an industry that is 9 percent of our GDP, nothing to be taken lightly.

Yet what you have before you is something of a miracle. It is a unanimous and bipartisan bill where Members have put aside their selfish concerns, and we do have them, for the greater good of the Postal Service, because one thing we have to come to grips with is not a single Member that can go home and say, well, it was not good enough for me, so I put your Postal Service in jeopardy. Just try that out on your constituents.

At the same time, the Postal Service had to wake up to the 21st century, had to modernize in ways that 9/11 had nothing to do with, had to modernize because the world has come forward with technology that challenges them, the way UPS and FedEx will never challenge them. How do you do that?

They are still trying to do that. But one of the things you do is give the Postal Service some of the flexibility that is associated with the private sector, as much of it as you can, consistent with the fact that this is a controlled section of the economy, because there are some things that the Postal Service must do and nobody else can do; that is, go to some of the far reaches of your rural districts where they better get their mail on time the way I do mine nine blocks from the Capitol.

Even those who had serious problems with this bill, the mail handlers, for example, have a real problem and one that has to be taken seriously with the way in which the bill deals with single pieces of parcels, single parcels, where we have allowed the Postal Service to transfer revenue in order to keep this part of the service lower, and we are getting rid of that to make them more competitive with the private sector.

They say, watch out because you are going to raise the costs, and that is not good. But you know what they have said and agreed to? Perhaps we can resolve it in conference. So they say, pass the bill. I say as well, because we need to modernize the Postal Service. And we have even gotten around for ourselves the part that says that we might contribute to the deficit by giving back to the Treasury what they put on to the Postal Service, which is the cost of military pensions.

We say you have held billions of dollars from the Postal Service. Tell you one thing, if we did not do that, what it means is that the Postal Service, which has already filed for a rate increase, would be forced to go ahead. I, for one, do not want to go home in 2006 and say, I voted for a mail increase. That is what you will vote for if you vote against this bill.

My thanks to the sponsors once again for this historic work.

Mr. SESSIONS. Mr. Speaker, as you know, this bill is about the taxpayer. It is also about high-tech areas that depend upon a Postal Service that works properly. And our next speaker is from one of those areas, a high-tech area that is important to this country in not only manufacturing, but also delivery of goods and products.

Mr. Speaker, I yield 3 minutes to the gentlewoman from West Virginia (Mrs. CAPITO).

Mrs. CAPITO. Mr. Speaker, I rise today in strong support of this rule and underlying postal reform legislation. I commend the gentleman from Virginia (Chairman DAVIS) and the ranking member, the gentleman from California (Mr. WAXMAN), along with the much heralded sponsor of this bill, the gentleman from New York (Mr. MCHUGH), for working in a bipartisan manner that has twice allowed this bill to be reported from committee by a unanimous vote.

Now, I have only been here 5 years, and like my colleague from Washington, DC, says, she feels like every year it is painstakingly making its way through the process. And even in the 5 years since I have been here, I know how important this bill is, and I am so pleased that we are at the point we are today.

I am pleased to be a cosponsor of H.R. 22 because of its importance to businesses, postal employees, and all of us who have mail delivered to our homes or our businesses. This legislation has provisions that will allow the Postal Service to operate more efficiently and would require that it focus primarily on its main focus, which is delivering the mail.

H.R. 22 helps enable mailers to partner with the Postal Service to reduce the cost of mailings, providing an efficiency to the Postal Service, and helping businesses to save money that can be invested in jobs and job growth.

The bill is a good idea for postal employees for a lot of different reasons, one of which is because it returns the responsibility for the military service portion of postal retiree benefits back to the government and corrects overpayments by the Postal Service to the Civil Service Retirement System.

□ 1530

In short, the bill provides the changes necessary to keep the Postal Service operating. It is so important to all of us every day. I mean, I know at certain times in my life I felt like if I did not see my friendly mailman or mailwoman at my door, I felt like I did not have a friend in the world. So let us keep the Postal Service operating without the hefty rate increases that would inevitably come with the status quo.

This bill means a great deal to very many people. After so many years of work, I congratulate all of those intimately involved. I urge my colleagues to join me in support of the rule and the underlying bill.

Mr. HASTINGS of Florida. Mr. Speaker, I yield myself such time as I may consume.

Mr. Speaker, we come to the close offering praise to those who brought us this far. I add my congratulations to the distinguished leadership of this committee on both sides of the aisle for fashioning a piece of legislation that I believe will pass the House overwhelmingly and that I certainly intend to support, and I ask all of our colleagues to do likewise.

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

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

Today, we have had an opportunity to bring forth this postal bill with not only bipartisanship, but really some pats on the back to a lot of people who have been engaged in this issue for a long time, and perhaps none more diligent about this than the gentleman from New York (Mr. MCHUGH), our wonderful colleague. I think the way he has gone about this, Mr. Speaker, has been good, not only for this House but a credit to the men and women who have also been engaged in this.

I remember some 9 years ago as I went with a rural letter carrier down in Jeuitt, Texas, Stan Waltrip. I had a chance to go and deliver the mail with Stan and to see firsthand the kinds of, not only the people he came in contact with but the importance of doing this. So this bill is important that we have done this.

There are other people who have contributed to the success, rural letter carriers, certainly the postal carriers, letter carriers, those people who represent the Post Masters, the Financial Services Roundtable and many others. I would also like to thank the White House for their involvement. Three people in particular from the Leg Affairs office, Brian Conklin, Elan Liang, and Chris Frech, have been very diligent in making sure that this House and its Members are updated about the position of the White House.

Mr. Speaker, I would say this is a good piece of legislation. It is one that comes at a great time for this country. It is one that will spur the economy and make sure we are prepared for the future.

I ask my colleagues to please make sure they support this rule and also the underlying legislation.

Mr. Speaker, I yield back the balance of my time, and I move the previous question on the resolution.

The previous question was ordered.

The resolution was agreed to.

A motion to reconsider was laid on the table.

SMALL BUSINESS HEALTH FAIRNESS ACT OF 2005

Mr. BOEHNER. Mr. Speaker, pursuant to H. Res. 379, I call up the bill (H.R. 525) to amend title I of the Employee Retirement Income Security Act of 1974 to improve access and choice for entrepreneurs with small businesses with respect to medical care for their employees, and ask for its immediate consideration.

The Clerk read the title of the bill.

The SPEAKER pro tempore (Mr. GILLMOR). Pursuant to House Resolution 379, the bill is considered read for amendment.

The text of H.R. 525 is as follows:

H.R. 525

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

SECTION 1. SHORT TITLE AND TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the ''Small Business Health Fairness Act of 2005''.

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

SEC. 2. RULES GOVERNING ASSOCIATION HEALTH PLANS.

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

''PART 8—RULES GOVERNING ASSOCIATION HEALTH PLANS

''SEC. 801. ASSOCIATION HEALTH PLANS.

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

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

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

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

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

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

''SEC. 802. CERTIFICATION OF ASSOCIATION HEALTH PLANS.

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

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

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

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

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

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

''(1) a plan which offered such coverage on the date of the enactment of the Small Business Health Fairness Act of 2005,

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

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

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

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

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

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

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

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

''(A) BOARD MEMBERSHIP.—

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

''(ii) LIMITATION.—

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

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

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

''(iii) CERTAIN PLANS EXCLUDED.—Clause (i) shall not apply to an association health plan which is in existence on the date of the enactment of the Small Business Health Fairness Act of 2005.

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

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

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

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

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

''SEC. 804. PARTICIPATION AND COVERAGE REQUIREMENTS.

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

''(1) each participating employer must be—

''(A) a member of the sponsor,

''(B) the sponsor, or

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

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

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

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

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

''(b) COVERAGE OF PREVIOUSLY UNINSURED EMPLOYEES.—In the case of an association health plan in existence on the date of the enactment of the Small Business Health Fairness Act of 2005, an affiliated member of the sponsor of the plan may be offered coverage under the plan as a participating employer only if—

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

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

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

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

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

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

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

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

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

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

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

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

''(C) incorporates the requirements of section 806.

''(2) CONTRIBUTION RATES MUST BE NONDISCRIMINATORY.—

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

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

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

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

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

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

''(4) MARKETING REQUIREMENTS.—

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

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

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

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

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

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

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

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

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

''(i) a reserve sufficient for unearned contributions;

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

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

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

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

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

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

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

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

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

''(1) $500,000, or

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

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

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

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

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

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

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

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

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

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

''(3) ASSOCIATION HEALTH PLAN FUND.—

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

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

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

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

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

''(B) which is guaranteed renewable; and

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

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

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

''(B) which is guaranteed renewable; and

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

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

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

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

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

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

''(j) SOLVENCY STANDARDS WORKING GROUP.—

''(1) IN GENERAL.—Within 90 days after the date of the enactment of the Small Business Health Fairness Act of 2005, the applicable authority shall establish a Solvency Standards Working Group. In prescribing the initial regulations under this section, the applicable authority shall take into account the recommendations of such Working Group.

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

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

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

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

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

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

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

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

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

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

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

''(A) the sponsor; and

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

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

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

''(4) PLAN DOCUMENTS.—A copy of the documents governing the plan (including any bylaws and trust agreements), the summary

plan description, and other material describing the benefits that will be provided to participants and beneficiaries under the plan.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

''(3) to invest any assets of the plan which the Secretary holds in accordance with the provisions of the plan, regulations prescribed

by the Secretary, and applicable provisions of law;

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

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

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

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

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

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

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

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

''(1) the sponsor and plan administrator;

''(2) each participant;

''(3) each participating employer; and

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

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

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

''(f) JURISDICTION OF COURT.—

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

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

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

''SEC. 811. STATE ASSESSMENT AUTHORITY.

''(a) IN GENERAL.—Notwithstanding section 514, a State may impose by law a contribution tax on an association health plan described in section 806(a)(2), if the plan commenced operations in such State after the date of the enactment of the Small Business Health Fairness Act of 2005.

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

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

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

''(3) such tax is otherwise nondiscriminatory; and

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

''SEC. 812. DEFINITIONS AND RULES OF CONSTRUCTION.

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

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

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

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

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

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

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

''(7) INDIVIDUAL MARKET.—

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

''(B) TREATMENT OF VERY SMALL GROUPS.—

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

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

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

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

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

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

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

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

''(C) in the case of an association health plan in existence on the date of the enactment of the Small Business Health Fairness Act of 2005, a person eligible to be a member of the sponsor or one of its member associations.

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

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

''(b) RULES OF CONSTRUCTION.—

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

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

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

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

(b) CONFORMING AMENDMENTS TO PREEMPTION RULES.—

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

''(2) Nothing in any other provision of law enacted on or after the date of the enactment of the Small Business Health Fairness Act of 2005 shall be construed to alter, amend, modify, invalidate, impair, or supersede any provision of this title, except by specific cross-reference to the affected section.''.

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

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

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

(f) REPORT TO THE CONGRESS REGARDING CERTIFICATION OF SELF-INSURED ASSOCIATION HEALTH PLANS.—Not later than January 1, 2010, the Secretary of Labor shall report to the Committee on Education and the Workforce of the House of Representatives and the Committee on Health, Education, Labor, and Pensions of the Senate the effect association health plans have had, if any, on reducing the number of uninsured individuals.

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

''PART 8—RULES GOVERNING ASSOCIATION HEALTH PLANS

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

SEC. 5. COOPERATION BETWEEN FEDERAL AND STATE AUTHORITIES.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

The SPEAKER pro tempore. After 1 hour of debate on the bill, it shall be in order to consider the amendment in the nature of a substitute printed in House Report 109–183, if offered by the gentleman from Wisconsin (Mr. KIND) or his designee, which shall be considered read and shall be debatable for 1 hour equally divided and controlled by the proponent and an opponent.

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

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

GENERAL LEAVE

Mr. BOEHNER. Mr. Speaker, I ask unanimous consent that all Members may have 5 legislative days within which to revise and extend their remarks on H.R. 525.

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

There was no objection.

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

Mr. Speaker, the most pressing crisis we face in health care today is the number of Americans who lack basic health insurance. The number of uninsured Americans today stands at 45 million Americans; 27 million are fully employed. And 63 percent of these working uninsured are either self-employed or work for a small business with fewer than 100 employees. It is tragic that so many employers cannot afford to purchase high-quality health insurance benefits for their workers.

The problem is not going away, and we have a responsibility to confront it. With health care costs continuing to rise sharply across the country, more and more employers and their employees are sharing the burden of increased insurance premiums. Employer-based health insurance premiums jumped by 11 percent last year following a 15 percent increase in 2003.

Clearly, we need to focus on providing affordable health care to the uninsured as well as ensure employers

who provide health benefits to their employees are not forced to drop their coverage because of rising premiums and high administrative costs.

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

President Bush addressed this point directly last year during his speech at the United States Chamber of Commerce where he said, ''AHPs would provide small businesses the same opportunity that big businesses get, and that is the economies of scale, the economies of purchase, the abilities to share risk in larger pools which drives down the costs of health care for small businesses.''

The President is right, and we should help level the playing field so small businesses can offer quality coverage to their workers.

Americans overwhelmingly agree with President Bush that association health plans are the right plan to help the uninsured. A poll conducted last year showed that 93 percent of Americans support association health plans as a way of providing access to affordable care for American workers who lack coverage. Over the last year, we have seen how large corporations are now starting to band together to provide health care to their part-time workers. Do small businesses and their workers not deserve the same opportunity?

Importantly, the bill gives AHPs the freedom from costly State mandates because small businesses deserve to be treated in the same fashion as large corporations and unions who receive the same exemptions today. Clearly, these mandates are useless to families who have no health coverage in the first place. If you do not have health care coverage, State mandates requiring health plans to offer specific benefits do you and your family no good at all. This measure includes strong safeguards to protect American workers.

Despite the bipartisan nature of this bill, I would like to correct some of the misinformation that I have heard. The measure protects against cherry-picking because we make clear that AHPs must comply with the 1996 Health Insurance Portability and Accountability Act, which prohibits group health plans from excluding or charging a higher rate to high-risk individuals with a high claims experience.

Under our bill, sick or high-risk groups or individuals cannot be denied coverage. In addition, AHPs cannot charge higher rates for employers with sicker individuals within the plan except to the extent already allowed by State law where the employer is located. The bill also includes strict requirements under which only bona fide professional and trade associations can sponsor an association health plan, and, therefore, does not allow sham association plans set up by health insurance companies. These organizations must be established for purposes other than providing health insurance for at least 3 years.

We in Congress have a responsibility to deal with a problem of small businesses who cannot afford to provide health insurance because of skyrocketing health care costs. The U.S. economy is getting stronger by the day, and more and more employers are hiring workers each month. Earlier this month the unemployment rate dropped to its lowest level since September of 2001 and the Labor Department reported that 3.7 million new jobs have been created since March of 2003. That is 25 consecutive months of sustained job creation.

We want to make sure that these workers have the opportunity to receive quality health insurance through their employer, and this bill can help make that happen.

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

Mr. ANDREWS. Mr. Speaker, I rise in opposition to the bill and I yield myself 4 minutes.

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

Mr. ANDREWS. Mr. Speaker, today there is a point of agreements and a strong point of disagreement. There is a point of agreement that health care costs are rising too fast for too many people. There is a point of agreement that the consequences of that price increase is a tremendous burden on small business and a high likelihood that more people will be uninsured.

I do not think there is a Member of this body that does not favor finding an intelligent and effective way to reduce health care costs for small business so they can continue to insure the people they do insure and expand and insure more people in the future.

Where we disagree is over whether this underlying bill is the right way to do it, and we emphatically believe that it is not.

There are four reasons to oppose this bill. The first is that there is a better idea. There is a better way to solve this problem, and the gentleman from Wisconsin (Mr. KIND) will address that issue when our substitute is brought to the floor in a little while.

The second reason is that this bill will not result in a reduction of the number of uninsured. To the contrary, it will result in an increase in the number of uninsured people, and here is how. It is estimated by the experts in this field that 8 million people will be shifted from conventional health care policies and plans to association health plans. These 8 million people will, in fact, probably have a lower premium than they do right now for a little while. But when those 8 million people are shifted out of conventional health care plans and they will tend to be younger and healthier people, the people remaining in the conventional health care plans will have to bear more of the costs, and premiums will go up by an estimate of 23 percent. When the premiums go up on the rest of those in the pool, fewer of them will be insured.

The experts estimate that while 8 million people will be shifted from regular plans to AHPs, 9 million people approximately will lose their coverage altogether, and the results will be a net loss in the number of insured of 1 million people.

So supporting this bill will increase the number of uninsured, not decrease it; and it will increase premiums by 23 percent.

The second reason to oppose this bill is that it fails to provide the protection to patients, providers and consumers that good insurance regulation provides. There are simply no effective regulations that will keep an insurance company from going bankrupt and being unable to meet its obligations to its policy holders and pay its claims. We have seen this happen before in multiemployer welfare associations. We will be submitting at the appropriate time a list for the RECORD of MEWAs that have failed.

This is the reason that the National Governors Association, that attorneys general, that commissioners of insurance both Republican and Democrat oppose this bill because the regulation that would protect patients and providers and consumers is not there.

The third reason that we should oppose this bill, the final reason, is that the coverage that people have fought for over the years, so that women have a minimum stay in the hospital after they have a C section, so that women have the right to an annual mammogram, so that people with diabetes have the right to insulin or diabetic care, so that people struggling with mental health problems or with substance abuse have the right to have those services covered, those protections which have been supported by Republicans and Democrats in State legislatures around this country are effectively repealed by the underlying bill, a judgment being made in Washington that contravenes the good judgment of Republicans and Democrats around the country.

This bill should be opposed. There is a better way that the gentleman from Wisconsin (Mr. KIND) will be putting forward with my assistance. This is a bill that will increase the number of uninsured and increase health insurance premiums for small businesses.

□ 1545

This is a bill that will leave patients and providers and consumers unprotected if and when insurance companies go bankrupt. Finally, this is a bill

that effectively repeals protections for breast cancer screening, colon cancer screening, diabetes care, substance abuse care, and mental health care. It is a bill that should be defeated.

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

Mr. BOEHNER. Mr. Speaker, I yield 4 minutes to the gentleman from Texas (Mr. SAM JOHNSON), chairman of the Subcommittee on Employer-Employee Relations.

Mr. SAM JOHNSON of Texas. Mr. Speaker, I thank the gentleman from Ohio for yielding me this time.

As you know, Mr. Speaker, the cost of providing health care for employees has become the number one issue for small businesses around this country. It is especially important to me, because in my home State of Texas, one in four workers are uninsured. Small businesses have it especially tough because there is an inherent problem in a small number of people. You need to be able to pool risk to make insurance work. To make matters worse, there is a lack of competition in the small group health insurance market, allowing a few insurers to charge whatever they want. That is why we need association health plans.

These AHPs would allow small businesses to pool together to purchase health insurance. So instead of one individual company shopping for health care insurance, they would bring an entire trade association, for example, the U.S. Chamber of Commerce, to the table with much better bargaining power.

However, pooling risk and buying in bulk is not enough. If your association had members all across the United States, you would have to abide by 50 different sets of mandated benefits in order to offer your insurance. Not only is that a headache, but it is more costly. Some of the mandates that have been enacted by State legislatures include infertility treatment and alternative health solutions such as acupuncture. These mandates drive up the cost of premiums.

To resolve this, AHPs would allow small businesses to buy insurance under the same terms that large corporations and unions enjoy today. ERISA, a law that governs employer benefits, lets these sort of self-insured plans use one set of Federal rules, not 50 State rules. Talk about a quick way to lower administrative costs.

And lower administrative costs, Mr. Speaker, means lower premiums, up to 30 percent lower by some estimates, and that means affordable health care for employers and their employees alike. So who would not want AHPs to pass?

Some critics say AHPs will be an opportunity for fly-by-night groups that front as insurance companies and then leave employers with unpaid claims. The AHP bill in both the House and the Senate has tough safeguards to protect small businesses and their employees. A bona fide trade organization must have been in existence for 3 years before enactment of the law in order to offer an AHP. And there are Federal solvency standards set up for these health plans, including requirements for a reserve fund and stop-loss coverage. This is beyond and above what ERISA requires.

Moreover, the Department of Labor would be charged with the oversight of these plans, and the bill gives them the power to pursue criminal penalties against those who commit fraud. The Department of Labor has testified in hearings that they are up to the task and support the legislation.

Who else? Groups that have worked so hard to get coverage for their particular treatment mandated by State legislatures do not want AHPs to be exempt from the 50 different State laws. Let me say it plainly: That is the point of the legislation. One uniform set of benefits lowers administrative costs. If it is good enough for large corporations and unions, it ought to be good enough for small businesses.

Mr. Speaker, AHPs are a big step in the right direction for our hard-working families who need health insurance now.

Mr. ANDREWS. Mr. Speaker, I am pleased to yield 3 minutes to the gentleman from Wisconsin (Mr. KIND), who has come up with a very constructive and progressive alternative.

Mr. KIND. Mr. Speaker, I want to commend my friend and colleague, the gentleman from New Jersey (Mr. ANDREWS), for the leadership he has shown on this issue.

Here we are again, Mr. Speaker. Year after year after year it seems we continue to rise in this Chamber to debate the same issue. One of the reasons we have to do this year after year is because bad policy is tough to sell, and especially tough to sell in the Senate right now, which has refused to take this up and move it forward because it has been bad policy.

The chairman of the full committee, the gentleman from Ohio (Mr. BOEHNER), had a chart showing us a 93 percent approval of AHPs. That is not surprising, Mr. Speaker. There is such a craving throughout America for any type of legislative proposal that would bring price relief to the rising cost of health care, that I am afraid people will chase any proposal and even jump off a cliff without looking where they are going to land.

That is why, Mr. Speaker, especially under these conditions, it is more incumbent upon us here in this Chamber to be extra careful in regard to the policy proposals that we are proposing so we do not violate the Hippocratic oath, and that is: first do no harm to the current health care system. There is plenty of places where this legislation that is being offered today would do substantial harm.

We have had studies outside and inside this body that have come back explaining the true deficiencies of this legislation, but none probably summarize it better than the National Small Business Association that recently sent us a letter expressing their concerns. Now, this is an organization of some of the largest Chambers of Commerce and some of the biggest local and national organizations throughout the country, all of which see this AHP proposal for what it really is: an empty promise.

Mr. Speaker, I quote from this letter from the National Small Business Association in which they state, ''The biggest loser from the passage of AHPs would be small businesses. AHPs are not an answer to rising health care costs and would significantly worsen the state of health care for all businesses. More and more small businesses are realizing that despite the bumper sticker pitch in its favor, AHPs are, simply put, bad public policy.''

