115TH CONGRESS
1st Session
HOUSE OF REPRESENTATIVES
REPORT
115–43

SMALL BUSINESS HEALTH FAIRNESS ACT OF 2017

MARCH 17, 2017.—Committed to the Committee of the Whole House on the State of the Union and ordered to be printed

Ms. FOXX, 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. 1101]

The Committee on Education and the Workforce, to whom was referred the bill (H.R. 1101) 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; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the "Small Business Health Fairness Act of 2017".

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

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 2017.

"(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.

"(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 cos-

metology; certified public accounting practices; child care; construction; dance, theatrical and orchestra productions; disinfecting and pest control; financial services; fishing; food service 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 2017.

"(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 2017, an affiliated member of the sponsor of the plan may be offered coverage under the plan as a participating employer only if—

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

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

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

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

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

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

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

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

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

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

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

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

"(C) incorporates the requirements of section 806.

"(2) CONTRIBUTION RATES MUST BE NONDISCRIMINATORY.—

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

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

health insurance coverage in connection with an association health plan, from—

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

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

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

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

"(4) MARKETING REQUIREMENTS.—

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

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

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

"(b) ABILITY OF ASSOCIATION HEALTH PLANS TO DESIGN BENEFIT OPTIONS.—Subject to section 514(d), nothing in this part or any provision of State law (as defined in section 514(c)(1)) shall be construed to preclude an association health plan, or a health insurance issuer offering health insurance coverage in connection with an association health plan, from exercising its sole discretion in selecting the specific items and services consisting of medical care to be included as benefits under such plan or coverage, except (subject to section 514) in the case of (1) any law to the extent that it is not preempted under section 731(a)(1) with respect to matters governed by section 711, 712, or 713, or (2) any law of the State with which filing and approval of a policy type offered by the plan was initially obtained to the extent that such law prohibits an exclusion of a specific disease from such coverage.

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

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

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

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

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

"(i) a reserve sufficient for unearned contributions;

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

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

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

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

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

for and maintains reserves in excess of the amounts required under subparagraph (A).

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

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

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

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

"(1) $500,000, or

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

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

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

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

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

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

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

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

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

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

"(3) ASSOCIATION HEALTH PLAN FUND.—

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

"(B) INVESTMENT.—Whenever the Secretary determines that the moneys of the fund are in excess of current needs, the Secretary may request the investment of such amounts as the Secretary determines advisable by the Secretary of the Treasury in obligations issued or guaranteed by the United States.

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

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

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

"(B) which is guaranteed renewable; and

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

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

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

"(B) which is guaranteed renewable; and

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

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

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

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

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

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

"(j) SOLVENCY STANDARDS WORKING GROUP.—

"(1) IN GENERAL.—Within 90 days after the date of the enactment of the Small Business Health Fairness Act of 2017, 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.

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

"SEC. 807. REQUIREMENTS FOR APPLICATION AND RELATED REQUIREMENTS.

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

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

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

"(A) the sponsor; and

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

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

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

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

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

"(6) FUNDING REPORT.—In the case of association health plans providing benefits options in addition to health insurance coverage, a report setting forth information with respect to such additional benefit options determined as of a date within the 120-day period ending with the date of the application, including the following:

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

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

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

statement shall identify separately the plan's administrative expenses and claims.

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

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

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

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

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

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

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

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

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

"SEC. 808. NOTICE REQUIREMENTS FOR VOLUNTARY TERMINATION.

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

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

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

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

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

"SEC. 809. CORRECTIVE ACTIONS AND MANDATORY TERMINATION.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

"(1) the sponsor and plan administrator;

"(2) each participant;

"(3) each participating employer; and

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

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

"(e) OTHER PROCEEDINGS.—An application by the Secretary under this subsection may be filed notwithstanding the pendency in the same or any other court of any bankruptcy, mortgage foreclosure, or equity receivership proceeding, or any proceeding to reorganize, 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 2017.

"(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 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 2017, 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 (f)";

(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"; and

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

"(f)(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(d) of such Act (29 U.S.C. 1144(d)) 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 2017 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, 2022, 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

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

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 by adding at the end the following new subsection:

"(c) 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 the Employee Retirement Income Security Act of 1974 (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 the Employee Retirement Income Security Act of 1974 (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 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 1 year after the date of the enactment of this Act. The Secretary of Labor shall first issue all regulations necessary to carry out the amendments made by this Act within 1 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

H.R. 1101, the *Small Business Health Fairness Act of 2017,* amends the *Employee Retirement Income Security Act of 1974* (ERISA)[1] to improve access to affordable health coverage options for workers employed by small businesses. The bill amends Title I of ERISA to authorize the creation of association health plans (AHPs). The legislation allows small businesses to band together across state lines through bona fide trade or professional associations to purchase health insurance for their workers, thus increasing their bargaining power with plans and providers and placing them on a more level playing field with larger companies and unions. H.R. 1101 frees small businesses from costly state mandated benefit packages, spreads risk among a larger group, and lowers overhead costs, enabling employers to offer more affordable health care coverage to their workers.

COMMITTEE ACTION

109TH CONGRESS

Introduction of H.R. 525, Small Business Health Fairness Act

On February 2, 2005, Rep. Sam Johnson (R–TX), then-Chairman of the Employer-Employee Relations Subcommittee of the Committee on Education and the Workforce (Committee), introduced the *Small Business Health Fairness Act* (H.R. 525),[2] along with 53 bipartisan original cosponsors, including then-Chairman of the Committee, John Boehner (R–OH) and Reps. Nydia Velázquez (D–NY) and Albert Wynn (D–MD).

Committee Passes H.R. 525, Small Business Health Fairness Act

On March 16, 2005, the Committee ordered H.R. 525, without amendment, favorably reported to the House of Representatives by a vote of 25 to 22.[3] On April 13, 2005, the Committee filed its committee report, which detailed the history of the need for the legislation and prior committee action.[4] On July 26, 2015, H.R. 525 passed the full House by a vote of 263 to 165.

111TH CONGRESS

Full Committee markup of H.R. 3200, America's Affordable Health Choices Act of 2009

Between July 15–17, 2009, the Committee met to mark up H.R. 3200, the *America's Affordable Health Choices Act of 2009*.[5] During the markup, Rep. Howard P. "Buck" McKeon (R–CA) offered an amendment to create a new title at the end of Division A of H.R. 3200, titled Title IV—Small Business Health Fairness. The amendment included rules governing AHPs, the treatment of single employer arrangements, enforcement provisions, and other provisions

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[1] U.S.C. § 1001 *et seq.* (1974) [hereinafter *ERISA*].
[2] H.R. 525, 109th Cong. (2005).
[3] *H.R. 525, Small Business Health Fairness Act: Markup Before the H. Comm. on Educ. and the Workforce,* 109th Cong. (Feb. 2, 2005).
[4] H. Rept. 109–41, (2005).
[5] H.R. 3200, 111th Cong. (2009). H.R. 3200 was the House precursor to the law known as the *Affordable Care Act* (*See infra* note 8).

related to AHPs. The amendment was defeated by a vote of 21 to 27.

Passage of Affordable Health Care for America Act

On November 7, 2009, the House passed H.R. 3962, the *Affordable Health Care for America Act*.[6] During the debate, former-Speaker John Boehner (R–OH) included the AHP legislative text in the Republican motion to recommit.[7]

Passage of the Affordable Care Act

On March 21, 2010, the U.S. House of Representatives passed the *Patient Protection and Affordable Care Act* (PPACA) by a vote of 219 to 212 to resolve differences with the Senate. The bill was signed by President Obama on March 23, 2010.[8] On March 25, 2010, the U.S. House of Representatives passed the *Health Care and Education Reconciliation Act of 2010* by a vote of 220 to 207 to resolve differences with the Senate. This bill was signed into law by President Obama on March 30, 2010.[9] Collectively, the two bills are known as the *Affordable Care Act* (ACA or Obamacare).[10] The ACA did not include AHP legislative text.

112TH CONGRESS

Full Committee hearing on examining The Impact of the Health Care Law on the Economy, Employers, and the Workforce

On February 9, 2011, the Committee held a hearing entitled "The Impact of the Health Care Law on the Economy, Employers, and the Workforce." This was the Committee's first hearing to investigate Obamacare and hear directly from job creators about how the 2010 law affects their ability to expand their business and hire new workers. The witnesses before the Committee were Dr. Paul Howard, Senior Fellow, Manhattan Institute, New York, New York; Ms. Gail Johnson, President and CEO, Rainbow Station, Inc., Glenn Allen, Virginia; Dr. Paul Van de Water, Senior Fellow, Center on Budget and Policy Priorities, Washington, D.C.; and Mr. Neil Trautwein, Vice President and Employee Benefits Policy Counsel, National Retail Federation, Washington, D.C.

Subcommittee hearing examining The Pressures of Rising Costs on Employer Provided Health Care

On March 10, 2011, the Subcommittee on Health, Employment, Labor, and Pensions (HELP) held a hearing entitled "The Pressures of Rising Costs on Employer Provided Health Care" to examine how increased health care costs are creating uncertainty for employers, including an examination of the impact of ACA on employer coverage. The witnesses were Mr. Tom Miller, Resident Fellow, American Enterprise Institute, Washington, D.C.; Mr. Brett Parker, Vice Chairman and Chief Financial Officer, Bowlmor Lanes, New York, New York; Mr. John Houser, Owner, Hawthorne

[6] H.R. 3962, 111th Cong. (2009).
[7] H. Amend. 510 to H.R. 3962, 111th Cong. (2009).
[8] Patient Protection and Affordable Care Act, Pub. L. No. 111–148 (2010).
[9] Health and Education Reconciliation Act, Pub. L. No. 111–152 (2010).
[10] Patient Protection and Affordable Care Act, Pub. L. No. 111–148 (2010), and Health and Education Reconciliation Act, Pub. L. No. 111–152 (2010) [hereinafter Affordable Care Act, Obamacare, or ACA].

Auto, Portland, Oregon; and Mr. J. Michael Brewer, President, Lockton Benefit Group, Lockton Companies, LLC, Kansas City, Missouri.

Subcommittee hearing examining Barriers to Lower Health Care Costs for Workers and Employers

On May 31, 2012, the HELP Subcommittee held a hearing entitled "Barriers to Lower Health Care Costs for Workers and Employers" to examine rising health care costs facing employers and employees, including the destructive impact of ACA. The witnesses were Mr. Ed Fensholt, Senior Vice President, Lockton Companies, LLC, Kansas City, Missouri; Mr. Roy Ramthun, President, HAS Consulting Services, Washington, D.C.; Ms. Jody Hall, Founder and Owner, Cupcake Royale, Seattle, Washington; and Mr. Bill Streitberger, Vice President of Human Resources, Red Robin, Greenwood Village, Colorado.

113TH CONGRESS

Joint Subcommittee hearing regarding The Employer Mandate: Examining the Delay and Its Effect on Workplaces

On July 23, 2013, the HELP Subcommittee and the Workforce Protections Subcommittee jointly held a hearing entitled "The Employer Mandate: Examining the Delay and Its Effect on Workplaces" to review the impact of the Obama administration's decision to delay the employer mandate. Witnesses before the subcommittees were Ms. Grace-Marie Turner, President, Galen Institute, Alexandria, Virginia; Mr. Jamie T. Richardson, Vice President, White Castle System, Inc., Columbus, Ohio; Mr. Ron Pollack, Executive Director, Families USA, Washington, D.C.; and Dr. Douglas Holtz-Eakin, President, American Action Forum, Washington, D.C.

Subcommittee hearing regarding Health Care Challenges Facing Kentucky's Workers and Job Creators

On August 27, 2013, the HELP Subcommittee held a field hearing entitled "Health Care Challenges Facing Kentucky's Workers and Job Creators," which included an examination of the harmful impact of ACA on Kentucky's employers and their employees. Witnesses before the subcommittee were Mr. Tim Kanaly, Owner and President, Gary Force Honda, Bowling Green, Kentucky; Mr. Joe Bologna, Owner, Joe Bologna's—Italian Restaurant & Pizzeria, Lexington, Kentucky; Ms. Carrie Banahan, Executive Director, Office of the Kentucky Health Benefit Exchange, Frankfort, Kentucky; Mr. John Humkey, President, Employee Benefit Associates, Inc., Lexington, Kentucky; Ms. Janey Moores, President and CEO, BJM & Associates, Inc., Lexington, Kentucky; Mr. Donnie Meadows, Vice President of Human Resources, K–VA–T Food Stores, Inc., Abingdon, VA; Ms. Debbie Basham, Southwest Breast Cancer Awareness Group, Louisville, Kentucky; and Mr. John McPhearson, CEO, Lectrodryer, Richmond, Kentucky.

114TH CONGRESS

Subcommittee hearing on Five Years of Broken Promises: How the President's Health Care Law is Affecting America's Workplaces

On April 14, 2015, the HELP Subcommittee held a hearing entitled "Five Years of Broken Promises: How the President's Health Care Law is Affecting America's Workplaces," which examined the continuing negative impact of ACA on employer-sponsored health coverage. Witnesses before the subcommittee were the Honorable Tevi Troy, Ph.D., President, American Health Policy Institute, Washington, D.C.; Mr. Rutland Paal, Jr., President, Rutland Beard Floral Group, Scotch Plains, New Jersey; Michael Brev, President, Brev Corp. t/a Hobby Works®, WingTOTE Manufacturing, LLC, Laurel, Maryland; and Ms. Sally Roberts, Human Resources Director, Morris Communications Company, LLC, Augusta, Georgia.

115TH CONGRESS

Full Committee hearing on Rescuing Americans from the Failed Health Care Law and Advancing Patient-Centered Solutions

On February 1, 2017, the Committee held a hearing entitled "Rescuing Americans from the Failed Health Care Law and Advancing Patient-Centered Solutions," which examined failures of the ACA. Witnesses before the Committee were Mr. Scott Bollenbacher, CPA, Managing Partner, Bollenbacher & Associates, LLC, Portland, Indiana; Mr. Joe Eddy, President and Chief Executive Officer, Eagle Manufacturing Company, Wellsburg, West Virginia; Ms. Angela Schlaack, St. Joseph, Michigan; and Dr. Tevi Troy, Chief Executive Officer, American Health Policy Institute, Washington, D.C.

Introduction of H.R. 1101, Small Business Health Fairness Act of 2017

On February 16, 2017, Rep. Sam Johnson (R–TX) introduced the *Small Business Health Fairness Act of 2017* (H.R. 1101) along with HELP Subcommittee Chairman Tim Walberg (R–MI).[11] As Congress works to provide Americans with a patient-centered health care system, H.R. 1101 reduces burdens on small businesses in order to promote a healthy workforce and enable employers to offer more affordable health care coverage to employees.

Full Committee hearing on Legislative Proposals to Improve Health Care Coverage and Provide Lower Costs for Families

On March 1, 2017, the Committee held a hearing entitled "Legislative Proposals to Improve Health Care Coverage and Provide Lower Costs for Families," which examined H.R. 1101, among other proposals. Witnesses before the Committee were Mr. Jon B. Hurst, President, Retailers Association of Massachusetts, Boston, Massachusetts; Ms. Allison R. Klausner, J.D., Principal, Government Relations Leader, Conduent, Secaucus, New Jersey; Ms. Lydia Mitts, Associate Director of Affordability Initiatives, Families USA, Washington, D.C.; and Mr. Jay Ritchie, Executive Vice President, Tokio Marine HHC, Kennesaw, Georgia.

