SMALL BUSINESS HEALTH FAIRNESS ACT OF 2004

Mr. BOEHNER. Mr. Speaker, pursuant to House Resolution 638, I call up the bill (H.R. 4281) to amend title I of the Employee Retirement Income Security Act of 1974 to improve access and choice for entrepreneurs with small businesses with respect to medical care for their employees, and ask for its immediate consideration in the House.

The Clerk read the title of the bill.

The SPEAKER pro tempore. Pursuant to H. Res. 638, the bill is considered read for amendment.

The text of H.R. 4281 is as follows:

H.R. 4281

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

SECTION 1. SHORT TITLE AND TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the ''Small Business Health Fairness Act of 2004''.

(b) TABLE OF CONTENTS.—The table of contents 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 2004,

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

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

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

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

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

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

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

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

''(A) BOARD MEMBERSHIP.—

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

''(ii) LIMITATION.—

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

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

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

''(iii) CERTAIN PLANS EXCLUDED.—Clause (i) shall not apply to an association health plan which is in existence on the date of the enactment of the Small Business Health Fairness Act of 2004.

''(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 2004, 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 2004, the applicable authority shall establish a Solvency Standards Working Group. In prescribing the initial regulations under this section, the applicable authority shall take into account the recommendations of such Working Group.

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

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

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

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

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

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

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

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

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

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

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

''(A) the sponsor; and

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

''SEC. 808. NOTICE REQUIREMENTS FOR VOLUNTARY TERMINATION.

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

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

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

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

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

''SEC. 809. CORRECTIVE ACTIONS AND MANDATORY TERMINATION.

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

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

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

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

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

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

''(a) APPOINTMENT OF SECRETARY AS TRUSTEE FOR INSOLVENT PLANS.—Whenever the Secretary determines that an association health plan which is or has been certified under this part and which is described in section 806(a)(2) will be unable to provide benefits when due or is otherwise in a financially hazardous condition, as shall be defined by the Secretary by regulation, the Secretary shall, upon notice to the plan, apply to the appropriate United States district court for appointment of the Secretary as trustee to administer the plan for the duration of the insolvency. The plan may appear as a party and other interested persons may intervene in the proceedings at the discretion of the court. The court shall appoint such Secretary trustee if the court determines that the trusteeship is necessary to protect the interests of the participants and beneficiaries or providers of medical care or to avoid any unreasonable deterioration of the financial condition of the plan. The 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 2004.

''(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 2004, a person eligible to be a member of the sponsor or one of its member associations.

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

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

''(b) RULES OF CONSTRUCTION.—

''(1) EMPLOYERS AND EMPLOYEES.—For purposes of determining whether a plan, fund, or

program is an employee welfare benefit plan which is an association health plan, and for purposes of applying this title in connection with such plan, fund, or program so determined to be such an employee welfare benefit plan—

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

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

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

(b) CONFORMING AMENDMENTS TO PREEMPTION RULES.—

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

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

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

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

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

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

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

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

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

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

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

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

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

''(B) relating to prompt payment of claims.

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

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

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

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

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

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

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

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

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

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

''(2) Nothing in any other provision of law enacted on or after the date of the enactment of the Small Business Health Fairness Act of 2004 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, 2009, 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—

(1) by inserting ''(a)'' after ''Sec. 501.''; and

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

SEC. 5. COOPERATION BETWEEN FEDERAL AND STATE AUTHORITIES.

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

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

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

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

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

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

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

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

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

(a) EFFECTIVE DATE.—The amendments made by this Act shall take effect one year 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 one year after the date of the enactment of this Act.

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

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

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

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

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

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

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

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

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

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

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

The SPEAKER pro tempore. After 1 hour of debate on the bill, it shall be in order to consider the amendment printed in part B of House Report 108–484, if offered by the gentleman from Wisconsin (Mr. KIND), or his designee, which shall be considered read, and shall be debatable for 1 hour, equally divided and controlled by the proponent and an opponent.

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

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

GENERAL LEAVE

Mr. BOEHNER. Mr. Speaker, I ask unanimous consent that all Members may have 5 legislative days within which to revise and extend their remarks on H.R. 4281.

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

There was no objection.

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

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

The number of uninsured Americans today stands at 43.6 million. This problem is not going to go away, and I think we have a responsibility to confront it.

With health care costs continuing to rise sharply across the country, more and more employers and workers are sharing the burden of increased health care premiums. Employer-based health

insurance premiums jumped by 15 percent on average in 2003, the largest increase in a decade; and, for many small employers, those increases were far larger.

The second number is 60, which represents the percentage of these uninsured working Americans who either work for a small business or are dependent upon someone who does. Many of these Americans work for small employers who cannot afford to purchase quality health insurance benefits for their workers.

Notably, the Census Bureau statistics show that employer-sponsored health coverage has declined because small businesses with less than 25 workers have been forced to drop coverage because of the rising cost of health insurance.

□ 1345

The next number is $130 billion. Yes, that is right, $130 billion which represents the annual cost to the citizens of our country of the poor health and premature deaths of individuals without health insurance, according to a study released last year by the Institute of Medicine.

The implications of these numbers I think are tragic. Clearly, we need to focus on providing affordable health care to the uninsured, as well as to ensure employers who provide health benefits to their employees are not forced to drop their coverage because of rising premiums and high administrative costs.

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

President Bush addressed this point directly last year during a speech at the Women's Entrepreneurship Summit, and he said, ''Small businesses will be able to pool together and spread their risk across a large employee base. It makes no sense in America to isolate small businesses as little health care islands unto themselves. We must have association health plans.''

Well, the President is right, and we should help level this playing field so that small businesses can offer high-quality coverage to their employees.

Americans overwhelmingly agree with President Bush that AHPs are the right approach to helping the uninsured. A recent poll conducted in March reveals that 93 percent of Americans support association health plans as a way of providing access to affordable care for American workers who lack coverage. Media reports from the last few days reveal how large corporations are now starting to band together to provide health care insurance to their part-time workers. Do not small businesses and their workers deserve this same opportunity?

Importantly, the bill gives AHPs freedom from costly State mandates because small businesses deserve to be treated in the same fashion as large corporations and unions who receive the same type of an exemption. Clearly, these mandates are useless to families who have no health coverage in the first place. And if you do not have health coverage, State mandates requiring health mandates and specific benefits do you and your family no good at all. This measure includes, I believe, strong safeguards to protect workers.

Despite the bipartisan nature of this bill, some misinformation has been spread and I would like to correct it. This measure protects against cherry-picking because we make clear that AHPs must comply with the 1996 Health Insurance Portability and Accountability Act which prohibits group health plans from excluding or charging a higher rate to high-risk individuals with high claims experience. Under our bill, sick or high-risk groups or individuals cannot be denied coverage. In addition, AHPs cannot charge higher rates for employers with sicker individuals within the plan except to the extent already allowed by State law, based on where the employer is located.

The bill also contains strict requirements under which only bona fide professional and trade organizations can sponsor an association health plan and, therefore, does not allow ''sham association plans'' set up by health insurance companies. These organizations must be established for purposes other than providing health insurance and they have to be in business for at least 3 years.

Now, some may ask why we need to pass this bill again, especially after it passed with significant bipartisan support last year. We are here today because we want to remind the American people and uninsured working families that we are here working on their behalf. We have a bipartisan solution to help address the problem of the uninsured, and passing this bill again demonstrates our commitment to helping Americans without health insurance. The next step is for the other body across the Capitol to begin to deal with this bill in a serious way. On Tuesday of this week, the Senate Task Force on the Uninsured included association health plans amongst its proposals to address the needs of uninsured working Americans, so we remain hopeful.

We in Congress, I think, have a responsibility to deal with the problems of small businesses who cannot afford to provide health insurance because of skyrocketing health care costs and being stuck in small State insurance pools.

The United States economy is improving, and more and more employers are hiring workers each month. Last Friday, the Labor Department reported that 1.1 million new jobs have been created over the last 8 months, including 625,000 new net jobs over the last 2 months alone. We want to make sure that those new workers have opportunity to receive quality health insurance through their employer, and we believe that this bill can help make that happen.

