# H. R. 5886

To amend the Social Security Act and the Internal Revenue Code of 1986 to provide for an AmeriCare that assures the provision of health insurance coverage to all residents, and for other purposes.

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## IN THE HOUSE OF REPRESENTATIVES

JULY 25, 2006

Mr. STARK (for himself, Ms. SCHAKOWSKY, Mr. McDERMOTT, Mr. RANGEL, Mr. LEWIS of Georgia, Mr. BROWN of Ohio, Mr. GEORGE MILLER of California, Mr. WAXMAN, Mr. BECERRA, Ms. CORRINE BROWN of Florida, Ms. CARSON, Mrs. CHRISTENSEN, Mr. CONYERS, Mr. DAVIS of Illinois, Mr. FILNER, Mr. GRIJALVA, Mr. HINCHEY, Ms. NORTON, Ms. JACKSON-LEE of Texas, Ms. KILPATRICK of Michigan, Mr. LANTOS, Ms. LEE, Mr. MCGOVERN, Mr. NADLER, Mr. OWENS, Mr. PALLONE, Mr. THOMPSON of Mississippi, Mr. TOWNS, Ms. WOOLSEY, and Ms. SOLIS) introduced the following bill; which was referred to the Committee on Energy and Commerce, and in addition to the Committees on Ways and Means and Education and the Workforce, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned

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## A BILL

To amend the Social Security Act and the Internal Revenue Code of 1986 to provide for an AmeriCare that assures the provision of health insurance coverage to all residents, and for other purposes.

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

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

2 (a) **SHORT TITLE.**—This Act may be cited as  
3 “AmeriCare Health Care Act of 2006”.

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

Sec. 1. Short title; table of contents.

**TITLE I—HEALTH CARE ELIGIBILITY AND BENEFITS**

Sec. 101. Eligibility and benefits.

“**TITLE XXII—AMERICARE HEALTH BENEFITS**

“**PART A—ELIGIBILITY**

“Sec. 2201. Eligibility.

“Sec. 2202. Enrollment and AmeriCare cards.

“**PART B—BENEFITS**

“Sec. 2221. Scope of benefits.

“Sec. 2222. Exclusions.

“**PART C—PAYMENT FOR BENEFITS AND FINANCING**

“Sec. 2241. Payments for benefits.

“Sec. 2242. AmeriCare Trust Fund.

“**PART D—ADMINISTRATIVE SIMPLIFICATION**

“Sec. 2251. Requirement for entitlement verification system.

“Sec. 2252. Requirements for uniform claims and electronic claims data set.

“Sec. 2253. Electronic medical records and reporting.

“Sec. 2254. Uniform hospital cost reporting.

“Sec. 2255. Health service provider defined.

“**PART E—GENERAL PROVISIONS**

“Sec. 2261. Definitions relating to beneficiaries and income.

“Sec. 2262. Incorporation of certain medicare provisions and other provisions.

“Sec. 2263. State maintenance of effort payments.

“Sec. 2264. Modification of medicaid and other programs to avoid duplication of benefits.

“Sec. 2265. Construction regarding continuation of obligations under current group health plan contracts and provision of additional benefits.

“Sec. 2266. Standards and requirements for AmeriCare supplemental policies.

**TITLE II—FINANCING PROVISIONS**

Subtitle A—Individual Contributions

- Sec. 201. General obligation for individuals.  
 Sec. 202. Additional premium subsidies.  
 Sec. 203. Effective date.

Subtitle B—Employer Contributions

- Sec. 211. General obligation for employers.  
 Sec. 212. Effective date.

1                   **TITLE I—HEALTH CARE**  
 2                   **ELIGIBILITY AND BENEFITS**

3 **SEC. 101. ELIGIBILITY AND BENEFITS.**

4           (a) IN GENERAL.—The Social Security Act is amend-  
 5 ed by adding at the end the following new title:

6           “TITLE XXII—AMERICARE HEALTH BENEFITS

7                                   “PART A—ELIGIBILITY

8           “SEC. 2201. ELIGIBILITY.

9           “ (a) UNIVERSAL ELIGIBILITY FOR RESIDENTS.—

10                   (1) IN GENERAL.—Except as provided in sec-  
 11 tion 2263(a), each individual who is a resident of  
 12 the United States is entitled to health insurance  
 13 benefits under this title.

14

15                   “ (2) EFFECTIVE DATE FOR BENEFITS.—This  
 16 title shall apply to items and services furnished on  
 17 or after January 1, 2010.

18           “ (b) SPECIAL ELIGIBILITY GROUPS.—For purposes  
 19 of this title, an individual described in subsection (a) may  
 20 obtain special benefits under this title on the basis of one  
 21 or more of the following special eligibility groups:

1           “(1) Children (as defined in section  
2           2261(a)(1)).

3           “(2) Low-income individuals (as defined in sec-  
4           tion 2261(a)(2)).

5           “(3) Pregnant women (as defined in section  
6           2261(a)(3)).

7           “(c) RECIPROCAL COVERAGE OF NONRESIDENTS.—

8           An individual who—

9           “(1) is not a resident of the United States,

10           “(2) is in the United States, and

11           “(3) is a national of a foreign state which pro-  
12           vides health benefits to nationals of the United  
13           States who are nonresidents in that state,

14           is entitled to such health insurance benefits under this  
15           title, but only to the extent the Secretary determines that  
16           such benefits would be available to nationals of the United  
17           States similarly situated as a nonresident in the foreign  
18           state.

19           **“SEC. 2202. ENROLLMENT AND AMERICARE CARDS.**

20           “(a) ENROLLMENT.—The Secretary shall provide a  
21           mechanism for the enrollment of individuals entitled to  
22           benefits under this title and, in conjunction with such en-  
23           rollment, the issuance of an AmeriCare card which may  
24           be used for purposes of identification and processing of  
25           claims for benefits under this title. AmeriCare cards shall

1 identify (as appropriate) the date of birth (for purposes  
2 of identifying children) and provide a coded means for  
3 identifying whether the individual is a low-income indi-  
4 vidual for the year involved.

5 “(b) CLASSES OF ENROLLMENT.—The mechanism  
6 under subsection (a) shall provide for individuals to be en-  
7 rolled on the basis of the following classes of enrollment:

8 (1) Coverage only of an individual.

9 (2) Coverage of a married couple without chil-  
10 dren.

11 (3) Coverage of an unmarried individual and  
12 one or more children.

13 (4) Coverage of a married couple and one or  
14 more children.

15 “(c) ENROLLMENT AT BIRTH.—The mechanism  
16 under subsection (a) shall include a process for the auto-  
17 matic enrollment of individuals at the time of birth in the  
18 United States.

19 “(d) OPT OUT FOR THOSE COVERED UNDER GROUP  
20 HEALTH PLAN.—Notwithstanding any other provision of  
21 this title, an individual may elect not to be enrolled for  
22 benefits under this title if the individual demonstrates to  
23 the satisfaction of the Secretary that the individual has  
24 health benefits coverage under a group health plan (as de-  
25 fined in section 5000(b)(1) of the Internal Revenue Code

1 of 1986) that is at least equivalent to the coverage other-  
2 wise provided under this title, as certified by the Sec-  
3 retary.

4 “PART B—BENEFITS

5 “SEC. 2221. SCOPE OF BENEFITS.

6 “(a) IN GENERAL.—Except as provided in the suc-  
7 ceeding provisions of this part, the benefits provided to  
8 an individual described in section 2201(a) by the program  
9 established by this title shall consist of entitlement to the  
10 same benefits as are provided under parts A and B of title  
11 XVIII to individuals entitled to benefits under part A, and  
12 enrolled under part B, of title XVIII.

13 “(b) CHANGE IN THE COST-SHARING.—

14 “(1) DEDUCTIBLE.—Except as provided in the  
15 succeeding provisions of this part, the amount of ex-  
16 penses (other than expenses for benefits described in  
17 subsection (c)) with respect to which an individual is  
18 entitled to have payment made under this title for  
19 any year shall first be reduced by a deductible of  
20 \$350, except that in no case shall the amount of the  
21 deductible for all the members of a family exceed  
22 \$500. Such deductible shall be instead of the deduct-  
23 ible for inpatient hospital services under the first  
24 sentence of section 1813(a)(1) and the deductible  
25 under section 1833(b).

1           “(2) COINSURANCE.—After the application of  
2           the deductible under paragraph (1), the expenses re-  
3           ferred to in such paragraph shall be subject to a co-  
4           insurance of 20 percent until the limit on out-of-  
5           pocket expenses under paragraph (3) is met.

6           “(3) LIMIT ON OUT-OF-POCKET EXPENSES AND  
7           TOTAL EXPENSES.—

8           “(A) LIMITATION ON COST-SHARING.—  
9           Subject to subparagraph (B), whenever in a cal-  
10          endar year an individual’s expenses for the de-  
11          ductible and coinsurance with respect to serv-  
12          ices covered under this title (including expenses  
13          for benefits described in subsection (e)) and  
14          furnished during the year equals \$2,500, or  
15          \$4,000 for all the members of a family, pay-  
16          ment of benefits under this title for the indi-  
17          vidual (or for the members of such family, re-  
18          spectively) for services furnished during the re-  
19          mainder of the year shall be paid without the  
20          application of any coinsurance.

21          “(B) LIMITATION ON PREMIUMS AND  
22          COST-SHARING FOR CERTAIN INDIVIDUALS  
23          BASED ON INCOME.—

24                  “(i) INCOME BETWEEN 200 AND 300  
25                  PERCENT OF POVERTY LINE.—In the case

1 of a family whose applicable modified gross  
2 income (expressed as a percentage of the  
3 poverty level, as defined in section  
4 2261(b)(2)) is equal to or exceeds 200 per-  
5 cent, but does not exceed 300 percent, of  
6 the poverty level applicable to a family of  
7 the size involved, whenever in a calendar  
8 year an individual's expenses in the family  
9 for premiums under this title and for the  
10 deductible and coinsurance with respect to  
11 services covered under this title (including  
12 expenses for benefits described in sub-  
13 section (c)) and furnished during the year  
14 equals 5 percent of the amount of such ap-  
15 plicable modified gross income for the fam-  
16 ily—

17 “(I) no additional premiums shall  
18 be imposed for remaining months in  
19 the year; and

20 “(II) payment of benefits under  
21 this title for members of such family  
22 for services furnished during the re-  
23 mainder of the year shall be paid  
24 without the application of any deduct-  
25 ible or coinsurance.

