AMERICARE HEALTH CARE ACT OF 2006

Section-By-Section

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AmeriCare Health Care Act of 2006

TITLE I – HEALTH CARE ELIGIBILITY AND BENEFITS

Section 101 (page 3): Eligibility and Benefits

Amends the Social Security Act by adding a new Title XXII – AmeriCare Health Benefits.

PART A - ELIGIBILITY

Sec. 2201. Eligibility and Effective Date (page 3)
Provides universal eligibility for all residents of the US, with special eligibility for children (under age 24), pregnant women, and individuals with limited incomes (<300% FPL). Coverage of non-residents is available to the extent the Secretary determines that such benefits would be available to US nationals in other countries.

Effective date for benefits is January 1, 2010.

Sec. 2202. Enrollment (page 4, 5)
Requires the Secretary of HHS to develop a mechanism to enroll eligible individuals, including automatic enrollment of children at birth. Individuals with proof of equivalent coverage under a group health plan may opt out. Enrollees would receive an AmeriCare card. Special eligibility status for the year involved would be coded to assure proper benefits and cost-sharing.

Provides for four classes of enrollment: individual, couple, unmarried individual with children; married couple with children.

PART B – BENEFITS

Sec. 2221. Scope of Benefits (pages 6-13)
Special eligibility categories (children, pregnant women, and low-income below 200% of the federal poverty level) receive comprehensive benefits and pay no cost-sharing. Children receive EPSDT coverage. Cost-sharing is subsidized for individuals with income between 200% and 300% of the federal poverty level.

Other enrollees receive: Medicare Part A and Part B benefits; preventive services recommended by the US Preventive Services Task Force; coverage for treatment of substance abuse; mental health parity; and prescription drug coverage equivalent to the BC/BS Standard Option in 2005. Cost sharing includes deductible of $350 for individuals and $500 for a family and 20%

coinsurance up to an out-of-pocket maximum of $2,500 individual/$4,000 family. Any expenses paid on behalf of the individual are counted toward these spending limits. Total spending (premiums, deductibles, and co-insurance) is capped at 5% of income for individuals and families with income between 200% and 300% FPL, and 7.5% of income for individuals and families with income between 300% and 500% of FPL. Cost sharing and catastrophic limits are indexed to CPI after 2006.

Title XVIII (Medicare) benefits are modified to conform with the AmeriCare benefit package.

Allows for enrollment in private health plans using Medicare Part C rules and AAPCC rates.

Sec. 2222. Exclusions (pages 13-14)
Conforms to Title XVIII policy on benefit exclusions. Exceptions for well-child services provided in accordance with the periodicity schedule and services for pregnant women, as well as eyeglasses, hearing aids, and necessary examinations for children and low-income individuals.

Exempts employers from Medicare secondary payer requirements (note that the Secretary has the authority to establish a surcharge to prevent adverse selection). Establishes AmeriCare as secondary to Medicare.

PART C – PAYMENT FOR BENEFITS AND FINANCING

Sec. 2241. Payments For Benefits (pages 14-17)
Conforms with Title XVIII payment system – including prohibition on balance billing – with adjustments for new services (e.g., OB, well-child care, etc.) and new populations (e.g., re-weighting DRGs). Requires the Secretary to establish a global fee for obstetrical services provided throughout the course of pregnancy, with a 5 percent bonus for women who present for prenatal care during the first trimester.

Establishes a fee schedule for outpatient prescription drugs. The use of more affordable therapeutic equivalents shall be encouraged to the extent such practices do not override medical necessity. The Secretary is required to negotiate with pharmaceutical manufacturers to reduce the purchase cost of outpatient prescription drugs and biologicals using strategies similar to those used by other Federal purchasers. Such fee schedule also applies to Title XVIII.

Sec. 2242. AmeriCare Trust Fund (page 17-19)
Establishes an AmeriCare Trust Fund based on Title XVIII model. All premiums and state maintenance of effort payments will be deposited into the AmeriCare Trust Fund and used to support program operations.

PART D – ADMINISTRATIVE SIMPLIFICATION

Sec. 2251. Requirement for Entitlement Verification System (pages 19-21)
Requires the Secretary to establish standards for an electronic system to verify an individual's entitlement to benefits, the extent to which the individual has fulfilled out-of-pocket requirements, and enrollment of qualified providers within 12 months after enactment. Provides

for the development of a website through which health service providers and AmeriCare health plans may make inquiries and receive responses about eligibility for benefits and liability for cost-sharing. System queries must be available through a variety of electronic and other forms. Plans may not assess a fee for system queries made through electronic means.

Sec. 2252. Requirements for Uniform Claims and Electronic Claims Data Set (pages 22-28)
Requires the Secretary to establish national standards for claims submission within six months of enactment. Requires the Secretary to assure that standards are developed in coordination with standards for EMR. Requires Secretary to take into account recommendations of current task forces. Provides for the development of a website to enable providers to submit claims and receive verification of claims electronically. Requires clinical laboratory tests to be submitted directly to the health plan by the person or entity that performed the test. Provides for CMP of $100 per day or the amount of the claim (if greater) for each violation within 36 months of effective date. Requires Medicare and Medicaid to comply with AmeriCare standards.

