118TH CONGRESS
2d Session
HOUSE OF REPRESENTATIVES
REPORT
118–877

PROVIDING FOR CONGRESSIONAL DISAPPROVAL UNDER CHAPTER 8 OF TITLE 5, UNITED STATES CODE, OF THE RULE SUBMITTED BY THE DEPARTMENT OF LABOR RELATING TO "DEFINITION OF 'EMPLOYER'-ASSOCIATION HEALTH PLANS"

DECEMBER 16, 2024.—Committed to the Committee of the Whole House on the State of the Union and ordered to be printed

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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.J. Res. 181]

[Including cost estimate of the Congressional Budget Office]

The Committee on Education and the Workforce, to whom was referred the joint resolution (H.J. Res 181) providing for congressional disapproval under chapter 8 of title 5, United States Code, of the rule submitted by the Department of Labor relating to "Definition of 'Employer'-Association Health Plans", having considered the same, reports favorably thereon without amendment and recommends that the joint resolution do pass.

PURPOSE

The purpose of H.J. Res. 181 is to disapprove of the rule related to "Definition of 'Employer'-Association Health Plans" that was published as a final rule in the Federal Register on April 30, 2024.

COMMITTEE ACTION

109TH CONGRESS

Legislative Action

On February 2, 2005, Representative Sam Johnson (R–TX), then-Chairman of the Employer-Employee Relations Subcommittee of the Committee on Education and the Workforce (Committee), introduced the *Small Business Health Fairness Act* (H.R. 525). On March 16, 2005, the Committee ordered H.R. 525, without amend-

ment, favorably reported to the House of Representatives by a vote of 25 to 22. On July 26, 2005, H.R. 525 passed the full House by a vote of 263 to 165.

111TH CONGRESS

Legislative Action

Between July 15 and 17, 2009, the Committee met to mark up H.R. 3200, the *America's Affordable Health Choices Act of 2009*.[1] During the markup, Representative Howard P. "Buck" McKeon (R–CA) offered an amendment including rules governing association health plans (AHPs), the treatment of single-employer arrangements, enforcement provisions, and other provisions related to AHPs. The amendment was defeated by a vote of 21 to 27.

On November 7, 2009, the House passed H.R. 3962, the *Affordable Health Care for America Act*. During the debate, former Speaker John Boehner (R–OH) included the AHP legislative text in the Republican motion to recommit.[2]

On March 21, 2010, the House passed the *Patient Protection and Affordable Care Act* by a vote of 219 to 212 to resolve differences with the Senate. The bill was signed by President Obama on March 23, 2010.[3] On March 25, 2010, the House passed the *Health Care and Education Reconciliation Act* of 2010 by a vote of 220 to 207 to resolve differences with the Senate. This bill was signed into law by President Obama on March 30, 2010.[4] Collectively, the two bills are known as the *Affordable Care Act* (ACA or Obamacare).[5] The ACA did not include AHP legislative text.

112TH CONGRESS

First Session—Hearing

On February 9, 2011, the Committee held a hearing entitled "The Impact of the Health Care Law on the Economy, Employers, and the Workforce," which examined AHPs, among other topics. The witnesses were Dr. Paul Howard, Senior Fellow, Manhattan Institute, New York, NY; Ms. Gail Johnson, President and CEO, Rainbow Station, Inc., Glenn Allen, VA; 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.

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; it also examined AHPs. Witnesses were Mr. Scott Bollenbacher, CPA, Managing Partner, Bollenbacher and Associates, LLC, Portland, IN; Mr. Joe Eddy, President and Chief Executive Officer, Eagle Manufacturing Company, Wellsburg, WV; Ms.

[1] H.R. 3200 was the House precursor to the law known as the Affordable Care Act.
[2] H. Amend. 510 to H.R. 3962, 111th Cong. (2009).
[3] Patient Protection and Affordable Care Act, Pub. L. No. 111–148 (2010).
[4] Health and Education Reconciliation Act, Pub. L. No. 111–152 (2010).
[5] Patient Protection and Affordable Care Act, Pub. L. No. 111–148 (2010), and Health and Education Reconciliation Act, Pub. L. No. 111–152 (2010).

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 the *Small Business Health Fairness Act of 2017* (H.R. 1101) addressing AHPs, among other proposals. Witnesses were Mr. Jon B. Hurst, President, Retailers Association of Massachusetts, Boston, MA; Ms. Allison R. Klausner, J.D., Principal, Government Relations Leader, Conduent, Secaucus, NJ; Ms. Lydia Mitts, Associate Director of Affordability Initiatives, Families USA, Washington, D.C.; and Mr. Jay Ritchie, Executive Vice President, Tokio Marine HHC, Kennesaw, GA.

Legislative Action

On February 16, 2017, Representative Sam Johnson introduced the *Small Business Health Fairness Act of 2017* (H.R. 1101) with then-Subcommittee on Health, Employment, Labor, and Pensions (HELP) Chairman Tim Walberg (R–MI).

On March 8, 2017, the Committee considered H.R. 1101. Representative Walberg offered an amendment in the nature of a substitute (ANS), making technical changes to the introduced bill. The Committee voted to adopt the ANS by voice vote. The Committee favorably reported H.R. 1101, as amended, to the House of Representatives by a vote of 22 to 17. On March 22, 2017, the House passed H.R. 1101 by a vote of 236–175.

Second Session—Hearing

On March 20, 2018, the HELP Subcommittee held a hearing entitled "Expanding Affordable Health Care Options: Examining the Department of Labor's Proposed Rule on Association Health Plans." Witnesses were Mr. Christopher Condeluci, Principal and Sole Shareholder, CC Law and Policy PLLC, Washington, D.C.; Mr. Michael McGrew, CEO McGrew Real Estate, Lawrence, KS; Ms. Catherine Monson, CEO and President, FASTSIGNS International, Inc., Carrollton, TX; and Mr. John Arensmeyer, Founder and CEO, Small Business Majority, Washington, D.C.

117TH CONGRESS

Second Session—Hearing

On February 17, 2022, the HELP Subcommittee held a hearing entitled "Exploring Pathways to Affordable, Universal Health Coverage," which examined, among other topics, the benefits of expanding AHPs. The witnesses were Dr. Brian Blase, President, Paragon Health Institute, Ponte Verde, Florida; Dr. Georges C. Benjamin, Executive Director, the American Public Health Association, Washington, D.C.; Ms. Katie Keith, Center on Health Insurance Reforms, Georgetown University, Washington, D.C.; and Mr. Robert B. Reich, Carmel P. Friesen Professor of Public Policy, Goldman School of Public Policy, University of California, Berkley, CA.

First Session—Hearing

On April 26, 2023, the HELP Subcommittee held a hearing entitled "Reducing Health Care Costs for Working Americans and Their Families," which examined H.R. 2868, the *Association Health Plans Act*, 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.; Marcie Strouse, Partner, Capitol Benefits Group, Des Moines, IA; 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, Representative Walberg introduced the *Association Health Plans Act* (H.R. 2868) with Chairwoman Foxx, HELP Subcommittee Chairman Bob Good (R–VA), and Representatives Rick Allen (R–GA), Dan Crenshaw (R–TX), and Michael Burgess (R–TX) as original cosponsors. On June 6, 2023, the Committee considered H.R. 2868 in legislative session and reported it favorably, as amended, to the House of Representatives by a recorded vote of 23 to 18. Representative Walberg offered an ANS clarifying that an organization has to be active for two years prior to the establishment of an AHP in order for the AHP to qualify as a group health plan under the bill. In section 3, the ANS also struck "employee welfare benefit plan" and inserted "group health plan" to clarify that premium rates are for health care only. The ANS was adopted by voice vote.

Second Session—Hearing

On May 15, 2024, the Committee held a hearing entitled "Examining the Policies and Priorities of the Department of Health and Human Services." The sole witness was the Honorable Xavier Becerra, Secretary of Health and Human Services, Washington, D.C. During this hearing, Members asked Secretary Becerra about the increase in the cost of health insurance premiums after the Biden-Harris administration rescinded the 2018 AHP rule.

On September 10, 2024, the HELP Subcommittee held a hearing entitled "ERISA's 50th Anniversary: The Value of Employer-Sponsored Health Benefits," which discussed the 2024 Department of Labor (DOL) final rule rescinding the 2018 Trump administration AHP rule. Witnesses were Ms. Ilyse Schuman, Senior Vice President, Health and Paid Leave Policy, American Benefits Council, Washington, D.C.; Ms. Holly Wade, Executive Director, National Federation of Independent Business Research Center, Washington, D.C.; Dr. Paul Fronstin, Director, Health Benefits Research, Employee Benefit Research Institute, Washington, D.C.; and Mr. Anthony Wright, Executive Director, Families USA, Davis, CA.

