Congressional Budget Office
Cost Estimate

July 16, 2019

At a Glance

S.1895, Lower Health Care Costs Act

As ordered reported by the Senate Committee on Health, Education, Labor, and Pensions on June 26, 2019

By Fiscal Year, Millions of Dollars	2019	2019-2024	2019-2029
Direct Spending (Outlays)	0	18,348	18,664
Revenues	0	8,940	26,242
Net Increase or Decrease (-) in the Deficit	0	9,408	-7,578
Spending Subject to Appropriation (Outlays)	0	458	not estimated

Statutory pay-as-you-go procedures apply?	Yes	**Mandate Effects**	
Increases on-budget deficits in any of the four consecutive 10-year periods beginning in 2030?	No	Contains intergovernmental mandate?	Yes, Over Threshold
		Contains private-sector mandate?	Yes, Over Threshold

The bill would

- Protect patients from surprise medical billing and reduce payments to some health care providers working in facilities where surprise bills are likely
- Allow some generic or biosimilar drugs to enter the market earlier, on average, than under current law
- Impose new rules for insurers' contracts with pharmacy benefit managers and health care providers
- Extend funding for community health centers and certain other federal health care programs
- Increase access to health, cost, and quality information among patients, providers, and insurers, which would create new administrative responsibilities that increase costs for insurers and pharmacy benefit managers
- Impose intergovernmental and private-sector mandates by prohibiting certain medical billing practices, limiting other commercial activities, and prohibiting the sale of tobacco products to anyone under the age of 21, among many other duties

Estimated budgetary effects would primarily stem from

- Reduced federal subsidies for health care and health insurance
- Increased direct spending for community health centers and other federal health programs

Areas of significant uncertainty include

- Accurately anticipating the nature and effects of provider and insurer responses to the bill's provisions
- Accurately projecting how federal and state agencies would implement the law
- Estimating quantities, sales, and market effects of introductions of new pharmaceutical products
- Determining how increased transparency would affect prices and private insurance premiums

Detailed estimate begins on the next page.

Bill Summary

S. 1895 contains many provisions intended to lower the cost of health care to individuals and to the federal government, and it extends funding for several federal health care programs.

Estimated Federal Cost

The estimated budgetary effect of S. 1895 is shown in Table 1. The costs of the legislation fall within budget functions 550 (health) and 570 (Medicare).

Table 1.
Estimated Budgetary Effects of S. 1895

	By Fiscal Year, Millions of Dollars												
	2019	2020	2021	2022	2023	2024	2025	2026	2027	2028	2029	2019-2024	2019-2029
Increases or Decreases (-) in Direct Spending													
Estimated Budget Authority	0	4,740	4,595	4,391	4,252	4,187	-624	-659	-692	-767	-729	22,165	18,695
Estimated Outlays	0	1,876	3,688	4,365	4,242	4,178	2,220	253	-667	-762	-729	18,348	18,664
Increases or Decreases (-) in Revenues													
Estimated Revenues	0	2	1,231	2,299	2,617	2,791	2,929	3,294	3,525	3,685	3,868	8,940	26,242
Net Increase or Decrease (-) in the Deficit From Changes in Direct Spending and Revenues													
Effect on the Deficit	0	1,874	2,457	2,066	1,625	1,387	-708	-3,042	-4,192	-4,447	-4,597	9,408	-7,578
On-budget	0	1,885	2,842	2,769	2,422	2,222	162	-2,131	-3,244	-3,460	-3,564	12,140	-98
Off-budget	0	-11	-385	-703	-797	-835	-870	-910	-948	-987	-1,033	-2,732	-7,480
Increases in Spending Subject to Appropriation													
Authorization	0	225	128	101	79	74	n.e.	n.e.	n.e.	n.e.	n.e.	607	n.e.
Estimated Outlays	0	56	125	125	81	71	n.e.	n.e.	n.e.	n.e.	n.e.	458	n.e.

Components may not sum to totals because of rounding; n.e. = not estimated.

Basis of Estimate

For this estimate, CBO assumes that the bill will be enacted near the end of fiscal year 2019 and that the authorized amounts will be appropriated each year. Outlay estimates are based on historical spending patterns for affected programs.

Direct Spending and Revenues

CBO and the staff of the Joint Committee on Taxation (JCT) estimate that several of the bill's provisions would reduce the cost of health insurance subsidized by the federal government—through Medicare, Medicaid, the health insurance marketplaces established under the Affordable Care Act, or employment-based plans. Because lower premiums for

private health insurance affect both outlays and revenues, this section combines the discussion of those effects. A reduction in premiums for private health insurance would reduce federal subsidies for insurance purchased through the marketplaces and shift employees' compensation from tax-favored health insurance to taxable wages.

CBO and JCT estimate that, on net, enacting S. 1895 would increase direct spending by about $18.7 billion and increase revenues by $26.2 billion over the 2019-2029 period, for a net decrease in the deficit of $7.6 billion (see Table 2).

Title I, Ending Surprise Medical Bills. CBO and JCT estimate that, over the 2019-2029 period, enacting title I of S. 1895 would increase revenues by $23.8 billion and reduce direct spending by $1.1 billion, for a total reduction in the deficit of about $24.9 billion over that period.

That estimate accounts for effects on federal subsidies for insurance purchased through the marketplaces and for the effects that arise from lower premiums for employment-based insurance. CBO and JCT estimate that in affected markets in most years, premiums would be just over 1 percent lower than they are projected to be under current law. The decline in premiums would occur because the bill would require insurers to reimburse out-of-network providers on the basis of their own median rates for in-network providers (that is, the amount at which half of payment rates are higher and half are lower). Those median rates are generally lower than the current overall average rates.

CBO and JCT anticipate that under S. 1895, in facilities where surprise bills are likely, payment rates would move toward the median and that insurers' payments to providers currently commanding in-network rates well above the median would drop to more typical amounts. The decrease in premiums resulting from lower payment rates would be offset somewhat by increases in rates for providers that now receive below-median payments. Lower premiums also would be offset somewhat by increased costs for insurers to cover out-of-network care that they do not cover under current law (such as laboratory fees for out-of-network, nonemergency services), any increase in the use of health care resulting from improved out-of-network coverage, and new administrative costs to comply with the law.

In addition to expecting a net reduction in private health insurance premiums, CBO and JCT anticipate a small decrease in the number of people who claim the itemized medical tax deduction, which would increase federal revenues.

Table 2.
Estimated Effect of S. 1895 on Direct Spending and Revenues

	By Fiscal Year, Millions of Dollars												
	2019	2020	2021	2022	2023	2024	2025	2026	2027	2028	2029	2019-2024	2019-2029
Increases or Decreases (-) in Direct Spending, Revenues, and the Deficit													
Title I, Ending Surprise Medical Bills													
Estimated Change in Outlays	0	0	-54	-110	-122	-124	-131	-138	-140	-142	-147	-410	-1,107
Estimated Change in Revenues	0	0	1,027	2,025	2,354	2,506	2,651	3,001	3,228	3,396	3,585	7,912	23,774
Estimated Change in the Deficit	**0**	**0**	**-1,081**	**-2,134**	**-2,477**	**-2,630**	**-2,782**	**-3,139**	**-3,368**	**-3,538**	**-3,732**	**-8,322**	**-24,881**
Title II, Reducing the Prices of Prescription Drugs													
Estimated Change in Outlays	0	-13	-83	-235	-365	-418	-483	-512	-542	-615	-573	-1,115	-3,840
Estimated Change in Revenues	0	3	17	43	69	84	91	100	108	112	119	215	744
Estimated Change in the Deficit	**0**	**-15**	**-100**	**-278**	**-434**	**-502**	**-574**	**-612**	**-650**	**-728**	**-691**	**-1,330**	**-4,584**
Title III, Improving Transparency in Health Care													
Estimated Change in Outlays	0	4	-5	-12	-12	-8	-5	-4	-3	-3	-2	-33	-50
Estimated Change in Revenues	0	33	279	344	312	295	276	286	287	280	272	1,263	2,665
Estimated Change in the Deficit	**0**	**-29**	**-283**	**-355**	**-324**	**-304**	**-281**	**-290**	**-291**	**-283**	**-275**	**-1,296**	**-2,715**
Title IV, Improving Public Health													
Estimated Change in Outlays	0	1,884	3,814	4,699	4,718	4,718	2,835	901	13	-7	-13	19,834	23,562
Estimated Change in Revenues	0	-34	-56	-63	-67	-72	-77	-81	-85	-89	-94	-292	-718
Estimated Change in the Deficit	**0**	**1,918**	**3,871**	**4,761**	**4,785**	**4,790**	**2,912**	**982**	**98**	**82**	**81**	**20,125**	**24,280**
Title V, Improving the Exchange of Health Information													
Estimated Change in Outlays	0	0	16	23	23	10	5	5	5	6	6	72	99
Estimated Change in Revenues	0	0	-35	-50	-51	-22	-11	-12	-13	-14	-14	-158	-223
Estimated Change in the Deficit	0	0	50	73	75	33	16	18	19	19	20	231	322
Total Change in Outlays	**0**	**1,876**	**3,688**	**4,365**	**4,242**	**4,178**	**2,220**	**253**	**-667**	**-762**	**-729**	**18,348**	**18,664**
Total Change in Revenues	**0**	**2**	**1,231**	**2,299**	**2,617**	**2,791**	**2,929**	**3,294**	**3,525**	**3,685**	**3,868**	**8,940**	**26,242**
Total Change in the Deficit	**0**	**1,874**	**2,457**	**2,066**	**1,625**	**1,387**	**-708**	**-3,042**	**-4,192**	**-4,447**	**-4,597**	**9,408**	**-7,578**

For section-by-section estimates, see Supplemental Table 1.

