

Hayworth Mica Ryun (KS)
 Hefley Miller (FL)
 Hensarling Miller, Gary
 Herger Moran (KS)
 Hobson Murphy
 Hoekstra Musgrave
 Hostettler Myrick
 Houghton Nethercutt
 Hulshof Neugebauer
 Hunter Ney
 Hyde Northup
 Isakson Norwood
 Issa Nunes
 Istook Nussle
 Janklow Osborne
 Jenkins Ose
 Johnson (CT) Otter
 Johnson (IL) Oxley
 Johnson, Sam Paul
 Jones (NC) Pearce
 Keller Pence
 Kelly Peterson (PA)
 Kennedy (MN) Petri
 King (IA) Pickering
 King (NY) Pitts
 Kingston Platts
 Kirk Pombo
 Kline Porter
 Knollenberg Portman
 Kolbe Pryce (OH)
 LaHood Putnam
 Latham Quinn
 LaTourette Radanovich
 Leach Ramstad
 Lewis (CA) Regula
 Lewis (KY) Rehberg
 Linder Renzi
 LoBiondo Reynolds
 Lucas (OK) Rogers (AL)
 Manzullo Rogers (KY)
 McCotter Rogers (MI)
 McCrery Rohrabacher
 McHugh Ros-Lehtinen
 McInnis Royce
 McKeon Ryan (WI)

Camp Cannon
 Cantor Schrock
 Capito Sensenbrenner
 Cardoza Sessions
 Carson (OK) Shadegg
 Carter Shaw
 Case Shays
 Castle Sherwood
 Chabot Shimkus
 Choccola Shuster
 Coble Simmons
 Cole Simpson
 Collins Smith (MI)
 Cramer Smith (TX)
 Crane Souder
 Crenshaw Stearns
 Cubin Sullivan
 Culberson Sweeney
 Cunningham Tancredo
 Davis (AL) Tauzin
 Davis (TN) Taylor (NC)
 Davis, Jo Ann Terry
 Davis, Tom Thomas
 Deal (GA) Thornberry
 DeFazio Tiahrt
 DeLay Tiberi
 DeMint Toomey
 Diaz-Balart, L. Turner (OH)
 Diaz-Balart, M. Upton
 Doolittle Vitter
 Dreier Walden (OR)
 Duncan Walsh
 Dunn Ramstad
 Edwards Wamp
 Ehlers Weldon (FL)
 Emerson Weldon (PA)
 Engel Weller
 English Whitfield
 Everett Wicker
 Feeney Wilson (NM)
 Ferguson Wilson (SC)
 Flake Wolf
 Fletcher Young (AK)
 Foley Young (FL)
 Forbes
 Fossella
 Franks (AZ)
 Frelinghuysen
 Gallegly
 Garrett (NJ)
 Gerlach
 Gibbons
 Gilchrest
 Gillmor
 Gingrey
 Goodlatte
 Goss
 Granger
 Graves
 Green (WI)
 Greenwood
 Gutknecht
 Hall
 Harris
 Hart
 Hastings (WA)
 Hayes
 Hayworth
 Hefley
 Hensarling
 Herger
 Hobson

Hoekstra
 Hostettler
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 Istook
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 Johnson (IL)
 Johnson, Sam
 Jones (NC)
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 McCarthy (NY)
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 Miller, Gary
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Pickering
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 Platts
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 Rogers (AL)
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 Royce
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 Ryun (KS)
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 Sessions
 Shadegg
 Shaw
 Shays
 Sherwood
 Shimkus
 Shuster
 Simmons
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 Skelton
 Smith (MI)
 Smith (TX)
 Souder
 Stearns
 Stenholm
 Sullivan
 Sweeney
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 Tauzin
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 Tiberi
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 Turner (OH)
 Turner (TX)
 Upton
 Vitter
 Walden (OR)
 Walsh
 Wamp
 Weldon (FL)
 Weldon (PA)
 Weller
 Whitfield
 Wicker
 Wilson (NM)
 Wilson (SC)
 Wolf
 Wu
 Young (AK)
 Young (FL)

Miller, George
 Mollohan
 Moore
 Murtha
 Nadler
 Napolitano
 Neal (MA)
 Oberstar
 Obey
 Olver
 Ortiz
 Owens
 Pallone
 Pascrell
 Pastor
 Payne
 Pelosi
 Pomeroy
 Price (NC)
 Rahall
 Rangel
 Reyes
 Rodriguez
 Ross
 Rothman
 Roybal-Allard
 Ruppertsberger
 Rush
 Ryan (OH)
 Sabo
 Sanchez, Linda
 T.
 Sanchez, Loretta
 Sanders
 Sandlin
 Schakowsky
 Schiff
 Scott (GA)
 Scott (VA)
 Serrano
 Sherman
 Slaughter
 Snyder
 Solis
 Spratt
 Stark
 Strickland
 Stupak
 Tanner
 Tauscher
 Thompson (CA)
 Thompson (MS)
 Tierney
 Towns
 Udall (CO)
 Udall (NM)
 Van Hollen
 Velazquez
 Vislosky
 Waters
 Watson
 Watt
 Waxman
 Weiner
 Wexler
 Woolsey
 Wynn

NOT VOTING—9

Carson (IN) Gephardt
 Conyers Hastings (FL)
 Costello Kleczka

Miller (MI)
 Smith (NJ)
 Smith (WA)

ANNOUNCEMENT BY THE SPEAKER PRO TEMPORE
 The SPEAKER pro tempore (Mrs. EMERSON) (during the vote). There are 2 minutes remaining to vote.

□ 1346

Mr. RUPPERSBERGER changed his vote from “no” to “aye.”
 So the motion to recommit was rejected.
 The result of the vote was announced as above recorded.
 The SPEAKER pro tempore. The question is on the passage of the bill.
 The question was taken; and the Speaker pro tempore announced that the ayes appeared to have it.

RECORDED VOTE

Mr. PRICE of North Carolina. Madam Speaker, I demand a recorded vote.
 A recorded vote was ordered.
 The SPEAKER pro tempore. This will be a 5-minute vote.
 The vote was taken by electronic device, and there were—ayes 252, noes 170, not voting 12, as follows:

[Roll No. 293]
 AYES—252

Aderholt Biggart Boswell
 Akin Bilirakis Boyd
 Alexander Bishop (NY) Bradley (NH)
 Bachus Bishop (UT) Brady (TX)
 Baker Blackburn Brown (SC)
 Ballenger Blunt Brown-Waite,
 Barrett (SC) Boehlert Ginny
 Bartlett (MD) Boehner Burgess
 Barton (TX) Bonilla Burr
 Bass Bonner Burton (IN)
 Beauprez Bono Buyer
 Bereuter Boozman Calvert

Abercrombie Crowley
 Ackerman Cummings
 Allen Davis (CA)
 Andrews Davis (FL)
 Baca Davis (IL)
 Baird DeGette
 Baldwin Delahunt
 Ballance DeLauro
 Becerra Deutsch
 Bell Dicks
 Berkley Dingell
 Berry Doggett
 Bishop (GA) Dooley (CA)
 Blumenauer Doyle
 Boucher Emanuel
 Brady (PA) Eshoo
 Brown, Corrine Etheridge
 Capps Evans
 Capuano Farr
 Cardin Fattah
 Clay Filner
 Clyburn Ford
 Cooper Frank (MA)
 Frost

Gonzalez
 Goode
 Gordon
 Green (TX)
 Grijalva
 Gutierrez
 Harman
 Hill
 Hinchey
 Hinojosa
 Hoeffel
 Holden
 Holt
 Honda
 Hooley (OR)
 Hoyer
 Inslee
 Jackson (IL)
 Jackson-Lee
 (TX)
 Jefferson
 Johnson, E. B.
 Jones (OH)
 Kanjorski

NOT VOTING—12

Brown (OH) Costello Kleczka
 Burns Cox Miller (MI)
 Carson (IN) Gephardt Smith (NJ)
 Conyers Hastings (FL) Smith (WA)

ANNOUNCEMENT BY THE SPEAKER PRO TEMPORE
 The SPEAKER pro tempore (Mrs. EMERSON) (during the vote). There are 2 minutes left on this vote.

□ 1352

Mr. MORAN of Virginia changed his vote from “aye” to “no.”
 So the bill was passed.
 The result of the vote was announced as above recorded.
 A motion to reconsider was laid on the table.

GENERAL LEAVE

Mr. PORTMAN. Madam Speaker, I ask unanimous consent that all Members may have 5 legislative days within which to revise and extend their remarks on the subject of H.R. 1528, the bill just passed.
 The SPEAKER pro tempore. Is there objection to the request of the gentleman from Ohio?
 There was no objection.

SMALL BUSINESS HEALTH FAIRNESS ACT OF 2003

Mr. BOEHNER. Madam Speaker, pursuant to House Resolution 283, I call up the bill (H.R. 660) to amend title I of the Employee Retirement Income Security Act of 1974 to improve access and choice for entrepreneurs with small businesses with respect to medical care for their employees, and ask for its immediate consideration in the House.
 The Clerk read the title of the bill.
 The SPEAKER pro tempore. Pursuant to House Resolution 283, the bill is considered read for amendment.
 The text of H.R. 660 is as follows:

H.R. 660

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE AND TABLE OF CONTENTS.

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

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

Sec. 1. Short title and table of contents.

Sec. 2. Rules governing association health plans.

“PART 8—RULES GOVERNING ASSOCIATION HEALTH PLANS

“Sec. 801. Association health plans.

“Sec. 802. Certification of association health plans.

“Sec. 803. Requirements relating to sponsors and boards of trustees.

“Sec. 804. Participation and coverage requirements.

“Sec. 805. Other requirements relating to plan documents, contribution rates, and benefit options.

“Sec. 806. Maintenance of reserves and provisions for solvency for plans providing health benefits in addition to health insurance coverage.

“Sec. 807. Requirements for application and related requirements.

“Sec. 808. Notice requirements for voluntary termination.

“Sec. 809. Corrective actions and mandatory termination.

“Sec. 810. Trusteeship by the Secretary of insolvent association health plans providing health benefits in addition to health insurance coverage.

“Sec. 811. State assessment authority.

“Sec. 812. Definitions and rules of construction.

Sec. 3. Clarification of treatment of single employer arrangements.

Sec. 4. Clarification of treatment of certain collectively bargained arrangements.

Sec. 5. Enforcement provisions relating to association health plans.

Sec. 6. Cooperation between Federal and State authorities.

Sec. 7. Effective date and transitional and other rules.

SEC. 2. RULES GOVERNING ASSOCIATION HEALTH PLANS.

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

“PART 8—RULES GOVERNING ASSOCIATION HEALTH PLANS

“SEC. 801. ASSOCIATION HEALTH PLANS.

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

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

“(1) is organized and maintained in good faith, with a constitution and bylaws specifically stating its purpose and providing for periodic meetings on at least an annual basis, as a bona fide trade association, a bona fide industry association (including a rural electric cooperative association or a rural telephone cooperative association), a bona fide professional association, or a bona fide chamber of commerce (or similar bona fide business association, including a corporation or similar organization that operates on a cooperative basis (within the mean-

ing of section 1381 of the Internal Revenue Code of 1986)), for substantial purposes other than that of obtaining or providing medical care;

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

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

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

“SEC. 802. CERTIFICATION OF ASSOCIATION HEALTH PLANS.

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

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

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

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

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

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

“(1) a plan which offered such coverage on the date of the enactment of the Small Business Health Fairness Act of 2003,

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

“(3) a plan whose eligible participating employers represent one or more trades or busi-

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

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

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

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

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

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

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

“(A) **IN GENERAL.**—Except as provided in subparagraphs (B) and (C), the members of the board of trustees are individuals selected from individuals who are the owners, officers, directors, or employees of the participating employers or who are partners in the participating employers and actively participate in the business.

“(B) **LIMITATION.**—

“(i) **GENERAL RULE.**—Except as provided in clauses (ii) and (iii), no such member is an owner, officer, director, or employee of, or partner in, a contract administrator or other service provider to the plan.

“(ii) **LIMITED EXCEPTION FOR PROVIDERS OF SERVICES SOLELY ON BEHALF OF THE SPONSOR.**—Officers or employees of a sponsor which is a service provider (other than a contract administrator) to the plan may be members of the board if they constitute not more than 25 percent of the membership of the board and they do not provide services to the plan other than on behalf of the sponsor.

“(iii) **TREATMENT OF PROVIDERS OF MEDICAL CARE.**—In the case of a sponsor which is an association whose membership consists primarily of providers of medical care, clause (i) shall not apply in the case of any service provider described in subparagraph (A) who is a provider of medical care under the plan.

“(C) **CERTAIN PLANS EXCLUDED.**—Subparagraph (A) shall not apply to an association health plan which is in existence on the date of the enactment of the Small Business Health Fairness Act of 2003.

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

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

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

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

The Secretary may by regulation, through negotiated rulemaking, define for purposes of this subsection the terms ‘franchiser’, ‘franchise network’, and ‘franchisee’.

“(d) CERTAIN COLLECTIVELY BARGAINED PLANS.—

“(1) IN GENERAL.—In the case of a group health plan described in paragraph (2)—

“(A) the requirements of subsection (a) and section 801(a)(1) shall be deemed met;

“(B) the joint board of trustees shall be deemed a board of trustees with respect to which the requirements of subsection (b) are met; and

“(C) the requirements of section 804 shall be deemed met.

“(2) REQUIREMENTS.—A group health plan is described in this paragraph if—

“(A) the plan is a multiemployer plan; or

“(B) the plan is in existence on April 1, 2003, and would be described in section 3(40)(A)(i) but solely for the failure to meet the requirements of section 3(40)(C)(ii).

“(3) CONSTRUCTION.—A group health plan described in paragraph (2) shall only be treated as an association health plan under this part if the sponsor of the plan applies for, and obtains, certification of the plan as an association health plan under this part.

“SEC. 804. PARTICIPATION AND COVERAGE REQUIREMENTS.

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

“(1) each participating employer must be—

“(A) a member of the sponsor,

“(B) the sponsor, or

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

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

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

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

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

“(b) COVERAGE OF PREVIOUSLY UNINSURED EMPLOYEES.—In the case of an association health plan in existence on the date of the enactment of the Small Business Health Fairness Act of 2003, an affiliated member of the sponsor of the plan may be offered cov-

erage under the plan as a participating employer only if—

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

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

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

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

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

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

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

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

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

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

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

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

“(C) incorporates the requirements of section 806.

“(2) CONTRIBUTION RATES MUST BE NON-DISCRIMINATORY.—

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

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

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

“(ii) varying contribution rates for small employers in a State to the extent that such rates could vary using the same methodology employed in such State for regulating premium rates in the small group market with respect to health insurance coverage offered in connection with bona fide associations (within the meaning of section 2791(d)(3) of the Public Health Service Act), subject to the requirements of section 702(b) relating to contribution rates.

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

“(4) MARKETING REQUIREMENTS.—

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

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

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

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

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

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

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

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

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

“(i) a reserve sufficient for unearned contributions;

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

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

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

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

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

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

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

Any regulations prescribed by the applicable authority pursuant to clause (i) or (ii) of subparagraph (B) may allow for such adjustments in the required levels of excess/stop loss insurance as the qualified actuary may recommend, taking into account the specific circumstances of the plan.

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

“(1) \$500,000, or

“(2) such greater amount (but not greater than \$2,000,000) as may be set forth in regulations prescribed by the applicable authority through negotiated rulemaking, based on the level of aggregate and specific excess/stop loss insurance provided with respect to such plan.

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

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

“(e) ALTERNATIVE MEANS OF COMPLIANCE.—The applicable authority may permit an association health plan described in subsection (a)(2) to substitute, for all or part of the requirements of this section (except subsection (a)(2)(B)(iii)), such security, guarantee, hold-harmless arrangement, or other financial arrangement as the applicable authority determines to be adequate to enable the plan to fully meet all its financial obligations on a timely basis and is otherwise no less protective of the interests of participants and bene-

ficiaries than the requirements for which it is substituted. The applicable authority may take into account, for purposes of this subsection, evidence provided by the plan or sponsor which demonstrates an assumption of liability with respect to the plan. Such evidence may be in the form of a contract of indemnification, lien, bonding, insurance, letter of credit, recourse under applicable terms of the plan in the form of assessments of participating employers, security, or other financial arrangement.

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

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

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

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

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

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

“(3) ASSOCIATION HEALTH PLAN FUND.—

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

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

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

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

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

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

“(B) which is guaranteed renewable; and

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

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

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

“(B) which is guaranteed renewable; and

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

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

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

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

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

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

“(j) SOLVENCY STANDARDS WORKING GROUP.—

“(1) IN GENERAL.—Within 90 days after the date of the enactment of the Small Business Health Fairness Act of 2003, the applicable authority shall establish a Solvency Standards Working Group. In prescribing the initial regulations under this section, the applicable authority shall take into account the recommendations of such Working Group.

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

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

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

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

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

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

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

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

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

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

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

“(A) the sponsor; and

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

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

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

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

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

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

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

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

“(C) **CURRENT AND PROJECTED VALUE OF ASSETS AND LIABILITIES.**—A statement of actuarial opinion signed by a qualified actuary,

which sets forth the current value of the assets and liabilities accumulated under the plan and a projection of the assets, liabilities, income, and expenses of the plan for the 12-month period referred to in subparagraph (B). The income statement shall identify separately the plan’s administrative expenses and claims.

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

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

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

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

“(e) **REPORTING REQUIREMENTS FOR CERTAIN ASSOCIATION HEALTH PLANS.**—An association health plan certified under this part which provides benefit options in addition to health insurance coverage for such plan year shall meet the requirements of section 503B by filing an annual report under such section which shall include information described in subsection (b)(6) with respect to the plan year and, notwithstanding section 503C(a)(1)(A), shall be filed with the applicable authority not later than 90 days after the close of the plan year (or on such later date as may be prescribed by the applicable authority). The applicable authority may require by regulation through negotiated rulemaking such interim reports as it considers appropriate.

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

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

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

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

“SEC. 808. NOTICE REQUIREMENTS FOR VOLUNTARY TERMINATION.

“Except as provided in section 809(b), an association health plan which is or has been certified under this part may terminate (upon or at any time after cessation of accruals in benefit liabilities) only if the board of trustees—

“(1) not less than 60 days before the proposed termination date, provides to the participants and beneficiaries a written notice of intent to terminate stating that such termination is intended and the proposed termination date;

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

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

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

“SEC. 809. CORRECTIVE ACTIONS AND MANDATORY TERMINATION.

“(a) **ACTIONS TO AVOID DEPLETION OF RESERVES.**—An association health plan which is certified under this part and which provides benefits other than health insurance coverage shall continue to meet the requirements of section 806, irrespective of whether such certification continues in effect. The board of trustees of such plan shall determine quarterly whether the requirements of section 806 are met. In any case in which the board determines that there is reason to believe that there is or will be a failure to meet such requirements, or the applicable authority makes such a determination and so notifies the board, the board shall immediately notify the qualified actuary engaged by the plan, and such actuary shall, not later than the end of the next following month, make such recommendations to the board for corrective action as the actuary determines necessary to ensure compliance with section 806. Not later than 30 days after receiving from the actuary recommendations for corrective actions, the board shall notify the applicable authority (in such form and manner as the applicable authority may prescribe by regulation through negotiated rulemaking) of such recommendations of the actuary for corrective action, together with a description of the actions (if any) that the board has taken or plans to take in response to such recommendations. The board shall thereafter report to the applicable authority, in such form and frequency as the applicable authority may specify to the board, regarding corrective action taken by the board until the requirements of section 806 are met.

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

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

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

the board of trustees of the plan shall, at the direction of the applicable authority, terminate the plan and, in the course of the termination, take such actions as the applicable authority may require, including satisfying any claims referred to in section 806(a)(2)(B)(iii) and recovering for the plan

any liability under subsection (a)(2)(B)(iii) or (e) of section 806, as necessary to ensure that the affairs of the plan will be, to the maximum extent possible, wound up in a manner which will result in timely provision of all benefits for which the plan is obligated.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

“(1) the sponsor and plan administrator;

“(2) each participant;

“(3) each participating employer; and

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

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

“(e) OTHER PROCEEDINGS.—An application by the Secretary under this subsection may be filed notwithstanding the pendency in the same or any other court of any bankruptcy, mortgage foreclosure, or equity receivership proceeding, or any proceeding to reorganize, conserve, or liquidate such plan or its property, or any proceeding to enforce a lien against property of the plan.

“(f) JURISDICTION OF COURT.—

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

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

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

“SEC. 811. STATE ASSESSMENT AUTHORITY.

“(a) IN GENERAL.—Notwithstanding section 514, a State may impose by law a contribution tax on an association health plan described in section 806(a)(2), if the plan commenced operations in such State after the date of the enactment of the Small Business Health Fairness Act of 2003.

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

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

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

“(3) such tax is otherwise nondiscriminatory; and

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

“SEC. 812. DEFINITIONS AND RULES OF CONSTRUCTION.

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

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

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

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

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

“(5) APPLICABLE AUTHORITY.—

“(A) IN GENERAL.—Except as provided in subparagraph (B), the term ‘applicable authority’ means, in connection with an association health plan—

“(i) the State recognized pursuant to subsection (c) of section 506 as the State to which authority has been delegated in connection with such plan; or

“(ii) if there is no State referred to in clause (i), the Secretary.

“(B) EXCEPTIONS.—

“(i) JOINT AUTHORITIES.—Where such term appears in section 808(3), section 807(e) (in the first instance), section 809(a) (in the second instance), section 809(a) (in the fourth instance), and section 809(b)(1), such term means, in connection with an association health plan, the Secretary and the State referred to in subparagraph (A)(i) (if any) in connection with such plan.

“(ii) REGULATORY AUTHORITIES.—Where such term appears in section 802(a) (in the first instance), section 802(d), section 802(e), section 803(d), section 805(a)(5), section 806(a)(2), section 806(b), section 806(c), section 806(d), paragraphs (1)(A) and (2)(A) of section 806(g), section 806(h), section 806(i), section 806(j), section 807(a) (in the second instance), section 807(b), section 807(d), section 807(e) (in the second instance), section 808 (in the matter after paragraph (3)), and section 809(a) (in the third instance), such term means, in connection with an association health plan, the Secretary.

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

“(7) INDIVIDUAL MARKET.—

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

“(B) TREATMENT OF VERY SMALL GROUPS.—

“(i) IN GENERAL.—Subject to clause (ii), such term includes coverage offered in connection with a group health plan that has

fewer than 2 participants as current employees or participants described in section 732(d)(3) on the first day of the plan year.

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

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

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

“(10) QUALIFIED ACTUARY.—The term ‘qualified actuary’ means an individual who is a member of the American Academy of Actuaries or meets such reasonable standards and qualifications as the Secretary may provide by regulation through negotiated rule-making.

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

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

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

“(C) in the case of an association health plan in existence on the date of the enactment of the Small Business Health Fairness Act of 2003, a person eligible to be a member of the sponsor or one of its member associations.

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

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

“(b) RULES OF CONSTRUCTION.—

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

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

“(B) in the case of a self-employed individual, the term ‘employer’ (as defined in section 3(5)) and the term ‘employee’ (as de-

finied in section 3(6)) shall include such individual.

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

(b) CONFORMING AMENDMENTS TO PREEMPTION RULES.—

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

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

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

(A) in subsection (b)(4), by striking “Subsection (a)” and inserting “Subsections (a) and (e)”;

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

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

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

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

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

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

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

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

“(4) For purposes of this subsection, the term ‘association health plan’ has the meaning provided in section 801(a), and the terms

‘health insurance coverage’, ‘participating employer’, and ‘health insurance issuer’ have the meanings provided such terms in section 811, respectively.”

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

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

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

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

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

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

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

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

“(2) Nothing in any other provision of law enacted on or after the date of the enactment of the Small Business Health Fairness Act of 2003 shall be construed to alter, amend, modify, invalidate, impair, or supersede any provision of this title, except by specific cross-reference to the affected section.”

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

(d) DISCLOSURE OF SOLVENCY PROTECTIONS RELATED TO SELF-INSURED AND FULLY INSURED OPTIONS UNDER ASSOCIATION HEALTH PLANS.—Section 102(b) of such Act (29 U.S.C. 102(b)) is amended by adding at the end the following: “An association health plan shall include in its summary plan description, in connection with each benefit option, a description of the form of solvency or guarantee fund protection secured pursuant to this Act or applicable State law, if any.”

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

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

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

“PART 8—RULES GOVERNING ASSOCIATION HEALTH PLANS

“Sec. 801. Association health plans.

“Sec. 802. Certification of association health plans.

“Sec. 803. Requirements relating to sponsors and boards of trustees.

“Sec. 804. Participation and coverage requirements.

“Sec. 805. Other requirements relating to plan documents, contribution rates, and benefit options.

“Sec. 806. Maintenance of reserves and provisions for solvency for plans providing health benefits in addition to health insurance coverage.

"Sec. 807. Requirements for application and related requirements.

"Sec. 808. Notice requirements for voluntary termination.

"Sec. 809. Corrective actions and mandatory termination.

"Sec. 810. Trusteeship by the Secretary of insolvent association health plans providing health benefits in addition to health insurance coverage.

"Sec. 811. State assessment authority.

"Sec. 812. Definitions and rules of construction."

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

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

(1) in clause (i), by inserting "for any plan year of any such plan, or any fiscal year of any such other arrangement;" after "single employer", and by inserting "during such year or at any time during the preceding 1-year period" after "control group";

(2) in clause (iii)—

(A) by striking "common control shall not be based on an interest of less than 25 percent" and inserting "an interest of greater than 25 percent may not be required as the minimum interest necessary for common control"; and

(B) by striking "similar to" and inserting "consistent and coextensive with";

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

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

"(iv) in determining, after the application of clause (i), whether benefits are provided to employees of two or more employers, the arrangement shall be treated as having only one participating employer if, after the application of clause (i), the number of individuals who are employees and former employees of any one participating employer and who are covered under the arrangement is greater than 75 percent of the aggregate number of all individuals who are employees or former employees of participating employers and who are covered under the arrangement;"

SEC. 4. CLARIFICATION OF TREATMENT OF CERTAIN COLLECTIVELY BARGAINED ARRANGEMENTS.

(a) IN GENERAL.—Section 3(40)(A)(i) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1002(40)(A)(i)) is amended to read as follows:

"(i)(I) under or pursuant to one or more collective bargaining agreements which are reached pursuant to collective bargaining described in section 8(d) of the National Labor Relations Act (29 U.S.C. 158(d)) or paragraph Fourth of section 2 of the Railway Labor Act (45 U.S.C. 152, paragraph Fourth) or which are reached pursuant to labor-management negotiations under similar provisions of State public employee relations laws, and (II) in accordance with subparagraphs (C), (D), and (E);"

(b) LIMITATIONS.—Section 3(40) of such Act (29 U.S.C. 1002(40)) is amended by adding at the end the following new subparagraphs:

"(C) For purposes of subparagraph (A)(i)(II), a plan or other arrangement shall be treated as established or maintained in accordance with this subparagraph only if the following requirements are met:

"(i) The plan or other arrangement, and the employee organization or any other entity sponsoring the plan or other arrangement, do not—

"(I) utilize the services of any licensed insurance agent or broker for soliciting or enrolling employers or individuals as participating employers or covered individuals under the plan or other arrangement; or

"(II) pay any type of compensation to a person, other than a full time employee of the employee organization (or a member of the organization to the extent provided in regulations prescribed by the Secretary through negotiated rulemaking), that is related either to the volume or number of employers or individuals solicited or enrolled as participating employers or covered individuals under the plan or other arrangement, or to the dollar amount or size of the contributions made by participating employers or covered individuals to the plan or other arrangement;

except to the extent that the services used by the plan, arrangement, organization, or other entity consist solely of preparation of documents necessary for compliance with the reporting and disclosure requirements of part 1 or administrative, investment, or consulting services unrelated to solicitation or enrollment of covered individuals.

"(ii) As of the end of the preceding plan year, the number of covered individuals under the plan or other arrangement who are neither—

"(I) employed within a bargaining unit covered by any of the collective bargaining agreements with a participating employer (nor covered on the basis of an individual's employment in such a bargaining unit); nor

"(II) present employees (or former employees who were covered while employed) of the sponsoring employee organization, of an employer who is or was a party to any of the collective bargaining agreements, or of the plan or other arrangement or a related plan or arrangement (nor covered on the basis of such present or former employment),

does not exceed 15 percent of the total number of individuals who are covered under the plan or arrangement and who are present or former employees who are or were covered under the plan or arrangement pursuant to a collective bargaining agreement with a participating employer. The requirements of the preceding provisions of this clause shall be treated as satisfied if, as of the end of the preceding plan year, such covered individuals are comprised solely of individuals who were covered individuals under the plan or other arrangement as of the date of the enactment of the Small Business Health Fairness Act of 2003 and, as of the end of the preceding plan year, the number of such covered individuals does not exceed 25 percent of the total number of present and former employees enrolled under the plan or other arrangement.

