118TH CONGRESS
1st Session
" HOUSE OF REPRESENTATIVES !
REPORT
118–

SELF-INSURANCE PROTECTION ACT

JUNE --, 2023.—Ordered to be printed

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

R E P O R T

together with

MINORITY VIEWS

[To accompany H.R. 2813]

[Including cost estimate of the Congressional Budget Office]

The Committee on Education and the Workforce, to whom was referred the bill (H.R. 2813) to amend the Employee Retirement Income Security Act of 1974, the Public Health Service Act, and the Internal Revenue Code of 1986 to exclude from the definition of health insurance coverage certain medical stop-loss insurance obtained by certain plan sponsors of group health plans, and for other purposes, having considered the same, reports favorably thereon with amendment and recommends that the bill as amended do pass.

The amendment is as follows:

Strike all after the enacting clause and insert the following:

SECTION 1. SHORT TITLE.

This Act may be cited as the "Self-Insurance Protection Act".

SEC. 2. FINDINGS.

Congress finds the following:

(1) Small and large employers offer health benefit plan coverage to employees in self-funded arrangements using company assets or a fund, or by paying pre- miums to purchase fully-insured coverage from a health insurance company.

(2) Employers that self-fund health benefit plans will often purchase stop-loss insurance as a financial risk management tool to protect against excess or unexpected catastrophic health plan claims losses that arise above projected costs paid out of company assets.

(3) Stop-loss coverage insures the employer sponsoring the health benefit plan against unforeseen health plan claims, does not insure the employee health ben-

efit plan itself, and does not pay health care providers for medical services provided to the employees.

(4) Employer-sponsored health benefit plans are regulated under the Employee Retirement Income Security Act of 1974, however, States regulate the availability and the coverage terms of stop-loss insurance coverage that employers purchase to protect company assets and to protect a fund against excess or unexpected claims losses.

(5) Both large and small employers that choose to self-fund must also be able to protect company assets or a fund against excess or unexpected claims losses and States must reasonably regulate stop-loss insurance to assure its avail- ability to both large and small employers.

SEC. 3. CERTAIN MEDICAL STOP-LOSS INSURANCE OBTAINED BY CERTAIN PLAN SPONSORS OF GROUP HEALTH PLANS NOT INCLUDED UNDER THE DEFINITION OF HEALTH INSURANCE COVERAGE.

Section 733(b)(1) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1191b(b)(1)) is amended by adding at the end the following sentence: "Such term shall not include a stop-loss policy obtained by a self-insured group health plan or a plan sponsor of a group health plan that self-insures the health risks of its plan participants to reimburse the plan or sponsor for losses that the plan or sponsor incurs in providing health or medical benefits to such plan participants in excess of a predetermined level set forth in the stop-loss policy obtained by such plan or sponsor.".

SEC. 4. EFFECT ON OTHER LAWS.

Section 514(b) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1144(b)) is amended by adding at the end the following:

"(10) The provisions of this title (including part 7 relating to group health plans) shall preempt State laws insofar as they may now or hereafter prevent an employee benefit plan that is a group health plan from insuring against the risk of excess or unexpected health plan claims losses.".

Amend the title so as to read:

A bill to amend the Employee Retirement Income Security Act of 1974 to exclude from the definition of health insurance coverage certain medical stop-loss insurance obtained by certain plan sponsors of group health plans, and for other purposes.

118TH CONGRESS
1ST SESSION

H. R. 2813

[Report No. 118–]

To amend the Employee Retirement Income Security Act of 1974, the Public Health Service Act, and the Internal Revenue Code of 1986 to exclude from the definition of health insurance coverage certain medical stop-loss insurance obtained by certain plan sponsors of group health plans, and for other purposes.

IN THE HOUSE OF REPRESENTATIVES

APRIL 25, 2023

Mr. GOOD of Virginia (for himself and Mr. WALBERG) introduced the fol- lowing bill; which was referred to the Committee on Education and the Workforce, and in addition to the Committees on Energy and Commerce, and Ways and Means, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned

JUNE --, 2023

Reported from the Committee on Education and the Workforce with amendments

[Strike out all after the enacting clause and insert the part printed in italic]

[For text of introduced bill, see copy of bill as introduced on April 25, 2023]

A BILL

To amend the Employee Retirement Income Security Act of 1974, the Public Health Service Act, and the Internal Revenue Code of 1986 to exclude from the definition of health insurance coverage certain medical stop-loss insurance obtained by certain plan sponsors of group health plans, and for other purposes.

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

SECTION 1. SHORT TITLE.

This Act may be cited as the "Self-Insurance Protection Act".

SEC. 2. FINDINGS.

Congress finds the following:

(1) Small and large employers offer health benefit plan coverage to employees in self-funded arrangements using company assets or a fund, or by paying premiums to purchase fully-insured coverage from a health insurance company.

(2) Employers that self-fund health benefit plans will often purchase stop-loss insurance as a financial risk management tool to protect against excess or unexpected catastrophic health plan claims losses that arise above projected costs paid out of company assets.

(3) Stop-loss coverage insures the employer sponsoring the health benefit plan against unforeseen health plan claims, does not insure the employee health benefit plan itself, and does not pay health care providers for medical services provided to the employees.

(4) Employer-sponsored health benefit plans are regulated under the Employee Retirement Income Security Act of 1974, however, States regulate the availability and the coverage terms of stop-loss insurance coverage that employers purchase to protect company assets and to protect a fund against excess or unexpected claims losses.

(5) Both large and small employers that choose to self-fund must also be able to protect company assets or a fund against excess or unexpected claims losses and States must reasonably regulate stop-loss insurance to assure its availability to both large and small employers.

SEC. 3. CERTAIN MEDICAL STOP-LOSS INSURANCE OBTAINED BY CERTAIN PLAN SPONSORS OF GROUP HEALTH PLANS NOT INCLUDED UNDER THE DEFINITION OF HEALTH INSURANCE COVERAGE.

Section 733(b)(1) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1191b(b)(1)) is amended by adding at the end the following sentence: "Such term shall not include a stop-loss policy obtained by a self-insured group health plan or a plan sponsor of a group health plan that self-insures the health risks of its plan participants to reimburse the plan or sponsor for losses that the

plan or sponsor incurs in providing health or medical benefits to such plan participants in excess of a predetermined level set forth in the stop-loss policy obtained by such plan or sponsor.".

SEC. 4. EFFECT ON OTHER LAWS.

Section 514(b) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1144(b)) is amended by adding at the end the following:

"(10) The provisions of this title (including part 7 relating to group health plans) shall preempt State laws insofar as they may now or hereafter prevent an employee benefit plan that is a group health plan from insuring against the risk of excess or unexpected health plan claims losses.".

Amend the title so as to read: "A bill to amend the Employee Retirement Income Security Act of 1974 to exclude from the definition of health insurance coverage certain medical stop-loss insurance obtained by certain plan sponsors of group health plans, and for other purposes.".

PURPOSE

H.R. 2813, the *Self-Insurance Protection Act*, amends the *Employee Retirement Income Security Act of 1974* (ERISA)[1] to clarify that federal regulators cannot redefine stop-loss insurance as traditional health insurance in order to preserve the option of self-funding. The bill also prohibits states from regulating stop-loss insurance if regulations make stop-loss insurance inaccessible to employers. By providing legal certainty, the bill will help ensure workers and families continue to have access to affordable, flexible self-insured health plans.

COMMITTEE ACTION

112TH CONGRESS

First Session—Hearings

On February 9, 2011, the Committee on Education and the Workforce (Committee) held a hearing entitled "The Impact of the Health Care Law on the Economy, Employers, and the Workforce," which examined, among other things, the benefits of self-insuring. Testifying before the Committee were Dr. Paul Howard, Senior Fellow, Manhattan Institute, New York, New York; Ms. Gail Johnson, President and CEO, Rainbow Station, Inc., Glenn Allen, Virginia; Dr. Paul Van de Water, Senior Fellow, Center on Budget and Policy Priorities, Washington, D.C.; and Mr. Neil Trautwein, Vice President and Employee Benefits Policy Counsel, National Retail Federation, Washington, D.C.

