United States
of America

Congressional Record

PROCEEDINGS AND DEBATES OF THE *108th* CONGRESS, SECOND SESSION

Vol. 150 WASHINGTON, THURSDAY, MAY 13, 2004 *No. 67—Part II*

House of Representatives

SMALL BUSINESS HEALTH FAIRNESS ACT OF 2004—Continued

□ 1415

Mr. HOLT. Mr. Speaker, I rise in opposition to this bill and in support of the substitute that the gentleman from Wisconsin (Mr. KIND) and the gentleman from New Jersey (Mr. ANDREWS) will be submitting.

Mr. ANDREWS. Mr. Speaker, I yield 2 minutes to the gentlewoman from New York (Ms. VELÁZQUEZ), for whom I have the most profound respect, the ranking Democrat member of the Committee on Small Business.

Ms. VELÁZQUEZ. Mr. Speaker, I thank the gentleman from New Jersey (Mr. ANDREWS) for yielding me this time.

Today, we should be focusing on helping small businesses address the health care problems they face. Instead, our debate is not about policy but about politics. The House has already passed this once, and it is a bit early for summer reruns. It is a good bill with broad bipartisan support. Passing it twice will not change that.

As we move forward, small businesses are facing a real health care crisis. Small firms that can afford health insurance are seeing costs rise by nearly 20 percent every single year, and many small businesses do not even have health insurance.

This is a good bill. It has strong solvency requirements and safeguards to ensure there will be no cherrypicking of healthy employees.

Critics of this legislation will cite an outdated study that examines legislation far different than the bill before us today. This has the same validity as saying Columbus should never have sailed to the New World because previous studies had shown the world was flat.

Association health plans will give small businesses the same advantages that corporate America and unions already have. I always say, if it is good enough for IBM, GM, and Lockheed Martin, it is good enough for small businesses.

But we should stop playing politics with small business. If the Bush administration was truly committed to small businesses, association health plans would already be law.

Today's debate is not going to help small businesses lower their health care costs, it is not going to help them cope with the constant fear of being just one illness away from bankruptcy. It is about time small businesses were able to afford quality health care. That is why I will encourage my Democrat colleagues to support this proposal and show as a party that we are bigger than this political gamesmanship.

I call on the Republican leadership in the Senate and President Bush to make this bill a priority and pass it. I urge a ''yes'' vote.

Mr. BOEHNER. Mr. Speaker, I am pleased to yield 2 minutes to the gentlewoman from West Virginia (Mrs. CAPITO).

Mrs. CAPITO. Mr. Speaker, today I rise in strong support of association health plans. As we have heard, small businesses pay 17 percent more for their health care than employees of large companies. In a State like West Virginia, where over 90 percent of our business is small business, this is impossible for our small business owners.

Over 44 million Americans, sadly, are without health insurance, and more than 60 percent of those are employed by a small business. The high costs small businesses have to bear to provide health care, for what in many cases are just a few employees, prohibits owners from providing affordable health insurance and losing employees at the same time.

Through a trade association, like the National Federation of Independent Businesses, small businesses would be allowed to band together, pool their resources, drive down health care costs and gain buying power.

Nondiscrimination provisions in the legislation ensure health coverage will be offered to those who need it most, and solvency requirements will make sure that the health plans have the financial resources on hand to cover their employees' needs.

Mr. Speaker, during a roundtable I had several weeks ago with small business owners in my district, everyone was concerned about offering health care coverage. Small business owners want to be able to afford this, not only for them as owners but also for their employees.

This House has passed this association health plan legislation before. Workers need health care coverage, their children need health care coverage, and small business owners want to offer health care coverage. I urge my colleagues to support association health plans.

Mr. TIERNEY. Mr. Speaker, I yield myself 3½ minutes.

Mr. Speaker, the so-called Small Business Health Fairness Act is a bill that is attractive to a few but it is sufficient for none, and it seems to be harmful for everyone else. While there are employers, workers and family members who do depend on health insurance, what they really need is solutions that are going to work for everybody and not just some empty promises.

The Congressional Budget Office did an estimate on this proposed bill and estimated that approximately 4.6 million people might obtain some coverage through these proposed associated health plans but only about 330,000 of those people would be new customers.

The fact of the matter is that there is not going to be the dramatic savings that is proposed here. That simply will not materialize. The Congressional Budget Office found that these AHP

premiums would only be marginally less than the traditional health care plans. In fact, the Mercer Consulting STUDY that was done for the National Small Business Association found that premiums would increase by 23 percent for those outside the AHP market. It also found there would be an increase in the number of uninsured workers in small firms, an increase of a million people, as a result of this being implemented.

The fact of the matter is that Americans would also lose their right to vital medical coverage, like OB-GYN and pediatrician services, cervical, colon, mammography and prostrate cancer screening, maternity benefits, well-care child services, and diabetes treatment.

When we had witnesses testifying at the committee hearing, Mr. Speaker, we specifically asked the small business witness whether that is what she wanted to have happen to her company. And her testimony indicated clearly she did not, and she did not understand that was going to be the result of this bill passing.

This bill is going to disallow a lot of State protections, and almost all the States have in protections for people under this bill. This House voted for a Federal Patients' Bill of Rights that would have recognized States' protections that are in place for insurance programs. Almost every single Member on both sides of the aisle voted for that legislation; yet this piece of legislation, the AHP bill, would peel that away and take away the State protections for all those things that people in small business want.

As a person in a small business and representing a number of small businesses for over 22 years, I can tell you small business employers do not want an inferior policy for their employees.

With respect to the question one of our colleagues on the other side raised about the distrust of the private sector, we are all very much in favor of the private sector, but most people are in favor of it being a balanced situation in this country. We understand unless there is some reasonable regulation, some private industries will go too far in one direction, as has happened in the past with programs similar to this, the so-called MEWAs that existed at one time that were replete with fraud, corruption, and solvency problems.

This is a situation that has to be corrected. We cannot allow it to happen again here, and there is evidence in recent times that that is exactly what would happen with this bill.

Mr. Speaker, small business owners and their employees deserve protections. They deserve to go to the emergency room. Women small business owners deserve to go to gynecologists without referral from another doctor. Why should we treat small business owners and employees like second-class citizens by giving them second-class health care? Instead of extending the patient protections to all Americans, this bill would roll back the limited protections that exist today.

I think if we speak plainly, Mr. Speaker, this bill eliminates the State regulation of AHPs and is in fact an anti-patients' bill of rights. For this reason and the other reasons I have mentioned, and others have said, and the fact that over a thousand different organizations oppose this bill, including the National Governors Association, the Republican Governors Association, 41 State attorneys general, the National Small Business Administration, the National Association of Insurance Commissioners, as well as a dozen other groups of labor business and consumer groups, I believe this is not a good bill for small business, it is not a good bill for the employees of small businesses. We can do better and we should.

Mr. BOEHNER. Mr. Speaker, I yield 3 minutes to the gentleman from Maryland (Mr. WYNN).

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

It is interesting to note the gentleman just said, why should small businesses be treated as second class citizens. The fact of the matter is, they are already treated as second-class citizens because they do not have and cannot afford to have health insurance for their employees. Sixty percent of the 44 million uninsured people in America work in small businesses.

Now, there is something very interesting happening in this debate, and I want to lay it on the line. All the people who are against this bill have health insurance. Yes, the unions and the governors, be they Democrat or Republican, and all the other folks who are saying this is a bad bill, have health insurance. On the other side, the folks who want this bill, are small business owners, 12 million of them, who cannot afford to provide health insurance for their employees. Why should they not have an opportunity to pool together to gain the leverage that would enable them to provide affordable health insurance?

Now, you hear people saying the benefits are too skimpy and you do not have the State mandated benefits and all these other things. Those benefits are fine, and I have supported them. But the fact of the matter is if you do not have any health insurance, then the benefits and the protections and the consumerism and all that does not mean a thing because you do not have any health insurance.

Number one, why not let the employees make the decision? If the benefits are too skimpy, the employees will not buy them. On the other hand, if a basic plan enables you to see a doctor or save money on going to a doctor, that is a good thing and people will buy it.

The second item I might mention, large corporations that self-insure and unions that cross States lines do not have to adhere to these mandates that people are saying is so important. So what is the difference? It seems to me that if we do not want to treat folks as second-class citizens, let small businesses have the same benefits that big corporations and unions currently enjoy.

Now, the other item you will hear about is cherrypicking. There are provisions in this bill to prevent cherrypicking. You will hear about solvency problems. There are provisions in the bill to ensure that the solvency is the same as the solvency for other insurance companies.

Now, who gets insured? You have heard, well, people will lose insurance, insurance rates will rise. CONSAD Research Institute conducted a study that concluded that 8.5 million more Americans, uninsured workers, would have access to insurance under this bill.

Now, this bill is not a panacea. It is not perfect. But it is a step forward that will enable us to insure the group of people who do not have insurance. Instead of listening to all the thousands and hundreds of groups that they are saying are against this bill, but who for some reason have insurance, let us provide a benefit to the uninsured small businessperson, give them the opportunity to have associated health plans and move towards insuring the uninsured.

This is National Insure the Uninsured Week, not National Let Us Talk About Insuring the Uninsured Week. The thing that we can do that would do the most good is to pass this bill and move toward insuring the uninsured.

Mr. ANDREWS. Mr. Speaker, may I inquire as to how much time is remaining on our side?

The SPEAKER pro tempore. The gentleman from New Jersey has 12¾ minutes remaining, and the gentleman from Ohio has 10 minutes remaining.

Mr. ANDREWS. Mr. Speaker, I yield myself 30 seconds.

My friend from Maryland, whom I respect very much, when they talk about the number of people who would gain insurance with AHPs, the Congressional Budget Office drew the conclusion that the vast majority of members of AHPs would not be newly-insured people. They would be people shifted from existing plans into the AHPs.

I think the better authority is that one million people, net, one million more people would be uninsured as a result of this bill.

Mr. Speaker, I yield 2 minutes to the gentleman from Ohio (Mr. BROWN) a member of the Committee on Energy and Commerce.

Mr. BROWN of Ohio. Mr. Speaker, I thank the gentleman from New Jersey for yielding me this time and for his leadership on health care issues.

In my home State of Ohio, we have a successful multi-employer health insurance program sponsored by the Council of Smaller Enterprises, or COSE. Some 14,000 businesses participate. For 30 years, Ohio's COSE has been negotiating with commercial insurers to offer small businesses coverage and rates usually reserved for the

largest companies. Each year, COSE members collectively save almost $50 million in health insurance premiums.

Unlike the association plans envisioned under 4281, COSE works within the framework of State insurance law. That means COSE is not subject to the scams, to the insolvencies, to the indiscriminatory coverage schemes that are the hallmark of association plans. This bill puts Ohio COSE at risk.

It is like a poker game. If one person is playing by the rules and the other is cheating, the cheater will probably win. Now the stakes are even higher. Not only is health coverage at risk for those who play by the rules, but the gains are short-lived for those who do not.

Companies that join an association health plan may see favorable premiums one year and be priced out of coverage the next. Their employees may or may not be covered for needed health care and claims may or may not be paid. It is simply a crap shoot.

The American Academy of Actuaries has no stake in the outcome of this debate. Private insurers hire actuaries to calculate premiums. Here is what the Academy has to say about this bill. ''This bill will likely have unintended negative consequences.'' The Academy says ''AHPs produce fragmentation of the market,'' as we have heard over and over and over today. They say, ''AHPs are likely to lead to cherry-picking, to adverse selection, and to increased costs for sicker individuals.''

□ 1430

The academy says that AHPs create an unlevel playing field, there have been many examples of AHP-like organizations becoming insolvent, and that the anticipated expense reductions are simply unlikely to materialize. Even though 44 million Americans are uninsured, the Republican majority has no intention of seriously considering proposals to expand access to health insurance.

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

Let me remind all of my colleagues that we are talking about 44 million Americans who have no health insurance. They get to the doctor, albeit very late, they get to the hospitals, albeit very late, they die sooner, and they have higher health care costs that we all who have health insurance pay for. It all ends up in the size of our bill.

But the bigger disgrace is that there are 44 million Americans who have no health insurance, no preventive care; and we are attempting to do something about it. The gentleman from Ohio (Mr. BROWN) denigrated these interstate plans as scams that could go corrupt. Let me see. If I recall, we have companies like General Electric which have employees in virtually every State. They have a plan under the Employee Retirement Income Security Act. How about the Teamsters? I would say the Teamsters have plans that cover virtually every State.

Why would we not allow small employers that belong to the NFIB, belong to the U.S. Chamber of Commerce, belong to the Electrical Contractors Association, why would we not let them come together to form the same kinds of health insurance plans that large companies and unions offer from coast to coast? What do we have to fear? What do we have to fear in trying to help 44 million Americans have a chance at good health insurance?

Mr. ANDREWS. Mr. Speaker, will the gentleman yield?

Mr. BOEHNER. I yield to the gentleman from New Jersey.

Mr. ANDREWS. Mr. Speaker, I assume the gentleman's question was not rhetorical. What we have to fear, we should listen to the advice of attorneys general and Governors and insurance commissioners from around the country who say we have to fear this: we have to fear a poorly regulated or unregulated structure that is not properly accountable under fiduciary standards and has no experience in running insurance companies, which is why they oppose the bill.

Mr. BOEHNER. Mr. Speaker, reclaiming my time, those regulatory requirements are not on the GEs that we talked about, they are not on the Teamsters, they are not on other big employer or union plans. They are governed under a Federal statute called ERISA that has worked very well to insure and provide the basis for health insurance in America, and we ought to trust small businesses that would join these associations and give them the same rights that big companies and unions have.

Mr. Speaker, I yield 2 minutes to the gentleman from Georgia (Mr. KINGSTON).

Mr. KINGSTON. Mr. Speaker, I thank the gentleman from Ohio (Mr. BOEHNER) for yielding me this time.

I want to talk about this as a former insurance agent. I sold property and casualty insurance to small businesses all over Georgia before I came to Congress. I was not in the health care business, but quite frequently my clients would come to me and say, Can you help us with health care? Can you point us in the right direction? So I have some knowledge of it on the ground from the perspective of a pet store, a barber shop, a brick mason, small employers with 5 to 15 people.

What their problem is, they have been priced out of the health care business because we insist through state-mandated benefit that they have to buy a Cadillac insurance plan. They cannot buy a stripped down Toyota; they have to buy the Cadillac with all of the options. That is what we are doing. Because of that, that brick mason with seven employees says to his employees, We cannot do health care any more. If your wife or somebody in your family cannot put you on as a dependent, you do not have any health care.

What this plan does is it gets uninsured employees back in the business of health insurance, those employees who are making too much money for Medicaid, for example, and workers comp is only going to cover them on the job. This gives them access to the health care. It makes it affordable because that brick mason, that pet store, that barber shop can combine with other similar businesses all around the country, and they can go into the marketplace with the economy of scale, the buying clout which the GEs and big unions have, and then they can have affordable health care. It gives relief from some of these mandated benefits. A mandated benefit is not necessarily bad; but if you require someone to have pediatric shots, nobody is going to say that is a bad idea, it makes sense, but it might not apply to you or you might want to assume that risk or cost yourself.

We are saying to these employers and employees you have no option, you have to buy this because we are the government and we know what is best for you. This gives them a commonsense approach, a great compromise so they can afford health care again. I urge my colleagues to support this bipartisan legislation.

Mr. ANDREWS. Mr. Speaker, I yield 2 minutes to the gentleman from Ohio (Mr. KUCINICH), another voice who joins the coalition of AFL–CIO, 66 chambers of commerce and the National Governors Association, a gentleman who has brought great honor to this House during his Presidential campaign.

Mr. KUCINICH. Mr. Speaker, when a doctor prescribes a path of care that does not work out, patients are always advised to get a second opinion, so I want to offer a second opinion in answer to the gentleman from Ohio (Mr. BOEHNER).

This bill would increase the number of uninsured. It would increase costs. It would increase discrimination against older workers, and it would remove patient protections. Despite the widespread agreement on the need to provide more health care coverage, decrease cost and improve care, this bill moves in the opposite direction. Instead of improving access to health care, this legislation would worsen access.

Approximately 1 million people would lose their insurance coverage if this bill is enacted. Instead of reducing premium costs, this bill would increase premiums for 20 million small business workers. Instead of making coverage more equitable, AHPs would lead to discrimination against older workers who would have a much more difficult time getting coverage. Instead of increasing patient protections, this bill would remove them. State patient protection laws would be effectively waived for AHPs, leaving patients without the ability to enforce protections for basic benefits, like emergency medical services and access to specialists.

The Hippocratic Oath says ''Above all, do no harm.'' This bill takes a bad

health care situation in this country and makes it worse, which is not what the people ought to expect from this Congress. I urge the Congress to reject the underlying bill and at some point in the future we are going to have to answer the issue of universal, single-payer, not-for-profit health care so we do not look at these kinds of phony, stopgap measures.

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

I remind my colleagues one more time that we are talking about trying to assist 44 million Americans who have no health insurance. This may not be the perfect product, it may not be the perfect package, but for the life of me, I cannot understand why people do not want to come to the plate and try to do something to help these Americans who do not have access to affordable health insurance.

Maybe the answer is what we just heard from my good friend and colleague, a member of the committee from the other end of the great State of Ohio who wants a single-payer national health plan. I think most Americans looked up in the mid-1990s when this idea was floating around and said, Oh, no. No, no, I like my health insurance. I like going to the doctor I choose. I do not need the government running my health insurance plan.

Mr. Speaker, I yield 1 minute to the gentleman from Illinois (Mr. CRANE).

Mr. CRANE. Mr. Speaker, today the House has a chance to help small business with their number one concern: health care. Many Members are already aware of this, but 25 million small business owners, their families and employees currently do not have health insurance. It is simply too expensive. We have a system in our country today that puts small business on one playing field and big business on another, and that is not acceptable. Small business is the driving force of our economy, the number one job creator in the Nation, and the backbone of our local communities.

