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109TH CONGRESS, 1st Session | HOUSE OF REPRESENTATIVES | REPORT 109–41

SMALL BUSINESS HEALTH FAIRNESS ACT OF 2005

APRIL 13, 2005.—Committed to the Committee of the Whole House on the State of the Union and ordered to be printed

Mr. BOEHNER, from the Committee on Education and the Workforce, submitted the following

R E P O R T

together with

ADDITIONAL AND MINORITY VIEWS

[To accompany H.R. 525]

[Including cost estimate of the Congressional Budget Office]

The Committee on Education and the Workforce, to whom was referred the bill (H.R. 525) to amend title I of the Employee Retirement Income Security Act of 1974 to improve access and choice for entrepreneurs with small businesses with respect to medical care for their employees, having considered the same, report favorably thereon without amendment and recommend that the bill do pass.

PURPOSE

The purpose of H.R. 525 is to reduce the ranks of the uninsured by improving access to health care for uninsured working families, particularly those who are employed in small businesses. The bill would authorize the creation of association health plans ("AHPs") which would allow small businesses to join together through bona fide trade associations to purchase health insurance for their workers, thus enjoying the larger economies of scale presently enjoyed by many large corporations and unions and enabling them to purchase coverage at a lower cost than they currently must pay. H.R. 525 would increase small businesses' bargaining power with health care providers, give them freedom from costly state mandated benefit packages, and lower overhead costs, thus better enabling them to offer health care coverage for their workers.

39–006

COMMITTEE ACTION

Employer-Employee Relations Subcommittee Chairman Sam Johnson, (R–TX) introduced H.R. 525 on February 2, 2005 along with 53 bipartisan original cosponsors including Education and the Workforce Committee Chairman John Boehner; the number of bipartisan cosponsors rose to 121 by the time the bill was reported by the Committee to the full House of Representatives. The bill is the culmination of legislative activity started by the Committee in the 104th Congress through the present 109th Congress.

104TH CONGRESS

The Subcommittee on Employer-Employee Relations held an oversight hearing entitled "Health Insurance Reform—The ERISA Title I Framework: A 20-Year Success Story" on February 14, 1995. Testimony was received from: Representative Pat Williams; Former Representative John Erlenborn; Frank Cummings, Esq., LeBoeuf, Lamb, Greene & MacRae; Randal Johnson, Director of Benefits Planning, Motorola, Inc.; Ralph Brennan, President, Mr. B.'s Inc.; William Goodrich, President, United Agribusiness League; and Brian Atchinson, Vice President, National Association of Insurance Commissioners, Superintendent, Bureau of Insurance, State of Maine.

On February 21, 1995, H.R. 995, the ERISA Targeted Health Insurance Reform Act was introduced by then Chairman of the Subcommittee on Employer-Employee Relations, Representative Harris Fawell with 15 original cosponsors. The Subcommittee on Employer-Employee Relations held a hearing on this bill on March 10, 1995. Witnesses at the hearing were: Jack Faris, President, National Federation of Independent Business; Jerry Jasinowski, President, National Association of Manufacturers; Sean Sullivan, President and CEO, National Business Coalition on Health; Timothy Flaherty, American Medical Association; Charles Masten, Inspector General, Department of Labor; Gerald McGeehan, Graphic Arts Benefits Corp; Kala Ladenheim, Intergovernmental Health Policy Project, George Washington University; and Judith Waxman, Director of Government Affairs of Families, USA. A second hearing was held on H.R. 995 on March 28, 1995. Testimony was presented by: Richard Lesher, President, U.S. Chamber of Commerce; Keith Richman, President, Medco Associates, Inc.; Jon Reiker, Vice President, Benefits, General Mills Restaurants, Inc.; Frank Cummings, Esq., LeBoeuf, Lamb, Greene & MacRae; and Lee Douglas, Insurance Commissioner of Arkansas, President, National Association of Insurance Commissioners.

The Committee on Economic and Educational Opportunities (the previous name of the Committee on Education and the Workforce) on March 6, 1996 discharged H.R. 995 from the Subcommittee on Employer-Employee Relations, approved H.R. 995 as amended by voice vote, and, by a rollcall vote of 24 ayes to 18 nays, ordered the bill favorably reported to the House of Representatives. However, the bill was not considered by the House before the conclusion of the 104th Congress.

105TH CONGRESS

On May 1, 1997, H.R. 1515, the Expansion of Portability and Health Insurance Coverage Act of 1997 ("EPHIC") was introduced by Representative Harris Fawell with 136 bipartisan original cosponsors.

The Subcommittee on Employer-Employee Relations held a legislative hearing on H.R. 1515 on May 8, 1997. Testimony was received from: Representative James P. Moran (D–VA,); Jack Faris, President and CEO, National Federation of Independent Business; Mary Castro, Vice President, Employee Benefits, Independent Grocers Alliance, Inc.; Cathy Hurwit, Deputy Director, Citizen Action; Kathleen Sebelius, Commissioner of Insurance, State of Kansas; Donald Dressler, President of Insurance Services, Western Growers Association, on behalf of The Association Healthcare Coalition; and Jeffrey H. Joseph, Vice President, Domestic Policy, U.S. Chamber of Commerce.

On June 11, 1997, the Committee on Education and the Workforce discharged H.R. 1515 from the Subcommittee on Employer-Employee Relations. The full Committee approved the bill as amended on a voice vote and by a vote of 24 ayes to 20 nays ordered the bill favorably reported, and: (a) incorporated into subtitle D of the reconciliation package transmitted to the Budget Committee; and (b) reported as amended to the House of Representatives. The bill became part of H.R. 2015, the Balanced Budget Act of 1997, which passed the House of Representatives on June 25, 1967 on a vote of 270 yeas to 162 nays; however, association health plan provisions were deleted during House/Senate conference on the bill. A version of the association health plan provisions of the bill was then incorporated into H.R. 4250, the Patient Protection Act of 1998, which was introduced by Representative Newt Gingrich, then Speaker of the House of Representatives, on July 16, 1998. On July 24, 1998, the House of Representatives passed the bill, including a version of the provisions of H.R. 1515, by a vote of 216 yeas to 210 nays. On October 9, 1998, the Senate tabled consideration of the measure by a vote of 50 yeas to 47 nays.

106TH CONGRESS

On March 25, 1999, the Subcommittee on Employer-Employee Relations held a hearing on "Expanding Affordable Health Care Coverage: Benefits and Consequences of Association Health Plans." Witnesses at the hearing were: Ms. Mary Nell Lehnhard, Senior Vice President Policy and Representation, BlueCross BlueShield Association, Washington, DC; Ms. Victoria Caldeira, Manager of Legislation Affairs, National Federation of Independent Business, Washington, DC; Mr. Donald G. Dressler, CAE President for Insurance Services, Western Growers Association, Newport Beach, CA; and Mr. Steven B. Larsen, Commissioner of Insurance State of Maryland, Baltimore, MD, testifying on behalf of the National Association of Insurance Commissioners.

On April 20, 1999, Representative Jim Talent (R–MO) introduced H.R. 1496, the Small Business Access and Choice for Entrepreneurs Act of 1999 with 13 bipartisan original cosponsors. H.R. 1496 was incorporated into H.R. 2990, a broader health care reform package introduced by Representative Talent on September 30,

1999. H.R. 1496 passed the House of Representatives on a vote of 227 yeas to 205 nays on October 6, 1999. After Senate passage of a similar bill, S. 1344, a House-Senate conference did not reach agreement before the end of the 106th Congress.

107TH CONGRESS

Representative Ernie Fletcher (R–KY) introduced H.R. 1774, the Small Business Health Fairness Act of 2001, on May 9, 2001 with 46 bipartisan original cosponsors.

On July 19, 2001, Representative Greg Ganske (R–IA) introduced H.R. 2563, a broad health care reform package. During the House of Representatives consideration of H.R. 2563, an amendment to include the provisions was adopted on a vote of 236–194. H.R. 2563 passed the House on August 2, 2001, by a vote of 226 ayes to 203 nays. The bill was not taken up by the Senate before the conclusion of the 107th Congress.

On June 18, 2002, the Subcommittee on Employer-Employee Relations held a hearing on "The Rising Cost of Health Care: How are Employers and Employees Responding?" Witnesses at the hearing were: Dr. Paul Ginsburg, President, Center for Studying Health System Change, Washington, DC; Ms. S. Catherine Longley, Commissioner, Maine Department of Professional and Financial Regulation, Augusta, ME; Dr. Henry Simmons, President, National Coalition on Health Care, Washington, DC; Mr. Patrick McGinnis, CEO, Trover Solutions, Louisville, KY; Ms. Carol Miller, Frontier Education Center, Santa Fe, NM; and Ms. Cathy A. Streker, Director of Employee Benefits and Planning, Textron, Inc., Providence, RI.

On July 9, 2002, the Subcommittee on Employer-Employee Relations held a hearing entitled "Expanding Access to Quality Health Care: Solutions for Uninsured Americans." Testimony at the hearing was received from: Representative Ernie Fletcher (R–KY) and Representative John Tierney (D–MA); Dr. Mark B. McClellan, Member, Council of Economic Advisors, Washington, DC; Mr. Harry Kraemer, Jr., Chairman and Chief Executive Officer, Baxter International Inc., Deerfield, IL, testifying on behalf of The Healthcare Leadership Council; Mr. Joseph Rossman, Vice President of Fringe Benefits, Associated Builders and Contractors, Rosslyn, VA, testifying on behalf of the Association Health Plan Coalition; and Mr. Ron Pollack, Executive Director, Families USA, Washington, DC.

108TH CONGRESS

On February 11, 2003, Rep. Ernie Fletcher introduced H.R. 660, the "Small Business Health Fairness Act of 2003" with 70 bipartisan original cosponsors. The Subcommittee on Employer-Employee Relations held a hearing on H.R. 660 on March 13, 2003. Witnesses at the hearing presenting testimony were: the Honorable Ann L. Combs, Assistant Secretary of Labor, Employee Benefits Security Administration, Washington, DC; Ms. Phyllis Burlage, Burlage Associates, PA, Millersville, MD, testifying on behalf of the National Federation of Independent Business; Alice Weiss, Esq., Director of Health Policy, National Partnership for Families, Washington, DC; and Mr. Greg Scandlen, Director, Center for Consumer Driven Health Care, The Galen Institute, Alexandria, VA.

The Subcommittee on Employer-Employee Relations reported H.R. 660 by a bipartisan vote of 13 yeas to 8 nays on April 8, 2003. On June 12, 2003, the Committee on Education and the Workforce ordered H.R. 660, as amended, reported to the House of Representatives by a vote of 26–21. On June 19, 2003 the House of Representatives passed H.R. 660 by a vote of 262–162. On May 15, 2004, to reiterate its commitment to helping the uninsured, the House passed identical legislation, H.R. 4281. Neither bill was enacted into law before the end of the 108th Congress.

109TH CONGRESS

On February 2, 2005, Employer-Employee Relations Subcommittee Chairman Sam Johnson (R–TX) introduced H.R. 525, the Small Business Health Fairness Act, along with 53 bipartisan original cosponsors, including Education and the Workforce Committee Chairman John Boehner, and Representatives Nydia Velazquez (D–NY) and Albert Wynn (D–MD). On March 16, 2005, the Committee on Education and the Workforce ordered H.R. 525, without amendment, favorably reported to the House of Representatives by a vote of 25–22.

SUMMARY

The Small Business Health Fairness Act addresses both the access and cost issues at the heart of the health care reform debate. The bill, introduced by a bipartisan group of legislators led by Employer-Employee Relations Subcommittee Chairman Sam Johnson (R–TX), Education and Workforce Committee Chairman John Boehner (R–OH), and Representatives Nydia Velazquez (D–NY) and Albert Wynn (D–MD), would improve access to quality health care for uninsured families. Specifically, it would authorize the creation of association health plans ("AHPs") to allow small businesses to join together through bona fide trade associations to purchase health insurance for their workers at a lower cost. The measure would increase small businesses' bargaining power with health care providers, give them freedom from costly state-mandated benefit packages, and lower their overhead costs by as much as 30 percent—benefits that many large corporations and unions already enjoy because of their larger economies of scale.

The bill has 129 cosponsors, including House Majority Leader Tom DeLay (R–TX), House Majority Whip Roy Blunt (R–MO), House Republican Conference Chairwoman Deborah Pryce (R–OH), Small Business Committee Chairman Don Manzullo (R–IL), Representatives Ed Case (D–HI) and Jim Cooper (D–TN). A broad and diverse coalition of more than 100 groups has endorsed the bill, including the U.S. Chamber of Commerce, the National Federation of Independent Business, the American Farm Bureau Federation, the Associated Builders and Contractors, the Latino Coalition, the National Black Chamber of Commerce, the National Association of Women Business Owners, and the National Restaurant Association. On February 16, 2005, Sen. Olympia Snowe (R–ME) introduced companion legislation in the United States Senate (S. 406).

The bill establishes that an AHP is a group health plan that offers fully-insured and/or self-insured medical benefits, has been certified by the Labor Department, and is operated by a board of

trustees with complete fiscal control and responsibility for all operations. The association sponsoring the plan must have been in existence for at least three years for substantial purposes *other than* providing health insurance coverage.

To be certified by the Labor Department, a "self-insured" AHP must have at least 1,000 participants and beneficiaries. The self-insured AHP must have also offered benefits coverage on the date of enactment, represent a broad cross-section of industry trades, or represent one or more industry trades with average or above health insurance risk.

The bill requires all employers participating in the AHP to be members or affiliated members of the sponsor. All individuals under the plan must be active or retired employees, owners, officers, directors, partners, or their beneficiaries.

The measure expressly prohibits discrimination by requiring that all employers that are association members are eligible for participation, all geographically available coverage options are made available upon request to eligible employers, and eligible individuals cannot be excluded from enrolling because of health status. The bill prohibits AHPs from charging higher rates for sicker individuals or groups within the plan, except to the extent already allowed under the relevant state rating law.

H.R. 525 makes clear that AHPs must comply with the Health Insurance Portability and Accountability Act (HIPAA), which prohibits group health plans from excluding high-risk individuals with high claims experience. Thus, it will not be possible for AHPs to "cherry pick" because sick or high risk groups or individuals cannot be denied coverage. As an additional protection, state-licensed health insurance agents must be used to distribute health insurance coverage provided to small employers under an AHP and must also be used to distribute self-insured benefits to small employers through an AHP.

The bill includes solvency standards that are similar to or stronger than standards enacted by states for association plans. These new solvency protections go far beyond what is required of single employer and labor union plans under current law. H.R. 525 requires self-insured AHPs to maintain reserves that are sufficient for unearned contributions, benefit liabilities, expected administrative costs, and any other obligations. A qualified actuary who is a member of the American Academy of Actuaries must recommend these reserve levels.

AHPs must also obtain aggregate and specific stop-loss insurance and indemnification insurance for any claims if the plan is terminated; they must also make annual payments to an Association Health Plan Fund. In addition, an AHP must maintain surplus reserves of between $500,000 and $2 million. If an AHP is unable to provide benefits when due or is otherwise in a financially troubled condition, the Secretary of Labor must act as a trustee to administer the plan for the duration of the insolvency. A certified AHP may terminate only if the trustees provide 60 days advance written notice to participants and beneficiaries and submit a plan for timely payment of all benefit obligations. The measure establishes a Solvency Standards Working Group within 90 days after enactment to recommend initial regulations.

The bill gives certified AHPs freedom from costly state-mandated benefit packages by exempting them from state benefit mandates, except that AHPs must comply with any state laws that require coverage of specific diseases. The measure clarifies that states may regulate self-insured multiple employer welfare arrangements providing medical care which do not elect to meet the certification requirements for AHPs.

H.R. 525 requires the Labor Secretary to consult with the states about the regulation of AHPs located in their state. It establishes criminal penalties for willful misrepresentation as a certified AHP or collectively bargained status; authorizes the Department of Labor to issue cease activity orders against fraudulent health plans; and outlines the responsibility of the board of trustees for meeting required claims procedures. The Labor Secretary must report to Congress no later than January 1, 2008, on the impact of AHPs on reducing the number of uninsured.

COMMITTEE STATEMENT AND VIEWS

A. BACKGROUND AND NEED FOR LEGISLATION

Strengths of our nation's employer-provided health care system

When the Employee Retirement Income Security Act (ERISA)[1] was enacted in 1974, the Congress found that employee benefit plans, including employer provided health benefits, directly impacted the continued well being and security of millions of employees and their dependents.[2] The well being of these workers and their families was of such national importance that Congress, through the enactment of ERISA, preempted the states' regulatory role in order to assure uniform federal standards. It is the belief of the Committee on Education and the Workforce (hereinafter the "Committee"), that the ability to utilize uniform standards is the cornerstone of our nation's successful employer-provided health care system.

When Congress enacted ERISA, much of the dialogue about employer-sponsored benefits pertained to pension plans. Today, more than 131 million Americans obtain their health insurance coverage through an employer-sponsored health plan covered under ERISA. This means that more Americans receive health benefits voluntarily provided by their employer than any other form of health care insurance, including Medicare and Medicaid.

The Committee believes our nation's employer-provided health care system to be an enormous success story. Indeed, the Committee views its task with regard to this system to be to protect it from federal proscriptions, such as increased federal mandates, that cause the provision of health care insurance to become more costly, thereby making it more difficult for employers to offer health coverage to their employees. It is the view of the Committee that ERISA's preemption of state mandates and regulation has provided a stable framework by which employers have been able to offer health plans to workers and their families.

An April 2002 study by PriceWaterhouseCoopers notes that state mandates have increased 25-fold over the time period from 1970–

[1] 29 U.S.C. § 1001, et seq.
[2] 29 U.S.C. § 1001(a).

1996.[3] Thus, during the three decades since ERISA was enacted, self-insured employers offering health plans would have seen their regulatory and administrative burden increase accordingly, were it not for ERISA's preemption.

Under ERISA, employers and unions offering health insurance products to their employees must comply with state regulation for these health policies. This is the result of the Supreme Court's ruling in Metropolitan Life Insurance Co. v. Massachusetts, 471 U.S. 724 (1985). In that decision, the court held that if an employer's health plan purchases a fully insured product offered by an insurer regulated by the states, then such insurance regulation may include imposing requirements that specific benefits be included in the products sold to the plan.[4] These state laws then fall within the jurisdiction of Section 514(b)(2)(A) of ERISA, which saves any law of any state that regulates insurance from being preempted by ERISA.[5]

However, when an employer or union self-funds the health benefits it provides to workers (i.e. taking on the risk of insurable events), ERISA ensures that the employer or union cannot be deemed to be in the business of insurance.[6]

Thus, those employers and unions who self-fund or self-insure their benefits are able to take advantage of ERISA's preemption of state regulation to offer a uniform health benefit package that can be offered to individuals across state lines. Approximately 67 million of the 131 million Americans who obtain health insurance from their employer receive benefits through a self-funded plan.

The preemption of state benefit mandates serves employers, unions, and employees well. PriceWaterhouseCoopers estimates that the 1500 state benefit mandates make up 15 percent of the increased cost of health insurance for 2002.[7] These costs may well price many employers out of the business of offering insurance were it not for the opportunity to self-fund their health care under ERISA.

However, rather than use the preemption of state benefit mandates to offer inferior health care to workers, unions and self-insured large employers offer rich benefit packages to their workers. As cited in a 1996 GAO report, a KPMG study found that self-funded plans are more likely to offer benefits and services that are most commonly mandated by states than fully insured plans.[8] This pattern holds true for other benefits that are not typically mandated.

Uniformity also provides for lower administrative costs. A 2002 Robert Wood Johnson Research Synthesis Report cites the fact that administrative costs make up only 12 percent of health care costs for large employers. This is compared to the administrative costs for smaller employers that make up 40 percent of overall health costs.[9]

Employees surveyed about their health benefits conclude in wide majorities that they are pleased with their employer-sponsored cov-

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[3] PriceWaterhouseCoopers, The Factors Fueling Rising Health Care Costs, April 2002.
[4] Metropolitan Life Insurance Co. v. Massachusetts, 471 U.S. 724 (1985).
[5] 29 U.S.C. § 1144(b)(2)(A).
[6] 29 U.S.C. § 1144(b)(2)(B).
[7] PriceWaterhouseCoopers, The Factors Fueling Rising Health Care Costs, April 2002.
[8] US GAO "Health Insurance Regulation—Varying State Requirements Affect Cost of Insurance," August 1996.
[9] Robert Wood Johnson Foundation, "Are Health Insurance Premiums Higher for Small Firms?" September 2002.

erage and that they are not willing to risk losing this coverage in order to obtain additional mandated benefits.[10] While the Committee views the history of employer-sponsored health benefits since the enactment of ERISA as a success story, the Committee acknowledges that the employer sponsored health care system faces challenges. In particular, the Committee is concerned about the issue of rising health care costs and the extent to which these health care costs result in less coverage.

Challenges to employer-provided health care

At a hearing before the Subcommittee on Employer-Employee Relations in June of 2002, Paul Ginsburg, President of the Center for Studying Health System Change, testified about the threat rising health costs pose to the employer-sponsored health care system:

> Rising health costs affect people's ability to afford health insurance. When insurance premiums rise faster than workers' wages, fewer people obtain employment-based health insurance. This happens through small employers deciding not to provide coverage to their employees and employees deciding not to take up employer coverage because the employee contribution is too high. If health care costs trends continue to exceed increases in wage rates by a large margin, this could result in substantial loss of employer-based health insurance.[11]

Catherine Longley, then Commissioner of Professional and Financial Regulation for the state of Maine, agreed with Ginsburg's testimony and shared these insights about the situation Maine employers face:

> In the State of Maine, we are facing a health care cost crisis. Although health care costs have increased dramatically across the country, they have increased even faster in Maine. Nationally, from 1990–1998, the per capital expenditures for personal health care increased an average of 53.3 percent; in Maine, the increase was 80.4 percent for the same period of time * * * Maine employers are faced with difficult choices—do they continue existing policies at a significant increase in cost and shift more of the cost of the health insurance to employees; do they retain coverage but offer higher deductible policies; do they forego increasing employee salaries to maintain coverage; or do they drop coverage altogether?[12]

Commissioner Longley also testified that the State of Maine and Independent Governor Angus King had recognized that state imposed benefit mandates impose significant costs on employers and took dramatic steps to address this:

> For example, in 1995, Governor King signed a progressive mental health parity law that required health insur-

[10] 2002 Health Confidence Survey, September 2002; Kaiser Family Foundation/Harvard School of Public Health, "National Survey on Consumer Experiences With and Attitudes Toward Health Plans: Key Findings," August, 2001.

[11] Hearing on "The Rising Costs of Health Care: How are Employers and Employees Responding?" before the Subcommittee on Employer-Employee Relations, Committee on Education and the Workforce, U.S. House of Representatives, 107th Congress, Second Session, June 18, 2002.

[12] Id.

> ance coverage for 7 specific biologically based mental illnesses in policies held by employer groups of 20 or more. Since that time, the King Administration has grown more and more concerned about the dramatic increases in health care costs and effect of public policy on those increases. As a result, in 2002 the Administration adopted a presumption against further mandates, which only the most compelling of arguments should overturn. Given the circumstances this year, Governor King felt that he could no longer support additional mandates and accordingly, vetoed LD 1627, "An Act to Ensure Equality in Mental Health Coverage," the only health insurance mandate vetoed during his nearly eight years as governor * * * it was felt that Maine could ill afford any new mandate that would further increase costs. As Governor King stated in his April 11, 2002 veto message to the Maine Legislature, "When you are in a hole, the first rule is not to dig any deeper." [13]

While some states have taken steps to slow the growth in health insurance costs, the Committee recognizes that in order to truly be effective Congress must past measures such as Association Health Plans. According to the 2004 Annual Employer Health Benefits Survey released by the Kaiser Family Foundation and Health Research and Educational Trust (HRET) the cost of providing health insurance increased by 11.2 percent for the average employer; the fourth straight year of double digit increases.[14] Though 2005 premium increases have not yet been released, experts expect the increase to once again be in the double digits.

Challenges to small employers

Nowhere is the threat to employer-sponsored health care more apparent than in the situation regarding small businesses. For those small employers who can afford health insurance for their employees, a fully insured plan is often their only available option. The net effect of the Metropolitan Life decision has been to subject these smaller employers that fully insure to the burdens of costly state mandates, thereby making health insurance for their employees even less affordable than it is for larger employers who are not subject to state mandates.

Because of their size and limited resources, self-insuring is not a viable option for most small firms, and thus they must purchase fully insured health products that are subject to state benefit mandates. In fact, firms with fewer than 100 employees offered self-insured plans at just 11 percent of all work sites in 2000.[15] This means that small firms bear the entire state regulatory burden—and the increased costs that accompany it—that their larger employer and union counterparts are able to avoid.

Small businesses also suffer from greater variability in claims costs. In a firm with very few employees, a sick employee will have

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[13] Id.

[14] Kaiser Family Foundation, Employer Health Benefits 2004 Annual Survey, September 2004.

[15] Medical Expenditure Panel Survey from Agency for Healthcare Research and Quality, as cited by NovaRest Consulting, "New York State Mandated Health Insurance Benefits," May 2003.

a greater impact on health care premiums, and these rising premiums sometimes price these firms out of insurance altogether. By contrast, in a firm with a large number of employees, a sick employee will not have a great impact on premiums and will not cause premiums to rise significantly.

In July of 2002, the Subcommittee on Employer-Employee Relations held a hearing on the problem of the uninsured. At the hearing, Joe Rossmann, Vice President of Fringe Benefits, Associated Builders and Contractors (ABC), testified as to the increases in costs that ABC's member companies, most of which are smaller employers, were experiencing:

> For example, in Houston, Texas, Acoustical Concepts, Inc. was forced to accept a premium increase of 47% this year, even though they had no significant claims. Moreover, their insurance company, Blue Cross/Blue Shield, has informed them that in 1–2 years, the 87 employees at this company will be offered only catastrophic coverage.[16]

Mr. Rossmann went on to say that, "Indeed, massive premium increases of 40 percent, 50 percent and higher, and/or benefit reductions, are typical of what small businesses throughout the nation are experiencing today."[17]

At a later hearing on the Small Business Health Fairness Act, Phyllis Burlage, President, Burlage Associates, shared her experience:

> My rate hike this year is 45% with our health maintenance organization (HMO). This is real money since I absorb all the cost increases for my employees. Since 1996, my company has experienced a 226% increase in premiums—how can any business survive with these types of increases over just a few years?[18]

There is ample evidence to indicate that small employers face greater challenges than larger employers or unions in providing health coverage, thus putting workers in small businesses at a greater risk of being uninsured.

