

109TH CONGRESS
2D 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.

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

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 provi-
 sions.

“Sec. 2263. State maintenance of effort payments.

“Sec. 2264. Modification of medicaid and other programs to avoid dupli-
 cation of benefits.

“Sec. 2265. Construction regarding continuation of obligations under cur-
 rent group health plan contracts and provision of addi-
 tional benefits.

“Sec. 2266. Standards and requirements for AmeriCare supplemental poli-
 cies.

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 (c)) 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 stead of the actual modified gross income
2 for that taxable year.

3 “(C) TRANSMITTAL OF INFORMATION.—By
4 not later than October 1 of each year, the Sec-
5 retary of the Treasury shall transmit to the
6 Secretary such information relating to the ap-
7 plicable modified gross income of individuals for
8 the taxable year ending in the previous year as
9 may be necessary to apply this title in the suc-
10 ceeding calendar year.

11 “(2) POVERTY LEVEL.—The term ‘poverty
12 level’ means, for an individual in a family, the offi-
13 cial poverty line (as defined by the Office of Man-
14 agement and Budget, and revised annually in ac-
15 cordance with section 673(2) of the Omnibus Budget
16 Reconciliation Act of 1981) applicable to a family of
17 the size involved.

18 **“SEC. 2262. INCORPORATION OF CERTAIN MEDICARE PRO-**
19 **VISIONS AND OTHER PROVISIONS.**

20 “(a) USE OF MEDICARE ADMINISTRATIVE CONTRAC-
21 TORS.—The Secretary shall provide for the administration
22 of this title through the use of medicare administrative
23 contractors in the same manner as title XVIII is carried
24 out through the use of such contractors, except that no
25 payment shall be made under this title except on the basis

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-

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

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

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

“(B) NOTICES AND RENEWAL PERIODS.—

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

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

“(ii) provide the same premium rates
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 INDIVIDUAL.—In this section, the term “premium sub-
8 sidy eligible individual” means an individual receiv-
9 ing coverage under title XXII of the Social Security
10 Act who—
11

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(c)(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.

