Congressional Budget Office
Cost Estimate

November 12, 2024

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.

Detailed estimate begins on the next page.

See also
CBO's Cost Estimates Explained, *CBO Describes Its Cost-Estimating Process*, *Glossary*

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’-Association 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*	*-4*	*-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*
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

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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.

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 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).

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