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HOUSE OF REPRESENTATIVES
REPORT
118–112

ASSOCIATION HEALTH PLANS ACT

JUNE 14, 2023.—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. 2868]

[Including cost estimate of the Congressional Budget Office]

The Committee on Education and the Workforce, to whom was referred the bill (H.R. 2868) to amend the Employee Retirement Income Security Act of 1974 to clarify the treatment of certain association health plans as employers, and for other purposes, having considered the same, reports favorably thereon with an amendment and recommends 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.

This Act may be cited as the "Association Health Plans Act".

SEC. 2. TREATMENT OF GROUP OR ASSOCIATION OF EMPLOYERS.

(a) IN GENERAL.—Section 3(5) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1002(5)) is amended—

(1) by striking "The term" and inserting "(A) The term"; and

(2) by adding at the end the following:

"(B) For purposes of subparagraph (A), a group or association of employers shall be treated as an 'employer', regardless of whether the employers composing such group or association are in the same industry, trade, or profession, if such group or association—

"(i)(I) has established and maintains an employee welfare benefit plan that is a group health plan (as defined in section 733(a)(1));

"(II) provides coverage under such plan to at least 51 employees after all of the employees employed by all of the employer members of such group or association have been aggregated and counted together as described in subparagraph (D);

"(III) has been actively in existence for at least 2 years prior to establishing and maintaining an employer welfare benefit plan that is a group health plan (as defined in section 733(a)(1));

"(IV) has been formed and maintained in good faith for purposes other than providing medical care (as defined in section 733(a)(2)) through the purchase of insurance or otherwise;

"(V) does not condition membership in the group or association on any health status-related factor (as described in section 702(a)(1)) relating to any individual;

"(VI) makes coverage under such plan available to all employer members of such group or association regardless of any health status-related factor (as described in section 702(a)(1)) relating to such employer members;

"(VII) does not provide coverage under such plan to any individual other than an employee of an employer member of such group or association;

"(VIII) has established a governing board with by-laws or other similar indications of formality to manage and operate such plan in both form and substance, of which at least 75 percent of the board members shall be made up of employer members of such group or association participating in the plan that are duly elected by each participating employer member casting 1 vote during a scheduled election;

"(IX) is not a health insurance issuer (as defined in section 733(b)(2)), and is not owned or controlled by such a health insurance issuer or by a subsidiary or affiliate of such a health insurance issuer, other than to the extent such a health insurance issuer—

"(aa) may participate in the group or association as a member; and

"(bb) may provide services such as assistance with plan development, marketing, and administrative services to such group or association;

"(ii) meets any set of criteria to qualify for such treatment in an advisory opinion issued by the Secretary prior to the date of enactment of the Association Health Plans Act; or

"(iii) meets any other set of criteria to qualify for such treatment that the Secretary by regulation may provide.

"(C)(i) For purposes of subparagraph (B), a self-employed individual shall be treated as—

"(I) an employer who may become a member of a group or association of employers;

"(II) an employee who may participate in an employee welfare benefit plan established and maintained by such group or association; and

"(III) a participant of such plan subject to the eligibility determination and monitoring requirements set forth in clause (iii).

"(ii) For purposes of this subparagraph, the term 'self-employed individual' means an individual who—

"(I) does not have any common law employees;

"(II) has an ownership right in a trade or business, regardless of whether such trade or business is incorporated or unincorporated;

"(III) earns wages (as defined in section 3121(a) of the Internal Revenue Code of 1986) or self-employment income (as defined in section 1402(b) of such Code) from such trade or business; and

"(IV) works at least 10 hours per week or 40 hours per month providing personal services to such trade or business.

"(iii) The board of a group or association of employers shall—

"(I) initially determine whether an individual meets the requirements under clause (ii) to be considered a self-employed individual for the purposes of being treated as an—

"(aa) employer member of such group or association (in accordance with clause (i)(I)); and

"(bb) employee who may participate in the employee welfare benefit plan established and maintained by such group or association (in accordance with clause (i)(II));

"(II) through reasonable monitoring procedures, periodically determine whether the individual continues to meet such requirements; and

"(III) if the board determines that an individual no longer meets such requirements, not make such plan coverage available to such individual (or dependents thereof) for any plan year following the plan year during which the board makes such determination. If, subsequent to a determination that an individual no longer meets such requirements, such individual furnishes evidence of satisfying such requirements, such individual (and dependents thereof) shall be eligible to receive plan coverage.

"(D) For purposes of subparagraph (B), all of the employees (including self-employed individuals) employed by all of the employer members (including self-employed individuals) of a group or association of employers shall be—

"(i) treated as employed by a single employer; and

"(ii) aggregated and counted together for purposes of any regulation of an employee welfare benefit plan established and maintained by such group or association.".

(b) DETERMINATION OF EMPLOYER OR JOINT EMPLOYER STATUS.—The provision of employee welfare benefit plan coverage by a group or association of employers shall not be construed as evidence for establishing an employer or joint employer relationship under any Federal or State law.

SEC. 3. RULES APPLICABLE TO GROUP HEALTH PLANS ESTABLISHED AND MAINTAINED BY A GROUP OR ASSOCIATION OF EMPLOYERS.

Part 7 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1181, et seq.) is amended by adding at the end the following:

"SEC. 736. RULES APPLICABLE TO GROUP HEALTH PLANS ESTABLISHED AND MAINTAINED BY A GROUP OR ASSOCIATION OF EMPLOYERS.

"(a) PREMIUM RATES FOR A GROUP OR ASSOCIATION OF EMPLOYERS.—

"(1)(A) In the case of a group health plan established and maintained by a group or association of employers described in section 3(5)(B), such plan may—

"(i) establish base premium rates formed on an actuarially sound, modified community rating methodology that considers the pooling of all plan participant claims; and

"(ii) utilize the specific risk profile of each employer member of such group or association to determine contribution rates for each such employer member's share of a premium by actuarially adjusting above or below the established base premium rates.

"(B) For purposes of paragraph (1), the term 'employer member' means—

"(i) an employer who is a member of such group or association of employers and employs at least 1 common law employee; or

"(ii) a group made up solely of self-employed individuals, within which all of the self-employed individual members of such group or association are aggregated together as a single employer member group, provided the group includes at least 20 self-employed individual members.

"(2) In the event a group or association is made up solely of self-employed individuals (and no employers with at least 1 common law employee are members of such group or association), the group health plan established by such group or association shall—

"(A) treat all self-employed individuals who are members of such group or association as a single risk pool;

"(B) pool all plan participant claims; and

"(C) charge each plan participant the same premium rate.

"(b) DISCRIMINATION AND PRE-EXISTING CONDITION PROTECTIONS.—A group health plan established and maintained by a group or association of employers described in section 3(5)(B) shall be prohibited from—

"(1) establishing any rule for eligibility (including continued eligibility) of any individual (including an employee of an employer member or a self-employed individual, or a dependent of such employee or self-employed individual) to enroll for benefits under the terms of the plan that discriminates based on any health status-related factor that relates to such individual (consistent with the rules under section 702(a)(1));

"(2) requiring an individual (including an employee of an employer member or a self-employed individual, or a dependent of such employee or self-employed individual), as a condition of enrollment or continued enrollment under the plan, to pay a premium or contribution that is greater than the premium or contribution for a similarly situated individual enrolled in the plan based on any health status-related factor that relates to such individual (consistent with the rules under section 702(b)(1)); and

"(3) denying coverage under such plan on the basis of a pre-existing condition (consistent with the rules under section 2704 of the Public Health Service Act).".

SEC. 4. RULE OF CONSTRUCTION.

Nothing in this Act shall be construed to exempt a group health plan which is an employee welfare benefit plan offered through a group or association of employers from the requirements of part 7 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1181 et. seq.), including the provisions of part A of title XXVII of the Public Health Service Act as incorporated by reference into this Act through section 715.

PURPOSE

There is an urgent need to address health care challenges facing working families and small businesses. Democrat policies, like Obamacare, have sold Americans a faulty bill of goods and led to consolidation in the marketplace, skyrocketing premiums, and a broken individual health market that costs taxpayers more than a trillion dollars while covering only 9 percent of the population.

H.R. 2868, the *Association Health Plans Act*, amends the *Employee Retirement Income Security Act* of 1974 (ERISA) to improve access to affordable health coverage options for workers employed by small businesses. The bill amends ERISA to authorize the creation of association health plans (AHPs) sponsored by groups or associations of employers. The legislation allows small businesses and self-employed individuals to band together across state lines through associations, 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. 2868 frees small businesses from costly state-mandated benefit packages, spreads risk for self-employed individuals, and lowers overhead costs, enabling employers to offer more affordable health care coverage to their workers and enabling self-employed individuals to access more affordable health care coverage.

COMMITTEE ACTION

109TH CONGRESS

Legislative Action

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), 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).

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. On April 13, 2005, the Committee filed its committee report, which detailed the history of the need for the legislation and prior committee action.[1] On July 26, 2015, H.R. 525 passed the full House by a vote of 263 to 165.

111TH CONGRESS

Legislative Action

Between July 15–17, 2009, the Committee met to mark up H.R. 3200, the *America's Affordable Health Choices Act of 2009*.[2] 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

[1] H.R. Rep. No. 109–41 (2005).
[2] H.R. 3200 was the House precursor to the law known as the *Affordable Care Act*.

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

On November 7, 2009, the House passed H.R. 3962, the *Affordable Health Care for America Act*. During the debate, former Speaker John Boehner (R–OH) included the AHP legislative text in the Republican motion to recommit.[3]

On March 21, 2010, the House passed the *Patient Protection and Affordable Care Act* by a vote of 219 to 212 to resolve differences with the Senate. The bill was signed by President Obama on March 23, 2010.[4] On March 25, 2010, the House 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.[5] Collectively, the two bills are known as the *Affordable Care Act* (ACA or Obamacare).[6] The ACA did not include AHP legislative text.

112TH CONGRESS

First Session—Hearing

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 hearing also examined AHPs. The witnesses 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.