[11] H.R. 1101, 115th Cong. (2017).

Committee passes H.R. 1101, Small Business Health Fairness Act of 2017

On March 8, 2017, the Committee considered H.R. 1101, the *Small Business Health Fairness Act of 2017.*[12] HELP Subcommittee Chairman Walberg offered an amendment in the nature of a substitute, making technical changes to the introduced bill. The Committee voted to adopt the amendment in the nature of a substitute by voice vote. Rep. Susan Davis (D–CA) offered an amendment to prevent the bill from taking effect under certain circumstances. The amendment failed by a vote of 17 to 22. The Committee favorably reported H.R. 1101, as amended, to the House of Representatives by a vote of 22 to 17.

SUMMARY

On February 16, 2017, Rep. Sam Johnson (R–TX) and HELP Subcommittee Chairman Walberg introduced H.R. 1101, the *Small Business Health Fairness Act.* H.R. 1101 amends the *Employee Retirement Income Security Act of 1974* (ERISA) to allow for the establishment of AHPs. H.R. 1101 allows small businesses to join together across state lines through *bona fide* trade associations to become larger purchasers of health insurance. The bill puts small businesses on an equal playing field with unions and larger corporations, enabling them to have greater ability to negotiate lower health care costs for their employees. In turn, this makes it easier for small businesses to offer their employees access to quality, affordable health care coverage.

More specifically, H.R. 1101 relieves small businesses that form AHPs from costly state-mandated benefit laws that often make coverage prohibitively expensive, thus lowering the costs of health insurance and making it possible for small firms to offer coverage. H.R. 1101 establishes a class certification for fully-insured AHPs prescribed by the Secretary of Labor. Likewise, self-funded AHPs must meet certain criteria to insure the businesses covered will be of average health risk to avoid pulling healthy individuals from the small group market (to avoid cherry picking). The legislation also contains protections to ensure self-funded AHPs meet and maintain solvency standards (e.g., maintaining at minimum $500,000 in surplus reserves), which will be reviewed quarterly by the AHP's board of trustees to determine they are being met. Self-funded AHPs also will be required to obtain stop-loss and indemnification insurance coverage. Additionally, H.R. 1101 allows small business owners to have the option to provide coverage to their employees by driving down costs and lowering barriers to access.

COMMITTEE VIEWS

Background on Employer-sponsored insurance coverage

Since World War II, employers have offered health care benefits as a way to recruit and retain talent and ensure a healthy and productive workforce. Employer-sponsored insurance is one of the primary means by which Americans obtain health care coverage. According to the Kaiser Family Foundation, more than 150 million

[12] *H.R. 1101, Small Business Health Fairness Act of 2017: Markup Before the H. Comm. on Educ. and the Workforce,* 115th Cong. (Mar. 8, 2017).

Americans, or 55.5 percent of working Americans, are covered by a health benefit plan offered by their employer.[13] A report by the American Health Policy Institute found that employers spent $578.6 billion in 2012 providing health coverage for 168.6 million employees, retirees, and dependents.[14] Almost all firms with at least 200 or more employees offer health benefits, and just over half of smaller firms with 3–199 employees offer health benefits.[15]

Employer-provided health benefits are regulated by a number of laws, including ERISA as amended by the ACA. The Department of Labor (DOL) implements and enforces ERISA. By virtue of its jurisdiction over ERISA, the Committee has jurisdiction over employer-provided health coverage.

Small and large employers offer health care coverage to employees in self-funded arrangements (self-insurance) or purchase fully-insured plans. ERISA regulates both fully-insured and self-insured plans, but only self-insured plans are exempt from a patchwork of benefit mandates imposed under state insurance law. Employers sponsoring self-insured plans are not subject to the same requirements under the ACA as those with fully-insured plans. Therefore, employer-provided plans have different requirements and costs depending on funding arrangements. Last year, approximately 61 percent of workers with coverage were enrolled in a self-funded plan, up from 49 percent in 2000 and 54 percent in 2005.[16]

Obamacare has failed, proving the need for a better way of providing access to affordable, quality health care

The ACA attempted to expand access to health insurance through a complicated structure of federal subsidies, Medicaid expansion, and new rules governing health insurance markets. The law has severely damaged America's health care system and is collapsing under its own weight. For example, President Obama famously promised the ACA would "lower premiums by up to $2,500 for a typical family per year," yet the evidence suggests otherwise.[17] Additionally, small businesses and their employees have been "badly hurt by the cost increases of the ACA"[18] as the law did nothing to address the affordability of coverage crisis small businesses had been struggling with for years.[19]

The ACA placed additional mandates and administrative burdens on employers, increasing the cost of insurance coverage and making it more difficult to hire workers and grow their businesses. According to a recent study by the American Action Forum, roughly

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[13] Kaiser Family Found., *Employer Health Benefits Survey* (2016), *http://files.kff.org/attachment/Report-Employer-Health-Benefits-2016-Annual-Survey.*

[14] Troy, T., and Wilson, D.M., *Health Coverage Cost Per Covered Life: Government vs. Employment-Sponsored Programs,* AMERICAN HEALTH POLICY INSTITUTE (2014), *http://www.americanhealthpolicy.org/Content/documents/resources/AHPI_STUDY_Cost_Per_Covered_Life.pdf.*

[15] Kaiser Family Found., *supra* note 11.

[16] *Id.*

[17] Jess Henig & Lori Robertson, *Obama's Inflated Health 'Savings',* FACTCHECK.ORG (Jun. 16, 2008), *http://www.factcheck.org/2008/06/obamas-inflated-health-savings/.*

[18] *Rescuing Americans from the Failed Health Care Law and Advancing Patient-Centered Solutions: Hearing Before the H. Comm. on Educ. and the Workforce,* 115th Cong. (2017). (Statement of Scott Bollenbacher, Managing Partner, Bollenbacher & Assoc's., LLC).

[19] *Statement on the Small Business Health Care Crisis: Possible Solutions,* U.S. Chamber of Commerce (Feb. 5, 2003), *https://www.uschamber.com/testimony/statement-small-business-health-care-crisis-possible-solutions* (Statement of the U.S. Chamber of Commerce before the S. Comm. on Small Bus. & Entrepreneurship).

300,000 small business jobs were lost and 10,000 small businesses closed as a result of ACA's costs and regulations.[20]

Since 2008, approximately 36 percent of small businesses with fewer than 10 employees have stopped offering coverage, leaving workers with even fewer health care options.[21] In 2015, the offer rate for businesses with fewer than 50 employees dropped to 29 percent, compared with 39 percent in 2010 when ACA passed.[22] Due to their size and economies of scale, large businesses and labor organizations have the ability to negotiate on behalf of their employees for high-quality health care at more affordable costs. By offering a qualified group health plan under ERISA, these large employers and labor organizations are also exempt from myriad state rules and regulations on health insurance. Small businesses, however, do not have the same bargaining power as larger businesses and are unable to band together to increase their bargaining power in the health insurance marketplace.

According to a National Federation of Independent Business (NFIB) study, 52 percent of small business employers that do not currently offer coverage cite the cost of health insurance coverage as the top reason for not offering their employees coverage.[23] In testimony before the Committee, on behalf of the National Retail Federation, Mr. Jon Hurst, President of the Retailers Association of Massachusetts, noted just how significantly the ACA hurt small businesses, saying:

> Under the Affordable Care Act (ACA) our nation's small businesses and their employees have been relegated to a second class consumer status versus their large, self-funded, ERISA exempt competitors when it comes to access and affordability of health insurance coverage. . . . The ACA, in mandating the purchase of health insurance coverage yet failing to provide consumer equitable treatment under the law in terms of access and pricing[,] is not only unfair it is discriminatory.[24]

One significant factor contributing to the high cost of health care for small employers is their inability to band together in order to unlock the financial benefits of small business pooling arrangements. These cost-saving benefits—economies of scale, freedom from state regulation, and increased administrative efficiencies—would help small employers access coverage at a more affordable price and decrease the number of uninsured individuals who work

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[20] Gitis, B. and Batkins, S., Update: Obamacare's Impact on Small Business Wages and Employment, AMERICAN ACTION FORUM, (2017), *https://www.americanactionforum.org/research/update-obamacares-impact-small-business-wages-employment/*.

[21] Paul Fronstin, *Fewer Small Employers Offering Health Coverage; Large Employers Holding Steady,* EBRI Educ. and Research Fund (Jul. 2016), *https://www.ebri.org/pdf/notespdf/EBRI_*Notes_07-No8-July16.Small-ERs.pdf.

[22] *2015 Medical Expenditure Panel Survey-Insurance Component: Table I.A.2,* AGENCY FOR HEALTHCARE AND QUALITY, CENTER FOR FINANCING, ACCESS AND COSTS TRENDS (2015), *https://meps.ahrq.gov/data_stats/summ_tables/insr/national/series_1/2015/tia2.pdf; 2010 Medical Expenditure Panel Survey-Insurance Component: Table I.A.2,* AGENCY FOR HEALTHCARE AND QUALITY, CENTER FOR FINANCING, ACCESS AND COSTS TRENDS (2010), *https://meps.ahrq.gov/data_stats/summ_tables/insr/national/series_1/2010/tia2.pdf.*

[23] Holly Wade, *Small Business's Introduction to the Affordable Care Act Part III,* NFIB Research Found. (Nov. 2015), *http://www.nfib.com/assets/nfib-aca-study-2015.pdf.*

[24] *Legislative Proposals to Improve Health Care Coverage and Provide Lower Costs for Families: Hearing Before the H. Comm. On Educ. and the Workforce,* 115th Cong. (2017). (Statement of Jon Hurst, President, Retailers Association of Massachusetts).

in small businesses.[25] That is particularly important because the percentage of smaller firms that offer coverage has fallen from 57 percent to 53 percent since 2011.[26]

To address the damage to small businesses caused by the ACA, Mr. Hurst added, "the solution to this problem is to provide small businesses more flexibility . . . to look outside the traditional markets available to them to secure their coverage,"[27] namely the ability to pool together through industry or professional organizations to offer health insurance coverage to their employees.

In June 2016, House Republicans released "A Better Way," which included a step-by-step approach to give every American access to quality, affordable health care. This consensus plan is the basis for repealing and replacing Obamacare in the 115th Congress. The Committee has jurisdiction over three components of "A Better Way": preserving the option for employers of all sizes to self-insure; eliminating resulting roadblocks to employee wellness programs; and, amending ERISA to allow small businesses to band together in AHPs to increase their purchasing power and negotiate better health coverage prices. These three components were the focus of a Committee legislative hearing, as part of broader Republican efforts to replace the ACA.

The need for small business pooling

More specifically, AHPs will give small businesses another option for offering health insurance coverage. In a letter to Rep. Johnson and HELP Subcommittee Chairman Walberg, 34 groups representing small businesses affirmed the potential benefits of AHPs, saying:

> We believe AHPs will help lower the cost of health insurance by allowing small business owners the same opportunities that larger businesses now experience. AHPs will allow small business owners to band together across state lines through their membership in bona fide trade or professional association to purchase health coverage. Establishing health insurance benefits through associations will make coverage more affordable by spreading risk among a much larger group, strengthening negotiating power with plans and providers, and reducing administrative costs.[28]

Mr. Hurst agreed, noting these pooling arrangements would level the playing field for small businesses in relation to larger businesses and unions, while providing additional benefits beyond health insurance.[29] In August 2010, Massachusetts enacted Chapter 288 of the Acts of 2010,[30] establishing small business group

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[25] According to 2010 Census data, smaller firms (less than 500 employees) were almost twice as likely to be uninsured than larger firms (more than 500 employees), with 36 percent of the uninsured working population being employed at a firm with 10 or fewer employees. SMALL BUS. ADMIN., WHAT IS THE LEVEL OF AVAILABILITY AND COVERAGE OF HEALTH INSURANCE IN SMALL FIRMS? (2012), *https://www.sba.gov/sites/default/files/Health-Insurance.pdf.*

[26] Kaiser Family Found., *supra* note 11.

[27] *Id.*

[28] *Legislative Proposals to Improve Health Care Coverage and Provide Lower Costs for Families: Hearing Before the H. Comm. On Educ. and the Workforce,* 115th Cong. (2017). (Letter from Coalition of AHP supporters entered into the record by HELP Subcommittee Chairman Walberg).

[29] Hurst, *supra* note 22.

[30] MASS. GEN. LAWS ch. 3, § 38C (2017) *https://malegislature.gov/Laws/SessionLaws/Acts/2010/Chapter288.*

purchasing cooperatives similar to association health plans. During the Committee's hearing examining H.R. 1101, Mr. Hurst testified that the Retailers Association of Massachusetts Health Insurance Cooperative "is outperforming similarly sized large groups in terms of overall claims experience and is below several small group benchmarks"[31] and covers more lives than those covered by the Massachusetts Health Connector, the state's ACA exchange, at no cost to the taxpayer. Mr. Hurst's testimony underscores the fact that small businesses want pooling as an option to purchase health insurance coverage. This is not surprising, because as Mr. Hurst explained:

> Employment-based group coverage can be distinguished from public pools because employees come to the business to work rather than seek coverage, as opposed to public pool[s, like the ACA exchanges,] where the sole objective is to obtain coverage. The difference in presentation of risk, though subtle, is important. Private, employment-based group plans work better and provide more affordable coverage.[32]

A key element of H.R. 1101 is that AHPs would have the ability to self-fund, which in turn would allow small businesses to band together across state lines to offer coverage. Self-insuring also allows employers to offer plans designed to meet the needs of their employees, while controlling costs. These plans provide excellent, well-regulated benefits. As Mr. Jay Ritchie, Executive Vice President of Tokio Marine HCC Stop-Loss Group and the current Chairman of the Board of the Self-Insurance Institute of America, Inc. recently testified, "Self-insurance plans are regulated by no less than 10 federal laws, including [ERISA] and [HIPAA]."[33] Larger businesses and unions that self-fund are regulated under these rules, and prohibiting AHPs from self-funding would punish small businesses and deny them the same protections. Further, there is no data to substantiate critics' claims that self-funded AHPs will have any effect on the fully-insured small group market or ACA's Small Business Health Options Program Exchanges.[34]

Some states already allow pooling arrangements within their state. Association Health Plans not certified under Part 8 of ERISA remain subject to all federal and state laws otherwise applicable to such plans, and the provisions of the Act are not intended to modify the application or interpretation of such laws to such plans.

Support for creating options and flexibility for small businesses

Because this legislation benefits both employers and working families, the legislation is endorsed by a broad swath of groups representing job creators, including: National Federation of Independent Businesses, U.S. Chamber of Commerce, American Association of Advertising Agencies, Air Conditioning Contractors of America, American Council of Engineering Companies, American Farm Bureau Federation, American Foundry Society, American

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[31] Hurst, *supra* note 22.
[32] *Id.*
[33] *Legislative Proposals to Improve Health Care Coverage and Provide Lower Costs for Families: Hearing Before the H. Comm. On Educ. and the Workforce*, 115th Cong. (2017). (Statement of Jay Ritchie, Exec. Vice President, Tokio Marine HHC).
[34] *Id.*

Hotel & Lodging Association, American Rental Association, American Society of Association Executives, Associated Builders and Contractors, Associated General Contractors, Auto Care Association, Electronic Security Association, Far West Equipment Dealers Association, Farm Equipment Manufacturers Association, FASTSIGNS International, Inc., Heating, Air-Conditioning & Refrigeration Distributors International, International Franchise Association, Manufacturers Education and Training Alliance of CT, National Association of Chemical Distributors, National Association of Home Builders, National Association of Manufacturers, National Association of REALTORS®, National Association of Wholesaler-Distributors, National Restaurant Association, National Retail Federation, National Roofing Contractors Association, National Tooling and Machining Association, National Utility Contractors Association, North American Die Casting Association, Precision Machined Products Association, Precision Metalforming Association, Self-Insurance Institute of America, Inc., Small Business & Entrepreneurship Council, and the Western Equipment Dealers Association.