1           “(ii) INCOME BETWEEN 300 AND 500  
2           PERCENT OF POVERTY LINE.—In the case  
3           of a family whose applicable modified gross  
4           income (expressed as a percentage of the  
5           poverty level, as defined in section  
6           2261(b)(2)) exceeds 300 percent, but does  
7           not exceed 500 percent, of such poverty  
8           level applicable to a family of the size in-  
9           volved, whenever in a calendar year an in-  
10          dividual’s expenses in the family for pre-  
11          miums under this title and for the deduct-  
12          ible and coinsurance with respect to serv-  
13          ices covered under this title (including ex-  
14          penses for benefits described in subsection  
15          (c)) and furnished during the year equals  
16          7.5 percent of the amount of such applica-  
17          ble modified gross income for the family—

18                   “(I) no additional premiums shall  
19                   be imposed for remaining months in  
20                   the year; and

21                   “(II) payment of benefits under  
22                   this title for members of such family  
23                   for services furnished during the re-  
24                   mainder of the year shall be paid

1 without the application of any deduct-  
2 ible or coinsurance.

3 “(C) COUNTING ALL EXPENSES FOR PRE-  
4 MIUMS, DEDUCTIBLES AND COINSURANCE  
5 WITHOUT REGARD TO TRUE OUT-OF-POCKET  
6 COSTS.—In applying subparagraphs (A) and  
7 (B), expenses for an individual’s premiums, de-  
8 ductible, and coinsurance shall be counted with-  
9 out regard to whether such expenses are paid,  
10 payable, reimbursed, or reimbursable by an-  
11 other person, including through a group health  
12 plan, insurance or otherwise, or other third  
13 party payment arrangement.

14 “(4) INDEXING DOLLAR AMOUNTS BY CPI.—  
15 Each dollar amount specified in paragraphs (1) and  
16 (3)(A) shall be increased to the year involved by the  
17 compounded sum of the increase in the consumer  
18 price index for all urban consumers (U.S. City aver-  
19 age, as published by the Bureau of Labor Statistics  
20 of the Department of Labor) for each year after  
21 2006 and up to the year involved. Any increase  
22 under this paragraph for a year shall be rounded,  
23 with respect to paragraph (1), to the nearest mul-  
24 tiple of \$5 and, with respect to paragraph (2), to the  
25 nearest multiple of \$100.

1       “(c) PRESCRIPTION DRUGS.—Benefits shall also be  
2 made available under this title (as specified by the Sec-  
3 retary) for prescription drugs and biologicals which are  
4 not less than the benefits for such drugs and biologicals  
5 under the standard option for the service benefit plan de-  
6 scribed in section 8903(1) of title 5, United States Code,  
7 offered during 2005.

8       “(d) CHILDREN.—

9           “(1) NO DEDUCTIBLES OR COINSURANCE.—In  
10 the case of children (as defined in section  
11 2261(a)(1)), there shall be no deductible or coinsur-  
12 ance applicable to covered benefits (including bene-  
13 fits described in paragraphs (2) and (3)).

14           “(2) ADDITIONAL PREVENTIVE BENEFITS.—

15           “(A) IN GENERAL.—Subject to the perio-  
16 dicity schedule established with respect to the  
17 services under subparagraph (B), for children  
18 benefits shall be available under this title for  
19 the following items and services:

20           “(i) Newborn and well-baby care, in-  
21 cluding normal newborn care and pediatri-  
22 cian services for high-risk deliveries.

23           “(ii) Well-child care, including routine  
24 office visits, routine immunizations (includ-

1           ing the vaccine itself), routine laboratory  
2           tests, and preventive dental care.

3           “(B) PERIODICITY SCHEDULE.—The Sec-  
4           retary, in consultation with the American Acad-  
5           emy of Pediatrics and the American Dental As-  
6           sociation, shall establish a schedule of perio-  
7           dicity which reflects the general, appropriate  
8           frequency with which services listed in subpara-  
9           graph (A) should be provided to healthy chil-  
10          dren.

11          “(3) COVERAGE OF EPSDT.—For children, ben-  
12          efits also shall be available under this title for early  
13          and periodic screening, diagnostic, and treatment  
14          services (as defined in section 1905(r)) not otherwise  
15          covered under paragraph (2).

16          “(4) OTHER ADDITIONAL SERVICES FOR CHIL-  
17          DREN.—For children, benefits also shall be available  
18          under this title for the following:

19                 “(A) Inpatient hospital services (without  
20                 regard to the restrictions described in sub-  
21                 sections (a)(1) and (b)(1) of section 1812 and  
22                 the coinsurance described in section  
23                 1813(a)(1)).

24                 “(B) Eyeglasses and hearing aids, and ex-  
25                 aminations therefor.

1       “(e) PREGNANCY-RELATED SERVICES.—In the case  
2 of a pregnant woman (as defined in section 2261(a)(3)),  
3 benefits under this title shall include entitlement to have  
4 payment made for the following, without the application  
5 of a deductible or coinsurance:

6           “(1) Prenatal care, including care for all com-  
7 plications of pregnancy.

8           “(2) Inpatient labor and delivery services.

9           “(3) Postnatal care.

10       “(f) LOWER-INCOME INDIVIDUALS.—

11           “(1) LIMITATIONS ON DEDUCTIBLES AND COIN-  
12 SURANCE.—

13           “(A) NONE FOR LOW-INCOME INDIVID-  
14 UALS.—In the case of a low-income individual,  
15 there shall be no deductible or coinsurance  
16 under this title.

17           “(B) PHASE-IN FOR OTHER LOWER-IN-  
18 COME INDIVIDUALS.—In the case of an indi-  
19 vidual whose applicable modified gross income  
20 (as defined in section 2261(b)(1)) exceeds twice  
21 the poverty level (as defined in section  
22 2261(b)(2)) but does not exceed three times the  
23 poverty level, the deductible and coinsurance  
24 applicable under this title shall bear the same

1 ratio to the deductible or coinsurance otherwise  
2 applicable as—

3 “(i) the excess of the applicable modi-  
4 fied gross income over the poverty level,  
5 bears to

6 “(ii) the poverty level.

7 If the ratio determined under the preceding  
8 sentence is not a multiple of 25 percentage  
9 points, such ratio shall be rounded to the near-  
10 est 25 percentage points.

11 “(2) ADDITIONAL BENEFITS FOR LOW-INCOME  
12 INDIVIDUALS.—In the case of low-income individuals  
13 (as defined in section 2261(a)(2)), benefits under  
14 this title shall also include entitlement to have pay-  
15 ment made for the following, without the application  
16 of a deductible or coinsurance:

17 “(A) Inpatient hospital services (without  
18 regard to the restrictions described in sub-  
19 sections (a)(1) and (b)(1) of section 1812 and  
20 the coinsurance described in section  
21 1813(a)(1)).

22 “(B) Eyeglasses and hearing aids and ex-  
23 aminations therefor.

24 “(g) PREVENTIVE BENEFITS.—Benefits shall also be  
25 made available under this title, without the application of

1 any deductible or coinsurance for preventive services that  
2 are recommended by the United States Preventive Serv-  
3 ices Task Force.

4 “(h) MENTAL HEALTH PARITY AND SUBSTANCE  
5 ABUSE BENEFITS.—Benefits shall be made available  
6 under this title for mental health services and for sub-  
7 stance abuse treatment in the same manner as such bene-  
8 fits are made available for medical and surgical services.

9 “(i) FAMILY PLANNING SERVICES.—Benefits  
10 shall be made available under this title for family  
11 planning services.

12 “(j) CONFORMING MEDICARE BENEFITS.—Notwith-  
13 standing any other provision of law, benefits under title  
14 XVIII shall be expanded and conformed to the benefits  
15 made available under this title (including the application  
16 of a single deductible and uniform coinsurance amounts,  
17 a limitation on the coinsurance, and additional benefits for  
18 low-income individuals under subsection (f)), but nothing  
19 in this subsection shall be construed as providing for any  
20 such additional benefits under this title rather than under  
21 such title.

22 “(k) ENROLLMENT IN HEALTH PLANS.—The Sec-  
23 retary shall provide for the offering of benefits under this  
24 title through enrollment in a health benefit plan that  
25 meets the same (or similar) requirements as the require-

1 ments that apply to Medicare Advantage plans under part  
2 C of title XVIII (other than any such requirements that  
3 relate to part D of such title). In the case of individuals  
4 enrolled under this title in such a plan, the payment rate  
5 to the plan under this title shall be based on adjusted aver-  
6 age per capita cost (AAPCC) payment rate methodology  
7 described in section 1853(c)(1)(D) for benefits under this  
8 title and for individuals entitled to benefits under this title  
9 who are not enrolled in such a plan.

10 **“SEC. 2222. EXCLUSIONS.**

11       “(a) IN GENERAL.—Except as provided in this sec-  
12 tion, section 1862 shall apply to expenses incurred for  
13 items and services provided under this title the same man-  
14 ner as such section applies to items and services provided  
15 under title XVIII.

16       “(b) BENEFITS EXCEPTION.—

17               “(1) CHILDRENS’ SERVICES.—In applying sec-  
18 tion 1862(a) with respect to services described in  
19 section 2221(d)(2)(A) (relating to well-child serv-  
20 ices), payment shall not be denied under paragraph  
21 (1), (7), or (12) of such section 1862(a) if the serv-  
22 ices are provided in accordance with the periodicity  
23 schedule described in section 2221(d)(2)(B).

24               “(2) TREATMENT OF EYEGLASSES AND HEAR-  
25       ING AIDS FOR CHILDREN AND LOW-INCOME INDIVID-

1 UALS.—Payment shall not be denied under this title  
2 under section 1862(a)(7) with respect to eyeglasses  
3 and hearing aids and examinations therefor in the  
4 case of children and low-income individuals.

5 “(c) COORDINATION OF PAYMENTS.—

6 “(1) PRIMARY TO GROUP HEALTH PLANS.—  
7 Section 1862(b)(1) (relating to requirements of  
8 group health plans) shall not apply under this title.

9 “(2) SECONDARY TO MEDICARE.—Payment  
10 shall not be made under this title with respect to  
11 benefits to the extent that payment for such benefits  
12 may be made under title XVIII.

