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.

IN THE HOUSE OF REPRESENTATIVES

February 16, 2017

Mr. SAM JOHNSON of Texas (for himself and Mr. WALBERG) introduced the following bill; which was referred to the Committee on Education and the Workforce

A BILL

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.

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

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

(a) Short Title.—This Act may be cited as the “Small Business Health Fairness Act of 2017”.

(b) Table of Contents.—The table of contents for this Act is as follows:

Sec. 1. Short title; table of contents.
Sec. 2. Rules governing association health plans.
Sec. 3. Clarification of treatment of single employer arrangements.
Sec. 4. Enforcement provisions relating to association health plans.
Sec. 5. Cooperation between Federal and State authorities.
Sec. 6. Effective date and transitional and other rules.

SEC. 2. RULES GOVERNING ASSOCIATION HEALTH PLANS.

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

“PART 8—RULES GOVERNING ASSOCIATION HEALTH PLANS

“SEC. 801. ASSOCIATION HEALTH PLANS.

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

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

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

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

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

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

“SEC. 802. CERTIFICATION OF ASSOCIATION HEALTH PLANS.

“(a) In General.—The applicable authority shall prescribe by regulation a procedure under which, subject to subsection (b), the applicable authority shall certify as-
sociation 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 applica-
ble authority shall certify such plan as meeting the re-
quirements 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 ap-
licable 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 CERTIFI-
CATION.—The applicable authority may provide by regula-
tion 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 pro-
vide 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 connec-
tion with plans in such class and payment of the pre-
scribed fee under section 807(a).

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

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

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

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

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

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

“(b) Board of Trustees.—The requirements of this subsection are met with respect to an association health plan if the following requirements are met:
“(1) Fiscal control.—The plan is operated, pursuant to a trust agreement, by a board of trustees which has complete fiscal control over the plan and which is responsible for all operations of the plan.

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

“(3) Rules governing relationship to participating employers and to contractors.—

“(A) Board membership.—

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

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

“(II) Limited exception for providers of services solely on behalf of the sponsor.—Officers or employees of a sponsor which is a service provider (other than a contract administrator) to the plan may be members of the board if they constitute not more than 25 percent of the membership of the board and they do not provide services to the plan other than on behalf of the sponsor.

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

“(iii) Certain plans excluded.—Clause (i) shall not apply to an association health plan which is in existence on the date of the enactment of the Small Business Health Fairness Act of 2017.

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

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

“(1) the requirements of subsection (a) and section 801(a) shall be deemed met if such requirements would otherwise be met if the franchiser were deemed to be the sponsor referred to in section 801(b), such network were deemed to be an association described in section 801(b), and each franchisee were deemed to be a member (of the association and the sponsor) referred to in section 801(b); and
“(2) the requirements of section 804(a)(1) shall be deemed met.

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

“SEC. 804. PARTICIPATION AND COVERAGE REQUIREMENTS.

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

“(1) each participating employer must be—

“(A) a member of the sponsor,

“(B) the sponsor, or

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

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

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

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

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

“(b) Coverage of Previously Uninsured Employees.—In the case of an association health plan in existence on the date of the enactment of the Small Business Health Fairness Act of 2017, an affiliated member of the sponsor of the plan may be offered coverage under the plan as a participating employer only if—

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

“(2) during the 12-month period preceding the date of the offering of such coverage, the affiliated member has not maintained or contributed to a group health plan with respect to any of its employ-
ees 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 par-
ticipate is furnished information regarding all cov-
erage 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 INSTRU-
MENTS.—The instruments governing the plan in-
clude a written instrument, meeting the require-
ments 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 ca-
pacity of a plan administrator (referred to in
section 3(16)(A));
“(B) provides that the sponsor of the plan is to serve as plan sponsor (referred to in section 3(16)(B)); and

“(C) incorporates the requirements of section 806.

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

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

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

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

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

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

“(3) Floor for number of covered individuals with respect to certain plans.—If any benefit option under the plan does not consist of health insurance coverage, the plan has as of the beginning of the plan year not fewer than 1,000 participants and beneficiaries.

“(4) Marketing requirements.—

“(A) In general.—If a benefit option which consists of health insurance coverage is offered under the plan, State-licensed insurance agents shall be used to distribute to small employers coverage which does not consist of health insurance coverage in a manner comparable to the manner in which such agents are used to distribute health insurance coverage.
“(B) State-licensed insurance agents.—For purposes of subparagraph (A), the term ‘State-licensed insurance agents’ means one or more agents who are licensed in a State and are subject to the laws of such State relating to licensure, qualification, testing, examination, and continuing education of persons authorized to offer, sell, or solicit health insurance coverage in such State.