Legislative Action

On July 2, 2024, Representative Walberg introduced H.J. Res. 181, *Providing for congressional disapproval under chapter 8 of title 5, United States Code, of the rule submitted by the Department of Labor relating to "Definition of 'Employer'-Association Health*

Plans," with Chairwoman Virginia Foxx (R–NC) and Representatives Neal Dunn (R–FL), Burgess, Allen, Crenshaw, Aaron Bean (R–FL), Good (HELP Subcommittee Chairman), Adrian Smith (R–NE), Russ Fulcher (R–ID), Dan Meuser (R–PA), Claudia Tenney (R–NY), Troy Balderson (R–OH), Dusty Johnson (R–SD), Andy Ogles (R–TN), Lloyd Smucker (R–PA), Glenn Grothman (R–WI), Glenn Thompson (R–PA), and Burgess Owens (R–UT). On September 11, 2024, the Committee considered H.J. Res. 181 in legislative session and reported it favorably to the House of Representatives by a recorded vote of 23 to 12.

COMMITTEE VIEWS

Introduction

The Committee has a long history of supporting expanded access to AHPs which give small employers increased ability to spread risk and lower health care costs. The Committee supports expanded access to more affordable health care coverage for small employers and self-employed individuals. Expanding AHPs would allow small businesses and independent contractors to band together across state lines through associations, thus increasing their bargaining power with health plans and providers and placing them on a more level playing field with larger companies and unions. AHPs free small businesses from costly state-mandated benefit packages, distribute the risk for self-employed individuals among all enrolled, and lower overhead costs, enabling employers to offer more affordable health care coverage to their workers and enabling self- employed individuals to access more affordable health care coverage. Nullifying the Biden-Harris administration's reversal of the Trump administration's efforts to expand AHPs is an important first step in helping small businesses.

Background on employer-sponsored health insurance

The Committee on Education and the Workforce has jurisdiction over employer-sponsored health coverage. Employer-sponsored insurance (ESI) covers over half of the non-elderly population—an estimated 153 million employees and their dependents.[6] Employer-sponsored health benefits are governed by several laws, including the *Employee Retirement Income Security Act of 1974* (ERISA), which is the foundation of employer-sponsored health care.

ERISA establishes federal guidelines governing the conduct of employee benefit plans, including employer-sponsored group health plans. Private employers that implement group health plans may implement uniform benefit plans because ERISA preempts state regulation of such plans. Approximately 99 million employees and family members have coverage from employers that self-insure their own health plans, making them subject to regulation only under ERISA and the Internal Revenue Code (Code).[7] The remainder of private employers offering health benefits purchase fully insured coverage from traditional insurance companies, which is generally governed by ERISA, the Code, the *Public Health Service Act* (PHSA), and state insurance laws.

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[6] https://files.kff.org/attachment/Employer-Health-Benefits-Survey-2023-Annual-Survey.pdf.
[7] *Id.*

ESI is the core of America's health care system. Employers have historically been at the forefront of creating innovative, market-driven approaches to providing health benefits. Ninety-three percent of Americans covered by ESI are satisfied with their employer-sponsored coverage.[8] Fifty-three percent of small firms (firms with 3–199 workers) and 98 percent of large firms (firms with 200 or more workers) offered health benefits to their workers in 2023.[9] When employees can participate in ESI, 75 percent enroll.[10]

Challenges facing small employers' ability to offer health insurance

Health costs continue to rise at unsustainable rates. In 2023, health care spending was 17.6 percent of the U.S. Gross Domestic Product (GDP) or $14,423 per person and is expected to rise to 19.7 percent of GDP or $21,927 per person within the next decade.[11] In 2023, annual premiums for family coverage rose by 7 percent.[12] The increase in health costs has led large employers subject to the Affordable Care Act (ACA) employer mandate to reduce benefits and has led small employers increasingly to drop coverage. For more than 30 years, NFIB members have identified the cost of health insurance as the top small business problem, with 48 percent ranking it as a critical problem.[13]

While the ACA requires employers with more than 50 full-time employees to offer ESI coverage, many small employers (with fewer than 50 employees) choose to offer coverage anyway. Sixty-three percent of small employers believe it is important for them to offer health coverage in order to recruit and retain employees.[14] According to the NFIB Small Business Health Insurance Survey, 56 percent of small employers offer health insurance, including 89 percent of employers with more than 30 employees and 39 percent of employers with fewer than 10 employees. Seventy-seven percent of small employers fully insure their plans, meaning they pay premiums to an insurance company that bears the financial risk for the plan, while 8 percent of small employers self-fund, meaning the employer itself bears the financial risk.[15]

However, many small employers dropped health insurance coverage for their employees due to the increased financial risks in offering health coverage after the ACA, which are further exacerbated by rising health care costs. In testimony before the HELP Subcommittee on April 26, 2023, Mr. Joel White, President of the Council for Affordable Health Coverage, argued that ACA mandates applicable to small businesses increase the cost of providing health care coverage and limit choices: "As Congress increased [costs for small businesses] and limited their choices, the authors of ACA created powerful incentives for small businesses to drop coverage. And they did."[16] Among small employers that do not offer health insurance, 65 percent say that it is simply too expen-

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[8] https://www.techtarget.com/healthcarepayers/news/366603783/93-of-Employees-Satisfied-with-Employer-Sponsored-Health-Insurance#:~:text=93%25%20of%20Employees%20Satisfied%20with%20Employer%20Sponsored%20Health%20Insurance%20%7C%20TechTarget&text=Follow:.

[9] https://files.kff.org/attachment/Employer-Health-Benefits-Survey-2023-Annual-Survey.pdf.

[10] *Id.*

[11] https://www.healthaffairs.org/doi/10.1377/hlthaff.2024.00469#:~:text=Health%20care%20spending%20in%20the,health%20spending%20(exhibit%201).

[12] https://www.kff.org/report-section/ehbs-2023-section-1-cost-of-health-insurance/.

[13] https://strgnfibcom.blob.core.windows.net/nfibcom/Health-Insurance-Survey-2023.pdf.

[14] https://strgnfibcom.blob.core.windows.net/nfibcom/Health-insurance-survey-NFIB.pdf.

[15] *Id.*

[16] https://edworkforce.house.gov/calendar/eventsingle.aspx?EventID=409078.

sive, but only 9 percent cited government-run health care options as the reason they do not offer coverage. Overall, 94 percent of small employers find it challenging to manage the cost of their health plans, and 98 percent believe that the cost of their health plans will become unsustainable within the next decade. Seventy-nine percent of small employers expressed interest in joining an AHP because it could help alleviate their health care costs.[17]

AHPs would help small businesses offer affordable coverage

An AHP is a type of group health plan that allows multiple employers to band together to purchase health coverage. The term AHP is not in ERISA but operates as a type of multiple employer welfare arrangement (MEWA) for federal regulatory purposes. By participating in AHPs, employers can obtain coverage that is not subject to the burdensome state and federal regulations that govern individual and small-group coverage and extend to MEWAs. Under current law, AHPs can form under limited circumstances that are governed by a series of advisory opinions and guidance documents from DOL. For employers to band together, they must (1) have a common nexus and a "genuine organizational relationship" between the association and participating employees and (2) provide benefits to the employees of two or more employers.[18] AHPs permit multiple small businesses to deliver lower-cost health plans by pooling risk and self-funding.

In 2018, DOL under the Trump administration published a final rule to expand AHPs by expanding the commonality-of-interest standard to include geographic proximity (bona fide association provision) and allowing for the participation of self-employed individuals (working owner provision).[19] New AHPs produced savings of up to 29 percent on average while the rule was in effect, and realtor groups saw average savings of up to 50 percent.[20] The Congressional Budget Office (CBO) predicted that 400,000 people who would have been uninsured would enroll in AHPs and 3.3 million people would enroll in AHPs who would have had other coverage, resulting in 3.7 million additional people enrolling in AHPs.[21]

In her testimony before the HELP Subcommittee on September 10, 2024, Ms. Holly Wade from the NFIB Research Center urged support for policies to allow "small businesses and self-employed individuals to band together to achieve savings through economies of scale":

> [AHPs] are one option for small businesses to offer more affordable insurance to employees. AHPs level the playing field between large employers and small businesses subject to more regulation and benefit mandates in the small group market. By pooling their resources and leveraging the purchasing power of larger groups, small businesses

[17] *Id.*

[18] https://www.dol.gov/sites/dolgov/files/ebsa/about-ebsa/our-activities/resource-center/publications/mewa-under-erisa-a-guide-to-federal-and-state-regulation.pdf.

[19] Definition of "Employer" Under Section 3(5) of ERISA—Association Health Plans, 83 Fed. Reg. 28,912 (June 21, 2018).