High costs for small employers means workers in small businesses are uninsured

The increase in costs for small employers means that workers in small businesses are not offered health care insurance or are at risk of losing their health insurance. According to figures released by the U.S. Census Bureau in August 2004, the number of Americans who have no health insurance had increased to more than 45 million by 2003. Declining coverage in the employer based market accounts for the increase in the uninsured. Significantly, the reduction in employer-sponsored coverage comes almost totally from a

[16] Hearing on "Expanding Access to Quality Health Care: Solutions for Uninsured Americans" Subcommittee on Employer-Employee Relations, Committee on Education and the Workforce, U.S. House of Representatives, 107th Congress, Second Session, July 9, 2002.

[17] Id.

[18] Hearing on "H.R. 660, the Small Business Health Fairness Act, Subcommittee on Employer-Employee Relations," Committee on Education and the Workforce, U.S. House of Representatives, 108th Congress, First Session, March 13, 2003.

decrease in the number of individuals covered by small employers.[19]

Over 50 percent of the 45 million uninsured Americans either work in a small business or are a dependent of a small business worker.[20] The cost of insurance is the most significant barrier to insurance coverage for workers and their families.[21]

Indeed, the cost of health coverage is the most important factor employers cite in their decision whether to offer health care to their employees and their families. A 1997 survey by the Henry J. Kaiser Family Foundation indicated that small firms are extremely price sensitive. This survey found that even a 5 percent decrease in price would result in a 10 to 15 percent increase in the likelihood of a small firm purchasing a plan.

Hearing testimony from Ann L. Combs, Assistant Secretary of the Employee Benefits Security Administration, U.S. Department of Labor, explained some of the barriers to coverage that small firms face:

> Cost is clearly the biggest barrier for small employers that want to provide health insurance. For a variety of reasons, insurers typically charge small firms more per employee than large firms for comparable coverage. Small company premiums are 20 percent to 30 percent higher than those of large self-insured companies with similar claims per covered employee. Cost drivers include small businesses administrative overhead, insurance company marketing and underwriting expenses, adverse selection, and state regulatory burdens. Small firms are likely to offer less generous benefits and more of their premiums are consumed by administrative costs.[22]

Though the primary barrier to health coverage for small businesses is cost, other factors also deter small firms from offering coverage. Testimony from Harry M.J. Kraemer, Jr., Chairman and CEO, Baxter International, Inc., on behalf of the Healthcare Leadership Council, provided additional reasons that small firms are less likely to offer health care coverage:

> In an April 2002 survey by the Kaiser Family Foundation, over one third of small businesses not offering coverage said that administrative hassle was a very important reason * * * A 2000 focus group of the California Health Care Foundation found that a lack of unbiased, easily understood information on health insurance was a major barrier in acquiring coverage. Many small business owners do not fully understand the health insurance market and are skeptical of information from insurance com-

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[19] U.S. Census Bureau, "Income, Poverty, and Health Insurance Coverage in the United States: 2003," August 2004.

[20] Department of Labor estimates of working families' health insurance status, based on the Census Bureau's annual March Current Population Survey.

[21] Testimony of Harry M.J. Kraemer, Jr., Chairman and CEO, Baxter International, Inc., on behalf of the Healthcare Leadership Council, at Subcommittee on Employer-Employee Relations Hearing on "Expanding Access to Quality Health Care: Solutions for Uninsured Americans," Committee on Education and the Workforce, U.S. House of Representatives, 107th Congress, Second Session, July 9, 2002 (Serial No. 107–69).

[22] Hearing on "H.R. 660, the Small Business Health Fairness Act," Subcommittee on Employer-Employee Relations, Committee on Education and the Workforce, U.S. House of Representatives, 108th Congress, First Session, March 13, 2003 (Serial No. 108–10).

> panies, the focus group report stated. This lack of credible information could be leading to inaction on the part of employers * * * An EBRI [Employee Benefit Research Institute] 2000 Small Employer Health Benefits Survey found that many small employers make decisions about whether to offer health benefits to their workers without being fully aware of the tax advantages that can make this benefit more affordable. This survey found that 57 percent of small employers do not know that health insurance premiums are 100 percent tax deductible.[23]

These factors, administrative costs, necessity of information about health insurance, and tax structure, are easily borne by larger employers. Taken together, however, they add to the difficulties that small employers face in offering health care coverage to their employees.

Solutions for our Nation's uninsured—the Small Business Health Fairness Act, H.R. 525

It is the strong belief of the Committee that solutions to the growing problem of the uninsured, particularly in small businesses, can only be found by utilizing the strengths of the employer-based health care system. Harry Kraemer's testimony puts it this way:

> In all of our research, the single most important point that cannot be ignored is that the uninsured issue is a workplace issue, with millions of wage-earning households representing the lion's share of the uninsured population. It then stands to reason that our most effective solutions must be found within the existing private employer-based health care system.[24]

The Committee believes that if smaller employers were able to band together to become larger purchasers of health insurance, that this would give small businesses greater economies of scale, allowing them to bargain for health insurance with the clout of much larger businesses. In addition, if small businesses were able to self-fund their health plans, they would be relieved from the regulatory burden of state mandated benefit laws. The Committee believes that these two factors would combine to significantly lower the costs of health insurance, making it possible for very small firms to offer insurance.

The Small Business Health Fairness Act would allow small businesses to join together under the umbrella of bona fide trade associations to become larger purchasers of health insurance. In addition, AHPs make it possible for small employers to self-insure, thereby avoiding costly state benefit mandates. The Committee expects that this will lower costs for small employers by 15–30 percent, making it possible for small firms to offer health insurance to workers and their families, many of whom are uninsured. Because of this, the Committee expects that AHPs will reduce the number of the uninsured by millions.

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[23] Subcommittee on Employer-Employee Relations Hearing on "Expanding Access to Quality Health Care: Solutions for Uninsured Americans" Committee on Education and the Workforce, U.S. House of Representatives, 107th Congress, Second Session, July 9, 2002 (Serial No. 107–69).

[24] Id.

It is the strong belief of the Committee that Congress can not afford to wait any longer to provide access to health care to our nation's uninsured, particularly those employed by small businesses.

Benefits of association health plans

The preemption of state mandates is an integral aspect of ERISA. Because most small employers do not have the resources to take on the risk of self-insurance, they have been foreclosed from ERISA's federal preemption, and are held captive instead to the states' regulation of fully insured health products. Thus, small employers are not on a level playing field with large employers and unions.

Representative Bill Archer (R–TX) predicted this dynamic at ERISA's passage:

> I think it is interesting to note that here we are trying to permit small employers to compete with big business, and that this * * * will have just the reverse effect; the large corporations and the unions have been basically excepted by this bill. But the small employer * * * will no longer be able to compete, in many instances, with the big corporations.[25]

AHPs will solve many of these problems for small employers. Testimony from Ann L. Combs, Assistant Secretary for the Employee Benefits Security Administration, U.S. Department of Labor, at a March 2003 Subcommittee on Employer-Employee Relations hearing on H.R. 660, discussed the benefits of AHPs for small businesses:

> In an AHP, the current market and financial barriers that face small businesses would be reduced or eliminated. Small businesses would enjoy greater bargaining power, economies of scale, administrative efficiencies, and the benefits of a uniform regulatory structure, giving them more access to affordable coverage.[26]

Joe Rossmann, Vice President of Fringe Benefits, Associated Builders and Contractors (ABC), described the experience of the association health plan offered by ABC before it was forced to discontinue its health coverage due to overlapping, inconsistent and incompatible state laws:

> We estimate that AHPs * * * can reduce the cost of health benefits by 15–30 percent for small business workers. We know this because association plans have already proven they can deliver savings compared with the cost of small employers purchasing directly from an insurance company. For example, the AHP sponsored by ABC for more than 40 years, which operated nationally, had total administrative expenses of 13½ cents (13.5 percent) for every dollar of premium. These costs included all marketing, administration, insurance company risk, claim pay-

[25] Debate on H.R. 2, the Welfare and Pension Plans Disclosure Act, U.S. House of Representatives, February 27, 1974.

[26] Hearing on "H.R. 660, the Small Business Health Fairness Act," Subcommittee on Employer-Employee Relations, Committee on Education and the Workforce, U.S. House of Representatives, 108th Congress, First Session, March 13, 2003 (Serial No. 107–51).

> ment expenses and state premium taxes. Alternatively, small employers who purchase coverage directly from an insurance company can experience total expenses of 25 to 35 cents (25–35 percent) for every dollar of premium.[27]

By utilizing the time-tested feature of federal preemption contained in ERISA, AHPs build upon the successes produced by private sector innovation and market competition. Rather than creating a new federal law, H.R. 525 builds on the current successful ERISA framework upon which plan sponsors have relied for almost thirty years. The enactment of AHP legislation would put the nation well on its way to closing the gap in health insurance coverage by offering millions of uninsured workers, their spouses and their children, the opportunity to access more affordable health coverage.

Unfortunately, the smallest employers have not shared in the advantages of ERISA. AHPs build on ERISA to give smaller employers the same economies of scale and freedom to offer affordable coverage that larger employers and unions enjoy. In short, the bill clears the way for market forces to bring small employers costs down.

Why current ERISA law needs changes to clarify the status of association health plans under federal and state law

Allowing small employers to join together to form multiple employer plans is the most efficient means to deliver affordable health coverage to employees, particularly for smaller employers and employees who work in industries with high job mobility or above-average insurance risk. However, current law has not achieved the twin goals of preserving self-insurance as an option for multiple employer plans of legitimate business and industry associations while keeping "bogus unions" and fraudulent insurance schemes from using ERISA's federal preemption clause as a shield against state regulation of their abusive health insurance practices.

Under ERISA, a multiple employer welfare arrangement (MEWA) is defined as a plan or other "non-plan" arrangement established to offer or provide ERISA welfare benefits (e.g., health benefits) to the employees of two or more employers.[28] Under current law, the breadth of this definition should be read to sweep in the following types of entities: (1) large employer plans that include employees of entities outside the "control group" of the employer; (2) "church plans" and governmental plans currently exempt from ERISA; (3) multiple employer entities, such as those maintained by legitimate trade, industry and professional associations, which meet the definition under ERISA of an "employee benefit plan";

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[27] Subcommittee on Employer-Employee Relations Hearing on "Expanding Access to Quality Health Care: Solutions for Uninsured Americans" Committee on Education and the Workforce, U.S. House of Representatives, 107th Congress, Second Session, July 9, 2002 (Serial No. 107–69).

[28] The statute expressly excludes from the MEWA definition plans or other arrangements which are established or maintained—(i) under or pursuant to one or more agreements which the Secretary (of Labor) finds to be collective bargaining agreements, (ii) by a rural electric cooperative, or (iii) by a rural telephone cooperative association. The Department issued a regulation establishing standards and procedures for determinations as to whether a plan or other arrangement would be treated as established or maintained under or pursuant to one or more collective bargaining agreements for purposes of the above noted exception under ERISA section 3(40)(A)(i). See 20 CFR 2510.3–40.

and (4) other multiple employer welfare arrangements which do not meet the definition under ERISA of an "employee benefit plan."[29]

In general, ERISA's federal preemption provisions allow states to regulate insurance products that employee benefit plans purchase, but preclude states from applying state insurance law directly to ERISA-covered employee benefit plans.[30] As originally enacted, this broad preemption included self-insured multiple employer which met ERISA's definition of "employee benefit plan."

Unfortunately, illegitimate schemes (which did not rise to the level of ERISA "employee benefit plans") promoted by "bogus unions" and others (known as MEWAs) were able to delay and thwart legitimate state enforcement efforts by claiming ERISA preemption. To remedy this, ERISA was amended in 1983 in an attempt to clarify the ability of states to regulate the non-ERISA-plan entities as well as legitimate self-insured ERISA multiple employer plans (but the regulation by the states of the latter was conditional, i.e., regulation is permitted only "to the extent not inconsistent with the provisions" * * * of ERISA Title I).[31] This later clause was intended to facilitate state regulation of all self-insured benefit arrangements by allowing responsible state regulation of self-insured multiple employer ERISA plans. It was not expected that states would use this authority to terminate legitimate self-insured plans solely because they were not licensed under state laws designed to regulate commercial insurance companies.

Unfortunately, the 1983 amendment to ERISA did not achieve its two primary objectives. While a few states have enacted specific statutes regulating legitimate self-insured multiple employer plans, others have outlawed all self-insured multiple employer benefit arrangements, even legitimate self-insured ERISA plans. Some state actions have been selective in nature and have not followed any consistent basis either within a state or among states. Neither did the 1983 amendment achieve the objective of stemming the number of illegitimate enterprises that continue to bilk the public under arrangements that are not legitimate ERISA "employee benefit plans."

H.R. 525 will meet these dual objectives by enabling legitimate associations to maintain or establish multiple employer plans by voluntarily seeking licensure in the few states permitting them to do so or by seeking federal certification as an AHP. Entities that do not have either a state or federal certification will be fully subject to state law. Therefore the states, as they choose, may force such entities to meet any insurance or multiple employer plan licensing requirements or shut them down. Under the bill, all such entities must register with the Department of Labor (DOL) and the states and are subject to the criminal penalties under ERISA for failure to do so (illegitimate entities will become criminal enterprises). In addition, DOL is given "cease and desist" authority to curtail the activities of any such illegitimate entities. These changes are necessary to clarify ERISA preemption and the role of the states and the federal government in relation to MEWAs.

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[29] 29 U.S.C. § 1003(40).

[30] This concept is incorporated in ERISA section 514 as the so-called "deemer clause" prohibiting states from deeming ERISA plans to be an insurance company or engaged in the business of insurance for purposes of any state law purporting to regulate insurance. 29 U.S.C. § 1144(b)(2)(B).

[31] 29 U.S.C. § 1144.

The clarification of ERISA preemption relating to MEWAs will free substantial federal resources that have been spent to stop health insurance fraud and abuse. Moreover, the considerable state resources involved in stopping MEWA fraud will be released for more productive purposes. Additional resources of the federal government can also be redirected more productively in administering the new law and helping expand more affordable health coverage.

As described in more detail below, the bill requires self-insured AHPs to meet solvency, fiduciary, and other necessary standards. The fact is that, under the bill, legitimate association self-insured arrangements will be subject to greater solvency regulation than union-sponsored multiemployer plans and the self-insured single-employer plans of even the largest employers.

Conclusion

H.R. 525 will open up the health insurance market to the millions of American workers and their families who today do not have access to or cannot afford private health insurance. It does so by removing the structural barriers that prevent some employers from voluntarily providing health insurance to their employees, either on their own or as part of an association health plan.

H.R. 525 amends Title I of ERISA to provide a 21st century model of freedom for employees and employers to negotiate benefits, letting market forces help reduce health care costs, thus making health insurance coverage more available and affordable for the American worker.

Cost-conscious small employers must be given the same opportunity to achieve the economies of scale and freedom from excessive government regulation that large employers and unions already enjoy. Removing barriers and allowing small employers to pool together to voluntarily form ERISA multiple employer health plans can effectively address the problems of uninsured workers and their families. AHPs build on what is already working in the employer-based health care system; and the increased health plan competition that results will mean improved access to more affordable coverage for millions of employees, particularly those uninsured individuals and their families who work for small businesses.

In conclusion, the only way major strides in expanding access to health coverage for the uninsured can be achieved in a voluntary market is to make reforms that bring down the cost of providing health coverage to employers, particularly small employers. Health care reform that is effective in expanding access and based on free market principles is possible. It is in the grasp of this Congress in the form of AHPs. It is the strong belief of the Committee that H.R. 525 presents this Congress with perhaps its best opportunity since the passage of ERISA to expand access to affordable health insurance for the many American families who are currently uninsured.

B. LEGISLATION

Providing access to affordable health care coverage for American workers and their families has been the subject of considerable Committee attention during the current and past Congresses. H.R. 525, the Small Business Health Fairness Act, will do just that.

H.R. 525's rules governing establishment of association health plans

H.R. 525 amends Subtitle B of Title I of ERISA to add a new Part 8 that sets forth rules governing the establishment of AHPs. AHPs are defined as group health plans whose sponsors are bona fide trade, industry or professional associations or bona fide chambers of commerce. These organizations must be structured and maintained in good faith for a continuous period of not less than three years with purposes other than that of obtaining or providing medical care. AHPs must be established as permanent entities, receiving the active support of members and requiring for membership payment on a periodic basis of dues or payments necessary to maintain eligibility for membership in the sponsor. These bona fide organizations must not condition membership, dues or payments, or coverage under the association health plan on the basis of health-status related factors. In addition to the associations described above, franchise networks would be eligible to seek certification as AHPs.

Opponents of H.R. 525 have charged that the bill will result in a segmented small group market, i.e. that associations will form AHPs in order to select or "cherry pick" healthy individuals away from state small group markets. Indeed, under current law, sham "unions" and other fraudulent insurance organizations have claimed ERISA preemption in order to evade state regulation. Not all states have statutes dealing with MEWAs and many states suffer from insufficient resources and ineffective enforcement of regulations, leaving these fraudulent insurance schemes unchallenged.

The Committee intends the bill's requirements that only allow bona fide trade and professional associations, such as the National Federation of Independent Business and the National Restaurant Association, to offer AHPs to protect against "cherry picking," or selection of lower risk individuals into AHPs. This ensures that AHPs will not be formed in order to select healthy individuals; rather, associations must have a larger purpose in order to form or establish an AHP. Additional protections against "cherry picking" will be discussed later.

H.R. 525's procedures and conditions for certification for AHPs

H.R. 525 establishes procedures for the certification of AHPs. In the case of a self-insured AHP, the Department of Labor shall grant certification only if all of the requirements of the newly established Part 8 are met, or will be met upon the date on which the plan is to commence operations. Self-insured association health plans must have at least 1,000 participants and beneficiaries and may only be certified if they are one of the following:

(1) A plan that offered such coverage on the date of enactment of H.R. 525;

(2) A plan where the sponsor does not restrict membership to one or more trades or businesses or industries and whose eligible participating employers represent a broad cross-section of trades or businesses or industries; or

(3) A plan whose eligible participating employers represent one or more trades, businesses, or industries specified in the bill; or which have been indicated as having average or above-average health insurance risk or health claims experience by reason of state rate filings, denials of coverage, or proposed

premium rate levels, or other means demonstrated by such plan in accord with regulations prescribed by DOL.

In addition to the requirement that only bona fide trade and industry associations may offer AHPs, the Committee believes that these requirements, allowing only multi-industry associations or trade associations with average risk to self-insure, offer further protection against "cherry picking."

In the case of AHPs that offer fully insured health products, the Secretary of Labor shall establish a class certification procedure. Because of the states role in regulating insurance, the Committee envisions the class certification process to involve the appropriate state regulatory authorities. For example, as state insurance commissioners will continue to govern the solvency of fully insured health insurance products offered by AHPs, the Committee intends the Department of Labor to consult with state insurance commissioners to ensure that issuers offering products to AHPs meet appropriate solvency standards. The Committee expects that this consultation would be maintained on an ongoing basis to ensure that certified AHPs offering fully insured health products continue to meet appropriate state standards.

All AHPs must be operated, pursuant to a trust agreement, by a board of trustees which has fiscal control and which is responsible for all operations of the plan. The board of trustees must develop rules of operation and financial control based on a three-year plan of operation, which is adequate to carry out the terms of the plan and to meet all applicable requirements of Title I of ERISA. The board of trustees must consist of individuals who are owners, officers, directors, or employees of the employers who participate in the plan. Instruments governing the AHP must provide that the board of trustees serves as the named fiduciary and plan administrator, that the sponsor serves as plan sponsor, and that certain reserve requirements are met.

AHPs must meet all of ERISA's fiduciary rules requiring that the assets of an employee benefit plan be held in trust for the exclusive benefit of plan participants and their beneficiaries, and for defraying reasonable expenses of administering the plan. Part 4 of Title I of ERISA explains the fundamental duties of fiduciaries to employee benefit plans. In short, fiduciaries are to act solely in the interest of participants and beneficiaries with care, skill, prudence and diligence.[32] The Committee believes that the fiduciary duty of loyalty—the highest duty of loyalty that exists in the law—is the ultimate protection to participants and beneficiaries in ERISA plans.[33] Accordingly, the Committee believes that the employers and employees who participate in AHPs will be well-protected.

Additional certification criteria include the filing of a complete application; a filing fee of $5,000; financial, actuarial, reporting, and participation requirements; and such other requirements as may be specified by the Secretary of Labor as a condition of the certification. In addition, the application must include the following: (1) identifying information about the arrangement and the states in which it will operate; (2) evidence that ERISA's bonding requirements will be met; (3) copies of all plan documents and

[32] 29 U.S.C. § 1104.
[33] See, e.g., Donovan v. Bierwith, 680 F.2d 263, 272n.8 (2d Cir. 1982).

agreements with service providers; (4) a funding report indicating that the reserve requirements will be met, that contribution rates will be adequate to cover obligations, and that a qualified actuary who is a member in good standing of the American Academy of Actuaries has issued an opinion with respect to the arrangement's assets, liabilities, and projected costs; and (5) any other information prescribed by the Secretary. Certified AHPs must notify the applicable authority of any material changes in this information at any time, must file annual reports with the Secretary, and must engage a qualified actuary. AHPs are also required to file their certification with the applicable state authority of each state in which at least 25 percent of the participants and beneficiaries under the plan are located.

Protection against discrimination

H.R. 525 prohibits discrimination against eligible employers and employees by requiring that all employers who are association members must be eligible to participate under the terms of the plan and must be informed of all benefit options available. In addition, H.R. 525 requires that eligible individuals may not be excluded from enrolling in the plan because of health status.

Despite these protections, opponents of H.R. 525 have criticized it as allowing anti-selection with respect to the small group market. The Committee notes that requiring all employers who are members of the bona fide association to be eligible for the AHP is equal to or greater than any state law governing insurers.

In addition, employers participating in the AHP are forbidden from selectively providing sick individuals with coverage in the individual health insurance market. The Committee intends this prohibition to be an additional protection against "cherry picking" by ensuring that AHPs may not in effect select against sick individuals by allowing their employers to provide coverage to these workers outside of the AHP. H.R. 525 allows AHPs to include minimum participation, contribution, and size requirements to the extent that they meet the nondiscrimination and other rules under sections 701, 702, and 703 of ERISA.[34]

AHPs are specifically prohibited from denying or conditioning health insurance for individuals on the basis of health status. Specifically, the bill requires AHPs to follow the same rules on portability, pre-existing conditions, nondiscrimination and renewability that large employers and insurance companies must follow under the 1996 Health Insurance Portability, Accessibility and Accountability Act (HIPAA).

In addition to H.R. 525's protections for individuals, the bill also requires that the contribution rates for any particular employer must be nondiscriminatory. This means that contribution rates for employers cannot vary on the basis of any health status-related factor with respect to employees of particular employers or the type of business or industry in which the employer is engaged, unless the state where that small employer is located would specifically allow such a variation, and then, only to the extent that the state would allow.

[34] 29 U.S.C. §§ 1171, 1172, 1173.

During consideration of the bill, the Committee rejected an amendment that would have prohibited AHPs from varying rates for small employers even if the state law allowed such a variance. The Committee has included many protections in the bill in order to prevent the practice of "cherry picking" by AHPs. The Committee believes that it is important to note that if H.R. 525 did not allow AHPs to vary contribution rates for small employers in a state to the extent that the state law would allow, it would be likely that health insurance issuers would "cherry pick" the healthier small employer groups out of the AHP.

Some opponents of the bill believe that AHPs should be required to "community rate" or average the claims of all participating employers in the AHP and charge each an equivalent contribution rate. They assert that group pooling is all that is needed to lower health insurance costs and thus avoid the "cherry picking" of healthier groups by health insurance issuers.

Though the Committee believes that pooling of risk will indeed lower costs in some cases, it would not be enough to prevent the "cherry picking" of healthy groups by health insurance issuers. For example, the state of Illinois allows issuers to vary rates for small employers on the basis of medical information. Thus, an issuer might attempt to draw healthier groups away from the AHP by offering a rate that could be 67 percent lower than a sick group. While economies of scale will lower the health insurance costs of the employers participating in an AHP, it is unlikely that they will be lowered by 67 percent. Thus in the Illinois case, it is obvious that the AHP would need to have the same flexibility as other state regulated products to attract the participation of a broad cross section of its membership versus only the unhealthy groups.

The Committee notes that almost every state allows rates for small employers to vary by some factors, such as age, gender or geography. Only two states, New York and Vermont, have gone so far as to require strict "community rating" in the small group market. Allowing issuers to vary rates while requiring community rating for AHPs would virtually ensure that issuers have an advantage over AHPs in the marketplace, thereby resulting in adverse selection against AHPs.

Another argument that has been used to support the contention that H.R. 525 will allow "cherry-picking" is the assertion that state insurance rating rules will not apply to fully insured health products offered by AHPs. It is the view of the Committee that in the case of AHPs that offer fully insured health coverage, H.R. 525 would not generally preempt state laws that govern the rating of insurance products offered by associations except in the cases discussed below.

The Committee intends H.R. 525 to preempt state insurance rating laws for fully insured plans to the extent that they would prohibit AHPs from setting premiums on the basis of the claims of the AHP plan. For example, some state laws require that claims for all small employers in the state (those in and out of the AHP) be averaged to determine a general average for premium setting purposes. In those states, these laws would be preempted. Importantly, should a state attempt to regulate federally certified AHPs more strictly with regard to allowable rating practices than other non-

AHP associations offering coverage in a state, H.R. 525 would preempt these laws as well.

In contrast to the situation for AHPs that offer fully insured health products, self-insured AHPs, like self-insured union and employer plans, will not be subject to state rating laws because they are not in the business of insurance. ERISA sets no federal requirements for self-insured plans—it does not require that large employers or unions "community rate" their plans. These plans can and do vary their rates for employees, particularly on geography. Nothing in federal law prohibits a union or large employer from varying rates for a group of their similarly situated individuals. For example, a different collective bargaining unit, a different employer in a multi-employer plan, or a set of employees located in a different geographic location could have different rates. It is the intention of the Committee that self-insured AHPs be allowed to vary rates on geography, age, family composition, gender or other criteria, as is the case for other self-insured plans.