On March 10, 2011, the Subcommittee on Health, Employment, Labor and Pensions (HELP) held a hearing entitled "The Pressures of Rising Costs on Employer Provided Health Care," which examined, among other things, the benefits of self-insurance. The witnesses were Mr. Tom Miller, Resident Fellow, American Enterprise Institute, Washington, D.C.; Mr. Brett Parker, Vice Chairman and Chief Financial Officer, Bowlmor Lanes, New York, New York; Mr. Jim Houser, Owner, Hawthorne Auto, Portland, Oregon; and Mr. J. Michael Brewer, President, Lockton Benefit Group, Lockton Companies, LLC, Kansas City, Missouri.

On June 7, 2011, the HELP Subcommittee held a field hearing in Evansville, Indiana, entitled "The Recent Health Care Law: Consequences for Indiana Families and Workers," which examined, among other things, the impact of the *Affordable Care Act* (ACA) on self-funded plans. The witnesses were the Honorable Mark Messmer, Indiana House of Representatives, Messmer Mechanical, Jasper, Indiana; Ms. Robyn Crosson, Company Compliance Services, State of Indiana Department of Insurance, Indianapolis, Indiana; Ms. Sherry Lang, Human Resources Director, Womack Restaurants, Terre Haute, Indiana; Mr. Denis Johnson, VP of Operations, Boston Scientific, Spencer, Indiana; Mr. David J. Carlson, M.D., General Surgeon, Deaconess Hospital, Evansville, Indiana; and Mr. Glen Graber, President, Graber Post Building, Inc., Odon, Indiana.

On October 13, 2011, the HELP Subcommittee held a hearing entitled "Regulations, Costs, and Uncertainty in Employer Provided Health Care," which examined, among other things, the

[1] 29 U.S.C. § 1001 *et seq*.

characteristics and attributes of self-funded plans. The witnesses were Ms. Grace-Marie Turner, President, Galen Institute, Alexandria, Virginia; Mr. Dennis M. Donahue, Managing Director, Wells Fargo Insurance Services USA, Inc., Chicago, Illinois; Mr. Ron Pollack, Executive Director, Families USA, Washington, D.C.; and Ms. Robyn Piper, President, Piper Jordan, San Diego, California.

Second Session—Hearings

On February 22, 2012, the HELP Subcommittee held a field hearing in Butler, Pennsylvania, entitled "Health Care: Challenges Facing Pennsylvania's Workers and Job Creators," which examined, among other things, the benefits of self-insuring. The witnesses were the Honorable Donald C. White, Senator, Pennsylvania State Senate, Harrisburg, Pennsylvania; Ms. Kathleen Bishop, President and CEO, Meadville-Western Crawford, County Chamber of Commerce, Meadville, Pennsylvania; Ms. Georgeanne Koehler, Pittsburg, Pennsylvania; Ms. Lori Joint, Director of Government Affairs, Manufacturer and Business Association, Erie, Pennsylvania; Ms.Patti-Ann Kanterman, Chief Financial Officer, Associated Ceramics and Technology, Inc., Sarver, Pennsylvania; Mr. Paul T. Nelson, Owner and CEO, Waldameer Park, Inc., Erie, Pennsylvania; Mr. Ralph Vitt, Owner, Vitt Insure, Pittsburg, Pennsylvania; and Mr. Will Knecht, President, Wendell August Forge, Grove City, Pennsylvania.

On May 31, 2012, the HELP Subcommittee held a hearing entitled "Barriers to Lower Health Care Costs for Workers and Employers," which examined, among other things, self-insured plans. The witnesses were Mr. Ed Fensholt, Senior Vice President, Lockton Companies, LLC, Kansas City, Missouri; Mr. Roy Ramthun, President, HAS Consulting Services, Washington, D.C.; Ms. Jody Hall, Founder & Owner, Cupcake Royale, Seattle, Washington; and Mr. Bill Streitberger, Vice President of Human Resources, Red Robin, Greenwood Village, Colorado.

113TH CONGRESS

First Session—Hearings

On April 30, 2013, the HELP Subcommittee held a field hearing in Concord, North Carolina, entitled "Health Care Challenges Facing North Carolina's Workers and Job Creators," during which witnesses discussed the negative impact of the ACA, including on businesses that self-insure. The witnesses were Mr. Chuck Horne, President, Hornwood Inc., Lilesville, North Carolina; Ms. Tina Haynes, Chief Human Resource Officer, Rowan-Cabarrus Community College, Salisbury, North Carolina; Mr. Adam Searing, Director, Health Access Coalition, Raleigh, North Carolina; Mr. Ken Conrad, Chairman, Libby Hill Seafood Restaurants, Greenboro, North Carolina; Mr. Dave Bass, Vice President, Compensation and Associate Wellness, Delhaize America, Concord, North Carolina; Mr. Ed Tubel, Founder and CEO, Tricor Inc., Charlotte, North Carolina; Dr. Olson Huff, Pediatrician, Asheville, North Carolina; and Mr. Bruce Silver, President and CEO, Racing Electronics, Concord, North Carolina.

On June 4, 2013, the Committee held a hearing entitled "Reviewing the President's Fiscal Year 2014 Budget Proposal for the U.S. Department of Health and Human Services," during which members discussed the experiences of employers that self-insure. The sole witness at the hearing

was the Honorable Kathleen Sebelius, Secretary of the U.S. Department of Health and Human Services, Washington, D.C.

On July 23, 2013, the HELP Subcommittee and the Workforce Protections Subcommittee jointly held a hearing entitled "The Employer Mandate: Examining the Delay and Its Effect on Workplaces," which reviewed, among other things, the impact of the ACA on the self-insured market. Witnesses were Ms. Grace-Marie Turner, President, Galen Institute, Alexandria, Virginia; Mr. Jamie T. Richardson, Vice President, White Castle System, Inc., Columbus, Ohio; Mr. Ron Pollack, Executive Director, Families USA, Washington, D.C.; and Dr. Douglas Holtz-Eakin, President, American Action Forum, Washington, D.C.

On August 27, 2013, the HELP Subcommittee held a field hearing in Lexington, Kentucky, entitled "Health Care Challenges Facing Kentucky's Workers and Job Creators," which included an examination of self-insurance. Witnesses before the subcommittee were Mr. Tim Kanaly, Owner and President, Gary Force Honda, Bowling Green, Kentucky; Mr. Joe Bologna, Owner, Joe Bologna's—Italian Pizzeria and Restaurant, Lexington, Kentucky; Ms. Carrie Banahan, Executive Director, Office of the Kentucky Health Benefit Exchange, Frankfort, Kentucky; Mr. John Humkey, President, Employee Benefit Associates, Inc., Lexington, Kentucky; Ms. Janey Moores, President and CEO, BJM and Associates, Inc., Lexington, Kentucky; Mr. Donnie Meadows, Vice President of Human Resources, K–VA–T Food Stores, Inc., Abingdon, Virginia; Ms. Debbie Basham, Southwest Breast Cancer Awareness Group, Louisville, Kentucky; and Mr. John McPhearson, CEO, Lectrodryer, Richmond, Kentucky.

Second Session—Hearings

On February 26, 2014, the HELP Subcommittee held a hearing entitled "Providing Access to Affordable, Flexible Health Plans through Self-Insurance," which examined self-insurance and stop-loss insurance. The witnesses were Mr. Michael Ferguson, President and CEO, Self-Insurance Institute of America, Simpsonville, South Carolina; Mr. Wes Kelley, Executive Director, Columbia Power and Water Systems, Columbia, Tennessee; Ms. Maura Calsyn, Director of Health Policy, Center for American Progress, Washington, D.C.; and Mr. Robert Melillo, National Vice President of Risk Financing Solutions, USI Insurance, Glastonbury, Connecticut.

On March 26, 2014, the Committee held a hearing entitled "Reviewing the President's Fiscal Year 2015 Budget Proposal for the Department of Labor," during which the Secretary of Labor was questioned about whether the Department had plans to regulate stop-loss insurance. The sole witness was the Honorable Thomas E. Perez, Secretary of the U.S. Department of Labor, Washington, D.C.