Components may not sum to totals because of rounding; * = between -$500,000 and zero.

Surprise Medical Bills. For this estimate, surprise medical bills are those that a patient receives unexpectedly from out-of-network providers either for emergency care or for out-of-network care from providers at an in-network facility. For example, a patient may receive a surprise bill from an out-of-network anesthesiologist after selecting an in-network hospital and an in-network surgeon because hospitals, surgeons, and anesthesiologists often bill and negotiate with insurers separately. In most cases, patients' cost sharing is lower for in-network care, and therefore patients can incur significant out-of-pocket costs for out-of-network care even though they have not deliberately selected an out-of-network provider.

Costs to patients tend to be higher outside their network because copayment and coinsurance rates are higher. Additionally, many plans have separate deductibles and out-of-pocket spending limits for in-network and out-of-network care. In such cases, in-network spending will not count toward an out-of-network deductible or spending limit, and vice versa. Having separate deductibles increases the amount of health care for which patients bear the entire cost, whereas having separate out-of-pocket limits increases the total amount patients may have to pay over the course of the year. Furthermore, out-of-network providers may bill patients directly for any differences between insurers' payments and providers' charges—a practice known as balance billing.

Federal law provides people who have private health insurance with some protections against surprise bills for emergency care, but it does not prohibit providers from balance billing or prevent insurers from using separate out-of-network deductibles. (Health care providers cannot balance bill Medicare or Medicaid patients.) Although some states have laws that protect patients generally from surprise bills, federal law precludes state governments from regulating most employment-based coverage provided through large, self-insuring employers.

The cost of surprise bills is a small portion of all health care spending, but policies to address surprise bills can have important consequences for the health care system because they affect negotiations between insurers and providers. Insurers negotiate lower in-network payments to providers by promising increased patient volume and by declining to cover out-of-network care, but those tools are largely ineffective for the providers that generate the majority of surprise bills. Certain types of providers can negotiate higher payment rates by declining to join a network and threatening to balance bill patients. That strategy is most effective for providers whose services are not chosen directly by patients—such as anesthesiologists, pathologists, and emergency physicians.

Patient Protections. Title I of S. 1895 would protect patients from surprise medical bills by prohibiting balance billing and by requiring insurers to treat out-of-network care as in-network care for the purpose of calculating copayments, coinsurance, deductibles, and spending toward out-of-pocket limits. Additionally, title I would require insurers to

reimburse out-of-network providers at the median in-network rate for a given provider type and geographic area. By establishing a method for determining out-of-network payment rates, the bill would require insurers to pay something for out-of-network care and also prohibit providers from charging prices that are substantially higher than in-network rates.

Effects on Private Insurance Premiums. CBO and JCT anticipate that title I would affect private insurance premiums in several ways:

- It would reduce average payment rates—from the current average rate to the current median rate—for providers who practice in facilities where surprise bills are likely;
- It would require insurers' to pay median in-network rates for out-of-network care in situations involving surprise bills;
- It would require insurers to pay for some care that they do not currently cover (including care provided outside a network and increased care that would result from new patient protections); and
- It would create new administrative costs for insurers.

CBO and JCT estimated changes in the cost of health insurance premiums according to insurance market (nongroup and employment based), type of health plan (preferred provider organization or PPO, point-of-service plan or POS, and health maintenance organization or HMO), and the setting in which services are delivered (emergency department, inpatient hospital, or outpatient facility). The effects of title I would differ according to the type of plan and the market.[1] The effects are different for various settings because of differences in payment rates, the amount of care that is paid for inside or outside of a network, the amount of care that is delivered outside a network and not reimbursed by insurers, and the applicable current-law protections against surprise bills. Nationally, the net effect of all those changes would be lower insurance premiums and savings to the federal budget.

Reducing Payments for In-Network Care. The vast majority of health care is delivered inside patients' networks, and more than 80 percent of the estimated budgetary effects of title I would arise from changes to in-network payment rates. CBO and JCT estimate that by creating a method for reimbursing out-of-network care at median in-network rates, payments to providers—inside and outside of networks—would converge around those median rates.

To see how such a convergence would affect average payment rates for in-network care, consider a market in which a given insurer pays in-network emergency room physicians at an

1. In particular, the agencies' analyses show that payment rates are generally higher for PPOs and POS plans than they are for HMOs, and that they are higher in the employment-based market than in the nongroup market. In addition to paying lower average rates, HMOs are less likely than the other plan types to pay anything for out-of-network care. The most common employment-based plans are PPOs; HMOs are most common for nongroup coverage.

average rate that is 260 percent of the rate that Medicare pays. In this example, some of the providers are paid as much as 500 percent or 600 percent of the Medicare rate, so the insurer's average rate is higher than the median, which might be 225 percent of the Medicare rate. Under title I of S. 1895, this insurer would reimburse out-of-network emergency physicians at 225 percent of the Medicare rate.

CBO and JCT expect that such an insurer would reduce rates for providers with rates higher than 225 percent of the Medicare rate even if some of those providers refused the lower payment rates and dropped out of the network. (Out-of-network rates also would be 225 percent of the Medicare rate.) The agencies expect that providers earning less than 225 percent of the Medicare rate would demand a payment increase or drop out of the network. As a result of the convergence in payment rates, in this example, the insurer's average payment rate would fall from 260 percent to 225 percent of the Medicare rate.

Because in-network rates reflect the dynamics of local health insurance and health care markets, actual median in-network rates vary tremendously across the nation, as do the relative differences between the average and median rates in a given market. Although CBO and JCT's estimate of the savings from title I reflects differences between average and median payment rates nationally, effects in any given market could be quite different.

Because the median is the midpoint of the distribution, CBO and JCT anticipate that affected providers would see their payments either increase or decrease in roughly equal numbers under this provision of S. 1895. Under current law, the distribution of payment rates across all providers is highly skewed—some command rates that are well above the median. For that reason, a reduction in CBO and JCT's estimate of average payment rates from the current-law average to the current-law median would cause the average rate to drop by 15 percent to 20 percent at the national level. Although the national average rate may drop by such an amount, the effects within a given market for any particular insurer and for specific providers will be quite different, with payment rates rising in some cases and falling in others.

In this estimate, CBO and JCT do not include any changes in the growth of the median rate over time because growth could be either faster or slower than under current law. (See the "Uncertainty" section.)

Other Effects on Premiums. Although the most significant effects of title I would stem from lower payments for in-network care, CBO and JCT estimate that private insurance premiums also would be affected by changes in payment rates for out-of-network care and increased administrative costs, which, on net, account for less than 20 percent of the estimated reduction in premiums. Under S. 1895, insurers would be required to pay for out-of-network care at the median in-network rate. If an insurer was already paying for out-of-network care, reimbursing such care at in-network rates would reduce payments and premiums, on average.

CBO and JCT estimate that the premium reduction would be partially offset by new costs for insurers. Establishing a payment method for reimbursing out-of-network care would require most insurers to pay for some health care that they do not cover under current law. Some health plans now offer no coverage for nonemergency out-of-network care; others have separate deductibles that sometimes result in patients' bearing virtually all costs for out-of-network care. By limiting patients' cost sharing to in-network amounts, title I would increase insurers' payments in cases of surprise billing. CBO and JCT also expect that the use of health care would increase slightly among patients who would have greater protections against surprise billing.