13 “PART C—PAYMENT FOR BENEFITS AND FINANCING

14 “**SEC. 2241. PAYMENTS FOR BENEFITS.**

15 “(a) IN GENERAL.—Except as otherwise provided in  
16 this section and in section 2221—

17 “(1) payment of benefits under this title with  
18 respect to benefits shall be made on the same basis  
19 as payment is made with respect to such benefits  
20 under title XVIII, and

21 “(2) the provisions of sections 1814, 1833,  
22 1834, 1842, 1848, and 1886 shall apply to payment  
23 of benefits under this title in the same manner as  
24 they apply to benefits under title XVIII.

1       “(b) NO EXTRA BILLING PERMITTED.—Payment  
2 under this title may only be made on an assignment-re-  
3 lated basis (as defined in section 1842(i)(1)). If an entity  
4 knowingly and willfully presents or causes to be presented  
5 a claim or bills an individual enrolled under this title for  
6 charges for services other than on an assignment-related  
7 basis, the Secretary may apply sanctions against such en-  
8 tity in accordance with section 1842(j)(2).

9       “(c) ADJUSTMENT OF PAYMENTS.—

10           “(1) ESTABLISHMENT OF NEW DRGS AND  
11 WEIGHTS.—In making payment under this title with  
12 respect to inpatient hospital services, the Secretary  
13 shall establish such additional diagnosis-related  
14 groups (and weighting factors with respect to dis-  
15 charges within such groups) and make such adjust-  
16 ments in the diagnosis-related groups and weighting  
17 factors with respect to discharges within such groups  
18 otherwise established under section 1886(d)(4) as  
19 may be necessary to reflect the types of discharges  
20 occurring under this title which are not occurring  
21 under title XVIII.

22           “(2) PAYMENT FOR OBSTETRICAL SERVICES.—

23           “(A) GLOBAL FEE.—In making payment  
24 under this title with respect to the group of ob-  
25 stetrical services typical of treatment through-

1 out a course of pregnancy, the Secretary shall  
2 establish, as a schedule under section 1848, a  
3 global fee with respect to such group of serv-  
4 ices.

5 “(B) BONUS FOR EARLY PRESEN-  
6 TATION.—The fee schedule amount with respect  
7 to obstetrical services under this title shall be  
8 increased by 5 percent in the case of services  
9 furnished to women who have presented for pre-  
10 natal care during the first trimester.

11 “(d) CONDITIONS OF AND LIMITATIONS ON PAY-  
12 MENTS.—The provisions of sections 1814 and 1835 shall  
13 apply to payment for services under this title in the same  
14 manner as they apply to payment for services under parts  
15 A and B, respectively, of title XVIII.

16 “(e) USE OF TRUST FUND.—In carrying out this sec-  
17 tion, any reference in title XVIII to a trust fund shall be  
18 treated as a reference to the AmeriCare Trust Fund estab-  
19 lished under section 2242.

20 “(f) PAYMENT FOR OUTPATIENT PRESCRIPTION  
21 DRUGS AND BIOLOGICALS.—The Secretary shall establish  
22 a fee schedule for the payment for outpatient prescription  
23 drugs and biologicals under this title and, notwithstanding  
24 section 1860D–11(i)(1), under title XVIII. The Secretary  
25 shall negotiate with pharmaceutical manufacturers with

1 respect to the purchase price of such drugs and biologicals  
2 and shall encourage the use of more affordable therapeutic  
3 equivalents to the extent such practices do not override  
4 medical necessity, as determined by the prescribing physi-  
5 cian. To the extent practicable and consistent with the  
6 previous sentence, the Secretary shall implement strate-  
7 gies similar to those used by other Federal purchasers of  
8 prescription drugs, and other strategies, to reduce the pur-  
9 chase cost of outpatient prescription drugs and biologicals.

10 **“SEC. 2242. AMERICARE TRUST FUND.**

11       “(a) ESTABLISHMENT.—(1) There is hereby created  
12 on the books of the Treasury of the United States a trust  
13 fund to be known as the ‘AmeriCare Trust Fund’ (in this  
14 section referred to as the ‘Trust Fund’). The Trust Fund  
15 shall consist of such gifts and bequests as may be made  
16 as provided in section 201(i)(1) and amounts appropriated  
17 under paragraph (2).

18       “(2) There are hereby appropriated to the Trust  
19 Fund amounts equivalent to 100 percent of the increase  
20 in revenues to the Treasury by reason of the provisions  
21 of and amendments made by title II of the AmeriCare  
22 Health Care Act of 2006. The amounts appropriated by  
23 the preceding sentence shall be transferred from time to  
24 time from the general fund in the Treasury to the Trust  
25 Fund, such amounts to be determined on the basis of esti-

1 mates by the Secretary of the Treasury of the increase  
2 in revenues which are paid to or deposited into the Treas-  
3 ury; and proper adjustments shall be made in amounts  
4 subsequently transferred to the extent prior estimates  
5 were in excess of or were less than such increase.

6 “(b) INCORPORATION OF PROVISIONS.—

7 “(1) IN GENERAL.—Subject to paragraph (2),  
8 the provisions of subsections (b) through (e) and (g)  
9 through (i) of section 1817 shall apply to the Trust  
10 Fund in the same manner as they apply to the Fed-  
11 eral Hospital Insurance Trust Fund.

12 “(2) EXCEPTIONS.—In applying paragraph  
13 (1)—

14 “(A) the Board of Trustees and Managing  
15 Trustee of the Trust Fund shall be composed of  
16 the members of the Board of Trustees and the  
17 Managing Trustee, respectively, of the Federal  
18 Hospital Insurance Trust Fund; and

19 “(B) any reference in section 1817 to the  
20 Federal Hospital Insurance Trust Fund or to  
21 title XVIII (or part A thereof) is deemed a ref-  
22 erence to the Trust Fund under this section  
23 and this title, respectively.

1           “PART D—ADMINISTRATIVE SIMPLIFICATION

2   **“SEC.   2251.   REQUIREMENT   FOR   ENTITLEMENT**  
3                   **VERIFICATION SYSTEM.**

4           “(a) IN GENERAL.—

5                   “(1) REQUIREMENT.—The Secretary with re-  
6           spect to the plan provided under this title, and each  
7           AmeriCare supplemental plan (as defined in section  
8           2279(3)), shall provide for an electronic system, that  
9           is certified by the Secretary as meeting the stand-  
10          ards established under subsection (b), for the  
11          verification of an individual’s entitlement to benefits  
12          under such plan.

13                   “(2) DEADLINE FOR APPLICATION OF REQUIRE-  
14          MENT.—The deadline specified under this paragraph  
15          for the requirement under paragraph (1) is 6  
16          months after the date the standards are established  
17          under subsection (b).

18          “(b) STANDARDS FOR ENTITLEMENT VERIFICATION  
19          SYSTEMS.—

20                   “(1) IN GENERAL.—The Secretary shall estab-  
21          lish standards consistent with this subsection re-  
22          specting the requirements for certification of entitle-  
23          ment verification systems.

1           “(2) INFORMATION AVAILABLE.—Such stand-  
2           ards shall require a system to provide information,  
3           with respect to individuals, concerning the following:

4                   “(A) The specific benefits to which the in-  
5                   dividual is entitled under the plan.

6                   “(B) Current status of the individual with  
7                   respect to fulfillment of deductibles, coinsur-  
8                   ance, and out-of-pocket limits on cost-sharing.

9                   “(C) Restrictions on providers who may  
10                  provide covered services, including utilization  
11                  controls (such as preadmission certification).

12           “(3) FORM OF INQUIRY.—Each verification sys-  
13           tem shall be capable of accepting inquiries under  
14           this subsection from health care providers in a vari-  
15           ety of electronic forms. The system shall also pro-  
16           vide, for an additional fee, for the acceptance of in-  
17           quiries in a nonelectronic form.

18           “(4) FORM OF RESPONSE.—Each such system  
19           shall be capable of responding to such inquiries  
20           under this subsection in a variety of electronic and  
21           other forms, including—

22                   “(A) through modem transmission of infor-  
23                   mation,

24                   “(B) through computer synthesized voice  
25                   communication, and

1           “(C) through transmission of information  
2           to a facsimile (fax) machine.

3           The system shall also provide, for an additional fee,  
4           for the response to inquiries in a nonelectronic form.

5           “(5) LIMITATION ON FEES.—Neither the Sec-  
6           retary nor an AmeriCare supplemental plan may im-  
7           pose a fee for the acceptance or response to an in-  
8           quiry under this subsection except where the accept-  
9           ance or response is in a nonelectronic form.

10          “(6) WEBSITE AVAILABILITY TO PROVIDERS.—  
11          The Secretary shall establish and maintain a website  
12          through which—

13                 “(A) health service providers may make in-  
14                 quiries, and receive responses, with respect to  
15                 the eligibility and benefits of an individual  
16                 under plans; and

17                 “(B) AmeriCare supplemental plans may  
18                 make inquiries, and receive responses, to deter-  
19                 mine the liability of other plans for the provi-  
20                 sion or payment of benefits.

21          “(7) DEADLINE.—The Secretary shall first es-  
22          tablish the standards under this subsection (and  
23          shall establish the website under paragraph (6)) by  
24          not later than 12 months after the date of the enact-  
25          ment of this title.

1 **“SEC. 2252. REQUIREMENTS FOR UNIFORM CLAIMS AND**  
2 **ELECTRONIC CLAIMS DATA SET.**

3 “(a) REQUIREMENTS.—

4 “(1) SUBMISSION OF CLAIMS.—Each health  
5 service provider that furnishes services in the United  
6 States for which payment may be made under this  
7 title or under an AmeriCare supplemental plan shall  
8 submit any claim for payment for such services only  
9 in a form and manner consistent with standards es-  
10 tablished under subsection (c).

11 “(2) ACCEPTANCE OF CLAIMS.—The Secretary  
12 and an AmeriCare supplemental plan may not reject  
13 a claim for payment under this title or the plan on  
14 the basis of the form or manner in which the claim  
15 is submitted if the claim is submitted in accordance  
16 with the standards established under subsection (c).

17 “(3) EFFECTIVE DATE.—This subsection shall  
18 apply to claims for services furnished on or after the  
19 date that is 6 months after the date standards are  
20 established under subsection (c).