Mr. Speaker, I reserve the balance of my time.

Mr. ANDREWS. Mr. Speaker, it is my pleasure to yield such time as he may consume to the gentleman from California (Mr. GEORGE MILLER), the Democratic leader of our committee.

Mr. GEORGE MILLER of California. Mr. Speaker, I thank the gentleman for yielding me this time and I thank him for all of his leadership on this legislation.

I was wondering why we were here today, but I guess we are here today to demonstrate that we are working on behalf of the American people. It is an interesting definition of work, that we are going to repeat something that we have already done earlier in the year that has already been completed, but we are going to go through it again, so you think we are working for you. I thought they called that featherbedding or something in the old days, when you looked like you were working but you were not working.

But anyway, what is interesting here is that once again we see the Republicans offering another piece of legislation that just continues an assault on middle-income Americans. They did it with overtime pay: cut it, will not let us consider it; comp time, ended; unemployment insurance assistance, terminated; job training, slashed; negotiations for cheaper prescription drugs, prohibited. When is it the middle class is going to get to win one with this Republican leadership in the Congress?

Now we come to this health care plan which is to basically give an offer to people of health care that is unregulated, that is opposed by all of the State Attorneys General and the National Governors Association and so many others who have experience with these plans in trying to make sure that people are not cheated out of the money that they pay and the benefits that are offered.

But they are not going to allow us to have the amendments that would substantially change this bill, because they do not want to vote on those amendments. They do not want to vote on amendments that would improve this legislation. That is unfortunate, because as they do continue their assault on the middle class, at least those of us 206 Members on the Democratic side ought to be able to reflect the voices of the people that we represent. We ought to be able to offer the amendments to provide for their protection and for their expanded health care, but that is not the way they run the House nowadays. Nowadays you either have to take their idea or no idea.

And that is just unacceptable when we are considering a problem as complicated and with the absolute sense of urgency that the Nation has about health care.

So this is very unfortunate, that we would take these 4 hours that we will probably consume on this legislation and simply go through a charade that was already acted out in the House of Representatives last year in this Congress. The Senate can consider it anytime they want. But we are going to go through this charade rather than allowing amendments that could be offered to substantially improve this legislation, amendments much like the effort we made yesterday on overtime, to offer a chance to vote on overtime, we would prevail on a bipartisan basis, but the Republicans are so concerned that they would rather choke off the debate and not allow those amendments to take place.

Mr. BOEHNER. Mr. Speaker, I am pleased to yield 2 minutes to the gentleman from Texas (Mr. SAM JOHNSON), the chairman of the Subcommittee on Employer-Employee Relations.

Mr. SAM JOHNSON of Texas. Mr. Speaker, as the House moves forward with its competitiveness agenda to make America's businesses more attractive and efficient, it is imperative that we help the backbone of our economy: small business.

Health care costs are rising at a rate of 15 percent annually, and double that for many small businesses. What is astounding is that according to the Congressional Budget Office, for each percentage point rise in health insurance costs, the number of uninsured increases by 300,000. That is a terrible ratio.

Since this trend shows no sign of slowing, it means we need to act now. By allowing small businesses to band together in trade associations, this bill will give small businesses access to more affordable health care, give them freedom from costly State-mandated benefit requirements, and lower their administrative costs by as much as 30 percent.

Some critics of the bill say there will be a loss in consumer protection because AHPs exempt small business from burdensome State mandates such as covering in vitro fertilization. Obviously, these mandates just cost the States more money. Large employers and unions have been exempt from State mandates since 1974, and they continue to offer fantastic coverage to working families. We ought to act now to help small businesses enjoy that same privilege or they will not be able to offer any health coverage to employees and their family members.

In my home State of Texas, a shocking 27 percent of all employed or self-employed adults are uninsured, according to a recent study. The facts are clear and the facts demand action.

An overwhelming majority of small businesses agree that AHPs are the right solution. This bill has the support of NFIB, the Associated Builders and Contractors, the U.S. Chamber of Commerce, and many others. I would like to be sure and thank my good friend, the gentleman from Ohio (Mr. BOEHNER), and other cosponsors of this legislation: the gentleman from Georgia (Mr. BURNS), the gentlewoman from New York (Ms. VELÁZQUEZ), and the gentleman from California (Mr. DOOLEY). They have shown their commitment to small business employees and their families by supporting this legislation, and I commend them for it.

This bill gets to the heart of health care reform. Let us just do it.

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

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

Mr. ANDREWS. Mr. Speaker, I rise in strong opposition to this bill. My friend, the chairman, went through a series of numbers about this bill a few minutes ago, and I would respectfully suggest that he got some numbers wrong.

I think the most important numbers about this bill are 1 million, zero, and 50. There will be an addition of 1 million people to the roll of the uninsured should this bill become law, and here is why. The chairman argues that the provisions of this bill would limit the ability of association health plans to choose only the youngest and the most healthy would be affected. I think the evidence is strongly to the contrary. I think there are loopholes in this law that are wide enough to drive an ambulance through that would allow association health plans to refuse to insure, or raise the premiums to insure people who are older or more infirm.

Mercer & Associates, a respected, nonpartisan study group on health care is the source of this number. They believe that when we add up the number of people who will gain health insurance as a result of AHPs and we subtract from that that number of people who will lose health insurance because of rising premiums in plans that are more traditional, that we will add 1 million people to the ranks of the uninsured.

The second number is zero. That is the number of consumer protections that the law will guarantee if this bill became law. Legislators across this country, Republican and Democrat, have fought for the right of women to have guaranteed mammograms and OB–GYN care, the right of people dealing with the difficulties of substance abuse or mental health problems to have guaranteed coverage, the right of couples who wish to have children to have infertility coverage, the rights for diabetic care, for mental health care. These are rights that people have fought for and won in State legislatures across the country. Every single one of those protections is repealed should this bill become law. There will be zero consumer protections guaranteed to our constituents should this happen.

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The final number that we should take into consideration is 50 because that is the number of State Attorneys General who oppose this bill. That is the number of insurance commissioners, Republican and Democrat, who oppose this bill. The National Governors Association, Republicans, Democrats and Independents across the country oppose this bill.

Mr. Speaker, it is customary on the floor of the House for us to have our partisan differences, that happens; but do not listen to the partisan differences here. Listen to the experts of both parties who spent their careers out in the several States regulating health care. Republican Governors and Democratic Governors, Republican Attorneys General and Democratic Attorneys General, Republican insurance commissioners and Democratic insurance commissioners oppose this bill because it opens the door for the possibility of fraud and loss in these plans.

There is a better way; and later this afternoon my friend, the gentleman from Wisconsin (Mr. KIND), and I will be offering a plan which truly will reduce premiums for small businesses, which truly will expand health care opportunities for the uninsured and will do so without risking or jeopardizing the important protections that people presently enjoy under the law.

I would urge my colleagues to oppose this bill, to support our substitute.

Mr. Speaker, I reserve the balance of my time.

Mr. BOEHNER. Mr. Speaker, I am pleased to yield 3 minutes to the gentleman from Hickory, North Carolina (Mr. BALLENGER), a senior member of our committee.

Mr. BALLENGER. Mr. Speaker, I thank the gentleman for yielding me the time.

Mr. Speaker, I am a small business owner, and I know the burden that rising health care costs are having on small companies across America. My health insurance costs in my company have skyrocketed over the past few years, and I know that other small U.S. firms are experiencing the same burden. In my particular case, over the last 10 years my sales have doubled, but my health care costs have gone up by 450 percent.

When I first started my business, we could cover the full cost of an employee's medical insurance; but even with growing sales, we have not been able to keep pace with the ever-increasing cost of medical premiums, and I hear this same story over and over again from other small business owners in my district.

Like me, most employers care deeply about their employees and want to give them access to quality health care. Unfortunately, soaring costs have forced many small businesses to shift their health insurance costs to the employees, to drop health care coverage or to close up shop altogether.

Considering that more than half of the uninsured are small business employees and their dependents, this is nothing short of a tragedy. We must act to help small businesses which are at the mercy of the insurance companies. They simply do not have the bargaining power or resources needed to get the best deal.