"(iii) The employee organization or other entity sponsoring the plan or other arrangement certifies to the Secretary each year, in a form and manner which shall be prescribed by the Secretary through negotiated rulemaking that the plan or other arrangement meets the requirements of clauses (i) and (ii).

"(D) For purposes of subparagraph (A)(i)(II), a plan or arrangement shall be treated as established or maintained in accordance with this subparagraph only if—

"(i) all of the benefits provided under the plan or arrangement consist of health insurance coverage; or

"(ii)(I) the plan or arrangement is a multi-employer plan; and

"(II) the requirements of clause (B) of the proviso to clause (5) of section 302(c) of the Labor Management Relations Act, 1947 (29 U.S.C. 186(c)) are met with respect to such plan or other arrangement.

"(E) For purposes of subparagraph (A)(i)(II), a plan or arrangement shall be treated as established or maintained in accordance with this subparagraph only if—

"(i) the plan or arrangement is in effect as of the date of the enactment of the Small Business Health Fairness Act of 2003; or

"(ii) the employee organization or other entity sponsoring the plan or arrangement—

"(I) has been in existence for at least 3 years; or

"(II) demonstrates to the satisfaction of the Secretary that the requirements of subparagraphs (C) and (D) are met with respect to the plan or other arrangement."

(c) CONFORMING AMENDMENTS TO DEFINITIONS OF PARTICIPANT AND BENEFICIARY.—Section 3(7) of such Act (29 U.S.C. 1002(7)) is amended by adding at the end the following new sentence: "Such term includes an individual who is a covered individual described in paragraph (40)(C)(ii)."

SEC. 5. ENFORCEMENT PROVISIONS RELATING TO ASSOCIATION HEALTH PLANS.

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

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

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

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

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

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

"(3) being a plan or arrangement with respect to which the requirements of subparagraph (C), (D), or (E) of section 3(40) are met, shall, upon conviction, be imprisoned not more than 5 years, be fined under title 18, United States Code, or both."

(b) CEASE ACTIVITIES ORDERS.—Section 502 of such Act (29 U.S.C. 1132), as amended by sections 141 and 143, is further amended by adding at the end the following new subsection:

"(p) ASSOCIATION HEALTH PLAN CEASE AND DESIST ORDERS.—

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

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

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

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

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

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

"(B) with respect to each State in which the plan or arrangement offers or provides

benefits, the plan or arrangement is operating in accordance with applicable State laws that are not superseded under section 514.

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

(c) RESPONSIBILITY FOR CLAIMS PROCEDURE.—Section 503 of such Act (29 U.S.C. 1133), as amended by section 301(b), is amended by adding at the end the following new subsection:

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

SEC. 6. COOPERATION BETWEEN FEDERAL AND STATE AUTHORITIES.

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

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

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

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

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

“(2) RECOGNITION OF PRIMARY DOMICILE STATE.—In carrying out paragraph (1), the Secretary shall ensure that only one State will be recognized, with respect to any particular association health plan, as the State to which consultation is required. In carrying out this paragraph, the Secretary shall take into account the places of residence of the participants and beneficiaries under the plan and the State in which the trust is maintained.”.

SEC. 7. EFFECTIVE DATE AND TRANSITIONAL AND OTHER RULES.

(a) EFFECTIVE DATE.—The amendments made by sections 2, 5, and 6 shall take effect one year from the date of the enactment. The amendments made by sections 3 and 4 shall take effect on the date of the enactment of this Act. The Secretary of Labor shall first issue all regulations necessary to carry out the amendments made by this subtitle within one year from the date of the enactment. Such regulations shall be issued through negotiated rulemaking.

(b) EXCEPTION.—Section 801(a)(2) of the Employee Retirement Income Security Act of 1974 (added by section 2) does not apply in connection with an association health plan (certified under part 8 of subtitle B of title I of such Act) existing on the date of the enactment of this Act, if no benefits provided thereunder as of the date of the enactment of this Act consist of health insurance coverage (as defined in section 733(b)(1) of such Act).

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

(1) IN GENERAL.—In any case in which, as of the date of the enactment of this Act, an arrangement is maintained in a State for the purpose of providing benefits consisting of medical care for the employees and beneficiaries of its participating employers, at least 200 participating employers make contributions to such arrangement, such arrangement has been in existence for at least

10 years, and such arrangement is licensed under the laws of one or more States to provide such benefits to its participating employers, upon the filing with the applicable authority (as defined in section 812(a)(5) of the Employee Retirement Income Security Act of 1974 (as amended by this subtitle)) by the arrangement of an application for certification of the arrangement under part 8 of subtitle B of title I of such Act—

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

(B) the requirements of sections 801(a)(1) and 803(a)(1) of the Employee Retirement Income Security Act of 1974 shall be deemed met with respect to such arrangement;

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

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

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

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

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

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

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

The SPEAKER pro tempore. The committee amendment in the nature of a substitute printed in the bill is adopted.

The text of the committee amendment in the nature of a substitute is as follows:

H.R. 660

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE AND TABLE OF CONTENTS.

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

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

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

“PART 8—RULES GOVERNING ASSOCIATION HEALTH PLANS

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

“Sec. 807. Requirements for application and related requirements.

“Sec. 808. Notice requirements for voluntary termination.

“Sec. 809. Corrective actions and mandatory termination.

“Sec. 810. Trusteeship by the Secretary of insolvent association health plans providing health benefits in addition to health insurance coverage.

“Sec. 811. State assessment authority.

“Sec. 812. Definitions and rules of construction.

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

SEC. 2. RULES GOVERNING ASSOCIATION HEALTH PLANS.

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

“PART 8—RULES GOVERNING ASSOCIATION HEALTH PLANS

“SEC. 801. ASSOCIATION HEALTH PLANS.

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

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

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

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

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

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

“SEC. 802. CERTIFICATION OF ASSOCIATION HEALTH PLANS.

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

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

date on which the plan is to commence operations, will be met) with respect to the plan.

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

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

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

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

“(1) a plan which offered such coverage on the date of the enactment of the Small Business Health Fairness Act of 2003.

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

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

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

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

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

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

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

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

“(A) BOARD MEMBERSHIP.—

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

“(ii) LIMITATION.—

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

“(II) LIMITED EXCEPTION FOR PROVIDERS OF SERVICES SOLELY ON BEHALF OF THE SPONSOR.—Officers or employees of a sponsor which is a service provider (other than a contract administrator) to the plan may be members of the board if they constitute not more than 25 percent of the membership of the board and they do not provide services to the plan other than on behalf of the sponsor.

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

“(iii) CERTAIN PLANS EXCLUDED.—Clause (i) shall not apply to an association health plan which is in existence on the date of the enactment of the Small Business Health Fairness Act of 2003.

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

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

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

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

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

“SEC. 804. PARTICIPATION AND COVERAGE REQUIREMENTS.

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

“(1) each participating employer must be—

“(A) a member of the sponsor,

“(B) the sponsor, or

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

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

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

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

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

“(b) COVERAGE OF PREVIOUSLY UNINSURED EMPLOYEES.—In the case of an association

health plan in existence on the date of the enactment of the Small Business Health Fairness Act of 2003, an affiliated member of the sponsor of the plan may be offered coverage under the plan as a participating employer only if—

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

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

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

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

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

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

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

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

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

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

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

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

“(C) incorporates the requirements of section 806.

“(2) CONTRIBUTION RATES MUST BE NON-DISCRIMINATORY.—

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

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

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

“(ii) varying contribution rates for small employers in a State to the extent that such rates

could vary using the same methodology employed in such State for regulating premium rates in the small group market with respect to health insurance coverage offered in connection with bona fide associations (within the meaning of section 2791(d)(3) of the Public Health Service Act), subject to the requirements of section 702(b) relating to contribution rates.

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

“(4) MARKETING REQUIREMENTS.—

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

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

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

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

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

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

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

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

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

“(i) a reserve sufficient for unearned contributions;

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

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

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

“(B) establishes and maintains aggregate and specific excess/stop loss insurance and solvency

indemnification, with respect to such additional benefit options for which risk of loss has not yet been transferred, as follows:

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

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

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

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

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

“(1) \$500,000, or

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

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

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

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

may be in the form of a contract of indemnification, lien, bonding, insurance, letter of credit, recourse under applicable terms of the plan in the form of assessments of participating employers, security, or other financial arrangement.

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

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

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

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

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

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

“(3) ASSOCIATION HEALTH PLAN FUND.—

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

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

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

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

“(A) under which an insurer (meeting such minimum standards as the applicable authority may prescribe by regulation) provides for payment to the plan with respect to aggregate

claims under the plan in excess of an amount or amounts specified in such contract;

“(B) which is guaranteed renewable; and

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

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

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

“(B) which is guaranteed renewable; and

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

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

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

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

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

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

“(j) SOLVENCY STANDARDS WORKING GROUP.—

“(1) IN GENERAL.—Within 90 days after the date of the enactment of the Small Business Health Fairness Act of 2003, the applicable authority shall establish a Solvency Standards Working Group. In prescribing the initial regulations under this section, the applicable authority shall take into account the recommendations of such Working Group.

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

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

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

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

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

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

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

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

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

“(b) INFORMATION TO BE INCLUDED IN APPLICATION FOR CERTIFICATION.—An application for

certification under this part meets the requirements of this section only if it includes, in a manner and form which shall be prescribed by the applicable authority by regulation, at least the following information:

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

“(A) the sponsor; and

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

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

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

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

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

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

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

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

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

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

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

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

vidual is located or in which such individual is employed.

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

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

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

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

“(2) represent such actuary’s best estimate of anticipated experience under the plan. The opinion by the qualified actuary shall be made with respect to, and shall be made a part of, the annual report.

“SEC. 808. NOTICE REQUIREMENTS FOR VOLUNTARY TERMINATION.

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

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

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

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

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

“SEC. 809. CORRECTIVE ACTIONS AND MANDATORY TERMINATION.

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

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

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

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

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

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

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

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

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

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

done by the plan administrator or any trustee of the plan;

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

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

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

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

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

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

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

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

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

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

“(1) the sponsor and plan administrator;

“(2) each participant;

“(3) each participating employer; and

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

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

“(e) OTHER PROCEEDINGS.—An application by the Secretary under this subsection may be filed notwithstanding the pendency in the same or any other court of any bankruptcy, mortgage foreclosure, or equity receivership proceeding, or any proceeding to reorganize, conserve, or liquidate such plan or its property, or any proceeding to enforce a lien against property of the plan.

“(f) JURISDICTION OF COURT.—

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

retary as trustee, the court may stay any proceeding to enforce a lien against property of the plan or the sponsor or any other suit against the plan or the sponsor.

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

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

“SEC. 811. STATE ASSESSMENT AUTHORITY.

“(a) IN GENERAL.—Notwithstanding section 514, a State may impose by law a contribution tax on an association health plan described in section 806(a)(2), if the plan commenced operations in such State after the date of the enactment of the Small Business Health Fairness Act of 2003.

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

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

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

“(3) such tax is otherwise nondiscriminatory; and

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

“SEC. 812. DEFINITIONS AND RULES OF CONSTRUCTION.

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

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

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

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

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

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

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

“(7) INDIVIDUAL MARKET.—

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

“(B) *TREATMENT OF VERY SMALL GROUPS.*—

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

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

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

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

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

“(11) *AFFILIATED MEMBER.*—The term ‘affiliated member’ means, in connection with a sponsor—

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

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

“(C) in the case of an association health plan in existence on the date of the enactment of the Small Business Health Fairness Act of 2003, a person eligible to be a member of the sponsor or one of its member associations.

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

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

“(b) *RULES OF CONSTRUCTION.*—

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

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

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

“(2) *PLANS, FUNDS, AND PROGRAMS TREATED AS EMPLOYEE WELFARE BENEFIT PLANS.*—In the case

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

(b) *CONFORMING AMENDMENTS TO PREEMPTION RULES.*—

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

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

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

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

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

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

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

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

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

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

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

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

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

“(B) relating to prompt payment of claims.

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

“(5) For purposes of this subsection, the term ‘association health plan’ has the meaning pro-

vided in section 801(a), and the terms ‘health insurance coverage’, ‘participating employer’, and ‘health insurance issuer’ have the meanings provided such terms in section 812, respectively.”

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

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

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

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

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

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

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

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

“(2) Nothing in any other provision of law enacted on or after the date of the enactment of the Small Business Health Fairness Act of 2003 shall be construed to alter, amend, modify, invalidate, impair, or supersede any provision of this title, except by specific cross-reference to the affected section.”

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

(d) *DISCLOSURE OF SOLVENCY PROTECTIONS RELATED TO SELF-INSURED AND FULLY INSURED OPTIONS UNDER ASSOCIATION HEALTH PLANS.*—Section 102(b) of such Act (29 U.S.C. 102(b)) is amended by adding at the end the following: “An association health plan shall include in its summary plan description, in connection with each benefit option, a description of the form of solvency or guarantee fund protection secured pursuant to this Act or applicable State law, if any.”

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

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

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

"PART 8—RULES GOVERNING ASSOCIATION HEALTH PLANS

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

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

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

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

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

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

"(II) in any other case, the determination";

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

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

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

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

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

(1) by inserting "(a)" after "SEC. 501."; and
 (2) by adding at the end the following new subsection:

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

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

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

"(3) being a plan or arrangement described in section 3(40)(A)(i), shall, upon conviction, be imprisoned not more than 5 years, be fined under title 18, United States Code, or both."

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

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

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

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

"(B) is an association health plan certified under part 8 and is not operating in accordance with the requirements under part 8 for such certification, a district court of the United States shall enter an order requiring that the plan or arrangement cease activities.

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

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

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

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

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

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

SEC. 5. COOPERATION BETWEEN FEDERAL AND STATE AUTHORITIES.

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

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

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

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

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

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

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

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

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

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

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

(1) **IN GENERAL.**—In any case in which, as of the date of the enactment of this Act, an arrangement is maintained in a State for the purpose of providing benefits consisting of medical care for the employees and beneficiaries of its participating employers, at least 200 participating employers make contributions to such arrangement, such arrangement has been in existence for at least 10 years, and such arrangement is licensed under the laws of one or more States to provide such benefits to its participating employers, upon the filing with the applicable authority (as defined in section 812(a)(5) of the Employee Retirement Income Security Act of 1974 (as amended by this subtitle)) by the arrangement of an application for certification of the arrangement under part 8 of subtitle B of title I of such Act—

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

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

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

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

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

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

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

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

(2) **DEFINITIONS.**—For purposes of this subsection, the terms "group health plan", "medical care", and "participating employer" shall

have the meanings provided in section 812 of the Employee Retirement Income Security Act of 1974, except that the reference in paragraph (7) of such section to an "association health plan" shall be deemed a reference to an arrangement referred to in this subsection.

The SPEAKER pro tempore. After 1 hour of debate on the bill, it shall be in order to consider the further amendment printed in House Report 108-160, if offered, by the gentleman from Wisconsin (Mr. KIND) or his designee, which shall be considered read and shall be debatable for 1 hour, equally divided and controlled by the proponent and an opponent.

The gentleman from Ohio (Mr. BOEHNER) and the gentleman from New Jersey (Mr. ANDREWS) each will control 30 minutes.

The Chair recognizes the gentleman from Ohio (Mr. BOEHNER).

Mr. BOEHNER. Madam Speaker, I yield myself such time as I may consume.

Madam Speaker, the most pressing crisis that we face in health care today is the number of Americans who lack basic health insurance benefits. It is a problem that can be illustrated by just a few numbers, so let us just look at the facts.

Today, 41 million Americans are uninsured. This problem is not going to go away, and we have a responsibility to confront it. With health care costs continuing to rise sharply across the country, more and more employers and workers are sharing the burden of increased premiums. Employer-based health insurance premiums leaped an average of 15 percent in 2003, the largest increase in at least a decade, according to a study just released June 11 by the Center for Studying Health System Change. We know that for every 1 percent increase in coverage, additional price increase, 300,000 more people lose their health insurance, according to a 1999 study by the Lewin Group, a national health care and human services consulting firm.

The second number is 60. Sixty is the percentage of the 41 million uninsured Americans who either work for a small business or who are dependent upon someone who does. So let us remember, there are 60 percent of the uninsured where they or one of their dependents works every day for a company that likely does not offer health insurance. Many of these Americans work for small employers who cannot afford to purchase quality health insurance benefits for their workers. Notably, the 2002 Census Bureau statistics show that employer-sponsored health care coverage has declined because small businesses with less than 25 workers have been forced to drop coverage because of rising health care costs. These small employers are denied the ability to purchase quality health benefits that compare with the coverage that large, multi-State corporations and unions have been offering to their workers for decades.

The last number is \$130 billion. Yes, \$130 billion is the cost to the American

economy every year of poor health and premature deaths amongst those 41 million Americans who lack basic health insurance coverage, according to a study released just this week by the Institute of Medicine. Madam Speaker, \$130 billion a year of additional costs to our society and disproportionately aimed at the 41 million Americans that do not have any health insurance.

The implications of these numbers are tragic, not just for employers who cannot afford the high cost of health insurance, but the millions of uninsured families who are being denied access to quality care. Clearly, we need to focus on providing affordable health care to the uninsured as well as ensure that employers who provide health benefits to their employees are not forced to drop coverage because of rising premiums and high administrative costs.

The Small Business Health Fairness Act, which we have on the floor today, responds to this problem and can help reduce the high cost of health insurance for small businesses and uninsured working families. By creating association health plans, which would be strictly regulated by the Department of Labor, small businesses could pool their resources and increase their bargaining power with benefit providers, which will allow them to negotiate better rates and purchase quality health care at a lower cost.

President Bush addressed this point directly last year during his speech at the Women's Entrepreneurship Summit when he said, "Small businesses will be able to pool together and spread their risk across a large employee base.

□ 1400

It makes no sense in America to isolate small businesses as little health care islands unto themselves. We must have association health plans.

Well, the President is right, and we should help level this playing field so that small businesses can afford to offer the kind of quality coverage that large companies and unions do across America today.

Importantly, the bill gives AHPs the freedom from costly State mandates because small businesses deserve to be treated in the same fashions as corporations like GM and UPS, and unions who receive the same exemption so that they can offer high quality plans and benefits to their workers. Clearly, State health care mandates are useless to families who do not have the health care coverage in the first place. And if you do not have health care coverage, State mandates requiring health plans to offer specific benefits to those they cover do you and your family no good at all.

Let us be clear on the protections this bill provides workers, however, because it includes strong safeguards to protect workers. In fact, the solvency standards in the bill go far beyond what is required any single employer

plan or labor union plan under law. And despite the bipartisan nature of this bill, some misinformation has been spread about the bill that I would like to take a moment to correct.

The measure protects against cherry-picking because we make clear that the AHPs must comply with the 1996 Health Insurance Portability and Accountability Act, HIPAA, which prohibits group health plans from excluding or charging a higher rate to high-risk individuals with a high-claims experience.

Under our bill, sick or high-risk groups or individuals cannot be denied coverage. In addition, AHPs cannot charge higher rates for employers with sicker individuals within the plan, except to the extent already allowed by State law based on where the employer is located.

The bill also contains strict requirements under which only bona fide professional and trade associations can sponsor an association health plan, and therefore does not allow sham association plans set up by health insurance companies to go out and do what some did over the next decade or so. These organizations must be established for purposes other than providing health insurance and they have to be in existence for at least 3 years prior to the passage of this bill.

This campaign of disinformation believes not just the need for the bill, but the bipartisan support behind it. Not only is it strongly supported by the President of the United States, President Bush and Secretary Chao at the Department of Labor, but it has more than 160 bipartisan co-sponsors, including my colleague, the gentleman from Texas (Mr. SAM JOHNSON), the subcommittee chairman; the gentleman from Kentucky (Mr. FLETCHER), the former member of our committee, now on the Committee on Energy and Commerce; or the Democrat member, the gentleman from California (Mr. DOOLEY); and the Democrat member, the gentlewoman from New York (Ms. VELÁZQUEZ).

It is noteworthy and significant that Republicans and Democrats alike are joining together to deal with the crisis affecting more than 41 million uninsured Americans. Uninsured workers deserve the security of knowing that health care is not just a dream but a reality for them and for their families. This bill can help make that happen.

Madam Speaker, I reserve the balance of my time.

Mr. ANDREWS. Madam Speaker, I yield myself such time as I may consume.

(Mr. ANDREWS asked and was given permission to revise and extend his remarks.)

Mr. ANDREWS. Madam Speaker, I rise in strong opposition to this bill.

The chairman of the committee is precisely right, that the problem of massive amounts of people not having health insurance is the central problem in health care. Most of the 41 million

Americans who have no health care who are adults work for a living. And most of those adults who work for a living work for a small business, so there is an intuitive appeal to an argument that says let us help make it easier for small businesses to acquire health insurance.

In fact, the substitute that the gentleman from Wisconsin (Mr. KIND) and I will be offering later in this debate does that, and we would urge our colleagues to support that.

The reality, though, is that small businesses who do not provide health care for their employees do not do so because the gap between what they can afford to pay and what they have must pay is huge. It is immense. Even the most optimistic proponents of this bill admit that the premium savings that could be generated by this bill will slender indeed, usually in the single digits of percentage points, if that.

The reality is small businesses are not going to be able to afford to expand health care without significant public subsidies. That is a fact. The majority has drained well in excess of \$2 trillion from the public Treasury with its insatiable appetite for tax cuts, and as a result, there is no money in the till. There is no money to provide those necessary subsidies. So this is the fig leaf. This is the shallow argument that says we can do something to help those small businesses.

Frankly, this bill belongs in the Orwellian hall of fame for misnomers of a piece of legislation. It is called the Small Business Health Care Fairness Act. With respect to small businesses, it provides nothing in subsidies for employers who cannot afford health insurance, not a dime. It provides for market reforms that offer an illusory and ultimately empty promise of lower premiums.

It is not a health care bill because what it does is supplant benefits that have been provided by State legislatures across this country by Republicans and Democrats, benefits that guarantee women breast cancer care, benefits that guarantee people with diabetes care for their illness, benefits that guarantee pregnant women and small children important care, benefits that protect consumers when they have been wronged by their HMO. Because this bill invalidates and wipes out those protections, the National Governors Association, Republicans and Democrats, oppose this bill. Because this bill invalidates those protections, the Attorneys General of a huge majority of the States oppose this bill. Because the bill eliminates protections for mammograms, for diabetes care, for well baby care, wipes them out, the insurance commissioners across this country oppose the bill.

It is not a health care bill. It is a political bill designed to paper over the fact that the majority already spent the money it needs to provide real relief.

Finally, it is called fairness. Where is the fairness in creating two sets of

rules for those who attempt to buy health insurance for their employees? Because that is what this bill does. It sets up one set of rules where all the protections and regulations and safeguards that most people enjoy are wiped off the books for AHPs, and then another set of rules where the remaining insurance companies must compete on an unlevel playing field. Many of us who support the substitute believe in market competition, but we believe in market competition on a level playing field. That is not what this bill does.

One of the of the most respected health care analysis firms in this country, Madam Speaker, Certified Public Accountants and Associates, looked at this bill and that firm concluded that the chairman would have to change one of his charts because he started with a chart that says there are 41 million uninsured. If this bill is enacted, the chairman will have to change his chart and X out the 41 and put 42 uninsured, because that firm has concluded that the net effect of this bill will be to drive up the premiums for insurance companies who are not AHPs, drive them up so high that it will result in the loss of coverage for one million more Americans.

This bill is an illusion. It should be defeated. Later in this debate, the gentleman from Wisconsin (Mr. KIND) and I will be presenting a substitute which we believe truly addresses the real needs of small businesses in America's uninsured.

Madam Speaker, I reserve the balance of my time.

Mr. SAM JOHNSON of Texas. Madam Speaker, I yield myself such time as I may consume.

(Mr. SAM JOHNSON of Texas asked and was given permission to revise and extend his remarks.)

Mr. SAM JOHNSON of Texas. Madam Speaker, to my friend, the gentleman from New Jersey (Mr. ANDREWS), that is total misinformation. And I would agree that the gentleman is politicizing this bill. But he is doing it, not us.

This bill makes it illegal to cherry-pick. This bill does not eliminate any form of insurance and the gentleman stated it did. It does not stop insurance companies from insuring on whatever they want to insure. And as a matter of fact, they probably will.

Furthermore, one million more people became uninsured in the past year and it was primarily because of small businesses getting out of the insurance business because it is too expensive. And I think that there is the one way in which we can ensure that people will be insured, more of them through small businesses. As a matter of fact, a private study has said about 8.5 million more will be insured.

Under our bill, sick or high risk groups or individuals cannot be denied coverage. Moreover, AHPs are severely limited in their ability to charge higher rates which my cohort said would

happen. They can not charge higher rates for sicker people or groups within the plan. AHPs can only charge different rates to the extent allowed under the law of the State where the employer is based.

The bill contains strict requirements under which only bona fide professional and trade associations can sponsor an AHP, and these organizations must be established for purposes other than providing health insurance for at least 3 years.

Now, there is considerable comment about AHPs being exempt from State coverage. As we all know, labor unions and large corporations that self-insure are already exempt from State health care mandates, and they provide quality benefits because it is in the best interest of their employees. And I will charge you that small business would apply the same reasoning. It is really a moral fairness issue. If it is good enough for labor unions, good enough for Fortune 500 companies, it ought to be good enough for small business.

We must remember that our ultimate goal here is to bring quality coverage to the 41 million Americans who have no insurance. Further, AHPs will significantly expand access to health coverage to uninsured Americans by increasing small businesses bargaining power with health care providers by giving employers freedom from costly State-mandated benefit packages.

According to a private study, as I said, AHPs should increase the number of insured Americans by up to 8.5 million people. Sadly, last year one in seven Americans went without health insurance. The increase in the number of uninsured comes solely from the declining market in the small business community. With health insurance costs continuing to rise, businesses face increases more than double the national average. Health insurance costs are still rising and many small employers are forced to drop health coverage. Some cannot even offer it in the first place.

The cost saving benefits of AHPs would help small employers of main street access coverage at a more affordable price. According to the Congressional Budget Office, AHPs would save small business owners and their employees as much as 25 percent of their health insurance costs. Just like buying a case of soda at a supermarket costs less per can than buying 24 individual cans at a vending machine, AHPs would allow groups like the National Restaurant Association to buy thousands of health insurance policies at a lower person policy cost and pass the savings along.

Let us face facts. Costs are rising. Businesses are dropping coverage, and more people are going uninsured. Congress must address the uninsured problem and move forward with increasing the insured through association health plans. It is the least this Congress can do to make certain that the American people will receive better health care at a more reasonable price.

Madam Speaker, I reserve the balance of my time.

Mr. ANDREWS. Madam Speaker, I yield myself 15 seconds.

Madam Speaker, I think it is important to point out for the record that the gentleman did admit that the benefit protections like mammogram screenings are, in fact, wiped out by the bill before us.

□ 1415

The bill before us will take away health coverage for more than 1 million people and add to the uninsured.

Madam Speaker, I yield 3 minutes to the gentleman from Wisconsin (Mr. KIND), who has offered a plan that will actually decrease the number of uninsured, which we will talk about later.

Mr. KIND. Madam Speaker, I thank the gentleman from New Jersey for yielding me this time and also commend him for his leadership and the energy he has shown on this subject, as well as the ranking member, the gentleman from California (Mr. GEORGE MILLER).

Madam Speaker, there is a serious problem throughout America in regards to the rising cost of health insurance, double-digit premium increases. As I travel around my congressional district in western Wisconsin visiting businesses large and small alike, it is the number one topic on their lips, the difficulty of being able to provide health insurance coverage for their employees with the double-digit increases that they are facing today.

Part of the problem in western Wisconsin deals with the inadequacy of Medicare reimbursement rates, which then is cost-shifted on to the private plans; but also part of the problem is the number of uninsured and the cost shifting that occurs when they receive treatment. We saw the statistics a little earlier, 41 million uninsured. Those numbers are going up. Between 50 and 60 percent of the uninsured are employees working in small businesses. It is a crisis situation out there, and I have not met a small business owner yet that is happy with the fact when they cannot provide some basic health coverage for their employees. Unless we deal with it in an honest and, I think, straightforward plan, the numbers will only get worse.

There are some here today that think H.R. 660 is the answer to the crisis we are all experiencing in our own districts. I happen to disagree. I think there are some serious flaws with H.R. 660. I believe that, at best, the underlying legislation would do very little to address the plight of the uninsured. There is a recent CBO analysis that said that, at best, we might be able to extend additional coverage for half a million Americans, a far cry from the 41 million who are currently uninsured or the 25 million who are working right now in small businesses. At worst, there is a Mercer report that shows that because of the premium increases in other health plans, we could see an-

other million Americans losing their health insurance coverage because of H.R. 660.