On September 4, 2014, the HELP Subcommittee held a field hearing in Greenfield, Indiana, entitled "The Effects of the President's Health Care Law on Indiana's Classrooms and Workplaces," during which witnesses testified about employer-provided health coverage and self-insured plans. The witnesses were Mr. Mike Shafer, Chief Financial Officer, Zionsville Community Schools, Zionsville, Indiana; Mr. Tom Snyder, President, Ivy Tech Community College, Indianapolis, Indiana; Mr. Danny Tanoos, Superintendent, Vigo County School Corporation, Terre Haute, Indiana; Mr. Tom Forkner, President, Anderson Federation of Teachers,

AFT Local 519, Anderson, Indiana; Mr. Mark DeFabis, President and Chief Executive Officer, Integrated Distribution Services, Plainfield, Indiana; Mr. Nate LaMar, International Regional Manager, Draper, Inc., Spiceland, Indiana; Mr. Dan Wolfe, Owner, Wolfe's Auto Auction, Terre Haute, Indiana; and Mr. Robert Stone, Director of Palliative Care, IU Health Bloomington Hospital, Bloomington, Indiana.

114TH CONGRESS

First Session—Legislative Action

On March 18, 2015, Rep. David ''Phil'' Roe (R-TN), then-Chairman of the HELP Subcommittee, introduced the *Self-Insurance Protection Act* (H.R. 1423), to ensure employees and employers could continue to have access to affordable, flexible health care plans by having the option to self-fund those plans.

First Session—Hearings

On March 18, 2015, the Committee held a hearing entitled "Reviewing the President's Fiscal Year 2016 Budget Proposal for the Department of Labor," during which the Secretary of Labor was questioned about the Department's plans to regulate stop-loss. The sole witness was the Honorable Thomas E. Perez, Secretary of the U.S. Department of Labor, Washington, D.C.

On April 14, 2015, the HELP Subcommittee held a hearing entitled "Five Years of Broken Promises: How the President's Health Care Law is Affecting America's Workplaces," which examined the continuing negative impact of the ACA on employer-sponsored health coverage, including on self-insured plans. Witnesses were the Honorable Tevi Troy, President, American Health Policy Institute, Washington, D.C.; Mr. Rutland Paal, Jr., President, Rutland Beard Floral Group, Scotch Plains, New Jersey; Michael Brev, President, Brev Corp. t/a Hobby Works, WingTOTE Manufacturing, LLC, Laurel, Maryland; and Ms. Sally Roberts, Human Resources Director, Morris Communications Company, LLC, Augusta, Georgia.

Second Session—Hearings

On March 15, 2016, the Committee held a hearing entitled "Examining the Policies and Priorities of the U.S. Department of Health and Human Services," during which self-insured plans were discussed. The sole witness at the hearing was the Honorable Sylvia Mathews Burwell, Secretary of the U.S. Department of Health and Human Services, Washington, D.C.

On April 14, 2016, the HELP Subcommittee held a hearing entitled "Innovations in Health Care: Exploring Free-Market Solutions for a Healthy Workforce," which examined, among other things, the benefits of self-insuring. Witnesses before the subcommittee were Ms. Sabrina Corlette, Senior Research Professor, Center on Health Insurance Reforms, Georgetown University's Health Policy Institute, Washington, D.C.; Ms. Tresia Franklin, Director, Total Rewards and Employee Relations, Hallmark Cards, Inc. Kansas City, Missouri; Ms. Amy McDonough, Vice President and General Manager of Corporate Wellness, Fitbit, San Francisco, California; and Mr. John Zern, Executive Vice President and Global Health Leader, Aon, Chicago, Illinois.

115TH CONGRESS

First Session—Hearings

On February 1, 2017, the Committee held a hearing entitled "Rescuing Americans from the Failed Health Care Law and Advancing Patient-Centered Solutions," which examined failures of the ACA, including its effects on self-insurance. Witnesses were Mr. Scott Bollenbacher, CPA, Managing Partner, Bollenbacher and Associates, LLC, Portland, Indiana; Mr. Joe Eddy, President and Chief Executive Officer, Eagle Manufacturing Company, Wellsburg, West Virginia; Ms. Angela Schlaack, St. Joseph, Michigan; and Dr. Tevi Troy, Chief Executive Officer, American Health Policy Institute, Washington, D.C.

On March 1, 2017, the Committee held a hearing entitled "Legislative Proposals to Improve Health Care Coverage and Provide Lower Costs for Families," which examined H.R. the *Self-Insurance Protection Act* (H.R. 1304), among other proposals. Witnesses were Mr. Jon B. Hurst, President, Retailers Association of Massachusetts, Boston, Massachusetts; Ms. Allison R. Klausner, Principal, Government Relations Leader, Conduent, Secaucus, New Jersey; Ms. Lydia Mitts, Associate Director of Affordability Initiatives, Families USA, Washington, D.C.; and Mr. Jay Ritchie, Executive Vice President, Tokio Marine HHC, Kennesaw, Georgia.

Legislative Action

On March 2, 2017, Rep. Roe introduced the *Self-Insurance Protection Act* (H.R. 1304) along with then-HELP Subcommittee Chairman Tim Walberg (R-MI) to ensure self-funding remains an option for employee and employers offering health care coverage.

On March 8, 2017, the Committee considered the *Self-Insurance Protection Act* (H.R. 1304). Rep. Roe offered an amendment in the nature of a substitute, making a technical change to the introduced bill. The Committee voted to adopt the amendment in the nature of a substitute by voice vote. Rep. Jared Polis (D-CO) offered an amendment that was ruled non-germane, and the ruling of the Chair was upheld by a vote of 22 to 17 on a motion to table the appeal of the ruling of the Chair. Rep. Bonamici (D-OR) offered a clarifying amendment to ensure that the legislation would not be construed to restrict the ability of states to regulate stop-loss policies. H.R. 1304 does not preempt states from regulating stop-loss coverage. At the request of Ranking Member Robert C. "Bobby" Scott (D-VA), Committee Chairwoman Virginia Foxx (R-NC) agreed to include such clarifying language in the Committee report. This clarification ensures that nothing in the bill is erroneously construed to restrict states' ability to regulate stop-loss policies. Based on the understanding between Chairwoman Foxx and Ranking Member Scott that this clarification would be included in the Committee's official report, Rep. Bonamici withdrew her amendment. The Committee favorably reported H.R. 1304, as amended, to the House of Representatives by voice vote.

On April 5, 2017, the House of Representatives passed H.R. 1304, the *Self-Insurance Protection Act* by a vote of 400-16.

First Session—Hearing

On April 24, 2023, the HELP Subcommittee held a hearing entitled "Reducing Health Care Costs for Working Americans and Their Families," which examined the *Self-Insurance Protection Act* (H.R. 2813), among other proposals. Witnesses were Mr. Joel White, President, Council for Affordable Health Coverage (CAHC), Washington, D.C.; Mrs. Tracy Watts, Senior Partner, Mercer, Washington, D.C.; Ms. Marcie Strouse, Partner, Capitol Benefits Group, Des Moines, Iowa; and Ms. Sabrina Corlette, J.D., Senior Research Professor, Center on Health Insurance Reforms, Georgetown University's Health Policy Institute, Washington, D.C.

Legislative Action

On April 25, 2023, HELP Subcommittee Chairman Bob Good (R-VA) introduced the *Self-Insurance Protection Act* (H.R. 2813) along with Rep. Tim Walberg (R-MI) to ensure self-funding remains an option for employee and employers offering health care coverage. The bill was referred to the Committee on Education and the Workforce, the Committee on Energy and Commerce, and the Committee on Ways and Means. On June 6, 2023, the Committee considered H.R. 2813 in legislative session and reported it favorably, as amended, to the House of Representatives by a recorded vote of 24-18. The Committee adopted the following amendment to H.R. 2813: Rep. Good offered an Amendment in the Nature of a Substitute (ANS) that, with respect to the language amending ERISA, strikes duplicate language amending the *Public Health Service Act* and the Internal Revenue Code. The ANS also changes the term "self-funded health plan" to "self-insured group health plan."

