I

110TH CONGRESS
1ST SESSION

H. R. 1841

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

MARCH 29, 2007

Mr. STARK (for himself, Ms. SCHAKOWSKY, Mr. BECERRA, Ms. CORRINE BROWN of Florida, Ms. CARSON, Mrs. CHRISTENSEN, Mr. COHEN, Mr. CONYERS, Mr. FILNER, Mr. GRIJALVA, Mr. HINCHEY, Ms. NORTON, Mr. JACKSON of Illinois, Ms. KILPATRICK, Ms. LEE, Mr. LEWIS of Georgia, Mr. MCNULTY, Mr. GEORGE MILLER of California, Mr. NADLER, Mr. PASTOR, Mr. RANGEL, Mr. THOMPSON of Mississippi, Mr. TOWNS, Mr. WAXMAN, and Ms. WOOLSEY) 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 Labor, 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.

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

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the ''AmeriCare Health Care Act of 2007''.

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

TITLE I—HEALTH CARE ELIGIBILITY AND BENEFITS

SEC. 101. ELIGIBILITY AND BENEFITS.

(a) IN GENERAL.—The Social Security Act is amended by adding at the end the following new title:

''TITLE XXII—AMERICARE HEALTH BENEFITS

''PART A—ELIGIBILITY

''SEC. 2201. ELIGIBILITY.

''(a) UNIVERSAL ELIGIBILITY FOR RESIDENTS.—

''(1) IN GENERAL.—Except as provided in section 2263(a), each individual who is a resident of the United States is entitled to health insurance benefits under this title.

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

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

''(1) Children (as defined in section 2261(a)(1)).

''(2) Low-income individuals (as defined in section 2261(a)(2)).

''(3) Pregnant women (as defined in section 2261(a)(3)).

''(c) RECIPROCAL COVERAGE OF NONRESIDENTS.—An individual who—

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

''(2) is in the United States, and

''(3) is a national of a foreign state which provides health benefits to nationals of the United States who are nonresidents in that state,

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

''SEC. 2202. ENROLLMENT AND AMERICARE CARDS.

''(a) ENROLLMENT.—The Secretary shall provide a mechanism for the enrollment of individuals entitled to benefits under this title and, in conjunction with such enrollment, the issuance of an AmeriCare card which may be used for purposes of identification and processing of claims for benefits under this title. AmeriCare cards shall

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

''(b) CLASSES OF ENROLLMENT.—The mechanism under subsection (a) shall provide for individuals to be enrolled on the basis of the following classes of enrollment:

''(1) Coverage only of an individual.

''(2) Coverage of a married couple without children.

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

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

''(c) ENROLLMENT AT BIRTH.—The mechanism under subsection (a) shall include a process for the automatic enrollment of individuals at the time of birth in the United States.

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

of 1986) that is at least equivalent to the coverage otherwise provided under this title, as certified by the Secretary.

''PART B—BENEFITS

''SEC. 2221. SCOPE OF BENEFITS.

''(a) IN GENERAL.—Except as provided in the succeeding provisions of this part, the benefits provided to an individual described in section 2201(a) by the program established by this title shall consist of entitlement to the same benefits as are provided under parts A and B of title XVIII to individuals entitled to benefits under part A, and enrolled under part B, of title XVIII.

''(b) CHANGE IN THE COST-SHARING.—

''(1) DEDUCTIBLE.—Except as provided in the succeeding provisions of this part, the amount of expenses (other than expenses for benefits described in subsection (c)) with respect to which an individual is entitled to have payment made under this title for any year shall first be reduced by a deductible of $350, except that in no case shall the amount of the deductible for all the members of a family exceed $500. Such deductible shall be instead of the deductible for inpatient hospital services under the first sentence of section 1813(a)(1) and the deductible under section 1833(b).

"(2) COINSURANCE.—After the application of the deductible under paragraph (1), the expenses referred to in such paragraph shall be subject to a coinsurance of 20 percent until the limit on out-of-pocket expenses under paragraph (3) is met.

"(3) LIMIT ON OUT-OF-POCKET EXPENSES AND TOTAL EXPENSES.—

"(A) LIMITATION ON COST-SHARING.—Subject to subparagraph (B), whenever in a calendar year an individual's expenses for the deductible and coinsurance with respect to services covered under this title (including expenses for benefits described in subsection (c)) and furnished during the year equals $2,500, or $4,000 for all the members of a family, payment of benefits under this title for the individual (or for the members of such family, respectively) for services furnished during the remainder of the year shall be paid without the application of any coinsurance.

"(B) LIMITATION ON PREMIUMS AND COST-SHARING FOR CERTAIN INDIVIDUALS BASED ON INCOME.—

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

of a family whose applicable modified gross income (expressed as a percentage of the poverty level, as defined in section 2261(b)(2)) is equal to or exceeds 200 percent, but does not exceed 300 percent, of the poverty level applicable to a family of the size involved, whenever in a calendar year an individual's expenses in the family for premiums under this title and for the deductible and coinsurance with respect to services covered under this title (including expenses for benefits described in subsection (c)) and furnished during the year equals 5 percent of the amount of such applicable modified gross income for the family—

"(I) no additional premiums shall be imposed for remaining months in the year; and

"(II) payment of benefits under this title for members of such family for services furnished during the remainder of the year shall be paid without the application of any deductible or coinsurance.

"(ii) INCOME BETWEEN 300 AND 500 PERCENT OF POVERTY LINE.—In the case of a family whose applicable modified gross income (expressed as a percentage of the poverty level, as defined in section 2261(b)(2)) exceeds 300 percent, but does not exceed 500 percent, of such poverty level applicable to a family of the size involved, whenever in a calendar year an individual's expenses in the family for premiums under this title and for the deductible and coinsurance with respect to services covered under this title (including expenses for benefits described in subsection (c)) and furnished during the year equals 7.5 percent of the amount of such applicable modified gross income for the family—

"(I) no additional premiums shall be imposed for remaining months in the year; and

"(II) payment of benefits under this title for members of such family for services furnished during the remainder of the year shall be paid

without the application of any deductible or coinsurance.

"(C) COUNTING ALL EXPENSES FOR PREMIUMS, DEDUCTIBLES AND COINSURANCE WITHOUT REGARD TO TRUE OUT-OF-POCKET COSTS.—In applying subparagraphs (A) and (B), expenses for an individual's premiums, deductible, and coinsurance shall be counted without regard to whether such expenses are paid, payable, reimbursed, or reimbursable by another person, including through a group health plan, insurance or otherwise, or other third party payment arrangement.