115TH CONGRESS

First Session—Hearings

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 and also examined association health plans. Witnesses were Mr. Scott Bollenbacher, CPA, Managing Partner, Bollenbacher and 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.

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[3] H. Amend. 510 to H.R. 3962, 111th Cong. (2009).
[4] Patient Protection and Affordable Care Act, Pub. L. No. 111–148 (2010).
[5] Health and Education Reconciliation Act, Pub. L. No. 111–152 (2010).
[6] Patient Protection and Affordable Care Act, Pub. L. No. 111–148 (2010), and Health and Education Reconciliation Act, Pub. L. No. 111–152 (2010).

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.

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 the *Small Business Health Fairness Act of 2017* (H.R. 1101), among other proposals. H.R. 1101 provides a legislative solution for association health plans. Witnesses 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.

Legislative Action

On February 16, 2017, Rep. Sam Johnson (R–TX) introduced the *Small Business Health Fairness Act of 2017* (H.R. 1101) along with then-Subcommittee on Health, Employment, Labor, and Pensions (HELP) Chairman Tim Walberg (R–MI).[7]

On March 8, 2017, the Committee considered H.R. 1101, the *Small Business Health Fairness Act of 2017*.[8] Then-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.

On March 22, 2017, the House passed H.R. 1101, the *Small Business Health Fairness Act of 2017* by a vote of 236–175.

Second Session—Hearing

On March 16, 2018, the HELP Subcommittee held a hearing entitled "Expanding Affordable Health Care Options: Examining the Department of Labor's Proposed Rule on Association Health Plans," which examined the U.S. Department of Labor's (DOL) recent proposed rule on AHPs as an alternative to Obamacare. Witnesses were Mr. Christopher Condeluci, Principal and Sole Shareholder, CC Law and Policy PLLC, Washington, D.C.; Mr. Michael McGrew, CEO McGrew Real Estate, Lawrence, Kansas; Ms. Catherine Monson, CEO and President, FASTSIGNS International, Inc., Carrollton, Texas; and Mr. John Arensmeyer, Founder and CEO, Small Business Majority, Washington, D.C.

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

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

117TH CONGRESS

First Session—Hearing

On June 9, 2021, the Committee held a hearing entitled "Examining the Policies and Priorities of the U.S. Department of Labor," during which the Secretary of Labor was questioned about the Department's Fiscal Year 2022 budget priorities. The Committee also examined the Department's views on the Trump administration's rule to expand AHPs. The sole witness was the Honorable Martin J. Walsh, Secretary of DOL, Washington, D.C.

Second Session—Hearing

On February 17, 2022, the HELP Subcommittee held a hearing entitled "Exploring Pathways to Affordable, Universal Health Coverage," which examined, among other things, the benefits of expanding AHPs. The witnesses were Dr. Brian Blase, President, Paragon Health Institute, Ponte Verde, Florida; Dr. Georges C. Benjamin, Executive Director, the American Public Health Association, Washington, D.C.; Ms. Katie Keith, Center on Health Insurance Reforms, Georgetown University, Washington, D.C.; and Mr. Robert B. Reich, Carmel P. Friesen Professor of Public Policy, Goldman School of Public Policy, University of California, Berkley, California.

118TH CONGRESS

First Session—Hearing

On April 26, 2023, the HELP Subcommittee held a hearing entitled "Reducing Health Care Costs for Working Americans and Their Families," which examined H.R. 2868, the Association Health Plans Act, among other proposals, and also examined the continuing negative impact of the ACA on employer-sponsored health coverage and on lowering costs by expanding AHPs. Witnesses were Mr. Joel White, President, Council for Affordable Health Coverage (CAHC), Washington, D.C.; Mrs. Tracy Watts, Senior Partner, Mercer, Washington, D.C.; Marcie Strouse, Partner, Capitol Benefits Group, Des Moines, Iowa; and Ms. Sabrina Corlette, J.D., Senior Research Professor, Center on Health Insurance Reforms, Georgetown University's Health Policy Institute, Washington, D.C.

Legislative Action

On April 25, 2023, Rep. Walberg introduced the *Association Health Plans Act* (H.R. 2868) with Chairwoman Foxx, HELP Subcommittee Chairman Bob Good (R–VA), Rep. Rick Allen (R–GA), Rep. Dan Crenshaw (R–TX), and Rep. Michael Burgess (R–TX) as original cosponsors. The bill was referred solely to the Committee on Education and the Workforce. On June 6, 2023, the Committee considered H.R. 2868, the *Association Health Plans Act* in legislative session and reported it favorably, as amended, to the House of Representatives by a recorded vote of 23–18. The Committee adopted the following amendment to H.R. 2868: Rep. Walberg offered an Amendment in the Nature of a Substitute (ANS) clarifying that an organization has to be actively in existence for two years prior to the establishment of an AHP in order for the AHP to qualify as a group health plan under H.R. 2868. In Section 3, the ANS also

strikes "employee welfare benefit plan" and inserts "group health plan" to clarify that premium rates are for health care only.

COMMITTEE VIEWS

INTRODUCTION

Background on employer-sponsored insurance coverage

Since World War II, employers have offered health care benefits to recruit and retain talent and to ensure a healthy and productive workforce. Employer-sponsored health insurance covers almost 159 million American workers and family members.[9] According to the U.S. Census Bureau, 54.3 percent of Americans were covered by employment-based health coverage in 2021.[10] When given the option for employment-based health coverage, 77 percent of workers take up coverage.[11] Almost all businesses with at least 200 or more employees offer health benefits.[12] According to the Kaiser Family Foundation, however, smaller firms (with 3 to 199 employees) are significantly less likely to offer health benefits.[13] As a result, in 2022, just over half of all employers offered some health benefits.[14]

Employer-provided health benefits are regulated by a number of laws, including ERISA as amended by the ACA. 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 65 percent of workers with employer-sponsored health coverage were enrolled in a self-funded plan, up from 44 percent in 1999 and 55 percent in 2007.[15]

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 other-

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[9] Kaiser Family Found., Employer Health Benefits: 2022 Annual Survey, 2022 Employer Health Benefits Survey 58, http://files.kff.org/attachment/Report-Employer-Health-Benefits-2022–Annual-Survey.pdf.

[10] U.S. Census Bur., U.S. Dep't of Com., Health Insurance Coverage in the United States: 2021, http://census.gov/content/dam/Census/library/publications/2022/demo/p60-278.pdf.

[11] Kaiser Family Found., *supra* note 9, at 12.

[12] *Id.*

[13] *Id.*

[14] *Id.*

[15] *Id.* at 157.

wise.[16] Additionally, small businesses and their employees have been "hurt badly by the cost increases caused by the ACA."[17] Small businesses continue to struggle with the cost of health care coverage, with adverse impacts to growth, hiring, and workforce pay.[18] In June 2022, Kaiser Family Foundation reported that individual health care debt is a significant problem in the United States. The same study reports that half of adults find it difficult to afford health care and that cost is often a barrier to obtaining needed health care or filling prescriptions. [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 study by the American Action Forum, ACA regulations have a significant negative impact on the labor market. The study concluded that roughly 300,000 small business jobs were lost, and 10,000 small businesses closed as a result of ACA's costs and regulations.[20]

In the aftermath of ACA, approximately 36 percent of small businesses with fewer than 10 employees stopped offering coverage, leaving workers with even fewer health care options.[21] In 2021, the offer rate for businesses with fewer than 50 employees had dropped to 31.9 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 survey released by the National Federation of Independent Business (NFIB) in March of 2023, 65 percent of small business employers that do not currently offer coverage cite the

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

[17] *Rescuing Americans from the Failed Health Care Law and Advancing Patient-Centered Solutions: Hearing Before the H. Comm. on Educ. & the Workforce*, 115th Cong. 42 (2017) (statement of Scott Bollenbacher, Managing Partner, Bollenbacher & Assoc., LLC).

[18] SMALL BUS. FOR AM. FUTURE, SURVEY: HEALTH CARE COSTS PUTTING FINANCIAL PRESSURE ON SMALL BUSINESS (Oct. 2022), http://irp.cdn-website.com/b4559992/files/uploaded/SBAF%20National%20_health_care%20Survey%20Oct.%202022.pdf (reporting survey results of 1,209 small business owners finding that, to offset rising health care costs, nearly half increased prices of goods or services, 38 percent delayed growth opportunities, and 28 percent slowed hiring).

[19] ALEX MONTERO ET AL., KAISER FAMILY FOUND., AMERICANS' CHALLENGES WITH HEALTH CARE COSTS (July 14, 2022), https://www.kff.org/health-costs/issue-brief/americans-challenges-with-health-care-costs/ (reporting that 41 percent of adults have medical or dental care debt owed to credit cards, collections agencies, families and friends, banks, and other lenders).

[20] BEN GITIS & SAM BATKINS, UPDATE: OBAMACARE'S IMPACT ON SMALL BUSINESS WAGES AND EMPLOYMENT, AM. ACTION FORUM (2017), https://americanactionforum.org/research/update-obamacares-impact-small-business-wages-employment/.

[21] PAUL FRONSTIN, EBRI EDUC. & RESEARCH FUND, FEWER SMALL EMPLOYERS OFFERING HEALTH COVERAGE; LARGE EMPLOYERS HOLDING STEADY (2016) (Jul. 2016), http://ebri.org/content/fewer-small-employers-offering-health-coverage-large-employers-holding-steady-3367 (studying the impact of the ACA on employer health insurance offer rates).