What also is a major problem is that it exempts State laws. These are community value judgments made in each of our States in regards to what health care practices should be covered for the citizens. Yet the legislation today is calling for a preemption of that State law, an eradication of the federalism that has existed in this country for a very long period of time. It is one of the reasons why we have so many people opposing the legislation, from the National Governors' Association, from the Democratic Governors' Association and Republican Governors' Association, the State Attorneys General Association, not to mention the Association of Insurance Plans, as well as the National Conference of State Legislatures.

Why would you, if you believe in the free market, as I think most of us do, and believe in price competition, try to set up an uneven system where you have two different sets of plans playing by two different sets of rules? It does not make sense. If you are going to force price competition in the free market system, you need to have everyone playing on a level playing field playing by the same set of rules, such as the State laws that exist right now, rather than exempting a whole category of people.

I think our substitute offers a better alternative, and I would encourage our colleagues to support that.

Mr. BOEHNER. Madam Speaker, I yield myself 15 seconds. What we want to do in this bill is to give small employers the same advantages in the marketplace that large companies and unions have today. And that is the real secret behind this. Why can they not go out as a group and design a plan that would meet their needs just like a big company can for their employees?

Madam Speaker, I yield 4 minutes to the gentleman from Kentucky (Mr. FLETCHER), the author of this bill and someone who has worked on it for many, many years.

Mr. FLETCHER. Madam Speaker, I thank the gentleman for yielding me this time and for his leadership and work on this very important piece of legislation.

Health care coverage is becoming more unaffordable for workers and small businesses all across America. In fact, the cost of providing health care now exceeds the cost of taxes. For that reason, I have introduced the Small Business Health Fairness Act to ensure that more workers can afford their health care, regardless of whether they work for a large international company or for just a small hardware store on Main Street. A farmer in Kentucky should have the same access to health benefits as someone who works for a large company like Ford Motor Company. That is where the fairness is.

Why should small business employees not be able to obtain the same econo-

mies of scale, bargaining power, benefit design and choices now available to those in large corporations and to those in labor unions? You will not hear our opponents attack those plans, I do not believe. Ninety-eight percent of large businesses offer health insurance to their employees. Less than half of small businesses offer this important benefit.

When we look at the fact that the morbidity rate of an uninsured hospitalized patient is more than twice that of an insured one, I think we can see that that is a resounding call to decrease the number of uninsured, which this bill will do. Experts estimate that up to 8½ million uninsured small business workers will be covered by AHP legislation. This plan will decrease the number of uninsured Americans, will reduce health care costs by up to 30 percent for small businesses, and provide new coverage options for self-employed, like farmers and small business workers across this Nation. It will not only give more health care coverage but allow small businesses to create more jobs.

Many have made false claims against this bill, and I would like to take a moment to set the record straight. In redrafting this bill, we have taken great lengths to ensure that these plans remain solvent. We have set up strict solvency provisions that include reserves, cash reserves, surplus reserves, stop-loss insurance, both specific and aggregate, indemnification for plan termination, insolvency funds, and a certification fee required for application.

Opponents of this legislation have also asserted AHP plans will engage in cherrypicking, taking only the young and healthy and leaving the sick to fend for themselves. These false accusers overlook or are unaware that all members of an association must be offered the plan coverage. Furthermore, plans must demonstrate that they have average or above-average risk to even be able to form an association health plan to begin with. That means an association could not be formed of young marathon runners just to provide a low-risk group.

Opponents of this legislation falsely charge that the Department of Labor is unable to handle such a program. Such statements, I believe, are baseless and contradict the facts. The DOL currently administers 2.5 million private job-based health plans. These programs serve 131 million workers. Sixty-seven million individuals now are in self-insured plans and are monitored exclusively under DOL oversight. DOL has the experience, the personnel, and the vision to monitor and enforce these plans. Besides, I know Secretary Elaine Chao. She is a friend of mine; she is a good Kentuckian. Believe me, she can effectively oversee these plans.

In conclusion, the President favors association health plans and strongly supports them. The Department of Labor is ready for AHPs; and small businesses, farmers, and the self-employed are ready for association health

plans. Uninsured Americans have waited far too long, so I ask my colleagues to do the right thing for the uninsured Americans of small businesses, not only in Kentucky but across America. Support this bill.

Mr. ANDREWS. Madam Speaker, I yield such time as he may consume to the gentleman from California (Mr. GEORGE MILLER), the leader of our committee and one of the leading opponents of this plan that would take health care coverage away from 1 million people.

Mr. GEORGE MILLER of California. Madam Speaker, I thank the gentleman for yielding me this time and for his leadership on this issue in our committee.

Once again, as with pension legislation, unemployment assistance, tax policy, and many other examples, the Republican majority of this House is bringing forward a bill that they claim is in the interest of working families. But once again this is head-fakes and sleight of hand. This bill hurts working people, places their already-meager health insurance coverage at risk, and serves only the interest of the business lobbyists.

I want to add that once again, as with those earlier bills, the Republican majority continues to deprive 206 Members of the House on the Democratic side and the tens of millions of people we represent from being able to conduct a serious debate on this issue. Once again, a contentious bill comes to the floor with no amendments allowed, just a substitute. So there is little time to debate the bill that will cost millions of Americans, including millions of children and women workers, their health coverage, with no ability to offer amendments to improve this bill. These tyrannical and corrupt rules under which we are operating under the Republican leadership in this House prevent us from having that debate and prevent the Republicans from taking votes on amendments we would like to offer.

Let us be clear: this is not a question of whether or not we have time to devote to debate. Week in and week out the Congress comes in on Tuesday or late Monday night and leaves on Thursday or early Friday morning. The Congress has time to adjourn for fundraisers, the Congress has time to adjourn for golf tournaments, the Congress has time to adjourn for the White House picnic; but apparently we do not have time to be able to offer amendments to legislation so that we can have an honest debate about the legislation before us or have opportunities to improve it or to offer an alternative view on how that should be carried out.

So what do we find out now? We do not have that opportunity here when we are risking 8 million people's health care coverage, according to the Congressional Budget Office. So we will pass today, with almost entirely Republican votes, a bill that deprives 47 percent of the people in this country a

role in debating and improving this legislation.

The heart of this ill-conceived bill is a provision that overrides State laws requiring access to basic health care services. These State laws say to people that when they have a health insurance plan, that plan will mean something. It means that they will have access to mammograms, that means that they will have access to emergency services, that means that they will have maternity benefits and well-baby care and diabetes treatment, and it means there will be some mental health coverage and cancer screening. Because those are the things that the American families need in a health care plan.

Now, why are those the rules today in States across this country? Why did the States make this determination? Not to burden small businesses, not to burden health care plans, but because what people were being offered prior to that were essentially phantom plans. They were phantom plans that had little or no benefits to individuals, that did not meet the needs that families had. They had little or no benefits in terms of what women needed in their health care policies. That is the reason for these regulations, or these requirements, that health care insurance plans provide in their health care. That is the purpose of the plans. But that was not what was happening.

So now what we see is that this comes along, and it says we are going to override the judgment of these States, we are going to override the judgment of the legislators, the collective wisdom of the Governors and legislatures, the attorneys general, the insurance commissioners and others to make sure that people have adequate health insurance. And the consequences are that we are stripping much of this treatment away from the individuals in terms of preventive services for men, women and children.

We know that these services and treatments save money, we know they preserve health in the long run, and we know that these services were rarely provided voluntarily by employers in the past. That is precisely why so many States have moved to guarantee this coverage. The proponents of this legislation constantly want to say, well, this was good for labor unions and this was good for big industry. Yes, and in those instances the employees are organized and they negotiate on an equal level. That is not the situation with these plans. These people are given a health care plan which they can take or leave. And the purpose here is to reduce the cost of those plans.

The fact of the matter is CBO has reported that approximately 8.5 million workers would end up in AHPs, and over 95 percent would simply be dumped into those from existing health care plans. That means that 8 million workers would be stripped of their current legal right to critical treatments and preventive health care services.

Eight million people would end up with less health care the next morning than they currently have under this provision.

I recognize that that means that new people will be given health insurance that do not have it, but we have to weigh the question of the people who will get this stripped-down policy as their health insurance to those people who have relatively decent policies who will lose their access to those policies. Because that is really what this is about. It is about cutting the cost to businesses, not about providing health insurance that families truly need.

That is why, again, these plans were protected in the States and were regulated in the States, and that is why so many of the Governors, both Republican and Democrat, oppose this legislation. That also means that these people are not going to have the kind of peace of mind that so many of them now have with respect to their insurance policies.

We also know that one of the reasons this bill is offered is that health insurance costs are increasing. They are increasing about 20, 25 percent for small employers. What that suggests is that, as people move into these plans, the individuals with higher risk will be left out. Those people who stayed in those kinds of insured pools, those costs will continue to go up; and it means that we will have uneven health insurance for people in this country.

□ 1430

Madam Speaker, this is a very bad bill. It is a bad bill. It really is about false advertising. It is suggesting that somehow this is going to extend to millions of people health insurance that will cover their families. That is not what it is going to do. It would if we were not overriding State law, but here the majority has decided that the collective wisdom of the States and the protection of residents and consumers in those States, that is going to be overridden and individuals be under no requirements to offer those components as part of this health insurance plan. I would hope that the House would reject this plan when it comes time to vote on the legislation.

GENERAL LEAVE

Mr. BOEHNER. Madam Speaker, I ask unanimous consent that all Members may have 5 legislative days within which to revise and extend their remarks on H.R. 660.

The SPEAKER pro tempore (Mrs. EMERSON). Is there objection to the request of the gentleman from Ohio?

There was no objection.

Mr. BOEHNER. Madam Speaker, I yield 2 minutes to the gentlewoman from New York (Ms. VELÁZQUEZ).

(Ms. VELÁZQUEZ asked and was given permission to revise and extend her remarks.)

Ms. VELÁZQUEZ. Madam Speaker, our country is in a health care crisis. Today, in the world's largest remaining superpower, 41 million Americans live

without health insurance. No place in this epidemic is more apparent than with our Nation's small businesses. They represent 60 percent of this country's uninsured.

Small business owners and their employees do not have health insurance, not because they do not want it or are trying to cut corners, but because they cannot afford it. Small companies see their insurance costs rising upwards of 25 percent each year. They are unfairly suffering this burden, and their employees are unfairly suffering without insurance.

Small businesses provide more than half of the Nation's gross domestic product, create 75 percent of all new jobs, and give two-thirds of Americans their first paychecks. Yet many small businesses are unable to provide the benefits they know the workers deserve.

Today, with the passage of this bipartisan Small Business Health Fairness Act of 2003, we take an important first step in helping millions of Americans afford what so many in this Chamber take for granted, health care.

During the debate on this legislation, Members are going to hear terms like cherrypicking, solvency, and MEWAs. If Members take one thing away from today's debate, it should be that H.R. 660 is simply about fairness, fairness for small business owners to offer health insurance to their employees just as large corporations and unions already do. If we trust large corporations and unions, we should trust small businesses in America.

If it is good enough for IBM, Lockheed-Martin and GM, it should be good enough for mainstream American businesses. H.R. 660 will give small business owners the ability to provide quality health care for themselves, their families, and, most importantly, their workers. I urge my colleagues to vote yes on H.R. 660.

Mr. ANDREWS. Madam Speaker, I yield 4 minutes to the gentleman from North Dakota (Mr. POMEROY) who, as a former insurance commissioner from North Dakota, has direct experience with AHPs running out of money and not paying their claims.

Mr. POMEROY. Madam Speaker, I appreciate the comments of my colleague about the crisis in small employer health care; but as we address this issue, I think we have to ascribe ourselves fully to the Hippocratic oath, First, do no harm.

The AHP proposal before us would do a great deal of harm. I would recommend to my colleagues, study this issue before you vote, it is very serious. If there is not enough time to get into the technical details, just look at who is against this bill. This bill could be called a wonderful, unifying force because it has brought together people who do not agree on anything, but they do agree this is bad policy for this country. The Republican Governors Association, the Democrat Governors Association, 41 State attorneys general of

both political parties, the National Association of Insurance Commissioners, again representing regulators of both political parties have reached their conclusion based on several fundamental facts.

We have spent a lot of time in this Chamber debating the Patients' Bill of Rights worrying about protections. I guess we could call this the "Patient Bill of No Rights" because it literally exposes those who would be insured under these mechanisms to whatever might be written with no consumer protections and no State insurance department to go to for those protections.

There is a nice populist argument which has been used this afternoon that if big companies can do it, little companies ought to be able to do it, too. I represent North Dakota. That is the place of small employers. The difference in a fundamental one. IBM can self-insure. They do it themselves. They basically pay themselves. A small hardware store in an AHP would be joining an association, sending their premiums not to themselves but off to others, and that is why we need the check. We have tried this before. What happens is promoters come up with these schemes, the employer goes for the lowest premium, they ship their hard-earned dollars off to provide the coverage for their employees, and someone makes off with the money. It has time and time again.

The protections protect coverage, but they also protect to make sure the plan is solvent so they can pay the health claim when the insured needs it. We have seen this tried before under the guise of multiple employer trusts. They went bankrupt; there was a slew of scandals. We have seen it now under multiple employer welfare arrangements. There were scandals, busts, uncertain insurance framework for our consumers.

Madam Speaker, now they want to call them AHPs, but the result will be precisely the same.

If it were simply a benign issue of let the buyer beware, it would be one thing; but it is much worse than that because this makes the premiums go up for all who remain in existing insurance pools. Small employers insuring through insurance companies are not viewed just on their own little group, they are part of a pool. Well, as AHPs would take off smaller healthy groups, those left would be older, sicker groups. Premiums would go up, coverage would be diminished, or dropped altogether. It has been estimated that as many as a million people would lose their coverage.

Again, do not take my word for it, look at what the Congressional Budget Office has written on this, or consider the quotes by the Mercer Consulting Group in analyzing this proposal, Health insurance premiums would increase 23 percent for small employers that continue to purchase State-regulated coverage. This would result from

AHPs' ability to attract healthier-than-average firms out of the small, regulated market. This makes the problem worse.

First, let us do no harm. We need to address small employers. The substitute to be presented has a better approach in that regard, but the underlying bill is a stinker, and let us beat it.

Mr. BOEHNER. Madam Speaker, I yield myself 30 seconds.

The foundation of our health insurance market in the United States is employer-provided coverage set up through ERISA, the Employee Retirement Income Security Act of 1974. It covers 150 million American lives. We are trying to allow small employers who belong to statewide associations, national associations, the opportunity to band together to create an insurance policy that will benefit not only the small business but, more importantly, their employees.

Madam Speaker, I yield 2 minutes to the gentlewoman from Tennessee (Mrs. BLACKBURN).

Mrs. BLACKBURN. Madam Speaker, I rise today in strong support of H.R. 660, the Small Business Health Fairness Act. Small business owners know that it is far too important to their employees to let this issue slide off the table. Employees want to have health coverage and the increasing cost is making it ever more difficult. It is important to note also in my State of Tennessee, small business is the largest employer.

This bill works to alleviate the problems by establishing the association health plans that would allow small businesses to band together under an umbrella of a bona fide trade association to act as a large purchaser of health insurance, having that ability to buy health care coverage as a large group for their employees. All employees benefit by having better coverage, increased options and lower deductibles.

Madam Speaker, last weekend I had the opportunity to address a national convention of women. It was a national convention of women who own their own businesses. Their number one concern, their top priority is passing this legislation, seeing it passed. That is, millions of women who own and work for women-owned businesses and they are very concerned about this. It is at the top of their list.

Madam Speaker, it is unfortunately that there are so many myths surrounding the debate of this bill. I join my colleagues in helping to dispel these myths, that it would allow cherrypicking. In reality, this legislation has explicit language prohibiting such. This legislation also contains solvency provisions to protect employees against the risk of health plans that default or go bankrupt. These health plans must certify through a qualified actuary that an AHP is financially sound on a quarterly basis.

Madam Speaker, I agree with thousands of female business owners that it is time to pass this legislation now.

Mr. ANDREWS. Madam Speaker, I yield 3 minutes to the gentlewoman from New York (Mrs. MCCARTHY).

Mrs. MCCARTHY of New York. Madam Speaker, I stand in strong opposition of H.R. 660. We are hearing all the time about do no harm, and I think Members need to remember, why do 48 States have good basic health care insurance? It is mainly because our advocates, breast cancer or diabetes, all of the diseases that we are trying to prevent, have made the States realize that the monies that we spend to make sure that people stay healthy certainly is cheaper in the long run. That is 48 States including New York, and what we are doing here, we are wiping that out. We are wiping that out.

As patients and advocates across this Nation quickly discovered that their basic health care needs were not being served by their insurance companies, that is why the States have forced the insurance companies to make sure that the treatments that we are asking for, like a mammogram, and how many lives have we saved over the years because we have made the insurance companies make sure they have it in their policies. The States made them do that.

What we are doing here is taking that away. They demanded that their States step in and protect them. Madam Speaker, as I said in 48 States, we have our attorneys general, we have our governors, Republicans and Democrats. What we are doing here is harm. All of us, there is not one Member in this Chamber that does not want to make sure that our small businesses are able to offer health care insurance. That is why the gentleman from New Jersey (Mr. ANDREWS) and the gentleman from Wisconsin (Mr. KIND) are going to offer an amendment that will offer help to our small businesses.

There is not one penny in this bill that is going to help small businesses get health care. The Kind-Andrews amendment will. As a nurse and certainly with the constituents I have coming into my office yesterday, today, last week, every single week, all they are asking for is to make sure that their basic health care needs are met. What we are doing here is taking it away. I will say again, there is not one Member, Republican or Democrat, that does not want to help our small businesses. We would like to see health care be out there for everybody. I certainly would, but again, we keep hearing about budget constraints. Well, if we had not passed those large tax cuts, maybe we could do some good health care policy around here.

Madam Speaker, this bill will do harm to millions of people. It is always the devil is in the details, and on the top of this legislation it might look good, but in the end it is not. All 48 States, as I have said over and over again, have fought to make sure that

our insurance companies give the services that our constituents need. That is why it was passed. That is why this bill should be defeated.

□ 1445

Mr. BOEHNER. Madam Speaker, as I said earlier, this bill does have broad bipartisan support. I am happy to yield 2 minutes to the gentleman from Maryland (Mr. WYNN).

Mr. WYNN. Madam Speaker, I rise in strong support of this piece of legislation. It is interesting, in the 10 years I have been down here, we have been able to talk about regulations, talk about cherrypicking, corporations have had insurance, big unions have had insurance, Members of Congress have had insurance; but small businesses have been crying out as they have not had insurance, and those that had it lost it because the price continues to go up.

Bottom line: we have not done anything to help small businesses and their employees have health insurance. It is time we do something.

Second, I hear a lot of talk about the great State regulations and the protections they offer and these mandated benefits and those mandated benefits. Let me tell you something. If you do not have health insurance in the first place, the mandated benefits and the regulations and the protections do not mean anything because they do not apply to you because you do not have health insurance. The fundamental bottom line is you have to have health insurance. At the end of the day that will be the question you have to ask yourself: Do you want some health insurance, or do you want to continue with no health insurance?

This plan works because it provides enhanced purchasing power for small businesses. They come together, and they have the leverage to put together an insurance plan to help those small businesses. They also can lower administrative costs so they get savings. Small businesses are very price sensitive. They will buy insurance even if they can get just a small amount of savings. So on balance it is a very good idea.

We hear a lot of talk about the vaunted cherrypicking. Again if you do not have health insurance, there is no cherrypicking because you are not there to be picked. But the important issue is there are regulations in this bill strictly regarding cherrypicking, prohibiting cherrypicking, so that is not really a problem.

Finally and most importantly, what people are saying is this is a bare bones policy and so you should not get it because it does not have all the protections that admittedly we would all like. I am submitting that it is better to have a basic policy that gets you into the doctor's office, because if you get into the doctor's office, your cancer, your heart attack, your diabetes and your blood pressure all can be picked up by your doctor. They say, it is a bare bones policy and no one's

going to get it. Let me tell you, if it is that bare bones, if it is that bad, if it does not provide any benefits at all to the employee, they are not going to purchase it. They purchase it because it provides the basic insurance that they can use.

It is not everything we would like, but it is better than nothing; and at the end of the day, half a loaf is better than none.

Mr. ANDREWS. Madam Speaker, I yield myself 30 seconds. The gentleman is correct. At the end of the day, the question is whether one has health insurance or not. At the end of the day if this bill is enacted, 1 million more people will not have health insurance than do today because of the damage that this bill does. That is one of the reasons why State legislators across this country oppose this bill. Our next colleague is someone who served in the Minnesota State legislature, who fought for laws that protect women against discrimination. She will point out that this law does not do that.

Madam Speaker, I am happy to yield 3 minutes to the gentlewoman from Minnesota (Ms. MCCOLLUM).

Ms. MCCOLLUM. Madam Speaker, I rise today in strong opposition to the substandard health coverage that will be proposed in this bill. Americans deserve affordable, quality health care coverage for our children and for our families, not this substandard bill filled with gaps, holes and exceptions that leave women and children especially vulnerable. This bill leaves gaps for expecting mothers, leaves holes for children with diabetes, leaves exceptions for families requiring mental health care coverage. This legislation rewards bad medicine by preempting every State standard that guarantees quality health care, that protects women, children, and our families.

As a Minnesota State legislator, I fought hard for our State's health care requirements. People were not getting the care that they needed or deserved. Families living with diabetes came into my office and would tell me how their health plans would cover their insulin but would not cover the needles to deliver the insulin or the test strips to test their sugar levels. This basic health care is needed to keep people with diabetes healthy and enables them to manage and control their disease. We passed laws in Minnesota mandating basic coverage that health plans were not providing. They were not providing basic health coverage.

Today we are considering legislation that rolls back these basic health care protections. Minnesotans want comprehensive, affordable health care. Minnesota health care professionals in a hearing I held, nurses, pediatricians, psychologists and, yes, their patients, told me they strongly oppose these substandard association plans.

Let us ensure quality. Let us ensure affordable health care that protects women, protects children, protects our families and does not only protect

them but protects those who we have heard over and over again, the million people who stand to lose health insurance should this bill be enacted.

Mr. BOEHNER. Madam Speaker, I am pleased to yield 2 minutes to the gentleman from California (Mr. DOOLEY), one of my good friends and colleagues on the Committee on Agriculture.

Mr. DOOLEY of California. Madam Speaker, I rise in strong support of this legislation. One of the most difficult challenges facing those of us in Congress is how do we deal with the growing number of uninsured in our country, a number that is currently over 40 million. With the increases in health care costs that we are going to be seeing in the near future, that number is only going to continue to grow. This piece of legislation is an attempt to ensure that we can find ways in which small employers and farmers across the country can come together to develop a purchasing power that can allow them to negotiate better benefits at a less cost for the people they employ.

I represent a district in the central valley of California. It is 65 percent Latino. Many of those families are farm-worker families. They are low-wage workers. They are almost without exception without health insurance today. If they do have health insurance, it is through an association health plan that was offered by Western growers. They have coverage today that is benefiting them, and it is just basic coverage. This legislation is an attempt to ensure that more of those low-wage workers will have access to health care. It is unfortunate that it is not going to be a plan that has all the mandates that some of the States would require, but what I get so frustrated with is that we are willing to deny the ability of employers to come together to offer a basic level of health insurance to a lot of their low-wage workers and their families that right now are not having access to care. We can do better. This legislation is an attempt to do so.

I am struck by a lot of the opponents of this legislation that are saying that this is going to lead to cherrypicking. I will tell you today, there are not many insurance companies that are offering a plan through the State HIPCs or whatever else that are interested in coming out and trying to market a health insurance plan to a lot of the farmers and the farm workers whom they employ. This is an attempt to ensure that we can have an association of people who are committed to that industry and to those employers that will be able to come together to develop a basic health insurance product that will benefit the health of these low-wage workers. I urge my colleagues to support this legislation.

Mr. ANDREWS. Madam Speaker, one of the Members who is opposed to expanding the ranks of the uninsured by 1 million people and, therefore, opposes this bill is the gentleman from New

York (Mr. MEEKS) to whom I yield 3 minutes.

Mr. MEEKS of New York. Madam Speaker, when I first saw the headlines of the bill, I looked at the bill, it came across my desk, because everybody wants to do something about small business. I first said to my staff, let's get on this bill; it will help small business. But then after I read it a second time and a third time, the devil is always in the details. The devil is in the fine print. The devil is in what you read.

When I really read the bill, I found that this bill would actually be devastating; it is what we call short-term gain for long-term pain. When you look over the years, the pain that really will happen to people who we are trying to help in the long-term will be devastating. Then when I looked even a little bit closer and tried to watch it to see how it affected those low-wage earners that my colleague just talked about and minorities and women in particular, then I noticed another substantial devastating event, the fact that what this bill does because many of the people that we want to help, they happen to be minority and women and how they disproportionately will be affected by this bill.

In fact, when you look at it, certain diseases because of people who are of color, Latino and African American, you look at approximately 2.8 million or 13 percent of all African Americans and 2 million or 10.2 percent of all Latino Americans have diabetes. They would not be covered under this. They could be cherrypicked. African American men have a 20 percent higher incident rate and a 40 percent higher death rate from all forms of cancer combined than white men do. They will be affected by this bill disproportionately. African American women with breast cancer are 67 percent more likely to die from the disease than Caucasians. They will be disproportionately affected under this cherrypicking, what this bill will do to them.

Hispanics experience the highest invasive cervical cancer incidence rates of any group other than Vietnamese. They will be hurt and devastated by this. Hispanics account for nearly one-fifth of HIV/AIDS cases in the United States. African Americans account for approximately 35 percent of HIV/AIDS cases in the United States. They will not be covered. They will not be picked up by these folks.

Now, more than ever, minority populations and women depend on health care. H.R. 660 stands to make this needed health care harder for those populations to obtain in the long run, not in the short run. In fact, most States require insurance to cover cancer screenings, maternity, diabetes treatment, and other benefits that provide medical care for minorities and women. However, Federal AHP legislation would allow certain insurers to avoid complying with these State laws. This means a loss of crucial benefits

for many families, that 1 million that we hear my other colleagues talking about.

While our Nation is faced with a new health care crisis, H.R. 660 is not the solution. It is absolutely not the solution. We must work to pass legislation that offers genuine relief to small employers while preserving the significant health care reforms undertaken by the States. I urge my colleagues to voice their opposition to H.R. 660, the so-called Small Business Health Fairness Act.

Mr. SAM JOHNSON of Texas. Madam Speaker, I yield 2 minutes to the gentleman from Iowa (Mr. KING), a member of the committee.

Mr. KING of Iowa. Madam Speaker, I am amazed at how the race card can be played on every single trick and every single issue that comes up. To me, this is just simply dollars and cents.

I started a small business in 1975 with actually a negative net worth of \$5,000, no capital and a dream. By the mid-80s when then Congressman Grandy came to my hometown and held a hearing on health care, 70 or 80 of us in the basement of the Lutheran church in Odebolt, Iowa, sitting in the front row because I do not hear that good, he said, how many of you provide health insurance for your employees? I raised my hand as did about 11 other people in that room. No, excuse me. I raised my hand when he said, how many of you are employers? I kept it up when he said, how many of you provide health insurance for your employees? I was the only one in that room that provided health insurance for my employees. I can tell you, I know why. It is because the cost is too high for a group plan. Because the rules and the laws discriminate against small business. This association health care plan is designed exactly to correct that.

I have been involved in association work all of my life. That is the only bargaining chip that small business has. A sole proprietor of a small business is in a position where they cannot fully deduct all of their own health care insurance unless, of course, they happen to be a corporation and they are paying themselves a wage. That was put in place at the end of World War II when we had wage and price controls, and it was put in place because large business had the leverage, unions had the leverage, but small business did not. That is what this bill corrects, this association health care bill. It corrects the inequity to some degree, and it is a small degree, that was created in World War II.

I as a small business owner simply just sold out to my oldest son, and now he is in that situation, that predicament, where he can utilize this. About 60 percent of the uninsured are employed or are the proprietors of small business. It is not because they do not care about their employees. It is because of the law; it is because of the structure of the regulations. It is essential that we pass this bill.

Madam Speaker, that is why I rise here today to stand in support of this bill for association health care plans. It is essential to small business which provides most of the new jobs and most of the new innovation in America.

Mr. ANDREWS. Madam Speaker, I yield myself 30 seconds. I want to again reemphasize that the objective analysis of this bill, contrary to what we have heard repeatedly today, is that it will increase the number of uninsured persons. It will do so because those who are not in AHPs who must still comply with the mandated benefits and other consumer protection laws will experience an escalation in premiums which will cause a reduction in coverage. We believe the record is clear, that the passage of this bill will increase the number of uninsured persons by 1 million people.

