COMMITTEE ON EDUCATION
AND THE WORKFORCE
U.S. HOUSE OF REPRESENTATIVES
2176 RAYBURN HOUSE OFFICE BUILDING
WASHINGTON, DC 20515–6100

March 5, 2018

SUBMITTED VIA REGULATIONS.GOV

The Honorable R. Alexander Acosta
Secretary
U.S. Department of Labor
200 Constitution Avenue, NW
Washington, DC 20210

Re: RIN 1210-AB85, Comments on the Department of Labor's Proposed Rule, "Definition of 'Employer' Under Section 3(5) of ERISA – Association Health Plans"

Dear Secretary Acosta:

On January 4, 2018, the Department of Labor's Employee Benefits Security Administration (EBSA) released a proposed rule[1] to revise the definition of "employer" under Section 3(5) of the *Employee Retirement Income Security Act of 1974* (ERISA) to expand access to association health plans (AHPs) pursuant to President Trump's Executive Order 13813, "Promoting Healthcare Choice and Competition Across the United States."[2] The Committee on Education and the Workforce (Committee) supports the administration's continued commitment to our shared goal of delivering free-market and patient-centered solutions that benefit American workers and families.

America's small businesses and the millions of workers they employ are in desperate need of affordable health care options. Since 2008, approximately 39 percent of small businesses with fewer than 10 employees have stopped offering coverage, leaving the nation's workers with fewer health care options.[3] In 2016, the number of businesses with fewer than 50 employees that offered health insurance to their workers dropped to 29 percent, compared with 39 percent in

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[1] Definition of "Employer" Under Section 3(5) of ERISA—Association Health Plans, 83 Fed. Reg. 614 (proposed Jan. 5, 2018).
[2] Exec. Order No. 13,813, 82 Fed. Reg. 48,385 (Oct. 17, 2017).
[3] Paul Fronstin, *After Years of Erosion, Mid-size and Some Small Employers Added Health Coverage in 2016*, EBRI EDUC. AND RESEARCH FUND (Aug. 2017), https://www.ebri.org/pdf/notespdf/EBRI_Notes_v38no8_OfferRates.31Aug17.pdf.

2010 when the *Patient Protection and Affordable Care Act* was signed into law.[4] Due to their size and economies of scale, large businesses and labor organizations have the ability to negotiate on behalf of their employees for high-quality health care at more affordable costs. By offering a qualified group health plan under ERISA, these large employers and labor organizations are exempt from a myriad of state rules and regulations on health insurance. Small businesses, however, do not have the same negotiating capacity as larger businesses and are unable to band together to increase their bargaining power in the health insurance marketplace.

According to a National Federation of Independent Business study, 52 percent of small business employers that do not currently offer coverage cite the cost of health insurance coverage as the top reason for not offering it to their employees.[5] One significant factor contributing to the high cost of health care for small employers is their inability to band together in order to unlock the financial benefits of small business pooling arrangements. These cost-saving benefits — economies of scale, freedom from state regulation, and increased administrative efficiencies — would help small employers access coverage at a more affordable price and decrease the number of uninsured individuals who work in small businesses.[6] This is particularly important because the percentage of smaller firms that offer coverage has fallen from 57 percent to 50 percent since 2011.[7]

As the primary House committee of jurisdiction over employer-provided health coverage, the Committee approved and the U.S. House of Representatives passed the *Small Business Health Fairness Act of 2017* to empower small employers to band together through AHPs.[8] This legislation received widespread support from the business community, including the American Benefits Council, International Franchise Association, National Association of Wholesaler-Distributors, National Federation of Independent Business, National Retail Federation, U.S. Chamber of Commerce, and many others.

As the Department considers additional rulemaking related to AHPs, we ask that you consider the provisions included in the *Small Business Health Fairness Act of 2017* as a strong, workable, and bipartisan model to successfully promote affordability, flexibility, and predictability for American businesses. Excerpts from the Committee's report on the legislation are attached as additional comments for your consideration on the proposed rule.

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[4] AGENCY FOR HEALTHCARE AND QUALITY, CENTER FOR FINANCING, ACCESS AND COSTS TRENDS, 2016 MEDICAL EXPENDITURE PANEL SURVEY-INSURANCE COMPONENT: TABLE I.A.2 (2016), https://meps.ahrq.gov/data_stats/summ_tables/insr/national/series_1/2016/tia2.pdf; *Id.*, 2010 MEDICAL EXPENDITURE PANEL SURVEY-INSURANCE COMPONENT: TABLE I.A.2 (2010), https://meps.ahrq.gov/data_stats/summ_tables/insr/national/series_1/2010/tia2.pdf.