COMMITTEE VIEWS

INTRODUCTION

Background on employer-sponsored insurance coverage

Since World War II, employers have offered health care benefits to recruit and retain talent and to ensure a healthy and productive workforce. Employer-sponsored health insurance is one of the primary means by which Americans obtain health care coverage. Almost 159 million American workers and family members are covered by a health benefit plan offered by an employer.[2] The U.S. Census Bureau reports that 54.3 percent of Americans were covered by employment-based health coverage in 2021.[3] When given the option for employment-based health coverage, 77 percent of workers take up coverage.[4] Almost all businesses with at least 200 or more employees offer health benefits.[5] According to the Kaiser Family Foundation, however, smaller firms (with 3

[2] KAISER FAMILY FOUND., EMPLOYER HEALTH BENEFITS: 2022 ANNUAL SURVEY, 2022 EMPLOYER HEALTH BENEFITS SURVEY 58, http://files.kff.org/attachment/Report-Employer-Health-Benefits-2022-Annual-Survey.pdf.
[3] U.S. CENSUS BUR., U.S. DEP'T OF COM., HEALTH INSURANCE COVERAGE IN THE UNITED STATES: 2021, http://census.gov/content/dam/Census/library/publications/2022/demo/p60-278.pdf.
[4] Kaiser Family Found., *supra* note 2, Summary of Findings, 12.
[5] *Id.*

to 199 employees) are significantly less likely to offer health benefits.[6] As a result, in 2022, just over half of all employers offered some health benefits.[7]

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

Self-insured health plans

Small and large employers offer health care coverage to employees in self-funded arrangements (self-insurance) or purchase fully insured plans. ERISA regulates both fully insured and self-insured plans, but only self-insured plans are exempt from a patchwork of benefit mandates and regulations imposed under state insurance law. Employers sponsoring self-insured plans are not subject to the same requirements under ACA as those with fully-insured plans. Therefore, employer-provided plans have different requirements and costs depending on funding arrangements. Last year, approximately 65 percent of workers with employer-sponsored health coverage were enrolled in a self-funded plan, up from 44 percent in 1999 and 55 percent in 2007.[8]

An employer can provide health insurance to employees either by fully insuring or self-insuring. An employer who is fully insured enters into a contractual agreement with a health insurer to purchase a product for the employer's employees. The employer and employees pay a fixed, monthly premium to the insurance company. This arrangement is what many consider "traditional" insurance. An employer that self-funds provides for employees' medical costs by paying providers directly or reimbursing employees as claims arise, instead of paying a fixed premium to an insurance company. Although self-insured employers are responsible for employees' health care expenses, they may customize the design of their health plans to meet the specific needs of their workforce and can retain savings in years with low claims.

A self-insured employer may administer health claims in-house or subcontract the administrative services to a third party administrator (TPA).[9] The employer or TPA coordinates provider network contracts[10] and stop-loss insurance for unexpected high claims.[11] By making a conscious choice to bear the financial risk of an employee's health care expenses, employers can experience cost savings that are not available from a coverage purchased in the fully insured market. In 2017, Mr. Jay Richie, Executive Vice President, Tokio Marino HCC Stop-Loss Group, testifying before the Committee on behalf of the Self-Insurance Institute of America, Inc., discussed the value of self-funding:

If you're a health insurer, you're going to take the increasing cost of medical

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[6] *Id.*
[7] *Id.*
[8] *Id.* Fig. 10.2, at 157.
[9] SELF-INSURANCE INST. OF AMERICA, INC., SELF-INSURED GROUP HEALTH PLANS, http://www.siaa.org/i4a/pages/inde.cfm?pageid=7533.
[10] *Id.*
[11] SELF-INSURANCE INST. OF AMERICA, INC., STOP-LOSS EXCESS INSURANCE, https://www.siia.org/i4a/pages/index.cfm?pageid=7535.

> insurance and, due to our new medical loss ratio law, get a profit percentage on the rising increase of that cost. So, you take it into a self-insured model, and you're not paying the health insurer's profits on top of your rising costs. That's the value of self-insurance. You're taking it and controlling your own destination, and keeping it at a true costs basis.[12]

According to Kaiser Family Foundation, 65 percent of employees with employer-sponsored health coverage receive that coverage through a self-insured plan.[13] The more employees an employer has, the more likely that employer is to self-insure. Kaiser reports that 20 percent of covered employees at small firms (3 to 199 employees) are covered through a self-insured plan, while 82 percent of employees at large firms are covered through a self-insured plan.[14] Small businesses are less likely to self-insure because unlike their larger counterparts, they have fewer employees to spread the risk[15] and often smaller margins to pay the claims. A combination arrangement of self-funded insurance combined with significant stop-loss coverage (called "level-funded arrangements") has evolved in recent years to mitigate a small business' risk for self-funding.[16]

Many employers choose to self-insure because they can customize their plans to their workforce. For example, self-insured plans are not required to cover all categories of essential health benefits mandated by the ACA, so employers can structure their plans to meet the specific needs of their employees. The Self-Insurance Institute of America lists the following advantages of self-insured health plans:

1. The employer can customize the plan to meet the specific health needs of its workforce, as opposed to purchasing a 'one-size-fits- all' insurance policy.
2. The employer maintains control over the health plan reserves, enabling maximization of interest income – income that would be otherwise generated by an insurance carrier through the investment of premium dollars.
3. The employer does not have to pre-pay for coverage, thereby improving case flow.
4. The employer is not subject to conflicting state health insurance regulations/benefit mandates, [because] self-insured health plans are regulated under federal law (ERISA).
5. The employer is not subject to state health insurance premium taxes which are generally 2-3 percent of the premium's dollar value.
6. The employer is free to contract with the providers or provider network best suited to meet the health care needs of its employees. [17]

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[12] *Legislative Proposals to Improve Health Care Coverage and Provide Lower Costs for Families: Hearing Before the H. Comm. on Educ. & the Workforce,* 115th Cong. 83 (2017) (testimony of Jay Ritchie, Exec. Vice President, Tokio Marine HHC).

[13] Kaiser Family Found., *supra* note 2, at 156.

[14] *Id.*

[15] *Id.* ("Self-funding is common among larger firms because they can spread risk of costly claims over a larger number of workers and dependents.")

[16] *Id.*

[17] SELF-INSURANCE INST. OF AMERICA, INC., SELF-INSURED GROUP HEALTH PLANS,

Self-insurance is also attractive to employers due to the long-term financial savings it may provide. Mr. Joel White, President of the Council for Affordable Health Coverage, explained that self-funding is a tool for small businesses "to better manage costs and innovate benefits."[18] In 2017, Mr. Jay Ritchie, Executive Vice President, Tokio Marino HCC Stop-Loss Group, explained why self-insurance may provide long-term financial savings when he stated

> [O]ver a three- to five-year period, we see that self-insurance is generally cheaper than health insurance. Now, on a year-to-year basis, that may be very different because the health insurance is prospectively priced where the self-insurance is actually priced. Whatever you actually spend that year is your cost, where for health insurance, they're predicting that."[19]

Stop Loss Insurance

Many self-insured employers also purchase stop-loss insurance, a financial risk-management tool designed to protect against catastrophic claims expenses. Stop-loss insurance reimburses a self-insured plan sponsor for medical claims that exceed a certain pre-established level of liability; it does not insure employees, nor does it reimburse medical providers for care. As Mr. Ritchie stated in his testimony before the Committee in 2017, "stop-loss does not insure employees nor do we reimburse medical providers for care, but rather stop-loss reimburses a self-insured entity for health care payments they have made that exceed a certain, pre-determined level similar to a liability product."[20]

The point at which the stop-loss carrier begins to pay its obligations for stop-loss insurance is called the "attachment point."[21] There are two types of stop-loss insurance: "specific" and "aggregate." Specific stop-loss insurance protects against a high claim of a single employee (or dependent).[22] Aggregate stop-loss insurance limits the total amount a self-insured employer must pay for all claims during a certain period.[23] Stop-loss insurance may also be purchased for certain types of claims.[24] An employer could purchase more than one type of stop-loss coverage.[25] Kaiser reports that over the last few years, the percentage of employees in self-insured plans that have stop-loss insurance in 2022 is about the same for small firms (73 percent) and large firms (72 percent).[26]

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http://www.siaa.org/i4a/pages/inde.cfm?pageid=7533.