[20] https://thefga.org/wp-content/uploads/2020/10/AHPsWork-Trump-admin-expanded-access-to-affordable-quality-health-care.pdf; *see also* https://www.govinfo.gov/content/pkg/CHRG-118hhrg51857/pdf/CHRG-118hhrg51857.pdf, at 149 (statement of Coalition to Protect & Promote Ass'n Health Plans) (citing savings from AHPs of between 5 and 35 percent for employers in different industries and between 2 and 50 percent for self-employed individuals).

[21] https://www.cbo.gov/system/files/2019-01/54915-New_Rules_for_AHPs_STPs.pdf, at 9.

> can reduce premiums and increase their bargaining power, resulting in health insurance at a more affordable price with better networks. . . . Lawmakers should improve existing regulations to allow for industry-based and non-industry-based small businesses to establish an AHP, including self-employed individuals. Additionally, lawmakers should push back against rules that restrict or limit the use of AHPs.[22]

Ms. Wade further elaborated during the hearing:

> [A]ssociation health plans, the way it's constructed is very specific and confined, and restricted to a lot of small business owners currently. Expanding the availability of association health plans to a larger population would allow them to purchase in economies of scale that are more afforded by large firms and will give them a competitive leg up from their current status right now in being able to afford.[23]

Democrat efforts to hinder AHP expansion

In March 2019, in *New York v. Department of Labor* (a lawsuit filed by 12 Democrat attorneys general), the U.S. District Court for the District of Columbia partially vacated the Trump DOL's final rule, holding that it exceeded DOL's authority under ERISA.[24] The court found that the rule's expansion of "commonality of interest" standards to include geographic proximity (bona fide association provision) and inclusion of self-employed individuals (working-owner provision) were unlawful under ERISA.[25] In April 2019, the Trump DOL appealed the ruling,[26] but in February 2021, the appellate court agreed to the Biden-Harris DOL's request to hold the appeal in abeyance pending further action by the administration.[27]

On April 30, 2024, DOL published a final rule rescinding the 2018 Trump AHP rule and not providing any alternative rules for AHPs.[28] Although the rule does not make an immediate change to the status quo, given the 2019 federal district court decision blocking implementation of the 2018 Trump rule, the 2024 rule demonstrates the Biden-Harris administration's unwillingness to pursue new rulemaking to expand access to AHPs.

The 2024 rule cites the district court's conclusion in *New York v. Department of Labor* that the bona fide association provision and working-owner provision in the Trump rule are incompatible with ERISA.[29] Under the guise that AHPs are "junk insurance,"[30] the rule continues the Biden-Harris administration's attempts to force all Americans into one-size-fits-all government-run plans or stringently regulated plans.

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[22] https://edworkforce.house.gov/uploadedfiles/9.10.24_help_hearing_on_erisa_anniversary_wade_testimony.pdf.
[23] https://edworkforce.house.gov/calendar/eventsingle.aspx?EventID=411878.
[24] New York v. DOL, 363 F. Supp. 3d 109 (2019).
[25] *Id.* at 141.
[26] https://www.dol.gov/newsroom/releases/ebsa/ebsa20190429.
[27] Definition of "Employer"—Association Health Plans, 89 Fed. Reg. 34,106, 34,110 (Apr. 30, 2024).
[28] *Id.*, 89 Fed. Reg. 34,106.
[29] *Id.* at 34,406.
[30] https://www.dol.gov/newsroom/releases/ebsa/ebsa20240429.

The Biden-Harris administration has also hindered state efforts to promote AHPs. A 2022 Virginia law allows self-employed individuals and employees of real estate brokerage firms to band together to create an AHP.[31] In May 2023, the Department of Health and Human Services Centers for Medicare and Medicaid Services sent a letter to Governor Glenn Youngkin (R–VA) notifying the state that it failed to enforce certain coverage mandates required by the *Affordable Care Act* (ACA).[32] The letter claimed that self-employed individuals cannot form AHPs because the definition of employee organization under ERISA does not allow for the participation of self-employed individuals.

Support for creating options and flexibility for small businesses

Because it benefits both employers and working families, AHP legislation has been consistently supported over the years, including by a broad swath of groups representing job creators, including the National Federation of Independent Businesses, the Council for Affordable Coverage, the National Association of Realtors, the North Carolina Chamber of Commerce, the Associated General Contractors of America, the MLD Foundation, the Main Street Freedom Alliance, the National Association of Wholesaler-Distributors, the Small Business and Entrepreneurship Council, the American Farm Bureau Federation, the American Society of Association Executives, the Associated Employers Benefit and Trust, the Indiana Credit Union League, the Manufacturer and Business Association, the Michigan Business and Professional Association, the Michigan Dental Association, the National Restaurant Association, the Small Business Association of Michigan, and the U.S. Chamber of Commerce.

H.J. Res. 181

On July 2, Representative Walberg introduced H.J. Res. 181, a *Congressional Review Act* joint resolution of disapproval nullifying the Biden-Harris AHP final rule published on April 30, 2024, with 18 cosponsors.[33] By nullifying the Biden-Harris rule, the resolution would effectively reinstate the portions of the Trump administration 2018 rule that were not vacated by the federal district court in 2019 in *New York v. Department of Labor*. However, that decision vacated key provisions of the Trump rule regarding the definition of a bona fide group or association of employers, which permitted working owners to participate in association health plans. Even so, enacting H.J. Res. 181 would be a first step to expanding flexible health care coverage options and providing lower costs to workers.

Conclusion

AHPs make it easier for small businesses to promote a healthy workforce and offer more affordable health care coverage. AHPs put smaller businesses on a more level playing field with larger companies and unions while also increasing small businesses' bargaining power with insurance providers. More importantly, AHPs provide smaller employers—many of whom have limited re-

[31] https://www.governor.virginia.gov/newsroom/news-releases/2022/june/name-934901-en.html.
[32] https://www.cms.gov/files/document/virginia-preliminary-determination-letter.pdf.
[33] Definition of "Employer"-Association Health Plans, 89 Fed. Reg. 34,106 (Apr. 30, 2024).

sources—with an opportunity to offer their workers higher-quality and more affordable health care coverage than they otherwise could. Expanding access to AHPs will also allow independent contractors to obtain high-quality, affordable health care coverage. H.J. Res. 181 would reverse the Biden-Harris administration's rescission of the Trump administration's regulations that expanded access to AHPs, and the resolution would tee up future actions to expand small businesses' ability to join AHPs to provide high-quality, low-cost health plans for their employees.

SUMMARY

H.J. RES. 181 SECTION-BY-SECTION SUMMARY

H.J. Res. 181 resolves that Congress disapproves of the rule related to "Definition of 'Employer'-Association Health Plans," published as a final rule in the Federal Register on April 30, 2024.

EXPLANATION OF AMENDMENTS

No amendments to the resolution were adopted.

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.J. Res 181 provides for congressional disapproval under chapter 8 of title 5, United States Code, of the rule submitted by the Department of Labor relating to "Definition of 'Employer'-Association Health Plans" and therefore would ensure the standard is not applied, which would affect the Legislative Branch in a manner similar to other employers.

UNFUNDED MANDATE STATEMENT

Pursuant to Section 423 of the Congressional Budget and Impoundment Control Act of 1974, Pub. L. No. 93–344 (as amended by Section 101(a)(2) of the Unfunded Mandates Reform Act of 1995, Pub. L. No. 104–4), the Committee adopts as its own the cost estimate prepared by the Director of the Congressional Budget Office (CBO) pursuant to section 402 of the Congressional Budget and Impoundment Control Act of 1974.