Madam Speaker, I reserve the balance of my time.

Mr. BOEHNER. Madam Speaker, I yield myself the balance of my time. We could look at the problem of the 41 million Americans through many different lenses, and we could talk about solutions. We believe that we are bringing a solution here where we are showing the glass half full.

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My colleagues on the other side want to look at this solution as a glass that is half empty. The fact is that 41 million Americans have no health insurance, and we in this Congress, over the last decade, have talked about it and talked about it and talked about it. As a matter of fact, we brought this bill to the floor on two occasions before today, and unfortunately the other body did not see fit to move the legislation. But we are not going to quit because if we do not help these 41 million Americans who have no health insurance, guess what, they are going to continue to get sicker. They are going to end up getting treatment later in their illness, and they are going to continue to pile up massive amounts of healthcare debt that by and large they do not pay for, those who purchase health insurance pay for in terms of higher fees.

We have heard all of the discussion about the fact that we do not mandate this coverage and mandate this coverage.

The reason that we have the crisis in many States is because they have mandated every coverage known to man be stipulated in each of the policies, whether they need the coverage or not. Large employer plans do not have mandates other than two small mandates that are in ERISA. Neither did the union plans. They cover virtually all of these diseases and all of these treatments because that is what their employees want. We know that bare-bones policies do not work because employers do not buy them and their employees do not want them. And if we look at the best plans in America, they happen to be large employer plans, union plans

that cover broad healthcare coverage and those employees love those plans.

Why would we not allow small businesses to come together, and whether it is through the Ohio Chamber of Commerce or the National Restaurant Association or the Lumbermen's Association, or how about the Farm Bureau, why would we not allow them to allow their members to come together where they could offer them a package of healthcare plans? Maybe it is one or two, maybe it is four or five potential plans that their members would get to choose from.

Take the issue of farmers, I have got a lot of farmers in my district. They are independent contractors. Their ability to go out and buy health insurance on not on their own is about zero unless they want to pay \$1,000 to \$2,000 a month. If they were allowed to come together with other farmers around Ohio, other farmers around the country, guess what? They would get much better coverage than they are getting today at far less cost, and why should we not give them the opportunity to do this?

So I say to my colleagues as we end the general debate today, this is a good bill. It has strong bipartisan support, and I urge my colleagues to support the underlying bill.

Ms. MAJETTE. Madam Speaker, today I voted against passage of H.R. 660, the legislation that would establish Association Health Plans (AHP's). Despite its intention to allow small businesses to band together in order to offer affordable health care benefits to their workers, this proposal will, in fact, make coverage more expensive for most small businesses and their employees. Though I support the intent of this legislation, some serious flaws became apparent during my consideration of the legislation in the Education and Workforce Committee, which prevented my support.

According to the Congressional Budget Office, 4 out of 5 of the small businesses that now have health coverage would face higher costs if H.R. 660 was enacted. A recent report by Mercer Risk, Finance & Insurance Consulting for National Small Business United underscored this fact, finding that H.R. 660 would make health coverage more, not less expensive for many small businesses. In Georgia there are 722,535 people that get insurance coverage through small businesses. If H.R. 660 passes, 578,028 of these individuals will pay higher premiums.

The problem with the legislation that will cause insurance costs to increase is a provision which preempts State laws regarding the degree to which insurance premiums can vary for different companies with a plan. Therefore, firms can be charged wildly different rates based on a variety of factors, including health status and age. This legislation would allow some nefarious companies to unfairly discriminate against consumers on the basis of age, gender or race. The ultimate effect, is that firms with sicker employees will not be able to afford coverage under an AHP. This means those firms and the firms currently in the traditional insurance market will end up paying higher premiums. Instead of offering a meaningful coverage alternative, AHP's would only

help to those healthy enough to qualify for lower rates.

Furthermore, this legislation prevents a State's insurance commissioner from protecting consumers' rights when they have concerns about their association health plan. The bill does not specify who has the duty or the authority to help consumers if they have a problem with their AHP. Instead, the bill creates a complex web of authority, in which consumers might only have recourse through the U.S. Department of Labor, which does not have the manpower or expertise to provide that help.

When consumers have a serious problem with their health insurance coverage, they need to know they have somewhere they can go for real assistance. H.R. 660 just fails to guarantee that and could make it very difficult for consumers to get any assistance with their health insurance problems.

I offered amendments in the Education and the Workforce Committee to correct both of these key concerns and improve H.R. 660, but both were rejected. For this reason, and because of my overarching concern that the bill falls short in delivering real help for small businesses, I opposed final passage of H.R. 660. In doing so, I was supported by a diverse array of over 500 national, State and local organizations including small business, consumer, insurance, union, provider, and patient advocate groups, as well as Georgia's Attorney General and Insurance Commissioner, who have joined in opposition to H.R. 660. I will continue to be an advocate for the interests of small businesses, but am convinced that H.R. 660 does not address the problems they face.

I will continue to work with my colleagues to draft legislation that would give small businesses more options in offering health insurance without supplanting Georgia's consumer protection laws.

Mrs. JONES of Ohio. Madam Speaker, I rise today in opposition to H.R. 660. The bill will exempt those businesses that decide to form Association Health Plans from health insurance regulation of the various States. Thus, under the bill, these association health plans could operate in different States but would not be subject to the different health insurance regulations of those States. Instead, they would be subject to regulation by the Labor Department. This Bill would allow "Cherry Picking." As the premiums rise, the employers will have the chance to pick who will receive the health care, which means, the employers will pick the youngest, and the healthiest for the plan so that it would not cost them as much. As a result, thousands of the sickest workers would end up losing coverage altogether. AHP will offer a very minimum benefits package that does not include cancer screening, mental health benefits, or autism coverage. CBO reports show that there are 41 million uninsured Americans and only 550,000 currently uninsured Americans would gain coverage and this number is less than one percent of the country's Americans uninsured. As health care cost rises, the problem of the uninsured shall only get worse. Ooh I get it. Hurt small employers and make coverage unaffordable for all but the healthiest groups. According to the Congressional Budget Office. Two-thirds of the lower premiums realized through AHPs would come from risk selection, and most of the rest would come from eliminating benefits.

Insured individuals switching from their current plan to an AHP would outnumber the newly insured 14-to-1.

20 million individuals would face additional rate increases under AHPs, and 10,000 of the sickest individuals would lose coverage entirely.

The 80 percent of small business employees not participating in AHPs would almost uniformly see their premiums increase.

Madam Speaker, Associated Health Plans will hurt Small Businesses and increase the ranks of the uninsured.

Mr. UDALL of Colorado. Madam Speaker, I rise in opposition to H.R. 660, the Association Health Plan bill we are considering today.

While I sympathize with the challenges that many small businesses face in providing health insurance to their employees, I do not think that exempting AHPs from State oversight is the right solution. I agree with the National Governor's Association, the National Association of Insurance Commissioners, the National Association of Attorneys General, the Health Insurance Association of America, and many other groups that oppose Federally regulated AHPs. I am most concerned that AHPs would be regulated under Federal laws and would be exempted from State laws that govern premium increases, benefits, consumer protections, and financial standards. H.R. 660 would override Colorado's new AHP law even before we have time to see if it is working. Additionally, H.R. 660 does not provide any resources to the Department of Labor to carry out important oversight functions. I believe this leaves room for much of the same abuse and fraud that we experienced with Multiple Employer Welfare Associations in the 1980s.

Insurance is based on the principle of pooling healthy and sick groups together so that the cost is more evenly distributed. Under this bill, associations would be able to circumvent State pooling requirements and siphon off healthier groups. As a result, sicker people would be left in State regulated pools, and the cost of care for these individuals would be shifted to the rest of us through higher taxes and premiums. The non-partisan Congressional Budget Office estimates that 80 percent of small employers and their families would face rate increases under this legislation.

I continue to believe that refundable health care tax credits and investments in our public health system would go much further in making health care more affordable and reducing the number of uninsured in our Nation. That's why I am supporting the substitute offered by Rep. RON KIND, which would establish the Small Employer Health Benefits plan and provide Federal subsidies to small employers who have fewer than 100 employees and offer health insurance to them.

Madam Speaker, Americans are concerned that if they get sick, they won't have health insurance coverage, or they are worried they will lose their health care in this sluggish economy. I too am concerned about the rising cost of health care and the uninsured, but removing oversight over insurance and scaling back consumer protections, benefits and coverage is not the way to go. I will continue to work on meaningful health care reform that makes insurance more affordable and provides coverage to the uninsured.

Mr. STARK. Madam Speaker, I rise today to oppose H.R. 660, the "Small Business Health Fairness Act of 2003." This bill is badly mis-

named. Rather than make the cost of health insurance for small businesses more fair, this bill would have the perverse effect of increasing the cost of health insurance for many people and increase the number of people without health insurance altogether.

This bill would allow these new entities, called Association Health Plans (AHPs), to bypass State regulation and offer bare-bones health insurance policies. Small businesses that don't choose to offer these inadequate policies would see their premiums increase by 23 percent on average. This premium hike would occur because AHPs, which would offer only skeletal coverage, would attract the healthiest individuals, leaving traditional health insurance plans with the sickest and most expensive patients. This shift would penalize businesses with sicker employees, and make health insurance for those who need it the most even more unaffordable.

Further, this legislation would swell the ranks of the uninsured by over one million more individuals. As traditional health insurance becomes increasingly expensive, more and more businesses would have no choice but to drop health insurance for their employees, leaving these individuals with little or no opportunity to purchase health coverage.

Contrary to what proponents of this bill claim, AHPs would not truly help small businesses purchase health insurance for their employees. Although proponents claim that AHPs would give small-employers bargaining power to purchase affordable health insurance, most States already have laws in place that allow for group purchasing arrangements. This bill would only harm existing laws while usurping the traditional role of States to regulate insurance.

In fact, this bill would override key State laws and regulations that protect millions of Americans. For example, many States regulate insurance premiums to prevent insurers from discriminating against the ill. But under this bill those laws wouldn't apply. AHPs would be allowed to offer extremely-low "teaser" rates, and then rapidly increase the premium if the enrollee becomes sick. Furthermore, nearly all States have enacted external review laws which guarantee patients an independent doctor review if a health plan denies them coverage for a particular service. Patients who join AHPs would lose this vitally important consumer protection.

This bill also exempts AHPs from State laws that require health insurance to cover particular benefits. These laws have helped to ensure that millions of Americans get access to the healthcare that they need—such as mammography screenings, maternity care, well-child care, and prompt payment rules. In my State, California, employees who join AHPs could well lose access to these services as well as certain emergency services, direct access to OB/GYNs, mental health parity, and other important benefits. Moreover, this law would allow health plans to "gag" doctors, the currently illegal practice of health insurers preventing doctors from discussing treatment options that the plan does not cover, even if some of those options are in the patient's best medical interest.

The problems go on. AHPs are likely to create new fraud and abuse problems in health care as well. These plans are very similar to Multiple Employer Welfare Plans (MEWAs) which Congress created in the 1970s. MEWAs

were also exempt from State insurance regulation. The Department of Labor found that many of these plans were frauds and left their enrollees holding the bag for more than \$123 million in unpaid health expenses. Congress had to come back and clean up the law to end this blatant abuse. We should learn from that mistake—not repeat it!

This bill is bad for patients, bad for small business, and bad for States. It is opposed by over 500 organizations—including both the Democratic and Republican Governors Associations, local Chambers of Commerce, small business associations, physician organizations, labor unions, and healthcare coalitions. H.R. 660 would increase premiums, increase the number of uninsured, lead to massive fraud, and remove key State protections. I urge my colleagues to reject this legislation.

Mr. CUMMINGS. Madam Speaker, I rise today to speak against the bill being considered today. With over 41 million Americans uninsured, Congress' chief objective should be to ensure that these people have access to quality health care coverage. However, today we consider legislation that actually would be an even greater detriment to the current health insurance coverage crisis, than doing nothing at all.

The Congressional Budget Office estimates that over 4 million individuals who currently have health coverage will be switched to lower benefit Association Health Plans (AHP) if this bill is passed. This means that these individuals could be forced into plans that would exclude benefits such as mammography screening, cervical cancer screening, check-ups for children, bone marrow transplants and diabetic supplies. These are critical needs, not options and this is an unfair result.

Another flaw with this bill is that it doesn't actually help small employers. The problem for most small employers is not their lack of desire to provide healthcare coverage, but often the lack of cash flow to afford monthly healthcare coverage. However, this bill does not assist small employers or their employees to afford rising monthly healthcare premiums. CBO found that the small businesses most likely to get more affordable coverage with lower premiums under AHPs would be those with the healthiest groups of employees. What this means is that least healthy, older employees and their employers would have higher premiums. This is just plain cherry-picking, which only puts the rest of non-AHP employees at risk of higher rates of coverage.

The CBO also estimates that AHPs would provide coverage for less than one percent (1 percent) of the 41 million uninsured Americans. As such, H.R. 660 fails to significantly expand health coverage for the uninsured and in fact, would reduce coverage for those who are currently insured by forcing them to switch to lower benefit AHP health plans. This will drive up the costs for other insured and will result in the loss of affordable health care coverage for at least 1,000,000 employees. This represents a net loss, not a net gain in helping the 41 million uninsured in this country.

Any bill that excludes significant health care benefits, especially for women, children and the elderly; that does not significantly expand health coverage for the uninsured; and that may allow minority communities and the elderly to be redlined and denied affordable health insurance, is "fig leaf" legislation which will do little to nothing to meet the needs of those small business employers it alleges to help.

Every American, despite his/her employer deserves to have first-class health coverage. This bill does not accomplish this goal—which explains why it is opposed by over 500 groups, including the AFL–CIO, AFSCME, the National Governors' Association, many State Attorneys General and many consumer organizations. I lend my voice to this opposition and urge my colleagues to vote against H.R. 660.

Mr. WELDON of Florida. Madam Speaker, one of the issues about which my constituents most frequently contact me is the high cost of health insurance and the need for affordable insurance coverage. We all know health insurance premiums are increasing significantly each year. As such, many small businesses are unable to afford health insurance for their employees. Furthermore, for those who can afford insurance for their employees, rising costs make U.S. products more expensive, harming U.S. competitiveness and costing American jobs.

Just last month I received a letter in my office written by a small business owner in Palm Bay, Florida. In it he wrote, "As an independent businessman, I can only afford the most basic of health insurance policies for myself, of which premiums have gone up over 100 percent in the past two years, I might add. I sacrifice greatly to insure myself. But it is getting to the point I may not be able to afford health insurance myself." I know he is not alone. We have all heard similar stories.

Small businesses are the backbone of our economy, but the financial viability of many small businesses is being hurt by the escalating costs of health insurance. This hurts job creation and economic growth. The U.S. Small Business Administration's Office of Advocacy found that administrative expenses for small health plans make up about 35 percent of total costs. This is not good for small business owners, their employees, or the American economy. Congress must address this problem, which is why I support H.R. 660, the Small Business Health Fairness Act.

By passing H.R. 660 Congress will be leveling the playing field between small businesses, the self-employed and large corporations. This allows organizations of individuals and businesses to enter into an Association Health Plan (AHP). Under an AHP, small businesses can pool their resources and purchase health care similar to the way large corporations do. They can get better bargaining power in terms of costs and benefits for their employees. It gives workers, who do not have health insurance today, the opportunity to obtain health insurance coverage.

Whether it is a small business, a trade association, a farm bureau, or a local community organization that is seeking to purchase more affordable health insurance, this legislation will help them.

It is generally accepted that there are 41 million people in America without health insurance at any given time. According to the Congressional Budget Office, a more accurate estimate of the number of people who were uninsured for all of an entire year is 21 million to 31 million. Regardless, almost 60 percent of those individuals are employed by a small business. As health care costs increase, fewer and fewer employers and working families will be able to afford coverage, and more Americans will be without adequate health insurance. Those who work for small businesses

should have the same type of access to quality health insurance that their counterparts in large corporations already enjoy.

I urge Congress to pass H.R. 660. Congress must pass this bipartisan legislation to give much needed relief to American small businesses, farmers, and hard working families.

Mr. NORWOOD. Madam Speaker, it is my opinion that H.R. 660 will hurt the ability of small employers to access insurance coverage. Contrary to creating larger pools of small employers, H.R. 660 will fragment the small group insurance market into a myriad of smaller and smaller pools with healthy small firms separated from those firms with sick employees. The basic fabric of small employer insurance—that healthy and sick must be pooled together to create cross-subsidies—will be irreparably torn to the detriment of all small firms. Small firms will be returned to the unstable and erratic marketplace of the 1980's—before states imposed small group reform protections. Specifically, the dissenting Members of the Committee find that H.R. 660 will lead to:

- (I) Higher Premiums for Most Small Firms and Rampant Discrimination
- (II) Widespread AHP Failure and Millions of Dollars in Unpaid Claims
- (III) More Uninsured—Particularly Among the Most Vulnerable
- (IV) Consumers Stripped of Their State Protections
- (V) No Administrative Cost Savings

(1) HIGHER PREMIUMS FOR MOST SMALL FIRMS AND RAMPANT DISCRIMINATION

H.R. 660 would allow insured Association Health Plans (AHPs) to avoid covering the oldest and sickest smallest employers by charging them unaffordable rates that would not be allowed if the AHP was subject to state law. As a result, the Congressional Budget Office (CBO) found that 80 percent of small employers would see their premiums increased as a result of the passage of H.R. 660. A June 2003 Mercer study predicts health insurance premiums will increase by 23 percent for small employers that continue to purchase state regulated insurance.

Under H.R. 660, insured AHPs could "forum-shop" for the state with the weakest rating rules (a handful of states lack any formal premium restrictions). Once the AHP's policy is approved in a weekly regulated state, the AHP may sell the coverage across the country without regard to the rating rules in the remaining 49 states.

For instance, New York is normally a community rating state that does not allow variation of rates between small employers because of differences in the health status of their employees. But an insured AHP could sell coverage in New York that charges much higher premiums to small employers with sick employees. This will allow the AHP to attract low-risk employers from the state regulated pool—a practice known as "cherry-picking". Employers with sick employees would remain in the state regulated pool because they would be effectively barred from the AHP through the quotation of exorbitant rates. The Small Business Administration 2003 study on Association Health Plans describes it as follows:

"Thus AHPs located in states with the less stringent state laws could offer insurance to the lower cost groups that are now forced to subsidize higher cost groups in those states

that require community rating or narrow rate "bands."

The American Academy of Actuaries warns against this exemption of AHPs from state rating rules:

"The result would be that small employers whose employees are greater health risks are more likely to obtain coverage from the private health insurance market, where rates are limited, than through AHPs, who may not have the same limitations. State small group legislation sought to eliminate this sort of selection in the market by requiring health insurers to put all their small groups in one pool and to limit the premium charged to one employer relative to another. Introducing AHPs that are not required to adhere to the same rating rules brings selection back into the market. The consequence will be that the rates for the two pools will diverge, causing further instability in an already fragile marketplace."

The Committee had an opportunity to clarify this critical point during the Committee markup. Representative Majette (D–GA) offered an amendment that would have prohibited AHPs from varying the rates of small employers beyond the variance allowed under state law. The Committee rejected this amendment.

Indeed, it appears that proponents of AHP passage have long held evasion of state rating rules as a key objective. In "Insuring the Uninsured through Association Health Plans," the AHP proponent National Center for Policy Analysis argues against premium rating restrictions in the small group market because they "keep premiums artificially low for the sickest groups and artificially high for the healthiest." NCPA argues that "in a competitive market, every new person in a plan will tend to be charged a premium that reflects the expected costs of that person's health care at the time of entry into the plan. . . . However, in health insurance the tradition is to scorn new entrants for 'cherry picking.' Yet cherry picking is nothing more than trying to satisfy consumer needs better than a rival."

It is also important to recognize that H.R. 660 would allow discrimination against small firms with sick employees before and after enrollment with an AHP. In this cruel "bait and switch" game, a small firm believes it has secure health insurance coverage only to find it placed in jeopardy when an employee falls ill. The Small Business Administration 2003 study describes the post-enrollment discrimination process:

The House legislation, however, would also permit some of the abuses of the insurance principle that led states to adopt the rate reform legislation in the early 1990's. Some states still permit insurers to use forms of durational tier rating based on claims experience or "reunderwriting", the practice of processing claims information in a manner similar to the initial underwriting process, typically using diagnosis-based or other risk adjustment to determine like future claims experience and appropriate rating action. The association's insurer could offer very low rates as long as all of a group's members are in good health, but increase the premium to reflect the fully anticipated cost when one or more group members develop expensive health conditions. AHPs would be mainly regulated by DOL which does not have the resources and experience of state insurance departments.⁷

The ability of AHP's to forum shop for the most lenient state means that a small firm enrolled in an AHP who has an employee contract cancer, or another dread disease, could

face an immediate—and unlimited—premium increase. The AHP would not necessarily have to wait until renewal to impose this premium increase and the premium increase could be of such a magnitude that the small firm would have no choice but to drop coverage. Although the firm could return to the state regulated market on a guaranteed issue basis, the premiums offered by regulated carriers would be very high because of the fact that AHPs had “cherry picked” the low-risk firms away from the state regulated pool. Ultimately, this dramatic adverse selection will drive carriers from the unsustainable state regulated small group market leaving high-risk small firms with no access to coverage within a short period following AHP passage.

With regard to self-funded AHPs, H.R. 660 allows them to differentiate the premiums of small firms based on health status to the extent state law allows. This is contrary to the Committee’s stated objective of furthering the ability of AHPs to play the same role that large employers play under ERISA. Section 702 (b) of ERISA—added by the Health Insurance Portability and Accountability Act—clearly prohibits large employers from charging similarly situated employees different premiums based on their health status:

A group health plan, and a health insurance issuer offering health insurance coverage in connection with a group health plan, may not require any individual (as a condition of enrollment or continued enrollment under the plan) to pay a premium or contribution which is greater than such premium or contribution for a similarly situated individual enrolled in the plan on the basis of any health status-related factor in relation to the individual or to an individual enrolled under the plan as a dependent of the individual.

This means that two computer engineers working in Seattle for Microsoft can expect to pay the same premium for their employer group health plan—even though one is very sick with cancer and the other perfectly healthy. Under H.R. 660 however, a sick computer engineer’s firm could be charged a much higher premium than a healthy computer engineer’s firm even though both firms are members of the same Association—perhaps a Seattle Association dedicated to technology startups.

Clearly H.R. 660 is not furthering the ability of small employers to access the stability of large employer coverage; instead it is retracting the stabilizing protections small employers enjoy under current state law. Furthermore, limiting a self-funded AHP’s ability to rate based upon health status to state law will not limit an AHP’s ability to “cherry-pick” from the state regulated market. Ample opportunity for risk selection remains, including:

Rating based upon age and gender: H.R. 660 would exempt AHPs from state rules that limit the ability to increase a firm’s premiums based on the age and gender of employees. Older individuals typically generate claims costs nearly seven times those of younger individuals. In fact, actuaries consider age as a very close proxy for health status. Young females typically generate significantly higher claims than those of their male counterparts. With the unlimited age/gender rating flexibility granted under H.R. 660, AHPs could offer very low rates to firms with low-cost younger workers, draining the state regulated pool of the types of firms needed to keep premiums

stable for firms dominated by older individuals or women in their childbearing years.

Geographic “Redlining”: H.R. 660 allows AHPs flexibility to determine their geographic service area. AHPs would be free to avoid geographic locations with high health care costs. They could choose to avoid certain parts of a city with populations with a high prevalence of expensive illnesses. For instance, Hispanic Americans have a disproportionately high rate of diabetes, and the African American community has been particularly hard hit by AIDS. AHPs could avoid selling coverage in minority neighborhoods—or charge a much higher premium to firms located in those areas—as a proxy for rating for health status. AHPs also could avoid geographic locations where significant portions of residents engage in high-risk occupations—they could avoid lumberjacking towns or farming communities. The League of United Latin American Citizens and the National Council of La Raza recognize these risks and have opposed H.R. 660.

Exclusion of Very Small Firms: So-called “baby groups”—firms with fewer than 5 employees—are actuarially very expensive to insure. Their claims expenses generally are much higher than those of firms with more employees. HIPAA requires insurers to accept these very small groups and states require insurers to pool these very small firms with the rest of the small group pool. H.R. 660 would allow AHPs to exclude very small firms from their membership altogether (e.g. establish a “mid-sized” business association) or accept the small firms as members but charge them much higher premiums than their larger counterparts.

The use of age, gender, geography and firm size in rating practices provide the flexibility necessary for self-funded AHPs to limit their covered lives to low-risk, low-cost firms. Opponents to this legislation recognize that the rampant cherry picking H.R. 660 will foster will hurt all small firms in the long run. That is why the American Academy of Actuaries and the National Association of Insurance Commissioners are joined in their opposition to H.R. 660 by the following business organizations:

- National Small Business United
- 28 Chambers of Commerce
- Four Farm Bureaus
- 10 Local Small Business Associations (e.g. New Hampshire High Tech Council)
- 17 Labor Organizations

(II) WIDESPREAD AHP FAILURE AND MILLIONS OF DOLLARS IN UNPAID CLAIMS

The General Accounting Office (GAO) reported that a previous 1974 preemption of state law for Multiple Employer Welfare Arrangements (note: all AHPs are MEWAs) left nearly 400,000 consumers with over \$123 million in unpaid bills. H.R. 660 will force this sad history to repeat itself—but the unfortunate results will be magnified since the growth of the internet and other communications channels will allow unsound AHPs to attract vulnerable members at a much more rapid rate.

Former Chief Counsel for the Senate Permanent Subcommittee on Investigations and Inspector General for the Department of Defense Eleanor Hill warns:

AHPs are fundamentally the same types of organizations as many MEWAs that have, in the past, been sponsored through associations. If exempted from state regulation, AHPs would pose the same kinds of unacceptable risks to consumers. . . . Nothing in

this legislation would prevent the same proliferation of plan failures and consumers losses that occurred when these types of organizations were last clearly exempt from state regulation.⁸

Former FDIC and Resolution Trust Corporation Chairman Bill Seidman also has issued warnings regarding the exemption of AHPs from state oversight: “I am concerned that it places consumers at risk and could set the stage for a taxpayer bailout similar to the one necessitated by the savings and loan failures of the 1980’s.

AHP failures will be driven by three fundamental weaknesses in H.R. 660:

1. DOL Lacks Resources and Expertise to Takeover State Regulation of Self-funded AHPs

2. Insured AHPs will Exist in a Regulatory Vacuum, with Neither the States or DOL Able to Regulate

3. Solvency Standards are Inadequate

DOL LACKS RESOURCES AND EXPERTISE TO TAKEOVER STATE REGULATION OF SELF-FUNDED AHPs

Transferring regulatory authority of self-funded AHPs to DOL will represent a monumental change in the scope of DOL’s regulatory responsibilities. Although it is often quoted that DOL currently administers ERISA for current group health plans—DOL’s role is very limited. They are not responsible for reviewing reserve levels or assuring that actuarially fair premiums are charged and they are not in constant monitoring mode as state insurance commissioners are. DOL has admitted that its enforcement efforts under ERISA are:

. . . considerably different from and often more limited than the remedies generally available to the states under their insurance laws. In this regard, it is important to note that, in many instances, states may be able to take immediate action with respect to a MEWA upon determining that the MEWA has failed to comply with licensing, contribution or reserve requirements under State insurance laws whereas investigating and substantiating a fiduciary breach under ERISA may take considerably longer.

In fact, H.R. 660 does not even authorize the Secretary to immediately terminate a failing AHP’s operations. Instead, it directs the Secretary to apply to the appropriate United States district court for appointment as trustee to administer the termination of the plan.

A 2002 General Accounting Office (GAO) report found that DOL’s Office of Pension and Welfare Benefits Administration (PWBA) is understaffed for its current responsibilities. With regard to pension responsibilities, the report found that DOL faces an “overabundance of work” as well as “limited investigative resources” and “staff shortages.” It found that a review to determine pension plan noncompliance with ERISA would “require PWBA’s full investigative staff 90 years to fully and accurately complete.

Similarly in 1997, Assistant Secretary of Labor Olena Berg testified: “An infrastructure adequate to handle the new responsibilities [for Association Health Plans] replicating the functions of 50 state insurance commissioners, simply does not exist.” Berg noted that the current staff would be able to review each health plan once every 300 years.

H.R. 660 includes no provisions that would address this problem. No additional resources or retraining dollars for DOL are included.

