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108TH CONGRESS, 1st Session } HOUSE OF REPRESENTATIVES { REPORT 108–156

SMALL BUSINESS HEALTH FAIRNESS ACT OF 2003

JUNE 16, 2003.—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

MINORITY VIEWS

[To accompany H.R. 660]

[Including cost estimate of the Congressional Budget Office]

The Committee on Education and the Workforce, to whom was referred the bill (H.R. 660) 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 with an amendment and recommend that the bill as amended do pass.

The amendment is as follows:

Strike all after the enacting clause and insert the following:

SECTION 1. SHORT TITLE AND TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the "Small Business Health Fairness Act of 2003".

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

Sec. 1. Short title and table of contents.
Sec. 2. Rules governing association health plans.

"PART 8—RULES GOVERNING ASSOCIATION HEALTH PLANS

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

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"Sec. 807. Requirements for application and related requirements.
"Sec. 808. Notice requirements for voluntary termination.
"Sec. 809. Corrective actions and mandatory termination.
"Sec. 810. Trusteeship by the Secretary of insolvent association health plans providing health benefits in addition to health insurance coverage.
"Sec. 811. State assessment authority.
"Sec. 812. Definitions and rules of construction.

Sec. 3. Clarification of treatment of single employer arrangements.
Sec. 4. Enforcement provisions relating to association health plans.
Sec. 5. Cooperation between Federal and State authorities.
Sec. 6. Effective date and transitional and other rules.

SEC. 2. RULES GOVERNING ASSOCIATION HEALTH PLANS.

(a) IN GENERAL.—Subtitle B of title I of the Employee Retirement Income Security Act of 1974 is amended by adding after part 7 the following new part:

"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 2003,

"(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 2003.

"(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 2003, 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) 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 payments 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 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 2003, 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 trustee-

ship 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, conserve, 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, actu-

aries, 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 2003.

"(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 imposed 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 re-

quirements 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 2003, 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.".

(b) CONFORMING AMENDMENTS TO PREEMPTION RULES.—

(1) Section 514(b)(6) of such Act (29 U.S.C. 1144(b)(6)) is amended by adding at the end the following new subparagraph:

"(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.".

(2) Section 514 of such Act (29 U.S.C. 1144) is amended—

(A) in subsection (b)(4), by striking "Subsection (a)" and inserting "Subsections (a) and (d)";

(B) in subsection (b)(5), by striking "subsection (a)" in subparagraph (A) and inserting "subsection (a) of this section and subsections (a)(2)(B) and (b) of section 805", and by striking "subsection (a)" in subparagraph (B) and inserting "subsection (a) of this section or subsection (a)(2)(B) or (b) of section 805";

(C) by redesignating subsection (d) as subsection (e); and

(D) by inserting after subsection (c) the following new subsection:

"(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.".

(3) Section 514(b)(6)(A) of such Act (29 U.S.C. 1144(b)(6)(A)) is amended—

(A) in clause (i)(II), by striking "and" at the end;

(B) in clause (ii), by inserting "and which does not provide medical care (within the meaning of section 733(a)(2))," after "arrangement,", and by striking "title." and inserting "title, and"; and

(C) by adding at the end the following new clause:

"(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.".

(4) Section 514(e) of such Act (as redesignated by paragraph (2)(C)) is amended—

(A) by striking "Nothing" and inserting "(1) Except as provided in paragraph (2), nothing"; and

(B) by adding at the end the following new paragraph:

"(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 2003 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.".

(c) PLAN SPONSOR.—Section 3(16)(B) of such Act (29 U.S.C. 102(16)(B)) is amended by adding at the end the following new sentence: "Such term also includes a person serving as the sponsor of an association health plan under part 8.".

(d) DISCLOSURE OF SOLVENCY PROTECTIONS RELATED TO SELF-INSURED AND FULLY INSURED OPTIONS UNDER ASSOCIATION HEALTH PLANS.—Section 102(b) of such Act (29 U.S.C. 102(b)) is amended by adding at the end the following: "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.".

(e) SAVINGS CLAUSE.—Section 731(c) of such Act is amended by inserting "or part 8" after "this part".

(f) REPORT TO THE CONGRESS REGARDING CERTIFICATION OF SELF-INSURED ASSOCIATION HEALTH PLANS.—Not later than January 1, 2008, the Secretary of Labor shall report to the Committee on Education and the Workforce of the House of Representatives and the Committee on Health, Education, Labor, and Pensions of the Senate the effect association health plans have had, if any, on reducing the number of uninsured individuals.

(g) CLERICAL AMENDMENT.—The table of contents in section 1 of the Employee Retirement Income Security Act of 1974 is amended by inserting after the item relating to section 734 the following new items:

"PART 8—RULES GOVERNING ASSOCIATION HEALTH PLANS

"Sec. 801. Association health plans.

"Sec. 802. Certification of association health plans.
"Sec. 803. Requirements relating to sponsors and boards of trustees.
"Sec. 804. Participation and coverage requirements.
"Sec. 805. Other requirements relating to plan documents, contribution rates, and benefit options.
"Sec. 806. Maintenance of reserves and provisions for solvency for plans providing health benefits in addition to health insurance coverage.
"Sec. 807. Requirements for application and related requirements.
"Sec. 808. Notice requirements for voluntary termination.
"Sec. 809. Corrective actions and mandatory termination.
"Sec. 810. Trusteeship by the Secretary of insolvent association health plans providing health benefits in addition to health insurance coverage.
"Sec. 811. State assessment authority.
"Sec. 812. Definitions and rules of construction.".

SEC. 3. CLARIFICATION OF TREATMENT OF SINGLE EMPLOYER ARRANGEMENTS.

Section 3(40)(B) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1002(40)(B)) is amended—

(1) in clause (i), by inserting after "control group," the following: "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,";

(2) in clause (iii), by striking "(iii) the determination" and inserting the following:

"(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";

(3) by redesignating clauses (iv) and (v) as clauses (v) and (vi), respectively; and

(4) by inserting after clause (iii) the following new clause:

"(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,".

SEC. 4. ENFORCEMENT PROVISIONS RELATING TO ASSOCIATION HEALTH PLANS.

(a) CRIMINAL PENALTIES FOR CERTAIN WILLFUL MISREPRESENTATIONS.—Section 501 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1131) is amended—

(1) by inserting "(a)" after "SEC. 501."; and

(2) by adding at the end the following new subsection:

"(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.".

(b) CEASE ACTIVITIES ORDERS.—Section 502 of such Act (29 U.S.C. 1132) is amended by adding at the end the following new subsection:

"(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.".

(c) RESPONSIBILITY FOR CLAIMS PROCEDURE.—Section 503 of such Act (29 U.S.C. 1133) is amended by inserting "(a) IN GENERAL.—" before "In accordance", and by adding at the end the following new subsection:

"(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.".

SEC. 5. COOPERATION BETWEEN FEDERAL AND STATE AUTHORITIES.

Section 506 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1136) is amended by adding at the end the following new subsection:

"(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 to 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.".

SEC. 6. EFFECTIVE DATE AND TRANSITIONAL AND OTHER RULES.

(a) EFFECTIVE DATE.—The amendments made by this Act shall take effect one year from the date of the enactment. The Secretary of Labor shall first issue all regulations necessary to carry out the amendments made by this Act within one year after the date of the enactment of this Act.

(b) TREATMENT OF CERTAIN EXISTING HEALTH BENEFITS PROGRAMS.—

(1) IN GENERAL.—In any case in which, as of the date of the enactment of this Act, an arrangement is maintained in a State for the purpose of providing benefits consisting of medical care for the employees and beneficiaries of its participating employers, at least 200 participating employers make contributions to such arrangement, such arrangement has been in existence for at least 10 years, and such arrangement is licensed under the laws of one or more States to provide such benefits to its participating employers, upon the filing with the applicable authority (as defined in section 812(a)(5) of the Employee Retirement

Income Security Act of 1974 (as amended by this subtitle)) by the arrangement of an application for certification of the arrangement under part 8 of subtitle B of title I of such Act—

(A) such arrangement shall be deemed to be a group health plan for purposes of title I of such Act;

(B) the requirements of sections 801(a) and 803(a) of the Employee Retirement Income Security Act of 1974 shall be deemed met with respect to such arrangement;

(C) the requirements of section 803(b) of such Act shall be deemed met, if the arrangement is operated by a board of directors which—

(i) is elected by the participating employers, with each employer having one vote; and

(ii) has complete fiscal control over the arrangement and which is responsible for all operations of the arrangement;

(D) the requirements of section 804(a) of such Act shall be deemed met with respect to such arrangement; and

(E) the arrangement may be certified by any applicable authority with respect to its operations in any State only if it operates in such State on the date of certification.

The provisions of this subsection shall cease to apply with respect to any such arrangement at such time after the date of the enactment of this Act as the applicable requirements of this subsection are not met with respect to such arrangement.

(2) DEFINITIONS.—For purposes of this subsection, the terms "group health plan", "medical care", and "participating employer" shall have the meanings provided in section 812 of the Employee Retirement Income Security Act of 1974, except that the reference in paragraph (7) of such section to an "association health plan" shall be deemed a reference to an arrangement referred to in this subsection.

PURPOSE

The purpose of H.R. 660 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 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. 660 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.

COMMITTEE ACTION

Representative Ernie Fletcher (R–KY) introduced H.R. 660 on February 11, 2003 along with 70 bi-partisan original co-sponsors including Education and the Workforce Committee Chairman John Boehner and Subcommittee on Employer-Employee Relations Chairman Sam Johnson; the number of bi-partisan co-sponsors rose to 156 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 108th Congress. This activity included bill introductions, hearings, mark-ups, floor consideration, and House Senate Conference activity that had the goal of expanding health coverage through the sponsorship of health plans by bona fide trade associations.