"(4) INDEXING DOLLAR AMOUNTS BY CPI.—Each dollar amount specified in paragraphs (1) and (3)(A) shall be increased to the year involved by the compounded sum of the increase in the consumer price index for all urban consumers (U.S. City average, as published by the Bureau of Labor Statistics of the Department of Labor) for each year after 2007 and up to the year involved. Any increase under this paragraph for a year shall be rounded, with respect to paragraph (1), to the nearest multiple of $5 and, with respect to paragraph (2), to the nearest multiple of $100.

''(c) PRESCRIPTION DRUGS.—Benefits shall also be made available under this title (as specified by the Secretary) for prescription drugs and biologicals which are not less than the benefits for such drugs and biologicals under the standard option for the service benefit plan described in section 8903(1) of title 5, United States Code, offered during 2006.

''(d) CHILDREN.—

''(1) NO DEDUCTIBLES OR COINSURANCE.—In the case of children (as defined in section 2261(a)(1)), there shall be no deductible or coinsurance applicable to covered benefits (including benefits described in paragraphs (2) and (3)).

''(2) ADDITIONAL PREVENTIVE BENEFITS.—

''(A) IN GENERAL.—Subject to the periodicity schedule established with respect to the services under subparagraph (B), for children benefits shall be available under this title for the following items and services:

''(i) Newborn and well-baby care, including normal newborn care and pediatrician services for high-risk deliveries.

''(ii) Well-child care, including routine office visits, routine immunizations (includ-

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

''(B) PERIODICITY SCHEDULE.—The Secretary, in consultation with the American Academy of Pediatrics and the American Dental Association, shall establish a schedule of periodicity which reflects the general, appropriate frequency with which services listed in subparagraph (A) should be provided to healthy children.

''(3) COVERAGE OF EPSDT.—For children, benefits also shall be available under this title for early and periodic screening, diagnostic, and treatment services (as defined in section 1905(r)) not otherwise covered under paragraph (2).

''(4) OTHER ADDITIONAL SERVICES FOR CHILDREN.—For children, benefits also shall be available under this title for the following:

''(A) Inpatient hospital services (without regard to the restrictions described in subsections (a)(1) and (b)(1) of section 1812 and the coinsurance described in section 1813(a)(1)).

''(B) Eyeglasses and hearing aids, and examinations therefor.

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

''(1) Prenatal care, including care for all complications of pregnancy.

''(2) Inpatient labor and delivery services.

''(3) Postnatal care.

''(f) LOWER-INCOME INDIVIDUALS.—

''(1) LIMITATIONS ON DEDUCTIBLES AND COINSURANCE.—

''(A) NONE FOR LOW-INCOME INDIVIDUALS.—In the case of a low-income individual, there shall be no deductible or coinsurance under this title.

''(B) PHASE-IN FOR OTHER LOWER-INCOME INDIVIDUALS.—In the case of an individual whose applicable modified gross income (as defined in section 2261(b)(1)) exceeds twice the poverty level (as defined in section 2261(b)(2)) but does not exceed three times the poverty level, the deductible and coinsurance applicable under this title shall bear the same

ratio to the deductible or coinsurance otherwise applicable as—

"(i) the excess of the applicable modified gross income over the poverty level, bears to

"(ii) the poverty level.

If the ratio determined under the preceding sentence is not a multiple of 25 percentage points, such ratio shall be rounded to the nearest 25 percentage points.

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

"(A) Inpatient hospital services (without regard to the restrictions described in subsections (a)(1) and (b)(1) of section 1812 and the coinsurance described in section 1813(a)(1)).

"(B) Eyeglasses and hearing aids and examinations therefor.

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

any deductible or coinsurance for preventive services that are recommended by the United States Preventive Services Task Force.

''(h) MENTAL HEALTH PARITY AND SUBSTANCE ABUSE BENEFITS.—Benefits shall be made available under this title for mental health services and for substance abuse treatment in the same manner as such benefits are made available for medical and surgical services.

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

''(j) CONFORMING MEDICARE BENEFITS.—Notwithstanding any other provision of law, benefits under title XVIII shall be expanded and conformed to the benefits made available under this title (including the application of a single deductible and uniform coinsurance amounts, a limitation on the coinsurance, and additional benefits for low-income individuals under subsection (f)), but nothing in this subsection shall be construed as providing for any such additional benefits under this title rather than under such title.

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

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

"SEC. 2222. EXCLUSIONS.

''(a) IN GENERAL.—Except as provided in this section, section 1862 shall apply to expenses incurred for items and services provided under this title the same manner as such section applies to items and services provided under title XVIII.

''(b) BENEFITS EXCEPTION.—

''(1) CHILDREN'S SERVICES.—In applying section 1862(a) with respect to services described in section 2221(d)(2)(A) (relating to well-child services), payment shall not be denied under paragraph (1), (7), or (12) of such section 1862(a) if the services are provided in accordance with the periodicity schedule described in section 2221(d)(2)(B).

''(2) TREATMENT OF EYEGLASSES AND HEARING AIDS FOR CHILDREN AND LOW-INCOME INDIVID-

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

''(c) COORDINATION OF PAYMENTS.—

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

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

''PART C—PAYMENT FOR BENEFITS AND FINANCING

''**SEC. 2241. PAYMENTS FOR BENEFITS.**

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

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

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

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

''(c) ADJUSTMENT OF PAYMENTS.—

''(1) ESTABLISHMENT OF NEW DRGS AND WEIGHTS.—In making payment under this title with respect to inpatient hospital services, the Secretary shall establish such additional diagnosis-related groups (and weighting factors with respect to discharges within such groups) and make such adjustments in the diagnosis-related groups and weighting factors with respect to discharges within such groups otherwise established under section 1886(d)(4) as may be necessary to reflect the types of discharges occurring under this title which are not occurring under title XVIII.

''(2) PAYMENT FOR OBSTETRICAL SERVICES.—

''(A) GLOBAL FEE.—In making payment under this title with respect to the group of obstetrical services typical of treatment through-

out a course of pregnancy, the Secretary shall establish, as a schedule under section 1848, a global fee with respect to such group of services.

''(B) BONUS FOR EARLY PRESENTATION.—The fee schedule amount with respect to obstetrical services under this title shall be increased by 5 percent in the case of services furnished to women who have presented for prenatal care during the first trimester.

''(d) CONDITIONS OF AND LIMITATIONS ON PAYMENTS.—The provisions of sections 1814 and 1835 shall apply to payment for services under this title in the same manner as they apply to payment for services under parts A and B, respectively, of title XVIII.