Finally, the Committee intends that since the AHP bill is an amendment to ERISA, it does not change the relationship between ERISA and Title VII of the Civil Rights Act. Because of this, protections for individuals under the Title VII of the Civil Rights Act will be the same for workers participating in AHPs as for those workers who receive health coverage under ERISA plans today.

Preemption of state mandates

H.R. 525 allows AHPs to exercise sole discretion in selecting specific items and services to be covered under the plan. This is true for AHPs that offer fully insured health products as well as AHPs that self-insure. As such, the bill preempts any state law that would specify items or services to be covered under the plan.

Clearly, AHPs that self-insure would be exempt from state laws that require specific items or services as they are not in the business of insurance. However, preemption is also granted in the case of fully insured health products. As the bill specifically requires that a self-insured AHP have at least 1000 participants, in order for smaller associations to take advantage of the preemption from benefit mandates, they must also be preempted on the fully insured side. However, the bill does not preempt state laws that require health plans to cover individuals with specific diseases, such as diabetes or AIDS, in the state where the AHP is domiciled.

During consideration of the bill, the Committee rejected numerous amendments that would have allowed general preemption of state benefit mandates with specific exceptions. The Committee feels strongly that many individuals who receive coverage through AHPs would otherwise have had no health care coverage, and that coverage offered by AHPs will be high quality, covering most if not all of the benefits that are typically mandated by the states.

Because of this, the Committee confidently rejected the need to micromanage the provision of health care by AHPs, instead giving AHPs the freedom that large employers and unions already enjoy, to select the benefit packages that best serve their employees. The Committee also notes that for many workers, passage of AHPs will mean the difference between access to coverage and no health care coverage at all. Though state laws may guarantee particular benefits when coverage is offered, in general, state laws do not require

that health coverage be offered. Therefore for those many individuals who are not offered health insurance by their employer, the coverage their employer is able to access through the AHP, with or without particular state mandates, will provide health benefits the individual would not otherwise have.

Opponents of the bill have suggested that the bill's preemption from state benefit mandates also preempts laws such as those that regulate solvency, external review and prompt payment of claims. This is not the case. The Committee intends that, under the bill, state laws such as those that govern external review and prompt payment of claims will apply to AHPs that offer fully insured health coverage and Assistant Secretary Ann Combs clarified this issue during a Subcommittee hearing on the bill in the 108th Congress.[35] Since these laws do not impact the selection of specific items or services consisting of medical care, these laws are not preempted. Though the Committee believes that the bill does not preempt these laws, it has seen fit to include two provisions to clarify the application of these laws. First, H.R. 525 includes language that amends section 514 of ERISA to clarify that the preceding amendments should not be construed to supersede or impair the law of any state with respect to issuers or health insurance coverage that provides solvency standards. H.R. 525 also includes language clarifying that laws relating to prompt payment of claims were also not superseded.

During consideration of the bill, the Committee also rejected amendments that would have subjected AHPs to federal mandates. The Committee believes that adding federal benefit mandates to ERISA is an issue separate and apart from legislation to create AHPs. Should Congress decide to establish additional federal patient protections, the Committee believes that they should be applied to all plans equally.

Solvency requirements

Health insurance issuers that offer fully insured coverage to AHPs will continue to be subject to state laws regarding solvency as discussed above. In addition, the Committee expects that the Department of Labor would condition its class certification of fully insured AHPs on the issuer's satisfaction of state solvency and other insurance regulations.

With respect to self-insured AHPs, H.R. 525 sets forth strict solvency requirements. Solvency provisions are as follows:

> AHPs are required to maintain: (1) reserves adequate for unearned contributions from employers, (2) reserves for liabilities incurred, (3) reserves for any other obligations, and (4) reserves for a margin of error. The amount of each of these reserve components must be recommended by a qualified actuary, certified by the American Academy of Actuaries;
>
> AHPs are required to maintain aggregate stop loss insurance in the event that claims exceed the plan's expectation by 25 percent, and specific stop loss insurance as recommended by a qualified actuary. Both of these insurance products will be

[35] Subcommittee on Employer-Employee Relations hearing on H.R. 660, "Small Business Health Fairness Act" Committee on Education and the Workforce, U.S. House of Representatives, 108th Congress, First Session, March 13, 2003 (Serial No. 108–10).

fully regulated by the state, and the Secretary of Labor is able to modify or increase these requirements by regulation;

AHPs are required to maintain indemnification insurance in order to prevent unpaid claims in the event of plan termination;

The board of trustees of an AHP is required to certify on a quarterly basis that the AHP is financially sound. If the board determines that the solvency requirements of the bill are not being met, they must, in consultation with the qualified actuary, develop a plan to ensure compliance and report such information to the Secretary;

AHPs are required to maintain a minimum surplus reserve of $500,000. This amount may be increased to up to $2 million by the Secretary of Labor;

AHPs are also required to contribute $5000 per year to a new Association Health Plan Fund, established to assist in paying claims in the event of an AHP termination. The Secretary may increase the required contribution if this amount is inadequate; and

The bill establishes a new Solvency Standards Working Group. Members from the National Association of Insurance Commissioners, the American Academy of Actuaries, the state governments, and others will make recommendations to the Secretary to assist in the formation of solvency regulations.

The Committee notes that these requirements are much stronger than current law for employers or unions who self-insure, as ERISA contains no solvency standards for these entities. Further, the Committee notes that these standards are generally analogous to state solvency standards for health insurance issuers.

H.R. 525 grants authority to the Secretary of Labor to make payments to stop loss or indemnification insurers in any case in which the Secretary determines that an AHP is failing or will fail to meet the federal solvency requirements or will terminate. H.R. 525 also requires that the issuers of stop loss and indemnification insurance for self-insured AHPs notify the Secretary of Labor if the AHP fails to make a payment that would result in the cancellation of the insurance policy. This provision is intended to ensure that the Secretary of Labor maintains insurance products if necessary, so that in the event of an AHP failure, the insured products meet plan losses and satisfy workers claims.

The Committee also grants authority to the Secretary to permit an AHP to substitute, for all or part of the reserves required, such security, guarantee, hold-harmless arrangements, insurance, or other financial arrangement as the Secretary determines to be adequate to enable the plan to fully satisfy all benefit liabilities on a timely basis. Such an alternative must not be less protective than the basic provisions for which it is substituted. H.R. 525 requires a self-insured AHP to meet the reserve requirements even if its certification is no longer in effect.

In any case where an AHP notifies the Secretary that it has failed to meet the reserve requirements and corrective action has not restored compliance, and the Secretary determines that there is a reasonable expectation that the plan will continue to fail to meet the applicable requirements, the Secretary may direct the board to terminate the arrangement.

H.R 525 provides that an AHP may also voluntarily terminate only if the board of trustees provides 60 days advance written notice to participants and beneficiaries and submits to the Secretary a plan providing for timely payment of all benefit obligations.

Whenever the Secretary determines an AHP will not be able to provide benefits, or is otherwise in financial distress, the Secretary shall apply to the appropriate United States District Court for appointment as trustee to administer the termination of the plan.

State assessment authority

H.R. 525 specifically allows a state to assess a self-insured AHP with a contribution tax to the same extent the state taxes health insurance plans that offer coverage to fully insured AHPs. Such tax must be computed by subtracting the amount of any tax or assessment otherwise imposed by the state on other insured products maintained by the self-insured AHP.

Amendments to ERISA's preemption rules

H.R. 525 adds a new subsection 514(d) of ERISA (current subsection (d) is redesignated as (e)) to clarify the ability of health insurance issuers to offer health insurance coverage under AHPs. Should states attempt to preclude AHPs from operating by passing laws that preclude them from doing so or have this effect, these laws will be preempted under ERISA. For example, should a state law refuse to license health insurance issuers that intend to provide health coverage to an AHP, the Committee intends this law to be preempted by the bill. The Committee intends this language to serve as a warning to state regulators that their ability to regulate fully insured health products provided by AHPs stops at the point where they attempt to prevent AHPs from operating.

H.R. 525 also makes two changes to ERISA's preemption laws regarding MEWAs. First, paragraph (6) of section 514(b) is made inapplicable with respect to any state law in the case of a certified AHP. This change ensures that AHPs will not be forced to comply with the same level of confusing and duplicative dual regulation that MEWAs have been subject to. Second, the bill removes the current restriction on state regulation of self-insured multiple employer welfare arrangements providing medical care (which do not elect to meet the certification requirements for AHPs) under section 514(b)(6)(A)(ii) by eliminating the requirement that such state laws otherwise "be consistent with the provisions of ERISA Title I." As discussed above, H.R. 525 provides that legitimate associations may choose to either remain subject to the few state multiple plan laws or to apply for a federal certification as an AHP. The legislation draws bright lines regarding state and federal authority regarding self-insured multiple employer plans. Current law is confusing regarding the responsibility of the states and the Department of Labor under ERISA. Under the bill, MEWAs have two choices, apply for and become a certified AHP, or be regulated entirely by the states.

H.R. 525 includes two other important provisions: (1) It allows any health insurance issuer to offer the same type of health insurance coverage provided to an AHP to other eligible employers that may not be a member of the AHP; and (2) It clarifies that health insurance coverage policy forms filed and approved in a particular

state in connection with an insurer's offering under an association health plan are deemed to be approved in any other state in which such coverage is offered when the insurer provides a complete filing in the same form and manner to the authority in the other state. The Committee intends the preemption amendment with regard to the filing of policy forms in other states to remedy the administrative burden of filing differing policy forms in different states, and to speed the process of approval, as once the policy form is approved in one state, it is deemed to be approved in every other state.

Section 514 of ERISA is also amended to include a necessary cross-reference to the newly created section 805(b) (relating to the ability of AHPs and health insurance issuers to design association health insurance options) and to section 805(a)(2)(B) (relating to the ability of AHPs and health insurance issuers to base contribution rates on the experience of such plans). The cross-references are necessary in order ensure the proper rules are established for AHPs. As discussed above, the bill also includes language regarding the solvency of fully insured health products or health insurance issuers and the prompt payment of claims by health insurers providing to an AHP.

Enforcement provisions relating to AHPs and MEWAs

H.R. 525 amends ERISA to establish enforcement provisions relating to AHPs and MEWAs. Specifically, the bill would: (1) establish that willful misrepresentation that an entity is a certified AHP or collectively-bargained arrangement may result in criminal penalties; (2) allow for cease activity orders for arrangements found to be neither licensed, registered, or otherwise approved under state insurance law, or operating in accordance with the terms of the certification granted by the Secretary under Part 8; and (3) require the named fiduciary or board of trustees of an AHP to comply with the required claims procedure under ERISA.

Cooperation between federal and state authorities

H.R. 525 amends section 506 of ERISA (relating to coordination and responsibility of agencies enforcing ERISA and related laws) to require the Secretary of Labor to consult with state insurance departments with regard to the Secretary's authority under section 502 and 504 to enforce provisions applicable to certified AHPs. In the case of AHPs offering fully insured health coverage, the Secretary shall consult with the state in which filing and approval of a policy type offered by the plan was initially obtained. In all other cases, the Secretary shall take into account the places of residence of the participants and beneficiaries under the plan and the state in which the trust is maintained in determining which state is the state with which consultation is required.

Effective date

In general, the amendments made by H.R. 525 are effective one year after enactment of the Act. In addition, the Secretary is required to issue all regulations needed to carry out the amendments within one year after enactment of the Act and report to Congress within five years the effect of AHPs on reducing the number of uninsured workers.

SECTION-BY-SECTION

Section 1—Short title and table of contents.

Section 2(a) creates a new Part 8 under ERISA (as described below).

Section 801 outlines that a sponsor of an AHP must be a bona fide association established for substantial purposes other than that of obtaining or providing medical care. The association must charge dues to its small business members and must not condition membership, dues or coverage under the health plan on the basis of health status.

Section 802 establishes a procedure for the certification of Association Health Plans as prescribed by the Secretary of Labor. For AHPs that purchase health insurance from an insurance company, the Secretary will establish a class certification. For those that will offer a self-insured health benefit, the bill establishes several criteria in order to insure that the businesses covered will be of average health risk, to avoid pulling only healthy individuals from the small employer market ("cherry-picking").

Section 803 establishes additional eligibility requirements for AHPs. Applicants must demonstrate that the arrangement's sponsor has been in existence for a continuous period of at least three years for substantial purposes other than providing coverage under a group health plan. AHPs must be operated, pursuant to a trust agreement, by a "board of trustees" which has complete fiscal control and which is responsible for all operations of the plan. The board of trustees must consist of individuals who are owners, officers, directors or employees of the employers who participate in the plan.

Section 804 prohibits discrimination against eligible employers and employees by requiring that, (1) all employers who are association members be eligible for participation under the terms of the plan, (2) that eligible employers be informed of all benefit options available, and (3) that eligible individuals of such participating employers not be excluded from enrolling in the plan because of health status. The bill also stipulates that no participating employer may exclude an employee from enrollment under an AHP by purchasing an individual policy of health insurance coverage for such person based on his or her health status.

Section 805 requires that contribution rates for any particular employer must be nondiscriminatory—they cannot vary on the health status of the particular employer or on the type of business or industry in which the employer is engaged, unless the state in which the employer is located would specifically allow such a variance, and then, only to the degree allowed in the state. In the case of AHPs offering fully insured health coverage, state rating laws that prevent an AHP from setting contribution rates based on the claims experience of the plan or that regulate a federally certified AHP more strictly than other associations offering fully insured coverage shall also be preempted. In addition, this section outlines that association health plans must be allowed to design benefit options. Specifically, the bill mandates that no provision of state law shall preclude an AHP or health insurance issuer from exercising its sole discretion in designing the items and services of medical care to be included as health insurance coverage under the plan.

Section 806 establishes capital reserve requirements for self-insured AHPs and requires them to obtain stop loss and indemnification insurance. In addition, the AHP must maintain minimum surplus reserves of $500,000 or such greater amount (up to $2,000,000) as the Secretary of Labor may prescribe. Any person issuing stop loss or indemnification insurance to a plan is required to notify the Secretary of Labor of any failure of premium payment meriting cancellation of the policy. The bill also establishes an "Association Health Plan Fund" which is to be managed by the Department of Labor for the purpose of making payments to cover any outstanding benefit claims which are not fulfilled in accord with the solvency standards described above. All certified AHPs would be required to pay $5,000 into the fund annually. The bill also establishes a "Solvency Standards Working Group" for the purpose of providing input to the Secretary with respect to solvency requirements for AHPs certified under the Act. The bill grants authority to the Secretary to permit an association health plan to substitute, for all or part of the reserves required, such security, guarantee, hold-harmless arrangements, insurance, or other financial arrangement as the Secretary determines to be adequate to enable the plan to fully satisfy all benefit liabilities on a timely basis. Such an alternative must not be less protective than the basic provisions for which it is substituted. If the Secretary determines that there will be a failure or termination of an AHP, the bill grants the Secretary authority to make payments to insurers in order to maintain the stop loss or indemnification insurance.

Section 807 sets forth additional criteria which association health plans must meet to qualify for certification. The Secretary shall grant certification to a plan only if: (1) a complete application has been filed, accompanied by the filing fee of $5,000; and (2) all other terms of the certification are met (including financial, actuarial, reporting, participation, and such other requirements as may be specified as a condition of the certification). AHPs are also required to file their certification with the applicable state authority of each state in which at least 25% of the participants and beneficiaries under the plan are located.

Section 808 requires that, except as provided in section 809, an AHP may voluntarily terminate only if the board of trustees provides 60 days advance written notice to participants and beneficiaries and submits to the applicable authority a plan providing for timely payment of all benefit obligations.

Section 809 requires that the board of trustees of a self-insured AHP must determine quarterly whether the reserve requirements of section 806 are being met and, if they are not, must, in consultation with the qualified actuary, develop a plan to ensure compliance and report such information to the Secretary. In any case where an AHP notifies the Secretary that it has failed to meet the reserve requirements and corrective action has not restored compliance, and the Secretary determines that there is a reasonable expectation that the plan will continue to fail to meet the requirements applicable to the AHPs; the Secretary may direct the board to terminate the arrangement.

Section 810 sets forth procedures whereby the Secretary may become the trustee of insolvent AHPs. Whenever the Secretary determines an AHP won't be able to provide benefits, or is otherwise in

financial distress, the Secretary shall apply for appointment as trustee to administer the termination of the plan.

Section 811 allows a state to assess newly certified AHPs with a contribution tax to the same extent they tax health insurance plans. Such tax must be computed by subtracting the amount of any tax or assessment otherwise imposed by the state on other insured products maintained by the self-insured AHP.

Section 812 defines the following terms: group health plan, medical care, health insurance coverage, health insurance issuer, applicable authority, health status-related factor, individual market, treatment of very small groups, participating employer, applicable state authority, qualified actuary, affiliated member, large employer, and small employer.

Section 2(b) includes other conforming amendments to ERISA with regard to state preemption—The bill makes conforming amendments to ERISA to clarify the treatment of ERISA's preemption rules with regard to AHPs. For certified AHPs, state law is preempted to the extent that it would preclude an AHP from existing in a state. In addition, state law is also preempted in order to allow health insurance issuers to offer health insurance coverage of the same policy type as offered in connection with a particular AHP to eligible employers, regardless of whether such employers are members of the particular association. Health insurance coverage policy forms filed and approved in a particular state in connection with an insurer's offering under an AHP are deemed to be approved in any other state in which such coverage is offered when the insurer provides a complete filing in the same form and manner to the authority in the other state. The bill also makes two changes to ERISA's preemption laws regarding MEWAs. First, paragraph (6) of section 514(b) is made inapplicable with respect to any state law in the case of a certified AHP. Second, the bill removes the current restriction on state regulation of self-insured multiple employer welfare arrangements providing medical care (which do not elect to meet the certification requirements for AHPs) under section 514(b)(6)(A)(ii) by eliminating the requirement that such state laws otherwise "be consistent with the provisions of ERISA Title I." The bill also amends Section 514 to clarify that the preceding amendments to 514 should not be construed to supersede or impair the law of any State with respect to issuers or health insurance coverage, that provides solvency standards or prompt payment of claims.

Section 3 clarifies the treatment of single employer arrangements.

Section 4 establishes enforcement provisions relating to AHPs and multiple employer welfare arrangements (MEWAs): (1) willful misrepresentation that an entity is an exempted AHP or collectively-bargained arrangement may result in criminal penalties; (2) the section provides for cease activity orders for arrangements found to be neither licensed, registered, or otherwise approved under State insurance law, or operating in accordance with the terms of the certification granted by the Secretary under Part 8; and (3) the section provides for the responsibility of the named fiduciary or board of trustees of an AHP to comply with the required claims procedure under ERISA.

Section 5 amends section 506 of ERISA (relating to coordination and responsibility of agencies enforcing ERISA and related laws) to require the Secretary of Labor to consult with state insurance departments with regard to the Secretary's authority under section 502 and 504 to enforce provisions applicable to certified AHPs.

Section 6. In general, the amendments made by the act will be effective one year after enactment of the Act. In addition, the Secretary will be required to issue all regulations needed to carry out the amendments within one year after enactment of the Act.

EXPLANATION OF AMENDMENTS

No amendments were accepted by the Committee.

ROLLCALL VOTES

COMMITTEE ON EDUCATION AND THE WORKFORCE

ROLL CALL 1 BILL H.R. 525 DATE March 16, 2005
AMENDMENT NUMBER 1 DEFEATED 21 – 22
SPONSOR/AMENDMENT Mr. Kind/ amendment in the nature of a substitute

MEMBER	AYE	NO	PRESENT	NOT VOTING
Mr. BOEHNER, Chairman		X		
Mr. PETRI, Vice Chairman		X		
Mr. McKEON				X
Mr. CASTLE		X		
Mr. JOHNSON		X		
Mr. SOUDER		X		
Mr. NORWOOD		X		
Mr. EHLERS		X		
Mrs. BIGGERT		X		
Mr. PLATTS				X
Mr. TIBERI		X		
Mr. KELLER		X		
Mr. OSBORNE		X		
Mr. WILSON		X		
Mr. PORTER		X		
Mr. KLINE		X		
Mrs. MUSGRAVE		X		
Mr. INGLIS				X
Ms. McMORRIS		X		
Mr. MARCHANT				X
Mr. PRICE		X		
Mr. FORTUNO				X
Mr. JINDAL		X		
Mr. BOUSTANY		X		
Mrs. FOXX		X		
Mrs. DRAKE		X		
Mr. KUHL		X		
Mr. MILLER	X			
Mr. KILDEE	X			
Mr. OWENS	X			
Mr. PAYNE	X			
Mr. ANDREWS	X			
Mr. SCOTT				X
Ms. WOOLSEY	X			
Mr. HINOJOSA	X			
Mrs. McCARTHY	X			
Mr. TIERNEY	X			
Mr. KIND	x			
Mr. KUCINICH	X			
Mr. WU	X			
Mr. HOLT	X			
Mrs. DAVIS	X			
Ms. McCOLLUM	X			
Mr. DAVIS	X			
Mr. GRIJALVA	X			
Mr. VAN HOLLEN	X			
Mr. RYAN	X			
Mr. BISHOP	X			
Mr. BARROW	X			
TOTALS	21	22		6

COMMITTEE ON EDUCATION AND THE WORKFORCE

ROLL CALL 2 BILL H.R. 525 DATE March 16, 2005

AMENDMENT NUMBER 2 DEFEATED 24 - 24

SPONSOR/AMENDMENT Mr. Norwood / amendment to restrict the ability of self insured plans to vary premiums and contribution rates for Association Health Plans

MEMBER	AYE	NO	PRESENT	NOT VOTING
Mr. BOEHNER, Chairman		X		
Mr. PETRI, Vice Chairman		X		
Mr. McKEON				X
Mr. CASTLE		X		
Mr. JOHNSON		X		
Mr. SOUDER		X		
Mr. NORWOOD	X			
Mr. EHLERS		X		
Mrs. BIGGERT		X		
Mr. PLATTS		X		
Mr. TIBERI		X		
Mr. KELLER		X		
Mr. OSBORNE		X		
Mr. WILSON		X		
Mr. PORTER		X		
Mr. KLINE		X		
Mrs. MUSGRAVE		X		
Mr. INGLIS		X		
Ms. McMORRIS		X		
Mr. MARCHANT		X		
Mr. PRICE	X			
Mr. FORTUNO		X		
Mr. JINDAL		X		
Mr. BOUSTANY		X		
Mrs. FOXX		X		
Mrs. DRAKE		X		
Mr. KUHL		X		
Mr. MILLER	X			
Mr. KILDEE	X			
Mr. OWENS	X			
Mr. PAYNE	X			
Mr. ANDREWS	X			
Mr. SCOTT	X			
Ms. WOOLSEY	X			
Mr. HINOJOSA	X			
Mrs. McCARTHY	X			
Mr. TIERNEY	X			
Mr. KIND	X			
Mr. KUCINICH	X			
Mr. WU	X			
Mr. HOLT	X			
Mrs. DAVIS	X			
Ms. McCOLLUM	X			
Mr. DAVIS	X			
Mr. GRIJALVA	X			
Mr. VAN HOLLEN	X			
Mr. RYAN	X			
Mr. BISHOP	X			
Mr. BARROW	X			
TOTALS	24	24		1

COMMITTEE ON EDUCATION AND THE WORKFORCE

ROLL CALL 3 BILL H.R. 525 DATE March 16, 2005

AMENDMENT NUMBER 3 DEFEATED 17 – 24

SPONSOR/AMENDMENT Ms. McCollum / amendment to mandate coverage for maternity and child care for Association Health Plans

MEMBER	AYE	NO	PRESENT	NOT VOTING
Mr. BOEHNER, Chairman		X		
Mr. PETRI, Vice Chairman		X		
Mr. McKEON		X		
Mr. CASTLE		X		
Mr. JOHNSON		X		
Mr. SOUDER		X		
Mr. NORWOOD		X		
Mr. EHLERS				X
Mrs. BIGGERT		X		
Mr. PLATTS		X		
Mr. TIBERI		X		
Mr. KELLER		X		
Mr. OSBORNE		X		
Mr. WILSON				X
Mr. PORTER		X		
Mr. KLINE		X		
Mrs. MUSGRAVE		X		
Mr. INGLIS		X		
Ms. McMORRIS		X		
Mr. MARCHANT		X		
Mr. PRICE		X		
Mr. FORTUNO		X		
Mr. JINDAL				X
Mr. BOUSTANY		X		
Mrs. FOXX		X		
Mrs. DRAKE		X		
Mr. KUHL		X		
Mr. MILLER	X			
Mr. KILDEE	X			
Mr. OWENS				X
Mr. PAYNE				X
Mr. ANDREWS	X			
Mr. SCOTT	X			
Ms. WOOLSEY	X			
Mr. HINOJOSA				X
Mrs. McCARTHY	X			
Mr. TIERNEY				X
Mr. KIND	X			
Mr. KUCINICH				X
Mr. WU	X			
Mr. HOLT	X			
Mrs. DAVIS	X			
Ms. McCOLLUM	X			
Mr. DAVIS	X			
Mr. GRIJALVA	X			
Mr. VAN HOLLEN	X			
Mr. RYAN	X			
Mr. BISHOP	X			
Mr. BARROW	X			
TOTALS	17	24		8

COMMITTEE ON EDUCATION AND THE WORKFORCE

ROLL CALL 4 voted en bloc BILL H.R. 525 DATE March 16, 2005
AMENDMENT NUMBER 4 DEFEATED 21 - 23
SPONSOR/AMENDMENT Mr. Kildee / amendment to mandate coverage for diabetes treatment for Association Health Plans