CONCLUSION

H.R. 1101, the *Small Business Health Fairness Act*, makes it easier for small businesses to promote a healthy workforce and offer more affordable health care coverage. By allowing small businesses to join together in AHPs, the bill puts smaller businesses on a more level playing field with larger companies and unions, and it increases their bargaining power with insurance providers. More importantly, it provides smaller employers—many of whom have limited resources—with a greater opportunity to offer their workers quality and affordable health care coverage. If enacted, H.R. 1101 will empower small businesses to provide quality health care coverage at a lower cost for their employees.

SECTION-BY-SECTION

The following is a section-by-section analysis of the Amendment in the Nature of a Substitute offered by HELP Subcommittee Chairman Walberg and reported favorably by the Committee.

Section 1. Short title; Table of Contents

Section 1 provides the short title is the "Small Business Health Fairness Act of 2017."

Section 2. Rules governing association health plans

Section 2 amends Subtitle B of Title I of ERISA to add a new Part 8 (Rules Governing Association Health Plans), after part 7:

Section 801. Provides that a sponsor of an AHP must be a *bona fide* trade, industry, or professional association; chamber of commerce; or similar organization established for substantial purposes other than that of obtaining or providing medical care. The sponsor must be a permanent entity receiving membership payment on a periodic basis that does not condition membership, dues, or coverage under the health plan on the basis of health status.

Section 802. Requires the Secretary of Labor (Secretary) to promulgate regulations to certify AHPs and maintain certifi-

cation. For AHPs that purchase a fully-insured group health plan 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 the businesses covered will be of average health risk, to avoid pulling only healthy individuals from the small employer market (cherry-picking). To be certified, a self-funded AHP must have one of the following: (1) offered such self-funded coverage on the date of enactment, (2) represent a broad cross-section of trades and businesses or industries, or (3) represent one or more trades with average or above average health insurance risk or health claims experience.

Section 803. Establishes additional eligibility requirements for AHPs. Applicants must demonstrate the sponsor of the AHP 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 serves as the plan sponsor and is the fiduciary of the plan. The board of trustees must have complete fiscal control and be 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. 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. This applies to partnerships and self-employed individuals. Expressly prohibits discrimination by requiring (1) all employers that are association members are eligible for participation; (2) all geographically available coverage options are made available upon request to eligible employers; and (3) eligible individuals cannot be excluded from enrolling because of health status. The bill also stipulates that no participating employer may exclude an employee by purchasing an individual policy of health insurance coverage for such person based on his or her health status.

Section 805. Requires contribution rates for any particular employer comply with the *Health Insurance Portability and Accountability Act* (HIPAA), which prohibits group health plans from excluding high-risk individuals based on 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. Contribution rates can only vary to the extent already allowed under the relevant state community rating insurance law. 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, if the AHP also offers fully-insured plans. In addition, AHPs 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 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 (unearned contributions, benefit liabilities, expected administrative costs, any other obligations) for self-insured AHP's and requires them to obtain both specific and aggregate stop loss coverage and solvency indemnification insurance. In addition, the AHP must maintain minimum surplus reserves of at least $500,000, and the Secretary may increase the surplus reserve minimum to $2 million. Establishes an Association Health Plan Fund, managed by the Department of Labor, to guarantee that indemnification insurance is always available, and penalties apply if payments are not made. All certified AHPs would be required to pay $5,000 into the fund annually. The measure requires the Secretary to establish a Solvency Standards Working Group within 90 days of enactment to recommend initial regulations.

Section 807. Sets forth additional criteria that AHPs 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 by the Secretary as a condition of the certification). AHPs also are required to file their certification with the applicable state authority of each state in which at least 25 percent of the participants and beneficiaries under the plan are located.

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

Section 809. Requires that the board of trustees of a self-insured AHP must determine quarterly whether the capital reserve requirements under section 806 are met. If not, in consultation with the qualified actuary, the board must develop a plan to ensure compliance and report such information to the Secretary.

Section 810. Sets forth procedures whereby the Secretary may become the trustee of insolvent AHPs. Whenever the Secretary determines an AHP will not be able to provide benefits, or is otherwise in financial distress, the Secretary must act as trustee to administer the plan for the duration of insolvency.

Section 811. Allows a state to assess newly certified AHPs a contribution tax to the same extent they tax health insurance plans. This will enable states to maintain the revenue source for funding state priorities such as high-risk insurance pools.

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. Also, clarifies 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 ad-

dition, 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. Not later than January 1, 2022, the Secretary shall report to Congress regarding the effect AHPs have had, if any, on reducing the number of uninsured individuals.

Section 3. Clarification of treatment of single employer arrangements

Section 3 amends the definition of multiple employer welfare arrangement and control group with regard to the treatment of single employer arrangements and collectively bargained arrangements.

Section 4. Enforcement provisions relating to association health plans

Section 4 amends ERISA to establish enforcement provisions relating to AHPs and multiple employer welfare arrangements (MEWAs). Establishes criminal penalties for willful misrepresentation as a certified AHP, or as a collectively-bargained plan, or as a MEWA established pursuant to a collective bargaining agreement; authorizes DOL to issue cease activity orders against fraudulent health plans; and outlines the responsibility of the board of trustees for meeting the required claims procedures.

Section 5. Cooperation between federal and state authorities

Section 5 amends section 506 of ERISA (relating to coordination and responsibility of agencies enforcing ERISA and related laws) to require the Secretary 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. Effective date and transitional and other rules

Section 6 provides the amendments made by this Act shall take effect one year after the date of enactment. Requires the Secretary to issue regulations to carry out the amendments made by this Act within one year after the date of enactment. Deems certain requirements of this legislation met for previously existing AHPs meeting certain stringent requirements.

EXPLANATION OF AMENDMENTS

The amendments, including the amendment in the nature of a substitute, are explained in the body of this report.

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. H.R. 1101 im-

proves access to affordable health coverage options for workers employed by small businesses.

UNFUNDED MANDATE STATEMENT

With respect to the requirements of Section 423 of the Congressional Budget and Impoundment Control Act (as amended by Section 101(a)(2) of the Unfunded Mandate Reform Act, P.L. 104–4), the Committee has requested but not received from the Director of the Congressional Budget Office a statement as to whether the provisions of the reported bill include unfunded mandates.

EARMARK STATEMENT

H.R. 1101 does not contain any congressional earmarks, limited tax benefits, or limited tariff benefits as defined in clause 9 of House Rule XXI.

ROLL CALL VOTES

Clause 3(b) of rule XIII of the Rules of the House of Representatives requires the Committee Report to include for each record vote on a motion to report the measure or matter and on any amendments offered to the measure or matter the total number of votes for and against and the names of the Members voting for and against.

Date: March 8, 2017

COMMITTEE ON EDUCATION AND THE WORKFORCE RECORD OF COMMITTEE VOTE

Roll Call: 1 Bill: H.R. 1101 Amendment Number: 8

Disposition: Adopted by a vote of 19 yeas and 16 nays

Sponsor/Amendment: Mr. Thompson - motion to table the appeal of the ruling of the chair on the Polis amendment (support hospital pricing transparency)

Name & State	Aye	No	Not Voting	Name & State	Aye	No	Not Voting
Mrs. FOXX (NC) (Chairwoman)	X			Mr. SCOTT (VA) (Ranking)		X	
Mr. WILSON (SC)	X			Mrs. DAVIS (CA)		X	
Mr. HUNTER (CA)	X			Mr. GRIJALVA (AZ)		X	
Mr. ROE (TN)			X	Mr. COURTNEY (CT)			X
Mr. THOMPSON (PA)	X			Ms. FUDGE (OH)		X	
Mr. WALBERG (MI)	X			Mr. POLIS (CO)		X	
Mr. GUTHRIE (KY)	X			Mr. SABLAN (MP)		X	
Mr. ROKITA (IN)	X			Ms. WILSON (FL)		X	
Mr. BARLETTA (PA)	X			Ms. BONAMICI (OR)		X	
Mr. MESSER (IN)	X			Mr. TAKANO (CA)		X	
Mr. BYRNE (AL)	X			Ms. ADAMS (NC)		X	
Mr. BRAT (VA)	X			Mr. DeSAULNIER (CA)		X	
Mr. GROTHMAN (WI)	X			Mr. NORCROSS (NJ)		X	
Mr. RUSSELL (OK)	X			Ms. BLUNT ROCHESTER (DE)		X	
Ms. STEFANIK (NY)	X			Mr. KRISHNAMOORTHI (IL)		X	
Mr. ALLEN (GA)	X			Ms. SHEA-PORTER (NH)		X	
Mr. LEWIS (MN)			X	Mr. ESPAILLAT (NY)		X	
Mr. ROONEY (FL)	X						
Mr. MITCHELL (MI)	X						
Mr. GARRETT (VA)	X						
Mr. SMUCKER (PA)	X						
Mr. FERGUSON (GA)	X						
vacancy							

TOTALS: Aye: 19 No: 16 Not Voting: 3

Total: 40 / Quorum: 14 / Report: 21

(23 R - 17 D)

Date: March 8, 2017

COMMITTEE ON EDUCATION AND THE WORKFORCE RECORD OF COMMITTEE VOTE

Roll Call: 2 Bill: H.R. 1101 Amendment Number: 9

Disposition: Defeated by a vote of 17 yeas and 22 nays

Sponsor/Amendment: Mrs. Davis - Regarding coverage for maternity care or women's preventative health services

Name & State	Aye	No	Not Voting	Name & State	Aye	No	Not Voting
Mrs. FOXX (NC) (Chairwoman)		X		Mr. SCOTT (VA) (Ranking)	X		
Mr. WILSON (SC)		X		Mrs. DAVIS (CA)	X		
Mr. HUNTER (CA)		X		Mr. GRIJALVA (AZ)	X		
Mr. ROE (TN)		X		Mr. COURTNEY (CT)	X		
Mr. THOMPSON (PA)		X		Ms. FUDGE (OH)	X		
Mr. WALBERG (MI)		X		Mr. POLIS (CO)	X		
Mr. GUTHRIE (KY)		X		Mr. SABLAN (MP)	X		
Mr. ROKITA (IN)		X		Ms. WILSON (FL)	X		
Mr. BARLETTA (PA)		X		Ms. BONAMICI (OR)	X		
Mr. MESSER (IN)		X		Mr. TAKANO (CA)	X		
Mr. BYRNE (AL)		X		Ms. ADAMS (NC)	X		
Mr. BRAT (VA)		X		Mr. DeSAULNIER (CA)	X		
Mr. GROTHMAN (WI)		X		Mr. NORCROSS (NJ)	X		
Mr. RUSSELL (OK)		X		Ms. BLUNT ROCHESTER (DE)	X		
Ms. STEFANIK (NY)		X		Mr. KRISHNAMOORTHI (IL)	X		
Mr. ALLEN (GA)		X		Ms. SHEA-PORTER (NH)	X		
Mr. LEWIS (MN)		X		Mr. ESPAILLAT (NY)	X		
Mr. ROONEY (FL)		X					
Mr. MITCHELL (MI)		X					
Mr. GARRETT (VA)		X					
Mr. SMUCKER (PA)		X					
Mr. FERGUSON (GA)		X					
vacancy							

TOTALS: Aye: 17 No: 22 Not Voting:

Total: 40 / Quorum: 14 / Report: 21

(23 R - 17 D)

Date: March 8, 2017

COMMITTEE ON EDUCATION AND THE WORKFORCE RECORD OF COMMITTEE VOTE

Roll Call: 3 Bill: H.R. 1101 Amendment Number:

Disposition: Ordered favorably reported to the House, as amended, by a vote of 22 yeas and 17 nays.

Sponsor/Amendment: Mr. Wilson - motion to report the bill to the House with an amendment and with the recommendation that the amendment be agreed to, and the bill as amended do pass.

Name & State	Aye	No	Not Voting	Name & State	Aye	No	Not Voting
Mrs. FOXX (NC) (Chairwoman)	X			Mr. SCOTT (VA) (Ranking)		X	
Mr. WILSON (SC)	X			Mrs. DAVIS (CA)		X	
Mr. HUNTER (CA)	X			Mr. GRIJALVA (AZ)		X	
Mr. ROE (TN)	X			Mr. COURTNEY (CT)		X	
Mr. THOMPSON (PA)	X			Ms. FUDGE (OH)		X	
Mr. WALBERG (MI)	X			Mr. POLIS (CO)		X	
Mr. GUTHRIE (KY)	X			Mr. SABLAN (MP)		X	
Mr. ROKITA (IN)	X			Ms. WILSON (FL)		X	
Mr. BARLETTA (PA)	X			Ms. BONAMICI (OR)		X	
Mr. MESSER (IN)	X			Mr. TAKANO (CA)		X	
Mr. BYRNE (AL)	X			Ms. ADAMS (NC)		X	
Mr. BRAT (VA)	X			Mr. DeSAULNIER (CA)		X	
Mr. GROTHMAN (WI)	X			Mr. NORCROSS (NJ)		X	
Mr. RUSSELL (OK)	X			Ms. BLUNT ROCHESTER (DE)		X	
Ms. STEFANIK (NY)	X			Mr. KRISHNAMOORTHI (IL)		X	
Mr. ALLEN (GA)	X			Ms. SHEA-PORTER (NH)		X	
Mr. LEWIS (MN)	X			Mr. ESPAILLAT (NY)		X	
Mr. ROONEY (FL)	X						
Mr. MITCHELL (MI)	X						
Mr. GARRETT (VA)	X						
Mr. SMUCKER (PA)	X						
Mr. FERGUSON (GA)	X						
vacancy							

TOTALS: Aye: 22 No: 17 Not Voting:

Total: 40 / Quorum: 14 / Report: 21

(23 R - 17 D)

STATEMENT OF GENERAL PERFORMANCE GOALS AND OBJECTIVES

In accordance with clause (3)(c) of House Rule XIII, the goal of H.R. 1101 is to improve access to affordable health coverage options for workers employed by small businesses.

DUPLICATION OF FEDERAL PROGRAMS

No provision of H.R. 1101 establishes or reauthorizes a program of the Federal Government known to be duplicative of another Federal program, a program that was included in any report from the Government Accountability Office to Congress pursuant to section 21 of Public Law 111–139, or a program related to a program identified in the most recent Catalog of Federal Domestic Assistance.

DISCLOSURE OF DIRECTED RULE MAKINGS

The committee estimates that enacting H.R. 1101 does not specifically direct the completion of any specific rule makings within the meaning of 5 U.S.C. 551.

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.

NEW BUDGET AUTHORITY AND CBO COST ESTIMATE COMMITTEE COST ESTIMATE

With respect to the requirements of clause 3(c)(2) of rule XIII of the Rules of the House of Representatives and section 308(a) of the Congressional Budget Act of 1974 and with respect to requirements of clause (3)(c)(3) of rule XIII of the Rules of the House of Representatives and section 402 of the Congressional Budget Act of 1974, the Committee has requested but not received a cost estimate for this bill from the Director of Congressional Budget Office. The Committee has requested but not received from the Director of the Congressional Budget Office a statement as to whether this bill contains any new budget authority, spending authority, credit authority, or an increase or decrease in revenues or tax expenditures.