H.R. 4281, the Small Business Health Fairness Act, puts small business and big business on a level playing field. It gives small business the capability of buying health insurance at the same cost and with the same rules that big business plays by. I think it is time we gave our small businesses a helping hand.

I am confident that we will pass legislation to create association health plans today, and I encourage all of my colleagues to support it; but it is time for the other body to act and pass the Small Business Health Fairness Act. The time has come to address this problem, and the entire Congress should support this legislation.

Mr. ANDREWS. Mr. Speaker, I yield myself 10 seconds.

Mr. Speaker, we certainly take up the challenge to present a better idea, which the gentleman from Wisconsin (Mr. KIND) and I will be doing in a few minutes under the alternative. We understand that the American Academy of Actuaries, a group with no vested interest in this debate, has concluded that 1 million people will be added to the roles of the uninsured by this bill.

Mr. Speaker, I yield 2 minutes to the gentleman from Illinois (Mr. EMANUEL).

Mr. EMANUEL. Mr. Speaker, I rise in opposition to this bill. I do it as the son of a pediatrician and the brother of an oncologist. I appreciate that the Congress today and the Senate, the other body, is having a debate about health care. Senator KERRY is out presenting his health care plan; the only person lacking a health care plan in this debate, after 3 years in office, is the President of the United States.

The Institute of Medicine estimates that 18,000 Americans die prematurely because of not having health care. This is not just a problem of the poor. The fastest growing group of working uninsured in this country are people earning up to $50,000 a year. Kaiser Family Foundation found that the system, the insurance system, literally pays somewhere close to $125 billion to cover the uninsured who do not receive health care. All of us who have health care pay an uninsured premium in our health care cost for those who show up at hospitals without health insurance, getting critical care rather than preventive care.

Even as we spend more money than any other industrialized nation on health care, we have 44 million uninsured, of whom 33 million work and 10 million are children.

To address the needs, we can do better than the bill which experts say will damage, rather than benefit, the insurance market. We can do better than a bill that takes away important insurance requirements like cancer screenings and other critical preventive care rather than relying on the emergency care which is what the uninsured patient receives today.

This bill would actually increase the uninsured premium all of us pay who have health insurance by putting additional strains on the insurance system and increasing premiums for many Americans. In 2000, the health costs for a family of four was $6,500. Today it is $9,000. It is going up exponentially by a third. Nobody has gotten an increase in salary by a third. What is the driving force behind that inflationary fact in health care insurance premiums? The uninsured who show up at hospitals. Hospitals recoup the cost by passing it on, which raises premiums.

Mr. Speaker, I urge my colleagues to reject this bill and pass the substitute which will help small businesses provide health insurance, reduce the number of uninsured while reducing the premiums the rest of us pay.

Mr. ANDREWS. Mr. Speaker, I yield 3 minutes to the gentleman from North Dakota (Mr. POMEROY), who had a career in State government in insurance regulation and, frankly, I think knows more about this subject than any other Member of the House.

Mr. POMEROY. Mr. Speaker, I thank the gentleman for yielding me this time and commend the gentleman as well as the chairman for what is a very interesting debate with some technical sophistication on the business of how we expand health insurance in the small business environment.

Let me begin by explaining briefly how purchase decisions work in a small business, unlike General Electric. General Electric has a human resources department. They have actuaries on contract. They can thoroughly do due diligence on any health insurance program they are evaluating for their employees.

Our Own Hardware store in Valley City, North Dakota, my hometown, is quite different. There is one business proprietor, may a half a dozen or a dozen employees, and when he sits down to visit with a person promoting a health insurance program, he does not have an ability to evaluate the rating scheme. He does not have an ability to assess the adequacy of the fairness of the medical underwriting. That Our Own Hardware store does not have the ability to determine whether the company is solvent and reserving adequately to pay future claims, the Our Own Hardware does not have to do that because when they sell health insurance now, it is regulated. We have a State insurance department that does that. That used to be my job. And the State insurance commissioners across this country are in their offices every day making certain that the presentations to the Our Own Hardware stores represents a product that is going to be there when they need it.

When we buy insurance, we pay premiums today with the hope of getting the claim paid tomorrow, and that means we have to have a reliable entity on the other end. That is what regulation brings us.

□ 1445

The bill before us would depart from that. They would basically substantially do away with State solvency checks, with the State regulation on underwriting criteria, with the assessment of whether or not the rating is fair. I believe there would be very, very damaging results. In order to bring the cost of insurance down, we have seen self-regulated companies like the AHPs try to cheat on the business of paying claims. They do not have the capital to pay the claims when the claims come due. In fact, the most recent version of the AHPs that have been out there, these MEWAs, the insurance commissioners tell us they left more than 400,000 people holding the bag with medical claims but no insurance company to pay them.

The majority talks a lot about trying to get coverage to those who do not have it. You sure do not want to give people the illusion of coverage that is not real because they count on that company in paying the claim. And what we see with these self-regulated

outfits, when you need them, they are not there. They have taken your money and they have left. So not only does it fail in a meaningful way to get coverage to those who need it, it undercuts the coverage of those who already have insurance. In fact, the estimate from the actuarial firm that a million would lose their coverage is yet another solid reason why we should not take this path and adopt the AHPs.

Vote ''no'' on this measure.

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

With all due respect to my good friend from North Dakota who is one of the real experts on insurance and pension matters in the House, he is a former State insurance regulator, we have heard this claim that Governors, State insurance regulators and attorneys general are opposed to this bill. Of course they are. Every State, we know what they want to do. They want to regulate, regulate, regulate, regulate.

Let us go back to the example. The Procter & Gambles, the GEs, the Teamsters, they are not regulating those plans. They have got some of the best benefits that they offer to their employees. Let us go back to your example of the dry cleaner. The dry cleaner does not have the actuary. He has got the regulator, the attorney general. What if all those dry cleaners in a State, the State of North Dakota, or all those dry cleaners from around the country in their national association came together and formed an association health care plan? Those employees at that local dry cleaner would have better benefits at more competitive prices than they could ever get in a State insurance risk pool.

What do we have to fear from giving those small employers and, more importantly, their employees the chance to come together to have the same kind of a plan that big companies and unions have today?

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

Mr. ANDREWS. Mr. Speaker I yield myself the balance of my time.

I agree completely with the chairman that the number one issue on the health care agenda of this country is finding insurance for the 43, 44 million uninsured. I agree with him completely that it is a worthy project for this House to pursue. Long overdue. Usually it does not persuade me when you submit a list of people who are against a bill or for a bill, because I think each one of us has the obligation to make our own judgment about these matters, as each one of us should here.

At this point in the RECORD, by the way, I include the Mercer study to which I referred, the actuarial study to which I referred, and the letter from the Congressional Budget Office to which I referred.

[Prepared for: National Small Business United, June 2003]

IMPACT OF ASSOCIATION HEALTH PLAN LEGISLATION ON PREMIUMS AND COVERAGE FOR SMALL EMPLOYERS

(By Beth Fritchen, FSA, MAAA; and Karen Bender, FCA, ASA, MAAA, Mercer Risk, Finance & Insurance)

EXECUTIVE SUMMARY

National Small Business United (NSBU) engaged Mercer Risk, Finance & Insurance (Mercer) to analyze the ''Small Business Health Fairness Act of 2003'' (H.R. 660 and S. 545). This legislation would encourage the formation of federally certified Association Health Plans (AHPs) by exempting these plans from various state laws that govern health insurance sold to small employers today.

Proponents of H.R. 660 and S. 545 argue that federally certified AHPs would expand access to affordable health insurance for small employers and reduce the number of uninsured. Opponents believe the legislation would have the exact opposite effect—that is, it would cause premiums to rise and the number of uninsured to increase.

Mercer developed an actuarial model to assess how this legislation would affect premiums for small firms that purchase state-regulated coverage and firms that enroll in AHPs over a four year period as well as the impact on the number of uninsured.

The analysis concludes that federal AHP legislation would not alleviate the health insurance cost pressures faced by small employers. Rather, the proposed AHP legislation would have a detrimental impact on small employer premiums, especially for firms with high-cost workers, and would cause a significant number of small employers to drop coverage, thereby increasing the nation's uninsured population.

In brief, we found that once federal AHP legislation was fully implemented:

Health insurance costs would increase significantly for small businesses in the state-regulated insurance market. Health insurance premiums would increase by 23% for small employers that continued to purchase state-regulated coverage This increase would result from AHPs' ability to attract healthier-than-average firms out of the state-regulated market. AHPs' exemption from mandated benefits would allow them to tailor products attractive to healthier populations. Moreover, exemption from sate limits on premiums and marketing standards would allow AHPs to enroll healthier-than-average groups and encourage firms with high cost workers to switch back to the state-regulated market.

As AHPs attract small employers whose perceived health status is good, firms with greater expected health care utilization would remain in the state-regulated market, where they have the protection of mandated benefits and other requirements. The resulting outflow of low-cost groups from the state-regulated market and the remaining concentration of high-cost groups would start an adverse selection spiral that would accelerate premium increases for employers in the state-regulated market.

AHP legislation would increase, not decrease, the number of uninsured. The number of uninsured would increase by over 1 million as a result of coverage losses among workers in small firms and their dependents. As premiums for small employers in the sate-regulated market increased, some firms would drop coverage and not switch to an AHP. Coverage declines would also result when groups covered by AHPs drop their coverage when their rates increase because someone in the group gets sick. While some of these groups would switch back to the state-regulated market, others would drop coverage entirely.

Federal AHPs would gain a pricing advantage through risk-selection, not greater administrative efficiency. The modeling predicts that after four years premiums for AHPs would average 10% below that of the existing small group market. However, we expect these price reductions to result from favorable risk selection and exclusion of benefits rather than improved purchasing efficiency or lower administrative costs. AHPs could use a variety of techniques to select healthier-than-average firms—techniques available to AHPs because the legislation preempts key provisions of state law designed to prevent risk selection.

Specifically, under H.R. 660 and S. 545 AHPs could: charge firms with high-cost workers much higher premiums than permitted under state law; experience rate each association based on the risk of only their members; and offer pared-down products without benefits that would be needed or desired by higher-risk small employers. Together, these strategies would allow AHPs to offer the most attractive rates to healthy groups and avoid the cross-subsidies that state small employer health insurance reforms require.

Federal AHPs would insure the healthiest small employers. The modeling estimates that the average morbidity (a measure of whether a firm is ''sick'' or ''healthy'') of firms enrolling in AHPs would be 21% lower than the average morbidity of small employers in the market today. Further, as higher-cost small employers dropped coverage in response to rate increases resulting from the movement of healthy employers out of the state-regulated market, the average morbidity of the uninsured population would increase by 12.3%. AHPs would appeal most to firms with younger workers given the close correlation between age and health status.

Small employers would face higher premiums overall. Average small employer premiums (considering both cost increases for the state-regulated market and premium reductions for AHPs) would increase by 6%. Average premiums would increase because the size of the average premium increase for the population remaining in the state-regulated market (23%) would outweigh the smaller average premium decrease for those covered by AHPs (10%).

These results indicate that AHP legislation is not a solution to rising health care costs for small employers. While some firms obtaining coverage through AHPs may see lower premiums, firms with higher-cost employees would see their premiums increase. Overall, small employers would pay higher premiums and the uninsured population would increase if this legislation were enacted.

ASSOCIATION HEALTH PLAN BILLS NEED CHANGES: ACTUARIES FIND AHP LEGISLATION FLAWED

In a letter to members of Congress, the nonpartisan American Academy of Actuaries identified several serious concerns with the Small Business Health Fairness Act of 2003 (H.R. 660 and S. 545). The bills would amend the Employee Retirement Income Security Act to allow trade, industry, professional and similar associations to be sponsors of health insurance plans for their members. The Academy offered to work with proponents of the bills, which bill sponsors hope will expand the availability, affordability, and accessibility of health insurance coverage.

Karen Bender, M.A.A.A., chairperson of the Association Health Plan Work Group, said that while the legislation has merit and is

well intentioned, ''we have serious concerns about some of the bills' provisions. As written, the bills are flawed and need significant rewriting to be actuarially sound and protect consumers.''

Some of the concerns that the group has with the legislation are:

Risk of Insolvency—The proposed rules governing the minimum surplus requirements for an AHP does not account for the growth of the AHP. Similar organizations have become insolvent in the past. In response, most states enacted solvency standards. To maintain the benefit of such standards to consumers, the surplus standards should be similar to the minimum requirements for Health Risk-Based Capital developed by the National Association of Insurance Commissioners. The legislation also relies on reinsurance vehicles that do not currently exist in the market.

Unclear Regulatory Authority—AHP government regulation is not clearly defined in the law. Consumers, AHPs, and regulators may have no place to go for redress and guidance without clear regulatory authority.

Unlevel Playing Field—The consequences of different rules for AHPs vs. state-regulated plans fragments the market, producing an unlevel playing field in insurance coverage that will lead to cherry-picking, adverse selection, and increased costs for some individuals.

The House Committee on Education and the Workforce is considering the House bill, and the Senate bill has yet to be scheduled for committee consideration. For a copy of the letter, go to the Academy website at www.actuary.org, or call Tracey Young at 202–785–7872.

AMERICAN ACADEMY OF ACTUARIES,
April 28, 2003.

Hon. JOHN A. BOEHNER,
Chairman, House Committee on Education and the Workforce, Rayburn House Office Building, Washington, DC.

DEAR REPRESENTATIVE BOEHNER: This letter presents the comments of the American Academy of Actuaries Association Health Plan Work Group regarding the Small Business Health Fairness Act of 2003 (H.R. 660 and S. 545). As you know, these bills would amend ERISA to establish a new ''Part 8—Rules Governing Association Health Plans.''

H.R. 660 and S. 545 are designed to expand access to affordable health insurance by promoting the use of Association Health Plans (AHPs). We support efforts to increase the availability, affordability, and accessibility of health insurance. While the goals of the legislation are laudable, the bills do not address the core problem, which is the high cost of health care. As currently written, the bills will likely have unintended negative consequences that would hinder the intent of the legislation.

Members of the American Academy of Actuaries are available to assist Congress in developing solutions to address the issue of small-employer health insurance reform.

EXECUTIVE SUMMARY

Some of the unintended negative consequences of the legislation and our related concerns are as follows:

Unlevel Playing Field: The consequences of different rules for AHPs versus state-regulated insured plans is a fragmentation of the market resulting from an unlevel playing field. This is likely to lead to cherry-picking, adverse selection, and increased costs for sicker individuals.

Risk of Insolvency: The proposed rules governing the minimum surplus requirements for AHPs do not account for the growth of the AHP. Historically, there have been many examples of AHP-like organizations becoming insolvent. Following such events, most states enacted solvency standards. To maintain the benefit of these standards to consumers, the surplus standards should be similar to the minimum requirements for Health Risk-Based Capital (RBC) developed by the National Association of Insurance Commissioners (NAIC). Also, the bills at issue rely on affordable reinsurance vehicles that do not currently exist in today's marketplace.

Unclear Regulatory Authority: Governmental authority for regulating AHPs should be clearly specified. Absent this clarification, it is likely that nobody will be regulating AHPs or that there will be conflicting regulation. When regulatory authority is unclear, consumers have no place to turn for redress.

Unclear State Assessment Authority: The authority to levy assessments will depend on what governmental body has regulatory authority over AHPs. It should be clear what states are allowed to do with assessments generated by AHPs.

Actuarial Certification: The definition of a ''qualified actuary'' should require membership in the American Academy of Actuaries and should specify that the individual must have pertinent health actuarial expertise.

Other Concerns: Anticipated expense reductions are unlikely to materialize.

ISSUES CONTRIBUTING TO AN UNLEVEL PLAYING FIELD AND SUBSEQUENT DESTABILIZATION OF THE SMALL-GROUP MARKET

Allowable Rating Practice Differences Contribute to an Unlevel Playing Field Section 805(a)(2) requires that contribution rates must be nondiscriminatory with regard to individual participants. It also states that contribution rates for any participating small employer must not vary on the basis of any health status-related factor or the small employer's type of business or industry.

However, the term ''contribution rates'' is not defined. Clarification of whether this refers to a contribution by an individual within a small employer group or the rate an individual employer within an AHP pays is necessary. If this is intended to eliminate the possibility of varying rates for individual small employers by health status, there is a conflict in the language of the paragraphs that follow. The language states that nothing in the bill shall be construed to preclude an AHP from varying contribution rates for small employers to the extent allowed under the state for regulating small group insurance rates. Later in the legislation, it allows an AHP to choose a single state as its ''applicable authority'' and it need only follow the rating rules of that state for the nationwide plan. If an AHP chooses a state that has no restrictions on small group rates, it seems the limitation on varying contribution rates by health status is not enforceable, thereby resulting in cherry-picking.

This provision would permit an AHP to be exempt from small-group rating laws, which have been enacted by many states. The AHP could charge small employers with less healthy employees a higher rate than would be permitted for health insurers operating under the small-employer rating restrictions. The result would be that small employers whose employees are greater health risks are more likely to obtain coverage from the private health insurance market, where rates are limited, than through AHPs, who may not have the same limitations. State small group legislation sought to eliminate this sort of selection in the market by requiring health insurers to put all their small groups in one pool and to limit the premium charged to one employer relative to another. Introducing AHPs that are not required to adhere to the same rating rules brings selection back into the market. The consequence will be that the rates for the two pools will diverge, causing further instability in an already fragile market.

Lower Solvency Standards Contribute to an Unlevel Playing Field.—State-regulated, non-AHP insured plans are subject to state solvency regulation. Ongoing surplus requirements are normally met by risk or profit charges within the premiums or contributions. While this may result in short-term premium savings for the AHPs, the inadequate contributions to surplus likely will contribute to AHP insolvencies, resulting in consumers and providers being responsible for unpaid claims.