21 “(b) ENFORCEMENT THROUGH CIVIL MONEY PEN-  
22 ALTIES.—

23 “(1) IN GENERAL.—

24 “(A) PROVIDERS.—In the case of a health  
25 service provider that submits a claim in viola-  
26 tion of subsection (a)(1), the provider is subject

1 to a civil money penalty of not to exceed \$100  
2 (or, if greater, the amount of the claim) for  
3 each such violation.

4 “(B) PLANS.—In the case of an  
5 AmeriCare supplemental plan that rejects a  
6 claim in violation of subsection (a)(2), the plan  
7 is subject to a civil money penalty of not to ex-  
8 ceed \$100 (or, if greater, the amount of the  
9 claim) for each such violation.

10 “(2) PROCESS.—The provisions of section  
11 1128A of the Social Security Act (other than sub-  
12 sections (a) and (b)) shall apply to a civil money  
13 penalty under paragraph (1) in the same manner as  
14 such provisions apply to a penalty or proceeding  
15 under section 1128A(a) of such Act.

16 “(c) STANDARDS RELATING TO UNIFORM CLAIMS  
17 AND ELECTRONIC CLAIMS DATA SET.—

18 “(1) ESTABLISHMENT OF STANDARDS.—The  
19 Secretary shall establish standards that—

20 “(A) relate to the form and manner of sub-  
21 mission of claims for benefits under this title  
22 and under an AmeriCare supplemental plan,  
23 and

1           “(B) define the data elements to be con-  
2           tained in a uniform electronic claims data set to  
3           be used with respect to such claims.

4           “(2) SCOPE OF INFORMATION.—

5           “(A) ENSURING ACCOUNTABILITY FOR  
6           CLAIMS SUBMITTED ELECTRONICALLY.—In es-  
7           tablishing standards under this section, the Sec-  
8           retary, in consultation with appropriate agen-  
9           cies, shall include such methods of ensuring  
10          provider responsibility and accountability for  
11          claims submitted electronically that are de-  
12          signed to control fraud and abuse in the sub-  
13          mission of such claims.

14          “(B) COMPONENTS.—In establishing such  
15          standards the Secretary shall—

16                 “(i) with respect to data elements, de-  
17                 fine data fields, formats, and medical no-  
18                 menclature, and plan benefit and insurance  
19                 information;

20                 “(ii) develop a single, uniform coding  
21                 system for diagnostic and procedure codes;  
22                 and

23                 “(iii) provide for standards for the  
24                 uniform electronic transmission of such  
25                 elements.

1           “(3) COORDINATION WITH STANDARDS FOR  
2 ELECTRONIC MEDICAL RECORDS.—In establishing  
3 standards under this subsection, the Secretary shall  
4 assure that—

5                   “(A) the development of such standards is  
6 coordinated with the development of the stand-  
7 ards for electronic medical records under sec-  
8 tion 2253, and

9                   “(B) the coding of data elements under the  
10 uniform electronic claims data set and the cod-  
11 ing of the same elements in the uniform hos-  
12 pital clinical data set are consistent.

13           “(4) USE OF TASK FORCES.—In adopting  
14 standards under this subsection—

15                   “(A) the Secretary shall take into account  
16 the recommendations of current task forces;  
17 and

18                   “(B) the Secretary shall provide that the  
19 electronic transmission standards are con-  
20 sistent, to the extent practicable, with the appli-  
21 cable standards established by the Accredited  
22 Standards Committee X-12 of the American  
23 National Standards Institute.

1           “(5) UNIFORM, UNIQUE PROVIDER IDENTIFICA-  
2           TION CODES.—In establishing standards under this  
3           subsection—

4                   “(A) the Secretary shall provide for a  
5           unique identifier code for each health service  
6           provider that furnishes services for which a  
7           claim may be submitted under this title or  
8           under an AmeriCare supplemental plan, and

9                   “(B) in the case of a provider that has a  
10          unique identifier issued for purposes of title  
11          XVIII, the code provided under subparagraph  
12          (A) shall be the same as such unique identifier.

13           “(6) WEBSITE AVAILABILITY TO PROVIDERS.—  
14          The Secretary shall establish and maintain a website  
15          that will enable health service providers, without  
16          charge, to submit claims and to receive verification  
17          of claims status electronically.

18           “(7) STANDARDS FOR PAPER CLAIMS.—The  
19          standards shall provide for a uniform paper claims  
20          form which is consistent with data elements required  
21          for the submission of claims electronically.

22           “(8) STANDARDS FOR CLAIMS FOR CLINICAL  
23          LABORATORY TESTS.—The standards shall provide  
24          that claims for clinical laboratory tests for which  
25          benefits are provided under this title or under an

1 AmeriCare supplemental plan shall be submitted di-  
2 rectly by the person or entity that performed (or su-  
3 pervised the performance of) the tests to the plan in  
4 a manner consistent with (and subject to such excep-  
5 tions as are provided under) the requirement for di-  
6 rect submission of such claims under title XVIII.

7 “(9) DEADLINE.—The Secretary shall first pro-  
8 vide for the standards for the uniform claims under  
9 this subsection (and shall develop and make avail-  
10 able the software under paragraph (6)) by not later  
11 than 1 year after the date of the enactment of this  
12 title.

13 “(d) USE UNDER THIS TITLE AND MEDICARE AND  
14 MEDICAID PROGRAMS.—

15 “(1) REQUIREMENT FOR PROVIDERS.—In the  
16 case of a health service provider that submits a  
17 claim for services furnished under this title in viola-  
18 tion of subsection (a)(1), no payment shall be made  
19 under this title for such services.

20 “(2) REQUIREMENTS OF MEDICARE ADMINIS-  
21 TRATIVE CONTRACTORS UNDER MEDICARE PRO-  
22 GRAM.—The Secretary shall provide, in regulations  
23 promulgated to carry out this title, that the claims  
24 process provided under this title conforms to the  
25 standards established under subsection (c).

1           “(3) REQUIREMENTS OF STATE MEDICAID  
2 PLANS.—As a condition for the approval of State  
3 plans under the medicaid program, effective as of  
4 the effective date specified in subsection (a)(3), each  
5 such plan shall provide, in accordance with regula-  
6 tions of the Secretary, that the claims process pro-  
7 vided under the plan is modified to the extent re-  
8 quired to conform to the standards established under  
9 subsection (c).

10 **“SEC. 2253. ELECTRONIC MEDICAL RECORDS AND REPORT-**  
11 **ING.**

12           “(a) STANDARDS FOR ELECTRONIC MEDICAL  
13 RECORDS.—

14           “(1) PROMULGATION OF STANDARDS.—

15           “(A) IN GENERAL.—Not later than Janu-  
16 ary 1, 2008, the Secretary shall promulgate  
17 standards described in paragraph (2) for hos-  
18 pitals and other health care providers con-  
19 cerning electronic medical records. Such stand-  
20 ards shall include the standards established  
21 under part C of title XI.

22           “(B) REVISION.—The Secretary may from  
23 time to time revise the standards promulgated  
24 under this paragraph.

1           “(2) CONTENTS OF STANDARDS.—The stand-  
2           ards promulgated under paragraph (1) shall include  
3           at least the following:

4                   “(A) A definition of a uniform provider  
5                   clinical data set, including a definition of the  
6                   set of comprehensive data elements, for use by  
7                   utilization and quality control peer review orga-  
8                   nizations.

9                   “(B) Standards for an electronic patient  
10                  care information system with data obtained at  
11                  the point of care.

12                  “(C) A specification of, and manner of  
13                  presentation of, the individual data elements of  
14                  the set and system under this paragraph.

15                  “(D) Standards concerning the trans-  
16                  mission of electronic medical data.

17                  “(E) Standards relating to confidentiality  
18                  of patient-specific information, which include  
19                  the physical security of electronic data and the  
20                  use of keys, passwords, encryption, and other  
21                  means to ensure the protection of the confiden-  
22                  tiality and privacy of electronic data.

23           “(3) COORDINATION WITH STANDARDS FOR  
24           UNIFORM ELECTRONIC CLAIMS DATA SET.—In es-

1       tablishing standards under this subsection, the Sec-  
2       retary shall assure that—

3               “(A) the development of such standards is  
4               coordinated with the development of the stand-  
5               ards for the uniform electronic claims data set  
6               under subsection (b), and

7               “(B) the coding of data elements under the  
8               uniform provider clinical data set and the cod-  
9               ing of the same elements under the uniform  
10              electronic claims data set are consistent.

11             “(4) CONSULTATION.—In establishing stand-  
12             ards under this subsection, the Secretary shall—

13               “(A) consult with the American National  
14               Standards Institute, hospitals and other health  
15               care providers, health benefit plans, and other  
16               interested parties, and

17               “(B) take into consideration, in developing  
18               standards under paragraph (2)(A), the data set  
19               used by the utilization and quality control peer  
20               review program under part B of title XI.

21             “(b) REQUIREMENT FOR APPLICATION OF ELEC-  
22             TRONIC RECORDS STANDARDS.—

23               “(1) AS CONDITION OF MEDICARE, MEDICAID,  
24               SCHIP, AND AMERICARE PARTICIPATION.—Effective  
25               January 1, 2009, each hospital or other institutional

1 or noninstitutional health care provider, as a re-  
2 quirement of each participation agreement under  
3 this title, title XVIII, title XIX, and title XXI, shall,  
4 in accordance with the standards promulgated under  
5 subsection (a)(1)—

6 “(A) maintain clinical data included in the  
7 uniform provider clinical data set under sub-  
8 section (a)(2)(A) in electronic form on all pa-  
9 tients,

10 “(B) upon request of the Secretary or of a  
11 utilization and quality control peer review orga-  
12 nization (with which the Secretary has entered  
13 into a contract under part B of title XI), trans-  
14 mit electronically data requested from such  
15 data set, and

16 “(C) upon request of the Secretary, or of  
17 a fiscal intermediary or carrier, transmit elec-  
18 tronically any data (with respect to a claim)  
19 from such data set.