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 (new matter is printed in italic and existing law in which no change is proposed is shown in roman):

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,

and existing law in which no change is proposed is shown in roman):

EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974

SHORT TITLE AND TABLE OF CONTENTS

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

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TITLE I—PROTECTION OF EMPLOYEE BENEFIT RIGHTS

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Subtitle B—Regulatory Provisions

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PART 7—GROUP HEALTH PLAN REQUIREMENTS

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Subpart C—General Provisions

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PART 8. RULES GOVERNING ASSOCIATION HEALTH PLANS

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

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TITLE I—PROTECTION OF EMPLOYEE BENEFIT RIGHTS

SUBTITLE A—GENERAL PROVISIONS

* * * * * * *

DEFINITIONS

SEC. 3. For purposes of this title:

(1) The terms "employee welfare benefit plan" and "welfare plan" mean any plan, fund, or program which was heretofore or is hereafter established or maintained by an employer or by an employee organization, or by both, to the extent that such plan, fund, or program was established or is maintained for the purpose of providing for its participants or their beneficiaries, through the purchase of insurance or otherwise, (A) medical, surgical, or hospital care or benefits, or benefits in the event of sickness, accident, disability, death or unemployment, or vacation benefits, apprenticeship or

other training programs, or day care centers, scholarship funds, or prepaid legal services, or (B) any benefit described in section 302(c) of the Labor Management Relations Act, 1947 (other than pensions on retirement or death, and insurance to provide such pensions).

(2)(A) Except as provided in subparagraph (B), the terms "employee pension benefit plan" and "pension plan" mean any plan, fund, or program which was heretofore or is hereafter established or maintained by an employer or by an employee organization, or by both, to the extent that by its express terms or as a result of surrounding circumstances such plan, fund, or program—

(i) provides retirement income to employees, or

(ii) results in a deferral of income by employees for periods extending to the termination of covered employment or beyond,

regardless of the method of calculating the contributions made to the plan, the method of calculating the benefits under the plan or the method of distributing benefits from the plan. A distribution from a plan, fund, or program shall not be treated as made in a form other than retirement income or as a distribution prior to termination of covered employment solely because such distribution is made to an employee who has attained age 62 and who is not separated from employment at the time of such distribution.

(B) The Secretary may by regulation prescribe rules consistent with the standards and purposes of this Act providing one or more exempt categories under which—

(i) severance pay arrangements, and

(ii) supplemental retirement income payments, under which the pension benefits of retirees or their beneficiaries are supplemented to take into account some portion or all of the increases in the cost of living (as determined by the Secretary of Labor) since retirement,

shall, for purposes of this title, be treated as welfare plans rather than pension plans. In the case of any arrangement or payment a principal effect of which is the evasion of the standards or purposes of this Act applicable to pension plans, such arrangement or payment shall be treated as a pension plan. An applicable voluntary early retirement incentive plan (as defined in section 457(e)(11)(D)(ii) of the Internal Revenue Code of 1986) making payments or supplements described in section 457(e)(11)(D)(i) of such Code, and an applicable employment retention plan (as defined in section 457(f)(4)(C) of such Code) making payments of benefits described in section 457(f)(4)(A) of such Code, shall, for purposes of this title, be treated as a welfare plan (and not a pension plan) with respect to such payments and supplements.

(3) The term "employee benefit plan" or "plan" means an employee welfare benefit plan or an employee pension benefit plan or a plan which is both an employee welfare benefit plan and an employee pension benefit plan.

(4) The term "employee organization" means any labor union or any organization of any kind, or any agency or employee representation committee, association, group, or plan, in which employees participate and which exists for the purpose, in whole or in part, of dealing with employers concerning an employee benefit plan, or other matters incidental to employment relationships; or any employees' beneficiary association organized for the purpose in whole or in part, of establishing such a plan.

(5) The term "employer" means any person acting directly as an employer, or indirectly in the interest of an employer, in relation to an employee benefit plan; and includes a group or association of employers acting for an employer in such capacity.

(6) The term "employee" means any individual employed by an employer.

(7) The term "participant" means any employee or former employee of an employer, or any member or former member of an employee organization, who is or may become eligible to receive a benefit of any type from an employee benefit plan which covers employees of such employer or members of such organization, or whose beneficiaries may be eligible to receive any such benefit.

(8) The term "beneficiary" means a person designated by a participant, or by the terms of an employee benefit plan, who is or may become entitled to a benefit thereunder.

(9) The term "person" means an individual, partnership, joint venture, corporation, mutual company, joint-stock company, trust, estate, unincorporated organization, association, or employee organization.

(10) The term "State" includes any State of the United States, the District of Columbia, Puerto Rico, the Virgin Islands, American Samoa, Guam, Wake Island, and the Canal Zone. The term "United States" when used in the geographic sense means the States and the Outer Continental Shelf lands defined in the Outer Continental Shelf Lands Act (43 U.S.C. 1331–1343).

(11) The term "commerce" means trade, traffic, commerce, transportation, or communication between any State and any place outside thereof.

(12) The term "industry or activity affecting commerce" means any activity, business, or industry in commerce or in which a labor dispute would hinder or obstruct commerce or the free flow of commerce, and includes any activity or industry "affecting commerce" within the meaning of the Labor Management Relations Act, 1947, or the Railway Labor Act.

(13) The term "Secretary" means the Secretary of Labor.

(14) The term "party in interest" means, as to an employee benefit plan—

(A) any fiduciary (including, but not limited to, any administrator, officer, trustee, or custodian), counsel, or employee of such employee benefit plan;

(B) a person providing services to such plan;

(C) an employer any of whose employees are covered by such plan;

(D) an employee organization any of whose members are covered by such plan;

(E) an owner, direct or indirect, of 50 percent or more of—

(i) the combined voting power of all classes of stock entitled to vote or the total value of shares of all classes of stock of a corporation,

(ii) the capital interest or the profits interest of a partnership, or

(iii) the beneficial interest of a trust or unincorporated enterprise,

which is an employer or an employee organization described in subparagraph (C) or (D);

(F) a relative (as defined in paragraph (15)) of any individual described in subparagraph (A), (B), (C), or (E);

(G) a corporation, partnership, or trust or estate of which (or in which) 50 percent or more of—

(i) the combined voting power of all classes of stock entitled to vote or the total value of shares of all classes of stock of such corporation,

(ii) the capital interest or profits interest of such partnership, or

(iii) the beneficial interest of such trust or estate,

is owned directly or indirectly, or held by persons described in subparagraph (A), (B), (C), (D), or (E);

(H) an employee, officer, director (or an individual having powers or responsibilities similar to those of officers or directors), or a 10 percent or more shareholder directly or indirectly, of a person described in subparagraph (B), (C), (D), (E), or (G), or of the employee benefit plan; or

(I) a 10 percent or more (directly or indirectly in capital or profits) partner or joint venturer of a person described in subparagraph (B), (C), (D), (E), or (G).

The Secretary, after consultation and coordination with the Secretary of the Treasury, may by regulation prescribe a percentage lower than 50 percent for subparagraph (E) and (G) and lower than 10 percent for subparagraph (H) or (I). The Secretary may prescribe regulations for determining the ownership (direct or indirect) of profits and beneficial interests, and the manner in which indirect stockholdings are taken into account. Any person who is a party in interest with respect to a plan to which a trust described in section 501(c)(22) of the Internal Revenue Code of 1986 is permitted to make payments under section 4223 shall be treated as a party in interest with respect to such trust.

(15) The term "relative" means a spouse, ancestor, lineal descendant, or spouse of a lineal descendant.

(16)(A) The term "administrator" means—

(i) the person specifically so designated by the terms of the instrument under which the plan is operated;

(ii) if an administrator is not so designated, the plan sponsor; or

(iii) in the case of a plan for which an administrator is not designated and a plan sponsor cannot be identified, such other person as the Secretary may by regulation prescribe.

(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.*

(17) The term "separate account" means an account established or maintained by an insurance company under which income, gains, and losses, whether or not realized, from assets allocated to such account, are, in accordance with the applicable contract, cred-

ited to or charged against such account without regard to other income, gains, or losses of the insurance company.

(18) The term "adequate consideration" when used in part 4 of subtitle B means (A) in the case of a security for which there is a generally recognized market, either (i) the price of the security prevailing on a national securities exchange which is registered under section 6 of the Securities Exchange Act of 1934, or (ii) if the security is not traded on such a national securities exchange, a price not less favorable to the plan than the offering price for the security as established by the current bid and asked prices quoted by persons independent of the issuer and of any party in interest; and (B) in the case of an asset other than a security for which there is a generally recognized market, the fair market value of the asset as determined in good faith by the trustee or named fiduciary pursuant to the terms of the plan and in accordance with regulations promulgated by the Secretary.

(19) The term "nonforfeitable" when used with respect to a pension benefit or right means a claim obtained by a participant or his beneficiary to that part of an immediate or deferred benefit under a pension plan which arises from the participant's service, which is unconditional, and which is legally enforceable against the plan. For purposes of this paragraph, a right to an accrued benefit derived from employer contributions shall not be treated as forfeitable merely because the plan contains a provision described in section 203(a)(3).

(20) The term "security" has the same meaning as such term has under section 2(1) of the Securities Act of 1933 (15 U.S.C. 77b(1)).

(21)(A) Except as otherwise provided in subparagraph (B), a person is a fiduciary with respect to a plan to the extent (i) he exercises any discretionary authority or discretionary control respecting management of such plan or exercises any authority or control respecting management or disposition of its assets, (ii) he renders investment advice for a fee or other compensation, direct or indirect, with respect to any moneys or other property of such plan, or has any authority or responsibility to do so, or (iii) he has any discretionary authority or discretionary responsibility in the administration of such plan. Such term includes any person designated under section 405(c)(1)(B).

(B) If any money or other property of an employee benefit plan is invested in securities issued by an investment company registered under the Investment Company Act of 1940, such investment shall not by itself cause such investment company or such investment company's investment adviser or principal underwriter to be deemed to be a fiduciary or a party in interest as those terms are defined in this title, except insofar as such investment company or its investment adviser or principal underwriter acts in connection with an employee benefit plan covering employees of the investment company, the investment adviser, or its principal underwriter. Nothing contained in this subparagraph shall limit the duties imposed on such investment company, investment adviser, or principal underwriter by any other law.

(22) The term "normal retirement benefit" means the greater of the early retirement benefit under the plan, or the benefit under the plan commencing at normal retirement age. The normal retirement benefit shall be determined without regard to—

(A) medical benefits, and

(B) disability benefits not in excess of the qualified disability benefit.

For purposes of this paragraph, a qualified disability benefit is a disability benefit provided by a plan which does not exceed the benefit which would be provided for the participant if he separated from the service at normal retirement age. For purposes of this paragraph, the early retirement benefit under a plan shall be determined without regard to any benefit under the plan which the Secretary of the Treasury finds to be a benefit described in section 204(b)(1)(G).

(23) The term "accrued benefit" means—

(A) in the case of a defined benefit plan, the individual's accrued benefit determined under the plan and, except as provided in section 204(c)(3), expressed in the form of an annual benefit commencing at normal retirement age, or

(B) in the case of a plan which is an individual account plan, the balance of the individual's account.

The accrued benefit of an employee shall not be less than the amount determined under section 204(c)(2)(B) with respect to the employee's accumulated contribution.

(24) The term "normal retirement age" means the earlier of—

(A) the time a plan participant attains normal retirement age under the plan, or

(B) the later of—

(i) the time a plan participant attains age 65, or

(ii) the 5th anniversary of the time a plan participant commenced participation in the plan.

(25) The term "vested liabilities" means the present value of the immediate or deferred benefits available at normal retirement age for participants and their beneficiaries which are nonforfeitable.

(26) The term "current value" means fair market value where available and otherwise the fair value as determined in good faith by a trustee or a named fiduciary (as defined in section 402(a)(2)) pursuant to the terms of the plan and in accordance with regulations of the Secretary, assuming an orderly liquidation at the time of such determination.

(27) The term "present value", with respect to a liability, means the value adjusted to reflect anticipated events. Such adjustments shall conform to such regulations as the Secretary of the Treasury may prescribe.

(28) The term "normal service cost" or "normal cost" means the annual cost of future pension benefits and administrative expenses assigned, under an actuarial cost method, to years subsequent to a particular valuation date of a pension plan. The Secretary of the Treasury may prescribe regulations to carry out this paragraph.

(29) The term "accrued liability" means the excess of the present value, as of a particular valuation date of a pension plan, of the projected future benefit costs and administrative expenses for all plan participants and beneficiaries over the present value of future contributions for the normal cost of all applicable plan participants and beneficiaries. The Secretary of the Treasury may prescribe regulations to carry out this paragraph.

(30) The term "unfunded accrued liability" means the excess of the accrued liability, under an actuarial cost method which so pro-

vides, over the present value of the assets of a pension plan. The Secretary of the Treasury may prescribe regulations to carry out this paragraph.

(31) The term "advance funding actuarial cost method" or "actuarial cost method" means a recognized actuarial technique utilized for establishing the amount and incidence of the annual actuarial cost of pension plan benefits and expenses. Acceptable actuarial cost methods shall include the accrued benefit cost method (unit credit method), the entry age normal cost method, the individual level premium cost method, the aggregate cost method, the attained age normal cost method, and the frozen initial liability cost method. The terminal funding cost method and the current funding (pay-as-you-go) cost method are not acceptable actuarial cost methods. The Secretary of the Treasury shall issue regulations to further define acceptable actuarial cost methods.

(32) The term "governmental plan" means a plan established or maintained for its employees by the Government of the United States, by the government of any State or political subdivision thereof, or by any agency or instrumentality of any of the foregoing. The term "governmental plan" also includes any plan to which the Railroad Retirement Act of 1935 or 1937 applies, and which is financed by contributions required under that Act and any plan of an international organization which is exempt from taxation under the provisions of the International Organizations Immunities Act (59 Stat. 669). The term "governmental plan" includes a plan which is established and maintained by an Indian tribal government (as defined in section 7701(a)(40) of the Internal Revenue Code of 1986), a subdivision of an Indian tribal government (determined in accordance with section 7871(d) of such Code), or an agency or instrumentality of either, and all of the participants of which are employees of such entity substantially all of whose services as such an employee are in the performance of essential governmental functions but not in the performance of commercial activities (whether or not an essential government function)

(33)(A) The term "church plan" means a plan established and maintained (to the extent required in clause (ii) of subparagraph (B)) for its employees (or their beneficiaries) by a church or by a convention or association of churches which is exempt from tax under section 501 of the Internal Revenue Code of 1986.

(B) The term "church plan" does not include a plan—

(i) which is established and maintained primarily for the benefit of employees (or their beneficiaries) of such church or convention or association of churches who are employed in connection with one or more unrelated trades or businesses (within the meaning of section 513 of the Internal Revenue Code of 1986), or

(ii) if less than substantially all of the individuals included in the plan are individuals described in subparagraph (A) or in clause (ii) of subparagraph (C) (or their beneficiaries).

(C) For purposes of this paragraph—

(i) A plan established and maintained for its employees (or their beneficiaries) by a church or by a convention or association of churches includes a plan maintained by an organization, whether a civil law corporation or otherwise, the principal purpose or function of which is the administration or funding

of a plan or program for the provision of retirement benefits or welfare benefits, or both, for the employees of a church or a convention or association of churches, if such organization is controlled by or associated with a church or a convention or association of churches.