Finally, CBO and JCT estimate that insurers would incur administrative costs to comply with the law. Among those costs are expenses of calculating median in-network rates, submitting the required documentation about new rates to the applicable regulatory authorities, and acquiring external data to estimate median in-network rates in markets for which there are insufficient data to calculate rates.

Effects on the Medical Tax Deduction. By eliminating surprise bills, title I of S. 1895 would reduce the number of people who qualify for and claim the itemized medical tax deduction. Under current law, CBO and JCT estimate that more than 4 million people will claim that deduction in 2019, thus reducing federal revenues by about $7 billion. The agencies anticipate that eliminating surprise bills could lower the amounts claimed by that population by about 0.05 percent, thus increasing federal revenues by roughly $71 million over 10 years.

Title II, Reducing the Prices of Prescription Drugs. Title II of the bill contains several provisions that would modify the Food and Drug Administration's (FDA's) regulatory framework and affect the approval for certain drugs and biologics. CBO expects that implementing those changes would allow some generic or biosimilar drugs to enter the market earlier, on average, than would be the case under current law.

Because those provisions would expedite the market entry of some lower-priced generic or biosimilar drugs, CBO and JCT estimate that federal spending for prescription drugs and subsidies for health insurance would decline. In total, CBO and JCT estimate that over the 2019-2029 period, enacting title II would reduce direct spending by $3.8 billion and increase revenues by $0.7 billion, for a total reduction in the deficit of about $4.6 billion.

Section 203, Ensuring Timely Access to Generics. Section 505(q) of the Federal Food, Drug, and Cosmetic Act governs the treatment of citizen petitions submitted to the FDA. Such petitions request the FDA to take or refrain from taking an action by the agency that could delay approval of pending marketing applications, including applications for lower-priced generic and biosimilar drugs. The FDA's draft guidance details how the FDA assesses whether a petition has been submitted with the primary purpose of delaying the approval of

an application. If such a determination is made, the FDA may summarily deny the petition if it also does not on its face raise valid scientific or regulatory issues.

Section 203 would allow the FDA to deny a citizen petition based on intent to delay if the agency determines that the petition was submitted with the primary purpose of delaying the approval of an application or if the petition does not raise valid scientific or regulatory issues. Currently, both conditions must be satisfied for the agency to summarily deny the petition. As a result, CBO expects that this change in the determination criteria would allow the FDA to more quickly deny such petitions. The bill also would require a petition to be submitted within 60 days after the petitioner knew, or reasonably should have known, the information that forms the basis of the petition. CBO expects that the new timely-submission requirement and related changes to the dismissal procedures involving civil actions would further enhance the FDA's ability to expeditiously deny petitions that otherwise would have delayed the marketing approval of generic or biosimilar applications.

To estimate the effects of reducing the number of petitions that delay the approval of a lower-priced generic or biosimilar drug by the FDA, CBO examined information about past cases involving petitions that potentially delayed the marketing approval for a competitor's drug. CBO estimates that the bill would affect between $4 billion and $5 billion in brand-name sales for drugs over the 2019-2029 period (more than half of that amount is for brand-name drugs facing competition from biosimilars), and would accelerate initial competition from lower-priced products for affected drugs by six months, on average.

CBO expects that the bill would accelerate the availability of lower-priced drugs that would otherwise have been delayed, thus enacting section 203 would reduce the average prices of drugs that are paid for by federal health programs that purchase drugs or provide health insurance that covers drugs. As result, CBO and JCT estimate that enacting the section would reduce direct spending by $212 million and increase revenues by $41 million, for a total decrease in the deficit of $253 million over the 2019-2029 period.

Section 205, Preventing Blocking of Generic Drugs. Section 205 would allow the FDA to approve some generic drug applications that are ready for full approval if no first generic applicant has received final approval and other conditions are satisfied. In such cases, CBO expects, the provision would allow generic drugs to enter the market earlier than they would under current law. CBO estimates that the bill would affect between $2 billion and $3 billion in sales of brand-name drugs over the 2019-2029 period and would accelerate initial competition from generic products for affected drugs by one year, on average. CBO and JCT estimate that enacting section 205 would decrease direct spending by $356 million and increase revenues by $68 million, for a total decrease in the deficit of $424 million.

Section 211, Prompt Approval of Drugs Related to Safety Information. Under current law, the FDA is unable to approve an application submitted by a sponsor of a generic drug if

safety information contained in the reference product's label is protected by market exclusivity. Section 211 would permit the FDA to require the affected application sponsors to include a statement of appropriate safety information on the label of the generic drug to ensure safe use. In so doing, the bill would allow the FDA to approve the product for marketing, and CBO expects that the FDA would approve generic drugs earlier than would occur otherwise.

CBO estimates that section 211 would affect between $1 billion and $2 billion in sales of brand-name drugs over the 2019-2029 period and would accelerate initial competition from generic products for affected drugs by between six months and a year, on average. CBO and JCT estimate that earlier entry of generic products into the market would decrease direct spending by $137 million and increase revenues by $27 million, for a total decrease in the deficit of $164 million over the 2019-2029 period.

Section 214, Actions for Delays of Generic Drugs and Biosimilar Biological Products. Under current law, manufacturers of generic and biosimilar products must verify that they have tested their products to demonstrate that they meet all approval criteria. Manufacturers must use reference samples of brand-name drugs in that testing, even though brand-name manufacturers have little incentive to sell their samples to competitors. As a result, the market entry of lower-priced generic or biosimilar products can be delayed.

Section 214 would create a private right of action that would allow developers of generic drugs or biosimilar products to bring civil lawsuits against manufacturers of brand-name drugs if sufficient quantities of reference samples of a branded product are not made available for premarket testing. That section also would remove a statutory requirement that manufacturers of generic or biosimilar versions of certain drugs that carry a significant risk of serious side effects use the same risk management system as the brand-name reference drug to ensure safe use of the product. Instead, it would allow the FDA more discretion to permit manufacturers to use comparable safety systems on a case-by-case basis.

CBO estimates that about $20 billion in total spending on brand-name drugs through 2029 would be affected by section 214. In addition, the entry of certain generic or biosimilar products could be accelerated by one to two years, on average, as a result of more timely access to samples for premarket testing and shorter regulatory delays under the bill. By reducing spending on brand-name drugs, section 214 would reduce federal and private insurance spending for prescription drugs. As a result, CBO and JCT estimate that section 214 would decrease direct spending by $3.1 billion and increase revenues by $0.6 billion, for a net decrease in the deficit of $3.7 billion over the 2019-2029 period.

Title III, Improving Transparency in Health Care. Several provisions of title III would impose new rules for insurers' contracts with health care providers and pharmacy benefit managers. Sections 302, 303, and 306 would affect direct spending or revenues. CBO and

JCT estimate that over the 2019-2029 period, title III would decrease direct spending by $50 million and increase revenues by $2.7 billion, for a total decrease in the deficit of $2.7 billion.

Section 302, Banning Anticompetitive Terms in Facility and Insurance Contracts That Limit Access to Higher Quality, Lower Cost Care. CBO and JCT estimate that section 302 would decrease average premiums for private health insurance by roughly 0.05 percent after the effects are fully in place. As a result, employees' compensation would shift somewhat to taxable wages, and revenues would increase by $1.1 billion over the 2019-2029 period.

The decline in premiums would occur primarily because section 302 would prohibit health care providers and insurers from entering into contracts that include "anti-tiering" and "anti-steering" clauses. That change would allow more insurers to offer tiered provider networks and other incentives for enrollees to use lower-cost health care providers or those with higher quality ratings. CBO and JCT anticipate that enrollment in such plans would increase in the employment-based insurance market. (The agencies do not expect a similar effect on nongroup premiums because insurers—in an effort to constrain premium growth—have been more aggressive in using different types of provider networks in the nongroup market than in the employment-based market.)

Providers in tiered plans are ranked on the basis of cost and quality. Although all of those providers are included in the insurers' network, the network may have two or more tiers, and enrollees' out-of-pocket costs vary by tier. Patients who see preferred-tier providers—those with some combination of higher relative quality or lower relative costs—pay less than they would for care from providers in nonpreferred tiers. Thus, an enrollee might face a copayment of $250 for care at a preferred-tier hospital but a copayment of $750 for care from a hospital in a nonpreferred tier (which would have higher costs than local competing hospitals). In addition to different copayment rates, insurers might introduce other financial incentives—cash payments or rebates, for example—to encourage enrollees to seek care from specific providers in preferred tiers.