Benefit Differences Contribute to an Unlevel Playing Field.—AHP groups, according to the bills, will be exempt from state mandated benefits. Healthier groups are less likely to utilize mandates and, therefore are more likely to choose AHP coverage, while groups with higher health risks and higher utilization of these mandated services are more likely to remain in the traditional insured market, thus widening the gap between the two markets. Currently, both high and low utilizers are in the same insured pool and the cost for mandates is spread across a larger pool for a small incremental cost. Splitting the required mandates by market will lower the cost for some, but raise the incremental cost for others.

In summary, market destabilization is a likely result of the proposed AHP legislation, as currently written, because of the disparity in allowable rating practices and solvency standards, which would be compounded by benefit differentials. The only way to maintain a level playing field is to have a common set of rating rules and consumer protection laws for every entity, whether it is an insurance company, health maintenance organization (HMO), or a self-funded AHP.

SOLVENCY STANDARDS

Solvency standards should include both claim reserves and surplus requirements. The description of claim reserve requirements for AHPs in Section 806 of the bills seems adequate. The proposed rules governing AHPs should include ongoing requirements that are similar to the minimum requirements for Health Risk-Based Capital (RBC) developed by the National Association of Insurance Commissioners (NAIC). The start-up capital included in Section 806(b), ''Minimum Surplus in Addition to Claims Reserves,'' does not adjust for future inflation or size of the AHP. Many states had similar minimum surplus requirements that became inadequate until they made legislative changes to increase minimums for inflation.

However, capital requirements also need to increase with the growth of AHP claim volume. Recognizing that capital requirements need to be tied to the size and risk profile of risk-bearing entities, states are now implementing the NAIC Health RBC formula. Under the Health RBC Underwriting Risk Factor, an approximation of surplus for many entities would be a minimum of eight percent to 10 percent of the total projected claims for the AHP during the year following the evaluation of such claims. The minimum surplus is adjusted to reflect the purchase of stop-loss reinsurance and other types of reinsurance.

While the requirements for claim reserves, surplus, and other factors may be adequate for the start-up phase of an AHP, they appear inadequate if the total annual claims volume of the AHP exceeds $5 million to $10 million (5,000 to 10,000 individuals). As the AHP gets larger, the total surplus requirement for solvency rises with claim volume. AHPs that provide coverage for employers in

higher-risk industries may have even larger surplus requirements. Such employers may not have higher initial claims, but due to higher employee turnover they may have higher claims in future years, necessitating larger surplus requirements.

ACTUARIAL CERTIFICATION

Section 806 of the bills provides for the certification of AHP solvency by a ''qualified actuary.'' The work group wishes to stress the importance of defining that term as ''an individual who is a member of the American Academy of Actuaries,'' and they further recommend that the definition be strengthened by requiring pertinent health actuarial expertise.

It is important that the definition of a ''qualified actuary'' should be ''an individual who is a member of the American Academy of Actuaries.'' As the U.S.-based organization with primary responsibility for promoting actuarial professionalism, the Academy staffs and supports the Actuarial Standards Board (which promulgates actuarial standards of practice), the Committee on Qualifications (which develops qualification standards), and the Joint Committee on the Code of Professional Conduct (which develops and maintains standards of conduct for actuaries).

The Academy also staffs and supports the Actuarial Board for Counseling and Discipline (ABCD), which provides confidential guidance to actuaries on how to maintain high professional standards in their practices and investigates complaints that may be brought against them. Academy members who fail to comply with applicable professional standards are subject to public discipline up to and including expulsion from membership. Academy membership thus brings with it the obligation to comply with high standards of qualification, conduct, and practice, and we believe Academy members will satisfy that obligation when making the solvency certification required by Section 806.

Actuaries who are not members of the Academy, or one of the other U.S.-based actuarial organizations, are not subject to the professional standards and discipline process just described. Therefore, in a situation where a non-member actuary had issued a flawed certification of an AHP's solvency, the Academy would be unable to help monitor the situation.

APPLICABLE AUTHORITY

Section 812(a)(5) provides a definition for ''applicable authority'' that allows the U.S. Department of Labor (DOL) to delegate responsibility to enforce federal standards for AHPs to states in certain instances. However, this authority is not universal. The section provides for situations in which there is ''joint authority,'' presumably between the state and federal levels. There are also situations in which the DOL has sole authority over an AHP and state jurisdiction is preempted.

These provisions create confusion about which regulatory entity has responsibility for oversight of the various functions of AHPs. We make note of the bills' recognition of the value of the expertise and resources currently in place at the state level. However, we are concerned that the current language will create situations similar to previously proposed legislation on Multiple Employer Welfare Arrangements (MEWAs) in which the scope of regulatory responsibility over such plans was unclear. As an example, Section 802 of the bills gives certification authority to the secretary of labor. It may be difficult for an individual department of insurance to monitor the certification status of AHPs operating within their state. It is crucial that the oversight responsibility regarding solvency standards be clear to avoid situations where AHPs fail because of confusion regarding what entity is to be monitoring and taking action when necessary.

There are a number of specific questions not answered by this language in the bills. For example, does the current language enable individual states to require AHPs operating within their boundaries to abide by all existing insurance regulations, including small-group rating laws and mandated benefits? Or is the scope of states' responsibilities limited to verifying the solvency of an AHP? Can the states require AHPs to meet minimum solvency standards required for insurance companies if those requirements are more stringent than those described in these bills? Thus, it is not clear that states would be willing to effectively regulate these entities if the exemptions are viewed as contrary to the intent of the state legislature.

Section 813(b)(2)(D) establishes that each AHP can identify a single state to act as its ''applicable authority.'' This section further provides that the laws of this single state ''supersede any and all laws of any other State in which health insurance coverage of such type is offered.'' Many states have devoted much time and many resources to developing requirements pertaining to rating, benefit coverage, and consumer disclosures that they believe serve the best interests of their citizens. However, this section would exempt AHPs from having to abide by these laws if the AHP has elected a different state to act as its ''applicable authority.'' This could result in AHPs ''shopping'' for the state perceived to have the least oversight, effectively negating the existing health insurance laws in most states. In some states with small employer regulations that significantly increase the cost of health insurance, all of the small employers could migrate to AHPs, resulting in federalization of the state's small group market.

In addition to rating and benefit regulations, provider and claim payment laws add further complexity to this issue. These include, but are not limited to: any willing provider laws, prompt payment rules, privacy and patient protection laws, and regulations regarding assignment of claims.

The work group is concerned that by dividing the oversight responsibilities between the state and federal governments, confusion will result regarding which entity has authority over which function. The end result could be either overregulation to the point that AHPs cannot operate, or underregulation. When regulatory authority is unclear, consumers have no place to turn for redress.

STATE ASSESSMENT AUTHORITY

Section 811 of the legislation allows states to impose assessments on AHPs based on the amount of premiums or contributions received from employers and employees who make up the plan. Many states use assessments to subsidize ''high-risk'' pools for uninsured individuals. However, it is questionable whether a state would have the authority to levy such assessments if it defers to the DOL to regulate its AHPs or if a multistate AHP is domiciled in another state's jurisdiction.

The states also may have problems enforcing the provision, given the requirement that such assessment ''is otherwise nondiscriminatory . . . .'' Section 811 provides that the rate of the assessment cannot exceed premium taxes paid by health insurers or HMOs. In most states, HMOs are not taxed or pay a lower tax than health insurance companies. AHPs might argue that imposing an assessment based on the premium tax rate applied to a health insurer would be discriminatory if a lower rate or no premium tax was applied to HMOs. The work group recommends that the legislation clearly delineate where assessment authority will be placed, at the state or federal level, and what the provisions of the assessments will be.

OTHER CONCERNS

Expense reductions are not likely to materialize. Administratively, each employer group will require the same amount of underwriting, enrollment, mailings, and customer support as they currently do in the small group insurance market. It is unlikely that the AHPs will have more buying power than the insurers that represent small employers today.

CONCLUSION

The work group supports efforts to expand access to health insurance. However, H.R. 660 and S. 545 can have many unintended negative consequences. These include: An unlevel playing field, leading to market destabilization and higher rates for sicker individuals; potential AHP insolvencies, resulting in unpaid claims for consumers and providers; unclear regulatory responsibility; unclear directives relating to assessments; and a promise of expense reductions that are unlikely to materialize.

Again, members of the American Academy of Actuaries are available to assist Congress in developing solutions to address the issue of small-employer health insurance reform. If you or your staff would like additional information or assistance, please feel free to contact Holly Kwiatkowski, the Academy's senior health policy analyst (federal), by phone at (202) 223–8196 or by e-mail at kwiatkowski@actuary.org.

Sincerely,

KAREN BENDER,
Chairperson.

Other Academy members contributing to this letter are: Michael S. Abroe, FSA, MAAA; David J. Bahn, FSA, MAAA; Jennifer J. Brinker, FSA, MAAA; Michael L. Burks, MAAA; James E. Drennan, FSA, MAAA, FCA; Richard M. Niemiec, MAAA; Donna C. Novak, ASA, MAAA, FCA; John R. Parsons, MAAA, FCA; John J. Schubert, ASA, MAAA, FCA; David A. Shea, Jr., FSA, MAAA; Mark Wernicke, FSA, MAAA; and Jerome Winkelstein, FSA, MAAA.

U.S. CONGRESS,
CONGRESSIONAL BUDGET OFFICE,
Washington, DC, June 18, 2003.

Hon. GEORGE MILLER,
Senior Democratic Member, Committee on Education and the Workforce,
House of Representatives, Washington, DC.

DEAR CONGRESSMAN: This letter responds to your request of June 17, 2003, for additional information on CBO's estimate of the impact of H.R. 660 on enrollment in the health insurance markets for small employers and self-employed workers. We expect that the effects of the bill would be fully reflected in those markets by 2008, and all of the following numbers refer to that year.

Under current law, CBO estimates that approximately 30.1 million people will be enrolled in health insurance offered by plans in the state-regulated small group insurance market. Under the bill, CBO estimates that combined enrollment in state-regulated plans and association health plans (AHPs) would rise by about 550,000 people to a total of 30.7 million people. Of this, approximately 23.2 million people would retain coverage in the state-regulated market. About 7.5 million people would be enrolled in AHPs, including the additional 550,000 people who would not have been covered by any small-employer plan under current law, and 6.9 million people who would have been covered in the state-regulated market.

The same considerations apply to self-employed people. We estimate that approximately 4.7 million people will be enrolled in

state-regulated coverage purchased by self-employed workers under current law. Under H.R. 660, CBO estimates that combined enrollment through state-regulated insurers and AHPs would rise by about 70,000 people to 4.8 million people. Of this, approximately 3.8 million people would retain state-regulated coverage. About 1.0 million people would obtain coverage through AHPs, including the additional 70,000 people who would not have been insured under current law, and 0.9 million people who would have been covered in the state-regulated market.

If you would like additional information on this estimate, the CBO staff contact is Stuart Hagen, who can be reached at 225–2644.

Sincerely,

DOUGLAS HOLTZ-EAKIN,
Director.

There is a reason that it is not just Democratic Governors but Republican Governors who object to this bill. There is a reason why Democratic and Republican attorneys general object to this bill, why Democratic insurance commissioners and Republican insurance commissioners object to this bill. It does not work. What it does is offer a Faustian bargain, where people give up their guaranteed protection for breast cancer screenings, care for OB-GYN services, care for diabetics. They give that up. They leave it to the whim of the insurance industry. What they get for it is not lower premiums and more people insured, but you get more uninsured.

The actuaries have concluded that 1 million people will be added to the rolls of the uninsured by this bill. Outside experts who do not favor either side in a partisan sense have concluded that 1 million persons will be added to the ranks of the uninsured by this bill. The insurance commissioners, the attorneys general and the Governors of both parties throughout the country do not object to this bill because they have some turf desire to regulate. They object to this bill because it presents an unworkable situation where insurance companies will fail, where creditors will not be paid, where people depending upon insurance will not be insured, and we will have the chaos that we had some years ago under the multiple employer welfare associations.

There is a better way to cover the uninsured. We will debate that better way in just a few minutes in the substitute that the gentleman from Wisconsin and I are putting forward. But we should not add to the ranks of the uninsured. It is our responsibility to offer a better alternative, and we do. But it is the responsibility of this entire House to join with Governors of both parties, 66 chambers of commerce, the National Association of Health Underwriters who perhaps best understand this, insurance regulators, attorneys general, and not turn to a gimmicky, insufficient solution to this problem. I urge defeat of the legislation.

Mr. BOEHNER. Mr. Speaker, I yield myself the balance of my time.

We often have debates here in Congress about public policy and how to change public policy. Many times the debates, once they get here, the perfect becomes the enemy of the good. We do not claim that the underlying bill is going to cover all of the uninsured and eliminate that problem, but we do think it is a giant step forward in helping the uninsured get access to high-quality health insurance at affordable prices.

Even the flawed study that my colleague has pointed to on a number of occasions, the CBO study which was flawed in a number of areas, says that 330,000 of the uninsured will in fact get health insurance. I think the number is far, far higher than that. I think we are talking about millions of Americans will have a chance at good health insurance. But let us say it is only 330,000, 330,000 families that would get coverage under this bill. I think that is a good step in the right direction.

Let me take an example of how this would work. Let us take a Realtor. We all know Realtors work all over the country. They are independent contractors. They have their own business. In many cases they are not employees of the firm that they work for, but they have to go buy an individual policy or family policy in a State insurance pool, the most expensive way to buy health insurance in America. In the case of Realtors, you could take the Ohio Association of Realtors, New Jersey Association of Realtors, maybe the National Association of Realtors, could put together a plan of maybe 5 or 6 choices, maybe 10 choices for their members all over the country. I will guarantee that those Realtors would have much better health insurance policies than they have today and the cost of that policy will be far more competitive than what they are paying in these State insurance pools.

This is a very good opportunity to help many small employers and their employees all across the country. We should not miss this opportunity.

Mr. CANTOR. Mr. Speaker, I rise today in support of three important initiatives we took this week to meet the uninsured crisis head-on and to address the rising costs of health care.

We have a crisis on our hands—over 40 million Americans are without health insurance. In addition, it is becoming increasingly difficult to not only obtain affordable health coverage, but to keep it—especially for America's small businesses.

According to the Associated Builders and Contractors, over 60 percent of the Nation's uninsured are small business employees. Small businesses are the backbone of our economy. We must ensure that we create an environment that allows these businesses access to affordable health care. If we do not address the issue, we will see more and more small businesses stop growing or close their doors. It is imperative, therefore, that we pass legislation creating Association Health Plans and legislation that allows families to roll-over money year-to-year from their Flexible Spending Accounts or into new Health Savings Accounts.

These two pieces of legislation will dramatically improve our Nation's health care climate, especially for small businesses. More individuals and their employers will be able to afford health care; and in turn, we will see the health of Americans improve and the costs of health care decline.

The third piece of legislation addresses America's medical liability crisis. Physicians in Virginia and across the country are being forced to close their doors due to the astronomically rising costs of medical malpractice premiums.

On February 4, 2004, as many as 1,500 physicians from all over my State marched on the Virginia Capitol to make the case for common-sense medical liability from reform in the State legislature. Led by the Medical Society of Virginia, Virginia's White Coat Day march on Richmond was designed to educate state lawmakers on how doctors' skyrocketing malpractice insurance is limiting patients' access to medical care. Outrageous runaway jury awards are causing malpractice premiums to rise uncontrollably,and many doctors are being forced to raise prices or shut their doors. These higher costs are then passed on to working families and small businesses.

Not only should the Virginia legislature address this issue, but we as a Congress need to do the same. We need to take President Bush's lead in ending the jackpot payouts that our legal system encourages.

Mr. Speaker, we must pass these common sense reforms into law in order to help our Nation's uninsured and address the rising costs of health care. These are issues we cannot afford to ignore.

Mr. BLUMENAUER. Mr. Speaker, one of the most frustrating aspects of the way we run Congress today is an interest in scoring political points as opposed to solving problems. Nowhere is that more in evidence than the symbolic political acts surrounding healthcare this week in the House of Representatives.

We are in the midst of a healthcare crisis for the uninsured, for small businesses, and for practitioners. There is a complicated, interconnected fabric that provides healthcare in this country that includes insurance companies, HMO's, public agencies, Federal Government programs and the institutions that represent and train medical professionals. Advocacy groups, legal experts and consumers all have legitimate interests and something to say.

Sadly, the Republican leadership in the House of Representatives continues to be more interested in scoring political points than solving problems. Simply recycling the same flawed legislation, is clearly far less than our best effort and stands little likelihood of passage to the Senate, where similar legislation continues to languish.

These bills would undermine our efforts by insuring only the healthiest and wealthiest, leaving 511,00 uninsured Oregonians and tens of millions of Americans behind. Furthermore, the Association Health Plans proposals would exempt state solvency requirements, leaving the consumers at a significant risk.

If we were able to openly debate these proposals on the floor I know that the healthcare community would be well served because the majority of Congress does not want to short change it or our citizens. Most in Congress do not want to artificially restrict payments and are sincerely interested in making sure that Federal policy does not create or enhance abusive or distorted behaviors.

The most dramatic example would be fixing flawed funding. There is a gusher of money going to items far less important, far less essential to the American public, such as the unaffordable, unnecessary additional tax benefits to those who need help the least. It is time for the vast array of interests represented by the healthcare community and the people vitally dependent upon it to insist that the Republican Leadership stop the games. Everyone should commit to full, fair, honest debate in a more open legislative process. This is the only way we will enact cost effective legislation, and stop the funding abuses. We must stop holding legislation hostage, to another political agenda. I will continue to work with my healthcare community at home along with national groups and organizations to produce the type of process, discussion and legislation Americans critically deserve.

Mr. SANDLIN. Mr. Speaker, with nearly 44 million Americans lacking basic health care coverage, it is time to take action. Today, in a disingenuous public attempt to respond to the crisis of the uninsured, the Republican leadership has decided to spend the valuable time and limited resources of the American taxpayers debating Association Health Plan (AHP) legislation that has already been voted on in the 108th Congress.