EARMARK STATEMENT

H.J. Res. 181 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 9/11/2024

COMMITTEE ON EDUCATION AND THE WORKFORCE RECORD OF COMMITTEE VOTE

Roll Call 4 Bill H J Res 181 Amendment Number n/a

Disposition Motion to Report H J Res 181, passed by a Full Committee Roll Call Vote

(23 y – 12 n)

Sponsor/Amendment Rep Walberg

Name & State	Aye	No	Not Voting	Name & State	Aye	No	Not Voting
Mrs FOXX (NC) (Chairwoman)	X			Mr SCOTT (VA) (Ranking)		X	
Mr WILSON (SC)			X	Mr GRIJALVA (AZ)			X
Mr THOMPSON (PA)	X			Mr COURNTEY (CT)		X	
Mr WALBERG (MI)	X			Mr SABLAN (MP)			X
Mr GROTHMAN (WI)	X			Ms WILSON (FL)			X
Ms STEFANIK (NY)	X			Ms BONAMICI (OR)		X	
Mr ALLEN (GA)	X			Mr TAKANO (CA)		X	
Mr BANKS (IN)	X			Ms ADAMS (NC)		X	
Mr COMER (KY)	X			Mr DESAULNIER (CA)		X	
Mr SMUCKER (PA)	X			Mr NORCROSS (NJ)		X	
Mr OWENS (UT)	X			Ms JAYAPAL (WA)			X
Mr GOOD (VA)	X			Ms WILD (PA)			X
Mrs MCCLAIN (MI)	X			Ms MCBATH (GA)			X
Mrs MILLER (IL)	X			Mrs HAYES (CT)		X	
Mrs STEEL (CA)	X			Ms OMAR (MN)			X
Mr ESTES (KS)			X	Ms STEVENS (MI)		X	
Ms LETLOW (LA)	X			Ms LEGER FERNÁNDEZ (NM)		X	
Mr KILEY (CA)	X			Ms MANNING (NC)		X	
Mr BEAN (FL)	X			Mr MRVAN (IN)		X	
Mr BURLISON (MO)	X			Mr BOWMAN (NY)			X
Mr MORAN (TX)	X						
Ms CHAVEZ-DEREMER (OR)	X						
Mr WILLIAMS (NY)	X						
Ms HOUCHIN (IN)	X						
Mr RULLI (OH)	X						

TOTALS Ayes 23 Nos 12 Not Voting 10

Total 45 / Quorum / Report

(25 R - 20 D)

STATEMENT OF GENERAL PERFORMANCE GOALS AND OBJECTIVES

In accordance with clause (3)(c) of House rule XIII, the goal of H.J. Res. 181 is to provide for congressional disapproval under chapter 8 of title 5, United States Code, of the rule submitted by the Department of Labor relating to "Definition of 'Employer'-Association Health Plans."

DUPLICATION OF FEDERAL PROGRAMS

No provision of H.J. Res 181 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

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.J. Res. 181: On April 26, 2023, the Committee on Education and the Workforce, Subcommittee on Health, Employment, Labor and Pensions held a hearing on "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, the Committee adopts as its own the cost estimate for the bill prepared by the Director of the Congressional Budget Office.

At a Glance

Health Care Legislation

As ordered reported by the House Committee on Education and the Workforce on September 11, 2024

On September 11, 2024, the House Committee on Education and the Workforce ordered reported six pieces of legislation related to health care and education. This comprehensive document provides estimates for three of those pieces of legislation related to health care. Details of the estimated costs are discussed in the text.

CBO estimates that all three pieces of legislation would affect direct spending, revenues, or both; thus, pay-as-you-go procedures apply. Two, H.R. 3120 and H.R. 9457, would affect spending subject to appropriation.

One piece of legislation would impose an intergovernmental mandate and two would impose private-sector mandates.

Bill	Net Increase or Decrease (-) in the Deficit Over the 2025-2034 Period (Millions of Dollars)	Changes in Spending Subject to Appropriation Over the 2025-2029 Period (Outlays, Millions of Dollars)	Mandate Effects?
H.J. Res. 181[a]	2,930	0	No
H.R. 3120[b]	-4,932	-61	Yes
H.R. 9457[b]	-154	*	Yes

* = between zero and $500,000.

a. CBO estimates that this bill would increase net direct spending by more than $2.5 billion in any of the four consecutive periods beginning in 2035 and would increase on-budget deficits by more than $5 billion in any of the four consecutive periods beginning in 2035.

b. CBO estimates that this bill would not increase net direct spending by more than $2.5 billion in any of the four consecutive periods beginning in 2035 and would not increase on-budget deficits by more than $5 billion in any of the four consecutive periods beginning in 2035.

Summary of legislation: On September 11, 2024, the House Committee on Education and the Workforce ordered six pieces of legislation on health care and education to be reported. This document provides estimates for the three pieces of legislation in that package that are related to health care:

- H.J. Res. 181 would disapprove a final rule concerning association health plans (AHPs),
- H.R. 3120 would prohibit the use of certain anticompetitive language in private health insurance contracts, and
- H.R. 9457 would modify certain telehealth billing requirements for private health insurers in the group market.

Estimated Federal cost: The costs of the legislation fall within budget functions 370 (commerce and housing credit) and 550 (health).

Basis of estimate: For this estimate, CBO assumes that all three pieces of legislation will be enacted by the end of calendar year 2024. This cost estimate does not include any effects of interactions among the various pieces of legislation. If all three were combined and enacted as one, the effects could be different from the sum of the separate estimates.

Direct spending and revenues: CBO and the staff of the Joint Committee on Taxation (JCT) estimate that enacting two pieces of legislation in the group would affect direct spending over the 2025–2034 period and that enacting all three pieces would affect revenues over that period (see Table 1).

H.J. Res. 181, providing for Congressional disapproval under chapter 8 of title 5, United States Code, of the rule submitted by the Department of Labor relating to "Definition of 'Employer'-Asso-

ciation Health Plans," would disapprove a final rule that took effect in July 2024, which rescinded a rule from 2018 that defined "employer" and established a pathway for groups of unrelated employers to form AHPs.[1] The 2018 final rule also loosened regulation of AHPs and broadened the definition of "small employer" to include self-employed people. Under H.J. Res. 181, disapproving the final 2024 rule would restore the 2018 rule in its entirety.

[1] See Department of Labor, Employee Benefits Security Administration, "Definition of 'Employer'-Association Health Plans," Final Rule, Rescission, 89 *Fed. Reg.* 34106 (April 30, 2024), https://tinyurl.com/2p9wmb2c, and "Definition of 'Employer' Under Section 3(5) of ERISA-Association Health Plans," Final Rule, 83 *Fed. Reg.* 28912 (June 21, 2018), https://tinyurl.com/29cy6uz2.

TABLE 1.—ESTIMATED BUDGETARY EFFECTS OF HEALTH CARE LEGISLATION, AS ORDERED REPORTED BY THE HOUSE COMMITTEE ON EDUCATION AND THE WORKFORCE ON SEPTEMBER 11, 2024

	By fiscal year, millions of dollars—											
	2025	2026	2027	2028	2029	2030	2031	2032	2033	2034	2025–2029	2025–2034
Increases or Decreases (−) in Direct Spending												
H.J. Res. 181												
Estimated Budget Authority	0	20	46	72	105	126	123	136	142	157	243	927
Estimated Outlays	0	20	46	72	105	126	123	136	142	157	243	927
H.R. 3120												
Estimated Budget Authority	0	0	−16	−21	−26	−28	−29	−30	−32	−34	−63	−216
Estimated Outlays	0	0	−16	−21	−26	−28	−29	−30	−32	−34	−63	−216
On-Budget	*0*	*0*	*−14*	*−19*	*−23*	*−25*	*−26*	*−27*	*−29*	*−30*	*−56*	*−193*
Off-Budget	*0*	*0*	*−2*	*−2*	*−3*	*−3*	*−3*	*−3*	*−3*	*−3*	*−7*	*−23*
Increases or Decreases (−) in Revenues												
H.J. Res. 181												
Estimated Revenues	0	−15	−89	−171	−247	−274	−281	−294	−307	−325	−522	−2,003
On-Budget	*0*	*−12*	*−81*	*−158*	*−229*	*−255*	*−261*	*−274*	*−287*	*−304*	*−480*	*−1,861*
Off-Budget	*0*	*−3*	*−8*	*−13*	*−18*	*−19*	*−20*	*−20*	*−20*	*−21*	*−42*	*−142*
H.R. 3120												
Estimated Revenues	0	38	261	437	547	604	645	689	727	768	1,283	4,716
On-Budget	*0*	*28*	*193*	*323*	*405*	*447*	*478*	*512*	*540*	*570*	*949*	*3,496*
Off-Budget	*0*	*10*	*68*	*114*	*142*	*157*	*167*	*177*	*187*	*198*	*334*	*1,220*
H.R. 9457												
Estimated Revenues	0	0	6	14	20	27	27	24	20	16	40	154
On-Budget	*0*	*0*	*4*	*10*	*15*	*20*	*20*	*18*	*15*	*12*	*29*	*114*
Off-Budget	*0*	*0*	*2*	*4*	*5*	*7*	*7*	*6*	*5*	*4*	*11*	*40*
Net Increase or Decrease (−) in the Deficit From Changes in Direct Spending and Revenues												
H.J. Res. 181												
Effect on the Deficit	0	35	135	243	352	400	404	430	449	482	765	2,930
On-Budget	*0*	*32*	*127*	*230*	*334*	*381*	*384*	*410*	*429*	*461*	*723*	*2,788*
Off-Budget	*0*	3	*8*	*13*	*18*	*19*	*20*	*20*	*20*	*21*	*42*	*142*
H.R. 3120												
Effect on the Deficit	0	−38	−277	−458	−573	−632	−674	−719	−759	−802	−1,346	−4,932
On-Budget	*0*	*−28*	*−207*	*−342*	*−428*	*−472*	*−504*	*−539*	*−569*	*−600*	*−1,005*	*−3,689*

TABLE 1.—ESTIMATED BUDGETARY EFFECTS OF HEALTH CARE LEGISLATION, AS ORDERED REPORTED BY THE HOUSE COMMITTEE ON EDUCATION AND THE WORKFORCE ON SEPTEMBER 11, 2024—Continued

	By fiscal year, millions of dollars—											
	2025	2026	2027	2028	2029	2030	2031	2032	2033	2034	2025–2029	2025–2034
Off-Budget	*0*	*−10*	*−70*	*−116*	*−145*	*−160*	*−170*	*−180*	*−190*	*−202*	*−341*	*−1,243*
H.R. 9457												
Effect on the Deficit	0	0	−6	−14	−20	−27	−27	−24	−20	−16	−40	−154
On-Budget	*0*	*0*	*−4*	*−10*	*−15*	*−20*	*−20*	*−18*	*−15*	*−12*	*−29*	*−114*
Off-Budget	*0*	*0*	*−2*	*−4*	*−5*	*−7*	*−7*	*−6*	*−5*	*−4*	*−11*	*−40*

Sources: Congressional Budget Office; staff of the Joint Committee on Taxation.
Off-budget effects would come from decreases in revenues from Social Security payroll taxes and decreases in federal outlays for health insurance for active employees of the Postal Service.