That is why I am a strong supporter of the Small Business Health Fairness Act. This bill allows small businesses to pool their resources into association health plans, giving them purchasing clout and power to do what they do not have today. AHPs will allow small businesses to negotiate better rates and purchase better plans at a lower cost. It is good for small employers. It is good for employees.

Now, we know the problem of the uninsured will not got away with this bill, but it will help small employers and millions of their employees and their dependents to gain access to quality care; and it may help prevent some companies from dropping their health care plans altogether.

I strongly urge my colleagues to support this employer- and employee-friendly bill, and I thank the gentleman for yielding me the time.

Mr. ANDREWS. Mr. Speaker, I yield 2½ minutes to the gentleman from Maryland (Mr. VAN HOLLEN), one of our Members who has extensive experience as a State legislator in achievement in this area.

Mr. VAN HOLLEN. Mr. Speaker, I thank my colleague for yielding me the time, and I want to thank him for all his work on this issue.

As the chairman of the committee said at the beginning of his remarks, we have 43.6 million Americans who have no health insurance today. Now, the Congressional Budget Office tells us that the associated health plan approach might cover 550,000 of them, less than 1 percent of the insured. If that were the end of the story, we might say, okay, does not do much, but it is better than nothing.

The problem is it is not better than nothing because it violates the first principle in medicine, which is first do no harm, because the Congressional Budget Office also tells us that 7.9 million Americans who currently are covered will get worse coverage or pay more as a result of the actions taken in this bill.

Mercer Consultants has said that 1 million Americans will lose their coverage. Do the math. Clearly, it is a lousy bargain. Much more harm, very, very little benefit, and that is because associated health plans, by design, eliminate many of the protections that are currently provided through State legislatures around the country for our consumers: basic commonsense rules of the road, like the right to external review if a person's insurance claim is denied; direct access for women to OB/GYNs; access to emergency room treatment; a prohibition against gag orders on doctors. In fact, these basic patient protections are so fundamental, they have been adopted in a bipartisan manner by this House before. When this House passed a Patients' Bill of Rights, it was going to apply those rights to ERISA plans and the other plans. Why not do the same thing today?

Well, my colleague, the gentleman from Massachusetts (Mr. TIERNEY), and I just the other day went to the Committee on Rules and said let us have an amendment here on the floor of the House that guarantees those patients the same protections this House, in a bipartisan manner, guaranteed them a number of years ago. We were not even allowed a vote on that very simple amendment. Why is the other side afraid of a vote on providing patients the very same rights that this House has already provided those patients?

Let me just say that if my colleagues ask State legislators and Governors from around this country whether they are for or against this, we have heard the National Governors Association is against this. In fact, my Governor, the Governor of the State of Maryland, a Republican Governor, one of our former colleagues, Governor Ehrlich, has written to the Maryland congressional delegation and said please do not pass this bill because it will interfere with a primary piece of legislation that was passed in the State of Maryland to provide for small group insurance benefits, and small employers throughout the State of Maryland are taking advantage of it. This would undercut it.

There is a better alternative. We are going to be debating that later. We are not saying we do not have any proposal out here. We have a much better proposal.

I urge my colleagues to reject this idea and later adopt the substitute.

Mr. BOEHNER. Mr. Speaker, I am pleased to yield 1 minute to my colleague, the gentleman from Ohio (Mr. GILLMOR).

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

Mr. GILLMOR. Mr. Speaker, I thank the chairman for yielding me the time.

Mr. Speaker, I rise in support of H.R. 4281. This bill will open the door to nearly 41 million Americans that are currently without health care coverage. Providing small businesses with an opportunity to offer their employees affordable health care access is essential in promoting not only the physical health of the American workforce but also the overall economic health of the United States.

The American economy has always been driven by the entrepreneurial nature of its citizens, and blocking access to affordable health care will only suffocate growth within the small business sector of our economy. Recently, I had the honor of addressing a group of small business owners from my northwest Ohio district at an NFIB regional luncheon, and the most common concern I heard from them was their inability to secure affordable health care for themselves and their employees.

This piece of legislation provides a real solution to one of the major problems plaguing our business and health care industries, and I urge its support.

ANNOUNCEMENT BY THE SPEAKER PRO TEMPORE

The SPEAKER pro tempore (Mr. SIMPSON). Would Members please remove their electronic devices from the floor or turn them off.

Mr. ANDREWS. Mr. Speaker, it is my pleasure to yield such time as he may consume to the gentleman from Michigan (Mr. DINGELL), the senior Member and the dean of the House of Representatives, my very dear friend.

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

Mr. DINGELL. Mr. Speaker, I rise in opposition to the legislation and to applaud the efforts of my good friend and colleague from New Jersey and his opposition to it.

This legislation is bad. It is going to encourage cherry-picking and cream-skimming. It is going to create a bunch of plans that are going to be exempt from State regulation. It is going to actually reduce the quality of care available, the quality of health insurance available, and also the amount of insurance available and the people who will be covered.

More than 1,000 organizations oppose AHPs: the National Governors, Republicans and Democrats alike; the National Association of Insurance Commissioners who say that it is going to encourage cherry-picking and cream-skimming; the National Association of Attorneys General, Republicans and Democrats alike; the American Academy of Pediatrics; the Consumers Union; and Families USA, plus many others.

What it is going to do is to actually undermine the current employer-sponsored market. As I mentioned, it will encourage cherry-picking of healthier and younger populations because they will be permitted to cover specific types of employers and thus establish a special new, separate market and will be a market where it will not cover many people, who will find that the difficulties in procuring insurance will be more difficult because of this.

The Congressional Budget Office tells us that AHPs will cut benefits for 8 million Americans who now have coverage. That alone is argument enough to defeat this legislation. Additionally, CBO determined that AHPs will only increase enrollment in employer-sponsored coverage by 330,000 people.

A Mercer study commissioned by the National Small Business Association found that AHPs would cause the uninsured to grow by better than 1 million. That, again, should be warning enough.

At a time when 43 million of our people are uninsured, AHPs will simply move us backwards. I urge us to defeat this legislation. It is bad. It is not in the interest of the country. Everybody who is responsible for dealing with insurance has said this is bad legislation. Reject it.

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

With all due respect to my good friend from Michigan, I think what we see here at the central issue of this debate is a basic distrust of the private sector. Now, two-thirds of the American people get their health insurance through their employer. We have an employer-based system in America, and it has worked very well; and some of the best coverage and the most high-quality health plans are offered by employers to their employees.

Today, both employers, and increasingly employees, are paying for the cost of those plans. What we are attempting to do here is to give small businesses who do not have big purchasing power in the marketplace the ability to join together and to offer the same kinds of plans that large companies and unions offer to their employees and members, give those small employers and their employees the same opportunity.

Plain and simple.

Mr. Speaker, I am pleased to yield 2 minutes to the gentlewoman from Tennessee (Mrs. BLACKBURN), a member of the committee.

Mrs. BLACKBURN. Mr. Speaker, I thank the chairman for his excellent work on this issue for our Nation's small businesses.

We know that those small businesses fuel this economic growth in our country, and we appreciate their efforts; and we know that our small business employees are being burdened paying on average 17 percent more for their health benefits than their counterparts at large companies.

I recently held a small business health care roundtable in my district and talked with these small business employers about their desire to make better health benefits available to their employees and still stay competitive. This legislation is an opportunity that Congress has to help bring about that affordable health care to millions of employees.

AHPs would save the typical small business owner between 15 and 30 percent on health insurance and help make that coverage available. As our chairman said, too often regulations and mandates add to the cost burden.

Current law exempts large employers and unions from State mandates so that they are able to offer quality benefits across State lines. The Small Business Health Fairness Act will give that same opportunity to our small businesses in this country.

This is a benefit that will help them to be competitive in the world market. It is bipartisan legislation. It passed overwhelmingly last year, and I urge all of my colleagues to support this commonsense legislation for our Nation's small businesses.

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

My friend said that the opposition is evidence of distrust of the private sector. It is odd, because 66 local chambers of commerce have mounted an objection to the bill and the Republican Governors Association. I guess they share our distrust for the private sector.