''(e) USE OF TRUST FUND.—In carrying out this section, any reference in title XVIII to a trust fund shall be treated as a reference to the AmeriCare Trust Fund established under section 2242.

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

respect to the purchase price of such drugs and biologicals and shall encourage the use of more affordable therapeutic equivalents to the extent such practices do not override medical necessity, as determined by the prescribing physician. To the extent practicable and consistent with the previous sentence, the Secretary shall implement strategies similar to those used by other Federal purchasers of prescription drugs, and other strategies, to reduce the purchase cost of outpatient prescription drugs and biologicals.

"SEC. 2242. AMERICARE TRUST FUND.

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

''(2) There are hereby appropriated to the Trust Fund amounts equivalent to 100 percent of the increase in revenues to the Treasury by reason of the provisions of and amendments made by title II of the AmeriCare Health Care Act of 2007. The amounts appropriated by the preceding sentence shall be transferred from time to time from the general fund in the Treasury to the Trust Fund, such amounts to be determined on the basis of esti-

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

''(b) INCORPORATION OF PROVISIONS.—

''(1) IN GENERAL.—Subject to paragraph (2), the provisions of subsections (b) through (e) and (g) through (i) of section 1817 shall apply to the Trust Fund in the same manner as they apply to the Federal Hospital Insurance Trust Fund.

''(2) EXCEPTIONS.—In applying paragraph (1)—

''(A) the Board of Trustees and Managing Trustee of the Trust Fund shall be composed of the members of the Board of Trustees and the Managing Trustee, respectively, of the Federal Hospital Insurance Trust Fund; and

''(B) any reference in section 1817 to the Federal Hospital Insurance Trust Fund or to title XVIII (or part A thereof) is deemed a reference to the Trust Fund under this section and this title, respectively.

''PART D—ADMINISTRATIVE SIMPLIFICATION

''SEC. 2251. REQUIREMENT FOR ENTITLEMENT VERIFICATION SYSTEM.

''(a) IN GENERAL.—

''(1) REQUIREMENT.—The Secretary with respect to the plan provided under this title, and each AmeriCare supplemental plan (as defined in section 2279(3)), shall provide for an electronic system, that is certified by the Secretary as meeting the standards established under subsection (b), for the verification of an individual's entitlement to benefits under such plan.

''(2) DEADLINE FOR APPLICATION OF REQUIREMENT.—The deadline specified under this paragraph for the requirement under paragraph (1) is 6 months after the date the standards are established under subsection (b).

''(b) STANDARDS FOR ENTITLEMENT VERIFICATION SYSTEMS.—

''(1) IN GENERAL.—The Secretary shall establish standards consistent with this subsection respecting the requirements for certification of entitlement verification systems.

''(2) INFORMATION AVAILABLE.—Such standards shall require a system to provide information, with respect to individuals, concerning the following:

''(A) The specific benefits to which the individual is entitled under the plan.

''(B) Current status of the individual with respect to fulfillment of deductibles, coinsurance, and out-of-pocket limits on cost-sharing.

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

''(3) FORM OF INQUIRY.—Each verification system shall be capable of accepting inquiries under this subsection from health care providers in a variety of electronic forms. The system shall also provide, for an additional fee, for the acceptance of inquiries in a nonelectronic form.

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

''(A) through modem transmission of information,

''(B) through computer synthesized voice communication, and

"(C) through transmission of information to a facsimile (fax) machine.

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

"(5) LIMITATION ON FEES.—Neither the Secretary nor an AmeriCare supplemental plan may impose a fee for the acceptance or response to an inquiry under this subsection except where the acceptance or response is in a nonelectronic form.

"(6) WEBSITE AVAILABILITY TO PROVIDERS.—The Secretary shall establish and maintain a website through which—

"(A) health service providers may make inquiries, and receive responses, with respect to the eligibility and benefits of an individual under plans; and

"(B) AmeriCare supplemental plans may make inquiries, and receive responses, to determine the liability of other plans for the provision or payment of benefits.

"(7) DEADLINE.—The Secretary shall first establish the standards under this subsection (and shall establish the website under paragraph (6)) by not later than 12 months after the date of the enactment of this title.

"SEC. 2252. REQUIREMENTS FOR UNIFORM CLAIMS AND ELECTRONIC CLAIMS DATA SET.

''(a) REQUIREMENTS.—

''(1) SUBMISSION OF CLAIMS.—Each health service provider that furnishes services in the United States for which payment may be made under this title or under an AmeriCare supplemental plan shall submit any claim for payment for such services only in a form and manner consistent with standards established under subsection (c).

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

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

''(b) ENFORCEMENT THROUGH CIVIL MONEY PENALTIES.—

''(1) IN GENERAL.—

''(A) PROVIDERS.—In the case of a health service provider that submits a claim in violation of subsection (a)(1), the provider is subject

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

''(B) PLANS.—In the case of an AmeriCare supplemental plan that rejects a claim in violation of subsection (a)(2), the plan is subject to a civil money penalty of not to exceed $100 (or, if greater, the amount of the claim) for each such violation.

''(2) PROCESS.—The provisions of section 1128A of the Social Security Act (other than subsections (a) and (b)) shall apply to a civil money penalty under paragraph (1) in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a) of such Act.

''(c) STANDARDS RELATING TO UNIFORM CLAIMS AND ELECTRONIC CLAIMS DATA SET.—

''(1) ESTABLISHMENT OF STANDARDS.—The Secretary shall establish standards that—

''(A) relate to the form and manner of submission of claims for benefits under this title and under an AmeriCare supplemental plan, and

''(B) define the data elements to be contained in a uniform electronic claims data set to be used with respect to such claims.

''(2) SCOPE OF INFORMATION.—

''(A) ENSURING ACCOUNTABILITY FOR CLAIMS SUBMITTED ELECTRONICALLY.—In establishing standards under this section, the Secretary, in consultation with appropriate agencies, shall include such methods of ensuring provider responsibility and accountability for claims submitted electronically that are designed to control fraud and abuse in the submission of such claims.

''(B) COMPONENTS.—In establishing such standards the Secretary shall—

''(i) with respect to data elements, define data fields, formats, and medical nomenclature, and plan benefit and insurance information;

''(ii) develop a single, uniform coding system for diagnostic and procedure codes; and

''(iii) provide for standards for the uniform electronic transmission of such elements.

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

''(A) the development of such standards is coordinated with the development of the standards for electronic medical records under section 2253, and

''(B) the coding of data elements under the uniform electronic claims data set and the coding of the same elements in the uniform hospital clinical data set are consistent.