Under H.J. Res. 181, some small employers would pay lower premiums through an AHP than is the case under current law. The premiums that small employers pay in the small group market or, in the case of self-employed people, the nongroup market, are modified community-rated premiums, which can vary only on the basis of enrollees' age, location, and tobacco use. By contrast, AHPs can adjust premiums on the basis of additional factors related to health status, such as the type of employment of the AHP's members. Consequently, a small employer with a healthier-than-average workforce can pay premiums through an AHP that are lower than the premiums for modified community-rated plans in the small group or nongroup market.

Using a comparison of premium prices under AHPs and small group and nongroup market plans, CBO and JCT estimate that enacting H.J. Res. 181 would increase the number of people obtaining insurance through AHPs by about 600,000 per year, on average, over the 2026–2034 period. The agencies estimate that under current law, about 120,000 people (or 20 percent of the 600,000) have no health insurance and that the remaining 480,000 obtain insurance through the nongroup or small-group markets.

CBO and JCT anticipate that enacting the resolution would increase federal deficits, for two reasons in particular:

- Some self-employed people who are uninsured under current law would instead take up insurance offered through AHPs, thereby increasing new claims for the tax deduction for health insurance for self-employed people.
- A slight increase in premiums in the nongroup and remaining small-group markets would result from people with lower-than-average health costs shifting to AHPs. That change would increase federal costs for premium tax credits for health insurance purchased through the marketplaces established by the Affordable Care Act and would shift a portion of some employees' compensation from taxable wages to tax-favored health insurance for those insured in the small group market.

CBO and JCT estimate that the resulting increases in the deficit would be partially offset by effects stemming from lower premiums for people who currently have insurance from the fully regulated nongroup and small-group markets who would instead enroll in AHPs.

On net, CBO and JCT estimate that enacting H.J. Res. 181 would increase direct spending by $0.9 billion and decrease revenues by $2.0 billion, for a total increase in the deficit of $2.9 billion over the 2025–2034 period.

H.R. 3120, the Healthy Competition for Better Care Act, would generally prohibit private health insurers from entering into agreements with health care providers that contain language restricting insurers from steering enrollees to specific providers or that require insurers to contract with affiliate providers as a condition of contracting with those providers.

CBO and JCT expect that banning the use of anticompetitive terms in contracts would allow more insurers to offer products with tiered networks and to steer patients to providers with lower costs, higher quality, or both. As a result, the agencies estimate that enacting H.R. 3120 would reduce premiums for employment-based health insurance by about 0.1 percent once the policies are fully

implemented and all parties have fully adjusted to them. To arrive at that estimate, CBO first reviewed evidence on the effects of tiered networks on spending for services provided by hospitals and physicians.[2]

CBO then adjusted those estimates downward to account for the following:

- The limited potential increase in enrollment in tiered networks;[3]
- The small subset of markets that CBO expects would be affected, including markets in states that have not already banned anticompetitive contracts and where there is a dominant but nonmonopolistic provider and no single dominant insurer; and
- Spending for services provided by physicians and hospitals, which constitutes only a portion of overall spending that is the basis for premiums.

H.R. 3120 also would apply to the nongroup market, but CBO and JCT do not anticipate a reduction in premiums as an effect of enactment because that market already tends to use tiered networks to control the cost of premiums.

CBO and JCT expect that the estimated reduction in private health insurance premiums would shift a portion of some employees' compensation from tax-favored health insurance to taxable wages and would reduce outlays for the Federal Employees Health Benefits Program.

In total, CBO and JCT estimate that enacting H.R. 3120 would decrease direct spending by $0.2 billion and increase revenues by $4.7 billion, for a total reduction in the deficit of $4.9 billion over the 2025–2034 period.

H.R. 9457, the Transparent Telehealth Bills Act of 2024, would prohibit providers from charging and group health plans from paying certain facility fees for telehealth services. Facility fees are paid to hospitals—in addition to physicians' direct charges—to cover operating and staffing costs. Facility fees paid for services like telehealth, which can reasonably be expected to have similar labor and overhead costs in physicians' offices and in hospitals, result in larger amounts being paid for services billed by hospitals than for otherwise similar services delivered in a physician's office.

CBO estimates that the effect of enacting H.R. 9457 would be largest in 2030 once the requirements are fully implemented and all parties have fully adjusted to them, when premiums would decrease by less than 0.01 percent, but would moderate by 2034, when premiums would decrease by less than 0.005 percent. That projection is based on the estimate that less than 0.5 percent of private health insurance spending on hospital outpatient services would be affected by limiting charges for facility fees for telehealth services, a share that was calculated on the basis of commercial claims that include hospital outpatient spending for telehealth. About 23 percent of all private health insurance spending is for

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[2] See Elena Prager, "Healthcare Demand Under Simple Prices: Evidence From Tiered Hospital Networks," *American Economic Journal: Applied Economics*, vol. 12, no. 4 (October 2020), pp. 196 223, https://doi.org/10.1257/app.20180422; and Anna D. Sinaiko, Mary Beth Landrum, and Michael E. Chernew, "Enrollment in a Health Plan With a Tiered Provider Network Decreased Medical Spending by 5 Percent," *Health Affairs*, vol. 36, no. 5 (May 2017), pp. 870–875, https://doi.org/10.1377/hlthaff.2016.1087.

[3] See Anna D. Sinaiko and others, "Variation in Tiered Network Health Plan Penetration and Local Provider Market Characteristics," *Health Services Research*, vol. 59, issue 4 (August 2024), https://doi.org/10.1111/1475-6773.14223.

hospital outpatient services; CBO scaled its estimate accordingly, making adjustments as follows:

- Reducing the estimate of affected spending to account for the fact that some group health plans already avoid paying off-campus facility fees,
- Adding an offsetting increase in physician payments to reflect a shift toward office-based billing for services performed in hospital outpatient departments,
- Incorporating the expectation that savings erode over time as providers find alternative ways to increase their charges, and
- Accounting for the expectation that not all hospital outpatient departments would comply with the new billing requirements and that some insurers would lack the market leverage to negotiate lower rates in their contracts with providers.

CBO and JCT estimate that, over the 2025–2034 period, enacting H.R. 9457 would increase revenues by $154 million by shifting a portion of some employees' compensation from tax-favored health insurance to taxable wages.

Spending subject to appropriation: CBO estimates that implementing H.R. 3120 would result in a significant decrease in spending subject to appropriation and that implementing H.R. 9457 would increase such spending by an insignificant amount (see Table 2). Any related spending would be subject to the availability of appropriated funds.

TABLE 2.—ESTIMATED INCREASES IN SPENDING SUBJECT TO APPROPRIATION UNDER HEALTH CARE LEGISLATION AS ORDERED REPORTED BY THE HOUSE COMMITTEE ON EDUCATION AND THE WORKFORCE ON SEPTEMBER 11, 2024

	By fiscal year, millions of dollars—					
	2025	2026	2027	2028	2029	2025–2029
H.R. 3120:						
Estimated Authorization	0	0	−15	−21	−25	−61
Estimated Outlays	0	0	−15	−21	−25	−61
H.R. 9457:						
Estimated Authorization	*	*	0	0	0	*
Estimated Outlays	*	*	0	0	0	*

* = between zero and $500,000.

H.R. 3120, the Healthy Competition for Better Care Act, would, beginning in 2027, lead to a reduction in premiums for enrollees in the Federal Employees Health Benefits Program for the same reasons described above. CBO estimates that implementing the bill would reduce federal spending for the employer's share of active federal employees' health insurance premiums by $61 million over the 2025–2029 period. That spending is considered discretionary and would be subject to reductions in appropriations by the estimated amounts.