On the basis of a research review and discussions with stakeholders (insurers, health care providers, industry associations, academics, and policy experts), CBO and JCT estimated the extent to which the prohibition would lower premiums and other costs. Other studies of tiered provider networks showed small reductions in total spending for physician and hospital services in tiered-network plans. On the basis of those studies, CBO and JCT estimate that increased enrollment in such plans would reduce spending for nonemergency medical care and therefore reduce average health insurance premiums for employment-based coverage.

CBO and JCT expect that prohibiting anti-tiering and anti-steering agreements would reduce premiums in areas where there is a dominant but nonmonopolistic health care provider and

no single dominant insurer. Under current law, as a means of maintaining market dominance, providers in such areas could demand anti-tiering and anti-steering clauses that preclude insurers from encouraging enrollees to see lower-priced competitors. However, CBO and JCT do not expect the prohibition to have an effect in areas with monopolistic providers because insurers would have no alternative health care providers to direct patients toward. Finally, for competitive provider markets and markets with a single dominant insurer, CBO and JCT find it unlikely, under current law, that health care providers can negotiate anti-tiering or anti-steering agreements with insurers.

Based on estimates of hospital and insurer market structure and physician market concentration, CBO and JCT estimate that roughly a quarter of hospital and physician spending among people with employment-based health insurance would be in areas affected by this provision.[2] In the affected markets, the agencies estimate that, by 2029, the provision would boost enrollment in tiered networks—increasing the share of total spending directed through those networks by roughly 10 percentage points. Spending for those enrollees would be roughly 5 percent lower because of a shift to lower-cost providers, with a resulting reduction of total employment-based health care costs by 0.05 percent, on average. The agencies based this estimate in part on the experience of Massachusetts, which prohibited anti-tiering and anti-steering clauses in 2010 and also required insurers to offer at least one narrow-network or tiered-network insurance plan. However, in the agencies' assessment, the adoption of tiered networks in the markets affected by S. 1895 would occur more slowly than the adoption of tiered networks in Massachusetts because this bill would not require insurers to offer such plans.

Section 303, Designation of a Nongovernmental, Nonprofit Transparency Organization to Lower Americans' Health Care Costs. Section 303 would appropriate $20 million in 2020 to fund an organization that would establish and maintain a database to track health care claims and related information. Based on spending for similar activities, CBO estimates that the provision would cost $20 million over the 2019-2029 period.

Section 306, Health Plan Oversight of Pharmacy Benefit Manager Services. Section 306 would impose the following requirements on pharmacy benefit managers (PBMs) operating in commercial health care markets:

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2. CBO estimated hospital market structures at the level of core-based statistical areas (which include metropolitan statistical areas and micropolitan areas) using data from the American Hospital Association's Annual Survey Database. Health insurance market structures were measured using data from the National Association of Insurance Commissioners, compiled by Mark Farrah Associates. CBO determined that rural areas would be most similar to monopolistic provider markets and thus would not be affected by the policy change. CBO relied on published estimates to measure physicians' market concentration (see Laurence C. Baker and others, "Physician Practice Competition and Prices Paid by Private Insurers for Office Visits," *JAMA*, vol. 312, no. 16, pp. 1653-1662, October 2014, http://tinyurl.com/yxzwq4y8). Two states that have banned such contract provisions were excluded from this analysis.

- Provide specific information to sponsors of group health plans including costs, aggregate rebates, fees, use of prescription drugs, and cost sharing by enrollees;
- Pass on to sponsors of group health plans 100 percent of the rebates, fees, discounts, or other remuneration received from pharmaceutical manufacturers, distributors, or other third parties that are related to use of prescription drugs by plan enrollees; and
- Prohibit spread pricing—charging a plan sponsor, health insurance plan, or patient more for a drug than the PBM paid to the pharmacy for that drug.

CBO expects that those provisions would allow some plan sponsors to better evaluate the trade-offs among contract provisions and could lead to more efficient competition among PBMs. As a result, CBO estimates, implementing section 306 would lower costs for drug benefits offered by some plan sponsors.

CBO expects that under current law, a growing share of contracts between PBMs and plan sponsors in the private health insurance market will include terms that require full pass-through—from manufacturers to plan sponsors—of rebates received by PBMs and require payment approaches other than spread pricing for administering pharmacy benefits. Even so, CBO expects that the disclosure of information required by section 306—especially information on total amounts in rebates and about other fees and payments tied to prescription drug use that flow from manufacturers to PBMs—would help a subset of PBMs' clients obtain better terms. In particular, CBO expects that sponsors of smaller plans would benefit because many currently have only limited access to such information. That information would put such sponsors in a marginally better position to negotiate over how much to share in the payments received by PBMs. CBO expects that some plans would use the information to lower their PBM contract costs.

CBO also expects PBMs to recoup some of the income lost as a result of compliance with section 306 through higher fees charged to plan sponsors, in a manner similar to full pass-through contracts under current law. After accounting for those higher fees, CBO estimates, on net, section 306 would initially reduce plan costs by roughly 1 percent for prescription drugs across all plans in the private health insurance market. Because S. 1895 would reduce the prescription drug costs for health plan sponsors in the private health insurance market, premiums for some private health insurance plans also could decrease.

CBO estimates that the bill would reduce average premiums charged in the private health insurance market by nearly 0.2 percent in the first full year of implementation, although plan savings would probably erode quickly. By 2029, CBO estimates, average premiums charged in the commercial market would be 0.02 percent lower relative to those under current law. The lack of standard definitions for the reporting and pass-through requirements could increasingly dilute the usefulness of the information to plan sponsors over subsequent

bidding cycles. (The utility of the information would diminish over time as contract terms between parties are redefined and the complex monetary flows fall out of reach of the new requirements.)

CBO estimates that section 306 would lower private health insurance premiums, thereby reducing federal subsidies for insurance purchased through the marketplaces, and shift employees' compensation somewhat from tax-favored health insurance to taxable wages. That last change would increase federal revenues from income and payroll taxes. CBO and JCT estimate that section 306 would increase revenues by $1.6 billion and decrease direct spending by $70 million, for a net decrease in the deficit of $1.7 billion over the 2019-2029 period.

Title IV, Improving Public Health. Title IV would extend funding for several federal health care programs. CBO and JCT estimate that over the 2019-2029 period, title IV would increase direct spending by $23.6 billion and decrease revenues by $0.7 billion, for a total increase in the deficit of about $24.3 billion.

Section 411, Extension for Community Health Centers, the National Health Service Corps, and Teaching Health Centers That Operate Graduate Medical Education Programs. For each fiscal year from 2020 through 2024, section 411 would appropriate $4.0 billion for community health centers, $310 million for the National Health Service Corps, and $126.5 million for Teaching Health Centers that operate graduate medical education programs. Based on historical spending patterns for those activities, CBO estimates that section 411 would increase direct spending by $22.2 billion over the 2019-2029 period.

Section 412, Extension of the Special Diabetes Programs for the National Institutes of Health and the Indian Health Service. For each fiscal year from 2020 through 2024, section 412 would appropriate $150 million for the special diabetes program of the National Institutes of Health and another $150 million for the Indian Health Service's program. Based on historical spending patterns for those activities, CBO estimates that section 412 would increase direct spending by $1.5 billion over the 2019-2029 period.

Section 414, Minimum Age of Sale of Tobacco Products. Section 414 would prohibit the sale of tobacco products to any person under the age of 21. CBO and JCT estimate that the section would reduce revenues by $718 million and reduce direct spending by $90 million over the 2019-2029 period, for a net increase in the deficit of about $628 million. CBO and JCT expect that over the 10-year period, the provision would lead to a decline in tobacco use among people under the age of 30. That decline would reduce revenues from the sale of tobacco products, which would be partially offset by a decrease in the deficit from improvements in the health of people who would have been tobacco users under current law but not under the proposal. The decline in revenues would be further offset, CBO estimates, by an increase in civil monetary penalties collected from retailers who sold tobacco products

to anyone under the age of 21. Because this provision focuses on tobacco use among people under the age of 21, CBO and JCT estimate that the overall reduction in the number of adult tobacco users would be less than 1 percent over the 2019-2029 period. That effect would be likely to grow in the longer run.

Title V, Improving the Exchange of Health Information. Title V includes various provisions aimed at increasing access to health information. CBO expects that implementing those changes would slightly increase both direct and discretionary spending.

Section 501, Requirement to Provide Health Claims, Network, and Cost Information. Section 501 would require health insurers to create and maintain "application programming interfaces (or successor technology or standards)" that would enable patients to have access to specified information through third-party applications, if authorized by the patient. Such information would include claims, costs, provider information, and estimated out-of-pocket costs for specific services. Although such "APIs" and ensuing third-party applications may take on a variety of forms, CBO anticipates that from a consumer perspective, they would function similarly to a smartphone app or web portal.