104TH CONGRESS

In the 104th Congress, the Subcommittee on Employer-Employee Relations held an oversight hearing "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, Rep. Harris Fawell with 15 original cosponsors that rose to 50 bi-partisan 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 third hearing was held on March 28, 1995 during which the Subcommittee continued its review of H.R. 995. 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 Education and the Workforce Committee) on March 6, 1996 discharged H.R. 995 from the Subcommittee on Employer-Employee Relations, approved H.R. 995, as amended, on voice vote, and, by a roll call 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 full body 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 bi-partisan original cosponsors that rose to 157 bi-partisan cosponsors.

The Subcommittee on Employer-Employee Relations held a legislative hearing on EPHIC on May 8, 1997. Testimony was received from: the Honorable 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., Chicago, IL; 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, Newport Beach, CA; and Jeffrey H. Joseph, Vice President, Domestic Policy, U.S. Chamber of Commerce.

On Wednesday, June 11, 1997, the Committee on Education and the Workforce discharged H.R. 1515 from the Subcommittee on Employer-Employee Relations and then followed on Thursday June 12, 1997, with full Committee approval of it, as amended, on a voice vote, and, by a vote of 24 ayes to 20 nays, ordered the bill favorably reported and incorporated into subtitle D of the reconciliation package transmitted to the Budget Committee and ordered reported the bill, as amended, to the House of Representatives. It 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, the association health plan provisions were deleted from the Conference agreement that was eventually signed into law. A version of the association health plan provisions of the bill were then incorporated into H.R. 4250, the Patient Protection Act of 1998, which was introduced by Representative Newt Gingrich, the 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, on a vote of 216 yeas to 210 nays; however, on October 9, 1998 the U.S. Senate tabled consideration of the measure on a vote of 50 yeas to 47 nays where it remained until the conclusion of the 105th Congress.

106TH CONGRESS

At the commencement of the 106th Congress, Representative John A. Boehner (R–OH) succeeded the retired Representative Harris Fawell as the Chairman of the Subcommittee on Employer-Employee Relations. 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; Mr. Steven B. Larsen, Commissioner of Insurance State of Maryland, Baltimore, MD, testifying on behalf of 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 bi-partisan original cosponsors that rose to 47 bi-partisan cosponsors. This bill was then incorporated into H.R. 2990 introduced by Rep. Talent on September 30, 1999 and passed by the House of Representatives on a vote of 227 yeas to 205 nays on October 6, 1999. After passage of a similar bill, S. 1344, a Conference was held between the House of Representatives and the Senate but it did not conclude by the end of the 106th Congress.

107TH CONGRESS

At the commencement of the 107th Congress, Representative John A. Boehner (R–OH) succeeded the retired Representative William Goodling as the Chairman of the Committee on Education and the Workforce; Representative Sam Johnson (R–TX) then succeeded Representative Boehner as the Chairman of the Subcommittee on Employer-Employee Relations. Representative Ernie Fletcher (R–KY) introduced H.R. 1774, the Small Business Health Fairness Act of 2001, on May 9, 2001 with 46 bi-partisan original cosponsors that rose to 111 bi-partisan cosponsors.

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; Ms Cathy A. Streker, Director of Employee Benefits and Planning, Textron, Inc., Providence, RI.

Following the June hearing, on July 9, 2002, the Subcommittee on Employer 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), U.S. House of Representatives; Dr. Mark B. McClellan, Member, Council of Economic Advisors, Washington, D.C.; 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, D.C.

On July 19, 2001, Representative Greg Ganske (R–IA) introduced HR 2563. When the House of Representatives passed H.R. 2563 on August 2, 2001, by a vote of 226 ayes to 203 nays, it contained H.R. 1774, the Small Business Health Fairness Act of 2001, as an amendment. The bill was not taken up by the Senate before the conclusion of the 107th Congress.

108TH CONGRESS

On February 11, 2003, Representative Ernie Fletcher introduced H.R. 660, the "Small Business Health Fairness Act of 2003" with 70 bi-partisan original cosponsors that rose to 156 bi-partisan 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: Hon. 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 marked-up, approved and reported H.R. 660 to the full Committee on Education and the Workforce by a bi-partisan vote of 13 yeas to 8 nays on April 8, 2003. On June 12, 2003, the Committee on Education and the Workforce ordered reported, as amended, H.R. 660 to the full House of Representatives by a vote of 26–21.

SUMMARY

The Small Business Health Fairness Act (H.R. 660) addresses both the access and cost issues at the heart of the health care reform debate. The bipartisan bill, introduced by a bipartisan group of legislators led by Employer-Employee Relations Subcommittee Chairman Sam Johnson (R–TX), Representatives Ernie Fletcher (R–KY), Nydia Velazquez (D–NY), and Cal Dooley (D–CA), would improve access to quality health care for uninsured families. Specifically, it would create 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 more than 150 cosponsors, including House Speaker Dennis Hastert (R–IL), Small Business Committee Chairman Don Manzullo (R–IL), Representatives Brad Carson (D–OK), Jerry Costello (D–IL), and Johnny Isakson (R–GA). A broad and diverse coalition of more than 100 groups have 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, National Black Chamber of Commerce, the National Association of Women Business Owners, and the National Restaurant Association. Sen. Olympia Snowe (R–ME introduced companion legislation in the Senate (S. 545).

The bill establishes that an association health plan (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 coverage on the date of enactment, represent a broad cross-section of trades, or represent one or more 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 partici-

pation, 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. 660 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. 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 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. 660 requires self-insured AHPs to maintain reserves that are sufficient for unearned contribution, 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; indemnification insurance for any claims if the plan is terminated; and 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 Labor Secretary 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. 660 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 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 1970–1996.[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

[1] 29 U.S.C. § 1001, et seq.
[2] 29 U.S.C. § 1001(a).
[3] PriceWaterhouseCoopers, The Factors Fueling Rising Health Care Costs, April 2002.
[4] *Metropolitan Life Insurance Co.* v. *Massachusetts,* 471 U.S. 724 (1985).

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. 67 million of the 131 million Americans who obtain their health insurance from their employer receive benefits through a self-funded plan.

The preemption of state benefit mandates well serves employers, unions, and employees. PriceWaterhouseCoopers estimates that the 1500 state benefit mandates make up 15 percent of the increased cost of health insurance for 2002.[7] These costs might 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 study, 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 coverage and that they are not willing to risk losing this coverage in order to obtain additional mandated benefits.[10]

However, though 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

Estimates for 2001 show that for the average employer, the cost of providing health care increased by 11 percent. Though 2002 premium increases have not yet been released, experts expect the increase to be in the area of 13 percent. At a hearing before the Sub-

[5] 29 U.S. C § 1144(b)(2)(A).
[6] 29 U.S.C. § 1144(b)(2)(B).
[7] Ibid.
[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.
[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.

committee on Employer-Employee Relations in June of 2002, Paul Ginsburg, President of the Center for Studying Health System Change, testified about the threat these increases 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, Commissioner of Professional and Financial Regulation, 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%; in Maine, the increase was 80.4% 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 testified that the State of Maine and Independent Governor Angus King, have recognized that state imposed benefit mandates impose significant costs on employers and have taken dramatic steps to address this:

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

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

> toed 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]

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 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.[14] 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 a greater impact on health care premiums, and these rising premiums sometimes price these firms out of insurance altogether. By contrast, because the employer pool is larger, sick employees in a larger group are less likely to cause premiums to rise as the healthy employees balance out the sicker individuals.

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 to the increases in costs that ABC's member companies, most of which are smaller employers, are 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.[15]

He went on to say that, "Indeed, massive premium increases of 40 percent, 50 percent and higher, and/or benefit reductions, are

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

[14] 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."

[15] 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.

typical of what small businesses throughout the nation are experiencing today." [16]

At a later hearing on H.R. 660, 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?" [17]

There is ample evidence to indicate that small employers face greater challenges than larger employers or unions in providing health coverage—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 September 2002, the number of Americans who have no health insurance increased to more than 41 million. 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 decrease in the number of individuals covered by small employers.

Over 50 percent of the 41 million uninsured Americans either work in a small business or are a dependent of a small business worker.[18] The cost of insurance is the most significant barrier to insurance coverage for workers and their families.[19]

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 10–15 percent increase in the likelihood of purchasing a plan.

Testimony from Ann L. Combs, Assistant Secretary for Employee Benefits Security, U.S. Department of Labor, explains 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

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[16] Ibid.

[17] 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.

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

[19] 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.

> 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.[20]

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, provides 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 companies, the focus group report stated. This lack of credible information could be leading to inaction on the part of employers * * *An EBRI 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.[21]

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. 660

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

[20] 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.

[21] 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.

> 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.[22]

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 relieve 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, H.R. 660, introduced by Representatives. Ernie Fletcher (R–KY), Subcommittee on Employer-Employee Relations Chairman Sam Johnson (R–TX), Nydia Velázquez (D–NY) and Cal Dooley (D–CA) amends ERISA to allow the establishment of Association Health Plans (AHPs). AHPs 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.

The Association Health Plan (AHP) bill is not new to the Committee on Education and the Workforce. AHP provisions were first included in H.R. 995, the ERISA Targeted Health Insurance Reform Act of 1995, introduced by then Subcommittee on Employer-Employee Relations Chairman Harris Fawell (R–IL) on February 21, 1995.

During the 105th Congress, Representative Fawell introduced the AHP bill as the Expansion of Portability and Health Insurance Coverage Act of 1997. This bill was added to the Balanced Budget Act and approved by the House of Representatives in July of 1998, however a House-Senate Conference Committee again dropped the provisions from the final report. In 1998, the AHP bill was included in broader Patients' Bill of Rights legislation that passed the House of Representative in July of 1998

During the 106th Congress, Representative Jim Talent (R–MO) introduced the bill as the Small Business Access and Choice for Entrepreneurs Act of 1999, H.R. 1496. The provisions of this bill passed the House of Representatives in October of 1999 with a bipartisan vote of 227–205.