[18] *Reducing Health Care Costs for Working Americans and Their Families: Hearing Before the H. Subcomm. on Health, Emp., Lab., & Pensions of the H. Comm. on Educ. & the Workforce*, 118th Cong. (2023) (statement of Joel White, President, Council for Affordable Health Coverage).

[19] *Legislative Proposals to Improve Health Care Coverage and Provide Lower Costs for Families: Hearing Before the H. Comm on Educ. & the Workforce,* 115th Cong. 110 (2017) (testimony of Jay Ritchie, Exec. Vice President, Tokio Marine HCC).

[20] *Id.* at 41 (statement of Jay Ritchie, Exec. Vice President, Tokio Marine HCC).

[21] Kaiser Family Found., *supra* note 2, at 163.

[22] *Id.* at 161.

[23] *Id.*

[24] *Id.*

[25] *Id.*

[26] *Id.* at 162. For these purposes, a small firm is 50 to 199 employees, and a large firm is 200 or more employees.

A combination arrangement of self-funded insurance combined with significant stop loss coverage (called "level-funded arrangements") has evolved in recent years to mitigate a small business' risk for self-insuring.[27] According to Mr. White's testimony in 2023, level-funded plans have three parts: administration (processing of claims and estimating premiums); claims costs (payment of actual employee medical expenses); and stop-loss (insurance coverage for excess losses). His testimony detailed the use of level-funding arrangements as a tool to allow small businesses flexibly to design their plans under the self-insured rules and to reduce risk with stop-loss coverage.[28]

Stop-loss insurance is sometimes regulated at the state level but not at the federal level. However, the Obama administration repeatedly signaled interest in regulating stop-loss insurance as health insurance. In 2014, DOL posted guidance on state regulation of stop-loss insurance[29] stating its position that a state law would not be preempted by ERISA. In response to DOL's guidance, then-Chairman of the HELP Subcommittee Phil Roe (R-TN) introduced H.R. 1304 (115th Congress), the *Self-Insurance Protection Act*, which passed the House on suspension by a vote of 400-16.

Mr. White testified that some states have started to limit small employers' ability to maintain self-funded group health coverage for employees.[30] Even though states may not directly regulate self-funded plans established under ERISA, "some states have effectively eliminated small employer access [to self-funded coverage] by banning the sale of level-funded plans to certain size groups or making the sale of low attachment point plans illegal."[31] Mr. White recommended that Congress clarify that ERISA preempts state laws which adversely impact the ability of small businesses to maintain self-funded arrangements, including the ability to coordinate stop-loss coverage that is paired with a self-funded arrangement.[32]

Stop-loss coverage is not and should not be defined as health insurance coverage under ERISA, the PHSA, or the Code. Stop-loss insurance differs from health insurance in that it does not insure employees or reimburse medical providers for care.

Support for creating options and flexibility for small businesses

The Council for Affordable Health Coverage, the Self-Insurance Institute of America, Inc., the Partnership for Employer-Sponsored Coverage, the U.S. Chamber of Commerce, the Associated General Contractors of America, the MLD Foundation, Main Street Freedom Alliance, National Association of Wholesaler-Distributors, National Federation of Independent Business, Small Business & Entrepreneurship Council, and the Coalition to Protect and Promote Association Health Plans support H.R. 2813 because it protects a funding mechanism option that businesses should be permitted to consider when offering a self-insured health plan to their employees. Moreover, the legislation ensures that thousands of employers—large and small—who currently

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[27] *Id.* at 156.
[28] White statement, *supra* note 20.
[29] DOL, TECHNICAL RELEASE NO. 2014-01: GUIDANCE ON STATE REGULATION OF STOP-LOSS INSURANCE (Nov. 6, 2014), https://dol.gov/node/63762.
[30] White statement, *supra* note 20.
[31] *Id.*
[32] *Id.*

self-insure their health plans will be able to continue providing affordable benefits that best meet the needs of workers and their families.

H.R. 2813, THE SELF-INSURANCE PROTECTION ACT

H.R. 2813, the *Self-Insurance Protection Act*, amends ERISA to clarify that federal regulators cannot redefine stop-loss insurance as traditional health insurance in order to preserve the option of self-funding. The bill also prohibits states from regulating stop-loss insurance if state laws or regulations would make stop-loss insurance inaccessible to employers. By providing legal certainty, the bill will help ensure workers and families continue to have access to affordable, flexible self-insured health plans.

CONCLUSION

H.R. 2813, the *Self-Insurance Protection Act,* makes it easier for small businesses to promote a healthy workforce and offer more affordable health care coverage. By allowing small businesses to sponsor self-insured health coverage for their employees while mitigating financial risk for the employer through stop-loss insurance, the bill puts smaller businesses on a more level playing field with larger companies and unions. More importantly, it provides smaller employers—many of whom have limited resources—with a greater opportunity to offer their workers quality and affordable health care coverage. If enacted, H.R. 2813 will empower small businesses to provide quality health care for their employees.

SUMMARY

H.R. 2813 SECTION-BY-SECTION

Section 1. Short title

Section 1 provides that the short title is "Self-Insurance Protection Act."

Section 2. Findings

Section provides the following findings by Congress:

(1) Small and large employers offer health benefits plan coverage to employees in self-funded arrangements using company assets or a fund, or by paying premiums to purchase fully insured coverage from a health insurance company.
(2) Employers that self-fund health benefit plans will often purchase stop-loss insurance as a financial risk-management tool to protect against excess or unexpected catastrophic health plan claims losses that arise above projected costs paid out of company assets.
(3) Stop-loss coverage insures the employer sponsoring the health benefit plan against unforseen health plan claims, does not insure the employee health benefit plan itself, and does not pay health care providers for medical services

provided to the employees.

(4) Employer-sponsored health benefit plans are regulated under the Employee Retirement Income Security Act of 1974; however, States regulate the availability and the coverage terms of stop-loss insurance coverage that employers purchase to protect company assets and to protect a fund against excess or unexpected claims losses.
(5) Both large and small employers that choose to self-fund must also be able to protect company assets or a fund against excess or unexpected claims losses and States must reasonably regulate stop-loss insurance to assure its availability to both large and small employers.

Section 3. Certain medical stop-loss insurance obtained by certain plan sponsors of group health plans not included in the definition of health insurance coverage

Section 3(a) amends Subpart C, Part 7, Subtitle B, of Title I of ERISA by adding a new sentence at the end of Section 733(b)(1): "Such term shall not include a stop-loss policy obtained by a self-funded health plan or a plan sponsor of a group health plan that self-funds the health risks of its plan participants to reimburse the plan or sponsor for losses that the plan or sponsor incurs in providing health or medical benefits to such plan participants in excess of a predetermined level set forth in the stop-loss policy obtained by such plan or sponsor." This provision is to clarify that federal regulators cannot re-define stop loss insurance as traditional health insurance, thereby ensuring that employers can continue to use stop-loss insurance as an important financial tool to help provide health care coverage.

Section 4. Effect on other laws

Section 4 amends Part 5, Subtitle B of Title I of ERISA by adding a subsection (10) at the end of Section 514(b)) providing that Title I of ERISA (including part 7 relating to group health plans) preempts state laws that may prevent a group health plan from insuring against the risk of excess or unexpected health plan claims or losses. This provision renders ineffective any state law that may make stop-loss insurance inaccessible to employers.