The absolute irony, of course, is that instead of strengthening the health of our nation, AHPs will increase the ranks of the uninsured, increase the health insurance costs for small businesses that don't participate in AHPs and destroy consumer protections currently safeguarded by state regulations. Clearly, this is not sound policy.

Why are AHPs so bad? The creation of Association Health Plans will destabilize health insurance markets by forcing the state-regulated market and national AHP market to compete with each other. Few will benefit and most will suffer from this damaging division. Small businesses who choose to stay in the safer, state-regulated health insurance market will see their health insurance premiums skyrocket by 23 percent. The reality is that AHPs can offer lower premiums mainly because they offer fewer benefits—which is attractive to people in good health. With the AHPs siphoning off healther people into their market, state-regulated insurers will be responsible for covering a larger proportion of people with higher health care costs. Rather than risk being spread out and absorbed by many, it is divided, thereby threatening the solvency and accessibility of the state-regulated insurance businesses.

Mr. Speaker, it is clear that Association Health Plans hurt American workers and their families. The lower costs available to small businesses opting into AHPs are simply not worth it when you consider the damaging strings attached. This legislation allows AHPs to pre-empt over 1,000 important state laws that States enacted to protect the basic health care needs of our communities. These laws include critically necessary benefits like mammographies, diabetes care, well-child visits, mental health services, and direct access to OB/GYN and pediatricians. Pre-empting state laws also allows AHPs to redline and re-underwrite insurance for higher risk people, allowing discrimination against consumers and causing insurance premiums to rise.

Employees will be further compromised by the lack of rights afforded to them under their AHP policies. If consumers are denied important healthcare treatment, they will not be allowed an independent external review and/or Consumer Ombudsmen program as state consumer-protection laws regulate. Further, there are very weak protections against insolvency under the AHP program which means small employers, American workers and their families may be burdened with millions of dollars of unpaid claims, which is exactly what health insurance is supposed to insure against.

Finally, Mr. Speaker, it is worth noting that a recent study by Mercer and the National Small Business Association concluded that AHPs would swell the ranks of the uninsured to rise by more than one million people—an increase of 8.5 percent. This is because as premiums for small business employers in the state-regulated market increase, some firms would drop coverage. Further, businesses covered by AHPs might have to drop coverage if they are forced to pay new, higher premiums if someone in their group gets sick.

Mr. Speaker, it's hard to imagine why anyone would vote for such a flawed piece of legislation that would be devastating to American families. Sadly, the answer is clear: The Wall Street Journal recently said that a major business trade organization stands to reap more than $100 million of annual revenue by selling AHP policies if H.R. 4281 is passed. Mr. Speaker, our constituents deserve better than this.

The fact is that there are clear alternatives. Yesterday, I introduced H.R. 4356, the Small Business Health Insurance Promotion Act. This legislation will provide immediate, concrete relief by securing affordable health insurance coverage for millions of self-insured individuals and employees of small businesses.

Mr. Speaker, as an incentive to provide coverage, the Small Business Health Insurance Promotion Act would make small businesses or self-employed individuals eligible to receive a 50 percent tax credit for four years to defray the cost of health insurance. The bill would also authorize funding to create state and national multi-insurer pools to provide comprehensive and affordable health insurance choices to small employers and the self-employed. Regardless of whether a business elected to enter the state or national pool consumers would be guaranteed quality coverage—coverage in each pool must be substantially similar to health benefits coverage offered in any of the four largest health plans in the Federal Employees Health Benefit Program (FEHBP). In this legislation, unlike in AHPs, important consumer protections would be safeguarded, the same coverage available to Members of Congress and other federal employees.

Forget the gimmick. Rather than offering up stale legislation which will hurt—not help—the health of our nation, let's take real action and pass sound coverage policies. Pass the Kind substitute, and take up the Small Business Health Insurance Promotion Act, as well as other new Democratic initiatives like the FamilyCare Act and the Medicare Early Access Act. Together these initiatives could provide health coverage to more than one-half of the 44 million uninsured Americans. Our American families deserve no less.

Mr. STARK. Mr. Speaker, I rise today to oppose H.R. 4281, the ''Small Business Health Fairness Act of 2004.'' This bill would hurt small businesses and patients by increasing the costs of health insurance and the number of uninsured.

If my comments today sound familiar, it is because they are almost exactly the same arguments I made last June, when this exact same bill passed the House. It was a bad idea then, and it is an even worse idea today. During this ''Cover the Uninsured Week'' the Republicans suggest association health plans can cover millions of uninsured Americans. In reality H.R. 4281 would actually add to the nearly 44 million uninsured in this country. This warmed over re-vote is a waste of time and taxpayer resources, and has nothing to do with providing affordable healthcare options to our citizens.

According to recent studies, association health plans would actually increase costs for most small businesses and their employees. Our own Congressional Budget Office has estimated that over 80 percent of small businesses would see increased premium costs under H.R. 4281. Those small employers that currently offer traditional, state-regulated health insurance would see their premiums increase by 23 percent on average. Premiums will increase because AHPs will offer only bare-bones coverage, attracting the healthiest individuals, leaving traditional health insurance plans with the sickest and most expensive patients. This shift would penalize businesses with sicker employees, and make health insurance even more unaffordable for those who need it most.

I am glad to see my Republican friends are concerned about the 43.6 million people in this country who lack health insurance. However, AHPs are not a real solution, and will actually add 1 million people to the continuously growing number of uninsured. As traditional health insurance becomes increasingly expensive, more and more businesses would have no choice but to drop health insurance for their employees, leaving these individuals with little or no opportunity to purchase health coverage.

Not only will this bill increase the number of uninsured, it will blatantly discriminate against small businesses with sicker employees—often those businesses with lower-income and minority workers. Because H.R. 4281 would allow AHPs to avoid state laws against cherry picking, these plans would only offer insurance to small businesses with the healthiest employees. Any premium reductions touted by the bill sponsors—at most a modest 10 percent reduction—would be a direct result of cherry-picking and reduced benefits, not greater efficiency. As healthy people move into AHP's skeletal coverage, sicker people are left without health insurance, increasing the morbidity of the uninsured population by over 12 percent.

Small businesses will not be able to provide more affordable health insurance to their employees under this bill. Although proponents claim that AHPs would give small-employers bargaining power to purchase affordable health insurance, most states already have laws in place that allow for group purchasing arrangements. This bill would harm existing State laws and usurp the traditional role of States to regulate small-employer health insurance.

This bill would also preempt key State provisions that protect millions of insured Americans. For example, many States regulate insurance premiums to prevent insurers from discriminating against the sick. But under this

bill, AHPs could offer extremely-low ''teasers'' rates, and then rapidly increase premiums if the enrollee becomes sick. Many small businesses would find these high rates unaffordable, and would be forced to drop coverage. Furthermore, nearly all States have enacted external review laws, which allow patients to have an independent doctor review a claim that has been denied by the insurer. Patients who join AFPs would lose this right.

Additionally, this legislation would be a setback to government efforts to reign in fraud and abuse. Association health plan exemptions in this bill are nearly identical to those Congress grated to multiple employer welfare arrangements (MEWAs) in the 1970s, which led to widespread fraud and abuse. These exemptions allowed MEWAs to rack up $123 million in unpaid healthcare bills, and prompted the Department of Labor to open 90 fraud and abuse investigations. Congress recognized and corrected this problem, but now my Republican colleagues are ignoring the lessons of the past and are headed right back down the same dangerous road with AHPs.

Finally, this bill would exempt AHPs from state-required benefits, which have helped to ensure that millions of Americans get access to necessary healthcare services. These benefits include mammography screenings, maternity care, well-child care, and prompt payment rules. In my State, California, employees who join AHPs could also lose access to certain emergency services, direct access to OB/GYNs, mental health parity, and other important benefits.

The Democratic substitute offered today by Representatives ANDREWS and KIND is a real solution for providing small-businesses access to affordable health insurance. Using the $50 billion President Bush included in his FY04 budget for the uninsured, this proposal would allow small businesses to buy-into a small employer health benefits plan (SEHBP). Republicans have been stammering for years about giving people the same insurance options as members of Congress and this substitute would do just that. The SEHBP would be substantially similar to the Federal Employers Health Benefits Plan (FEHBP) and millions of uninsured would finally have the same options we have as Members of Congress.

This association health plan bill is bad for patients, bad for small businesses, and bad for states. It is opposed by over 1,000 organizations, including the National Governors Association, local Chambers of Commerce, small business associations, physician organizations, labor unions, and healthcare coalitions. H.R. 4281 would increase premiums, increase the number of uninsured, lead to massive fraud, and remove key state patient protections. I urge my colleagues to reject this legislation.

Mr. JONES of Ohio. Mr. Speaker, I rise today in support of Small Businesses, and I am an advocate of Small Businesses providing quality health insurance to the men, and women, and the families of those who work for them. But, because I oppose H.R. 4281 that does not make me anti-Small Business, just like opposing the war in Iraq does not make one unpatriotic. What it makes me is an advocate for the truth and the facts. And the fact is that these association health plans would be exempt from almost all state consumer protection laws regarding benefits, premiums, and solvency. States are generally the primary regulators of health insurers, and assure appropriate access to health care, and protect against fraudulent marketing schemes. It is no wonder the National Governors Association, the National Conference of State Legislature, and Consumer Unions oppose this legislation. This initiative would allow Associated Health Plans to engage in the cherry picking of the healthiest population nationwide. In Ohio, AHPs would not be required to provide basic mammography screening, direct access to OB–GYN's, mental health services, alcoholism treatment, and vital primary health care. In addition to not providing particular types of services, there would be no limitation on how frequently AHPs could increase an employee's premium to continue coverage. AHPs could then also vary their rates for older or sicker members of their plans. Establishing association health plans will not significantly reduce the number of uninsured Americans. The Congressional Budget Office estimates that while 4.8 million Americans would join association health plans; only 330,000 of them would come form the ranks of those currently uninsured. The remaining 4.5 million would simply switch from an existing health plan to an association health plan. These plans would discriminate against older and sicker Americans, putting an extra burden on those who rely on health plans, and forcing the state to provide coverage for those who may not otherwise find an AHP. I believe governmental authority for regulating AHPs should be clearly specified. Absent this clarification, it is likely that no one will be regulating AHPs, or there will be conflicting regulation. When regulatory authority is unclear, consumers have no place to turn for redress. If is for these reasons that I support Small Business and oppose this bill.

Mrs. BIGGERT. Mr. Speaker, I rise today in support of H.R. 4281, the Small Business Health Fairness Act.

Sixty percent of those who are uninsured are employed. Their employers either cannot afford to offer health insurance, or the premiums are so high, employees cannot afford to pay their share.

When small companies are allowed to band together, they can take advantage of the same economies of scale that large companies have enjoyed for years. The costs of insurance are spread out over a larger pool of individuals. By spreading the cost of insurance among a larger number of employees, we make health insurance affordable for working families.

The Congressional Budget Office has estimated that small businesses that participate in AHPs will save an average of 9 to 25 percent of their healthcare costs. CBO also concluded that AHP legislation would cover up to 2 million uninsured American workers, with no cost to the government.

It is simply not fair that individuals who work for a small business do not have the same access to healthcare that they would if they worked for a large corporation. I am proud to support this fair, common-sense bill and I urge my colleagues to do the same.

Mr. RUPPERSBERGER. Mr. Speaker, I rise in opposition to this bill because it will negatively impact my home state of Maryland. To paraphrase what was in Governor Ehrlich's letter to Chairman BOEHNER, this legislation will undue what the state of Maryland has worked so hard on for the past 10 years.

The rising cost of health care is a concern for all Americans. We need to find ways to make sure that we help people reduce their healthcare cost. We need to find a way to provide insurance for the 44 million Americans without any coverage at all.

Association Health Plans has many benefits such as allowing a group of shared interest businesses and individuals to purchase health insurance at a group rate. However, what we should be working toward is a solution where everyone benefits. One of my concerns with Association Health Plans is one I also have with the prescription drug bill that is law. My concern is that AHP's will be able to skim off the healthiest individuals leaving those most in need without coverage. Also, the legislation would allow the AHP's to not comply with state health mandates.

I would be more supportive of tax credits for businesses to purchase health insurance and also allow for states to establish insurance pools like we have in Maryland. Again, we need to make sure the states and businesses have the tools to address this issue. We cannot have a forced federal mandate that will hurt what the state of Maryland has already done.

The SPEAKER pro tempore (Mr. SIMPSON). All time for debate on the bill has expired.

AMENDMENT IN THE NATURE OF A SUBSTITUTE OFFERED BY MR. KIND

Mr. KIND. Mr. Speaker, I offer an amendment in the nature of a substitute.

The SPEAKER pro tempore. The Clerk will designate the amendment in the nature of a substitute.

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

Part B amendment in the nature of a substitute printed in House Report 108–484 offered by Mr. KIND:

Strike all after the enacting clause and insert the following:

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the ''Small Employer Health Benefits Program Act of 2004''.

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

SEC. 2. ESTABLISHMENT OF SMALL EMPLOYER HEALTH BENEFITS PROGRAM (SEHBP).

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

''PART 8—SMALL EMPLOYER HEALTH BENEFITS PROGRAM (SEHBP)

''SEC. 801. ESTABLISHMENT OF PROGRAM.

''(a) IN GENERAL.—The Secretary shall establish, in accordance, with this part, a program under which—

''(1) qualifying small employers (as defined in subsection (b)) are provided access to qualifying health insurance coverage (as defined in subsection (c)) for their employees, and

''(2) such employees may elect alternative forms of coverage offered by various health insurance issuers.

''(b) QUALIFYING SMALL EMPLOYER DEFINED; OTHER DEFINITIONS.—For purposes of this part:

''(1) QUALIFYING SMALL EMPLOYER.—

''(A) IN GENERAL.—The term 'qualifying small employer' means a small employer (as defined in paragraph (2)) that—

''(i) elects to offer health insurance coverage provided under this part to each employee who has been employed by that employer for 3 months or longer; and

''(ii) elects, with respect to an employee electing coverage under qualified health insurance coverage, to pay at least 50 percent of the total premium for qualifiing health insurance coverage provided under this part.

''(B) ELECTIONS.—Elections under sub paragraph (A) may be filed with the Secretary during the 180-day period beginning with the first enrollment period occurring under section 803 and during open enrollment periods occurring thereafter under such section. Such elections shall be filed in such form and manner as shall be prescribed by the Secretary.

''(C) PART-TIME EMPLOYMENT.—Under regulations of the Secretary, in the case of an employee serving in a position in which service is customarily less than 1,500 hours per year, the reference in subparagraph (A) (ii) to '50 percent' shall be deemed a percentage reduced to a percentage that bears the same ratio to 50 percent as the number of hours of service per year customarily in such position bears to 1,500.

''(2) SMALL EMPLOYER.—The term 'small employer' means, with respect to a year under the program, an employer who employed an average of fewer than 100 employees on business days during the preceding calendar year and who employs at least 1 employee on the first day of such year under the program.

''(3) SEHBP.—The term 'SEHBP' means the small employer health benefits program provided under this part.

''(c) QUALIFYING HEALTH INSURANCE COVERAGE.—For purposes of this part, the term 'qualifying health insurance coverage' means health insurance coverage that meets the following requirements:

''(1) The coverage is offered by a health insurance issuer.

''(2) The benefits under such coverage are equivalent to or greater than the lower level of benefits provided under the service benefit plan described in section 8903(1) of title 5, United States Code.

''(3) The coverage includes, with respect to an employee that elects coverage, coverage of the same dependents that would be covered if the coverage were offered under FEHBP.

''(4) (A) Subject to subparagraph (B), there is no underwriting, through a preexisting condition limitation, differential benefits, or different premium levels, or otherwise, with respect to such coverage for covered employees or their dependents.

''(B) The premiums charged for such coverage are community-rated for employees within any State and may vary only—

''(i) by individual or family enrollment, and

''(ii) to the extent permitted under the laws of such State relating to health insurance coverage offered in the small group market, on the basis of geography.

''(d) OTHER TERMS.—

''(1) HEALTH INSURANCE COVERAGE; HEALTH INSURANCE ISSUER; HEALTH STATUS-RELATED FACTOR.—The terms 'health insurance coverage', 'health insurance issuer', 'health status-related factor' have the meanings provided such terms in section 733.

''(2) SMALL GROUP MARKET.—The term 'small group market' has the meaning provided such term in section 2791(e)(5) of the Public Health Service Act (42 U.S.C. 300gg–91(e)(5)).

''(3) FEHBP.—The term 'FEHBP' means the Federal Employees Health Benefits Program under chapter 89 of title 5, United States Code.

''(e) TREATMENT OF PARTNERSHIPS AND SELF-EMPLOYED INDIVIDUALS.—For purposes of this part, and for purposes of applying section 3 to this part and to part 5 as it applies to this part, in any case in which qualifying health insurance coverage is, or is to be, provided under a plan, fund, or program to individuals covered thereunder—

''(1) if such plan, fund, or program is maintained by 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

''(2) if such plan, fund, or program is maintained by 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.

"SEC. 802. CONTRACTS WITH QUALIFYING INSURERS.

''(a) IN GENERAL.—The Secretary shall enter into contracts with health insurance issuers for the offering of qualifying health insurance coverage under this part in the States in such manner as to offer coverage to employees of employers that elect to offer coverage under this part. Nothing in this part shall be construed as requiring the Secretary to enter into arrangements with all such issuers seeking to offer qualifying health insurance coverage in a State.

''(b) CONTINUED REGULATION.—Nothing in this part shall be construed as preempting State laws applicable to health insurance issuers that offer coverage under this part in such State.

''(c) COORDINATION WITH STATE INSURANCE COMMISSIONERS.—The Secretary shall coordinate with the insurance commissioners for the various States in establishing a process for handling and resolving any complaints relating to health insurance coverage offered under this part, to the extent necessary to augment processes otherwise available under State law.