Representative Ernie Fletcher introduced the AHP bill in the 107th as the Small Business Health Fairness Act, H.R. 1774. The bill was added to broader Patients' Bill of Rights legislation and

[22] 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.

passed the House of Representatives in August of 2001 by a vote of 226–203.

AHPs have been a companion of Patients' Bill of Rights legislation because they offer the most basic patient protection of all, access to health care. However, because of the inherent controversy of patients' rights legislation, the issue of access to health care has remained dormant while Congress debated the controversial provisions, which expand liability for health care coverage provided by employers.

It is the strong belief of the Committee that Congress can no longer wait to provide access to health care to our nation's uninsured, particularly those employed by small businesses. Thus, the Committee again moves forward with the AHP bill, hoping that this time it will be considered by the House of Representatives without the accompaniment of controversial patients' rights legislation.

Benefits of Association Health Plans

As discussed supra, 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.[23]

AHPs will solve many of these problems for small employers. Testimony from Ann L. Combs, Assistant Secretary for Employee Benefits Security, U.S. Department of Labor, at a March 2003 Subcommittee on Employer-Employee Relations Hearing on H.R. 660, discusses 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.[24]

Joe Rossmann, Vice President of Fringe Benefits, Associated Builders and Contractors (ABC) describes 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:

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

[24] 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

> 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 payment 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.[25]

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. 660 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.[26] Under cur-

[25] 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.

[26] 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 col-

Continued

rent 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"; and (4) other multiple employer welfare arrangements which do not meet the definition under ERISA of an "employee benefit plan".[27]

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.[28] As originally enacted, this broad preemption included self-insured multiple employer entities that 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 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).[29] 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 intended objective. 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. 660 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 this or to seek federal certification. 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 them to meet any insurance

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lective bargaining agreements for purposes of the above noted exception under ERISA section 3(40)(A)(i). See 20 C.F.R. § 2510.3–40.

[27] 29 U.S.C. § 1003(40).

[28] 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).

[29] U.S.C. § 1144.

or multiple employer plan licensing requirements or shut them down. Under the bill, all such entities must register with 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, the Department of Labor is given "cease and desist" authority to curtail the activities of any such illegitimate entities.

The above-described changes are necessary to clarify ERISA preemption and the role of the states and the federal government in relation to MEWAs.

These clarifications 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 will require 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. 660 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.

The bill employs Title I of ERISA to provide a twenty-first-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.

It is long overdue that cost-conscious small employers 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 our 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.

660 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

As described supra, 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. 660, the Small Business Health Fairness Act, will do just that.

H.R. 660's rules governing establishment of association health plans

H.R. 660 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 organized 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. They 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 are eligible to seek certification as AHPs.

Opponents of H.R. 660 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 MEWA's 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 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. 660's procedures and conditions for certification for AHPs

H.R. 660 establishes procedures for the certification of AHPs. In the case of a self-insured AHP, the Department of Labor (DOL) 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 this Act;

(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, will be a further protection against "cherry picking."

In the case of AHPs that offer fully insured health products, the Secretary 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.[30] The Committee believes that the fiduciary duty of

[30] 29 U.S.C. § 1104.

loyalty—the highest duty of loyalty known to the law—is the ultimate protection to participants and beneficiaries in ERISA plans.[31]

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 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 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% of the participants and beneficiaries under the plan are located.

H.R. 660's Protections Against Discrimination

H.R. 660 prohibits discrimination against eligible employers and employees by requiring that all employers who are association members must be eligible for participation under the terms of the plan and informed of all benefit options available. In addition, H.R. 660 requires that all eligible individuals of such participating employers may not be excluded from enrolling in the plan because of health status.

Despite these protections, opponents of H.R. 660 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. 660 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.[32]

AHPs are specifically prohibited from denying or conditioning health insurance for individuals on the basis of health status. Spe-

[31] See, e.g., Donovan v. Bierwith, 680 F.2d 263, 272 n.8 (2d Cir. 1982).
[32] 29 U.S.C. § 1171, 1172, 1173.

cifically, 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. 660'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 on 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.

During full Committee consideration of the bill, the Committee considered and rejected two amendments 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. 660 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 would propose 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% 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%. Thus, in the Illinois case, it is obvious that the AHP may need to have the same flexibility as other state regulated products to attract a broad cross section of its membership versus only the unhealthy groups.

The Committee also 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. 660 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. 660 does 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. 660 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. 660 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.

During full Committee consideration of the bill, there was discussion about the interplay of ERISA and the rights and protections of individuals under Title VII of the Civil Rights Act. As the AHP bill is simply an amendment to ERISA, it does not change the relationship of these two laws. 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 they are for workers who receive health coverage under ERISA plans today.

H.R. 660's preemption of State mandates

H.R. 660 allows AHPs to exercise sole discretion in selecting specific items and services to be covered under the plan. This rule is true for both 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 Committee consideration of the bill, the Committee rejected amendment after amendment that would have allowed general preemption of state benefit mandates with specific exceptions. The Committee feels strongly that (1) many individuals who receive coverage through AHPs would otherwise have had no health care coverage, and (2) 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 them the freedom that large employers and unions already enjoy, to select the benefit packages that most 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. Asst. Sec. Ann Combs and Subcommittee Chairman Johnson clarified during both hearings on the bill and its consideration by the Subcommittee that this is not the case, and that it is the intent of the Committee that state laws such as those that govern external review and prompt payment of claims will apply to AHPs that offer fully insured health coverage. 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 as introduced did not preempt these laws, during Committee consideration of the bill, two amendments were adopted to clarify the application of these laws. The Subcommittee Chairman's mark added language that amended Section 514 of ERISA 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. During full Committee consideration, the Committee amended this section to clarify that laws relating to prompt payment of claims were also not superseded.

During Committee 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 the decision to create AHPs. Should Congress decide to establish additional federal patient protections, the Committee believes that they should be applied to all plans equally.

H.R. 660's 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 issuers, satisfaction of state solvency and other insurance regulations.

With respect to self-insured AHPs, H.R. 660 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 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 $5,000 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;
- The bill also 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. 660 also grants authority to the Secretary 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. During consideration of the bill at Subcommittee, H.R. 660 was strengthened by requiring 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 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.

H.R. 660 also 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 660 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 won't 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.

H.R. 660's State assessment authority

H.R. 660 specifically allows a state to assess self-insured AHPs 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.

H.R. 660's amendments to ERISA's preemption rules

H.R. 660 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. The Committee intends this change to be one of the most important provisions of the bill. 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. 660 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." As discussed supra, H.R. 660 provides that legitimate associations may choose to either remain subject to the few state multiple plan laws or to apply for a federal certification. 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. 660 includes two other important changes: (1) It clarifies the ability of any health insurance issuer 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 choose or do not choose to become members of the particular association; 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 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). As discussed above, during Committee consideration, two other changes were made to the bill's preemption 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.

H.R. 660's enforcement provisions relating to AHPs and MEWAs

H.R. 660 amends ERISA to establish enforcement provisions relating to AHPs and MEWAs. Specifically, the bill establishes that: (1) willful misrepresentation that an entity is a certified AHP or collectively-bargained arrangement may result in criminal penalties; (2) Section 502 of ERISA is amended to 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) Section 503 of ERISA is amended to require the named fiduciary or board of trustees of an AHP to comply with the required claims procedure under ERISA.

H.R. 660's cooperation between Federal and State authorities

H.R. 660 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.

H.R. 660's effective date

In general, the amendments made by H.R. 660 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. In addition, the Secretary shall report to Congress AHPs effect on reducing the number of uninsured workers after five years.

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 in force 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 bene-

ficiaries 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. During full Committee consideration, the Committee amended this section to clarify that laws relating to prompt payment of claims were also not superseded.

• Section 3 of the bill clarifies the treatment of single employer arrangements.

• Section 4 amends ERISA to establish 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 sections 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

The provisions of the substitute are explained in this report.

ROLLCALL VOTES

COMMITTEE ON EDUCATION AND THE WORKFORCE

ROLL CALL 1 **BILL** H.R. 660 **DATE** June 11, 2003

AMENDMENT NUMBER 2 **Defeated 20 – 25**

SPONSOR/AMENDMENT Mr. Kind /amendment in the nature of a substitute to replace the existing bill with a $50 billion grant program for health care

MEMBER	AYE	NO	PRESENT	NOT VOTING
Mr. BOEHNER, Chairman		X		
Mr. PETRI, Vice Chairman		X		
Mr. BALLENGER		X		
Mr. HOEKSTRA		X		
Mr. McKEON		X		
Mr. CASTLE		X		
Mr. JOHNSON		X		
Mr. GREENWOOD		X		
Mr. NORWOOD		X		
Mr. UPTON		X		
Mr. EHLERS		X		
Mr. DeMINT		X		
Mr. ISAKSON		X		
Mrs. BIGGERT				X
Mr. PLATTS		X		
Mr. TIBERI		X		
Mr. KELLER		X		
Mr. OSBORNE		X		
Mr. WILSON		X		
Mr. COLE		X		
Mr. PORTER				X
Mr. KLINE		X		
Mr. CARTER		X		
Mrs. MUSGRAVE		X		
Mrs. BLACKBURN		X		
Mr. GINGREY		X		
Mr. BURNS		X		
Mr. MILLER	X			
Mr. KILDEE	X			
Mr. OWENS	X			
Mr. PAYNE	X			
Mr. ANDREWS	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. CASE	X			
Mr. GRIJALVA	X			
Ms. MAJETTE	X			
Mr. VAN HOLLEN	X			
Mr. RYAN	X			
Mr. BISHOP	X			
TOTALS	20	25		4

COMMITTEE ON EDUCATION AND THE WORKFORCE

ROLL CALL 2 **BILL** H.R. 660 **DATE** June 11, 2003

AMENDMENT NUMBER 3 **Defeated 14 - 24**

SPONSOR/AMENDMENT Ms. McCollum / amendment regarding maternity and child care coverage