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

“(b) Ability of association health plans to design benefit options.—Subject to section 514(d), nothing in this part or any provision of State law (as defined in section 514(c)(1)) shall be construed to preclude an association health plan, or a health insurance issuer offering health insurance coverage in connection with an association health plan, from exercising its sole discretion in selecting the specific items and services consisting of medical care to be included as benefits under such plan or coverage, except (subject to section 514) in the case of (1) any law to the extent that it is not preempted under
section 731(a)(1) with respect to matters governed by sec-
tion 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 pro-
hibits an exclusion of a specific disease from such cov-
erage.

“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 cov-
erage, the plan—
“(A) establishes and maintains reserves
with respect to such additional benefit options,
in amounts recommended by the qualified actu-
ary, consisting of—
“(i) a reserve sufficient for unearned
contributions;
“(ii) a reserve sufficient for benefit li-
abilities 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 re-
spect 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 sol-
vency indemnification, with respect to such ad-
ditional 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 speci-
fied circumstances in which the plan spe-
cifically provides for and maintains re-
serves 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 rec-
ommend, 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 SEC-
RETARY.—The Secretary shall not cease to
carry out the provisions of paragraph (2) on ac-
count of the failure of a plan to pay any pay-
ment when due.

“(2) PAYMENTS BY SECRETARY TO CONTINUE
EXCESS/STOP LOSS INSURANCE COVERAGE AND IN-
DEMNIFICATION INSURANCE COVERAGE FOR CER-
TAINT 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 de-
scribed 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, cer-
tifies such determination to the Secretary), the Sec-
retary shall determine the amounts necessary to
make payments to an insurer (designated by the
Secretary) to maintain in force excess/stop loss in-
surance coverage or indemnification insurance cov-
erage 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 insur-
ance’ 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 insur-
ance’ 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 stand-
ards under part 4 and such additional requirements regard-
ing liquidity as the applicable authority may prescribe by regulation.

“(j) SOLVENCY STANDARDS WORKING GROUP.—

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

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

“(A) A representative of the National Association of Insurance Commissioners.
“(B) A representative of the American Academy of Actuaries.
“(C) A representative of the State governments, or their interests.
“(D) A representative of existing self-insured arrangements, or their interests.
“(E) A representative of associations of the type referred to in section 801(b)(1), or their interests.

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

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

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

“(b) Information To Be Included in Application for Certification.—An application for certification under this part meets the requirements of this section only if it includes, in a manner and form which shall be prescribed by the applicable authority by regulation, at least the following information:

“(1) Identifying Information.—The names and addresses of—
“(A) the sponsor; and

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

“(2) States in which plan intends to do business.—The States in which participants and beneficiaries under the plan are to be located and the number of them expected to be located in each such State.

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

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

“(5) Agreements with service providers.—A copy of any agreements between the plan and contract administrators and other service providers.

“(6) Funding report.—In the case of association health plans providing benefits options in ad-
dition 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 ac-
tuarial 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 pe-
riod referred to in subparagraph (B). The in-
come statement shall identify separately the
plan’s administrative expenses and claims.

“(D) COSTS OF COVERAGE TO BE
CHARGED AND OTHER EXPENSES.—A state-
ment of the costs of coverage to be charged, in-
cluding an itemization of amounts for adminis-
tration, reserves, and other expenses associated
with the operation of the plan.

“(E) OTHER INFORMATION.—Any other
information as may be determined by the appli-
cable 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 au-
thority by regulation. The applicable authority may re-
quire 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 As-
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 infor-
mation 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 ap-
plicable 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 mate-
rials comprising information necessary to be submitted by
a qualified actuary under this part. The qualified actuary
shall utilize such assumptions and techniques as are nec-
essary 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 expecta-
tions; 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 re-
quirements of section 806, irrespective of whether such
certification continues in effect. The board of trustees of
such plan shall determine quarterly whether the require-
ments 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 com-
pliance with section 806. Not later than 30 days after re-
ceiving 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 speci-
fy 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 sen-

•HR 1101 IH
tence of this subsection are remedied or the plan is termi-
nated.

“(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 Sec-
retary 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 adminis-
trator, any participating employer, and any employee
organization representing plan participants to fur-
nish 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 trust-
eeship;
“(6) to commence, prosecute, or defend on behalf of the plan any suit or proceeding involving the plan;

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

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

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

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

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

“(1) the sponsor and plan administrator;

“(2) each participant;
“(3) each participating employer; and

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

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

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

“(f) JURISDICTION OF COURT.—

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

“(2) VENUE.—An action under this section may be brought in the judicial district where the sponsor or the plan administrator resides or does business or where any asset of the plan is situated. A district court in which such action is brought may issue process with respect to such action in any other judicial district.
“(g) PERSONNEL.—In accordance with regulations which shall be prescribed by the Secretary, the Secretary shall appoint, retain, and compensate accountants, actuaries, and other professional service personnel as may be necessary in connection with the Secretary’s service as trustee under this section.