[22] AGENCY FOR HEALTHCARE & QUALITY, CTR. FOR FINANCING, ACCESS AND COST TRENDS 2021 MEDICAL EXPENDITURE PANEL SURVEY-INSURANCE COMPONENT, TABLE 1.A.2. (2021), http://meps.ahrq.gov/data_stats/summ_tables/insr/state/series_2/2021/ic21_iia_f_pdf; Agency for Healthcare & Quality, Ctr. for Financing, Access and Costs Trends 2010 Medical Expenditure Panel Survey—Insurance Component, Table I.A.2 (2010), http://meps.ahrq.gov/data_stats/summ_tables/insr/state/series_2/2010/9c10_iaa_f.pdf.

cost of health insurance coverage as the top reason.[23] In testimony before the HELP Subcommittee, Mr. Joel White, President of the Council for Affordable Health Coverage, stated that ACA mandates applicable to small businesses increase the cost of providing health care coverage and limit choices: "As Congress increased [costs for small businesses] and limited their choices, the authors of ACA created powerful incentives for small businesses to drop coverage. And they did."[24]

One significant factor contributing to the high cost of health care for small employers is their inability to band together 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 in small businesses. That is particularly important because, as stated above, the percentage of smaller firms that offer coverage has fallen from 39 percent to 31.9 percent since 2010.

To address the damage to small business caused by the ACA, Mr. White added, "A good start would be to pass Congressman Walberg's bill the *Association Health Plan Act* to ensconce AHPs in statute, clarify regulatory authority, and expand AHPs as an option for employers," namely, the ability to pool together to offer health insurance coverage to their employees.

The need for small business pooling

AHPs will give small businesses another option for offering health insurance coverage. In a statement submitted to the HELP Subcommittee, 18 organizations comprising the Coalition to Protect and Promote Association Health Plans (the "AHP Coalition") affirmed the benefits of AHPs, with data from AHPs demonstrating significant savings to employers in different industries from five to 35 percent and to participating self-employed individuals from two to 50 percent.[25] The AHP Coalition stated that several beneficial AHPs were "discontinued due to the legal uncertainty surrounding AHPs" following an adverse ruling by the U.S. District Court for the District of Columbia regarding DOL's final regulations of June 18, 2018, expanding AHP coverage.

AHPs allow small businesses to pool risk. Mr. White's testimony underscores the advantages of risk pooling that AHPs provide to small businesses:

> According to a recent survey from the Small Business Entrepreneurship Council, only 1 in 5 (17 percent) small business leaders agree that the employer health care solutions available to them have kept up with changing market conditions. In addition, small firms do not have large pools of employees to spread risk across broad populations or to reduce administrative costs associated with offering coverage. One sick person at

[23] HOLLY WADE, NFIB RESEARCH CTR., SMALL BUSINESS HEALTH INSURANCE SURVEY (Mar. 2023), https://strgnfibcom.blob.core.windows.net/nfibcom/Health-insurance-survey-NFIB.pdf.

[24] *Reducing Health Care Costs for Working Americans and Their Families: Hearing Before the Subcomm. on Health, Employment, Labor & Pensions of the H. Comm. on Educ. & the Workforce*, 118th Cong. (2023) (statement of Joel White, President, Council for Affordable Health Coverage).

[25] *Id.* (statement of The Coalition to Protect and Promote Association Health Plans).

a small business can blow a hole in profits and potentially sink the enterprise.[26]

A key element of H.R. 2868 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. White testified, "To help small businesses across the country, Congress should protect access to level-funded plans and reinsurance (including low attachment point reinsurance) policies by ensuring they remain available for sale and purchase in all states. This would involve clarifying ERISA preemption with respect to self-funded arrangements for small businesses."[27] As Mr. Jay Ritchie, Executive Vice President of Tokio Marine HCC Stop-Loss Group and the Chairman of the Board of the Self-Insurance Institute of America, Inc., testified that "[s]elf-insurance plans are regulated by no less than 10 federal laws, including [ERISA] and [HIPAA]."[28] Larger businesses and unions that are self-funded are regulated under these rules; 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 the ACA's Small Business Health Options Program Exchanges.[29]

Some states already allow pooling arrangements within their state. AHPs remain subject to all federal and state laws otherwise applicable to such plans, and the provisions of H.R. 2868 are not intended to modify the application or interpretation of such laws to such plans.

Department of Labor regulation expanding AHPs

On June 21, 2018, DOL issued a final regulation to expand the groups and associations of employers eligible to sponsor employment-based health coverage.[30] The rule was intended to expand access to affordable, high-quality health care options, particularly for employees of small employers. On March 28, 2019, the U.S. District Court of the District of Columbia invalidated key portions of the rule.[31] An appeal is pending with the U.S. Court of Appeals for the D.C. Circuit.

In the brief period before the rule was blocked by the district court, 28 new AHPs were established. Due to the short period these plans were operating, little data is available. However, reported savings for the plans averaged 29 percent for self-funded AHPs and 23 percent for fully insured AHPs.[32]

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[26] *Id.* (White statement).
[27] *Id.* (White statement).
[28] *Legislative Proposals to Improve Health Care Coverage and Provide Lower Costs for Families: Hearing Before the H. Comm on Educ. & the Workforce*, 115th Cong. 42 (2017) (statement of Jay Ritchie, Exec. Vice President, Tokio Marine HCC).
[29] *Id.* at 43.
[30] Definition of "Employer" Under Section 3(5) of ERISA—Association Health Plans, 83 Fed. Reg. 28,912 (June 21, 2018).
[31] New York v. DOL, 363 F. Supp. 3d 109 (D.D.C. 2019).
[32] KEV COLEMAN, ASS'N HEALTH PLANS, INC., FIRST PHASE OF NEW ASSOCIATION HEALTH PLANS REVEAL PROMISING TRENDS, https://associationhealthplans.com/reports/new-ahp-study.

The federal government's attack on small business owners

On May 31, the Centers for Medicare and Medicaid Services (CMS) sent a letter to Gov. Glenn Youngkin (R–VA) alleging that the state is not enforcing certain coverage mandates required by the ACA.[33] A 2022 Virginia law allows self-employed individuals and employees of real estate brokerage firms to band together to create an AHP.[34] The letter claims these groups cannot form AHPs because the definition of employee organization under ERISA does not allow for the participation of self-employed individuals. Federal legislation is needed to expand AHPs in order to help protect access for small business owners in Virginia and other states.

Support for creating options and flexibility for small businesses

Because it benefits both employers and working families, AHP legislation has been consistently supported over the years, including by a broad swath of groups representing job creators, including: the National Federation of Independent Businesses, Council for Affordable Coverage, National Association of REALTORS®, the North Carolina Chamber, Associated General Contractors of America, MLD Foundation, Main Street Freedom Alliance, National Association of Wholesaler-Distributors, Small Business & Entrepreneurship Council, the American Farm Bureau Federation, American Society of Association Executives, Associated Employers Benefit & Trust; Indiana Credit Union League, Manufacturer & Business Association, Michigan Business and Professional Association, Michigan Dental Association, National Restaurant Association, Small Business Association of Michigan, and U.S. Chamber of Commerce.

H.R. 2868, THE ASSOCIATION HEALTH PLANS ACT

The Committee is advancing this legislation to expand access to more affordable health care coverage for small employers and self-employed individuals by authorizing the creation of AHPs sponsored by groups or associations of employers, including self-employed individuals. The legislation allows small businesses and independent contractors to band together across state lines through associations 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. 2868 frees small businesses from costly state-mandated benefit packages, spreads risk for self- employed individuals, and lowers overhead costs, enabling employers to offer more affordable health care coverage to their workers and self-employed individuals to access more affordable health care coverage.

CONCLUSION

H.R. 2868, the *Association Health Plans 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

[33] Letter from Chiquita Brooks-LaSure, Ctr. For Medicare & Medicaid Serv., to Gov. Glenn Youngkin (May 31, 2023), https://www.cms.gov/files/document/virginia-preliminary-determination-letter.pdf.

[34] Press Release, Governor Glenn Youngkin Signs Bipartisan Legislation To Expand Health Care Coverage Options For Virginia's Realtor Community (June 16, 2022), https://www.governor.virginia.gov/newsroom/news-releases/2022/june/name-934901-en.html.

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. 2868 will empower small businesses to provide quality health care for their employees and independent contractors to obtain quality affordable health care coverage.

SUMMARY

H.R. 2868 SECTION-BY-SECTION SUMMARY

Section 1. Short title

Section 1 provides that the short title is "Association Health Plans Act."

Section 2. Treatment of group or association of employers

Section 2 amends the definition of "employer" under ERISA to confirm that a group or association of employers—regardless of profession or geography—may be considered a single large employer if the group or association:

- Establishes a group health plan;
- Includes at least 51 employees;
- Has been actively in existence for a minimum of two years;
- Has been formed in good faith for a purpose other than purchasing insurance;
- Has no membership restrictions based on health status-related factors;
- Makes coverage available to all employees regardless of health status;
- Does not offer coverage to anyone outside the group or association;
- Has established a governing board with at least 75 percent of board members being duly elected by the employer members participating in the health plan; and
- Is not a health insurance issuer itself or controlled or owned by a health insurance issuer or its subsidiary.

For purposes of determining whether the group or association includes at least 51 employees, all employees of employer members of the group or association are aggregated and treated as being employed by a single employer.

Grandfather clause and additional pathways

Section 2 grandfathers existing AHPs by allowing a group or association to be considered an "employer" for purposes of sponsoring an ERISA-covered health plan if the group or association (1) satisfies criteria outlined in DOL advisory opinions issued prior to the enactment of H.R. 2868 or (2) satisfies any criteria in prospective DOL regulations.

Section 2 allows self-employed individuals to participate in an ERISA-covered health plan established by a group or association by treating a self-employed individual as an "employer" and an "employee" as well as a "participant" in the health plan. For these purposes, a self-employed individual:

- Does not have any common-law employees;

- Has ownership right in a trade or business;
- Earns wages or income from this trade or business; and
- Works at least 10 hours per week or 40 hours per month.

Section 2 requires that all AHPs have established a governing board with at least 75 percent of board members duly elected by the employer members participating in the health plan. The board shall (1) determine whether a self-employed individual satisfies the criteria to join a group or association prior to the individual enrolling in the health plan and (2) periodically monitor whether an individual continues to be considered a self-employed individual. If the board determines that a self-employed individual no longer satisfies the criteria, the individual and their dependents will no longer be eligible for coverage (other than COBRA continuation coverage, if applicable) starting in the next plan year, although an individual has the right to provide evidence that he or she continues to meet (or subsequently meets) the criteria to maintain or restore coverage.