Mr. Speaker, I am submitting a list of over 1,050 organizations that oppose this bill for the RECORD.

ORGANIZATIONS AND PUBLIC OFFICIALS OPPOSED TO FEDERAL AHP LEGISLATION, APRIL 23, 2004

Over 1,050 Organizations Have Expressed Opposition:

STATE OFFICIALS

National Groups

National Governors Association
Republican Governors Association
Democratic Governors Association
Attorneys General Representing 41 States
National Association of Insurance Commissioners
National Association of State Mental Health Program Directors
National Conference of Insurance Legislators
National Conference of State Legislatures

CHAMBERS OF COMMERCE

Albuquerque (NM) Chamber
Arapahoe Chamber of Commerce (Nebraska)
Ashland Chamber of Commerce (Nebraska)
Black Chamber of Commerce of Greater Kansas City
Blanding Chamber of Commerce (Utah)
Bloomfield Chamber of Commerce (Nebraska)
Boise Metro Chamber of Commerce (Idaho)
Boston Chamber
Broken Bow Chamber of Commerce (Nebraska)
Buffalo-Niagara Partnership (New York)
Carey Area Chamber of Commerce (Ohio)
Cherry Creek Chamber (Colorado)
Colorado Black Chamber of Commerce
Colorado Hispanic Chamber of Commerce
Council of Smaller Enterprises/Greater Cleveland Growth Association (COSE)
Denver Metro
Detroit
Draper Chamber of Commerce (Utah)
Duchesne Chamber of Commerce (Utah)
Evans Chamber of Commerce (Colorado)
Florence, Colorado
Grand Raids Area Chamber of Commerce
Greater Akron Chamber (Ohio)
Greater Cincinnati Chamber
Greater Columbus Chamber (Ohio)
Greater Des Moines Partnership (Iowa)
Greater Indianapolis Chamber (Indiana)
Greater Louisville, Inc. (Louisville, Kentucky Chamber of Commerce)
Greater Manchester, New Hampshire
Greater North Dakota Association
Greater Seattle Chamber
Heber Valley Economic Development (Utah)
Herington Chamber of Commerce (Kansas)
Hiawatha Chamber of Commerce (Kansas)
Holton Area Chamber of Commerce (Kansas)
Lake City Chamber of Commerce (Colorado)
Lansing Regional Chamber (Michigan)
Lehi Chamber of Commerce (Utah)
Merrimack Valley Chamber of Commerce
Metro Jackson, Mississippi
Michigan Chamber of Commerce
Midvale Chamber of Commerce (Utah)
New Hampshire Business and Industry Association
North Central Massachusetts Chamber of Commerce
North Park Chamber (Colorado)
Northern Kentucky Chamber of Commerce
Northern Ohio Chamber of Commerce
Oklahoma City
Oklahoma State
Oregon Association of Industries (Oregon State Chamber of Commerce)
Palisade Chamber (Colorado)
Paola Chamber of Commerce (Kansas)
Ravenna Area Chamber of Commerce (Ohio)
Salem Economic Development (Utah)
Saratoga County Chamber of Commerce (New York)
Spanish Fork Area Chamber of Commerce (Utah)
Springfield Chamber of Commerce (Colorado)
Springville Area Chamber of Commerce (Utah)
Tacoma-Pierce County Chamber of Commerce
Toledo Area Chamber of Commerce
Tulsa, Oklahoma
Washington State (Association of Washington Business)
West Jordan Chamber (Utah)
Woodson County Chamber of Commerce (Kansas)
Worland Chamber of Commerce (Wyoming)
Youngstown-Warren Chamber (Ohio)

FARM BUREAUS:

Alabama Farmers Association (ALFA)
Mississippi Farm Bureau
Tennessee Farm Bureau Federation—Tennessee Rural Health
Virginia Farm Bureau

SMALL BUSINESS ASSOCIATIONS

Alaska Coalition of Small Business
Arizona Small Business Association
4D Industries (Oregon)
Indiana Association of Community and Economic Development
Indiana Manufacturers' Association
Fargo-Moorhead Homebuilders' Association
Ohio/Kentucky Concrete Pavement Association
National Small Business Association (Represents over 150,000 small businesses nationwide)
New England Council
New Hampshire Business Council
New Hampshire High Tech Council
Oregon Business Alliance
Professional Musicians Of Arizona
Rhode Island Small Business Association
SMC Business Councils (Pennsylvania)
Santaquin Economic Development Agency (Utah)
Small Business Association of Michigan
Utah Small Business Development Center—Utah Valley State College

LABOR UNIONS

AFL-CIO—American Federation of Labor and Congress of Industrial Organizations

With additional letters from: Alabama AFL-CIO, Alaska AFL-CIO, Arkansas AFL-CIO, Arizona AFL-CIO, California AFL-CIO, Indiana AFL-CIO, Kansas AFL-CIO, Louisiana AFL-CIO, Maine AFL-CIO, Minnesota AFL-CIO, Missouri AFL-CIO, Montana State AFL-CIO, Nebraska AFL-CIO, Nevada State AFL-CIO, New Mexico Federation of Labor, North Carolina State AFL-CIO, Northern Nevada Central Labor Council, Nevada State AFL-CIO, District 2, Ohio AFL-CIO, Oregon AFL-CIO, Rhode Island AFL-CIO, Southern Nevada Central Labor Council, Nevada State AFL-CIO, District 3, Tennessee Labor Council, Utah State AFL-CIO, Virginia AFL-CIO, Washington State Labor Council

Alabama Education Retirees Association
Alabama Retired State Employees Association
Alabama Teacher's Union (AEA)
American Federation of State, County and Municipal Employees (AFSCME)

With additional letters from: Alabama, Colorado, Indiana, Kansas Council 72 (Local 1715—Chapter 3371), Louisiana AFSCME Council 17, Nebraska, New Mexico, Ohio AFSCME United, AFSCME Local 4, AFSCME Council 8, Ohio Local 11 OCSEA, AFSCME Local 11, Rhode Island Council 94, Utah Local 1004, Virginia Local 27

American Federation of Teachers (AFT)

With additional letters from: Albuquerque, New Mexico Federation of Teachers, Arkansas Federation of Teachers, Colorado Federation of Teachers, Kansas Southwest and Mountain States Region for the AFT, Louisiana Federation of Teachers, Oregon Federation of Teachers, Rapides (Louisiana), Utah American Federation of Teachers

Atlanta Labor Council
Boilermaker's Lodge 101 (Colorado)
Cement Masons Local 577 (Colorado)
Central Georgia Federation of Trades and Labor Council
Colorado Federation of Public Employees
International Brotherhood of Electrical Workers (IBEW)

With additional letters from: Cleveland, Ohio Local 1377, Dayton, Ohio Local 82, Kansas Local 304, Milan, Ohio Local 1194, Oak Harbor, Ohio Local 1432, Ohio Local 2331, Oregon

International Union, United Auto Workers (UAW)

With additional letters from: Indiana UAW—Region 3 (Indiana and Kentucky), Kansas Local 31

International Union of Bricklayers and Allied Craftworkers
Kansas Association of Public Employees
Kansas Postal Workers Union
Labor Federation of Central Kansas
Laborers' International Union—Local 149—Aurora, Illinois
Maine Teacher's Union/Maine Educational Association
Middle Georgia Central Labor Council
Missouri Steelworkers Union
Montana Progressive Labor Caucus
National Education Association—Rhode Island
Nebraska State Education Association
Ocean State Action (AFT—Rhode Island)
Ohio AFSCME Retiree Chapter 1184
Ohio Association of Public School Employees
Oregon Federation of Nurses
Paper Allied-Industrial, Chemical and Energy Workers International Union (PACE)
Providence (Rhode Island) Central Federation of Labor
Service Employees International Union (SEIU)

With additional letters from: Alabama, Arkansas, Colorado, Georgia, Local 1985, Kansas, Missouri, Local 2000, New Hampshire, Local 1984, Ohio, District 1199, Oregon, Local 503, Rhode Island, Washington