(ii) The term employee of a church or a convention or association of churches includes—

(I) a duly ordained, commissioned, or licensed minister of a church in the exercise of his ministry, regardless of the source of his compensation;

(II) an employee of an organization, whether a civil law corporation or otherwise, which is exempt from tax under section 501 of the Internal Revenue Code of 1986 and which is controlled by or associated with a church or a convention or association of churches; and

(III) an individual described in clause (v).

(iii) A church or a convention or association of churches which is exempt from tax under section 501 of the Internal Revenue Code of 1986 shall be deemed the employer of any individual included as an employee under clause (ii).

(iv) An organization, whether a civil law corporation or otherwise, is associated with a church or a convention or association of churches if it shares common religious bonds and convictions with that church or convention or association of churches.

(v) If an employee who is included in a church plan separates from the service of a church or a convention or association of churches or an organization, whether a civil law corporation or otherwise, which is exempt from tax under section 501 of the Internal Revenue Code of 1986 and which is controlled by or associated with a church or a convention or association of churches, the church plan shall not fail to meet the requirements of this paragraph merely because the plan—

(I) retains the employee's accrued benefit or account for the payment of benefits to the employee or his beneficiaries pursuant to the terms of the plan; or

(II) receives contributions on the employee's behalf after the employee's separation from such service, but only for a period of 5 years after such separation, unless the employee is disabled (within the meaning of the disability provisions of the church plan or, if there are no such provisions in the church plan, within the meaning of section 72(m)(7) of the Internal Revenue Code of 1986) at the time of such separation from service.

(D)(i) If a plan established and maintained for its employees (or their beneficiaries) by a church or by a convention or association of churches which is exempt from tax under section 501 of the Internal Revenue Code of 1986 fails to meet one or more of the requirements of this paragraph and corrects its failure to meet such requirements within the correction period, the plan shall be deemed to meet the requirements of this paragraph for the year in which the correction was made and for all prior years.

(ii) If a correction is not made within the correction period, the plan shall be deemed not to meet the requirements of this para-

graph beginning with the date on which the earliest failure to meet one or more of such requirements occurred.

(iii) For purposes of this subparagraph, the term "correction period" means—

(I) the period ending 270 days after the date of mailing by the Secretary of the Treasury of a notice of default with respect to the plan's failure to meet one or more of the requirements of this paragraph; or

(II) any period set by a court of competent jurisdiction after a final determination that the plan fails to meet such requirements, or, if the court does not specify such period, any reasonable period determined by the Secretary of the Treasury on the basis of all the facts and circumstances, but in any event not less than 270 days after the determination has become final; or

(III) any additional period which the Secretary of the Treasury determines is reasonable or necessary for the correction of the default,

whichever has the latest ending date.

(34) The term "individual account plan" or "defined contribution plan" means a pension plan which provides for an individual account for each participant and for benefits based solely upon the amount contributed to the participant's account, and any income, expenses, gains and losses, and any forfeitures of accounts of other participants which may be allocated to such participant's account.

(35) The term "defined benefit plan" means a pension plan other than an individual account plan; except that a pension plan which is not an individual account plan and which provides a benefit derived from employer contributions which is based partly on the balance of the separate account of a participant—

(A) for the purposes of section 202, shall be treated as an individual account plan, and

(B) for the purposes of paragraph (23) of this section and section 204, shall be treated as an individual account plan to the extent benefits are based upon the separate account of a participant and as a defined benefit plan with respect to the remaining portion of benefits under the plan.

(36) The term "excess benefit plan" means a plan maintained by an employer solely for the purpose of providing benefits for certain employees in excess of the limitations on contributions and benefits imposed by section 415 of the Internal Revenue Code of 1986 on plans to which that section applies, without regard to whether the plan is funded. To the extent that a separable part of a plan (as determined by the Secretary of Labor) maintained by an employer is maintained for such purpose, that part shall be treated as a separate plan which is an excess benefit plan.

(37)(A) The term "multiemployer plan" means a plan—

(i) to which more than one employer is required to contribute,

(ii) which is maintained pursuant to one or more collective bargaining agreements between one or more employee organizations and more than one employer, and

(iii) which satisfies such other requirements as the Secretary may prescribe by regulation.

(B) For purposes of this paragraph, all trades or businesses (whether or not incorporated) which are under common control within the meaning of section 4001(b)(1) are considered a single employer.

(C) Notwithstanding subparagraph (A), a plan is a multiemployer plan on and after its termination date if the plan was a multiemployer plan under this paragraph for the plan year preceding its termination date.

(D) For purposes of this title, notwithstanding the preceding provisions of this paragraph, for any plan year which began before the date of the enactment of the Multiemployer Pension Plan Amendments Act of 1980, the term "multiemployer plan" means a plan described in section 3(37) of this Act as in effect immediately before such date.

(E) Within one year after the date of the enactment of the Multiemployer Pension Plan Amendments Act of 1980, a multiemployer plan may irrevocably elect, pursuant to procedures established by the corporation and subject to the provisions of sections 4403(b) and (c), that the plan shall not be treated as a multiemployer plan for all purposes under this Act or the Internal Revenue Code of 1954 if for each of the last 3 plan years ending prior to the effective date of the Multiemployer Pension Plan Amendments Act of 1980—

(i) the plan was not a multiemployer plan because the plan was not a plan described in section 3(37)(A)(iii) of this Act and section 414(f)(1)(C) of the Internal Revenue Code of 1954 (as such provisions were in effect on the day before the date of the enactment of the Multiemployer Pension Plan Amendments Act of 1980); and

(ii) the plan had been identified as a plan that was not a multiemployer plan in substantially all its filings with the corporation, the Secretary of Labor and the Secretary of the Treasury.

(F)(i) For purposes of this title a qualified football coaches plan—

(I) shall be treated as a multiemployer plan to the extent not inconsistent with the purposes of this subparagraph; and

(II) notwithstanding section 401(k)(4)(B) of the Internal Revenue Code of 1986, may include a qualified cash and deferred arrangement.

(ii) For purposes of this subparagraph, the term "qualified football coaches plan" means any defined contribution plan which is established and maintained by an organization—

(I) which is described in section 501(c) of such Code;

(II) the membership of which consists entirely of individuals who primarily coach football as full-time employees of 4-year colleges or universities described in section 170(b)(1)(A)(ii) of such Code; and

(III) which was in existence on September 18, 1986.

(G)(i) Within 1 year after the enactment of the Pension Protection Act of 2006—

(I) an election under subparagraph (E) may be revoked, pursuant to procedures prescribed by the Pension Benefit Guaranty Corporation, if, for each of the 3 plan years prior to the date of the enactment of that Act, the plan would have been a multiemployer plan but for the election under subparagraph (E), and

(II) a plan that meets the criteria in clauses (i) and (ii) of subparagraph (A) of this paragraph or that is described in clause (vi) may, pursuant to procedures prescribed by the Pension Benefit Guaranty Corporation, elect to be a multiemployer plan, if—

(aa) for each of the 3 plan years immediately preceding the first plan year for which the election under this paragraph is effective with respect to the plan, the plan has met those criteria or is so described,

(bb) substantially all of the plan's employer contributions for each of those plan years were made or required to be made by organizations that were exempt from tax under section 501 of the Internal Revenue Code of 1986, and

(cc) the plan was established prior to September 2, 1974.

(ii) An election under this subparagraph shall be effective for all purposes under this Act and under the Internal Revenue Code of 1986, starting with any plan year beginning on or after January 1, 1999, and ending before January 1, 2008, as designated by the plan in the election made under clause (i)(II).

(iii) Once made, an election under this subparagraph shall be irrevocable, except that a plan described in clause (i)(II) shall cease to be a multiemployer plan as of the plan year beginning immediately after the first plan year for which the majority of its employer contributions were made or required to be made by organizations that were not exempt from tax under section 501 of the Internal Revenue Code of 1986.

(iv) The fact that a plan makes an election under clause (i)(II) does not imply that the plan was not a multiemployer plan prior to the date of the election or would not be a multiemployer plan without regard to the election.

(v)(I) No later than 30 days before an election is made under this subparagraph, the plan administrator shall provide notice of the pending election to each plan participant and beneficiary, each labor organization representing such participants or beneficiaries, and each employer that has an obligation to contribute to the plan, describing the principal differences between the guarantee programs under title IV and the benefit restrictions under this title for single employer and multiemployer plans, along with such other information as the plan administrator chooses to include.

(II) Within 180 days after the date of enactment of the Pension Protection Act of 2006, the Secretary shall prescribe a model notice under this clause.

(III) A plan administrator's failure to provide the notice required under this subparagraph shall be treated for purposes of section 502(c)(2) as a failure or refusal by the plan administrator to file the annual report required to be filed with the Secretary under section 101(b)(1).

(vi) A plan is described in this clause if it is a plan sponsored by an organization which is described in section 501(c)(5) of the Internal Revenue Code of 1986 and exempt from tax under section 501(a) of such Code and which was established in Chicago, Illinois, on August 12, 1881.

(vii) For purposes of this Act and the Internal Revenue Code of 1986, a plan making an election under this subparagraph shall be treated as maintained pursuant to a collective bargaining agreement if a collective bargaining agreement, expressly or otherwise, provides for or permits employer contributions to the plan by one or more employers that are signatory to such agreement, or participation in the plan by one or more employees of an employer that is signatory to such agreement, regardless of whether the plan was created, established, or maintained for such employees by virtue of another document that is not a collective bargaining agreement.

(38) The term "investment manager" means any fiduciary (other than a trustee or named fiduciary, as defined in section 402(a)(2))—

(A) who has the power to manage, acquire, or dispose of any asset of a plan;

(B) who (i) is registered as an investment adviser under the Investment Advisers Act of 1940; (ii) is not registered as an investment adviser under such Act by reason of paragraph (1) of section 203A(a) of such Act, is registered as an investment adviser under the laws of the State (referred to in such paragraph (1)) in which it maintains its principal office and place of business, and, at the time the fiduciary last filed the registration form most recently filed by the fiduciary with such State in order to maintain the fiduciary's registration under the laws of such State, also filed a copy of such form with the Secretary; (iii) is a bank, as defined in that Act; or (iv) is an insurance company qualified to perform services described in subparagraph (A) under the laws of more than one State; and

(C) has acknowledged in writing that he is a fiduciary with respect to the plan.

(39) The terms "plan year" and "fiscal year of the plan" mean, with respect to a plan, the calendar, policy, or fiscal year on which the records of the plan are kept.

(40)(A) The term "multiple employer welfare arrangement" means an employee welfare benefit plan, or any other arrangement (other than an employee welfare benefit plan), which is established or maintained for the purpose of offering or providing any benefit described in paragraph (1) to the employees of two or more employers (including one or more self-employed individuals), or to their beneficiaries, except that such term does not include any such plan or other arrangement which is established or maintained—

(i) under or pursuant to one or more agreements which the Secretary finds to be collective bargaining agreements,

(ii) by a rural electric cooperative, or

(iii) by a rural telephone cooperative association.

(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 busi-*

nesses are within the same control group during such year or at any time during the preceding 1-year period,

(ii) the term "control group" means a group of trades or businesses under common control,

[(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) any organization which is exempt from tax under section 501(a) of the Internal Revenue Code of 1986 and which is engaged primarily in providing electric service on a mutual or cooperative basis, and

(II) any 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 described in subclause (I), and

[(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.

(41) SINGLE-EMPLOYER PLAN.—The term "single-employer plan" means an employee benefit plan other than a multiemployer plan.

(41) The term "single-employer plan" means a plan which is not a multiemployer plan.

(42) the term "plan assets" means plan assets as defined by such regulations as the Secretary may prescribe, except that under such regulations the assets of any entity shall not be treated as plan assets if, immediately after the most recent acquisition of any equity interest in the entity, less than 25 percent of the total value of each class of equity interest in the entity is held by benefit plan investors. For purposes of determinations pursuant to this paragraph, the value of any equity interest held by a person (other than such a benefit plan investor) who has discretionary authority or control with respect to the assets of the entity or any person who provides investment advice for a fee (direct or indirect) with respect to such assets, or any affiliate of such a person, shall be disregarded for purposes of calculating the 25 percent threshold. An entity shall be considered to hold plan assets only to the extent of the percentage of the equity interest held by benefit plan investors. For purposes of this paragraph, the term "benefit plan investor" means an employee benefit plan subject to part 4, any plan to which section 4975 of the Internal Revenue Code of 1986 applies, and any entity whose underlying assets include plan assets by reason of a plan's investment in such entity.

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SUBTITLE B—REGULATORY PROVISIONS

PART 1—REPORTING AND DISCLOSURE

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SUMMARY PLAN DESCRIPTION

SEC. 102. (a) A summary plan description of any employee benefit plan shall be furnished to participants and beneficiaries as provided in section 104(b). The summary plan description shall include the information described in subsection (b), shall be written in a manner calculated to be understood by the average plan participant, and shall be sufficiently accurate and comprehensive to reasonably apprise such participants and beneficiaries of their rights and obligations under the plan. A summary of any material modification in the terms of the plan and any change in the information required under subsection (b) shall be written in a manner calculated to be understood by the average plan participant and shall be furnished in accordance with section 104(b)(1).

(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)), 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), and if the employer so elects for purposes of complying with section 701(f)(3)(B)(i), the model notice applicable to the State in which the participants and beneficiaries reside. *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.*

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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 that violates section 519 shall upon conviction be imprisoned not more than 10 years or fined under title 18, United States Code, or both.

(c) 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) A civil action may be brought—

(1) by a participant or beneficiary—

(A) for the relief provided for in subsection (c) of this section, or

(B) to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan;

(2) by the Secretary, or by a participant, beneficiary or fiduciary for appropriate relief under section 409;

(3) by a participant, beneficiary, or fiduciary (A) to enjoin any act or practice which violates any provision of this title or the terms of the plan, or (B) to obtain other appropriate equitable relief (i) to redress such violations or (ii) to enforce any provisions of this title or the terms of the plan;

(4) by the Secretary, or by a participant, or beneficiary for appropriate relief in the case of a violation of 105(c);

(5) except as otherwise provided in subsection (b), by the Secretary (A) to enjoin any act or practice which violates any provision of this title, or (B) to obtain other appropriate equitable relief (i) to redress such violation or (ii) to enforce any provision of this title;

(6) by the Secretary to collect any civil penalty under paragraph (2), (4), (5), (6), (7), (8), or (9) of subsection (c) or under subsection (i) or (l);

(7) by a State to enforce compliance with a qualified medical child support order (as defined in section 609(a)(2)(A));

(8) by the Secretary, or by an employer or other person referred to in section 101(f)(1), (A) to enjoin any act or practice which violates subsection (f) of section 101, or (B) to obtain appropriate equitable relief (i) to redress such violation or (ii) to enforce such subsection;

(9) in the event that the purchase of an insurance contract or insurance annuity in connection with termination of an individual's status as a participant covered under a pension plan with respect to all or any portion of the participant's pension benefit under such plan constitutes a violation of part 4 of this title or the terms of the plan, by the Secretary, by any individual who was a participant or beneficiary at the time of the alleged violation, or by a fiduciary, to obtain appropriate relief, including the posting of security if necessary, to assure receipt by the participant or beneficiary of the amounts provided or to be provided by such insurance contract or annuity, plus reasonable prejudgment interest on such amounts;

(10) in the case of a multiemployer plan that has been certified by the actuary to be in endangered or critical status under section 305, if the plan sponsor—

(A) has not adopted a funding improvement or rehabilitation plan under that section by the deadline established in such section, or

(B) fails to update or comply with the terms of the funding improvement or rehabilitation plan in accordance with the requirements of such section,

by an employer that has an obligation to contribute with respect to the multiemployer plan or an employee organization that represents active participants in the multiemployer plan, for an order compelling the plan sponsor to adopt a funding improvement or rehabilitation plan or to update or comply with the terms of the funding improvement or rehabilitation plan in accordance with the requirements of such section and the funding improvement or rehabilitation plan; or

(11) in the case of a multiemployer plan, by an employee representative, or any employer that has an obligation to contribute to the plan, (A) to enjoin any act or practice which violates subsection (k) of section 101 (or, in the case of an employer, subsection (l) of such section), or (B) to obtain appropriate equitable relief (i) to redress such violation or (ii) to enforce such subsection.

