# Fax Cover Sheet

## Office of Senator Bingaman

110 Hart Senate Office Building Washington, D.C. 20510 (202) 224-5521

TO: Chris Jennings
OFFICE: White House Health Policy

FROM: Carrie Billy
OFFICE: Office of Senator Jeff Bingaman
United States Senate
Washington, DC 20510

PAGES: 2 total (including cover sheet)

**Comments:**

This is a summary of the amendment Senator Bingaman would like to offer on the employer mandate (small employer exemption). As you know, we are trying to cost this out, and find out whether the administration can live with something like this. The employer mandate is Jeff's chief concern, as he has mentioned several times. Thanks for you help.

Sending to Fax Number: (202) 456-7431

# SUMMARY:

## AMENDMENT TO BE PROPOSED BY SENATOR JEFF BINGAMAN

## EMPLOYER SHARE RESPONSIBILITY: TITLE VI -- PART 2

### Small Employer Exemption; Mid-size Employer Transition Part-time Worker Responsibility & Seasonal Worker Study

**(A) Subpart A: Small Employer Exemption:** (beginning in sec. 6117): Low-wage firms with 1-10 employees would be exempt from the employer mandate. Specifically:

- Smallest firms **(1-5 employees)** with average wages of $24,000/worker would pay **1 percent** of payroll to the new system.

- Other small, low-wage firms (between **6-10 employees**) would pay **2 percent** of payroll to the new system.

- The firms would not be mandated to provide health benefits to employees, but like all other employers would be required to make information on health plan enrollment available to employees.

- The firms have the option of providing coverage to employees. If this option is exercised, they will be treated as firms with 11 or more employees for purposes of discounts and tax treatment, as specified in the Chairman's mark.

**(B) Transition for Mid-size Firms:** Transition from payroll contribution and contribution based on individual employee wages would be phased in through a sliding scale of caps on employer contributions, based on firm size and employee wage:

| FIRM SIZE | CONTRIBUTION CAP (based on average wage) |
|---|---|
| 11-15 employees | 4.0 percent |
| 16-24 employees | 5.5 percent |
| 25-49 employees | 6.8 percent |
| 50-74 employees | 8.1 percent |

**(C) Part-time Workers:** An employer's obligation to make premium contributions for part-time workers would be established at the commencement of the employee's second month of work, after having worked for the employer part-time for a four-week period.

**(D) <u>New Section: Study on Seasonal Workers</u>:** Six months before the general effective date of the Act, the Secretary of Labor is required to submit to the Congress a report on the economic impact of requiring employers of seasonal workers to make premium contributions. The report will make recommendations for easing the paperwork and administrative burdens on employers, individuals, and health plans.

**(E) <u>Section 6104: Family Contributions</u>:** Expanded family contribution discounts and co-payment discounts, as provided in the Chairman's mark, would be retained (overall family obligation limit of 3.9 percent). If necessary, further adjustments in section 6104 (Premium Discount Based On Income) will be made to ensure that low-income workers are not adversely impacted by changes in employer contribution requirements.

1 # Subtitle A—Quality Management
2 # and Improvement

3 **SEC. 5001. NATIONAL QUALITY COUNCIL.**

4 (a) ESTABLISHMENT.—Not later than 1 year after
5 the date of enactment of this Act, the Secretary of Health
6 and Human Services shall establish a council to be known
7 as the National Quality Council to oversee a program of
8 quality management and improvement designed to en-
9 hance the quality, appropriateness, and effectiveness of
10 health care services and access to such services.

can it become part of NHB?

11 (b) APPOINTMENT.—The National Quality Council
12 shall consist of 15 members appointed by the President,
13 with the advice and consent of the Senate, who are broadly
14 representative of the population of the United States and
15 shall include the following:

16 (1) Individuals and health care providers distin-
17 guished in the fields of medicine, public health,
18 health care quality, and related fields of health serv-
19 ices research. Such members shall constitute at least
20 one-third of the Council's membership.

21 (2) Individuals representing consumers of
22 health care services. Such members shall constitute
23 at least one-third of the Council's membership.

1 (3) Other individuals representing purchasers of
2 health care, health plans, States, and nationally rec-
3 ognized health care accreditation organizations.
4 (c) DUTIES.—The National Quality Council shall—
5 (1) develop national goals and performance
6 measures of quality;
7 (2) develop uniform quality goals and perform-
8 ance measures for plans;
9 (3) ~~design and~~ oversee national surveys of plans
10 and consumers;
11 (4) ~~design and~~ oversee the production of
12 Consumer Report Cards;
13 (5) ~~establish and~~ oversee Quality Improvement
14 Foundations;
15 (6) ~~establish and~~ oversee State Offices of
16 Consumer Information and Advocacy; and
17 (7) evaluate the impact of the implementation
18 of this Act on the quality of health care services in
19 the United States and the access of consumers to
20 such services.
21 (d) CONSULTATION.—In carrying out these duties,
22 the National Quality Council shall establish a process of
23 consultation with appropriate interested parties.
24 (e) TERMS.—

1 (1) IN GENERAL.—Except as provided in para-
2 graph (2), members of the Council shall serve for a
3 term of 4 years.
4 (2) STAGGERED ROTATION.—Of the members
5 first appointed to the Council under subsection (b),
6 the President shall appoint members to serve for a
7 term of between 1 and 4 years so that no more than
8 one third of the Council seats are vacated each year.
9 (3) SERVICE BEYOND TERM.—A member of the
10 Council may continue to serve after the expiration of
11 the term of the member until a successor is ap-
12 pointed.
13 (f) VACANCIES.—If a member of the Council does not
14 serve the full term applicable under subsection (e), the in-
15 dividual appointed to fill the resulting vacancy shall be ap-
16 pointed for the remainder of the term of the predecessor
17 of the individual.
18 (g) CHAIR.—The President shall designate an indi-
19 vidual to serve as the chair of the Council.
20 (h) MEETINGS.—The Council shall meet not less than
21 once during each 4-month period and shall otherwise meet
22 at the call of the President or the chair.
23 (i) COMPENSATION AND REIMBURSEMENT OF EX-
24 PENSES.—Members of the Council shall receive compensa-
25 tion for each day (including travel time) engaged in carry-

1 ing out the duties of the Council. Such compensation may
2 not be in an amount in excess of the maximum rate of
3 basic pay payable for level IV of the Executive Schedule
4 under section 5315 of title 5, United States Code.

5 (j) CONFLICTS OF INTEREST.—Members of the
6 Council shall disclose upon appointment to the Council or
7 at any subsequent time that it may occur, conflicts of in-
8 terest.

9 (k) STAFF.—The Secretary of Health and Human
10 Services shall provide to the Council such staff, informa-
11 tion, and other assistance as may be necessary to carry
12 out the duties of the Council.

13 (l) HEALTH CARE PROVIDER.—For purposes of this
14 subtitle, the term "health care provider" means an individ-
15 ual who, or entity that, provides an item or service to an
16 individual that is covered under the health plan (as de-
17 fined in section 1111) in which the individual is enrolled.

18 **SEC. 5002. NATIONAL GOALS AND PERFORMANCE MEAS-**
19 **URES OF QUALITY.**

20 (a) IN GENERAL.—The National Quality Council
21 shall develop a set of national quality goals and perform-
22 ance measures of quality for both the general population
23 and for population subgroups defined by demographic
24 characteristics and health status. The goals and measures
25 shall incorporate ~~standards~~ goals identified by the Secretary of

1 Health and Human Services for meeting public health ob-
2 jectives utilizing, but not limited to, goals delineated in
3 Healthy People 2000.
4 (b) SUBJECT OF MEASURES.—National measures of
5 quality performance shall be developed under subsection
6 (a) in a manner that provides statistical and other infor-
7 mation on at least the following subjects:
8 (1) Outcomes of health care services and proce-
9 dures.
10 (2) Population health status.
11 (3) Health promotion.
12 (4) Prevention of diseases, disorders, and other
13 health conditions.
14 (5) Access to care and appropriateness of care.
(6) Satisfaction w/ care
15 **SEC. 5003. STANDARDS AND PERFORMANCE MEASURES**
16 **FOR HEALTH PLANS.**
17 (a) IN GENERAL.—The National Quality Council
18 shall establish national standards and performance meas-
19 ures for health plans, which may be used to assess the
20 provision of health care services and access to such serv-
21 ices, both for the general population and population
22 subgroups defined by demographic characteristics and
23 health status. In subject matter areas with which the Na-
24 tional Quality Council determines that sufficient informa-
25 tion and consensus exist, the Council shall establish goals

1 for performance by health plans consistent with the na-
2 tional goals and performance measures established under
3 section 5002. Quality measures under this section shall
4 relate, at a minimum, to:

5 (1) Access to health care services by consumers,
6 including provider to patient ratios, waiting times
7 for appointments, travel distances, and community
8 involvement and outreach.

9 (2) Appropriateness of health care services, in-
10 cluding failure to provide appropriate services and
11 continuity of care.

12 (3) Consumer satisfaction with care and compli-
13 ance with members rights, including dissenrollment,
14 referral, patterns of claims denials and out-of-net-
15 work utilization patterns.

16 (4) Quality improvement and accountability, in-
17 cluding demonstrating that the plan can continu-
18 ously monitor and improve the quality of health care
19 provided.

20 (5) Documenting provider credentialing and
21 competency.

22 (6) Management of clinical, and administrative
23 and financial information.

24 (7) Utilization management, including criteria
25 for monitoring underutilization, techniques and pro-

1 vider feedback to minimize interference with the pro-
2 vider-patient relationship, and supervision of utiliza-
3 tion determinations by qualified medical profes-
4 sionals.

5 (b) CERTIFICATION OF PLANS.—The National Qual-
6 ity Council shall provide information and technical assist-
7 ance to the Board and the States concerning the use of
8 national standards and performance measures developed
9 under this section for State certification of health plans.

10 **SEC. 5004. PLAN DATA ANALYSIS AND CONSUMER SURVEYS.**

11 (a) IN GENERAL.—The National Quality Council
12 shall conduct (either directly or through contract) periodic
13 surveys of health care consumers and plans to gather in-
14 formation concerning the quality measures established
15 under sections 5002 and 5003. The surveys shall monitor
16 consumer reaction to the implementation of this Act and,
17 in coordination with relevant data from health plans and
18 other sources, be designed to assess the impact of this Act
19 both for the general population of the United States and
20 for populations vulnerable to discrimination or to receiving
21 inadequate care due to health status, demographic charac-
22 teristics, or geographic location.

23 (b) SURVEY ADMINISTRATION AND DATA ANALY-
24 SIS.—The National Quality Council shall approve a stand-
25 ard design for the consumer surveys and sampling of rel-

1 evant plan data described in subsection (a) which shall be
2 administered by the Administrator for Health Care Policy
3 and Research or such other appropriate entity as the
4 Council shall designate on a plan-by-plan and State-by-
5 State basis. Sufficient consumer survey and plan data
6 shall be collected and verified to provide for reliable and
7 valid analysis. A State may add survey questions on qual-
8 ity measures of local interest to surveys conducted in the
9 State. The plan-level survey shall include a subset of
10 consumer survey responses related to consumer satisfac-
11 tion, perceived health status, access, and such other survey
12 items designated by the Council.

13 (c) SAMPLING STRATEGIES.—The National Quality
14 Council shall approve sampling strategies under sub-
15 section (a) that ensure that appropriate survey samples
16 adequately measure populations that are considered to be
17 at risk of receiving inadequate health care or may be dif-
18 ficult to reach through consumer-sampling methods, in-
19 cluding individuals who—

20 (1) fail to enroll in a health plan;

21 (2) resign from a plan; or

22 (3) are vulnerable to discrimination or to receiv-
23 ing inadequate care due to health status, demo-
24 graphic characteristics, or geographic location.