“SEC. 811. STATE ASSESSMENT AUTHORITY.

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

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

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

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

“(3) such tax is otherwise nondiscriminatory; and

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

“SEC. 812. DEFINITIONS AND RULES OF CONSTRUCTION.

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

“(1) GROUP HEALTH PLAN.—The term ‘group health plan’ has the meaning provided in section 733(a)(1) (after applying subsection (b) of this section).
“(2) Medical care.—The term ‘medical care’ has the meaning provided in section 733(a)(2).

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

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

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

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

“(7) Individual market.—

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

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

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

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

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

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

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

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

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

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

“(12) LARGE EMPLOYER.—The term ‘large em-
ployer’ 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 em-
ployer’ 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 pur-
poses of determining whether a plan, fund, or pro-
gram 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 pro-
gram so determined to be such an employee welfare
benefit plan—

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

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

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

(b) Conforming Amendments to Preemption Rules.—

(1) Section 514(b)(6) of such Act (29 U.S.C. 1144(b)(6)) is amended by adding at the end the following new subparagraph:
“(E) The preceding subparagraphs of this paragraph do not apply with respect to any State law in the case of an association health plan which is certified under part 8.”.

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

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

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

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

“(f)(1) Except as provided in subsection (b)(4), the provisions of this title shall supersede any and all State laws insofar as they may now or hereafter preclude, or have the effect of precluding, a health insurance issuer from offering health insurance coverage in connection with an association health plan which is certified under part 8.
“(2) Except as provided in paragraphs (4) and (5) of subsection (b) of this section—

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

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

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

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

“(B) relating to prompt payment of claims.

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

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

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

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

(B) in clause (ii), by inserting “and which does not provide medical care (within the mean-
ing of section 733(a)(2)),” after “arrange-
ment,”, 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 in-
surance may apply.”.

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

(A) by striking “Nothing” and inserting
“(1) Except as provided in paragraph (2), noth-
ing”; 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 Busi-
ness Health Fairness Act of 2017 shall be construed to
alter, amend, modify, invalidate, impair, or supersede any
provision of this title, except by specific cross-reference to
the affected section.”.
(c) Plan Sponsor.—Section 3(16)(B) of such Act (29 U.S.C. 102(16)(B)) is amended by adding at the end the following new sentence: “Such term also includes a person serving as the sponsor of an association health plan under part 8.”.

(d) Disclosure of Solvency Protections Related to Self-Insured and Fully Insured Options Under Association Health Plans.—Section 102(b) of such Act (29 U.S.C. 102(b)) is amended by adding at the end the following: “An association health plan shall include in its summary plan description, in connection with each benefit option, a description of the form of solvency or guarantee fund protection secured pursuant to this Act or applicable State law, if any.”.

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

(f) Report to the Congress Regarding Certification of Self-Insured Association Health Plans.—Not later than January 1, 2022, the Secretary of Labor shall report to the Committee on Education and the Workforce of the House of Representatives and the Committee on Health, Education, Labor, and Pensions of the Senate the effect association health plans have had, if any, on reducing the number of uninsured individuals.
(g) **Clerical Amendment.**—The table of contents in section 1 of the Employee Retirement Income Security Act of 1974 is amended by inserting after the item relating to section 734 the following new items:

```
"PART 8. RULES GOVERNING ASSOCIATION HEALTH PLANS

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

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 deter-
mination” and inserting the following:

“(iii)(I) in any case in which the benefit re-
ferred to in subparagraph (A) consists of medical
care (as defined in section 812(a)(2)), the deter-
mination of whether a trade or business is under
‘common control’ with another trade or business
shall be determined under regulations of the Sec-
retary 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 sec-
tion 4001(b), except that, for purposes of this para-
graph, 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 par-
ticipating 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 employ-
ees of participating employers and who are covered
under the arrangement,”.

SEC. 4. ENFORCEMENT PROVISIONS RELATING TO ASSO-
CIATION HEALTH PLANS.

(a) CRIMINAL PENALTIES FOR CERTAIN WILLFUL
MISREPRESENTATIONS.—Section 501 of the Employee
is amended by adding at the end the following new sub-
section:

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

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

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

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

(b) CEASE ACTIVITIES ORDERS.—Section 502 of 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 1 year after the date of the enactment of this Act. The Secretary of Labor shall first issue all regulations necessary to carry out the amendments made by this Act within 1 year after the date of the enactment of this Act.

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

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