MEMBER	AYE	NO	PRESENT	NOT VOTING
Mr. BOEHNER, Chairman		X		
Mr. PETRI, Vice Chairman				X
Mr. McKEON		X		
Mr. CASTLE		X		
Mr. JOHNSON		X		
Mr. SOUDER		X		
Mr. NORWOOD				X
Mr. EHLERS		X		
Mrs. BIGGERT		X		
Mr. PLATTS				X
Mr. TIBERI		X		
Mr. KELLER		X		
Mr. OSBORNE		X		
Mr. WILSON		X		
Mr. PORTER		X		
Mr. KLINE		X		
Mrs. MUSGRAVE		X		
Mr. INGLIS		X		
Ms. McMORRIS		X		
Mr. MARCHANT		X		
Mr. PRICE		X		
Mr. FORTUNO		X		
Mr. JINDAL				X
Mr. BOUSTANY		X		
Mrs. FOXX		X		
Mrs. DRAKE		X		
Mr. KUHL		X		
Mr. MILLER	X			
Mr. KILDEE	X			
Mr. OWENS	X			
Mr. PAYNE	X			
Mr. ANDREWS	X			
Mr. SCOTT	X			
Ms. WOOLSEY				X
Mr. HINOJOSA	X			
Mrs. McCARTHY	X			
Mr. TIERNEY	X			
Mr. KIND	X			
Mr. KUCINICH	X			
Mr. WU	X			
Mr. HOLT	X			
Mrs. DAVIS	X			
Ms. McCOLLUM	X			
Mr. DAVIS	X			
Mr. GRIJALVA	X			
Mr. VAN HOLLEN	X			
Mr. RYAN	X			
Mr. BISHOP	X			
Mr. BARROW	X			
TOTALS	21	23		5

COMMITTEE ON EDUCATION AND THE WORKFORCE

ROLL CALL 4 voted en bloc BILL H.R. 525 DATE March 16, 2005
AMENDMENT NUMBER 5 DEFEATED 21 - 23
SPONSOR/AMENDMENT Mrs. McCarthy / amendment to mandate that Association Health Plans provide additional mastectomy and breast and cervical cancer screening

MEMBER	AYE	NO	PRESENT	NOT VOTING
Mr. BOEHNER, Chairman		X		
Mr. PETRI, Vice Chairman				X
Mr. McKEON		X		
Mr. CASTLE		X		
Mr. JOHNSON		X		
Mr. SOUDER		X		
Mr. NORWOOD				X
Mr. EHLERS		X		
Mrs. BIGGERT		X		
Mr. PLATTS				X
Mr. TIBERI		X		
Mr. KELLER		X		
Mr. OSBORNE		X		
Mr. WILSON		X		
Mr. PORTER		X		
Mr. KLINE		X		
Mrs. MUSGRAVE		X		
Mr. INGLIS		X		
Ms. McMORRIS		X		
Mr. MARCHANT		X		
Mr. PRICE		X		
Mr. FORTUNO		X		
Mr. JINDAL				X
Mr. BOUSTANY		X		
Mrs. FOXX		X		
Mrs. DRAKE		X		
Mr. KUHL		X		
Mr. MILLER	X			
Mr. KILDEE	X			
Mr. OWENS	X			
Mr. PAYNE	X			
Mr. ANDREWS	X			
Mr. SCOTT	X			
Ms. WOOLSEY				X
Mr. HINOJOSA	X			
Mrs. McCARTHY	X			
Mr. TIERNEY	X			
Mr. KIND	X			
Mr. KUCINICH	X			
Mr. WU	X			
Mr. HOLT	X			
Mrs. DAVIS	X			
Ms. McCOLLUM	X			
Mr. DAVIS	X			
Mr. GRIJALVA	X			
Mr. VAN HOLLEN	X			
Mr. RYAN	X			
Mr. BISHOP	X			
Mr. BARROW	X			
TOTALS	21	23		5

COMMITTEE ON EDUCATION AND THE WORKFORCE

ROLL CALL 4 voted en bloc BILL H.R. 525 DATE March 16, 2005
AMENDMENT NUMBER 6 DEFEATED 21 - 23
SPONSOR/AMENDMENT Mr. Kind / amendment to mandate coverage for autism for Association Health Plans

MEMBER	AYE	NO	PRESENT	NOT VOTING
Mr. BOEHNER, Chairman		X		
Mr. PETRI, Vice Chairman				X
Mr. McKEON		X		
Mr. CASTLE		X		
Mr. JOHNSON		X		
Mr. SOUDER		X		
Mr. NORWOOD				X
Mr. EHLERS		X		
Mrs. BIGGERT		X		
Mr. PLATTS				X
Mr. TIBERI		X		
Mr. KELLER		X		
Mr. OSBORNE		X		
Mr. WILSON		X		
Mr. PORTER		X		
Mr. KLINE		X		
Mrs. MUSGRAVE		X		
Mr. INGLIS		X		
Ms. McMORRIS		X		
Mr. MARCHANT		X		
Mr. PRICE		X		
Mr. FORTUNO		X		
Mr. JINDAL				X
Mr. BOUSTANY		X		
Mrs. FOXX		X		
Mrs. DRAKE		X		
Mr. KUHL		X		
Mr. MILLER	X			
Mr. KILDEE	X			
Mr. OWENS	X			
Mr. PAYNE	X			
Mr. ANDREWS	X			
Mr. SCOTT	X			
Ms. WOOLSEY				X
Mr. HINOJOSA	X			
Mrs. McCARTHY	X			
Mr. TIERNEY	X			
Mr. KIND	X			
Mr. KUCINICH	X			
Mr. WU	X			
Mr. HOLT	X			
Mrs. DAVIS	X			
Ms. McCOLLUM	X			
Mr. DAVIS	X			
Mr. GRIJALVA	X			
Mr. VAN HOLLEN	X			
Mr. RYAN	X			
Mr. BISHOP	X			
Mr. BARROW	X			
TOTALS	21	23		5

COMMITTEE ON EDUCATION AND THE WORKFORCE

ROLL CALL 4 voted en bloc BILL H.R. 525 DATE March 16, 2005
AMENDMENT NUMBER 8 DEFEATED 21 - 23
SPONSOR/AMENDMENT Mr. Holt / amendment to mandate Association Health Plans to provide mental illness and substance abuse coverage

MEMBER	AYE	NO	PRESENT	NOT VOTING
Mr. BOEHNER, Chairman		X		
Mr. PETRI, Vice Chairman				X
Mr. McKEON		X		
Mr. CASTLE		X		
Mr. JOHNSON		X		
Mr. SOUDER		X		
Mr. NORWOOD				X
Mr. EHLERS		X		
Mrs. BIGGERT		X		
Mr. PLATTS				X
Mr. TIBERI		X		
Mr. KELLER		X		
Mr. OSBORNE		X		
Mr. WILSON		X		
Mr. PORTER		X		
Mr. KLINE		X		
Mrs. MUSGRAVE		X		
Mr. INGLIS		X		
Ms. McMORRIS		X		
Mr. MARCHANT		X		
Mr. PRICE		X		
Mr. FORTUNO		X		
Mr. JINDAL				X
Mr. BOUSTANY		X		
Mrs. FOXX		X		
Mrs. DRAKE		X		
Mr. KUHL		X		
Mr. MILLER	X			
Mr. KILDEE	X			
Mr. OWENS	X			
Mr. PAYNE	X			
Mr. ANDREWS	X			
Mr. SCOTT	X			
Ms. WOOLSEY				X
Mr. HINOJOSA	X			
Mrs. McCARTHY	X			
Mr. TIERNEY	X			
Mr. KIND	X			
Mr. KUCINICH	X			
Mr. WU	X			
Mr. HOLT	X			
Mrs. DAVIS	X			
Ms. McCOLLUM	X			
Mr. DAVIS	X			
Mr. GRIJALVA	X			
Mr. VAN HOLLEN	X			
Mr. RYAN	X			
Mr. BISHOP	X			
Mr. BARROW	X			
TOTALS	21	23		5

COMMITTEE ON EDUCATION AND THE WORKFORCE

ROLL CALL 4 voted en bloc BILL H.R. 525 DATE March 16, 2005
AMENDMENT NUMBER 9 DEFEATED 21 - 23
SPONSOR/AMENDMENT Mr.Van Hollen / amendment to impose state mandates relating to specific event benefits, external review, and required processes

MEMBER	AYE	NO	PRESENT	NOT VOTING
Mr. BOEHNER, Chairman		X		
Mr. PETRI, Vice Chairman				X
Mr. McKEON		X		
Mr. CASTLE		X		
Mr. JOHNSON		X		
Mr. SOUDER		X		
Mr. NORWOOD				X
Mr. EHLERS		X		
Mrs. BIGGERT		X		
Mr. PLATTS				X
Mr. TIBERI		X		
Mr. KELLER		X		
Mr. OSBORNE		X		
Mr. WILSON		X		
Mr. PORTER		X		
Mr. KLINE		X		
Mrs. MUSGRAVE		X		
Mr. INGLIS		X		
Ms. McMORRIS		X		
Mr. MARCHANT		X		
Mr. PRICE		X		
Mr. FORTUNO		X		
Mr. JINDAL				X
Mr. BOUSTANY		X		
Mrs. FOXX		X		
Mrs. DRAKE		X		
Mr. KUHL		X		
Mr. MILLER	X			
Mr. KILDEE	X			
Mr. OWENS	X			
Mr. PAYNE	X			
Mr. ANDREWS	X			
Mr. SCOTT	X			
Ms. WOOLSEY				X
Mr. HINOJOSA	X			
Mrs. McCARTHY	X			
Mr. TIERNEY	X			
Mr. KIND	X			
Mr. KUCINICH	X			
Mr. WU	X			
Mr. HOLT	X			
Mrs. DAVIS	X			
Ms. McCOLLUM	X			
Mr. DAVIS	X			
Mr. GRIJALVA	X			
Mr. VAN HOLLEN	X			
Mr. RYAN	X			
Mr. BISHOP	X			
Mr. BARROW	X			
TOTALS	21	23		5

COMMITTEE ON EDUCATION AND THE WORKFORCE

ROLL CALL 4 voted en bloc BILL H.R. 525 DATE March 16, 2005
AMENDMENT NUMBER 11 DEFEATED 21 - 23
SPONSOR/AMENDMENT Mr. Scott / amendment to require Association Health Plans to meet certain requirements set by the National Association of Insurance Commissioners

MEMBER	AYE	NO	PRESENT	NOT VOTING
Mr. BOEHNER, Chairman		X		
Mr. PETRI, Vice Chairman				X
Mr. McKEON		X		
Mr. CASTLE		X		
Mr. JOHNSON		X		
Mr. SOUDER		X		
Mr. NORWOOD				X
Mr. EHLERS		X		
Mrs. BIGGERT		X		
Mr. PLATTS				X
Mr. TIBERI		X		
Mr. KELLER		X		
Mr. OSBORNE		X		
Mr. WILSON		X		
Mr. PORTER		X		
Mr. KLINE		X		
Mrs. MUSGRAVE		X		
Mr. INGLIS		X		
Ms. McMORRIS		X		
Mr. MARCHANT		X		
Mr. PRICE		X		
Mr. FORTUNO		X		
Mr. JINDAL				X
Mr. BOUSTANY		X		
Mrs. FOXX		X		
Mrs. DRAKE		X		
Mr. KUHL		X		
Mr. MILLER	X			
Mr. KILDEE	X			
Mr. OWENS	X			
Mr. PAYNE	X			
Mr. ANDREWS	X			
Mr. SCOTT	X			
Ms. WOOLSEY				X
Mr. HINOJOSA	X			
Mrs. McCARTHY	X			
Mr. TIERNEY	X			
Mr. KIND	X			
Mr. KUCINICH	X			
Mr. WU	X			
Mr. HOLT	X			
Mrs. DAVIS	X			
Ms. McCOLLUM	X			
Mr. DAVIS	X			
Mr. GRIJALVA	X			
Mr. VAN HOLLEN	X			
Mr. RYAN	X			
Mr. BISHOP	X			
Mr. BARROW	X			
TOTALS	21	23		5

COMMITTEE ON EDUCATION AND THE WORKFORCE

ROLL CALL 5 BILL H.R. 525 DATE March 16, 2005
AMENDMENT NUMBER 7 DEFEATED 19 – 22 with 1 Member Voting Present
SPONSOR/AMENDMENT Mr. Holt /amendment to mandate contraceptive coverage for Association Health Plans

MEMBER	AYE	NO	PRESENT	NOT VOTING
Mr. BOEHNER, Chairman		X		
Mr. PETRI, Vice Chairman				X
Mr. McKEON		X		
Mr. CASTLE		X		
Mr. JOHNSON		X		
Mr. SOUDER		X		
Mr. NORWOOD				X
Mr. EHLERS		X		
Mrs. BIGGERT		X		
Mr. PLATTS				X
Mr. TIBERI		X		
Mr. KELLER		X		
Mr. OSBORNE		X		
Mr. WILSON		X		
Mr. PORTER		X		
Mr. KLINE		X		
Mrs. MUSGRAVE		X		
Mr. INGLIS		X		
Ms. McMORRIS		X		
Mr. MARCHANT				X
Mr. PRICE		X		
Mr. FORTUNO		X		
Mr. JINDAL				X
Mr. BOUSTANY		X		
Mrs. FOXX		X		
Mrs. DRAKE		X		
Mr. KUHL		X		
Mr. MILLER	X			
Mr. KILDEE			X	
Mr. OWENS	X			
Mr. PAYNE	X			
Mr. ANDREWS	X			
Mr. SCOTT				X
Ms. WOOLSEY				X
Mr. HINOJOSA	X			
Mrs. McCARTHY	X			
Mr. TIERNEY	X			
Mr. KIND	X			
Mr. KUCINICH	X			
Mr. WU	X			
Mr. HOLT	X			
Mrs. DAVIS	X			
Ms. McCOLLUM	X			
Mr. DAVIS	X			
Mr. GRIJALVA	X			
Mr. VAN HOLLEN	X			
Mr. RYAN	X			
Mr. BISHOP	X			
Mr. BARROW	X			
TOTALS	19	22	1	7

COMMITTEE ON EDUCATION AND THE WORKFORCE

ROLL CALL 6 BILL H.R. 525 DATE March 16, 2005
AMENDMENT NUMBER 10 DEFEATED 18 – 25
SPONSOR/AMENDMENT Mr. Kucinich / amendment to prohibit Association Health Plans payment for certain patented drugs

MEMBER	AYE	NO	PRESENT	NOT VOTING
Mr. BOEHNER, Chairman		X		
Mr. PETRI, Vice Chairman				X
Mr. McKEON		X		
Mr. CASTLE		X		
Mr. JOHNSON		X		
Mr. SOUDER		X		
Mr. NORWOOD				X
Mr. EHLERS		X		
Mrs. BIGGERT		X		
Mr. PLATTS		X		
Mr. TIBERI		X		
Mr. KELLER		X		
Mr. OSBORNE		X		
Mr. WILSON		X		
Mr. PORTER		X		
Mr. KLINE		X		
Mrs. MUSGRAVE		X		
Mr. INGLIS		X		
Ms. McMORRIS		X		
Mr. MARCHANT				X
Mr. PRICE		X		
Mr. FORTUNO		X		
Mr. JINDAL				X
Mr. BOUSTANY		X		
Mrs. FOXX		X		
Mrs. DRAKE		X		
Mr. KUHL		X		
Mr. MILLER	X			
Mr. KILDEE	X			
Mr. OWENS	X			
Mr. PAYNE	X			
Mr. ANDREWS	X			
Mr. SCOTT				X
Ms. WOOLSEY	X			
Mr. HINOJOSA	X			
Mrs. McCARTHY	X			
Mr. TIERNEY	X			
Mr. KIND	X			
Mr. KUCINICH	X			
Mr. WU	X			
Mr. HOLT		X		
Mrs. DAVIS				X
Ms. McCOLLUM		X		
Mr. DAVIS	X			
Mr. GRIJALVA	X			
Mr. VAN HOLLEN	X			
Mr. RYAN	X			
Mr. BISHOP	X			
Mr. BARROW	X			
TOTALS	18	25		6

COMMITTEE ON EDUCATION AND THE WORKFORCE

ROLL CALL 7 BILL H.R. 525 DATE March 16, 2005

H.R. 525 was ordered favorably reported by a vote of 25 – 22

SPONSOR/AMENDMENT Mr. Johnson / motion to report the bill to the House with the recommendation that the bill do pass

MEMBER	AYE	NO	PRESENT	NOT VOTING
Mr. BOEHNER, Chairman	X			
Mr. PETRI, Vice Chairman				X
Mr. McKEON	X			
Mr. CASTLE	X			
Mr. JOHNSON	X			
Mr. SOUDER	X			
Mr. NORWOOD	X			
Mr. EHLERS	X			
Mrs. BIGGERT	X			
Mr. PLATTS	X			
Mr. TIBERI	X			
Mr. KELLER	X			
Mr. OSBORNE	X			
Mr. WILSON	X			
Mr. PORTER	X			
Mr. KLINE	X			
Mrs. MUSGRAVE	X			
Mr. INGLIS	X			
Ms. McMORRIS	X			
Mr. MARCHANT	X			
Mr. PRICE	X			
Mr. FORTUNO	X			
Mr. JINDAL				X
Mr. BOUSTANY	X			
Mrs. FOXX	X			
Mrs. DRAKE	X			
Mr. KUHL	X			
Mr. MILLER		X		
Mr. KILDEE		X		
Mr. OWENS		X		
Mr. PAYNE		X		
Mr. ANDREWS		X		
Mr. SCOTT		X		
Ms. WOOLSEY		X		
Mr. HINOJOSA		X		
Mrs. McCARTHY		X		
Mr. TIERNEY		X		
Mr. KIND		X		
Mr. KUCINICH		X		
Mr. WU		X		
Mr. HOLT		X		
Mrs. DAVIS		X		
Ms. McCOLLUM		X		
Mr. DAVIS		X		
Mr. GRIJALVA		X		
Mr. VAN HOLLEN		X		
Mr. RYAN		X		
Mr. BISHOP		X		
Mr. BARROW		X		
TOTALS	25	22		2

CORRESPONDENCE

CONGRESS OF THE UNITED STATES,
HOUSE OF REPRESENTATIVES,
Washington, DC, April 6, 2005.

Hon. JOHN BOEHNER,
Chairman, Committee on Education and the Workforce,
Washington, DC.

DEAR MR. CHAIRMAN: Due to other legislative duties, I was unavoidably detained during Committee consideration of H.R. 525, "Small Business Health Fairness Act of 2005." Consequently, I missed roll call number three on amendment number three offered by Representative McCollum. Had I been present, I would have voted against the amendment.

I would appreciate your including this letter in the Committee Report to accompany H.R. 525. Thank you for your attention to this matter.

Sincerely,

JOE WILSON,
Member of Congress.

CONGRESS OF THE UNITED STATES,
HOUSE OF REPRESENTATIVES,
Washington, DC, April 6, 2005.

Hon. JOHN BOEHNER,
Chairman, Committee on Education and the Workforce,
Washington, DC.

DEAR MR. CHAIRMAN: Due to other legislative duties, I was unavoidably detained during Committee consideration of H.R. 525, "Small Business Health Fairness Act of 2005". Consequently, I missed Roll Call Vote Number 1, Amendment Number 1 offered by Representative Kind, Roll Call Vote Number 5, Amendment Number 7, offered by Representative Holt, and Roll Call Vote Number 6, Amendment Number 10 offered by Representative Kucinich. Had I been present, I would have voted against each of the amendments.

I would appreciate your including this letter in the Committee Report to accompany H.R. 525. Thank you for your attention to this matter.

Sincerely,

Hon. KENNY MARCHANT.

CONGRESS OF THE UNITED STATES,
HOUSE OF REPRESENTATIVES,
Washington, DC, April 6, 2005.

Hon. JOHN BOEHNER,
Chairman, Committee on Education and the Workforce,
Washington, DC.

DEAR MR. CHAIRMAN: Due to other legislative duties, I was unavoidably detained during Committee consideration of H.R. 525, "Small Business Health Fairness Act of 2005". Consequently, I missed roll call number ONE on amendment nunmber ONE offered

by Representative Kind. Had I been present, I would have voted against the amendment.

I would appreciate your including this letter in the Committee Report to accompany H.R. 525.

Thank you for your attention to this matter.

Sincerely,

LUIS FORTUÑO.

APPLICATION OF LAW TO THE LEGISLATIVE BRANCH

Section 102(b)(3) of Public Law 104–1 requires a description of the application of this bill to the legislative branch. This bill reduces the ranks of the uninsured by improving access to health care for uninsured working families, particularly those who are employed in small businesses. The bill would create association health plans ("AHPs") that would allow small businesses to join together through bona-fide trade associations, thus enjoying larger economies of scale presently enjoyed by many large corporations and unions, to purchase health insurance for their workers at a lower cost than they are presently experiencing. H.R. 525 would increase small businesses' bargaining power with health care providers, give them freedom from costly state mandated benefit packages, and lower overhead costs that would better enable them to offer health care coverage for their workers. Since ERISA excludes governmental plans, the bill does not apply to legislative branch employees. As public employees, legislative branch employees are eligible to participate in the healthcare offered through federal arrangements with private insurers.

STATEMENT OF OVERSIGHT FINDINGS AND RECOMMENDATIONS OF THE COMMITTEE

In compliance with clause 3(c)(1) of rule XIII and clause 2(b)(1) of rule X of the Rules of the House of Representatives, the Committee's oversight findings and recommendations are reflected in the body of this report.

UNFUNDED MANDATE STATEMENT

Section 423 of the Congressional Budget and Impoundment Control Act (as amended by Section 101(a)(2) of the Unfunded Mandates Reform Act, P.L. 104–4) requires a statement of whether the provisions of the reported bill include unfunded mandates. This bill reduces the ranks of the uninsured by improving access to health care for uninsured working families, particularly those who are employed in small businesses. The bill would create association health plans ("AHPs") that would allow small businesses to join together through bona fide trade associations, thus enjoying larger economies of scale presently enjoyed by many large corporations and unions, to purchase health insurance for their workers at a lower cost than they are presently experiencing. H.R. 525 would increase small businesses' bargaining power with health care providers, give them freedom from costly state mandated benefit packages, and lower overhead costs that would better enable them to offer health care coverage for their workers. In compliance with this requirement, the Committee has received a letter from the Congressional Budget Office included herein.

BUDGET AUTHORITY AND CONGRESSIONAL BUDGET OFFICE COST ESTIMATE

With respect to the requirements of clause 3(c)(2) of rule XIII of the House of Representatives and section 308(a) of the Congressional Budget Act of 1974 and with respect to requirements of 3(c)(3) of rule XIII of the House of Representatives and section 402 of the Congressional Budget Act of 1974, the Committee has received the following cost estimate for H.R. 525 from the Director of the Congressional Budget Office:

U.S. CONGRESS,
CONGRESSIONAL BUDGET OFFICE,
Washington, DC, April 8, 2005.

Hon. JOHN A. BOEHNER,
Chairman, Committee on Education and the Workforce,
House of Representatives, Washington, DC.

DEAR MR. CHAIRMAN: The Congressional Budget Office has prepared the enclosed cost estimate for H.R. 525, the Small Business Health Fairness Act of 2005.

If you wish further details on this estimate, we will be pleased to provide them. The CBO staff contact is Shinobu Suzuki.

Sincerely,

DOUGLAS HOLTZ-EAKIN,
Director.

Enclosure.

H.R. 525—Small Business Health Fairness Act of 2005

Summary: H.R. 525 would establish a regulatory framework and certification process for association health plans (AHPs). AHPs could be established by trade, industry, and professional associations as a vehicle for providing health care benefits to employees of businesses that are association members. AHPs would not, in general, have to offer coverage of state-mandated benefits and would be subject in a limited way to state rules that compress health insurance premiums across a state's group market. Many firms would be able to pay lower health insurance premiums by purchasing such coverage through AHPs rather than through the traditional small employer health insurance market, where premiums would reflect the full extent of state insurance regulations. (Self-employed individuals also would be able to purchase coverage through AHPs; this analysis of H.R. 525 includes the impact of AHPs on the health insurance market for the self-employed.)

Because AHPs would be a vehicle for providing health care benefits to workers and such benefits are excluded from taxable income, enacting H.R. 525 could affect federal tax revenues by changing the share of employee compensation furnished as tax-excluded health benefits as opposed to taxable wages and salaries. CBO estimates that H.R. 525 would increase total spending on employer-sponsored health insurance, and, as a result, reduce federal tax revenues. As a result, CBO estimates that enacting H.R. 525 would decrease federal revenues by $3 million in 2006, by $71 million over the 2006–2010 period, and by $261 million over the 2006–2015 period. About $76 million of the 10-year revenue loss would be in off-budget Social Security payroll taxes.

By expanding private health insurance coverage to small business employees and their dependents, H.R. 525 would decrease enrollment in the Medicaid program. The bill also would cause some individuals to lose employer coverage and to enroll in Medicaid. CBO estimates that the bill would reduce net federal spending for Medicaid by $1 million in 2006, by $24 million over the 2006–2010 period, and by $80 million over the 2006–2015 period.

H.R. 525 also would require additional spending for administration and regulatory activities by the Department of Labor (DoL). CBO estimates that DoL would hire 150 workers over the next three years to regulate the AHP market and certify AHPs, beginning in 2006. We estimate that implementing this provision would cost $4 million in 2006, $55 million over the 2006–2010 period, and $136 million over the 2006–2015 period, assuming the appropriation of the necessary amounts.

H.R. 525 would preempt a number of state laws that regulate health coverage, including the ability of states to tax existing entities that become certified as association health plans; those preemptions would be intergovernmental mandates as defined in the Unfunded Mandates Reform Act (UMRA). The preemptions of state regulatory laws would limit the exercise of state authority and preclude the application of state laws, but would not result in additional costs to state, local, or tribal governments. Limitations on state taxing authority, however, would result in a net decrease in state revenues of over $25 million in 2006. As a greater number of the uninsured became insured through association plans, states would, over time, realize a net increase in revenues due to the new taxing authority. By 2010, that increase would total about $10 million. The losses that states would face in the early years would not exceed the statutory threshold established in UMRA ($62 million in 2005, adjusted annually for inflation). The effects of the bill on Medicaid would result in savings to states of $18 million over the 2006–2010 period and $60 million over the 2006–2015 period.

H.R. 525 contains no private-sector mandates as defined in UMRA.

Estimated cost to the Federal government: The estimated budgetary impact of H.R. 525 is shown in the following table. The effects of this legislation fall within budget functions 550 (health) and 600 (income security). This estimate assumes that H.R. 525 would be enacted by October 1, 2005.