1 (d) SURVEY INTEGRATION.—To the extent feasible,
2 the consumer and plan surveys developed under this sec-
3 tion shall be integrated with existing Federal surveys.

4 **SEC. 5005. EVALUATION AND REPORTING OF QUALITY PER-**
5 **FORMANCE.**

6 (a) HEALTH PLAN REPORTS.—Each State annually
7 shall publish and make available to the public and the
8 Consumer Information and Advocacy Office a perform-
9 ance report, in a standard format designated by the Na-
10 tional Quality Council, outlining the performance of each
11 health plan offered in the State with respect to the set
12 of national measures of quality performance developed
13 under sections 5002 and 5003. The report shall include—

14 (1) the results of a smaller number of such
15 measures for health care providers if the available
16 information is statistically meaningful; and

17 (2) the results of consumer surveys described in
18 section 5004 that were conducted in the State dur-
19 ing the year that is the subject of the report and be
20 based on the data collected and analyzed in section
21 5004.

22 (b) CONSUMER REPORT CARDS.—The health plan re-
23 ports under subsection (a) shall be summarized in a
24 consumer report card as specified by the National Quality
25 Council and made available by the State through the

unfunded ~~state~~ obligation

what is diff than A+B?

1 Consumer Information and Advocacy Offices to all individ-
2 uals in the State.

3 (c) QUALITY REPORTS.—The National Quality Coun-
4 cil annually shall provide recommendations to the Con-
5 gress, the National Health Benefits Board, and the Sec-
6 retary in the form of a summary report that—

7 (1) outlines in a standard format the perform-
8 ance of each State;

9 (2) discusses State-level and national trends re-
10 lating to health care quality; and

11 (3) presents data for each State from health
12 plan reports and consumer surveys that were con-
13 ducted during the year that is the subject of the re-
14 port.

15 (d) STATE REPORTS.—The National Quality Council
16 shall assist each State in annually developing a summary
17 report that—

18 (1) outlines in a standard format the perform-
19 ance of each health plan;

20 (2) discusses State-level trends relating to
21 health care quality; and

22 (3) presents data for each health plan from
23 health plan reports and consumer surveys that were
24 conducted during the year that is the subject of the
25 report.

1 **SEC. 5006. DEVELOPMENT AND DISSEMINATION OF PRAC-**
2 **TICE GUIDELINES.**
3 (a) DEVELOPMENT OF GUIDELINES.—The National
4 Quality Council may advise the Secretary and the Admin-
5 istrator for Health Care Policy and Research concerning
6 priorities for the development and periodic review and up-
7 dating of clinically relevant guidelines established under
8 section 912 of the Public Health Service Act.
9 (b) HEALTH SERVICE UTILIZATION PROTOCOLS.—
10 The National Quality Council shall establish standards
11 and procedures for evaluating the clinical appropriateness
12 of protocols used to manage health service utilization.

take out

13 **SEC. 5007. RESEARCH ON HEALTH CARE QUALITY.**
14 The National Quality Council may make rec-
15 ommendations to the Secretary and the Administrator for
16 Agency for Health Care Policy and Research concerning
17 priorities for research with respect to the quality, appro-
18 priateness, and effectiveness of health care.
19 **SEC. 5008. QUALITY IMPROVEMENT FOUNDATIONS.**
20 (a) ESTABLISHMENT.—The National Quality Council
21 shall oversee the operation of quality improvement founda-
22 tions in performing the duties specified in subsection (c).
23 (b) STRUCTURE AND MEMBERSHIP.—
24 (1) GRANT PROCESS.—The Secretary, in con-
25 sultation with the Council, shall, through a competi-
26 tive grantmaking process, award grants for the es-

1 tablishment and operation of a quality improvement
2 foundation in each State or region (as defined in
3 subsection (b)(2)).
4 (2) ESTABLISHMENT OF GEOGRAPHIC AREAS.—
5 The Secretary shall establish throughout the United
6 States geographic areas with respect to which grants
7 under this section will be made. In establishing such
8 areas, the Secretary shall take into account the fol-
9 lowing criteria:
10 (A) STATE AREAS.—Each State shall gen-
11 erally be designated as a geographic area for
12 purposes of this paragraph.
13 (B) MULTI-STATE AREAS.—The Secretary
14 may establish geographic areas comprised of
15 multiple contiguous States only where the the
16 Secretary determines that volume of activity or
17 other relevant factors justifies such an estab-
18 lishment.
19 (3) ELIGIBLE APPLICANTS.—To be eligible to
20 receive a grant for the establishment of a quality im-
21 provement foundation under paragraph (1), an ap-
22 plicant entity shall meet the following conditions:
23 (A) NOT-FOR-PROFIT.—The entity shall be
24 a not-for-profit entity operating within the
25 State or region involved.

1 (B) BOARD.—The entity shall have a
2 board which includes—
3 (i) representatives of health care pro-
4 viders from throughout the State or region
5 involved, including both practicing provid-
6 ers and experts in the field of quality
7 measurement and improvement, which to-
8 gether shall comprise at least one-fourth of
9 the advisory board's membership; governing
10 (ii) at least one representative of Aca-
11 demic Health Centers or schools defined in
12 section 799 of the Public Health Service
13 Act operating within the State or region
14 involved (or operating outside of the State
15 or region if no such Centers or schools op-
16 erate within the State or region), which
17 shall comprise up to one-fourth of the
18 membership;
19 (iii) representatives of consumers re-
20 siding within the State or region involved,
21 who shall comprise one-fourth of the mem-
22 bership; and
23 (iv) representatives of purchasers of
24 health care, health plans, and other inter-
25 ested parties residing within the State or

1 region involved, and representatives of the
2 State or States within a region.
3 (C) STAFFING.—Each entity shall have
4 sufficient, competent staff of experts possessing
5 the skills and knowledge necessary to enable the
6 foundation perform its duties.
7 (c) DUTIES.—
8 (1) IN GENERAL.—Each quality improvement
9 foundation shall carry out the duties described in
10 paragraph (2) for the State or region in which the
11 foundation is located. The foundation shall establish
12 a program of activities incorporating such duties and
13 shall be able to demonstrate the involvement of a
14 broad cross-section of the providers and health care
15 institutions throughout the State or region. A foun-
16 dation may apply for and conduct research described
17 in section 5007.
18 (2) DUTIES DESCRIBED.—The duties described
19 in this paragraph include the following:
20 (A) Collaboration with and technical assist-
21 ance to providers and health plans in ongoing
22 efforts to improve the quality of health care
23 provided to individuals in the State.
24 (B) Population-based monitoring of prac-
25 tice patterns and patient outcomes, ~~and audit-~~

1 ing samples of such data to assure its validity
2 (on an other than a case-by-case basis).
3 (C) Developing programs in lifetime learn-
4 ing for health professionals to improve the qual-
5 ity of health care by ensuring that health pro-
6 fessionals remain informed about new knowl-
7 edge, acquire new skills, and adopt new roles as
8 technology and societal demands change.
9 (D) Disseminating information about suc-
10 cessful quality improvement programs, practice
11 guidelines, and research findings, including in-
12 formation on innovative staffing of health pro-
13 fessionals.
14 (E) Assist in developing innovative patient
15 education systems that enhance patient involve-
16 ment in decisions relating to their health care,
17 including an emphasis on shared decisionmak-
18 ing between patients and health care providers.
19 (F) Issuing a report to the public regard-
20 ing the foundation's activities for the previous
21 year including areas of success during the pre-
22 vious year and areas for opportunities in im-
23 proving health outcomes for the community,
24 and the adoption of guidelines.

1 (G) Providing notice to the State or appro-
2 priate entity if the foundation determines, after
3 reasonable opportunities for improvement, that
4 the quality of a provider or plan remains so in-
5 adequate that the patients or enrollees of such
6 a provider or plan are subject to potential harm
7 in utilizing the services of such provider or serv-
8 ices under such plan.

9 **SEC. 5009. CONSUMER INFORMATION AND ADVOCACY.**

10 (a) ESTABLISHMENT.—
11 (1) IN GENERAL.—The Secretary shall establish
12 (by grant or contract) and oversee a National Center
13 of Consumer Information and Advocacy to provide
14 technical assistance, adequate training and support
15 to States and Offices of Consumer Information and
16 Advocacy in each State (hereafter referred to in this
17 section as the "Office") to carry out the duties of
18 this section, including providing public education to
19 consumers concerning this Act.
20 (2) REQUIREMENTS FOR NATIONAL CENTER.—
21 The National Center of Consumer Information and
22 Advocacy shall be a national non-profit organization
23 with public education and health policy expertise and
24 shall have sufficient staff to carry out its duties and
25 a demonstrated ability to represent and work with a

1 broad spectrum of consumers, including vulnerable
2 and under served populations.
3 (3) ~~STATE~~ COMMUNITY-BASED OFFICES.—The Office of Consumer
4 Information and Advocacy in each State shall dis-
5 seminate State reports on quality performance (as
6 defined in section 5005(4)) and health plan
7 consumer report cards (as defined in section
8 5005(2)) in order to facilitate consumer choice of
9 health plans, perform public outreach and provide
10 education and assistance regarding consumer rights
11 and responsibilities under this Act, and assist con-
12 sumers in dealing with problems that arise with
13 consumer purchasing cooperatives, large group pur-
14 chasers, health plans, and health care providers op-
15 erating in such State.
16 (b) CONTRACTS.—
17 (1) SOLICITATION.—The Secretary shall solicit
18 contracts from private non-profit organizations
19 based in each State to fulfill the duties of the ~~Office~~
20 in the State. The Secretary may develop such regu-
21 lations and guidelines as necessary to oversee the
22 process of considering and awarding competitive con-
23 tracts under this section. In awarding such con-
24 tracts, the Secretary shall consult with the National
25 Center of Consumer Information and Advocacy and

1 shall, at a minimum, consider the demonstrated abil-
2 ity of the organization to represent and work with
3 a broad spectrum of consumers, including vulnerable
4 and underserved populations.

5 (2) CONTRACT PERIOD.—The contract period
6 for the State Offices of Consumer Information and
7 Advocacy and the National Center of Consumer In-
8 formation and Advocacy under this section shall be
9 not less than 4 years and not more than 7 years.

10 (c) FUNCTIONS AND RESPONSIBILITIES.—

11 (1) DISSEMINATION OF REPORTS.—Each office
12 shall disseminate State reports on quality perform-
13 ance (as defined in section 5005(2)) and health plan
14 consumer report cards (as defined in section
15 5005(2)) in order to facilitate consumer choice of
16 health plans.

17 (2) STAFF, OFFICES AND HOTLINES.—Each Of-
18 fice shall have sufficient staff, local offices through-
19 out the State, and a State-wide toll-free hotline to
20 carry out the advocacy duties of this section.
21 Through direct contact and the hotline, the Office
22 shall provide the following services in the State, in-
23 cluding appropriate assistance to individuals with
24 limited English language ability—

1 (A) outreach and education relating to
2 consumer rights and responsibilities under this
3 Act, including such rights and services available
4 through the Office;
5 (B) assistance with enrollment in health
6 plans, or obtaining services or reimbursement
7 from health plans;
8 (C) assistance with filing an application for
9 premium or cost sharing subsidies;
10 (D) information to enrollees about existing
11 grievance procedures and coordination with
12 other entities to assist in identifying, investigat-
13 ing, and resolving enrollee grievances under this
14 Act (including grievances before State medical
15 boards);
16 (E) regular and timely access in the area
17 to the services provided through the Office and
18 its local offices and timely responses from rep-
19 resentatives of the Office to complaints;
20 (F) referrals to appropriate local providers
21 of legal assistance and to appropriate State and
22 Federal agencies which may be of assistance to
23 aggrieved individuals in the area; and

1 (G) conduct public hearings no less fre-
2 quently than once a year to identify and ad-
3 dress community health care needs.