MEMBER	AYE	NO	PRESENT	NOT VOTING
Mr. BOEHNER, Chairman		X		
Mr. PETRI, Vice Chairman		X		
Mr. BALLENGER		X		
Mr. HOEKSTRA		X		
Mr. McKEON		X		
Mr. CASTLE		X		
Mr. JOHNSON		X		
Mr. GREENWOOD		X		
Mr. NORWOOD				X
Mr. UPTON		X		
Mr. EHLERS		X		
Mr. DeMINT				X
Mr. ISAKSON		X		
Mrs. BIGGERT				X
Mr. PLATTS		X		
Mr. TIBERI		X		
Mr. KELLER		X		
Mr. OSBORNE		X		
Mr. WILSON		X		
Mr. COLE		X		
Mr. PORTER		X		
Mr. KLINE		X		
Mr. CARTER		X		
Mrs. MUSGRAVE		X		
Mrs. BLACKBURN		X		
Mr. GINGREY		X		
Mr. BURNS		X		
Mr. MILLER	X			
Mr. KILDEE	X			
Mr. OWENS				X
Mr. PAYNE				X
Mr. ANDREWS	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. CASE				X
Mr. GRIJALVA	X			
Ms. MAJETTE				X
Mr. VAN HOLLEN	X			
Mr. RYAN				X
Mr. BISHOP	X			
TOTALS	14	24		11

COMMITTEE ON EDUCATION AND THE WORKFORCE

ROLL CALL 3 **BILL** H.R. 660 **DATE** June 11, 2003
AMENDMENT NUMBER 4 **Defeated 17 - 20**
SPONSOR/AMENDMENT Mrs. McCarthy / amendment regarding breast cancer coverage

MEMBER	AYE	NO	PRESENT	NOT VOTING
Mr. BOEHNER, Chairman		X		
Mr. PETRI, Vice Chairman		X		
Mr. BALLENGER		X		
Mr. HOEKSTRA		X		
Mr. McKEON		X		
Mr. CASTLE				X
Mr. JOHNSON		X		
Mr. GREENWOOD		X		
Mr. NORWOOD				X
Mr. UPTON				X
Mr. EHLERS		X		
Mr. DeMINT		X		
Mr. ISAKSON		X		
Mrs. BIGGERT				X
Mr. PLATTS		X		
Mr. TIBERI				X
Mr. KELLER				X
Mr. OSBORNE				X
Mr. WILSON		X		
Mr. COLE		X		
Mr. PORTER		X		
Mr. KLINE		X		
Mr. CARTER		X		
Mrs. MUSGRAVE		X		
Mrs. BLACKBURN		X		
Mr. GINGREY		X		
Mr. BURNS		X		
Mr. MILLER	X			
Mr. KILDEE	X			
Mr. OWENS				X
Mr. PAYNE	X			
Mr. ANDREWS	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. CASE				X
Mr. GRIJALVA	X			
Ms. MAJETTE	X			
Mr. VAN HOLLEN	X			
Mr. RYAN	X			
Mr. BISHOP	X			
TOTALS	17	20		12

COMMITTEE ON EDUCATION AND THE WORKFORCE

ROLL CALL 4 **BILL** H.R. 660 **DATE** June 12, 2003

AMENDMENT NUMBER 5 **Defeated 23 - 24**

SPONSOR/AMENDMENT Mr. Tierney / amendment to require AHPs cover certain benefits mandates

MEMBER	AYE	NO	PRESENT	NOT VOTING
Mr. BOEHNER, Chairman		X		
Mr. PETRI, Vice Chairman		X		
Mr. BALLENGER		X		
Mr. HOEKSTRA		X		
Mr. McKEON		X		
Mr. CASTLE		X		
Mr. JOHNSON		X		
Mr. GREENWOOD				X
Mr. NORWOOD	X			
Mr. UPTON		X		
Mr. EHLERS				X
Mr. DeMINT		X		
Mr. ISAKSON		X		
Mrs. BIGGERT		X		
Mr. PLATTS		X		
Mr. TIBERI		X		
Mr. KELLER		X		
Mr. OSBORNE		X		
Mr. WILSON		X		
Mr. COLE		X		
Mr. PORTER		X		
Mr. KLINE		X		
Mr. CARTER		X		
Mrs. MUSGRAVE		X		
Mrs. BLACKBURN		X		
Mr. GINGREY		X		
Mr. BURNS		X		
Mr. MILLER	X			
Mr. KILDEE	X			
Mr. OWENS	X			
Mr. PAYNE	X			
Mr. ANDREWS	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. CASE	X			
Mr. GRIJALVA	X			
Ms. MAJETTE	X			
Mr. VAN HOLLEN	X			
Mr. RYAN	X			
Mr. BISHOP	X			
TOTALS	23	24		2

COMMITTEE ON EDUCATION AND THE WORKFORCE

ROLL CALL 5 **BILL** H.R. 660 **DATE** June 12, 2003

AMENDMENT NUMBER 11 **Defeated 22 - 26**

SPONSOR/AMENDMENT Mr. Holt / amendment to mandate contraception coverage for AHP plans

MEMBER	AYE	NO	PRESENT	NOT VOTING
Mr. BOEHNER, Chairman		X		
Mr. PETRI, Vice Chairman		X		
Mr. BALLENGER		X		
Mr. HOEKSTRA		X		
Mr. McKEON		X		
Mr. CASTLE		X		
Mr. JOHNSON		X		
Mr. GREENWOOD	X			
Mr. NORWOOD		X		
Mr. UPTON		X		
Mr. EHLERS		X		
Mr. DeMINT		X		
Mr. ISAKSON		X		
Mrs. BIGGERT		X		
Mr. PLATTS		X		
Mr. TIBERI		X		
Mr. KELLER		X		
Mr. OSBORNE		X		
Mr. WILSON		X		
Mr. COLE		X		
Mr. PORTER		X		
Mr. KLINE		X		
Mr. CARTER		X		
Mrs. MUSGRAVE		X		
Mrs. BLACKBURN		X		
Mr. GINGREY		X		
Mr. BURNS		X		
Mr. MILLER	X			
Mr. KILDEE				X
Mr. OWENS	X			
Mr. PAYNE	X			
Mr. ANDREWS	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. CASE	X			
Mr. GRIJALVA	X			
Ms. MAJETTE	X			
Mr. VAN HOLLEN	X			
Mr. RYAN	X			
Mr. BISHOP	X			
TOTALS	22	26		1

COMMITTEE ON EDUCATION AND THE WORKFORCE

ROLL CALL 6 **BILL** H.R. 660 **DATE** June 12, 2003

AMENDMENT NUMBER 14 **Defeated 23 - 26**

SPONSOR/AMENDMENT Mr. Norwood / amendment to restrict the ability of self insured plans to vary contribution rates for AHP plans

MEMBER	AYE	NO	PRESENT	NOT VOTING
Mr. BOEHNER, Chairman		X		
Mr. PETRI, Vice Chairman		X		
Mr. BALLENGER		X		
Mr. HOEKSTRA		X		
Mr. McKEON		X		
Mr. CASTLE		X		
Mr. JOHNSON		X		
Mr. GREENWOOD		X		
Mr. NORWOOD	X			
Mr. UPTON		X		
Mr. EHLERS		X		
Mr. DeMINT		X		
Mr. ISAKSON		X		
Mrs. BIGGERT		X		
Mr. PLATTS		X		
Mr. TIBERI		X		
Mr. KELLER		X		
Mr. OSBORNE		X		
Mr. WILSON		X		
Mr. COLE		X		
Mr. PORTER		X		
Mr. KLINE		X		
Mr. CARTER		X		
Mrs. MUSGRAVE		X		
Mrs. BLACKBURN		X		
Mr. GINGREY		X		
Mr. BURNS		X		
Mr. MILLER	X			
Mr. KILDEE	X			
Mr. OWENS	X			
Mr. PAYNE	X			
Mr. ANDREWS	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. CASE	X			
Mr. GRIJALVA	X			
Ms. MAJETTE	X			
Mr. VAN HOLLEN	X			
Mr. RYAN	X			
Mr. BISHOP	X			
TOTALS	23	26		

COMMITTEE ON EDUCATION AND THE WORKFORCE

ROLL CALL 7 **BILL** H.R. 660 **DATE** June 12, 2003

AMENDMENT NUMBER 19A **Defeated 22 - 27**

SPONSOR/AMENDMENT Mr. Andrews /amendment to amendment #19 to expand civil remedies against AHPs

MEMBER	AYE	NO	PRESENT	NOT VOTING
Mr. BOEHNER, Chairman		X		
Mr. PETRI, Vice Chairman		X		
Mr. BALLENGER		X		
Mr. HOEKSTRA		X		
Mr. McKEON		X		
Mr. CASTLE		X		
Mr. JOHNSON		X		
Mr. GREENWOOD		X		
Mr. NORWOOD		X		
Mr. UPTON		X		
Mr. EHLERS		X		
Mr. DeMINT		X		
Mr. ISAKSON		X		
Mrs. BIGGERT		X		
Mr. PLATTS		X		
Mr. TIBERI		X		
Mr. KELLER		X		
Mr. OSBORNE		X		
Mr. WILSON		X		
Mr. COLE		X		
Mr. PORTER		X		
Mr. KLINE		X		
Mr. CARTER		X		
Mrs. MUSGRAVE		X		
Mrs. BLACKBURN		X		
Mr. GINGREY		X		
Mr. BURNS		X		
Mr. MILLER	X			
Mr. KILDEE	X			
Mr. OWENS	X			
Mr. PAYNE	X			
Mr. ANDREWS	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. CASE	X			
Mr. GRIJALVA	X			
Ms. MAJETTE	X			
Mr. VAN HOLLEN	X			
Mr. RYAN	X			
Mr. BISHOP	X			
TOTALS	22	27		