"SEC. 803. ADDITIONAL CONDITIONS.

''(a) LIMITATION ON ENROLLMENT PERIODS.—The Secretary may limit the periods of times during which employees may elect coverage offered under this part, but such election shall be consistent with the elections permitted for employees under FEHBP and shall provide for at least annual open enrollment periods and enrollment at the time of initial eligibility to enroll and upon appropriate changes in family circumstances.

''(b) AUTHORIZING USE OF STATES IN MAKING ARRANGEMENTS FOR COVERAGE.—In lieu of the coverage otherwise arranged by the Secretary under this part, the Secretary may enter an arrangement with a State under which a State arranges for the provision of qualifying health insurance coverage to qualifying small employers in such manner as the Secretary would otherwise arrange for such coverage.

''(c) USE OF FEHBP MODEL.—The Secretary shall carry out the SEHBP using the model of the FEHBP to the extent practicable and consistent with the provisions of this part, and, in carrying out such model, the Secretary shall, to the maximum extent practicable, negotiate the most affordable and substantial coverage possible for small employers.

"SEC. 804. DISSEMINATION OF INFORMATION.

''The Secretary shall widely disseminate information about SEHBP through the media, the Internet, public service announcements, and other employer and employee directed communications.

"SEC. 805. SUBSIDIES.

''(a) EMPLOYER SUBSIDIES.—

''(1) ENROLLMENT DISCOUNT.—

''(A) IN GENERAL.—In the case of a qualifying small employer who is eligible under subparagraph (B), the portion of the total premium for coverage otherwise payable by such employer under this part shall be reduced by 5 percent. Such reduction shall not cause an increase in the portion of the total premium payable by employees.

''(B) EMPLOYERS ELIGIBLE FOR DISCOUNTS.—A qualifying small employer is eligible under this subparagraph if such employer employed an average of fewer than 25 employees on business days during the preceding calendar year.

''(2) EMPLOYER PREMIUM SUBSIDY.—

''(A) IN GENERAL.—The Secretary shall provide to qualifying small employers who. are eligible under subparagraph (C) and who elect to offer health insurance coverage under this part a subsidy for premiums paid by the employer for coverage of employees whose individual income (as determined by the Secretary) is at or below 200 percent of the poverty line (as defined in section 673(2) of the Community Services Block Grant Act (42 U.S.C. 9902(2)), including any revision required by such section) for an individual.

''(B) SUBSIDY SCALED ACCORDING TO SIZE OF EMPLOYER.—The subsidy provided under subparagraph (A) shall be designed so that the subsidy equals, for any calendar year—

''(i) 50 percent of the portion of the premium payable by the employer for the coverage, in the case of eligible qualifyng small employers who employ an average of fewer than 11 employees on business days during the preceding calendar year;

''(ii) 35 percent of the portion of the premium payable by the employer for the coverage, in the case of eligible qualifying small employers who employ an average of more than 10 employees but fewer than 26 employees on business days during the preceding calendar year; and

''(iii) 25 percent of the portion of the premium payable by the employer for the coverage, in the case of eligible qualifying small employers who employ an average of more than 25 employees but fewer than 51 employees on business days during the preceding calendar year.

''(C) EMPLOYERS ELIGIBLE FOR PREMIUM SUBSIDY.—A qualifying small employer is eligible under this subparagraph if such employer employed an average of fewer than 50 employees on business days during the preceding calendar year.

''(b) EMPLOYEE SUBSIDIES.—

'' (1) IN GENERAL.—The Secretary shall provide subsidies to employees of qualifying small employers in any case in which the family income of the employee (as determined by the Secretary) is at or below 200 percent of the poverty line (as defined in section 673(2) of the Community Services Block Grant Act (42 U.S.C. 9902(2)), including any revision required by such section) for a family of the size involved.

''(2) AMOUNT OF SUBSIDY.—Such subsidies shall be in an amount equal to the excess of the portion of the total premium for coverage otherwise payable by the employee under this part for any period, over 5 percent of the family income (as determined under paragraph (1) (A)) of the employee for such period.

''(3) COORDINATION OF SUBSIDIES.—Notwithstanding paragraph (1), under regulations of the Secretary, an employee may be entitled to subsidies under this subsection for any period only if such employee is not eligible for

subsidies for such period under any Federal or State health insurance subsidy program (including a program under title V, XIX, or XXI of the Social Security Act). For purposes of this paragraph, an employee is 'eligible' for a subsidy under a program if such employee is entitled to such subsidy or would, upon filing application therefore, be entitled to such subsidy.

''(4) AUTHORITY TO EXPAND ELIGIBILITY.—The Secretary may, to the extent of available funding, provide for expansion of the subsidy program under this subsection to employees whose family income (as defined by the Secretary) is at or below 300 percent of the poverty line (as determined under paragraph (1)).

''(c) LIMITATIONS.—For purposes of this section—

''(1) RESTRICTIONS ON TREATMENT OF EMPLOYMENT RELATIONSHIP.—Section 801(e) shall not apply.

''(2) REQUIREMENT OF MULTIPLE EMPLOYEES.—A small employer shall not be treated as a qualifying small employer with respect to an applicable year unless the employer employs at least 2 employees on the first day of such year.

''(d) PROCEDURES.—The Secretary shall establish by regulation applications, methods, and procedures for carrying out this section, including measures to ascertain or confirm levels of income.

''SEC. 806. AUTHORIZATION OF APPROPRIATIONS.

''There are authorized to be appropriated, for the period beginning with fiscal year 2005 and ending with fiscal year 2014, $50,000,000,000 to carry out this part, including the establishment of subsidies under section 805.''.

(b) REPORT ON OFFERING NATIONAL HEALTH PLANS.—Not later than 18 months after the date of the enactment of this Act, the Secretary of Labor shall report to Congress the Secretary's recommendations regarding the feasibility of offering national health plans under part 8 of subtitle B of title I of the Employee Retirement Income Security Act of 1974, as added by subsection (a).

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

''PART 8—SMALL EMPLOYER HEALTH BENEFITS PROGRAM (SEHBP)

''Sec. 801. Establishment of program.
''Sec. 802. Contracts with qualifying insurers.
''Sec. 803. Additional conditions.
''Sec. 804. Dissemination of information.
''Sec. 805. Subsidies.
''Sec. 806. Authorization of appropriations.''.

The SPEAKER pro tempore. Pursuant to House Resolution 638, the gentleman from Wisconsin (Mr. KIND) and the gentleman from Ohio (Mr. BOEHNER) each will control 30 minutes.

The Chair recognizes the gentleman from Wisconsin (Mr. KIND).

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

Mr. Speaker, first of all I want to recognize the gentleman from New Jersey for the fine work and the leadership that he has shown on such an important issue. This is an important issue.

It has been said that the definition of insanity is doing the same thing over and over again without any change in the result. Yet that is what we have been having this week in Congress, bills that have already been debated and deliberated upon and voted upon last year coming back again for another kick at the can, which is fine. In an issue as important as this, I think it is important for the Congress to take a moment and start talking about the plight of small businesses and family farmers across the country who are suffering under rising health care costs and fearful of the inability of being able to provide coverage for their families or their employees because of the cost of insurance today.

This is such a fundamental and crucial issue if we want to be serious about economic growth, if we want to be concerned about the 43-million-plus uninsured that exist in this country. As I travel through my congressional district in western Wisconsin meeting with small business owners and their employees, meeting with family farmers, the number one, chief concern that they continuously raise is the expensive health care and accessing the quality system that exists in this country right now on an affordable basis.

It is a travesty that 20 percent of my dairy farmers in Wisconsin have no health coverage at all for themselves or their families, one of the more dangerous occupations in the entire country. It is a travesty that as I talk to small business owners who would like nothing better than to provide some health coverage for their employees, tell me that they cannot because they cannot afford it. In a country as great and as powerful and as wealthy as ours, we have got to do better and we have to get serious.

What we are about to talk about in the remaining minutes of the duration of this debate is there is a better way. The gentleman from New Jersey and I have drafted a substitute to what is being offered before the House today. It is one based in common sense, in reality in regards to what will work and what will not, what will extend coverage to the uninsured and what will not; what will bring more affordability to the health care system, to these small business owners, their employees and to our family farmers, and what will not.

Our bill is very simple. It is based on the Federal Employee Health Plan. It does establish national purchasing pools but it goes through State-licensed insurers so we do not have Federal preemption of State law over such crucial areas as cancer screening, whether it is mammograms, breast cancer, cervical cancer screenings, whether it is emergency care or maternity care, issues that the States have wrestled with with themselves and found it important enough to pass law on a State-to-State basis to provide coverage for these important services. And also to cover autism health care. I am proud that the State of Wisconsin is one of 17 that does mandate the coverage of autism health care for our citizens in the State, one that is exploding right now and very expensive for society. Health care experts and those affected by autism, those families of autistic children, realize that the key to effective treatment is early identification. If we allow this AHP plan to pass, which preempts State law, that says, hey, insurers, you don't have to provide coverage even though the State of Wisconsin says this is the right policy to do, it is only going to exacerbate the system in this country in regard to effective autistic treatment for children in our communities.

That is what this debate is all about. It is a very simple, commonsense approach to dealing with what is a national crisis and, I view, a national emergency.

Rather than offering a piece of legislation where the American Academy of Actuaries, where Mercer has released a study indicating that it would increase rather than decrease the rolls of the uninsured by 1 million people, our substitute version that provides national purchasing options, that provides subsidy payments to employers with 50 or fewer employees in order to keep those health care premiums down and our ability to potentially extend health care coverage to the 43 million uninsured to an additional 33 million Americans, we think this is the best approach to take. This is not an issue about who supports small business or family farmers more or who is more concerned about the plight of the uninsured. This is about what will work and what will not work. That is why we have the National Governors Association, the Republican and Democratic Governors Association, the National Association of Attorneys General and Insurance Commissioners, over 1,000 organizations including 66 chambers of commerce who are saying that the majority AHP plan will not work. Not because they desire some power grab and to maintain their own State regulations, but because it is based on reality and an independent and objective study of what will and what will not work.

That is why I would hope that my colleagues, before they ultimately make up their mind and cast their vote today, that they have a chance to quickly look at the actuary study, to quickly look at the Mercer study and to pause before we embark upon a road that could potentially lead to another million uninsured in our society. Enough is enough.

□ 1500

We need to be going in the opposite direction rather than where I fear the AHP bill would go. The substitute that the gentleman from New Jersey (Mr. ANDREWS) and I are offering offers that hope and that potential to achieve that, and I would encourage my colleagues to support the substitute, vote ''no'' on the AHP bill, and let us move forward together on something that has the potential of working very well for small businesses and family farmers throughout the country.

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

Mr. BOEHNER. Mr. Speaker, I yield 2 minutes to the gentleman from Nebraska (Mr. OSBORNE), one of the active members of our committee.

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

Mr. Speaker, I represent a district that is entirely rural and has nothing but small businesses in it. The number one complaint that I hear is about the cost of health insurance. These businesses employ more employees than all of the other industries in the country. They are the driving force behind it; and more and more of these individuals, as has been mentioned in the previous debate, are simply having to reduce or eliminate their health care coverage because it is going up 15, 20 percent every year and they simply cannot afford it.

I would like to give one personal example. I have a son-in-law who is managing a small franchise company, has 130 franchises in roughly 30, 40 States, and he says that this is the number one priority they have as far as health insurance, that if they could have an association of health plans, this would certainly cut their costs and enable them to maintain their health insurance at the present level.

So I realize that there are some problems with some of the States; but from my perspective and from what I have heard, I would say this is certainly a good bill. I appreciate the authors of the substitute. I think they are thoughtful people. I am sure they have done a good job at doing their homework, but at this point I would certainly have to oppose the substitute and support the underlying bill.

Mr. KIND. Mr. Speaker, I yield 3 minutes to the gentlewoman from the Virgin Islands (Mrs. CHRISTENSEN), a true champion of small business owners and their employees.

Mrs. CHRISTENSEN. I thank the gentleman for yielding me this time.

Mr. Speaker, this is Insure the Uninsured Week, and for me as a physician and Chair of the Health Brain Trust of the Congressional Black Caucus, ensuring health coverage to everyone is a priority every day.

And so I want to be very clear that I rise in strong support of providing small businesses and their employees access to high-quality health insurance that is truly affordable. That is why I oppose H.R. 4281, the Association Health Plan bill, and support the Kind-Andrews substitute.

We in the minority caucuses have spent a great deal of time looking at the issue of insurance, of how we can allow small business associations to come together to pool their purchasing power to buy quality health coverage at the lowest possible cost. We examined the AHPs. I did not originally sign on to the bill, but after a closer look at what it would do and as a physician who understands how important it is to do no harm, I removed my name from what I consider a harmful bill.

In H.R. 4281, the base bill, AHPs would be exempt from State insurance regulations and consumer protections. They would increase health care costs for most small business employees, cause premiums to rise for those outside of the AHP market, and eventually not lower, but increase, the number of uninsured in small business firms.

While AHP supporters will insist that this will not happen, by removing these important protections, the major harm this bill can do is too great a risk to take. We are talking about workers' health; we are talking about their lives. There is a better way to provide this insurance which will not harm, and that is the Kind-Andrews substitute. It would establish an employer health benefit plan similar to the Federal employees' health benefits, which would contract with state-licensed health insurers to offer an insurance package for employees of businesses of fewer than 100 employees.

Unlike the underlying bill, this better Democratic substitute will keep these small employer plans subject to State health insurance and consumer regulations and protections. It would provide small businesses and their employees access to high-quality health coverage; and by ensuring that the risk is spread, that everyone is included, not keeping sicker employees out, it keeps it truly affordable.

As a member of the Committee on Small Business since coming to this Congress, I am for helping small businesses. This substitute does that. H.R. 4281 will not.

I urge my colleagues to join the more than 150 organizations, including all of the prominent civil rights organizations, in opposing H.R. 4281. Instead, I urge them to vote for the Kind-Andrews substitute. Let us make sure we cover this important group who are over 60 percent of all the uninsured; and above all, let us do no harm.

Mr. BOEHNER. Mr. Speaker, I yield 2 minutes to the gentleman from Oklahoma (Mr. SULLIVAN).

Mr. SULLIVAN. Mr. Speaker, I would like to commend the gentleman from Ohio (Chairman BOEHNER) for his hard work on this very important legislation.

I rise in support of this commonsense legislation which will deliver quality health care to millions of Oklahomans. One of the greatest challenges the State of Oklahoma faces is our uninsured population. With 650,000 uninsured, Oklahoma ranks fourth in the number of uninsured across the country. This is a shocking statistic, an unacceptable situation; and today I am proud to take action to fix this problem.

Association Health Plans will allow small businesses to group together with their national trade associations to utilize their collective buying power when dealing with large insurance companies. AHPs will bring quality health care to Oklahomans covering specific diseases, maternal and newborn hospitalization, and mental health. With the enactment of this legislation, up to 8.5 million uninsured Americans will gain coverage immediately.

Nationwide, 44 million Americans are uninsured; and 60 percent of those uninsured are employed by small businesses who will benefit. AHPs will cut an average of 13 percent, up to 25 percent, off insurance premiums.

This is smart legislation that will bring better health care to American families. It is time that 5th Avenue benefits find their way to shops on Main Street. I urge my colleagues to support this legislation.

Mr. KIND. Mr. Speaker, I yield 3 minutes to the gentleman from Arkansas (Mr. ROSS), an expert in the health care field and one who does not want to embark upon a course of adding an additional 1 million people to the uninsured ranks.

Mr. ROSS. Mr. Speaker, in America we have 44 million people today without health insurance. We are the only industrialized nation in the world where people go without health insurance. And who are they? It is the folks that are trying to do the right thing and work. Unfortunately, they are working jobs with no benefits.

Nearly 80 percent of the uninsured are the working poor and often work in small businesses. They have jobs and are trying to do the right thing, but cannot afford a policy, an insurance policy, for themselves or for their families.

Each weekend as I go back home to Arkansas, I meet more and more small business owners, and I understand this because my wife and I are small business owners. We provide health insurance for our employees back home. And just as it is for us, I learn it is for so many small business owners across this Nation. They are struggling to be able to continue to afford the premiums, not only for their employees but for themselves as well.

Association Health Plans, quite frankly, are not the answer. It would do little to help the 44 million uninsured Americans. In fact, Mercer Consulting analyzed the Association Health Plans proposal and found that the number of the uninsured would increase by over 1 million as a result of coverage losses among workers in small firms and their dependents.

I support the Kind substitute that truly addresses the problem of the uninsured in this country. It is fully paid for. It will not preempt State law, and it offers meaningful and immediate help to small businesses.

The substitute legislation would create a Small Employer Health Benefits Plan similar to the Federal Employee Health Benefit Plan and would offer coverage to all small businesses with fewer than 100 workers.

This legislation works with existing State laws and does not preempt State laws regarding health care coverage.

Also, this legislation goes far beyond vague words and empty promises and actually commits Federal funds to aid small businesses in offering insurance to its employees by offering to help subsidize the cost of insurance for small businesses to the tune of 50 percent of the cost of the premiums.

I urge my colleagues to support the Kind substitute and oppose H.R. 4281.

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

I believe that the underlying bill does, in fact, address the needs of many of our uninsured, and I am concerned about the substitute that we have before us. And I know that the gentleman from Wisconsin (Mr. KIND) and the gentleman from New Jersey (Mr. ANDREWS), my good friends from the committee, have worked hard on this. But I have to take issue with the comment that was just said that this commits the Congress to spend money. It does not.

There is a $50 billion price tag on the substitute that we have before us, and all we do here is authorize it. It still has to go through the entire appropriation process, no guarantee that it is going to be appropriated; but even more troubling is that the substitute that is being offered would allow the Secretary of Labor to set up this national risk pool, but they would still be subject to every state-mandated benefit in each of the States, over 1,500 state-mandated benefits from one coast to the next. And on top of that, even if the Congress were to appropriate the money and the Secretary were to set up the plan, employers would still have to pay 50 percent of the premium cost, and they would have to cover every employee who was there as little as 3 months.