4 (d) ACCESS TO INFORMATION.—The Secretary and
5 the States shall ensure that, for purposes of carrying out
6 the Office's duties under this section, the Office (and offi-
7 cers and employees of the Office in local offices) have ap-
8 propriate access to relevant information subject to protec-
9 tions for confidentiality of enrollee information.

10 (e) EVALUATION AND REPORT.—The Secretary shall
11 have the right to evaluate the quality and effectiveness of
12 the organization in carrying out the functions specified in
13 the contract. The Office shall report to the Secretary and
14 the State annually on the nature and patterns of consumer
15 complaints received in the Office and its local offices dur-
16 ing each year and any policy, regulatory, and legislative
17 recommendations for needed improvements together with
18 a record of the activities of the Office.

19 (f) CONFLICTS OF INTEREST.—The Secretary shall
20 ensure that no individual involved in the designation of
21 a State Office, the Office itself, or of any delegate thereof
22 is subject to a conflict of interest, including affiliation with
23 (through ownership or common control) a health care fa-
24 cility, managed care organization, health insurance com-
25 pany or association of health care facilities or providers.

1 No grantee under this section may have a direct involve-
2 ment with the licensing, certification, or accreditation of
3 a health care facility, a health care plan, or a provider
4 of health care services .
5 (g) LEGAL COUNSEL.—The Secretary shall ensure
6 that adequate legal counsel is available, and is able, with-
7 out conflict of interest, to assist the Office, and the local
8 offices thereof in the performance of their official duties.
9 (h) COORDINATION.—The Office shall coordinate its
10 activities with all appropriate entities including Quality
11 Improvement Foundations (established under section
12 5008) and the State agencies designated to carry out cli-
13 ent advocacy activities pursuant to section **[**2106**]**.
14 (i) CONSTRUCTION.—Nothing in this section shall re-
15 place grievance procedures established or otherwise re-
16 quired under this Act.

17 **SEC. 5010. AUTHORIZATION OF APPROPRIATIONS.**

18 (a) NATIONAL QUALITY COUNCIL.—For the purpose
19 of carrying out this subtitle with respect to the establish-
20 ment and activities of the National Quality Council, there
21 are authorized to be appropriated $4,000,000 for each of
22 the fiscal years 1995 through 2000.
23 (b) QUALITY IMPROVEMENT FOUNDATIONS.—For
24 the purpose of carrying out section 5008, the are author-
25 ized to be appropriated $100,000,000 for fiscal year 1996,

1 $200,000,000 for fiscal year 1997, and $300,000,000 for
2 each of the fiscal years 1998 through 2000.
3 (c) CONSUMER INFORMATION AND ADVOCACY.—For
4 the purpose of carrying out section 5009, the are author-
5 ized to be appropriated $100,000,000 for fiscal year 1996,
6 $200,000,000 for fiscal year 1997, $300,000,000 for each
7 of the fiscal years 1998 through 2000, of which
8 $4,000,000 for each fiscal year shall be made available
9 to the National Center of Consumer Information and Ad-
10 vocacy.

11 **SEC. 5011. ROLE OF HEALTH PLANS IN QUALITY MANAGE-**
12 **MENT.**

13 Each health plan shall—
14 (1) measure and disclose performance on qual-
15 ity measures as designated by this Act;
16 (2) furnish information required under [subtitle
17 B of this title] and provide such other reports and
18 information on the quality of care delivered by
19 health care providers who are members of a provider
20 network of the plan (as defined in section
21 [1502(h)(3)]) as may be required under this Act;
22 and
23 (3) maintain quality management systems
24 that—

1 (A) use the national measures of quality
2 performance developed by the National Quality
3 Council under section 5003; and
4 (B) measure the quality of health care fur-
5 nished to enrollees under the plan by all health
6 care providers of the plan.

delete

7 **SEC. 5012. INFORMATION ON HEALTH CARE PROVIDERS.**

8 (a) STATE OBLIGATIONS.—Each State shall make
9 available to consumers, upon request, information con-
10 cerning providers of health care services or supplies. Such
11 information shall include—
12 (1) the identity of any provider that has been
13 convicted, under Federal or State law, of a criminal
14 offense relating to fraud, corruption, breach of fidu-
15 ciary responsibility, or other financial misconduct in
16 connection with the delivery of a health care service
17 or supply;
18 (2) the identity of any provider that has been
19 convicted, under Federal or State law, of a criminal
20 offense relating to neglect or abuse of patients in
21 connection with the delivery of a health care service
22 or supply;
23 (3) the identity of any provider that has been
24 convicted, under Federal or State law, of a criminal
25 offense relating to the unlawful manufacture, dis-

1 tribution, prescription, or dispensing of a controlled
2 substance; and
3 (4) the identity of any provide whose license to
4 provider health care services or supplies has been re-
5 voked, suspended, restricted, or not renewed, by a
6 State licensing authority for reasons relating to the
7 provider's professional competence, professional per-
8 formance, or financial integrity, or any provider who
9 surrendered such a license while a formal discipli-
10 nary proceeding was pending before such an author-
11 ity, if the proceeding concerned the provider's pro-
12 fessional competence, professional performance, or
13 financial integrity.
14 (b) PUBLIC AVAILABILITY OF INFORMATION IN NA-
15 TIONAL PRACTITIONER DATA BANK ON DEFENDANTS,
16 AWARDS, AND SETTLEMENTS.—
17 (1) IN GENERAL.—Section 427(a) of the Health
18 Care Quality Improvement Act (42 U.S.C. 11137
19 (a)) is amended by adding at the end the following
20 new sentence: "Not later the January 1, 1996, the
21 Secretary shall promulgate regulations under which
22 individuals seeking to enroll in health plans under
23 the Health Security Act shall be able to obtain infor-
24 mation reported under this part with respect to phy-
25 sicians and other licensed health practitioners par-

1 ticipating in such plans for whom information has
2 been reported under this part on repeated occa-
3 sions.".
4 (2) ACCESS TO DATA BANK FOR POINT-OF-
5 SERVICE CONTRACTORS UNDER MEDICARE.—Section
6 427(a) of such Act (42 U.S.C. 11137(a)) is
7 amended—
8 (A) by inserting "to sponsors of point-of-
9 service networks under section 1990 of the So-
10 cial Security Act,", and
11 (B) in the heading, by inserting "RELAT-
12 ED" after "CARE".
13 **SEC. 5013. CONFORMING AMENDMENTS TO PUBLIC**
14 **HEALTH SERVICE ACT.**
15 Title IX of the Public Health Service Act is
16 amended—
17 (1) in section 903(a)(4) (42 U.S.C. 299a–
18 1(a)(4)), by inserting "and Quality Improvement
19 Foundations" after "health agencies";
20 (2) in section 904(c)(1) (42 U.S.C. 299a–
21 2(c)(1)), by inserting "the National Quality Council
22 and" after "in consultation with";
23 (3) in section 912(b)(4) (42 U.S.C. 299b–
24 1(b)(4))—

1 (A) by inserting "outcomes," before
2 "risks"; and
3 (B) by inserting before the semicolon "to
4 the extent feasible given the availability of unbi-
5 ased, reliable, and valid data";
6 (4) in section 914 (42 U.S.C. 299b–3)—
7 (A) in subsection (a)(2)(B)—
8 (i) by inserting "the National Quality
9 Council," after "shall consult with"; and
10 (ii) by inserting before the period
11 "and relevant sections of the Health Secu-
12 rity Act";
13 (B) in subsection (c), by inserting "Quality
14 Improvement Foundations and other" after
15 "carried out through"; and
16 (C) in subsection (f)—
17 (i) by striking "TO ADMINISTRATOR"
18 in the subsection heading;
19 (ii) by striking "Administrator" and
20 inserting "National Quality Council and
21 the"; and
22 (5) in section 927 (42 U.S.C. 299c–6), by add-
23 ing at the end thereof the following new paragraphs:

1 "(5) The term 'National Quality Council' means
2 the Council established under section 5001 of the
3 Health Security Act.
4 "(6) The term "Quality Improvement Founda-
5 tions" means the Foundations established under sec-
6 tion 5008 of the Health Security Act.".

OFFICE OF PUBLIC LIAISON
THE WHITE HOUSE

MEMORANDUM FOR HAROLD ICKES
ALEXIS HERMAN
BOB RUBIN
IRA MAGAZINER
GREG LAWLER
CHRIS JENNINGS
JACK LEW
MIKE LUX

cc: STEVE HILTON

FROM: CAREN WILCOX

SUBJECT: ERISA/MULTI-STATE ISSUES

DATE: JULY 29, 1994

ERISA/STATE FLEXIBILITY/MANAGED CARE

A substantial group of companies including: Allied Signal, Ameritech, Amoco, ARCO, Bell Atlantic, Boeing, Cox Enterprises, Digital Equipment, Dow Chemical, DuPont, Eastman Kodak, General Electric, GTE Corporation, Hershey Foods, Intel, IBM, McDonnell Douglas, MCI, Pacific Telesis, Southwestern Bell, United parcel Service and U S West, have joined together in a coalition to maintain ERISA exempt multi-state plans.

These companies felt that the President had signalled them at the BRT speech that he understood their desire to operate multi-state plans and maintain ERISA. This speech was made following a discussion the President had with Mr. Gerstner, CEO of IBM.

They had signalled that they would find it difficult to continue to support universal coverage and employer mandate if they saw their ability to function independently significantly curtailed. They had been negotiating with a group of state officials and with members of Congress. They had obtained a letter via Mr. Tanner's office signed by many moderate Democrats indicating their support for these issues in health care reform.

This issue appeared to be reaching enough consensus to hold these 22 companies in the Corporate Health Care Coalition. This is after enormous work by the construction unions and companies since last night. However, we now understand that there may be difficulty due to a desire on the part of some parts of the unions to have enhanced state authority to pass stronger health plans.

State flexibility: they are still concerned about the loss of the groups of 5000 employees. Some of their interim issues seem to have been solved behind the scenes.

Discussions with staff for Feingold and Wellstone: they had discussions with these staffs on Friday. Theresa Alberghini of Leahy's staff was along.

> Results: agreement to find data about how many individuals would be removed from a statewide plan if groups of 5000 were exempt.
>
> Wellstone's or Feingold's staff apparently floated a population percentage exemption on the companies. If the company had 5000 but was a minuscule part of the population of a state, then they would be exempt. The companies rejected due to the fact that they believe that this would really force them into the single payer system of that state anyway. There may be some ground here for discussion however.

Managed Care: While they are concerned about any willing provider language under cutting their managed care networks, they know that there are behind the scenes discussions going on with the Black Caucus and they hope this will be resolved.

State interim solution: This is language developed by them, the Milbank state officials group and Leahy's staff, and they believe this is going to run.

These companies do not like the Finance bill and they are very concerned about having the cost shift reduced into legislative language, without a mandate to share the burden.

A few members of the group believe that a premium tax would lead to cost containment, but this is not an overriding issue with them.

This group is continuing to try hold on for the long run of health care reform, but they are also worried about results. They have been less supportive of the President's efforts than have the Pre-Medicare coalition companies.

We have continuously told this group that they would not get a total solution in these bills, or probably be entirely satisfied in the Conference. It is desirable not to have them join with the U.S. Chamber and others in opposition to the final bills, and therefore, we need to try to hold on to them as well even though they have not been as supportive.