Section 2 also clarifies that participation in an ERISA-covered plan sponsored by a group or association of employers is not evidence of joint employment.

Section 3. Rules applicable to employee welfare benefit plans established and maintained by a group or association of employers

Section 3 requires that premiums and underwriting be based on the risk pool of employer groups instead of on an individual level. A group or association of employers made up solely of employers with at least one common-law employee (i.e., a group or association with no self-employed individuals) may develop premium rates in the following manner:

a. Establish premium rates after considering the collective health claims experience of all employees and their dependents participating in the plan.

b. Vary rates up or down for each individual employer member of the group or association based on the collective health claims experience of the employees employed by each respective employer.

A mixed group or association of employers that includes both employers with at least one common-law employee and self-employed individuals may develop premium rates in the same manner as above. However, for purposes of varying the premiums by the employer member, all self-employed individuals must be aggregated and counted together as their own single group made up of at least 20 self-employed individuals. Any premium variation for this self-employed individual group shall consider the collective health claims experience of all self-employed individuals and their dependents in this group.

For a group or association of employers made up solely of self-employed individuals (i.e., a group or association with no employers with at least one common-law employee), premium rates will be developed by considering the collective health claims experience of all the self-employed individuals and their dependents participating in the plan. The base rates will then be charged equally to all self-employed individuals and their dependents participating in the plan. If the aggregated group of self-employed individuals is less than 20 individuals, this group or association cannot permit self-employed individuals to participate in the plan.

Section 3 reconfirms current law and reiterates that an ERISA-covered health plan shall: not establish a rule for eligibility or continued eligibility in the health plan that discriminates against any participant based on a health status-related factor; not require any participant to pay a premium rate that is higher than the premium rate similarly situated individuals pay based on a health-status-related factor relating to that participant; and not deny coverage based on a pre-existing condition.

Section 4. Rules of construction

Section 4 confirms current law and requires an ERISA-covered health plan to comply with the ACA's group health plan coverage requirements and ERISA's coverage 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. 2868 takes important steps to expand access to affordable, high-quality healthcare coverage for small employers and self-employed individuals.

UNFUNDED MANDATE STATEMENT

Section 423 of the Congressional Budget and Impoundment Control Act (as amended by Section 101(a)(2) of the Unfunded Mandates Reform Act, P.L. 104–4) requires a statement of whether the provisions of the reported bill include unfunded mandates. This issue will be addressed in the CBO letter.

EARMARK STATEMENT

H.R. 2868 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:

COMMITTEE ON EDUCATION AND LABOR RECORD OF COMMITTEE VOTE

Roll Call: 6 Bill: H.R. 2868 Amendment Number: 2

Disposition: Defeated by a Full Committee Roll Call Vote

Sponsor/Amendment: Jayapal / AHP_MATERNITY_AMD

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		Mr. GRIJALVA (AZ)	X		
Mr. THOMPSON (PA)		X		Mr. COURNTEY (CT)	X		
Mr. WALBERG (MI)		X		Mr. SABLAN (MP)			X
Mr. GROTHMAN (WI)		X		Ms. WILSON (FL)			X
Ms. STEFANIK (NY)		X		Ms. BONAMICI (OR)	X		
Mr. ALLEN (GA)		X		Mr. TAKANO (CA)	X		
Mr. BANKS (IN)		X		Ms. ADAMS (NC)	X		
Mr. COMER (KY)		X		Mr. DESAULNIER (CA)	X		
Mr. SMUCKER (PA)		X		Mr. NORCROSS (NJ)	X		
Mr. OWENS (UT)		X		Ms. JAYAPAL (WA)	X		
Mr. GOOD (VA)		X		Ms. WILD (PA)	X		
Mrs. MCCLAIN (MI)		X		Ms. MCBATH (GA)	X		
Mrs. MILLER (IL)		X		Mrs. HAYES (CT)	X		
Mrs. STEEL (CA)		X		Ms. OMAR (MN)	X		
Mr. ESTES (KS)		X		Ms. STEVENS (MI)	X		
Ms. LETLOW (LA)		X		Ms. LEGER FERNÁNDEZ (NM)	X		
Mr. KILEY (CA)		X		Ms. MANNING (NC)	X		
Mr. BEAN (FL)		X		Mr. MRVAN (IN)	X		
Mr. BURLISON (MO)		X		Mr. BOWMAN (NY)	X		
Mr. MORAN (TX)			X				
Mr. JAMES (MI)			X				
Ms. CHAVEZ-DEREMER (OR)		X					
Mr. WILLIAMS (NY)		X					
Ms. HOUCHIN (IN)		X					

TOTALS: Ayes: 18 Nos: 23 Not Voting: 4

Total: 45 / Quorum: / Report:

(25 R - 20 D)

^Although not present for the recorded vote, Member expressed he/she would have voted AYE if present at time of vote.

*Although not present for the recorded vote, Member expressed he/she would have voted NO if present at time of vote.

Date: 06/06/202

COMMITTEE ON EDUCATION AND LABOR RECORD OF COMMITTEE VOTE

Roll Call: 7 Bill: H.R. 2868 Amendment Number: 3

Disposition: Defeated by a Full Committee Roll Call Vote

Sponsor/Amendment: Scott / AHP_PEC_AMD

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		Mr. GRIJALVA (AZ)	X		
Mr. THOMPSON (PA)		X		Mr. COURNTEY (CT)	X		
Mr. WALBERG (MI)		X		Mr. SABLAN (MP)			X
Mr. GROTHMAN (WI)		X		Ms. WILSON (FL)			X
Ms. STEFANIK (NY)		X		Ms. BONAMICI (OR)	X		
Mr. ALLEN (GA)		X		Mr. TAKANO (CA)	X		
Mr. BANKS (IN)		X		Ms. ADAMS (NC)	X		
Mr. COMER (KY)		X		Mr. DESAULNIER (CA)	X		
Mr. SMUCKER (PA)		X		Mr. NORCROSS (NJ)	X		
Mr. OWENS (UT)		X		Ms. JAYAPAL (WA)	X		
Mr. GOOD (VA)		X		Ms. WILD (PA)	X		
Mrs. MCCLAIN (MI)		X		Ms. MCBATH (GA)	X		
Mrs. MILLER (IL)		X		Mrs. HAYES (CT)	X		
Mrs. STEEL (CA)		X		Ms. OMAR (MN)	X		
Mr. ESTES (KS)		X		Ms. STEVENS (MI)	X		
Ms. LETLOW (LA)		X		Ms. LEGER FERNÁNDEZ (NM)	X		
Mr. KILEY (CA)		X		Ms. MANNING (NC)	X		
Mr. BEAN (FL)		X		Mr. MRVAN (IN)	X		
Mr. BURLISON (MO)		X		Mr. BOWMAN (NY)	X		
Mr. MORAN (TX)			X				
Mr. JAMES (MI)			X				
Ms. CHAVEZ-DEREMER (OR)		X					
Mr. WILLIAMS (NY)		X					
Ms. HOUCHIN (IN)		X					

TOTALS: Ayes: 18 Nos: 23 Not Voting: 4

Total: 45 / Quorum: / Report:

(25 R - 20 D)

^Although not present for the recorded vote, Member expressed he/she would have voted AYE if present at time of vote.

*Although not present for the recorded vote, Member expressed he/she would have voted NO if present at time of vote.

Date: 06/06/2023

COMMITTEE ON EDUCATION AND LABOR RECORD OF COMMITTEE VOTE

Roll Call: 8 Bill: H.R. 2868 Amendment Number: 4

Disposition: Defeated by a Full Committee Roll Call Vote

Sponsor/Amendment: Norcross / AHPMHEALTH_AMD

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		Mr. GRIJALVA (AZ)	X		
Mr. THOMPSON (PA)		X		Mr. COURNTEY (CT)	X		
Mr. WALBERG (MI)		X		Mr. SABLAN (MP)			X
Mr. GROTHMAN (WI)		X		Ms. WILSON (FL)			X
Ms. STEFANIK (NY)		X		Ms. BONAMICI (OR)	X		
Mr. ALLEN (GA)		X		Mr. TAKANO (CA)	X		
Mr. BANKS (IN)		X		Ms. ADAMS (NC)	X		
Mr. COMER (KY)		X		Mr. DESAULNIER (CA)	X		
Mr. SMUCKER (PA)		X		Mr. NORCROSS (NJ)	X		
Mr. OWENS (UT)		X		Ms. JAYAPAL (WA)	X		
Mr. GOOD (VA)		X		Ms. WILD (PA)	X		
Mrs. MCCLAIN (MI)		X		Ms. MCBATH (GA)	X		
Mrs. MILLER (IL)		X		Mrs. HAYES (CT)	X		
Mrs. STEEL (CA)		X		Ms. OMAR (MN)	X		
Mr. ESTES (KS)		X		Ms. STEVENS (MI)	X		
Ms. LETLOW (LA)		X		Ms. LEGER FERNÁNDEZ (NM)	X		
Mr. KILEY (CA)		X		Ms. MANNING (NC)	X		
Mr. BEAN (FL)		X		Mr. MRVAN (IN)	X		
Mr. BURLISON (MO)		X		Mr. BOWMAN (NY)	X		
Mr. MORAN (TX)			X				
Mr. JAMES (MI)			X				
Ms. CHAVEZ-DEREMER (OR)		X					
Mr. WILLIAMS (NY)		X					
Ms. HOUCHIN (IN)		X					

TOTALS: Ayes: 18 Nos: 23 Not Voting: 4

Total: 45 / Quorum: / Report:

(25 R - 20 D)

^Although not present for the recorded vote, Member expressed he/she would have voted AYE if present at time of vote.

*Although not present for the recorded vote, Member expressed he/she would have voted NO if present at time of vote.