20 “(2) APPLICATION OF PRESENTATION AND  
21 TRANSMISSION STANDARDS TO ELECTRONIC TRANS-  
22 MISSION TO FEDERAL AGENCIES.—Effective Janu-  
23 ary 1, 2008, if a hospital or other health care pro-  
24 vider is required under a Federal program to trans-  
25 mit a data element that is subject to a standard,

1 promulgated under subsection (a)(1), described in  
2 subparagraph (C) or (D) of subsection (a)(2), the  
3 head of the Federal agency responsible for such pro-  
4 gram (if not otherwise authorized) is authorized to  
5 require the provider to present and transmit the  
6 data element electronically in accordance with such  
7 a standard.

8 “(c) LIMITATION ON DATA REQUIREMENTS WHERE  
9 STANDARDS IN EFFECT.—

10 “(1) IN GENERAL.—On or after January 1,  
11 2008, the Secretary under this title or under title  
12 XVIII (including any carrier or fiscal intermediary  
13 or any utilization and quality control peer review or-  
14 ganization) and an AmeriCare supplemental plan  
15 may not require, for the purpose of utilization review  
16 or as a condition of providing benefits or making  
17 payments under this title, title XVIII, or the plan,  
18 that a hospital or other health care provider—

19 “(A) provide any data element not in the  
20 uniform provider clinical data set specified  
21 under the standards promulgated under sub-  
22 section (a), or

23 “(B) transmit or present any such data  
24 element in a manner inconsistent with such

1 standards applicable to such transmission or  
2 presentation.

3 “(2) COMPLIANCE.—The Secretary may impose  
4 a civil money penalty on any AmeriCare supple-  
5 mental plan that fails to comply with paragraph (1)  
6 in an amount not to exceed \$100 for each such fail-  
7 ure. The provisions of section 1128A of the Social  
8 Security Act (other than the first sentence of sub-  
9 section (a) and other than subsection (b)) shall  
10 apply to a civil money penalty under this paragraph  
11 in the same manner as such provisions apply to a  
12 penalty or proceeding under section 1128A(a) of  
13 such Act.

14 “(3) APPLICATION TO MEDICAID PROGRAM.—As  
15 a condition for the approval of State plans under the  
16 medicaid program and in accordance with regula-  
17 tions of the Secretary, effective as of January 1,  
18 2008, each such plan may not require that a hos-  
19 pital or other health care provider, for the purpose  
20 of utilization review or as a condition of providing  
21 benefits or making payments under the plan—

22 “(A) provide any data element not in the  
23 uniform provider clinical data set specified  
24 under the standards promulgated under sub-  
25 section (a), or

1           “(B) transmit or present any such data  
2           element in a manner inconsistent with such  
3           standards applicable to such transmission or  
4           presentation.

5           “(d) PREEMPTION OF STATE QUILL PEN LAWS.—

6           “(1) IN GENERAL.—Any provision of State law  
7           that requires medical or health insurance records  
8           (including billing information) to be maintained in  
9           written, rather than electronic, form shall deemed to  
10          be satisfied if the records are maintained in an elec-  
11          tronic form that meets standards established by the  
12          Secretary under paragraph (2).

13          “(2) SECRETARIAL AUTHORITY.—Not later  
14          than 1 year after the date of the enactment of this  
15          title, the Secretary shall issue regulations to carry  
16          out paragraph (1). The regulations shall provide for  
17          an electronic substitute that is in the form of a  
18          unique identifier (assigned to each authorized indi-  
19          vidual) that serves the functional equivalent of a sig-  
20          nature. The regulations may provide for such excep-  
21          tions to paragraph (1) as the Secretary determines  
22          to be necessary to prevent fraud and abuse, to pre-  
23          vent the illegal distribution of controlled substances,  
24          and in such other cases as the Secretary deems ap-  
25          propriate.

1           “(3) EFFECTIVE DATE.—Paragraph (1) shall  
2           take effect on the first day of the first month that  
3           begins more than 30 days after the date the Sec-  
4           retary issues the regulations referred to in para-  
5           graph (2).

6   **“SEC. 2254. UNIFORM HOSPITAL COST REPORTING.**

7           “Each hospital, as a requirement under a participa-  
8           tion agreement under this title for each cost reporting pe-  
9           riod beginning during or after fiscal year 2007, shall pro-  
10          vide for the reporting of information to the Secretary with  
11          respect to any hospital care provided in a uniform manner  
12          consistent with standards established by the Secretary to  
13          carry out section 4007(c) of the Omnibus Budget Rec-  
14          onciliation Act of 1987 and in an electronic form con-  
15          sistent with standards established by the Secretary.

16   **“SEC. 2255. HEALTH SERVICE PROVIDER DEFINED.**

17          “In this part, the term ‘health service provider’ in-  
18          cludes a provider of services (as defined in section  
19          1861(u)), physician, supplier, and other entity furnishing  
20          health care services.

21                   **“PART E—GENERAL PROVISIONS**

22   **“SEC. 2261. DEFINITIONS RELATING TO BENEFICIARIES**  
23                   **AND INCOME.**

24          “(a) TERMS RELATING TO BENEFICIARIES.—In this  
25          title:

1           “(1) CHILD.—The term ‘child’ means an indi-  
2           vidual who throughout a month has not attained 24  
3           years of age.

4           “(2) LOW-INCOME INDIVIDUAL.—The term  
5           ‘low-income individual’ means an individual whose  
6           applicable modified gross income (as defined in sub-  
7           section (b)(1)) is less than 200 percent of the pov-  
8           erty level (as defined in subsection (b)(2)). The de-  
9           termination that an individual is a low-income indi-  
10          vidual shall be effective for a period of one year and  
11          shall be redetermined on an annual basis.

12          “(3) PREGNANT WOMAN.—The term ‘pregnant  
13          woman’ means a woman (regardless of age) who has  
14          been certified by a physician (in a manner specified  
15          by the Secretary) as being pregnant, until the last  
16          day of the month in which the 60-day period (begin-  
17          ning on the date of termination of the pregnancy)  
18          ends.

19          “(b) TERMS RELATING TO INCOME.—In this title:

20                 “(1) APPLICABLE MODIFIED GROSS INCOME.—

21                         “(A) IN GENERAL.—Except as provided in  
22                         this paragraph, the term ‘applicable modified  
23                         gross income’ means, for a calendar year for an  
24                         individual, the modified gross income (as de-  
25                         fined in section 202(a)(3)(B) of the Americare

1 Health Care Act of 2006) of the taxpayer (or  
2 the taxpayer for whom the individual may be  
3 claimed as a dependent) for the taxable year  
4 ending in the second previous calendar year.

5 “(B) APPLICATION OF CURRENT YEAR  
6 MODIFIED GROSS INCOME.—

7 “(i) IN GENERAL.—Subject to clause  
8 (ii), the Secretary shall establish a proce-  
9 dure under which an individual may file a  
10 declaration of estimated modified gross in-  
11 come for a taxable year ending in a cal-  
12 endar year, which modified gross income  
13 will apply under this subsection as the ap-  
14 plicable modified gross income for the cal-  
15 endar year. Subject to clause (ii), such pro-  
16 cedure shall be applicable regardless of  
17 whether or not the individual filed a tax  
18 return for the taxable year ending in the  
19 second previous calendar year.

20 “(ii) LIMITATION ON APPLICATION.—  
21 The Secretary may limit the application of  
22 clause (i), in the case of individuals who  
23 have filed tax returns for the taxable year  
24 ending in the second previous calendar  
25 year, to individuals with respect to whom

1 the applicable modified gross income will  
2 be reduced by at least 20 percent as a re-  
3 sult of the application of such clause.

4 “(iii) REQUIREMENT FOR RETURN.—

5 Any individual who has filed a declaration  
6 under clause (i) for a calendar year is re-  
7 quired to file an income tax return for the  
8 taxable year in the calendar year, regard-  
9 less of whether any income tax is actually  
10 owed for the year. The failure of the indi-  
11 vidual to file such a return makes the indi-  
12 vidual liable for overpayments under this  
13 title under clause (iv) in the same manner  
14 as if this paragraph had not applied.

15 “(iv) COLLECTION FOR OVERPAY-

16 MENTS.—If a declaration of estimated  
17 modified gross income is made applicable  
18 to a calendar year under clause (i) and the  
19 actual modified gross income for that tax-  
20 able year exceeds such estimated modified  
21 gross income, the individual shall be liable  
22 to the United States for 110 percent of the  
23 amount of additional payments made  
24 under this title as a result of the use of  
25 such estimated modified gross income in-



1 of bills or charges that are submitted electronically in a  
2 manner specified by the Secretary.

3 “(b) DEFINITIONS.—

4 “(1) IN GENERAL.—Except as otherwise pro-  
5 vided in this title, the definitions contained in sec-  
6 tion 1861 shall apply for purposes of this title in the  
7 same manner as they apply for purposes of title  
8 XVIII.

9 “(2) STATE; UNITED STATES.—(A) The term  
10 ‘State’ means the 50 States and includes the Dis-  
11 trict of Columbia, Puerto Rico, the Virgin Island,  
12 Guam, American Samoa, and the Northern Mariana  
13 Islands.

14 “(B) The term ‘United States’ means all the  
15 States.

16 “(c) CERTIFICATION, PROVIDER QUALIFICATION,  
17 ETC.—The provisions of sections 1863 through 1875, sec-  
18 tions 1877 through 1880, section 1883, section 1885, and  
19 sections 1887 through 1895 shall apply to this title in the  
20 same manner as they apply to title XVIII.

21 “(d) TITLE XI PROVISIONS.—The following provi-  
22 sions shall apply to this title in the same manner as they  
23 apply to title XVIII:

24 “(1) Sections 1124, 1126, and 1128 through  
25 1128E (relating to fraud and abuse).

1           “(2) Section 1134 (relating to nonprofit hos-  
2           pital philanthropy).

3           “(3) Section 1138 (relating to hospital proto-  
4           cols for organ procurement and standards for organ  
5           procurement agencies).

6           “(4) Section 1142 (relating to research on out-  
7           comes of health care services and procedures), ex-  
8           cept that any reference in such section to a Trust  
9           Fund is deemed a reference to the AmeriCare Trust  
10          Fund.

11          “(5) Part B of title XI (relating to peer review  
12          of the utilization and quality of health care services).

13          “(6) Part C of title XI (relating to administra-  
14          tive simplification).

15          “(e) OTHER PROVISIONS.—The provisions of section  
16          201(i) shall apply to this title and the AmeriCare Trust  
17          Fund in the same manner as they apply to title XVIII  
18          and the Federal Hospital Insurance Trust Fund.