Shipbuilders and Boilermakers International Union—Virginia Chapter
Teamsters Union—Maine
Teamsters' 190—Montana
Teamsters Local 407—Ohio
United Food and Commercial Workers Union—Nebraska (Local 22)
United Food and Commercial Workers Union—Washington
United Teachers of Wichita, Kansas
United Transportation Union—Louisiana

CONSUMER/ADVOCACY GROUPS

National Groups

Alliance for Children and Families
American Agricultural Movement, Inc.
American Association of Pastoral Counselors
American Association of People with Disabilities
American Association of University Women—Oregon Chapter
American Cancer Society
American Congress of Community Supports and Employment Services
American Corn Growers Association
American Diabetes Association

With additional letters from: Alabama Chapter, Arkansas Chapter, Central Ohio Chapter, Cleveland Ohio Chapter, Colorado Chapter, Indiana Chapter, Kansas Chapter, Louisiana Chapter, Maine Chapter, Minnesota Chapter, Montana Chapter, Nebraska Chapter, Nevada Chapter, New Hampshire Chapter, New Mexico Chapter, North Carolina Chapter, Northeast Ohio Chapter, Oregon Chapter, Utah Chapter, Seattle, Washington Chapter, Southwest Ohio & Northern Kentucky Chapter, Washington Chapter

American Family Foundation
American Homeowners Grassroots Alliance
Americans for a Balanced Budget
Anxiety Disorders Association of America
Association for the Advancement of Psychology
Bazelon Center for Mental Health Law
Center on Disability and Health
Child Welfare League of America
Children & Adults with Attention-Deficit/Hyperactivity Disorder

With additional letters from: Ohio Chapter

Children's Defense Fund—With additional letters from: Ohio Chapter

Coalition Against Insurance Fraud
Consumer Federation of America
Consumers Union
Depression and Bipolar Support Alliance

With additional letters from: Depression and Bi-Polar Support Alliance of Ohio, Depression and Bi-Polar Support Alliance of Columbus, Ohio, Depression and Bi-Polar Support Alliance of Dayton, Ohio, Depression and Bi-Polar Support Alliance of Medina, Ohio

Families USA
Federation of Families for Children's Mental Health
Federation of Southern Cooperatives
Friends Committee on National Legislation
International Certification and Reciprocity Consortium
League of United Latin American Citizens (LULAC)—With additional letters from: Arkansas Chapter
Maternal and Child Health Coalition for Healthy Families
National Alliance for the Mentally Ill

With additional letters from: Arkansas Chapter, Colorado Chapter, Georgia Chapter, Kansas Chapter, Louisiana Chapter, Maine Chapter, Montana Chapter, Nebraska Chapter, New Hampshire Chapter, New Mexico Chapter, North Carolina Chapter.

Ohio Chapter: Allen, Auglaize & Hardin Counties, Adams County, Butler County, Clark County, Clermont County, Cleveland Metro, Fairfield County, Franklin County, Licking County, Logan & Champaign County, Richland County, Ross/Pickaway Counties, Seneca, Sandusky and Wyandot Counties, Stark County, Warren County.

Oregon Chapter, Rhode Island Chapter, St. Louis Chapter, Utah Chapter, Washington Chapter

National Association for Children's Behavioral Health
National Association for Rural Mental Health
National Association for the Advancement of Colored People (NAACP) North Carolina Chapter
National Association of Anorexia Nervosa and Associated Disorders
National Association of Farmer Elected Committees
National Association of Protection and Advocacy Systems
National Coalition for the Homeless
National Council of La Raza
National Farmers Organization
National Foundation for Depressive Illness
National Mental Health Association

With additional letters from: California Chapter, Colorado Chapter, Franklin County (Ohio), Georgia Chapter, Greater St. Louis Chapter (Missouri), Illinois Chapter, Indiana Chapter, Knox County (Ohio), Licking County (Ohio), Louisiana Chapter, Lucas County (Ohio), Miami County (Ohio), Minnesota Chapter, Montana Chapter, New Mexico Chapter, Nebraska Chapter, North Carolina, Oregon Chapter (Mental Health Association of Oregon—MHAO), Ottawa County (Ohio), Stillwater-Sweetgrass Counties (Montana), Summit County (Ohio), Union County (Ohio), Utah Chapter, Wyoming Chapter

National Partnership for Women & Families
National Patient Advocate Foundation
Planned Parenthood Federation of America
Research Institute for Independent Living
Soybean Producers of America
Suicide Prevention Action Network
Tourette Syndrome Association
United Cerebral Palsy Association
USAction
Women Involved in Farm Economics

Local Groups

9 to 5 National Working Women's Association (Colorado)
AIDS Alliance Service (North Carolina)
AIDS Prevention ACTION Network (California)
AIDS Project Rhode Island
AIDS Response Seacoast—New Hampshire
AIDS Survival Project (Georgia)
ARC of Alabama
ARC of Colorado
ARC of Indiana
ARC of Norfolk, Nebraska
ARC of Ohio
ARC of Oregon
ARC of Utah
Access Utah Network
Adoption Options (Colorado)
Advocacy Coalition of Seniors and People with Disabilities (Oregon)
Alabama Council on Substance Abuse
Alabama Watch
Alaskans for Tax Reform
Alliance Against Family Violence (Kansas)
Allies With Families (Utah)
American Agricultural Movement of Arkansas, Inc.
American Association of University Women—Oregon Chapter
American Lung Association—Alaska Chapter
American Lung Association—Colorado Chapter
Arkansas Interfaith Conference
Arizona Association of Community Mental Health Centers
Assistive Technology Through Action in Indiana (ATTAIN)
Association of Community Organizations for Reform Now (California)
Bethpage Omaha (Nebraska)
Best Buddies International—Indiana Chapter
Big Brother and Big Sister—Illinois
Bosom Buddies of Georgia, Inc.
Brain Injury Association of Colorado
Brain Injury Association of Utah
Buckeye Art Therapy Association of Ohio
California Coalition for Mental Health
California Pan-Ethnic Health Network
Campaign for Better Health Care (Illinois)
Campaign for Health Security (Oregon)
Cancer World (Oregon)
Catholic Charities of Colorado
Catholic Charities of Colorado Springs
Catholic Charities of Omaha, Nebraska
Catholic Charities Pueblo (Colorado)
Catholic Community Services of Utah
Catholic Conference of Kentucky
Center for Policy Analysis (California)
Central Ohio Diabetes Association
Centro Legal (Minnesota Minority Support Group)
Child Connect (Nebraska)
Children's Defense Fund—Ohio Chapter
Children's Diabetes Foundation—Denver Chapter