Date: 06/06/2023

COMMITTEE ON EDUCATION AND LABOR RECORD OF COMMITTEE VOTE

Roll Call: 9 Bill: H.R. 2868 Amendment Number: 5

Disposition: Defeated by a Full Committee Roll Call Vote

Sponsor/Amendment: Hayes / AHP_OW_AMD

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		Mr. GRIJALVA (AZ)	X		
Mr. THOMPSON (PA)		X		Mr. COURNTEY (CT)	X		
Mr. WALBERG (MI)		X		Mr. SABLAN (MP)			X
Mr. GROTHMAN (WI)		X		Ms. WILSON (FL)			X
Ms. STEFANIK (NY)		X		Ms. BONAMICI (OR)	X		
Mr. ALLEN (GA)		X		Mr. TAKANO (CA)	X		
Mr. BANKS (IN)		X		Ms. ADAMS (NC)	X		
Mr. COMER (KY)		X		Mr. DESAULNIER (CA)	X		
Mr. SMUCKER (PA)		X		Mr. NORCROSS (NJ)	X		
Mr. OWENS (UT)		X		Ms. JAYAPAL (WA)	X		
Mr. GOOD (VA)		X		Ms. WILD (PA)	X		
Mrs. MCCLAIN (MI)		X		Ms. MCBATH (GA)	X		
Mrs. MILLER (IL)		X		Mrs. HAYES (CT)	X		
Mrs. STEEL (CA)		X		Ms. OMAR (MN)	X		
Mr. ESTES (KS)		X		Ms. STEVENS (MI)	X		
Ms. LETLOW (LA)		X		Ms. LEGER FERNÁNDEZ (NM)	X		
Mr. KILEY (CA)		X		Ms. MANNING (NC)	X		
Mr. BEAN (FL)		X		Mr. MRVAN (IN)	X		
Mr. BURLISON (MO)		X		Mr. BOWMAN (NY)	X		
Mr. MORAN (TX)			X				
Mr. JAMES (MI)			X				
Ms. CHAVEZ-DEREMER (OR)		X					
Mr. WILLIAMS (NY)		X					
Ms. HOUCHIN (IN)		X					

TOTALS: Ayes: 18 Nos: 23 Not Voting: 4

Total: 45 / Quorum: / Report:

(25 R - 20 D)

^Although not present for the recorded vote, Member expressed he/she would have voted AYE if present at time of vote.

Date: 06/06/23

COMMITTEE ON EDUCATION AND LABOR RECORD OF COMMITTEE VOTE

Roll Call: 10 Bill: H.R. 2868 Amendment Number: 1

Disposition: Walberg Motion to Report H.R. 2868 to the House with amendment and recommendation that the amendment be agreed to, and the bill as amended, do pass

Sponsor/Amendment: Walberg / AHP_ANS

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	Mr. GRIJALVA (AZ)		X	
Mr. THOMPSON (PA)	X			Mr. COURNTEY (CT)		X	
Mr. WALBERG (MI)	X			Mr. SABLAN (MP)			X
Mr. GROTHMAN (WI)	X			Ms. WILSON (FL)			X
Ms. STEFANIK (NY)	X			Ms. BONAMICI (OR)		X	
Mr. ALLEN (GA)	X			Mr. TAKANO (CA)		X	
Mr. BANKS (IN)	X			Ms. ADAMS (NC)		X	
Mr. COMER (KY)	X			Mr. DESAULNIER (CA)		X	
Mr. SMUCKER (PA)	X			Mr. NORCROSS (NJ)		X	
Mr. OWENS (UT)	X			Ms. JAYAPAL (WA)		X	
Mr. GOOD (VA)	X			Ms. WILD (PA)		X	
Mrs. MCCLAIN (MI)	X			Ms. MCBATH (GA)		X	
Mrs. MILLER (IL)	X			Mrs. HAYES (CT)		X	
Mrs. STEEL (CA)	X			Ms. OMAR (MN)		X	
Mr. ESTES (KS)	X			Ms. STEVENS (MI)		X	
Ms. LETLOW (LA)	X			Ms. LEGER FERNÁNDEZ (NM)		X	
Mr. KILEY (CA)	X			Ms. MANNING (NC)		X	
Mr. BEAN (FL)	X			Mr. MRVAN (IN)		X	
Mr. BURLISON (MO)	X			Mr. BOWMAN (NY)		X	
Mr. MORAN (TX)			X				
Mr. JAMES (MI)	X						
Ms. CHAVEZ-DEREMER (OR)	X						
Mr. WILLIAMS (NY)	X						
Ms. HOUCHIN (IN)	X						

TOTALS: Ayes: 23 Nos: 18 Not Voting:

Total: 45 / Quorum: / Report:

(25 R - 20 D)

*Although not present for the recorded vote, Member expressed he/she would have voted AYE if present at time of vote.

*Although not present for the recorded vote, Member expressed he/she would have voted NO if present at time of vote.

STATEMENT OF GENERAL PERFORMANCE GOALS AND OBJECTIVES

In accordance with clause (3)(c) of House Rule XIII, the goal of H.R. 2868, the Association Health Plans Act, is to improve access to affordable health coverage options for workers employed by small businesses.

DUPLICATION OF FEDERAL PROGRAMS

No provision of H.R. 2868 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.

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.

REQUIRED COMMITTEE HEARING AND RELATED HEARINGS

In compliance with clause 3(c)(6) of rule XIII the following hearing held during the 118th Congress was used to develop or consider H.R. 2868: On April 24, 2023, the HELP Subcommittee held a hearing entitled "Reducing Health Care Costs for Working Americans and Their Families."

NEW BUDGET AUTHORITY AND CBO 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, a cost estimate was not made available to the Committee in time for the filing of this report. The Chairwoman of the Committee shall cause such estimate to be printed in the Congressional Record upon its receipt by the Committee.

COMMITTEE COST ESTIMATE

Clause 3(d)(1) of rule XIII of the Rules of the House of Representatives requires an estimate and a comparison of the costs that would be incurred in carrying out H.R. 2868. However, clause 3(d)(2)(B) of that rule provides that this requirement does not apply when, as with the present report, the committee adopts as its own the cost estimate of the bill being prepared by the Director of the Congressional Budget Office under section 402 of the Congressional Budget Act.

CHANGES IN EXISTING LAW MADE BY THE BILL, AS REPORTED

In compliance with clause 3(e) of rule XIII of the Rules of the House of Representatives, changes in existing law made by the bill,

as reported, are shown as follows (existing law proposed to be omitted is enclosed in black brackets, new matter is printed in italics, and existing law in which no change is proposed is shown in roman):

EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974

* * * * * * *

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 in-

creases 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.

(C) A pooled employer plan shall be treated as—

(i) a single employee pension benefit plan or single pension plan; and

(ii) a plan to which section 210(a) applies.

(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❳ *(A) 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.

(B) For purposes of subparagraph (A), a group or association of employers shall be treated as an "employer", regardless of whether the employers composing such group or association are in the same industry, trade, or profession, if such group or association—

(i)(I) has established and maintains an employee welfare benefit plan that is a group health plan (as defined in section 733(a)(1));

(II) provides coverage under such plan to at least 51 employees after all of the employees employed by all of the employer members of such group or association have been aggregated and counted together as described in subparagraph (D);

(III) has been actively in existence for at least 2 years prior to establishing and maintaining an employer welfare benefit plan that is a group health plan (as defined in section 733(a)(1));

(IV) has been formed and maintained in good faith for purposes other than providing medical care (as defined in

section 733(a)(2)) through the purchase of insurance or otherwise;

(V) does not condition membership in the group or association on any health status-related factor (as described in section 702(a)(1)) relating to any individual;

(VI) makes coverage under such plan available to all employer members of such group or association regardless of any health status-related factor (as described in section 702(a)(1)) relating to such employer members;

(VII) does not provide coverage under such plan to any individual other than an employee of an employer member of such group or association;

(VIII) has established a governing board with by-laws or other similar indications of formality to manage and operate such plan in both form and substance, of which at least 75 percent of the board members shall be made up of employer members of such group or association participating in the plan that are duly elected by each participating employer member casting 1 vote during a scheduled election;

(IX) is not a health insurance issuer (as defined in section 733(b)(2)), and is not owned or controlled by such a health insurance issuer or by a subsidiary or affiliate of such a health insurance issuer, other than to the extent such a health insurance issuer—

(aa) may participate in the group or association as a member; and

(bb) may provide services such as assistance with plan development, marketing, and administrative services to such group or association;

(ii) meets any set of criteria to qualify for such treatment in an advisory opinion issued by the Secretary prior to the date of enactment of the Association Health Plans Act; or

(iii) meets any other set of criteria to qualify for such treatment that the Secretary by regulation may provide.

(C)(i) For purposes of subparagraph (B), a self-employed individual shall be treated as—

(I) an employer who may become a member of a group or association of employers;

(II) an employee who may participate in an employee welfare benefit plan established and maintained by such group or association; and

(III) a participant of such plan subject to the eligibility determination and monitoring requirements set forth in clause (iii).

(ii) For purposes of this subparagraph, the term "self-employed individual" means an individual who—

(I) does not have any common law employees;

(II) has an ownership right in a trade or business, regardless of whether such trade or business is incorporated or unincorporated;

(III) earns wages (as defined in section 3121(a) of the Internal Revenue Code of 1986) or self-employment income (as defined in section 1402(b) of such Code) from such trade or business; and

(IV) works at least 10 hours per week or 40 hours per month providing personal services to such trade or business.

(iii) The board of a group or association of employers shall—

(I) initially determine whether an individual meets the requirements under clause (ii) to be considered a self-employed individual for the purposes of being treated as an—

(aa) employer member of such group or association (in accordance with clause (i)(I)); and

(bb) employee who may participate in the employee welfare benefit plan established and maintained by such group or association (in accordance with clause (i)(II));

(II) through reasonable monitoring procedures, periodically determine whether the individual continues to meet such requirements; and

(III) if the board determines that an individual no longer meets such requirements, not make such plan coverage available to such individual (or dependents thereof) for any plan year following the plan year during which the board makes such determination. If, subsequent to a determination that an individual no longer meets such requirements, such individual furnishes evidence of satisfying such requirements, such individual (and dependents thereof) shall be eligible to receive plan coverage.