Creating and maintaining an API would generate new administrative costs for insurers that CBO and JCT expect would be passed along to enrollees in the form of higher premiums for private health insurance. Using information from stakeholders and information on spending patterns for similar activities, CBO and JCT estimate that, in most years, premiums would increase slightly above the rates projected under current law.

As a consequence of increased premiums resulting from those requirements, federal spending on subsidies for insurance in the nongroup market would increase. In addition, because employers would spend more on premiums, employees' compensation would shift somewhat away from taxable wages. CBO and JCT estimate that, over the 2019-2029 period, section 501 would increase direct spending by $99 million and decrease revenues by $223 million, for a total increase in the deficit of about $322 million.

Spending Subject to Appropriation

CBO estimates that S. 1895 would authorize the appropriation of $607 million over the 2019-2024 period for various health programs. Assuming appropriation of those amounts, CBO estimates that the bill would cost $458 million over the same period (see Table 3).

Table 3.
Estimated Increases in Spending Subject to Appropriation Under S. 1895

	By Fiscal Year, Millions of Dollars						
	2019	2020	2021	2022	2023	2024	2019-2024
Section 303, Transparency Organization and State Grants							
Authorization	0	100	15	15	15	15	160
Estimated Outlays	0	12	43	49	20	15	139
Section 415, State Grants Concerning Tobacco Sales							
Authorization	0	19	19	19	19	19	93
Estimated Outlays	0	6	16	19	19	19	78
Sections 303, 307, 314, and 503 GAO Reports							
Estimated Authorization	0	1	1	*	*	*	3
Estimated Outlays	0	1	1	*	*	*	3
Section 313, Federal Reporting on Prescription Drug costs							
Estimated Authorization	0	1	1	*	*	*	2
Estimated Outlays	0	1	1	*	*	*	2
Sections 401, 402, 403, and 405, CDC-Sponsored Activities							
Estimated Authorization	0	62	63	64	64	66	320
Estimated Outlays	0	20	48	59	63	64	254
Sections 404, 406, 407, 408, and 410, HHS-Sponsored Activities							
Estimated Authorization	0	25	26	26	25	25	127
Estimated Outlays	0	1	12	21	24	24	82
FDA Regulation, Implementation, and Enforcement Activities							
Estimated Authorization	0	9	5	5	5	5	28
Estimated Outlays	0	7	6	6	5	5	28
HHS Regulation, Implementation, and Enforcement Activities							
Estimated Authorization	0	5	5	2	1	1	14
Estimated Outlays	0	5	5	2	1	1	14
DOL Regulation, Implementation, and Enforcement Activities							
Estimated Authorization	0	5	5	2	1	1	14
Estimated Outlays	0	5	5	2	1	1	14

Continued

Table 3.
Continued

	By Fiscal Year, Millions of Dollars						
	2019	2020	2021	2022	2023	2024	2019-2024
Title II, Reducing the Prices of Prescription Drugs							
Effects on Other Federal Health Programs							
Estimated Authorization	0	-2	-13	-33	-51	-57	-155
Estimated Outlays	0	-2	-13	-33	-52	-58	-157
Reporting Costs to HHS							
Estimated Authorization	0	1	1	*	*	*	2
Estimated Outlays	0	1	1	*	*	*	2
Total Changes in Discretionary Spending							
Estimated Authorization	0	225	128	101	79	74	607
Estimated Outlays	0	56	125	125	81	71	458

For section-by-section estimates, see Supplemental Table 2.

Components may not sum to totals because of rounding; CDC = Centers for Disease Control and Prevention; DOL = Department of Labor; FDA = Food and Drug Administration; GAO = Government Accountability Office; HHS = Department of Health and Human Services; * = between zero and $500,000.

Several sections of the bill contain specified authorizations of appropriations; in total, CBO estimates that those provisions would cost $217 million over the 2019-2024 period:

- Section 303 would authorize $15 million annually over the 2021-2025 period to fund a nongovernmental, nonprofit transparency organization to establish and maintain a database to track health care claims and related information;
- Section 303 would authorize $100 million over the 2020-2029 period to award grants to states to establish and maintain state all-payer claims databases (that amount shows up as an authorization in 2020 in Table 3 because that is the first year of the authorization); and
- Section 415 would authorize about $19 million annually over the 2020-2024 period for grants to states to plan for and ensure compliance with new rules prohibiting the sale of tobacco products to people under the age of 21.

Several other sections of the bill would authorize such sums as may be necessary for other activities or would authorize activities normally funded with discretionary appropriations. CBO estimates implementation of those activities would increase discretionary costs as follows:

- The Government Accountability Office would be directed to report on the performance of a health care information database (section 303), profit and revenue sharing in

commercial health care markets (section 307), the role of PBMs in the health care system (section 314), and the security risks of sharing electronic personal health information (section 503). CBO estimates that those reports would cost a total of $3 million over the 2019-2024 period.

- Section 313 would authorize the Assistant Secretary of Planning and Evaluation and the Inspector General of the Department of Health and Human Services (HHS) to complete biennial reports on prescription drug reimbursement, pricing, and costs. CBO estimates that those reports would cost roughly $2 million over the 2019-2024 period.
- Several sections would authorize HHS to develop information for Indian Tribes and Tribal organizations concerning evidence-based methods of preventing obesity (section 403), to award grants for promoting awareness of vaccines (sections 401 and 402), and to modernize public health departments' information technology systems (section 405). Based on historical spending patterns for similar activities, CBO estimates that those provisions would be implemented by the Centers for Disease Control and Prevention for a combined cost of $254 million over the 2019-2024 period.
- Several sections would authorize HHS to award grants to study technology-enabled collaborative models for delivering health care in underserved areas (section 404) and for maternal health care (sections 406, 407, 408, and 410). Based on historical spending patterns for similar activities, CBO estimates that those provisions would be implemented by the Health Resources and Services Administration for a combined cost of $82 million over the 2019-2024 period.

In addition, S. 1895 would change the regulatory framework for private health insurance and for much of the health care sector. Assuming appropriation action consistent with those provisions, CBO estimates that over the 2019-2024 period, the costs of implementing the provisions would be $28 million for the FDA, $14 million for HHS, and $14 million for the Department of Labor.

Finally, the provisions of title II that are estimated to accelerate the entry of lower-priced drugs into the market would reduce the costs of certain discretionary health programs, including programs in the Veterans Health Administration, the Department of Defense, and the Indian Health Service. Those provisions also would reduce payments by federal agencies for premiums for enrollees in the Federal Employees Health Benefits Program. CBO estimates that those effects would reduce discretionary spending by about $157 million over the 2019-2024 period, assuming that appropriations are reduced to account for the estimated reduction in costs. Title II also would require HHS to publish redacted versions of reports that are submitted to the agency by drug manufacturers and to submit annual summaries of those reports to the Congress. CBO estimates that those activities would cost about $2 million over the 2019-2024 period.

Uncertainty

This estimate of the budgetary effects of S. 1895, which would involve a wide swath of the health care system, is subject to uncertainty in many areas.

Ending Surprise Medical Bills. The estimate of title I provisions concerning surprise billing is subject to significant uncertainty about the growth rates of payments to health care providers. CBO and JCT estimate that prices would converge around median in-network rates, but changes arising from the provisions addressing surprise billing could cause those rates to be significantly higher or lower than the agencies estimate. Title I could cause payment rates to increase more quickly or more slowly than estimated.

CBO and JCT did not forecast net changes in the growth of median in-network rates relative to the estimated growth under current law because growth rates for in-network payments may rise in some markets and fall in others. The relative competitiveness of provider and insurer markets—and changes in that relationship over time—would determine the changes in median in-network rates.

On the one hand, CBO and JCT anticipate that the total reduction in payments to providers with rates higher than the current median would be larger than the increase for providers with rates lower than the current median. In isolation, reducing the bargaining power of providers who practice in locations where surprise bills are likely would probably slow the growth of in-network prices for affected specialties, relative to current law. (The provision would probably reduce bargaining power by lowering out-of-network payment rates and prohibiting balance billing.) On the other hand, if title I initially causes significant downward pressure on prices, CBO and JCT anticipate that a resulting increase in consolidation among providers could place upward pressures on price growth.