They go on to cite the Mercer study, saying that ''premiums for those outside the AHP market would increase an additional 23 percent, and an additional 1 million people would become uninsured as this policy plays out.'' They go on to state that ''the minimal price savings realized by some businesses through AHPs would come from attracting healthier participants and depleting benefits that are currently required by States. AHPs could create plans that manipulate benefits and are extremely unattractive to sicker, less healthy participants.

''Furthermore, the CBO found most of the enrollment in AHPs would come from businesses switching coverage. Only 1 in 14 would be newly insured. AHPs do nothing to solve the problem in rising health care costs to small businesses and their employees.'' And they conclude by saying, ''They simply shift the cost from the overall market to a more concentrated group of people. This is hardly a long-term solution.''

There is a better proposal, one that we will talk about in more detail when our substitute is offered. There is a way for us, I believe, to come together in a bipartisan fashion to address one of the most pressing issues of the day, and that is affordability and access to quality health care.

Businesses large and small, family farmers, individual employees are all suffering alike, and that is why it is important for us to come together and do something meaningful to relieve the health care pressures in this economy.

Mr. BOEHNER. Mr. Speaker, I yield 3 minutes to the gentleman from Georgia (Mr. NORWOOD), the chairman of the Subcommittee on Workforce Protections.

Mr. NORWOOD. Mr. Speaker, I thank the chairman very much for yielding me this time.

Mr. Speaker, it is my understanding that H.R. 525 is supposed to decrease the cost of health insurance for small businesses that cannot afford it today. Well, I support that. That is a good goal. All of us support that. Yet, unfortunately, I believe that in this bill that

has been undermined a little bit, and my logic is fairly simple.

As I read it, in section 805 of the bill, it allows an AHP to preempt State-level patient protection laws that prevent cherry-picking against small businesses with sick employees. Now, that troubles me a great deal. Look at the bill. Line 8 through 14 gives us the right, and line 21 through 22 takes it away. Sure, everybody can buy an AHP. It is just if you have anybody sick, you are in serious trouble, because the premium is going to be so high you cannot afford it.

After all, H.R. 525 is supposed to allow small businesses to come together to form large pools and purchase affordable health care through an association. That is a good idea. This makes sense, since large employers use this concept under ERISA to provide employees good rates, regardless of preexisting conditions. But in my opinion we, somewhere along the way, allowed this very good idea to be corrupted by a very bad provision, a sort of fly in the buttermilk of health care reform, in the form of section 805.

Mr. Speaker, 49 out of 50 States have instituted at least some patient protections that prevent insurers from using health status to discriminate against patients. Yet in plain English it appears to me that section 805 allows an AHP to preempt those rating laws. This simply makes no sense.

This is the bottom line: A small business owner in remission from cancer likely cannot get health insurance for himself, his family, or his employees if he lives in a State that allows for rating based on health status. Will that small business owner be able to afford high-quality health insurance from an AHP if H.R. 525 becomes law? Based on the language as I understand it, as I believe it to be true, he will not be able to get that insurance. Now, I believe that if H.R. 525 becomes law, it may even be much harder for that employer to get insurance. Why is that? Because all other employers with healthy employees will be in the AHPs.

I do not believe that is the intention of this bill. I hope I am wrong. I am going to vote for this bill. I am going to vote for it to move it forward, and I dearly hope I am wrong, and I hope that my chairman is right. But if time proves my position correct, I want these comments on the record so we will know exactly where to go to fix this when the milk turns sour.

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

Mr. Speaker, the gentleman from Georgia and I have had a disagreement over this particular provision for several years. It is very clear in the bill, as I read it, not the way the gentleman from Georgia (Mr. NORWOOD) reads it, and this is where the source of the disagreement comes in terms of how plans can choose groups of employees.

Under current ERISA law, you are allowed to have different rates for different groups of employees as long as there is a reason other than the health status of that group to have a separate group. Maybe you have a plant located in one part of the State, another plant in another part of the State. You could have two different rates at those two different plants, just like you can under most State laws and what you can under ERISA.

So I look forward to continuing to work with my friend from Georgia to resolve our misunderstanding of this issue.

Mr. ANDREWS. Mr. Speaker, I am pleased to yield 3 minutes to the gentlewoman from California (Ms. WOOLSEY), a person who is a strong voice for the rights of patients and families.

Ms. WOOLSEY. Mr. Speaker, there currently are 45 million Americans who do not have health insurance and are looking for real solutions for their lack of health care coverage. Unfortunately, H.R. 525, the so-called Small Business Health Fairness Act, is not their answer. In fact, this bill allows insurance companies to preempt State law, making possible a race to the bottom by associated health plans as companies, because of this bill, can offer the cheapest insurance with the least coverage.

The idea that we would allow insurance companies to trump State law is really outrageous. Laws to protect those with diabetes, those with cancer, and a host of other ailments are at risk under this plan. That is why I offered an amendment in the Committee on Rules, along with the gentlewoman from New York (Mrs. MCCARTHY), that would protect mammograms and cervical cancer screenings from being preempted by association health plans. Unfortunately, the Republican majority does not see the value in protecting women from breast and/or cervical cancer, because they would not allow our amendment to come to the floor to be debated before we voted on this bill.

□ 1600

Mr. Speaker, in my district, the Sixth Congressional District of California, the women of Marin County are plagued by an unusually high rate of breast cancer, and particularly young woman have the high incidence of breast cancers. But, fortunately, in California we require insurance companies to cover mammograms. So while the women of Marin County still have to worry about their community's high rate of breast cancer, at least they know their insurance companies cannot deny them access to the best available screening tools.

I cannot accept the idea of even one woman in this Nation foregoing an annual mammogram or a pap smear only to be diagnosed later with advanced breast or cervical cancer because an association health plan does not provide coverage. This is a risk we cannot afford, and I urge my colleagues to vote ''no'' on H.R. 525.

Mr. BOEHNER. Mr. Speaker, I yield 2 minutes to the gentleman from Louisiana (Mr. BOUSTANY), a physician.

Mr. BOUSTANY. Mr. Speaker, 45 million Americans lack health insurance today, and the number is rapidly growing. Twenty-six percent of all adults in Louisiana lack health insurance, and 22.6 percent of all working adults in Louisiana lack insurance.

It has been said over here that we need the insurance mandates to protect the patient. Insurance mandates are meaningless without insurance. We need a free market health care system that allows doctors to make decisions and not insurance companies. Fifty-two percent of Louisiana's small businesses offer health insurance, and the number is constantly declining. We must act to ensure that Americans can afford the health insurance that they need, and we can do so by passing H.R. 525, the Small Business Health Fairness Act.

This bill will create association health plans that will allow small businesses to band together through bona fide trade associations to become larger purchasers of health insurance, thus giving small businesses the same benefits that Fortune 500 companies now enjoy.

The Congressional Budget Office has estimated that small businesses obtaining insurance through AHPs would average premium reductions of 13 percent and some as high as 25 percent reductions. Overhead costs alone would decrease by as much as 30 percent under these plans. What is wrong with this? This is offering affordable coverage to workers.

There is additional research that also shows that up to 8.5 million Americans who are currently uninsured would become insured under AHPs. And this bill offers very many protections, consumers protections and protections with regard to solvency, as outlined.

If we are going to lower costs and increase accessibility to health care, we need to create choices and enhance competition. This bill is an important first step, and I urge its passage.

Mr. ANDREWS. Mr. Speaker, I yield 3 minutes to the gentleman from New Jersey (Mr. HOLT), a Member who does not want to see a 23-percent increase in premiums for his constituents.

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

Mr. HOLT. Mr. Speaker, today Member after Member has been talking about the 45 million Americans who lack health insurance. At the origin of our problem, we are the only major country where your health care coverage depends on who you work for. But that is not to be debated today.

We are talking about the small businesses in New Jersey and elsewhere around the country that face the high cost of health insurance. We all hear about it from our small businesses and their employees. Unfortunately, what has been brought to the floor here is a bill that creates more problems than it solves.

The concept of companies working together to control costs has worked in

some States, and it is certainly something I support. However, I cannot support allowing association health plans to achieve cost savings by offering inferior coverage. Allowing AHPs to circumvent existing State laws, for example, with regard to mental health coverage or contraceptive equity or mammograms or prostate screening or countless other necessary benefits is not an acceptable means to cut premiums.

Supporters of this legislation claim that millions of small businesses and their employees will be eligible for this new insurance option. However, the Congressional Budget Office estimates that only 600,000 of those eligible are currently uninsured, a small fraction of this huge population.

And H.R. 525 would allow AHPs to offer artificially lower costs by offering cheaper premiums to lower-risk populations, a policy that will lead to older and sicker people paying higher premiums. The CBO found that more than 20 million workers and their dependents would see their premiums increase due to AHPs cherry-picking.

States require that qualified health plans cover certain basic items. States say that anything that is worthy of the name health plan must cover certain things. Well, under this bill I could create a health plan that covers nothing but ingrown toenail surgery. It would be the cheapest plan out there, but it would not help employees very much.

I urge my colleagues to vote against H.R. 525 and to support the Andrews-Kind substitute. Their legislation would address the real needs of small employers. It would establish a small employer health benefits plan that would grant small business employees the same benefits as Federal employees receive. It provides prorated premium assistance for companies of varying sizes and employees of varying income. It would be much preferable to H.R. 525.

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

Mr. PRICE of Georgia. Mr. Speaker, I thank the gentleman for yielding me this time and for his work on this issue and so many other important issues.

When I go home, and especially as a physician in Congress, when I go home and talk to small businesses, they say whatever you do, whatever you do, do something about my health care costs. Make it so I can help my employees get insurance.

Mr. Speaker, 45 million uninsured we have heard, 60 percent or more of those are employed currently, and why do they not have health insurance. Either they are self-employed or they work for small businesses so they have to purchase health insurance in the individual market.

So what is the solution? Pool together. Six people can buy insurance for cheaper than one person; 60 cheaper than 6; 600 cheaper than 60; and 6 million cheaper than 600, and it can be quality insurance, and H.R. 525 is a step in the right direction.

We have heard that the number of uninsured will go up, the cost for the premium will go up 23 percent. I will take that wager. This is the same crowd that said welfare reform would not work. I will take that bet.

Once again, the rhetoric we have heard is disgraceful. We have heard that Republicans do not care about women with breast cancer. Come on. What kind of nonsense is this. Who do you think will be making the decisions about the kinds of provisions that will be in that insurance policy? It is patients. It is patients in the associations, and they are much closer I would argue to the individuals making decisions about what is going to be included under those plans than human resources officers in large companies.

H.R. 525 is a step in the right direction. I encourage my colleagues on both sides of the aisle to support it.

Mr. ANDREWS. Mr. Speaker, I yield 3 minutes to the gentlewoman from New York (Ms. VELÁZQUEZ), a person with whom I share an important goal, but have a disagreement on means.

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

Ms. VELAZQUEZ. Mr. Speaker, in every State and every district when we meet with small business owners, their number one concern is rising health care costs. Even as we sit here, the cost of health care continues to rise.

Today's legislation will help address this problem. Association health plans will provide an employer-based solution to help the sector of the economy that is being hit the hardest: small businesses. Critics of the bill will come forward today and tell you how association health plans are going to lead to a devastating impact on small businesses and the insurance market. Well, from where I stand, it is hard to imagine that it could get any worse.

We have 45 million Americans without health insurance and over half are small businesses and their employees. This includes up to 7 million children that have family members working for small firms. And for the last 5 years, small businesses have seen insurance costs increase by over 60 percent. These are statistics that are so often stated in this town that we forget what the real impact is. When an employer has to spend an additional $3,000 a year for coverage per employee year after year, it is easy to understand why some are dropping coverage all together.

We have a modest solution before us today that no one can claim will address all of the problems, but it can provide some help in a market that needs it. I think it is important to talk about what association health plans are and what they are not. These plans will be under the same set of rules that apply to corporate and union plans. In fact, the requirements for association health plans are even more strict. It will require that an association health plan have sufficient reserves to pay all claims. It includes protections against cherry-picking to prevent adverse selection. It provides a structure to ensure that the DOL can monitor these plans.

Critics will cite an outdated CBO study that does not even examine the legislation before us today. Will association health plans cure all of the problems when it comes to health insurance in the small group market? Absolutely not. But will it bring some elements of affordability and competition in these markets? I think so.

By some estimates, this bill is estimated to provide as many as 8 million Americans with insurance, no small sum. One of the best indicators as to whether AHPs will increase competition is the strong opposition from insurance companies. They are worried that they will lose their stranglehold on the small-group market. These insurance companies with highly paid lobbyists from Blue Cross/Blue Shield, for example, that hold monopolies on State markets are worried that they will have to start negotiating premiums rather than dictating them.

I rise in strong support of this legislation. I ask my colleagues to do the same. Just as important, I call on the Senate to act on this legislation and the administration to put its full backing behind this bill. This Nation's entrepreneurs deserve it.

Mr. SAM JOHNSON of Texas. Mr. Speaker, I reserve the balance of my time.

Mr. ANDREWS. Mr. Speaker, I yield 3 minutes to the gentleman from Massachusetts (Mr. TIERNEY), a Member who understands that this bill will increase the number of uninsured by at least 1 million people.

Mr. TIERNEY. Mr. Speaker, this so-called Small Business Health Fairness Act is a bill that is attractive to a few, seems to be sufficient for none, and is going to be harmful for many.

The Congressional Budget Office did an estimate of the proposed bill. It estimated that only 600,000 of the 45 million uninsured will be provided new insurance coverage by these AHPs. In fact, the respected 2003 Mercer Consultant Study that was done for the National Small Business Association found that the number of uninsured will increase by 1 million, as increased nonassociated market costs force small employers to drop coverage.

The fact of the matter is there is not going to be the dramatic savings proposed here. That is not going to materialize. The Congressional Budget Office found that these premiums for AHPs would only be marginally less than traditional premiums for health care plans.

In fact, the 2003 Mercer Study found that premiums would increase by 23 percent for those outside the AHP market. It also found that there would be an increase in the number of uninsured workers in small firms, an increase of 1

million people as a result of this plan being implemented.

Again, 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 prostate cancer screening, maternity benefits, well-care child services, and diabetes treatment.

Mr. Speaker, this bill is going to disallow a lot of State protections. In fact, that is how you get cheaper insurance. If you want to lower the price, you just do not give people the coverage that they need and deserve. Almost all of the States that we talk about have protections for people with coverage. Almost every Member of this House voted for the Federal Patient Bill of Rights that would have recognized these State protections that are in place for insurance programs; yet this bill would take those out carte blanche.

□ 1615

As a person in small business for over 22 years, and having represented a lot of small businesses, I can tell you from personal experience that small business employers do not want inferior coverage for their employees. We cannot allow it to happen again here. In fact, Mr. Speaker, I can tell you that AHPs really already exist. They are called the multiple employer welfare arrangements, the MEWAs. The public record is filled with stories of failed MEWAs that left employers and employees alike with unpaid medical bills. From 1988 to 1991, dozens of MEWAs failed, leaving 400,000 individuals with over $123 million of unpaid medical claims.

Small business owners and their families and their employees deserve protections. They deserve to go to the emergency room. Women in small businesses deserve to go to gynecologists without referral from another doctor. Why should we treat small business owners and employees as second-class citizens and give them second-class health care? Instead of extending the patient protections to all Americans, this AHP bill would actually roll them back and roll back the limited protections that they get today.

Plainly speaking, Mr. Speaker, this bill eliminates all those protections. For this reason and for the other reasons I have mentioned, and the fact that over 1,000 different organizations oppose this bill, 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 labor, business and consumer groups think that this is not a good bill, I urge my colleagues to reject this bill and vote for the substitute.

ANNOUNCEMENT BY THE SPEAKER PRO TEMPORE

The SPEAKER pro tempore (Mr. GILLMOR). The Chair would request that Members, as a courtesy to their colleagues, respect those time limits.

Mr. SAM JOHNSON of Texas. Mr. Speaker, I yield 4 minutes to the gentleman from Maryland (Mr. WYNN).

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

Mr. Speaker, I rise in strong support of H.R. 525, the Small Business Health Fairness Act, designed to allow small businesses to create large insurance pools in order to give them market power which will allow them to purchase quality health insurance at affordable prices through association health plans.

In truth, our biggest bipartisan failure in this Congress has been our inability to help 45 million, now pushing 50 million, Americans who do not have health insurance. Sixty percent of these people work in small businesses or are self-employed. Unfortunately, small business employers either cannot afford to offer health insurance or offer it at premium costs that employees cannot afford. Small businesses and their employees need our help. AHPs are not a panacea, but they are a step in the right direction.

AHPs, association health plans, will be subject to Federal consumer protections, unlike what you may have heard, such as continuation of coverage; Federal claims procedures for benefit denials and appeals; guaranteed portability and renewability of health coverage for those with preexisting conditions; as well as the Mental Health Parity Act, the Women's Health and Cancer Rights Act, and the Newborns' and Mothers' Health Protection Act.

We have also heard that AHPs will allow for cherry-picking, that only the healthiest will be signed up. That is not true due to the antidiscrimination language in the bill. Really and centrally, opponents claim that AHPs are bad because they do not provide mandated State benefits. This misanalysis reflects some of the backward thinking in our health care system, that people would put mandated benefits ahead of prevention. That does not make sense.

Consider a State's mandated coverage for diabetes supplies. But what good is mandated benefits for diabetes supplies if you cannot afford to go to the doctor, and therefore do not know you have diabetes? Under AHPs you have an affordable, basic policy which covers doctors' visits. Therefore, you can get checkups and learn about your risk of diabetes or other health problems. The doctor can give you advice, prescribe life-style changes, and help you overcome, control, or avoid health problems. In fact, the American Diabetes Association cited a recently completed study on diabetes prevention that conclusively showed that people with prediabetes can prevent the development of Type 2, or full-blown, diabetes by making changes in their diet and increasing their level of physical activity.

Our approach provides affordable access to this kind of preventive care, allowing people to lead healthier lives and not go to the emergency room, which is driving up costs for all of us.

Some of our elitist opponents will call these policies worthless because they do not offer 30 or more State mandates. For a single mother who is a waitress who is able to take her son to the doctor, that is not a worthless policy. That is called progress. If the plans are so inadequate, don't worry, the people won't buy them.

Most professional men and women have health insurance. Members of Congress have a great health insurance plan. Members of labor unions have health insurance. Why do they not want the mechanics and the barbers and the waitresses and the realtors to have health insurance? The attitude of our opponents seems to be, ''I drive a Cadillac. If you can't afford to drive a Cadillac, you don't get to drive at all.'' That does not make sense.

Today 45 million Americans cannot afford a Cadillac health insurance policy with all the mandated benefits. However, they might be able to afford a more modest vehicle that would get them to their doctor's office where they could at least get a diagnosis, advice and recommendations in order to improve their quality of life.

A broad and diverse coalition of more than 180 groups support this bill, including the U.S. Chamber of Commerce, the National Federation of Independent Business, the American Farm Bureau, the Associated Builders and Contractors, the Latino Coalition, and the National Black Chamber of Commerce. People want health insurance. Opponents of AHPs say, ''If you can't do everything for everyone, do nothing.'' We say this bill will help some people get health insurance, and we think that is a good thing.

Please, support AHPs. Let us quit talking about health insurance and actually deliver it to the American people who work in small businesses and who are self-employed, because they really need it.

Mr. ANDREWS. Mr. Speaker, among those who know the difference between a Cadillac and a lemon are the insurance commissioners of our States who oppose this bill.

Mr. Speaker, I yield 2 minutes to the gentleman from North Dakota (Mr. POMEROY), one of their former members.

Mr. POMEROY. I thank the gentleman for yielding time.

Mr. Speaker, let us understand something fundamental here. People do not just want the appearance of health insurance. They want a program that they can trust and that will pay when they incur the claim, and that is the critical problem with the bill being put before us. There are no meaningful consumer safeguards. This can manifest itself in three critical ways. First, as to content. We all know about insurance loopholes, the fine print that says, oh, we will pay your claim unless you file a claim, in which case we

won't pay the claim. This kind of malarkey has been with us ever since insurance first came in the marketplace. Insurance commissioners make certain that the policy does what it purports to do, no fine print taking away the meaningful coverage. This bill takes away that insurance commissioner protection provided to the consumers.

The second protection, rating. Do you know that in our States, there was a company that tried to sell a policy that actually raised the premium whenever you went to see a doctor? You thought you had good health care coverage, you went to see a doctor, your premium went up until it quickly became unaffordable. That is no insurance coverage. There is not the kind of protection on this kind of terrible rating scheme in this plan. As an insurance commissioner, I have seen rating schemes. Do not think for a second there are not people that will try this under this legislation. Consumers need protection there.

Thirdly, solvency. If there is one part of this bill that I think just screams out, ''This is stupid,'' it is the part on solvency. There is a $2 million cap on the solvency required for an AHP, no matter how many lives you have. Millions and millions of lives, $2 million maximum coverage. Do you know that the claims incurred by two premature babies could totally bust this plan? Again, people want coverage that is there when they need it, not coverage that gives them the appearance of having something only to have it go bust because it did not have enough capitalization. This business of capping solvency stands in stark contrast to any actuarial approach and shows that this is absolute danger for our consumers. Reject this bill.

Mr. BOEHNER. Mr. Speaker, I am pleased to yield 2 minutes to the gentleman from Louisiana (Mr. BOUSTANY).

Mr. BOUSTANY. I thank the gentleman for yielding me this time.

Mr. Speaker, first of all, I have respect for our insurance commissioners, but I want to say that three out of the last four in Louisiana went to jail. So that is no automatic protection. I think other States have had similar problems.

The preemption language in the bill only grants two limited exceptions from State laws that regulate insurance. Fully insured AHPs are exempted from State laws that would, one, preclude them from establishing an AHP; or, two, prevent them from designing their own benefit package. These two exemptions are narrowly tailored to allow AHPs to set a uniform benefit package that can be offered across State lines and to ensure that State regulators will not pass laws that prohibit the establishment of AHPs. State laws that regulate insurance and do not impact benefit design will apply, including prompt pay, external review, and solvency requirements. Assistant Secretary Ann Combs testified to this at a March 2003 Subcommittee on Employer-Employee Relations hearing. At that hearing she noted that, quote, ''fully insured AHPs would purchase insurance products with solvency standards and consumer protections regulated by the States.''

Further specifying which State laws are not preempted is unnecessary. All State laws will apply except those that prevent a uniform benefit design or prevent an AHP from existing. Consumer protection laws that States see fit to pass will apply to fully insured AHPs. No further change in the legislation is necessary. Benefit mandates, as we have discussed, will be preempted as is the case for unions and large employers.

Mr. ANDREWS. Mr. Speaker, I yield 3 minutes to the gentleman from Maryland (Mr. VAN HOLLEN), a Member who understands that this bill will raise premiums by 23 percent and cost 1 million people their coverage.