Children's First of Oregon
Citizen Action of Arizona
Citizen Action of Illinois
Citizen Action of New York
Citizen Action Network of Iowa
Coalition for Accountable Government (Utah)
Coalition for Independence (Kansas)
Coalition of New Hampshire Taxpayers
Colorado Classified School Employees Association
Colorado Forum on Community
Colorado Developmental Disabilities Planning Council
Colorado Programs for Children with Disabilities
Colorado Progress Coalition
Colorado Women's Agenda
Columbus Ohio Chapter of N.O.W.
Community Action Directors of Oregon
Community Connection (Utah)
Community Connections (Nebraska)
Community Harvest Food Bank of Northeast Indiana
Community Humanitarian Resource Center (Nebraska)
Community Pharmacists of Indiana
Community Support Services (Oregon)
Concerned Christian Americans—Illinois
Congress of California Seniors
Connecticut Citizen Action Group
Damien Center—Indiana
Day At A Time Club (Colorado)
Denver, Adams and Arapahoe County (CO) CARES
Diocese of Salt Lake City (Utah)
Durango Ltd. (Illinois)
Eagle Forum (Illinois)
East Liverpool (Ohio) Breast Cancer Support Group
Ecumenical Ministries of Oregon
El Comite—Colorado
Electric League (Missouri)
EMPOWER Colorado
Families First (Georgia)
Family Planning Association of Maine
Family Planning Association of Northeast Ohio
Family Ties Adoption Center of Colorado
Federation of Families for Children's Mental Health—Colorado
Future Coalition (Ohio)
Gathering Place (Nebraska)
Georgia Abortion and Reproductive Rights Action League (GARAL)
Georgia Rural—Urban Summit
Georgia Watch
Georgians for Healthcare
Good Faith Fund (Arkansas)
Granite State Independent Living Foundation (New Hampshire)
Gray Panthers California
Gray Panthers of Oregon
Gray Panthers of Rhode Island
Health Action New Mexico
Health Care for All (Massachusetts)
Health Law Advocates (Massachusetts)
Healthy Kids Learn Better (Oregon)
Healthy Mothers/Healthy Babies (Montana)
Helena Indian Alliance—Montana
Hispanic Community Center (Nebraska)
Hispanic Contractors Association (Colorado)
Human Services Coalition of Oregon
Illinois Caucus for Adolescent Health
Indiana Association of Area Agencies on Aging
Indiana Central Association of Diabetes Educators (ICADE)
Indiana Coalition on Housing and Homeless Issues
Indiana Pharmacy Alliance
Individual and Family Counseling—Illinois
Insure the Uninsured Project (California)
Interfaith Service Bureau (California)
Iowa Christian Coalition
Jewish Community Relations Council—Indiana
Kansas Alcohol & Drug Services Providers Association
Kansas Association of Middle School Administrators
Kansas United School Administrators
Kentuckians for Health Care Reform
Kentucky Minority Farmers Association
Latin American Research and Service Agency (Colorado)
Louisiana Maternal and Children's Health Coalition
Maine Consumers for Affordable Healthcare
Maine Women's Lobby
Maine Women's Policy Center
Mental Health Consumer Advocates of Rhode Island
MESA (Moving to End Sexual Assault) Administrative Office (Colorado)
Minnesota AIDS Project 10
Minnesota Lawsuit Abuse Watch (M–LAW)
Minnesota State Council on Disability
Montana Children's Initiative
Montana Coalition for Competitive Choices
Montana Council for Families
Montana March of Dimes
Montana NARAL
Montana Peoples Action
Montana Senior Citizens Association
Montana's Child Project
Multiple Sclerosis Society of Indiana
Mutual Ground—Illinois
National Barter and Commodity Association (Formerly the Colorado Citizens for an Alternative Tax System)
National Kidney Foundation of Georgia
Navajo County Arizona Special Public Health District
Nebraska Arthritis Foundation
Nebraska Tax Research Council
Nebraskans for Equal Taxation
Neighborhood Activists Inter-Linked Empowerment Movement (NAILEM)—Arizona
Nevada Alliance for Retired Americans
Nevada Cancer Institute
Nevada Diabetes Assocaition for Children and Adults
Nevadans for Affordable Health Care
New Mexico Voices for Children (formerly—New Mexico Advocates for Children and Families)
New Mexico Teen Pregnancy Coalition
New Hampshire Commission on the Status of Women
New Hampshire Developmental Disabilities Commission
New Hampshire for Health Care
Noble/ARC of Central Indiana
Noble/ARC of Greater Indianapolis
North Carolina Committee to Defend Healthcare
Ohio AIDS Coalition
Ohio Advocates for Mental Health
Ohio Association of Mental Retardation
Ohio Citizen Advocates for Chemical Dependency, Prevention and Treatment
Ohioans for Diabetes Control
Oregon Alliance of Retired Americans
Oregon Association of Retired Persons (AARP Chapter)
Oregon Council of Senior Citizens
Oregon Disabilities Commission
Oregon Health Action Campaign
Oregon Heart and Lung Association
Oregon Law Center
Oregon Special Concerns Ministry
Oregonians for Health Security
Paola Foster Grandparent Program (Kansas)
People First of Nebraska
People Living Through Cancer—New Mexico
Planned Parenthood of Alaska
Planned Parenthood of Georgia
Planned Parenthood of Greater Indiana
Planned Parenthood of Mid/East Tennessee
Planned Parenthood of Northern New England
Precita Park Democratic Club (California)
Protectmontanakids.org
Pulaski County Democratic Women (Arkansas)
Pulaski County Young Democrats (Arkansas)
Quality Care for Children (Georgia)
Redemptorist Social Services Center (Missouri)
Religious Action Center of Reform Judaism
Rhode Island Kids Count
Rhode Island Poverty Institute
Rhode Island Public Health Association
Safe Kids—Safe Communities—Montana
Self-Determination Resources (Oregon)
Small Business Lobby (Virginia)
Special Concerns Ministry (Oregon)
Sudden Arrhythmia Death Syndrome (Utah)
Support Oregon Services Alliance
Tennessee Association of Alcohol and Drug Abuse Services
United Cerebral Palsy Association—Colorado
United Cerebral Palsy Association—Nebraska
United Cerebral Palsy Association—Utah
United Seniors of Oregon
Universal Health Care Action Network of Ohio
University Village Association (Illinois)
Utah Association of Counties
Utah Center for Persons With Disabilities
Utah Coalition Against Sexual Assault
Utah Hispanic Advisory Council
Utah State University
Victim Assistance Team of Grand County Colorado
Virginia Coalition of Police and Deputy Sheriffs
Washington Citizen Action
Wisconsin Citizen Action
Wisdom of Wellness Foundation (Georgia)
WISE Foundation (Tennessee)
Women's Association of Northshore Democrats—Louisiana
Women's Policy Group (Georgia)
Women's Rights Organization (Oregon)
Working for Equality and Economic Liberation (WEEL)—Montana

PHYSICIAN GROUPS

NATIONAL GROUPS

American Academy of Child and Adolescent Psychiatry
American Academy of Neurology
American Academy of Pediatrics

With additional letters from: Alabama Chapter, Illinois Chapter, Indiana Chapter, Iowa Chapter, Louisiana Chapter, Minnesota Chapter, Montana Chapter, Nebraska Chapter, New Hampshire Chapter, New Mexico Chapter, Ohio Chapter, Oregon Chapter, Rhode Island Chapter, Tennessee Chapter, Utah Chapter

American Association for Geriatric Psychiatry
American College of Foot & Ankle Surgeons
American Psychiatric Association

With additional letters from: Colorado Chapter, Kansas Chapter, Louisiana Chapter, New Hampshire Chapter, New Mexico Chapter, Ohio Chapter, Tennessee Chapter, Utah Chapter

National Alliance of Medical Researchers and Teaching Physicians
National Hispanic Medical Association
Pediatrix Medical Group
The Society for Maternal Fetal Medicine

Local Groups

Alabama Academy of Family Physicians
Alabama Medical Association
American Academy of Physicians—Nebraska Chapter
American College of Cardiology—Alabama Chapter
American College of Emergency Physicians—Alabama Chapter
American College of Surgeons—Rhode Island Chapter

Arkansas Medical Society
Bellevue Pediatric Center (Nebraska)
Bennett Breast Cancer Center (Maine)
Colorado Medical Society
Family Medicine Specialists of St. George (Utah)
Internal Medicine and Pediatric Medicine (Utah)
Missouri State Medical Association
Nebraska Academy of Family Physicians
Nebraska Academy of Physicians
Nebraska Medical Association
New Hampshire Health Care Association
New Mexico Medical Society
Rhode Island Medical Association
Rhode Island Neurological Society
Rose Breast Center (Colorado)
Utah Optometric Physicians
Utah Valley Pediatrics
Virginia Medical Society
Washington Healthcare Forum

PROVIDER GROUPS

National Groups

American Association for Marriage and Family Therapy
American Association for Psychosocial Rehabilitation
American Association on Mental Retardation
American Chiropractic Association

With additional letters from: Alabama Chapter, Arkansas Chapter, Indiana Chapter, Kansas Chapter, Kentucky Chapter, Louisiana Chapter, Maine Chapter, Minnesota Chapter, Montana Chapter, New Hampshire Chapter, New Mexico Chapter, North Carolina Chapter, Oregon Chapter, Rhode Island Chapter, Tennessee Chapter, Washington Chapter

American College of Nurse-Midwives
American Counseling Association
American Group Psychotherapy Association
American Mental Health Counselors Association
American Nurses Association

With additional letters from: Alabama Chapter, Arkansas Chapter, California Chapter, Colorado Chapter, Illinois Chapter, Kansas Chapter, Maine Chapter, Minnesota Chapter, Montana Chapter, Nebraska Chapter, Nevada Chapter, New Hampshire Chapter, New Mexico Chapter, Ohio Chapter, Oregon Chapter, Rhode Island Chapter, Tennessee Chapter, Utah Chapter, Virginia Chapter, Wyoming Chapter