(D) For purposes of subparagraph (B), all of the employees (including self-employed individuals) employed by all of the employer members (including self-employed individuals) of a group or association of employers shall be—

(i) treated as employed by a single employer; and

(ii) aggregated and counted together for purposes of any regulation of an employee welfare benefit plan established and maintained by such group or association.

(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, (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, or (iv) in the case of a pooled employer plan, the pooled plan provider.

(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, credited 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 forfeit-

able 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 provides, 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 associa-

tion 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 paragraph 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,

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

(iii) 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) 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) 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.

(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.

(43) POOLED EMPLOYER PLAN.—

(A) IN GENERAL.—The term "pooled employer plan" means a plan—

(i) which is an individual account plan established or maintained for the purpose of providing benefits to the employees of 2 or more employers;

(ii) which is a plan described in section 401(a) of the Internal Revenue Code of 1986 which includes a trust exempt from tax under section 501(a) of such Code, a plan that consists of annuity contracts described in section 403(b) of such Code, or a plan that consists of individual retirement accounts described in section 408 of such Code (including by reason of subsection (c) thereof); and

(iii) the terms of which meet the requirements of subparagraph (B).

Such term shall not include a plan maintained by employers which have a common interest other than having adopted the plan, but such term shall include any plan (other than a plan excepted from the application of this title by section 4(b)(2)) maintained for the benefit of the employees of more than 1 employer that consists of annuity contracts described in section 403(b) of such Code and that meets the requirements of subparagraph (B) of section 413(e)(1) of such Code.

(B) REQUIREMENTS FOR PLAN TERMS.—The requirements of this subparagraph are met with respect to any plan if the terms of the plan—

(i) designate a pooled plan provider and provide that the pooled plan provider is a named fiduciary of the plan;

(ii) designate a named fiduciary (other than an employer in the plan) to be responsible for collecting contributions to the plan and require such fiduciary to im-

plement written contribution collection procedures that are reasonable, diligent, and systematic;

(iii) provide that each employer in the plan retains fiduciary responsibility for—

(I) the selection and monitoring in accordance with section 404(a) of the person designated as the pooled plan provider and any other person who, in addition to the pooled plan provider, is designated as a named fiduciary of the plan; and

(II) to the extent not otherwise delegated to another fiduciary by the pooled plan provider and subject to the provisions of section 404(c), the investment and management of the portion of the plan's assets attributable to the employees of the employer (or beneficiaries of such employees);

(iv) provide that employers in the plan, and participants and beneficiaries, are not subject to unreasonable restrictions, fees, or penalties with regard to ceasing participation, receipt of distributions, or otherwise transferring assets of the plan in accordance with section 208 or paragraph (44)(C)(i)(II);

(v) require—

(I) the pooled plan provider to provide to employers in the plan any disclosures or other information which the Secretary may require, including any disclosures or other information to facilitate the selection or any monitoring of the pooled plan provider by employers in the plan; and

(II) each employer in the plan to take such actions as the Secretary or the pooled plan provider determines are necessary to administer the plan or for the plan to meet any requirement applicable under this Act or the Internal Revenue Code of 1986 to a plan described in section 401(a) of such Code, a plan that consists of annuity contracts described in section 403(b) of such Code, or to a plan that consists of individual retirement accounts described in section 408 of such Code (including by reason of subsection (c) thereof), whichever is applicable, including providing any disclosures or other information which the Secretary may require or which the pooled plan provider otherwise determines are necessary to administer the plan or to allow the plan to meet such requirements; and

(vi) provide that any disclosure or other information required to be provided under clause (v) may be provided in electronic form and will be designed to ensure only reasonable costs are imposed on pooled plan providers and employers in the plan.

(C) EXCEPTIONS.—The term "pooled employer plan" does not include—

(i) a multiemployer plan; or

(ii) a plan established before the date of the enactment of the Setting Every Community Up for Retire-

ment Enhancement Act of 2019 unless the plan administrator elects that the plan will be treated as a pooled employer plan and the plan meets the requirements of this title applicable to a pooled employer plan established on or after such date.

(D) TREATMENT OF EMPLOYERS AS PLAN SPONSORS.—Except with respect to the administrative duties of the pooled plan provider described in paragraph (44)(A)(i), each employer in a pooled employer plan shall be treated as the plan sponsor with respect to the portion of the plan attributable to employees of such employer (or beneficiaries of such employees).

(44) POOLED PLAN PROVIDER.—

(A) IN GENERAL.—The term "pooled plan provider" means a person who—

(i) is designated by the terms of a pooled employer plan as a named fiduciary, as the plan administrator, and as the person responsible for the performance of all administrative duties (including conducting proper testing with respect to the plan and the employees of each employer in the plan) which are reasonably necessary to ensure that—

(I) the plan meets any requirement applicable under this Act or the Internal Revenue Code of 1986 to a plan described in section 401(a) of such Code, a plan that consists of annuity contracts described in section 403(b) of such Code, or to a plan that consists of individual retirement accounts described in section 408 of such Code (including by reason of subsection (c) thereof), whichever is applicable; and

(II) each employer in the plan takes such actions as the Secretary or pooled plan provider determines are necessary for the plan to meet the requirements described in subclause (I), including providing the disclosures and information described in paragraph (43)(B)(v)(II);

(ii) registers as a pooled plan provider with the Secretary, and provides to the Secretary such other information as the Secretary may require, before beginning operations as a pooled plan provider;

(iii) acknowledges in writing that such person is a named fiduciary, and the plan administrator, with respect to the pooled employer plan; and

(iv) is responsible for ensuring that all persons who handle assets of, or who are fiduciaries of, the pooled employer plan are bonded in accordance with section 412.

(B) AUDITS, EXAMINATIONS AND INVESTIGATIONS.—The Secretary may perform audits, examinations, and investigations of pooled plan providers as may be necessary to enforce and carry out the purposes of this paragraph and paragraph (43).

(C) GUIDANCE.—The Secretary shall issue such guidance as the Secretary determines appropriate to carry out this paragraph and paragraph (43), including guidance—

(i) to identify the administrative duties and other actions required to be performed by a pooled plan provider under either such paragraph; and

(ii) which requires in appropriate cases that if an employer in the plan fails to take the actions required under subparagraph (A)(i)(II)—

(I) the assets of the plan attributable to employees of such employer (or beneficiaries of such employees) are transferred to a plan maintained only by such employer (or its successor), to an eligible retirement plan as defined in section 402(c)(8)(B) of the Internal Revenue Code of 1986 for each individual whose account is transferred, or to any other arrangement that the Secretary determines is appropriate in such guidance; and

(II) such employer (and not the plan with respect to which the failure occurred or any other employer in such plan) shall, except to the extent provided in such guidance, be liable for any liabilities with respect to such plan attributable to employees of such employer (or beneficiaries of such employees).

The Secretary shall take into account under clause (ii) whether the failure of an employer or pooled plan provider to provide any disclosures or other information, or to take any other action, necessary to administer a plan or to allow a plan to meet requirements described in subparagraph (A)(i)(II) has continued over a period of time that demonstrates a lack of commitment to compliance. The Secretary may waive the requirements of subclause (ii)(I) in appropriate circumstances if the Secretary determines it is in the best interests of the employees of the employer referred to in such clause (and the beneficiaries of such employees) to retain the assets in the plan with respect to which the employer's failure occurred.

(D) GOOD FAITH COMPLIANCE WITH LAW BEFORE GUIDANCE.—An employer or pooled plan provider shall not be treated as failing to meet a requirement of guidance issued by the Secretary under subparagraph (C) if, before the issuance of such guidance, the employer or pooled plan provider complies in good faith with a reasonable interpretation of the provisions of this paragraph, or paragraph (43), to which such guidance relates.

(E) AGGREGATION RULES.—For purposes of this paragraph, in determining whether a person meets the requirements of this paragraph to be a pooled plan provider with respect to any plan, all persons who perform services for the plan and who are treated as a single employer under subsection (b), (c), (m), or (o) of section 414 of the Internal Revenue Code of 1986 shall be treated as one person.

(45) PENSION-LINKED EMERGENCY SAVINGS ACCOUNT.—The term "pension-linked emergency savings account" means a short-term savings account established and maintained as part of an individual account plan, in accordance with section 801, on behalf of an eligible participant (as such term is defined in section 801(b)) that—

(A) is a designated Roth account (within the meaning of section 402A of the Internal Revenue Code of 1986) and accepts only participant contributions, as described in section 801(d)(1)(A), which are designated Roth contributions subject to the rules of section 402A(e) of such Code; and

(B) meets the requirements of part 8 of subtitle B.

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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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SEC. 736. RULES APPLICABLE TO GROUP HEALTH PLANS ESTABLISHED AND MAINTAINED BY A GROUP OR ASSOCIATION OF EMPLOYERS.

(a) PREMIUM RATES FOR A GROUP OR ASSOCIATION OF EMPLOYERS.—

(1)(A) In the case of a group health plan established and maintained by a group or association of employers described in section 3(5)(B), such plan may—

(i) establish base premium rates formed on an actuarially sound, modified community rating methodology that considers the pooling of all plan participant claims; and

(ii) utilize the specific risk profile of each employer member of such group or association to determine contribution rates for each such employer member's share of a premium by actuarially adjusting above or below the established base premium rates.

(B) For purposes of paragraph (1), the term "employer member" means—

(i) an employer who is a member of such group or association of employers and employs at least 1 common law employee; or

(ii) a group made up solely of self-employed individuals, within which all of the self-employed individual members of such group or association are aggregated together as a single employer member group, provided the group includes at least 20 self-employed individual members.

(2) In the event a group or association is made up solely of self-employed individuals (and no employers with at least 1 common law employee are members of such group or association), the group health plan established by such group or association shall—

(A) treat all self-employed individuals who are members of such group or association as a single risk pool;

(B) pool all plan participant claims; and

(C) charge each plan participant the same premium rate.