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

[6] According to 2010 Census data, smaller firms (less than 500 employees) were almost twice as likely to be uninsured as larger firms (more than 500 employees), with 36 percent of workers in firms with less than 10 employees uninsured. SMALL BUS. ADMIN., WHAT IS THE LEVEL OF AVAILABILITY AND COVERAGE OF HEALTH INSURANCE IN SMALL FIRMS? (2012).

[7] KAISER FAMILY FOUND., EMPLOYER HEALTH BENEFITS SURVEY (2017), http://files.kff.org/attachment/Report-Employer-Health-Benefits-Annual-Survey-2017.

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

We are pleased to see the administration's leadership on this important rulemaking effort, and we look forward to working alongside it to make AHPs a reality for small business employees across the country.

Respectfully,

Virginia Foxx
Chairwoman
Committee on Education and the Workforce

Tim Walberg
Chairman
Subcommittee on Health, Employment, Labor and Pensions

Enclosure

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

SMALL BUSINESS HEALTH FAIRNESS ACT OF 2017

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

Ms. FOXX, from the Committee on Education and the Workforce, submitted the following

R E P O R T

together with

MINORITY VIEWS

[To accompany H.R. 1101]

The Committee on Education and the Workforce, to whom was referred the bill (H.R. 1101) to amend title I of the Employee Retirement Income Security Act of 1974 to improve access and choice for entrepreneurs with small businesses with respect to medical care for their employees, having considered the same, report favorably thereon with an amendment and recommend that the bill as amended do pass.

The amendment is as follows:

Strike all after the enacting clause and insert the following:

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

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

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

SEC. 2. RULES GOVERNING ASSOCIATION HEALTH PLANS.

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

"PART 8—RULES GOVERNING ASSOCIATION HEALTH PLANS

"SEC. 801. ASSOCIATION HEALTH PLANS.

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

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

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

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

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

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

"SEC. 802. CERTIFICATION OF ASSOCIATION HEALTH PLANS.

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

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

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

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

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

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

"(1) A plan which offered such coverage on the date of the enactment of the Small Business Health Fairness Act of 2017.

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

"(3) A plan whose eligible participating employers represent one or more trades or businesses, or one or more industries, consisting of any of the following: agriculture; equipment and automobile dealerships; barbering and cos-

metology; certified public accounting practices; child care; construction; dance, theatrical and orchestra productions; disinfecting and pest control; financial services; fishing; food service establishments; hospitals; labor organizations; logging; manufacturing (metals); mining; medical and dental practices; medical laboratories; professional consulting services; sanitary services; transportation (local and freight); warehousing; wholesaling/distributing; or any other trade or business or industry which has been indicated as having average or above-average risk or health claims experience by reason of State rate filings, denials of coverage, proposed premium rate levels, or other means demonstrated by such plan in accordance with regulations.

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

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

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

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

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

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

"(A) BOARD MEMBERSHIP.—

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

"(ii) LIMITATION.—

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

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

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

"(iii) CERTAIN PLANS EXCLUDED.—Clause (i) shall not apply to an association health plan which is in existence on the date of the enactment of the Small Business Health Fairness Act of 2017.

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

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

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

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

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

"SEC. 804. PARTICIPATION AND COVERAGE REQUIREMENTS.

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

"(1) each participating employer must be—

"(A) a member of the sponsor,

"(B) the sponsor, or

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

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

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

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

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

"(b) COVERAGE OF PREVIOUSLY UNINSURED EMPLOYEES.—In the case of an association health plan in existence on the date of the enactment of the Small Business Health Fairness Act of 2017, an affiliated member of the sponsor of the plan may be offered coverage under the plan as a participating employer only if—

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

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

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

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

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

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

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

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

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

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

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

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

"(C) incorporates the requirements of section 806.

"(2) CONTRIBUTION RATES MUST BE NONDISCRIMINATORY.—

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

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

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

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

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

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

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

"(4) MARKETING REQUIREMENTS.—

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

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

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

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

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

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

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

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

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

"(i) a reserve sufficient for unearned contributions;

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

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

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

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

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

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

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

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

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

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

"(1) $500,000, or

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

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

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

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

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

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

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

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

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

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

"(3) ASSOCIATION HEALTH PLAN FUND.—

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

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

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

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

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

"(B) which is guaranteed renewable; and

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

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

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

"(B) which is guaranteed renewable; and

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

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

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

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

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

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

"(j) SOLVENCY STANDARDS WORKING GROUP.—

"(1) IN GENERAL.—Within 90 days after the date of the enactment of the Small Business Health Fairness Act of 2017, the applicable authority shall establish a Solvency Standards Working Group. In prescribing the initial regulations under this section, the applicable authority shall take into account the recommendations of such Working Group.