INSURED AHPs WILL EXIST IN A REGULATORY VACUUM, WITH NEITHER THE STATES NOR DOL ABLE TO REGULATE

H.R. 660 includes very broad preemption language that appears to authorize an insured

AHPO to sell insurance coverage nationwide and disregard the laws of 49 states once its policy is approved in one state. Thus once an AHP has an approved filing in Michigan, it could sell insurance coverage to New Yorkers. But who would protect the interests of New York policyholders? The New York state insurance commissioner will not know which consumer protection laws are or are not included in Michigan statute. And even if the New York commissioner was an expert regarding Michigan law, it is unlikely he would be authorized to enforce such protections. The enforcement authority of insurance commissioners is generally limited to the enforcement of their state's laws—not the laws of other states. Conversely, it is unlikely the Michigan insurance commissioner is authorized to take action against an insurer for behavior against a resident of another state. His role is to protect the interests of his residents.

Thus, the insured AHP would exist in a regulatory vacuum. State insurance commissioners' hands would be tied by the Federal preemption provisions, and the Department of Labor's oversight authority is quite limited with regard to insured AHPs—the focus being on the initial certification of meeting the Board and other requirements to be considered a "bona fide" association. This regulatory vacuum will allow fraudulent and sham operations to flourish. Premium dollars will have disappeared into personal off-shore bank accounts before any action by regulators can be taken, leaving consumers uninsured and providers with large unpaid medical bills.

SOLVENCY STANDARDS ARE INADEQUATE

The National Association of Insurance Commissioners, the American Academy of Actuaries and others have all criticized H.R. 660 for inadequate solvency standards. H.R. 660 allows AHPs to maintain as little as \$500,000 in surplus and caps even the largest AHPs at a \$2,000,000 requirement—an amount equivalent to just two premature million dollar babies in a neo-natal intensive care unit. This is contrary to typical state solvency regimes which use open-ended rules, recognizing that the larger an AHP grows the larger a capital base is necessary. The American Academy of Actuaries notes:

The proposed rules governing the minimum surplus requirements for AHPs do not account for the growth of the AHP. Historically, there have been many examples of AHP-like organizations becoming insolvent. Following such events, most states enacted solvency standards. To maintain the benefit of these standards to consumers, the surplus standards should be similar to the minimum requirements for Health Risk-Based Capital (RBC) developed by the National Association of Insurance Commissioners (NAIC). Also the bills at issue rely on affordable reinsurance vehicles that do not currently exist in today's marketplace.

Former Resolution Trust Chairman Bill Seidman warns that "The Savings and Loan experience teaches us that a lack of adequate solvency standards or investment guidelines can quickly lead to financial failures." The NAIC also criticizes H.R. 660 as including "woefully inadequate capital reserve requirements" and further cautions:

The most troubling aspect of the NFIB plan is it lacks sufficient oversight to ensure that financial struggles do not result in failures. Under the NFIB legislation, the AHP would work with an actuary chosen by the

company to set reserve levels with little or no government oversight to ensure the levels are sufficient or maintained. Also, that AHP is required to "self-report" any financial problems. As we have seen in recent months, relying on a company-picked accountant or actuary to alert the government of any problems can have dire consequences for the consumers who expect to have protection under their health plan.

The combination of a regulatory vacuum for insured AHPs, an understaffed and inexperienced DOL and inadequate solvency standards lay the seeds for a large crop of devastating AHP failures and frauds across the country that injures thousands of consumers. Organizations with vast experience in health care fraud—such as the National Association of Attorneys General—recognize that opposition to H.R. 660 is imperative because "State oversight and regulation is the best way to insure that plans remain solvent and that consumers are protected against fraud.

(III) MORE UNINSURED, PARTICULARLY AMONG THE MOST VULNERABLE

A June 2003 Mercer study performed for National Small Business United indicates that an additional one million individuals would lose coverage and become uninsured if H.R. 660 became law. A 1999 Urban Institute study predicted the uninsured would increase by 250,000 if AHPs were exempt from state law and the Congressional Budget Office (CBO) indicated that as many as 100,000 of the sickest individuals could lose coverage.

While these reports differ in magnitude, they all predict that AHPs will worsen the uninsured problem, not solve it as proponents contend.

(IV) CONSUMERS STRIPPED OF THEIR STATE PROTECTIONS

States have enacted a broad pantheon of state consumer protections in the last decade. A sampling of these protections include:

44 states ensure access to independent review;

48 states limit how much insurers can charge sicker groups;

50 states impose detailed requirements to assure fair marketing;

50 states require mammography screening coverage; and

47 states require diabetic supplies and education.

Self-funded AHPs would be exempt from state consumer protection laws under H.R. 660. Insured AHPs could forum shop for the state with the least consumer protection laws and only use those limited protections when selling in the remaining 49 states. The Committee accepted an amendment by Rep. VAN HOLLEN (D-MD) that would apply state prompt payment laws to insured AHPs. This amendment did not apply any other state consumer protection laws to insured AHPs, nor did it apply state prompt payment laws to self-funded AHPs. With one stroke, passage of H.R. 660 would eliminate thousands of state consumer protections across the country.

(V) NO ADMINISTRATIVE COST SAVINGS

Numerous research reports have reviewed Association Health Plans and all found that lower premiums offered by AHPs would stem from "cherry-picking"—because the AHP limits its coverage to the healthiest small employers—and the avoidance of state mandated benefits. The 2003 Small Business Administration Study found:

From an objective standpoint, AHPs are likely to lead to moderately lower insurance

premiums from a combination of lower direct and indirect taxes, avoiding anti-selection and other cross subsidies, avoiding some mandated benefits and avoiding the cost to comply with multiple state regulations.

The Congressional Budget Office assumed no administrative savings from AHPs and predicted that nearly two-thirds of any cost savings from AHPs would result from attracting healthier members from the existing insurance pool, with virtually all of the remaining savings stemming from reduced benefits.

A June 2003 Mercer study estimates that AHPs would gain a pricing advantage through risk selection, not greater administrative efficiency. The modeling estimates that the average morbidity (a measure of whether a firm is "sick" or "healthy") of firms enrolling in AHPs would be 21 percent lower than the average morbidity of small employers in the market today.

These reports found no administrative savings for AHPs because AHPs would need to perform the same functions as insurers today—enrollment, billing, claims administration. Providing health insurance to small firms is resource intensive because the insurer is often providing the types of services that a large employer receives internally from a dedicated employee benefits department. Research report after research report indicates that AHPs cannot avoid those costly functions and that their prime avenue for costs savings is "cherry picking" and benefit reduction.

CONCLUSION

Exemptions from state law for Association Health Plans have been tried and failed before. Far from being a solution to the plight of the small employer, H.R. 660 would exacerbate the cost and stability problems in the small employer market. Consumers will find themselves uninsured just when they need coverage the most—when they fall ill. And providers will be left with millions in unpaid medical bills. Furthermore, H.R. 660 will undo the small group reforms woven together by states over the last decade to respond to the damage and pain that rampant cherry picking imposed on the small employer community in the late 80's.

Mr. McKEON. Madam Speaker, I rise today in strong support of H.R. 660, the Small Business Health Fairness Act, which will allow small businesses to join together to better provide their hard-working employees with health care coverage. This important legislation will solve a serious problem with the growing number of uninsured American workers.

In September 2002, the Census Bureau reported that as many as 60 percent of the 41 million uninsured Americans were employed in small businesses throughout the country. Over the last few years, small business employers have become unable to provide their workers with affordable health care as a result of the rapid and unjust rise in the cost of health insurance. A survey by Mercer Human Resource Consulting found that health insurance costs rose 14.7 percent in 2002.

As a former small business owner, I understand the plight felt by employers, who want to provide employees and their families with quality health care.

The Small Business Health Fairness Act will afford these smaller businesses the same rights that large corporations and unions have and enable their representative associations to form Association Health Plans (AHPs), which

will offer health care nationwide to member businesses. AHPs will be crucial in closing the gap the small business community is facing with the increase of uninsured American workers.

The opponents of this bill will consistently tell wild tales about this legislation saying that AHPs will only offer health care to the healthiest. This assertion is wholly untrue, as the bill specifically prohibits AHPs from denying people on the basis of health status.

It is imperative that we act now by passing this legislation so that our nation's small business employees can immediately begin receiving health care for their families.

We can no longer allow these dedicated employees to live and work without health insurance.

Mr. KILDEE. Madam Speaker, today we are considering a bill that will nullify coverage requirements and patient protections that states across the nation have determined are appropriate and necessary for the health and well-being of their citizens.

Association health plans will be exempt from state laws that protect patients, including requirements for external independent review of denied claims and laws requiring coverage for, mammography screening, prostate screening, maternity benefits and coverage of diabetes supplies and education.

The American Diabetes Association states that, "if allowed to pass as written, this legislation will undermine state laws that ensure coverage of essential diabetes medication, equipment, supplies, and education by state-regulated health insurance policies. Over 475 organizations have voiced their opposition to AHP's, including state governors, insurance commissioners, attorneys general, state legislators, providers and physician groups, consumer and advocacy organizations, chambers of commerce, unions, farm bureaus, and small business associations.

H.R. 660 will not lead to health insurance cost decrease. According to the CBO, more than 800,000 workers in my state of Michigan will pay higher premiums under H.R. 660.

I urge my colleagues to vote for the substitute and oppose H.R. 660, a bill that hurt, not help, the small business community.

Ms. EDDIE BERNICE JOHNSON of Texas. Madam Speaker, I rise in strong opposition to the Small Business Health Fairness Act of 2003, H.R. 660. This legislation would exempt Association Health Plans from state regulations and oversight.

As a former nurse, I have spent much of my public career working to ensure that the nation's health care system is affordable and provides the best services possible to all Americans.

Although I agree in principle with the Small Business Health Fairness Act (H.R. 660), legislation that attempts to reduce the high cost of health insurance for small businesses and the self-employed, after careful review I have developed.

One of the problems I have with H.R. 660 is that it would exempt associated Health Plans (AHPs) from state regulation and oversight. I am afraid that this could lead to soaring insurance premiums, discriminatory coverage and loss of crucial protections, such as guaranteed access to medical care and critical benefits. With over 41 million Americans uninsured, and almost 65 percent of them being Hispanic or African America, I am extremely

concerned that this legislation could lead to loss of critical health services for some of the neediest families.

Madam Speaker, while proponents claim that federal AHPs would make insurance more affordable, and analysis by the Congressional Budget Office (CBO) concluded that AHPs would save money primarily by "cherry picking" the healthy from the existing insurance pool. The CBO estimated that as a result of the risk pool fragmentation caused by AHPs, health premiums would rise for 20 million workers and dependents while only 4.6 million would experience premium reductions. The CBO also found that the other source of savings would be the result of the elimination of state mandated benefits. Examples of benefits likely to be dropped by AHPs include mental health services, breast and prostate cancer screenings, maternity coverage and prescription drugs.

I agree that all families should have access to a affordable health care coverage. But schemes that would exempt association health plans from state oversight would exacerbate existing problems by causing further segmentation of the risk pool and putting consumers at greater risk of plan insolvency and outright fraud. For these reasons urge my colleagues to oppose H.R. 660.

Mr. MARIO DIAZ-BALART. Madam Speaker, small businesses across the country face no greater challenge than access to affordable health care. Too often, small businesses are forced to sacrifice growth in order to provide health care to the employees. Many others are unable to meet the rising costs of health care and force their employees to go without altogether.

Over 60 percent of the uninsured in America are small business owners and employees. Not only are high costs an enormous burden on small businesses and a large danger for employees, but also an unfortunate disincentive for growth. Capital lost on high health care costs limit economic growth of countless small businesses throughout the nation.

No matter the size of business, all Americans deserve access to affordable health care. Small businesses should have the same access to health care as their counterparts in large corporations and unions. There is no rationale for punishing America's entrepreneurs by blocking the access to affordable health care.

As an original cosponsor of the Small Business Health Fairness Act (H.R. 660), I stand committed to ending this great injustice to America's small businesses. As the true foundation of America's economy, it is essential to ensure small businesses have every incentive to grow and succeed. Without affordable health care for employees, small businesses will continue to be burdened with unfair health care costs resulting in reduced growth.

Associated health plans will allow small businesses owners to join together in order to purchase health care for their families and employees. This will not only lower health care costs for small business owners, but will also provide greater choice.

I ask my colleagues to join me in supporting H.R. 660 and helping the 41 million uninsured Americans receive access to affordable health care.

Mr. BEREUTER. Madam Speaker, this Member wishes to add his strong support for the Small Business Health Fairness Act of

2003 (H.R. 660) which would allow small business owners to band together across state lines through associations to purchase health insurance for families and employees.

This Member would like to commend the distinguished gentleman from Ohio [Mr. BOEHNER], the Chairman of the House Committee on Education and the Workforce, and the distinguished gentleman from California [Mr. MILLER], the ranking member of the House Committee on Education and the Workforce for bringing this important resolution to the House Floor today; this issue is very timely as this week is Small Business Week. This Member would also like to commend the distinguished gentleman from Kentucky [Mr. FLETCHER] for sponsoring H.R. 660.

Over the past several years, we have witnessed significant changes in our health care system. Congress, employers, and the American people are currently searching for ways to control the cost of health care. In doing so, it is important that we do not compromise access and quality. This Member believes that Congress must evaluate three key areas when considering health care proposals: affordability so that people can purchase health care that best fits their needs; accountability, so patients are guaranteed the quality they were promised; and accessibility, so millions more Americans can receive high-quality health care coverage that best fits their personal and family needs.

Access to affordable health insurance is a major problem for many of the 26 million uninsured Americans who live in families supported by the self-employed or small business employees. Professional societies and trade associations have tried to fill that void by offering health insurance plans to their members. Unfortunately, the myriad of state regulations and mandatory coverage requirements make it very difficult, expensive, and often impossible to offer coverage in all 50 states. If health insurance is not affordable it's not accessible.

The Small Business Health Fairness Act is intended to enhance the purchasing power of small businesses so that they could purchase such insurance more cheaply, and thereby provide health insurance coverage to more people. The association health plans created by the measure would be exempt from health insurance regulations of the various states. Thus, under the bill, these association health plans could operate in different states but would not be subject to the different health insurance regulations of those states. Instead they would be subject to regulation by the Labor Department. Similar association health plan language has been included in patient protection bills that Congress has recently considered. This Member has always supported these proposals.

Madam Speaker, in closing, this Member urges his colleagues to support H.R. 660.

Mr. ANDREWS. Madam Speaker, for all the reasons we have stated, we oppose the bill.

Madam Speaker, I yield back the balance of my time.

The SPEAKER pro tempore. All time for debate on the bill has expired.

AMENDMENT IN THE NATURE OF A SUBSTITUTE
OFFERED BY MR. KIND

Mr. KIND. Madam Speaker, I offer an amendment in the nature of a substitute.

The SPEAKER pro tempore. The Clerk will designate the amendment in the nature of a substitute.

The text of the amendment in the nature of a substitute is as follows:

Amendment in the nature of a substitute offered by Mr. KIND:

Strike all after the enacting clause and insert the following:

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

(a) **SHORT TITLE.**—This Act may be cited as the “Small Employer Health Benefits Program Act of 2003”.

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

Sec. 1. Short title.

Sec. 2. Establishment of Small Employer Health Benefits Program (SEHBP).

“PART 8—SMALL EMPLOYER HEALTH BENEFITS PROGRAM

“Sec. 801. Establishment of program.

“Sec. 802. Contracts with qualifying insurers.

“Sec. 803. Additional conditions.

“Sec. 804. Dissemination of information.

“Sec. 805. Subsidies.

“Sec. 806. Authorization of appropriations.

SEC. 2. ESTABLISHMENT OF SMALL EMPLOYER HEALTH BENEFITS PROGRAM (SEHBP).

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

“PART 8—SMALL EMPLOYER HEALTH BENEFITS PROGRAM (SEHBP)

“SEC. 801. ESTABLISHMENT OF PROGRAM.

“(a) **IN GENERAL.**—The Secretary shall establish, in accordance with this part, a program under which—

“(1) qualifying small employers (as defined in subsection (b)) are provided access to qualifying health insurance coverage (as defined in subsection (c)) for their employees, and

“(2) such employees may elect alternative forms of coverage offered by various health insurance issuers.

“(b) **QUALIFYING SMALL EMPLOYER DEFINED; OTHER DEFINITIONS.**—For purposes of this part:

“(1) **QUALIFYING SMALL EMPLOYER.**—

“(A) **IN GENERAL.**—The term ‘qualifying small employer’ means a small employer (as defined in paragraph (2)) that—

“(i) elects to offer health insurance coverage provided under this part to each employee who has been employed by that employer for 3 months or longer; and

“(ii) elects, with respect to an employee electing coverage under qualified health insurance coverage, to pay at least 50 percent of the total premium for qualifying health insurance coverage provided under this part.

“(B) **ELECTIONS.**—Elections under subparagraph (A) may be filed with the Secretary during the 180-day period beginning with the first enrollment period occurring under section 803 and during open enrollment periods occurring thereafter under such section. Such elections shall be filed in such form and manner as shall be prescribed by the Secretary.

“(C) **PART-TIME EMPLOYMENT.**—Under regulations of the Secretary, in the case of an employee serving in a position in which service is customarily less than 1,500 hours per year, the reference in subparagraph (A)(ii) to ‘50 percent’ shall be deemed a percentage reduced to a percentage that bears the same ratio to 50 percent as the number of hours of service per year customarily in such position bears to 1,500.

“(2) **SMALL EMPLOYER.**—The term ‘small employer’ means, with respect to a year, an

employer who employed an average of fewer than 100 employees on business days during the preceding calendar year and who employs at least 2 employees on the first day of the year.

“(3) **SEHBP.**—The term ‘SEHBP’ means the small employer health benefits program provided under this part.

“(c) **QUALIFYING HEALTH INSURANCE COVERAGE.**—For purposes of this part, the term ‘qualifying health insurance coverage’ means health insurance coverage that meets the following requirements:

“(1) The coverage is offered by a health insurance issuer.

“(2) The benefits under such coverage are equivalent to or greater than the lower level of benefits provided under the service benefit plan described in section 8903(1) of title 5, United States Code.

“(3) The coverage includes, with respect to an employee that elects coverage, coverage of the same dependents that would be covered if the coverage were offered under FEHBP.

“(4)(A) Subject to subparagraph (B), there is no underwriting, through a preexisting condition limitation, differential benefits, or different premium levels, or otherwise, with respect to such coverage for covered employees or their dependents.

“(B) The premiums charged for such coverage are community-rated for employees within any State and may vary only—

“(i) by individual or family enrollment, and

“(ii) to the extent permitted under the laws of such State relating to health insurance coverage offered in the small group market, on the basis of geography.

“(d) **OTHER TERMS.**—

“(1) **HEALTH INSURANCE COVERAGE; HEALTH INSURANCE ISSUER; HEALTH STATUS-RELATED FACTOR.**—The terms ‘health insurance coverage’, ‘health insurance issuer’, ‘health status-related factor’ have the meanings provided such terms in section 733.

“(2) **SMALL GROUP MARKET.**—The term ‘small group market’ has the meaning provided such term in section 2791(e)(5) of the Public Health Service Act (42 U.S.C. 300gg-91(e)(5)).

“(3) **FEHBP.**—The term ‘FEHBP’ means the Federal Employees Health Benefits Program under chapter 89 of title 5, United States Code.

“SEC. 802. CONTRACTS WITH QUALIFYING INSURERS.

“(a) **IN GENERAL.**—The Secretary shall enter into contracts with health insurance issuers for the offering of qualifying health insurance coverage under this part in the States in such manner as to offer coverage to employees of employers that elect to offer coverage under this part. Nothing in this part shall be construed as requiring the Secretary to enter into arrangements with all such issuers seeking to offer qualifying health insurance coverage in a State.

“(b) **CONTINUED REGULATION.**—Nothing in this part shall be construed as preempting State laws applicable to health insurance issuers that offer coverage under this part in such State.

“(c) **COORDINATION WITH STATE INSURANCE COMMISSIONERS.**—The Secretary shall coordinate with the insurance commissioners for the various States in establishing a process for handling and resolving any complaints relating to health insurance coverage offered under this part, to the extent necessary to augment processes otherwise available under State law.

“SEC. 803. ADDITIONAL CONDITIONS.

“(a) **LIMITATION ON ENROLLMENT PERIODS.**—The Secretary may limit the periods of times during which employees may elect

coverage offered under this part, but such election shall be consistent with the elections permitted for employees under FEHBP and shall provide for at least annual open enrollment periods and enrollment at the time of initial eligibility to enroll and upon appropriate changes in family circumstances.

“(b) **AUTHORIZING USE OF STATES IN MAKING ARRANGEMENTS FOR COVERAGE.**—In lieu of the coverage otherwise arranged by the Secretary under this part, the Secretary may enter an arrangement with a State under which a State arranges for the provision of qualifying health insurance coverage to qualifying small employers in such manner as the Secretary would otherwise arrange for such coverage.

“(c) **USE OF FEHBP MODEL.**—The Secretary shall carry out the SEHBP using the model of the FEHBP to the extent practicable and consistent with the provisions of this part, and, in carrying out such model, the Secretary shall, to the maximum extent practicable, negotiate the most affordable and substantial coverage possible for small employers.

“SEC. 804. DISSEMINATION OF INFORMATION.

“The Secretary shall widely disseminate information about SEHBP through the media, the Internet, public service announcements, and other employer and employee directed communications.

“SEC. 805. SUBSIDIES.

“(a) **EMPLOYER SUBSIDIES.**—

“(1) **ENROLLMENT DISCOUNT.**—

“(A) **IN GENERAL.**—In the case of a qualifying small employer who is eligible under subparagraph (B), the portion of the total premium for coverage otherwise payable by such employer under this part shall be reduced by 5 percent. Such reduction shall not cause an increase in the portion of the total premium payable by employees.

“(B) **EMPLOYERS ELIGIBLE FOR DISCOUNTS.**—A qualifying small employer is eligible under this subparagraph if such employer employed an average of fewer than 25 employees on business days during the preceding calendar year.

“(2) **EMPLOYER PREMIUM SUBSIDY.**—

“(A) **IN GENERAL.**—The Secretary shall provide to qualifying small employers who are eligible under subparagraph (C) and who elect to offer health insurance coverage under this part a subsidy for premiums paid by the employer for coverage of employees whose individual income (as determined by the Secretary) is at or below 200 percent of the poverty line (as defined in section 673(2) of the Community Services Block Grant Act (42 U.S.C. 9902(2)), including any revision required by such section) for an individual.

“(B) **SUBSIDY SCALED ACCORDING TO SIZE OF EMPLOYER.**—The subsidy provided under subparagraph (A) shall be designed so that the subsidy equals, for any calendar year—

“(i) 50 percent of the portion of the premium payable by the employer for the coverage, in the case of eligible qualifying small employers who employ an average of fewer than 11 employees on business days during the preceding calendar year;

“(ii) 35 percent of the portion of the premium payable by the employer for the coverage, in the case of eligible qualifying small employers who employ an average of more than 10 employees but fewer than 26 employees on business days during the preceding calendar year; and

“(iii) 25 percent of the portion of the premium payable by the employer for the coverage, in the case of eligible qualifying small employers who employ an average of more than 25 employees but fewer than 51 employees on business days during the preceding calendar year.

“(C) EMPLOYERS ELIGIBLE FOR PREMIUM SUBSIDY.—A qualifying small employer is eligible under this subparagraph if such employer employed an average of fewer than 50 employees on business days during the preceding calendar year.

“(b) EMPLOYEE SUBSIDIES.—

“(1) IN GENERAL.—The Secretary shall provide subsidies to employees whose family income (as determined by the Secretary) is at or below 200 percent of the poverty line (as defined in section 673(2) of the Community Services Block Grant Act (42 U.S.C. 9902(2)), including any revision required by such section) for a family of the size involved.

“(2) AMOUNT OF SUBSIDY.—Such subsidies shall be in an amount equal to the excess of the portion of the total premium for coverage otherwise payable by the employee under this part for any period, over 5 percent of the family income (as determined under paragraph (1)(A)) of the employee for such period.

“(3) COORDINATION OF SUBSIDIES.—Notwithstanding paragraph (1), under regulations of the Secretary, an employee may be entitled to subsidies under this subsection for any period only if such employee is not eligible for subsidies for such period under any Federal or State health insurance subsidy program (including a program under title V, XIX, or XXI of the Social Security Act). For purposes of this paragraph, an employee is ‘eligible’ for a subsidy under a program if such employee is entitled to such subsidy or would, upon filing application therefore, be entitled to such subsidy.

“(4) AUTHORITY TO EXPAND ELIGIBILITY.—The Secretary may, to the extent of available funding, provide for expansion of the subsidy program under this subsection to employees whose family income (as defined by the Secretary) is at or below 300 percent of the poverty line (as determined under paragraph (1)).

“(c) PROCEDURES.—The Secretary shall establish by regulation applications, methods, and procedures for carrying out this section, including measures to ascertain or confirm levels of income.

“SEC. 806. AUTHORIZATION OF APPROPRIATIONS.

“There are authorized to be appropriated, for the period beginning with fiscal year 2004 and ending with fiscal year 2014, \$50,000,000,000 to carry out this part, including the establishment of subsidies under section 805.”.

(b) REPORT ON OFFERING NATIONAL HEALTH PLANS.—Not later than 18 months after the date of the enactment of this Act, the Secretary of Labor shall report to Congress the Secretary’s recommendations regarding the feasibility of offering national health plans under part 8 of subtitle B of title I of the Employee Retirement Income Security Act of 1974, as added by subsection (a).

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

“PART 8—SMALL EMPLOYER HEALTH BENEFITS PROGRAM (SEHBP)

“Sec. 801. Establishment of program.

“Sec. 802. Contracts with qualifying insurers.

“Sec. 803. Additional conditions.

“Sec. 804. Dissemination of information.

“Sec. 805. Subsidies.

“Sec. 806. Authorization of appropriations.”.

Amend the title so as to read: “A Bill to provide for the establishment in the Department of Labor of a Small Employer Health Benefits Program.”.

The SPEAKER pro tempore. Pursuant to House Resolution 283, the gen-

tleman from Wisconsin (Mr. KIND) and a Member opposed each will control 30 minutes.

The Chair recognizes the gentleman from Wisconsin (Mr. KIND).

Mr. KIND. Madam Speaker, I yield myself such time as I may consume.

Madam Speaker, we have had I think a very enlightening discussion so far today in regards to the real impact of these associated health plans, what they are potentially capable of doing and what the danger of them are. As the gentleman from New Jersey (Mr. ANDREWS) has been citing repeatedly, there is an objective study there indicating the potential impact if this legislation enacted of increasing the ranks of the uninsured throughout the country by an additional million people. That is heading in the wrong direction considering we have 41 million uninsured today, many of them, between 50 and 60 percent of that 41 million, working in small businesses throughout our Nation.

We have a serious issue that requires a serious response and a serious plan to provide some real relief for small business employers to their employees. These are people who wake up every morning. They go to work. They play by the rules. They are asking for basic health care coverage like their neighbors next to them.

Unfortunately, H.R. 660 pulls up a little bit short in a couple of respects. First of all, it creates a current two-tiered system exempting the health care plans from currently State-regulated requirements. These are decisions made by State legislatures reflecting community values in regards to what type of health care coverage is important for their citizens, for their communities, for the society at large. And what is being proposed now is exempting a whole category of health insurance plans from basic health coverage such as cancer screening, mammographies, prenatal care, maternity care, diabetes, autism coverage in some States, and for those who ever worked with autistic children understand the importance of treating autism is early recognition, early intervention, and a lot of times that will not occur unless there are health plans that provide such coverage, and if we do not intervene early in these children’s lives, there are exponentially greater costs for society at large down the road.

We offer a substitute, which I believe addresses the challenge that we are facing as a Nation more honestly and more fairly. The Democratic alternative that I have worked on with the gentleman from New Jersey (Mr. ANDREWS) and others on the committee would provide direct assistance to small businesses and their employees, another shortcoming of H.R. 660. There is no incentive, there is no help financially to enable employers to provide this type of coverage for their employees. And everyone I know is familiar with the small business employer that

is operating on the margin, oftentimes losing money rather than making money.

And if there is not some type of financial incentive that our substitute bill offers it is unlikely that they are going to be able to extend their health insurance coverage to their employees who currently do not have them.

What our substitute would do is it would direct the Department of Labor to establish a small employer health benefit plan similar to the Federal Employee Health Benefits Plan. Many of the Members of Congress here today are members of the Federal Employee Health Benefits Plan. I have not encountered too much criticism of the health plan that Members of Congress are receiving. I think small business owners and their employees should be given the same opportunity on an affordable basis. The program would contract with State license insurers to offer a minimum insurance package for all employees of businesses of fewer than 100 people. Small businesses would be eligible for a premium assistance under our plan as would employees earning below 200 percent of the poverty level.