(b) DISCRIMINATION AND PRE-EXISTING CONDITION PROTECTIONS.—A group health plan established and maintained by a group or association of employers described in section 3(5)(B) shall be prohibited from—

(1) establishing any rule for eligibility (including continued eligibility) of any individual (including an employee of an employer member or a self-employed individual, or a dependent of such employee or self-employed individual) to enroll for benefits under the terms of the plan that discriminates based on any health status-related factor that relates to such individual (consistent with the rules under section 702(a)(1));

(2) requiring an individual (including an employee of an employer member or a self-employed individual, or a dependent of such employee or self-employed individual), as a condition of enrollment or continued enrollment under the plan, to pay a premium or contribution that is greater than the premium or contribution for a similarly situated individual enrolled in the plan based on any health status-related factor that relates to such individual (consistent with the rules under section 702(b)(1)); and

(3) denying coverage under such plan on the basis of a preexisting condition (consistent with the rules under section 2704 of the Public Health Service Act).

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MINORITY VIEWS

INTRODUCTION

Committee Democrats oppose H.R. 2868, the *Association Health Plans Act*. This misguided legislation would put comprehensive and affordable coverage for small businesses and workers at risk, create loopholes that undermine critical consumer protections, and raise costs across the broader health insurance market.

Before the *Affordable Care Act* (ACA),[1] workers often had limited options for obtaining affordable health coverage.[2] People with preexisting conditions were particularly disadvantaged, because they could be charged higher rates or denied coverage altogether in the individual market. Small businesses employing women or workers with chronic or high-cost illnesses could be charged higher premiums, often making coverage unaffordable. Those who could afford to buy coverage in the individual and small group market often found their insurance did not cover vital services, such as behavioral health or maternity care.[3]

The ACA took steps to level the playing field—establishing safeguards for workers and employers alike. The ACA created Marketplaces where individuals, self-employed people, and families can access affordable health coverage, and the law has also protected workers and businesses in the small group market from unfair practices.[4] Consumers have benefited from these protections for over a decade despite dozens of attempts to undermine this progress through Republican votes to repeal the ACA in Congress[5] and ideologically-driven litigation—most recently through a lawsuit attacking coverage for lifesaving preventive health services such as lung cancer screenings, preexposure prophylaxis for HIV prevention, and medications to lower the risk of breast cancer for high-risk women.[6]

In addition to instituting crucial consumer protections, the ACA has led to historic improvements in the number of people with health coverage. In 2022, the uninsured rate fell to 8 percent—the

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[1] Pub. L. No. 111–148 (2010).

[2] Sara R. Collins et al., *How the Affordable Care Act Has Improved Americans' Ability to Buy Health Insurance on Their Own*, Commonwealth Fund (Feb. 1, 2017), https://www.commonwealthfund.org/publications/issue-briefs/2017/feb/how-affordable-care-act-has-improved-americans-ability-buy.

[3] Center on Budget and Policy Priorities, *Essential Health Benefits Under Threat*, https://www.cbpp.org/essential-health-benefits-under-threat (last visited June 8, 2023).

[4] Nicole Rapfogel et al., *10 Ways the ACA Has Improved Health Care in the Past Decade,* Center for American Progress (Mar. 23, 2020), https://www.americanprogress.org/article/10-ways-aca-improved-health-care-past-decade/.

[5] Chris Riotta, *GOP Aims To Kill Bazaar Yet Again After Failing 70 Times*, Newsweek (July 29, 2017), http://www/gop-health-care-bill-repeal-and-replace-70-failed-attempts-643832.

[6] Laurie Sob el et al., *Explaining Litigation Challenging the ACA's Preventive Services Requirements: Braid wood Management Inc. v. Becker, Kaiser Family Foundation* (May 15, 2023), http://www/omens-health-policy/issue-brief/explaining-litigation-challenging-the-acas-preventive-services-requirements-braidwood-management/.

lowest level in history.[7] During the 117th Congress, Democrats took bold action to build upon this progress and further improve affordability. The *American Rescue Plan Act* (ARPA)[8] and the Inflation Reduction Act (IRA)[9] strengthened the advance premium tax credits and eliminated the subsidy "cliff" for individuals earning over 400 percent of the Federal Poverty Level through 2025. Thanks to these reforms, during the most recent Open Enrollment Period, a record 16.3 million people signed up for coverage through Healthcare and State-Based Marketplaces, and the average consumer saved $800 per year in premiums.[10]

While health care costs for many workers and businesses remain a challenge, association health plans (Apes) are not the answer. Apes are arrangements sponsored by small employer groups or individuals to provide health insurance to their members outside the traditional small group and individual market. Expanding these arrangements, as proposed under H.R. 2868, threatens to harm workers and small businesses by making coverage more expensive for many and entirely out of reach for some. In the April 26, 2023, hearing held by the Subcommittee on Health, Employment, Labor, and Pensions titled *Reducing Health Care Costs for Working Americans and Their Families,* Sabrina Corvette, Research Professor and Co-Director of the Center on Health Insurance Reforms at Georgetown University's McCourt School of Public Policy, warned of the consequences of AHPs, stating that "AHPs just create new winners and losers, with the losers being those who are older and sicker."[11] This is why more than 30 leading consumer and patient groups have expressed serious concerns with H.R. 2868[12] and why Committee Democrats unanimously reject this harmful legislation.

H.R. 2868 Recycles Failed Republican Policies

Under current law, coverage offered through a group or association to individuals or small employers must generally comply with the patient protections of the ACA and state insurance law.[13] However, Republicans have long sought legislative and regulatory changes that eliminate guardrails that protect consumers, por-

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[7] Aiden Lee et al., *National Uninsured Rate Reaches All-Time Low in Early 2022*, Assistant Secretary for Planning and Evaluation, U.S. Dept. of Health and Human Services (Aug. 2022), http://ape/sites/default/files/documents/15c1f9899b3f203887deba90e3005f5a/Uninsured-Q1-2022-Data-Point-HP 2022 23 08.pdf.

[8] Pub. L. No. 117–2 (2021).

[9] Pub. L. No. 117–169 (2022).

[10] Centers for Medicare & Medicaid Services, *Biden-Harris Administration Announces Record-Breaking 16.3 Million People Signed Up for Health Care Coverage in ACA Marketplaces During 2022–2023 Open Enrollment Season* (Jan. 25, 2023), http://www/about/news/2023/01/25/maiden-hair-breaking-16-3-million-people-signed-up-health-care-coverage-aca-marketplaces-during-2022 2023-open-enrollment-season.html.

[11] *Reducing Health Care Costs for Working Americans and Their Families: Hearing Before the Subcomm. on Health, Empl., Lab., and Pensions of the H. Comm. On Educ. & the Workforce*, 118th Cong. 10 (2023) (testimony of Sabrina Corlette, Research Professor and Co-Director, Center on Health Insurance Reforms at the Georgetown University McCourt School of Public Policy).

[12] *Patient community concerns about the detrimental impact of policies included in HR 2868, the Association Health Plans Act; HR 824, the Telehealth Benefit Expansion for Workers Act; and HR 2813, the Self-Insurance Protection Act*, Letter to Chair Virginia Foxx and Ranking Member Bobby Scott, H. Comm. on Educ. & the Workforce, Full Committee Markup (June 6, 2023) *(on file with author)*.

[13] 29 U.S.C. §1144(b)(6); Centers for Medicare and Medicaid Services, *Application of Individual and Group Market Requirements under Title XXVII of the Public Health Service Act when Insurance Coverage Is Sold to, or through, Associations* (Sept. 1, 2011), https://www.cms.gov/CCIIO/Resources/Files/Downloads/association_9coverage_9_1_2011.pdf.

traying such proposals as extending affordable health insurance options to small businesses. By radically expanding the circumstances in which AHPs can provide coverage to small employers and individuals without complying with critical safeguards, H.R. 2868 recycles this harmful idea.

Expansion of AHPs has been central to the Republican health care agenda for decades, most recently in Republican attempts to repeal the ACA.[14] In 2017, the Committee marked up H.R. 1101, the *Small Business Health Fairness Act*, which would have expanded AHPs in a manner that would undermine important consumer protections. At the time, Committee Republicans described this legislation as a key component of their plan for "repealing and replacing Obamacare in the 115th Congress."[15] These partisan repeal efforts were rejected in the Senate and the ACA remains the law of the land.

Since Republicans failed to enact their AHP proposals legislatively, in 2018, the Trump Administration attempted to do so through executive action by proposing and finalizing a rule[16] to expand AHPs under the Employee Retirement Income Security Act of 1974 (ERISA).[17] This rule would have dramatically expanded the circumstances under which AHPs could be offered as single-employer group health plans—even to self-employed individuals without any common law employees. However, on March 28, 2019, in *State of New York* v. *United States Department of Labor*, Judge John D. Bates, an appointee of President George W. Bush, struck down the core provisions of the final rule, describing it as "an end-run around the ACA"[18] that "does violence to ERISA."[19] Accordingly, the court vacated and remanded the remaining provisions of the final rule to the Department of Labor for reconsideration.[20]

Having failed time and again in their efforts to expand AHPs, Committee Republicans have now put forward H.R. 2868 in yet another attempt to achieve this goal. Under this legislation, ERISA's standards would be eroded such that sole proprietors with no common law employees would be considered "employers," and AHP arrangements would be able to evade many of the consumer protections that would otherwise apply to the individual or small group market. In addition, the bill would treat AHPs as ERISA-covered

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[14] *See*, e.g., H.R. 1136, *Affordable Health Care Act of 1999* (106th Congress); H.R. 1101, *Small Business Health Fairness Act of 2017* (115th Congress).

[15] H. Rep. 115–43 at 24 (2017).

[16] U.S. Dep't of Lab., Final Rule: Definition of "Employer" Under Section 3(5) of ERISA Association Health Plans, 83 Fed. Reg. 28912 (June 21, 2018), https://www.federalregister.gov/documents/2018/06/21/2018-12992/definition-of-employer-under-section-35-of-erisa-association-health-plans.

[17] Pub. L. No. 93–406 (1974).

[18] *New York* v. *United States Dep't of Lab.*, 363 F. Supp. 3d 109, 117 (D.D.C. 2019).