COMMITTEE ON EDUCATION AND THE WORKFORCE

ROLL CALL 8 (en bloc) **BILL** H.R. 660 **DATE** June 12, 2003

AMENDMENT NUMBER 6 **Defeated 22 - 27**

SPONSOR/AMENDMENT Mrs. Davis / amendment to mandate direct access to obstetrician and gynecologist coverage for AHP plans

MEMBER	AYE	NO	PRESENT	NOT VOTING
Mr. BOEHNER, Chairman		X		
Mr. PETRI, Vice Chairman		X		
Mr. BALLENGER		X		
Mr. HOEKSTRA		X		
Mr. McKEON		X		
Mr. CASTLE		X		
Mr. JOHNSON		X		
Mr. GREENWOOD		X		
Mr. NORWOOD		X		
Mr. UPTON		X		
Mr. EHLERS		X		
Mr. DeMINT		X		
Mr. ISAKSON		X		
Mrs. BIGGERT		X		
Mr. PLATTS		X		
Mr. TIBERI		X		
Mr. KELLER		X		
Mr. OSBORNE		X		
Mr. WILSON		X		
Mr. COLE		X		
Mr. PORTER		X		
Mr. KLINE		X		
Mr. CARTER		X		
Mrs. MUSGRAVE		X		
Mrs. BLACKBURN		X		
Mr. GINGREY		X		
Mr. BURNS		X		
Mr. MILLER	X			
Mr. KILDEE	X			
Mr. OWENS	X			
Mr. PAYNE	X			
Mr. ANDREWS	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. CASE	X			
Mr. GRIJALVA	X			
Ms. MAJETTE	X			
Mr. VAN HOLLEN	X			
Mr. RYAN	X			
Mr. BISHOP	X			
TOTALS	22	27		

COMMITTEE ON EDUCATION AND THE WORKFORCE

ROLL CALL 8 (en bloc) **BILL** H.R. 660 **DATE** June 12, 2003

AMENDMENT NUMBER 8 **Defeated 22 - 27**

SPONSOR/AMENDMENT Mr. Kildee / amendment to mandate coverage for diabetes treatment for AHP plans

MEMBER	AYE	NO	PRESENT	NOT VOTING
Mr. BOEHNER, Chairman		X		
Mr. PETRI, Vice Chairman		X		
Mr. BALLENGER		X		
Mr. HOEKSTRA		X		
Mr. McKEON		X		
Mr. CASTLE		X		
Mr. JOHNSON		X		
Mr. GREENWOOD		X		
Mr. NORWOOD		X		
Mr. UPTON		X		
Mr. EHLERS		X		
Mr. DeMINT		X		
Mr. ISAKSON		X		
Mrs. BIGGERT		X		
Mr. PLATTS		X		
Mr. TIBERI		X		
Mr. KELLER		X		
Mr. OSBORNE		X		
Mr. WILSON		X		
Mr. COLE		X		
Mr. PORTER		X		
Mr. KLINE		X		
Mr. CARTER		X		
Mrs. MUSGRAVE		X		
Mrs. BLACKBURN		X		
Mr. GINGREY		X		
Mr. BURNS		X		
Mr. MILLER	X			
Mr. KILDEE	X			
Mr. OWENS	X			
Mr. PAYNE	X			
Mr. ANDREWS	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. CASE	X			
Mr. GRIJALVA	X			
Ms. MAJETTE	X			
Mr. VAN HOLLEN	X			
Mr. RYAN	X			
Mr. BISHOP	X			
TOTALS	22	27		

COMMITTEE ON EDUCATION AND THE WORKFORCE

ROLL CALL 8 (en bloc) **BILL** H.R. 660 **DATE** June 12, 2003

AMENDMENT NUMBER 9 **Defeated 22 - 27**

SPONSOR/AMENDMENT Mr. Kucinich / amendment to mandate levels of coverage and premium costs for AHP plans

MEMBER	AYE	NO	PRESENT	NOT VOTING
Mr. BOEHNER, Chairman		X		
Mr. PETRI, Vice Chairman		X		
Mr. BALLENGER		X		
Mr. HOEKSTRA		X		
Mr. McKEON		X		
Mr. CASTLE		X		
Mr. JOHNSON		X		
Mr. GREENWOOD		X		
Mr. NORWOOD		X		
Mr. UPTON		X		
Mr. EHLERS		X		
Mr. DeMINT		X		
Mr. ISAKSON		X		
Mrs. BIGGERT		X		
Mr. PLATTS		X		
Mr. TIBERI		X		
Mr. KELLER		X		
Mr. OSBORNE		X		
Mr. WILSON		X		
Mr. COLE		X		
Mr. PORTER		X		
Mr. KLINE		X		
Mr. CARTER		X		
Mrs. MUSGRAVE		X		
Mrs. BLACKBURN		X		
Mr. GINGREY		X		
Mr. BURNS		X		
Mr. MILLER	X			
Mr. KILDEE	X			
Mr. OWENS	X			
Mr. PAYNE	X			
Mr. ANDREWS	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. CASE	X			
Mr. GRIJALVA	X			
Ms. MAJETTE	X			
Mr. VAN HOLLEN	X			
Mr. RYAN	X			
Mr. BISHOP	X			
TOTALS	22	27		

COMMITTEE ON EDUCATION AND THE WORKFORCE

ROLL CALL 8 (en bloc) **BILL** H.R. 660 **DATE** June 12, 2003

AMENDMENT NUMBER 10 **Defeated 22 - 27**

SPONSOR/AMENDMENT Mr. Andrews / amendment to disallow certain factors for establishing rates for employer participation in AHP plans

MEMBER	AYE	NO	PRESENT	NOT VOTING
Mr. BOEHNER, Chairman		X		
Mr. PETRI, Vice Chairman		X		
Mr. BALLENGER		X		
Mr. HOEKSTRA		X		
Mr. McKEON		X		
Mr. CASTLE		X		
Mr. JOHNSON		X		
Mr. GREENWOOD		X		
Mr. NORWOOD		X		
Mr. UPTON		X		
Mr. EHLERS		X		
Mr. DeMINT		X		
Mr. ISAKSON		X		
Mrs. BIGGERT		X		
Mr. PLATTS		X		
Mr. TIBERI		X		
Mr. KELLER		X		
Mr. OSBORNE		X		
Mr. WILSON		X		
Mr. COLE		X		
Mr. PORTER		X		
Mr. KLINE		X		
Mr. CARTER		X		
Mrs. MUSGRAVE		X		
Mrs. BLACKBURN		X		
Mr. GINGREY		X		
Mr. BURNS		X		
Mr. MILLER	X			
Mr. KILDEE	X			
Mr. OWENS	X			
Mr. PAYNE	X			
Mr. ANDREWS	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. CASE	X			
Mr. GRIJALVA	X			
Ms. MAJETTE	X			
Mr. VAN HOLLEN	X			
Mr. RYAN	X			
Mr. BISHOP	X			
TOTALS	22	27		

COMMITTEE ON EDUCATION AND THE WORKFORCE

ROLL CALL 8 (en bloc) **BILL** H.R. 660 **DATE** June 12, 2003
AMENDMENT NUMBER 12 **Defeated 22 - 27**
SPONSOR/AMENDMENT Mr. Kind / amendment to mandate coverage for autism for AHP plans

MEMBER	AYE	NO	PRESENT	NOT VOTING
Mr. BOEHNER, Chairman		X		
Mr. PETRI, Vice Chairman		X		
Mr. BALLENGER		X		
Mr. HOEKSTRA		X		
Mr. McKEON		X		
Mr. CASTLE		X		
Mr. JOHNSON		X		
Mr. GREENWOOD		X		
Mr. NORWOOD		X		
Mr. UPTON		X		
Mr. EHLERS		X		
Mr. DeMINT		X		
Mr. ISAKSON		X		
Mrs. BIGGERT		X		
Mr. PLATTS		X		
Mr. TIBERI		X		
Mr. KELLER		X		
Mr. OSBORNE		X		
Mr. WILSON		X		
Mr. COLE		X		
Mr. PORTER		X		
Mr. KLINE		X		
Mr. CARTER		X		
Mrs. MUSGRAVE		X		
Mrs. BLACKBURN		X		
Mr. GINGREY		X		
Mr. BURNS		X		
Mr. MILLER	X			
Mr. KILDEE	X			
Mr. OWENS	X			
Mr. PAYNE	X			
Mr. ANDREWS	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. CASE	X			
Mr. GRIJALVA	X			
Ms. MAJETTE	X			
Mr. VAN HOLLEN	X			
Mr. RYAN	X			
Mr. BISHOP	X			
TOTALS	22	27		

COMMITTEE ON EDUCATION AND THE WORKFORCE

ROLL CALL 8 (en bloc) **BILL** H.R. 660 **DATE** June 12, 2003

AMENDMENT NUMBER 13 **Defeated 22 - 27**

SPONSOR/AMENDMENT Mr. Holt / amendment to mandate coverage for treatment of mental health, alcoholism, and drug abuse for AHP plans

MEMBER	AYE	NO	PRESENT	NOT VOTING
Mr. BOEHNER, Chairman		X		
Mr. PETRI, Vice Chairman		X		
Mr. BALLENGER		X		
Mr. HOEKSTRA		X		
Mr. McKEON		X		
Mr. CASTLE		X		
Mr. JOHNSON		X		
Mr. GREENWOOD		X		
Mr. NORWOOD		X		
Mr. UPTON		X		
Mr. EHLERS		X		
Mr. DeMINT		X		
Mr. ISAKSON		X		
Mrs. BIGGERT		X		
Mr. PLATTS		X		
Mr. TIBERI		X		
Mr. KELLER		X		
Mr. OSBORNE		X		
Mr. WILSON		X		
Mr. COLE		X		
Mr. PORTER		X		
Mr. KLINE		X		
Mr. CARTER		X		
Mrs. MUSGRAVE		X		
Mrs. BLACKBURN		X		
Mr. GINGREY		X		
Mr. BURNS		X		
Mr. MILLER	X			
Mr. KILDEE	X			
Mr. OWENS	X			
Mr. PAYNE	X			
Mr. ANDREWS	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. CASE	X			
Mr. GRIJALVA	X			
Ms. MAJETTE	X			
Mr. VAN HOLLEN	X			
Mr. RYAN	X			
Mr. BISHOP	X			
TOTALS	22	27		