	By fiscal year, in millions of dollars—									
	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015
CHANGES IN REVENUES										
Income and HI Payroll Taxes (on-budget)	−2	−5	−9	−14	−19	−23	−25	−27	−29	−32
Social Security Payroll Taxes (off-budget)	−1	−2	−4	−6	−8	−9	−10	−11	−12	−13
Total Changes in Revenues	−3	−8	−13	−20	−27	−32	−35	−38	−41	−44
CHANGES IN DIRECT SPENDING										
Estimated Budget Authority	−1	−3	−5	−7	−9	−9	−10	−11	−12	−13
Estimated Outlays	−1	−3	−5	−7	−9	−9	−10	−11	−12	−13
CHANGES IN SPENDING SUBJECT TO APPROPRIATION										
Estimated Authorization Level	4	9	14	14	15	15	16	16	17	17

	By fiscal year, in millions of dollars—									
	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015
Estimated Outlays	4	9	14	14	15	15	16	16	17	17

Note: HI = Hospital Insurance (Part A of Medicare).

Basis of estimate: H.R. 525 would allow organizations such as trade, industry, and professional associations and chambers of commerce to sponsor association health plans for their members and affiliated members. These entities, which would be certified and regulated to DoL, could provide a range of health insurance options to employers under different sets of rules than apply to insurers or other health plan arrangements that fall under state insurance regulation. In general, an AHP would not have to comply with state benefit requirements and would not be subject to statewide availability rules, although it would have to make its plans available to all members of its sponsoring association.

AHPs could offer both fully-insured health insurance plans (products issued by a state-licensed insurance carrier) and, subject to certain limitations, self-insured plans. An AHP could offer the same fully-insured plans to member firms of its sponsoring association in any state; it would only have to obtain plan approval in the original state in which it filed. (It also would have to comply with the original state's laws mandating coverage of certain diseases.) All other states would be obligated to accept that approved plan. The bill would not exempt health insurance carriers offering AHP coverage from state licensing requirements and other state laws regulating health insurance except to the extent that the laws and regulations would effectively preclude the AHP from offering coverage in that state.

State laws regulating premiums would affect AHPs differently than they would carriers in the traditional small group health insurance market. In general, fully-insured AHP plans would have to abide by the premium-setting regulations of each state for their member firms that reside in that state. Some states require insurers that offer small-group policies to community-rate their premiums (a practice in which the price for a given health policy must be the same for all firms despite variations in those firms' expected costs per enrollee). Other states limit the degree to which premiums for a particular policy can vary among firms. Fully-insured AHP plans would have to follow the state's rating rules, but the premiums they offered would be based on the average expected costs per enrollee of the association's Member firms—not on the costs of the broader (and potentially more expensive) groups that insurers offering traditional coverage must serve under availability rules that apply to the traditional small group market.

Self-insured plans offered by AHPs would not be subject to state insurance regulations. To offer such coverage, AHPs would follow a certification process with the Department of Labor. The requirements for certification include meeting certain solvency standards and paying $5,000 annually into a fund, which would be used by the Secretary of Labor to maintain in force excess stop-loss insurance coverage or indemnification insurance coverage to ensure payment of the health care claims of self-insured AHPs that became insolvent. AHPs would be restricted from varying premiums on the basis of health status (or industry) except to the extent allowed by

each state's premium-setting rules for coverage offered through associations. In any case, such AHPs could charge different premiums to different employers on the basis of factors other than health status and industry.

CBO's estimate of H.R. 525 used an analytical model designed to simulate how small firms and their employees would respond to the introduction of AHPs.[1] The model incorporates assumptions that characterize economic behavior in the small group health insurance market. Those assumptions include the responsiveness of firms and their employees to changes in the price and quality of health insurance, the variation of health insurance premiums likely to occur in the AHP market compared with premium variation as it exists today in the regulated market for small-group health insurance, savings arising from the exemption from state-mandated benefits, and administrative cost savings that could be achieved by spreading fixed costs over more enrollees.

CBO estimates that, by 2010, when the legislation is assumed to have its full impact, about 620,000 more people (including employees and their dependents) would be insured through small employers than would be insured under current law. In total, about 8.5 million people would obtain health insurance through association health plans. However, under current law, most of those AHP enrollees would have been insured in the state-regulated market rather than being uninsured. CBO also estimates that about 10,000 people would lose coverage in response to rising premiums in the small-group market.

Effects on Federal revenues

The bill would reduce federal tax revenues because the share of employee compensation paid in the form of taxable wages and salaries would decrease as employers and employees spent more on tax-excluded health benefits. That increase in net spending on health benefits is the result of several factors that move in different directions. In general, spending on health benefits would decline for firms that switched from coverage purchased in the traditional, state-regulated market to AHP coverage due to savings from the exemption from requiring certain benefits, and from administrative savings. Eligible firms could attain additional premium savings by joining an AHP whose members had lower average costs than those of the insurance pools existing in the state-regulated market.

As relatively low-cost firms are attracted to the new AHP market, the average costs and thus the premiums facing firms in the state-regulated market would increase. In general, firms that remained in the state-regulated market would spend more on health benefits under the proposal while firms that dropped coverage in response to those premium increases would spend less on health coverage. Since AHPs would offer lower premiums, on average, than did state-regulated insurers, some otherwise-uninsured firms would become covered through AHPs. For those firms, spending on tax-excluded health benefits would increase (since they would have spent nothing on health insurance in the absence of AHPs).

[1] See Congressional Budget Office, Increasing Small-Firm Health Insurance Coverage Through Association Health Plans and Healthmarts, CBO Paper, January 2000.

CBO estimates that the net effect of those various changes would be a small increase in total spending by employers on employer-sponsored health insurance. Since the composition of the total compensation packages of employees would shift toward nontaxable health benefits and away from taxable wages and salaries, CBO estimates that total federal revenues would decrease by $3 million in 2006, by $71 million over the 2006–2010 period, and by $261 million over the 2006–2015 period. Social Security receipts, which are off-budget, would account for about 30 percent of the total.

The size and direction of the predicted change in employer spending on health insurance are sensitive to assumptions about the health insurance purchasing behavior of small firms. If fewer uninsured firms picked up coverage for their employees through the existence of AHPs than CBO has estimated, federal revenues could actually increase because aggregate spending by employers on health insurance could fall as otherwise-insured employees switched to lower-cost AHPs. Alternatively, if more otherwise-uninsured firms become covered by AHPs than CBO has estimated, the decline in federal revenues would be larger than projected because even more employer compensation would take the form of tax-excluded health care benefits.

Effects on Medicaid spending

Because H.R. 525 would increase (on net) the number of people with employer-sponsored insurance, it would affect the number of people who enroll in Medicaid. Some people who would lose employer-sponsored health insurance would enroll in Medicaid, whereas others who, under current law, would be covered by Medicaid would instead enroll in health insurance offered by AHPs. On net, CBO estimates that enacting H.R. 525 would reduce spending in the Medicaid program by $1 million in 2006, by $24 million over the 2006–2010 period, and by $80 million over the 2006–2015 period.

Medicaid spending for people who lose private coverage. About one-third of employees in small firms are in families with incomes under 200 percent of the Federal Poverty Line (FPL). Many children and some adults in families with incomes below 200 percent of the FPL are eligible for Medicaid. CBO estimates that about 40 percent of people losing employer-sponsored coverage would be under 200 percent of the FPL, and about one-eighth of them would enroll in Medicaid. CBO assumes that those people would be somewhat more costly than the average Medicaid-eligible individual, and that federal spending for Medicaid would increase by about $38 million over the 2006–2015 period.

Medicaid savings for people who gain private coverage. Of the people gaining employer-sponsored insurance via AHPs under H.R. 525, CBO estimates that approximately 10 percent would be under 200 percent of the FPL. Of these, about 40 percent are children and 60 percent are adults. About one-third of those children would otherwise be enrolled in Medicaid, and about 8 percent of adults would otherwise be enrolled in Medicaid, CBO estimates. Assuming that those children and adults would be less costly than average, implementing H.R. 525 would decrease federal Medicaid spending by $118 million over the 2006–2015 period as a result of this shift to private health insurance coverage.

Spending subject to appropriation

The bill also would require additional spending for administration and regulatory activities, subject to appropriation of the necessary amounts. CBO assumes that DoL would hire an additional 150 workers over the next three years to certify AHPs and to regulate the AHP market, beginning in 2006. CBO estimates that DoL would need about 125 employees at the GS–12 level (on average) to implement and regulate the program and about 25 support staff. We estimate that implementing this provision would cost $4 million in 2006, $55 million over the 2006–2010 period, and $136 million over the 2006–2015 period, assuming the appropriation of the necessary amounts.

Estimated impact on state, local, and tribal governments: H.R. 525 would preempt state laws that would limit an AHP's ability to determine which services or items are part of their package of health benefits. (A law in the state in which an AHP initially filed its policy for approval that prohibits the exclusion of specific diseases would still apply, as would requirements in the Employee Retirement Income Security Act governing minimum maternity stays, mental health benefits, and reconstructive surgery following mastectomies.) The bill also would preclude states from regulating reserve levels, contribution amounts, and trusts of AHPs. Those preemptions would not result in additional costs to state, local, or tribal governments, but because they would limit the exercise of state authority and preclude the application of state laws, they would be intergovernmental mandates as defined in UMRA.

H.R. 525 also would limit the ability of states to tax association health plans that operated before the enactment of the bill, while allowing states to levy a contribution tax, similar to a premium tax, on new AHPs. On the one hand, state contribution taxes on new AHPs that become certified under the bill would increase state tax collections to the extent that those AHPs provide coverage to individuals who were previously uninsured. On the other hand, some existing multiple employer welfare arrangements (MEWAs) could become certified to operate as AHPs, and it is not clear that states would be able to collect contribution taxes from them. Some states currently levy taxes on MEWAs, so if they were unable to collect the contribution tax from MEWAs that became certified AHPs, their tax revenues would decrease.

The combination of these changes would have mixed effects on state tax collections, and CBO estimates that the effect would be a new decrease in state revenues in the early years after enactment, and a net increase in state revenues in later years. CBO estimates that state revenues would decrease by over $25 million in 2006, but as a greater number of the uninsured became insured through association plans, states would realize a net increase in revenues due to the contribution tax totaling about $10 million in 2010. The losses that states would face in the early years would not exceed the statutory threshold established in UMRA ($62 million in 2005, adjusted annually for inflation).

The effects of the bill on Medicaid would result in estimated savings to states of $18 million over the 2006–2010 period and $60 million over the 2006–2015 period.

Estimated impact on the private sector: This bill contains no private-sector mandates as defined in UMRA.

Estimates prepared by: Federal costs: Shinobu Suzuki for revenue effects and discretionary spending; Jeanne De Sa and Eric Rollins for the Medicaid effects; impact on state, local, and tribal governments: Leo Lex; impact on the private sector: Stuart Hagen.

Estimate approved by: Peter H. Fontaine, Deputy Assistant Director for Budget Analysis.

STATEMENT OF GENERAL PERFORMANCE GOALS AND OBJECTIVES

In accordance with Clause 3(c) of House Rule XIII, the goals of H.R. 525 are to reduce the ranks of the uninsured by improving access to health care for uninsured working families, particularly those who are employed in small businesses. The bill would create association health plans ("AHPs") that would allow small businesses to join together through bona-fide trade associations, thus enjoying larger economies of scale presently enjoyed by many large corporations and unions, to purchase health insurance for their workers at a lower cost than they are presently experiencing. H.R. 525 would increase small businesses' bargaining power with health care providers, give them freedom from costly state mandated benefit packages, and lower overhead costs that would better enable them to offer health care coverage for their workers. The Committee expects the Department of Labor to implement the changes to the law in accordance with these stated goals.

CONSTITUTIONAL AUTHORITY STATEMENT

Under clause 3(d)(1) of rule XIII of the Rules of the House of Representatives, the Committee must include a statement citing the specific powers granted to Congress in the Constitution to enact the law proposed by H.R. 525. The Employee Retirement Income Security Act (ERISA) has been determined by the federal courts to be within Congress' Constitutional authority. In Commercial Mortgage Insurance, Inc. v. Citizens National Bank of Dallas, 526 F.Supp. 510 (N.D. Tex. 1981), the court held that Congress legitimately concluded that employee benefit plans so affected interstate commerce as to be within the scope of Congressional powers under Article 1, Section 8, Clause 3 of the Constitution of the United States. In Murphy v. Wal-Mart Associates' Group Health Plan, 928 F.Supp. 700 (E.D. Tex 1996), the court upheld the preemption provisions of ERISA. Because H.R. 525 modifies but does not extend the federal regulation of pensions, the Committee believes that the Act falls within the same scope of Congressional authority as ERISA.

COMMITTEE ESTIMATE

Clause 3(d)(2) of rule XIII of the Rules of the House of Representatives requires an estimate and a comparison by the Committee of the costs that would be incurred in carrying out H.R. 525. However, clause 3(d)(3)(B) of that rule provides that this requirement does not apply when the Committee has included in its report a timely submitted cost estimate of the bill prepared by the Director of the Congressional Budget Office under section 402 of the Congressional Budget Act.

ADDITIONAL VIEWS

The stated goal of H.R. 525 is to provide affordable health insurance to small businesses that cannot get it today. It is a laudable goal that I support. However, as currently written, I strongly believe that the Small Business Health Fairness Act will not accomplish this goal because of a significant loophole that allows an AHP to discriminate against small businesses with sick employees based on their ability to ignore state rating limitations.

Despite the title in paragraph (2) of section 805(a) that states "contribution rates must be nondiscriminatory," I believe the language in subparagraph b(ii) clearly allows an AHP to discriminate against a small business based on health status inasmuch as state law allows (a practice prohibited under ERISA). In my opinion, that is the very definition of a loophole.

During the Committee Markup I offered an amendment to close this loophole that will prevent small businesses with a sick employee from getting a better price for insurance under an AHP, though it ultimately was not agreed to. In the same way federal ERISA plans are prohibited from using health status to vary rates among its plan participants, my amendment sought to prohibit an association health plan from varying rates among its participants based on health status. It sought to do so by striking the language in subparagraph b(ii) that would allow an AHP to discriminate against businesses with sick employees by using health status.

I offered this amendment in a good faith effort to improve the legislation, because if this loophole is not closed and H.R. 525 eventually becomes law, the cost of healthcare insurance will undoubtedly be even higher due to other state-enacted rating limitations AHPs are free to ignore. This will only exacerbate the already unacceptable number of uninsured Americans.

After working in the healthcare industry for over thirty years and running several small businesses of my own, I know for firsthand that many small employers are struggling to afford and maintain coverage for their workers. Small business owners want to do the right thing and provide health insurance to their workers, but double-digit premium increases are making it increasingly difficult to do so.

In fact, in my home state of Georgia alone, nearly 1.4 million individuals and families lack health insurance coverage. Many of these people work for small-firms, but are not offered coverage or cannot afford the premiums. We need to do more to assure that health insurance coverage is more available and affordable to these small businesses workers.

One of the proposed ways to help small businesses and their employees, though certainly not the only way, is through enhanced pooling—one of the key goals of H.R. 525. Broad pooling of risk is the very foundation for viable and well-functioning health insur-

ance markets. Pooling helps assure that the premiums of younger, healthier workers subsidize the premiums of older, sicker workers. This cross-subsidization of premiums is the very essence of pooling.

Yet while I strongly support the concept of pooling, I am very concerned that H.R. 525 will lead to less pooling, not more. That is because under H.R. 525, each AHP would be rated separately from the state small employer pools and would see their premiums directly tied to the health-risk of the group. Under AHPs, employers with high-risk workers could bear the full-cost of coverage—without any cross subsidies.

In the 1990s states recognized the need for more pooling and protection for high-cost workers by enacting small-employer market reforms, including limits on how much insurers can charge employers with sick workers. In fact, my own home state of Georgia demands insurers to pool all their small businesses together for rating purposes while limiting how much employers' premiums can vary based on health-status or claims experience. Moreover, Georgia law also strictly limits the amount insurers can charge at renewal and limits premium increases to only once a year.

Yet the language I attempted to amend, as currently written, allows AHPs to preempt state laws that limit how much and how often employers' premiums can increase when an employee gets sick. This exemption from state rating protections would make it difficult, if not impossible, for small business with sick employees (or employees with a history of health problems) to have access to affordable coverage in an AHP; a loophole I find unacceptable.

Ultimately, my amendment was straightforward, simple and completely consistent with the principal goal of the legislation—which is to expand access to affordable health insurance for small businesses via small employer pooling. While it was ultimately not adopted (failing by a 24 to 24 vote), it underscores the clear division within the Committee about allowing AHPs to be exempt from small employer pooling laws. AHPs' exemption from these pooling laws will allow them the ability to exclude firms with sicker workers by charging unaffordable premiums. This will cause premiums to rise for most small-firms and leave vulnerable workers at serious risk of becoming uninsured.

While I supported H.R. 525 in Committee and share its proponent's goal to provide small businesses with access to affordable and high quality healthcare, I am very concerned that this bill, as currently written, will hurt the very small businesses and employees that its proponents claim to help.

I am committed to helping small businesses and their workers have access to more affordable coverage, but firmly believe that the language as currently written actually moves us in the wrong direction. It is my hope that in moving this bill forward through the legislative process, Congress can continue to improve the language I called into question during the Committee Markup and find a real solution to make healthcare coverage more affordable to hard-pressed small businesses, their workers, and their families instead of allowing AHPs to discriminate against older, sicker employees.

CHARLIE NORWOOD.

MINORITY VIEWS

Once again, the majority proposed legislation it claims is in the interest of the 45 million employees and small employers without health insurance, but in fact is likely to reduce their health care benefits and coverage.[1] Rather than proposing real solutions for delivering meaningful health coverage for uninsured Americans, this legislation will cut health benefits for 7 million workers who currently have coverage and make coverage more expensive for four out of five small businesses. The proposed Association Health Plans (AHPs) would be almost entirely exempt from oversight by state regulators, undermining coverage for serious diseases and increasing consumers' vulnerability to fraud and insolvencies.

Over 80 million Americans lack health coverage for some part of a year and are looking to Congress for help.[2] Approximately half of those Americans work for or are family members of someone who works for a small employer. Many small employers lack the financial resources to afford health insurance coverage. These employers, and the workers and family members who depend upon them, need solutions that will provide an expanded pool for affordable coverage and subsidize the costs of low wage workers. HR 525 not only fails to deliver help, it actually will reduce health care coverage and raise health insurance costs for millions of Americans.

The independent Congressional Budget Office analyzed the impact of AHP legislation in 2002 and 2003 and concluded:

> "* * * about 600,000 more people (including employees and their dependents) would be insured through small employers than would be insured under current law. By 2008, about 7.5 million people would obtain health insurance through association health plans. However, under current law, most of those AHP enrollees would have been insured in the state-regulated market rather than being uninsured. CBO also estimates that about 10,000 people would lose coverage in response to rising premiums in the small-group market."[3]

CBO also warns us that far from reducing health expenses, this bill will increase health care costs, because it will encourage cherry picking of the most desirable employees, leaving the more expensive employers in the current system. CBO concluded that AHPs primarily will compete by offering less generous benefit packages and thus, reducing coverage for 7 million workers and families. And those who remain covered by non-AHP insurance will pay in-

[1] "The Uninsured and Their Access to Care." Publication No.: 1420–06, The Kaiser Commission on Medicare and the Uninsured, The Henry J. Kaiser Family Foundation, December 2004.

[2] "One in Three: Non-Elderly Americans Without Health Insurance, 2002–2003" Families USA, June 2004.

[3] Congressional Budget Office Cost Estimate, H.R. 660 Small Business Health Fairness Act of 2003, July 11, 2003.

creased costs to compensate for those who are siphoned off into AHPs.

A 2003 study by Mercer Consultants, commissioned by National Small Business United, made even more dire predictions. Mercer found that AHP legislation would increase the number of the uninsured by 1 million as employers in the non-AHP market dropped coverage due to premium increases. Health insurance premiums in the non-AHP market were estimated to rise 23% due to the exodus of healthier firms to non-regulated AHPs.[4]

Rather than expanding health coverage and health services; it is going to lead to the reduction of health coverage for 7 million Americans who will lose the right to vital medical coverage such as OB/GYN and pediatrician services, cervical, colon, mammography and prostate cancer screening and treatment, maternity benefits and well-care child services, and diabetes treatment.

That is why over 1300 local and national organizations oppose this bill, including the National Governors Association, the Republican Governors Association, Democratic Governors Association, 41 state Attorney General, the National Association of Insurance Commissioners, National Small Business United, Blue Cross Blue Shield, the Association of Health Insurance Plans, and well as hundreds of labor, consumer, and business groups (see attached list).

H.R. 525 CUTS BENEFITS FOR MILLIONS OF WORKERS BY OVERRIDING VITAL STATE CONSUMER PROTECTION LAWS

Under H.R. 525, AHP generally would have sole discretion to select the specific items and services to be covered, notwithstanding state laws. AHPs would be exempt from key consumer protection laws, including state laws requiring access to mammography screening, emergency services, maternity care for expectant mother, well-baby care for infants, and other protections that ensure appropriate access to health care.

This bill would result in a two-tiered small group health insurance marketplace, one tier consisting primarily of healthy individuals and groups who benefit from preemption of state health mandates, and another tier comprised significantly of sicker individuals and groups who remain subject to state consumer protections. As Members of Congress, we should be seeking ways to eliminate the health care disparities in current markets, not creating new ones.

The Republican Majority contend that given the choice, AHPs will freely choose to provide ample health care coverage. However, history demonstrates that for years businesses provided health coverage without providing adequate health care coverage. Access to mammograms, maternity payments for expectant mothers, cancer-screening procedures, well-baby care, and other preventive health treatment were routinely omitted in health care coverage until states required it.

States were forced to enact consumer protections because businesses did not insist on providing comprehensive coverage for their employees. Today, nearly all states and the District of Columbia have laws that protect access to mammography screening, emer-

[4] "Impact of Association Health Plan Legislation on Premiums and Coverage for Small Employers," Beth Fritchen and Karen Bender, Mercer Risk, Finance & Insurance Consulting, prepared for National Small Business Association, 2003.

gency services, allow direct access to OB/GYNs, diabetic supplies and education, and prompt payment rules.[5]

More than 25 states and the District of Columbia have laws that protect access to prostate cancer screening, cervical cancer screening, and well-baby care. Over 30 states have mental health parity laws and more than 33 state require insurance plans to cover a minimum amount of mental health benefits.[6]

We believe, as do hundreds of organizations, public officials, and health care providers, that state consumer protection laws represent significant steps towards Congress' goal of improving access to comprehensive health care for all. Our Republican colleagues do not. They would prefer to roll back the protections we have today. Therefore, the Republican Majority rejected each of the 10 amendments offered by Democrats to restore consumer protections lost under this legislation. Several members of the Majority argued that "bare bones" coverage was better than no coverage. But, those who understand illnesses and health insurance know this often is not true. To offer health insurance that does not cover many diseases or requires a $1000 or even a $5000 deductible, in many cases will be worse than no insurance at all. Individuals and employers will pay scarce resources each month for policies that will not help them when they need it.

H.R. 525 ENCOURAGES "CHERRY-PICKING" OR "SKIMMING" OF YOUNGER, HEALTHIER POPULATIONS

In addition to eliminating critical consumer protections, the bill permits AHPs to engage in cherry picking, skimming off the healthiest consumers and leaving the sickest patients uninsured.

H.R. 525 allows AHPs to offer coverage to specific types of employers, allowing plans to seek memberships with better risks and less costly populations. In addition, AHPs may offer different premiums to each of their member employers. Thus, AHPs may charge lower rates for lower risk persons and charge far more for higher risk persons, forcing them out of the pool. The bill's only restriction is that the difference in premiums cannot be health-status based. But the provision is meaningless because it permits AHPs to accomplish the same goal by "cherry-picking" and varying premiums based on age, sex, race, national origin, or any other key factor of an employer's workforce, including claims experience, geography and membership.

Unlike the Republican Majority, we are convinced by the Congressional Budget Office (CBO) finding that AHP legislation would result in higher premiums for 80 percent of small employers, while as many as 7 million of the sickest individuals would have reduced coverage.

Similarly, the Mercer Consulting study found that health insurance premiums would increase 23% for small employers that continued to purchase state regulated coverage, and the number of uninsured would increase by over 1 million as a result of coverage losses among workers and their dependents.

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[5] Blue Cross and Blue Shield Association, December 2002.
[6] Blue Cross and Blue Shield Association, December 2002.

During the committee markup, we supported the amendment offered by our Republican colleague Representative Charlie Norwood requiring AHPs to charge the same premium to all employer groups. However, the Republican Majority rejected this amendment, arguing that AHPs have no competitive advantage if they cannot limit and control their risks.

H.R. 525 GIVES AHPS UNPRECEDENTED POWERS THAT LARGE EMPLOYERS DO NOT ENJOY

One of the key arguments made by the supporters of AHPs is that some large employers are exempt from state laws and therefore, so should be small employers. The supporters fail to note that H.R. 525 would provide small employers exemptions from state and federal law that far exceed the limited exemption large employers enjoy.

Health insurance generally is regulated by the states, not the federal government. When Congress enacted the Employee Retirement Income Security Act of 1974 (ERISA), it primarily intended to establish federal standards for pension plans. At that time, Congress did have some expectation that federal regulation of health care was imminent and ERISA broadly preempted state laws that regulated all employee benefit plans. In 1985, the Supreme Court, in Metropolitan Life Insurance Co. v. Massachusetts, 471 US 724, held that employer health plans that were provided through insurance were subject to state law, but when employers provided health care directly, through self-insurance, they were exempt from state laws.

H.R. 525 would give small employers far broader protection than larger employers currently enjoy under ERISA. First, H.R. 525 exempts all AHP plans, self-insured and insured, from state regulation. Second, large employers currently cannot cherry-pick among their employees the same way AHPs are allowed to under H.R. 525. Under ERISA, employers that self-insure are prohibited from varying premiums charged based on health status. Further, employers are subject to civil rights law prohibitions on discrimination on the basis of race, sex, age, national origin, etc. As a result, large employers charge all employees the same premium varying only by family size and geography (due to varying local costs). In contrast, H.R. 525 specifically authorized AHPs to discriminate in premiums. AHPs may vary premiums among employers on any basis except health status and AHPs may increase premiums of individual employers based upon their claims experience. Finally, H.R. 525 is not limited to small employers. Large employers may join AHPs and may well do so based on H.R. 525's almost complete exemption from state insurance regulation and consumer protection laws.