''(4) USE OF TASK FORCES.—In adopting standards under this subsection—

''(A) the Secretary shall take into account the recommendations of current task forces; and

''(B) the Secretary shall provide that the electronic transmission standards are consistent, to the extent practicable, with the applicable standards established by the Accredited Standards Committee X–12 of the American National Standards Institute.

''(5) UNIFORM, UNIQUE PROVIDER IDENTIFICATION CODES.—In establishing standards under this subsection—

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

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

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

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

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

AmeriCare supplemental plan shall be submitted directly by the person or entity that performed (or supervised the performance of) the tests to the plan in a manner consistent with (and subject to such exceptions as are provided under) the requirement for direct submission of such claims under title XVIII.

''(9) DEADLINE.—The Secretary shall first provide for the standards for the uniform claims under this subsection (and shall develop and make available the software under paragraph (6)) by not later than 1 year after the date of the enactment of this title.

''(d) USE UNDER THIS TITLE AND MEDICARE AND MEDICAID PROGRAMS.—

''(1) REQUIREMENT FOR PROVIDERS.—In the case of a health service provider that submits a claim for services furnished under this title in violation of subsection (a)(1), no payment shall be made under this title for such services.

''(2) REQUIREMENTS OF MEDICARE ADMINISTRATIVE CONTRACTORS UNDER MEDICARE PROGRAM.—The Secretary shall provide, in regulations promulgated to carry out this title, that the claims process provided under this title conforms to the standards established under subsection (c).

''(3) REQUIREMENTS OF STATE MEDICAID PLANS.—As a condition for the approval of State plans under the medicaid program, effective as of the effective date specified in subsection (a)(3), each such plan shall provide, in accordance with regulations of the Secretary, that the claims process provided under the plan is modified to the extent required to conform to the standards established under subsection (c).

''SEC. 2253. ELECTRONIC MEDICAL RECORDS AND REPORTING.

''(a) STANDARDS FOR ELECTRONIC MEDICAL RECORDS.—

''(1) PROMULGATION OF STANDARDS.—

''(A) IN GENERAL.—Not later than January 1, 2009, the Secretary shall promulgate standards described in paragraph (2) for hospitals and other health care providers concerning electronic medical records. Such standards shall include the standards established under part C of title XI.

''(B) REVISION.—The Secretary may from time to time revise the standards promulgated under this paragraph.

''(2) CONTENTS OF STANDARDS.—The standards promulgated under paragraph (1) shall include at least the following:

''(A) A definition of a uniform provider clinical data set, including a definition of the set of comprehensive data elements, for use by utilization and quality control peer review organizations.

''(B) Standards for an electronic patient care information system with data obtained at the point of care.

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

''(D) Standards concerning the transmission of electronic medical data.

''(E) Standards relating to confidentiality of patient-specific information, which include the physical security of electronic data and the use of keys, passwords, encryption, and other means to ensure the protection of the confidentiality and privacy of electronic data.

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

tablishing standards under this subsection, the Secretary shall assure that—

"(A) the development of such standards is coordinated with the development of the standards for the uniform electronic claims data set under subsection (b), and

"(B) the coding of data elements under the uniform provider clinical data set and the coding of the same elements under the uniform electronic claims data set are consistent.

"(4) CONSULTATION.—In establishing standards under this subsection, the Secretary shall—

"(A) consult with the American National Standards Institute, hospitals and other health care providers, health benefit plans, and other interested parties, and

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

"(b) REQUIREMENT FOR APPLICATION OF ELECTRONIC RECORDS STANDARDS.—

"(1) AS CONDITION OF MEDICARE, MEDICAID, SCHIP, AND AMERICARE PARTICIPATION.—Effective January 1, 2010, each hospital or other institutional

or noninstitutional health care provider, as a requirement of each participation agreement under this title, title XVIII, title XIX, and title XXI, shall, in accordance with the standards promulgated under subsection (a)(1)—

"(A) maintain clinical data included in the uniform provider clinical data set under subsection (a)(2)(A) in electronic form on all patients,

"(B) upon request of the Secretary or of a utilization and quality control peer review organization (with which the Secretary has entered into a contract under part B of title XI), transmit electronically data requested from such data set, and

"(C) upon request of the Secretary, or of a fiscal intermediary or carrier, transmit electronically any data (with respect to a claim) from such data set.

"(2) APPLICATION OF PRESENTATION AND TRANSMISSION STANDARDS TO ELECTRONIC TRANSMISSION TO FEDERAL AGENCIES.—Effective January 1, 2009, if a hospital or other health care provider is required under a Federal program to transmit a data element that is subject to a standard,

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

''(c) LIMITATION ON DATA REQUIREMENTS WHERE STANDARDS IN EFFECT.—

''(1) IN GENERAL.—On or after January 1, 2009, the Secretary under this title or under title XVIII (including any carrier or fiscal intermediary or any utilization and quality control peer review organization) and an AmeriCare supplemental plan may not require, for the purpose of utilization review or as a condition of providing benefits or making payments under this title, title XVIII, or the plan, that a hospital or other health care provider—

''(A) provide any data element not in the uniform provider clinical data set specified under the standards promulgated under subsection (a), or

''(B) transmit or present any such data element in a manner inconsistent with such

standards applicable to such transmission or presentation.

''(2) COMPLIANCE.—The Secretary may impose a civil money penalty on any AmeriCare supplemental plan that fails to comply with paragraph (1) in an amount not to exceed $100 for each such failure. The provisions of section 1128A of the Social Security Act (other than the first sentence of subsection (a) and other than subsection (b)) shall apply to a civil money penalty under this paragraph in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a) of such Act.

''(3) APPLICATION TO MEDICAID PROGRAM.—As a condition for the approval of State plans under the medicaid program and in accordance with regulations of the Secretary, effective as of January 1, 2009, each such plan may not require that a hospital or other health care provider, for the purpose of utilization review or as a condition of providing benefits or making payments under the plan—

''(A) provide any data element not in the uniform provider clinical data set specified under the standards promulgated under subsection (a), or

"(B) transmit or present any such data element in a manner inconsistent with such standards applicable to such transmission or presentation.

"(d) PREEMPTION OF STATE QUILL PEN LAWS.—

"(1) IN GENERAL.—Any provision of State law that requires medical or health insurance records (including billing information) to be maintained in written, rather than electronic, form shall deemed to be satisfied if the records are maintained in an electronic form that meets standards established by the Secretary under paragraph (2).