COMMITTEE ON EDUCATION AND THE WORKFORCE

ROLL CALL 8 (en bloc vote amended by unanimous consent) **BILL** H.R. 660 **DATE** June 12, 2003

AMENDMENT NUMBER 15 **Defeated 23 - 26**

SPONSOR/AMENDMENT Ms. Majette / amendment to restrict the ability of self and fully insured plans to vary contribution rates for AHP plans

*** amended by unanimous consent**

MEMBER	AYE	NO	PRESENT	NOT VOTING
Mr. BOEHNER, Chairman		X		
Mr. PETRI, Vice Chairman		X		
Mr. BALLENGER		X		
Mr. HOEKSTRA		X		
Mr. McKEON		X		
Mr. CASTLE		X		
Mr. JOHNSON		X		
Mr. GREENWOOD		X		
Mr. NORWOOD	X *			
Mr. UPTON		X		
Mr. EHLERS		X		
Mr. DeMINT		X		
Mr. ISAKSON		X		
Mrs. BIGGERT		X		
Mr. PLATTS		X		
Mr. TIBERI		X		
Mr. KELLER		X		
Mr. OSBORNE		X		
Mr. WILSON		X		
Mr. COLE		X		
Mr. PORTER		X		
Mr. KLINE		X		
Mr. CARTER		X		
Mrs. MUSGRAVE		X		
Mrs. BLACKBURN		X		
Mr. GINGREY		X		
Mr. BURNS		X		
Mr. MILLER	X			
Mr. KILDEE	X			
Mr. OWENS	X			
Mr. PAYNE	X			
Mr. ANDREWS	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. CASE	X			
Mr. GRIJALVA	X			
Ms. MAJETTE	X			
Mr. VAN HOLLEN	X			
Mr. RYAN	X			
Mr. BISHOP	X			
TOTALS	23	26		

COMMITTEE ON EDUCATION AND THE WORKFORCE

ROLL CALL 8 (en bloc) **BILL** H.R. 660 **DATE** June 12, 2003

AMENDMENT NUMBER 16 **Defeated 22 - 27**

SPONSOR/AMENDMENT Ms. Majette / amendment to expand the powers and duties of the state insurance commissioners over AHP plans

MEMBER	AYE	NO	PRESENT	NOT VOTING
Mr. BOEHNER, Chairman		X		
Mr. PETRI, Vice Chairman		X		
Mr. BALLENGER		X		
Mr. HOEKSTRA		X		
Mr. McKEON		X		
Mr. CASTLE		X		
Mr. JOHNSON		X		
Mr. GREENWOOD		X		
Mr. NORWOOD		X		
Mr. UPTON		X		
Mr. EHLERS		X		
Mr. DeMINT		X		
Mr. ISAKSON		X		
Mrs. BIGGERT		X		
Mr. PLATTS		X		
Mr. TIBERI		X		
Mr. KELLER		X		
Mr. OSBORNE		X		
Mr. WILSON		X		
Mr. COLE		X		
Mr. PORTER		X		
Mr. KLINE		X		
Mr. CARTER		X		
Mrs. MUSGRAVE		X		
Mrs. BLACKBURN		X		
Mr. GINGREY		X		
Mr. BURNS		X		
Mr. MILLER	X			
Mr. KILDEE	X			
Mr. OWENS	X			
Mr. PAYNE	X			
Mr. ANDREWS	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. CASE	X			
Mr. GRIJALVA	X			
Ms. MAJETTE	X			
Mr. VAN HOLLEN	X			
Mr. RYAN	X			
Mr. BISHOP	X			
TOTALS	22	27		

COMMITTEE ON EDUCATION AND THE WORKFORCE

ROLL CALL 8 (en bloc) **BILL** H.R. 660 **DATE** June 12, 2003

AMENDMENT NUMBER 17 **Defeated 22 - 27**

SPONSOR/AMENDMENT Mr. Miller / amendment to restrict an employer from changing their current health plan in order to participate in an AHP plan

MEMBER	AYE	NO	PRESENT	NOT VOTING
Mr. BOEHNER, Chairman		X		
Mr. PETRI, Vice Chairman		X		
Mr. BALLENGER		X		
Mr. HOEKSTRA		X		
Mr. McKEON		X		
Mr. CASTLE		X		
Mr. JOHNSON		X		
Mr. GREENWOOD		X		
Mr. NORWOOD		X		
Mr. UPTON		X		
Mr. EHLERS		X		
Mr. DeMINT		X		
Mr. ISAKSON		X		
Mrs. BIGGERT		X		
Mr. PLATTS		X		
Mr. TIBERI		X		
Mr. KELLER		X		
Mr. OSBORNE		X		
Mr. WILSON		X		
Mr. COLE		X		
Mr. PORTER		X		
Mr. KLINE		X		
Mr. CARTER		X		
Mrs. MUSGRAVE		X		
Mrs. BLACKBURN		X		
Mr. GINGREY		X		
Mr. BURNS		X		
Mr. MILLER	X			
Mr. KILDEE	X			
Mr. OWENS	X			
Mr. PAYNE	X			
Mr. ANDREWS	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. CASE	X			
Mr. GRIJALVA	X			
Ms. MAJETTE	X			
Mr. VAN HOLLEN	X			
Mr. RYAN	X			
Mr. BISHOP	X			
TOTALS	22	27		

COMMITTEE ON EDUCATION AND THE WORKFORCE

ROLL CALL 8 (en bloc) **BILL** H.R. 660 **DATE** June 12, 2003

AMENDMENT NUMBER 18 **Defeated 22 - 27**

SPONSOR/AMENDMENT Ms. McCarthy / amendment to mandate prostate cancer screenings for AHP plans

MEMBER	AYE	NO	PRESENT	NOT VOTING
Mr. BOEHNER, Chairman		X		
Mr. PETRI, Vice Chairman		X		
Mr. BALLENGER		X		
Mr. HOEKSTRA		X		
Mr. McKEON		X		
Mr. CASTLE		X		
Mr. JOHNSON		X		
Mr. GREENWOOD		X		
Mr. NORWOOD		X		
Mr. UPTON		X		
Mr. EHLERS		X		
Mr. DeMINT		X		
Mr. ISAKSON		X		
Mrs. BIGGERT		X		
Mr. PLATTS		X		
Mr. TIBERI		X		
Mr. KELLER		X		
Mr. OSBORNE		X		
Mr. WILSON		X		
Mr. COLE		X		
Mr. PORTER		X		
Mr. KLINE		X		
Mr. CARTER		X		
Mrs. MUSGRAVE		X		
Mrs. BLACKBURN		X		
Mr. GINGREY		X		
Mr. BURNS		X		
Mr. MILLER	X			
Mr. KILDEE	X			
Mr. OWENS	X			
Mr. PAYNE	X			
Mr. ANDREWS	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. CASE	X			
Mr. GRIJALVA	X			
Ms. MAJETTE	X			
Mr. VAN HOLLEN	X			
Mr. RYAN	X			
Mr. BISHOP	X			
TOTALS	22	27		

COMMITTEE ON EDUCATION AND THE WORKFORCE

ROLL CALL 8 (en bloc) **BILL** H.R. 660 **DATE** June 12, 2003

AMENDMENT NUMBER 20 **Defeated 22 - 27**

SPONSOR/AMENDMENT Mr. Bishop / amendment to mandate minimum service requirements for AHP plan coverage

MEMBER	AYE	NO	PRESENT	NOT VOTING
Mr. BOEHNER, Chairman		X		
Mr. PETRI, Vice Chairman		X		
Mr. BALLENGER		X		
Mr. HOEKSTRA		X		
Mr. McKEON		X		
Mr. CASTLE		X		
Mr. JOHNSON		X		
Mr. GREENWOOD		X		
Mr. NORWOOD		X		
Mr. UPTON		X		
Mr. EHLERS		X		
Mr. DeMINT		X		
Mr. ISAKSON		X		
Mrs. BIGGERT		X		
Mr. PLATTS		X		
Mr. TIBERI		X		
Mr. KELLER		X		
Mr. OSBORNE		X		
Mr. WILSON		X		
Mr. COLE		X		
Mr. PORTER		X		
Mr. KLINE		X		
Mr. CARTER		X		
Mrs. MUSGRAVE		X		
Mrs. BLACKBURN		X		
Mr. GINGREY		X		
Mr. BURNS		X		
Mr. MILLER	X			
Mr. KILDEE	X			
Mr. OWENS	X			
Mr. PAYNE	X			
Mr. ANDREWS	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. CASE	X			
Mr. GRIJALVA	X			
Ms. MAJETTE	X			
Mr. VAN HOLLEN	X			
Mr. RYAN	X			
Mr. BISHOP	X			
TOTALS	22	27		

COMMITTEE ON EDUCATION AND THE WORKFORCE

ROLL CALL 8 (en bloc) **BILL** H.R. 660 **DATE** June 12, 2003

AMENDMENT NUMBER 23 **Defeated 22 - 27**

SPONSOR/AMENDMENT Mr. Andrews / amendment to prevent existing MEWA's from being a certified AHP