[19] Id.

[20] *Id.* at 141. Note that the ruling was appealed to the United States Court of Appeals for the District of Columbia Circuit but has been on hold since February 8, 2021, while "[t]he matter remains under consideration by the Department." Status Report at 1, New York v. United States Dep't of Lab., Case No. 19–5125 (D.C. Cir. Aug. 2022). Democrats have since encouraged the Department to act to protect consumers from harm. On Feb. 13, 2023, Ranking Member Scott and HELP Subcommittee Ranking Member DeSaulnier wrote to the Assistant Secretary for the Employee Benefits Security Administration to express support for the agency's proposed rulemaking to rescind the Trump Administration's AHP final rule. See Letter from Ranking Member Bobby Scott and Ranking Member Mark DeSaulnier to the Assistant Secretary of Labor Lisa M. Gomez (Feb. 13, 2023), https://democrats-edworkforce.house.gov/imo/media/doc/rm_scott_letter_ to_ebsa_ on_ trump-era_association_ health_ plan_rule.pdf.

group health plans exempt from state law, thereby circumventing the authority of state insurance regulators.

H.R. 2868 Creates Market Fragmentation and Raises Health Care Costs

Under the ACA, health insurance sold through an association to individuals and small employers generally must meet the same standards that apply to coverage sold in the individual and small group market.[21] However, by allowing small employers and individuals to instead be subject to requirements applicable to large employers, H.R. 2868 unravels these protections and allows association health plans to operate under different rules.

Experts have consistently warned that this approach—which is antithetical to the foundational principles of the ACA that ensure no one gets left behind—would fragment the health insurance market. According to the American Academy of Actuaries, allowing AHPs to operate under different rules could result in adverse selection that raises costs throughout the insurance pool and creates a market in which higher-cost groups—namely, those that are generally sicker or older—"could find it more difficult to obtain coverage."[22] Similarly, in its assessment of the Trump Administration's final rule on AHPs, the Congressional Budget Office determined that "the primary factor driving lower premiums for AHPs is the ability to price premiums on the basis of each association's expected health care spending and thereby attract employers with relatively low-risk employees and avoid those with higher-risk employees."[23]

H.R. 2868 Threatens Comprehensive, Affordable Coverage

Under H.R. 2868, AHPs could evade state and federal benefit standards and consumer protections, threatening the quality of coverage provided to their own enrollees. As a result, enrollees run the risk of—potentially unknowingly—losing out on comprehensive care that would otherwise be guaranteed under the ACA and state law. While the bill applies some superficial consumer protections to AHPs (e.g., nominal protections against discrimination based on preexisting conditions), it creates other large loopholes that leave consumers vulnerable.

Disturbingly, this legislation explicitly authorizes AHPs to set premiums based on the "specific risk profile" of employer members, enabling AHPs to charge higher premiums to groups based on their age, gender, or other factors. Moreover, even if premiums are not set directly on health-related factors by an association, under this bill, premiums could take into account numerous other factors that raise costs for people who are older or have preexisting condi-

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[21] Centers for Medicare & Medicaid Services, *supra note* 13 (2011).

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

[23] Cong. Budget Office, How CBO and JCT Analyzed Coverage Effects of New Rules for Association Health Plans and Short-Term Plans 5 (Jan. 2019), https://www.cbo.gov/system/files/2019 01/54915-New_Rules_ for_AHPs_STPs.pdf.

tions.[24] As a result, this bill would all but invite AHPs to charge workers with more expensive health needs far higher premiums—if those workers could even afford to participate in the associations at all.

Allowing insurers and health plans to avoid covering needed benefits is a longstanding tenet of Republicans' approach to health care.[25] H.R. 2868 is no different. Despite coverage of essential health benefits being both popular and necessary,[26] under the legislation, AHPs would be exempt from this foundational protection of the ACA. As a result, AHPs could exclude certain categories of coverage, such as maternity care, mental health, or substance use disorder, to dissuade certain groups or individuals from enrolling. Reducing benefit levels or avoiding the costs of providing comprehensive benefits can reduce costs in the short-term but will ultimately negatively impact consumers and people who need coverage the most. Individuals enrolled in AHPs could be shocked to find they do not have access to the care they need or the financial security they expected.

H.R. 2868 Gambles With the Financial Security of Workers, Employers, and Providers

H.R. 2868 allows AHPs to evade state regulations that prevent fraud and mismanagement. This is profoundly dangerous for consumers and employers who participate in these arrangements, as well as the doctors, health centers, and hospitals who may not receive reimbursement for the medical care they provide. Ms. Corlette explained the high stakes at the HELP Subcommittee hearing:

> [I]f history is any guide, many AHPs may seem strong at first because they are able to attract healthy groups and can offer low rates and generous benefits to those groups. Over time, however, as workers get older and sicker, the risk in the pool deteriorates. AHPs then either must raise rates, reduce benefits, disband, or, in the worst cases, become insolvent.[27]

The history of multiple employer welfare arrangements (MEWAs) offers a sobering warning for the financial risks posed by the proliferation of AHPs. H.R. 2868 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.[28] In 2001, Sunkist

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[24] *See* Sarah Lueck, *Association Health Plan Expansion Likely to Hurt Consumers, State Insurance Markets*, Cen. on Budg. & Poli. Priorities (Mar. 7, 2019), https://www.cbpp.org/research/health/association-health-plan-expansion-likely-to-hurt-consumers-state-insurance-markets.

[25] See e.g., Lydia Mitts et al., House Republicans Gut Protections for Pre-Existing Conditions in Latest Proposal, Families USA (Mar. 26, 2017), https://familiesusa.org/ resources/house-republicans-gut-protections-for-pre-existing-conditions-in- latest-proposal/.

[26] Dania Palanker, Eliminating Essential Health Benefits Will Shift Financial Risk Back to Consumers, The Commonwealth Fund (Mar. 24, 2017), https://www.commonwealthfund.org/blog/2017/eliminating-essential-health-benefits-will-shift-financial-risk-back-consumers.

[27] Corlette, supra note 11 at 10.

[28] U.S. Dept. of Lab., MEWAs Multiple Employer Welfare Arrangements under the Employee Retirement Income Security Act (ERISA): A Guide to Federal and State Regulation at 3 ("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, the U.S. Congress amended ERISA in 1983, as part of Public Law 97–473, to provide an exception to ERISA's broad preemption provisions for the regulation of MEWAs under State insurance laws.").

Growers, Inc., a California-based MEWA that covered 23,000 people, became insolvent, leaving behind approximately $11 million in unpaid claims.[29] Similarly, New Jersey's Coalition of Automotive Retailers became insolvent in 2002, leaving 20,000 individuals without coverage and $15 million in unpaid claims.[30]

Unfortunately, MEWAs continue to face financial challenges and heightened risk of fraud to this day. The Department of Labor routinely documents investigations and enforcement actions against MEWAs that have committed violations of ERISA and failed to pay promised benefits.[31] Just last month, it was announced that health plan participants, employers, and medical providers harmed by a MEWA operating in 36 states would begin to finally receive payments related to more than $54 million in unpaid health claims.[32] Unfortunately, despite these enforcement efforts, victims are often not made whole, leaving workers, employers, and health care providers to absorb financial losses caused by fraudulent and mismanaged MEWAs.[33] By expanding AHPs and undermining states' ability to regulate these arrangements, H.R. 2868 would dramatically worsen this already serious problem.

DEMOCRATIC AMENDMENTS OFFERED DURING MARKUP OF H.R. 2868

Committee Democrats put forward four amendments to improve the bill. These amendments would have ensured that AHPs would have to cover benefits provided by plans in the ACA-compliant small group and individual market and would have protected consumers from other potential harms that could result from enactment of this legislation.

Committee Republicans rejected all four of the Democratic amendments that were considered.

Amendment	Offered By	Description	Action Taken
#2	Ms. Jayapal	To require association health plans to cover maternity and newborn care.	Defeated
#3	Mr. Scott	To provide that the bill will not take effect if it will raise premiums for people with preexisting conditions.	Defeated
#4	Mr. Norcross	To require association health plans to cover mental health and substance use disorder.	Defeated
#5	Mrs. Hayes	To provide that the bill will not take effect if it will raise premiums for older workers.	Defeated

CONCLUSION

H.R. 2868, the *Association Health Plans Act*, would erode the protections in the ACA and leave small businesses and their workers vulnerable to unaffordable health coverage and fewer benefits. The expansion of AHPs will threaten affordable coverage for those

[29] Mila Kofman, et al., MEWAs: The Threat of Plan Insolvency and Other Challenges, Commonwealth Fund (Mar. 2004), https://www.commonwealthfund.org/sites/default/files /documents/ _media_files_publications_issue_brief_2004_mar_mewas_the_threat_of_plan_insolvency_and_ other_challenges_kofman_mewas_pdf.pdf.

[30] *Id.*

[31] Christine Monahan, *Updates from the MEWA Files: The Good, the Bad, and the Ugly of Federal Enforcement Efforts*, CHIRblog (Dec. 19, 2019), https://chirblog.org/mewa-files-part-3-good-bad-ugly/.

[32] Press Release, U.S. Dep't of Labor, Federal Court Approves Plan To Distribute Assets to Participants Harmed by Underfunded Group Health Plan Arrangement Operating in 36 States (May 1, 2023), https://www.dol.gov/newsroom/releases/ ebsa/ebsa20230501.

[33] Monahan, *supra* note 29.

outside of the associations while failing to provide comprehensive, reliable coverage to their own enrollees. This misguided legislation is simply a recycled attack on affordable health care and yet another effort to roll back the historic progress made under the ACA.

For the reasons stated above, Committee Democrats unanimously opposed H.R. 2868 when the Committee on Education and the Workforce considered it on June 6, 2023. We urge the House of Representatives to do the same.

ROBERT C. "BOBBY" SCOTT,
Ranking Member.
JOE COURTNEY.
MARK TAKANO.
MARK DESAULNIER.
PRAMILA JAYAPAL.
LUCY MCBATH.
RAÚL M. GRIJALVA.
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