Mr. VAN HOLLEN. Mr. Speaker, I thank the gentleman from New Jersey for his leadership on this.

This is a bad bill, Mr. Speaker, for many reasons. I want to focus on one of them, which is that this bill will strip away the consumer protections and the patient protections that exist under State law for our constituents today. I understand that we have 50 States, and in those 50 States many of them have different mandates for what has to be covered and what does not have to be covered, and there is some sense when you are talking about organizations operating across State lines that you would streamline that effort.

That is exactly what the gentleman from Massachusetts (Mr. TIERNEY) and I tried to do when we took an amendment the other day to the Rules Committee. We said, let us look at six patients' rights that have been agreed to on a bipartisan basis by this Congress in previous legislation and which are overwhelmingly agreed to in our States, and let us say with respect to those six rights, you can't take that right away from one of our constituents, one of our patients, one of our consumers if you are an associated health plan.

What happened to that amendment? We did not even get to hear it or vote on it in this House. What are we afraid of? What were those six provisions that we wanted to make sure all our constituents, all our consumers, were protected by? The right to an independent external review of coverage decisions. Forty-three States have this rule already. It says if you disagree with your insurance company as to whether or not you are covered, let us not ask the insurance company who is right and who is wrong, let us have an independent individual who can make that decision. Does that make sense? Most of our constituents think they will have that right. If you pass this legislation and if you are in an AHP, you are not going to get it.

Second, direct access to obstetric, gynecological, or pediatric services. You do not have to wait in line before you take your child to see the pediatrician.

Third, imposition of prudent layperson decision-making standards. If you show up at the hospital, and you have a good faith reason for thinking you are sick, and it turns out you did not have a heart attack, but you went thinking you had one and you had good reason to think so, your insurance company cannot deny you coverage for that visit. You do not have to be the doctor. That is why we have doctors.

Use of drug formularies, access to hospital emergency room treatment, 42 States have this requirement; and making sure that we do not restrict the ability of our doctors to give us their opinions, to make sure that those States where they say you cannot have a gag rule, where your physician can tell you, the patient, what he or she thinks is in your best medical interest, they cannot be punished by the insurance company for telling you the truth.

These are common-sense provisions, six common-sense provisions. That is what our amendment would have done. It would have made this piece of legislation stronger and protected our constituents. What happened? We did not even allow a vote on that.

I would just like to quote from 42 State attorneys general, Republicans and Democrats, who say, ''Consumers rightfully expect their States to protect them from fraud and abuse. Elimination of the State role and replacement with weak Federal oversight is a bad deal for small businesses and for consumers.'' Those are State attorneys general, Republican and Democrat, who, like us, are trying to look out for the consumer interest.

Do not pass this bill. If you do, you are going to have a lot of explaining to do to your constituents when they are denied by their insurance companies coverage that they thought they rightfully had.

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

Mr. ANDREWS. Mr. Speaker, I am pleased to yield 3 minutes to the gentleman from California (Mr. GEORGE MILLER), the ranking member of the full committee and a fighter for working families throughout his career here.

(Mr. GEORGE MILLER of California asked and was given permission to revise and extend his remarks.)

□ 1630

Mr. GEORGE MILLER of California. Mr. Speaker, I thank the gentleman for yielding me this time.

I must say the Republicans are on a roll here. Last week they voted in the Committee on Education and the Workforce to raise the cost of education to those students seeking a higher education by raising the cost of the loans that they will seek to finance that education. In this legislation what we see them doing is taking away vital

health benefits that millions of Americans currently have but will lose if this legislation is passed. And later this week they are going to bring an energy to the bill to the floor of the Congress that The Wall Street Journal says will raise the price of gasoline.

What is it that the middle class did to them to make them so angry at them? They raise the cost of their education, they take away their health care benefits, and now they are going to increase the price of gasoline. Do the Members know what the price of gasoline is in California? It is $2.67, $2.77, $2.87 a gallon. Do the Members know how hard people have struggled in these States to have minimum health care benefits so that they can have a mammogram, so they can have diabetes testing, and now they are going to take that away. And now they raise the cost of college education. It just does not make any sense.

The theory is that Congress should be trying to extend meaningful health care coverage to families and to making sure that they have benefits that, in fact, are there when they need them. But that is not what this legislation does. This legislation overrides all of the hard work that was done in 40 or 45 States to make sure that people would have access to well baby care, to make sure that they would have access to maternity benefits, to make sure that they would have access to mammograms, crucial services that families need. This legislation says not necessarily so, they do not get that, on the theory that we have heard argued here that some plan is better than no plan.

But a plan without benefits is not worth much at all. And why would one keep paying premiums even if they are low premiums if they do not get the coverage that their family needs?

The point is for the people running that plan, that can turn out to be very profitable. That is why they do not want the insurance commissioners involved, because at some point the insurance commissioners would do what they have done in the past. They would blow the whistle on people running plans where they take premiums from middle-class workers, but they do not give the benefit that they want. The record is replete with that, replete with that in State after State after State. But that is stripped out of this legislation.

This legislation should be rejected because it just is not the benefits that people need. What we ought to be doing is extending that kind of universal access to plans that provide people the benefits.

The Congressional Budget Office in its most recent report, April of this year, analyzed the legislation two other times and concluded that 8½ million workers would end up in AHPs under this bill, and over 90 percent of them would come from existing health care plans where in all likelihood their benefits are better. The CBO looked at it once, it looked at it twice, it looked at it three times, and it said that is their conclusion.

This means that millions of Americans, working Americans today with health insurance, under this plan would get stripped of the health care coverage that they now have and that they need, that they need. They are talking about trying to cover a couple hundred thousand people. That is their argument, but they are going to strip the health care benefits away from almost 8 million people that have this kind of coverage. It is unacceptable.

We ought to reject this. Later this week we ought to reject the energy bill, and maybe we can do something to keep people in decent health care plans, lower their energy costs, and, when the higher ed bill comes, reject that, and we can save them some money on a college education.

Mr. BOEHNER. Mr. Speaker, I yield 3 minutes to the gentleman from Texas (Mr. SAM JOHNSON), the chairman of the Employer-Employee Relations Subcommittee.

Mr. SAM JOHNSON of Texas. Mr. Speaker, we have heard it over and over again today on the floor. Too many working Americans have a job, but are uninsured because their employers cannot afford to purchase quality health insurance benefits for their workers.

This bill addresses the two most important issues in the health care reform debate: cost and access. H.R. 525 would, one, increase small businesses' bargaining power with health care providers; two, give them much-needed freedom from costly State-mandated benefit packages; and, three, lower their overhead costs by as much as 30 percent.

Our small businesses are denied the ability to purchase health coverage with the benefits large multistate companies and unions have enjoyed for decades. This bill fixes that problem.

By pooling their resources, increasing their bargaining power, AHPs will help small businesses reduce their health insurance costs. As the Members have heard me say before, if it is good enough for Wall Street, it is good enough for Main Street. Small businesses in most States are stuck with disproportionately higher costs because they have to choose from fewer than five providers. So AHPs offer them a new option to choose from. Most importantly, AHPs will expand access to quality health care for the people for whom it is currently out of reach: uninsured working families.

This bill has had unwavering support in the House for nearly a decade now. The other body is taking a serious look at the legislation this year, and it is a priority in the President's health care agenda. I look forward to working with our colleagues from the other body to make this bill law this year.

The problem is getting worse every day. Small businesses need our help now. Let us vote ''yes'' on H.R. 525.

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

Mr. Speaker, the argument for this bill rests upon a false choice that I believe would have catastrophic consequences for many Americans. We are told by proponents of the bill that if we are willing to yield the guarantees that they presently enjoy under the law that guarantee them a mammogram, guarantee them care for diabetic illness, guarantee them other rights that they fought and won for, if we make that trade-off, we will get more people health insurance. If that were true, this would be a difficult choice, but it is not true.

The net impact of this bill will be to increase the number of uninsured people by nearly 1 million people because the increases in premiums for small business that will occur in businesses that stay in conventional plans will chase more people out of these plans. The experts estimate that these increases will be in excess of 20 percent.

So this is a false choice. This bill does not say that if we yield these benefits that people cherish, more people will be insured. The opposite is true. If we were to make the mistake of yielding these cherished benefits, more people would lose their coverage than would gain it.

This is a choice not worth making, and it is why the National Governors Association opposes the bill, Republicans and Democrats. And it is why the Attorneys General oppose the bill, Republicans and Democrats. And it is why commissioners of insurance, Republicans and Democrats, oppose the bill.

I urge our colleagues on both sides of the aisle to protect the benefits that our constituents earned and deserve and to prevent the increase in the number of uninsured and the increase in health insurance benefit premiums and vote ''no'' on this bill.

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

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

Mr. Speaker, small employers today have a difficult problem. They are trying to keep their business alive. They are trying to make enough money to hire and grow their business and at the same time trying to provide affordable health insurance. About 60 percent of the 45 million people who have no health insurance work for small businesses of some sort. But what happens to those small employers in most of these State risk pools? They are in the small group coverage area, and guess what happens? There may be a provider or two that will offer them insurance. They are stuck in a small pool, and they pay the highest rates of any group that is out there, unless, unless, one happens to be self-employed.

Let us say that they were a realtor, and as a realtor they are self-employed, they are not an employee of a company, and they try to buy health insurance for themselves out in the open market again in these small State risk pools. Here it comes, $1,500 a month,

$2,000 a month. And, my goodness, if they are sick, they will not get it at all.

So what we have been proposing now for some 10 years, and the House has passed this on a bipartisan basis at least five times, is to allow businesses and self-employed individuals who belong to bona fide organizations to group together for the purposes of health insurance. Why should a realtor who belongs to the National Association of Realtors not have an opportunity, whether their State association or the national association wants to put together a package of plans and allow them to choose one of those plans that might fit the kind of coverage that they want, why would we not want to do this?

We have heard all this shtick about all these plans are lousy, they are low-cost coverage. No. These plans would look exactly like the plans that big companies and unions offer today. Everybody in America wants to work for a big company or a union. Why? Because they have got great health benefits. And why do they have great health benefits? Because that is what their employees and that is that their members want. People do not want to go out and buy low-cost coverage that does not cover anything. That does not accomplish anything.

So when we look at the opportunity for small businesses to go out and to be able to purchase health insurance for their employees, just like a big company or just like a union under the same set of rules, the same set of rules for small companies that big companies have today, we should not let the perfect become the enemy of the good. This will not solve the problem of all 45 million of the uninsured, but it will help millions of Americans who work for small businesses have a better opportunity at getting good health coverage at competitive prices.

We have heard an awful lot of talk about it does not have this mandate, that mandate, that mandate. And why do big companies who do not have to have any mandated coverages under ERISA, why do they provide those? Why do they have breast cancer screening? Why? Because it makes sense to screen for this to detect it early and to deal with it. Why do they have these benefits that are not mandated? Why? Because they make sense to find out early in the illness.

These small companies are going to have the same types of high-quality plans that big companies have today without State mandates, because what happens is every State has a mandate. Some of them have as many as 30 mandated benefits that drive up the cost of health insurance and drive the number of uninsured up as well. But companies that offer a lot of these benefits, they do so with, as an example, a breast cancer benefit that covers the whole country, one size, not 50 different States done in 50 different ways that they have to find out exactly how it is going to be covered in each of those 50 States.

I have no doubt that the policies that will be offered by these association health plans will, in fact, be high-quality policies at very competitive prices.

As I said before, this bill has passed the House on a number of occasions with broad bipartisan support, and I expect that will occur again today. So I would ask my colleagues to stand up and vote. We hope that the other body will eventually take this bill up and move it and to help reduce the number of uninsured Americans that we have.

Mrs. CHRISTENSEN. Mr. Speaker, I rise in strong opposition to the Small Business Fairness Act, which is not fair any place, but in its name, and in strong support for the Kind-Andrews substitute.

As a 5-term member of the Small Business Committee, I know and am very concerned that 60 percent of the uninsured are employees of small businesses.

We all want to make sure they are covered, but H.R. 525 will not do that, it is an empty promise.

Worse, it would more likely increase the number of uninsured instead of reduce them. Even for those who might be covered. This bill is designed to provide great coverage if you don't need it, but please don't get sick—what it provides then is a false sense of security.

The stories of individuals with similar low cost plans in States with little regulations are tragic, and must not be replicated as H.R. 525 would do.

AHPs specifically remove State consumer protection laws and appeal rights. It is fool hardy to think that the market will provide any protection, and our experience with the Department of Labor and hearings with the Secretary have added no reassurance.

People of color, who make up a sizeable portion of small business employees and who tend to be sicker because this government will not build fairness and equality into our healthcare system, will get the shortest end of the stick again. Because of the higher costs of taking care of them, minorities will be left out, and left behind.

There is nothing fair about this bill, I urge my colleagues vote ''no'' on 525 and vote for a bill that provides insurance relief to small businesses, keeps the cost low, and protects the consumer. I urge my colleagues to vote ''yes'' on the Kind/Andrews substitute. The only fair bill before us at this time.

Mr. REYES. Mr. Speaker, I rise in opposition to H.R. 525, the Small Business Health Fairness Act, but in strong support of meaningful measures to help small businesses offer affordable, quality health care coverage to their employees.

For many businesses in my congressional district and across the country, the rising cost of health insurance is a growing crisis. Currently, many small businesses devote significant resources to offer health insurance to their employees—money they could have otherwise invested in their businesses. Others have had to reduce or drop coverage entirely.

While I agree that we must find a solution to this problem, H.R. 525 is not the answer, for several reasons. First, supporters of H.R. 525 claim the legislation would reduce the number of uninsured. However, a recent Urban Institute survey states that the number would actually increase, because some small employers in the State-regulated market would be forced to drop coverage when premiums increase as a result of the creation of Association Health Plans, AHPs.

Second, AHPs would be exempt from State rules that limit how much and how often premiums can be increased, making it likely that premiums would go up rather than down. In fact, the Congressional Budget Office estimates that AHP legislation would result in higher premiums for 80 percent of small employers, and as many as 100,000 sick people would lose coverage because they would not be able to afford the increases.

Finally, AHPs would mean that consumers would lose important health benefits, such as treatment and care for diabetes, child immunizations, cancer screenings, and preventive care. Consumers would lose State-based patient protections such as direct access to specialty care, emergency care, and the right to an independent, external review of denied medical claims.

Instead of this flawed bill, I support the substitute offered by Representatives KIND and ANDREWS. This legislation would expand the health care options available for small businesses by building on the efforts of many State governments that are providing health care plans specifically for small businesses. Under the substitute, Federal and State health insurance pools would be created for small businesses to band together to purchase coverage. Participating businesses would be able to defray the costs of their participation through a 4-year tax credit provided under the legislation. By grouping small companies in healthcare pools, this bill would give small firms some of the same advantages large corporations have in trying to keep costs down.

Mr. Speaker, I urge my colleagues to oppose the Small Business Health Fairness Act, and instead support real relief for small businesses trying to meet the health care needs of their employees by voting for the Kind-Andrews substitute.

Mr. LARSON of Connecticut. Mr. Speaker, I rise today in opposition to H.R. 525, the Small Business Health Fairness Act of 2005. Today we face a problem. An estimated 45 million people are without health insurance. The number of uninsured has risen in almost every year since 1989 and is expected to continue its rise in the near term. Most people in the U.S. who have health insurance obtain it through their employer or a family member's employer as a workplace benefit. Due to the rising cost of health coverage, small employers are far less likely than larger employers to provide health insurance to their workers and almost half of the uninsured work for, or are family members of employees who work for, small employers. The Small Business Health Fairness Act would not address this problem.

As a former small business owner, I understand the need for employers to offer benefits like health insurance to attract the best employees. I also understand the desire to offer benefits to employees to reward them for their efforts in making their business a success. Small businesses are a vital part of our economy, and it is critical that we provide them with affordable heath coverage that not only covers their employees, but helps reduce the ranks of the uninsured in our Nation.

Unfortunately, the association health plans created by H.R. 525 would actually reduce

health care benefits and coverage. In fact, the Congressional Budget Office estimates that only 600,000 of the 45 million uninsured would receive coverage as a result of this bill. The CBO also found that almost 75 percent of workers would actually see their premiums rise. These numbers are evidence that this legislation will not address the problem.

The bill raises numerous other concerns as well. It would create an uneven playing field where Federal law would provide one set of favorable rules for employers who join association health plans and a different, less favorable set of rules for those who do not. Association health plans would be exempt from most State benefit requirements, including those that ensure access to emergency services, mental health services and cancer screening. They would be free to choose healthier individuals who are cheaper to insure and leave behind those most in need of health care coverage. Finally, association health plans under this bill would be allowed to license themselves in a State with looser consumer protection provisions than the State they offer coverage in, leaving consumers open to fraud and abuse. These loopholes will not address the problem.

However, today we will offer a real solution to this problem. The substitute amendment offered by the gentleman from Wisconsin, Mr. KIND, and the gentleman from New Jersey, Mr. ANDREWS, would address the needs of small businesses by providing them with the same access to health benefits as Federal employees through a Small Employer Health Benefits Plan. This plan would provide coverage to all small businesses and their employees, ensuring that every worker gets the coverage they need regardless of age, sex, race or any other factor. Additionally, it would commit Federal funds to aid small businesses in offering health insurance to employees. Finally, it would work within existing State laws and not preempt state regulations regarding health care coverage. This substitute will help small businesses more, cover more of the uninsured, and protect the rights of States.

Unfortunately, without the Kind/Andrews amendment, I cannot support the Small Business Health Fairness Act. This is the fourth time the House has voted on association health plans and the fourth time it has been the wrong answer for small businesses and the uninsured. This is just another example of the Majority bringing the same legislation to the floor year after year knowing that it will go nowhere because it is the wrong answer for Americans. I urge my colleagues to join me in supporting the Kind/Andrews amendment, which would provide real solutions to help our Nation's small businesses and cover the 45 million uninsured Americans.

Mr. MANZULLO. Mr. Speaker, as the chairman of the Small Business Committee, our Nation's small business men and women tell me over and over that finding accessible and affordable quality health care is their number one priority for themselves and their employees.

I have heard from thousands of small employers in America who have been pleading for options to help them manage their surging health care costs.

Small business owners tell me regularly how they struggle to provide their workers health insurance, but each year they face double digit increases.

''Mom and Pop'' businesses tell me how they want to provide healthcare for their employees, but every single year it gets more difficult.

Many are giving up. Our Nation's entrepreneurs, whose ingenuity and hard work ethic have driven the American economy, have run out of options to battle this crisis. They need our help.

And today, we bring forward a great option—Association Health Plans—to help them control these outrageous costs and continue offering vital health insurance to their employees and their families.

In March of this year, I held a hearing on AHPs. The Coca Cola Bottlers Association testified they have long offered AHPs.

However, in 1990, they had to stop offering AHPs to members with under 100 employees because of the disparity of law from State to State. Those small employers have incurred increased premiums of between 20–25 percent per year.

For those bottlers employing over 100 workers and who still were able to maintain an AHP, they only had an average increase of 9 percent a year.

The proof is irrefutable. AHPs work. I urge all of my colleagues to support H.R. 525. Give hope to America's entrepreneurs. Vote for H.R. 525.

Mr. ENGEL. Mr. Speaker, the so-called Small Business Health Fairness Act is anything but fair. Congress should not be in the business of promoting the reduction of healthcare benefits and coverage and that is exactly what this bill does.

Proponents of H.R. 525 argue that health insurance will be cheaper under this bill, but the devil is in the details. Healthy people would enjoy low premiums under association health plans because the plans are exempt from State consumer protections and minimum quality requirements, and therefore meaningful coverage. Without consumer safeguards, association health plans would be largely unregulated and unlikely to cover such benefits as mammography screening, cervical cancer screening, well-child visits, mental health services and diabetic supplies. While this might appeal to healthy people, it will be devastating to those who actually need medical care. Those who are sicker would remain in non-association health plans and would have to pay higher premiums to compensate for those individuals who are siphoned off into the association health plans.

It is also troublesome that this legislation exempts association health plans from State solvency standards. Many States have strict solvency laws that protect workers from insurance fraud and abuse. Any meaningful insurance company should have to adhere to adequate standards of protection.

We should reject this anti-consumer proposal in favor of the Kind/Andrews substitute. This measure would create a Small Employer Health Benefits Plan, SEHB, similar to the Federal Employee Health Benefit Plan and would offer coverage to all small businesses with fewer than 100 workers. Significantly, this legislation works with existing State laws and does not preempt State mandates regarding health care coverage. This substitute very clearly commits Federal funds to aid small businesses in offering insurance to employees.

True health insurance coverage offers meaningful benefits with appropriate solvency safeguards. Our constituents deserve no less. I urge my colleagues to reject H.R. 525 and pass the Kind/Andrews substitute today.

Mr. MORAN of Virginia. Mr. Speaker, I rise in support of the Small Business Health Fairness Act, H.R. 525, which will allow small businesses and associations to band together to purchase health insurance coverage for their workers and their families.

The Small Business Health Fairness Act can directly benefit the over 2,300 small businesses and associations in my congressional district and their employees.

H.R. 525 would allow AHPs and small businesses to be certified under one Federal law, instead of 50 different State regulations.

Like large employers and labor unions that offer health insurance to their employees and members, AHPs would be regulated by the U.S. Department of Labor.

Many opponents of the Small Business Health Fairness Act claim that AHPs will ''cherry pick'' and therefore only benefit healthy people. This is not true.

All AHPs must comply with the Health Insurance Portability and Accountability Act, which prohibits group plans from excluding high-risk individuals that have required repeated health insurance claims.

H.R. 525 also guarantees that only bona fide professional and trade associations can sponsor an AHP. This measure ensures that AHPs will undergo a strict, new certification process before they will be allowed to offer health benefits to employers. This new certification process includes stronger solvency standards, including stop-loss and indemnification insurance.

Studies have shown that AHPs would save the typical small business owner between 15 percent and 30 percent on health insurance.

Currently, there are 45 million Americans who are uninsured. Even more troubling is the fact that 60 percent of uninsured Americans work for small businesses that lack the resources to provide health care benefits to their workers.

In fact, 65 percent of small-business owners indicate high cost as the main reason why they do not offer health insurance.

Small employers are facing 50 percent premium hikes, even as many insurers are leaving the small group market because it is not profitable enough.

The time to offer small businesses and associations the ability to band together to offer health insurance to their employees is now.

The Small Business Health Fairness Act represents a first step in helping to lower the number of uninsured Americans, many of whom work for small businesses.

H.R. 525 would introduce more competition into the market, reduce unnecessary regulation and administrative costs and make health coverage more affordable for small employers and their employees.

I urge support of H.R. 525.