19          **“SEC. 2263. STATE MAINTENANCE OF EFFORT PAYMENTS.**

20          “(a) CONDITION OF COVERAGE.—Notwithstanding  
21          any other provision of this title, no individual who is a  
22          resident of a State is eligible for benefits under this title  
23          for a month in a calendar year, unless the State provides  
24          (in a manner and at a time specified by the Secretary)  
25          for payment to the AmeriCare Trust Fund of  $\frac{1}{12}$ th of the

1 amount specified in subsection (b) for the year. Such  
2 funds shall be used offset the costs of providing subsidies  
3 for low-income individuals under section 202.

4 “(b) MAINTENANCE OF EFFORT AMOUNT.—

5 “(1) IN GENERAL.—Subject to paragraph (3),  
6 the amount of payment specified in this subsection  
7 for a State for a year is equal to the amount of pay-  
8 ment (net of Federal payments) made by a State  
9 under its State plans under titles XIX and XXI for  
10 2006 for medical assistance for benefits described in  
11 paragraph (2).

12 “(2) BENEFITS DESCRIBED.—The benefits de-  
13 scribed in this paragraph with respect to State plans  
14 of a State under titles XIX and XXI are benefits  
15 which—

16 “(A) would be available under this title for  
17 low-income individuals if this title had been in  
18 effect in 2006; and

19 “(B) are for low-income individuals who—

20 “(i) with respect to the State plan  
21 under title XIX, were required to be fur-  
22 nished medical assistance under such title  
23 XIX; or

1                   “(ii) with respect to a State child  
2                   health plan under title XXI, were low-in-  
3                   come children.

4   **“SEC. 2264. MODIFICATION OF MEDICAID AND OTHER PRO-**  
5                   **GRAMS TO AVOID DUPLICATION OF BENE-**  
6                   **FITS.**

7                   “(a) IN GENERAL.—Notwithstanding any other pro-  
8   vision of law—

9                   “(1) a State plan under title XIX and a State  
10                  child health plan under title XXI shall not provide  
11                  any medical assistance for benefits with respect to  
12                  which any payments may be made under this title;  
13                  and

14                  “(2) a health benefits plan under chapter 89 of  
15                  title 5, United States Code, shall not provide bene-  
16                  fits for which any payment may be made under this  
17                  title.

18                  “(b) REVIEW OF APPLICATION TO OTHER PRO-  
19   GRAMS.—The Secretary shall conduct a review of the fea-  
20   sibility of applying the policy described in subsection (a)  
21   to additional Federal programs, such as the TRICARE  
22   program under title 10, United States Code. Not later  
23   than January 1, 2009, the Secretary submit to Congress  
24   on such review and shall include in such report such rec-

1 ommendations for extending such policy to other Federal  
2 programs as the Secretary deems appropriate.

3 **“SEC. 2265. CONSTRUCTION REGARDING CONTINUATION**  
4 **OF OBLIGATIONS UNDER CURRENT GROUP**  
5 **HEALTH PLAN CONTRACTS AND PROVISION**  
6 **OF ADDITIONAL BENEFITS.**

7 “Nothing in this title shall be construed as—

8 “(1) affecting obligations for health care bene-  
9 fits under group health plans as in effect on the date  
10 of the enactment of this title, including such plans  
11 established or maintained under or pursuant to one  
12 or more collective bargaining agreements;

13 “(2) limiting the additional benefits that may  
14 be provided under a group health plan to employees  
15 or their dependents, or to former employees or their  
16 dependents; or

17 “(3) limiting the benefits that may be made  
18 available under a State program to residents of the  
19 State at the expense of the State.

20 **“SEC. 2266. STANDARDS AND REQUIREMENTS FOR**  
21 **AMERICARE SUPPLEMENTAL POLICIES.**

22 “(a) CERTIFICATION REQUIRED.—

23 “(1) IN GENERAL.—The Secretary shall estab-  
24 lish rules and procedures consistent with this section  
25 under which AmeriCare supplemental policies may

1       only be issued if they are certified by the Secretary  
2       or under a State regulatory program approved by  
3       the Secretary as meeting standards established  
4       under subsection (b).

5           “(2) ENFORCEMENT.—Any person who issues  
6       an AmeriCare supplemental policy in violation of  
7       paragraph (1) is subject to a civil money penalty of  
8       not to exceed \$25,000 for each such violation. The  
9       provisions of section 1128A (other than the first  
10      sentence of subsection (a) and other than subsection  
11      (b)) shall apply to a civil money penalty under the  
12      previous sentence in the same manner as such provi-  
13      sions apply to a penalty or proceeding under section  
14      1128A(a).

15          “(3) AMERICARE SUPPLEMENTAL POLICY.—  
16      For purposes of this section, the term ‘AmeriCare  
17      supplemental policy’ is a health insurance policy or  
18      other health benefit plan offered by a private entity  
19      to individuals who are entitled to have payment  
20      made under this title, which provides reimbursement  
21      for expenses incurred for services and items for  
22      which payment may be made under this title but  
23      which are not reimbursable by reason of the applica-  
24      tion of deductibles, coinsurance amounts, or other

1 limitations imposed pursuant to this title; but does  
2 not include—

3 “(A) any such policy or plan of the trust-  
4 ees of a fund established by one or more em-  
5 ployers or labor organizations (or combination  
6 thereof) if the policy or plan offers benefits as  
7 a direct service organization under section  
8 1833, or

9 “(B) a policy or plan of a health mainte-  
10 nance organization which offers benefits under  
11 this title under section 2221(k).

12 For purposes of this section, the term ‘policy’ in-  
13 cludes a certificate issued under such policy.

14 “(b) CERTIFICATION STANDARDS.—

15 “(1) ISSUANCE.—The Secretary shall develop  
16 and publish specific standards consistent with this  
17 section for AmeriCare supplemental policies and  
18 shall consult with the Secretary of Labor regarding  
19 the application of such standards to employee wel-  
20 fare benefit plans under title I of the Employee Re-  
21 tirement Income Security Act of 1974.

22 “(2) MORE STRINGENT STATE STANDARDS PER-  
23 MITTED.—In the case of insured AmeriCare supple-  
24 mental policies (as defined in subsection (d)(3)), a  
25 State may implement standards that are more strin-

1       gent than the standards established under para-  
2       graph (1), including—

3               “(A) additional limitations on pre-existing  
4               exclusion limitations described in subsection  
5               (c)(1)(B);

6               “(B) additional restrictions on the groups  
7               of benefits described in subsection (c)(2) that  
8               may be offered in AmeriCare supplemental poli-  
9               cies in the State, so long as a core-only benefit  
10              package described in subparagraph (A)(i) of  
11              such subsection may be offered in the State;

12              “(C) requiring a higher loss-ratios than  
13              those specified in subsection (c)(3);

14       “(c) STANDARDS.—The Secretary shall establish  
15       standards for AmeriCare supplemental policies consistent  
16       with the following:

17              “(1) NO DISCRIMINATION BASED ON HEALTH  
18              STATUS.—

19              “(A) IN GENERAL.—Except as provided  
20              under subparagraph (B), an AmeriCare supple-  
21              mental policy may not deny, limit, or condition  
22              the coverage under (or benefits of) the policy,  
23              or vary premiums charged, based on the health  
24              status, claims experience, receipt of health care,

1 medical history, or lack of evidence of insur-  
2 ability, of an individual.

3 “(B) LIMITATION ON USE OF PRE-EXIST-  
4 ING CONDITION EXCLUSIONS.—An AmeriCare  
5 supplemental policy may exclude coverage with  
6 respect to services related to treatment of a  
7 pre-existing condition, except that—

8 “(i) the period of such exclusion may  
9 not exceed 6 months;

10 “(ii) such exclusion shall not apply to  
11 services furnished to newborns; and

12 “(iii) the period of exclusion under  
13 clause (i) shall be reduced by 1 month for  
14 each month in a period of continuous  
15 health benefits coverage (as defined by the  
16 Secretary) for the services involved.

17 For purposes of this subparagraph, a condition  
18 is not pre-existing unless it was diagnosed or  
19 treated during the 3-month period ending on  
20 the day before the first date of such coverage.

21 “(2) SIMPLIFICATION OF BENEFITS.—

22 “(A) IN GENERAL.—Each AmeriCare sup-  
23 plemental policy shall only offer benefits con-  
24 sistent with the standards, promulgated by the  
25 Secretary, that provide—

1           “(i) limitations on the groups or pack-  
2           ages of benefits, including a core group of  
3           basic benefits and not to exceed 9 other  
4           different benefit packages, that may be of-  
5           fered under an AmeriCare supplemental  
6           policy;

7           “(ii) that a person may not issue an  
8           AmeriCare supplemental policy without of-  
9           fering such a policy with only the core-  
10          group of basic benefits and without pro-  
11          viding an outline of coverage in a standard  
12          form approved by the Secretary;

13          “(iii) uniform language and defini-  
14          tions to be used with respect to such bene-  
15          fits, and

16          “(iv) uniform format to be used in the  
17          policy with respect to such benefits.

18          “(B) INNOVATION.—The Secretary may  
19          approve the offering of new or innovative and  
20          cost-effective benefit packages in addition to  
21          those provided under subparagraph (A).

22          “(3) MINIMUM LOSS RATIO REQUIRED.—An  
23          AmeriCare supplemental policy, a specific disease  
24          policy (as defined by the Secretary), or a hospital  
25          confinement indemnity policy (as defined by the Sec-

1       retary) may not be issued or renewed unless the pol-  
2       icy—

3               “(A) can be expected (in accordance with  
4               a uniform methodology developed by the Sec-  
5               retary and for periods beginning 24 months  
6               after the date of original issue) to return to pol-  
7               icyholders in the form of aggregate benefits at  
8               least 85 percent of the aggregate amount of  
9               premiums collected in the case of group policies  
10              or at least 75 percent in the case of individual  
11              policies (as defined by the Secretary); and

12              “(B) provides refunds and credits (in a  
13              manner specified by the Secretary) for pre-  
14              miums collected in excess of those consistent  
15              with subparagraph (A).