Attachments: Letter to President Clinton, letter to Speaker Foley, response to Majority Leader draft

# CORPORATE HEALTH CARE COALITION

1133 Connecticut Ave., N.W., Suite 1200, Washington, DC 20036
(202) 775-9834 Phone (202) 833-8491 Fax

AlliedSignal Inc.
Ameritech
Amoco Corporation
Atlantic Richfield Company
Bell Atlantic
The Boeing Company
Cox Enterprises, Inc.
Digital Equipment Corporation
Dow Chemical Company
DuPont Company
Eastman Kodak Company
General Electric Company
GTE Corporation
Hershey Foods Corporation
Intel Corporation
International Business Machines Corporation
McDonnell Douglas Corporation
MCI Communications Corporation
Pacific Telesis Group
Southwestern Bell Corporation
United Parcel Service
U S West Inc.

July 18, 1994

The Honorable William J. Clinton
The White House
1600 Pennsylvania Avenue, N.W.
Washington, DC 20500

Dear Mr. President:

As leaders of some of the largest Fortune 500 companies, we have supported the health care reform goals of controlling costs and achieving universal coverage. We have assumed the foundation for any national reform would be the successful comprehensive health plans that large, multistate employers provide for their employees and their dependents. As we have worked to help move health care reform through the committees of the Congress, we have become increasingly concerned that the emerging legislation would make it difficult, if not impossible, for us to continue operating our plans or managing our costs.

Our companies are committed to providing quality, cost effective health benefits for our employees and their dependents. This commitment is consistent with, and indeed, fundamental to, the goals of universal coverage and cost containment. We cannot support health care reform that conflicts with these goals by putting our health plan and our employees' health care benefits at risk.

Specifically, legislation that would give the states the flexibility to independently design their own health care systems not only would undermine national reform, but also would undermine our companies' national cost containment strategies. A major reason for our support of national reform this year is to preserve federal governance of our multistate plans, which now occurs under ERISA. National reform that grants new state authority over our plans is far worse for us than no reform.

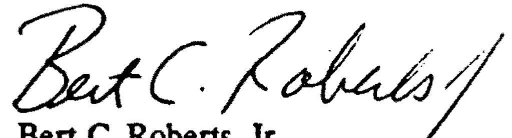
Emerging legislation would also undo the success we have had in controlling costs by placing prohibitions on provider selection and other managed care techniques that have been integral to our success. The new "anti-managed-care" provisions which some committees have adopted would eliminate our ability to manage our programs and substantially raise our costs and national health expenditures as well.

Moreover, it is unreasonable to impose new taxes or assessments on those who already pay for the millions of uninsured Americans through cost shifting, if the Congress is unwilling to impose any obligations on employers and individuals who now pay nothing. Additional financing for "social responsibility" is acceptable only if it is society wide and only in the context of universal coverage.

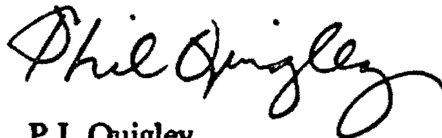
As health care reform moves to the congressional leadership and the House and Senate floors, we ask for your assistance in ensuring that the efforts of large, multistate employers are not undermined and the goals of health care reform undercut by the final bills presented to the full House and Senate.

Sincerely,

Robert B. Palmer
President and
Chief Executive Officer
Digital Equipment Corporation



Bert C. Roberts, Jr.
Chairman and Chief Executive
Officer
MCI Communications Corp.



P.J. Quigley
Chairman, President and
Chief Executive Officer
Pacific Telesis Group

Louis V. Gerstner, Jr.
Chairman of the Board and
Chief Executive Officer
International Business
Machines Corporation

Richard C. Notebaert
Chairman and Chief
Executive Officer
Ameritech

Ray Smith
Chairman and Chief
Executive Officer
Bell Atlantic

Frank P. Popoff
Chairman and Chief
Executive Officer
Dow Chemical Company

Larry Fuller
Chairman and Chief
Executive Officer
Amoco Corporation

Richard D. McCormick
Chairman of the Board and
Chief Executive Officer
U S West Incorporated

Edward E. Whitacre, Jr.
Chairman and Chief
Executive Officer
Southwestern Bell Corporation

Edgar S. Woolard, Jr.
Chairman and Chief
Executive Officer
DuPont Company

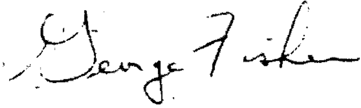
Kenneth L. Wolfe
Chairman and Chief
Executive Officer
Hershey Foods Corporation

Larry Bossidy
Chairman and Chief
Executive Officer
AlliedSignal, Inc.

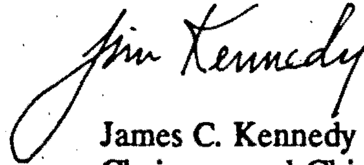
Gorden E. Moore
Chairman
Intel Corporation

Kent C. Nelson
Chairman and Chief
Executive Officer
United Parcel Service

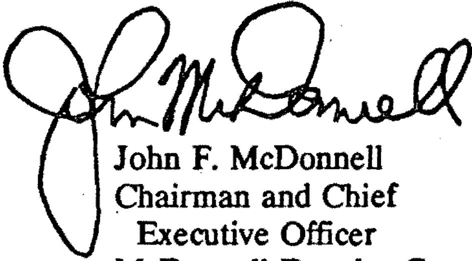
Charles R. Lee
Chairman of the Board
and Chief Executive Officer
GTE Corporation



George M.C. Fisher
Chairman, President
and Chief Executive Officer
Eastman Kodak Company

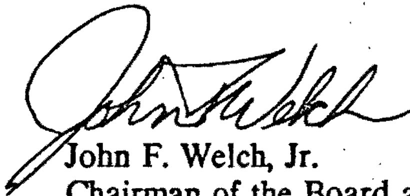


James C. Kennedy
Chairman and Chief
Executive Officer
Cox Enterprises, Inc.



John F. McDonnell
Chairman and Chief
Executive Officer
McDonnell Douglas Corporation

Frank Shrontz
Chairman and Chief
Executive Officer
The Boeing Company



John F. Welch, Jr.
Chairman of the Board and
Chief Executive Officer
General Electric Company

JOHN TANNER
8TH DISTRICT
TENNESSEE

COMMITTEES:
ARMED SERVICES
SCIENCE, SPACE, AND TECHNOLOGY

# Congress of the United States
## House of Representatives
### Washington, D.C. 20515-4208

July 19, 1994

Honorable Thomas S. Foley
Speaker Of The House
H209, The Capitol
Washington, D.C. 20515

Dear Mr. Speaker:

The principal House Committees of jurisdiction over health care reform have completed their markups. As a result, we all look forward to the opportunity to continue the debate and vote upon the important issues that the Committees have had under consideration.

We are concerned, however, that an issue of critical importance to us--the national uniform treatment of multi-state health care plans--will not be resolved satisfactorily in any of the Committees. Should that prove to be the case, we want to serve early notice that we will have great difficulty supporting the product of the Committees on the floor of the House, or supporting a rule that precludes an amendment addressing this important issue.

Thousands of our constituents participate in multi-state employer and Taft Hartley health care plans under which the goals of excellent health care coverage and rigorous cost containment have been achieved. We believe that plans which achieve these two goals should be encouraged to continue their efforts under any new legislation, as they have since the enactment of ERISA in 1974.

If the current system of uniform national treatment is undermined, multi-state employers and their employees will be subject to a wide variety of requirements and mandates in all fifty states. Over time, administrative complexity will become unmanageable, and plan costs due to increased liability and higher overhead will compromise the fiscal and management integrity of the plans. Perhaps even more damaging, hundreds of thousands of employees and their families will suffer as it becomes increasingly difficult to accept promotions and transfers where relocation is required. Employee health care and morale will decline as the differences in health benefits among states proliferate.

1427 LONGWORTH BUILDING
WASHINGTON, D.C. 20515
(202) 225-4714

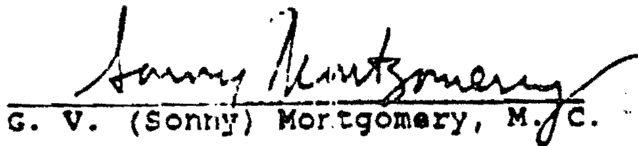
POST OFFICE BOX 629
203 WEST CHURCH STREET
UNION CITY, TN 38261
(901) 885-7070

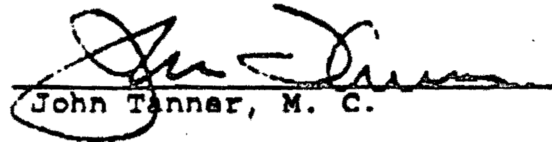
ROOM B-7, FEDERAL BUILDING
JACKSON, TN 38301
(901) 423-4848

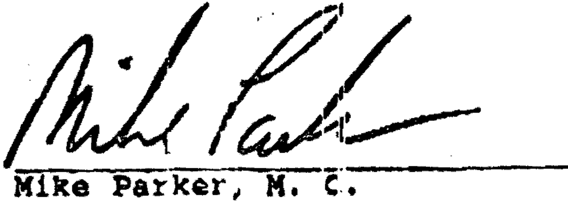
2850 COLEMAN ROAD
MEMPHIS, TN 38128
(901) 382-3220

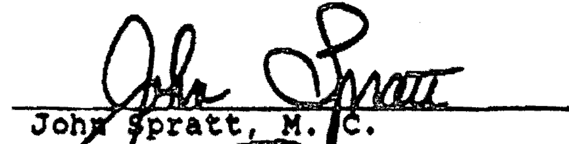
Mr. Speaker, abandonment of the national uniformity principle is certain to reduce the coverage for hundreds of thousands of employees and their families, while driving up costs for thousands of multi-state employers. We hope that you will use your best efforts and that of the House Leadership to maintain the national uniformity principle in the emerging health care reform bill.

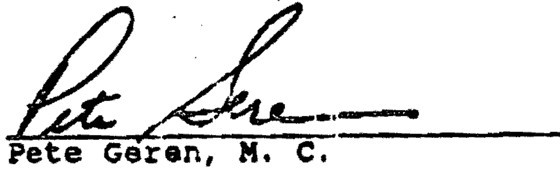
Sincerely,

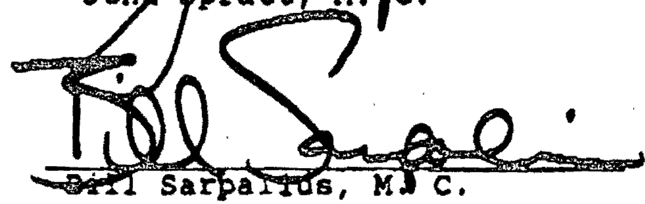

G. V. (Sonny) Montgomery, M. C.

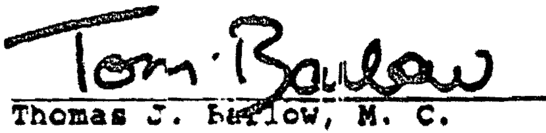

John Tanner, M. C.

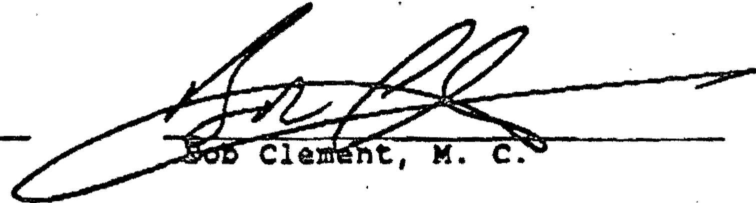

Mike Parker, M. C.

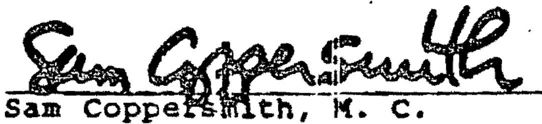

John Spratt, M. C.