Mr. BLUMENAUER. Mr. Speaker, it is unfortunate that while we are in the midst of a healthcare crisis for the uninsured, for small businesses, and for practitioners, Congress is recycling the same flawed legislation. The proposal would allow association health plans to bypass the State solvency framework requirements, leaving the consumers at a significant risk.

The reason that over 1,350 business, labor, and community organizations oppose H.R.

525—including organizations such as the National Governors Association, 41 Attorneys General, the National Association of Insurance Commissioners, Blue Cross/Blue Shield, National Small Business United and 69 local Chambers of Commerce—is because it not only misses the point, it will make things worse.

The bill would undermine our efforts to provide essential services to everyone by providing incentives to insure only the healthiest and wealthiest, leaving the vast majority of over ½ million uninsured Oregonians and 45 million uninsured Americans behind. Even worse, the adverse selection process will mean that the insurance pool will be narrower and sicker, resulting in more expensive insurance for most families. Furthermore, the Congressional Budget Office estimates that 8 million individuals who currently have health coverage will be switched to a lower benefit plan. Consumers may be denied the proper screening, procedures and treatment they deserve.

These are critical issues for taxpayers and businesses alike. I will continue to work with the healthcare and business community to produce the type of process, discussion and legislation Americans critically deserve.

Mr. STARK. Mr. Speaker, I rise today in strong opposition to H.R. 525, the regurgitated association health plan, AHP, bill. This is the fourth vote on this exact same legislation in as many years. So, if my statement sounds familiar, that's because it has all been said before.

While they've titled the bill the Small Business Health Fairness Act, its impact would be the opposite. This bill would have the perverse effect of increasing the cost of health insurance for many people and increase the number of people without health insurance altogether.

This bill would allow new entities, called association health plans, AHPs, to bypass State regulation and offer bare-bones health insurance policies. Small businesses that don't choose to offer these inadequate policies would see their premiums increase by 23 percent on average. This premium hike would occur because AHPs, which would offer only bare-bones coverage, would attract the healthiest individuals, leaving traditional health insurance plans with the sickest and most expensive patients. This shift would penalize businesses with sicker employees, and make health insurance for those who need it the most even more unaffordable.

Further, this legislation would swell the ranks of the uninsured by over 1 million more individuals. As traditional health insurance becomes increasingly expensive, more and more businesses would have no choice but to drop health insurance for their employees, leaving these individuals with little or no opportunity to purchase health coverage.

Contrary to what proponents of this bill claim, AHPs would not truly help small businesses purchase health insurance for their employees. Although proponents claim that AHPs would give small employers bargaining power to purchase affordable health insurance, most States already have laws in place that allow for group purchasing arrangements. This bill would only harm existing laws while usurping the traditional role of States to regulate insurance.

In fact, this bill would override key State laws and regulations that protect millions of Americans. For example, many States regulate insurance premiums to prevent insurers from discriminating against the ill. But under this bill those laws wouldn't apply. AHPs would be allowed to offer extremely low, ''teaser'' rates, and then rapidly increase the premium if the enrollee becomes sick. Furthermore, nearly all States have enacted external review laws that guaranteed patients an independent doctor review if a health plan denies them coverage for a particular service. Patients who join AHPs would lose this vitally important consumer protection.

This bill also exempts AHPs from State laws that require health insurance to cover particular benefits. These laws have helped to ensure that millions of Americans get access to the healthcare that they need—such as mammography screenings, maternity care, well-child care, and prompt payment rules. In my State of California, employees who join AHPs could well lose access to these services as well as certain emergency services, direct access to OB/GYNs, mental health parity, and other important benefits. Moreover, this law would allow health plans to ''gag'' doctors, the currently illegal practice of health insurers preventing doctors from discussing treatment options that the plan does not cover, even if some of those options are in the patient's best medical interest.

The problems go on. AHPs are likely to create new fraud and abuse problems in health care as well. These plans are very similar to multiple employer welfare plans, MEWAs, that Congress created in the 1970s. MEWAs were also exempt from State insurance regulation. The Department of Labor found that many of these plans were frauds and left their enrollees holding the bag for more than $123 million in unpaid health expenses. Congress had to come back and clean up the law to end this blatant abuse. We should learn from that mistake, not repeat it.

This bill is bad for patients, bad for small business, and bad for States. It is opposed by more than 1,300 organizations, including the National Governors Association, the National Association of Insurance Commissioners, the American Academy of Actuaries, local Chambers of Commerce, small business associations, physician organizations, labor unions, and healthcare coalitions.

The Senate has no intention of taking up this legislation. It's bad policy, and our colleagues on the other side of the Capitol know it. Taking yet another vote on AHPs is an enormous waste of time and taxpayer resources, and has nothing to do with providing affordable healthcare options to our citizens. Health care reform shouldn't raise premiums, increase the number of uninsured, lead to massive fraud, and remove key State patient protections. I urge my colleagues to reject this legislation once and for all.

Mr. SHUSTER. Mr. Speaker, I rise today in support of the Small Business Health Fairness Act, H.R. 525. This legislation is a prescription to provide quality, affordable health care to the Americans who need it most: 45 million people from working families across the country.

By lowering costs and strengthening bargaining power, Association Health Plans, AHPs, would allow small businesses to band together through associations and purchase quality health care for workers and their families at a lower cost. Small businesses currently have little buying power and few affordable options—five or fewer insurers control at least three-quarters of the small group market in most States, according to a GAO report in 2002. By banding together through bona-fide trade associations, AHPs would level the playing field and give participating small employers the exact same advantages Fortune 500 companies and unions currently enjoy.

It is important to note that this legislation does not make AHPs a mandatory program for employers. AHPs are about choice and healthy, competitive options for those seeking quality coverage. Each business would have the option of remaining with their current insurance provider, if they have one, or joining up with a legitimate, certified, and regulated association that is able to pool risk and offer small businesses a seat at the table when it comes to really being serious about providing health care for American workers.

Contrary to opponent's claims, H.R. 525 provides safeguards against fraud and abuse with a strict, new certification process that must be adhered to before any association can offer health benefits to employers. Included are strong solvency protections that go beyond what is required of single employer and labor union plans under current law. The bill requires self-insured AHPs to maintain reserves that are sufficient for unearned contribution, benefit liabilities, expected administrative costs, and any other obligations. With the reserve levels required to be recommended by a certified actuary who is a member of the American Academy of Actuaries, AHPs are designed to protect the employer from fraudulent abuse and those who would seek to take advantage of the system.

Under this bill, regulated by the Department of Labor and current ERISA and HIPPA laws, AHPs would be prohibited from excluding high-risk individuals from their plans and AHPs would also be barred from charging higher rates for sicker individuals or groups within the plan.

The lack of current competition in the health care market contributes to double-digit rate increases for many small businesses and a resulting rise in the number of small business employees who are uninsured. Too many small business owners and employers are forced to choose between offering health care benefits to their employees and hiring, expanding, or even maintaining their business. With the adoption of AHPs, the door of opportunity is opened to millions who do not currently have access to the kind of quality, affordable health care America's working families deserve.

Mr. Speaker, I would strongly encourage my colleagues in joining me and voting in favor of H.R. 525.

Mr. AKIN. Mr. Speaker, I rise today in support of H.R. 525, the Small Business Health Fairness Act of 2005.

In 2003, there were an estimated 45 million Americans without health insurance. Small businesses employ over 60 percent of those currently uninsured.

Without question, cost is often the biggest barrier to affordable health insurance for small businesses. Too often, I hear from small businesses owners back in my district in Missouri that the affordability of health insurance is their number one concern. This problem has been deepened in recent years as the overall cost of health care has risen. While large employer-sponsored health plans have seen an average 12-percent increase in health insurance premiums, small businesses have been

faced with annual premium increases of up to 50 percent, forcing many firms to drop coverage altogether.

By allowing small firms to join an association health plan as H.R. 525 would do, small employers would enjoy greater bargaining power because they would become part of a larger bargaining force, enabling them to offer their employees the same advantages and benefits that are currently available to larger companies.

I doubt that many of my colleagues here would deny the fact that small businesses are leaders in innovation. They pay the majority of our Nation's taxes and employ the majority of our Nation's workforce. Yet we have burdened them with excessive regulations to the point that they cannot afford to provide health insurance to their employees. We must not deny quality, affordable health care to these hardworking Americans who want to safeguard their own health and provide their families access to such protections.

I urge my colleagues to support the Small Business Health Fairness Act.

Mr. WELDON of Florida. Mr. Speaker, an issue I often hear about from my constituents is concern about the high cost of health insurance and the need for affordable insurance coverage. We all know health insurance premiums continue to increase substantially each year. As such, many small businesses are unable to afford health insurance for their employees. Furthermore, for those who can afford insurance for their employees, rising costs make U.S. products more expensive, harming U.S. competitiveness and costing American jobs.

Small businesses are the backbone of our economy, but the financial viability of many small businesses is being hurt by the escalating costs of health insurance. This hurts job creation and economic growth. The U.S. Small Business Administration's Office of Advocacy found that administrative expenses for small health plans make up about 35 percent of total costs. This is not good for small business owners, their employees, or the American economy. Congress must address this problem, which is why I support H.R. 525, the Small Business Health Fairness Act.

By passing H.R. 525 Congress will be leveling the playing field between small businesses, the self-employed, and large corporations. This allows organizations of individuals and businesses to enter into Association Health Plans, AHPs. Under AHPs, small business can pool their resources and purchase group health care similar to the way large corporations do today. They can get better bargaining power in terms of costs and benefits for their employees. It gives workers, who do not have health insurance today, the opportunity to obtain health insurance coverage.

Whether it is a small business a trade association, a farm bureau, or a local community organization that is seeking to purchase more affordable health insurance, this legislation will help them. They can join together with other groups and purchase health insurance at much more affordable rates and have better negotiating power with insurance providers.

It is generally reported that there are over 40 million people in America without health insurance at any given time. According to the Congressional Budget Office, a more accurate estimate of the number of people who were uninsured for all of an entire year is 21 million to 31 million. Regardless, almost 60 percent of those individuals are employed by a small business. As health care costs increase, fewer employers and working families will be able to afford coverage, and more Americans will be without health insurance. Those who work for small businesses should have the same type of access to health insurance that their counterparts in large corporations already enjoy.

I urge Congress to pass H.R. 525. Congress must pass this bipartisan legislation to give much needed relief to American small businesses, farmers, and hard working families.

Mr. SHAYS. Mr. Speaker, I rise in support of H.R. 525, the Small Business Health Fairness Act. This legislation would allow small businesses to pool their resources into what are known as Association Health Plans, AHPs, to purchase health insurance.

Pooled alliances, including AHPs, help control health care costs by permitting individuals to use their collective bargaining power to win cost concessions from insurance companies.

These alliances also achieve economies of scale for administrative functions—substantially cutting overhead costs, which currently amount to between 30 and 40 cents of every premium dollar paid by small businesses to insurers.

Purchasing alliances have been a popular response in many States to the problems many self-employed and small business owners have had securing affordable health insurance for themselves or their employees.

While I sensitive to the concerns many disease advocacy groups have about this legislation, the fact is this legislation provides the same exemption from State benefit mandates for small businesses already enjoyed by large employers.

The cost savings from avoiding benefit mandates has been estimated to be between 4 and 13 percent. This could make a huge difference for small businesses looking to offer their employees health insurance. Because small businesses are extremely cost-sensitive, studies indicate that even a 5 percent reduction in costs will result in a 10 to 15-percent increase in small businesses offering health insurance.

The legislation also protects against these plans ''cherry-picking'' the healthiest employees by restricting the ability of self-insured health plans to be qualified as an AHP. Unless a self-insured plan is in existence before the date of enactment, it would be required to offer membership to a broad cross-section of trades or to employers representing at least one higher-risk occupation.

Additionally, AHPs must comply with the Health Insurance Portability and Accountability Act, which prohibits group health plans from excluding high-risk individuals with high claims experience.

The bottom line is this legislation will help small businesses, which are the engine in our economy, provide health insurance to their employees. I urge the passage of this bill.

Mr. HONDA. Mr. Speaker, I rise today in strong opposition to the Small Business Health Fairness Act, H.R. 525. This bill would not only fail to expand health coverage for the uninsured, but would actually reduce health care benefits and coverage for 8 million individuals who would be switched to lower benefit AHP health plans. Only 1 percent—600,000 people—of the 45 million uninsured Americans would be provided new coverage by AHPs.

Instead of providing broader access to comprehensive health insurance for the millions of uninsured Americans, H.R. 525 will undermine access to quality, affordable health insurance and may actually increase the ranks of the uninsured. Under current law, the majority of health insurance plans are regulated at the State level. States have enacted a number of protections to ensure the fairness of health insurance coverage for patients. Most States now require insurers to allow direct access to emergency services, independent external appeal of health care claims denials, and access to an adequate range of health professionals. AHPs would be exempt from these requirements, leaving those with AHP coverage with inadequate protection.

Insurers naturally have incentives to select the healthiest individuals or groups that are seeking coverage. State regulations counter this incentive by mandating that certain benefits be covered, and by limiting and defining how policies are to be priced. By exempting AHPs from these State regulations, AHPs would offer less-generous policies that would be attractive to healthier individuals and groups. By permitting AHPs to offer coverage to specific types of employers, the bill allows them to hand pick populations that are better risks and therefore less costly to insure. Under H.R. 525, AHPs would offer different premiums to each member employer, charging lower rates for lower risk persons and charging much higher rates for higher risk persons.

The only restriction on premiums is that differences could not be based on health status. This provision is essentially meaningless because it permits AHPs to accomplish the same goal by varying premiums based on age, sex, race, national origin, or any other factor in the employers' workforce, including claims experience. As a Nation, we have recognized and are committed to eliminating health disparities based on race, ethnicity, and national origin. Why then would we create laws that perpetuate and encourage further health disparities?

Small businesses comprise nearly one-third of the private sector workforce, and are much less likely than large firms to provide health coverage for their employees. Although this is a serious concern, AHPs are not the answer. The Kind/Andrews substitute offers provisions that would address the real health insurance needs of small employers. It would provide small employers the same access to health benefits as Federal employees by establishing a Small Employer Health Benefits Plan, SEHB, similar to the Federal Employees Health Benefits Plan. It offers coverage to all small employers and their employees to apply for coverage under SEHB. Those working less than full-time would be eligible for pro rata coverage. It would also minimize adverse selection, use State-licenses insurers without preempting State laws, provide a minimum benefit package similar to Federal employees, and provide premium assistance to make employee and employer premiums affordable.

I urge my colleagues to support the Kind/Andrews substitute and oppose the Republican leadership's flawed approach to AHPs.

Ms. SCHAKOWSKY. Mr. Speaker, I rise today in support of the Kind/Andrews substitute and in strong opposition to H.R. 525, the Small Business Health Fairness Act of 2005. We have the opportunity to give small business owners and employees meaningful

access to affordable and comprehensive coverage by adopting the Kind/Andrews substitute. Or, by passing H.R. 525, we can give access to cheap, flimsy insurance policies that will not provide meaningful protection and leave those who need better coverage far worse off.

All of us are concerned about the high cost of health insurance, particularly for small businesses. We all agree that we need to allow small businesses to band together to achieve economies of scale in purchasing coverage. The Kind/Andrews substitute would give small businesses the ability to pool together through a Small Employer Health Benefits Plan. It would provide premium assistance to make coverage affordable for small business employers and employees. The Kind/Andrews substitute will guarantee that insurance policies are not worthless paper but provide meaningful access to benefits.

What the Kind/Andrews substitute will not do is preempt State consumer protection laws—laws that have been enacted by State legislatures on a bipartisan basis in response to real-life problems in the insurance market. The Kind/Andrews approach would benefit employers and consumers. The so-called Small Business Health Fairness Act of 2005 would not. In fact, this ill-conceived bill would make the current situation worse—adding to the ranks of the uninsured, reducing benefits, and leaving small business workers with insurance policies that do not provide the care that they and their families need.

There are three fundamental problems with this bill—all of which stem from the decision to preempt State laws and leave no other protections in their place. First, the bill will not significantly reduce the number of uninsured and may actually make this crisis worse. It would preempt State insurance regulation—allowing association health plans to cherry pick healthy small businesses. Small businesses with older workers, persons with disabilities or chronic conditions, and women of child-bearing age would face higher premiums. The nonpartisan Congressional Budget Office estimates that only 620,000 uninsured workers would buy these new, barebones policies but that 75 percent of currently insured small business employees—20 million—would see their premiums increase. National Small Business United—a group whose reason for being is to promote the interests of small businesses—opposes the bill because it would increase health ''insurance premiums for small employers by up to 23 percent and cause some to drop coverage altogether. A Mercer Consultants study in 2003 found that it would actually increase the number of uninsured by 1 million. The CBO says that up to 100,000 of the most medically needy workers—those with chronic, ongoing conditions or disabilities—would be among those losing coverage.

Second, the bill would take away protections from consumers victimized by fraud and abuse. All 50 States and the District of Columbia have passed tough laws to stop abuses in the small group health insurance market. Again, these laws would be preempted. The U.S. Department of Labor is not going to have the will or the resources to respond when consumers are injured by benefit denials, AHPs go belly-up, or fraud is committed. AHP policy holders and health consumers would be left in a regulatory blackhole—with no place to turn if they are defrauded, cheated, or denied benefits. That's why the National Association of Insurance Commissioners and 41 attorneys general oppose this bill.

Third, the bill would preempt basic benefit requirements and patient protections, allowing AHPs to drop coverage for preventive services, screening, mental health and other critical services. CBO estimates that 8 million workers with health coverage today would lose benefits under H.R. 525.

In Illinois, we have enacted benefits that include mammograms, pap tests, minimum mastectomy stays, colorectal screening, diabetes education and supplies, pre- and postnatal care, mental health parity that goes beyond inadequate federal requirements, and access to cancer drugs. We have a prudent layperson rule to ensure access to emergency services, direct access to OB–GYNs, and a ban on HMOs ''gagging'' doctors in their communications with patients. We have prompt payment rules for providers and fair marketing requirements. We require that insurance companies cover newborns. Those protections would be preempted under H.R. 525.

Many of us who previously served in State legislatures fought for those benefits because private insurance policies refused to cover items like mammograms, maternity care, diabetes education, prosthetics, or chemotherapy. We had constituents whose insurance companies refused to cover their babies, arguing that conditions developed in the mother's womb were ''preexisting.'' Dropping those critical benefits will not make health care more affordable; it will simply shift costs to employees and their families. And, despite having so-called insurance, if workers cannot afford to pay those costs on their own, they might as well be uninsured. That is why groups from Consumers Union to the American Diabetes Association, from the National Mental Health Association to the NAACP oppose this bill.

I also want to point out that women have a tremendous stake in this debate. Nearly all women-owned firms are small firms, most with fewer than five employees. Women are half of all workers at very small firms. And women are the beneficiaries of many of the State benefits enacted because private insurers refused to cover critical services—mammography, pap smears, reconstructive surgery following mastectomies, contraceptive services, breast and cervical cancer screening, direct access to OB–GYNs and nurse-midwives, and osteoporosis screening. A bill that raises premiums to women-owned small businesses and cuts women's health services is no solution.

Finally, I want to respond to the arguments of the proponents of H.R. 525 that something is better than nothing. As I have mentioned, for at least 8 million people, the something that would be provided under this bill would be a policy with lower benefits than they have today, for at least 20 million it would be a policy with higher premiums than they pay today. That is hardly a good deal. But there is a more important issue at stake here. H.R. 525 says that we owe small business owners and employees nothing better than barebones coverage, an insurance policy that may be affordable but that doesn't provide access to needed medical services and is stripped of consumer protections. I believe that we can do better and that is why I support the Kind/Andrews substitute.

Ms. JACKSON-LEE of Texas. Mr. Speaker, I rise today in support of H.R. 525. This bill, introduced by the Employer-Employee Relations Subcommittee Chairman SAM JOHNSON, Committee Chairman JOHN BOEHNER, Small Business Committee Ranking Member NYDIA VELÁZQUEZ and ALBERT WYNN, would allow small businesses to join together through association health plans, AHPs, to purchase health insurance for their workers at a lower cost. The measure would increase small businesses' bargaining power with health care providers, give them freedom from costly State-mandated benefit packages, and lower their overhead costs by as much as 30 percent. This is a benefit that many large corporations like GM and Ford already enjoy because of their larger economies of scale.

Furthermore, this bill expressly prohibits discrimination by requiring that all employers who are association members are eligible for participation, all geographically available coverage options are made available upon request to eligible employers, and eligible individuals cannot be excluded from enrolling because of health status. Premium contribution rates for any particular small employer cannot be based on the health status or claims experience of plan participants or beneficiaries or on the type of business or industry in which the employer is engaged.

The measure makes clear that AHPs must comply with the Health Insurance Portability and Accountability Act, HIPAA, which prohibits group health plans from excluding high-risk individuals with high claims experience. Thus, it will not be possible for AHPs to ''cherry pick'' because sick or high risk-groups or individuals cannot be denied coverage. The bill prohibits AHPs from charging higher rates for sicker individuals or groups within the plan, except to the extent already allowed under the relevant State rating law.

While I support all of these positive aspects of the bill, I do have concerns with other areas. Due to this fact, I also stand today to support the Kind/Andrews substitute. This substitute would strengthen the larger goal of the legislation which is to lower health care cost for workers. The substitute does this by providing small employers the same access to health benefits as Federal employees. Under the substitute, the Department of Labor will establish a Small Employer Health Benefits Plan, SEHB, similar to the Federal Employees Health Benefits Plan, FEHB. The States also may establish State small employer health pools.

In addition, the substitute offers coverage to all small employers and their employees. In essence, all employers with fewer than 100 employees during the previous calendar year shall be eligible to apply for coverage under SEHB. Employers must offer coverage to all employees who have completed 3 months of service. Employees working less than full-time are eligible for pro rata coverage.

Furthermore, the substitute also minimizes adverse selection. This is done by requiring the Secretary to establish an initial open enrollment period and thereafter an annual enrollment period.

One of the most important things achieved by the substitute is the fact that is uses State-licensed insurers without preempting State laws. It also provides a minimum benefit package similar to Federal employees, i.e., all participating insurers must offer benefits similar to the benefits offered under the four largest FEHB health plans.

As I close, I would hope that the differences I have mentioned are reconciled as this bill moves to conference.

Mr. GENE GREEN of Texas. Mr. Speaker, I rise in opposition to H.R. 525, the Small Business Health Fairness Act.

The sponsors of this legislation have a laudable intent: To make health insurance more affordable for small businesses by allowing them to band together to increase their purchasing power and negotiate lower health insurance rates.

With costs in the private health insurance growing 12.8 percent each year, no one would disagree that our small businesses are struggling to provide coverage for their employees.

But this legislation is not the answer to the rising cost of health insurance in this country.