EXPLANATION OF AMENDMENTS

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

APPLICATION OF LAW TO THE LEGISLATIVE BRANCH

Section 102(b)(3) of Public Law 104-1 requires a description of the application of this bill to the legislative branch. H.R. 2813 takes important steps to preserve and expand access to affordable, high-quality health care coverage for small employers by ensuring that employers may continue to use stop-loss insurance as an important tool in providing employees with self-insured health coverage.

UNFUNDED MANDATE STATEMENT

Section 423 of the Congressional Budget and Impoundment Control Act (as amended by Section 101(a)(2) of the Unfunded Mandates Reform Act, P.L. 104–4) requires a statement of whether the provisions of the reported bill include unfunded mandates. This issue is addressed in the CBO letter.

EARMARK STATEMENT

H.R. 2813 does not contain any congressional earmarks, limited tax benefits, or limited tariff benefits as defined in clause 9 of House Rule XXI.

ROLL CALL VOTES

Clause 3(b) of rule XIII of the Rules of the House of Representatives requires the Committee Report to include for each record vote on a motion to report the measure or matter and on any amendments offered to the measure or matter the total number of votes for and against and the names of the Members voting for and against.

Date: 06/06/2023

COMMITTEE ON EDUCATION AND LABOR RECORD OF COMMITTEE VOTE

Roll Call: 4 Bill: H.R. 2813 Amendment Number: 2

Disposition: Defeated by a Full Committee Roll Call Vote

Sponsor/Amendment: Courtney / SIPA_PREEMPT_AMD

Name & State	Aye	No	Not Voting	Name & State	Aye	No	Not Voting
Mrs. FOXX (NC) (CKDLrZRPDQ)		X		Mr. SCOTT (VA) (RDQNLQJ)	X		
Mr. WTLSON (SC)			X	Mr. GRTJALVA (AZ)	X		
Mr. THOMPSON (PA)		X		Mr. COURNTEY (CT)	X		
Mr. WALBERG (MT)		X		Mr. SABLAN (MP)			X
Mr. GROTHMAN (WT)		X		Ms. WTLSON (FL)			X
Ms. STEFANTK (NY)		X		Ms. BONAMTCT (OR)	X		
Mr. ALLEN (GA)		X		Mr. TAKANO (CA)	X		
Mr. BANKS (TN)		X		Ms. ADAMS (NC)	X		
Mr. COMER (KY)		X		Mr. DESAULNTER (CA)	X		
Mr. SMUCKER (PA)		X		Mr. NORCROSS (NJ)	X		
Mr. OWENS (UT)		X		Ms. JAYAPAL (WA)	X		
Mr. GOOD (VA)			X	Ms. WTLD (PA)	X		
Mrs. MCCLATN (MT)		X		Ms. MCBATH (GA)	X		
Mrs. MTLLER (TL)		X		Mrs. HAYES (CT)	X		
Mrs. STEEL (CA)		X		Ms. OMAR (MN)	X		
Mr. ESTES (KS)		X		Ms. STEVENS (MT)	X		
Ms. LETLOW (LA)		X		Ms. LEGER FERNANDEZ (NM)	X		
Mr. KTLEY (CA)		X		Ms. MANNTNG (NC)	X		
Mr. BEAN (FL)		X		Mr. MRVAN (TN)	X		
Mr. BURLTSON (MO)		X		Mr. BOWMAN (NY)	X		
Mr. MORAN (TX)			X				
Mr. JAMES (MT)		X					
Ms. CHAVEZ-DEREMER (OR)		X					
Mr. WTLLTAMS (NY)		X					
Ms. HOUCHTN (TN)		X					

TOTALS: Ayes: 18 Nos: 22 Not Voting: 5

Total: 45 / Quorum: / Report:

(25 R - 20 D)

^Although not present for the recorded vote, Member expressed he/she would have voted AYE if present at time of vote.

*Although not present for the recorded vote, Member expressed he/she would have voted NO if present at time of vote.

Date: 06/06/2023

COMMITTEE ON EDUCATION AND LABOR RECORD OF COMMITTEE VOTE

Roll Call: 5 Bill: H.R. 2813 Amendment Number: 1

Disposition: Good Motion to Report H.R. 2813 to the House with amendments and recommendation that the amendment be agreed to, and the bill as amended, do pass

Sponsor/Amendment: Good / SIPA_ANS

Name & State	Aye	No	Not Voting	Name & State	Aye	No	Not Voting
Mrs. FOXX (NC) (CKDLrZRPDQ)	X			Mr. SCOTT (VA) (RDQNLQJ)		X	
Mr. WlLSON (SC)	X			Mr. GRlJALVA (AZ)		X	
Mr. THOMPSON (PA)	X			Mr. COURNTEY (CT)		X	
Mr. WALBERG (Ml)	X			Mr. SABLAN (MP)			X
Mr. GROTHMAN (Wl)	X			Ms. WlLSON (FL)			X
Ms. STEFANlK (NY)	X			Ms. BONAMlCl (OR)		X	
Mr. ALLEN (GA)	X			Mr. TAKANO (CA)		X	
Mr. BANKS (lN)	X			Ms. ADAMS (NC)		X	
Mr. COMER (KY)	X			Mr. DESAULNlER (CA)		X	
Mr. SMUCKER (PA)	X			Mr. NORCROSS (NJ)		X	
Mr. OWENS (UT)	X			Ms. JAYAPAL (WA)		X	
Mr. GOOD (VA)	X			Ms. WlLD (PA)		X	
Mrs. MCCLAlN (Ml)	X			Ms. MCBATH (GA)		X	
Mrs. MlLLER (lL)	X			Mrs. HAYES (CT)		X	
Mrs. STEEL (CA)	X			Ms. OMAR (MN)		X	
Mr. ESTES (KS)	X			Ms. STEVENS (Ml)		X	
Ms. LETLOW (LA)	X			Ms. LEGER FERNANDEZ (NM)		X	
Mr. KlLEY (CA)	X			Ms. MANNlNG (NC)		X	
Mr. BEAN (FL)	X			Mr. MRVAN (lN)		X	
Mr. BURLlSON (MO)	X			Mr. BOWMAN (NY)		X	
Mr. MORAN (TX)			X				
Mr. JAMES (Ml)	X						
Ms. CHAVEZ-DEREMER (OR)	X						
Mr. WlLLlAMS (NY)	X						
Ms. HOUCHlN (lN)	X						

TOTALS: Ayes: 24 Nos: 18 Not Voting: 3

Total: 45 / Quorum: / Report:

(25 R - 20 D)

^Although not present for the recorded vote, Member expressed he/she would have voted AYE if present at time of vote.

*Although not present for the recorded vote, Member expressed he/she would have voted NO if present at time of vote.

STATEMENT OF GENERAL PERFORMANCE GOALS AND OBJECTIVES

In accordance with clause (3)(c) of House Rule XIII, the goal of H.R. 2813 is to preserve and expand access to affordable, high-quality health care coverage for small employers by ensuring that employers may continue to use stop-loss insurance as an important tool in providing employees with self-insured health coverage.

DUPLICATION OF FEDERAL PROGRAMS

No provision of H.R. 2813 establishes or reauthorizes a program of the Federal Government known to be duplicative of another Federal program, a program that was included in any report from the Government Accountability Office to Congress pursuant to section 21 of Public Law 111 -139, or a program related to a program identified in the most recent Catalog of Federal Domestic Assistance.

STATEMENT OF OVERSIGHT FINDINGS AND RECOMMENDATIONS OF THE COMMITTEE

In compliance with clause 3(c)(1) of rule XIII and clause 2(b)(1) of rule X of the Rules of the House of Representatives, the committee's oversight findings and recommendations are reflected in the body of this report.

REQUIRED COMMITTEE HEARING AND RELATED HEARINGS

In compliance with clause 3(c)(6) of rule XIII, the following hearing held during the 118th Congress was used to develop or consider H.R. 2813: On April 24, 2023, the HELP Subcommittee held a hearing entitled “Reducing Health Care Costs for Working Americans and Their Families.”