American Optometric Association

With additional letters from: Alabama Chapter, Arizona Chapter, Arkansas Chapter, Indiana Chapter, Iowa Chapter, Kentucky Chapter, Louisiana Chapter, Montana Chapter, Nebraska Chapter, Nevada Chapter, New Hampshire Chapter, New Mexico Chapter, Tennessee Chapter, Utah Chapter, Virginia Chapter, Wyoming Chapter

American Podiatric Medical Association
American Psychiatric Nurses Association
American Psychological Association

With additional letters from: Arkansas Chapter, Colorado Chapter, Illinois Chapter, Indiana Chapter, Iowa Chapter, Kansas Chapter, Kentucky Chapter, Louisiana Chapter, Minnesota Chapter, Montana Chapter, Nebraska Chapter, Nevada Chapter, North Carolina Chapter, Ohio Chapter, Oregon Chapter, Rhode Island Chapter, Tennessee Chapter, Utah Chapter, Wyoming Chapter

American Psychotherapy Association
American Society of Clinical Psychopharmacology, Inc.
Association for Ambulatory Behavioral Healthcare
Association of Women's Health, Obstetrics and Neonatal Nurses
Clinical Social Work Federation
Employee Assistance Professionals Association
Federation of Behavioral, Psychological and Cognitive Sciences
National Association of County Behavioral Health Directors
National Association of School Psychologists
National Association of Social Workers

With additional letters from: Alabama Chapter, Arkansas Chapter, Iowa Chapter, Kansas Chapter, Louisiana Chapter, Maine Chapter, Nebraska Chapter, New Hampshire Chapter, New Mexico Chapter, North Carolina Chapter, Ohio Chapter, Rhode Island Chapter, Utah Chapter

National Council for Community Behavioral Healthcare

Local Groups

AAC Association (Nebraska)
Access Utah Network
Act Now Counseling (Utah)
Action Counseling (Colorado)
Acupuncture Association of Colorado
Acupuncture Association of Utah
Acupuncture Association of Washington
Addiction and Behavioral Health Center (Nebraska)
Advance Women's Health Care (Utah)
Advantage Eye Care (Utah)
AIM Institute (Nebraska)
Affiliates in Psychology (Nebraska)
Alabama Association of Home Health Agencies
Alabama Association of State & Provincial Psychology Boards
Alabama Council for Community Mental Health Boards
Alabama Family Practitioners Rural Health
Alaska Ophthalmological Society
Alegent Health Psychiatric (Nebraska)
Alternative Health Center (Utah)
Alternative Pathways (Colorado)
Alzheimer's Association of Oregon and Greater Idaho
Alzheimer's Association of Utah
American Society of Addictive Medicine—Kansas Chapter
American Society of Addictive Medicine—Utah Chapter
Andrus Vision Center (Utah)
Arden Courts (Illinois)
Arkansas Association for Marriage and Family Therapy
Arkansas Chiropractic Legislative Council
Arkansas Independent Living Council
Arkansas Mental Health Counselors Association
Aspen Therapy (Utah)
Association of Community Service Agencies (California)
Association of Oregon Community Mental Health Programs
Association of School Based Health Centers (Oregon)
Asthma and Allergy Clinic (Utah)
Autism Coalition of Indiana
Autism Society of Arkansas
Autism Society of Nebraska
Autism Society of Ohio
Avenues to New Horizons (Nebraska)
Avera St. Anthony's Hospital (Nebraska)
A.W.A.R.E. Inc. (Mental Health Provider—Montana)
Bear River Medical Arts (Utah)
Bear River Mental Health Services (Utah)
Beaver Valley Hospital (Utah)
Behavioral Health Specialists (Nebraska)
Bergan Mercy Child Development Center (Nebraska)
Berner Eye Clinic (Utah)
Black River Mental Health Services (Utah)
Blue Valley Mental Health Center (Nebraska)
Boulder County Partners (Colorado)
Boulder Valley Women's Health Center (Colorado)
Broadway Counseling Services (Colorado)
Bungalow Care Center (Utah)
California Council of Community Mental Health Agencies
California Society for Clinical Social Work
Care Oregon
Cedar Springs Behavioral Health (Colorado)
Centennial Mental Health Center (Colorado)
Center for Counseling and Consultation (Kansas)
Center for Human Development (Kansas)
Center for Independent Living (Kansas)
Center for Psychological Services (Nebraska)
Central District Health Center (Nebraska)
Central Iowa Psychological Services
Central Kansas Psychological
Children and Adults with Attention Deficit/Hyperactivity Disorder (Ohio)
Chiropractic and Spinal Rehabilitation (Colorado)
City of Geneva Mental Health Board (Illinois)
Clarian Health (Methodist Hospital, Indiana University Hospital, Riley's Children's Hospital) (Indiana)
Collidge Mental Health Center (Nebraska)
Colorado Association of Surgical Technicians
Colorado Dental Association
Colorado Health and Hospital Association
Colorado Osteopathic Society
Colorado Podiatric Medical Society
Community Adolescent Counseling (Colorado)
Community Access Services (Oregon)
Community Counseling Center of Fox Valley (Illinois)
Community Nursing Services (Utah)
Community Pharmacists of Indiana
Community Providers Association of Oregon
Conway Regional Health Systems (Arkansas)
Council of Volunteers and Organizations for Hoosiers with Disabilities (Indiana)
Council on Substance Abuse (Alabama)
Counseling Associates (Utah)
Counseling Center for the Rockies (Colorado)
Coventry Group (Kansas)
Crawford County Health Department (Kansas)
Danville Services Corporation (Utah)
Delta Resource Independent Living Center (Arkansas)
Denver Naturopathic Clinic—Colorado
DPF Counseling Services (Kansas)
Dignity Health & Home Care (Utah)
Direct Benefits (Minnesota)
Elgin Mental Health Facility (Illinois)
Family Counseling Service of Aurora, Illinois
Family Life Center (Kansas)
Family Medicine Specialists of St. George (Utah)
Fetzer OB-GYN (Illinois)
First Call For Help (Nebraska)
First Plan in Two Harbors (Minnesota)
Fore Chiropractic Clinic (Kansas)
Four Corners Community Behavioral Health (Utah)
Four County Mental Health Center (Kansas)
Franklin County Memorial Hospital (Nebraska)
Full Circle Alternative Center (Colorado)
Gabriel Chiropractic Office (Colorado)
Geneva Mental Health (Illinois)
Gordon Memorial Hospital (Nebraska)
Greenwood Health Center (Utah)
Gynecology, Obstetrics & Infertility (Colorado)
Healthy Mothers—Healthy Babies (Montana)
Heartland Counseling and Consulting (Nebraska)
Higgins Center for Natural Health (Colorado)
Highland Family Eye Care (Utah)
Highland Ridge Hospital (Utah)
Holladay Family and Child Guidance Clinic (Utah)
Home Health Services and Staffing Association of New Jersey
Hutchinson Psychological & Family Services (Kansas)