16              “(4) GUARANTEED RENEWABILITY AND CON-  
17              VERTIBILITY.—Each AmeriCare supplemental pol-  
18              icy—

19              “(A) shall be guaranteed renewable and  
20              may not be cancelled or nonrenewed solely on  
21              the ground of health status of the individual or  
22              for any reason other than nonpayment of pre-  
23              mium or material misrepresentation; and

24              “(B) shall provide for—

1           “(i) a right of conversion to an indi-  
2           vidual policy (with continuation of bene-  
3           fits) in the case of termination by a group  
4           policyholder or termination by a  
5           certificateholder of membership in a group  
6           through which the individual obtained cov-  
7           erage;

8           “(ii) a right of continued coverage in  
9           the case of a group policy that succeeds  
10          another group policy; and

11          “(iii) suspension of coverage (for up  
12          to 24 months and in a manner specified )  
13          in the case of a policy holder who becomes  
14          entitled to benefits under this title as a  
15          low-income individual and who provides a  
16          timely notice of election of such suspen-  
17          sion.

18          “(5) ADDITIONAL STANDARDS APPLICABLE  
19          ONLY TO INSURED POLICIES.—A carrier that offers  
20          an insured AmeriCare supplemental policy (as de-  
21          fined in paragraph (6)) to individuals and groups in  
22          a State shall also comply with the following require-  
23          ments:

24                 “(A) OPEN ENROLLMENT.—The carrier  
25                 must offer the same policy to any other indi-

1           vidual or group in the State on a continuous,  
2           year-round basis; except that—

3                   “(i) in the case of policies offered  
4                   through an association which is composed  
5                   exclusively of employers (which may in-  
6                   clude self-employed individuals) and which  
7                   has been formed for purposes other than  
8                   obtaining health insurance, such require-  
9                   ment shall only apply to such employers  
10                  (and individuals) who are members of the  
11                  association; and

12                   “(ii) a health maintenance organiza-  
13                   tion may deny enrollment with respect to  
14                   an individual based on the uniform appli-  
15                   cation of a geographic service area or over-  
16                   all enrollment limitation based on its finan-  
17                   cial or administrative capacity.

18                  “(B) NOTICES AND RENEWAL PERIODS.—

19           The carrier shall provide advance notice of  
20           terms for policy renewal, which terms shall—

21                   “(i) be the same as the terms of  
22                   issuance, except for rates and administra-  
23                   tive changes;

24                   “(ii) provide the same premium rates  
25                   as for a new issue; and

1                   “(iii) provide a period of renewal of  
2                   not less than 12 months.

3                   “(c) ADDITIONAL REQUIREMENTS.—

4                   “(1) PROHIBITION OF DUPLICATION.—The Sec-  
5                   retary shall—

6                   “(A) establish requirements that prohibit  
7                   (other than as required under Federal or State  
8                   law) the knowing sale or issuance to an indi-  
9                   vidual entitled to benefits under this title of  
10                  health insurance that duplicates benefits under  
11                  this title, of an AmeriCare supplemental policy  
12                  that duplicates another AmeriCare supple-  
13                  mental policy, or of another health insurance  
14                  policy that duplicates other benefits to which  
15                  the individual is entitled; and

16                  “(B) provide exceptions to the prohibition  
17                  in subparagraph (A) for enrollment in group  
18                  health plans and similar employment-based poli-  
19                  cies and for policies which provide benefits di-  
20                  rectly and without regard to other coverage and  
21                  notice of such duplication.

22                  “(2) DISCLOSURE REQUIREMENT.—The Sec-  
23                  retary shall establish a requirement that prohibits  
24                  the sale or issuance of an AmeriCare supplemental  
25                  policy to an individual, other than as a replacement

1 policy, without obtaining a statement (in a form  
2 specified by the Secretary) that discloses other  
3 health benefits coverage and that acknowledges limi-  
4 tations on the need for an AmeriCare supplemental  
5 policy, particularly in the case of a low-income indi-  
6 vidual.

7 “(3) APPLICATION OF FALSE STATEMENT  
8 SANCTIONS.—The provisions of paragraphs (1) and  
9 (2) of section 1882(d) shall apply to an AmeriCare  
10 supplemental policy under this section in the same  
11 manner as they apply to medicare supplemental poli-  
12 cies under such section.

13 “(4) LIMITATIONS ON SALES COMMISSIONS.—

14 “(A) IN GENERAL.—It is unlawful for a  
15 person who provides for a commission or other  
16 compensation to an agent or other representa-  
17 tives with respect to the sale of an AmeriCare  
18 supplemental policy (or certificate)—

19 “(i) to provide for a first year com-  
20 mission or other first year compensation  
21 that exceeds 200 percent of the commis-  
22 sion or other compensation for the selling  
23 or servicing of the policy or certificate in  
24 a second or subsequent year; or

1                   “(ii) to provide for compensation with  
2                   respect to replacement of such a policy or  
3                   certificate that is greater than the com-  
4                   pensation that would apply to the renewal  
5                   of the policy or certificate.

6                   “(B) DEFINITION.—In subparagraph (A),  
7                   the term ‘compensation’ includes pecuniary and  
8                   nonpecuniary compensation of any kind relating  
9                   to the sale or renewal of a policy or certificate  
10                  and specifically includes bonuses, gifts, prizes,  
11                  awards, and finders’ fees.

12                  “(d) INFORMATION DISCLOSURE.—The Secretary  
13                  shall provide, to all individuals entitled to benefits under  
14                  this title, such information as will permit such individuals  
15                  to evaluate the value of AmeriCare supplemental policies  
16                  to them and the relationship of any such policies to bene-  
17                  fits provided under this title. Such information shall in-  
18                  clude information on—

19                         “(1) the requirements and prohibitions under  
20                         this section;

21                         “(2) State and Federal agencies responsible for  
22                         compliance with such requirements and enforcement  
23                         of such prohibitions; and

1           “(3) the manner of submitting complaints re-  
2           garding violations of such requirements and prohibi-  
3           tions.

4           “(e) DEFINITIONS.—In this section:

5           “(1) CARRIER.—The term ‘carrier’ means any  
6           person that offers an AmeriCare supplemental pol-  
7           icy.

8           “(2) GROUP.—The term ‘group’ means 2 or  
9           more employees of the same employer who normally  
10          perform on a monthly basis at least 17½ hours of  
11          service per week for that employer.

12          “(3) HEALTH MAINTENANCE ORGANIZATION.—  
13          The term ‘health maintenance organization’ has the  
14          meaning given the term ‘eligible organization’ in sec-  
15          tion 1876(b).

16          “(4) INSURED AMERICARE SUPPLEMENTAL  
17          POLICY.—The term ‘insured AmeriCare supple-  
18          mental policy’ means any AmeriCare supplemental  
19          policy provided through insurance.”.

20                   **TITLE II—FINANCING**  
21                   **PROVISIONS**  
22                   **Subtitle A—INDIVIDUAL**  
23                   **CONTRIBUTIONS**

24   **SEC. 201. GENERAL OBLIGATION FOR INDIVIDUALS.**

25           (a) PAYMENT OF PLAN PREMIUM.—

1           (1) IN GENERAL.—Each individual eligible for  
2 coverage under title XXII of the Social Security Act  
3 is liable for payment of the premium established  
4 under this section for such coverage of the individual  
5 and family members. An individual who is not re-  
6 ceiving such coverage due to coverage under a group  
7 health plan described in section 2202(d) of such Act  
8 is not liable for payment of such premium with re-  
9 spect to such individual.

10           (2) DETERMINATION OF PREMIUM.—Such pre-  
11 mium shall be established by the Secretary of Health  
12 and Human Services on the basis of the cost of cov-  
13 erage (determined on a State by State basis and in-  
14 cluding administrative costs) and shall be deter-  
15 mined separately based on the class of enrollment  
16 for the individual (as determined under section 2202  
17 of the Social Security Act).

18           (3) JOINT AND SEVERAL LIABILITY.—If more  
19 than one individual is liable under this subsection  
20 for payment of a premium for coverage of the same  
21 individual under title XXII of the Social Security  
22 Act, such individual shall be jointly and severally lia-  
23 ble with each other individual who is so liable.

1 (b) REDUCTION FOR EMPLOYER CONTRIBUTIONS  
2 AND LOW INCOME SUBSIDIES.—An individual's liability  
3 under subsection (a) is reduced by—

4 (1) the amount of any contributions made by  
5 the individual's employer (or employers) under sub-  
6 title B or otherwise (including voluntary employer  
7 contributions) with respect to coverage of the indi-  
8 vidual and family members, and

9 (2) the amount of any premium subsidies pro-  
10 vided with respect to the individual under section  
11 202.

12 (c) TIMING AND MANNER OF PAYMENT.—Each indi-  
13 vidual that is liable for a premium under subsection (a)  
14 shall pay such premium in such form and manner as the  
15 Secretary of the Treasury may specify. Except as other-  
16 wise provided by the Secretary of the Treasury, for pur-  
17 poses of subtitle F of such Code, the liabilities imposed  
18 under subsection (a) shall be treated as if they were a  
19 tax imposed under section 1 of such Code. The Secretary  
20 of the Treasury shall provide for the withholding of such  
21 payments from wages under rules similar to the rules of  
22 chapter 24 of such Code. The Secretary of the Treasury  
23 may prescribe special rules for withholding payments from  
24 wages of individuals who work seasonally, part-time, or for  
25 more than one employer.

1 **SEC. 202. ADDITIONAL PREMIUM SUBSIDIES.**

2 (a) ELIGIBILITY FOR ADDITIONAL PREMIUM SUB-  
3 SIDIES.—

4 (1) IN GENERAL.—Each premium subsidy eligi-  
5 ble individual is entitled to a premium subsidy in ac-  
6 cordance with this section.

7 (2) PREMIUM SUBSIDY ELIGIBLE INDI-  
8 VIDUAL.—In this section, the term “premium sub-  
9 sidy eligible individual” means an individual receiv-  
10 ing coverage under title XXII of the Social Security  
11 Act who—

12 (A) with respect to premiums for a taxable  
13 year ending in a year, has family income (as de-  
14 fined in paragraph (3)(A)) that is less than 300  
15 percent of the applicable poverty level, or

16 (B) with respect to a premium for a  
17 month, is an TANF or SSI recipient for the  
18 month.