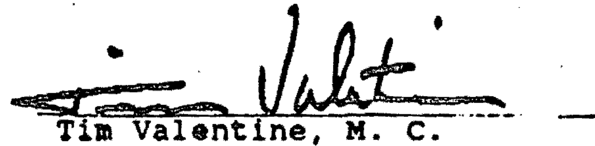

Pete Geren, M. C.

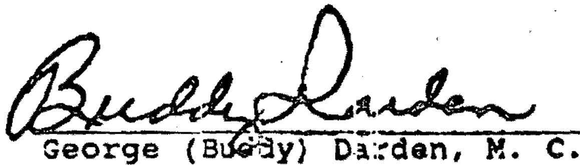

Bill Sarpalius, M. C.

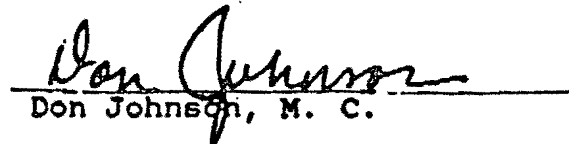

Thomas J. Barlow, M. C.


Bob Clement, M. C.

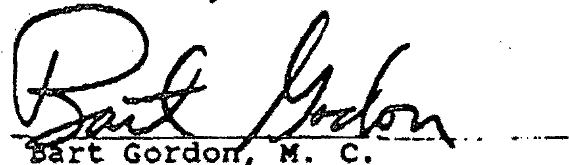

Sam Coppersmith, M. C.

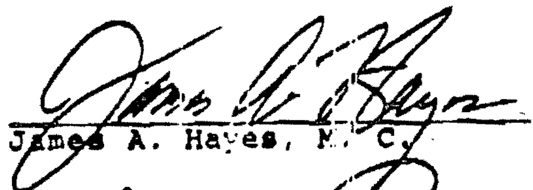

Tim Valentine, M. C.


George (Buddy) Darden, M. C.

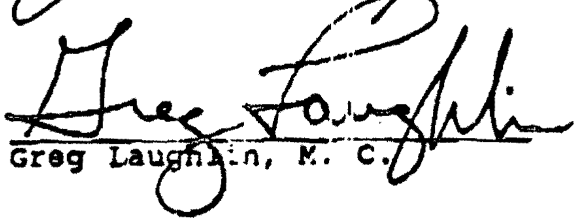

Don Johnson, M. C.

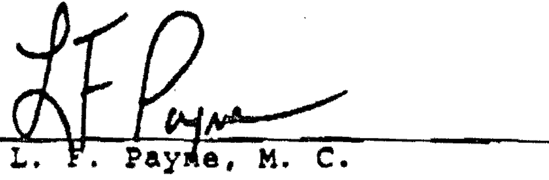
Earl Hutto, M. C.

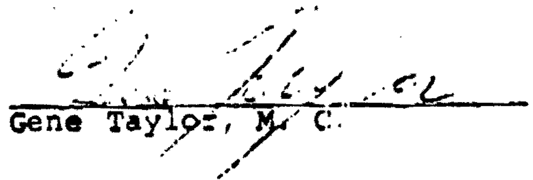

Bart Gordon, M. C.

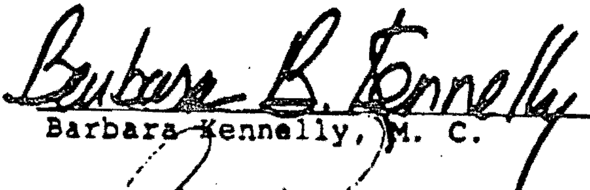

James A. Hayes, M. C.

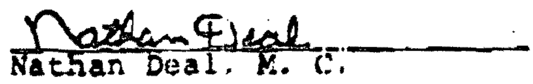
Marilyn Lloyd, M. C.

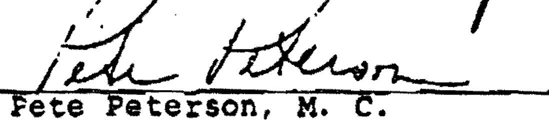

Greg Laughlin, M. C.

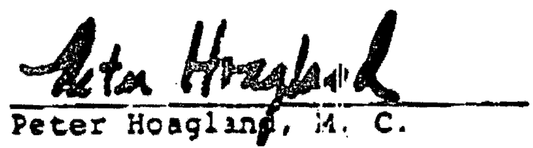

L. F. Payne, M. C.

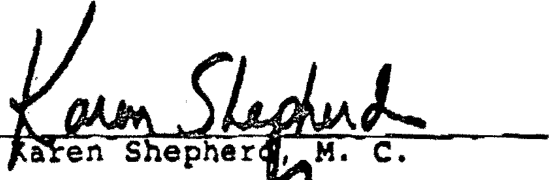

Gene Taylor, M. C.

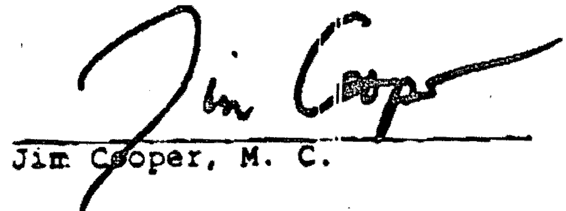

Barbara Kennelly, M. C.

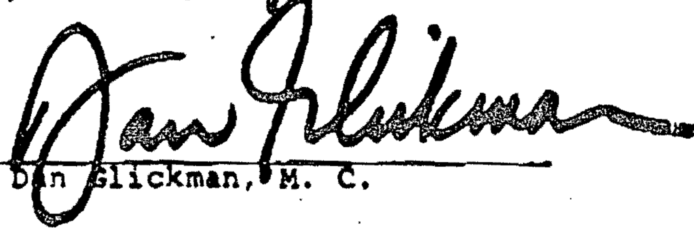

Nathan Deal, M. C.

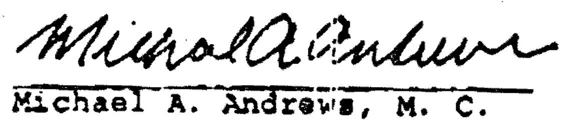

Pete Peterson, M. C.

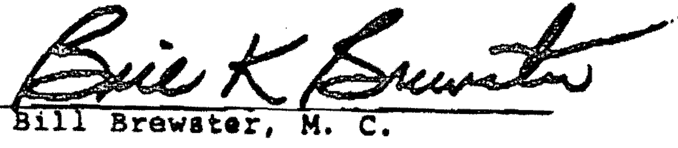

Peter Hoagland, M. C.


Karen Shepherd, M. C.


Jim Cooper, M. C.


Dan Glickman, M. C.


Michael A. Andrews, M. C.


Bill Brewster, M. C.

cc: The Honorable Richard Gephardt
The Honorable David Bonior
The Honorable Joseph Moakley

# CORPORATE HEALTH CARE COALITION

## RESPONSE TO THE JULY 25TH MAJORITY LEADER DRAFT
## JULY 28, 1994

The Corporate Health Care Coalition (CHCC) has supported health care reform legislation that would achieve universal coverage and control health care costs through an employer-based system. To achieve this goal, legislation must retain and strengthen the foundation of our current system – the plans sponsored by large, multistate employers.

Because it would interfere with the ability of multistate employers to continue providing health plans, the Coalition strongly opposes, and would work to defeat, the June 25th draft "Summary of Agreement" circulated by Mr. Gephardt. Despite the fact that this draft retains the structure of universal coverage and financing from the House Ways and Means bill which the Coalition supports, it contains a large number of other provisions that would create serious, if not fatal, problems for multistate employers and for their managed care plans.

Of these problem provisions, two are of critical importance to the Coalition and must be resolved as a precondition for Coalition support.

- State flexibility: The draft retains the unacceptable language on state flexibility and state ratesetting from the House Ways and Means bill and eliminates the exemption the Committee provided for firms with 5,000 or more employees.

  The Coalition proposes responding to state needs for flexibility by protecting existing state waivers and providing states the option for early implementation of national reform – as provided in language prepared by the Senate majority leader in conjunction with state and large company leaders.

  The Coalition further proposes modifying the state flexibility language to eliminate any options for the state other than the option to implement a pure single-payer system, and reinstating the exemption for firms of 5,000 or more employees from single-payer.

- Managed care: The draft undercuts the ability of employers to use managed care plans to control costs by requiring that plans accept any willing provider and contract with a wide array of essential community providers.

  The Coalition proposes eliminating the language that would require plans to accept any willing provider, and modifying the essential community provider language to meet the needs of rural and minority providers.

*AlliedSignal Ameritech Amoco ARCO Bell Atlantic Boeing Cox Enterprises Digital Equipment Dow Chemical DuPont Eastman Kodak General Electric GTE Corporation Hershey Foods Intel IBM McDonnell Douglas MCI Pacific Telesis Southwestern Bell United Parcel Service U S WEST*

1:30 PM

Draft ~~10 AM~~ 7/15/94 Description of Proposal

A. STATE FLEXIBILITY/GENERAL PROVISIONS

This Act will define what constitutes a state-regulated and a federally-regulated plan. Federally-regulated plans will be required to meet new Federal standards with respect to benefits, solvency, cost-sharing, data collection and other standards as specified in the Act.

States that already have taken steps to reform their health care systems and have been granted flexibility by Federal law, i.e., under Medicare, Medicaid or ERISA, will be permitted to continue to operate their systems with this flexibility.

B. EARLY IMPLEMENTATION OF COMPREHENSIVE STATE PROGRAMS

States that are able to demonstrate to a Federal agency that they have the capacity to move forward with early implementation of the national health care reform plan should be allowed to do so. The actions of these States will benefit the entire nation and should receive appropriate Federal support and cooperation.

Eligibility. To be eligible for this early implementation program, a State must enact legislation that is consistent with the national plan and present to a joint body composed of representatives of the Department of Labor and the Department of Health and Human Services a plan for implementation. This joint body shall be established within 60 days after enactment.

The areas in which a State must demonstrate that its comprehensive program is consistent with the national plan include:

-- benefits package (In the event that Federal benefit standards are set by a health board or regulatory agency rather than statute, plans meeting the Federal benefit standards for a federally-qualified HMO would be considered to be in good faith compliance during the transition period until the benefits are fully defined.)

-- insurance reforms and rating requirements

-- standards for health plans and purchasing cooperatives

-- data collection and uniform administrative procedures

-- employer and individual responsibilities

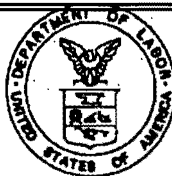
-- cost containment

Absent Federal regulations, the joint DOL/HHS body will develop interim standards, in consultation with the States and large, multi-state employers.

<u>Approval Process.</u> The joint DOL/HHS body has 90 days to approve or reject a State application and is required to notify multi-state employers when a State application has been approved.

<u>Employer Certification Process.</u> For purposes of compliance with State early implementation programs, employers with Federally-regulated plans must be certified by DOL to be in compliance with Federal standards described above. Upon enactment of national legislation, such an employer can at any time seek certification from DOL that it is in compliance with Federal standards, but in any case, must be certified with regard to a particular State by the effective date of that State's approved program.

<u>Financing.</u> From Federal revenues raised by this Act, (excluding Medicare and Medicaid savings and sin taxes), approved States will receive Federal funds, as determined in the approval process, to provide subsidies, cover medical education costs, and meet other costs associated with implementing the State program.