MEMBER	AYE	NO	PRESENT	NOT VOTING
Mr. BOEHNER, Chairman		X		
Mr. PETRI, Vice Chairman		X		
Mr. BALLENGER		X		
Mr. HOEKSTRA		X		
Mr. McKEON		X		
Mr. CASTLE		X		
Mr. JOHNSON		X		
Mr. GREENWOOD		X		
Mr. NORWOOD		X		
Mr. UPTON		X		
Mr. EHLERS		X		
Mr. DeMINT		X		
Mr. ISAKSON		X		
Mrs. BIGGERT		X		
Mr. PLATTS		X		
Mr. TIBERI		X		
Mr. KELLER		X		
Mr. OSBORNE		X		
Mr. WILSON		X		
Mr. COLE		X		
Mr. PORTER		X		
Mr. KLINE		X		
Mr. CARTER		X		
Mrs. MUSGRAVE		X		
Mrs. BLACKBURN		X		
Mr. GINGREY		X		
Mr. BURNS		X		
Mr. MILLER	X			
Mr. KILDEE	X			
Mr. OWENS	X			
Mr. PAYNE	X			
Mr. ANDREWS	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. CASE	X			
Mr. GRIJALVA	X			
Ms. MAJETTE	X			
Mr. VAN HOLLEN	X			
Mr. RYAN	X			
Mr. BISHOP	X			
TOTALS	22	27		

COMMITTEE ON EDUCATION AND THE WORKFORCE

ROLL CALL 9 **BILL** H.R. 660 **DATE** June 12, 2003

H.R. 660 was ordered favorably reported, as amended, by a vote of 26 - 21

SPONSOR/AMENDMENT Mr. Petri / motion to report the bill to the House with an amendment and with the recommendation that the bill as amended do pass

MEMBER	AYE	NO	PRESENT	NOT VOTING
Mr. BOEHNER, Chairman	X			
Mr. PETRI, Vice Chairman	X			
Mr. BALLENGER	X			
Mr. HOEKSTRA	X			
Mr. McKEON				X
Mr. CASTLE	X			
Mr. JOHNSON	X			
Mr. GREENWOOD	X			
Mr. NORWOOD		X		
Mr. UPTON	X			
Mr. EHLERS	X			
Mr. DeMINT	X			
Mr. ISAKSON	X			
Mrs. BIGGERT	X			
Mr. PLATTS	X			
Mr. TIBERI	X			
Mr. KELLER	X			
Mr. OSBORNE	X			
Mr. WILSON	X			
Mr. COLE	X			
Mr. PORTER	X			
Mr. KLINE	X			
Mr. CARTER	X			
Mrs. MUSGRAVE	X			
Mrs. BLACKBURN	X			
Mr. GINGREY	X			
Mr. BURNS	X			
Mr. MILLER				X
Mr. KILDEE		X		
Mr. OWENS		X		
Mr. PAYNE		X		
Mr. ANDREWS		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. CASE	X			
Mr. GRIJALVA		X		
Ms. MAJETTE		X		
Mr. VAN HOLLEN		X		
Mr. RYAN		X		
Mr. BISHOP		X		
TOTALS	26	21		2

CORRESPONDENCE

CONGRESS OF THE UNITED STATES,
HOUSE OF REPRESENTATIVES,
Washington, DC, June 12, 2003.

Hon. JOHN BOEHNER,
Chairman, Committee on Education and the Workforce,
Rayburn House Office Building, Washington, DC.

DEAR MR. CHAIRMAN: Due to other legislative duties, I was unavoidably detained during Committee consideration of H.R. 660, the "Small Business Health Fairness Act of 2003." Consequently, I missed roll call number three on the fourth amendment offered by Representative Carolyn McCarthy. 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. 660. Thank you for your attention to this matter.

Sincerely,

MICHAEL N. CASTLE,
Member of Congress.

CONGRESS OF THE UNITED STATES,
HOUSE OF REPRESENTATIVES,
Washington, DC, June 12, 2003.

Hon. JOHN BOEHNER,
Chairman, Committee on Education and the Workforce,
Rayburn House Office Building, Washington, DC.

DEAR MR. CHAIRMAN: Due to other legislative duties, I was unavoidably detained during Committee consideration of H.R. 660, the "Small Business Health Fairness Act of 2003." Consequently, I missed roll call number one on the second amendment offered by Representative Ron Kind. Had I been present, I would have voted NO.

I would appreciate your including this letter in the Committee Report to accompany H.R. 660. Thank you for your attention to this matter.

Sincerely,

JON C. PORTER,
Member of Congress.

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. 660 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. 660 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. 660 from the Director of the Congressional Budget Office:

U.S. CONGRESS,
CONGRESSIONAL BUDGET OFFICE,
Washington, DC, June 16, 2003.

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

DEAR MR. CHAIRMAN: The Congressional Budget Office has estimated the effect on revenues of H.R. 660, the Small Business Health Fairness Act of 2003, as ordered reported by the Committee on Education and the Workforce on June 11, 2003. However, CBO

has not yet completed the estimate of the effect of the bill on federal spending for Medicaid. We expect to provide you with a complete estimate shortly.

H.R. 660 would establish a certification process and regulatory structure for association health plans (AHPs). These entities, which would be regulated by the Department of Labor, could provide health plans to employers under different sets of rules than apply to insurers or other health plan arrangements that fall under state insurance regulation.

If H.R. 660 is enacted, CBO would expect a small net increase in total spending by employers on employer-sponsored health insurance. Such spending would increase as otherwise uninsured employees became insured through the new entities. Spending also would increase for those employers who continued to offer traditional, state-regulated plans because of a disproportionate tendency for higher-cost groups to remain with state-regulated plans, which are typically subject to rules that compress the range of premiums that can be charged across firms. Those spending increases would be partially offset by reduced spending among employers who found less expensive plans in the AHP market and chose to shift to those new plans instead of purchasing insurance in the traditional, state-regulated market, and among employers who responded to higher premiums for policies in the traditional market by dropping coverage. Thus, the composition of the total compensation packages of employees would shift toward non-taxable health benefits and away from taxable wages and salaries. CBO estimates that, as a result, total federal revenues would decrease by $3 million in 2004, by $60 million over the 2004–2008 period, and by $280 million over the 2004–2013 period. Of those amounts, Social Security payroll taxes, which are off-budget, account for about $1 million in 2004, $20 million over the 2004–2008 period, and $80 million over the 2004–2013 period.

CBO estimates that enacting H.R. 600 would result in a net increase of about 600,000 people with employment-based health insurance coverage by 2008. As a result, we expect that fewer people would be covered by Medicaid, and that Medicaid spending would decline. CBO has not yet estimated the effect of the bill on federal spending for Medicaid, but the amount of the outlay savings could approach or exceed the amount of the estimated revenue loss.

The Department of Labor would incur the costs of overseeing and regulating these plans. CBO has not completed an estimate of those costs, which would be subject to appropriation.

H.R. 660 would preempt a number of state laws that regulate health coverage and that would impose taxes on existing entities that become certified as AHPs. Those preemptions would be intergovernmental mandates as defined in the Unfunded Mandates Reform Act (UMRA). The preemptions of state regulatory laws 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 up to about $20 million in 2004. But, as a greater number of the uninsured became insured through association plans, states would realize a net increase of about $15 million in revenues from other taxes on such plans in 2008. The losses that states would face in the early years would not exceed the statutory threshold established in UMRA ($59 million in 2003,

adjusted annually for inflation). H.R. 660 contains no private-sector mandates as defined in UMRA.

If you wish further details on this estimate, we will be pleased to provide them. The CBO staff contacts are Alexis Ahlstrom (for changes in revenues); Leo Lex (for the state and local impact); and Stuart Hagen (for the private-sector impact).

Sincerely,

DOUGLAS HOLTZ-EAKIN,
Director.

STATEMENT OF GENERAL PERFORMANCE GOALS AND OBJECTIVES

In accordance with Clause (3)(c) of House rule XIII, the goals of H.R. 660 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. 660 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. 660. 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. 660 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. 660. 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 Direc-

tor of the Congressional Budget Office under section 402 of the Congressional Budget Act.

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

* * * * * * *

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Sec. 1. Short title and table of contents.

* * * * * * *

TITLE I—PROTECTION OF EMPLOYEE BENEFIT RIGHTS

* * * * * * *

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Sec. 802. Certification of association health plans.
Sec. 803. Requirements relating to sponsors and boards of trustees.
Sec. 804. Participation and coverage requirements.
Sec. 805. Other requirements relating to plan documents, contribution rates, and benefit options.
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Sec. 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[101—1]

* * * * * * *

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 to 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 2003 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 2003,

(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 2003.

(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 2003, 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 an-

nual 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) 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 2003, 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 con-

sidered 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, conserve, 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 2003.

(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 re-

ceived 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 imposed 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 2003, 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.

* * * * * * *

MINORITY VIEWS

Once again the majority proposes legislation it claims is in the interest of working families, but in fact undermines their workplace benefits. Rather than addressing real solutions for getting vital health coverage for uninsured Americans, this legislation will cut health benefits for 4.5 million workers who currently have coverage, and will make coverage more expensive for four out of five small businesses. The proposed AHPs would be almost entirely exempt from oversight by state regulators, undermining coverage for serious diseases, and increasing consumer's vulnerability to fraud and insolvencies.

Sixty million Americans lack health coverage for some part of a year and are looking to Congress for help. 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. H.R. 660 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 this bill:

> Under the most likely scenario for AHPs * * * the Congressional Budget office estimates that approximately 4.6 million of those people might obtain their coverage through the proposed new insurance arrangements. But overall enrollment in employer-sponsored health insurance would increase by only about 330,000 people. Because most firms purchasing coverage through an AHP would be switching from traditional insurance coverage—that is, insurance plans subject to the full array of state insurance regulations.

CBO also warns us that far from reducing health expenses, this bill will increase health costs, because it will allow 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 over 4.5 million workers and families. And those who remain covered by non-AHP insurance will pay increased costs to compensate for those who are siphoned off into AHPs.

A new study by Mercer Consultants, commissioned by National Business United, made even more dire predictions. Mercer found that H.R. 660 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.