19 (3) ADDITIONAL DEFINITIONS.—In this section:

20 (A) FAMILY INCOME.—The term “family  
21 income” means, with respect to an individual  
22 who—

23 (i) is not a dependent of another indi-  
24 vidual, the sum of the modified adjusted  
25 gross incomes (as defined in subparagraph  
26 (B)) for the individual, the individual’s

1 spouse, and children who are dependents of  
2 the individual, or

3 (ii) is a dependent of another indi-  
4 vidual, the sum of the modified adjusted  
5 gross incomes (as defined in subparagraph  
6 (B)) for the other individual, the other in-  
7 dividual's spouse, and children who are de-  
8 pendents of the other individual.

9 (B) MODIFIED ADJUSTED GROSS IN-  
10 COME.—The term “modified adjusted gross in-  
11 come” means adjusted gross income (as defined  
12 in the Internal Revenue Code of 1986)—

13 (i) determined without regard to sec-  
14 tions 911, 931, and 933 of such Code, and

15 (ii) increased by—

16 (I) the amount of interest re-  
17 ceived or accrued by the individual  
18 during the taxable year which is ex-  
19 empt from tax, and

20 (II) the amount of the social se-  
21 curity benefits (as defined in section  
22 86(d) of such Code) received during  
23 the taxable year to the extent not in-  
24 cluded in gross income under section  
25 86 of such Code.

1           The determination under the preceding sen-  
2           tence shall be made without regard to any car-  
3           ryover or carryback.

4           (C) APPLICABLE POVERTY LEVEL.—

5           (i) IN GENERAL.—The term “applica-  
6           ble poverty level” means, for a family for  
7           a year, the official poverty line (as defined  
8           by the Secretary of Health and Human  
9           Services) applicable to a family of the size  
10          involved for 2010 adjusted by the percent-  
11          age increase or decrease described in  
12          clause (ii) for the year involved.

13          (ii) PERCENTAGE ADJUSTMENT.—The  
14          percentage increase or decrease described  
15          in this clause for a year is the percentage  
16          increase or decrease by which the average  
17          Consumer Price Index for all urban con-  
18          sumers (U.S. city average), as published by  
19          the Bureau of Labor Statistics, for the 12-  
20          month-period ending with August 31 of the  
21          preceding year exceeds such average for  
22          the 12-month period ending with August  
23          31, 2009.

1 (iii) ROUNDING.—Any adjustment  
2 made under clause (ii) for a year shall be  
3 rounded to the nearest multiple of \$100.

4 (D) TANF RECIPIENT.—The term  
5 “TANF recipient” means, for a month, an indi-  
6 vidual who is receiving aid or assistance under  
7 any plan of the State approved under title I, X,  
8 XIV, or XVI, or part A or part E of title IV,  
9 of the Social Security Act, for the month.

10 (E) SSI RECIPIENT.—The term “SSI re-  
11 cipient” means, for a month, an individual—

12 (i) with respect to whom supplemental  
13 security income benefits are being paid  
14 under title XVI of the Social Security Act  
15 for the month,

16 (ii) who is receiving a supplementary  
17 payment under section 1616 of such Act or  
18 under section 212 of Public Law 93–66 for  
19 the month, or

20 (iii) who is receiving monthly benefits  
21 under section 1619(a) of the Social Secu-  
22 rity Act (whether or not pursuant to sec-  
23 tion 1616(e)(3) of such Act) for the  
24 month.

25 (b) AMOUNT OF PREMIUM SUBSIDY.—

1 (1) LOWEST INCOME INDIVIDUALS.—

2 (A) IN GENERAL.—In the case of an indi-  
3 vidual described in subparagraph (B), the pre-  
4 mium subsidy under this section is the amount  
5 which would (without regard to this section) re-  
6 duce the premium obligation of the individual  
7 (and family members) under section 201 to  
8 zero.

9 (B) LOWEST INCOME INDIVIDUALS DE-  
10 SCRIBED.—An individual described in this sub-  
11 paragraph is a premium subsidy eligible indi-  
12 vidual who would still be such an individual  
13 under subsection (a)(2) if “200 percent” were  
14 substituted for “300 percent” in subparagraph  
15 (A) of such subsection.

16 (2) OTHER INDIVIDUALS.—

17 (A) IN GENERAL.—In the case of a pre-  
18 mium subsidy eligible individual not described  
19 in paragraph (1), the premium subsidy under  
20 this section is the product of—

21 (i) the premium obligation of the indi-  
22 vidual (and family members) under section  
23 201, multiplied by

24 (ii) the number of percentage points  
25 by which the individual’s family income

1 (expressed as a percent of the applicable  
2 poverty level) is less than 300 percent.

3 (B) TABLE.—The Secretary may provide  
4 for a table which establishes the values for pre-  
5 mium subsidies under this paragraph.

6 (c) GENERAL REVENUE FINANCING FOR LOW IN-  
7 COME SUBSIDIES.—There are authorized to be appro-  
8 priated to the Americare Trust Fund from amounts in the  
9 Treasury not otherwise appropriated, such sums as may  
10 be necessary to cover the costs of premium subsidies pro-  
11 vided under this section.

12 **SEC. 203. EFFECTIVE DATE.**

13 The provisions of this subtitle shall apply with respect  
14 to periods beginning on or after January 1, 2010.

15 **Subtitle B—Employer**  
16 **Contributions**

17 **SEC. 211. GENERAL OBLIGATION FOR EMPLOYERS.**

18 (a) GENERAL OBLIGATION.—

19 (1) IN GENERAL.—Subject to the succeeding  
20 provisions of this subsection, each employer shall  
21 make a financial contribution toward the cost of  
22 health insurance coverage for employees in accord-  
23 ance with this section.

24 (2) ELIMINATION OF LIABILITY IN CASE OF  
25 CERTAIN GROUP HEALTH PLAN COVERAGE.—

1           (A) IN GENERAL.—Subject to subpara-  
2 graph (B), an employer shall not be liable for  
3 any contribution under this section with respect  
4 to any employee who is covered under a group  
5 health plan of the employer described in section  
6 2202(d) if such employer pays at least 80 per-  
7 cent of the cost of such health plan, as deter-  
8 mined by the Secretary of Health and Human  
9 Services.

10           (B) SURCHARGE PERMISSIBLE TO PRE-  
11 VENT ADVERSE SELECTION.—The Secretary  
12 may impose liability for a contribution under  
13 this section with respect to an employee de-  
14 scribed in subparagraph (A) in an amount (not  
15 to exceed the amount specified under subsection  
16 (b)) insofar as the Secretary determines it nec-  
17 essary to prevent adverse selection of the indi-  
18 viduals enrolled under this title as a result of  
19 the operation of such subparagraph.

20 (b) AMOUNT OF CONTRIBUTION.—

21           (1) FULL-TIME EMPLOYEES.—In the case of an  
22 employee receiving coverage under title XXII of the  
23 Social Security Act, the amount of the financial con-  
24 tribution is equal to at least 80 percent of the pre-  
25 mium determined with respect to such employee and

1 family members under section 201 (based on class of  
2 enrollment and without regard to subsection (b)  
3 thereof) or at least 80 percent of the cost of cov-  
4 erage under such group health plan, respectively.

5 (2) REDUCTION FOR PART-TIME EMPLOYEES.—

6 In the case of a part-time employee, the employer  
7 contribution requirements of paragraph (1) shall be  
8 treated as satisfied if the employer contribution with  
9 respect to such employee is not less than the part-  
10 time employment ratio of the contribution required  
11 under paragraph (1).

12 (3) RULES RELATED TO PART-TIME EMPLOY-  
13 MENT.—For purposes of this subsection—

14 (A) PART-TIME EMPLOYEE.—The term  
15 “part-time employee” means, with respect to  
16 any month, an employee who works on average  
17 fewer than 40 hours per week.

18 (B) PART-TIME EMPLOYMENT RATIO.—

19 The term “part-time employment ratio” means,  
20 with respect to a part-time employee of an em-  
21 ployer in a month, a fraction—

22 (i) the numerator of which is the  
23 number of hours in the employee’s normal  
24 work week, and

1                   (ii) the denominator of which is 40  
2                   hours.

3                   (C) SPECIAL RULES.—Under rules pre-  
4                   scribed by the Secretary of Health and Human  
5                   Services, in consultation with the Secretary of  
6                   the Treasury, in the case of an employee for an  
7                   employer whose defined work week for full-time  
8                   employees is less than 40 hours, any reference  
9                   in this subsection to 40 hours is deemed a ref-  
10                  erence to the number of hours in the work week  
11                  so defined.

12                  (D) CONVERSION TO HOURS OF EMPLOY-  
13                  MENT.—The Secretary of Health and Human  
14                  Services, in consultation with the Secretary of  
15                  the Treasury, shall establish rules for the con-  
16                  version of compensation to hours of employ-  
17                  ment, for purposes of this subsection in the  
18                  case of employees that receive compensation on  
19                  a salaried basis, or on the basis of a commis-  
20                  sion, or other contingent or bonus basis, rather  
21                  than based on an hourly wage.

22                  (c) TIMING AND MANNER.—

23                  (1) IN GENERAL.—Each employer that is re-  
24                  quired to make a financial contribution with respect  
25                  to an employee under this section (other than with

1 respect to coverage under a group health plan) or a  
2 surcharge under subsection (a)(2)(B) shall pay such  
3 contribution or surcharge in a form and manner,  
4 specified by the Secretary of the Treasury, based  
5 upon the form and manner in which employer excise  
6 taxes are required to be paid under section 3111 of  
7 the Internal Revenue Code of 1986.

8 (2) NON-ENROLLING EMPLOYERS.—In the case  
9 of an employee who is covered under the class of en-  
10 rollment of a family member, the Secretary of the  
11 Treasury shall provide that the financial contribu-  
12 tion of the employer with respect to such employee  
13 is paid directly or indirectly to the employer of such  
14 family member.

15 **SEC. 212. EFFECTIVE DATE.**

16 (a) IN GENERAL.—Subject to subsection (b), the pro-  
17 visions of this subtitle shall apply with respect to periods  
18 beginning on or after January 1, 2010.

19 (b) ADDITIONAL PERIOD FOR SMALL EMPLOYERS.—  
20 The provisions of this subtitle shall not apply with respect  
21 to an employer that has fewer than 100 employees (as de-  
22 termined by the Secretary of the Treasury in consultation  
23 with the Secretary of Health and Human Services) for pe-  
24 riods beginning before January 1, 2012.

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