NEW BUDGET AUTHORITY AND CBO COST ESTIMATE

With respect to the requirements of clause 3(c)(2) of rule XIII of the Rules of the House of Representatives and section 308(a) of the Congressional Budget Act of 1974 and with respect to requirements of clause 3(c)(3) of rule XIII of the Rules of the House of Representatives and section 402 of the Congressional Budget Act of 1974, a cost estimate was not made available to the Committee in time for the filing of this report. The Chairwoman of the Committee shall cause such estimate to be printed in the Congressional Record upon its receipt by the Committee.

COMMITTEE COST ESTIMATE

Clause 3(d)(1) of rule XIII of the Rules of the House of Representatives requires an estimate and a comparison of the costs that would be incurred in carrying out H.R. 2813. However, clause 3(d)(2)(B) of that rule provides that this requirement does not apply when, as with the present report, the committee adopts as its own the cost estimate of the bill prepared by the Director

of the Congressional Budget Office under section 402 of the Congressional Budget Act.

CHANGES IN EXISTING LAW MADE BY THE BILL, AS REPORTED

CHANGES IN EXISTING LAW MADE BY THE BILL, AS REPORTED

In compliance with clause 3(e) of rule XIII of the Rules of the House of Representatives, changes in existing law made by the bill, as reported, are shown as follows (new matter is printed in italics and existing law in which no change is proposed is shown in roman):

EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974

* * * * * * *

TITLE I—PROTECTION OF EMPLOYEE BENEFIT RIGHTS

* * * * * * *

SUBTITLE B—REGULATORY PROVISIONS

* * * * * * *

PART 5—ADMINISTRATION AND ENFORCEMENT

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EFFECT ON OTHER LAWS

SEC. 514. (a) Except as provided in subsection (b) of this section, the provisions of this title and title IV shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan described in section 4(a) and not exempt under section 4(b). This section shall take effect on January 1, 1975.

(b)(1) This section shall not apply with respect to any cause of action which arose, or any act or omission which occurred, before January 1, 1975.

(2)(A) Except as provided in subparagraph (B), nothing in this title shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities.

(B) Neither an employee benefit plan described in section 4(a), which is not exempt under section 4(b) (other than a plan established primarily for the purpose of providing death benefits), nor any trust established under such a plan, shall be deemed to be an insurance company or other insurer, bank, trust company, or in- vestment company or to be engaged in the business of insurance or banking for purposes of any law of any State purporting to regulate insurance companies, insurance contracts, banks, trust companies, or investment companies.

(3) Nothing in this section shall be construed to prohibit use by the Secretary of services or facilities of a State agency as permitted under section 506 of this Act.

(4) Subsection (a) shall not apply to any generally applicable criminal law of a State.

(5)(A) Except as provided in subparagraph (B), subsection (a) shall not apply to the Hawaii Prepaid Health Care Act (Haw. Rev. Stat. §§ 393–1 through 393–51).

(B) Nothing in subparagraph (A) shall be construed to exempt from subsection (a)—

(i) any State tax law relating to employee benefit plans, or

(ii) any amendment of the Hawaii Prepaid Health Care Act enacted after September 2, 1974, to the extent it provides for more than the effective administration of such Act as in effect on such date.

(C) Notwithstanding subparagraph (A), parts 1 and 4 of this subtitle, and the preceding sections of this part to the extent they govern matters which are governed by the provisions of such parts 1 and 4, shall supersede the Hawaii Prepaid Health Care Act (as in effect on or after the date of the enactment of this paragraph), but the Secretary may enter into cooperative arrangements under this paragraph and section 506 with officials of the State of Hawaii to assist them in effectuating the policies of provisions of such Act which are superseded by such parts 1 and 4 and the pre- ceding sections of this part.

(6)(A) Notwithstanding any other provision of this section—

(i) in the case of an employee welfare benefit plan which is a multiple employer welfare arrangement and is fully insured (or which is a multiple employer welfare arrangement subject to an exemption under subparagraph (B)), any law of any State which regulates insurance may apply to such arrangement to the extent that such law provides—

(I) standards, requiring the maintenance of specified levels of reserves and specified levels of contributions, which any such plan, or any trust established under such a plan, must meet in order to be considered under such law able to pay benefits in full when due, and

(II) provisions to enforce such standards, and

(ii) in the case of any other employee welfare benefit plan which is a multiple employer welfare arrangement, in addition to this title, any law of any State which regulates insurance may apply to the extent not inconsistent with the preceding sections of this title.

(B) The Secretary may, under regulations which may be prescribed by the Secretary, exempt from subparagraph (A)(ii), individually or by class, multiple employer welfare arrangements which are not fully insured. Any such exemption may be granted with respect to any arrangement or class of arrangements only if such arrangement or each arrangement which is a member of such class meets the requirements of section 3(1) and section 4 necessary to be considered an employee welfare benefit plan to which this title applies.

(C) Nothing in subparagraph (A) shall affect the manner or extent to which the provisions of this title apply to an employee welfare benefit plan which is not a multiple employer welfare arrangement and which is a plan, fund, or program participating in, subscribing to, or otherwise using a multiple employer welfare ar-

rangement to fund or administer benefits to such plan's participants and beneficiaries.

(D) For purposes of this paragraph, a multiple employer wel- fare arrangement shall be considered fully insured only if the terms of the arrangement provide for benefits the amount of all of which the Secretary determines are guaranteed under a contract, or policy of insurance, issued by an insurance company, insurance service, or insurance organization, qualified to conduct business in a State.

(7) Subsection (a) shall not apply to qualified domestic relations orders (within the meaning of section 206(d)(3)(B)(i)), qualified medical child support orders (within the meaning of section 609(a)(2)(A)), and the provisions of law referred to in section 609(a)(2)(B)(ii) to the extent they apply to qualified medical child support orders.

(8) Subsection (a) of this section shall not be construed to preclude any State cause of action—

(A) with respect to which the State exercises its acquired rights under section 609(b)(3) with respect to a group health plan (as defined in section 607(1)), or

(B) for recoupment of payment with respect to items or services pursuant to a State plan for medical assistance approved under title XIX of the Social Security Act which would not have been payable if such acquired rights had been executed before payment with respect to such items or services by the group health plan.

(9) For additional provisions relating to group health plans, see section 731.

(10) The provisions of this title (including part 7 relating to group health plans) shall preempt State laws insofar as they may now or hereafter prevent an employee benefit plan that is a group health plan from insuring against the risk of excess or unexpected health plan claims losses.

(c) For purposes of this section:

(1) The term "State law" includes all laws, decisions, rules, regulations, or other State action having the effect of law, of any State. A law of the United States applicable only to the District of Columbia shall be treated as a State law rather than a law of the United States.

(2) The term "State" includes a State, any political subdivisions thereof, or any agency or instrumentality of either, which purports to regulate, directly or indirectly, the terms and conditions of employee benefit plans covered by this title.

(d) Nothing in this title shall be construed to alter, amend, modify, invalidate, impair, or supersede any law of the United States (except as provided in sections 111 and 507(b)) or any rule or regulation issued under any such law.

(e)(1) Notwithstanding any other provision of this section, this title shall supersede any law of a State which would directly or indirectly prohibit or restrict the inclusion in any plan of an automatic contribution arrangement. The Secretary may prescribe regulations which would establish minimum standards that such an ar-

rangement would be required to satisfy in order for this subsection to apply in the case of such arrangement.

(2) For purposes of this subsection, the term "automatic contribution arrangement" means an arrangement—

(A) under which a participant may elect to have the plan sponsor make payments as contributions under the plan on behalf of the participant, or to the participant directly in cash,

(B) under which a participant is treated as having elected to have the plan sponsor make such contributions in an amount equal to a uniform percentage of compensation pro- vided under the plan until the participant specifically elects not to have such contributions made (or specifically elects to have such contributions made at a different percentage), and

(C) under which such contributions are invested in accordance with regulations prescribed by the Secretary under sec- tion 404(c)(5).

(3)(A) The plan administrator of an automatic contribution arrangement shall, within a reasonable period before such plan year, provide to each participant to whom the arrangement applies for such plan year notice of the participant's rights and obligations under the arrangement which—

(i) is sufficiently accurate and comprehensive to apprise the participant of such rights and obligations, and

(ii) is written in a manner calculated to be understood by the average participant to whom the arrangement applies.