**UNITED STATES DEPARTMENT OF LABOR**

**FACSIMILE TRANSMISSION**

**OFFICE OF CONGRESSIONAL AND INTERGOVERNMENTAL AFFAIRS**

200 Constitution Avenue,
N.W.
Room S-1325
Washington, DC 20210

Confirmation:
202/219-6141

June 2, 1994/6:50pm

**TO: CHRIS JENNINGS** ATT: STACEY

**DEPARTMENT/COMPANY: WHITE HOUSE**

**FACSIMILE NUMBER:** 456-7431

**FROM: MONICA HEALY**

**NUMBER OF PAGES INCLUDING COVER:** 23

**FACSIMILE REPLIES:**

| | |
|---|---|
| CONGRESSIONAL AFFAIRS | 202/219-5120 |
| INTERGOVERNMENTAL AFFAIRS | 202/219-5736 |
| IMMEDIATE OFFICE OF THE ASSISTANT SECRETARY | 202/219-5288 |

*MESSAGE:*

*Chris,*

*The Kennedy staff gave this to me tonight to review. It's the Bingaman proposed compromise amendment that I told you about the other day, dealing with mandates, alliances and MEWA's. You may already have it but in case you don't, I thought it would be helpful for you to know what's in it.*

*Monica*

1 Purchasing Group and as an independent third party contractor
2 as described in (a) within a given HCCA.
3 **Subtitle E-Large Employer Health Plans**
4 **PART 1-REQUIREMENTS ON LARGE EMPLOYER PLANS**
5 **SEC. 1401. STANDARDS APPLIED TO LARGE EMPLOYER SPONSOR.**
6 (a) IN GENERAL.-Each large employer sponsor shall meet
7 the applicable standards developed under section 1402.
8 (b) DEFINITION.-As used in this subtitle:
9 (1) GROUP HEALTH PLAN.-The term "group health plan"
10 means an employee welfare benefit plan (as defined in
11 section 3(1) of the Employee Retirement Income Security
12 Act of 1974) providing medical care (as defined in
13 section 213(d) of the Internal Revenue Code of 1986) to
14 participants or beneficiaries (as defined in section 3
15 of the Employee Retirement Income Security Act of 1974)
16 directly or through insurance, reimbursement, or
17 otherwise.
18 (2) LARGE GROUP SPONSOR.-The term "large group
19 sponsor" means an eligible sponsor that elects, in a
20 form and manner specified by the Secretary of Labor,
21 consistent with this subpart, to be treated as a large
22 group sponsor under this title and that does not have
23 such and election terminated under section 1405. A
24 large group sponsor may offer a State qualified health
25 plan or a self-insured plan that maintains enrollment of
26 at least 500 individuals.

1 paragraph (2). The Secretary shall develop and publish
2 such standards by not later than the date that is six
3 months after the date of enactment of this Act. Such
4 standards shall be the certified health plan standards
5 applicable under this part.
6 (2) REQUIREMENTS SPECIFIED.-Subject to paragraph
7 (3), the requirements referred to in paragraph (1) are
8 requirements specified in the following provisions:
9 (A) Section 1515 (relating to guaranteed
10 eligibility), except that such subsection shall be
11 applied (for purposes of this subsection) only with
12 respect to eligible employees of the large
13 employer.
14 (B) Section 1504 (relating to non-
15 discrimination based on health status).
16 (C) Section 1502 (relating to benefits).
17 (D) Section 1515 (relating to enrollment) or
18 establish such comparable enrollment procedures as
19 the Secretary of Labor specifies.
20 (E) Section 1503 (relating to collection and
21 provision of standardized information).
22 (F) Section 1510 (relating to quality
23 assurance).
24 (3) COLLECTIVE BARGAINING EXCEPTION.-Paragraph
25 (2)(A) shall not apply to a large employer plan that is

1 (3) MULTIEMPLOYER PLAN.-The term "multiemployer
2 plan" has the meaning given such term in section 3(37)
3 of the Employee Retirement Income Security Act of 1974,
4 and includes any plan that is treated as such a plan
5 under title I of such Act.
6 (4) PLAN SPONSOR OF A MULTIEMPLOYER PLAN.-The term
7 "plan sponsor of a multiemployer plan" means a plan
8 sponsor described in section 3(16)(B)(iii) of the
9 Employee Retirement Income Security Act of 1974, but
10 only with respect to a group health plan that is a
11 multiemployer plan and only if-
12 (A) such plan provided health benefits as of
13 September 1, 1993; and
14 (B) such plan is maintained by one or more
15 affiliates of labor organizations representing
16 employees in the same industry.
17 Each large employer plan shall meet the applicable
18 standards developed under section 1402.
19 **SEC. 1402. ESTABLISHMENT OF STANDARDS APPLICABLE TO**
20 **LARGE EMPLOYER PLANS.**
21 (a) ESTABLISHMENT OF STANDARDS BY SECRETARY OF HEALTH
22 AND HUMAN SERVICES.-
23 (1) IN GENERAL.-The Secretary of Health and Human
24 Services, in consultation with the Secretary of Labor,
25 shall develop and publish standards applicable to large
26 employer plans relating to the requirements described in

1 providing benefits pursuant to a collective bargaining
2 agreement.
3 (b) ESTABLISHMENT OF STANDARDS BY SECRETARY OF LABOR.-
4 (1) IN GENERAL.-The Secretary of Labor, in
5 consultation with the Secretary of Health and Human
6 Services, shall develop and publish standards applicable
7 to large employer plans relating to the requirements
8 specified in paragraph (2). The Secretary shall develop
9 and publish such standards by not later than the date
10 that is six months after the date of enactment of this
11 Act. Such standards shall be the certified health plan
12 standards applicable under this part.
13 (2) REQUIREMENTS SPECIFIED.-Subject to paragraph
14 (3), the requirements referred to in paragraph (1) are
15 comparable to requirements specified in the following
16 provisions:
17 (A) Section 1506 (relating to financial
18 solvency) or such standards similar to the
19 standards established under such section as the
20 Secretary of Labor specifies, except that such
21 standards shall be consistent with the applicable
22 rules under section 414 of the Employee Retirement
23 Income Security Act of 1974.
24 (B) Section 1505 (relating to use of standard
25 premiums) except that large employer groups may
26 utilize experience-rating.

1 (C) Section 1508 (relating to grievance
2 procedures).
3 (D) Section 1403 (relating to required offer
4 of different benefit packages).
5 (3) COLLECTIVE BARGAINING EXCEPTION.-Paragraph
6 (2)(A) shall not apply to a large employer plan that is
7 providing benefits pursuant to a collective bargaining
8 agreement.
9 (c) CONSIDERATION OF NAIC STANDARDS.-In establishing
10 standards under this section, the Secretary of Health and
11 Human Services and the Secretary of Labor shall take into
12 account standards established under section 1501 of Subtitle
13 F relating to comparable requirements.
14 (d) APPLICATION OF STANDARDS TO HEALTH PLANS OFFERED
15 UNDER FEHBP.-Notwithstanding any other provision of law, each
16 health plan offered under chapter 89 of title 5, United
17 States Code, shall meet the standards applicable to large
18 employer plans under this Subtitle, in the same manner and as
19 of the same date such standards first apply to such plans.
20 **SEC. 1403. OFFER OF DIFFERENT BENEFIT PACKAGES REQUIRED.**
21 (a) IN GENERAL.-Each large employer shall make available
22 to each eligible employee at least 3 health plans-
23 (1) a qualified large employer plan that includes
24 at least one fee-for-service plan, and

1 (2) a qualified large employer plan that includes
2 at least two health plans that are not fee-for-service
3 plans.
4 (b) SELECTION OF PLANS BY MAJORITY OF EMPLOYEES.-
5 (1) IN GENERAL.-The large employer shall make the
6 selections of qualified large employer plans under
7 subparagraphs (1) and (2) of subsection (a) on an annual
8 basis. In making each such selection, the large
9 employer shall comply with any selection of a qualified
10 large employer plan made by at least 50 percent of the
11 eligible employees of the large employer. The Secretary
12 of Labor shall prescribe rules which shall govern the
13 manner in which employees may make such a selection.
14 Nothing in this subsection shall be construed to require
15 an employer to make a qualified large employer plan or
16 for such an employer to refuse to offer such a plan for
17 good cause.
18 (2) LIMITATION.-Paragraph (1) shall not apply in
19 the case of a large employer that contributes to the
20 cost of the qualified large employer plan.
21 (c) CONTRACTS WITH PLANS.-Each large group sponsor may-
22 (1) negotiate with a State qualified health plan to
23 enter into a contract with the plan for the enrollment
24 of such individuals under the plan; or
25 (2) offer to individuals an appropriate self-
26 insured plan.

1 (d) In the case of an individual who qualifies for
2 coverage under large employer plan (and is not eligible for
3 coverage under an equivalent health care program or under a
4 qualified health plan that is not a large employer plan), the
5 individual shall satisfy the requirement of this Act
6 (relating to universal coverage) through enrollment in the
7 large employer plan.

8 **SEC. 1404. DEVELOPMENT OF LARGE OR MULTIPLE EMPLOYER**
9 **PURCHASING GROUPS.**

10 (a) IN GENERAL.-Nothing in this subtitle shall be
11 construed as prohibiting two or more large employers from
12 forming a purchasing group with respect to the employees of
13 such employer or employers. Such entities shall comply with
14 the requirements applicable to large group sponsors under
15 this subtitle.

16 (b) NO USE OF INDIVIDUAL AND SMALL EMPLOYER PURCHASING
17 GROUPS.-A large employer shall be ineligible to purchase
18 health insurance through an individual and small employer
19 Purchasing Group (defined in Subtitle D).

20 **SEC. 1405. CORRECTIVE ACTIONS.**

21 (a) IN GENERAL.-The plan sponsor of each large employer
22 plan shall determine semiannually whether the requirements of
23 this part are met. In any case in which the plan sponsor
24 determines that there is reason to believe that there is or
25 will be a failure to meet such requirements, or the Secretary
26 or the Secretary of Labor makes such a determination and so

1 notifies the plan sponsor, the plan sponsor shall, within 90
2 days after making such determination or receiving such
3 notification, notify such Secretary (in such form and manner
4 as such Secretary may prescribe by regulation) of a
5 description of the corrective actions (if any) that the plan
6 sponsor has taken or plans to take in response to such
7 recommendations. The plan sponsor shall thereafter report to
8 such Secretary, in such form and frequency as such Secretary
9 may specify to the plan sponsor, regarding corrective action
10 taken by the plan sponsor until such requirements are met.
11 Either such Secretary may make a determination that a large
12 employer plan has ceased to be a qualified large employer
13 plan only if such Secretary is satisfied that the necessary
14 corrective action cannot reasonably be expected to occur on a
15 timely basis necessary to avoid failure to provide benefits
16 of which the plan is obligated.
17 (b) DISQUALIFIED OR TERMINATION OF PLAN.-
18 (1) IN GENERAL.-In any case in which the plan
19 sponsor of a large employer plan determines that there
20 is reason to believe that the plan will cease to be a
21 qualified large employer plan or will terminate, the
22 plan sponsor shall so inform the Secretary and the
23 Secretary of Labor, shall develop a plan for winding up
24 the affairs of the plan in connection with such
25 disqualification or termination in a manner which will
26 result in timely payment of all benefits for which the