If we begin to look at how this plan would work, I think that the Members will find that it would actually be cheaper for those companies to get health insurance in their own States without this national bureaucracy.

But even more disturbingly, when we look at this substitute, it will not cover any of the self-employed individuals across the country, and whether they be Realtors, whether they be salesmen of some sort, small business people who operate by themselves, the self-employed, no coverage under this plan. Unlike under the underlying plan where if these self-employed people belong to some association, some State association, national association, local association, they would, in fact, be able to work through their associations to get high-quality coverage at competitive prices.

There has been a lot said about who is supporting the underlying bill and who is opposing the underlying bill. I have got pages and pages here of national associations and State associations that are supporting the underlying bipartisan bill. And I would remind my colleagues that this is the fourth time we have had this bill on the floor in the last 8 years, still waiting for the other body to deal with it. All three times previously that this bill has been on the floor, it has passed with broad bipartisan majorities, and I would suspect today we will see the same benefit.

Mr. Speaker, I include in the RECORD the list of companies and associations that are supporting the underlying bill.

GROUPS SUPPORTING AHPS

Adhesive and Sealant Council
Air Conditioning Contractors of America
American Alliance of Service Providers
American Association of Advertising Agencies
American Association of Engineering Societies
American Association of Small Property Owners
American Composites Manufacturers Association
American Concrete Pumping Association
American Council of Engineering Companies
American Disc Jockey Association
American Electronics Association
American Furniture Manufacturers Association
American Institute of Chemical Engineers
American International Automobile Dealers Association
American Hotel and Lodging Association
American Lighting Association
American Nursery and Landscape Association
American Rental Association
American Road and Transportation Builders Association
American Small Businesses Association
American Society of Association Executives
American Society of Civil Engineers
American Society of Home Inspectors
American Society of Mechanical Engineers, Board on Member Interests & Development
American Textile Machinery Association
American Veterinary Medical Association
American Wholesale Marketers Association
AOMALLIANCE
Archery Trade Association
Associated Builders and Contractors
Associated General Contractors of America
Associated Prevailing Wage Contractors, Inc.
Association for Manufacturing Technology
Association of California Water Agencies
Association of Equipment Manufacturers
Association of Independent Maryland Schools
Association of Ship Brokers and Agents
Association of Suppliers to the Paper Industry
Automotive Aftermarket Industry Association
Automotive Aftermarket Association Southeast
Automotive Service Association
Automotive Undercar Trade Organization
Automotive Wholesalers Association of New England
Automotive Wholesalers Association of Texas
California Motor Car Dealers Association
California Society of CPAs
California/Nevada Automotive Wholesalers Association
Center for New Black Leadership
Central Service Association
Chesapeake Automotive Business Association
Cleveland Automobile Dealers Association
Club Managers Association of America
Christian Schools International
Coca Cola Bottlers Association
Communicating for Agriculture
Consumer Specialty Products Association
Deep South Equipment Dealers Association
Electronics Representatives Association Insurance Trust
Far West Equipment Dealers Association
Farm Equipment Manufacturers Association
Financial Executives International
Financial Planning Association
First Health Group Corporation
Food Marketing Institute
GrassRoots Impact
Hearth, Patio and Barbecue Association
Hispanic Business Roundtable
Independent Electrical Contractors
Independent Office Products & Furniture Dealers Association
Independent Stationers, Inc.
Institute of Electrical and Electronics Engineers—United States of America
International Association of Professional Event Photographers
International Foodservice Distributors Association
International Franchise Association
Iowa Automobile Dealers Association
Iowa-Nebraska Equipment Dealers Association
The Latino Coalition
Mason Contractors Association
Material Handling Equipment Distributors Association (MHEDA)
Metal Manufacturers' Education and Training Alliance
Midwest Automotive Industry Association
Midwest Equipment Dealers Association
NAMM, the International Music Products Association
National Association for the Self-Employed
National Association of Chemical Distributors
National Association of Community Health Centers
National Association of Convenience Stores
National Association of Home Builders
National Association of Manufacturers
National Association of Plumbing-Heating-Cooling Contractors
National Association of Realtors
National Association of Theatre Owners
National Association of Wholesaler-Distributors
National Association of Women Business Owners
National Automobile Dealers Association
National Black Chamber of Commerce
National Burglar and Fire Alarm Association
National Cattlemen's Beef Association
National Club Association
National Concrete Masonry Association
National Council of Agricultural Employers
National Federation of Independent Business
National Franchisee Association
National Funeral Directors Association
National Lumber and Building Material Dealers Association
National Newspaper Association
National Office Products Alliance
National Paint and Coating Association
National Portable Storage Association
National Precast Concrete Association
National Rental Association
National Retail Federation
National Restaurant Association
National Roofing Contractors Association
National Spa and Pool Institute
National Society of Accountants
National Society of Professional Engineers
National Sporting Goods Association
National Tile Contractors Association
National Tooling & Machining Association
National Utility Contractors Association
Nebraska New Car and Truck Dealers Association
New Mexico Automotive Parts and Service Association
New York State Automotive Aftermarket Association
North American Die Casting Association

North American Equipment Dealers Association
North American Retail Dealers Association
North Dakota Automobile and Implement Dealers Association
Northeastern Retail Lumber Association
Office Furniture Dealers Alliance
Ohio Valley Automotive Aftermarket Association
Outdoor Industry Association
Piano Technicians Guild
Precision Machine Products Association
Precision Metalforming Association
Printing Industries of America
Printing Industries of Maryland
Process Equipment Manufacturers' Association
Professional Golfers' Association of America
Professional Photographers of America
Retailers Bakery Association
Service Station Dealers of America and Allied Trades
Self Insurance Institute of America
Small Business Survival Committee
Specialty Equipment Market Association (SEMA)
Society of American Florists
Society of the Plastics Industry
Society of Professional Benefit Administrators
Southern Equipment Dealers Association
Southeastern Equipment Dealers Association
Southeastern Farm Equipment Dealers Association
Southwestern Association
Snack Food Association
Student Photographic Society
Textile Rental Services Association of America
The Association Healthcare Coalition
Timber Operators Council Management Services
Timber Products Manufacturers Association
Tire Industry Association
U.S. Chamber of Commerce
U.S. Hispanic Chamber of Commerce
U.S. Pan Asian America Chamber of Commerce
Vermont Automobile Dealers Association
Virginia Bankers Association
Washington Area New Automobile Dealers Association
Western Growers Association
Women Impacting Public Policy
Wisconsin Automobile & Truck Dealers Association

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

Mr. KIND. Mr. Speaker, I yield myself 30 seconds.

With all due respect to the chairman of our committee, and I have great respect and admiration for him and I think he is well motivated with this underlying bill, but our bill does, in fact, cover self-employed. Under the definition of what constitutes an employer, an individual who is self-employed would also be covered. So I just wanted to clarify the record in that regard.

Mr. Speaker, I yield such time as he may consume to the gentleman from New Jersey (Mr. ANDREWS), the co-author of our substitute bill before us.

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

□ 1515

Mr. ANDREWS. Mr. Speaker, I would like to begin by thanking my coauthor, the gentleman from Wisconsin (Mr. KIND), for what has now been more than a year of hard work on this effort, a very practical, commonsense solution that would not have been possible without him; and I thank him for his effort.

It is important to understand how this proposal works. If a small employer, and we define that as an employer with 100 or fewer employees, chooses, only if he or she chooses, they may enroll their employees in a plan that would operate similarly to the Federal Employees Health Benefit Plan. It would create the largest purchasing pool of small businesses ever in the history of the country. It would achieve the economies of scale that the majority attempts to achieve in the underlying bill. But there are some important differences.

The first difference is that we believe our plan would in fact save money for that employer. In my home State, a small business pays about $12,000 or $13,000 a year to insure an employee and his or her family. The average cost under the Federal Employees Health Benefit Plan is slightly over $9,000. We believe a similar price reduction would occur by the option of joining this plan.

Secondly, under our plan, for very small employers, those with 25 and under, they would receive a 5 percent premium discount. That is to say, their premium would only be 95 percent of the premium paid by the others in the pool.

Thirdly, very small employers with a lot of low-income employees, those who are most likely to be uninsured, are offered additional subsidies that are drawn from the budget resolution passed by the majority. This fits within the majority's budget resolution.

So the first important difference is our version, our plan, would add to the rolls of the insured rather than subtracting from it the way the majority's plan would.

Second, under our plan, none of the protections that people enjoy, the right to a mammogram, the right to women's health services, the right to mental health services, guaranteed under State laws around the country, none of those rights would be lost or forfeited under our plan.

Third, the risks of insolvency, unpaid creditors, uninsured insurers that the majority's plan proposes, would be avoided here, because you would have a large plan under the regulatory jurisdiction of the Federal Government that would be solvent and would be prepared to meet its obligations because it is properly regulated.

This is a commonsense idea. We believe in pooling as well. Frankly, I think that the majority has half of a good idea. The idea of permitting small employers to pool their employees to get a better deal from the health insurance marketplace is a very good idea. The problem is that the majority's plan also includes the repeal and forfeiture of protections like mammogram coverage, like diabetic care, like women's health services; and that is both unnecessary and undesirable.

Second, the majority's plan does not include any subsidies or special incentives for small business. A lot of small businesses in my State, even if you dropped the price of the coverage from $12,000 to $11,000 or $10,000, could still not afford it. It does not do them any good.

Our plan, unlike the majority plan, puts some subsidy into this in the form of premium discounts for very small employers and even deeper discounts for small employers who hire many, many lower-compensated employees.

We have said a lot of critical things about the majority's plan because we believe they are right; but we also understand, Mr. Speaker, it is our responsibility to put forward a positive alternative. The work that the gentleman from Wisconsin (Mr. KIND) has done, that I am proud to join in, is such a positive alternative. It would offer real benefits in a meaningful way for the small business community of the country.

I would urge my colleagues to vote for its adoption.

Mr. BOEHNER. Mr. Speaker, I am pleased to yield 3 minutes to the gentleman from Pennsylvania (Mr. PETERSON).

Mr. PETERSON of Pennsylvania. Mr. Speaker, I thank the chairman for yielding me time.

Mr. Speaker, let us put some competition into the marketplace. We just have a proposal now that says we will have a government-subsidized program, and we all know where that will take us. The taxpayers will pay and pay.

Here is the problem: 50 percent of America has one insurer. That means you have a monopoly, and that is where we are getting 20, 30, and 40 percent increases annually, and businesses are straining. But when you only have one insurer, the new pharmacy plan, we have guaranteed everybody two. But in health care, over half of America have one.

Associated Health Plans would, I think, change the marketplace dramatically, because you would bring lots of competition to the marketplace. The monopolies would no longer rule. A lot of other companies that are not monopolies do not want health care either. Why? It is going to be competition. Whenever America is successful, we bring competition into the marketplace.

Yes, those monopolies are leaving community rating; yes, they are cherry-picking today. And State mandates are part of the problem, because 50 States have different mandates and we guarantee everybody gets a Cadillac plan. That means a lot of people cannot afford a plan at all, because you only can deliver a Cadillac plan. That is the system we have.

In rural areas, where monopolies exist, businesses, individuals and governments pay measurably more for

health insurance than neighboring counties. In my district, I have school districts and counties who will pay $650 for a family plan. Two counties away they pay $1,100 for the same insurance coverage under the current system. Why? Because there is no competition there.

Now, the hospitals, the doctors and providers under these monopolies get paid less too, because they have no bargaining power with the big insurance giants that are the monopolies.

The current system will change dramatically with Associated Health Plans, because, for the first time, all parts of America will have many people who they can purchase insurance from. Yes, maybe if I am a restaurateur, I will be part of a national restaurant association who has a plan tailored for restaurants.

I was a supermarket operator for 26 years. I probably, if I were back in that business, would have a plan that works well for super markets. But when you put them all in the same box, you put all kinds of employers in the same box, as we currently do with State mandates.

Let us give our businesses and our government service agencies choices. Let us give them Associated Health Plans, not another government-subsidized program. But let us turn the competitiveness of American ingenuity, and we will solve the uninsured problem in this country.

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

Mr. Speaker, again, this debate really is about two very distinct and different options: one that, again, through independent analysis and review, indicates could lead to an increase of 1 million more uninsured in this country, as opposed to the substitute that the gentleman from New Jersey (Mr. ANDREWS) and I are offering today; one that is based on reality and supported by a host of organizations throughout the Nation, including the Governors Association, the Attorneys General, and the insurance commissioners, those who work with this on a day-to-day basis and see the real impact it is having on real people in their individual States.

Our plan is simple. It also talks about establishing a national purchasing pool, but one working with state-licensed insurers, so we do not preempt State law and the judgment being made by State legislatures and local decisionmakers on what is or is not appropriate health care coverage in that particular State.

I am proud of many of the coverages that the State of Wisconsin has chosen to include under the State regulations. I am also proud of the fact that the State legislature and Governor are signing into law and setting up model programs of this purchasing pool concept in Wisconsin, allowing small business owners and family farmers to join cooperatives with a menu of health options, but under State regulation, not exempting them and not preempting what the State has already done.

I have a feeling that that is going to work, and work very well, if the demand that exists from back home is any indication of the desire to enter into these pilot programs.

That is the identical version that the gentleman from New Jersey (Mr. ANDREWS) and I are offering and talking about today, allowing this purchasing pool concept to go forward under State law, so that important health care services and screening does not get preempted and lead to a diminution in the quality of care that citizens in States have come to expect and desire.

Why is this important? 44 million uninsured is a travesty and a blemish on our national character. It gets to the real root and basis of us and what we are all about as a Nation. Being able to access quality and affordable health care is something that affects all of us, from businesses large and small, from individuals to small business owners, to farmers, to us here in Congress; and the fear we see in constituents' eyes back home when they know they do not have health coverage for their families and their children, it is real.

And when they do not have coverage and they do get sick or they do get hurt, they still are able to access the health care system, just through more expensive means, typically through the emergency door. And those costs then are shifted on to private plans that do have coverage, which contributes to the rising premium expenses that are sweeping the Nation today.

So I think it is in our fundamental national interest to do what we can to make sure that the 43 million or 44 million currently uninsured receive coverage, so we have better preventive care up front, so the children of our Nation have a way to access the health care system, which can save us money and pay dividends in the long run.

I think this is an objective that we share in a bipartisan fashion, but it is one that I think can better be achieved through the Kind-Andrews substitute.

It is paid for within the budget resolution that the majority party has passed in this session of Congress. It does offer premium support payments to employees with 50 or fewer employees, because the gentleman from New Jersey (Mr. ANDREWS) is correct, even if we have some savings in premium expenses, your average small business employer probably is still prohibited from being able to access an insurance pool and being able to pick up the expense and providing coverage for their employees.

We are saying we can do better by offering them some of this premium price assistance to make it more affordable and to create the incentives so we have small business owners who I believe want desperately to be able to provide coverage, to be in a position to better afford that type of coverage.

This is what we need to try to achieve. This should be a dream we all hold in this Congress. Because unless and until we fix this fundamental flaw in the health care system in our country, we are not going to see the robust job growth that we desperately need today. We are not going to see businesses, either large or small, anxious for additional hires for fear of incurring the additional health care expense. I think it is one of the reasons why we have not seen the explosion of job growth over the last couple of years, even though the administration has been fond of pointing to expanding economic conditions in this country. It is the health care system, and it needs to be addressed.

I think we desperately need to do it, and I think we have the opportunity today to make a significant step in that direction.

I would encourage my colleagues to vote ''no'' on the majority Associated Health Plan and support a real plan that can work for real Americans, the Kind-Andrews substitute.

Mr. Speaker, I yield back the balance of my time.

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

Mr. Speaker, I have great respect for my two committee colleagues, the gentleman from Wisconsin (Mr. KIND) and the gentleman from New Jersey (Mr. ANDREWS), and their thoughtful approach to bringing their substitute to the floor.

As the gentleman from Wisconsin (Mr. KIND) pointed out, there are some similarities here. We both create large pools of small employers in order to increase their purchasing power so that they can go into the marketplace like a large company or union and get as good a quality plan at a competitive price. But once you get beyond the big picture, that we are creating large pools in both the substitute and the underlying bill, there are a few differences.

The first difference I would say is that the underlying bill allows the private sector to create those large pools. Whether they be State associations, national associations, whatever, they will in fact create their own pools, while the substitute offered by the gentleman from Wisconsin (Mr. KIND) and the gentleman from New Jersey (Mr. ANDREWS) has the government creating this large pool.

Now, we all know when the government gets involved, it is just a matter of time before the government begins to believe, well, we have this large pool, we have got employers signed up in it, maybe we ought to require them to do X or Y or Z. I do not think anyone wants to take that risk.

Secondly, I would point out that the substitute pool will cost $50 billion of taxpayer funds in order to set up and to provide subsidies, while the underlying bill has no Federal taxpayer money involved in it in any way, shape, or form.

I am a big believer that we need to do something to reach out to help the uninsured gain better access to high-quality, affordable health insurance. I

think the underlying bill does it. It has passed on a broad bipartisan basis on a number of occasions here in the House. I urge my colleagues here today to reject the Kind-Andrews substitute and support the underlying bill.

Mr. HOLT. Mr. Speaker, I rise in support of the substitute legislation offered by Mr. KIND and Mr. ANDREWS and in opposition to H.R. 4281.

Across this great nation, over 40 million people continue to lack adequate health insurance coverage. This is a problem that merits immediate Congressional action.

Moreover, small businesses across my district in central New Jersey come to me all the time, telling me how difficult it is to continue providing health care to their employees. I am glad that so many of them believe in providing good benefits to their workers, but I know they are really hurting.