"(2) SECRETARIAL AUTHORITY.—Not later than 1 year after the date of the enactment of this title, the Secretary shall issue regulations to carry out paragraph (1). The regulations shall provide for an electronic substitute that is in the form of a unique identifier (assigned to each authorized individual) that serves the functional equivalent of a signature. The regulations may provide for such exceptions to paragraph (1) as the Secretary determines to be necessary to prevent fraud and abuse, to prevent the illegal distribution of controlled substances, and in such other cases as the Secretary deems appropriate.

''(3) EFFECTIVE DATE.—Paragraph (1) shall take effect on the first day of the first month that begins more than 30 days after the date the Secretary issues the regulations referred to in paragraph (2).

''SEC. 2254. UNIFORM HOSPITAL COST REPORTING.

''Each hospital, as a requirement under a participation agreement under this title for each cost reporting period beginning during or after fiscal year 2008, shall provide for the reporting of information to the Secretary with respect to any hospital care provided in a uniform manner consistent with standards established by the Secretary to carry out section 4007(c) of the Omnibus Budget Reconciliation Act of 1987 and in an electronic form consistent with standards established by the Secretary.

''SEC. 2255. HEALTH SERVICE PROVIDER DEFINED.

''In this part, the term 'health service provider' includes a provider of services (as defined in section 1861(u)), physician, supplier, and other entity furnishing health care services.

''PART E—GENERAL PROVISIONS

''SEC. 2261. DEFINITIONS RELATING TO BENEFICIARIES AND INCOME.

''(a) TERMS RELATING TO BENEFICIARIES.—In this title:

''(1) CHILD.—The term 'child' means an individual who throughout a month has not attained 24 years of age.

''(2) LOW-INCOME INDIVIDUAL.—The term 'low-income individual' means an individual whose applicable modified gross income (as defined in subsection (b)(1)) is less than 200 percent of the poverty level (as defined in subsection (b)(2)). The determination that an individual is a low-income individual shall be effective for a period of one year and shall be redetermined on an annual basis.

''(3) PREGNANT WOMAN.—The term 'pregnant woman' means a woman (regardless of age) who has been certified by a physician (in a manner specified by the Secretary) as being pregnant, until the last day of the month in which the 60-day period (beginning on the date of termination of the pregnancy) ends.

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

''(1) APPLICABLE MODIFIED GROSS INCOME.—

''(A) IN GENERAL.—Except as provided in this paragraph, the term 'applicable modified gross income' means, for a calendar year for an individual, the modified gross income (as defined in section 202(a)(3)(B) of the Americare

Health Care Act of 2007) of the taxpayer (or the taxpayer for whom the individual may be claimed as a dependent) for the taxable year ending in the second previous calendar year.

''(B) APPLICATION OF CURRENT YEAR MODIFIED GROSS INCOME.—

''(i) IN GENERAL.—Subject to clause (ii), the Secretary shall establish a procedure under which an individual may file a declaration of estimated modified gross income for a taxable year ending in a calendar year, which modified gross income will apply under this subsection as the applicable modified gross income for the calendar year. Subject to clause (ii), such procedure shall be applicable regardless of whether or not the individual filed a tax return for the taxable year ending in the second previous calendar year.

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

the applicable modified gross income will be reduced by at least 20 percent as a result of the application of such clause.

''(iii) REQUIREMENT FOR RETURN.—Any individual who has filed a declaration under clause (i) for a calendar year is required to file an income tax return for the taxable year in the calendar year, regardless of whether any income tax is actually owed for the year. The failure of the individual to file such a return makes the individual liable for overpayments under this title under clause (iv) in the same manner as if this paragraph had not applied.

''(iv) COLLECTION FOR OVERPAYMENTS.—If a declaration of estimated modified gross income is made applicable to a calendar year under clause (i) and the actual modified gross income for that taxable year exceeds such estimated modified gross income, the individual shall be liable to the United States for 110 percent of the amount of additional payments made under this title as a result of the use of such estimated modified gross income in-

stead of the actual modified gross income for that taxable year.

''(C) TRANSMITTAL OF INFORMATION.—By not later than October 1 of each year, the Secretary of the Treasury shall transmit to the Secretary such information relating to the applicable modified gross income of individuals for the taxable year ending in the previous year as may be necessary to apply this title in the succeeding calendar year.

''(2) POVERTY LEVEL.—The term 'poverty level' means, for an individual in a family, the official poverty line (as defined by the Office of Management and Budget, and revised annually in accordance with section 673(2) of the Omnibus Budget Reconciliation Act of 1981) applicable to a family of the size involved.

''**SEC. 2262. INCORPORATION OF CERTAIN MEDICARE PROVISIONS AND OTHER PROVISIONS.**

''(a) USE OF MEDICARE ADMINISTRATIVE CONTRACTORS.—The Secretary shall provide for the administration of this title through the use of medicare administrative contractors in the same manner as title XVIII is carried out through the use of such contractors, except that no payment shall be made under this title except on the basis

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

''(b) DEFINITIONS.—

''(1) IN GENERAL.—Except as otherwise provided in this title, the definitions contained in section 1861 shall apply for purposes of this title in the same manner as they apply for purposes of title XVIII.

''(2) STATE; UNITED STATES.—(A) The term 'State' means the 50 States and includes the District of Columbia, Puerto Rico, the Virgin Islands, Guam, American Samoa, and the Northern Mariana Islands.

''(B) The term 'United States' means all the States.

''(c) CERTIFICATION, PROVIDER QUALIFICATION, ETC.—The provisions of sections 1863 through 1875, sections 1877 through 1880, section 1883, section 1885, and sections 1887 through 1895 shall apply to this title in the same manner as they apply to title XVIII.

''(d) TITLE XI PROVISIONS.—The following provisions shall apply to this title in the same manner as they apply to title XVIII:

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

''(2) Section 1134 (relating to nonprofit hospital philanthropy).

''(3) Section 1138 (relating to hospital protocols for organ procurement and standards for organ procurement agencies).

''(4) Section 1142 (relating to research on outcomes of health care services and procedures), except that any reference in such section to a Trust Fund is deemed a reference to the AmeriCare Trust Fund.

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

''(6) Part C of title XI (relating to administrative simplification).

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

''SEC. 2263. STATE MAINTENANCE OF EFFORT PAYMENTS.