Mr. Speaker, the regulation of health insurance has long rested with the States.

For decades, State legislatures in each of our States have enacted State coverage mandates and consumer protections to ensure that residents of those States purchase a quality health insurance policy.

While some policies cost more than others, thanks to State regulations, consumers can be assured that all policies offer a minimum level of coverage.

In my home State of Texas, health plans must provide access to emergency services, immunizations for children, direct access to OB/GYNs, and coverage of diabetes supplies and education—just to name a few guaranteed benefits.

The State has also enacted important consumer protection laws that afford consumers external review and limit how much insurers can charge sicker groups of people.

Under H.R. 525, however, the State would have no authority to ensure that Federal association health plans provide these benefits and consumer protections.

By taking away these vital patient protections, the policies purchased under AHPs would be worth little more than the paper they are printed on.

The amendment offered by our colleagues Mr. KIND and Mr. ANDREWS would correct many of the flaws in this legislation.

Specifically, the alternative would allow small businesses to purchase insurance through a Small Employees Health Benefit Plan—similar to the Federal employees health plan.

The Kind/Andrews amendment would ensure that the quality of health plans is protected; that low income employees have assistance in purchasing policies; and that the smallest of small businesses get the additional assistance they need.

As a former small business employee charged with choosing my company's health plan, I am all too aware of the need for the assistance outlined in the Kind/Andrews amendment.

The employees choosing these health plans for small businesses most often are not human resources or insurance professionals.

The coverage and benefit mandates enacted by State legislatures ensure that small businesses won't fall victim to sham policies and that their employees can depend on quality health insurance when an illness strikes.

Because H.R. 525 eviscerates these assurances by preempting the laws enacted by State legislatures, I urge my colleagues to oppose the underlying bill and support the Kind/Andrews alternative.

Mr. BACA. Mr. Speaker, I rise in opposition of H.R. 525 and the association health plans it creates.

There are 44 million Americans who are uninsured in this country and this bill will not even affect 1 percent of them. Not 1 percent.

CBO found that only 360,000 uninsured Americans would join AHPs.

This bill in fact hurts those who enroll in the plans and will even cause healthcare costs to go up for many other Americans.

There has to be a better way to help 44 million uninsured Americans.

AHPs will not be accountable to State health regulations. This will leave consumers who enroll in these plans without protection or a right to appeal if their cancer or diabetes treatment or medicines are denied.

We cannot let AHPs become bargain basement plans that enroll only the healthiest Americans. What will happen to our sick, elderly and those with severe health conditions?

Twenty million Americans will face higher healthcare costs. Twenty million.

Health insurers will give breaks to the AHPs and charge other consumers more. Studies show that these higher healthcare costs could cause up to 10,000 Americans to become insured.

There is a better way to help small businesses and the uninsured.

H.R. 525 will not help small businesses or their employees. This is a shortsighted plan that does nothing to cover the 44 million uninsured Americans who cannot afford to get sick.

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

The SPEAKER pro tempore (Mr. REHBERG). 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:

Amendment in the nature of a substitute offered by Mr. KIND:

Strike all after the enacting clause and insert the following:

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the ''Small Business Affordable Health Insurance Act of 2005''.

(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 (to be known as the 'Small Employer Health Benefits Program' or 'SEHBP') providing—

''(1) access to qualified health pooling arrangements (consisting of both qualified State health pooling arrangements and a national health pooling arrangement) under which self-only and family coverage is offered to small employers and their employees, and

''(2) premium assistance to small employers and their employees to assist with the payment of premiums incurred for coverage offered under such arrangements.

''(b) LIMITATIONS.—

''(1) EMPLOYER MUST BEAR 50 PERCENT OF COST.—Premium assistance shall not be provided under this part with respect to premiums incurred for any period for coverage under a qualified health pooling arrangement unless at least 50 percent of the premiums are paid by the employer.

''(2) 10-YEAR PERIOD OF COVERAGE.—Premium assistance shall be provided under this part only with respect to coverage for the 10-year period beginning on the date the employer first begins participating in a qualified health pooling arrangement.

''(3) EMPLOYERS OFFERING OTHER HEALTH BENEFITS.—In the case of an employer who paid or incurred any expenses for health benefits for the employees of such employer during the first calendar year ending on or after the date of the enactment of this section, premium assistance shall be provided under this part only if the employer begins participating in a qualified health pooling arrangement during the 2-year period beginning on the later of—

''(A) the date of the enactment of this section, or

''(B) the first date that a qualified health pooling arrangement exists which allows such employer to participate.

''(4) PARTICIPATION REQUIREMENTS.—Premium assistance shall not be provided under this part with respect to premiums incurred for any period unless at all times during such period coverage for health benefits under a qualified health pooling arrangement is available to all employees of the employer under similar terms, except that, under regulations of the Secretary—

''(A) coverage under the arrangement may exclude employees with less than 90 days of service with the employer, and

''(B) in the case of an employee serving in a position in which service is customarily less than 1,000 hours per year, the reference in paragraph (1) 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 1,000.

''(5) AMOUNTS PAID UNDER SALARY REDUCTION ARRANGEMENTS.—No amount paid or incurred pursuant to a salary reduction arrangement shall be taken into account under subsection (a).

''(c) DEFINITIONS AND SPECIAL RULES.—For purposes of this part—

''(1) SMALL EMPLOYER.—

''(A) IN GENERAL.—The term 'small employer' means an employer who normally employed not more than 100 employees on a

typical business day during the preceding calendar year (determined under rules similar to the rules applicable under section 601(b)).

''(B) EMPLOYERS NOT IN EXISTENCE IN PRECEDING YEAR.—In the case of an employer which was not in existence throughout the preceding calendar year, the determination of whether such employer is a small employer shall be based on the number of employees that it is reasonably expected such employer will normally employ on business days in the current calendar year.

''(C) PREDECESSORS.—The Secretary may prescribe regulations which provide for references in this paragraph to an employer to be treated as including references to predecessors of such employer.

''(D) PERMANENT STATUS AS SMALL EMPLOYER.—In the case of an employer who meets the requirements of this paragraph with respect to the calendar year in which such employer first begins participating in a qualified health pooling arrangement, such employer shall not fail to be treated as a small employer for any subsequent calendar year.

''(2) FAMILY COVERAGE.—The term 'family coverage' means coverage for health benefits of the employee and qualified family members of the employee (as defined in section 35(d) of the Internal Revenue Code of 1986, but without regard to the last sentence of paragraph (1) thereof).

''(3) QUALIFIED HEALTH POOLING ARRANGEMENT.—The term 'qualified health pooling arrangement' means a qualified State health pooling arrangement described in section 802 or the national health pooling arrangement described in section 803.

''(4) ENTITIES UNDER COMMON CONTROL.—

''(A) CONTROLLED GROUP OF CORPORATIONS.—All employees of all corporations which are members of the same controlled group of corporations shall be treated as employed by a single employer. In any such case, the total premium assistance (if any) provided to each member of the controlled group and the total premium assistance (if any) provided to its employees shall be its proportionate share of the wages paid to all employees of members of the controlled group. For purposes of this subparagraph, the term 'controlled group of corporations' has the meaning given to such term by subsection (a) of section 1563 of the Internal Revenue Code of 1986, except that—

''(i) 'more than 50 percent' shall be substituted for 'at least 80 percent' each place it appears in subsection (a)(1) of such section 1563, and

''(ii) the determination shall be made without regard to subsections (a)(4) and (e)(3)(C) of such section 1563.

''(B) EMPLOYEES OF PARTNERSHIPS, PROPRIETORSHIPS, ETC., WHICH ARE UNDER COMMON CONTROL.—Under regulations prescribed by the Secretary—

''(i) all employees of trades or business (whether or not incorporated) which are under common control shall be treated as employed by a single employer, and

''(ii) the total premium assistance (if any) provided to each trade or business and the total premium assistance (if any) provided to its employees shall be its proportionate share of the wages paid to all employees of such trades or business under common control.

The regulations prescribed under this subparagraph shall be based on principles similar to the principles which apply in the case of subparagraph (A).

''SEC. 802. PREMIUM ASSISTANCE FOR SMALL EMPLOYERS AND THEIR EMPLOYEES.

''(a) EMPLOYER PREMIUM ASSISTANCE.—

''(1) IN GENERAL.—Pursuant to section 801(a)(2), the Secretary shall provide to small employers who are eligible under paragraph (3) and who elect to provide for coverage of their employees under a qualified health pooling arrangement premium assistance for premiums paid by the employer for such coverage with respect to 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.

''(2) PREMIUM ASSISTANCE SCALED ACCORDING TO SIZE OF EMPLOYER.—The premium assistance provided under paragraph (1) shall be designed so that the premium assistance equals, for any calendar year—

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

''(B) 35 percent of the portion of the premium payable by the employer for the coverage, in the case of 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

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

''(3) ELIGIBLE EMPLOYERS.—A small employer is eligible under this paragraph if such employer—

''(A) normally employed fewer than 25 employees on a typical business day during the preceding calendar year (determined under rules similar to the rules applicable under section 601(b)), and

''(B) paid such employees during such year at an average annual rate of income (consisting of wages and salary) per employee which was at or below the median income (as determined by the Secretary for the most recent calendar year for which data are available as of the end of the preceding calendar year) for an individual residing in the State in which the employer maintains its principal place of business.

''(b) EMPLOYEE PREMIUM ASSISTANCE.—

''(1) IN GENERAL.—Pursuant to section 801(a)(2), the Secretary shall provide to employees of small employers premium assistance for premiums for coverage under qualified health pooling arrangements paid by such employees in the case of employees whose family income (as determined by the Secretary) is at or below 200 percent of the poverty line (as defined in section 673(2) of the Community Services Block Grant Act (42 U.S.C. 9902(2)), including any revision required by such section) for a family of the size involved.

''(2) AMOUNT OF PREMIUM ASSISTANCE.—Such premium assistance 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 PREMIUM ASSISTANCE.—Notwithstanding paragraph (1), under regulations of the Secretary, the total premium assistance to which any employee may be provided under this subsection for any period shall be reduced (to not less than zero) by the total amount of subsidies for which such employee is eligible 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 premium assistance program under this subsection to employees whose family income (as defined by the Secretary) is at or below 300 percent of the poverty line (as determined under paragraph (1)).

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

''SEC. 803. QUALIFIED STATE HEALTH POOLING ARRANGEMENTS.

''(a) DEFINED.—For purposes of this part, the term 'qualified State health pooling arrangement' means an arrangement established by a State which meets the following requirements:

''(1) COVERAGE PROVIDED BY HEALTH INSURANCE ISSUER.—The health benefits coverage is provided by a health insurance issuer (as defined in section 733(b)(2)).

''(2) HEALTH BENEFITS COVERAGE.—The arrangement provides health benefits coverage that the Secretary determines is substantially similar to the health benefits coverage in any of the four largest health benefits plans (determined by enrollment) offered under chapter 89 of title 5, United States Code.

''(3) GROUP HEALTH PLAN REQUIREMENTS.—The health benefits coverage provided under the arrangement meets the requirements applicable to a group health plan under this title and State law.

''(4) GUARANTEED ISSUE AND RENEWABLE.—The arrangement does not deny coverage (including renewal of coverage) with respect to employees of any eligible small employer or qualifying family members of such employees on the basis of health status of such employees or family members or any other condition or requirement that the Secretary determines constitutes health underwriting.

''(5) NO PREEXISTING CONDITION EXCLUSION.—The arrangement does not permit a preexisting condition exclusion as defined under section 701(b)(1).

''(6) NO UNDERWRITING; COMMUNITY-RATED PREMIUMS.—(A) Subject to subparagraph (B), the arrangement does not permit underwriting, through a preexisting condition limitation, differential benefits, or different premium levels, or otherwise, with respect to such coverage for employees or their qualifying family members.

''(B) The premiums charged for such coverage are community-rated for individuals without regard to health status.

''(7) NO RIDERS.—The arrangement does not permit riders to the health benefits coverage.

''(8) ACCESSIBILITY TO ELIGIBLE SMALL EMPLOYERS.—The arrangement makes such coverage available to an eligible small employer without regard to whether premium assistance is available under section 802 with respect to such employer or its employees.

''(9) MINIMUM OF TWO PLANS OFFERED UNDER THE ARRANGEMENT.—The arrangement makes available at least two alternative forms of health benefits coverage.

''(b) LIMITATION ON ENROLLMENT PERIODS.—A qualified State health pooling arrangement may provide limits on the periods of times during which employees may elect coverage offered under the arrangement, but the arrangement shall not be treated as meeting the requirements of this section unless the arrangement provides for at least

annual open enrollment periods and enrollment at the time of initial eligibility to enroll and upon appropriate changes in family circumstances.

''(c) QUALIFYING FAMILY MEMBER.—For purposes of this part, the term 'qualifying family member' has the meaning given such term in section 35(d) of the Internal Revenue Code of 1986, applied without regard to the last sentence of paragraph (1) thereof.

''(d) STATE DEFINED.—For purposes of this part, the term 'State' includes the District of Columbia, Puerto Rico, the Virgin Islands of the United States, Guam, American Samoa, and the Northern Mariana Islands.

''(e) CONSTRUCTION.—Nothing in this section shall be construed as requiring a State to establish or maintain a qualified State health pooling arrangement.

''(f) CREDITABLE COVERAGE FOR PURPOSES OF HIPAA.—Health benefits coverage provided under a qualified State health pooling arrangement under this section (and coverage provided under a National Pooling Arrangement under section 803) shall be treated as creditable coverage for purposes of part 7.

''(g) ANNUAL REPORTS.—

''(1) IN GENERAL.—Each State that offers a qualified State health pooling arrangement under this section in a year shall submit, in a form and manner specified by the Secretary, a report on the operation of the arrangement in that year.

''(2) CONTENTS OF REPORT.—Reports required under paragraph (1) shall include the following:

''(A) A description of the health benefits coverage offered under the arrangement.

''(B) The number of employers that participated in the arrangement.

''(C) The number of employees and qualifying family members of employees who received health benefits coverage under the arrangement.

''(D) The premiums charged for the health benefits coverage under the arrangement.

''(3) CERTIFICATION.—Each State that offers a qualified State health pooling arrangement under this section in a year shall submit, in a form and manner specified by the Secretary, a certification that the arrangement meets the requirements of this part.

''(h) NEGOTIATIONS TO LOWER HEALTH CARE COSTS.—The Secretary and States offering qualified State health pooling arrangements may collectively negotiate for lower prices for medical services, supplies, equipment, and pharmaceuticals for the purpose of lowering the health care costs to employers and employees served by such arrangements.

''(i) COORDINATION WITH STATE REGULATION.—Nothing in this section shall be construed as preempting provisions of State law that provide protections in excess of the protections required under this section. 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 benefits coverage offered under this part, to the extent necessary to augment processes otherwise available under State law.

''SEC. 804. ESTABLISHMENT OF NATIONAL HEALTH POOLING ARRANGEMENT.

''(a) IN GENERAL.—The Secretary shall provide for the offering and oversight of a national health pooling arrangement to eligible small employers.

''(b) NATIONAL HEALTH POOLING ARRANGEMENT DEFINED.— For purposes of this section, the term 'national health pooling arrangement' means an arrangement under which health benefits coverage is offered under terms and conditions that meet the requirements of section 803(a).

''(c) USE OF FEHBP MODEL.—The Secretary shall provide for the national health pooling arrangement using the model of the Federal employees health benefits program under chapter 89 of title 5, United States Code, to the extent practicable and consistent with the provisions of this part. In carrying out such model, the Secretary shall, to the maximum extent practicable, negotiate the most affordable and substantial coverage possible for small employers.

''(d) LIMITATION ON ENROLLMENT PERIODS.—The Secretary may provide limits on the periods of times during which employees may elect coverage offered under the national health pooling arrangement, but the Secretary 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.

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

''SEC. 805. COORDINATION AND CONSULTATION.

''(a) COORDINATION OF STATE AND NATIONAL PROGRAMS.—The Secretary shall provide by regulation for coordination of the offering under this part of health benefits coverage to employees of small employers under State health pooling arrangements and the offering under this part of such coverage to such employees under the national health pooling arrangement.

''(b) CONSULTATION.—In carrying out the provisions of this part, the Secretary shall consult with the Secretary of Health and Human Services and the Director of the Office of Personnel Management.

''SEC. 806. PUBLIC EDUCATION.

''The Secretary shall maintain an ongoing program of public education under which the Secretary shall—

''(1) publicize the national health pooling arrangement established under section 804, and

''(2) assist, and participate with, the States in publicizing the qualified State health pooling arrangements established under section 803.

''SEC. 807. FUNDING FOR PREMIUM ASSISTANCE AND POOLING ARRANGEMENTS.

''(a) PREMIUM ASSISTANCE.—There are authorized to be appropriated to the Secretary such sums as may be necessary to provide for premium assistance under section 802.

''(b) GRANTS TO STATES ESTABLISHING AND OPERATING QUALIFIED STATE HEALTH POOLING ARRANGEMENTS.—The Secretary may provide for grants to States to establish and operate qualified State health pooling arrangements described in section 803. There are authorized to be appropriated to the Secretary such sums as may be necessary to provide such grants.

''(c) FUNDING FOR NATIONAL HEALTH POOLING ARRANGEMENT AND OTHER DUTIES OF THE SECRETARY.—There are authorized to be appropriated to the Secretary such sums as may be necessary to provide for the offering and operation of the national health pooling arrangement under section 804 and to carry out the other duties of the Secretary under this part.''.

(b) 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. Premium assistance for small employers and their employees.
''Sec. 803. Qualified State health pooling arrangements.
''Sec. 804. Establishment of national health pooling arrangement.
''Sec. 805. Coordination and consultation.
''Sec. 806. Public education.
''Sec. 807. Funding for premium assistance and pooling arrangements.''.

SEC. 3. INSTITUTE OF MEDICINE STUDY AND REPORT.

(a) STUDY.—The Secretary shall enter into an arrangement under which the Institute of Medicine of the National Academy of Sciences shall conduct a study on the operation of qualified State health pooling arrangements under section 803 of the Employee Retirement Income Security Act of 1974 and the national health pooling arrangement under section 804 of such Act.

(b) MATTERS STUDIED.—The study conducted under subsection (a) shall include the following:

(1) An assessment of the success of the arrangements.

(2) A determination of the affordability of health benefits coverage under the arrangements for employers and employees.

(3) A determination of the access of small employers to health benefits coverage.

(4) A determination of the extent to which part 8 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 provides premium assistance for eligible small employers (and premium assistance for employees of such employers) that provided (or would have provided) health benefits coverage in the absence of such premium assistance.

(5) Recommendations with respect to—

(A) extension of the period for which the premium assistance under part 8 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 is available to employers and employees or an appropriate phase-out of such premium assistance over time;

(B) expansion of categories of persons eligible for such premium assistance;

(C) expansion of persons eligible for health benefits coverage under the arrangements; and

(D) such other matters as the Institute determines appropriate.

(c) REPORT.—Not later than January 1, 2010, the Comptroller General shall submit to the Congress a report on the study conducted under subsection (a).

Amend the title so as to read: ''A bill to amend title I of the Employee Retirement Income Security Act of 1974 to encourage small employers to offer affordable health coverage to their employees through qualified health pooling arrangements, to encourage the establishment and operation of these arrangements, and for other purposes.''.

The SPEAKER pro tempore. Pursuant to House Resolution 379, the gentleman from Wisconsin (Mr. KIND) and a Member opposed each will control 30 minutes.

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

Mr. KIND. Mr. Speaker, I yield myself 5 minutes.

Mr. Speaker, this morning we fortunately witnessed the successful takeoff of the latest space shuttle mission into space, and I, and I know all my colleagues, our thoughts and prayers go with that crew and their families. We wish them a successful mission and a safe return here to Earth at the conclusion of that mission.

But, Mr. Speaker, ''Houston, we have got a problem'' right here on Earth today, and that problem we all can agree to is the rising cost of health care, the impact that it is having on businesses large and small, family farmers, individual employees. It is a crisis that has been building through a number of years, and there is nothing more heart-wrenching or gut-wrenching than to speak to young parents who have a young child in desperate need of emergency medical attention, having to take that child to the hospital knowing that they do not have adequate health care coverage to provide for their sick child.

□ 1645

Today, one of the major factors for individual and personal bankruptcies is health care-related costs. There is also nothing more disheartening than speaking to the multitude of small business owners throughout this country who would love nothing better than to be able to extend affordable health care coverage to their employees; but they cannot because it is too expensive.

I think we can all agree to the fact that this is something that we have to have focused attention to alleviate the high costs of health care and the growing ranks of the uninsured, which is roughly 45 million to 48 million today. When we think about who comprises these 45 million to 48 million uninsured, the vast majority of them are working Americans, working in small businesses who cannot afford to provide coverage. Again, it is something we all recognize, because we hear about it daily when we are back home traveling in our congressional districts. So, yes, action is needed; but there is a right way and a wrong way in taking action.

A wrong way would be doing more harm than good in passing legislation and, for the previous hour, we have had a discussion in regard to the deficiencies and the shortfalls of the underlying associated health plans bill. That is why over 1,400 organizations around the country have come out in opposition to it.

But today, the gentleman from New Jersey (Mr. ANDREWS) and I are offering the right way, an alternative way, another approach to dealing with the health care crisis that our small businesses are facing, one that we believe would extend health care coverage to millions of Americans, while keeping a lid on the rising premium costs.

What it does, in essence, Mr. Speaker, is it builds upon the successful framework that the Federal Employees Health Benefits Program has offered to countless Federal employees throughout the country. It is a purchasing pool concept that they can enter into, with the competition of the marketplace and different insurance plans competing for that business that has proven to be extremely cost effective in not only extending coverage to millions of Federal employees, but also by guaranteeing the State protections and consumer protections that have been passed by State legislatures throughout the country.

Mr. Speaker, it is one of the more amazing aspects of this debate that the party that claims to be for States' rights and tries to take political advantage of saying, listen, States, we stand for you and what you decide to do on a policy level, is so quick to jettison States' rights when it becomes politically inconvenient for their political allies, and that is exactly what is going on here today with the proposed associated health plans, which will preempt and trump the public policy decisions that have been made throughout this country by State legislatures.

Now, our plan also would offer a minimum guarantee of coverage, one that the Federal Employee Health Plan currently does. It does not preempt the consumer protections and the State laws that have been passed. And the reason those State laws have been passed throughout the years is because the free marketplace and the insurance companies competing for the business were not offering this type of coverage, and that is why the State legislatures, in working with the Governors, had to pass legislation requiring certain minimal safeguards of health care coverage. So if a State legislature has felt in the past that it is necessary to require prenatal care, for instance, or to prohibit drive-through deliveries, or to require screening for diabetes, autism, cancer, they have chosen to do so; and it has made sense for those States that have.