Unfortunately, the House leadership is more interested in scoring political points than in helping small businesses continue to provide quality health care for their employees. The very fact that we are poised to pass a bill that is virtually identical to what we did here last June is a clear indication that we are here to play partisan games, not to find a real solution.

I hope my colleagues do not believe the hype we're hearing today. H.R. 4281 is not a realistic way to help small businesses with their health care costs.

It looks like a good idea at first glance. Under this bill, small businesses could join together to form ''associations'' that will leverage their collective buying power to get lower-cost health insurance for their employees.

I certainly support the concept of companies working together collectively to control costs. It's an idea that has worked within individual states.

That is why I urge my colleagues to vote for the Kind-Andrews substitute. This legislation commits actual federal funds—the $50 billion allocated in the budget—to form Small Employer Health Benefit plans similar to our oft-cited Federal Employee Health Benefit plans. This would create a realistic, workable way for small businesses to use their collective buying power to lower costs and increase coverage.

Kind-Andrews would expand coverage for the uninsured and will help small businesses deal with the rising costs of insuring their employees. Moreover, it is fully paid for and will not preempt state law, maintaining the kind of minimum benefit levels that ensure quality coverage for beneficiaries and their dependents.

H.R. 4281, on the other hand, expands ERISA to preempt state law. States have traditionally taken the lead on insurance regulation, and they have implemented rules to protect beneficiaries and ensure minimum coverage levels. This bill would allow AHPs to avoid all of these regulations.

Most states require that any health plan cover some basic items such as mammograms, contraception, prostate cancer screenings, and many mental health services. H.R. 4281 would allow ''associations'' to avoid having to offer these basic benefits, to the detriment of policyholders.

For example, under this bill, I could create a plan that covers nothing but ingrown toenail surgery. It would certainly be the cheapest plan out there, but how much would it actually help beneficiaries?

Several of my colleagues and I tried to amend H.R. 660, the first iteration of the bill before us, in both subcommittee and full committee to ensure that AHPs would indeed have minimum benefit requirements. I offered one amendment requiring parity between physical and mental health benefits and another requiring coverage for oral contraception. Despite the fact that these common-sense minimum requirements are law in a number of states, my amendments were shot down by the majority.

So we're still left with a bill that brings a real possibility of the creation of comically inadequate health plans, which is rather disturbing.

What's even more alarming is the effect that this legislation will have on the overall health care environment.

The danger is, of course, cherry-picking. While AHPs may work well to help insure generally healthy, young people, the sickest of our population—those most in need of health care coverage—will be left with higher premiums. What kind of an effect will this have on our current health care environment? Could this actually take us farther away from covering the uninsured in this country? One study, in fact, said that AHPs would actually cause premiums to rise for the vast majority of small businesses and their employees.

Here's another important question. Exactly how many of the uninsured would get coverage from these new types of AHPs? CBO has estimated that about 8.5 million people might get coverage through the types of plans proposed under H.R. 4281. That sounds pretty good—until you realize that only 620,000 of them would come from the ranks of the uninsured, while the other 7.9 million would be in firms switching from traditional coverage. That means we'd be extending coverage to a miniscule fraction of the uninsured in this country.

The bottom line is that more than forty million Americans lack health insurance—a serious crisis that needs to be addressed. But H.R. 4281 won't do much good, and could very well make a bad situation even worse.

I urge my colleagues to oppose H.R. 4281 and vote for the Kind-Andrews substitute.

Ms. WOOLSEY. Mr. Speaker, as we once again celebrate Cover the Uninsured Week, I rise to support a sensible legislative proposal that will do just that: Cover the Uninsured.

I know that I've heard from constituents who wish they had the opportunity to purchase the same kind of high quality health insurance that we enjoy as Federal Employees. And they are right. The Federal Employee Health Benefits Program is an excellent model for effective health care coverage.

That's why I rise to proudly support the Kind-Andrews Substitute, which would give small businesses and their employees the opportunity to purchase coverage similar to ours.

The Small Employer Health Benefits Program created by this substitute would not ask employees to sacrifice the guaranteed coverage and protections provided by State law.

Small businesses and their employees would have real health coverage that provides them with access to the care they need—not sham insurance that serves only those who are healthy.

We've talked a great deal about how to expand health coverage to the uninsured this week, and I urge my colleagues to support their words with action by supporting this sensible substitute.

Mr. BOEHNER. Mr. Speaker, I yield back the balance of my time.

□ 1530

The SPEAKER pro tempore (Mr. LATOURETTE). Pursuant to House Resolution 638, the previous question is ordered on the bill and on the amendment by the gentleman from Wisconsin (Mr. KIND).

The question is on the amendment in the nature of a substitute offered by the gentleman from Wisconsin (Mr. KIND).

The question was taken; and the Speaker pro tempore announced that the noes appeared to have it.

Mr. KIND. Mr. Speaker, on that I demand the yeas and nays.

The yeas and nays were ordered.

The vote was taken by electronic device, and there were—yeas 193, nays 224, not voting 16, as follows:

[Roll No. 172]

YEAS—193

Abercrombie
Ackerman
Alexander
Allen
Andrews
Baca
Baird
Baldwin
Ballance
Becerra
Bell
Berkley
Berman
Berry
Bishop (GA)
Bishop (NY)
Blumenauer
Boswell
Boucher
Boyd
Brady (PA)
Brown (OH)
Brown, Corrine
Capps
Capuano
Cardin
Cardoza
Carson (IN)
Chandler
Clay
Clyburn
Conyers
Cooper
Costello
Crowley
Cummings
Davis (AL)
Davis (CA)
Davis (FL)
Davis (IL)
Davis (TN)
DeFazio
Delahunt
DeLauro
Deutsch
Dicks
Dingell
Doggett
Dooley (CA)
Doyle
Edwards
Emanuel
Engel
Eshoo
Etheridge
Evans
Farr
Fattah
Frank (MA)
Frost
Gephardt
Gonzalez
Gordon
Green (TX)
Grijalva
Gutierrez
Harman
Hastings (FL)
Hill
Hinchey
Hinojosa
Hoeffel
Holden
Holt
Honda
Hooley (OR)
Hoyer
Inslee
Jackson (IL)
Jackson-Lee (TX)
Jefferson
John
Johnson, E. B.
Jones (OH)
Kanjorski
Kaptur
Kennedy (RI)
Kildee
Kilpatrick
Kind
Kleczka
Lampson
Langevin
Lantos
Larsen (WA)
Larson (CT)
Lee
Levin
Lewis (GA)
Lipinski
Lofgren
Lowey
Lucas (KY)
Lynch
Maloney
Markey
Marshall
Matheson
Matsui
McCarthy (MO)
McCarthy (NY)
McCollum
McDermott
McGovern
McNulty
Meehan
Meek (FL)
Meeks (NY)
Menendez
Michaud
Millender-McDonald
Miller (NC)
Miller, George
Mollohan
Moore
Moran (VA)
Murtha
Nadler
Napolitano
Neal (MA)
Oberstar
Obey
Olver
Ortiz
Owens
Pallone
Pascrell
Pastor
Payne
Pelosi
Peterson (MN)
Pomeroy
Price (NC)
Rahall
Rangel
Rodriguez
Ross
Rothman
Roybal-Allard
Ruppersberger
Rush
Ryan (OH)
Sabo
Sánchez, Linda T.
Sanchez, Loretta
Sanders
Sandlin
Schakowsky
Schiff
Scott (VA)
Serrano
Sherman
Skelton
Slaughter
Smith (WA)
Snyder
Solis
Spratt
Stark
Stenholm
Strickland
Stupak
Tanner
Tauscher
Taylor (MS)
Thompson (CA)
Thompson (MS)
Tierney
Towns
Turner (TX)
Udall (CO)
Udall (NM)
Van Hollen
Visclosky
Waters
Watson
Watt
Waxman
Weiner
Wexler
Woolsey
Wu
Wynn

NAYS—224

Akin	Gerlach	Nussle
Bachus	Gibbons	Osborne
Baker	Gilchrest	Ose
Ballenger	Gillmor	Otter
Barrett (SC)	Gingrey	Oxley
Bartlett (MD)	Goode	Paul
Barton (TX)	Goodlatte	Pearce
Bass	Goss	Pence
Beauprez	Granger	Peterson (PA)
Bereuter	Graves	Petri
Biggert	Green (WI)	Pickering
Bilirakis	Greenwood	Pitts
Bishop (UT)	Gutknecht	Platts
Blackburn	Hall	Pombo
Blunt	Harris	Porter
Boehlert	Hart	Portman
Boehner	Hastings (WA)	Pryce (OH)
Bonilla	Hayes	Putnam
Bonner	Hayworth	Quinn
Bono	Hefley	Radanovich
Boozman	Hensarling	Ramstad
Bradley (NH)	Herger	Regula
Brady (TX)	Hobson	Rehberg
Brown (SC)	Hoekstra	Renzi
Brown-Waite, Ginny	Hostettler	Reynolds
	Houghton	Rogers (AL)
Burgess	Hunter	Rogers (KY)
Burns	Hyde	Rogers (MI)
Burr	Isakson	Rohrabacher
Burton (IN)	Issa	Ros-Lehtinen
Buyer	Istook	Royce
Calvert	Jenkins	Ryan (WI)
Camp	Johnson (CT)	Ryun (KS)
Cannon	Johnson (IL)	Saxton
Cantor	Johnson, Sam	Schrock
Capito	Jones (NC)	Sensenbrenner
Carson (OK)	Keller	Sessions
Carter	Kelly	Shaw
Case	Kennedy (MN)	Shays
Castle	King (IA)	Sherwood
Chabot	King (NY)	Shuster
Chocola	Kingston	Simmons
Coble	Kirk	Simpson
Cole	Kline	Smith (MI)
Collins	Knollenberg	Smith (NJ)
Cox	Kolbe	Smith (TX)
Cramer	Kucinich	Souder
Crane	LaHood	Stearns
Crenshaw	Latham	Sullivan
Cubin	LaTourette	Sweeney
Culberson	Leach	Tancredo
Cunningham	Lewis (CA)	Taylor (NC)
Davis, Jo Ann	Lewis (KY)	Terry
Davis, Tom	Linder	Thomas
DeLay	LoBiondo	Thornberry
Diaz-Balart, L.	Lucas (OK)	Tiahrt
Diaz-Balart, M.	Manzullo	Tiberi
Doolittle	McCotter	Toomey
Dreier	McCrery	Turner (OH)
Duncan	McHugh	Upton
Dunn	McIntyre	Velázquez
Ehlers	McKeon	Vitter
Emerson	Mica	Walden (OR)
English	Miller (FL)	Walsh
Everett	Miller (MI)	Wamp
Feeney	Miller, Gary	Weldon (FL)
Ferguson	Moran (KS)	Weldon (PA)
Flake	Murphy	Weller
Foley	Musgrave	Whitfield
Forbes	Myrick	Wicker
Fossella	Neugebauer	Wilson (NM)
Franks (AZ)	Ney	Wilson (SC)
Frelinghuysen	Northup	Wolf
Gallegly	Norwood	Young (AK)
Garrett (NJ)	Nunes	Young (FL)

NOT VOTING—16

Aderholt	Hulshof	Scott (GA)
Deal (GA)	Israel	Shadegg
DeGette	Majette	Shimkus
DeMint	McInnis	Tauzin
Filner	Nethercutt	
Ford	Reyes	

ANNOUNCEMENT BY THE SPEAKER PRO TEMPORE

The SPEAKER pro tempore (Mr. LATOURETTE) (during the vote). Members are advised 2 minutes remain in this vote.

□ 1554

Ms. VELÁZQUEZ and Mr. SAXTON changed their vote from ''yea'' to ''nay.''

So the amendment in the nature of a substitute was rejected.

The result of the vote was announced as above recorded.

Stated for:

Mr. FILNER. Mr. Speaker, on rollcall No. 172, I was attending to official business in my Congressional District, and I missed the vote. Had I been present, I would have voted ''yea.''

The SPEAKER pro tempore. The question is on engrossment and third reading of the bill.

The bill was ordered to be engrossed and read a third time, and was read the third time.

MOTION TO RECOMMIT OFFERED BY MRS. MC CARTHY OF NEW YORK

Mrs. MCCARTHY of New York. Mr. Speaker, I offer a motion to recommit.

The SPEAKER pro tempore. Is the gentlewoman opposed to the bill?

Mrs. MCCARTHY of New York. Yes, I am, Mr. Speaker.

The SPEAKER pro tempore. The Clerk will report the motion to recommit.

The Clerk read as follows:

Ms. MCCARTHY of New York moves to recommit the bill H.R. 4281 to the Committee on Education and the Workforce with instructions to report the same back to the House forthwith with the following amendment:

Page 13, insert after line 7 the following:

''(e) PROTECTION OF EXISTING GROUP HEALTH PLAN COVERAGE.—

''(1) IN GENERAL.—The requirements of this section are not met with respect to an association health plan if—

''(A) during the 1-year period preceding the date of the enactment of the Small Business Health Fairness Act of 2004, any participating employer of the plan maintained another group health plan providing a type of coverage described in paragraph (2), and

''(B) such association health plan does not provide such type of coverage.

''(2) TYPES OF COVERAGE.—A type of coverage is described in this paragraph if it consists of—

''(A) coverage for breast cancer screening and tests recommended by a physician,

''(B) coverage for the expenses of pregnancy and childbirth,

''(C) coverage for well child care, or

''(D) direct access to those obstetric or gynecological services which are provided by the plan.

''(3) PREDECESSORS AND CONTROLLED GROUPS.—For purposes of this subsection, a predecessor of an employer or any member of the employer's controlled group shall be treated as the employer. For purposes of this paragraph, the term 'controlled group' means any group treated as a single employer under subsection (b), (c), (m), or (o) of section 414 of the Internal Revenue Code of 1986.

Mrs. MCCARTHY of New York (during the reading). Mr. Speaker, I ask unanimous consent that the motion to recommit be considered as read and printed in the RECORD.

The SPEAKER pro tempore. Is there objection to the request of the gentlewoman from New York?

There was no objection.

The SPEAKER pro tempore. The gentlewoman is recognized for 5 minutes on her motion.

Mrs. MCCARTHY of New York. Mr. Speaker, this motion to recommit is very simple. The motion ensures that the bill does not preempt State regulations regarding coverage for breast cancer, pregnancy and childbirth, and well-child OB/GYN services.

Mr. Speaker, this bill, the National Republican Governors Association, the Democratic Governors Association, they are all against it. Forty-one State Attorneys General are against it. There is a reason for that, going back many years ago, when the insurance companies were not giving health care insurance to those that would carry it.

Mr. Speaker, this bill undermines health care legislation in 48 States, including New York. As patients and advocates across the Nation quickly discovered that their basic health care needs were not being served by their insurance companies, they demanded the State step in and protect them.

Mr. Speaker, 48 States responded overwhelmingly and gave basic health care to their citizens. Today, we are undermining the State's efforts. Today, we are saying that basic health care does not matter.

As a nurse, my policy is ''first do no harm.'' Mr. Speaker, this bill does harm to millions of patients across the country. Mr. Speaker, a reduction in health insurance in any form is a reduction in health care. It is just that simple.

Almost every State has recognized the need to cut down the cost of health care and still provide basic health care to their citizens. The States know that without guaranteeing basic health care patients will not get the health care they desperately need. They will only seek help when they are very sick, thus requiring much more expensive medical care for their diseases, putting their lives and the lives of their children at risk.

Let us just look at what it would mean for breast cancer, which is so high in New York State.

According to the American Cancer Society, over 211,000 new cases of breast cancer will be diagnosed in the United States this year. In my State of New York, there will be 2,000 new cases of breast cancer diagnosed alone. Breast cancer is a fatal, but eminently treatable, disease. However, early detection is the key to proper treatment of the disease.

Mammogram screenings are essential for the early detection of cancer. Timely screening can prevent approximately 15 to 30 percent of all deaths from breast cancer among women over the age of 40. Currently, New York and 48 States require insurance companies to cover mammogram screenings. However, under this bill associated health plans would be exempt from having to provide this critical benefit. This amendment would at least prevent a reduction of health care services to those who already have this benefit.

Preserving the coverage of mammogram screenings will help save the lives of our wives, our mothers, and

their daughters. I urge all of my colleagues to vote ''no,'' and as I said earlier, the National Association of Governors, Democratic Governors, Republican Governors are against this legislation.

Mr. Speaker, I yield the balance of my time to my colleague, the gentlewoman from Wisconsin (Ms. MCCOLLUM).

Ms. MCCOLLUM. Mr. Speaker, I am pleased to join the gentlewoman from New York (Mrs. MCCARTHY) in offering this motion to recommit.

To protect the health benefits that women and children currently have today, we must not allow association health plans to deny necessary care for women and their children.

This motion to recommit stops association health plans from refusing to cover state-mandated health benefits for well-child care visits and maternity coverage or other types of care that is vital to our families. Children deserve a healthy start in life.

In Minnesota and 30 other States, children are guaranteed regular visits to their pediatricians to get the necessary care they deserve. Well-child care ensures that children get the vaccinations and immunizations that they need to protect themselves from preventable diseases like measles and mumps.

Regular doctor visits for newborns are absolutely critical. Thirty-three children are born every day with severe hearing loss. If caught early through preventative doctor visits, we can make a positive difference in the lives of our children, and we can save future dollars spent on special education.

Having early access to adequate health care can prevent illness, identify disabilities and reduce future health costs.

The motion we are offering ensures that families who have health coverage that protects the health of women and children today will not lose it tomorrow.

Today, we should be considering legislation to ensure quality comprehensive health care for our Nation's working families, not cutting basic benefits.

I urge my colleagues to support the motion to recommit and to protect important State laws that protect the health of women and children.

□ 1600

Mr. BOEHNER. Mr. Speaker, I rise in opposition to the motion to recommit.

Mr. Speaker, AHPs that would self-insure are exempted from State insurance mandates exactly like large company plans and union plans all over the country. We all know that health insurance mandates drive up the cost of health insurance. When the cost of health insurance goes up for small employers, it is their employees who lose coverage.