''(a) CONDITION OF COVERAGE.—Notwithstanding any other provision of this title, no individual who is a resident of a State is eligible for benefits under this title for a month in a calendar year, unless the State provides (in a manner and at a time specified by the Secretary) for payment to the AmeriCare Trust Fund of 1/12th of the

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

''(b) MAINTENANCE OF EFFORT AMOUNT.—

''(1) IN GENERAL.—Subject to paragraph (3), the amount of payment specified in this subsection for a State for a year is equal to the amount of payment (net of Federal payments) made by a State under its State plans under titles XIX and XXI for 2007 for medical assistance for benefits described in paragraph (2).

''(2) BENEFITS DESCRIBED.—The benefits described in this paragraph with respect to State plans of a State under titles XIX and XXI are benefits which—

''(A) would be available under this title for low-income individuals if this title had been in effect in 2007; and

''(B) are for low-income individuals who—

''(i) with respect to the State plan under title XIX, were required to be furnished medical assistance under such title XIX; or

''(ii) with respect to a State child health plan under title XXI, were low-income children.

''SEC. 2264. MODIFICATION OF MEDICAID AND OTHER PROGRAMS TO AVOID DUPLICATION OF BENEFITS.

''(a) IN GENERAL.—Notwithstanding any other provision of law—

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

''(2) a health benefits plan under chapter 89 of title 5, United States Code, shall not provide benefits for which any payment may be made under this title.

''(b) REVIEW OF APPLICATION TO OTHER PROGRAMS.—The Secretary shall conduct a review of the feasibility of applying the policy described in subsection (a) to additional Federal programs, such as the TRICARE program under title 10, United States Code. Not later than January 1, 2010, the Secretary submit to Congress on such review and shall include in such report such rec-

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

"SEC. 2265. CONSTRUCTION REGARDING CONTINUATION OF OBLIGATIONS UNDER CURRENT GROUP HEALTH PLAN CONTRACTS AND PROVISION OF ADDITIONAL BENEFITS.

''Nothing in this title shall be construed as—

''(1) affecting obligations for health care benefits under group health plans as in effect on the date of the enactment of this title, including such plans established or maintained under or pursuant to one or more collective bargaining agreements;

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

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

"SEC. 2266. STANDARDS AND REQUIREMENTS FOR AMERICARE SUPPLEMENTAL POLICIES.

''(a) CERTIFICATION REQUIRED.—

''(1) IN GENERAL.—The Secretary shall establish rules and procedures consistent with this section under which AmeriCare supplemental policies may

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

''(2) ENFORCEMENT.—Any person who issues an AmeriCare supplemental policy in violation of paragraph (1) is subject to a civil money penalty of not to exceed $25,000 for each such violation. The provisions of section 1128A (other than the first sentence of subsection (a) and other than subsection (b)) shall apply to a civil money penalty under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a).

''(3) AMERICARE SUPPLEMENTAL POLICY.—For purposes of this section, the term 'AmeriCare supplemental policy' is a health insurance policy or other health benefit plan offered by a private entity to individuals who are entitled to have payment made under this title, which provides reimbursement for expenses incurred for services and items for which payment may be made under this title but which are not reimbursable by reason of the application of deductibles, coinsurance amounts, or other

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

"(A) any such policy or plan of the trustees of a fund established by one or more employers or labor organizations (or combination thereof) if the policy or plan offers benefits as a direct service organization under section 1833, or

"(B) a policy or plan of a health maintenance organization which offers benefits under this title under section 2221(k).

For purposes of this section, the term 'policy' includes a certificate issued under such policy.

"(b) CERTIFICATION STANDARDS.—

"(1) ISSUANCE.—The Secretary shall develop and publish specific standards consistent with this section for AmeriCare supplemental policies and shall consult with the Secretary of Labor regarding the application of such standards to employee welfare benefit plans under title I of the Employee Retirement Income Security Act of 1974.

"(2) MORE STRINGENT STATE STANDARDS PERMITTED.—In the case of insured AmeriCare supplemental policies (as defined in subsection (d)(3)), a State may implement standards that are more strin-

gent than the standards established under paragraph (1), including—

''(A) additional limitations on pre-existing exclusion limitations described in subsection (c)(1)(B);

''(B) additional restrictions on the groups of benefits described in subsection (c)(2) that may be offered in AmeriCare supplemental policies in the State, so long as a core-only benefit package described in subparagraph (A)(i) of such subsection may be offered in the State; and

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

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

''(1) NO DISCRIMINATION BASED ON HEALTH STATUS.—

''(A) IN GENERAL.—Except as provided under subparagraph (B), an AmeriCare supplemental policy may not deny, limit, or condition the coverage under (or benefits of) the policy, or vary premiums charged, based on the health status, claims experience, receipt of health care,

medical history, or lack of evidence of insurability, of an individual.

''(B) LIMITATION ON USE OF PRE-EXISTING CONDITION EXCLUSIONS.—An AmeriCare supplemental policy may exclude coverage with respect to services related to treatment of a pre-existing condition, except that—

''(i) the period of such exclusion may not exceed 6 months;

''(ii) such exclusion shall not apply to services furnished to newborns; and

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

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

''(2) SIMPLIFICATION OF BENEFITS.—

''(A) IN GENERAL.—Each AmeriCare supplemental policy shall only offer benefits consistent with the standards, promulgated by the Secretary, that provide—

''(i) limitations on the groups or packages of benefits, including a core group of basic benefits and not to exceed 9 other different benefit packages, that may be offered under an AmeriCare supplemental policy;

''(ii) that a person may not issue an AmeriCare supplemental policy without offering such a policy with only the core-group of basic benefits and without providing an outline of coverage in a standard form approved by the Secretary;

''(iii) uniform language and definitions to be used with respect to such benefits, and

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

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

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

retary) may not be issued or renewed unless the policy—

"(A) can be expected (in accordance with a uniform methodology developed by the Secretary and for periods beginning 24 months after the date of original issue) to return to policyholders in the form of aggregate benefits at least 85 percent of the aggregate amount of premiums collected in the case of group policies or at least 75 percent in the case of individual policies (as defined by the Secretary); and

"(B) provides refunds and credits (in a manner specified by the Secretary) for premiums collected in excess of those consistent with subparagraph (A).

"(4) GUARANTEED RENEWABILITY AND CONVERTIBILITY.—Each AmeriCare supplemental policy—

"(A) shall be guaranteed renewable and may not be cancelled or nonrenewed solely on the ground of health status of the individual or for any reason other than nonpayment of premium or material misrepresentation; and

"(B) shall provide for—

''(i) a right of conversion to an individual policy (with continuation of benefits) in the case of termination by a group policyholder or termination by a certificateholder of membership in a group through which the individual obtained coverage;

''(ii) a right of continued coverage in the case of a group policy that succeeds another group policy; and

''(iii) suspension of coverage (for up to 24 months and in a manner specified) in the case of a policyholder who becomes entitled to benefits under this title as a low-income individual and who provides a timely notice of election of such suspension.