But, instead, this one-size-fits-all approach comes in and tries to preempt what the States have been doing for many, many years.

But what is also different with our substitute is it actually offers premium support payments to make it more affordable to small businesses to offer health care coverage to their employees, something that the underlying AHP plan is silent on. Again, an analysis of our bill would show that it would actually increase the coverage of the uninsured, help premium prices come down by building on this purchasing-pool concept, but also maintaining important and safe consumer protections. There is a reason why the National Governors Association and the States attorneys general have opposed the underlying bill. It is for all of these reasons, and we would respectfully submit the right approach is the substitute that we are offering today.

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

Mr. SAM JOHNSON of Texas. Mr. Speaker, I rise in opposition to the amendment in the nature of a substitute.

The SPEAKER pro tempore (Mr. REHBERG). The gentleman from Texas (Mr. SAM JOHNSON) is recognized for 30 minutes.

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

Mr. Speaker, as the number of uninsured Americans continues to increase and health insurance costs continue to rise by double digits annually, it is clear that something must be done. I commend our friends across the aisle for coming up with a plan they think works. While I have great respect for the gentleman from New Jersey (Ranking Member ANDREWS) and the gentleman from Wisconsin (Mr. KIND), I have to disagree with them. Their substitute will have the unintended consequence of raising, not lowering, costs for small businesses trying to offer health insurance. It will impose new mandates on employers and saddle the American public with yet another government program to fund.

The proponents of the plan claim that the new ''small employer health benefits plan'' is modeled after ours here in the Federal Government. Unfortunately, unlike the Federal Employee Health Benefit Plan, health insurance provided under the Democrat substitute would be subject to more than 1,500 State mandates that make up 15 percent of the rising costs of health insurance. That increased cost would likely be funded by higher taxes, adding another burden to small businesses. And on top of that, the substitute would force small businesses to deal with a host of new mandates.

Their substitute mandates employers provide health coverage to every employee who has been employed for more than 3 months. It mandates that employers pay 50 percent of the health care premiums for employees. It mandates that they cover the dependents of their workers. More mandates are supposed to lower costs? The Democrat substitute just does not make sense.

In contrast, AHPs utilize the strengths of the employer-based system, the private market, competition, economy of scale enjoyed by large union and employer plans, and ERISA's preemption of State mandates, to lower costs. Mr. Speaker, AHPs are supported by our Nation's small businesses. The NFIB, the National Retail Federation; the National Association of Wholesalers and Distributors; the National Restaurant Association; Associated Builders and Contractors; National Association of Homebuilders; the United States Chamber of Commerce, and others are strongly supportive of this legislation.

I hope my colleagues will join me in offering assistance to our Nation's small businesses and their workers by supporting AHPs and opposing the Democrat substitute.

Mr. Speaker I reserve the balance of my time.

Mr. KIND. Mr. Speaker, at this time I yield 4 minutes to the gentlewoman from Colorado (Ms. DEGETTE), a person who certainly appreciates the role of States and consumer protection in this health care debate.

Ms. DEGETTE. Mr. Speaker, I rise today to urge a ''no'' vote on H.R. 525 and a ''yes'' vote on the Kind-Andrews substitute.

This debate is, frankly, misdirected. The question is not who recognizes that there is a health care crisis in this country and who does not. This is not a contest to see who among us truly understands that small businesses are finding themselves in an increasingly difficult predicament when it comes to providing health care insurance for their employees.

We all care about this issue, and we all have constituents who need help affording health care insurance. Small businesses, which do face unique challenges across the board compared to large corporations, are the backbone of our economy; and we should be doing more to help them. And providing better and more health care coverage is one of the biggest problems they face today.

So I ask our friends on the other side of the aisle, why do we have before us a bill that does nothing to really address the problem for small businesses and very well may end up hurting the people who we say we are trying to help? There is a reason why the National Governors Association and 41 attorneys general are against this bill. There is a reason why numerous advocacy associations, consumer groups, and others oppose this misguided legislation.

This bill has been hailed as the answer to covering many of the 45 million Americans who are currently uninsured; but in truth, a very small percentage of the population would be helped in any way. This is because association health plans would help a relatively small number of the youngest and healthiest among us who will gain access to cheap minimalist plans. But that would come at the expense of the vast majority of workers whose premiums would actually increase. It would also make it nearly impossible for those with previous health challenges or chronic diseases to obtain any coverage at all.

Let me give an example. I am the cochair of the bipartisan Diabetes Caucus in Congress. Forty-six States have mandated that insurance plans must cover diabetic supplies? Why? One little vial of strips, test strips costs $50, and insurance companies simply were not giving that benefit in the past. That is why 46 of the 50 States said, you have to pay for this. Now, if diabetics test their blood, long-term complications like heart disease, kidney failure, end-stage renal disease, all of those are eliminated; but they have to have insurance coverage for these supplies. This legislation wipes out that requirement. It says, you do not have to pay for that; you do not have to follow that State law. That is not only wrong for those beneficiaries who are diabetic; it is shortsighted in the long run for the cost of our health care system.

We need to address the real access and affordability issues that affect employees of small businesses, and the only way we can do that is by passing the Kind-Andrews substitute. This substitute will give small employers the ability to provide the same access to health benefits as Federal employees. It will also allow States to establish small employer health pools. It would also minimize adverse selection and use state-licensed insurers without preempting State laws. Sounds like a good substitute to me.

If we pass the substitute, we can make a true impact on the status of millions of uninsured workers across this country; and for that reason, I urge a ''no'' vote on H.R. 525 and a ''yes'' vote on the substitute.

Mr. SAM JOHNSON of Texas. Mr. Speaker, I yield such time as he may consume to the gentleman from Ohio (Mr. BOEHNER), the chairman of the committee.

Mr. BOEHNER. Mr. Speaker, I thank my colleague for yielding me this time to speak on the substitute that has been offered.

Now, if we think that having States regulate insurance in a small group market is a problem with state-mandated benefits, this is the mother of all complicated programs to offer health insurance, because what are we going to do? We are going to have the Federal Government do it. Now, none of us really believes that the Federal Government ought to be in the business of running big-risk pools and offering plans to small businesses.

Secondly, the bill is estimated, and it has changed from last year; last year there was a $50 billion authorization, but it is still going to cost an awful lot of money to do this bill.

One of the most damaging parts, though, is that each employer who would take part in this plan that is being offered would still be subjected to the State mandates on health insurance in their particular State. There are 1,500 State-mandated health benefits around the country. It also requires that the employer must pay at least 50 percent of the premium. In most cases, I would imagine the employer would pay far more than that of the premium; but maybe it is a small company, maybe it is five or six employees, and maybe together they decide, we want to qualify for this, but we will each pick up our own share of the cost. Why would we want to prohibit them from including themselves in this by this type of a requirement?

It also says that every employer must offer this to every employee who has worked at the company for 3 months. That seems like a very short period of time, especially in some industries where you have an awful lot of turnover where they would typically require that you wait 6 months before you would qualify. All this would do would be to drive up the cost.

But one of the most amazing parts of this substitute, we would subsidize this from the Federal Government and, for employers with 25 or fewer employees, we would give them a subsidy to help entice them into this program. And, if you qualified, you qualify for a 10-year period. Now, some small company with less than 25 employees may qualify, may get the subsidy and may, over a course of several years, become highly successful. But under this particular substitute, they would still qualify for the subsidy.

□ 1700

I do not think any of us believe that the Federal Government ought to be operating a health insurance company. There are a lot of mechanisms in the private market for this association health plan program to work. And, again, why do we want to make the perfect the enemy of the good?

The underlying bill that we have will, in fact, work. It will allow millions of Americans to get better-quality coverage at much more competitive prices than what they get today.

So let us allow the underlying bill to go forward. Let us defeat the substitute.

Mr. KIND. Mr. Speaker, I yield myself 1 minute to respond quickly, just to clarify a couple of facts.

Mr. Speaker, I have all of the respect and admiration for the chair of our committee, but a closer reading of the substitute bill would not, in fact, require a Federal-run program; rather the Department of Labor would contract out the State-licensed health insurance plans in order to administer these programs.

But we do feel that there is a requirement or a necessity to offer greater incentives and inducements for small businesses to offer this coverage. That is why we are offering a premium support program with it.

Mr. Speaker, I yield 5 minutes to the coauthor and codrafter of this substitute amendment, the gentleman from New Jersey (Mr. ANDREWS).

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

Mr. ANDREWS. Mr. Speaker, I thank my friend, the gentleman from Wisconsin (Mr. KIND), for yielding me the time.

I think the best way to understand the difference between the plan that the gentleman from Wisconsin (Mr. KIND) and I are putting forward and the majority plan is to look at it from the point of view of one of the small business people that we keep hearing referred to over and over again here today.

My friend, the gentleman from Wisconsin (Mr. OBEY), often refers to speeches on the floor as posing for holy pictures, and I think that is what is going on here today, where everyone is embracing the small businessman or small businesswoman and saying how much we love them and care about them, and I am sure everyone does. But I think what matters is the impact of these various proposals, what the proposals would have on the small business person.

In my State the cost of insuring a family is about $14,000 a year. So let us

take a small business person that has 10 employees and is looking at a situation where he or she would have to spend $140,000 to insure each of those employees and their families if the employer was going to bear the whole cost. That is a huge amount of money, but is probably well beyond the ability of that employer to pay for.

Under the majority's bill, if we give the majority every benefit of the doubt, if we assume that the majority's bill will work exactly as they say that it will, the most optimistic forecast is the majority's bill will save 13 percent in premiums for that employer. And let us round it up a little bit and give them the benefit of the doubt further and say it will save $2,000 per employee off that $14,000.

So what would happen? We would save $20,000, and the employer would be looking at spending $120,000 to insure the families instead of $140,000. That is not going to do it. That is still far more than the person running a machine shop or a small retail store or landscaping business or a delicatessen is ever going to be able to afford. This just is not going to happen. It is not going to happen.

Our proposal is very different. It says that in a case of a small business like the one I am hypothesizing here, where you have about 10 employees, and where those employees make less than 200 percent of the poverty level, which in my State for a family of four would be about $40,000, so just about anybody making less than $20 an hour or so would be eligible for this kind of subsidy, that is most people. That is most people. Under our plan that employer, if the employer chose to do this, my friend a minute ago said that the employers were mandated to do this, that is not so. No one is required to insure their employees under this plan, but if the employer chooses to insure his or her employees, what would happen is they would get a credit of $7,000 per employee toward the cost of this health insurance, a 50 percent credit. So the price of the coverage would drop from $140,000 down to $70,000. That is still an awful lot of money. It is an awful lot of money for a person running a small business, but it puts the person in reach of maybe covering that family, particularly if they ask the family to share with copays and deductibles and their own contribution.

Now, my friend, the gentleman from Ohio (Mr. BOEHNER), the chairman of the full committee, said, my goodness, the Government will be subsidizing small employers if we do this. It is big government. Well, government already subsidizes health care for large employers, because they permit the large employers to deduct every premium dollar. And that employer is paying at the 36 or 37 percent corporate tax rate, which most of them do. That constitutes a 36 or 37 percent subsidy. So General Motors is getting a nearly 40 percent subsidy, but the person running the delicatessen or the machine shop is not. This evens the playing field.

Now, how do we pay for this? Now, the chairman knows that under the rules of the House that it would not be appropriate or germane for us to identify the source of paying for this, because it would take it outside of the committee's jurisdiction.

There are different views as to how we could pay for this. I speak only for myself when I say this, but I would note for the record that the cost of tax breaks to companies that outsource their jobs outside of the United States is $100 billion over the next 10 years. So if that machine shop, if its competitor takes all of the jobs and moves them to Malaysia or Mexico, gets a tax break for doing that, which I think is a foolish policy, if we were to repeal that tax break for companies that are outsourcing their jobs out of this country, that would go a long way toward paying for the plan that we are talking about.

That to me is a pretty good trade-off. Companies that are sending their jobs overseas would lose a tax break; companies here in America would gain health insurance.

Vote yes on the Kind-Andrews substitute.

Mr. SAM JOHNSON of Texas. Mr. Speaker, I yield 3 minutes to the gentleman from Louisiana (Mr. BOUSTANY).

Mr. BOUSTANY. Mr. Speaker, you know what we are trying to do here is to make health care more affordable, available and accessible to all Americans. It seems to me that if we are going to achieve this goal, we have to adhere to some principles, and I can think of three right off the bat that are very important. One is to provide information to the consumer; second, choices to the consumer; and, thirdly, thirdly, control to the consumer.

Now, this amendment that is being proposed seems to me that it is going to limit choice rather than create choice. And I find it odd that there is no mention of what its cost is going to be to the Federal Government in putting forth these subsidies. I think we need to know that information. I think it is very important information.

And it also seems to me that this program is going to add to the cost of health care, and not lower the cost. What we need to do is foster competition in health care, and right now 45 percent of all of the health care dollars are within governmental systems, Medicare and Medicaid and so forth. The other 55 percent is in the insurance market, and there is no competition. There is no competition in this arena. And so if we stick to these three principles I mentioned earlier, we can create competition.

It seems to me that if we are going to give subsidies, why not give subsidies to individuals to buy health savings accounts which provide those choices which will allow for an information flow to the patient, to the consumer?

And so I urge colleagues on both sides of the aisle to not support this amendment and to vote for H.R. 525, which offers a good starting point to creating competition in the health care market.

Mr. KIND. Mr. Speaker, I just recommend to the previous speaker that he should talk to any Federal employee with regard to the choices that they are offered under the Federal Employee Health Plan.

Mr. Speaker, I yield 2 minutes to the gentlewoman from Ohio (Mrs. JONES), a person who would rather take millions of people off the ranks of the uninsured rather than add a million people into the uninsured.

Mrs. JONES of Ohio. Mr. Speaker, first of all, I want to thank my colleagues, the gentleman from Wisconsin (Mr. KIND) and the gentleman from New Jersey (Mr. ANDREWS), for offering this substitute.

I live in the city of Cleveland. We have a great organization representing many of our smaller enterprises called COSE, and COSE has come together in an attempt to provide health care coverage to small businesses.

I wanted to vote for a piece of legislation that will allow small business to have insurance policies for their people, but I did not want to vote for a plan that did not provide the same kind of coverage that everybody else has, meaning that it did not have to be responsible for State insurance regulations as did other policies.

So by presenting this amendment, the gentleman from Wisconsin (Mr. KIND) and the gentleman from New Jersey (Mr. ANDREWS) have offered me an opportunity to say to the small businesses in my community, I support you, and I want to make sure you can provide health care coverage to your employees.

What is also of particular concern to me is that offering something that does not provide the same safeguards is like offering nothing. All we have to do is go back and look at the MEWAs, the Multiple Employer Welfare Arrangement, I guess that is what they call them, the Multiple Employer Welfare Arrangements, which have been used by employers as vehicles to provide benefits. The public record is filled with instances where they have failed, left employees and employers alike with unpaid medical bills.

Mr. Speaker, the other thing that we have to look at is, and the prior speaker said something about subsidies, and you give them to people, and they do not get anything in return. We gave subsidies to the drug companies in the Medicare prescription drug bill, and they got money that they did not even have to use towards a prescription benefit. So do not talk to me about subsidizing anything.

Let us make sure that the people of America and the small businesses have an opportunity to have health care. If we do preventive health care, we would not have so many people coming into

hospitals with acute problems because they have not had any prevention.

It is so wonderful that we have a substitute that offers coverage to small employers. Vote for the substitute and vote against H.R. 525, the Small Business Fairness Act.

Mr. SAM JOHNSON of Texas. Mr. Speaker, I reserve the balance of my time.

Mr. KIND. Mr. Speaker, I yield 4 minutes to the gentleman from Tennessee (Mr. COOPER).

Mr. COOPER. Mr. Speaker, I think the Rules Committee has made a terrible mistake here, and not the usual Rules Committee sort of mistake, because they have actually allowed to come to the floor a substitute that is so clearly superior to the AHP bill it is amazing.

Now, let my friends on the other side understand, I am not against AHPs. I am an original cosponsor of the gentleman from Texas (Mr. JOHNSON's) legislation. AHPs would be an improvement over current market conditions, which are appalling. But this plan put forward by the gentleman from Wisconsin (Mr. KIND) and the gentleman from New Jersey (Mr. ANDREWS) is better than AHPs, and let me describe some of the ways.

First, the gentleman from Louisiana (Mr. BOUSTANY) mentioned choice earlier. Under the AHP approach, the average small business might be able to offer their employees one or two insurance plans, and that employee of the small business would have no idea whether their doctor was going to be a apart of one of those plans. But under the Federal employee approach, such as the one that we enjoy in this House of Representatives, they could have 10 or 20 or more plans to choose from, and the likelihood that their physician, their caregiver, would be part of one or more of those plans increases substantially.

So when you are talking about unleashing the free market to work for the individual, the Federal Employee Health Benefits-type plan, and this would not infringe on Federal employees' benefits, but it would set up a parallel organization that small businesses could benefit from, the opportunities for the small businesses of America are magnificent under this approach.

Another key aspect of this is the substitute approach is more likely to work. AHPs are largely a thought experiment. They have never really worked anywhere. But the Federal Employee Health Benefit System has worked well for decades, 30 or 40 years of a magnificent track record of experience. It has got bipartisan support. Men and women of goodwill on both sides of the aisle know that this sort of approach works; it lowers the sales load, it increases the risk pool to the maximum size which you need for lower group rates.

It really is the fairest and best way to approach this nagging small business problem that we have had. It is also going to be more affordable, because while it lowers the sales load and increases the size of the risk pool, it is fairer to all industries.

There are probably going to be a lot of insurance companies that want to offer insurance to software companies, because those employees tend to be young and healthy. How many are going to be eager to insure older Rust Belt industries?

The tax credit approach that my friend has mentioned has had to be adjusted for purposes of this substitute, but we need to acknowledge, as my friend from New Jersey (Mr. ANDREWS) mentioned, health care is already seriously subsidized in this country. All we are trying to do is make that subsidy fairer.

I think also the substitute approach would make the system higher quality. First of all, under AHPs, there would be minimal solvency requirements. By completely overturning all State regulation, as AHPs would do, that is a truly radical approach, and while my friends on the other side may be radicals in this regard, I think they are going further than they realize. These insurance plans need to be thoroughly solvent. You need to have adequate capital requirements so that you know the insurance is going to be there when you need it.

□ 1715

I think you would have better benefits under this plan, too, because you would have more proven traditional insurance policies that I think more folks who work for small businesses are accustomed to.

Let me admit, Mr. Speaker, in closing, our approach is less famous. Why? Because we do not have every PAC and trade association in Washington, D.C. favoring this because they stand to personally benefit from promoting AHPs to their members. They are desperate for non-dues revenue for those associations.

For any tourist who comes to Washington, if you do not think these PACs and trade associations are rich enough, come visit again. You will see skyscrapers full of these folks all over town, and they would love to make money as insurance salesmen to all the small businesses in America. That is not doing justice for our folks back home.

As I say, AHPs are an improvement, but they are not as good as the Kind-Andrews approach. Please vote for Kind-Andrews.

Mr. KIND. Mr. Speaker, how much time remains?

The SPEAKER pro tempore (Mr. REHBERG). The gentleman from Wisconsin (Mr. KIND) has 9½ minutes remaining. The gentleman from Texas (Mr. SAM JOHNSON) has 22 minutes remaining.

Mr. SAM JOHNSON of Texas. Mr. Speaker, I reserve the balance of my time.

Mr. KIND. Mr. Speaker, I yield 4 minutes to the gentleman from Rhode Island (Mr. KENNEDY), someone who understands the importance of maintaining consumer protections as we have in our substitute bill.

Mr. KENNEDY of Rhode Island. Mr. Speaker, I thank the gentleman for yielding me time.

As we all know, we are in a health care crisis and many propose many solutions. But let us just find out the simple facts. Facts are, insurance ratings are really dependent on the notion that some people are higher risk than others. Those are the people that insurance companies love to insure. They love to insure them because if they have low risk, every dollar that they pay in terms of premium is another dollar down on their bottom line of profit. However, if you are unfortunate enough to be born with a congenital defect in your organs, if you are unfortunate to be run over by a car, if you are struck by some ailment that is out of any control that you have whatsoever, under the insurance system you are known as a risk. Simply growing old titles you as a risk.

Do you think an insurance company wants to cover you? Of course they do not.

This is a zero sum game. If some get insurance, others get zero. But the fact of the matter is we all pay. The notion that some people are going to get away from paying, meaning some small businesses are going to get away from paying, is just hogwash.

The fact of the matter is, we all know that when we pay our premiums, we are paying for someone who is uninsured. We are paying for someone who is underinsured. The way out of this problem is not to escape giving people health insurance, which this legislation does. Of course it is going to be cheaper if you do not pay for care. That should not be a surprise to any of us. That is pretty obvious. If you want to get lower insurance costs, let us just cut out treatment for cancer. That will reduce insurance costs. Let us just cut out treatment for mental health.

That is just what this act does. It says ''no State mandates'' which means all the provisions, for example, for pregnant women to be able to have at least 72 hours after giving birth, all those provisions that States have put in for consumer protection, are no longer there under this legislation because this obviates all those State requirements that the people want in their insurance coverage. By joining the insurance pool of Federal employees, we bring everyone under a community rating, which means that we all pay our share, irrespective of whether someone is healthy and young versus old and sick.

All of us should be paying our fair share unless you want to escape paying for the notion that there but for the grace of God go you. The fact of the matter is there but for the grace of God go you, someone else, and I. All of us

have an obligation to those who have needs that need that health insurance.

Why? Because it could be any one of us that is the person that is in great need. And I do not think any one of us would be denied health care coverage simply because as a human being we have greater health care needs. And that is why I believe people ought to support the Kind substitute. We ought to support people's access to the same coverage all of us as Federal Members of Congress receive.

Thank you to my good friends, Mr. KIND and Mr. ANDREWS, for yielding me this time to speak in support of this substitute, the Small Employer Health Benefits Program, which will provide a real solution for many of the forty-five million Americans without health insurance.

Mr. Speaker, our health care system is broken.

To live in a country as great and as wealthy as ours, and to have millions of hard working, employed Americans who cannot afford quality health insurance is inexcusable.

My friends from across the aisle would like the American people to believe that Association Health Plans are the only available option to relieve the burden of increased health care costs on small business owners.

However, the fact remains that Association Health Plans not only ignore the unique needs of small businesses, but will actually undermine our insurance system by allowing healthy individuals to opt out.

We shouldn't be making policy only for the fortunate. We should be making policy for everybody.

The proposed substitute, the Small Employers Health Benefits Program, would provide the same access to health benefits as the Federal Employees Health Benefits Program, FEHBP.