(b)(1) In the case of a plan which is qualified under section 401(a), 403(a), or 405(a) of the Internal Revenue Code of 1986 (or with respect to which an application to so qualify has been filed and has not been finally determined) the Secretary may exercise his authority under subsection (a)(5) with respect to a violation of, or the enforcement of, parts 2 and 3 of this subtitle (relating to participation, vesting, and funding), only if—

(A) requested by the Secretary of the Treasury, or

(B) one or more participants, beneficiaries, or fiduciaries, of such plan request in writing (in such manner as the Secretary shall prescribe by regulation) that he exercise such authority on their behalf. In the case of such a request under this paragraph he may exercise such authority only if he determines that such violation affects, or such enforcement is necessary to protect, claims of participants or beneficiaries to benefits under the plan.

(2) The Secretary shall not initiate an action to enforce section 515.

(3) Except as provided in subsections (c)(9) and (a)(6) (with respect to collecting civil penalties under subsection (c)(9)), the Secretary is not authorized to enforce under this part any requirement of part 7 against a health insurance issuer offering health insurance coverage in connection with a group health plan (as defined in section 706(a)(1)). Nothing in this paragraph shall affect the authority of the Secretary to issue regulations to carry out such part.

(c)(1) Any administrator (A) who fails to meet the requirements of paragraph (1) or (4) of section 606, section 101(e)(1), section 101(f), or section 105(a) with respect to a participant or beneficiary, or (B) who fails or refuses to comply with a request for any information which such administrator is required by this title to furnish to a participant or beneficiary (unless such failure or refusal results from matters reasonably beyond the control of the administrator) by mailing the material requested to the last known address of the requesting participant or beneficiary within 30 days after

such request may in the court's discretion be personally liable to such participant or beneficiary in the amount of up to $100 a day from the date of such failure or refusal, and the court may in its discretion order such other relief as it deems proper. For purposes of this paragraph, each violation described in subparagraph (A) with respect to any single participant, and each violation described in subparagraph (B) with respect to any single participant or beneficiary, shall be treated as a separate violation.

(2) The Secretary may assess a civil penalty against any plan administrator of up to $1,000 a day from the date of such plan administrator's failure or refusal to file the annual report required to be filed with the Secretary under section 101(b)(1). For purposes of this paragraph, an annual report that has been rejected under section 104(a)(4) for failure to provide material information shall not be treated as having been filed with the Secretary.

(3) Any employer maintaining a plan who fails to meet the notice requirement of section 101(d) with respect to any participant or beneficiary or who fails to meet the requirements of section 101(e)(2) with respect to any person or who fails to meet the requirements of section 302(d)(12)(E) with respect to any person may in the court's discretion be liable to such participant or beneficiary or to such person in the amount of up to $100 a day from the date of such failure, and the court may in its discretion order such other relief as it deems proper.

(4) The Secretary may assess a civil penalty of not more than $1,000 a day for each violation by any person of subsection (j), (k), or (l) of section 101 or section 514(e)(3).

(5) The Secretary may assess a civil penalty against any person of up to $1,000 a day from the date of the person's failure or refusal to file the information required to be filed by such person with the Secretary under regulations prescribed pursuant to section 101(g).

(6) If, within 30 days of a request by the Secretary to a plan administrator for documents under section 104(a)(6), the plan administrator fails to furnish the material requested to the Secretary, the Secretary may assess a civil penalty against the plan administrator of up to $100 a day from the date of such failure (but in no event in excess of $1,000 per request). No penalty shall be imposed under this paragraph for any failure resulting from matters reasonably beyond the control of the plan administrator.

(7) The Secretary may assess a civil penalty against a plan administrator of up to $100 a day from the date of the plan administrator's failure or refusal to provide notice to participants and beneficiaries in accordance with subsection (i) or (m) of section 101. For purposes of this paragraph, each violation with respect to any single participant or beneficiary shall be treated as a separate violation.

(8) The Secretary may assess against any plan sponsor of a multiemployer plan a civil penalty of not more than $1,100 per day—

(A) for each violation by such sponsor of the requirement under section 305 to adopt by the deadline established in that section a funding improvement plan or rehabilitation plan with respect to a multiemployer plan which is in endangered or critical status, or

(B) in the case of a plan in endangered status which is not in seriously endangered status, for failure by the plan to meet the applicable benchmarks under section 305 by the end of the funding improvement period with respect to the plan.

(9)(A) The Secretary may assess a civil penalty against any employer of up to $100 a day from the date of the employer's failure to meet the notice requirement of section 701(f)(3)(B)(i)(I). For purposes of this subparagraph, each violation with respect to any single employee shall be treated as a separate violation.

(B) The Secretary may assess a civil penalty against any plan administrator of up to $100 a day from the date of the plan administrator's failure to timely provide to any State the information required to be disclosed under section 701(f)(3)(B)(ii). For purposes of this subparagraph, each violation with respect to any single participant or beneficiary shall be treated as a separate violation.

(10) SECRETARIAL ENFORCEMENT AUTHORITY RELATING TO USE OF GENETIC INFORMATION.—

(A) GENERAL RULE.—The Secretary may impose a penalty against any plan sponsor of a group health plan, or any health insurance issuer offering health insurance coverage in connection with the plan, for any failure by such sponsor or issuer to meet the requirements of subsection (a)(1)(F), (b)(3), (c), or (d) of section 702 or section 701 or 702(b)(1) with respect to genetic information, in connection with the plan.

(B) AMOUNT.—

(i) IN GENERAL.—The amount of the penalty imposed by subparagraph (A) shall be $100 for each day in the noncompliance period with respect to each participant or beneficiary to whom such failure relates.

(ii) NONCOMPLIANCE PERIOD.—For purposes of this paragraph, the term "noncompliance period" means, with respect to any failure, the period—

(I) beginning on the date such failure first occurs; and

(II) ending on the date the failure is corrected.

(C) MINIMUM PENALTIES WHERE FAILURE DISCOVERED.—Notwithstanding clauses (i) and (ii) of subparagraph (D):

(i) IN GENERAL.—In the case of 1 or more failures with respect to a participant or beneficiary—

(I) which are not corrected before the date on which the plan receives a notice from the Secretary of such violation; and

(II) which occurred or continued during the period involved;

the amount of penalty imposed by subparagraph (A) by reason of such failures with respect to such participant or beneficiary shall not be less than $2,500.

(ii) HIGHER MINIMUM PENALTY WHERE VIOLATIONS ARE MORE THAN DE MINIMIS.—To the extent violations for which any person is liable under this paragraph for any year are more than de minimis, clause (i) shall be applied by substituting "$15,000" for "$2,500" with respect to such person.

(D) LIMITATIONS.—

(i) PENALTY NOT TO APPLY WHERE FAILURE NOT DISCOVERED EXERCISING REASONABLE DILIGENCE.—No penalty shall be imposed by subparagraph (A) on any failure during any period for which it is established to the satisfaction of the Secretary that the person otherwise liable for such penalty did not know, and exercising reasonable diligence would not have known, that such failure existed.

(ii) PENALTY NOT TO APPLY TO FAILURES CORRECTED WITHIN CERTAIN PERIODS.—No penalty shall be imposed by subparagraph (A) on any failure if—

(I) such failure was due to reasonable cause and not to willful neglect; and

(II) such failure is corrected during the 30-day period beginning on the first date the person otherwise liable for such penalty knew, or exercising reasonable diligence would have known, that such failure existed.

(iii) OVERALL LIMITATION FOR UNINTENTIONAL FAILURES.—In the case of failures which are due to reasonable cause and not to willful neglect, the penalty imposed by subparagraph (A) for failures shall not exceed the amount equal to the lesser of—

(I) 10 percent of the aggregate amount paid or incurred by the plan sponsor (or predecessor plan sponsor) during the preceding taxable year for group health plans; or

(II) $500,000.

(E) WAIVER BY SECRETARY.—In the case of a failure which is due to reasonable cause and not to willful neglect, the Secretary may waive part or all of the penalty imposed by subparagraph (A) to the extent that the payment of such penalty would be excessive relative to the failure involved.

(F) DEFINITIONS.—Terms used in this paragraph which are defined in section 733 shall have the meanings provided such terms in such section.

(11) The Secretary and the Secretary of Health and Human Services shall maintain such ongoing consultation as may be necessary and appropriate to coordinate enforcement under this subsection with enforcement under section 1144(c)(8) of the Social Security Act.

(12) The Secretary may assess a civil penalty against any sponsor of a CSEC plan of up to $100 a day from the date of the plan sponsor's failure to comply with the requirements of section 306(j)(3) to establish or update a funding restoration plan.

(d)(1) An employee benefit plan may sue or be sued under this title as an entity. Service of summons, subpena, or other legal process of a court upon a trustee or an administrator of an employee benefit plan in his capacity as such shall constitute service upon the employee benefit plan. In a case where a plan has not designated in the summary plan description of the plan an individual as agent for the service of legal process, service upon the Secretary

shall constitute such service. The Secretary, not later than 15 days after receipt of service under the preceding sentence, shall notify the administrator or any trustee of the plan of receipt of such service.

(2) Any money judgment under this title against an employee benefit plan shall be enforceable only against the plan as an entity and shall not be enforceable against any other person unless liability against such person is established in his individual capacity under this title.

(e)(1) Except for actions under subsection (a)(1)(B) of this section, the district courts of the United States shall have exclusive jurisdiction of civil actions under this title brought by the Secretary or by a participant, beneficiary, fiduciary, or any person referred to in section 101(f)(1). State courts of competent jurisdiction and district courts of the United States shall have concurrent jurisdiction of actions under paragraphs (1)(B) and (7) of subsection (a) of this section.

(2) Where an action under this title is brought in a district court of the United States, it may be brought in the district where the plan is administered, where the breach took place, or where a defendant resides or may be found, and process may be served in any other district where a defendant resides or may be found.

(f) The district courts of the United States shall have jurisdiction, without respect to the amount in controversy or the citizenship of the parties, to grant the relief provided for in subsection (a) of this section in any action.

(g)(1) In any action under this title (other than an action described in paragraph (2)) by a participant, beneficiary, or fiduciary, the court in its discretion may allow a reasonable attorney's fee and costs of action to either party.

(2) In any action under this title by a fiduciary for or on behalf of a plan to enforce section 515 in which a judgment in favor of the plan is awarded, the court shall award the plan—

(A) the unpaid contributions,

(B) interest on the unpaid contributions,

(C) an amount equal to the greater of—

(i) interest on the unpaid contributions, or

(ii) liquidated damages provided for under the plan in an amount not in excess of 20 percent (or such higher percentage as may be permitted under Federal or State law) of the amount determined by the court under subparagraph (A),

(D) reasonable attorney's fees and costs of the action, to be paid by the defendant, and

(E) such other legal or equitable relief as the court deems appropriate.

For purposes of this paragraph, interest on unpaid contributions shall be determined by using the rate provided under the plan, or, if none, the rate prescribed under section 6621 of the Internal Revenue Code of 1986.

(h) A copy of the complaint in any action under this title by a participant, beneficiary, or fiduciary (other than an action brought by one or more participants or beneficiaries under subsection (a)(1)(B) which is solely for the purpose of recovering benefits due such participants under the terms of the plan) shall be served upon

the Secretary and the Secretary of the Treasury by certified mail. Either Secretary shall have the right in his discretion to intervene in any action, except that the Secretary of the Treasury may not intervene in any action under part 4 of this subtitle. If the Secretary brings an action under subsection (a) on behalf of a participant or beneficiary, he shall notify the Secretary of the Treasury.

(i) In the case of a transaction prohibited by section 406 by a party in interest with respect to a plan to which this part applies, the Secretary may assess a civil penalty against such party in interest. The amount of such penalty may not exceed 5 percent of the amount involved in each such transaction (as defined in section 4975(f)(4) of the Internal Revenue Code of 1986) for each year or part thereof during which the prohibited transaction continues, except that, if the transaction is not corrected (in such manner as the Secretary shall prescribe in regulations which shall be consistent with section 4975(f)(5) of such Code) within 90 days after notice from the Secretary (or such longer period as the Secretary may permit), such penalty may be in an amount not more than 100 percent of the amount involved. This subsection shall not apply to a transaction with respect to a plan described in section 4975(e)(1) of such Code.

(j) In all civil actions under this title, attorneys appointed by the Secretary may represent the Secretary (except as provided in section 518(a) of title 28, United States Code), but all such litigation shall be subject to the direction and control of the Attorney General.

(k) Suits by an administrator, fiduciary, participant, or beneficiary of an employee benefit plan to review a final order of the Secretary, to restrain the Secretary from taking any action contrary to the provisions of this Act, or to compel him to take action required under this title, may be brought in the district court of the United States for the district where the plan has its principal office, or in the United States District Court for the District of Columbia.

(l)(1) In the case of—

(A) any breach of fiduciary responsibility under (or other violation of) part 4 by a fiduciary, or

(B) any knowing participation in such a breach or violation by any other person,

the Secretary shall assess a civil penalty against such fiduciary or other person in an amount equal to 20 percent of the applicable recovery amount.

(2) For purposes of paragraph (1), the term "applicable recovery amount" means any amount which is recovered from a fiduciary or other person with respect to a breach or violation described in paragraph (1)—

(A) pursuant to any settlement agreement with the Secretary, or

(B) ordered by a court to be paid by such fiduciary or other person to a plan or its participants and beneficiaries in a judicial proceeding instituted by the Secretary under subsection (a)(2) or (a)(5).

(3) The Secretary may, in the Secretary's sole discretion, waive or reduce the penalty under paragraph (1) if the Secretary determines in writing that—

(A) the fiduciary or other person acted reasonably and in good faith, or

(B) it is reasonable to expect that the fiduciary or other person will not be able to restore all losses to the plan (or to provide the relief ordered pursuant to subsection (a)(9)) without severe financial hardship unless such waiver or reduction is granted.

(4) The penalty imposed on a fiduciary or other person under this subsection with respect to any transaction shall be reduced by the amount of any penalty or tax imposed on such fiduciary or other person with respect to such transaction under subsection (i) of this section and section 4975 of the Internal Revenue Code of 1986.

(m) In the case of a distribution to a pension plan participant or beneficiary in violation of section 206(e) by a plan fiduciary, the Secretary shall assess a penalty against such fiduciary in an amount equal to the value of the distribution. Such penalty shall not exceed $10,000 for each such distribution.

(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) provide adequate notice in writing to any participant or beneficiary whose claim for benefits under the plan has been denied, setting forth the specific reasons for such denial, writ-

ten in a manner calculated to be understood by the participant, and

(2) afford a reasonable opportunity to any participant whose claim for benefits has been denied for a full and fair review by the appropriate named fiduciary of the decision denying the claim.