''(5) ADDITIONAL STANDARDS APPLICABLE ONLY TO INSURED POLICIES.—A carrier that offers an insured AmeriCare supplemental policy (as defined in paragraph (6)) to individuals and groups in a State shall also comply with the following requirements:

''(A) OPEN ENROLLMENT.—The carrier 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 include self-employed individuals) and which has been formed for purposes other than obtaining health insurance, such requirement shall only apply to such employers (and individuals) who are members of the association; and

''(ii) a health maintenance organization may deny enrollment with respect to an individual based on the uniform application of a geographic service area or overall enrollment limitation based on its financial 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 administrative changes;

''(ii) provide the same premium rates as for a new issue; and

''(iii) provide a period of renewal of not less than 12 months.

''(c) ADDITIONAL REQUIREMENTS.—

''(1) PROHIBITION OF DUPLICATION.—The Secretary shall—

''(A) establish requirements that prohibit (other than as required under Federal or State law) the knowing sale or issuance to an individual entitled to benefits under this title of health insurance that duplicates benefits under this title, of an AmeriCare supplemental policy that duplicates another AmeriCare supplemental policy, or of another health insurance policy that duplicates other benefits to which the individual is entitled; and

''(B) provide exceptions to the prohibition in subparagraph (A) for enrollment in group health plans and similar employment-based policies and for policies which provide benefits directly and without regard to other coverage and notice of such duplication.

''(2) DISCLOSURE REQUIREMENT.—The Secretary shall establish a requirement that prohibits the sale or issuance of an AmeriCare supplemental policy to an individual, other than as a replacement

policy, without obtaining a statement (in a form specified by the Secretary) that discloses other health benefits coverage and that acknowledges limitations on the need for an AmeriCare supplemental policy, particularly in the case of a low-income individual.

''(3) APPLICATION OF FALSE STATEMENT SANCTIONS.—The provisions of paragraphs (1) and (2) of section 1882(d) shall apply to an AmeriCare supplemental policy under this section in the same manner as they apply to medicare supplemental policies under such section.

''(4) LIMITATIONS ON SALES COMMISSIONS.—

''(A) IN GENERAL.—It is unlawful for a person who provides for a commission or other compensation to an agent or other representatives with respect to the sale of an AmeriCare supplemental policy (or certificate)—

''(i) to provide for a first year commission or other first year compensation that exceeds 200 percent of the commission or other compensation for the selling or servicing of the policy or certificate in a second or subsequent year; or

"(ii) to provide for compensation with respect to replacement of such a policy or certificate that is greater than the compensation that would apply to the renewal of the policy or certificate.

"(B) DEFINITION.—In subparagraph (A), the term 'compensation' includes pecuniary and nonpecuniary compensation of any kind relating to the sale or renewal of a policy or certificate and specifically includes bonuses, gifts, prizes, awards, and finders' fees.

"(d) INFORMATION DISCLOSURE.—The Secretary shall provide, to all individuals entitled to benefits under this title, such information as will permit such individuals to evaluate the value of AmeriCare supplemental policies to them and the relationship of any such policies to benefits provided under this title. Such information shall include information on—

"(1) the requirements and prohibitions under this section;

"(2) State and Federal agencies responsible for compliance with such requirements and enforcement of such prohibitions; and

''(3) the manner of submitting complaints regarding violations of such requirements and prohibitions.

''(e) DEFINITIONS.—In this section:

''(1) CARRIER.—The term 'carrier' means any person that offers an AmeriCare supplemental policy.

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

''(3) HEALTH MAINTENANCE ORGANIZATION.—The term 'health maintenance organization' has the meaning given the term 'eligible organization' in section 1876(b).

''(4) INSURED AMERICARE SUPPLEMENTAL POLICY.—The term 'insured AmeriCare supplemental policy' means any AmeriCare supplemental policy provided through insurance.''.

TITLE II—FINANCING PROVISIONS

Subtitle A—Individual Contributions

SEC. 201. GENERAL OBLIGATION FOR INDIVIDUALS.

(a) PAYMENT OF PLAN PREMIUM.—

(1) IN GENERAL.—Each individual eligible for coverage under title XXII of the Social Security Act is liable for payment of the premium established under this section for such coverage of the individual and family members. An individual who is not receiving such coverage due to coverage under a group health plan described in section 2202(d) of such Act is not liable for payment of such premium with respect to such individual.

(2) DETERMINATION OF PREMIUM.—Such premium shall be established by the Secretary of Health and Human Services on the basis of the cost of coverage (determined on a State by State basis and including administrative costs) and shall be determined separately based on the class of enrollment for the individual (as determined under section 2202 of the Social Security Act).

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

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

(1) the amount of any contributions made by the individual's employer (or employers) under subtitle B or otherwise (including voluntary employer contributions) with respect to coverage of the individual and family members, and

(2) the amount of any premium subsidies provided with respect to the individual under section 202.

(c) TIMING AND MANNER OF PAYMENT.—Each individual that is liable for a premium under subsection (a) shall pay such premium in such form and manner as the Secretary of the Treasury may specify. Except as otherwise provided by the Secretary of the Treasury, for purposes of subtitle F of such Code, the liabilities imposed under subsection (a) shall be treated as if they were a tax imposed under section 1 of such Code. The Secretary of the Treasury shall provide for the withholding of such payments from wages under rules similar to the rules of chapter 24 of such Code. The Secretary of the Treasury may prescribe special rules for withholding payments from wages of individuals who work seasonally, part-time, or for more than one employer.

SEC. 202. ADDITIONAL PREMIUM SUBSIDIES.

(a) ELIGIBILITY FOR ADDITIONAL PREMIUM SUBSIDIES.—

(1) IN GENERAL.—Each premium subsidy eligible individual is entitled to a premium subsidy in accordance with this section.

(2) PREMIUM SUBSIDY ELIGIBLE INDIVIDUAL.—In this section, the term ''premium subsidy eligible individual'' means an individual receiving coverage under title XXII of the Social Security Act who—

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

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

(3) ADDITIONAL DEFINITIONS.—In this section:

(A) FAMILY INCOME.—The term ''family income'' means, with respect to an individual who—

(i) is not a dependent of another individual, the sum of the modified adjusted gross incomes (as defined in subparagraph (B)) for the individual, the individual's

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

(ii) is a dependent of another individual, the sum of the modified adjusted gross incomes (as defined in subparagraph (B)) for the other individual, the other individual's spouse, and children who are dependents of the other individual.