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

"(A) A representative of the National Association of Insurance Commissioners.

"(B) A representative of the American Academy of Actuaries.

"(C) A representative of the State governments, or their interests.

"(D) A representative of existing self-insured arrangements, or their interests.

"(E) A representative of associations of the type referred to in section 801(b)(1), or their interests.

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

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

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

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

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

"(A) the sponsor; and

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

"SEC. 808. NOTICE REQUIREMENTS FOR VOLUNTARY TERMINATION.

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

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

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

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

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

"SEC. 809. CORRECTIVE ACTIONS AND MANDATORY TERMINATION.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

"(1) the sponsor and plan administrator;

"(2) each participant;

"(3) each participating employer; and

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

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

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

"(f) JURISDICTION OF COURT.—

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

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

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

"SEC. 811. STATE ASSESSMENT AUTHORITY.

"(a) IN GENERAL.—Notwithstanding section 514, a State may impose by law a contribution tax on an association health plan described in section 806(a)(2), if the plan commenced operations in such State after the date of the enactment of the Small Business Health Fairness Act of 2017.

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

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

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

"(3) such tax is otherwise nondiscriminatory; and

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

plan, or any combination thereof provided by such insurers or health maintenance organizations in such State in connection with such plan.

"SEC. 812. DEFINITIONS AND RULES OF CONSTRUCTION.

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

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

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

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

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

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

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

"(7) INDIVIDUAL MARKET.—

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

"(B) TREATMENT OF VERY SMALL GROUPS.—

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

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

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

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

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

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

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

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

"(C) in the case of an association health plan in existence on the date of the enactment of the Small Business Health Fairness Act of 2017, a person eligible to be a member of the sponsor or one of its member associations.

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

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

"(b) RULES OF CONSTRUCTION.—

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

plan, fund, or program so determined to be such an employee welfare benefit plan—

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

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

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

(b) CONFORMING AMENDMENTS TO PREEMPTION RULES.—

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

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

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

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

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

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

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

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

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

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

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

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

"(B) relating to prompt payment of claims.

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

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

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

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

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

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

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

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

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

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

"(2) Nothing in any other provision of law enacted on or after the date of the enactment of the Small Business Health Fairness Act of 2017 shall be construed to alter, amend, modify, invalidate, impair, or supersede any provision of this title, except by specific cross-reference to the affected section.".

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

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

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

(f) REPORT TO THE CONGRESS REGARDING CERTIFICATION OF SELF-INSURED ASSOCIATION HEALTH PLANS.—Not later than January 1, 2022, the Secretary of Labor shall report to the Committee on Education and the Workforce of the House of Representatives and the Committee on Health, Education, Labor, and Pensions of the Senate the effect association health plans have had, if any, on reducing the number of uninsured individuals.

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

"PART 8. RULES GOVERNING ASSOCIATION HEALTH PLANS

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

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

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

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

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

"(iii)(I) in any case in which the benefit referred to in subparagraph (A) consists of medical care (as defined in section 812(a)(2)), the determination of whether a trade or business is under 'common control' with another trade or business shall be determined under regulations of the Secretary applying principles consistent and coextensive with the principles applied in determining whether employees of two or more trades or businesses are treated as employed by a single employer under section 4001(b), except that, for purposes of this

paragraph, an interest of greater than 25 percent may not be required as the minimum interest necessary for common control, or

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

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

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

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

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

(a) CRIMINAL PENALTIES FOR CERTAIN WILLFUL MISREPRESENTATIONS.—Section 501 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1131) is amended by adding at the end the following new subsection:

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

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

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

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

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

(b) CEASE ACTIVITIES ORDERS.—Section 502 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1132) is amended by adding at the end the following new subsection:

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

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

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

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

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

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

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

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

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

(c) RESPONSIBILITY FOR CLAIMS PROCEDURE.—Section 503 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1133) is amended by inserting "(a) IN GENERAL.—" before "In accordance", and by adding at the end the following new subsection:

"(b) ASSOCIATION HEALTH PLANS.—The terms of each association health plan which is or has been certified under part 8 shall require the board of trustees or

the named fiduciary (as applicable) to ensure that the requirements of this section are met in connection with claims filed under the plan.".