(B) A notice shall not be treated as meeting the requirements of subparagraph (A) with respect to a participant unless—

(i) the notice includes an explanation of the participant's right under the arrangement not to have elective contributions made on the participant's behalf (or to elect to have such contributions made at a different percentage),

(ii) the participant has a reasonable period of time, after receipt of the notice described in clause (i) and before the first elective contribution is made, to make such election, and

(iii) the notice explains how contributions made under the arrangement will be invested in the absence of any investment election by the participant.

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PART 7—GROUP HEALTH PLAN REQUIREMENTS

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SUBPART C—GENERAL PROVISIONS

* * * * * * *

SEC. 733. DEFINITIONS.

(a) GROUP HEALTH PLAN.—For purposes of this part—

(1) IN GENERAL.—The term "group health plan" means an employee welfare benefit plan to the extent that the plan provides medical care (as defined in paragraph (2) and including items and services paid for as medical care) to employees or their dependents (as defined under the terms of the plan) di-

rectly or through insurance, reimbursement, or otherwise. Such term shall not include any qualified small employer health reimbursement arrangement (as defined in section 9831(d)(2) of the Internal Revenue Code of 1986).

(2) MEDICAL CARE.—The term "medical care" means amounts paid for—

(A) the diagnosis, cure, mitigation, treatment, or prevention of disease, or amounts paid for the purpose of affecting any structure or function of the body,

(B) amounts paid for transportation primarily for and essential to medical care referred to in subparagraph (A), and

(C) amounts paid for insurance covering medical care referred to in subparagraphs (A) and (B).

(b) DEFINITIONS RELATING TO HEALTH INSURANCE.—For purposes of this part—

(1) HEALTH INSURANCE COVERAGE.—The term "health insurance coverage" means benefits consisting of medical care (provided directly, through insurance or reimbursement, or otherwise and including items and services paid for as medical care) under any hospital or medical service policy or certificate, hospital or medical service plan contract, or health maintenance organization contract offered by a health insurance issuer. *Such term shall not include a stop-loss policy obtained by a self-insured group health plan or a plan sponsor of a group health plan that self-insures the health risks of its plan participants to reimburse the plan or sponsor for losses that the plan or sponsor incurs in providing health or medical benefits to such plan participants in excess of a predetermined level set forth in the stop-loss policy obtained by such plan or sponsor.*

(2) HEALTH INSURANCE ISSUER.—The term "health insurance issuer" means an insurance company, insurance service, or insurance organization (including a health maintenance organization, as defined in paragraph (3)) which is licensed to engage in the business of insurance in a State and which is sub- ject to State law which regulates insurance (within the mean- ing of section 514(b)(2)). Such term does not include a group health plan.

(3) HEALTH MAINTENANCE ORGANIZATION.—The term "health maintenance organization" means—

(A) a federally qualified health maintenance organization (as defined in section 1301(a) of the Public Health Service Act (42 U.S.C. 300e(a))),

(B) an organization recognized under State law as a health maintenance organization, or

(C) a similar organization regulated under State law for solvency in the same manner and to the same extent as such a health maintenance organization.

(4) GROUP HEALTH INSURANCE COVERAGE.—The term "group health insurance coverage" means, in connection with a group health plan, health insurance coverage offered in connection with such plan.

(c) EXCEPTED BENEFITS.—For purposes of this part, the term "excepted benefits" means benefits under one or more (or any combination thereof) of the following:

(1) BENEFITS NOT SUBJECT TO REQUIREMENTS.—

(A) Coverage only for accident, or disability income insurance, or any combination thereof.

(B) Coverage issued as a supplement to liability insurance.

(C) Liability insurance, including general liability insurance and automobile liability insurance.

(D) Workers' compensation or similar insurance.

(E) Automobile medical payment insurance.

(F) Credit-only insurance.

(G) Coverage for on-site medical clinics.

(H) Other similar insurance coverage, specified in regulations, under which benefits for medical care are secondary or incidental to other insurance benefits.

(2) BENEFITS NOT SUBJECT TO REQUIREMENTS IF OFFERED SEPARATELY.—

(A) Limited scope dental or vision benefits.

(B) Benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof.

(C) Such other similar, limited benefits as are specified in regulations.

(3) BENEFITS NOT SUBJECT TO REQUIREMENTS IF OFFERED AS INDEPENDENT, NONCOORDINATED BENEFITS.—

(A) Coverage only for a specified disease or illness.

(B) Hospital indemnity or other fixed indemnity insurance.

(4) BENEFITS NOT SUBJECT TO REQUIREMENTS IF OFFERED AS SEPARATE INSURANCE POLICY.—Medicare supplemental health insurance (as defined under section 1882(g)(1) of the Social Security Act), coverage supplemental to the coverage pro- vided under chapter 55 of title 10, United States Code, and similar supplemental coverage provided to coverage under a group health plan.

(d) OTHER DEFINITIONS.—For purposes of this part—

(1) COBRA CONTINUATION PROVISION.—The term "COBRA continuation provision" means any of the following:

(A) Part 6 of this subtitle.

(B) Section 4980B of the Internal Revenue Code of 1986, other than subsection (f)(1) of such section insofar as it relates to pediatric vaccines.

(C) Title XXII of the Public Health Service Act.

(2) HEALTH STATUS-RELATED FACTOR.—The term "health status-related factor" means any of the factors described in section 702(a)(1).

(3) NETWORK PLAN.—The term "network plan" means health insurance coverage offered by a health insurance issuer under which the financing and delivery of medical care (including items and services paid for as medical care) are provided,

in whole or in part, through a defined set of providers under contract with the issuer.

(4) PLACED FOR ADOPTION.—The term "placement", or being "placed", for adoption, has the meaning given such term in section 609(c)(3)(B).

(5) FAMILY MEMBER.—The term "family member" means, with respect to an individual—

(A) a dependent (as such term is used for purposes of section 701(f)(2)) of such individual, and

(B) any other individual who is a first-degree, second-degree, third-degree, or fourth-degree relative of such individual or of an individual described in subparagraph (A).

(6) GENETIC INFORMATION.—

(A) IN GENERAL.—The term "genetic information" means, with respect to any individual, information about—

(i) such individual's genetic tests,

(ii) the genetic tests of family members of such individual, and

(iii) the manifestation of a disease or disorder in family members of such individual.

(B) INCLUSION OF GENETIC SERVICES AND PARTICIPATION IN GENETIC RESEARCH.—Such term includes, with respect to any individual, any request for, or receipt of, genetic services, or participation in clinical research which includes genetic services, by such individual or any family member of such individual.

(C) EXCLUSIONS.—The term "genetic information" shall not include information about the sex or age of any individual.

(7) GENETIC TEST.—

(A) IN GENERAL.—The term "genetic test" means an analysis of human DNA, RNA, chromosomes, proteins, or metabolites, that detects genotypes, mutations, or chromosomal changes.

(B) EXCEPTIONS.—The term "genetic test" does not mean—

(i) an analysis of proteins or metabolites that does not detect genotypes, mutations, or chromosomal changes; or

(ii) an analysis of proteins or metabolites that is directly related to a manifested disease, disorder, or pathological condition that could reasonably be detected by a health care professional with appropriate training and expertise in the field of medicine in- volved.

(8) GENETIC SERVICES.—The term "genetic services" means—

(A) a genetic test;

(B) genetic counseling (including obtaining, interpreting, or assessing genetic information); or

(C) genetic education.

(9) UNDERWRITING PURPOSES.—The term "underwriting purposes" means, with respect to any group health plan, or

health insurance coverage offered in connection with a group health plan—

(A) rules for, or determination of, eligibility (including enrollment and continued eligibility) for benefits under the plan or coverage;

(B) the computation of premium or contribution amounts under the plan or coverage;

(C) the application of any pre-existing condition exclusion under the plan or coverage; and

(D) other activities related to the creation, renewal, or replacement of a contract of health insurance or health benefits.

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MINORITY VIEWS