This alternative has the potential of providing health insurance coverage to 33 million Americans who currently go without it today. The number stands in stark contrast to the estimated 550,000 that the Congressional Budget Office has calculated under H.R. 660.

Perhaps most importantly, our plan is paid for under the budget resolution that the majority party has passed earlier this year. It fits within the budget confines by providing these premium assistance to small business employers, and to those employees at 200 percent less of poverty, providing financial assistance and the financial means to actually access health plans and provide coverage for their employees. H.R. 660 does not provide any of those means.

What we may see under their budget resolution coming back at us shortly is some form of tax credit or some type of tax deduction, which is not going to help the numerous employees and small businesses operating at 200 percent or less poverty level, who are paying very little Federal income taxes in order to qualify for such credits, unless they are willing to extend that coverage to those employees. But wait a minute. We are right now engaged in a heated debate over a child tax credit on these very same principles; so it is doubtful that they are going to be able to provide that type of tax relief to employees who need it and cannot afford health plans generally.

I mean there is a reason why the National Governors Association, Republican and Democratic governors alike, are in opposition, why the State Attorney Generals Association is opposing, why the State legislatures throughout the country are opposing, why many consumer interest groups and health care providers are opposing H.R. 660, because they fear that the ultimate income will be expanding the ranks of

the uninsured rather than reducing that number.

I think we all have the best intentions in the plans that we are advocating here today to try to reverse course on the 41 million, to try to provide small businesses with an opportunity of providing some health care coverage for their employees, but we believe there is a right and there is a wrong way of doing it. We believe that the Democratic substitute being offered which does not preempt State law, which does provide some financial assistance, premium assistance for small employers, which is paid for under the budget resolution is the way to go if we are truly interested in reducing the number of the uninsured in this country, and thereby affecting the premiums that other health plans have to pay.

Because if the uninsured get sick or get hurt, they still go in, they still access, they still get care, but those costs are then shifted on to those plans that pay for it. Our plan would reduce the number of uninsured and thereby save costs and help reduce the premium increases that so many of our employers, large and small, are experiencing today. And with that, I encourage my colleagues to support the substitute. Vote no on the H.R. 660.

Mr. Speaker, I reserve the balance of my time.

Mr. BOEHNER. Mr. Speaker, I am opposed to the gentleman's amendment and claim the time in opposition.

The SPEAKER pro tempore (Mr. SIMPSON). The gentleman from Ohio is recognized for 15 minutes.

Mr. BOEHNER. Mr. Speaker, I yield myself such time as I may consume.

Mr. Speaker, instead of embracing this bipartisan bill like many of their colleagues, some House Democrats have, instead, offered a substitute that is really no alternative at all.

Their plan does nothing to address one of the real issues that is really at the heart of this debate, and that is cost. In fact, it takes us exactly in the wrong direction of where we are trying to go, raising costs for small businesses and imposing with new mandates on employers. Instead of relying on competition that AHPs would provide, thereby lowering costs, their alternative could drive small employers out of business altogether.

Moreover, the substitute comes with a \$50 billion price tag establishing a complex new Federal program that includes health care subsidies for certain small businesses and some workers who work in small businesses. It would establish a national Government-subsidized health care plan that attempts to model itself after the Federal Employee Health Benefits Plan, but instead imposes a new mandate such as requiring small employers to pay 50 percent of their premiums for employees.

However, unlike the Federal Employee Health Benefits Plan that is exempt from costly State mandates and

regulations, coverage offered under this substitute would subject this plan to the more than 1,500 State mandates that make up about 15 percent of the rising cost of health insurance. In addition, in order to qualify, the substitute imposes new mandates on employer plans. For example, the substitute mandates that employers provide health care coverage to every employee who has been employed for at least 3 months.

In addition, it mandates that employers pay 50 percent of the cost of health care premiums for employees and that they cover all dependents of their workers. Well meaning, but in the end, these mandates will prohibit employers from proceeding. Self-employed individuals, however, are not covered by the substitute and would receive no benefits.

So let us make clear this fact. Small businesses today have the highest health care premiums of any other group. Premiums increased this year by at least 15 percent, the highest increase in a decade. And premiums are even higher for small businesses that see increases of 40 to 50 percent a year as employers continue to get out of small group activities and States. In fact, the increase in the uninsured this year, now 41 million Americans, was made up entirely of small business workers who lost their health care coverage because their employers could not afford to continue to provide this benefit.

So in answer to this, the substitute proposes to raise the cost to those small employers by adding new coverage requirements and subjecting it to more than 1,500 State mandates. And then we are going to spend \$50 billion worth of Federal taxpayers' money to subsidize this coverage.

In contrast, AHPs use the strengths of the employer-based system that cover about 150 million American lives today, and we rely on the private market. The benefits of competition, the economies of scales that are enjoyed by large unions and large companies all across the country to help lower costs and to provide better coverage for their workers.

AHPs allow small businesses to access the benefits of ERISA that are currently offered to large employers and unions. ERISA exempts large employers and unions from State mandates so that they are able to offer a quality benefit package from one coast to another or in just several adjoining States.

□ 1515

This uniformity reduces the cost so that more of the health care dollar that they are spending can actually go to benefits for their employees, and the lowering of the administrative costs also allows these companies and unions to offer more benefits to their members.

Through ERISA, employers and unions are able to offer benefits that

best fit the needs of their employees. Their small business counterparts deserve the same opportunity to craft benefit packages that are both high quality and affordable.

The substitute would offer employers a difficult Hobson's choice: Meet these conditions, which may strap a business to the point of going under; or face limited and costly alternatives to health care coverage; or they can just do what they do today, offer no health care coverage to their employees.

Instead of making it possible for small businesses to access more affordable coverage, their coverage options will actually be more expensive, and then we are going to finance it with higher taxes.

While AHP legislation would be implemented quickly, the Democrat substitute might take years to get up and running because we are going to require the Department of Labor to design this, then to figure out how they are going to sell it, and then figure out how they are going to parcel out the \$50 billion. If the appropriation does not go through, then you have got a plan with no financing behind it at all.

So, let me make myself clear, if I have not already: I believe our Nation's employer-sponsored health care system is a huge American success story. Employers provide coverage for the vast majority of our Nation's population, and almost 150 million Americans have coverage through ERISA.

The Committee on Education and the Workforce and the Department of Labor through our oversight of ERISA have jurisdiction over employer-sponsored health care, and I support the employer-based system to address the problem of the uninsured.

However, the way that the substitute does that is not by building on our strengths to offer really good plans. The mandates in their bill will basically say to small employers, you either offer the best health care plan in the entire market that is possible to your employees, or you get no help at all.

I think the strengths of the current system are good, and I think building on those by allowing Association Healthcare Plans will, in fact, work.

This bill is being supported by our nation's small business associations. The NIFB, the National Retail Association, the National Association of Wholesale Distributors, the National Association of Homebuilders, the U.S. Chamber of Commerce and others strongly support this bill, and the same groups oppose the substitute that we have before us.

So I hope Members will join me in offering assistance to our Nation's small businesses by supporting the underlying bill, and I ask my colleagues to reject the substitute we have before us.

Mr. Speaker, I reserve the balance of my time.

Mr. KIND. Mr. Speaker, I yield myself such time as I may consume.

Mr. Speaker, this is modeled after the Federal employee health plan. I

never heard so much complaining about the Federal employee health plan before, which Members of Congress participate in. It is the classic case of the double standard yet again.

There are no new mandates. We respect State law. We do not preempt state law. Furthermore, their own Congressional Budget Office estimates that the Associated Health Plans will lead to higher insurance costs for 80 percent of small business employers and employees. Their legislation will impose a higher cost burden on small businesses throughout the country.

Mr. Speaker, I yield 3 minutes to the distinguished gentleman from Rhode Island (Mr. LANGEVIN), someone who is concerned about the increase of 1 million more uninsured under H.R. 660 and also understands the importance of State health insurance coverage.

Mr. LANGEVIN. Mr. Speaker, I thank the gentleman for yielding me time.

Mr. Speaker, I rise today in opposition to H.R. 660, the Small Business Health Fairness Act, and in support of the substitute.

As health care costs soar and small business owners struggle to offer health benefits, it is critical to increase incentives for them to cover their workers. However, it is equally important that the health plans available to these workers be high quality and not jeopardize the stability of the health insurance marketplace.

This legislation, as it is written, encourages the formation of federally certified Association Health Plans by exempting these plans from State laws that govern health insurance sold to small employers today.

For years, patients have been denied necessary care as a result of HMOs' exemption from State regulation. As long as I have been in Congress, we have struggled to pass a meaningful Patients' Bill of Rights to assert the rights of individuals to a more basic minimum of health care.

Creating more exemptions is contrary to our efforts to preserve and enhance the existing regulatory system. We must think creatively about how to make health insurance affordable for small business owners and employees without threatening the progress we have made in ensuring patients' protection.

In Rhode Island, we have experimented with the successful program called RItE Share, which has made it possible for workers eligible for the State's Medicaid program who have access to employer-sponsored insurance to participate in the employer's programs. This month, I will reintroduce the Making Health Care Available for Low Income Workers Act, which would support demonstration projects such as RItE Share.

As we look for innovative ways to provide health care to all, we must not sell small business owners and employees short. The National Small Business United opposes this legislation, as they

recognize that it would ultimately have a detrimental impact on small employer premiums and would cause a significant number of small employers to drop coverage, thereby increasing the Nation's uninsured population and undermine the quality of available coverage.

To that end, I urge my colleagues to vote against H.R. 660 and for the substitute.

The SPEAKER pro tempore (Mr. SIMPSON). Does the gentleman from Texas (Mr. SAM JOHNSON) seek to control time for the opposition?

Mr. SAM JOHNSON of Texas. Yes, Mr. Speaker.

The SPEAKER pro tempore. Without objection, the gentleman from Texas (Mr. SAM JOHNSON) will control the time in opposition.

There was no objection.

Mr. SAM JOHNSON of Texas. Mr. Speaker, I yield 3 minutes to the gentleman from North Carolina (Mr. BALLENGER), a member of the Committee on Education and Workforce and a long-time Member of Congress and a small businessman.

Mr. BALLENGER. Mr. Speaker, I thank the gentleman for yielding me time.

Mr. Speaker, today we are going to hear a lot of discussion, important discussion, about over 40 million Americans who are uninsured. Very few people in Congress have actually had the experience of dealing with employees and their health insurance. Well, I have, with them and their dependents.

H.R. 660 will allow small business to pool their resources in Associated Health Plans, giving them healthcare purchasing power that they do not have today.

As one Member who is a small business owner, I know firsthand that ballooning costs are a major reason why so many Americans are uninsured. When the company I founded employed only 5 or 10 workers, I was at the mercy of the insurance companies. Small companies lack the bargaining power that is necessary to find the best deal, and the smaller the company, the worse it gets.

Like me, most employers care deeply about their employees and want to give them access to quality care. Unfortunately, skyrocketing costs have forced many of us to distribute health insurance costs to our employees, to drop health coverage or to close up shop altogether. And this is nothing short of a tragedy, not only for millions of uninsured or underinsured workers and their families, but also for employers who can no longer afford the high cost of health insurance.

Mr. Speaker, the problem is not going away. While AHPs may not cover every uninsured American, I know that it will help many Americans gain access to quality care.

Some Members of this Congress will only be satisfied with universal healthcare coverage. Let me just ask you, does small business want the U.S.

Government as a partner? Well, not where I come from.

These Members argue that we are somehow misguided when we want to take a common sense approach toward any American access to quality healthcare insurance. Associated Health Plans will allow small businesses to pool their resources and increase their bargaining power with insurance companies. This will allow them to negotiate better rates and purchase quality healthcare at a lower cost. In essence, AHPs will put small business on equal footing with the large, self-insured companies and unions.

Mr. Speaker, it is good to talk about the plight of the uninsured, but let us do something to help them. Let us support AHPs.

Mr. KIND. Mr. Speaker, I yield 2 minutes to the distinguished gentlewoman from California (Ms. WOOLSEY), a very knowledgeable member of the Committee on Education and the Workforce.

Ms. WOOLSEY. Mr. Speaker, I thank the gentleman for yielding me time, and I thank the gentleman from New Jersey (Mr. ANDREWS) for this substitute that we have here today.

Mr. Speaker, I rise in support of the Kind plan because it is actually kind to small businesses and it is kind to hard-working employees, and it makes affordable coverage accessible to the employees, the hard workers that need and deserve that coverage.

As a small business owner, I know firsthand how difficult it is to provide workers with first-class health coverage, but the reality is these hard-working families need access to quality healthcare, not just bare bones, expensive coverage. I would have appreciated the Kind plan for my employees, I can tell you that.

The Republican plan actually provides employers and employees with a false sense of security. It is a false security. They will assume they are paying for standard coverage, like the owner of the business has for his or her family. They will assume they are paying for mammograms, prenatal and postnatal coverage, coverage for illnesses like diabetes, and for prostate cancer, because these are generally State-mandated coverages. And when they find out differently after they have enrolled in one of these plans, it will be too late.

I support the Kind substitute, because it gives small businesses the option to enroll in a health plan that is similar to the Federal Employees Health Benefit Plan, giving workers a choice of plans. Why should the hard-working people of America, those employed by small businesses, have fewer options than Federal workers?

Mr. Speaker, the Kind substitute provides an affordable option to small businesses by granting subsidies. It gives them choices guaranteed to cover the most important medical procedures. This substitute provides working families, desperate for quality

health coverage, the choices they need and want, and I urge my colleagues to support the Kind substitute.

Mr. SAM JOHNSON of Texas. Mr. Speaker, I yield 2 minutes to the gentlewoman from Illinois (Mrs. BIGGERT), a member of the committee.

Mrs. BIGGERT. Mr. Speaker, I thank the gentleman for yielding me time.

Mr. Speaker, I rise in strong opposition to the substitute to H.R. 660. The mandates contained in this substitute will drive up costs and defeat the very purpose of H.R. 660, which is to make healthcare insurance more affordable.

Talk to most business owners, small business owners, in my district, and they will say that the fastest growing cost to their businesses is rising health insurance premiums for their workers. Talk to other small business owners in my district, and they will say that they cannot afford to offer their workers healthcare coverage.

In fact, if you talk to any of the 41 million Americans who have no health insurance, 6 out of 10 of them will say they work for a small business. It is not that these small business employers, employees or owners do not want health insurance or do not realize its importance; they simply cannot afford it.

Health insurance is expensive, even if you work for a large company. Studies show health insurance costs rose by 14.7 percent in 2002, and others predict they will rise another 15 percent for 2003.

In large companies, health coverage costs are spread out over many employees, making coverage more affordable for each employee. However, when there are fewer employees, each must bear a higher share of the costs and the cost per worker for the employer is very high. Far too often, small businesses either cannot afford to offer insurance, or, if they offer it, it is too costly and their employees cannot afford it.

Let us give small businesses the same economies of scale that are enjoyed by large businesses. I urge my colleagues to vote against this substitute which would establish new mandates and turn the plan into a nationalized, government-subsidized health care plan.

I urge a yes vote for final passage of H.R. 660. Let us give more working Americans access to affordable, quality insurance coverage.

Mr. KIND. Mr. Speaker, I yield myself such time as I may consume.

Mr. Speaker, let me quickly dispel a couple of myths. We have heard a couple of occasions new mandates are going to add costs to the employers.

First of all, there are no new mandates under the substitute. We merely respect State law. We do not require compliance. It is a voluntary program. If small business employers do not think it is a good financial deal for them, they do not have to join. There is nothing mandating their requirement.

We have also heard the word "taxes" being used, too. Let me reiterate, this

is paid for in their own budget resolution. So there is no new taxes that we are talking about with respect to this substitute.

Mr. Speaker, I yield such time as he may consume to the gentleman from New Jersey (Mr. ANDREWS), the co-author of this alternative bill.

(Mr. ANDREWS asked and was given permission to revise and extend his remarks.)

Mr. ANDREWS. Mr. Speaker, I would like to thank the gentleman from Wisconsin (Mr. KIND) for all the leadership he has shown on this, all the hard work he has done, and his usual, thoughtful approach to this problem.

□ 1530

Understand the desirability of the substitute versus the underlying bill. It would be helpful to think of a person who runs a tool and die shop with a dozen employees, or a cafe with 15 or 20 employees. Under the majority's Republican underlying bill, the most optimistic people believe there would be about a 15 percent premium savings for that employer. I think that is unduly optimistic, but let us give them the benefit of the doubt.

In my State, it costs about \$6,000 to provide a health care package for an individual, and about \$12,000 for family coverage. That means for that individual plan, the price would drop from \$6,000 down to about \$5,100. For the owner of that tool and die shop or that cafe, even if that price drop would occur, it is not nearly enough to afford the premiums that would be involved.

The majority's bill provides zero to the owner of that tool and die shop or that cafe to help them buy those premiums.

The substitute goes to the majority's budget resolution, identifies, as the majority did, \$50 billion over 5 years, without any increase in taxes or revenues, as the gentleman from Wisconsin (Mr. KIND) just said, and uses that \$50 billion creatively and wisely to provide subsidies to what we estimate would be 5 million employers and 16 million employees.

The person running the tool and die shop or the cafe, even if you are right, and we think you are wrong, meaning the majority, even if that person enjoys a reduction in premiums from \$6,000 down to \$5,100, it is not enough to increase coverage.

The plain fact is this: people who are employing people at the bottom of the wage ladder in low-margin businesses are not going to be able to afford the price of health insurance unless there is a significant subsidy. That is a fact. It is a fact the majority would choose to ignore, because the majority has taken over \$2 trillion from the public Treasury that could be used to address the problem of 41 million uninsured people and flushed that money away. This substitute is an appropriate way to close that gap.

I also again want to reiterate that we believe you do not have to make this

false choice between people being covered, as our various States would have them covered, with mammogram protection, with diabetes care, with prenatal and well-baby care. You do not have to make the choice between providing those vital benefits and no coverage at all.

The Mercer study shows that the underlying bill from the majority will result in an increase of 1 million people to the ranks of the uninsured. Eight million people, the CBO now tells us, will move from regular protected plans into these new unprotected, at-risk AHPs. We will get the worst of both worlds: eight million people for whom there is no guaranteed coverage against breast cancer, against diabetes, against the other diseases and conditions people worry about, and an increase in the number of uninsured.

The plan that the gentleman from Wisconsin (Mr. KIND) has taken the lead on would do the opposite. It will address the real needs of the owner of that tool and die shop and the real needs of the owner of that cafe by providing him or her with a meaningful subsidy that would help purchase health insurance benefits for his or her employees. There is a 5 million person difference when it comes to employers, a 16 million person difference when it comes to employees, and all the difference in the world when it comes to the approach here.

The plan the gentleman from Wisconsin (Mr. KIND) has put forward will work. It will work within the contours of the majority's own budget resolution. It provides real help and real aid to those who need it, not the empty promise of the majority's bill.

I urge our colleagues on both sides of the aisle to support the Kind substitute.

Mr. SAM JOHNSON of Texas. Mr. Speaker, I yield 1 minute to the gentleman from Ohio (Mr. BOEHNER), the chairman of the Committee on Education and the Workforce.

Mr. BOEHNER. Mr. Speaker, I thank my good colleague for yielding me this time.

We have heard about these studies today; and the gentleman knows that is the study, or at least has heard me say that the study done by Mercer is very similar to the study done by the Congressional Budget Office, and they are both flawed. They are very flawed. They do not take into account the fact that we have anti-cherrypicking language in the bill, and they assume in their studies that cherrypicking would be allowed.

Secondly, they assume that there would not be any difference in the administrative fees for running the plan. The fact is that we have studies that show that up to 8 million of the uninsured would have access to affordable, quality health insurance.

Let me also point out exactly what our bill does. The gentleman from New Jersey just said in the State of New Jersey, for a single person to buy a

health insurance plan is about \$6,000 and family coverage is about \$12,000. The average cost for a large employer for the cost of their health insurance is about \$3,300 for a single person and about \$5,500 for a family.

Mr. ANDREWS. Mr. Speaker, would the gentleman yield?

Mr. BOEHNER. I yield to the gentleman from New Jersey.

Mr. ANDREWS. Mr. Speaker, would the gentleman care to cite the source of that statistic?

Mr. BOEHNER. Mr. Speaker, I made some phone calls to find several plans that were both in the same area.

The fact is, that is exactly what this bill does. It allows small employers to band together to get themselves into a larger pool to design their own plan so that they can, in fact, offer better coverage at lower cost to their employees.

Mr. Speaker, I reserve the balance of my time.

Mr. KIND. Mr. Speaker, I shudder to think we may be making major policy based on a few phone calls here today.

Mr. Speaker, I yield 1 minute to the gentleman from New Jersey (Mr. ANDREWS).

Mr. ANDREWS. Mr. Speaker, I thank the gentleman for yielding me this time.

I understand there are variations in plan costs around the country. I would once again say, however, that the most enthusiastic proponents of the AHP plan do not talk about a reduction of the magnitude that the chairman of the full committee just talked about; they talk, at best case, about a 15 or 16 percent premium reduction.

If you live in a market that has a \$6,000-per-person premium, which I do, that is nowhere near a \$2,700 reduction which the chairman's phone calls have uncovered.

Mr. BOEHNER. Mr. Speaker, would the gentleman yield?

Mr. ANDREWS. I yield to the gentleman from Ohio.

Mr. BOEHNER. Mr. Speaker, the 15 percent reduction is only the reduction in the administrative costs of running the plan. When you begin to look at what pooling and larger pools will do, it brings the costs down significantly.

Mr. ANDREWS. Mr. Speaker, reclaiming my time, what premium benefit then would the chairman claim would result from this bill?

I yield to the chairman to tell us what premium benefit he predicts would result from the underlying bill.

Mr. BOEHNER. Mr. Speaker, we believe that the average reduction for a small employer would be somewhere between 15 and 30 percent.

Mr. ANDREWS. Fifteen and 30 percent. That is a new number for us, Mr. Speaker.

Mr. SAM JOHNSON of Texas. Mr. Speaker, I yield 4 minutes to the gentleman from Illinois (Mr. MANZULLO), the chairman of the Committee on Small Business.

Mr. MANZULLO. Mr. Speaker, as the chairman of the Committee on Small

Business, our Nation's small businessmen and -women tell me over and over that accessible and affordable health care is their number one priority. I have heard from thousands of small employers in America who have been pleading for options to help them manage their surging health care costs. In fact, so many letters came in, we put them into a binder called "Health Care Horror Stories from America's Small Employers." The NFIB assisted us in putting this together for us.

The small business owners tell us regularly how they struggle to provide their workers with health insurance but, each year, they face double-digit increases. Small business owners tell me they do not know how much longer they can continue to provide health care for their employees. Mom and pop businesses tell me they want to provide health care for their employees, but they cannot because of the expense of the policy. My own brother who runs a family restaurant is drowning in the surging costs and the exorbitant costs of health care insurance. This is a family business. We know personally what it costs when you are little, when you have a very small pool. People like my brother Frank are horrified at the thought of not being able to have insurance.

As one of my small business constituents wrote, "I have always wanted to take care of my employees and provide them with competitive benefits and wages, but each year it gets more and more difficult. Our health insurance costs were raised 43 percent last year and 34 percent this year."

Another constituent: "Health care costs and insurance are draining us. Last year we had a 14 percent increase, and now the costs are going up 21 percent again. I have nowhere else to go." So they go out of business because they cannot afford insurance.

Today we bring forward a great option, association health plans, to help control these outrageous costs. Of the 41 million Americans with no health insurance, 60 percent of these are small entrepreneurs, their families and their employees.

Why should the small businesses of this country not have the same right to band together as local labor unions do to purchase their insurance in large pools? That is all this is. It is just that simple. The more people you have in the pool, the cheaper the rates are for the insurance. It is a matter of equity. The little guys out there, the people that are struggling, why can they not have the same right, the same legal right to get together as labor unions? Why does there have to be a double standard, to allow labor unions to get together and do the smart thing, which they have been doing for 60 or 70 years, and using the union as the center post around which to buy their insurance, and allow associations as a center post around which to buy insurance for the small business people?

It is simply a matter of equity, it is a matter of fairness, and the biggest

argument that we have here is this: the larger the pool, the lower the rate. There is not anybody here on the floor today or in this country that can dispute that fact. My brother is a pool of two, him and his wife, at the restaurant.

As the Chairman of the Small Business Committee, our nation's small business men and women tell me over and over that accessible and affordable health care is their number one priority.

I have heard from thousands of small employers in America who have been pleading for options to help them manage their surging health care costs.

Small business owners tell me regularly how they struggle to provide their workers health insurance, but each year they face double digit increases.

Small business owners tell me they don't know how much longer they can continue to provide health care for their employees because each year the premiums rise, their coverage decreases and out of pocket expenses soar.

"Mom and Pop" businesses tell me how they want to provide healthcare for their employees, but they cannot because of the expense for a policy that covers less than ten people.

My own brother, who runs the family restaurant, is staggering at the exorbitant cost of health care insurance.

They are horrified at the thought of leaving their workers high and dry without health insurance.

As one of my small business constituents wrote, "I've always wanted to take care of my employees and provide them with competitive benefits and wages, but each year it is getting more and more difficult. Our health insurance costs were raised 43 percent last year and 34 percent this year and there is nothing we can do about it."

Another constituent writes, "Health care costs and insurance are draining us. Last year, we had a 14 percent increase. Now, the costs are going up 21 percent again. I have nowhere to go."

They are hopeless. Our entrepreneurs, whose ingenuity and hard work ethic have driven the American economy, have run out of options to battle this crisis. They need our help.

And today, we bring forward a great option—Association Health Plans—to help them control these outrageous costs and continue offering vital health insurance to their employees and their families.

Of the 41 million Americans with no health insurance, 60 percent are small entrepreneurs, their families and their employees.

One of the reasons small businesses cannot afford health coverage for their employees is that they are unable to achieve the economies of scale and purchasing power of larger corporations and unions.

Small businesses suffer from unequal treatment—what they want most is a level playing field when it comes to health care.

Large corporations and labor unions use the purchasing power of thousands of employees to offer affordable health insurance to their workers.

Small business owners have to find their insurance on an individual basis, making it very difficult and expensive to find affordable health coverage.

The premiums that small businesses pay for health insurance are typically 20–30 percent higher than those of large companies or unions which can self-insure.

Additionally, the administrative costs incurred by small businesses are likewise higher than those of large businesses; 25–27 percent versus 5–11 percent for large businesses.

Association Health Plans can provide hope to those who lack health care by expanding the pool of people and bringing down costs by 15 to 30 percent.

For small businesses, that savings can mean the difference between providing health care or not.

That savings can be the difference between profitability or losing money.

In March, I held a Small Business Committee hearing on this very topic.

The Washington State Farm Bureau testified to the success they have enjoyed operating an AHP for the last 3½ years.

Traditionally, farmers have had great difficulty buying health insurance because their business is usually made up entirely of their family.

Of those who have taken advantage of the Washington State Farm Bureau's AHP, 25 percent did not have health insurance prior to enrolling.

Additionally, the Washington State Farm Bureau AHP has operated with a 99 percent retention rate.

The proof is irrefutable. AHPs work.

I urge all of my colleagues to support H.R. 660.

Mr. KIND. Mr. Speaker, would the gentleman yield?

Mr. MANZULLO. I yield to the gentleman from Wisconsin.

Mr. KIND. Mr. Speaker, with all due respect to the gentleman from Illinois, my good friend, that is why our substitute is much better. We have one comprehensive pool that small businesses can buy into if they choose, therefore leveraging their bargaining power.

Mr. MANZULLO. Mr. Speaker, reclaiming my time, that is a government-run pool with a government-run subsidy, and that will end up like every other government-run program: it will bankrupt the country, and the small businessperson will be at the end of it.

Try this. See if this works. This is so simple. If it works for the labor unions, why can it not work for Frank and Mary Ann Manzullo?

Mr. KIND. Mr. Speaker, would the gentleman yield?

Mr. MANZULLO. I yield to the gentleman from Wisconsin.

Mr. KIND. Mr. Speaker, one of the strengths of the labor union is they are there representing the workers. They leverage the number of workers there, and they are representing their interests, and they oftentimes reduce wages in order to get a better health care plan.

The SPEAKER pro tempore (Mr. SIMPSON). The time of the gentleman from Illinois (Mr. MANZULLO) has expired.

Mr. KIND. Mr. Speaker, I yield such time as she may consume for the purposes of a colloquy to the gentlewoman

from Minnesota (Ms. MCCOLLUM), a former State legislator and a colleague on the Committee on Education and the Workforce.

Ms. MCCOLLUM. Mr. Speaker, I just want to make sure that I understand clearly the benefits of the Kind amendment in contrast to the underlying bill that we will be asked to vote on later.