(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) COORDINATION WITH OTHER AGENCIES AND DEPARTMENTS.—In order to avoid unnecessary expense and duplication of functions among Government agencies, the Secretary may make such arrangements or agreements for cooperation or mutual assistance in the performance of his functions under this title and the functions of any such agency as he may find to be practicable and consistent with law. The Secretary may utilize, on a reimbursable or other basis, the facilities or services of any department, agency, or establishment of the United States or of any State or political subdivision of a State, including the services of any of its employees, with the lawful consent of such department, agency, or establishment; and each department, agency, or establishment of the United States is authorized and directed to cooperate with the Secretary and, to the extent permitted by law, to provide such information and facilities as he may request for his assistance in the performance of his functions under this title. The Attorney General or his representative shall receive from the Secretary for appropriate action such evidence developed in the performance of his functions under this title as may be found to warrant consideration for criminal prosecution under the provisions of this title or other Federal law.

(b) RESPONSIBILITY FOR DETECTING AND INVESTIGATING CIVIL AND CRIMINAL VIOLATIONS OF EMPLOYEE RETIREMENT INCOME SECURITY ACT AND RELATED FEDERAL LAWS.—The Secretary shall have the responsibility and authority to detect and investigate and refer, where appropriate, civil and criminal violations related to the provisions of this title and other related Federal laws, including the detection, investigation, and appropriate referrals of related violations of title 18 of the United States Code. Nothing in this subsection shall be construed to preclude other appropriate Federal agencies from detecting and investigating civil and criminal violations of this title and other related Federal laws.

(c) COORDINATION OF ENFORCEMENT WITH STATES WITH RESPECT TO CERTAIN ARRANGEMENTS.—A State may enter into an agreement with the Secretary for delegation to the State of some or all of the Secretary's authority under sections 502 and 504 to enforce the requirements under part 7 in connection with multiple em-

ployer welfare arrangements, providing medical care (within the meaning of section 733(a)(2)), which are not group health plans.

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

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

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

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

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

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

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

* * * * * * *

EFFECT ON OTHER LAWS

SEC. 514. (a) Except as provided in subsection (b) of this section, the provisions of this title and title IV shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan described in section 4(a) and not exempt under section 4(b). This section shall take effect on January 1, 1975.

(b)(1) This section shall not apply with respect to any cause of action which arose, or any act or omission which occurred, before January 1, 1975.

(2)(A) Except as provided in subparagraph (B), nothing in this title shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities.

(B) Neither an employee benefit plan described in section 4(a), which is not exempt under section 4(b) (other than a plan established primarily for the purpose of providing death benefits), nor any trust established under such a plan, shall be deemed to be an insurance company or other insurer, bank, trust company, or investment company or to be engaged in the business of insurance or banking for purposes of any law of any State purporting to regulate insurance companies, insurance contracts, banks, trust companies, or investment companies.

(3) Nothing in this section shall be construed to prohibit use by the Secretary of services or facilities of a State agency as permitted under section 506 of this Act.

(4) **[**Subsection (a)**]** *Subsections (a) and (f)* 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) any State tax law relating to employee benefit plans, or

(ii) any amendment of the Hawaii Prepaid Health Care Act enacted after September 2, 1974, to the extent it provides for more than the effective administration of such Act as in effect on such date.

(C) Notwithstanding subparagraph (A), parts 1 and 4 of this subtitle, and the preceding sections of this part to the extent they govern matters which are governed by the provisions of such parts 1 and 4, shall supersede the Hawaii Prepaid Health Care Act (as in effect on or after the date of the enactment of this paragraph), but the Secretary may enter into cooperative arrangements under this paragraph and section 506 with officials of the State of Hawaii to assist them in effectuating the policies of provisions of such Act which are superseded by such parts 1 and 4 and the preceding sections of this part.

(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) standards, requiring the maintenance of specified levels of reserves and specified levels of contributions, which any such plan, or any trust established under such a plan, must meet in order to be considered under such law able to pay benefits in full when due, and

(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.

(B) The Secretary may, under regulations which may be prescribed by the Secretary, exempt from subparagraph (A)(ii), individually or by class, multiple employer welfare arrangements which are not fully insured. Any such exemption may be granted with respect to any arrangement or class of arrangements only if such arrangement or each arrangement which is a member of such class meets the requirements of section 3(1) and section 4 necessary to be considered an employee welfare benefit plan to which this title applies.

(C) Nothing in subparagraph (A) shall affect the manner or extent to which the provisions of this title apply to an employee welfare benefit plan which is not a multiple employer welfare arrangement and which is a plan, fund, or program participating in, subscribing to, or otherwise using a multiple employer welfare arrangement to fund or administer benefits to such plan's participants and beneficiaries.

(D) For purposes of this paragraph, a multiple employer welfare arrangement shall be considered fully insured only if the terms of the arrangement provide for benefits the amount of all of which the Secretary determines are guaranteed under a contract, or policy of insurance, issued by an insurance company, insurance service, or insurance organization, qualified to conduct business in a State.

(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.

(7) Subsection (a) shall not apply to qualified domestic relations orders (within the meaning of section 206(d)(3)(B)(i)), qualified medical child support orders (within the meaning of section 609(a)(2)(A)), and the provisions of law referred to in section 609(a)(2)(B)(ii) to the extent they apply to qualified medical child support orders.

(8) Subsection (a) of this section shall not be construed to preclude any State cause of action—

(A) with respect to which the State exercises its acquired rights under section 609(b)(3) with respect to a group health plan (as defined in section 607(1)), or

(B) for recoupment of payment with respect to items or services pursuant to a State plan for medical assistance approved under title XIX of the Social Security Act which would not have been payable if such acquired rights had been executed before payment with respect to such items or services by the group health plan.

(9) For additional provisions relating to group health plans, see section 731.

(c) For purposes of this section:

(1) The term "State law" includes all laws, decisions, rules, regulations, or other State action having the effect of law, of any State. A law of the United States applicable only to the District of Columbia shall be treated as a State law rather than a law of the United States.

(2) The term "State" includes a State, any political subdivisions thereof, or any agency or instrumentality of either, which purports to regulate, directly or indirectly, the terms and conditions of employee benefit plans covered by this title.

(d) **[**Nothing**]** *(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 2017 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.

(e)(1) Notwithstanding any other provision of this section, this title shall supersede any law of a State which would directly or indirectly prohibit or restrict the inclusion in any plan of an automatic contribution arrangement. The Secretary may prescribe regulations which would establish minimum standards that such an arrangement would be required to satisfy in order for this subsection to apply in the case of such arrangement.

(2) For purposes of this subsection, the term "automatic contribution arrangement" means an arrangement—

(A) under which a participant may elect to have the plan sponsor make payments as contributions under the plan on behalf of the participant, or to the participant directly in cash,

(B) under which a participant is treated as having elected to have the plan sponsor make such contributions in an amount equal to a uniform percentage of compensation provided under the plan until the participant specifically elects not to have such contributions made (or specifically elects to have such contributions made at a different percentage), and

(C) under which such contributions are invested in accordance with regulations prescribed by the Secretary under section 404(c)(5).

(3)(A) The plan administrator of an automatic contribution arrangement shall, within a reasonable period before such plan year, provide to each participant to whom the arrangement applies for such plan year notice of the participant's rights and obligations under the arrangement which—

(i) is sufficiently accurate and comprehensive to apprise the participant of such rights and obligations, and

(ii) is written in a manner calculated to be understood by the average participant to whom the arrangement applies.

(B) A notice shall not be treated as meeting the requirements of subparagraph (A) with respect to a participant unless—

(i) the notice includes an explanation of the participant's right under the arrangement not to have elective contributions made on the participant's behalf (or to elect to have such contributions made at a different percentage),

(ii) the participant has a reasonable period of time, after receipt of the notice described in clause (i) and before the first elective contribution is made, to make such election, and

(iii) the notice explains how contributions made under the arrangement will be invested in the absence of any investment election by the participant.

(f)(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.

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PART 7—GROUP HEALTH PLAN REQUIREMENTS

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SUBPART C—GENERAL PROVISIONS

SEC. 731. PREEMPTION; STATE FLEXIBILITY; CONSTRUCTION.

(a) CONTINUED APPLICABILITY OF STATE LAW WITH RESPECT TO HEALTH INSURANCE ISSUERS.—

(1) IN GENERAL.—Subject to paragraph (2) and except as provided in subsection (b), this part shall not be construed to supersede any provision of State law which establishes, implements, or continues in effect any standard or requirement solely relating to health insurance issuers in connection with group health insurance coverage except to the extent that such standard or requirement prevents the application of a requirement of this part.

(2) CONTINUED PREEMPTION WITH RESPECT TO GROUP HEALTH PLANS.—Nothing in this part shall be construed to affect or modify the provisions of section 514 with respect to group health plans.

(b) SPECIAL RULES IN CASE OF PORTABILITY REQUIREMENTS.—

(1) IN GENERAL.—Subject to paragraph (2), the provisions of this part relating to health insurance coverage offered by a

health insurance issuer supersede any provision of State law which establishes, implements, or continues in effect a standard or requirement applicable to imposition of a preexisting condition exclusion specifically governed by section 701 which differs from the standards or requirements specified in such section.

(2) EXCEPTIONS.—Only in relation to health insurance coverage offered by a health insurance issuer, the provisions of this part do not supersede any provision of State law to the extent that such provision—

(A) substitutes for the reference to "6-month period" in section 701(a)(1) a reference to any shorter period of time;

(B) substitutes for the reference to "12 months" and "18 months" in section 701(a)(2) a reference to any shorter period of time;

(C) substitutes for the references to "63 days" in sections 701 (c)(2)(A) and (d)(4)(A) a reference to any greater number of days;

(D) substitutes for the reference to "30-day period" in sections 701 (b)(2) and (d)(1) a reference to any greater period;

(E) prohibits the imposition of any preexisting condition exclusion in cases not described in section 701(d) or expands the exceptions described in such section;

(F) requires special enrollment periods in addition to those required under section 701(f); or

(G) reduces the maximum period permitted in an affiliation period under section 701(g)(1)(B).

(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.

(d) DEFINITIONS.—For purposes of this section—

(1) STATE LAW.—The term "State law" includes all laws, decisions, rules, regulations, or other State action having the effect of law, of any State. A law of the United States applicable only to the District of Columbia shall be treated as a State law rather than a law of the United States.

(2) STATE.—The term "State" includes a State, the Northern Mariana Islands, any political subdivisions of a State or such Islands, or any agency or instrumentality of either.

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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 pro-

viding 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 2017.

(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.

(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; food service 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 2017.

(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 2017, 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 as-

sociation health plan, from exercising its sole discretion in selecting the specific items and services consisting of medical care to be included as benefits under such plan or coverage, except (subject to section 514) in the case of (1) any law to the extent that it is not preempted under section 731(a)(1) with respect to matters governed by section 711, 712, or 713, or (2) any law of the State with which filing and approval of a policy type offered by the plan was initially obtained to the extent that such law prohibits an exclusion of a specific disease from such coverage.

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

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

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

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

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

(i) a reserve sufficient for unearned contributions;

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

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

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

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

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

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

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

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

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

(1) $500,000, or

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

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

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

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

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

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

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

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

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

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

(3) ASSOCIATION HEALTH PLAN FUND.—

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

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

as the Secretary determines advisable by the Secretary of the Treasury in obligations issued or guaranteed by the United States.

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

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

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

(B) which is guaranteed renewable; and

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

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

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

(B) which is guaranteed renewable; and

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

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

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

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

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

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

(j) SOLVENCY STANDARDS WORKING GROUP.—

(1) IN GENERAL.—Within 90 days after the date of the enactment of the Small Business Health Fairness Act of 2017, 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.

(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 recommenda-

tions 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 sec-

tion, 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 2017.

(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 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 2017, a person eligible to be a member of the sponsor or one of its member associations.

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

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

(b) RULES OF CONSTRUCTION.—

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

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

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

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

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MINORITY VIEWS

INTRODUCTION

Committee Democrats oppose H.R. 1101, the *Small Business Health Fairness Act* because it puts comprehensive and affordable coverage for small businesses and their employees at risk. Committee Democrats were also concerned about the Majority's insistence on considering health-related legislation while two other Committees (Energy and Commerce and Ways and Means) simultaneously considered legislation to gut the Affordable Care Act (ACA).

BEFORE THE AFFORDABLE CARE ACT WORKERS HAD FEW OPTIONS

Before the ACA, employer-provided coverage was shrinking and costs were increasing dramatically. From 1999 to 2010, the cost of premiums for employer-provided health insurance increased by 138%.[1] Additionally, workers often had limited options for affordable health insurance. Those who were employed were often locked in to their employment for fear of losing their health insurance, even if they wanted to retire, work part-time, or start a new business, due to inadequate coverage options outside the employer-sponsored system. Workers with pre-existing conditions were particularly disadvantaged, since they could be charged higher rates or denied coverage altogether in the individual market. Even those with comprehensive and affordable job-based health insurance saw higher premiums due to the high number of uninsured. Estimates show that every American family with insurance had to pay a hidden tax of roughly $1,000 for the cost of caring for people without insurance.[2]

Businesses were also struggling before the ACA. Historically, small businesses were charged more for the same benefits compared to large employers. Small businesses employing women or workers with chronic or high-cost illnesses were charged higher insurance rates in many states. Therefore, a single sick or older employee could make health insurance unaffordable. Because small employers have fewer employees to spread risk across than larger employers, premiums varied dramatically from year to year due to changes in workers' health status.

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[1] Kaiser Family Foundation, *Snapshots: Employer Health Insurance Costs and Worker Compensation*, (February 27, 2011) available at: *http://kff.org/health-costs/issue-brief/snapshots-employer-health-insurance-costs-and-worker-compensation/*.

[2] Families USA, *Hidden Tax: Americans Pay a Premium*, (2009) available at: *http://familiesusa.org/sites/default/files/product_*documents/hidden-health-tax.pdf.

PROGRESS OF THE ACA HELPS SMALL BUSINESSES & WORKING FAMILIES

The ACA took steps to level the playing field. The ACA added reforms to ensure that one small business with an older or sick employee or owner is not disadvantaged compared to other small businesses. The medical loss ratio provision of the ACA requires insurance, including plans that cover small businesses, to spend at least 80% of premiums on health care claims and quality improvement, ensuring that premium dollars go toward the actual health costs of covering the small business and its employees, and not just profits. Further, the ACA created more options for employers and workers through the creation of the Small Business Health Options Program (SHOP) and included a tax credit to defray the cost of health insurance for their employees.

The ACA also establishes several safeguards for workers and families. Thanks to the ACA, most insurance plans must now provide coverage without cost sharing for certain preventive health services, including pap smears and mammograms for women, well-child visits, flu shots, and more. Early estimates after the ACA's passage showed that there were around 129 million Americans with a pre-existing condition, 82 million of whom were enrolled in employer-based coverage.[3] For these millions of American workers, the ACA means that losing a job does not mean losing health insurance coverage. "Job lock" has been reduced, allowing workers to structure their careers in ways that make sense for them. This is particularly important for young workers, who are very often in school or making the early career choices that have a long-term impact on their careers. This is also important for entrepreneurs who want to start their own business.