A related source of uncertainty concerns implementation of title I at both the federal and the state level: The bill does not specify a methodology for calculating current and future median in-network rates. For example, it does not direct how narrowly or broadly providers, services, and insurance markets would be defined for the purposes of calculating median in-network rates. Moreover, under title I, health plans and insurers would need to rely on third-party data if they lacked sufficient claims data of their own from which to calculate median in-network rates in a given area or for a given specialty. CBO and JCT could not determine how insufficiency of data would be defined or how frequently insurers would need to use external data rather than their own to calculate median in-network rates.

Finally, the agencies could not accurately assess how often median in-network rates would be updated and, if the frequency was not annual, how payment rates would grow in the interim (for example, with inflation or by some other measure). For those reasons, among others, CBO and JCT anticipate that title I could create both upward and downward pressure

on the growth of payment rates. It is unclear whether the net effect would be to increase or decrease rates.

Reducing the Prices of Prescription Drugs and Health Plan Oversight of Pharmacy Benefit Manger Services. It is difficult to anticipate the quantity and pace at which new pharmaceutical products would be introduced into the market, the number of products and manufacturers affected, and the sales volume for those products. The effects of title II could differ from those included in CBO's analyses, depending on pharmaceutical companies' decisionmaking and the outcome of court proceedings. Significant uncertainty surrounds estimates of the number of applications or petitions that could be affected by the bill from the present through 2029 and of the value of brand-name sales for drugs facing competition relating to applications or petitions.

CBO's estimate of the budgetary effects arising from the market entry of lower-priced drugs accounts for the prospect that expected entry dates for certain generic or biosimilar drugs may not be influenced by the bill because patents and other market exclusivities would otherwise prevent their entry over that period. The timing and results of such legal matters are inherently uncertain.

Estimating the effects of section 306 of the bill, which would impose requirements on PBMs operating in the commercial market, also involves uncertainty, most notably related to the extent to which that section's requirements for additional contractual obligations would affect competitiveness in the PBM market. CBO estimates that requiring PBMs to provide plan sponsors with some information on the net prices that they pay for prescriptions will increase competition in the PBM market somewhat by making it easier for plan sponsors to compare bids across PBMs. The size of that effect, however, is highly uncertain. In addition, under current law, smaller PBMs compete with larger PBMs by offering more transparent contracts. Removing that point of leverage may reduce the competitiveness of those smaller PBMs, which could reduce competition if larger PBMs garner greater market share as a result. In total, the effect on premiums from changes to the competitiveness of the PBM market could be larger or smaller than CBO has projected.

Other sources of uncertainty relate to whether the trajectory of prices, on net, would be affected by provisions in section 306 and the extent to which they would increase PBMs' administrative costs. For example, net prices could change because of the requirement to report average rebates by a drug's therapeutic class when at least three drugs in a class are covered by a formulary. That information would probably be protected by nondisclosure agreements, but it also is possible that, if disclosed, that information could result in tacit collusion among competing manufacturers. CBO estimated that administrative costs would increase as a result of the additional reporting requirements. Those increased costs offset a

portion of the reduced premiums associated with increased transparency. However, the magnitude of those effects could be higher or lower than CBO's estimate.

Improving Transparency in Health Care. Title III includes provisions designed to increase transparency and improve competition in the markets for health care and health insurance. Many of those provisions aim to expand access to information for health insurers, providers, patients, or other market participants. The intent is to lower prices for certain health care services by increasing access to such information.

Other provisions aim to reduce costs by removing barriers to competitive contracting between health insurers and providers. CBO and JCT's estimates of the effects those policies, however, are highly uncertain for at least two reasons: First, evidence from past attempts at transparency shows that effects can vary widely, depending on the type of health care and the underlying structure of the market for services. Second, some of the critical pieces of information needed to model such policies typically are proprietary and thus unavailable.

Several provisions, primarily related to prices and patient cost sharing, are designed to make information more widely available. Evidence on the effects of increasing the transparency in those areas is limited, and the available studies show mixed results that depend on the type of service and characteristics of the market. For example, spending could decrease for routine, nonemergency medical services if patients used newly available information to select lower-cost providers. However, spending also could increase if providers became less willing to negotiate discounts once they had more information about their competitors' negotiated rates, particularly if the market is highly concentrated among a small number of providers. Finally, as some research shows, spending could remain unchanged if patients did not seek price information before choosing a health care provider or found they could not easily use or interpret that new information.

Several provisions of title III, including prohibitions on contracting practices and other provisions designed to increase price transparency, also could affect payment rates negotiated between insurers and providers by altering their relative negotiating positions. It is unclear whether implementing those provisions would result in higher or lower negotiated payment rates, on net.

In many insurer and provider markets, one side has considerable leverage in payment negotiations, and it is unclear how insurers and providers would respond to shifts in leverage. For provisions that would turn the advantage away from providers toward insurers, insurers might be able to negotiate lower payment rates. However, in some cases, dominant providers could respond to a decrease in leverage by using alternative means to exert their market power during negotiations. Dominant providers might respond by merging with competitors to regain their negotiating position. In those cases, overall costs may actually increase.

CBO and JCT estimate that prohibiting anti-tiering and anti-steering clauses in contracts initially would reduce average premiums by shifting more care toward lower-cost providers, but the extent is highly uncertain. Although in CBO and JCT's assessment the current use of such clauses constrains enrollment in plans that use tiered networks and other similar incentives to influence patients' choice of providers, the extent to which enrollment would grow after the elimination of those constraints is uncertain.

The longer-term effects on negotiated payment rates are even less certain because of the difficulty in forecasting the ways that different providers might respond to the increased preference for lower-cost providers that would result from increased enrollment in tiered-network plans. In some markets, higher-cost providers may be willing to accept lower rates to improve their relative ranking within a tiered network and thus to regain some losses of market share. Such actions would create larger savings than are estimated here, because tiered networks might put downward pressure on health care prices across entire markets. Alternatively, high-cost, dominant providers might respond in ways that would increase payments. For example, some of them might instead respond by demanding higher prices if they were kept in a less-preferred tier within an insurer's network. In those cases, or when providers seek alternative means of increasing market leverage as described above, overall costs may actually increase.

Pay-As-You-Go Considerations

The Statutory Pay-As-You-Go Act of 2010 establishes budget-reporting and enforcement procedures for legislation affecting on-budget direct spending or revenues. The net changes in outlays and revenues that are subject to those pay-as-you-go procedures are shown in Table 4.

Table 4.
CBO's Estimate of Pay-As-You-Go Effects of S. 1895

	By Fiscal Year, Millions of Dollars												
	2019	2020	2021	2022	2023	2024	2025	2026	2027	2028	2029	2019-2024	2019-2029
Net Increase or Decrease (-) in the On-Budget Deficit													
Statutory Pay-As-You-Go Effect	0	1,885	2,842	2,769	2,422	2,222	162	-2,131	-3,244	-3,460	-3,564	12,140	-98
Memorandum:													
Changes in Outlays	0	1,876	3,689	4,367	4,244	4,180	2,223	255	-665	-759	-726	18,356	18,685
Changes in Revenues	0	-9	847	1,598	1,822	1,959	2,061	2,387	2,580	2,701	2,838	6,216	18,783

Components may not sum to totals because of rounding.

Increase in Long-Term Deficits

CBO estimates that enacting S. 1895 would not increase on-budget deficits by more than $5 billion in any of the four consecutive 10-year periods beginning in 2030.

Mandates

S. 1895 would impose intergovernmental and private-sector mandates as defined in the Unfunded Mandates Reform Act (UMRA).

CBO estimates that the cost of the bill's intergovernmental mandates would average about $100 million annually and that, in each of the first five years the mandates are in effect, those costs would exceed the intergovernmental threshold established in UMRA ($82 million in 2019, adjusted annually for inflation).

CBO also estimates that the cost of the bill's private-sector mandates would average $15 billion annually and that, in each of the first five years the mandates are in effect, those costs would greatly exceed the private sector-threshold established in UMRA ($164 million in 2019, adjusted annually for inflation).

Mandates That Apply to Public and Private Entities

Title I, Ending Surprise Medical Bills. Title I would impose intergovernmental and private-sector mandates by prohibiting surprise billing, requiring insurers to treat certain out-of-network services as in-network services when calculating cost sharing for enrollees, and requiring providers to accept median in-network rates for those services. The cost of those mandates would include both the administrative costs of complying with the new requirements and the receipts forgone from the prohibited billing practices, which would fall primarily on health care providers, such as physicians practicing in hospitals and emergency rooms.