AHPS WOULD OPERATE LARGELY UNREGULATED

Regulation of insurance and public health has traditionally been the province of the states. H.R. 525 eliminates centuries of state law that establish minimum standards for the conduct of the business of insurance, and raises important questions about the future ability of states to regulate health insurance at all.

By allowing insurers who sell to AHPs to set up shop in a state with very lenient rules and oversight and market to small employ-

ers without meeting any state's rules, states would be rendered powerless to take action even where there is obvious risk to consumers.

We strongly disagree with the provisions of H.R. 525 that would federalize oversight of AHPs, but that provide the Department of Labor (DOL) with minimal specific and general regulatory authority over AHPs. States are in the business of regulating insurance for good reason. States can shut down fraudulent health plans faster than DOL. States can shut down crooked health plans by issuing emergency cease-and-desist orders within days, while DOL can take several years. Additionally, DOL lacks sufficient staff and budget. A 2004 report by the former Deputy Secretary of Labor under the first Bush Administration, Roderick A. DeArment, has concluded that DOL is not able to adequately regulate AHPs.[7]

Most state attorneys general, plus state governors, insurance regulators and state insurance legislators also publicly agree sole federal oversight of AHPs would expose small businesses to potentially widespread scams. In a June 11, 2003 press release, the Coalition Against Insurance Fraud stated, "State oversight is a vital part of the safety net our businesses need to help ensure health coverage provides reliable protection, not empty promises."

Experience with another form of health insurance pooling without adequate accountability already exist; Multiple Employer Welfare Arrangements (MEWAs). We know from past experience that these plans can harm consumers. MEWA fraud and abuse problems have resulted in 400,000 uninsured consumers with over $123 million in unpaid medical bills.[8]

H.R. 525 FAILS TO ADDRESS REAL PROBLEMS OF SMALL BUSINESSES

H.R. 525 does not address the major reasons that small businesses do not offer health insurance coverage—lack of stability, lack of profitability, and generally low wage workforces. A majority of small businesses do not survive their first year of operations and a small minority exist after 3 years of operation. And the majority of small business workforces employ low wage employees. Over half the uninsured earn less than two times the poverty rate. A minimum wage worker earns $1000 a month. An individual health insurance policy costs over $300 a month and a family policy costs over $800 a month. In order for a small business to offer health coverage to a low wage employee, at a 50% employer contribution rate, it would mean that a 10–30% salary increase for these workers would be necessary. These employers are unlikely to be able to afford such an increase and many of these employees would choose cash over health insurance.

CBO analyzed AHP legislation in 2003 and concluded much the same. Of the 45 million uninsured, CBO concluded that only 600,000 would receive coverage under AHPs. CBO concluded that

[7] "The Department of Labor lacks the staffing, experience, and regulatory authority to effectively regulate Association Health Plans", Roderick A. DeArment, Business Law Brief, Spring 2004.

[8] "MEWAs: The threat of Plan Insolvency and Other Challenges", Mila Kofman, Eliza Bangit and Kevin Lucia, Health Policy Institute, Georgetown University, commissioned by the Commonwealth Fund, March 2004.

AHPs primarily would cover employers who already have coverage and shift to cheaper AHP plans, potentially 7 million individuals.

THE DEMOCRATIC ALTERNATIVE

During markup, Representatives Kind and Andrews offered an amendment in the nature of a substitute that would authorize the Secretary of Labor and states to create small employer health plans similar to the Federal Employees Health Benefit Plan, without cutting vital health benefits. The substitute provides small businesses the same access and health care coverage that federal employees have. It also would authorize funds to provide subsidies to employers with low wage workforces recognizing the reality that most small employers cannot significantly increase spending for these workers.

The Democratic alternative allows all employers with fewer than 100 employees during the previous calendar to be eligible to apply for coverage under the federal or state plans. Employers must offer coverage to all employees who have completed 3 months of service. Employees working fewer than 30 hours a week are eligible for pro rata coverage. It authorizes the Secretary and the states to establish an initial open enrollment period and thereafter an annual enrollment period. Small employers currently providing coverage are provided a one-time election to join the federal or state plan during the initial open enrollment period. The substitute would require the Department of Labor to annually contract with state licensed health insurers to offer health insurance coverage in a state. Participating insurers remain subject to state laws applicable to the states in which they cover residents.

During Committee mark-up a number of other amendments were offered that would have addressed many of the bill's substantial deficiencies and maintained needed state law consumer protections. Representative McCollum offered an amendment to require AHPs to abide by state laws ensuring maternal and child care coverage; Representative McCarthy and Woolsey offered an amendment to protect state laws on mammography and cervical cancer screening coverage; Representative Holt offered amendments to protect state laws on mental health benefits and access to contraceptive coverage; Representatives Kildee and Hinojosa offered an amendment to retain state laws covering diabetes treatment; Representative Kind offered an amendment to protect state laws for treatment of autism; Representatives Tierney an Van Hollen offered an amendment to require Association Health Plans to comply with state patients' bill of rights protections, such as direct access to OB/GYNs, prudent layperson decision making standards, coverage of non-formulary prescription drugs in certain situations, access to hospital emergency room treatment; and independent external review of coverage decisions; Representative Scott offered an amendment to assure that AHPs have adequate capital as under NAIC model capital standards; and Representative Kucinich offered an amendment to ensure disclosure of pharmaceutical costs. The Majority rejected all of these amendments that would have protected consumers.

For these reasons the minority believes that HR 525 is fatally flawed and will reduce rather than improve health care coverage and benefits for American workers and their families.

Organizations and Public Officials Opposed to Federal AHP Legislation

Over 1300 Organizations Have Expressed Opposition:

State Officials:
National Governors Association
Republican Governors Association
Democratic Governors Association
Attorneys General Representing 41 States'
National Association of Insurance Commissioners
National Conference of State Legislatures
National Conference of Insurance Legislators
Southeastern Utah Association of Local Governments

Chambers of Commerce:
Albuquerque, New Mexico
Black Chamber of Commerce of Greater Kansas City
Boston
Cherry Creek Chamber (Colorado)
Cleveland (COSE)
Denver Metro
Detroit
Draper Chamber of Commerce (Utah)
Florence, Colorado
Greater Akron Chamber (Ohio)
Greater Columbus Chamber (Ohio)
Greater Manchester, New Hampshire
Greater Seattle
Heber Valley Economic Development (Utah)
Lansing Regional Chamber (Michigan)
Metro Jackson, Mississippi
Missouri
New Hampshire Business and Industry Association
Northern Ohio
Oklahoma City
Oklahoma State
Palisade Chamber (Colorado)
Philadelphia
North Park Chamber (Colorado)
Salem Economic Development (Utah)
Springville Economic Development (Utah)
Tulsa, Oklahoma
Washington State (Association of Washington Business)

Farm Bureaus:
Mississippi Farm Bureau
Tennessee Farm Bureau Federation – Tennessee Rural Health
Utah Farm Bureau Federation
Virginia Farm Bureau

Small Business Associations:
Arizona Small Business Association
Indiana Association of Community and Economic Development
Indiana Manufacturers' Association
Ohio/Kentucky Concrete Pavement Association
Mountain States Lumber and Building Materials Dealers Association (CO, UT)
National Small Business United (Represents over 16 associations)
New Hampshire Business Council
New Hampshire High Tech Council
Professional Musicians Of Arizona

Labor Unions:
AFL-CIO - American Federation of Labor and Congress of Industrial Organizations
AFSCME - American Federation of State, County and Municipal Employees
With additional letters from:
Louisiana Chapter
New Mexico Chapter
Rhode Island Council 94
American Federation of Teachers (AFT)
With additional letters from:
Louisiana Chapter
Utah Chapter
Atlanta Labor Council
Cement Masons Local 577 (Colorado)
BEW - Oregon
International Union, United Auto Workers (UAW)
Indiana UAW
Laborers' International Union – Local 149 – Aurora, Illinois
Montana Progressive Labor Caucus
National Education Association – Rhode Island Chapter
Providence (Rhode Island) Central Federation of Labor

Service Employees International Union (SEIU)
Teamsters' 190 – Montana
United Food and Commercial Workers Union – Washington
Washington State Labor Council

Consumer/Advocacy Groups:
National Groups
Alliance for Children and Families
American Association of Pastoral Counselors
American Association of People with Disabilities
American Congress of Community Supports and Employment Services
American Corn Growers Association
American Diabetes Association
American Family Foundation
American Homeowners Grassroots Alliance
Americans for a Balanced Budget
Anxiety Disorders Association of America
Association for the Advancement of Psychology
Bazelon Center for Mental Health Law
Center on Disability and Health
Child Welfare League of America
Children & Adults with Attention-Deficit/Hyperactivity Disorder
Coalition Against Insurance Fraud
Consumer Federation of America
Consumers Union
Depression and Bipolar Support Alliance
Families USA
Federation of Families for Children's Mental Health
Friends Committee on National Legislation
International Certification and Reciprocity Consortium
League of United Latin American Citizens (LULAC)
Maternal and Child Health Coalition for Healthy Families
National Alliance for the Mentally Ill
National Association for Children's Behavioral Health
National Association for Rural Mental Health
National Association of Anorexia Nervosa and Associated Disorders
National Association of Farmer Elected Committees
National Association of Protection and Advocacy Systems
National Council for Community Behavioral Healthcare
National Council of La Raza
National Foundation for Depressive Illness
National Mental Health Association
National Partnership for Women & Families
National Patient Advocate Foundation
Research Institute for Independent Living
Suicide Prevention Action Network
Tourette Syndrome Association
United Cerebral Palsy Association
USAction
Women Involved in Farm Economics
Local Groups
AIDS Project Rhode Island
AIDS Response Seacoast – New Hampshire
AIDS Survival Project (Georgia)
ARC of Colorado
ARC of Indiana
ARC of Norfolk, Nebraska
ARC of Ohio
ARC of Utah
Access Utah Network
Adoption Options (Colorado)
Allies With Families (Utah)
American Cancer Society – Montana Chapter
Arizona Citizen Action
Association of Community Organizations for Reform Now (California)
Autism Society of Nebraska
Bethpage Omaha
Best Buddies International- Indiana Chapter
Big Brother and Big Sister – Illinois
Bosom Buddies of Georgia, Inc.
Brain Injury Association of Colorado
Buckeye Art Therapy Association of Ohio
California Coalition for Mental Health
California Pan-Ethnic Health Network
Campaign for Better Health Care (Illinois)
Cancer World (Oregon)
Catholic Charities of Colorado
Catholic Charities of Colorado Springs
Catholic Charities of Omaha, Nebraska
Catholic Charities Pueblo (Colorado)
Catholic Conference of Kentucky
Catholic Conference of Minnesota
Center for Policy Analysis (California)
Central Ohio Diabetes Association
Centro Legal (Minnesota Minority Support Group)
Child Connect (Nebraska)
Children's' Diabetes Foundation - Denver Chapter
Citizen Action of Illinois
Citizen Action of New York
Coalition for Accountable Government (Utah)
Colorado Classified School Employees Association
Colorado Forum on Community
Colorado Developmental Disabilities Planning Council
Colorado Women's Agenda
Community Connection (Utah)
Community Connections (Nebraska)
Community Harvest Food Bank of Fort Wayne, Indiana
Community Humanitarian Resource Center (Nebraska)
Concerned Christian Americans – Illinois
Congress of California Seniors
Connecticut Citizen Action Group
Damien Center – Indiana
Day At A Time Club (Colorado)
Depression and Bi-Polar Support Alliance of Ohio
Denver, Adams and Arapahoe County (CO) CARES
Eagle Forum (Illinois)
El Comite – Colorado
Electric League (Missouri)
EMPOWER Colorado
Family Counseling Service (Illinois)
Family Ties Adoption Center of Colorado
Federation of Families for Children's Mental Health – Colorado
Gathering Place (Nebraska)
Georgia Abortion and Reproductive Rights Action League (GARAL)
Georgia Rural – Urban Summit
Granite State Independent Living Foundation
Gray Panthers California
Health Action New Mexico
Health Care for All (Massachusetts)
Health Law Advocates (Massachusetts)
Helena Indian Alliance – Montana
Hispanic Community Center (Nebraska)
Illinois Caucus for Adolescent Health
Indiana Association of Area Agencies on Aging
Indiana Coalition on Housing and Homeless Issues
Individual and Family Counseling – Illinois
Insure the Uninsured Project (California)
Interfaith Service Bureau (California)
Iowa Christian Coalition
Iowa Citizen Action Network
Jewish Community Relations Council – Indiana
Kentuckians for Health Care Reform
Kentucky Catholic Charities and Diocese
Kentucky Minority Farmers Association
Louisiana Maternal and Children's Health Coalition
Maine Consumers for Affordable Healthcare
Maine Women's Lobby
Maine Women's Policy Center
Marshalltown Cancer Resource Center (Iowa)
Maternal and Children's Health Coalition (Louisiana)
Mental Health Care Associates (Nebraska)
Mental Health Consumer Advocates of Rhode Island
Minnesota Catholic Conference
Minnesota Lawsuit Abuse Watch (M-LAW)
Minnesota State Council on Disability
Montana Coalition for Competitive Choices
Montana Council for Families
Montana Peoples Action
Montana Senior Citizens Association
Multiple Sclerosis Society of Indiana
Mutual Ground - Illinois
National Barter and Commodity Association (Formerly the Colorado Citizens for an Alternative Tax System)
National Kidney Foundation of Georgia
Navajo County Arizona Special Public Health District
Nebraska Arthritis Foundation
Nebraska Tax Research Council
Nebraskans for Equal Taxation
New Mexico Advocates for Children and Families
New Mexico Teen Pregnancy Coalition
New Hampshire Coalition of State Taxpayers
New Hampshire Commission on the Status of Women
Noble/ARC of Greater Indianapolis
Ocean State Action – Rhode Island
Ohio AIDS Coalition
Ohio Advocates for Mental Health
Ohio Citizen Advocates for Chemical Dependancy, Prevention and Treatment
Ohioans for Diabetes Control
Planned Parenthood of Georgia
Planned Parenthood of Mid/East Tennessee
Planned Parenthood of Northern New England
People Living Through Cancer – New Mexico
Protectmontanakids.org
Quality Care for Children (Georgia)
Redemptorist Social Services Center (Missouri)
Religious Action Center of Reform Judaism
Rhode Island Kids Count

Safe Kids – Safe Communities – Montana
Small Business Lobby (Virginia)
Sudden Arrhythmia Death Syndrome (Utah)
United Cerebral Palsy Association – Nebraska
Utah Coalition Against Sexual Assault
Victim Assistance Team of Grand County Colorado
Washington Citizen Action
Wisconsin Citizen Action
Wisdom of Wellness Foundation (Georgia)
WISE Foundation
Women's Association of Northshore Democrats – Louisiana
Women's Policy Group (Georgia)

Physician Groups:
National Groups
American Academy of Child and Adolescent Psychiatry
American Academy of Neurology
American Academy of Pediatrics
American Association for Geriatric Psychiatry
American College of Foot & Ankle Surgeons
American Psychiatric Association – With additional letters from:
Louisiana Chapter
New Hampshire Chapter
National Alliance of Medical Researchers and Teaching Physicians
Local Groups
American Academy of Physicians – Nebraska Chapter
Bennet Breast Cancer Center (Maine)
Missouri State Medical Association
Nebraska Academy of Family Physicians
Nebraska Medical Association
New Hampshire Health Care Association
New Mexico State Health Association
Rhode Island Medical Association
Rose Breast Center (Colorado)
Virginia Medical Society
Washington Healthcare Forum

Provider Groups:
National Groups
American Association for Marriage and Family Therapy
American Association for Psychosocial Rehabilitation
American Association on Mental Retardation
American Chiropractic Association
American Counseling Association
American Group Psychotherapy Association
American Managed Behavioral Healthcare Association
American Mental Health Counselors Association
American Nurses Association
American Optometric Association – With additional letters from:
Arkansas Chapter
Indiana Chapter
Kentucky Chapter
New Hampshire Chapter
New Mexico Chapter
Tennessee Chapter
Virginia Chapter
American Podiatric Medical Association
American Psychiatric Nurses Association
American Psychological Association
American Psychotherapy Association
American Society of Clinical Psychopharmacology, Inc.
Association for Ambulatory Behavioral Healthcare
Association of Women's Health, Obstetrics and Neonatal Nurses
Clinical Social Work Federation
Employee Assistance Professionals Association
Federation of Behavioral, Psychological and Cognitive Sciences
National Association of County Behavioral Health Directors
National Association of School Psychologists
National Association of Social Workers
National Association of State Mental Health Program Directors

Local Groups
AAC Association (Nebraska)
Action Counseling (Colorado)
Acupuncture Association of Colorado
Acupuncture Association of Utah
Acupuncture Association of Washington
Addiction and Behavioral Health Center (Nebraska)
AIM Institute (Nebraska)
Alegent Health Psychiatric (Nebraska)
Alzheimer's Association of Utah
Arden Courts (Illinois)
Arkansas Association for Marriage and Family Therapy
Arkansas Chiropractic Legislative Council
Arkansas Independent Living Council
Arkansas Mental Health Counselors Association
Aspen Therapy (Utah)
Association of Community Service Agencies (California)
Avenues to New Horizons (Nebraska)
Avera St. Anthony's Hospital (Nebraska)
A.W.A.R.E. Inc. (Mental Health Provider – Montana)
Bear River Mental Health Services (Utah)
Beaver Valley Hospital (Utah)
Behavioral Health Specialists (Nebraska)
Bergan Mercy Child Development Center
Black River Mental Health Services (Utah)
Boulder County Partners (Colorado)
Bungalow Care Center (Utah)
California Council of Community Mental Health Agencies
California Society for Clinical Social Work
Cedar Springs Behavioral Health (Colorado)
Central District Health Center (Nebraska)
Centennial Mental Health Center (Colorado)
Central Iowa Psychological Services
Coldige Mental Health Center (Nebraska)
Community Adolescent Counseling (Colorado)
Community Counseling Center of Aurora, Illinois
Conway Regional Health Systems (Arkansas)
Counseling Center for the Rockies (Colorado)
Danville Services Corporation (Utah)
Direct Benefits (Minnesota)
First Call For Help (Nebraska)
Franklin County (Ohio) Mental Health Association
Full Circle Alternative Center (Colorado)
Geneva Mental Health (Illinois)
Gordon Memorial Hospital (Nebraska)
Greater Portland (Maine) Pediatric Associates
Healthy Mothers – Healthy Babies (Montana)
Heartland Counseling and Consulting (Nebraska)
Highland Ridge Hospital (Utah)
Holladay Family and Child Guidance Clinic (Utah)
Home Health Services and Staffing Association of NewJersey
Institute for Alcohol Awareness (Fort Collins, Colorado)
Institute for Alcohol Awareness (Greeley, Colorado)
Jane Phillips Nowata Health Center (Oklahoma)
Kane County Hospital (Utah)
Kentucky Dental Association
Kentucky Mental Health Consortium
Leo Pocha Clinic (Montana)
LifeWise Health Plan of Oregon
Lincoln/Lancaster County Human Services Federation (Nebraska)
Louisiana Academy of Medical Psychologists
Louisiana Alliance for the Mentally Ill
Louisiana Association for Ambulatory Healthcare
Louisiana Association for the Advancement of Psychology
Louisiana Healthcare Commission
Louisiana Mental Health Consortium
Leukemia Lymphoma Society of Oregon
Maine Association of Mental Health Services
Maine Nurse Practitioners Association
Medical Weight Management (California)
Melham Medical Center (Nebraska)
Mental Health Corporation (Colorado)
Mental Health Liaison Group
Mesability (Colorado)
Minnesota Association of Community Mental Health Programs
Minnesota Council of Health Plans
Missouri Ambulance Association
Montana Council of Community Mental Health Centers
Nemaha County Breast Cancer Support Group (Nebraska)
New Hampshire Mental Health Coalition
New Hampshire Pastoral Psychotherapists Association
New West Health Services (Montana)
Niobrara Valley Hospital (Nebraska)
Northstar Mental Health Services (Nebraska)
Northwest Alzheimer's Association (Nebraska)
Ogallala Counseling Center (Nebraska)
Ohio Ambulatory Healthcare Association
Ohio Association of County Behavioral Health Authorities
Ohio Clinical Social Work Society
Ohio Counseling Association
Ohio Council of Behavioral Healthcare Providers
Ohio Dietetic Association
Old Mill Counseling (Nebraska)
Omni Behavioral Health (Nebraska)
Providence Medical Center (Nebraska)
Rainbow Center (Nebraska)
Rhode Island Association of Health Centers
Rhode Island Autism Project
Rhode Island Council of Community Mental Health Organizations
Rhode Island Dental Society
Rural Counties Program, Spanish Peaks Mental Health Center (Colorado)
Sanpete Valley Hospital (Utah)
Saunders County (Nebraska) Health Services
Serenity Place (Nebraska)
Steiner & Associates, P.C.
Stoney Ridge Day Treatment Center (Nebraska)
Sweetgrass-Stillwater Mental Health Association (Montana)
Swope Parkway Health Center (Missouri)
Tri-County Mental Health Services - Maine
Tulane University Health Sciences Center (Louisiana)
Utah Association of Pathologists
Valley Community Clinic (California)
Wasatch Canyon Mental Health (Utah)
Washington Massage Therapy Association
West Holt Memorial Hospital (Nebraska)
Willowbrook Mental Health Center (Nebraska)

Health Insurance Trade Associations:
American Association of Health Plans – With additional letters from:
Kentucky Association of Health Plans
New Jersey Association of Health Plans
Ohio Association of Health Plans
Virginia Association of Health Plans
Association of Washington Healthcare Plans
American Republic Insurance Company (Iowa)
Association of Health Insurance Advisors/National Association of Insurance and Financial Advisors – With additional letters from:
Maine Chapter
Blue Cross and Blue Shield Association
Delta Dental Plans Association – With additional letters from all 50 state plans
Christiana Care Health Plans
Federation of Iowa Insurers
Health Insurance Association of America
Magellan Health Services
National Association of Health Underwriters – With additional letters from:

Principal Financial Group – with additional letters from:
Iowa Office
Tufts Health Plan

GEORGE MILLER.
RAÚL M. GRIJALVA.
ROBERT C. "BOBBY" SCOTT.
DALE E. KILDEE.
JOHN F. TIERNEY.
RUBÉN HINOJOSA.
MAJOR R. OWENS.
DENNIS J. KUCINICH.
BETTY MCCOLLUM.
CAROLYN MCCARTHY.
LYNN WOOLSEY.
RON KIND.
CHRIS VAN HOLLEN.
TIMOTHY BISHOP.
DAVID WU.
TIM RYAN.
ROBERT ANDREWS.
DONALD M. PAYNE.
DANNY K. DAVIS.
SUSAN DAVIS.
RUSH HOLT.

CHANGES IN EXISTING LAW MADE BY THE BILL, AS REPORTED

In compliance with clause 3(e) of rule XIII of the Rules of the House of Representatives, changes in existing law made by the bill, as reported, are shown as follows (existing law proposed to be omitted is enclosed in black brackets, new matter is printed in italic, existing law in which no change is proposed is shown in roman):

EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974

SHORT TITLE AND TABLE OF CONTENTS

SECTION 1. This Act may be cited as the "Employee Retirement Income Security Act of 1974".

TABLE OF CONTENTS

Sec. 1. Short title and table of contents.

TITLE I—PROTECTION OF EMPLOYEE BENEFIT RIGHTS

* * * * * * *

SUBPART B—OTHER REQUIREMENTS

Sec. 711. Standards relating to benefits for mothers and newborns.

* * * * * * *

PART 8—RULES GOVERNING ASSOCIATION HEALTH PLANS

801. Association health plans.
802. Certification of association health plans.
803. Requirements relating to sponsors and boards of trustees.
804. Participation and coverage requirements.
805. Other requirements relating to plan documents, contribution rates, and benefit options.
806. Maintenance of reserves and provisions for solvency for plans providing health benefits in addition to health insurance coverage.
807. Requirements for application and related requirements.
808. Notice requirements for voluntary termination.

809. Corrective actions and mandatory termination.
810. Trusteeship by the Secretary of insolvent association health plans providing health benefits in addition to health insurance coverage.
811. State assessment authority.
812. Definitions and rules of construction.

* * * * * * *

TITLE I—PROTECTION OF EMPLOYEE BENEFIT RIGHTS

SUBTITLE A—GENERAL PROVISIONS

* * * * * * *

DEFINITIONS

SEC. 3. For purposes of this title:

(1) * * *

* * * * * * *

(16)(A) * * *

(B) The term "plan sponsor" means (i) the employer in the case of an employee benefit plan established or maintained by a single employer, (ii) the employee organization in the case of a plan established or maintained by an employee organization, or (iii) in the case of a plan established or maintained by two or more employers or jointly by one or more employers and one or more employee organizations, the association, committee, joint board of trustees, or other similar group of representatives of the parties who establish or maintain the plan. *Such term also includes a person serving as the sponsor of an association health plan under part 8.*

* * * * * * *

(40)(A) * * *

(B) For purposes of this paragraph—

(i) two or more trades or businesses, whether or not incorporated, shall be deemed a single employer if such trades or businesses are within the same control group, *except that, in any case in which the benefit referred to in subparagraph (A) consists of medical care (as defined in section 812(a)(2)), two or more trades or businesses, whether or not incorporated, shall be deemed a single employer for any plan year of such plan, or any fiscal year of such other arrangement, if such trades or businesses are within the same control group during such year or at any time during the preceding 1-year period,*

* * * * * * *

[(iii) the determination**]** *(iii)(I) in any case in which the benefit referred to in subparagraph (A) consists of medical care (as defined in section 812(a)(2)), the determination of whether a trade or business is under "common control" with another trade or business shall be determined under regulations of the Secretary applying principles consistent and coextensive with the principles applied in determining whether employees of two or more trades or businesses are treated as employed by a single employer under section 4001(b), except that, for purposes of this paragraph, an interest of greater than 25 percent may not be required as the minimum interest necessary for common control, or*

(II) in any other case, the determination of whether a trade or business is under "common control" with another trade or business shall be determined under regulations of the Secretary applying principles similar to the principles applied in determining whether employees of two or more trades or businesses are treated as employed by a single employer under section 4001(b), except that, for purposes of this paragraph, common control shall not be based on an interest of less than 25 percent,

(iv) in any case in which the benefit referred to in subparagraph (A) consists of medical care (as defined in section 812(a)(2)), in determining, after the application of clause (i), whether benefits are provided to employees of two or more employers, the arrangement shall be treated as having only one participating employer if, after the application of clause (i), the number of individuals who are employees and former employees of any one participating employer and who are covered under the arrangement is greater than 75 percent of the aggregate number of all individuals who are employees or former employees of participating employers and who are covered under the arrangement,

[(iv)**]** *(v)* the term "rural electric cooperative" means—

(I) * * *

* * * * * * *

[(v)**]** *(vi)* the term "rural telephone cooperative association" means an organization described in paragraph (4) or (6) of section 501(c) of the Internal Revenue Code of 1986 which is exempt from tax under section 501(a) of such Code and at least 80 percent of the members of which are organizations engaged primarily in providing telephone service to rural areas of the United States on a mutual, cooperative, or other basis.