Rather than expanding health coverage and health services; it is going to lead to the reduction of health coverage for 4.6 million Americans who will lose the right to urgently needed medical coverage like 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 500 local and national organizations oppose this bill, including the National Governors Association, the Republicans Governors Associations, Democratic Governors Association, 41 state Attorneys General, the National Association of Insurance Commissioners, National Small Business United, Blue Cross and Blue Shield, and the Health Insurance Association of America, and well as dozens and dozens of labor, consumer, and business groups (see attached list).

H.R. 660 Allows and Encourages Employers to Dump their Existing Plans, More Generous Health Plans in Order to Avoid State Regulation

Although the proponents of the bill contend that the purpose of the bill is to encourage employers who currently offer no insurance to provide such coverage, the bill does nothing to prohibit existing employers from dumping their current, more generous insurance plans and join an AHP. In fact, as we've noted above, the CBO and Mercer study predict that the vast majority of AHP participants will be those who simply dropped their existing coverage. Representative Miller offered an amendment to prohibit employers from dumping their existing, more generous health insurance plans, in order to join the AHP. The Majority rejected this amendment.

H.R. 660 Cuts Benefits For Millions of Workers by Overriding Critical State Consumer Protections Laws

Under H.R. 660, AHPs would have sole discretion to select the specific items and services to be covered, and 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 mothers, 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 of those who benefit from preemption of state health mandates, and another tier comprised of those who remain subject to state consumer protections. As Members of Congress, we should be seeking ways to eliminate the gap in health care disparity, not creating a new one.

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 basic health care reliability. In the past, access to mammograms, maternity payments for expectant moth-

ers, cancer-screening procedures, well-baby care, and other preventive health treatment were routinely omitted in health coverage.

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, emergency services, allow direct access to OBGYNs, diabetic supplies and education, and prompt payment rules.

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 36 states have mental health parity laws and more than 32 states require insurance plans to cover a minimum amount of mental health benefits.

Both CBO and Mercer concluded that AHPs would be driven to compete by limiting covered benefits for the employees of small employers.

We believe, as do hundreds of organizations, public officials, and health care providers that state consumer protection laws represent significant steps toward Congress's 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. Among their many dubious arguments, one member of the Republican Majority argued that access to preventive health screening constituted health insurance with "whistles and bells."

State consumer protections are not "whistles and bells." They are wellness programs that save lives and billions of dollars in acute health care cost.

H.R. 660 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", by skimming off the healthiest consumers and leaving the sickest patients uninsured.

H.R. 660 allows AHPs to offer coverage to specific types of employers, allowing plans to seek memberships with better risk 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 geography and membership.

Unlike the Republican Majority, we are convinced by the independent Congressional Budget Office (CBO) finding that AHP legislation would result in higher premiums for 80 percent of small employers, while as many as 100,000 of the sickest individuals would lose coverage altogether. As noted above, the Mercer Consulting study found that health insurance premiums would substantially increase for small employers that continued to purchase state regu-

lated coverage, and the number of uninsured would increase by over 1 million as a result of coverage losses among workers and their dependents.

During the committee markup, we supported the amendment offered by our colleague Representative Robert Andrews (D–NJ) to preclude AHPs from varying employer contributions or premiums based on the age, race, or religion of the employer's workforce. Amendments also were offered by Representatives Majette and Norwood that would have limited the ability of AHPs to vary premiums among member employers. However, the Republican Majority rejected these amendments, preferring to exacerbate current health disparities in our health care system.

AHPs Would Operate Largely Unregulated

Regulation of insurance and public health has traditionally been the province of the states. H.R. 660 eliminates centuries of state law that established 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.

The bill contains several vaguely drafted provisions that would preempt a wide swath of state laws and will lead to decades of litigation in the courts. During Committee debate, the Majority could not clearly articulate the specific state laws that would be preempted under the bill. For example, the bill preempts state laws "Insofar as they preclude or have the effect of precluding an insurer from offering coverage in connection with an AHP". The American Law Division of the Congressional Research Service has concluded that the courts will have to determine which laws affect the operation of an AHP and preemption will depend on the applicable state law at issue.

By allowing insurers who sell to AHPs to set up business in a state with very lenient rules and oversight and market to small employers without meeting any state's rules, states would be rendered powerless to take action even where there is obvious risk to consumers. AHPs are permitted to domicile in a single state and operate nationally. For example, the individuals in Florida covered by a Michigan AHP are unlikely to travel to Michigan if they have a problem and Florida will be unable to help them.

We strongly disagree with the provisions of HR 660 that would federalize oversight of AHPs, providing the Department of Labor (DOL) with minimal 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 order within days, while DOL can take several years. Additionally, DOL lacks sufficient staff and budget to regulate AHP plans adequately.

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 upaid medical bills.

During Committee markup, Representative Andrews offered an amendment to preclude any MEWA from operating as an AHP. We supported this amendment because we wanted to ensure that the abysmal failure of MEWAs would not replicate itself under a new name.

During committee markup we supported an amendment offered by Representative Denise Majette (D–GA) to permit state insurance commissioners to retain full authority to protect the residents of thier states covered by AHPs. In addition, that amendment provided that no AHP may offer coverage to residents of a state unless the insurance commissioner of the state of the AHP's domicile agrees to carry out any order or judgment issued by the state insurance commissioner or other duly authorized state official of an aggrieved out-of-state resident.

H.R. 660 Fails to Address Real Problems of Small Business

H.R. 660 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 $200 a month and a family policy costs over $600 a month. In order for a small business to offer health coverage to a low wage employee, at a 50% employer contribution rate, would mean 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.

As noted above, CBO analyzed AHP legislation in 2000 and concluded much the same. Of the 42 million uninsured, CBO concluded that only 330,000 would receive coverage under AHPs. CBO concluded that AHPs primarily would cover employers who already have coverage and shift to cheaper AHP plans, potentially 4.5 million individuals.

Does Not Level the Playing Field with Large Employers

AHP supporters claim their bill is simply designed to level the playing field between small and and large employers. However, H.R. 660 actually gives small employers better treatment than exists for large employers. Large employers that provide coverage through insurance are covered by state insurance and consumer protection laws. Further, large employers don't and can't cherry pick. Large employers only vary premiums to their workers based upon family size and geographic location. H.R. 660 would permit

AHPs to vary preimums for any and every reason other than health status, including age, race and sex.

By contrast, AHPs would be mostly exempt from these state requirements and protections; self-insured AHPs would be fully exempt from state regulations; and fully insure AHPs would be subject to limited state protections only in the state where the AHP chose to be licensed. Group health insurers and ERISA plans are also subject to rating restrictions that either limit or bar them from charging individuals more based on health-related factors. H.R. 660 would permit AHPs to discriminate against group members, charging them more if they are less health or more likely to use health care services. Far from "leveling the playing field," AHPs would create grossly unfair competition between these new quasi-insurers and traditional health insurers or ERISA plans.

The Democratic Alternative

During the markup, Representative Ron Kind offered an amendment in the nature of a substitute would direct the Secretary of Labor to create a small employer health pool and plan similar to the Federal Employees Health Benefit Plan (SEHB), without cutting vital health benefits. The substitute provides small businesses the same access and health care coverage that federal employees have. It also authorizes the funds reserved in the FY 2004 budget resolution to DOL 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 SEHB. 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 of Labor 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 SEHB 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 shall remain subject to state laws applicable to the states in which they cover residents. The plan authorizes up to $10 billion a year to provide small employer health coverage subsidies in fiscal year 2004–2008 (in accordance with the FY 2004 Budget Resolution).

During Committee mark-up a number of other amendments were offered that would have maintained needed state law consumer protections. The Majority rejected all amendments that would have protected consumers.

The Majority also rejected a number of other amendments that would have addressed many of the bill's substantial deficiencies. Representative McCollum offered an amendment to require AHPs to provide maternal and child care coverage; Representatives McCarthy and Woolsey offered an amendment to provide mammography screening coverage; Representative McCarthy also offered an amendment to cover prostate screening; Representative Holt offered an amendment to provide contraceptive coverage; Representa-

tive Susan Davis offered an amendment to require compliance with state laws requiring direct access to OB/GYN services; Representatives Kildee and Hinojosa offered an amendment to require coverage of diabetes; Mr. Kind offered an amendment to cover treatment of autism; Representative Holt offered an amendment to require coverage of state mental health and substance abuse laws; Representatives Tierney and Van Hollen offered an amendment to require Association Health Plans to comply with state patients' bill of rights protections, such as prompt payment of claims and independent external review of coverage decisions; and Representative Kucinich offered an amendment to prevent benefit cuts and limit annual out-of-pocket increases for employees.

ORGANIZATIONS AND PUBLIC OFFICIALS OPPOSED TO FEDERAL AHP LEGISLATION

Over 500 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 Federal of State, County and Municipal Employees—With additional letters from: Louisiana Chapter; New Mexico Chapter; Rhode Island Council 94
American Federal 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 III
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.
Brian 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 Reproduction 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 Dependency, 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 for Reform Judaism
Rhode Island Kids Count
Safe Kids—Safe Comunities—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 North Shore 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
Bennett 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 Behavorial 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 Behavorial 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)
Accupuncture Association of Colorado
Acupuncture Association of Utah
Acupuncture Association of Washington
Addiction and Behaviorial 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
Collidge 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 New Jersey
Institute for Alcohol Awareness (Fort Collins, Colorado)
Institute for Alcohol Awareness (Greeley, Colorado)
Jane Phillips Nawata 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)
Louisana Academy of Medical Psychologists
Louisana Alliance for the Mentally III
Louisana Association for Ambulatory Healthcare
Louisana Association for the Advancement of Psychology
Louisana Healthcare Commission
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
Nemeha 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
Rhole 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 Message 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
Megellan Health Services
National Association of Health
Underwriters—With additional letters from: Principal Financial Group—with additional letters from: Iowa Office, Tufts Health Plan

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