H.R. 9457, the Transparent Telehealth Bills Act of 2024, would direct the Government Accountability Office to report on the use of telehealth under group health plans. CBO estimates that implementing that requirement would increase spending subject to appropriation by less than $500,000 over the 2025–2029 period.

Pay-As-You-Go considerations: The Statutory Pay-As-You-Go Act of 2010 establishes budget-reporting and enforcement procedures for legislation affecting direct spending or revenues. The net

changes in outlays and revenues for the three pieces of legislation that are subject to pay-as-you-go procedures are shown in Table 1.

Increase in long-term net direct spending and deficits: CBO estimates that enacting H.J. Res. 181 would increase net direct spending by more than $2.5 billion in any of the four consecutive periods beginning in 2035.

CBO estimates that enacting H.R. 3120 and H.R. 9457 would not increase net direct spending by more than $2.5 billion in any of the four consecutive periods beginning in 2035.

CBO estimates that enacting H.J. Res. 181 would increase on-budget deficits by more than $5 billion in any of the four consecutive 10-year periods beginning in 2035.

CBO estimates that, if enacted, neither H.R. 3120 nor H.R. 9457 would increase on-budget deficits by more than $5 billion in any of the four consecutive 10-year periods beginning in 2035.

Mandates: H.R. 3120 would impose a private-sector mandate as defined in the Unfunded Mandates Reform Act (UMRA) by prohibiting the use of certain terms in contracts made between health insurers and health care providers. Specifically, the bill would prohibit agreements with health care providers that restrict insurers from steering enrollees to specific health care providers or that require insurers to contract with affiliate providers as a condition of contracting with those providers. CBO estimates that the cost of the mandate would average $1.1 billion in the first five years that the mandate is in effect and would exceed the annual private-sector threshold established in UMRA ($200 million in 2024, adjusted annually for inflation). The bill would not impose any intergovernmental mandates.

H.R. 9457 would impose intergovernmental and private-sector mandates as defined in UMRA by prohibiting health care providers from charging certain facility fees for telehealth services. Because some hospitals are operated by state and local governments, the restriction would impose an intergovernmental mandate. Such fees are already prohibited in several states, which would diminish the effect of the mandates. CBO estimates that the cost of the mandates would not exceed the annual intergovernmental or private-sector thresholds established in UMRA ($100 million and $200 million in 2024, respectively, adjusted annually for inflation).

Estimate prepared by: Federal Costs: Michael Cohen, Jessica Hale, Daria Pelech, Emily Vreeland. Revenues: Staff of the Joint Committee on Taxation. Mandates: Andrew Laughlin.

Estimate reviewed by: Kathleen FitzGerald, Chief, Public and Private Mandates Unit; Sarah Masi, Senior Adviser, Budget Analysis Division; Chad Chirico, Director of Budget Analysis.

Estimate approved by: Phillip L. Swagel, Director, Congressional Budget Office.

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.J. Res. 181. 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 for the bill prepared by the Director of the Congressional Budget Office.

CHANGES IN EXISTING LAW MADE BY THE BILL, AS REPORTED

H.J. Res. 181, as reported by the Committee, makes no changes to existing law.

MINORITY VIEWS

INTRODUCTION

Committee Democrats oppose H. J. Res. 181, *Providing for congressional disapproval under chapter 8 of title 5, United States Code, of the rule submitted by the Department of Labor relating to "Definition of 'Employer'-Association Health Plans."* This misguided use of the Congressional Review Act[1] would reinstate the Trump Administration's Association Health Plan (AHP) Final Rule[2] that was largely invalidated by a Federal court in 2019.[3] By attempting to reinstate a rule, the fundamental provisions of which have never taken effect and have been invalidated, would create confusion as to which regulation applies and the extent to which the Department of Labor (DOL) can take future actions in this area to protect consumers. As a result, this resolution would—like other Republican efforts to expand AHPs—threaten to put comprehensive and affordable coverage for small businesses and workers at risk, create loopholes that undermine critical consumer protections, and raise costs across the broader health insurance market. This is why H. J. Res. 181 is opposed by more than 15 leading consumer and patient groups[4] and why Committee Democrats unanimously reject this harmful application of the *Congressional Review Act*.

THE ACA IMPROVED ACCESS TO AFFORDABLE, QUALITY HEALTH COVERAGE

Before the *Affordable Care Act* (ACA),[5] workers often had limited options for obtaining affordable health coverage.[6] People with preexisting conditions were particularly disadvantaged because they could be charged higher rates or denied coverage altogether in the individual market. Small businesses employing women or workers with chronic or high-cost illnesses could be charged higher premiums, often making coverage unaffordable. Those who could afford to buy coverage in the individual and small group market

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[1] 5 U.S.C. §§ 801–808.

[2] U.S. Dep't of Lab., Final Rule: Definition of "Employer" Under Section 3(5) of ERISA Association Health Plans, 83 Fed. Reg. 28912 (June 21, 2018), https://www.federalregister.gov/documents/2018/06/21/2018-12992/definition-of-employer-under-section-35-of-erisa-association-health-plans.

[3] *New York v. United States Dep't of Lab.*, 363 F. Supp. 3d 109 (D.D.C. 2019).

[4] *Patient community concerns H.J. Res. 181, Congressional Review Act resolution to stop the Biden-Harris rule limiting access to Association Health Plans (AHPs)*, Letter to Chair Virginia Foxx and Ranking Member Bobby Scott, H. Comm. on Educ. & the Workforce, Full Committee Markup (Sept. 11, 2024) (*on file with Comm.*) (hereinafter Patient Community Letter).

[5] Pub. L. No. 111–148 (2010).

[6] Sara R. Collins et al., *How the Affordable Care Act Has Improved Americans' Ability to Buy Health Insurance on Their Own*, Commonwealth Fund (Feb. 1, 2017), https://www.commonwealthfund.org/publications/issue-briefs/2017/feb/how-affordable-care-act-has-improved-americans-ability-buy.

often found their insurance did not cover vital services, such as behavioral health or maternity care.[7]

The ACA took steps to level the playing field—establishing safeguards for workers and employers alike. Not only did the ACA create Marketplaces where individuals, self-employed people, and families can access affordable health coverage, the law also protects workers and businesses in the small group market from unfair practices.[8] Consumers have benefited from these protections for over a decade despite dozens of attempts by Republicans to repeal the ACA in Congress[9] and ideologically-driven litigation—most recently through a lawsuit attacking coverage for lifesaving preventive health services such as lung cancer screenings, preexposure prophylaxis for HIV prevention, and medications to lower the risk of breast cancer for high-risk women.[10]

In addition to instituting crucial consumer protections, the ACA has led to historic improvements in the number of people with health coverage. In 2022, the uninsured rate fell to 8 percent—the lowest level in history[11]—and remained stable at 8 percent in 2023.[12] During the 117th Congress, Democrats took bold action to build upon this progress and further improve affordability. The *American Rescue Plan Act*[13] and the *Inflation Reduction Act*[14] strengthened the advance premium tax credits and eliminated the subsidy "cliff" for individuals earning over 400 percent of the Federal Poverty Level through 2025. Thanks to these reforms, during the most recent Open Enrollment Period, a record 21.3 million people[15] signed up for coverage through Healthcare.gov and State-Based Marketplaces, and the average consumer saved $705 per year in premiums.[16]

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[7] Center on Budget and Policy Priorities, *Essential Health Benefits Under Threat*, https://www.cbpp.org/essential-health-benefits-under-threat (last visited Sept. 25, 2024).

[8] Nicole Rapfogel et al., *10 Ways the ACA Has Improved Health Care in the Past Decade*, Center for American Progress (Mar. 23, 2020), https://www.americanprogress.org/article/10-ways-aca-improved-health-care-past-decade/.

[9] Chris Riotta, *GOP Aims To Kill Obamacare Yet Again After Failing 70 Times*, Newsweek (July 29, 2017), https://www.newsweek.com/gop-health-care-bill-repeal-and-replace-70-failed-attempts-643832.

[10] Laurie Sobel et al., *Explaining Litigation Challenging the ACA's Preventive Services Requirements: Braidwood Management Inc. v. Becerra*, Kaiser Family Foundation (May 15, 2023), https://www.kff.org/womens-health-policy/issue-brief/explaining-litigation-challenging-the-acas-preventive-services-requirements-braidwood-management-inc-v-becerra/.

[11] Aiden Lee et al., *National Uninsured Rate Reaches All-Time Low in Early 2022*, Assistant Secretary for Planning and Evaluation, U.S. Dept. of Health and Human Services (Aug. 2022), https://aspe.hhs.gov/sites/default/files/documents/15c1f9899b3f203887deba90e3005f5a/Uninsured-Q1-2022-Data-Point-HP-2022-23-08.pdf.