If we are not ready to provide an overall solution to the Nation's health care crisis, then why don't we at least extend small businesses the courtesy of providing a plan that meets the same requirements that Members of Congress and their families currently enjoy.

My colleagues on the other side of the aisle are right about one thing, small business owners are facing a crisis. Now let's provide them with a solution.

Mr. KIND. Mr. Speaker, I yield 2 minutes to the gentleman from Maryland (Mr. CARDIN), a person who has built up considerable health care expertise from his position on the Committee on Ways and Means.

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

Mr. CARDIN. Mr. Speaker, I oppose the underlying bill for many reasons. Fundamentally, it violates the concept of federalism that is embodied in our Constitution, respect for our States, and the ability of our States to be able to regulate public safety issues and health issues for the people of our States.

This legislation would preempt the ability of my State and your State to protect the rights of our own citizens through regulation. That is wrong. That is the wrong usurpation of power by the Federal Government.

This underlying legislation would adversely affect the people of Maryland, and let me tell you why. Our legislature has passed small market reform. People who work for companies that are between two and 50 employees have the opportunity to purchase insurance, affordable health insurance in Maryland as a result of our small market reform. The passage of this legislation will mean the end of the small market reform and the opportunity to purchase insurance by small employers in my State. That is wrong.

We are going to be moving in the wrong direction with making affordable health insurance available for the people of this Nation.

Mr. Speaker, I want you to understand the Insurance Commissioner of Maryland is a Republican. The Governor of Maryland, who opposes this bill, is a Republican. This should not be a partisan issue. This should be a matter about the appropriate use of the Federal authority and it is being used wrong here.

I congratulate the gentleman from Wisconsin (Mr. KIND) for his substitute which is sensitive to the rights of our States. I hope Members will support the substitute and reject the underlying bill.

Mr. Speaker, as a member who is dedicated to protecting the rights of Americans who have health insurance and to ensuring that opportunities to secure affordable health insurance can be expanded, I rise in opposition to H.R. 525. Since coming to Congress, I have heard frequently from individuals who work in small business. They have spoken to me about the difficulties that result from a lack of health insurance coverage, skyrocketing premiums, and reductions in benefits. I remain committed to developing solutions that will alleviate the hardships faced by many Maryland families and small businesses.

However, the Association Health Plan (AHP) legislation we are considering on the House floor today is not a viable solution. H.R. 525 would exempt AHPs from State laws and State regulatory oversight. Through this special exemption, AHPs would be able to severely undermine the goal of greater health care access and affordability for Maryland residents. Although some supporters of this legislation claim it will benefit small employers, the reality is that H.R. 525 will only hurt the small business community.

H.R. 525 would leave the Maryland insurance commissioner powerless to protect our citizens. Under this misguided bill, unregulated out-of-state AHPs could operate in Maryland without being required to comply with health care safeguards enacted by our state legislature, such as:

Appropriate access to emergency care. The right to independent appeal of denied claims, Fair insurance premiums for small groups, Consumer marketing protections, Prevention of health plan failures due to insolvency.

Under this legislation, my constituents would not only lose their ability to demand an independent review of denied claims, but they would lose guaranteed access to important benefits such as emergency medical treatment and mammography screenings. Workers who purchase association health plan coverage—believing that they are getting comprehensive insurance—may very well find that they would still have to shoulder the costs of these essential services.

Not only would this bill be harmful to potential subscribers, it would destroy the small group market reforms already in place in Maryland. Twelve years ago, my home state of Maryland took a major step toward helping small businesses afford health insurance for their workers. Our reforms guarantee the availability of reasonably priced, comprehensive health insurance for all small employers. Specifically, Maryland requires all health insurers to sell a comprehensive standard benefit package designed by an independent commission to all employers with between 2 and 50 employees. The plan must have benefits that are actuarially equivalent to those required to be offered by federally qualified HMOs, and the average cost cannot exceed 12 percent of Maryland's average annual wage. Insurers have the option of offering additional benefits, but they must be priced separately. Insurers must use adjusted community rating to price their plans, and they cannot impose pre-existing condition limitations. The Maryland plan not only guarantees the availability of reasonably priced insurance, it also makes it easier for small employers to make ''apples to apples'' comparisons of health costs throughout the state.

Due to these reforms, more Maryland small businesses offer health care coverage to their employees than in any surrounding states or in the nation as a whole. Maryland's system is one in which healthy subscribers subsidize those who are less healthy. These reforms work because insurers are not allowed to ''cherry pick'' the businesses that have the healthiest workers. Association health plans have been outlawed in our state. The association health plan legislation before us would undermine our system by using the lure of lower premiums to attract firms whose workers have fewer health problems, firms whose employees might be willing to forgo some of the consumer protections offered under Maryland law. Businesses with older, sicker employees would remain in the state system, driving up premiums. H.R. 525 would, in effect, lead to the collapse of Maryland's system. I want to emphasize that this is not a partisan issue—AHS's are opposed by my own governor, our former colleague Robert Ehrlich, and by the National Governors' Association, and the National Association of Insurance Commissioners. I will submit for the RECORD an April 19 letter from Alfred Redmer, Maryland's Insurance Commissioner, expressing his opposition to H.R. 525.

This bill would be devastating on a national level, as well. The non-partisan Congressional Budget Office found that premiums would increase for 20 million employees and their dependents who are covered through small firms, and that 100,000 of the sickest workers would lose coverage altogether if this AHP legislation were enacted.

Passage of this legislation would be a disservice to every worker, every family, and every small business in Maryland. H.R. 525 fails to provide meaningful help for the uninsured, denies access to affordable health care for older, less healthy groups, and undermines the crucial consumer protections that our General Assembly has enacted. For these reasons, I urge my colleagues to vote against this bill.

Mr. Speaker, the following is a letter from our insurance commissioner who is opposed to H.R. 525:

MARYLAND INSURANCE ADMINISTRATION,
Baltimore, MD, April 19, 2005.

Hon. BENJAMIN L. CARDIN,
House of Representatives,
Washington, DC.

DEAR CONGRESSMAN CARDIN: As Commissioner of the Maryland Insurance Administration I am writing to express my strong opposition to federal legislation that would create Association Health Plans, AHPs. I understand such legislation, H.R. 525, has been passed, again, by the House Education and the Workforce Committee and may soon come to the floor of the House for a vote. H.R. 525 would allow AHPs to form and operate in Maryland outside the authority of my office and beyond the reach of proven State consumer safeguards and solvency laws. If enacted into law, this could do irreparable harm to our small group market and strip our citizens of critical protections.

Altough I share the sponsor's concern for the growing number of small business employees who cannot afford adequate coverage, the fact is this legislation would do little, if anything to address this problem. H.R. 525 ignores the root cause of the current crisis—skyrocketing healthcare spending. Unless spending is brought under control no attempts to increase competition or enhance options for small business will truly make insurance affordable and, thus, promote coverage.

Even more troubling is the harm the legislation would do to consumers, H.R. 525 would: (1) permit risk selection thereby creating opportunities for ''cherry-picking'' among healthier groups; (2) allow inadequate capital standards and solvency requirements, both of which are inferior to existing State standards; (3) eliminate proven State consumer protection laws, including those designed to allow consumer appeals of adverse plan decisions and those aimed at preventing and fighting fraud; and (4) allow AHPs to ignore State benefit requirements. To add insult to injury, while longstanding State oversight and consumer protections would be eliminated, H.R. 525 provides no additional resources to the Department of Labor to regulate AHPs or help consumers.

I remain committed to improving access to affordable insurance for small business owners and workers in Maryland. Together, we can find solutions that will be effective and not lead to greater problems in the future. H.R. 515 is clearly not the answer and I urge you to oppose it.

Sincerely,

AL REDMER, Jr.,
Insurance Commissioner.

Mr. SAM JOHNSON of Texas. Mr. Speaker, I yield 30 seconds to the gentleman from Louisiana (Mr. BOUSTANY).

Mr. BOUSTANY. Mr. Speaker, I would like to engage the gentleman from Wisconsin (Mr. KIND) in a colloquy.

My question is, I think we need to know this information, what is the cost of your amendment to the Federal Government?

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

Mr. BOUSTANY. I yield to the gentleman from Wisconsin.

Mr. KIND. We are waiting to get a cost estimate back, but based on two previous debates on this issue, it was comparable to the amount of money set aside for the health savings account that has been a part of this bill in the past, but is not this year.

Mr. BOUSTANY. I think we need to have that information. I am all for choices and the gentleman's plan is intriguing, it is interesting; but I think it may be premature.

Mr. SAM JOHNSON of Texas. Mr. Speaker, do I have the right to close?

The SPEAKER pro tempore. Yes.

Mr. SAM JOHNSON of Texas. Mr. Speaker, I reserve the balance of my time.

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

Mr. Speaker, I think there is wide agreement, bipartisan agreement that we have got a serious issue on our hands, a huge challenge that is facing our Nation, that is, rising health care costs and the impact it is having on economic growth, the opportunities for businesses large and small to grow and hire additional workers. I think it is one of the main reasons why we have experienced such anemic job growth in this country in recent years, because of the hesitancy of so many businesses, especially small businesses to hire additional workers because of the associated rising health care costs. It is something that we must address in order to deal with an expanding economy at a rate that we would all like to see, but also to get a grip on the stagnant wages right now that are holding so many of our workers back.

I think there is a direct cause and effect whereas the typical worker's wages have been frozen in effect in recent years because of the additional costs coming out of their pockets to afford health care. That is why, again, we have had an important debate today, but it is one we should be working on in a bipartisan fashion to address the underlying causes.

Volumes have been written about the underlying associated health plan that is before us today. And, unfortunately, the verdict is in and that verdict is this is just bad public policy. That is why so many of the Governors and so many of the attorneys general, and the commissioners of insurance, the Association of State Legislatures in a bipartisan fashion have roundly criticized and condemned the underlying associated health plan, because they feel as we do on this side that it will do more harm than good.

I understand and appreciate the motivation on the other side to try to move forward on this issue. But we are stuck. The wheels are stuck in the mud, and it is just spinning because it is not getting any traction. And that is because the Senate in their analysis of the underlying bill has found that it, too, is bad public policy. And I am afraid we are going to have this debate today, it is going to expire and it is going to get stuck with no progress being made.

Perhaps there may be some deficiencies in what we are offering in our substitute, just as we believe there are deficiencies in theirs. But now is the time for us to come together to try to find some common ground so we can make progress and deal with this issue that is affecting more and more Americans every year.

One of the issues that really has not received that much attention, and I would just like to close on and highlight it, is again the fact of the Federal preemption and taking away from States the ability to conduct proper oversight and accountability with these insurance plans.

Both the GAO in a study and a recent Georgetown University study that came out this summer indicated that the underlying AHP bill, as it is written with the weak provisions that would go to the Department of Labor, would lead to an explosion of fraud and abuse with these types of plans throughout the country. And there is a history of fraud and abuse.

Currently, there are over 144 plans that are set up fraudulently that are not paying the claims that are affecting well over 200,000 workers. But for the effective oversight and the policing that is taking place at the State level, even these would probably go unnoticed. It would impact more and more Americans. It is another reason why the underlying bill does not make sense, why the Federal preemption over State jurisdiction, which has been the history of health care regulation in this country, is another bad idea.

Our substitute addresses that by not preempting State law by allowing the State jurisdiction and oversight to continue. It does build upon the concept of a purchasing pool modeled after the Federal employee health plan which, as was stated earlier, has worked marvelously over the years. No one is recommending dismantling that.

I would encourage a ''yes'' on the substitute and a ''no'' on the underlying bill.

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

Mr. SAM JOHNSON of Texas. Mr. Speaker, I yield myself the balance of my time.

Mr. Speaker, we do not know the cost. It is going to be out of reason, I believe. And while AHP legislation will be implemented quickly, this Democrat substitute might take years to get up and running.

In addition, the funds are subject to appropriations. And if an appropriation did not go through or did not provide enough funds, small employers and their workers would be left hanging.

Let me make myself clear. I believe our Nation's employer-sponsored health care system is a success story. Employers provide coverage for the vast majority of our Nation's population; 131 million Americans obtain their coverage from private employers.

The Committee on Education and the Workforce and the Department of Labor through our oversight of ERISA have jurisdiction over employer-sponsored health care. So I support using

the employer-based system to address the problems of the uninsured.

□ 1730

However, the way to do that is to build on the success of the current system by utilizing the strengths that enable large employers and unions to offer Cadillac health plans. AHPs are the way to do that. Vote down this amendment. Vote for AHPs.

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

The SPEAKER pro tempore (Mr. REHBERG). Pursuant to House Resolution 379, the previous question is ordered on the bill and on the amendment in the nature of a substitute offered by the gentleman from Wisconsin (Mr. KIND).

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

The question was taken; and the Speaker pro tempore announced that the 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 197, nays 230, not voting 6, as follows:

[Roll No. 424]

YEAS—197

Abercrombie
Ackerman
Allen
Andrews
Baca
Baird
Baldwin
Barrow
Becerra
Berkley
Berman
Berry
Bishop (GA)
Bishop (NY)
Blumenauer
Boswell
Boucher
Boyd
Brady (PA)
Brown (OH)
Brown, Corrine
Butterfield
Capps
Capuano
Cardin
Cardoza
Carnahan
Carson
Case
Chandler
Clay
Cleaver
Clyburn
Conyers
Cooper
Costa
Costello
Crowley
Cuellar
Cummings
Davis (AL)
Davis (CA)
Davis (FL)
Davis (IL)
Davis (TN)
DeFazio
DeGette
Delahunt
DeLauro
Dicks
Dingell
Doggett
Doyle
Edwards
Emanuel
Engel
Eshoo
Etheridge
Evans
Farr
Fattah
Filner
Ford
Frank (MA)
Gonzalez
Gordon
Green, Al
Green, Gene
Grijalva
Gutierrez
Harman
Hastings (FL)
Herseth
Higgins
Hinchey
Hinojosa
Holden
Holt
Honda
Hooley
Hoyer
Inslee
Israel
Jackson (IL)
Jackson-Lee (TX)
Jefferson
Johnson, E. B.
Jones (OH)
Kanjorski
Kaptur
Kennedy (RI)
Kildee
Kilpatrick (MI)
Kind
Kucinich
Langevin
Lantos
Larsen (WA)
Larson (CT)
Lee
Levin
Lewis (GA)
Lipinski
Lofgren, Zoe
Lowey
Lynch
Maloney
Markey
Marshall
Matheson
Matsui
McCarthy
McCollum (MN)
McDermott
McGovern
McKinney
McNulty
Meehan
Meek (FL)
Meeks (NY)
Melancon
Menendez
Michaud
Millender-McDonald
Miller (NC)
Miller, George
Mollohan
Moore (KS)
Moore (WI)
Moran (VA)
Murtha
Nadler
Napolitano
Neal (MA)
Oberstar
Obey
Olver
Ortiz
Pallone
Pascrell
Pastor
Payne
Pelosi
Peterson (MN)
Pomeroy
Price (NC)
Rahall
Rangel
Reyes
Ross
Rothman
Roybal-Allard
Ruppersberger
Rush
Ryan (OH)
Sabo
Salazar
Sánchez, Linda T.
Sanchez, Loretta
Sanders
Schakowsky
Schiff
Schwartz (PA)
Schwarz (MI)
Scott (GA)
Scott (VA)
Serrano
Sherman
Skelton
Slaughter
Smith (WA)
Snyder
Solis
Spratt
Stark
Strickland
Stupak
Tanner
Tauscher
Taylor (MS)
Thompson (CA)
Thompson (MS)
Tierney
Towns
Udall (CO)
Udall (NM)
Van Hollen
Visclosky
Wasserman Schultz
Waters
Watson
Watt
Waxman
Weiner
Wexler
Woolsey
Wu

NAYS—230

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

NOT VOTING—6

Cramer
Feeney
Gibbons
Owens
Oxley
Westmoreland

□ 1753

Messrs. WYNN, WELLER, and SHERWOOD changed their vote from ''yea'' to ''nay.''

Mr. RUSH changed his vote from ''nay'' to ''yea.''

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

The result of the vote was announced as above recorded.

The SPEAKER pro tempore (Mr. HAYES). The question is on the engrossment and third reading of the bill.

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

MOTION TO RECOMMIT OFFERED BY MR. GEORGE MILLER OF CALIFORNIA

Mr. GEORGE MILLER of California. Mr. Speaker, I offer a motion to recommit.

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

Mr. GEORGE MILLER of California. I am, Mr. Speaker.

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

The Clerk read as follows:

Mr. GEORGE MILLER of California moves to recommit the bill H.R. 525 to the Committee on Education and the Workforce with instructions to report the same back to the House forthwith with the following amendments:

Page 17, line 16, insert ''subsection (c) and'' before ''section 514(d)''.

Page 18, insert after line 6 the following:

''(c) MAINTENANCE OF STATE LAWS PROVIDING FOR CERTAIN FORMS OF COVERAGE .—Nothing in this part or section 514 shall be construed to preclude the application of State law (as defined in section 514(c)(1)) to an association health plan, or any health insurance issuer offering health insurance coverage in connection with the plan—

''(1) to the extent that such law requires coverage for the expenses of—

''(A) pregnancy and childbirth, or

''(B) children's health services (including the application of any such State law to the extent such law requires certain numbers of child health supervision visits or requires exemption of reasonable and customary charges for child health supervision services from a deductible, copayment, or other coinsurance or dollar limitation requirement),

''(2) to the extent that such law requires—

''(A) a minimum hospital stay for mastectomy,

''(B) coverage for reconstructive surgery following mastectomies (in excess of coverage required under section 713), and

''(C) coverage for the expenses of screening and tests recommended by a physician for breast cancer,

''(3) to the extent that such law requires—

''(A) coverage for medical treatments relating to cervical cancer, and

''(B) coverage for the expenses of screening and tests recommended by a physician for cervical cancer,

''(4) to the extent that such law requires—

''(A) the offering of, or coverage for, medical treatments related to mental illness or substance abuse and other services related to the treatment of mental illness or substance abuse,

''(B) coverage for prescription medications associated with the management of mental illness or substance abuse, or

''(C) education and self-management training services relating to mental illness or substance abuse,

''(5) to the extent that such law requires—

''(A) coverage for medical treatments related to diabetes,

''(B) coverage for diabetes-specific supplies, including blood glucose monitors, insulin pumps, insulin syringes, and single-use medical supplies associated with the management of diabetes,

''(C) coverage for prescription medications when prescribed by a physician associated with the management of diabetes, including insulin, or

''(D) diabetes education and self-management training services, or

''(6) to the extent that such law imposes annual, lifetime, or day and visit benefit minimums or limits copayments, deductibles, or out-of-pocket or other coinsurance requirements in connection with coverage, or items and services, described in the preceding paragraphs of this subsection.

Mr. GEORGE MILLER of California (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 gentleman from California?

There was no objection.

The SPEAKER pro tempore. The gentleman from California (Mr. GEORGE MILLER) is recognized for 5 minutes in support of his motion to recommit.

Mr. GEORGE MILLER of California. Mr. Speaker, I submit a motion to recommit along with my colleagues on the Committee on Education and the Workforce, the gentlewoman from New York (Mrs. MCCARTHY), the gentlewoman from California (Ms. WOOLSEY), and the gentlewoman from Minnesota (Ms. MCCOLLUM).

This motion shows exactly what the issue is about. It is about the minimum standard of health care protection for all Americans, including those who work for small businesses.

Mr. Speaker, all employees, including the employees of small employers, may need access to pregnancy, to well-child care, to cancer treatment, mental health treatment, or even diabetes treatment. We should not encourage insurers to offer bare-bones treatment that does not protect anyone.

Everyone gets sick at some point in their lives, and everyone will need access to a meaningful package of benefits. That is why I am offering this motion to recommit.

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

Mrs. MCCARTHY. Mr. Speaker, as we worked on this on the Committee on Education and the Workforce, we tried to put our thoughts into it. People have to understand, if the main bill is passed, health care for our small employers is not going to help the majority of those employees seeking coverage.

The recommittal goes back to what the States have already done, mainly because in the beginning the insurance companies would not give health care to women that needed to have a mammogram or to have a pap smear to make sure they do not have cervical cancer.

This House spends money constantly on cancer research, and here we are using a tool that we can prevent cancer and make sure that women are treated earlier. With this bill, the mainline bill is taking that away. I ask my colleagues, do not be fooled, stand up for your State. Stand up for the health care of your constituents. That is what our job is.

Mr. GEORGE MILLER of California. Mr. Speaker, I yield to the gentlewoman from Minnesota (Ms. MCCOLLUM).

Ms. MCCOLLUM of Minnesota. Mr. Speaker, I rise to support the motion to recommit because AHPs are awful health plans. AHPs roll back State benefit standards that protect women and children. They are awful for women; they are awful for children.

Our motion protects Americans who have access to mental health benefits. It protects families' access to maternity care and well-baby checks.

□ 1800

Maternity coverage is critical for women. It should not be optional. Fortunately, many States require health plans to cover maternity care and well-baby checks for their children. The bottom line is healthy moms equal healthy children. Healthy children, valuing children's lives, should be a goal we all share.

Children deserve a healthy start in life with regular visits to the doctor and necessary immunizations. Preventive care makes economic sense. It can prevent avoidable illness and reduce future health care costs.

I encourage all Members to reject awful health plans and to support the motion to recommit.

Mr. GEORGE MILLER of California. Mr. Speaker, I yield to the gentlewoman from California (Ms. WOOLSEY).

Ms. WOOLSEY. Mr. Speaker, the preemption of State law that is allowed under H.R. 525 makes no sense. For example, 49 States guarantee that health insurance plans include mammograms, and for good reason. We know that if a woman has health insurance, the likelihood she will receive a mammogram is promising. We know that early detection increases a woman's chance of surviving breast cancer. No one knows this better than my constituents in Marin County, California, who suffer from the highest rates of breast cancer in the country. They deserve more protections from this deadly disease, not a rollback in coverage of the most basic screening tool we have, mammograms. They are looking to Congress to help more women get the services they need to catch this disease before it becomes fatal. Instead, today we are telling them that insurance companies are allowed to trump State law and decide what is best for their health.

I am sure that all of the men and women here today want their wives, sisters, mothers, and daughters to have annual screenings as recommended by physicians. It is common sense. I urge each of my colleagues, support the women in your lives. Support the motion to recommit.

Mr. GEORGE MILLER of California. Mr. Speaker, I would hope that people would support this motion to recommit. This is fundamental and basic. It is about whether or not people will have coverage that works for them when they or a member of their family becomes sick.

CBO has looked at this legislation three times, and three times they have determined that almost 8 million people who today have health care coverage that is good coverage, they will be stripped of that coverage and put into these AHPs. In fact, they expect that 90 percent of the new enrollees will be people who come out of better plans who will lose that coverage that people have fought hard for in almost every State in this Union, to have those kinds of health care protections that our three colleagues just spoke about in support of this motion to recommit.