One of the concerns I had in committee, as the gentleman knows, was that gender discrimination by the coverage that can be allowed under the existing bill that we are going to be voting on would have a direct impact on women's health care coverage, especially during their reproductive years.

So I would like to know, under the Kind plan, is cervical cancer screening covered if States cover it?

Mr. KIND. Mr. Speaker, would the gentlewoman yield?

Ms. MCCOLLUM. I yield to the gentleman from Wisconsin.

Mr. KIND. Mr. Speaker, it would be, because we respect existing State law.

Ms. MCCOLLUM. Mr. Speaker, would contraceptive coverage be allowed for women under the Kind plan?

Mr. KIND. Again, it is not mandated unless the State offers that right now.

Ms. MCCOLLUM. If the State requires mammography screening, is that covered under the Kind amendment?

Mr. KIND. That would be covered.

Ms. MCCOLLUM. If a State requires maternity coverage so it is not the drive-through maternity coverage that we have heard about in past years, is that covered?

Mr. KIND. That would also be covered under our substitute.

Ms. MCCOLLUM. Is a minimum mastectomy stay also covered if States have that as part of their law?

Mr. KIND. That would be covered.

Ms. MCCOLLUM. Would a minimum maternity stay be covered?

Mr. KIND. That is right.

Ms. MCCOLLUM. So we have good reproductive health coverage for women while we are expecting. But also I found with many of the women I have spoken with, and their husbands too, they would like to make sure that women have access to gynecologists, sometimes as their primary care physicians, and many States allow this. Would the Kind amendment allow this to continue?

Mr. KIND. Yes, it would.

Ms. MCCOLLUM. And does the Kind amendment also allow for second automatic referrals if States allow for second opinions?

Mr. KIND. It would, indeed.

Ms. MCCOLLUM. Mr. Speaker, I thank the gentleman.

Mr. ANDREWS. Mr. Speaker, would the gentlewoman yield?

Ms. MCCOLLUM. I yield to the gentleman from New Jersey.

Mr. ANDREWS. Mr. Speaker, and it is also true, is it not, like I said to my colleague from Minnesota, that in the underlying bill that the majority offered, that each one of those State pro-

tections that the gentlewoman just outlined would be invalidated?

Ms. MCCOLLUM. Mr. Speaker, reclaiming my time, that is totally correct. In fact, many of these I was directly involved in in the State of Minnesota, because we had families, women, mothers, husbands, brothers, aunts and uncles come and say that this was basic health care coverage that their mothers needed, that their grandmothers needed, that their nieces needed.

Mr. ANDREWS. Mr. Speaker, if the gentlewoman would further yield, what the gentlewoman is saying is that if the insurance industry chooses to keep these protections, it may; but if it chooses not to, the person who is covered under the plan does not get any of the coverage the gentlewoman just spoke of; is that correct?

Ms. MCCOLLUM. That is correct. And it is my understanding that insurance companies did not offer these coverages because they were, in their opinion, too expensive to cover, and that put gender discrimination at risk for women in their reproductive years.

□ 1545

Mr. KIND. Mr. Speaker, will the gentlewoman yield?

Ms. MCCOLLUM. I yield to the gentleman from Wisconsin.

Mr. KIND. One other significant difference between our substitute and H.R. 660 is ours would have a uniform premium rate for all employees. Employees could not be discriminated against with higher premium rates because they happen to be sicker than their fellow employees in the workforce. Ours would establish a uniform insurance premium rate for them so there would not be that type of price discrimination against the sicker in our population.

Ms. MCCOLLUM. I thank the gentleman. I will be supporting the Kind amendment because if the gentleman from Wisconsin (Mr. KIND), and the gentleman from New Jersey (Mr. ANDREWS) and I all worked for the same employer, I would like to think that my basic health care coverage, including my reproductive health, would be covered.

The SPEAKER pro tempore (Mr. SIMPSON). Does the gentleman from Ohio (Mr. BOEHNER) wish to reclaim the time in opposition?

Mr. BOEHNER. I do, Mr. Speaker.

The SPEAKER pro tempore. Without objection, the gentlemen from Ohio will control the time in opposition.

There was no objection.

Mr. BOEHNER. Mr. Speaker, I yield 4 minutes to the gentleman from Georgia (Mr. ISAKSON), a member of our committee.

Mr. ISAKSON. Mr. Speaker, I have not had any time to make any phone calls. I did not read the think tank studies. I did, however, for 22 years prior to coming to Congress, manage a company. When we left, we had 220 employees covered by an ERISA-qualified

group medical insurance coverage. And their salaries was paid and my salary was paid by the proceeds of sales made by independent contractors of which 90 percent were women.

Under the independent contractor law and IRS requirements, we could not offer them group medical insurance and they had no ERISA protection. They were at the mercy of what was available.

Now, those 220 for whom we provided group medical insurance, I would have to resent the fact that the illusion was made that an employer who had that many women as a percentage of their workforce would not provide gynecological benefits and other reproductive benefits available to women. Of course you would.

Now what this bill does it does not preclude a mandated 48-hour stay any more than it precludes any other benefit. It offers the employer the option of offering it. It is true there is an exemption from the State requirement. It is untrue that it necessarily, on its face, takes that benefit away from a company.

Who in here would believe for a moment that an employer who wants to offer a benefit to his employees would take away the very benefit that is most important to those employees? Facts are stubborn things.

The fact of the matter is, 41 million Americans do not have health insurance. Now there are contributing reasons to that. But one of the main contributing reasons are those independent contractors, small business people, laborers, people who make the money that pay the taxes who have no accessibility to health insurance.

Now, I have lobbied on both sides about this and I care about this very deeply. I have a campaign staff right now and I am providing insurance to those few individuals I have employed because I know how important it is to have it, and I know how expensive it is to go out and get it on an individual basis, even though they are basically young. But understand this, this bill does not preclude a health care benefit for women that is mandated in State law from being offered.

It gives the choice for companies to put together a cafeteria-type of plan which may or may not include it, but do not sell those employers short that they would not offer a benefit that the very basis of their employees have to have.

Secondly, as I understand it, the cost of this is about \$354 million in terms of CBO's estimate of H.R. 660 and \$50 billion in terms of the substitute. I would say this, if we can make an investment that is \$49,442,000,000 less expensive to offer insurance to 41 million Americans or a lot of them, we estimate 8 to 10, to provide benefits to give them health care that they do not have, then we should vote for the underlying bill. We should reject the substitute, and we should reject any false perception that this is taking away the integrity of a

business in offering a qualified plan to their qualified employees.

Mr. BOEHNER. Mr. Speaker, will the gentleman yield?

Mr. ISAKSON. I yield to the gentleman from Ohio.

Mr. BOEHNER. Mr. Speaker, the gentleman referred to his ability to offer a package under ERISA to your 220 employees on the business you managed, but what about those 900 real estate agents that work as independent contractors for this company, who had to go out and fight on their own, day in and day out, to get a policy for themselves or for their family? And under this bill, if I am correct, the National Association of Realtors or the Georgia Realtor Association could offer a group plan to their real estate agents which would bring their costs down substantially.

Mr. ISAKSON. Mr. Speaker, the gentleman is absolutely correct, and if I may take the remainder of the time to tell the gentleman that in that exact scenario, since I could not offer those benefits because they were independent contractors, but because I cared very deeply about my independent contractors and the quality of life they had, I tried to scratch and find those.

What this bill does, it opens up an opportunity for employers who have independent contractors as their employees, to take the benefits of pooling and provide for those independent contractors the benefit that ERISA guarantees the opportunity to provide in terms of the employees that company has. This is an important step forward for 41 million Americans.

Mr. KIND. Mr. Speaker, I yield myself such time as I may consume.

Mr. Speaker, again, we state that our substitute is fully paid for under the budget resolution, so we are not asking for new money. And with due respect to my friend from Georgia, we would hope a lot of employers would continue to offer the basic health care coverage that exists today. But the reason there were so many State battles throughout the country in State legislatures is because many of them were not. That is why these hard-fought battles need to be respected, and our substitute does.

Mr. Speaker, I yield 3 minutes to the gentlewoman from the Virgin Islands (Mrs. CHRISTENSEN).

Mrs. CHRISTENSEN. Mr. Speaker, I thank the gentleman for yielding me time.

Mr. Speaker, I rise today in opposition to H.R. 660, and in support of the Democratic substitute. As a member of the Committee on Small Business, a physician and former small business owner, the issue of meeting the health care needs of the small business community is a priority for me and it is alarming that their employees represent 60 percent of our Nation's uninsured.

Whereas, I commend my colleagues on both sides of the aisle for their work in bringing legislation to the floor, I cannot support H.R. 660. The Congress-

sional Budget Office estimates that AHPs could insure additional 330,000 Americans, but would drive up health care costs for the rest of the Nation to such an extent that 1 million presently insured Americans would be unable to afford coverage.

H.R. 660 would exempt AHPs from State insurance mandates regarding the coverage of such basic and life saving treatments as maternity care, emergency room visits, cancer screening and diabetes coverage, leaving it to individual plans to decide. More than 450 national and local organizations have joined in opposing Federal legislation that would allow associated health plans to operate without State oversight.

The American Diabetes Association has said it would be a disaster for people with diabetes. The American Nurses Association argued that by removing coverage for cost effective benefits such as well-child care, AHPs created by H.R. 660 could drive up the cost of health care. States have enacted safeguards to ensure that the health insurance plans offered to small employers and their families are fairly priced, cover a specific set of benefits, that they can not cherry-pick.

Under the proposed legislation, small employers who have joint AHPs could lose these important safeguards. The Kind-Andrews Democrat substitute addresses these concerns. It would use the Federal Employee Health Benefits Program as a base benefit package without superseding State laws and regulations. Most importantly, the Kind-Andrews substitute offers incentives and subsidies to firms of fewer than 50 employees and provides premium subsidies for employees who are below 200 percent of poverty. The Kind-Andrews substitute would make a real difference in covering the uninsured while maintaining consumer, personal and professional rights.

This is a good approach and a far better bill that can really do a lot to cover more than half of the 41 million uninsured.

Mr. Speaker, I urge support for the Kind-Andrews substitute and urge a no vote on H.R. 660.

Mr. BOEHNER. Mr. Speaker, I yield 1 minute to the gentleman from Pennsylvania (Mr. SHUSTER).

Mr. SHUSTER. Mr. Speaker, I thank the gentleman for yielding me time.

Mr. Speaker, I rise in opposition today to the substitute and in support of H.R. 660, the Small Business Health Fairness Act.

Of the more than 41 million Americans that are uninsured, almost 60 percent of those individuals are from families that are employed by small businesses that cannot afford to pay health benefits. We can no longer stand by as health insurance premiums for small businesses are increasing at double digit rates. Their choices of plans and benefits continue to decrease.

The passage of the Small Business Health Fairness Act would be an important step in providing access to affordable health insurance for millions of workers and their family, helping to stop the growing numbers of uninsured Americans. As a former small business owner for 13 years, I struggled with the skyrocketing costs of health care benefits. Employers, small business owners must decide whether to scale back or cut coverage altogether. By allowing businesses to join together in associated health plans, they will have the same opportunities that large businesses and unions have. Hard working Americans employed by small businesses deserve access to quality and affordable health care too.

Mr. Speaker, I would like to commend the gentleman from Ohio (Mr. BOEHNER), the gentleman from Illinois (Mr. MANZULLO) and the gentleman from Kentucky (Mr. FLETCHER) for their outstanding leadership, and as a small business owner, I urge my colleagues to support H.R. 660.

The SPEAKER pro tempore. The gentleman from Ohio (Mr. BOEHNER) has 8 minutes remaining. The gentleman from Wisconsin (Mr. KIND) has 5 minutes remaining.

Mr. BOEHNER. Mr. Speaker, I yield 2 minutes to the gentleman from Texas (Mr. BURGESS)

Mr. BURGESS. Mr. Speaker, today the United States is confronted with an increasing number of Americans who are without health insurance. The Census Bureau estimates that 41.2 million Americans are without insurance and the numbers continue to rise.

Remarkably, the policy makers here in Washington have all too often made attempts to remedy this situation with convoluted policies that have just exacerbated this very serious problem.

The bill before us today, H.R. 660, will make great strides in addressing this problem by not imposing a top-down Washington-type solution, but instead giving small businesses in Flower Mound, Texas and cities and towns, as in all of our districts, the ability to make responsible health care coverage decisions for their employees.

H.R. 660 will make American families without health insurance and help small businesses struggling with the high cost of insurance for their employees. As the owner of a medical practice in Lewisville, Texas, I understand how difficult it can be to provide health care insurance to your employees. Only 10 percent of businesses with 50 or fewer employees offer their employees health care coverage. This number is low because group coverage for small businesses is costly and heavily regulated.

H.R. 660 will give retailers, wholesalers, printers, medical practices, churches and other businesses the ability to purchase health insurance through associated health plans by freeing them from restrictive mandates and maximizing their ability to spread risks across a large number of employ-

ees. I believe this bill will decrease the number of uninsured in the United States, but I am afraid that the best our friends on the other side of the aisle can come up with in the form of this substitute is a continuation of the Washington, D.C. style solution that does not trust small business owners with decisions about what is best for their employees.

The substitute places more mandates on small business and does nothing to increase access to health insurance. By stacking requirement on top of requirement, it is clear that they do not trust Americans to make their own health decisions.

Mr. Speaker, the Democratic substitute is just another in a long line of unrealistic health care reform proposals that they simply cannot relinquish. I urge my colleagues to vote against the substitute and vote in favor of passage of H.R. 660.

Mr. BOEHNER. Mr. Speaker, I yield 1 minute to the gentleman from South Bend, Indiana (Mr. CHOCOLA).

Mr. CHOCOLA. Mr. Speaker, I thank the gentleman for yielding me time.

Mr. Speaker, before coming to Congress, I was a small business owner. Now that I am a member of Congress, I am on the Committee on Small Business. And not a day goes by that I do not hear from a constituent at home or someone talking to the Committee on Small Business that is a small business owner about the horrors of trying to provide health care to their employees.

We in government cannot make people successful. We cannot make businesses successful. But what we can do is create an environment that gives people and businesses the opportunity for success. In creating an environment where small business owners can join together with common interest on a nationwide basis and go out and provide health care for their employees to meet their particular employees needs, is exactly what we should be doing as Members of Congress.

□ 1600

I think that we have to pass this bill because the bottom line is that the people who have to live with the reality of providing health care for their employees will encounter lower costs and greater access to the health care coverage they wish to provide for their employees. So I urge my colleagues to vote in favor of H.R. 660 and against the substitute.

Mr. KIND. Mr. Speaker, I yield 2 minutes to the gentlewoman from New York (Mrs. MCCARTHY), a distinguished member of the Committee on Education and the Workforce.

Mrs. MCCARTHY of New York. Mr. Speaker, I thank my colleague from the Committee on Education and the Workforce for yielding me this time and for introducing this bill, because this substitute is actually the answer to what we are looking for, and it is also paid for.

Let me say what this amendment will do, the substitute. It provides

small employees the same access to health benefits that Federal employees have. All small business employees and employers are offered coverage. It minimizes the adverse selection. "The Secretary shall establish an initial open enrollment period and thereafter an annual enrollment period." It uses state-licensed insurers without preempting State laws.

For some reason, I thought basically, especially on the other side of the aisle, that we never wanted to preempt State laws.

This amendment provides a minimum benefit package similar to Federal employees. All participating insurers must offer benefits equal to or greater than the options offered to Federal employees. It also provides for affordable small employer premiums with premium assistance.

This is the answer to help our small businesses. And again I will say, on the main bill, when we have Republican and Democratic Governors throughout this country saying this is not the answer, when we have State attorneys general saying this is not the answer, and that this substitute is the answer, then I believe this can help our small businesses. We all want to do that.

So I would say to my colleagues here on the right, and certainly the right side and the left side of the aisle, that this substitute is the answer to what our Governors would like, certainly our State attorneys general would like. It would help the people and not take away the minimum health care benefits that we have been fighting for for gosh knows how many years.

I will stress again and again that the only reason that we have decent basic health care coverage in our States, 48 of them, is because they realized that was the way to go.

Mr. BOEHNER. Mr. Speaker, I am pleased to yield 2 minutes to the gentleman from Georgia (Mr. GINGREY), a member of our committee.

Mr. GINGREY. Mr. Speaker, I rise in strong support of the Small Business Health Fairness Act, H.R. 660, and against the amendment.

By anybody's estimate, 41 million uninsured Americans is entirely too many, and the Bureau of the Census has estimated that over 60 percent of those uninsured Americans are employed. They are not unemployed. They are just working for small businesses, small employers that cannot afford to go into that small market and purchase health insurance, which is rising at least 14 percent a year. The AHPs, with a minimum pool of 1,000 or more employees, spreads the risk, and it gives them the opportunity to get that same volume discount that the Fortune 500 companies and the large labor unions enjoy.

But maybe the most important savings and the reason that the premiums are lower is that they are not bound now by each and every of the 50 States with their multiple mandates. The

other side wants to talk about how unfair it is that these plans could not include a routine screening mammogram or could not exclude the fact that some plans have so-called drive-through deliveries, and that patients might not be able to stay overnight when they had a radical mastectomy. Mr. Speaker, these plans that are being offered under ERISA protection have all of these provisions in them.

What we are talking about, and I know this as a physician member of the State legislature, and the demands to include one mandate after another, things like coverage or screening for chronic adult fatigue syndrome, or carpal tunnel syndrome, or a blood test for this or a blood test for that, pretty soon they will be requiring routine screening for fission phosphate levels in everybody's blood. It just goes on and on and on, and it becomes absolutely ridiculous and prohibitively expensive.

So that is why we need this bill. That is why we need these AHPs. I think we will insure not 330,000 more people, but probably over 2 million.

Mr. KIND. Mr. Speaker, I yield 2 minutes to the gentleman from Texas (Mr. HINOJOSA), a distinguished member of the Committee on Education and the Workforce.

(Mr. HINOJOSA asked and was given permission to revise and extend his remarks.)

Mr. HINOJOSA. Mr. Speaker, I rise today in strong opposition to H.R. 660, the Small Business Health Fairness Act. Like many of my colleagues, I have heard from numerous industry groups, health plans, medical associations, and, most importantly, my constituents on whether or not AHPs are the best solution to address the growing number of uninsured in our Nation. I am particularly concerned about finding workable solutions for small business employers.

Like many of my colleagues, my district in south Texas is built on the foundation of small businesses. They employ a large percentage of the workforce in the Rio Grande Valley. Most employers are faced with difficult choices on how to offer loyal employees the benefit they deserve or risk losing them to larger companies in larger cities. The high cost of health insurance is extremely burdensome for these small firms, and that is why we are here today.

H.R. 660 is a well-intended bill. Many of the 41 million Americans without health insurance are employed by small businesses. If Congress can find a way to help these employers provide health insurance for their workforce, we will be well on our way to reducing the number of uninsured in this country. But in my view, AHPs are not the way to do it. AHPs will offer minimal coverage, sufficient only for the young and the healthy. Our workforce will have none of the protections that State benefit mandates offer. They will have no assurance against fraud or premium inflation and no assurance that Federal

oversight by the Department of Labor will even be conducive to fair handling of disputes. AHPs create an entirely new health care crisis, with 8.5 million newly underinsured Americans.

As a member of a heavily Hispanic border district, I am particularly concerned about what this will mean for the diagnosis and the treatment of diabetes, a disease that strikes many of my Hispanic constituents.

Mr. Speaker, over 11 million Americans have diagnosed diabetes, while another 6 million have diabetes but don't know it.

Diabetes hits minority populations especially hard. Untreated, this disease leads to end-stage renal failure, blindness, amputations and over 200,000 deaths annually. However, it has been demonstrated that appropriate use of diabetes medications, equipment, supplies, and education can dramatically reduce the incidence and impact of complications associated with diabetes. President Bush surely knew this when he was Governor of Texas and signed into law the diabetes coverage mandated currently in effect in Texas.

My principal concern is that the AHP legislation before us today preempts the State benefit mandates in Texas and 45 other States, your home States, for coverage of diabetes supplies and education. The amendment that the gentleman from Michigan, Mr. KILDEE and I offered, unsuccessfully, in committee would have corrected this dangerous omission. We also tried, again without success, to have the amendment made in order during floor consideration.

By refusing to include a requirement that AHPs adhere to State coverage laws associated with diabetes, we will be leaving millions of people with diabetes to fend for themselves. It is not a matter of cost effectiveness; it is a matter of right and wrong.

Mr. Speaker, the Democratic substitute offers small business employers and their workers a fair alternative. It establishes a small employer health benefit plan with minimum coverage similar to the Blue Cross/Blue Shield standard plan.

I urge my colleagues to support the Kind-Andrews substitute, and if that substitute is defeated, to vote against H.R. 660.

Mr. BOEHNER. Mr. Speaker, I am pleased to yield 1 minute to the gentleman from Texas (Mr. SAM JOHNSON), the chairman of the Subcommittee on Employer-Employee Relations, the gentleman who shepherded this bill through our committee.

(Mr. SAM JOHNSON of Texas asked and was given permission to revise and extend his remarks.)

Mr. SAM JOHNSON of Texas. Mr. Speaker, I rise in opposition to this amendment. We have been hearing all day that it is going to create all this stuff, and it is not going to create anything. Our bill allows for anything to be covered, and it will all be covered.

This amendment creates an incredibly complex \$50 billion government-run program. The program sets up brand-new health care subsidies, but only for certain small businesses and some workers. Unlike the Federal employee plan, the new program would be

subject to thousands of State mandates. As we have heard time and again, those mandates make up at least 15 percent of the rising cost of health insurance.

Now, here is the real kicker. In order to qualify for the subsidy, employers are required to pay at least 50 percent of the cost for the care of their employees. The Democrat substitute will raise health care costs for small employers and then spend \$50 billion to subsidize it.

AHPs are going to give everybody the ability to obtain insurance. Mr. Speaker, I urge rejection of this substitute.

Mr. KIND. Mr. Speaker, I yield myself the balance of my time.

Mr. Speaker, this is a very important debate that we are having today. Just to correct one of the things just stated by the previous speaker, the Department of Labor, just like H.R. 660, would be in charge of administering the substitute plan that we have before us today. They would actually contract with state-licensed insurers to offer basic insurance plans.

The significant difference, though, is that we are asking everyone to play on a level playing field, to respect States' rights, and to not have Federal preemption. Because for those who believe in the free market system, which I think most of us do, it can only work if everyone is playing by the same rules instead of trying to establish a two-tier system. And that, I believe, is going to be the best hope we have, through price competition, of keeping a check on rising premium costs.

There has been a lot of citing of statistics throughout the afternoon, a lot from the Congressional Budget Office, and so I will provide for the RECORD a letter from the Congressional Budget Office stating their analysis of H.R. 660.

Mr. Speaker, I would encourage our colleagues, in conclusion, to support the substitute, one that does provide an opportunity for more small employers to provide health care coverage to their employees, one that respects State law, one that provides some premium assistance so they can afford it. I encourage support of the substitute and a "no" vote on H.R. 660.

Mr. Speaker, the letter referred to above is as follows:

U.S. CONGRESS,
CONGRESSIONAL BUDGET OFFICE,
Washington, DC, June 18, 2003.

Hon. GEORGE MILLER,
Senior Democratic Member, Committee on Education and the Workforce, House of Representatives, Washington, DC.

DEAR CONGRESSMAN: This letter responds to your request of June 17, 2003, for additional information on CBO's estimate of the impact of H.R. 660 on enrollment in the health insurance markets for small employers and self-employed workers. We expect that the effects of the bill would be fully reflected in those markets by 2008, and all of the following numbers refer to that year.

Under current law, CBO estimates that approximately 30.1 million people will be enrolled in health insurance offered by plans in the state-regulated small group insurance

market. Under the bill, CBO estimates that combined enrollment in state-regulated plans and association health plans (AHPs) would rise by about 550,000 people to a total of 30.7 million people. Of this, approximately 23.2 million people would retain coverage in the state-regulated market. About 7.5 million people would be enrolled in AHPs, including the additional 550,000 people who would not have been covered by any small-employer plan under current law, and 6.9 million people who would have been covered in the state-regulated market.

The same consideration apply to self-employed people. We estimate that approximately 4.7 million people will be enrolled in state-regulated coverage purchased by self-employed workers under current law. Under H.R. 660, CBO estimates that combined enrollment through state-regulated insurers and AHPs would rise by about 70,000 people to 4.8 million people. Of this, approximately 3.8 million people would retain state-regulated coverage. About 1.0 million people would obtain coverage through AHPs, including the additional 70,000 people who would not have been insured under current law, and 0.9 million people who would have been covered in the state-regulated market.

If you would like additional information on this estimate, the CBO staff contact is Stuart Hagen, who can be reached at 225-2644.

Sincerely,

DOUGLAS HOLTZ-EAKIN,
Director.

Mr. BOEHNER. Mr. Speaker, I yield myself the balance of my time.

Mr. Speaker, we have 41 million Americans who do not have health insurance. As I said before, Congress has been talking about this for a decade. And while the underlying bill will not solve the entire problem, it will help in addressing the needs of the uninsured.

As we heard before, some 60 percent either work for or have a dependent who works for a business, and so they have jobs. We are not talking about the poor here, because the poor get covered by Medicaid. We are talking about people who go to work every day, but they happen to work in an industry that maybe does not traditionally cover health insurance, or they work for a small employer who just cannot afford it because they are locked in a small State insurance pool.

We know what the cost of health insurance and these increases do. It creates more uninsured. In the Wall Street Journal today, CALPERS, the country's largest health plan, is set to increase premiums on an average of 17 percent for the next year, a 17 percent increase from the largest health care plan in the country. It is time that we step up and take action.

The underlying bill will in fact help small businesses create more coverage for more people. Small businesses. And who are small businesses? How about the dry cleaner down the street or the convenience store? How about the farmers in America today who have to go fend for themselves as an individual in the marketplace? They may be by themselves, maybe just family coverage. How about the real estate agents we talked about before, independent contractors, and others who may be self-employed that have to go fight to

get insurance in very small risk pools in many States? If we allow them to come together with large State associations, national associations, and to group themselves, they can have real coverage for a much more reasonable cost.

This is the right thing to do today, to help those who pay high premiums; and it is also the right thing to do to help those who have no insurance at all. Those plans that are out there covered under ERISA are the Cadillac of plans in the country. Why not let small employers have the same advantage.

The SPEAKER pro tempore (Mr. SIMPSON). All time for debate on the amendment has expired.

Pursuant to House Resolution 283, the previous question is ordered on the bill and on the amendment offered by the gentleman from Wisconsin (Mr. KIND).

The question is on the amendment in the nature of a substitute offered by the gentleman from Wisconsin (Mr. KIND).

The question was taken; and the Speaker pro tempore announced that the yeas appeared to have it.

Mr. KIND. Mr. Speaker, on that I demand the yeas and nays.

The yeas and nays were ordered.