* * * * * * *

SUBTITLE B—REGULATORY PROVISIONS

PART 1—REPORTING AND DISCLOSURE

* * * * * * *

SUMMARY PLAN DESCRIPTION

SEC. 102. (a) * * *

(b) The summary plan description shall contain the following information: The name and type of administration of the plan; in the case of a group health plan (as defined in section 733(a)(1)), whether a health insurance issuer (as defined in section 733(b)(2)) is responsible for the financing or administration (including payment of claims) of the plan and (if so) the name and address of such issuer; the name and address of the person designated as agent for the service of legal process, if such person is not the administrator; the name and address of the administrator; names, titles, and addresses of any trustee or trustees (if they are persons different from the administrator); a description of the relevant provisions of any applicable collective bargaining agreement; the plan's requirements respecting eligibility for participation and benefits; a description of

the provisions providing for nonforfeitable pension benefits; circumstances which may result in disqualification, ineligibility, or denial or loss of benefits; the source of financing of the plan and the identity of any organization through which benefits are provided; the date of the end of the plan year and whether the records of the plan are kept on a calendar, policy, or fiscal year basis; the procedures to be followed in presenting claims for benefits under the plan including the office at the Department of Labor through which participants and beneficiaries may seek assistance or information regarding their rights under this Act and the Health Insurance Portability and Accountability Act of 1996 with respect to health benefits that are offered through a group health plan (as defined in section 733(a)(1)) and the remedies available under the plan for the redress of claims which are denied in whole or in part (including procedures required under section 503 of this Act). *An association health plan shall include in its summary plan description, in connection with each benefit option, a description of the form of solvency or guarantee fund protection secured pursuant to this Act or applicable State law, if any.*

* * * * * * *

PART 5—ADMINISTRATION AND ENFORCEMENT

CRIMINAL PENALTIES

SEC. 501. *(a)* Any person who willfully violates any provision of part 1 of this subtitle, or any regulation or order issued under any such provision, shall upon conviction be fined not more than $100,000 or imprisoned not more than 10 years, or both; except that in the case of such violation by a person not an individual, the fine imposed upon such person shall be a fine not exceeding $500,000.

(b) Any person who willfully falsely represents, to any employee, any employee's beneficiary, any employer, the Secretary, or any State, a plan or other arrangement established or maintained for the purpose of offering or providing any benefit described in section 3(1) to employees or their beneficiaries as—

(1) being an association health plan which has been certified under part 8;

(2) having been established or maintained under or pursuant to one or more collective bargaining agreements which are reached pursuant to collective bargaining described in section 8(d) of the National Labor Relations Act (29 U.S.C. 158(d)) or paragraph Fourth of section 2 of the Railway Labor Act (45 U.S.C. 152, paragraph Fourth) or which are reached pursuant to labor-management negotiations under similar provisions of State public employee relations laws; or

(3) being a plan or arrangement described in section 3(40)(A)(i),

shall, upon conviction, be imprisoned not more than 5 years, be fined under title 18, United States Code, or both.

CIVIL ENFORCEMENT

SEC. 502. (a) * * *

* * * * * * *

(n) ASSOCIATION HEALTH PLAN CEASE AND DESIST ORDERS.—

(1) IN GENERAL.—Subject to paragraph (2), upon application by the Secretary showing the operation, promotion, or marketing of an association health plan (or similar arrangement providing benefits consisting of medical care (as defined in section 733(a)(2))) that—

(A) is not certified under part 8, is subject under section 514(b)(6) to the insurance laws of any State in which the plan or arrangement offers or provides benefits, and is not licensed, registered, or otherwise approved under the insurance laws of such State; or

(B) is an association health plan certified under part 8 and is not operating in accordance with the requirements under part 8 for such certification,

a district court of the United States shall enter an order requiring that the plan or arrangement cease activities.

(2) EXCEPTION.—Paragraph (1) shall not apply in the case of an association health plan or other arrangement if the plan or arrangement shows that—

(A) all benefits under it referred to in paragraph (1) consist of health insurance coverage; and

(B) with respect to each State in which the plan or arrangement offers or provides benefits, the plan or arrangement is operating in accordance with applicable State laws that are not superseded under section 514.

(3) ADDITIONAL EQUITABLE RELIEF.—The court may grant such additional equitable relief, including any relief available under this title, as it deems necessary to protect the interests of the public and of persons having claims for benefits against the plan.

CLAIMS PROCEDURE

SEC. 503. *(a)* IN GENERAL.—In accordance with regulations of the Secretary, every employee benefit plan shall—

(1) * * *

* * * * * * *

(b) ASSOCIATION HEALTH PLANS.—The terms of each association health plan which is or has been certified under part 8 shall require the board of trustees or the named fiduciary (as applicable) to ensure that the requirements of this section are met in connection with claims filed under the plan.

* * * * * * *

COORDINATION AND RESPONSIBILITY OF AGENCIES ENFORCING EMPLOYEE RETIREMENT INCOME SECURITY ACT AND RELATED FEDERAL LAWS

SEC. 506. (a) * * *

* * * * * * *

(d) CONSULTATION WITH STATES WITH RESPECT TO ASSOCIATION HEALTH PLANS.—

(1) AGREEMENTS WITH STATES.—The Secretary shall consult with the State recognized under paragraph (2) with respect to an association health plan regarding the exercise of—

(A) the Secretary's authority under sections 502 and 504 to enforce the requirements for certification under part 8; and

(B) the Secretary's authority to certify association health plans under part 8 in accordance with regulations of the Secretary applicable to certification under part 8.

(2) RECOGNITION OF PRIMARY DOMICILE STATE.—In carrying out paragraph (1), the Secretary shall ensure that only one State will be recognized, with respect to any particular association health plan, as the State with which consultation is required. In carrying out this paragraph—

(A) in the case of a plan which provides health insurance coverage (as defined in section 812(a)(3)), such State shall be the State with which filing and approval of a policy type offered by the plan was initially obtained, and

(B) in any other case, the Secretary shall take into account the places of residence of the participants and beneficiaries under the plan and the State in which the trust is maintained.

* * * * * * *

EFFECT ON OTHER LAWS

SEC. 514. (a) * * *

(b)(1) * * *

* * * * * * *

(4) [Subsection (a)] *Subsections (a) and (d)* shall not apply to any generally applicable criminal law of a State.

(5)(A) Except as provided in subparagraph (B), [subsection (a)] *subsection (a) of this section and subsections (a)(2)(B) and (b) of section 805* shall not apply to the Hawaii Prepaid Health Care Act (Haw. Rev. Stat. §§393–1 through 393–51).

(B) Nothing in subparagraph (A) shall be construed to exempt from [subsection (a)] *subsection (a) of this section or subsection (a)(2)(B) or (b) of section 805—*

(i) * * *

* * * * * * *

(6)(A) Notwithstanding any other provision of this section—

(i) in the case of an employee welfare benefit plan which is a multiple employer welfare arrangement and is fully insured (or which is a multiple employer welfare arrangement subject to an exemption under subparagraph (B)), any law of any State which regulates insurance may apply to such arrangement to the extent that such law provides—

(I) * * *

(II) provisions to enforce such standards, [and]

(ii) in the case of any other employee welfare benefit plan which is a multiple employer welfare arrangement, *and which*

does not provide medical care (within the meaning of section 733(a)(2)), in addition to this title, any law of any State which regulates insurance may apply to the extent not inconsistent with the preceding sections of this [title.] *title, and*

(iii) subject to subparagraph (E), in the case of any other employee welfare benefit plan which is a multiple employer welfare arrangement and which provides medical care (within the meaning of section 733(a)(2)), any law of any State which regulates insurance may apply.

* * * * * * *

(E) The preceding subparagraphs of this paragraph do not apply with respect to any State law in the case of an association health plan which is certified under part 8.

* * * * * * *

(d)(1) Except as provided in subsection (b)(4), the provisions of this title shall supersede any and all State laws insofar as they may now or hereafter preclude, or have the effect of precluding, a health insurance issuer from offering health insurance coverage in connection with an association health plan which is certified under part 8.

(2) Except as provided in paragraphs (4) and (5) of subsection (b) of this section—

(A) In any case in which health insurance coverage of any policy type is offered under an association health plan certified under part 8 to a participating employer operating in such State, the provisions of this title shall supersede any and all laws of such State insofar as they may preclude a health insurance issuer from offering health insurance coverage of the same policy type to other employers operating in the State which are eligible for coverage under such association health plan, whether or not such other employers are participating employers in such plan.

(B) In any case in which health insurance coverage of any policy type is offered in a State under an association health plan certified under part 8 and the filing, with the applicable State authority (as defined in section 812(a)(9)), of the policy form in connection with such policy type is approved by such State authority, the provisions of this title shall supersede any and all laws of any other State in which health insurance coverage of such type is offered, insofar as they may preclude, upon the filing in the same form and manner of such policy form with the applicable State authority in such other State, the approval of the filing in such other State.

(3) Nothing in subsection (b)(6)(E) or the preceding provisions of this subsection shall be construed, with respect to health insurance issuers or health insurance coverage, to supersede or impair the law of any State—

(A) providing solvency standards or similar standards regarding the adequacy of insurer capital, surplus, reserves, or contributions, or

(B) relating to prompt payment of claims.

(4) For additional provisions relating to association health plans, see subsections (a)(2)(B) and (b) of section 805.

(5) For purposes of this subsection, the term "association health plan" has the meaning provided in section 801(a), and the terms "health insurance coverage", "participating employer", and "health insurance issuer" have the meanings provided such terms in section 812, respectively.

[(d) Nothing] *(e)(1) Except as provided in paragraph (2), nothing* in this title shall be construed to alter, amend, modify, invalidate, impair, or supersede any law of the United States (except as provided in sections 111 and 507(b)) or any rule or regulation issued under any such law.

(2) Nothing in any other provision of law enacted on or after the date of the enactment of the Small Business Health Fairness Act of 2005 shall be construed to alter, amend, modify, invalidate, impair, or supersede any provision of this title, except by specific cross-reference to the affected section.

* * * * * * *

PART 7—GROUP HEALTH PLAN REQUIREMENTS

* * * * * * *

SUBPART C—GENERAL PROVISIONS

SEC. 731. PREEMPTION; STATE FLEXIBILITY; CONSTRUCTION.

(a) * * *

* * * * * * *

(c) RULES OF CONSTRUCTION.—Except as provided in section 711, nothing in this part *or part 8* shall be construed as requiring a group health plan or health insurance coverage to provide specific benefits under the terms of such plan or coverage.

* * * * * * *

PART 8—RULES GOVERNING ASSOCIATION HEALTH PLANS

SEC. 801. ASSOCIATION HEALTH PLANS.

(a) IN GENERAL.—For purposes of this part, the term "association health plan" means a group health plan whose sponsor is (or is deemed under this part to be) described in subsection (b).

(b) SPONSORSHIP.—The sponsor of a group health plan is described in this subsection if such sponsor—

(1) is organized and maintained in good faith, with a constitution and bylaws specifically stating its purpose and providing for periodic meetings on at least an annual basis, as a bona fide trade association, a bona fide industry association (including a rural electric cooperative association or a rural telephone cooperative association), a bona fide professional association, or a bona fide chamber of commerce (or similar bona fide business association, including a corporation or similar organization that operates on a cooperative basis (within the meaning of section 1381 of the Internal Revenue Code of 1986)), for substantial purposes other than that of obtaining or providing medical care;

(2) is established as a permanent entity which receives the active support of its members and requires for membership payment on a periodic basis of dues or payments necessary to maintain eligibility for membership in the sponsor; and

(3) does not condition membership, such dues or payments, or coverage under the plan on the basis of health status-related factors with respect to the employees of its members (or affiliated members), or the dependents of such employees, and does not condition such dues or payments on the basis of group health plan participation.

Any sponsor consisting of an association of entities which meet the requirements of paragraphs (1), (2), and (3) shall be deemed to be a sponsor described in this subsection.

SEC. 802. CERTIFICATION OF ASSOCIATION HEALTH PLANS.

(a) IN GENERAL.—The applicable authority shall prescribe by regulation a procedure under which, subject to subsection (b), the applicable authority shall certify association health plans which apply for certification as meeting the requirements of this part.

(b) STANDARDS.—Under the procedure prescribed pursuant to subsection (a), in the case of an association health plan that provides at least one benefit option which does not consist of health insurance coverage, the applicable authority shall certify such plan as meeting the requirements of this part only if the applicable authority is satisfied that the applicable requirements of this part are met (or, upon the date on which the plan is to commence operations, will be met) with respect to the plan.

(c) REQUIREMENTS APPLICABLE TO CERTIFIED PLANS.—An association health plan with respect to which certification under this part is in effect shall meet the applicable requirements of this part, effective on the date of certification (or, if later, on the date on which the plan is to commence operations).

(d) REQUIREMENTS FOR CONTINUED CERTIFICATION.—The applicable authority may provide by regulation for continued certification of association health plans under this part.

(e) CLASS CERTIFICATION FOR FULLY INSURED PLANS.—The applicable authority shall establish a class certification procedure for association health plans under which all benefits consist of health insurance coverage. Under such procedure, the applicable authority shall provide for the granting of certification under this part to the plans in each class of such association health plans upon appropriate filing under such procedure in connection with plans in such class and payment of the prescribed fee under section 807(a).

(f) CERTIFICATION OF SELF-INSURED ASSOCIATION HEALTH PLANS.—An association health plan which offers one or more benefit options which do not consist of health insurance coverage may be certified under this part only if such plan consists of any of the following:

(1) a plan which offered such coverage on the date of the enactment of the Small Business Health Fairness Act of 2005,

(2) a plan under which the sponsor does not restrict membership to one or more trades and businesses or industries and whose eligible participating employers represent a broad cross-section of trades and businesses or industries, or

(3) a plan whose eligible participating employers represent one or more trades or businesses, or one or more industries, consisting of any of the following: agriculture; equipment and automobile dealerships; barbering and cosmetology; certified public accounting practices; child care; construction; dance, theatrical and orchestra productions; disinfecting and pest control; financial services; fishing; foodservice establishments; hospitals; labor organizations; logging; manufacturing (metals); mining; medical and dental practices; medical laboratories; professional consulting services; sanitary services; transportation (local and freight); warehousing; wholesaling/distributing; or any other trade or business or industry which has been indicated as having average or above-average risk or health claims experience by reason of State rate filings, denials of coverage, proposed premium rate levels, or other means demonstrated by such plan in accordance with regulations.

SEC. 803. REQUIREMENTS RELATING TO SPONSORS AND BOARDS OF TRUSTEES.

(a) SPONSOR.—The requirements of this subsection are met with respect to an association health plan if the sponsor has met (or is deemed under this part to have met) the requirements of section 801(b) for a continuous period of not less than 3 years ending with the date of the application for certification under this part.

(b) BOARD OF TRUSTEES.—The requirements of this subsection are met with respect to an association health plan if the following requirements are met:

(1) FISCAL CONTROL.—The plan is operated, pursuant to a trust agreement, by a board of trustees which has complete fiscal control over the plan and which is responsible for all operations of the plan.

(2) RULES OF OPERATION AND FINANCIAL CONTROLS.—The board of trustees has in effect rules of operation and financial controls, based on a 3-year plan of operation, adequate to carry out the terms of the plan and to meet all requirements of this title applicable to the plan.

(3) RULES GOVERNING RELATIONSHIP TO PARTICIPATING EMPLOYERS AND TO CONTRACTORS.—

(A) BOARD MEMBERSHIP.—

(i) IN GENERAL.—Except as provided in clauses (ii) and (iii), the members of the board of trustees are individuals selected from individuals who are the owners, officers, directors, or employees of the participating employers or who are partners in the participating employers and actively participate in the business.

(ii) LIMITATION.—

(I) GENERAL RULE.—Except as provided in subclauses (II) and (III), no such member is an owner, officer, director, or employee of, or partner in, a contract administrator or other service provider to the plan.

(II) LIMITED EXCEPTION FOR PROVIDERS OF SERVICES SOLELY ON BEHALF OF THE SPONSOR.—Officers or employees of a sponsor which is a service provider (other than a contract administrator) to

the plan may be members of the board if they constitute not more than 25 percent of the membership of the board and they do not provide services to the plan other than on behalf of the sponsor.

(III) TREATMENT OF PROVIDERS OF MEDICAL CARE.—In the case of a sponsor which is an association whose membership consists primarily of providers of medical care, subclause (I) shall not apply in the case of any service provider described in subclause (I) who is a provider of medical care under the plan.

(iii) CERTAIN PLANS EXCLUDED.—Clause (i) shall not apply to an association health plan which is in existence on the date of the enactment of the Small Business Health Fairness Act of 2005.

(B) SOLE AUTHORITY.—The board has sole authority under the plan to approve applications for participation in the plan and to contract with a service provider to administer the day-to-day affairs of the plan.

(c) TREATMENT OF FRANCHISE NETWORKS.—In the case of a group health plan which is established and maintained by a franchiser for a franchise network consisting of its franchisees—

(1) the requirements of subsection (a) and section 801(a) shall be deemed met if such requirements would otherwise be met if the franchiser were deemed to be the sponsor referred to in section 801(b), such network were deemed to be an association described in section 801(b), and each franchisee were deemed to be a member (of the association and the sponsor) referred to in section 801(b); and

(2) the requirements of section 804(a)(1) shall be deemed met.

The Secretary may by regulation define for purposes of this subsection the terms "franchiser", "franchise network", and "franchisee".

SEC. 804. PARTICIPATION AND COVERAGE REQUIREMENTS.

(a) COVERED EMPLOYERS AND INDIVIDUALS.—The requirements of this subsection are met with respect to an association health plan if, under the terms of the plan—

(1) each participating employer must be—

(A) a member of the sponsor,

(B) the sponsor, or

(C) an affiliated member of the sponsor with respect to which the requirements of subsection (b) are met,

except that, in the case of a sponsor which is a professional association or other individual-based association, if at least one of the officers, directors, or employees of an employer, or at least one of the individuals who are partners in an employer and who actively participates in the business, is a member or such an affiliated member of the sponsor, participating employers may also include such employer; and

(2) all individuals commencing coverage under the plan after certification under this part must be—

(A) active or retired owners (including self-employed individuals), officers, directors, or employees of, or partners in, participating employers; or

(B) the beneficiaries of individuals described in subparagraph (A).

(b) COVERAGE OF PREVIOUSLY UNINSURED EMPLOYEES.—In the case of an association health plan in existence on the date of the enactment of the Small Business Health Fairness Act of 2005, an affiliated member of the sponsor of the plan may be offered coverage under the plan as a participating employer only if—

(1) the affiliated member was an affiliated member on the date of certification under this part; or

(2) during the 12-month period preceding the date of the offering of such coverage, the affiliated member has not maintained or contributed to a group health plan with respect to any of its employees who would otherwise be eligible to participate in such association health plan.

(c) INDIVIDUAL MARKET UNAFFECTED.—The requirements of this subsection are met with respect to an association health plan if, under the terms of the plan, no participating employer may provide health insurance coverage in the individual market for any employee not covered under the plan which is similar to the coverage contemporaneously provided to employees of the employer under the plan, if such exclusion of the employee from coverage under the plan is based on a health status-related factor with respect to the employee and such employee would, but for such exclusion on such basis, be eligible for coverage under the plan.

(d) PROHIBITION OF DISCRIMINATION AGAINST EMPLOYERS AND EMPLOYEES ELIGIBLE TO PARTICIPATE.—The requirements of this subsection are met with respect to an association health plan if—

(1) under the terms of the plan, all employers meeting the preceding requirements of this section are eligible to qualify as participating employers for all geographically available coverage options, unless, in the case of any such employer, participation or contribution requirements of the type referred to in section 2711 of the Public Health Service Act are not met;

(2) upon request, any employer eligible to participate is furnished information regarding all coverage options available under the plan; and

(3) the applicable requirements of sections 701, 702, and 703 are met with respect to the plan.

SEC. 805. OTHER REQUIREMENTS RELATING TO PLAN DOCUMENTS, CONTRIBUTION RATES, AND BENEFIT OPTIONS.

(a) IN GENERAL.—The requirements of this section are met with respect to an association health plan if the following requirements are met:

(1) CONTENTS OF GOVERNING INSTRUMENTS.—The instruments governing the plan include a written instrument, meeting the requirements of an instrument required under section 402(a)(1), which—

(A) provides that the board of trustees serves as the named fiduciary required for plans under section 402(a)(1) and serves in the capacity of a plan administrator (referred to in section 3(16)(A));

(B) provides that the sponsor of the plan is to serve as plan sponsor (referred to in section 3(16)(B)); and

(C) incorporates the requirements of section 806.

(2) CONTRIBUTION RATES MUST BE NONDISCRIMINATORY.—

(A) The contribution rates for any participating small employer do not vary on the basis of any health status-related factor in relation to employees of such employer or their beneficiaries and do not vary on the basis of the type of business or industry in which such employer is engaged.

(B) Nothing in this title or any other provision of law shall be construed to preclude an association health plan, or a health insurance issuer offering health insurance coverage in connection with an association health plan, from—

(i) setting contribution rates based on the claims experience of the plan; or

(ii) varying contribution rates for small employers in a State to the extent that such rates could vary using the same methodology employed in such State for regulating premium rates in the small group market with respect to health insurance coverage offered in connection with bona fide associations (within the meaning of section 2791(d)(3) of the Public Health Service Act),

subject to the requirements of section 702(b) relating to contribution rates.

(3) FLOOR FOR NUMBER OF COVERED INDIVIDUALS WITH RESPECT TO CERTAIN PLANS.—If any benefit option under the plan does not consist of health insurance coverage, the plan has as of the beginning of the plan year not fewer than 1,000 participants and beneficiaries.

(4) MARKETING REQUIREMENTS.—

(A) IN GENERAL.—If a benefit option which consists of health insurance coverage is offered under the plan, State-licensed insurance agents shall be used to distribute to small employers coverage which does not consist of health insurance coverage in a manner comparable to the manner in which such agents are used to distribute health insurance coverage.

(B) STATE-LICENSED INSURANCE AGENTS.—For purposes of subparagraph (A), the term "State-licensed insurance agents" means one or more agents who are licensed in a State and are subject to the laws of such State relating to licensure, qualification, testing, examination, and continuing education of persons authorized to offer, sell, or solicit health insurance coverage in such State.

(5) REGULATORY REQUIREMENTS.—Such other requirements as the applicable authority determines are necessary to carry out the purposes of this part, which shall be prescribed by the applicable authority by regulation.

(b) ABILITY OF ASSOCIATION HEALTH PLANS TO DESIGN BENEFIT OPTIONS.—Subject to section 514(d), nothing in this part or any provision of State law (as defined in section 514(c)(1)) shall be construed to preclude an association health plan, or a health insurance issuer offering health insurance coverage in connection with an association health plan, from exercising its sole discretion in selecting the specific items and services consisting of medical care to be included as benefits under such plan or coverage, except (subject to section 514) in the case of (1) any law to the extent that it is not

preempted under section 731(a)(1) with respect to matters governed by section 711, 712, or 713, or (2) any law of the State with which filing and approval of a policy type offered by the plan was initially obtained to the extent that such law prohibits an exclusion of a specific disease from such coverage.

SEC. 806. MAINTENANCE OF RESERVES AND PROVISIONS FOR SOLVENCY FOR PLANS PROVIDING HEALTH BENEFITS IN ADDITION TO HEALTH INSURANCE COVERAGE.

(a) IN GENERAL.—The requirements of this section are met with respect to an association health plan if—

(1) the benefits under the plan consist solely of health insurance coverage; or

(2) if the plan provides any additional benefit options which do not consist of health insurance coverage, the plan—

(A) establishes and maintains reserves with respect to such additional benefit options, in amounts recommended by the qualified actuary, consisting of—

(i) a reserve sufficient for unearned contributions;

(ii) a reserve sufficient for benefit liabilities which have been incurred, which have not been satisfied, and for which risk of loss has not yet been transferred, and for expected administrative costs with respect to such benefit liabilities;

(iii) a reserve sufficient for any other obligations of the plan; and

(iv) a reserve sufficient for a margin of error and other fluctuations, taking into account the specific circumstances of the plan; and

(B) establishes and maintains aggregate and specific excess /stop loss insurance and solvency indemnification, with respect to such additional benefit options for which risk of loss has not yet been transferred, as follows:

(i) The plan shall secure aggregate excess /stop loss insurance for the plan with an attachment point which is not greater than 125 percent of expected gross annual claims. The applicable authority may by regulation provide for upward adjustments in the amount of such percentage in specified circumstances in which the plan specifically provides for and maintains reserves in excess of the amounts required under subparagraph (A).

(ii) The plan shall secure specific excess /stop loss insurance for the plan with an attachment point which is at least equal to an amount recommended by the plan's qualified actuary. The applicable authority may by regulation provide for adjustments in the amount of such insurance in specified circumstances in which the plan specifically provides for and maintains reserves in excess of the amounts required under subparagraph (A).