[12] Council for Economic Advisors, Executive Office of the President, *The 2023 Income, Poverty, and Health Insurance Reports: Strong household income gains, lower official poverty, uninsured rate near record low* (Sept. 10, 2024), https://www.whitehouse.gov/cea/written-materials/2024/09/10/the-2023-income-poverty-and-health-insurance-reports-strong-household-income-gains-lower-official-poverty-uninsured-rate-near-record-low/#:~:text=Health%20insurance%20coverage%20remained%20high,from%202022's%207.9%20percent%20rate.

[13] Pub. L. No. 117–2 (2021).

[14] Pub. L. No. 117–169 (2022).

[15] Centers for Medicare & Medicaid Services, *Historic 21.3 Million People Choose ACA Marketplace Coverage* (Jan. 24, 2024), https://www.cms.gov/newsroom/press-releases/historic-213-million-people-choose-aca-marketplace-coverage.

[16] Centers for Medicare & Medicaid Services, *Health Insurance Marketplaces 2024 Open Enrollment Report*, https://www.cms.gov/files/document/health-insurance-exchanges-2024-open-enrollment-report-final.pdf (last visited Sept. 25, 2024).

EXPANSION OF AHPS WOULD JEOPARDIZE HEALTH COVERAGE FOR CONSUMERS

Under current law, coverage offered through a group or association to individuals or small employers generally must comply with the patient protections of the ACA and state insurance law.[17] However, under the guise of lowering costs, Republicans have long sought to expand AHPs and eliminate many of these guardrails. Such proposals would take the country backwards and undermine the reforms made by the ACA to improve the quality and affordability of health coverage. Proposals to expand AHPs generally allow such arrangements to evade certain state and federal benefit standards and consumer protections.[18] As a result, AHP enrollees are at risk of—potentially unknowingly—losing out on comprehensive care that would otherwise be guaranteed under the ACA and state law. While proposals to expand AHPs may include some consumer protections (e.g., nominal protections against discrimination based on preexisting conditions), gaps in these requirements often leave consumers vulnerable to harm.

Crucially, allowing insurers and health plans to avoid covering needed benefits is a longstanding tenet of Republicans' approach to health care.[19] Despite coverage of Essential Health Benefits being both popular and necessary,[20] AHPs would be exempt from this foundational protection of the ACA because they would be considered large group plans.[21] As a result, AHPs could exclude certain categories of coverage, such as maternity care, mental health, or substance use disorder, to dissuade certain groups or individuals from enrolling. Reducing benefit levels or avoiding the costs of providing comprehensive benefits can reduce costs for AHPs in the short-term but will ultimately negatively impact consumers and people who need coverage the most. Individuals enrolled in AHPs could be shocked to find they do not have access to the care they need or the financial security they expected.

AHPS CREATE MARKET FRAGMENTATION AND RAISE COSTS THROUGHOUT THE SYSTEM

While health care costs for many workers and businesses remain a challenge, Republican efforts to expand AHPs are not the answer. Rather, AHPs harm workers and small businesses throughout the overall health care system by shifting costs, thereby making coverage more expensive for many and entirely out of reach for some.

Experts have consistently warned that the approach of pulling certain populations out of the risk pool—which is antithetical to the foundational principles of the ACA that ensure no one gets left behind—would fragment the health insurance market. According to

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[17] 29 U.S.C. § 1144(b)(6); Centers for Medicare and Medicaid Services, *Application of Individual and Group Market Requirements under Title XXVII of the Public Health Service Act when Insurance Coverage Is Sold to, or through, Associations* (Sept. 1, 2011), https://www.cms.gov/CCIIO/Resources/Files/Downloads/association_coverage_9_1_2011.pdf.

[18] See, e.g., H.R. 2868, the Association Health Plan Act (118th Cong.).

[19] *See* e.g., Lydia Mitts et al., *House Republicans Gut Protections for Pre-Existing Conditions in Latest Proposal,* Families USA (Mar. 26, 2017), https://familiesusa.org/resources/house-republicans-gut-protections-for-pre-existing-conditions-in-latest-proposal/.

[20] Dania Palanker, *Eliminating Essential Health Benefits Will Shift Financial Risk Back to Consumers,* The Commonwealth Fund (Mar. 24, 2017), https://www.commonwealthfund.org/blog/2017/eliminating-essential-health-benefits-will-shift-financial-risk-back-consumers.

[21] 42 U.S.C. § 18022.

the American Academy of Actuaries, allowing AHPs to operate under different rules could result in adverse selection that raises costs throughout the insurance pool and creates a market in which higher-cost groups—namely, those that are generally sicker or older—"could find it more difficult to obtain coverage." [22] Similarly, the Congressional Budget Office determined that "the primary factor driving lower premiums for AHPs is the ability to price premiums on the basis of each association's expected health care spending and thereby attract employers with relatively low-risk employees and avoid those with higher-risk employees." [23] The Federation of American Hospitals has also noted that "segmenting of risk would result in higher and increasing premiums for individuals left out of associations, which could spiral over time, ever worsening adverse selection that would destabilize the non-AHP products." [24]

The Committee also examined this issue during the current Congress and heard expert testimony reiterating the gravity of this concern. On April 26, 2023, during a hearing held by the Subcommittee on Health, Employment, Labor, and Pensions titled *Reducing Health Care Costs for Working Americans and Their Families* (HELP Subcommittee Hearing), Sabrina Corlette, Research Professor and Co-Director of the Center on Health Insurance Reforms at Georgetown University's McCourt School of Public Policy, warned of the consequences of AHPs, stating that "AHPs just create new winners and losers, with the losers being those who are older and sicker." [25]

EXPANDING AHPS GAMBLES WITH THE FINANCIAL SECURITY OF WORKERS, EMPLOYERS, AND HEALTH CARE PROVIDERS

As patient advocacy groups have pointed out, "Association Health Plans (AHPs) have historically proven risky for enrollees—sometimes leaving patients with thousands of dollars in medical debt." [26] Fraud and solvency issues among AHPs are profoundly dangerous for consumers and employers who participate in these arrangements, as well as the doctors, health centers, and hospitals who may not receive reimbursement for the medical care they provide. Ms. Corlette explained the high stakes at the HELP Subcommittee Hearing:

> . . . if history is any guide, many AHPs may seem strong at first because they are able to attract healthy groups and can offer low rates and generous benefits to those groups. Over time, however, as workers get older

[22] American Academy of Actuaries, *Issue Brief: Association Health Plans* (Feb. 2017), http://www.actuary.org/content/association-health-plans-0.

[23] Cong. Budget Office, How CBO and JCT Analyzed Coverage Effects of New Rules for Association Health Plans and Short-Term Plans 5 (Jan. 2019), https://www.cbo.gov/system/files/2019-01/54915-New_Rules_for_AHPs_STPs.pdf.

[24] *Statement of the Federation of American Hospitals to the U.S. House of Representatives Committee on Education & The Workforce, Re: Markup of 6 Bills on September 11, 2024,* Letter to Chair Virginia Foxx and Ranking Member Bobby Scott, H. Comm. on Educ. & the Workforce, Full Committee Markup (Sept. 11, 2024) (*on file with Comm.*).

[25] *Reducing Health Care Costs for Working Americans and Their Families: Hearing Before the Subcomm. on Health, Empl., Lab., and Pensions of the H. Comm. On Educ. & the Workforce,* 118th Cong. 10 (2023) (testimony of Sabrina Corlette, Research Professor and Co-Director, Center on Health Insurance Reforms at the Georgetown University McCourt School of Public Policy).

[26] Patient Community Letter, *supra* note 3.