Idaho Hospital Association
Independent Living Resource Center (New Mexico)
Indiana Association of Rehabilitation Facilities
Indiana Pharmacy Alliance
Institute for Alcohol Awareness (Fort Collins, Colorado)
Institute for Alcohol Awareness (Greeley, Colorado)
Intermountain Health Care (Utah)
Intermountain Health Care Diabetes Education (Utah)
Iowa Breast Cancer Education-Action (IBCE)
Iowa Dental Association
Iowa Podiatric Medical Society
Jane Phillips Nowata Health Center (Oklahoma)
Johnson County Hospital (Nebraska)
Josephine County Mental Health (Oregon)
Kane County Hospital (Utah)
KANZA—Mental Health and Guidance Center (Kansas)
Kelly Roybal-Sanchez Pediatric Clinic (Colorado)
Kentucky Dental Association
Kentucky Mental Health Coalition
Lane Independent Living Alliance (Oregon)
Larimer Center for Mental Health (Colorado)
Legislative Coalition of Virginia Nurses
Leo Pocha Clinic (Montana)
Leukemia Lymphoma Society of Oregon
LifeWise Health Plan of Oregon
Lincoln/Lancaster County Human Services Federation (Nebraska)
Longmont Psychiatric Associates (Colorado)
Louisiana Academy of Medical Psychologists
Louisiana Association of Ambulatory Healthcare
Louisiana Association for the Advancement of Psychology
Louisiana Healthcare Commission
Louisiana Mental Health Consortium
LTC Resolutions (Indiana)
Maine Association of Mental Health Services
Maine Association of Substance Abuse Programs
Maine Nurse Practitioners Association
Medical Weight Management (California)
Melham Medical Center (Nebraska)
Mental Health and Guidance Center (Kansas)
Mental Health Associates (Kansas)
Mental Health Care Associates (Nebraska)
Mental Health Corporation (Colorado)
Mental Health Liaison Group
Mesability (Colorado)
Metro Chiropractic (Nebraska)
Midwest Parkinson's Awareness of Northeast Ohio
Minnesota Association of Community Mental Health Programs
Minnesota Council of Health Plans
Missouri Ambulance Association
Montana Academy of Ophthalmology
Montana Academy of Otolaryngology
Montana Association of Ambulatory Surgery Centers
Montana Association of Independent Disability Services
Montana Council of Community Mental Health Centers
Montana Podiatric Medical Association
Nebraska Chiropractic Physicians Association
Nebraska Dental Association
Nebraska Health Care Association
Nebraska Methodist Hospital
Neighborhood Health Plan of Rhode Island
Nemaha County Breast Cancer Support Group (Nebraska)
Nevada Dental Hygienists Association
New Hampshire Mental Health Coalition
New Hampshire Mental Health Counselors Association
New Hampshire Pastoral Psychotherapists Association
New Mexico Podiatric Medical Association
New West Health Services (Montana)
Niobrara Valley Hospital (Nebraska)
Norfolk Psychological Service (Nebraska)
Northstar Mental Health Services (Nebraska)
Northwest Alzheimer's Association (Nebraska)
Norton Health Care (Kentucky)
Nurse Practitioners of Oregon
Ogallala Counseling Center (Nebraska)
Ohio Ambulatory Behavioral Healthcare Association
Ohio Association of Women's Health, Obstetrics and Neonatal Nurses
Ohio Clinical Social Work Society
Ohio Counseling Association
Ohio Council of Behavioral Healthcare Providers
Ohio Dietetic Association
Old Mill Counseling (Nebraska)
Omni Behavioral Health (Nebraska)
One Source (Nevada)
Oregon Advocates for the Mentally Ill
Oregon Association of Physicians' Assistants
Oregon Centers for Mental Health and Addiction
Oregon Dental Association
Oregon Health Sciences University
Oregon Optometric Physicians Association
Oregon State Denturists' Association
Oriental Medical Association of New Mexico
Palmer Chiropractic College (Iowa)
Park City Family Health and Urgent Care Center (Utah)
Parkview Medical Center Department of Pathology (Colorado)
Pediatric Pathways (Colorado)
Phelps Memorial Health Center (Nebraska)
Phoenix Rising Center (Utah)
Polk County Mental Health (Oregon)
Professional Christian Counseling Services (Nebraska)
Providence Medical Center (Nebraska)
Pueblo Women's Center—Obstetrics and Gynecology (Colorado)
Rainbow Center (Nebraska)
Region VI Behavioral Healthcare (Nebraska)
Rhode Island Association of Health Centers
Rhode Island Autism Project
Rhode Island Council of Community Mental Health Organizations
Rhode Island Dental Society
Richard H. Young Hospital (Nebraska)
River Park Psychology Services (Kansas)
Riverton Eye Care (Utah)
Rock County Hospital (Nebraska)
Rural Counties Program, Spanish Peaks Mental Health Center (Colorado)
Rural Health Management (Utah)
Rural Hospital Coalition (Louisiana)
Saint Francis Memorial Hospital (Nebraska)
Sanpete Valley Hospital (Utah)
Saunders County (Nebraska) Health Services
Serenity Place (Nebraska)
Shopko Eyecare Center
Southwest Kansas Independent Living Resources Center
Southwest Utah Community Health Center
Spa Area Independent Living Services (Arkansas)
St. Mary's Health Network—Oregon
Stoney Ridge Day Treatment Center (Nebraska)
Sundance Women's Healthcare (Utah)
Sweetgrass-Stillwater Mental Health Association (Montana)
Swope Parkway Health Center (Missouri)
Tennessee Academy of Ophthalmology
The Home Team of Kansas
The Psychology Clinic (Louisiana)
Three Rivers Independent Living (Kansas)
Topeka Independent Living Resource Center (Kansas)
Town Center Chiropractic (Montana)
Tri-County Hospital (Nebraska)
Tri-County Mental Health Services—Maine
Tulane University Health Sciences Center (Louisiana)
United Healthcare—Alabama
Utah Society of Pathologists
Valley Community Clinic (California)
Valley Counseling Services (Ohio)
Valley County Hospital (Nebraska)
Valley View Medical Center (Utah)
Van WYK Family Chiropractic Center (Colorado)
Virginia Academy of School Psychologists
Virginia Association of Community Services Boards
Virginia Association of Free Clinics
Virginia Association of Hospices
Vision Health Center (Utah)
Wasatch Canyon Mental Health (Utah)
Washington Massage Therapy Association
West Holt Memorial Hospital (Nebraska)
Wills Chiropractic Clinic (Nebraska)
Willowbrook Mental Health Center (Nebraska)
Wiseman Chiropractic Wellness Center (Nebraska)
Workman Chiropractic Clinic (Nebraska)
Wyoming Counseling Association

HEALTH INSURANCE TRADE ASSOCIATIONS

Alabama Associated Life Insurance Companies
America's Health Insurance Plans (AHIP)

With additional letters from: Alabama Association of Health Plans, California Association of Health Plans, Georgia Association of Health Plans, Indiana Association of Health Plans, Kansas Association of Health Plans, Kentucky Association of Health Plans, Nebraska Association of Health Plans, Nevada Association of Health Plans, New Jersey Association of Health Plans, North Carolina Association of Health Plans, Ohio Association of Health Plans, Virginia Association of Health Plans, Association of Washington Healthcare Plans, American Managed Behavioral Healthcare Association, American Republic Insurance Company (Iowa)

Association of Health Insurance Advisors/National Association of Insurance and Financial Advisors

With additional letters from: Indiana Chapter, Maine Chapter, Nebraska Chapter, Ohio Chapter, Utah Chapter

Blue Cross and Blue Shield Association
Delta Dental Plans Association

With additional letters from: Delta Dental Plan of Arkansas, Delta Dental Plan of Indiana, Delta Dental Plan of Iowa, Delta Dental Plan of Kentucky, Delta Dental Plan of Minnesota, Delta Dental Plan of New Mexico, Delta Dental Plan of North Carolina, Delta Dental Plan of Virginia

Christiana Care Health Plans
Cimarron Healthcare (New Mexico)

Federation of Iowa Insurers
Health Net (Oregon)
Louisiana Pest Control Insurance Company (LIPCA)
Lovelace Health Systems (New Mexico)
Magellan Health Services
National Association of Health Underwriters
With additional letters from: Alabama Chapter, Arkansas Chapter, Central Arkansas Chapter, Georgia Chapter, Indiana Chapter, Maine Chapter, Minnesota Chapter, Nevada Chapter, New Hampshire, New Mexico Chapter, North Carolina Chapter, Ohio Chapter, Oregon Chapter, Rhode Island Chapter, Virginia Chapter
Nebraska Association of Professional Insurance Agents
Nevada Hometown Health
NevadaCare
PacifiCare of Nevada
Principal Financial Group—with additional letters from: Iowa Office
Sierra Health Services (Nevada)
Tufts Health Plan

Mr. Speaker, I yield such time as he might consume to the gentleman from New Jersey (Mr. HOLT).

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

N O T I C E

Incomplete record of House proceedings. Today's House proceedings will be continued in the next issue of the Record.