CBO and JCT estimate that provider payment rates would converge around median in-network rates. The agencies anticipate that providers would see their payments either increase or decrease in roughly equal numbers. However, the distribution of payment rates across all providers is highly skewed—some command rates that are well above the median. The decline in payment rates to those providers would lead to an associated decrease in health insurance premiums. As premiums declined, premium tax credits for people who purchase insurance through the marketplaces would fall, and the mix of compensation for employees would shift from tax-favored health insurance to taxable wages. Those effects would result in a decrease in outlays and an increase in tax revenues, on net, of almost $25 billion over the 2019-2029 period. Consistent with that estimate, CBO projects that the cost of private-sector mandates would average roughly $8 billion annually over the first five years that the mandates are in effect.

Because public hospitals' emergency departments also would be affected by the new billing restrictions, title I would impose an intergovernmental mandate. Based on information about the number of public hospitals and the services they provide, CBO estimates that the cost of that mandate would average about $100 million annually over the first five years the mandates are in effect.

Title I would impose similar billing restrictions on operators of air ambulance services by requiring those entities to accept in-network rates. CBO estimates that the cost of those restrictions, in the form of reduced revenues, would average about $30 million annually. Because approximately 15 percent of air ambulance services are operated by public entities, the billing restrictions would impose both an intergovernmental and a private-sector mandate. CBO estimates that lost revenues would average $5 million annually for public entities and $25 million annually for private entities in each of the first five years the mandates are in effect.

Mandates That Apply to Private Entities Only

Title II, Reducing the Prices of Prescription Drugs. Title II would impose several private-sector mandates, primarily on drug and biological product manufacturers:

- Manufacturers would be required to share patent information with the FDA in certain circumstances, including upon approval of biological and biosimilar products and when the Patent Trial and Appeals Board finds a drug patent to be invalid;
- Manufacturers would be required to change generic drug labels to reflect new information and scientific evidence under the FDA's expanded authority; and
- Manufacturers would be required to submit a justification, along with other information, to HHS after increasing the price of a drug over a specified threshold.

Those mandates would impose administrative duties with a small incremental cost relative to current law or would require reporting information that the mandated entities already collect or possess. Therefore, CBO estimates that the cost of complying with title II's provisions would be small.

Title III, Improving Transparency in Health Care. Section 306 of title III would impose mandates on pharmacy benefit managers:

- Spread pricing, which currently allows PBMs to retain the difference between the amount paid to a pharmacy and the amount charged to a health plan, would be prohibited; and
- PBMs would be required to pass through to health plans the full amount of rebates and other remuneration received from drug manufacturers.

Those mandates would impose significant costs on PBMs by restricting commercial activities that now provide substantial revenue. Although CBO expects that PBMs would retain and pursue alternative methods for generating new revenue in response, UMRA does not allow such revenue shifts to be used in calculating the cost of the mandates. On the basis of discussions with stakeholders and using available market and financial data, CBO estimates that the cost of forgone revenues would average approximately $5.2 billion annually during the first five years the mandates are in effect.

Other private-sector mandates also would be imposed by title III:

- It would prohibit health care providers and insurers from entering into contracts that include anti-tiering and anti-steering clauses.
- It would establish notification, cost estimating, and data reporting requirements. Those duties would fall primarily on insurers, health plans, facilities, and providers to submit claims data, provide timely bills to patients, and disclose compensation, among other duties.

Although those mandates are primarily administrative, a large number of entities would have to provide the information. Consequently, compliance would require expenditures of tens of millions of dollars annually.

Title IV, Improving Public Health. Section 414 of title IV would impose a private-sector mandate by prohibiting retailers from selling tobacco products to anyone under the age of 21. CBO expects annual tobacco sales to exceed $120 billion per year in the first few years in which the prohibition is in effect. CBO expects that retailers' revenues would decline—as would tobacco use—as a result of the new prohibition. Using published data on smoking rates and the size of the tobacco retail market, and accounting for the portion of the market attributable to 18- to 21-year-olds (who can purchase tobacco products legally under current law), CBO estimates that the mandate would reduce retailer revenue by about $1.6 billion annually in the first five years the mandate is in effect.

Title V, Improving the Exchange of Information. Section 501 of title V would impose a private-sector mandate by requiring insurers to publish historical claims and payment data for all of their enrollees, directory information for all in-network providers, and estimated patient out-of-pocket costs imposed through cost-sharing requirements. CBO expects that the volume of required information and disclosures would be significant for the mandated insurers and that mandated entities would spend tens of millions of dollars annually to comply.

Other Effects

As noted above, section 414 would prohibit the sale of tobacco products to anyone under the age of 21. Taxes on tobacco products are a significant source of revenue for state and local governments, totaling between $17 and $20 billion annually in recent years. CBO anticipates that the bill would decrease tobacco use, and that revenue collected by state and local governments would fall by an estimated $255 million annually. However, those losses would be indirect costs, because the mandate would fall on retailers and not on state or local governments. Those effects would be smaller in the 16 states and the District of Columbia that already prohibit sales to anyone under the age of 21.

Title IV also would provide grants to states and private entities to carry out programs to improve various health outcomes. Over the 2020-2024 period, CBO estimates, about $330 million would be available to eligible grantees for those programs.

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Supplemental Table 1.
Estimated Effect of S. 1895 on Direct Spending and Revenues

By Fiscal Year, Millions of Dollars

	2019	2020	2021	2022	2023	2024	2025	2026	2027	2028	2029	2019-2024	2019-2029
Increases or Decreases (-) in Direct Spending													
Title I, Ending Surprise Medical Bills													
Estimated Budget Authority	0	0	-54	-110	-122	-124	-131	-138	-140	-142	-147	-410	-1,107
Estimated Outlays	0	0	-54	-110	-122	-124	-131	-138	-140	-142	-147	-410	-1,107
Title II, Reducing the Prices of Prescription Drugs													
203. Ensuring timely access to generics													
Estimated Budget Authority	0	-10	-17	-20	-20	-20	-22	-23	-25	-28	-26	-87	-212
Estimated Outlays	0	-10	-17	-20	-20	-20	-22	-23	-25	-28	-26	-87	-212
205. Preventing blocking of generic drugs													
Estimated Budget Authority	0	0	-12	-32	-37	-37	-42	-44	-47	-54	-50	-118	-356
Estimated Outlays	0	0	-12	-32	-37	-37	-42	-44	-47	-54	-50	-118	-356
211. Prompt approval of drugs related to safety information													
Estimated Budget Authority	0	-3	-9	-13	-13	-13	-15	-16	-17	-19	-18	-52	-137
Estimated Outlays	0	-3	-9	-13	-13	-13	-15	-16	-17	-19	-18	-52	-137
214. Actions for delays of generic drugs and biosimilar biological products													
Estimated Budget Authority	0	0	-45	-170	-295	-348	-404	-428	-454	-514	-478	-857	-3,135
Estimated Outlays	0	0	-45	-170	-295	-348	-404	-428	-454	-514	-478	-857	-3,135
Title III, Improving Transparency in Health Care													
303. Designation of a nongovernmental, nonprofit transparency organization to lower Americans' health care costs													
Budget Authority	0	20	0	0	0	0	0	0	0	0	0	20	20
Estimated Outlays	0	5	10	5	0	0	0	0	0	0	0	20	20
306. Health plan oversight of pharmacy benefit manager services													
Estimated Budget Authority	0	-1	-15	-17	-12	-8	-5	-4	-3	-3	-2	-53	-70
Estimated Outlays	0	-1	-15	-17	-12	-8	-5	-4	-3	-3	-2	-53	-70
Title IV, Improving Public Health													
411. Extension for community health centers, the national health service corps, and teaching health centers that operate GME programs													
Budget Authority	0	4,437	4,437	4,437	4,437	4,437	0	0	0	0	0	22,183	22,183
Estimated Outlays	0	1,799	3,576	4,415	4,430	4,430	2,631	854	16	0	0	18,651	22,152
412. Extension of Special Diabetes for NIH and Indian Health Services													
Budget Authority	0	300	300	300	300	300	0	0	0	0	0	1,500	1,500
Estimated Outlays	0	88	244	291	296	297	214	58	9	5	0	1,215	1,500
414. Minimum age of sale of tobacco products													
Estimated Budget Authority	0	-2	-5	-7	-8	-9	-10	-11	-12	-12	-13	-32	-90
Estimated Outlays	0	-2	-5	-7	-8	-9	-10	-11	-12	-12	-13	-32	-90
Title V, Improving the Exchange of Health Information													
501. Requirement to provide health claims, network, and cost information													
Estimated Budget Authority	0	0	16	23	23	10	5	5	5	6	6	72	99
Estimated Outlays	0	0	16	23	23	10	5	5	5	6	6	72	99
Total Changes In Direct Spending													
Budget Authority	0	4,740	4,595	4,391	4,252	4,187	-624	-659	-692	-767	-729	22,165	18,695
Outlays	0	1,876	3,688	4,365	4,242	4,178	2,220	253	-667	-762	-729	18,348	18,664
On-budget outlays	0	1,876	3,689	4,367	4,244	4,180	2,223	255	-665	-759	-726	18,356	18,685
Off-budget outlays	0	*	-1	-2	-2	-3	-3	-3	-3	-3	-3	-8	-21