The vote was taken by electronic device, and there were—yeas 183, nays 238, answered "present" 1, not voting 12, as follows:

[Roll No. 294]

YEAS—183

Abercrombie
Ackerman
Alexander
Allen
Andrews
Baca
Baldwin
Ballance
Becerra
Bell
Berkley
Berman
Berry
Bishop (GA)
Bishop (NY)
Blumenauer
Boswell
Boucher
Brady (PA)
Brady (OH)
Brown, Corrine
Capps
Capuano
Cardoza
Clay
Clyburn
Cooper
Crowley
Cummings
Davis (AL)
Davis (CA)
Davis (FL)
Davis (IL)
Davis (TN)
DeFazio
DeGette
Delahunt
DeLauro
Deutsch
Dicks
Dingell
Doggett
Doyle
Edwards
Emanuel
Engel
Eshoo
Etheridge

Evans
Farr
Fattah
Filner
Ford
Frank (MA)
Frost
Gordon
Green (TX)
Grijalva
Harman
Hill
Hinchey
Hinojosa
Hoeffel
Holden
Holt
Honda
Hooley (OR)
Hoyer
Inslee
Israel
Jackson (IL)
Jackson-Lee (TX)
Jefferson
John
Johnson, E. B.
Jones (OH)
Kanjorski
Kaptur
Kennedy (RI)
Kildee
Kilpatrick
Kind
Kleczka
Kucinich
Lampson
Langevin
Lantos
Larsen (WA)
Larson (CT)
Lee
Levin
Lewis (GA)
Lipinski
Lofgren
Lowey

Lynch
Majette
Maloney
Markey
Marshall
Matheson
Matsui
McCarthy (MO)
McCarthy (NY)
McCollum
McDermott
McGovern
McNulty
Meehan
Hoeffel
Meek (FL)
Meeks (NY)
Menendez
Michaud
Millender-
McDonald
Miller (NC)
Miller, George
Mollohan
Moore
Murtha
Nadler
Napolitano
Oberstar
Obey
Olver
Ortiz
Owens
Pallone
Pascarell
Pastor
Payne
Pelosi
Peterson (MN)
Pomeroy
Price (NC)
Rahall
Rangel
Reyes
Rodriguez
Ross
Rothman
Roybal-Allard
Ruppersberger

Rush
Ryan (OH)
Sabo
Sanchez, Linda
T.
Sanchez, Loretta
Sanders
Sandlin
Schakowsky
Schiff
Scott (GA)
Scott (VA)
Serrano
Sherman

Skelton
Slaughter
Snyder
Solis
Spratt
Stark
Stenholm
Strickland
Stupak
Tanner
Taylor (MS)
Thompson (CA)
Thompson (MS)
Tierney

Towns
Udall (CO)
Udall (NM)
Van Hollen
Vislosky
Waters
Watson
Watt
Waxman
Weiner
Wexler
Woolsey
Wu
Wynn

NAYS—238

Aderholt
Akin
Bachus
Baker
Ballenger
Barrett (SC)
Bartlett (MD)
Barton (TX)
Bass
Beauprez
Bereuter
Biggett
Bilirakis
Bishop (UT)
Blackburn
Blunt
Boehler
Boehner
Bonilla
Bonner
Bono
Boozman
Boyd
Bradley (NH)
Brady (TX)
Brown (SC)
Brown-Waite,
Ginny
Burgess
Burns
Burr
Burton (IN)
Buyer
Calvert
Camp
Cannon
Cantor
Capito
Cardin
Carson (OK)
Carter
Case
Castle
Chabot
Chocoma
Coble
Cole
Collins
Cox
Cramer
Crane
Crenshaw
Cubin
Culberson
Cunningham
Davis, Jo Ann
Davis, Tom
Deal (GA)
DeLay
DeMint
Diaz-Balart, L.
Diaz-Balart, M.
Dooley (CA)
Doolittle
Dreier
Duncan
Dunn
Ehlers
Emerson
English
Everett
Feeney
Ferguson
Flake
Fletcher
Foley
Forbes
Fossella
Franks (AZ)
Frelinghuysen

Gallegly
Garrett (NJ)
Gerlach
Gibbons
Gilchrest
Gillmor
Gonzalez
Goode
Goodlatte
Goss
Granger
Graves
Green (WI)
Greenwood
Gutknecht
Hall
Harris
Hart
Hastings (WA)
Hayes
Hayworth
Hefley
Hensarling
Herger
Hobson
Hoekstra
Hostettler
Houghton
Hulshof
Hunter
Hyde
Isakson
Issa
Istook
Janklow
Jenkins
Johnson (CT)
Johnson (IL)
Johnson, Sam
Jones (NC)
Keller
Kelly
Kennedy (MN)
King (IA)
King (NY)
Kingston
Kirk
Kline
Knollenberg
Kolbe
LaHood
Latham
LaTourette
Leach
Lewis (CA)
Lewis (KY)
Linder
LoBiondo
Lucas (KY)
Lucas (OK)
Manzullo
McCotter
McCrery
McHugh
McInnis
McIntyre
McKeon
Mica
Miller (FL)
Miller (MI)
Miller, Gary
Moran (KS)
Moran (VA)
Murphy
Musgrave
Nethercutt
Neugebauer
Ney
Northup

Norwood
Nunes
Nussle
Osborne
Ose
Otter
Oxley
Paul
Pearce
Pence
Peterson (PA)
Petri
Pickering
Pitts
Platts
Pombo
Porter
Portman
Pryce (OH)
Putnam
Quinn
Radanovich
Ramstad
Regula
Rehberg
Renzi
Reynolds
Rogers (AL)
Rogers (KY)
Rogers (MI)
Rohrabacher
Ros-Lehtinen
Royce
Ryan (WI)
Ryan (KS)
Saxton
Schrock
Sensenbrenner
Sessions
Shadegg
Shaw
Shays
Sherwood
Shimkus
Shuster
Simmons
Simpson
Smith (MI)
Smith (TX)
Stearns
Sullivan
Sweeney
Tancredo
Tauscher
Tauzin
Taylor (NC)
Terry
Thomas
Thornberry
Tiberi
Toomey
Turner (OH)
Turner (TX)
Upton
Velazquez
Vitter
Walden (OR)
Walsh
Wamp
Weldon (FL)
Weldon (PA)
Weller
Whitfield
Wicker
Myrick
Wilson (NM)
Wilson (SC)
Wolf
Young (AK)
Young (FL)

ANSWERED "PRESENT"—1

Baird

NOT VOTING—12

Carson (IN)	Gingrey	Smith (NJ)
Conyers	Gutierrez	Smith (WA)
Costello	Hastings (FL)	Souder
Gephardt	Neal (MA)	Tiahrt

ANNOUNCEMENT BY THE SPEAKER PRO TEMPORE

The SPEAKER pro tempore (Mr. SIMPSON) (during the vote). Members are advised that 2 minutes remain in this vote.

□ 1632

Messrs. OSE, BLUNT, NEUGEBAUER and OXLEY changed their vote from "yea" to "nay."

So the amendment in the nature of a substitute was rejected.

The result of the vote was announced as above recorded.

Stated against:

Mr. GINGREY. Mr. Speaker, on rollcall No. 294, the voting machine did not properly record my vote. I would have voted "nay."

The SPEAKER pro tempore. The question is on the engrossment and third reading of the bill.

The bill was ordered to be engrossed and read a third time, and was read the third time.

MOTION TO RECOMMIT OFFERED BY MRS. MCCARTHY OF NEW YORK

Mrs. MCCARTHY of New York. Mr. Speaker, I offer a motion to recommit.

The SPEAKER pro tempore. Is the gentlewoman opposed to the bill?

Mrs. MCCARTHY of New York. Yes, Mr. Speaker, in its present form.

The SPEAKER pro tempore. The Clerk will report the motion to recommit.

The Clerk read as follows:

Mrs. MCCARTHY of New York moves to recommit the bill H.R. 660 to the Committee on Education and the Workforce with instructions to report the same back to the House forthwith with the following amendment:

Page 14, insert after line 17 the following:
 "(e) PROTECTION OF EXISTING GROUP HEALTH PLAN COVERAGE.—

"(1) IN GENERAL.—The requirements of this section are not met with respect to an association health plan if—

"(A) during the 1-year period preceding the date of the enactment of the Small Business Health Fairness Act of 2003, any participating employer of the plan maintained another group health plan providing a type of coverage described in paragraph (2), and

"(B) such association health plan does not provide such type of coverage.

"(2) TYPES OF COVERAGE.—A type of coverage is described in this paragraph if it consists of—

"(A) coverage for breast cancer screening and tests recommended by a physician,

"(B) coverage for the expenses of pregnancy and childbirth,

"(C) coverage for well child care, or

"(D) direct access to those obstetric or gynecological services which are provided by the plan.

"(3) PREDECESSORS AND CONTROLLED GROUPS.—For purposes of this subsection, a predecessor of an employer or any member of the employer's controlled group shall be treated as the employer. For purposes of this paragraph, the term 'controlled group' means any group treated as a single employer under subsection (b), (c), (m), or (o) of section 414 of the Internal Revenue Code of 1986."

Mrs. MCCARTHY of New York (during the reading). Mr. Speaker, I ask

unanimous consent that the motion to recommit be considered as read and printed in the RECORD.

The SPEAKER pro tempore. Is there objection to the request of the gentlewoman from New York?

There was no objection.

The SPEAKER pro tempore. Pursuant to the rule, the gentlewoman from New York (Mrs. MCCARTHY) is recognized for 5 minutes in support of her motion.

Mrs. MCCARTHY of New York. Mr. Speaker, I yield myself 2 minutes.

I rise in strong support for the motion to recommit. This motion will prohibit employers from joining association health plans if it allows for a reduction in coverage for breast cancer services. A vote against this motion and for the bill will allow employers that already cover basic mammograms to drop this coverage.

Mr. Speaker, a reduction in health insurance in any form is a reduction in health care. It is just that simple. States know that without guaranteeing basic health care, patients will not get the services they desperately need. They will only seek help under extreme circumstances, requiring more expensive medical treatment for their disease, putting their lives and the lives of their children at risk.

According to the American Cancer Society, over 211,000 new cases of breast cancer will be diagnosed in the United States this year alone. Two thousand of those cases will be in my State. Breast cancer is potentially fatal, but early detection through mammogram screenings is the key to proper treatment of this disease. Timely screening could prevent approximately 15 percent to 30 percent of all deaths from breast cancer among women over the age of 40. Currently, New York and 47 other States require insurance companies to cover mammogram screenings. However, under this bill, associated health plans would be exempt from having to provide this critical benefit in these 48 States. This motion would at least present a reduction of health care services to those who already have this important benefit.

As a nurse, I cannot believe this House, after hearing from cancer survivors for years about the need for treatments and screenings to beat this deadly disease, is now going to be rolling back these patient protections.

Today before you vote, truly realize a vote against this motion to recommit will harm millions of patients across this country.

Mr. Speaker, I yield 1½ minutes to the gentlewoman from Minnesota (Ms. MCCOLLUM).

Ms. MCCOLLUM. Mr. Speaker, I am proud to join my colleagues today in offering a motion to recommit to protect the coverage that women and children currently have today. This motion simply states that associated health plans cannot stop coverage for well-child visits, maternity or other types

of visits that are vital to women's and children's health care. Children deserve a healthy start in life. Coverage to promote healthy children is required in Minnesota and 30 other States. This coverage ensures that children have regular visits to pediatricians to get immunizations and preventive care. Why would we not want to protect our children?

This coverage is particularly important because getting a good start in life can prevent avoidable illnesses, identify serious disabilities, and reduce future health care costs. We have all seen the importance of childhood immunizations. For example, today polio has been eradicated because of the determination and commitment our country had to immunize children when they were young. Regular doctor visits for newborns is absolutely critical. Thirty-three children are born every day with severe hearing loss. If caught early enough through preventive doctor visits, this screening can make a difference. It can make a difference in their lives and a difference in the money spent on special education.

This motion ensures that families who currently have well-child visits and maternity coverage will not lose it tomorrow. We should be ensuring access to quality, comprehensive health care for our Nation's working families and not rolling back basic coverage. I urge my colleagues to support the motion to recommit.

Mrs. MCCARTHY of New York. Mr. Speaker, I yield 30 seconds to the gentlewoman from California (Ms. WOOLSEY).

Ms. WOOLSEY. Mr. Speaker, few health services are as important to a woman as an annual mammogram. Early detection is necessary as a weapon in our fight against breast cancer. Breast cancer has already touched far too many families. I simply cannot accept the idea of even one woman in any of our districts forgoing her annual mammogram and then later being diagnosed with advanced breast cancer because her association health plan does not cover mammograms.

Support this motion to recommit. Help save the lives of our wives, mothers, daughters, and sisters. The women of this country are counting on your vote.

Mrs. MCCARTHY of New York. Mr. Speaker, I yield the balance of my time to the gentleman from New Jersey (Mr. ANDREWS).

The SPEAKER pro tempore. The gentleman from New Jersey is recognized for 1 minute.

Mr. ANDREWS. Mr. Speaker, if the underlying bill becomes law, 4 million American women who presently are guaranteed breast cancer care will only have it if the insurance companies they move to decide to let them have it. We can change that by voting "yes" on this motion to recommit. The question is simple: Do we want our mothers and our sisters and our daughters and our

wives to rely upon the whims of the insurance industry or the power of our votes? If you want to guarantee that this care goes forward, the only way to do it is to vote "yes" on the motion of the gentlewoman from New York. I urge a "yes" vote.

Mr. BOEHNER. Mr. Speaker, I rise in opposition to the motion to recommit.

The SPEAKER pro tempore. The gentleman from Ohio is recognized for 5 minutes.

Mr. BOEHNER. Mr. Speaker, the underlying bill seeks to address the needs of 41 million Americans who have no health insurance. What the motion to recommit does is essentially mandate coverage on association health care plans. If you have no health insurance, a mandate will do you no good. What we seek to do with the underlying bill is to cover more people. Sixty percent of the people who are uninsured either work in a small business or have a relative that works in a small business. What we are trying to do here is level the playing field so that small businesses can buy health insurance for their employees just like large companies and unions can do today.

Under ERISA, there are but several small mandates. We do not mandate every coverage. But if you ask employees of large companies and you ask employees and members of large unions, they will tell you that they have the best health care plans in America. These large plans in our country have great benefits. They cover virtually all the illnesses and all the diseases that are there. But they are allowed to design one benefit issue for each of these mandates that covers all 50 States. It may not read the same in every particular State. What we are trying to do with the underlying bill is to give small businesses the same advantage in the marketplace that big businesses have today.

I would urge my colleagues at this hour, reject the motion to recommit and vote for the final passage of this bill.

The SPEAKER pro tempore. Without objection, the previous question is ordered on the motion to recommit.

There was no objection.

The SPEAKER pro tempore. The question is on the motion to recommit.

The question was taken; and the Speaker pro tempore announced that the noes appeared to have it.

RECORDED VOTE

Mrs. MCCARTHY of New York. Mr. Speaker, I demand a recorded vote.

A recorded vote was ordered.

The SPEAKER pro tempore. Pursuant to clause 9 of rule XX, the Chair will reduce to 5 minutes the minimum time for any electronic vote on the question of final passage.

The vote was taken by electronic device, and there were—ayes 192, noes 230, not voting 12, as follows:

[Roll No. 295]

AYES—192

Abercrombie
Ackerman
Alexander
Allen
Andrews
Baca
Baird
Baldwin
Ballance
Becerra
Bell
Berkley
Berman
Berry
Bishop (GA)
Bishop (NY)
Blumenauer
Boswell
Boucher
Boyd
Brady (PA)
Brown (OH)
Brown, Corrine
Capps
Capuano
Cardin
Cardoza
Carson (OK)
Clay
Clyburn
Cooper
Cramer
Crowley
Cummings
Davis (AL)
Davis (CA)
Davis (FL)
Davis (IL)
Davis (TN)
DeFazio
DeGette
DeLahunt
DeLauro
Deutsch
Dicks
Dingell
Doggett
Doyle
Edwards
Emanuel
Engel
Eshoo
Etheridge
Evans
Farr
Fattah
Filner
Ford
Frank (MA)
Frost
Gordon
Green (TX)
Grijalva
Gutierrez
Hall

Herman
Hill
Hinchey
Hinojosa
Hoeffel
Holden
Holt
Honda
Hooley (OR)
Hoyer
Inslee
Israel
Jackson (IL)
Jackson-Lee (TX)
Jefferson
John
Jones (OH)
Kanjorski
Kaptur
Kennedy (RI)
Kildee
Kilpatrick
Kind
Kleczka
Kucinich
Lampson
Langevin
Lantos
Larsen (WA)
Larson (CT)
Lee
Levin
Lewis (GA)
Lipinski
Lofgren
Lowey
Lucas (KY)
Lynch
Majette
Maloney
Markey
Marshall
Matheson
Matsui
McCarthy (MO)
McCarthy (NY)
McCollum
McDermott
McGovern
McIntyre
McNulty
Meehan
Meek (FL)
Meeks (NY)
Menendez
Michaud
Millender-
McDonald
Miller (NC)
Miller, George
Mollohan
Moore
Murtha
Nadler

NOES—230

Napolitano
Oberstar
Obey
Olver
Ortiz
Owens
Pallone
Pascrell
Pastor
Payne
Pelosi
Peterson (MN)
Pomeroy
Price (NC)
Rahall
Rangel
Reyes
Rodriguez
Ross
Rothman
Roybal-Allard
Ruppersberger
Rush
Ryan (OH)
Sabo
Sanchez, Linda T.
Sanchez, Loretta
Sanders
Sandlin
Schakowsky
Schiff
Scott (GA)
Scott (VA)
Serrano
Sherman
Skelton
Slaughter
Snyder
Solis
Spratt
Stark
Stenholm
Strickland
Stupak
Tanner
Tauscher
Taylor (MS)
Thompson (CA)
Thompson (MS)
Tierney
Towns
Udall (CO)
Udall (NM)
Van Hollen
Visclosky
Waters
Watson
Watt
Waxman
Weiner
Wexler
Woolsey
Wu
Wynn

Graves
Green (WI)
Greenwood
Gutknecht
Harris
Hart
Hastings (WA)
Hayes
Hayworth
Hefley
Hensarling
Herger
Hobson
Hoekstra
Hostettler
Houghton
Hulshof
Hunter
Hyde
Isakson
Issa
Istook
Janklow
Jenkins
Johnson (CT)
Johnson (IL)
Johnson, Sam
Jones (NC)
Keller
Kelly
Kennedy (MN)
King (IA)
King (NY)
Kingston
Kirk
Kline
Knollenberg
Kolbe
LaHood
Latham
LaTourette
Leach
Lewis (CA)
Lewis (KY)
Linder
LoBiondo
Lucas (OK)
Manzullo

Carson (IN)
Conyers
Costello
Cox

McCotter
McCrary
McHugh
McInnis
McKeon
Mica
Miller (FL)
Miller (MI)
Miller, Gary
Moran (KS)
Moran (VA)
Murphy
Musgrave
Myrick
Nethercutt
Neugebauer
Northup
Norwood
Nunes
Nussle
Osborne
Ose
Otter
Oxley
Paul
Pearce
Pence
Peterson (PA)
Petri
Pickering
Pitts
Platts
Pombo
Porter
Portman
Pryce (OH)
Putnam
Quinn
Radanovich
Ramstad
Regula
Rehberg
Renzi
Reynolds
Rogers (AL)
Rogers (KY)
Rogers (MI)
Rohrabacher

NOT VOTING—12

Gephardt
Hastings (FL)
Johnson, E. B.
Neal (MA)

Ros-Lehtinen
Royce
Ryan (WI)
Ryan (KS)
Saxton
Schrock
Sensenbrenner
Sessions
Shadegg
Shaw
Shays
Sherwood
Shimkus
Shuster
Simmons
Simpson
Smith (MI)
Smith (TX)
Souders
Stearns
Sullivan
Sweeney
Tancredo
Tauzin
Taylor (NC)
Terry
Thomas
Thornberry
Tiberi
Toomey
Turner (OH)
Turner (TX)
Upton
Velazquez
Vitter
Walden (OR)
Walsh
Wamp
Weldon (FL)
Weldon (PA)
Weller
Whitfield
Wicker
Wilson (NM)
Wilson (SC)
Wolf
Young (AK)
Young (FL)

ANNOUNCEMENT BY THE SPEAKER PRO TEMPORE

The SPEAKER pro tempore (Mr. SIMPSON) (during the vote). Members are advised that 2 minutes remain in this vote.

□ 1700

Mr. DOOLEY of California changed his vote from "aye" to "no."

So the motion to recommit was rejected.

The result of the vote was announced as above recorded.

Stated against:

Mr. NEY. Mr. Speaker, on June 19, 2003, I was unable to be present for rollcall vote 295 on H.R. 660, the Small Business Health Fairness Act of 2003 due to important business in the Subcommittee on Housing and Community Opportunity, which I chair. Had I been present I would have voted "no" on rollcall vote No. 295.

The SPEAKER pro tempore. The question is on passage of the bill.

The question was taken; and the Speaker pro tempore announced that the ayes appeared to have it.

RECORDED VOTE

Mr. ANDREWS. Mr. Speaker, I demand a recorded vote.

A recorded vote was ordered.

The SPEAKER pro tempore. This will be a 5-minute vote.

The vote was taken by electronic device, and there were—ayes 262, noes 162, not voting 11, as follows:

Doolittle
Dreier
Duncan
Dunn
Ehlers
Emerson
English
Everett
Feeney
Ferguson
Flake
Fletcher
Foley
Forbes
Fossella
Franks (AZ)
Frelinghuysen
Gallegly
Garrett (NJ)
Gerlach
Gibbons
Gilchrest
Gillmor
Gingrey
Gonzalez
Goode
Goodlatte
Goss
Granger

[Roll No. 296]

AYES—262

Aderholt Gibbons Northrup
 Akin Gilchrist Nunes
 Bachus Gillmor Nussle
 Baker Gingrey Osborne
 Ballenger Gonzalez Ose
 Barrett (SC) Goode Otter
 Bartlett (MD) Goodlatte Oxley
 Barton (TX) Goss Paul
 Bass Granger Pearce
 Beauprez Graves Pence
 Bell Green (WI) Peterson (MN)
 Bereuter Greenwood Peterson (PA)
 Biggett Gutknecht Petri
 Bilirakis Hall Pickering
 Bishop (GA) Harman Pitts
 Bishop (UT) Harris Platts
 Blackburn Hart Pombo
 Blunt Hastert Porter
 Boehlert Hastings (WA) Portman
 Boehner Hayes Pryce (OH)
 Bonilla Hayworth Putnam
 Bonner Hefley Quinn
 Bono Hensarling Radanovich
 Boozman Herger Ramstad
 Bradley (NH) Hobson Regula
 Brady (TX) Hoekstra Rehberg
 Brown (SC) Hostettler Renzi
 Brown-Waite, Houghton Reynolds
 Ginny Hulshof Rogers (AL)
 Burgess Hunter Rogers (KY)
 Burns Hyde Rogers (MI)
 Burr Isakson Rohrabacher
 Burton (IN) Israel Ros-Lehtinen
 Buyer Issa Rothman
 Calvert Istook Royce
 Camp Jackson-Lee Rush
 Cannon (TX) Ryan (WI)
 Cantor Janklow Ryun (KS)
 Capito Jenkins Sanchez, Loretta
 Carson (OK) John Saxton
 Carter Johnson (CT) Schrock
 Case Johnson (IL) Sensenbrenner
 Castle Johnson, Sam Sessions
 Chabot Jones (NC) Shadegg
 Chocola Keller Shaw
 Coble Kelly Shays
 Cole Kennedy (MN) Sherwood
 Collins King (IA) Shimkus
 Cooper King (NY) Shuster
 Cox Kingston Simmons
 Cramer Kirk Simpson
 Crane Kline Skelton
 Crenshaw Knollenberg Smith (MI)
 Cubin Kolbe Smith (TX)
 Culberson LaHood Snyder
 Cunningham Latham Souder
 Davis (AL) LaTourette Stearns
 Davis (IL) Leach Stenholm
 Davis (TN) Lewis (CA) Sullivan
 Davis, Jo Ann Lewis (KY) Sweeney
 Davis, Tom Linder Tancredo
 Deal (GA) Lipinski Tauzin
 DeLay LoBiondo Taylor (MS)
 DeMint Lucas (KY) Taylor (NC)
 Diaz-Balart, L. Lucas (OK) Terry
 Diaz-Balart, M. Manzullo Thomas
 Doolley (CA) Marshall Thornberry
 Doolittle Matheson Tiberi
 Dreier McCarthy (MO) Toomey
 Duncan McCotter Turner (OH)
 Dunn McCrery Turner (TX)
 Edwards McHugh Upton
 Ehlers McLinnis Velazquez
 Emerson McIntyre Vitter
 English McKeon Walden (OR)
 Everett Meek (FL) Walsh
 Feeney Mica Wamp
 Ferguson Miller (FL) Weldon (FL)
 Flake Miller (MI) Weldon (PA)
 Fletcher Miller, Gary Weller
 Foley Moran (KS) Whitfield
 Forbes Moran (VA) Wicker
 Fossella Murphy Wilson (NM)
 Franks (AZ) Musgrave Wilson (SC)
 Frelinghuysen Myrick Wolf
 Gallegly Nethercutt Wynn
 Garrett (NJ) Neugebauer Young (AK)
 Gerlach Ney Young (FL)

NOES—162

Abercrombie Baird Berry
 Ackerman Baldwin Bishop (NY)
 Alexander Ballance Blumenauer
 Allen Becerra Boswell
 Andrews Berkeley Boucher
 Baca Berman Boyd

Brady (PA) Jones (OH)
 Brown (OH) Kanjorski
 Brown, Corrine Kaptur
 Capps Kennedy (RI)
 Capuano Kildee
 Cardin Kilpatrick
 Cardoza Kind
 Clay Kleczka
 Clyburn Kucinich
 Crowley Lampson
 Cummings Langevin
 Davis (CA) Lantos
 Davis (FL) Larsen (WA)
 DeFazio Larson (CT)
 DeGette Lee
 Delahunt Levin
 DeLauro Lewis (GA)
 Deutsch Lofgren
 Dicks Lowey
 Dingell Lynch
 Doggett Majette
 Doyle Maloney
 Emanuel Markey
 Engel Matsui
 Eshoo McCarthy (NY)
 Etheridge McCollum
 Evans McDermott
 Farr McGovern
 Fattah Meehan
 Filner Meeks (NY)
 Ford Menendez
 Frank (MA) Michaud
 Frost Millender-
 Gordon McDonald
 Green (TX) Miller (NC)
 Grijalva Miller, George
 Gutierrez Molohan
 Hill Moore
 Hinchey Murtha
 Hinojosa Nadler
 Hoeflief Napolitano
 Holden Norwood
 Holt Oberstar
 Honda Obey
 Hooley (OR) Olver
 Hoyer Ortiz
 Inslee Owens
 Jackson (IL) Pallone
 Jefferson Pascrell

NOT VOTING—11

Carson (IN) Hastings (FL) Smith (NJ)
 Conyers Johnson, E. B. Smith (WA)
 Costello McNulty Tiahrt
 Gephardt Neal (MA)

ANNOUNCEMENT BY THE SPEAKER PRO TEMPORE

The SPEAKER pro tempore (during the vote). Members are advised that 2 minutes remain in this vote.

□ 1707

Mr. RUSH changed his vote from “no” to “aye.”

So the bill was passed.

The result of the vote was announced as above recorded.

A motion to reconsider was laid on the table.

PERSONAL EXPLANATION

Ms. EDDIE BERNICE JOHNSON of Texas. Mr. Speaker, on rollcall No. 295, had I been present on the Motion to Recommit, I would vote “aye”; on the next rollcall, No. 296—final passage—I would vote “no”.

PERMISSION FOR COMMITTEE ON APPROPRIATIONS TO HAVE UNTIL MIDNIGHT MONDAY, JUNE 23, 2003, TO FILE PRIVILEGED REPORT ON DEPARTMENT OF HOMELAND SECURITY APPROPRIATIONS ACT, 2004

Mr. ROGERS of Kentucky. Mr. Speaker, I ask unanimous consent that the Committee on Appropriations have until midnight Monday, June 23, 2003,

to file a privileged report making appropriations for the Department of Homeland Security for the fiscal year ending September 30, 2004, and for other purposes.

The SPEAKER pro tempore. Is there objection to the request of the gentleman from Kentucky?

There was no objection.

The SPEAKER pro tempore. Pursuant to clause 1 of rule XXI, points of order are reserved.

STRENGTHEN AMERICORPS PROGRAM ACT

Mr. BOEHNER. Mr. Speaker, I ask unanimous consent to take from the Speaker's table the Senate bill (S. 1276) to improve the manner in which the Corporation for National and Community Service approves, and records obligations relating to national service positions, and ask for its immediate consideration in the House.

The Clerk read the title of the Senate bill.

The SPEAKER pro tempore. Is there objection to the request of the gentleman from Ohio?

There was no objection.

The Clerk read the Senate bill, as follows:

S. 1276

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the “Strengthen AmeriCorps Program Act”.

SEC. 2. PROCESS OF APPROVAL OF NATIONAL SERVICE POSITIONS.

(a) DEFINITIONS.—In this Act, the terms “approved national service position” and “Corporation” have the meanings given the terms in section 101 of the National and Community Service Act of 1990 (42 U.S.C. 12511).

(b) TIMING AND RECORDING REQUIREMENTS.—

(1) IN GENERAL.—Notwithstanding subtitles C and D of title I of the National and Community Service Act of 1990 (42 U.S.C. 12571 et seq., 12601 et seq.), and any other provision of law, in approving a position as an approved national service position, the Corporation—

(A) shall approve the position at the time the Corporation—

(i) enters into an enforceable agreement with an individual participant to serve in a program carried out under subtitle E of title I of that Act (42 U.S.C. 12611 et seq.) or title I of the Domestic Volunteer Service Act of 1973 (42 U.S.C. 4951 et seq.); or

(ii) except as provided in clause (i), awards a grant to (or enters into a contract or cooperative agreement with) an entity to carry out a program for which such a position may be approved under section 123 of the National and Community Service Act of 1990 (42 U.S.C. 12573); and

(B) shall record as an obligation an estimate of the net present value of the national service educational award associated with the position, based on a formula that takes into consideration historical rates of enrollment in such a program, and of earning and using national service educational awards for such a program.

(2) FORMULA.—In determining the formula described in paragraph (1)(B), the Corporation shall consult with the Director of the Congressional Budget Office.