> and sicker, the risk in the pool deteriorates. AHPs then either must raise rates, reduce benefits, disband, or, in the worst cases, become insolvent.[27]

The history of multiple employer welfare arrangements (MEWAs) offers a sobering warning for the financial risks posed by the proliferation of AHPs. Proposals to expand AHPs that are under limited regulation and oversight would bring us back to the time when MEWAs also enjoyed limited regulation and gambled with the financial security of both workers and employers.[28] In 2001, Sunkist Growers, Inc., a California-based MEWA that covered 23,000 people, became insolvent, leaving behind approximately $11 million in unpaid claims.[29] Similarly, New Jersey's Coalition of Automotive Retailers became insolvent in 2002, leaving 20,000 individuals without coverage and $15 million in unpaid claims.[30]

Unfortunately, MEWAs continue to face financial challenges and heightened risk of fraud to this day. DOL routinely documents investigations and enforcement actions against MEWAs that have committed violations of ERISA and failed to pay promised benefits.[31] In May of 2023, it was announced that health plan participants, employers, and medical providers harmed by a MEWA operating in 36 states would begin to finally receive payments related to more than $54 million in unpaid health claims.[32] Unfortunately, despite these enforcement efforts, victims are often not made whole, leaving workers, employers, and health care providers to absorb financial losses caused by fraudulent and mismanaged MEWAs.[33]

THE TRUMP AHP FINAL RULE RECYCLED HARMFUL IDEAS

Following years of failed Republican efforts to enact legislation to expand AHPs, in 2018 the Trump Administration attempted to circumvent Congress through a controversial rulemaking (the 2018 Final Rule) under the *Employee Retirement Income Security Act of 1974* (ERISA).[34] The 2018 Final Rule would have dramatically expanded the circumstances under which AHPs could be offered as single-employer group health plans—even to self-employed individuals without any common law employees. The AHP arrangements allowed under the rule would have been treated as large group health plans, allowing them to evade many of the consumer protec-

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[27] Corlette, *supra* note 24 at 10.

[28] U.S. Dept. of Lab., *MEWAs Multiple Employer Welfare Arrangements under the Employee Retirement Income Security Act (ERISA): A Guide to Federal and State Regulation* at 3 ("Recognizing that it was both appropriate and necessary for States to be able to establish, apply and enforce State insurance laws with respect to MEWAs, the U.S. Congress amended ERISA in 1983, as part of Public Law 97–473, to provide an exception to ERISA's broad preemption provisions for the regulation of MEWAs under State insurance laws.")

[29] Mila Kofman, et al., *MEWAs: The Threat of Plan Insolvency and Other Challenges*, Commonwealth Fund (Mar. 2004), https://www.commonwealthfund.org/sites/default/files/documents/media_files_publications_issue_brief_2004_mar_mewas_the_threat_of_plan_insolvency_and_other_challenges_kofman_mewas_pdf.pdf.

[30] *Id.*

[31] Christine Monahan, *Updates from the MEWA Files: The Good, the Bad, and the Ugly of Federal Enforcement Efforts*, CHIRblog (Dec. 19, 2019), https://chirblog.org/mewa-files-part-3-good-bad-ugly/.

[32] Press Release, U.S. Dep't of Labor, Federal Court Approves Plan To Distribute Assets to Participants Harmed by Underfunded Group Health Plan Arrangement Operating in 36 States (May 1, 2023), https://www.dol.gov/newsroom/releases/ebsa/ebsa20230501.

[33] Monahan, *supra* note 30.

[34] Pub. L. No. 93–406 (1974).

tions that would otherwise apply to the individual or small group market. In addition, the rule would have undermined the authority of state insurance regulators to meaningfully oversee these plans to prevent fraud and insolvencies.

The 2018 Final Rule would have been harmful to millions of consumers, including both the people enrolled in AHPs as well as those left behind in the traditional insurance market. AHPs established under the 2018 Final Rule would have been exempt from vital consumer protections, including the ACA's requirement to provide coverage of Essential Health Benefits, such as maternity and newborn care, prescription drugs, and mental health and substance use disorder care.[35] According to DOL's own analysis, these AHPs would provide fewer benefits than ACA-compliant plans while shifting costs to consumers remaining in the small group and individual markets in the form of higher premiums.[36] Accordingly, the 2018 Final Rule faced widespread opposition, with approximately 95 percent of comments received by the Department from health care groups opposing or criticizing its approach.[37] Patient groups, including the American Cancer Society, emphasized that the 2018 Final Rule would fail to protect participants against discriminatory insurance practices while leading to instability in the individual and small group markets, ultimately hindering access to affordable coverage for consumers who need it most.[38]

H.J. RES. 181 WOULD CREATE CONFUSION AND UNDERMINE DOL EFFORTS TO PROTECT CONSUMERS

Finally, H.J. Res. 181 is an inappropriate application of the *Congressional Review Act* that will create uncertainty for stakeholders, while undermining the ability of DOL to protect consumers from the proliferation of AHPs. Committee Republicans argue that H.J. Res. 181 will restore the 2018 Final Rule, however, that rule has never taken effect. On March 28, 2019, in *State of New York v. United States Department of Labor*, Judge John D. Bates, an appointee of President George W. Bush, vacated the core provisions of the 2018 Final Rule, describing it as "an end-run around the ACA"[39] that "does violence to ERISA."[40] Accordingly, the court va-

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[35] 42 U.S.C. § 18022.

[36] United States Dep't of Lab., *supra* note 1 at 28939 ("[AHPs] use their regulatory flexibility to design more tailored, less comprehensive health coverage . . . [which] will necessarily lead to some favorable risk selection toward AHPs and adverse selection against individual and small group markets.").

[37] Noam Levey, Trump's New Insurance Rules Are Panned by Nearly Every Healthcare Group that Submitted Formal Comments, Los Angeles Times (May 30, 2018), https://www.latimes.com/politics/la-na-pol-trump-insurance-opposition-20180530-story.html.

[38] American Cancer Society, RIN 1210–AB85: Definition of "Employer" Under Section 3(5) of ERISA—Association Health Plans Proposed Rule (Mar. 6, 2018), https://www.fightcancer.org/sites/default/files/National%20Documents/ACS%20CAN%20Comments%20on%20AHP%20Proposed%20Rule%20FINAL.pdf. *See also* I Am Essential (Coalition Of 118 Patient and Community Organizations), RE: Association Health Plans Proposed Rule (RIN 1210–AB85) (Mar. 6, 2018), https://www.aafa.org/wp-content/uploads/2022/08/AAFA-Comment-Letter-Opposing-Association-Health-Plans-Proposed-Rule.pdf; American Hospital Association, RIN 1210–AB85: Definition of "Employer" Under Section 3(5) of ERISA—Association Health Plans Proposed Rule (Mar. 6, 2018), https://www.aha.org/system/files/2018-03/180306-definition-employer-small-business-health-plans.pdf.

[39] *Supra* note 2 at 109.

[40] *Id.*

cated and remanded the remaining provisions of the rule to DOL for reconsideration.[41]

On April 29, 2024, the Biden-Harris Administration issued the regulation (2024 Final Rule) that H.J. Res. 181 seeks to nullify. The 2024 Final Rule ensures that the Code of Federal Regulations is consistent with the court's decision by rescinding the 2018 Final Rule, as the "core provisions of the 2018 [Final] Rule were, at a minimum, not consistent with the best reading of ERISA's statutory requirements governing the definition of 'employer' for purposes of establishing group health plans."[42] The 2024 Final Rule is consistent with ERISA and the ACA and was necessary to eliminate ambiguity for stakeholders as to the application of the regulations following the 2019 court decision.

However, by rescinding the 2024 Final Rule, H.J. Res. 181 would leave the 2018 Final Rule on the books, even though its core provisions remain vacated. Even more troubling than the confusion this would cause for stakeholders, application of the *Congressional Review Act* in this manner would prohibit DOL from undertaking "substantially the same" rulemaking, calling into question the Department's ability to correct the unlawful rulemaking and to further protect consumers from AHPs.[43] Accordingly, H.J. Res. 181 would be detrimental to ensuring that the law is followed and that consumers are protected in the future from harms presented by the proliferation of AHPs.

CONCLUSION

Republican proposals to expand AHPs undermine efforts to provide affordable health coverage to consumers. Such proposals would erode the protections of the ACA and leave small businesses and their enrollees at risk of less comprehensive coverage for enrollees and potentially devastating plan insolvencies. While some in the association may enjoy lower premiums, those savings will be in the form of lower quality coverage and a shift of costs to those in the broader risk pool. This misguided use of the *Congressional Review Act*—which will create regulatory uncertainty for stakeholders and undermine DOL's ability to protect consumers—is yet another effort by Republicans to roll back the clock on the crucial reforms of the ACA.

For the reasons stated above, Committee Democrats unanimously opposed H.J. Res. 181 when the Committee on Education and the Workforce considered it on September 11, 2024. We urge the House of Representatives to do the same.

ROBERT C. "BOBBY" SCOTT,
Ranking Member.
RAÚL M. GRIJALVA,
JOE COURTNEY,
GREGORIO KILILI CAMACHO SABLAN,
FREDERICA S. WILSON,

[41] *Id.* at 141.
[42] U.S. Dep't of Lab., *Fact Sheet: Department of Labor Rescinds Invalidated Rule on Association Health Plans* (Apr. 29, 2024), https://www.dol.gov/agencies/ebsa/about-ebsa/our-activities/resource-center/fact-sheets/dol-rescinds-invalidated-rule-on-ahp.
[43] 5 U.S.C. § 801(b)(2).

SUZANNE BONAMICI,
MARK TAKANO,
ALMA S. ADAMS,
MARK DESAULNIER,
Members of Congress.

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