SEC. 5. COOPERATION BETWEEN FEDERAL AND STATE AUTHORITIES.

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

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

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

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

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

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

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

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

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

(a) EFFECTIVE DATE.—The amendments made by this Act shall take effect 1 year after the date of the enactment of this Act. The Secretary of Labor shall first issue all regulations necessary to carry out the amendments made by this Act within 1 year after the date of the enactment of this Act.

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

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

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

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

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

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

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

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

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

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

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

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

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

SUMMARY

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

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

COMMITTEE VIEWS

Background on Employer-sponsored insurance coverage

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

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

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

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

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

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

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

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

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

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

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

[16] *Id.*

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

The need for small business pooling

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

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

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

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

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

[27] *Id.*

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

[29] Hurst, *supra* note 22.

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

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

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

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

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

Support for creating options and flexibility for small businesses

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

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

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

CONCLUSION

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

SECTION-BY-SECTION

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

Section 1. Short title; Table of Contents

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

Section 2. Rules governing association health plans

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

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

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

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

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

Section 804. Requires all employers participating in the AHP to be members or affiliated members of the sponsor. All individuals under the plan must be active or retired employees, owners, officers, directors, partners or their beneficiaries. This applies to partnerships and self-employed individuals. Expressly prohibits discrimination by requiring (1) all employers that are association members are eligible for participation; (2) all geographically available coverage options are made available upon request to eligible employers; and (3) eligible individuals cannot be excluded from enrolling because of health status. The bill also stipulates that no participating employer may exclude an employee by purchasing an individual policy of health insurance coverage for such person based on his or her health status.

Section 805. Requires contribution rates for any particular employer comply with the *Health Insurance Portability and Accountability Act* (HIPAA), which prohibits group health plans from excluding high-risk individuals based on high claims experience. Thus, it will not be possible for AHPs to cherry pick because sick or high-risk groups or individuals cannot be denied coverage. Contribution rates can only vary to the extent already allowed under the relevant state community rating insurance law. State-licensed health insurance agents must be used to distribute health insurance coverage provided to small employers under an AHP, and must also be used to distribute self-insured benefits to small employers through an AHP, if the AHP also offers fully-insured plans. In addition, AHPs must be allowed to design benefit options. Specifically, the bill mandates that no provision of state law shall preclude an AHP or health insurance issuer from exercising its discretion in designing the items and services of medical care to be included as health insurance coverage under the plan.

Section 806. Establishes capital reserve requirements (unearned contributions, benefit liabilities, expected administrative costs, any other obligations) for self-insured AHP's and requires them to obtain both specific and aggregate stop loss coverage and solvency indemnification insurance. In addition, the AHP must maintain minimum surplus reserves of at least $500,000, and the Secretary may increase the surplus reserve minimum to $2 million. Establishes an Association Health Plan Fund, managed by the Department of Labor, to guarantee that indemnification insurance is always available, and penalties apply if payments are not made. All certified AHPs would be required to pay $5,000 into the fund annually. The measure requires the Secretary to establish a Solvency Standards Working Group within 90 days of enactment to recommend initial regulations.

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

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

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

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

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

Section 812. Defines the following terms: group health plan, medical care, health insurance coverage, health insurance issuer, applicable authority, health status-related factor, individual market, treatment of very small groups, participating employer, applicable state authority, qualified actuary, affiliated member, large employer, and small employer. Also, clarifies the treatment of ERISA's preemption rules with regard to AHPs. For certified AHPs, state law is preempted to the extent that it would preclude an AHP from existing in a state. In ad-

dition, state law is also preempted in order to allow health insurance issuers to offer health insurance coverage of the same policy type as offered in connection with a particular AHP to eligible employers, regardless of whether such employers are members of the particular association. Health insurance coverage policy forms filed and approved in a particular state in connection with an insurer's offering under an AHP are deemed to be approved in any other state in which such coverage is offered when the insurer provides a complete filing in the same form and manner to the authority in the other state. Not later than January 1, 2022, the Secretary shall report to Congress regarding the effect AHPs have had, if any, on reducing the number of uninsured individuals.

Section 3. Clarification of treatment of single employer arrangements

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

Section 4. Enforcement provisions relating to association health plans

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

Section 5. Cooperation between federal and state authorities

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

Section 6. Effective date and transitional and other rules

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

EXPLANATION OF AMENDMENTS

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

APPLICATION OF LAW TO THE LEGISLATIVE BRANCH

Section 102(b)(3) of Public Law 104–1 requires a description of the application of this bill to the legislative branch. H.R. 1101 im-