(B) MODIFIED ADJUSTED GROSS INCOME.—The term ''modified adjusted gross income'' means adjusted gross income (as defined in the Internal Revenue Code of 1986)—

(i) determined without regard to sections 911, 931, and 933 of such Code, and

(ii) increased by—

(I) the amount of interest received or accrued by the individual during the taxable year which is exempt from tax, and

(II) the amount of the social security benefits (as defined in section 86(d) of such Code) received during the taxable year to the extent not included in gross income under section 86 of such Code.

The determination under the preceding sentence shall be made without regard to any carryover or carryback.

(C) APPLICABLE POVERTY LEVEL.—

(i) IN GENERAL.—The term ''applicable poverty level'' means, for a family for a year, the official poverty line (as defined by the Secretary of Health and Human Services) applicable to a family of the size involved for 2010 adjusted by the percentage increase or decrease described in clause (ii) for the year involved.

(ii) PERCENTAGE ADJUSTMENT.—The percentage increase or decrease described in this clause for a year is the percentage increase or decrease by which the average Consumer Price Index for all urban consumers (U.S. city average), as published by the Bureau of Labor Statistics, for the 12-month-period ending with August 31 of the preceding year exceeds such average for the 12-month period ending with August 31, 2010.

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

(D) TANF RECIPIENT.—The term ''TANF recipient'' means, for a month, an individual who is receiving aid or assistance under any plan of the State approved under title I, X, XIV, or XVI, or part A or part E of title IV, of the Social Security Act, for the month.

(E) SSI RECIPIENT.—The term ''SSI recipient'' means, for a month, an individual—

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

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

(iii) who is receiving monthly benefits under section 1619(a) of the Social Security Act (whether or not pursuant to section 1616(c)(3) of such Act) for the month.

(b) AMOUNT OF PREMIUM SUBSIDY.—

(1) LOWEST INCOME INDIVIDUALS.—

(A) IN GENERAL.—In the case of an individual described in subparagraph (B), the premium subsidy under this section is the amount which would (without regard to this section) reduce the premium obligation of the individual (and family members) under section 201 to zero.

(B) LOWEST INCOME INDIVIDUALS DESCRIBED.—An individual described in this subparagraph is a premium subsidy eligible individual who would still be such an individual under subsection (a)(2) if ''200 percent'' were substituted for ''300 percent'' in subparagraph (A) of such subsection.

(2) OTHER INDIVIDUALS.—

(A) IN GENERAL.—In the case of a premium subsidy eligible individual not described in paragraph (1), the premium subsidy under this section is the product of—

(i) the premium obligation of the individual (and family members) under section 201, multiplied by

(ii) the number of percentage points by which the individual's family income

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

(B) TABLE.—The Secretary may provide for a table which establishes the values for premium subsidies under this paragraph.

(c) GENERAL REVENUE FINANCING FOR LOW INCOME SUBSIDIES.—There are authorized to be appropriated to the Americare Trust Fund from amounts in the Treasury not otherwise appropriated, such sums as may be necessary to cover the costs of premium subsidies provided under this section.

SEC. 203. EFFECTIVE DATE.

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

Subtitle B—Employer Contributions

SEC. 211. GENERAL OBLIGATION FOR EMPLOYERS.

(a) GENERAL OBLIGATION.—

(1) IN GENERAL.—Subject to the succeeding provisions of this subsection, each employer shall make a financial contribution toward the cost of health insurance coverage for employees in accordance with this section.

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

(A) IN GENERAL.—Subject to subparagraph (B), an employer shall not be liable for any contribution under this section with respect to any employee who is covered under a group health plan of the employer described in section 2202(d) if such employer pays at least 80 percent of the cost of such health plan, as determined by the Secretary of Health and Human Services.

(B) SURCHARGE PERMISSIBLE TO PREVENT ADVERSE SELECTION.—The Secretary may impose liability for a contribution under this section with respect to an employee described in subparagraph (A) in an amount (not to exceed the amount specified under subsection (b)) insofar as the Secretary determines it necessary to prevent adverse selection of the individuals enrolled under this title as a result of the operation of such subparagraph.

(b) AMOUNT OF CONTRIBUTION.—

(1) FULL-TIME EMPLOYEES.—In the case of an employee receiving coverage under title XXII of the Social Security Act, the amount of the financial contribution is equal to at least 80 percent of the premium determined with respect to such employee and

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

(2) REDUCTION FOR PART-TIME EMPLOYEES.—In the case of a part-time employee, the employer contribution requirements of paragraph (1) shall be treated as satisfied if the employer contribution with respect to such employee is not less than the part-time employment ratio of the contribution required under paragraph (1).

(3) RULES RELATED TO PART-TIME EMPLOYMENT.—For purposes of this subsection—

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

(B) PART-TIME EMPLOYMENT RATIO.—The term ''part-time employment ratio'' means, with respect to a part-time employee of an employer in a month, a fraction—

(i) the numerator of which is the number of hours in the employee's normal work week, and

(ii) the denominator of which is 40 hours.

(C) SPECIAL RULES.—Under rules prescribed by the Secretary of Health and Human Services, in consultation with the Secretary of the Treasury, in the case of an employee for an employer whose defined work week for full-time employees is less than 40 hours, any reference in this subsection to 40 hours is deemed a reference to the number of hours in the work week so defined.

(D) CONVERSION TO HOURS OF EMPLOYMENT.—The Secretary of Health and Human Services, in consultation with the Secretary of the Treasury, shall establish rules for the conversion of compensation to hours of employment, for purposes of this subsection in the case of employees that receive compensation on a salaried basis, or on the basis of a commission, or other contingent or bonus basis, rather than based on an hourly wage.

(c) TIMING AND MANNER.—

(1) IN GENERAL.—Each employer that is required to make a financial contribution with respect to an employee under this section (other than with

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

(2) NON-ENROLLING EMPLOYERS.—In the case of an employee who is covered under the class of enrollment of a family member, the Secretary of the Treasury shall provide that the financial contribution of the employer with respect to such employee is paid directly or indirectly to the employer of such family member.

SEC. 212. EFFECTIVE DATE.

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

(b) ADDITIONAL PERIOD FOR SMALL EMPLOYERS.—The provisions of this subtitle shall not apply with respect to an employer that has fewer than 100 employees (as determined by the Secretary of the Treasury in consultation with the Secretary of Health and Human Services) for periods beginning before January 1, 2013.

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