I would urge the House to support the motion to recommit and reject this legislation that is harmful to the health care coverage of millions of Americans and their families.

Mr. BOEHNER. Mr. Speaker, I rise in opposition to the gentleman's motion.

The SPEAKER pro tempore (Mr. HAYES). The gentleman is recognized for 5 minutes.

Mr. BOEHNER. Mr. Speaker, the most coveted health insurance available to Americans is offered by big companies and unions. All we are trying to do in the underlying bill is to give small employers the same opportunity to provide high-quality health insurance to their employees at competitive prices.

The motion to recommit would require every AHP to cover every mandate known to man, driving up the cost of those policies and making sure that no new employees would ever be covered by an AHP. There are 45 million Americans with no health insurance. While this will not cover all 45 million Americans, it will help some Americans who have no access to health insurance today have access to high-quality, competitively priced health insurance. You can have all the mandates in the world; but if you do not have health insurance, you get no coverage at all. No doctors' visits. No nothing. It is a bad motion. Support the underlying bill.

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

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

There was no objection.

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

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

Mr. GEORGE MILLER of California. Mr. Speaker, on that I demand the yeas and nays.

The yeas and nays were ordered.

The SPEAKER pro tempore. Pursuant to clause 8 and clause 9 of rule XX, this 15-minute vote on the motion to recommit will be followed by 5-minute votes on passage of H.R. 525, if ordered, and suspending the rules on H.R. 2894.

The vote was taken by electronic device, and there were—yeas 198, nays 230, not voting 5, as follows:

[Roll No. 425]

YEAS—198

Abercrombie
Ackerman
Allen
Andrews
Baca
Baird
Baldwin
Barrow
Bean
Becerra
Berkley
Berman
Berry
Bishop (GA)
Bishop (NY)
Blumenauer
Boren
Boswell
Boucher
Boyd
Brady (PA)
Brown (OH)
Brown, Corrine
Butterfield
Capps
Capuano
Cardin
Cardoza
Carnahan
Carson
Case
Chandler
Clay
Cleaver
Clyburn
Conyers
Cooper
Costa
Costello
Crowley
Cuellar
Cummings
Davis (AL)
Davis (CA)
Davis (FL)
Davis (IL)
Davis (TN)
DeFazio
DeGette
Delahunt
DeLauro
Dicks
Dingell
Doggett
Doyle
Edwards
Emanuel
Engel
Eshoo
Etheridge
Farr
Fattah
Filner
Ford
Frank (MA)
Gonzalez
Gordon
Green, Al
Green, Gene
Grijalva
Gutierrez
Harman
Hastings (FL)
Herseth
Higgins
Hinchey
Hinojosa
Holden
Holt
Honda
Hooley
Hoyer
Inslee
Israel
Jackson (IL)
Jackson-Lee (TX)
Jefferson
Johnson, E. B.
Jones (OH)
Kanjorski
Kaptur
Kennedy (RI)
Kildee
Kilpatrick (MI)
Kind
Kucinich
Langevin
Lantos
Larsen (WA)
Larson (CT)
Lee
Levin
Lewis (GA)
Lipinski
Lofgren, Zoe
Lowey
Lynch
Maloney
Markey
Marshall
Matheson
Matsui
McCarthy
McCollum (MN)
McDermott
McGovern
McIntyre
McKinney
McNulty
Meehan
Meek (FL)
Meeks (NY)
Melancon
Menendez
Michaud
Millender-McDonald
Miller (NC)
Miller, George
Mollohan
Moore (KS)
Moore (WI)
Moran (VA)
Murtha
Nadler
Napolitano
Neal (MA)
Oberstar
Obey
Olver
Ortiz
Owens
Pallone
Pascrell
Pastor
Payne
Pelosi
Peterson (MN)
Pomeroy
Price (NC)
Rahall
Rangel
Reyes
Ross
Rothman
Roybal-Allard
Ruppersberger
Rush
Ryan (OH)
Sabo
Salazar
Sánchez, Linda T.
Sanchez, Loretta
Sanders
Schakowsky
Schiff
Schwartz (PA)
Scott (GA)
Scott (VA)
Serrano
Sherman
Skelton
Slaughter
Smith (WA)
Snyder
Solis
Spratt
Stark
Strickland
Stupak
Tanner
Tauscher
Taylor (MS)
Thompson (CA)
Thompson (MS)
Tierney
Towns
Udall (CO)
Udall (NM)
Van Hollen
Visclosky
Wasserman Schultz
Waters
Watson
Watt
Weiner
Wexler
Woolsey
Wu

NAYS—230

Aderholt
Akin
Alexander
Bachus
Baker
Barrett (SC)
Bartlett (MD)
Barton (TX)
Bass
Beauprez
Biggert
Bilirakis
Bishop (UT)
Blackburn
Blunt
Boehlert
Boehner
Bonilla
Bonner
Bono
Boozman
Boustany
Bradley (NH)
Brady (TX)
Brown (SC)
Brown-Waite, Ginny
Burgess
Burton (IN)
Buyer
Calvert
Camp
Cannon
Cantor
Capito
Carter
Castle
Chabot
Chocola
Coble
Cole (OK)
Conaway
Cox
Crenshaw
Cubin
Culberson
Cunningham
Davis (KY)
Davis, Jo Ann
Davis, Tom
Deal (GA)
DeLay
Dent
Diaz-Balart, L.
Diaz-Balart, M.
Doolittle
Drake
Dreier
Duncan
Ehlers
Emerson
English (PA)
Evans
Everett
Ferguson
Fitzpatrick (PA)
Flake
Foley
Forbes
Fortenberry
Fossella
Foxx
Franks (AZ)
Frelinghuysen
Gallegly
Garrett (NJ)
Gerlach
Gilchrest
Gillmor
Gingrey
Gohmert
Goode
Goodlatte
Granger
Graves
Green (WI)
Gutknecht
Hall
Harris
Hart
Hastings (WA)
Hayes
Hayworth
Hefley
Hensarling
Herger
Hobson
Hoekstra
Hostettler
Hulshof
Hunter
Hyde
Inglis (SC)
Issa
Istook
Jenkins
Jindal
Johnson (CT)
Johnson (IL)
Johnson, Sam
Jones (NC)
Keller
Kelly
Kennedy (MN)
King (IA)
King (NY)
Kingston
Kirk
Kline
Knollenberg
Kolbe
Kuhl (NY)
LaHood
Latham
LaTourette
Leach
Lewis (CA)
Lewis (KY)
Linder
LoBiondo
Lucas
Lungren, Daniel E.
Mack
Manzullo
Marchant
McCaul (TX)
McCotter
McCrery
McHenry
McHugh
McKeon
McMorris
Mica
Miller (FL)
Miller (MI)
Miller, Gary
Moran (KS)
Murphy
Musgrave
Myrick
Neugebauer
Ney
Northup
Norwood
Nunes
Nussle
Osborne
Otter
Paul
Pearce
Pence
Peterson (PA)
Petri
Pickering
Pitts
Platts
Poe
Pombo
Porter
Price (GA)
Pryce (OH)
Putnam
Radanovich
Ramstad
Regula
Rehberg
Reichert
Renzi
Reynolds
Rogers (AL)
Rogers (KY)
Rogers (MI)
Rohrabacher
Ros-Lehtinen
Royce
Ryan (WI)
Ryun (KS)
Saxton
Schwarz (MI)
Sensenbrenner
Sessions
Shadegg
Shaw
Shays
Sherwood
Shimkus
Shuster
Simmons
Simpson
Smith (NJ)
Smith (TX)
Sodrel
Souder
Stearns
Sullivan
Sweeney
Tancredo
Taylor (NC)
Terry
Thomas
Thornberry
Tiahrt
Tiberi
Turner
Upton
Velázquez
Walden (OR)
Walsh
Wamp
Weldon (FL)
Weldon (PA)
Weller
Westmoreland
Whitfield
Wicker
Wilson (NM)
Wilson (SC)
Wolf
Wynn
Young (AK)
Young (FL)

NOT VOTING—5

Cramer
Feeney
Gibbons
Oxley
Waxman

ANNOUNCEMENT BY THE SPEAKER PRO TEMPORE

The SPEAKER pro tempore (Mr. HAYES) (during the vote). Members are advised there are 2 minutes remaining in this vote.

□ 1821

So the motion to recommit was rejected.

The result of the vote was announced as above recorded.

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

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

Mr. ANDREWS. 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 263, nays 165, not voting 5, as follows:

[Roll No. 426]

YEAS—263

Aderholt
Akin
Alexander
Bachus
Baird
Baker
Barrett (SC)
Bartlett (MD)
Barton (TX)
Bass
Bean
Beauprez
Biggert
Bilirakis
Bishop (GA)
Bishop (UT)
Blackburn
Blunt
Boehlert
Boehner
Bonilla
Bonner
Bono
Boozman
Boren
Boustany
Bradley (NH)
Brady (TX)
Brown (SC)
Brown-Waite, Ginny
Burgess
Burton (IN)
Buyer
Calvert
Camp
Cannon
Cantor
Capito
Carter
Case
Castle
Chabot
Chocola
Coble
Cole (OK)
Conaway
Cooper
Costello
Cox
Crenshaw
Cubin
Cuellar
Culberson
Cunningham
Davis (AL)
Davis (KY)
Davis (TN)
Davis, Jo Ann
Davis, Tom
Deal (GA)
DeLay
Dent
Diaz-Balart, L.
Diaz-Balart, M.
Doolittle
Drake
Dreier
Duncan
Edwards
Ehlers
Emerson
English (PA)
Everett
Ferguson
Fitzpatrick (PA)
Flake
Foley
Forbes
Ford
Fortenberry
Fossella
Foxx
Franks (AZ)
Frelinghuysen
Gallegly
Garrett (NJ)
Gerlach
Gilchrest
Gillmor
Gingrey
Gohmert
Gonzalez
Goode
Goodlatte
Gordon
Granger
Graves
Green (WI)
Gutknecht
Hall
Harman
Harris
Hart
Hastings (WA)
Hayes
Hayworth
Hefley
Hensarling
Herger
Herseth
Hobson
Hoekstra
Hostettler
Hulshof
Hunter
Hyde
Inglis (SC)
Israel
Issa
Istook
Jackson-Lee (TX)
Jenkins
Jindal
Johnson (CT)
Johnson (IL)
Johnson, Sam
Jones (NC)
Keller
Kelly
Kennedy (MN)
King (IA)
King (NY)
Kingston
Kirk
Kline
Knollenberg
Kolbe
Kuhl (NY)
LaHood
Latham
LaTourette
Leach
Lewis (CA)
Lewis (KY)
Linder
Lipinski
LoBiondo
Lucas
Lungren, Daniel E.
Mack
Manzullo
Marchant
Marshall
Matheson
McCaul (TX)
McCotter
McCrery
McHenry
McHugh
McIntyre
McKeon
McMorris
Mica
Miller (FL)
Miller (MI)
Miller, Gary
Mollohan
Moran (KS)
Moran (VA)
Murphy
Musgrave
Myrick
Neugebauer
Ney
Northup
Norwood
Nunes
Nussle
Ortiz
Osborne
Otter
Paul
Pearce
Pence
Peterson (MN)
Peterson (PA)
Petri
Pickering
Pitts
Platts
Poe
Pombo
Porter
Price (GA)
Pryce (OH)
Putnam
Radanovich
Rahall
Ramstad
Regula
Rehberg
Reichert
Renzi
Reynolds
Rogers (AL)
Rogers (KY)
Rogers (MI)
Rohrabacher
Ros-Lehtinen
Rothman
Royce
Ryan (WI)
Ryun (KS)
Salazar
Sanchez, Loretta
Saxton
Schwarz (MI)
Sensenbrenner
Sessions
Shadegg
Shaw
Shays
Sherwood
Shimkus
Shuster
Simmons
Simpson
Skelton
Smith (NJ)
Smith (TX)
Snyder
Sodrel
Souder
Stearns
Sullivan
Sweeney
Tancredo
Taylor (MS)
Taylor (NC)
Terry
Thomas
Thompson (MS)
Thornberry
Tiahrt
Tiberi
Turner
Upton
Velázquez
Walden (OR)
Walsh
Wamp
Weldon (FL)
Weldon (PA)
Weller
Westmoreland
Whitfield
Wicker
Wilson (NM)
Wilson (SC)
Wolf
Wynn
Young (AK)
Young (FL)

NAYS—165

Abercrombie
Ackerman
Allen
Andrews
Baca
Baldwin
Barrow
Becerra
Berkley
Berman
Berry
Bishop (NY)
Blumenauer
Boswell
Boucher

Boyd
Brady (PA)
Brown (OH)
Brown, Corrine
Butterfield
Capps
Capuano
Cardin
Cardoza
Carnahan
Carson
Chandler
Clay
Cleaver
Clyburn
Conyers
Costa
Crowley
Cummings
Davis (CA)
Davis (FL)
Davis (IL)
DeFazio
DeGette
Delahunt
DeLauro
Dicks
Dingell
Doggett
Doyle
Emanuel
Engel
Eshoo
Etheridge
Evans
Farr
Fattah
Filner
Frank (MA)
Green, Al
Green, Gene
Grijalva
Gutierrez
Hastings (FL)
Higgins
Hinchey
Hinojosa
Holden
Holt
Honda
Hooley
Hoyer
Inslee
Jackson (IL)
Jefferson
Johnson, E. B.
Jones (OH)
Kanjorski
Kaptur
Kennedy (RI)
Kildee
Kilpatrick (MI)
Kind
Kucinich
Langevin
Lantos
Larsen (WA)
Larson (CT)
Lee
Levin
Lewis (GA)
Lofgren, Zoe
Lowey
Lynch
Maloney
Markey
Matsui
McCarthy
McCollum (MN)
McDermott
McGovern
McKinney
McNulty
Meehan
Meek (FL)
Meeks (NY)
Melancon
Menendez
Michaud
Millender-McDonald
Miller (NC)
Miller, George
Moore (KS)
Moore (WI)
Murtha
Nadler
Napolitano
Neal (MA)
Oberstar
Obey
Olver
Owens
Pallone
Pascrell
Pastor
Payne
Pelosi
Pomeroy
Price (NC)
Rangel
Reyes
Ross
Roybal-Allard
Ruppersberger
Rush
Ryan (OH)
Sabo
Sánchez, Linda T.
Sanders
Schakowsky
Schiff
Schwartz (PA)
Scott (GA)
Scott (VA)
Serrano
Sherman
Slaughter
Smith (WA)
Solis
Spratt
Stark
Strickland
Stupak
Tanner
Tauscher
Thompson (CA)
Tierney
Towns
Udall (CO)
Udall (NM)
Van Hollen
Visclosky
Wasserman Schultz
Waters
Watson
Watt
Weiner
Wexler
Woolsey
Wu

NOT VOTING—5

Cramer
Feeney
Gibbons
Oxley
Waxman

ANNOUNCEMENT BY THE SPEAKER PRO TEMPORE

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

□ 1834

Ms. MILLENDER-McDONALD changed her 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.

ABRAHAM LINCOLN BIRTHPLACE POST OFFICE BUILDING

The SPEAKER pro tempore. The unfinished business is the question of suspending the rules and passing the bill, H.R. 2894.

The Clerk read the title of the bill.

The SPEAKER pro tempore. The question is on the motion offered by the gentleman from California (Mr. ISSA) that the House suspend the rules and pass the bill, H.R. 2894, 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 421, nays 0, not voting 12, as follows:

[Roll No. 427]

YEAS—421

Abercrombie
Ackerman
Aderholt
Akin
Alexander
Allen
Andrews
Baca
Bachus
Baird
Baker
Baldwin
Barrett (SC)
Barrow
Bartlett (MD)
Barton (TX)
Bass
Bean
Beauprez
Becerra
Berkley
Berry
Biggert
Bilirakis
Bishop (GA)
Bishop (NY)
Bishop (UT)
Blackburn
Blumenauer
Blunt
Boehlert
Boehner
Bonilla
Bonner
Bono
Boozman
Boren
Boswell
Boucher
Boustany
Boyd
Bradley (NH)
Brady (PA)
Brady (TX)
Brown (OH)
Brown (SC)
Brown, Corrine
Burgess
Burton (IN)
Butterfield
Buyer
Calvert
Camp
Cannon
Cantor
Capito
Capps
Capuano
Cardin
Cardoza
Carnahan
Carson
Carter
Case
Castle
Chabot
Chandler
Chocola
Clay
Cleaver
Clyburn
Coble
Cole (OK)
Conaway
Conyers
Cooper
Costa
Costello
Cox
Crenshaw
Crowley
Cubin
Cuellar
Culberson
Cummings
Cunningham
Davis (AL)
Davis (CA)
Davis (FL)
Davis (IL)
Davis (KY)
Davis (TN)
Davis, Jo Ann
Davis, Tom
Deal (GA)
DeFazio
DeGette
Delahunt
DeLauro
DeLay
Dent
Diaz-Balart, L.
Diaz-Balart, M.
Dicks
Dingell
Doggett
Doolittle
Doyle
Drake
Dreier
Duncan
Edwards
Ehlers
Emanuel
Emerson
Engel
English (PA)
Eshoo
Etheridge
Evans
Everett
Farr
Fattah
Ferguson
Filner
Fitzpatrick (PA)
Flake
Foley
Forbes
Ford
Fortenberry
Fossella
Foxx
Frank (MA)
Franks (AZ)
Frelinghuysen
Gallegly
Garrett (NJ)
Gerlach
Gilchrest
Gillmor
Gingrey
Gohmert
Gonzalez
Goode
Goodlatte
Gordon
Granger
Graves
Green (WI)
Green, Al
Green, Gene
Grijalva
Gutierrez
Gutknecht
Hall
Harman
Harris
Hart
Hastings (FL)
Hastings (WA)
Hayes
Hayworth
Hefley
Hensarling
Herger
Herseth
Higgins
Hinchey
Hinojosa
Hobson
Hoekstra
Holden
Holt
Honda
Hooley
Hostettler
Hoyer
Hulshof
Hunter
Hyde
Inglis (SC)
Inslee
Israel
Issa
Istook
Jackson (IL)
Jackson-Lee (TX)
Jefferson
Jenkins
Jindal
Johnson (CT)
Johnson (IL)
Johnson, E. B.
Johnson, Sam
Jones (NC)
Jones (OH)
Kanjorski
Kaptur
Keller
Kelly
Kennedy (MN)
Kennedy (RI)
Kildee
Kilpatrick (MI)
Kind
King (IA)
King (NY)
Kingston
Kirk
Kline
Knollenberg
Kolbe
Kucinich
Kuhl (NY)
LaHood
Langevin
Lantos
Larsen (WA)
Larson (CT)
Latham
Leach
Lee
Levin
Lewis (CA)
Lewis (GA)
Lewis (KY)
Linder
Lipinski
LoBiondo
Lofgren, Zoe
Lowey
Lucas
Lungren, Daniel E.
Lynch
Mack
Maloney
Manzullo
Marchant
Markey
Marshall
Matheson
Matsui
McCarthy
McCaul (TX)
McCollum (MN)
McCotter
McCrery
McDermott
McGovern
McHugh
McIntyre
McKeon
McKinney
McMorris
McNulty
Meehan
Meek (FL)
Meeks (NY)
Melancon
Menendez
Mica
Michaud
Millender-McDonald
Miller (FL)
Miller (MI)
Miller (NC)
Miller, Gary
Miller, George
Mollohan
Moore (KS)
Moore (WI)
Moran (KS)
Moran (VA)
Murphy
Murtha
Musgrave
Myrick
Nadler
Napolitano
Neal (MA)
Neugebauer
Ney
Northup
Norwood
Nunes
Nussle
Oberstar
Obey
Olver
Ortiz
Osborne
Owens
Pallone
Pascrell
Pastor
Payne
Pearce
Pelosi
Pence
Peterson (MN)
Petri
Pickering
Pitts
Platts
Poe
Pombo
Pomeroy
Porter
Price (GA)
Price (NC)
Pryce (OH)
Putnam
Radanovich
Rahall
Ramstad
Rangel
Regula
Rehberg
Reichert
Renzi
Reyes
Reynolds
Rogers (AL)
Rogers (KY)
Rogers (MI)
Rohrabacher
Ros-Lehtinen
Ross
Rothman
Roybal-Allard
Royce
Ruppersberger
Rush
Ryan (OH)
Ryan (WI)
Ryun (KS)
Sabo
Salazar
Sánchez, Linda T.
Sanchez, Loretta
Sanders
Saxton
Schakowsky
Schiff
Schwartz (PA)
Schwarz (MI)
Scott (GA)
Scott (VA)
Sensenbrenner
Serrano
Sessions
Shadegg
Shaw
Shays
Sherman
Sherwood
Shimkus
Shuster
Simmons
Simpson
Skelton
Slaughter
Smith (NJ)
Smith (TX)
Smith (WA)
Snyder
Sodrel
Solis
Souder
Spratt
Stark
Stearns
Strickland
Stupak
Sullivan
Sweeney
Tancredo
Tanner
Tauscher
Taylor (MS)
Taylor (NC)
Terry
Thomas
Thompson (CA)
Thompson (MS)
Thornberry
Tiahrt
Tiberi
Tierney
Towns
Turner
Udall (CO)
Udall (NM)
Upton
Van Hollen
Velázquez
Visclosky
Walden (OR)
Walsh
Wamp
Wasserman Schultz
Waters
Watson
Watt
Weiner
Weldon (FL)
Weldon (PA)
Weller
Westmoreland
Wexler
Whitfield
Wicker
Wilson (NM)
Wilson (SC)
Wolf
Woolsey
Wu
Wynn
Young (AK)
Young (FL)

NOT VOTING—12

Berman
Brown-Waite, Ginny
Cramer
Feeney
Gibbons
LaTourette
McHenry
Otter
Oxley
Paul
Peterson (PA)
Waxman

ANNOUNCEMENT BY THE SPEAKER PRO TEMPORE

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

□ 1842

So (two-thirds having voted in favor thereof) the rules were suspended and the bill was passed.

The result of the vote was announced as above recorded.

A motion to reconsider was laid on the table.

PERMISSION TO FILE CONFERENCE REPORTS ON H.R. 2361, DEPARTMENT OF THE INTERIOR, ENVIRONMENT, AND RELATED AGENCIES APPROPRIATIONS ACT, 2006, AND H.R. 2985, LEGISLATIVE BRANCH APPROPRIATIONS ACT, 2006

Mr. LAHOOD. Mr. Speaker, I ask unanimous consent that the managers on the part of the House have until midnight tonight to file conference reports to accompany H.R. 2361 and H.R. 2985.

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