THE REPUBLICAN REPLACEMENT PLAN THREATENS THE HEALTH INSURANCE SECURITY OF AMERICAN FAMILIES

Two days prior to the Committee's consideration of the three bills, Republicans released their ACA replacement plan, the *American Health Care Act*. The Ways and Means and Energy and Commerce Committees moved the bill forward through the Committee process, despite the fact that the Congressional Budget Office had not yet released estimates on the legislation's impact on coverage or cost. Committee Democrats expressed their concern about the lack of transparency in moving the bill forward and also further expressed concern that the markup in the Education and the Workforce Committee occurred simultaneous to this process—essentially forcing the Committee to consider legislation that represents a moving target.

The *American Health Care Act* is an inadequate and unacceptable replacement plan. The legislation eliminates the ACA premium tax credits that millions of Americans depend on to pay for health coverage, in favor of a completely inadequate flat tax credit that leaves working families totally exposed to premium increases. The tax credits provided by the Affordable Care Act are based on

[3] Department of Health and Human Services, At Risk: Pre-Existing Conditions Could Affect 1 in 2 Americans: 129 Million People Could be Denied Affordable Coverage Without Health Reform, (November 1, 2011) available at: https://aspe.hhs.gov/sites/default/files/pdf/76376/index.pdf.

income and are also tied to the cost of insurance premiums. In general, the lower an individual's income, the larger the tax credit and the more expensive the premium, the larger the credit. Therefore, the tax credit adapts to address the situation of the individual. However, under the Republican's plan, the credits range from $2,000 to $4,000 depending on age, but do not take into account income or the cost of a typical plan in the area.

In addition, the bill dismantles Medicaid as we know it, endangering the health of 70 million Americans who rely on Medicaid, including seniors with long-term care needs, Americans with disabilities, pregnant women, and vulnerable children. Further, under the Republican bill, American workers could see their premiums and deductibles skyrocket. Also, the American public will have fewer protections—including losing the full protection of the ACA's prohibition against insurers discriminating against people with pre-existing conditions under all circumstances. While Republicans increase health costs for many working families, they give tax breaks to the wealthy.

Older Americans will be forced to pay premiums five times higher than what others pay for health coverage, undoing the current limitation that stipulates that older individuals can only be charged three times more than young enrollees are charged. The Republican bill also shortens the life of the Medicare Trust Fund.[4] Additionally, the bill includes a provision to defund Planned Parenthood for a year, threatening the health care of millions of women and men throughout the country.

The Congressional Budget Office's analysis of the proposal—released after Committee consideration—verified that 24 million more would be uninsured by 2026 under the Republican health care plan.[5] The report also showed that seven million fewer individuals would be enrolled in employer-sponsored insurance.[6] Further, the report demonstrated that millions would be worse off under the Republican plan and that millions more will end up paying more for less coverage.

For these abovementioned reasons, hospitals, providers, consumer groups and advocacy groups are opposing Republicans' attempts to cause irreparable harm to the health and financial security of Americans. AARP stated that, ". . . [the] bill would weaken Medicare's fiscal sustainability, dramatically increase health care costs for Americans aged 50–64, and put at risk the health care of millions of children and adults with disabilities, and poor seniors who depend on the Medicaid program for long-term services and supports and other benefits."[7] The AFL–CIO maintained that, "The reality is, this isn't a healthcare plan at all. It's a massive

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[4] Center on Budget and Policy Priorities, *House Republican Health Plan Would Weaken Medicare*, (March 14, 2017) available at: *http://www.cbpp.org/blog/house-republican-health-plan-would-weaken-medicare.*

[5] Congressional Budget Office, *Cost Estimate of the American Health Care Act*, (March 13, 2017) available at: *https://www.cbo.gov/sites/default/files/115th-congress-2017-2018/costestimate/americanhealthcareact*_0.pdf.

[6] *Id.*

[7] AARP, *Letter to Chairmen and Ranking Members of the Energy and Commerce and Ways and Means Committees*, (March 7, 2017) available at: http://www.aarp.org/content/dam/aarp/politics/advocacy/2017/03/aarp-letter-to-congress-on-american-healthcare-act-march-07-2017.pdf.

transfer of wealth from working people to Wall Street."[8] The Consortium for Citizens with Disabilities stated that, "[it is] simply unconscionable to pay for the repeal of the Affordable Care Act (ACA) by cutting services for low income individuals with disabilities, adults, older adults, and children."[9] Due to its glaring shortcomings, the American Hospital Association has stated that it, ". . . cannot support The American Health Care Act in its current form."[10]

H.R. 1101 Will Create Market Fragmentation and Threaten Benefits

Part of the Republican's repeal and replace effort is centered around expanding association health plans (AHPs). Association health plans are groups of small employer groups or individuals that band together to obtain health insurance. Proponents argue that AHPs would expand access and drive down costs, resulting in more health coverage options. However, there are likely to be winners and losers under this approach and many workers and employers will be left out in the cold.

Association health plans are not a new idea. In fact, they have been studied at length, including in a 2000 CBO report that found that they would have almost no impact in increasing health coverage.[11] Instead, they are likely to exacerbate adverse selection and shift costs on to workers. Although AHPs would be offered in competition with other small group and individual market plans, they would operate under different rules. This would fragment the market as lower-cost groups and individuals would move to establish an AHP, and higher-cost groups and individuals would remain stuck in traditional insurance plans. Such adverse selection would result in higher premiums in non-AHP plans. Ultimately, higher-cost (sicker or older) groups could find it more difficult to obtain coverage.[12]

With the passage of the ACA, health insurance sold through an association to individuals and small employers generally must meet the same insurance standards of coverage sold in the individual and small group market. The *Small Business Fairness Act,* introduced by Representatives Johnson and Walberg, essentially unravels these protections and allows association health plans to play by different rules. For example, they can evade state-mandated benefits and consumer protections. Therefore, those in an AHP may lose out on certain benefits and they may not be aware of that fact. While AHPs may save money if they do not have to bear the costs of these consumer protections, AHP enrollees are

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[8] AFL–CIO, *Press release: GOP Healthcare Plan Taxes Workers and Destroys Care*, (March 7, 2017) available at: http://www.aflcio.org/Press-Room/Press-Releases/GOP-Healthcare-Plan-Taxes-Workers-and-Destroys-Care.

[9] Consortium for Citizens with Disabilities, *Statement: CCD Responds To American Health Care Act*, (March 8, 2017) available at: http://www.c-c-d.org/fichiers/House-statement-3-8-final.pdf.

[10] American Hospital Association, *Letter to Congress*, (March 7, 2017) available at: http://www.aha.org/advocacy-issues/letter/2017/170307-let-aha-house-ahca.pdf.

[11] Congressional Budget Office, *Increasing Small-Firm Health Insurance Coverage Through Association Health Plans and HealthMarts, (January 2000)* available at: https://www.cbo.gov/sites/default/files/106th-congress-1999-2000/reports/healthins.pdf.

[12] The American Academy of Actuaries, *Issue Brief: Association Health Plans,* (February 2017) available at: http://www.actuary.org/content/association-health-plans-0.

likely to incur substantial costs for non-covered services down the road when it is too late for recourse.[13]

Committee Democrats have concerns about the impact that association health plans will have on businesses and workers. The legislation is opposed by a number of consumer and advocacy groups, including the Main Street Alliance and the National Association of Insurance Commissioners. Further, the American Academy of Actuaries outlined in its comment letter to Chairwoman Foxx and Ranking Member Scott that, "the bill as currently written will likely have unintended consequences . . . [14]

H.R. 1101 Gambles With the Financial Security of Both Workers and Employers

There are grave concerns around the solvency of association health plans. The history of multiple employer welfare arrangements (MEWAs) offers insight into the financial challenges that AHPs could face. In 2001, Sunkist Growers, Inc., a licensed MEWA in California covering 23,000 people, became insolvent.[15] When New Jersey's Coalition of Automotive Retailers, a longstanding MEWA that covered 20,000 people, became insolvent in 2002, it had $15 million in outstanding medical bills.[16] For years, self-funded MEWAs had no clear regulatory authority and multiple MEWA bankruptcies resulted. Recognizing that it was both appropriate and necessary for states to be able to establish, apply, and enforce state insurance laws with respect to MEWAs, Congress amended ERISA in 1983 to provide an exception to ERISA's broad preemption provisions by specifically allowing for state regulation of MEWAs. Unfortunately, HR 1101 prohibits state regulation of AHPs, so if the bill is enacted, AHPs will not be covered by state regulations which generally govern consumer protections and solvency requirements.[17]

H.R. 1101 allows AHPs to form under limited regulation and oversight, hearkening back to the time when MEWAs also enjoyed limited regulation and gambled with the financial security of both workers and employers. AHPs threaten both employers and workers and have been soundly dismissed as doing little to actually improve coverage or decrease costs in a sustainable way.

Committee Consideration of H.R. 1101

During Committee consideration, Representative Wilson offered an amendment that expressed a sense of Congress that any health care insurance legislation should build on the current progress of the ACA with CBO's analysis that demonstrates improvements in cost and coverage. That amendment was withdrawn.

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[13] *Id.*

[14] American Academy of Actuaries, *Letter to Chairwoman Foxx and Ranking Member Scott Re: Markup of H.R. 1101,* the Small Business Health Fairness Act of 2017, (March 8, 2017).

[15] The Commonwealth Fund, *MEWAs: The Threat of Plan Insolvency and Other Challenges,* (March 2004) available at: http://www.commonwealthfund.org/usr_doc/kofman_mewas.pdf.

[16] *Id.*

[17] United States Department of Labor, *MEWAs—Multiple Employer Welfare Arrangements under the Employee Retirement Income Security Act (ERISA): A Guide to Federal and State Regulation,* (August 2013) available at: https://www.dol.gov/sites/default/files/ebsa/about-ebsa/our-activities/enforcement/healthcare-fraud/mewa-under-erisa-a-guide-to-federal-and-state-regulation.pdf; Amendments enacted as part of Public Law 97–473, available at: https://www.gpo.gov/fdsys/pkg/STATUTE-96/pdf/STATUTE-96-Pg2605.pdf.

Several Committee Democrats offered amendments to ensure that association health plans did not unduly disadvantage certain pockets of small businesses and workers. Ranking Member Scott offered an amendment prohibiting the legislation from taking place if CBO determined small group market premiums would rise as a result of the legislation. In his remarks, Ranking Member Scott underscored the potential impact of AHPs on small group market premiums saying, "The reason people want to join an association is because they will be in a pool with younger, healthier people whose healthcare costs are less than average. Of course, no one would form an association for this purpose with people who have above average costs because it would be cheaper for them to just stay in the insurance pool and pay the average rate. So these association plans with healthier people will always work for those lucky enough to get in. But if you have all these healthy, cheaper people in an association, then that leaves those left behind with higher costs in the small group market and then the premiums for the small group market go up. It is simple arithmetic."

Representative Bonamici offered an amendment to require the legislation only take effect if CBO determined premiums for older workers would not increase. Representative Bonamici remarked, "Proponents of the bill argue that association health plans would expand the access and drive down costs. Is that the case for the young and the healthy? Well, what guarantee would older participants have that their costs will go down as well, that they will not be discriminated against? I have concerns that this legislation would actually make it more difficult for people who truly need coverage, older Americans, and that they would be losers."

Representative Norcross offered an amendment to prohibit the legislation from taking effect if the CBO determined that premiums for the middle class increased under the legislation. In offering his amendment, Representative Norcross stated, "I believe together we can make healthcare work better for working families. We can continue to protect those with preexisting conditions, protect women, and lower the cost. So let us put this into action, let us put partisanship aside, and focus on solutions we both can agree to. I hope you will join me in supporting this amendment, which will give Americans peace of mind that their premiums will not go up." These amendments were withdrawn due to germaneness concerns, but Committee Democrats remain troubled about the impact that AHPs would have on the affordability of coverage for certain workers. Underscoring these concerns, the Main Street Alliance asserts that, "H.R. 1101 would result in higher premiums and poorer coverage for the most vulnerable small business owners."[18] The National Association of Insurance Commissioners asserts that AHPs create a situation where "unhealthy groups are disadvantaged."[19]

Committee Democrats also recognize that the loss of state mandated benefits and consumer protections threaten comprehensive services for workers and small businesses in AHPs. Representative

[18] The Main Street Alliance, *Letter to Chairwoman Foxx and Ranking Member Scott,* (March 8, 2017) available at: https://d3n8a8pro7vhmx.cloudfront.net/mainstreetalliance/pages/487/attachments/original/1489503369/letteropposingHR1101.pdf?1489503369.

[19] National Association of Insurance Commissioners, *Letter to Chairwoman Foxx and Ranking Member Scott,* (February 28, 2017) available at: http://www.naic.org/documents/health_archive_naic_opposes_small_business_fairness_act.pdf.

Shea-Porter offered an amendment that was withdrawn, to ensure that substance abuse disorder coverage and treatment is not compromised through the expansion of AHPs. Representative Shea-Porter stated, "The fight against the heroin, fentanyl, and prescription opioid epidemic is multipronged, but it rests on a base of widespread access to coverage and care. . . My amendment would defend the gains we have made by ensuring that today's bill would not reduce access to substance use disorder treatment. Let us not pull the rug out from under people who are about to turn their lives around."

Representative Davis also offered an amendment to ensure that association health plans cover needed health services for women, such as maternity care and direct access to OB–GYN services. In offering her amendment Representative Davis stated, "Madame Chairwoman, we know from our own hearing the other day that these provisions are extremely popular. Both the witnesses from Democratic and Republican staffs suggested that these minimum essential benefits should continue to be offered. So that is why I am so concerned that the bill before us could allow association health plans to be offered that do not offer some of these essential benefits and protections for women . . . My colleagues insist that expanding unregulated association health plans is about choice. I can tell you, I am all about expanding choices in health care coverage, but not if it means giving plans the choice to charge women more for the services they need . . . [the amendment] says that reductions in coverage for maternity care or women's preventive health services or limits to direct access to OB–GYN care is not basically the intent of this legislation. This really is an opportunity for all of us to show our seriousness about women's health." The amendment failed on a party line vote (17–22).

Representative Polis offered two additional amendments to allow prescription drug importation and support hospital pricing transparency. Both amendments were withdrawn.

H.R. 1101 was favorably reported, as amended, on a party line vote (22–17) with all Democratic Members opposing.

CONCLUSION

After seven years of disparaging the ACA, Republicans released a repeal and replacement plan that will leave millions of Americans worse off. Meanwhile, the *Small Business Health Fairness Act* would erode the protections in the ACA and leave small businesses and their workers vulnerable to unaffordable health coverage and fewer benefits. Association health plans let the fortunate few form an association where they are able to pay less than average, but everyone else outside of the association will have to pay more. The Committee should protect the progress of the ACA and work to improve and expand coverage; the expansion of AHPs will only threaten affordable coverage for those outside of the associations. Committee Democrats are committed to health care as a right, not a privilege for only the healthiest and wealthiest Americans.

ROBERT C. "BOBBY" SCOTT,
Ranking Member.
RAÚL M. GRIJALVA.

MARCIA L. FUDGE.
GREGORIO KILILI CAMACHO SABLAN.
SUZANNE BONAMICI.
ALMA S. ADAMS.
DONALD NORCROSS.
RAJA KRISHNAMOORTHI.
ADRIANO ESPAILLAT.
SUSAN A. DAVIS.
JOE COURTNEY.
JARED POLIS.
FREDERICA S. WILSON.
MARK TAKANO.
MARK DESAULNIER.
LISA BLUNT-ROCHESTER.
CAROL SHEA PORTER.

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