Supplemental Table 1.
Estimated Effect of S. 1895 on Direct Spending and Revenues

By Fiscal Year, Millions of Dollars

	2019	2020	2021	2022	2023	2024	2025	2026	2027	2028	2029	2019-2024	2019-2029
Increases or Decreases (-) in Revenues													
Title I, Ending Surprise Medical Bills	0	0	1,027	2,025	2,354	2,506	2,651	3,001	3,228	3,396	3,585	7,912	23,774
Title II, Reducing the Prices of Prescription Drugs													
203. Ensuring timely access to generics	0	2	3	4	4	4	4	5	5	5	5	17	41
205. Preventing blocking of generic drugs	0	0	3	6	7	7	8	8	9	9	11	23	68
211. Prompt approval of drugs related to safety information	0	1	2	2	3	3	3	3	3	4	4	10	27
214. Actions for delays of generic drugs and biosimilar biological products	0	0	9	31	56	70	76	85	91	95	99	165	609
Title III, Improving Transparency in Health Care													
302. Banning anticompetitive terms in facility and insurance contracts that limit access to higher quality, lower cost care	0	7	34	61	88	110	122	142	158	171	186	300	1,080
306. Health plan oversight of pharmacy benefit manager services	0	26	245	282	224	186	154	144	129	109	87	963	1,585
Title IV, Improving Public Health													
414. Minimum age of sale of tobacco products	0	-34	-56	-63	-67	-72	-77	-81	-85	-89	-94	-292	-718
Title V, Improving the Exchange of Health Information													
501. Requirement to provide health claims, network, and cost information	0	0	-35	-50	-51	-22	-11	-12	-13	-14	-14	-158	-223
Total Changes In Revenues	0	2	1,231	2,299	2,617	2,791	2,929	3,294	3,525	3,685	3,868	8,940	26,242
On-budget revenues	0	-9	847	1,598	1,822	1,959	2,061	2,387	2,580	2,701	2,838	6,216	18,783
Off-budget revenues	0	11	384	701	795	833	868	908	946	984	1,030	2,724	7,459
Net Increases or Decreases (-) in the Deficit From Changes in Direct Spending and Revenues													
Effect on the Deficit	0	1,874	2,457	2,066	1,625	1,387	-708	-3,042	-4,192	-4,447	-4,597	9,408	-7,578
On-budget	0	1,885	2,842	2,769	2,422	2,222	162	-2,131	-3,244	-3,460	-3,564	12,140	-98
Off-budget	0	-11	-385	-703	-797	-835	-870	-910	-948	-987	-1,033	-2,732	-7,480

The estimates in this table also are shown at the title level in Table 2.
Components may not sum to totals because of rounding; GME = graduate medical education; NIH = National Institutes of Health; * = between -$500,000 and zero.

Supplemental Table 2.

Estimated Increases in Spending Subject to Appropriation Under S. 1895

	By Fiscal Year, Millions of Dollars						
	2019	2020	2021	2022	2023	2024	2019-2024
Title I, Ending Surprise Medical Bills							
Estimated Authorization	0	5	5	2	2	1	14
Estimated Outlays	0	5	5	2	2	1	14
Title II, Reducing the Prices of Prescription Drugs							
Administrative Costs to the Food and Drug Administration							
Estimated Authorization	0	9	5	5	5	5	28
Estimated Outlays	0	7	6	6	5	5	28
Effects on Other Federal Health Programs From Sections 203, 205, 211, and 214							
Estimated Authorization	0	-2	-13	-33	-51	-57	-155
Estimated Outlays	0	-2	-13	-33	-52	-58	-157
Other Costs to the Department of Health and Human Services							
Estimated Authorization	0	1	1	*	*	*	2
Estimated Outlays	0	1	1	*	*	*	2
Title III, Improving Transparency in Health Care							
302. Banning anticompetitive terms in facility and insurance contracts that limit access to higher quality, lower cost care							
Estimated Authorization	0	1	1	0	0	0	1
Estimated Outlays	0	1	1	0	0	0	1
303. Designation of a nongovernmental, nonprofit transparency organization to lower Americans' health care costs							
Estimated Authorization	0	100	15	15	15	15	161
Estimated Outlays	0	12	43	49	20	15	140
305. Timely bills for patients							
Estimated Authorization	0	1	1	0	0	0	1
Estimated Outlays	0	1	1	0	0	0	1
306. Health plan oversight of pharmacy benefit manager services							
Estimated Authorization	0	2	2	1	1	1	6
Estimated Outlays	0	2	2	1	1	1	6
307. Government Accountability Office study on profit- and revenue-sharing in health care							
Estimated Authorization	0	*	*	0	0	0	*
Estimated Outlays	0	*	*	0	0	0	*
308. Disclosure of direct and indirect compensation for brokers and consultants to employer-sponsored health plans and enrollees in plans on the individual market							
Estimated Authorization	0	1	1	*	*	*	2
Estimated Outlays	0	1	1	*	*	*	2
310. Strengthening parity in mental health and substance use disorder benefits							
Estimated Authorization	0	1	1	*	*	*	2
Estimated Outlays	0	1	1	*	*	*	2
313. Group health plan reporting requirements							
Estimated Authorization	0	1	1	*	*	*	2
Estimated Outlays	0	1	1	*	*	*	2
314. Study by Comptroller General of United States							
Estimated Authorization	0	*	*	*	0	0	1
Estimated Outlays	0	*	*	*	0	0	1

Supplemental Table 2.

Estimated Increases in Spending Subject to Appropriation Under S. 1895

	By Fiscal Year, Millions of Dollars						
	2019	2020	2021	2022	2023	2024	2019-2024
Title IV, Improving Public Health							
401. Improving awareness of disease prevention							
Estimated Authorization	0	3	3	3	1	1	10
Estimated Outlays	0	1	2	2	2	2	9
402. Grants to address vaccine-preventable diseases							
Estimated Authorization	0	7	7	7	7	7	36
Estimated Outlays	0	*	3	6	7	7	22
403. Guide on evidence-based strategies for public health department obesity prevention programs							
Estimated Authorization	0	1	1	1	1	1	5
Estimated Outlays	0	*	1	1	1	1	4
404. Expanding capacity for health outcomes							
Estimated Authorization	0	14	14	14	14	14	71
Estimated Outlays	0	*	7	12	14	14	46
405. Public health data system modernization							
Estimated Authorization	0	51	52	54	55	56	268
Estimated Outlays	0	18	42	50	53	55	218
406. Innovation for maternal health							
Estimated Authorization	0	*	*	1	1	1	2
Estimated Outlays	0	*	*	*	1	1	2
407. Training for health care providers							
Estimated Authorization	0	5	5	5	5	5	27
Estimated Outlays	0	*	3	4	5	5	18
408. Study on training to reduce and prevent discrimination							
Estimated Authorization	0	1	1	1	0	0	3
Estimated Outlays	0	1	1	1	0	0	3
410. Integrated services for pregnant and postpartum women							
Estimated Authorization	0	5	5	5	5	5	24
Estimated Outlays	0	*	1	4	5	4	14
415. Sale of tobacco products to individuals under the age of 21							
Estimated Authorization	0	19	19	19	19	19	93
Estimated Outlays	0	6	16	19	19	19	78
Title V, Improving the Exchange of Health Information							
501. Requirement to provide health claims, network, and cost information							
Estimated Authorization	0	1	1	0	0	0	1
Estimated Outlays	0	1	1	0	0	0	1
503. Government Accountability Office study on the privacy and security risks of electronic transmission of individually identifiable health information to and from entities not covered by the Health Insurance Portability and Accountability Act							
Estimated Authorization	0	*	*	0	0	0	*
Estimated Outlays	0	*	*	0	0	0	*
Total Changes In Discretionary Spending							
Estimated Authorization	**0**	**225**	**128**	**101**	**79**	**74**	**607**
Estimated Outlays	**0**	**56**	**125**	**125**	**81**	**71**	**458**

The estimates in this table also are shown in various levels of aggregation in Table 3.
Components may not sum to totals because of rounding; * = between and zero and $500,000.