1 plan is obligated, and shall submit such plan in writing
2 to such Secretaries. Actions required under this
3 subparagraph shall be taken in such form and manner as
4 may be prescribed in regulations jointly prescribed by
5 such Secretaries.
6 (2) ACTIONS REQUIRED IN CONNECTION WITH
7 DISQUALIFICATION OR TERMINATION.-
8 (A) IN GENERAL.-In any case in which-
9 (i) the Secretary or the Secretary of
10 Labor has been notified under paragraph (1) of
11 a failure of a large employer plan to meet the
12 requirements of this part and has not been
13 notified by the plan sponsor that corrective
14 action has restored compliance with such
15 requirements, and
16 (ii) such Secretary determines, in
17 consultation with the other Secretary referred
18 to in clause (i), that the continuing failure
19 to meet such requirements can be reasonably
20 expected to result in a continuing failure to
21 pay benefits for which the plan is obligated,
22 the plan sponsor and the large employer shall
23 comply with the requirements of subparagraph (B) or
24 (C), as applicable.
25 (B) ACTIONS BY PLAN SPONSOR.-Upon a
26 determination by the Secretary or the Secretary of

1 Labor under subparagraph (A)(ii), the plan sponsor
2 shall, at the direction of such Secretary,
3 terminate the plan and, in the course of the
4 termination, take such actions as such Secretary,
5 in consultation with the other Secretary referred
6 to in subparagraph (A)(i), may require as necessary
7 to ensure that the affairs of the plan will be, to
8 the maximum extent possible, wound up in a manner
9 which will result in timely payment of all benefits
10 for which the plan is obligated.
11 (C) ACTIONS BY LARGE EMPLOYER.-Upon a
12 determination by the Secretary or the Secretary of
13 Labor under subparagraph (A)(ii), the large
14 employer shall provide for such contingency
15 coverage for all eligible employees of the employer
16 in accordance with regulations which shall be
17 prescribed in joint regulations of such
18 Secretaries. Such regulations may provide for
19 temporary coverage of such employees under a plan
20 provided by a purchasing group in the appropriate
21 HCCA, a plan provided under chapter 89 of title 5,
22 United States Code, or other appropriate means
23 established in such regulations.".
24 **PART 2-AMENDMENTS TO ERISA**
25 **SEC. 1421. LIMITATION ON COVERAGE OF GROUP HEALTH PLANS**
26 **UNDER TITLE I OF ERISA.**

1 (a) IN GENERAL.-Section 4 of the Employee Retirement
2 Income Security Act of 1974 (29 U.S.C. 1003) is amended-
3 (1) in subsection (a), by striking "subsection (b)"
4 and inserting "subsections (b) and (c)";
5 (2) in subsection (b), by striking "The provisions"
6 and inserting "Except as provided in subsection (c), the
7 provisions"; and
8 (3) by adding at the end the following new
9 subsection:
10 "(c) COVERAGE OF GROUP HEALTH PLANS.-
11 "(1) LIMITED INCLUSION.-This title shall apply to a
12 group health plan to the extent provided in this
13 subsection. For purposes of this title, a plan, fund,
14 or program shall not be treated as a group health plan
15 solely because an employer makes the plan available (and
16 takes related actions) in compliance with the applicable
17 requirements of the Health Security Act of 1994.
18 "(2) COVERAGE UNDER CERTAIN PROVISIONS WITH RESPECT
19 TO LARGE EMPLOYER PLANS.-
20 "(A) IN GENERAL.-Except as provided in
21 subparagraph (B), parts 1 (relating to reporting
22 and disclosure) and 4 (relating to fiduciary
23 responsibility) of subtitle B shall apply to a
24 large employer plan.
25 "(B) IN APPLICABILITY WITH RESPECT TO INSURED
26 QUALIFIED HEALTH PLANS.-Subparagraph (A) shall not

1 apply with respect to any employee welfare benefit
2 plan to the extent such plan provides for health
3 benefits under or through a qualified insured
4 health plan.
5 "(3) CLAIMS PROCEDURES.-Section 503 shall apply the
6 case of any large employer plan.
7 "(4) CIVIL ACTIONS BY PARTICIPANTS, BENEFICIARIES,
8 AND FIDUCIARIES AND BY THE SECRETARY.-Section 502 shall
9 apply in the case of any large employer plan and any
10 other group health plan for which the plan sponsor makes
11 a contribution.
12 "(5) DEFINITIONS AND ENFORCEMENT PROVISIONS.-
13 Sections 3, 501, 504, 505, 506, 510, and 511 and the
14 preceding provisions of this section shall apply to a
15 group health plan to the extent necessary to effectively
16 carry out, and enforce the requirements under, the
17 provisions of this title as they apply pursuant to this
18 subsection.
19 "(6) APPLICABILITY OF PREEMPTION RULES.-Section 514
20 shall apply in the case of any group health plan to the
21 extent that parts 1 (relating to reporting and
22 disclosure) and 4 (relating to fiduciary responsibility)
23 of subtitle B apply to such plan under paragraph (2).".
24 (b) REPORTING AND DISCLOSURE REQUIREMENTS APPLICABLE TO
25 GROUP HEALTH PLANS.-

1 (1) IN GENERAL.-Part 1 of subtitle B of title I of
2 such Act is amended-
3 (A) in the heading for section 110, by adding
4 "BY PENSION PLANS" at the end;
5 (B) by redesignating section 111 as section
6 112; and
7 (C) by inserting after section 110 the
8 following new section:
9 "SPECIAL RULES FOR GROUP HEALTH PLANS
10 "SEC. 111. IN GENERAL.-The Secretary may by regulation
11 provide special rules for the application of this part to
12 group health plans which are consistent with the purposes of
13 this title and the Health Security Act of 1994 and which take
14 into account the special needs of participants,
15 beneficiaries, and health care providers under such plans.
16 "(b) EXPEDITIOUS REPORTING AND DISCLOSURE.-Such special
17 rules may include rules providing for-
18 "(1) reductions in the periods of time referred to
19 in this part,
20 "(2) increases in the frequency of reports and
21 disclosures required under this part, and
22 "(3) such other changes in the provisions of this
23 part as may result in more expeditious reporting and
24 disclosure of plan terms and changes in such terms to
25 the Secretary and to plan participants and
26 beneficiaries,

1 to the extent that the Secretary determines that the rules
2 described in this subsection are necessary to ensure timely
3 reporting and disclosure of information consistent with the
4 purposes of this part and the Health Security Act of 1994 as
5 they relate to group health plans.
6 "(c) ADDITIONAL REQUIREMENTS.-Such special rules may
7 include rules providing for reporting and disclosure to the
8 Secretary and to participants and beneficiaries of additional
9 information or at additional times with respect to group
10 health plans to which this part applies under section
11 4(c)(2), if such reporting and disclosure would be comparable
12 to and consistent with similar requirements applicable under
13 the Health Security Act of 1994 with respect to small
14 employer plans and applicable regulations of the Secretary of
15 Health and Human Services prescribed thereunder.".
16 (2) CLERICAL AMENDMENT.-The table of contents in
17 section 1 of such Act is amended by striking the items
18 relating to sections 110 and 111 and inserting the
19 following new items:
20 "Sec. 110. Alternative methods of compliance by pension
21 plans.
22 "Sec. 111. Special rules for group health plans.
23 "Sec. 112. Repeal and effective date.".
24 (c) TREATMENT OF MULTIPLE EMPLOYER WELFARE
25 ARRANGEMENTS.-

1 (1) INAPPLICABILITY OF PREEMPTION RULES.-Section
2 514(b)(6)(A) of such Act (29 U.S.C. 1144(b)(6)(A)) is
3 amended by adding at the end (after and below clause
4 (ii)) the following new sentence:
5 "This paragraph shall not apply in the case of a group health
6 plan.".
7 (2) TRANSITIONAL RULES FOR EXISTING MULTIPLE
8 EMPLOYER WELFARE ARRANGEMENT PROVIDING HEALTH BENEFITS.
9 (A) IN GENERAL.-Subject to subparagraph (B),
10 any multiple employer welfare arrangement which has
11 commenced operations on or before January 1, 1994,
12 and with respect to which there is in effect a
13 certification by the Secretary of Labor under this
14 paragraph shall be treated for purposes of this
15 title as a large employer plan.
16 (B) REQUIREMENTS.-Subparagraph (A) shall apply
17 to a multiple employer welfare arrangement only if-
18 (i) the benefits provided under the
19 arrangement consist solely of medical care (as
20 defined in section 213(d) of the Internal
21 Revenue Code of 1986),
22 (ii) such arrangement meets the
23 requirements of clause (i) of section
24 514(b)(6)(A) of the Employee Retirement Income
25 Security Act of 1974 (as in effect immediately
26 before the amendment made by paragraph (1)),

1 (iii) the sponsoring entity is organized
2 and maintained in good faith, with a
3 constitution and bylaws specifically stating
4 its purpose, as a trade association, an
5 industry association, a professional
6 association, or a chamber of commerce or other
7 business group, for substantial purposes other
8 than that of obtaining or providing medical
9 care described in section 213(d) of the
10 Internal Revenue Code of 1986, and the
11 applicant demonstrates to the satisfaction of
12 the Secretary that the sponsoring entity is
13 established as a permanent entity which
14 receives the active support of its members,
15 and
16 (iv) the sponsoring entity is not
17 enrolling members in a manner that
18 discriminates on the basis of health status.
19 (C) PROHIBITION ON COMMENCEMENT OF NEW
20 ARRANGEMENTS.-No multiple employer welfare
21 arrangement providing benefits which consist of
22 medical care (as defined in section 213(d) of the
23 Internal Revenue Code of 1986) which has not
24 commenced operations as of January 1, 1994, may
25 operate after such date.

1 (D) CERTIFICATION PROCEDURE.-The Secretary of
2 Labor shall certify, for a period of five-years
3 only, a multiple employer welfare arrangement under
4 this paragraph if-
5 (i) an application for such certification
6 with respect to such arrangement, identified
7 individually or by class, has been duly filed
8 in complete form with the Secretary of Labor
9 in accordance with this paragraph,
10 (ii) such application demonstrates
11 compliance with the requirements of section
12 1401, and
13 (iii) the Secretary of Labor finds that
14 such certification is -
15 (I) administratively feasible,
16 (II) not adverse to the interests of
17 the individuals covered under the
18 arrangement, and
19 (III) protective of the rights and
20 benefits of the individuals covered under
21 the arrangement.
22 In the case of an arrangement which has commenced
23 operations as of January 1, 1994, an application under
24 this paragraph must be filed not later than January 1,
25 1996.