Sec. 2253. Electronic Medical Records and Reporting (pages 28-35)
Requires the Secretary to promulgate standards for electronic medical records not later than January 1, 2008 including, at a minimum, the following:

- 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;
- standards for an electronic patient care information system with data obtained at the point of care;
- specification and manner of presentation for the individual data elements;
- standards concerning the transmission of electronic medical data; and
- 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.

Requires coordination with standards for uniform electronic claims data set. Requires health care providers to maintain EMR data for all patients and transmit electronically upon request of the Secretary as a condition of participation in public programs by January 1, 2009. Allows for the heads of federal agencies to require providers to comply with AmeriCare standards re: electronic transmission of data. Provides for a CMP of $100 for each failure of an AmeriCare supplemental plan to comply with the standards. Requires Medicare and Medicaid to comply with AmeriCare standards.

Sec. 2254 Uniform Hospital Cost Reporting (page 35)
Requires uniform hospital cost reporting beginning during or after FY 2007.

Sec. 2255. Health Service Provider Defined (page 35)
Uses Medicare definition of provider of services, physician, supplier, and other person furnishing health care services.

PART E – GENERAL PROVISIONS

Sec. 2261. Definitions Relating to Beneficiaries and Income (pages 35-39)
Defines special eligibility categories and modified gross income.

Sec. 2262. Incorporation of Certain Medicare Provisions and Other Provisions (pages 39-42)
Establishes administrative structure based on current Medicare program (i.e., using Medicare Administrative Contractors (MACs), certification, and provider qualifications). Incorporates Medicare fraud provisions.

Sec. 2263. State Maintenance of Effort Payments (pages 41-43)
Requires states to continue to pay their share of the cost of providing AmeriCare benefits in 2006 for individuals who would otherwise qualify for Medicaid and S-CHIP.

Sec. 2264. Modification of Medicaid and Other Programs to Avoid Duplication of Benefits (pages 43- 44)
Prohibits Medicaid and FEHBP from providing duplicate benefits. Requires the Secretary to review the feasibility of applying this policy to other federal programs and report to Congress no later than January 1, 2009.

Sec. 2265. Construction Regarding Continuation of Obligations Under Current Group Health Plan Contracts and Provision of Additional Benefits (page 44)
Specifies that AmeriCare does not affect contracts or collective bargaining agreements in effect as of the date of enactment. Clarifies that employers may offer additional benefits to their employees and dependents under group health plans or through state plans at the expense of the State.

Sec. 2266. Standards and Requirements for AmeriCare Supplemental Policies (pages 44-56)
Establishes standards for private supplemental health insurance policies. Requires consumer protections and prohibits duplication of benefits.

TITLE II – FINANCING PROVISIONS

SUBTITLE A – INDIVIDUAL CONTRIBUTIONS

Sec. 201. General Obligation for Individuals (pages 56-58)
Beginning January 1, 2010, each enrolled individual pays a premium established by Secretary of HHS based on the cost of coverage (determined on a State by State basis and taking into account administrative costs) and class of enrollment (i.e., individual, couple, family). Premiums are reduced for low-income individuals (see next section) and for people who are employed (because their employer makes a contribution on their behalf). Individuals who receive equivalent coverage through their employer do not pay AmeriCare premiums.

The Secretary of the Treasury establishes processes for collecting premiums using mechanisms similar to payroll tax withholding. Payment of premiums would be reconciled through regular

income tax filing. Special rules may be prescribed for individuals who work seasonally, part-time, or for more than one employer.

Section 202. Additional Premium Subsidies (pages 58-64)
Outlines eligibility for premium subsidies (MGI below 300% of the federal poverty level, TANF, or SSI) and the amount of the subsidy.

Section 203. Effective Date (page 64)
Periods beginning on or after January 1, 2010.

SUBTITLE B – EMPLOYER CONTRIBUTIONS

Sec. 211. General Obligation for Employers (pages 64-68)
Employers are required to contribute 80 percent of the premium for AmeriCare coverage or equivalent coverage offered by the employer for the applicable class of enrollment for full-time employees and their families in a time and manner specified by the Secretary of the Treasury. The Secretary of HHS may impose an additional liability for employers to the extent it is necessary to prevent adverse selection.

Employer contributions for part time employees are reduced according to the ratio of hours worked per week divided by 40 hours to 80 percent (page 66). Secretary of the Treasury shall establish a process for a non-enrolling employer to reimburse the enrolling employer in the case of a married couple that works for different employers but chooses to enroll in the same plan.

Sec. 212. Effective Date (page 68)
Periods beginning on or after January 1, 2010. January 1, 2012 for employers with fewer than 100 employees.