(iii) The plan shall secure indemnification insurance for any claims which the plan is unable to satisfy by reason of a plan termination.

Any person issuing to a plan insurance described in clause (i), (ii), or (iii) of subparagraph (B) shall notify the Secretary of any failure of premium payment meriting cancellation of the policy prior to undertaking such a cancellation. Any regulations prescribed by the applicable authority pursuant to clause (i) or (ii) of subparagraph (B) may allow for such adjustments in the required levels of excess /stop loss insurance as the qualified actuary may recommend, taking into account the specific circumstances of the plan.

(b) MINIMUM SURPLUS IN ADDITION TO CLAIMS RESERVES.—In the case of any association health plan described in subsection (a)(2), the requirements of this subsection are met if the plan establishes and maintains surplus in an amount at least equal to—

(1) $500,000, or

(2) such greater amount (but not greater than $2,000,000) as may be set forth in regulations prescribed by the applicable authority, considering the level of aggregate and specific excess /stop loss insurance provided with respect to such plan and other factors related to solvency risk, such as the plan's projected levels of participation or claims, the nature of the plan's liabilities, and the types of assets available to assure that such liabilities are met.

(c) ADDITIONAL REQUIREMENTS.—In the case of any association health plan described in subsection (a)(2), the applicable authority may provide such additional requirements relating to reserves, excess /stop loss insurance, and indemnification insurance as the applicable authority considers appropriate. Such requirements may be provided by regulation with respect to any such plan or any class of such plans.

(d) ADJUSTMENTS FOR EXCESS /STOP LOSS INSURANCE.—The applicable authority may provide for adjustments to the levels of reserves otherwise required under subsections (a) and (b) with respect to any plan or class of plans to take into account excess /stop loss insurance provided with respect to such plan or plans.

(e) ALTERNATIVE MEANS OF COMPLIANCE.—The applicable authority may permit an association health plan described in subsection (a)(2) to substitute, for all or part of the requirements of this section (except subsection (a)(2)(B)(iii)), such security, guarantee, hold-harmless arrangement, or other financial arrangement as the applicable authority determines to be adequate to enable the plan to fully meet all its financial obligations on a timely basis and is otherwise no less protective of the interests of participants and beneficiaries than the requirements for which it is substituted. The applicable authority may take into account, for purposes of this subsection, evidence provided by the plan or sponsor which demonstrates an assumption of liability with respect to the plan. Such evidence may be in the form of a contract of indemnification, lien, bonding, insurance, letter of credit, recourse under applicable terms of the plan in the form of assessments of participating employers, security, or other financial arrangement.

(f) MEASURES TO ENSURE CONTINUED PAYMENT OF BENEFITS BY CERTAIN PLANS IN DISTRESS.—

(1) PAYMENTS BY CERTAIN PLANS TO ASSOCIATION HEALTH PLAN FUND.—

(A) IN GENERAL.—In the case of an association health plan described in subsection (a)(2), the requirements of this subsection are met if the plan makes payments into the Association Health Plan Fund under this subparagraph when they are due. Such payments shall consist of annual payments in the amount of $5,000, and, in addition to such annual payments, such supplemental payments as the Secretary may determine to be necessary under paragraph (2). Payments under this paragraph are payable to the Fund at the time determined by the Secretary. Initial payments are due in advance of certification under this part. Payments shall continue to accrue until a plan's assets are distributed pursuant to a termination procedure.

(B) PENALTIES FOR FAILURE TO MAKE PAYMENTS.—If any payment is not made by a plan when it is due, a late payment charge of not more than 100 percent of the payment which was not timely paid shall be payable by the plan to the Fund.

(C) CONTINUED DUTY OF THE SECRETARY.—The Secretary shall not cease to carry out the provisions of paragraph (2) on account of the failure of a plan to pay any payment when due.

(2) PAYMENTS BY SECRETARY TO CONTINUE EXCESS /STOP LOSS INSURANCE COVERAGE AND INDEMNIFICATION INSURANCE COVERAGE FOR CERTAIN PLANS.—In any case in which the applicable authority determines that there is, or that there is reason to believe that there will be: (A) a failure to take necessary corrective actions under section 809(a) with respect to an association health plan described in subsection (a)(2); or (B) a termination of such a plan under section 809(b) or 810(b)(8) (and, if the applicable authority is not the Secretary, certifies such determination to the Secretary), the Secretary shall determine the amounts necessary to make payments to an insurer (designated by the Secretary) to maintain in force excess /stop loss insurance coverage or indemnification insurance coverage for such plan, if the Secretary determines that there is a reasonable expectation that, without such payments, claims would not be satisfied by reason of termination of such coverage. The Secretary shall, to the extent provided in advance in appropriation Acts, pay such amounts so determined to the insurer designated by the Secretary.

(3) ASSOCIATION HEALTH PLAN FUND.—

(A) IN GENERAL.—There is established on the books of the Treasury a fund to be known as the "Association Health Plan Fund". The Fund shall be available for making payments pursuant to paragraph (2). The Fund shall be credited with payments received pursuant to paragraph (1)(A), penalties received pursuant to paragraph (1)(B); and earnings on investments of amounts of the Fund under subparagraph (B).

(B) INVESTMENT.—Whenever the Secretary determines that the moneys of the fund are in excess of current needs, the Secretary may request the investment of such amounts as the Secretary determines advisable by the Secretary of

the Treasury in obligations issued or guaranteed by the United States.

(g) EXCESS /STOP LOSS INSURANCE.—For purposes of this section—

(1) AGGREGATE EXCESS /STOP LOSS INSURANCE.—The term "aggregate excess /stop loss insurance" means, in connection with an association health plan, a contract—

(A) under which an insurer (meeting such minimum standards as the applicable authority may prescribe by regulation) provides for payment to the plan with respect to aggregate claims under the plan in excess of an amount or amounts specified in such contract;

(B) which is guaranteed renewable; and

(C) which allows for payment of premiums by any third party on behalf of the insured plan.

(2) SPECIFIC EXCESS /STOP LOSS INSURANCE.—The term "specific excess /stop loss insurance" means, in connection with an association health plan, a contract—

(A) under which an insurer (meeting such minimum standards as the applicable authority may prescribe by regulation) provides for payment to the plan with respect to claims under the plan in connection with a covered individual in excess of an amount or amounts specified in such contract in connection with such covered individual;

(B) which is guaranteed renewable; and

(C) which allows for payment of premiums by any third party on behalf of the insured plan.

(h) INDEMNIFICATION INSURANCE.—For purposes of this section, the term "indemnification insurance" means, in connection with an association health plan, a contract—

(1) under which an insurer (meeting such minimum standards as the applicable authority may prescribe by regulation) provides for payment to the plan with respect to claims under the plan which the plan is unable to satisfy by reason of a termination pursuant to section 809(b) (relating to mandatory termination);

(2) which is guaranteed renewable and noncancellable for any reason (except as the applicable authority may prescribe by regulation); and

(3) which allows for payment of premiums by any third party on behalf of the insured plan.

(i) RESERVES.—For purposes of this section, the term "reserves" means, in connection with an association health plan, plan assets which meet the fiduciary standards under part 4 and such additional requirements regarding liquidity as the applicable authority may prescribe by regulation.

(j) SOLVENCY STANDARDS WORKING GROUP.—

(1) IN GENERAL.—Within 90 days after the date of the enactment of the Small Business Health Fairness Act of 2005, the applicable authority shall establish a Solvency Standards Working Group. In prescribing the initial regulations under this section, the applicable authority shall take into account the recommendations of such Working Group.

(2) MEMBERSHIP.—The Working Group shall consist of not more than 15 members appointed by the applicable authority. The applicable authority shall include among persons invited to membership on the Working Group at least one of each of the following:

(A) a representative of the National Association of Insurance Commissioners;

(B) a representative of the American Academy of Actuaries;

(C) a representative of the State governments, or their interests;

(D) a representative of existing self-insured arrangements, or their interests;

(E) a representative of associations of the type referred to in section 801(b)(1), or their interests; and

(F) a representative of multiemployer plans that are group health plans, or their interests.

SEC. 807. REQUIREMENTS FOR APPLICATION AND RELATED REQUIREMENTS.

(a) FILING FEE.—Under the procedure prescribed pursuant to section 802(a), an association health plan shall pay to the applicable authority at the time of filing an application for certification under this part a filing fee in the amount of $5,000, which shall be available in the case of the Secretary, to the extent provided in appropriation Acts, for the sole purpose of administering the certification procedures applicable with respect to association health plans.

(b) INFORMATION TO BE INCLUDED IN APPLICATION FOR CERTIFICATION.—An application for certification under this part meets the requirements of this section only if it includes, in a manner and form which shall be prescribed by the applicable authority by regulation, at least the following information:

(1) IDENTIFYING INFORMATION.—The names and addresses of—

(A) the sponsor; and

(B) the members of the board of trustees of the plan.

(2) STATES IN WHICH PLAN INTENDS TO DO BUSINESS.—The States in which participants and beneficiaries under the plan are to be located and the number of them expected to be located in each such State.

(3) BONDING REQUIREMENTS.—Evidence provided by the board of trustees that the bonding requirements of section 412 will be met as of the date of the application or (if later) commencement of operations.

(4) PLAN DOCUMENTS.—A copy of the documents governing the plan (including any bylaws and trust agreements), the summary plan description, and other material describing the benefits that will be provided to participants and beneficiaries under the plan.

(5) AGREEMENTS WITH SERVICE PROVIDERS.—A copy of any agreements between the plan and contract administrators and other service providers.

(6) FUNDING REPORT.—In the case of association health plans providing benefits options in addition to health insurance coverage, a report setting forth information with respect to such

additional benefit options determined as of a date within the 120-day period ending with the date of the application, including the following:

(A) RESERVES.—A statement, certified by the board of trustees of the plan, and a statement of actuarial opinion, signed by a qualified actuary, that all applicable requirements of section 806 are or will be met in accordance with regulations which the applicable authority shall prescribe.

(B) ADEQUACY OF CONTRIBUTION RATES.—A statement of actuarial opinion, signed by a qualified actuary, which sets forth a description of the extent to which contribution rates are adequate to provide for the payment of all obligations and the maintenance of required reserves under the plan for the 12-month period beginning with such date within such 120-day period, taking into account the expected coverage and experience of the plan. If the contribution rates are not fully adequate, the statement of actuarial opinion shall indicate the extent to which the rates are inadequate and the changes needed to ensure adequacy.

(C) CURRENT AND PROJECTED VALUE OF ASSETS AND LIABILITIES.—A statement of actuarial opinion signed by a qualified actuary, which sets forth the current value of the assets and liabilities accumulated under the plan and a projection of the assets, liabilities, income, and expenses of the plan for the 12-month period referred to in subparagraph (B). The income statement shall identify separately the plan's administrative expenses and claims.

(D) COSTS OF COVERAGE TO BE CHARGED AND OTHER EXPENSES.—A statement of the costs of coverage to be charged, including an itemization of amounts for administration, reserves, and other expenses associated with the operation of the plan.

(E) OTHER INFORMATION.—Any other information as may be determined by the applicable authority, by regulation, as necessary to carry out the purposes of this part.

(c) FILING NOTICE OF CERTIFICATION WITH STATES.—A certification granted under this part to an association health plan shall not be effective unless written notice of such certification is filed with the applicable State authority of each State in which at least 25 percent of the participants and beneficiaries under the plan are located. For purposes of this subsection, an individual shall be considered to be located in the State in which a known address of such individual is located or in which such individual is employed.

(d) NOTICE OF MATERIAL CHANGES.—In the case of any association health plan certified under this part, descriptions of material changes in any information which was required to be submitted with the application for the certification under this part shall be filed in such form and manner as shall be prescribed by the applicable authority by regulation. The applicable authority may require by regulation prior notice of material changes with respect to specified matters which might serve as the basis for suspension or revocation of the certification.

(e) REPORTING REQUIREMENTS FOR CERTAIN ASSOCIATION HEALTH PLANS.—An association health plan certified under this

part which provides benefit options in addition to health insurance coverage for such plan year shall meet the requirements of section 103 by filing an annual report under such section which shall include information described in subsection (b)(6) with respect to the plan year and, notwithstanding section 104(a)(1)(A), shall be filed with the applicable authority not later than 90 days after the close of the plan year (or on such later date as may be prescribed by the applicable authority). The applicable authority may require by regulation such interim reports as it considers appropriate.

(f) ENGAGEMENT OF QUALIFIED ACTUARY.—The board of trustees of each association health plan which provides benefits options in addition to health insurance coverage and which is applying for certification under this part or is certified under this part shall engage, on behalf of all participants and beneficiaries, a qualified actuary who shall be responsible for the preparation of the materials comprising information necessary to be submitted by a qualified actuary under this part. The qualified actuary shall utilize such assumptions and techniques as are necessary to enable such actuary to form an opinion as to whether the contents of the matters reported under this part—

(1) are in the aggregate reasonably related to the experience of the plan and to reasonable expectations; and

(2) represent such actuary's best estimate of anticipated experience under the plan.

The opinion by the qualified actuary shall be made with respect to, and shall be made a part of, the annual report.

SEC. 808. NOTICE REQUIREMENTS FOR VOLUNTARY TERMINATION.

Except as provided in section 809(b), an association health plan which is or has been certified under this part may terminate (upon or at any time after cessation of accruals in benefit liabilities) only if the board of trustees, not less than 60 days before the proposed termination date—

(1) provides to the participants and beneficiaries a written notice of intent to terminate stating that such termination is intended and the proposed termination date;

(2) develops a plan for winding up the affairs of the plan in connection with such termination in a manner which will result in timely payment of all benefits for which the plan is obligated; and

(3) submits such plan in writing to the applicable authority.

Actions required under this section shall be taken in such form and manner as may be prescribed by the applicable authority by regulation.

SEC. 809. CORRECTIVE ACTIONS AND MANDATORY TERMINATION.

(a) ACTIONS TO AVOID DEPLETION OF RESERVES.—An association health plan which is certified under this part and which provides benefits other than health insurance coverage shall continue to meet the requirements of section 806, irrespective of whether such certification continues in effect. The board of trustees of such plan shall determine quarterly whether the requirements of section 806 are met. In any case in which the board determines that there is reason to believe that there is or will be a failure to meet such requirements, or the applicable authority makes such a determination and

so notifies the board, the board shall immediately notify the qualified actuary engaged by the plan, and such actuary shall, not later than the end of the next following month, make such recommendations to the board for corrective action as the actuary determines necessary to ensure compliance with section 806. Not later than 30 days after receiving from the actuary recommendations for corrective actions, the board shall notify the applicable authority (in such form and manner as the applicable authority may prescribe by regulation) of such recommendations of the actuary for corrective action, together with a description of the actions (if any) that the board has taken or plans to take in response to such recommendations. The board shall thereafter report to the applicable authority, in such form and frequency as the applicable authority may specify to the board, regarding corrective action taken by the board until the requirements of section 806 are met.

(b) MANDATORY TERMINATION.—In any case in which—

(1) the applicable authority has been notified under subsection (a) (or by an issuer of excess /stop loss insurance or indemnity insurance pursuant to section 806(a)) of a failure of an association health plan which is or has been certified under this part and is described in section 806(a)(2) to meet the requirements of section 806 and has not been notified by the board of trustees of the plan that corrective action has restored compliance with such requirements; and

(2) the applicable authority determines that there is a reasonable expectation that the plan will continue to fail to meet the requirements of section 806,

the board of trustees of the plan shall, at the direction of the applicable authority, terminate the plan and, in the course of the termination, take such actions as the applicable authority may require, including satisfying any claims referred to in section 806(a)(2)(B)(iii) and recovering for the plan any liability under subsection (a)(2)(B)(iii) or (e) of section 806, as necessary to ensure that the affairs of the plan will be, to the maximum extent possible, wound up in a manner which will result in timely provision of all benefits for which the plan is obligated.

SEC. 810. TRUSTEESHIP BY THE SECRETARY OF INSOLVENT ASSOCIATION HEALTH PLANS PROVIDING HEALTH BENEFITS IN ADDITION TO HEALTH INSURANCE COVERAGE.

(a) APPOINTMENT OF SECRETARY AS TRUSTEE FOR INSOLVENT PLANS.—Whenever the Secretary determines that an association health plan which is or has been certified under this part and which is described in section 806(a)(2) will be unable to provide benefits when due or is otherwise in a financially hazardous condition, as shall be defined by the Secretary by regulation, the Secretary shall, upon notice to the plan, apply to the appropriate United States district court for appointment of the Secretary as trustee to administer the plan for the duration of the insolvency. The plan may appear as a party and other interested persons may intervene in the proceedings at the discretion of the court. The court shall appoint such Secretary trustee if the court determines that the trusteeship is necessary to protect the interests of the participants and beneficiaries or providers of medical care or to avoid any unreasonable deterioration of the financial condition of the plan. The

trusteeship of such Secretary shall continue until the conditions described in the first sentence of this subsection are remedied or the plan is terminated.

(b) POWERS AS TRUSTEE.—The Secretary, upon appointment as trustee under subsection (a), shall have the power—

(1) to do any act authorized by the plan, this title, or other applicable provisions of law to be done by the plan administrator or any trustee of the plan;

(2) to require the transfer of all (or any part) of the assets and records of the plan to the Secretary as trustee;

(3) to invest any assets of the plan which the Secretary holds in accordance with the provisions of the plan, regulations prescribed by the Secretary, and applicable provisions of law;

(4) to require the sponsor, the plan administrator, any participating employer, and any employee organization representing plan participants to furnish any information with respect to the plan which the Secretary as trustee may reasonably need in order to administer the plan;

(5) to collect for the plan any amounts due the plan and to recover reasonable expenses of the trusteeship;

(6) to commence, prosecute, or defend on behalf of the plan any suit or proceeding involving the plan;

(7) to issue, publish, or file such notices, statements, and reports as may be required by the Secretary by regulation or required by any order of the court;

(8) to terminate the plan (or provide for its termination in accordance with section 809(b)) and liquidate the plan assets, to restore the plan to the responsibility of the sponsor, or to continue the trusteeship;

(9) to provide for the enrollment of plan participants and beneficiaries under appropriate coverage options; and

(10) to do such other acts as may be necessary to comply with this title or any order of the court and to protect the interests of plan participants and beneficiaries and providers of medical care.

(c) NOTICE OF APPOINTMENT.—As soon as practicable after the Secretary's appointment as trustee, the Secretary shall give notice of such appointment to—

(1) the sponsor and plan administrator;

(2) each participant;

(3) each participating employer; and

(4) if applicable, each employee organization which, for purposes of collective bargaining, represents plan participants.

(d) ADDITIONAL DUTIES.—Except to the extent inconsistent with the provisions of this title, or as may be otherwise ordered by the court, the Secretary, upon appointment as trustee under this section, shall be subject to the same duties as those of a trustee under section 704 of title 11, United States Code, and shall have the duties of a fiduciary for purposes of this title.

(e) OTHER PROCEEDINGS.—An application by the Secretary under this subsection may be filed notwithstanding the pendency in the same or any other court of any bankruptcy, mortgage foreclosure, or equity receivership proceeding, or any proceeding to reorganize, con-

serve, or liquidate such plan or its property, or any proceeding to enforce a lien against property of the plan.

(f) JURISDICTION OF COURT.—

(1) IN GENERAL.—Upon the filing of an application for the appointment as trustee or the issuance of a decree under this section, the court to which the application is made shall have exclusive jurisdiction of the plan involved and its property wherever located with the powers, to the extent consistent with the purposes of this section, of a court of the United States having jurisdiction over cases under chapter 11 of title 11, United States Code. Pending an adjudication under this section such court shall stay, and upon appointment by it of the Secretary as trustee, such court shall continue the stay of, any pending mortgage foreclosure, equity receivership, or other proceeding to reorganize, conserve, or liquidate the plan, the sponsor, or property of such plan or sponsor, and any other suit against any receiver, conservator, or trustee of the plan, the sponsor, or property of the plan or sponsor. Pending such adjudication and upon the appointment by it of the Secretary as trustee, the court may stay any proceeding to enforce a lien against property of the plan or the sponsor or any other suit against the plan or the sponsor.

(2) VENUE.—An action under this section may be brought in the judicial district where the sponsor or the plan administrator resides or does business or where any asset of the plan is situated. A district court in which such action is brought may issue process with respect to such action in any other judicial district.

(g) PERSONNEL.—In accordance with regulations which shall be prescribed by the Secretary, the Secretary shall appoint, retain, and compensate accountants, actuaries, and other professional service personnel as may be necessary in connection with the Secretary's service as trustee under this section.

SEC. 811. STATE ASSESSMENT AUTHORITY.

(a) IN GENERAL.—Notwithstanding section 514, a State may impose by law a contribution tax on an association health plan described in section 806(a)(2), if the plan commenced operations in such State after the date of the enactment of the Small Business Health Fairness Act of 2005.

(b) CONTRIBUTION TAX.—For purposes of this section, the term "contribution tax" imposed by a State on an association health plan means any tax imposed by such State if—

(1) such tax is computed by applying a rate to the amount of premiums or contributions, with respect to individuals covered under the plan who are residents of such State, which are received by the plan from participating employers located in such State or from such individuals;

(2) the rate of such tax does not exceed the rate of any tax imposed by such State on premiums or contributions received by insurers or health maintenance organizations for health insurance coverage offered in such State in connection with a group health plan;

(3) such tax is otherwise nondiscriminatory; and

(4) the amount of any such tax assessed on the plan is reduced by the amount of any tax or assessment otherwise im-

posed by the State on premiums, contributions, or both received by insurers or health maintenance organizations for health insurance coverage, aggregate excess /stop loss insurance (as defined in section 806(g)(1)), specific excess /stop loss insurance (as defined in section 806(g)(2)), other insurance related to the provision of medical care under the plan, or any combination thereof provided by such insurers or health maintenance organizations in such State in connection with such plan.

SEC. 812. DEFINITIONS AND RULES OF CONSTRUCTION.

(a) DEFINITIONS.—For purposes of this part—

(1) GROUP HEALTH PLAN.—The term "group health plan" has the meaning provided in section 733(a)(1) (after applying subsection (b) of this section).

(2) MEDICAL CARE.—The term "medical care" has the meaning provided in section 733(a)(2).

(3) HEALTH INSURANCE COVERAGE.—The term "health insurance coverage" has the meaning provided in section 733(b)(1).

(4) HEALTH INSURANCE ISSUER.—The term "health insurance issuer" has the meaning provided in section 733(b)(2).

(5) APPLICABLE AUTHORITY.—The term "applicable authority" means the Secretary, except that, in connection with any exercise of the Secretary's authority regarding which the Secretary is required under section 506(d) to consult with a State, such term means the Secretary, in consultation with such State.

(6) HEALTH STATUS-RELATED FACTOR.—The term "health status-related factor" has the meaning provided in section 733(d)(2).

(7) INDIVIDUAL MARKET.—

(A) IN GENERAL.—The term "individual market" means the market for health insurance coverage offered to individuals other than in connection with a group health plan.

(B) TREATMENT OF VERY SMALL GROUPS.—

(i) IN GENERAL.—Subject to clause (ii), such term includes coverage offered in connection with a group health plan that has fewer than 2 participants as current employees or participants described in section 732(d)(3) on the first day of the plan year.

(ii) STATE EXCEPTION.—Clause (i) shall not apply in the case of health insurance coverage offered in a State if such State regulates the coverage described in such clause in the same manner and to the same extent as coverage in the small group market (as defined in section 2791(e)(5) of the Public Health Service Act) is regulated by such State.

(8) PARTICIPATING EMPLOYER.—The term "participating employer" means, in connection with an association health plan, any employer, if any individual who is an employee of such employer, a partner in such employer, or a self-employed individual who is such employer (or any dependent, as defined under the terms of the plan, of such individual) is or was covered under such plan in connection with the status of such individual as such an employee, partner, or self-employed individual in relation to the plan.

(9) APPLICABLE STATE AUTHORITY.—The term "applicable State authority" means, with respect to a health insurance issuer in a State, the State insurance commissioner or official or officials designated by the State to enforce the requirements of title XXVII of the Public Health Service Act for the State involved with respect to such issuer.

(10) QUALIFIED ACTUARY.—The term "qualified actuary" means an individual who is a member of the American Academy of Actuaries.

(11) AFFILIATED MEMBER.—The term "affiliated member" means, in connection with a sponsor—

(A) a person who is otherwise eligible to be a member of the sponsor but who elects an affiliated status with the sponsor,

(B) in the case of a sponsor with members which consist of associations, a person who is a member of any such association and elects an affiliated status with the sponsor, or

(C) in the case of an association health plan in existence on the date of the enactment of the Small Business Health Fairness Act of 2005, a person eligible to be a member of the sponsor or one of its member associations.

(12) LARGE EMPLOYER.—The term "large employer" means, in connection with a group health plan with respect to a plan year, an employer who employed an average of at least 51 employees on business days during the preceding calendar year and who employs at least 2 employees on the first day of the plan year.

(13) SMALL EMPLOYER.—The term "small employer" means, in connection with a group health plan with respect to a plan year, an employer who is not a large employer.

(b) RULES OF CONSTRUCTION.—

(1) EMPLOYERS AND EMPLOYEES.—For purposes of determining whether a plan, fund, or program is an employee welfare benefit plan which is an association health plan, and for purposes of applying this title in connection with such plan, fund, or program so determined to be such an employee welfare benefit plan—

(A) in the case of a partnership, the term "employer" (as defined in section 3(5)) includes the partnership in relation to the partners, and the term "employee" (as defined in section 3(6)) includes any partner in relation to the partnership; and

(B) in the case of a self-employed individual, the term "employer" (as defined in section 3(5)) and the term "employee" (as defined in section 3(6)) shall include such individual.

(2) PLANS, FUNDS, AND PROGRAMS TREATED AS EMPLOYEE WELFARE BENEFIT PLANS.—In the case of any plan, fund, or program which was established or is maintained for the purpose of providing medical care (through the purchase of insurance or otherwise) for employees (or their dependents) covered thereunder and which demonstrates to the Secretary that all requirements for certification under this part would be met with respect to such plan, fund, or program if such plan, fund, or program were a group health plan, such plan, fund, or program

shall be treated for purposes of this title as an employee welfare benefit plan on and after the date of such demonstration.

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