1 (E) DESIGNATION OF PLAN SPONSOR.-The Secretary of
2 Labor shall provide by regulation for designation of the
3 entities to be treated as the plan sponsor.
4 (F) REVOCATION OF CERTIFICATION.-The Secretary of
5 Labor may revoke a certification under this paragraph
6 for any cause that may serve as the basis for the denial
7 of an initial application for such a certification under
8 this paragraph.
9 (G) REVIEW OF ACTIONS BY SECRETARY OF LABOR.-Any
10 decision by the Secretary of Labor which involves the
11 denial of an application by a multiple employee welfare
12 arrangement for certification under this paragraph or
13 the revocation of such a certification shall contain a
14 statement of the specific reason or reasons supporting
15 the Secretary's action, including reference to the
16 specific terms of the certification and the statutory
17 provision or provisions relevant to the determination.
18 Any such denial or revocation shall be subject to review
19 as provided in section 502 of the Employee Retirement
20 Income Security Act of 1974.
21 **PART 3-REVISION OF COBRA CONTINUATION**
22 **COVERAGE REQUIREMENTS**
23 **SEC. 1431. AMENDMENTS TO THE EMPLOYEE RETIREMENT INCOME**
24 **SECURITY ACT OF 1974.**

when do we use this in UC

1 (a) PERIOD OF COVERAGE.-Subparagraph (D) of section
2 602(2) of the Employee Retirement Income Security Act of
3 1974(29 U.S.C. 1161(2)) is amended-
4 (1) by striking "or" at the end of clause (i), by
5 striking the period at the end of clause (ii) and
6 inserting ", or", and by adding at the end the following
7 new clause:
8 "(iii) eligible for coverage under a
9 qualified health plan in accordance with title
10 I of the Health Security Act.";
11 (2) by adding at the end thereof the following:
12 An individual terminated by a large group sponsor
13 must elect by the date of the termination to either
14 remain in the plan of the sponsor for a period of
15 not to exceed 12 months or until the individual is
16 reemployed, whichever is less, or has purchased
17 coverage from another plan in the marketplace.";
18 and
19 (3) by striking "OR MEDICARE ENTITLEMENT" in the
20 heading and inserting", MEDICARE ENTITLEMENT, OR
21 QUALIFIED HEALTH PLAN ELIGIBILITY".
22 (b) QUALIFIED BENEFICIARY.-Section 607(3) of such Act
23 (29 U.S.C. 1167(2)) is amended by adding at the end the
24 following new subparagraph:
25 "(D) SPECIAL RULE FOR INDIVIDUALS COVERED BY
26 HEALTH SECURITY ACT.-The term 'qualified

1 beneficiary' shall not include any individual who,
2 upon termination of coverage under a group health
3 plan, is eligible for coverage under a qualified
4 health plan in accordance with title I of the
5 Health Security Act."
6 (c) REPEAL UPON IMPLEMENTATION OF ACT.-
7 (1) IN GENERAL.-Part 6 of subtitle B of title I of
8 such Act (29 U.S.C. 601 et seq.) is amended by striking
9 sections 601 through 608 and by redesignating section
10 609 as section 601.
11 (2) CONFORMING AMENDMENTS.-
12 (A) Section 502(a)(7) of such Act (29 U.S.C.
13 1132(a)(7)) is amended by striking "609(a)(2)(A)"
14 and inserting "601(a)(2)(A)".
15 (B) Section 502(c)(1) is amended by striking
16 "paragraph (1) or (4) of section 606".
17 (C) Section 514 of such Act (29 U.S.C. 1144)
18 is amended by striking "609" each place it appears
19 in subsections (b)(7) and (b)(8) and inserting
20 "601".
21 (D) The table of contents in section 1 of such
22 Act is amended by striking the items relating to
23 sections 601 through 609 and inserting the
24 following new item:
25 "Sec. 601. Additional standards for group health plans."
26 (d) EFFECTIVE DATE.-

1 (1) SUBSECTIONS (a) AND (b).-The amendments made by
2 subsections (a) and (b) shall take effect on the date of
3 the enactment of this Act.
4 (2) SUBSECTION (c).-The amendments made by
5 subsection (c) shall take effect on the first January 1
6 following the deadline specified in section of this Act.

7 **SEC. 1432. AMENDMENT TO PUBLIC HEALTH SERVICE ACT.**
8 (a) PERIOD OF COVERAGE.-Subparagraph (D) of section
9 2202(2) of the Public Health Service Act (42 U.S.C. 300bb-
10 2(2)) is amended-
11 (1) by striking "or" at the end of clause (i), by
12 striking the period at the end of clause (ii) and
13 inserting ", or", and by adding at the end the following
14 new clause:
15 "(iii) eligible for coverage under a
16 qualified health plan in accordance with title
17 I of the Health Security Act,", and
18 (2) by striking "OR MEDICARE ENTITLEMENT" in the
19 heading and inserting ", MEDICARE ENTITLEMENT, OR
20 QUALIFIED HEALTH PLAN ELIGIBILITY".
21 (b) QUALIFIED BENEFICIARY.-Section 2208(3) of such Act
22 (42 U.S.C. 300bb-8(3)) is amended by adding at the end the
23 following new subparagraph:
24 "(C) SPECIAL RULE FOR INDIVIDUALS COVERED BY
25 ACT.-The term 'qualified beneficiary' shall not
26 include any individual who, upon termination of

1 coverage under a group health plan, is eligible
2 for coverage under a qualified health plan in
3 accordance with title I of the Health Security
4 Act.".
5 (c) REPEAL UPON IMPLEMENTATION OF HEALTH SECURITY ACT.-
6 (1) IN GENERAL.-Title XII of such Act (42 U.S.C.
7 300bb-1 et seq.) is hereby repealed.
8 (2) CONFORMING AMENDMENT.-The table of contents of
9 such Act is amended by striking the item relating to
10 title XXII.
11 (d) EFFECTIVE DATE.-
12 (1) SUBSECTIONS (a) AND (b).-The amendments made by
13 subsections (a) and (b) shall take effect on the date of
14 the enactment of this Act.
15 (2) SUBSECTION (c).-The amendments made by
16 subsection (c) shall take effect on the first January 1
17 following the deadline specified in section of this Act.
18 **Subtitle F-Health Plans**
19 **PART 1-REQUIREMENTS FOR HEALTH PLANS**
20 **SEC. 1501. STATE PLANS; REGISTRATION PROCESS; QUALIFICATIONS.**
21 (a) IN GENERAL.-The National Health Board (hereinafter
22 referred to as "the Board") shall provide a process for
23 development and approval of State plans (as established in
24 subsection (c)) whereby a State may register a health plan
25 (as defined in subsection (b)) as certified health plan. The
26 health plan shall remain registered unless and until the

1 # TITLE ___—ENSURING HEALTH
2 # CARE REFORM FINANCING

3 **SEC. ___01. ENSURING HEALTH CARE REFORM FINANCING.**

4 (a) PURPOSE.—The purpose of this section is to en-
5 sure that the enactment of this Act does not increase the
6 Federal deficit.

7 (b) LEGAL ENTITLEMENTS CONTINGENT.—Any enti-
8 tlement provided by this Act, including those to—

9 (1) premiums; and

10 (2) tax deductions for health insurance pre-
11 miums,

12 shall be subject to the operation of this section.

13 (c) DETERMINATION OF UNFINANCED HEALTH
14 SPENDING.—

15 (1) INITIAL HEALTH CARE BASELINE.—

16 (A) FISCAL YEARS THROUGH 2004.—Not
17 later than the date that is 60 days after the
18 date of enactment of this Act, the President
19 shall issue an executive order setting forth the
20 initial health care baseline for fiscal year 1995
21 and for each subsequent fiscal year through
22 2004, which shall consist of estimates (for each
23 year) projecting the following:

1 (i) total mandatory outlays resulting
2 from this Act and under the Medicare and
3 Medicaid programs; and
4 (ii) total revenues resulting from this
5 Act.
6 [(B) FISCAL YEARS AFTER 2004.—For
7 each fiscal year following fiscal year 2004, the
8 initial health care baseline is the baseline set
9 forth in the President's budget for fiscal year
10 2004, modified by an annual adjustment factor
11 set forth in the President's budget for fiscal
12 year 1997.]
13 (2) PRESIDENT'S BUDGET TO INCLUDE A CUR-
14 RENT HEALTH CARE BASELINE.—When the Presi-
15 dent submits the budget for fiscal year 1997 (as re-
16 quired by section 1105 of title 31), and for each fis-
17 cal year through 2004, the President shall include—
18 (A) a current health care baseline (as spec-
19 ified in paragraph (3)) with respect to the cur-
20 rent fiscal year, the budget year, and the 3 fol-
21 lowing fiscal years; and
22 (B) an estimate of the difference between
23 the current health care baseline and the initial
24 health care baseline for the current fiscal year,

1 the budget year, and the 3 following fiscal
2 years.
3 (3) CURRENT HEALTH CARE BASELINE.—The
4 current health care baseline shall, for the applicable
5 fiscal year, consist of—
6 (A) updated spending and revenue
7 amounts contained in the initial projection (as
8 set forth in paragraph (1)); plus or minus
9 (B) other outlays or revenue changes [con-
10 tained in legislation enacted after the date of
11 enactment of this Act?] offsetting outlays or
12 revenues resulting from this Act.
13 (4) COMPARING INITIAL AND CURRENT HEALTH
14 CARE BASELINES.—Once OMB has determined the
15 difference between the initial and current health care
16 baselines, OMB shall remove from that difference
17 [any health care variable not attributable to this Act
18 or any legislation described in paragraph (3)(B)].
19 (d) OFFSETTING UNFINANCED HEALTH SPEND-
20 ING.—
21 (1) REQUIREMENT TO FULLY OFFSET
22 UNFINANCED HEALTH SPENDING.—If the Presi-
23 dent's budget includes a determination that the cur-
24 rent health care baseline exceeds the initial health
25 care baseline pursuant to subsection (c)(2)(B) for

1 the budget year or the current fiscal year by more
2 than ____ [____ percent of total spending in the
3 current and budget years, or a fixed dollar
4 amount?], such determination shall be accompanied
5 by an executive order effective on October 1 of that
6 calendar year which fully offsets in the budget year
7 the sum of such excess (for the budget year and the
8 current fiscal year) in the manner provided in this
9 subsection. Such executive order shall be accom-
10 panied by such regulations as are required under
11 paragraph (5).
12 (2) OFFSETS.—The offsets required by this
13 subsection shall be accomplished through a combina-
14 tion of—
15 (A)
16 (B)
17 (C)
18 (3) PROPORTIONALITY.—The President shall
19 apply the offset mechanisms provided in paragraph
20 (2) (A), (B), and (C) proportionally, to the extent
21 possible, but in no case shall the total amount of off-
22 sets be less than the amount required by paragraph
23 (1).
24 (4) EFFECTIVE PERIOD.—At the end of any fis-
25 cal year in which the President has issued an execu-

1 tive order under this title, this Act and the amend-
2 ments made by this Act shall be assumed to con-
3 tinue as if the order had not been issued.
4 (5) REGULATIONS.—Any order modifying the
5 new tax deductions shall be accompanied by Treas-
6 ury regulations implementing such modification.
7 (6) CONSULTATION.—The President shall con-
8 fer with the National Health Board in carrying out
9 this subsection.
10 (e) FINAL SEQUESTER DETERMINATION.—Using the
11 same economic and technical assumptions as used in mak-
12 ing the preliminary determination under subsection (c),
13 the President shall reestimate the initial and current
14 health care baselines on September 15. If the aggregate
15 difference between the initial and updated baseline is more
16 than ____ [____ percent of total spending in the current
17 and budget years, or a fixed dollar amount?] in the cur-
18 rent fiscal year and budget year, the President shall issue
19 a final executive order (and accompanying final regula-
20 tions) following the procedure set forth in subsection (d).
21 (f) NO GROWTH SUSPENSION.—The President shall
22 not issue either a preliminary or final executive order if
23 the Office of Management and Budget notifies the Con-
24 gress that—

1 (1) during the period consisting of the quarter
2 during which such notification is given, the quarter
3 preceding such notification, and the 4 quarters fol-
4 lowing such notification, the Office of Management
5 and Budget has determined that real economic
6 growth is projected or estimated to be less than zero
7 with respect to each of any 2 consecutive quarters
8 within such period; or
9 (2) the most recent of the Department of Com-
10 merce's advance preliminary or final reports of ac-
11 tual real economic growth indicate that the rate of
12 real economic growth for each of the most recently
13 reported quarter and the immediately preceding
14 quarter is less than 1 percent.
15 (g) RECOMMENDATIONS FOR ALTERNATIVE REDUC-
16 TIONS.—If the President's budget for a fiscal year is ac-
17 companied by an executive order under subsection (d)(1),
18 the National Health Board shall, within a reasonable time,
19 transmit to the Speaker of the House of Representatives
20 and the President of the Senate a report including alter-
21 native proposals to offset the projected excess outlays.
22 (h) GAO AUDIT OF REDUCTIONS.—If the President
23 has issued an executive order under subsection (d)(1), the
24 General Accounting Office shall report to Congress, as
25 soon thereafter as possible following the date of transmit-

1 tal of the President's budget, an analysis of whether the
2 executive order has fully complied with the requirements
3 of this section.