The underlying bill attempts to help the 44 million Americans who do not have health insurance have a better chance of getting health insurance. And small employers, just because of their size, should not be denied the right to group together to get a better-quality product at a more competitive price for their employees.

I urge my colleagues to reject the motion to recommit, the same motion to recommit this House rejected last year, and to support the underlying bill.

Mr. Speaker, I yield back the balance of my time.

The SPEAKER pro tempore (Mr. LATOURETTE). Without objection, the previous question is ordered on the motion to recommit.

There was no objection.

The SPEAKER pro tempore. The question is on the motion to recommit.

The question was taken; and the Speaker pro tempore announced that the noes appeared to have it.

RECORDED VOTE

Mrs. MCCARTHY of New York. Mr. Speaker, I demand a recorded vote.

A recorded vote was ordered.

The SPEAKER pro tempore. Pursuant to clause 8 of rule XX, this 15-minute vote on the motion to recommit will be followed by 5-minute votes on the question of passage, if ordered, the motion to suspend the rules and pass House Joint Resolution 91, and adoption of House Concurrent Resolution 414.

The vote was taken by electronic device, and there were—ayes 196, noes 218, not voting 19, as follows:

[Roll No. 173]

AYES—196

Abercrombie
Ackerman
Alexander
Allen
Andrews
Baca
Baird
Baldwin
Ballance
Becerra
Bell
Berkley
Berman
Berry
Bishop (GA)
Bishop (NY)
Blumenauer
Boswell
Boucher
Boyd
Brady (PA)
Brown (OH)
Brown, Corrine
Capps
Capuano
Cardin
Cardoza
Carson (IN)
Carson (OK)
Chandler
Clay
Clyburn
Conyers
Cooper
Costello
Cramer
Crowley
Cummings
Davis (AL)
Davis (CA)
Davis (FL)
Davis (IL)
Davis (TN)
DeFazio
Delahunt
DeLauro
Deutsch
Dicks
Dingell
Doggett
Dooley (CA)
Doyle
Edwards
Emanuel
Engel
Eshoo
Etheridge
Evans
Farr
Fattah
Ford
Frank (MA)
Frost
Gephardt
Gonzalez
Gordon
Green (TX)
Grijalva
Gutierrez
Harman
Hastings (FL)
Hill
Hinchey
Hinojosa
Hoeffel
Holden
Holt
Honda
Hooley (OR)
Hoyer
Inslee
Jackson (IL)
Jackson-Lee (TX)
Jefferson
John
Johnson, E. B.
Jones (OH)
Kanjorski
Kaptur
Kennedy (RI)
Kildee
Kilpatrick
Kind
Kleczka
Kucinich
Lampson
Langevin
Lantos
Larsen (WA)
Larson (CT)
Lee
Levin
Lewis (GA)
Lipinski
Lofgren
Lowey
Lucas (KY)
Lynch
Maloney
Markey
Marshall
Matheson
Matsui
McCarthy (MO)
McCarthy (NY)
McCollum
McDermott
McGovern
McIntyre
McNulty
Meek (FL)
Meeks (NY)
Menendez
Michaud
Millender-McDonald
Miller (NC)
Miller, George
Mollohan
Moore
Moran (VA)
Murtha
Nadler
Napolitano
Neal (MA)
Oberstar
Obey
Olver
Ortiz
Owens
Pallone
Pascrell
Pastor
Payne
Pelosi
Peterson (MN)
Pomeroy
Price (NC)
Rangel
Rodriguez
Ross
Rothman
Roybal-Allard
Ruppersberger
Rush
Ryan (OH)
Sabo
Sánchez, Linda T.
Sanchez, Loretta
Sanders
Sandlin
Schakowsky
Schiff
Scott (VA)
Serrano
Sherman
Skelton
Slaughter
Smith (WA)
Snyder
Solis
Spratt
Stark
Stenholm
Strickland
Stupak
Tanner
Tauscher
Taylor (MS)
Thompson (CA)
Thompson (MS)
Tierney
Towns
Turner (TX)
Udall (CO)
Udall (NM)
Van Hollen
Visclosky
Waters
Watson
Watt
Waxman
Weiner
Wexler
Woolsey
Wu
Wynn

NOES—218

Akin
Bachus
Baker
Ballenger
Barrett (SC)
Bartlett (MD)
Barton (TX)
Bass
Beauprez
Bereuter
Biggert
Bilirakis
Bishop (UT)
Blackburn
Blunt
Boehlert
Boehner
Bonilla
Bonner
Bono
Boozman
Bradley (NH)
Brady (TX)
Brown (SC)
Brown-Waite, Ginny
Burgess
Burns
Burr
Burton (IN)
Buyer
Calvert
Camp
Cannon
Cantor
Capito
Carter
Case
Castle
Chabot
Chocola
Coble
Cole
Collins
Cox
Crane
Crenshaw
Cubin
Culberson
Cunningham
Davis, Jo Ann
Davis, Tom
DeLay
Diaz-Balart, L.
Diaz-Balart, M.
Doolittle
Dreier
Duncan
Dunn
Ehlers
Emerson
English
Everett
Feeney
Ferguson
Flake
Foley
Forbes
Fossella
Franks (AZ)
Frelinghuysen
Gallegly
Garrett (NJ)
Gerlach
Gibbons
Gilchrest
Gillmor
Gingrey
Goode
Goodlatte
Goss
Graves
Green (WI)
Greenwood
Gutknecht
Hall
Harris
Hart
Hastings (WA)
Hayes
Hayworth
Hefley
Hensarling
Herger
Hobson
Hoekstra
Hostettler
Houghton
Hunter
Hyde
Isakson
Issa
Istook
Jenkins
Johnson (CT)
Johnson (IL)
Johnson, Sam
Jones (NC)
Keller
Kelly
Kennedy (MN)
King (IA)
King (NY)
Kingston
Kirk
Kline
Knollenberg
Kolbe
LaHood
Latham
LaTourette
Leach
Lewis (CA)
Lewis (KY)
LoBiondo
Lucas (OK)
Manzullo
McCotter
McCrery
McHugh
McKeon
Mica
Miller (FL)
Miller (MI)
Miller, Gary
Moran (KS)
Murphy
Musgrave
Myrick
Neugebauer
Ney
Northup
Norwood
Nunes
Nussle
Osborne
Ose
Otter
Oxley
Paul
Pearce
Pence
Peterson (PA)
Petri
Pickering
Pitts
Platts
Pombo
Porter
Portman
Pryce (OH)
Putnam
Quinn
Radanovich
Rahall
Ramstad
Regula
Rehberg
Renzi
Reynolds
Rogers (AL)
Rogers (KY)
Rogers (MI)
Rohrabacher
Ros-Lehtinen
Royce
Ryan (WI)
Ryun (KS)
Saxton
Schrock
Sensenbrenner
Sessions
Shaw
Shays
Sherwood
Shuster
Simmons
Simpson
Smith (NJ)
Smith (TX)
Souder
Stearns
Sullivan
Sweeney
Tancredo
Taylor (NC)
Terry
Thomas
Thornberry
Tiahrt
Tiberi
Toomey
Turner (OH)
Upton
Velázquez
Vitter
Walden (OR)
Walsh
Wamp
Weldon (FL)
Weldon (PA)
Weller
Whitfield
Wicker
Wilson (NM)
Wilson (SC)
Wolf
Young (AK)
Young (FL)

NOT VOTING—19

Aderholt
Deal (GA)
DeGette
DeMint
Filner
Granger

Hulshof
Israel
Linder
Majette
McInnis
Meehan
Nethercutt
Reyes
Scott (GA)
Shadegg
Shimkus
Smith (MI)
Tauzin

ANNOUNCEMENT BY THE SPEAKER PRO TEMPORE

The SPEAKER pro tempore (Mr. LATOURETTE) (during the vote). Members are advised 2 minutes remain in this vote.

□ 1620

So the motion to recommit was rejected.

The result of the vote was announced as above recorded.

Stated for:

Mr. FILNER. Mr. Speaker, on rollcall No. 173, I was attending to official business in my Congressional District, and I missed the vote. Had I been present, I would have voted ''aye''.

The SPEAKER pro tempore. The question is on the passage of the bill.

The question was taken; and the Speaker pro tempore announced that the ayes appeared to have it.

Mr. CARDIN. Mr. Speaker, on that I demand the yeas and nays.

The yeas and nays were ordered.

The SPEAKER pro tempore. This will be a 5-minute vote.

The vote was taken by electronic device, and there were—yeas 252, nays 162, answered ''present'' 1, not voting 18, as follows:

[Roll No. 174]

YEAS—252

Akin
Bachus
Baker
Ballenger
Barrett (SC)
Bartlett (MD)
Barton (TX)
Bass
Beauprez
Bell
Bereuter
Biggert
Bilirakis
Bishop (GA)
Bishop (UT)
Blackburn
Blunt
Boehlert
Boehner
Bonilla
Bonner
Bono
Boozman
Boucher
Bradley (NH)
Brady (TX)
Brown (SC)
Brown-Waite, Ginny
Burgess
Burns
Burr
Burton (IN)
Buyer
Calvert
Camp
Cannon
Cantor
Capito
Carson (OK)
Carter
Case
Castle
Chabot
Chocola
Clay
Clyburn
Coble
Cole
Collins
Cooper
Costello
Cox
Cramer
Crane
Crenshaw
Cubin
Culberson
Cunningham
Davis (AL)
Davis (TN)
Davis, Jo Ann
Davis, Tom
DeLay
Diaz-Balart, L.
Diaz-Balart, M.
Dooley (CA)
Doolittle
Dreier
Duncan
Dunn
Edwards
Ehlers
Emerson
English
Everett
Feeney
Ferguson
Flake
Foley
Forbes
Fossella
Franks (AZ)
Frelinghuysen
Frost
Gallegly
Garrett (NJ)
Gerlach
Gibbons
Gilchrest
Gillmor
Gingrey
Gonzalez
Goode
Goodlatte
Goss
Graves
Green (WI)
Greenwood
Gutknecht
Hall
Harman
Harris
Hart
Hastings (WA)
Hayes
Hayworth
Hefley
Hensarling
Herger
Hobson
Hoekstra
Hostettler
Houghton
Hunter
Hyde
Isakson
Issa
Istook
Jackson-Lee (TX)
Jefferson
Jenkins
John
Johnson (CT)
Johnson (IL)
Johnson, E. B.
Johnson, Sam
Jones (NC)
Keller
Kelly
Kennedy (MN)
King (IA)
King (NY)
Kingston
Kirk
Kline
Knollenberg
Kolbe
LaHood
Latham
LaTourette
Leach
Lewis (CA)
Lewis (KY)
Linder
Lipinski
LoBiondo
Lucas (KY)
Lucas (OK)
Manzullo
Marshall
Matheson
McCotter
McCrery
McHugh
McIntyre
McKeon
Mica
Miller (FL)
Miller (MI)
Miller, Gary
Moran (KS)
Moran (VA)
Murphy
Musgrave
Myrick
Neugebauer
Ney
Northup
Nunes
Nussle
Osborne
Ose
Otter
Oxley
Paul
Pearce
Pence
Peterson (MN)
Peterson (PA)
Petri
Pickering
Pitts
Platts
Pombo
Porter
Portman
Pryce (OH)
Putnam
Quinn
Radanovich
Rahall
Ramstad
Regula
Rehberg
Renzi
Reynolds
Rogers (AL)
Rogers (KY)
Rogers (MI)
Rohrabacher
Ros-Lehtinen
Rothman
Royce
Ryan (WI)
Ryun (KS)
Saxton
Schrock
Sensenbrenner
Sessions
Shaw
Shays
Sherwood
Shuster
Simmons
Simpson
Smith (NJ)
Smith (TX)
Snyder
Souder
Stearns
Stenholm
Sullivan
Sweeney
Tancredo
Taylor (MS)
Taylor (NC)
Terry
Thomas
Thompson (MS)
Thornberry
Tiahrt
Tiberi
Toomey
Turner (OH)
Turner (TX)
Upton
Velázquez
Vitter
Walden (OR)
Walsh
Wamp
Weldon (FL)
Weldon (PA)
Weller
Whitfield
Wicker
Wilson (NM)
Wilson (SC)
Wolf
Wynn
Young (AK)
Young (FL)

NAYS—162

Abercrombie
Ackerman
Alexander
Allen
Andrews
Baca
Baird
Baldwin
Ballance
Becerra
Berkley
Berman
Berry
Bishop (NY)
Blumenauer
Boswell
Boyd
Brady (PA)
Brown (OH)
Brown, Corrine
Capps
Capuano
Cardin
Cardoza
Carson (IN)
Chandler
Conyers
Crowley
Cummings
Davis (CA)
Davis (FL)
Davis (IL)
DeFazio
Delahunt
DeLauro
Deutsch
Dicks
Dingell
Doggett
Doyle
Emanuel
Engel
Eshoo
Etheridge
Evans
Farr
Fattah
Ford
Frank (MA)
Gephardt
Gordon
Green (TX)
Grijalva
Gutierrez
Hastings (FL)
Hill
Hinchey
Hinojosa
Hoeffel
Holden
Holt
Honda
Hooley (OR)
Hoyer
Inslee
Jackson (IL)
Jones (OH)
Kanjorski
Kaptur
Kennedy (RI)
Kildee
Kilpatrick
Kind
Kleczka
Kucinich
Lampson
Langevin
Lantos
Larsen (WA)
Larson (CT)
Lee
Levin
Lewis (GA)
Lofgren
Lowey
Lynch
Maloney
Markey
Matsui
McCarthy (MO)
McCarthy (NY)
McCollum
McDermott
McGovern
McNulty
Meek (FL)
Meeks (NY)
Menendez
Michaud
Millender-McDonald
Miller (NC)
Miller, George
Mollohan
Moore
Murtha
Nadler
Napolitano
Neal (MA)
Oberstar
Obey
Olver
Ortiz
Owens
Pallone
Pascrell
Pastor
Payne
Pelosi
Pomeroy
Price (NC)
Rangel
Rodriguez
Ross
Roybal-Allard
Ruppersberger
Rush
Ryan (OH)
Sabo
Sánchez, Linda T.
Sanchez, Loretta
Sanders
Sandlin
Schakowsky
Schiff
Scott (VA)
Serrano
Sherman
Skelton
Slaughter
Smith (WA)
Solis
Spratt
Stark
Strickland
Stupak
Tanner
Tauscher
Thompson (CA)
Tierney
Towns
Udall (CO)
Udall (NM)
Van Hollen
Visclosky
Waters
Watson
Watt
Waxman
Weiner
Wexler
Woolsey
Wu

ANSWERED ''PRESENT''—1

Norwood

NOT VOTING—18

Aderholt
Deal (GA)
DeGette
DeMint
Filner
Granger
Hulshof
Israel
Majette
McInnis
Meehan
Nethercutt
Reyes
Scott (GA)
Shadegg
Shimkus
Smith (MI)
Tauzin

ANNOUNCEMENT BY THE SPEAKER PRO TEMPORE

The SPEAKER pro tempore (during the vote). Members are advised 2 minutes remain in this vote.

□ 1629

Mr. LEVIN, Mr. MOLLOHAN and Ms. KAPTUR changed their vote from ''yea'' to ''nay.''

So the bill was passed.

The result of the vote was announced as above recorded.

A motion to reconsider was laid on the table.

Stated against:

Mr. FILNER. Mr. Speaker, on rollcall No. 174, I was attending to official business in my Congressional District, and I missed the vote. Had I been present, I would have voted ''no''.

The SPEAKER pro tempore. Pursuant to section 4 of House Resolution 638, the text of H.R. 4280 and H.R. 4281 will be appended to the engrossment of H.R. 4279; and H.R. 4280 and H.R. 4281 shall be laid on the table.

RECOGNIZING THE 60TH ANNIVERSARY OF THE SERVICEMEN'S READJUSTMENT ACT OF 1944

The SPEAKER pro tempore. The unfinished business is the question of suspending the rules and passing the joint resolution, H.J. Res. 91.

The Clerk read the title of the joint resolution.

The SPEAKER pro tempore. The question is on the motion offered by the gentleman from New Jersey (Mr. SMITH) that the House suspend the rules and pass the joint resolution, H.J. Res. 91, on which the yeas and nays are ordered.

This will be a 5-minute vote.

The vote was taken by electronic device, and there were—yeas 409, nays 0, not voting 24, as follows:

[Roll No. 175]

YEAS—409

Abercrombie
Ackerman
Akin
Alexander
Allen
Andrews
Baca
Bachus
Baird
Baker
Baldwin
Ballance
Ballenger
Barrett (SC)
Bartlett (MD)
Barton (TX)
Bass
Beauprez
Becerra
Bell
Bereuter
Berkley
Berry
Biggert
Bilirakis
Bishop (GA)
Bishop (NY)
Bishop (UT)
Blackburn
Blumenauer
Blunt
Boehlert
Boehner
Bonilla
Bonner
Bono
Boozman
Boswell
Boucher
Boyd
Bradley (NH)
Brady (PA)
Brady (TX)
Brown (OH)
Brown (SC)
Brown, Corrine
Brown-Waite, Ginny
Burgess
Burns
Burr
Burton (IN)
Buyer
Calvert
Camp
Cannon
Cantor
Capito
Capps
Capuano
Cardin
Cardoza
Carson (IN)
Carson (OK)
Carter
Case
Castle
Chabot
Chandler
Chocola
Clay
Clyburn
Coble
Cole
Collins
Conyers
Cooper
Costello
Cox
Cramer
Crane
Crenshaw
Crowley
Cubin
Culberson
Cunningham
Davis (AL)
Davis (CA)
Davis (FL)
Davis (IL)
Davis (TN)
Davis, Jo Ann
Davis, Tom
DeFazio
Delahunt
DeLauro
DeLay
Deutsch
Diaz-Balart, L.