Congressional Budget Office
Cost Estimate

September 18, 2019

At a Glance

H.R. 2328, Reauthorizing and Extending America's Community Health Act

As ordered reported by the House Committee on Energy and Commerce on July 17, 2019

By Fiscal Year, Millions of Dollars	2019	2019-2024	2019-2029
Direct Spending (Outlays)	0	40,394	41,027
Revenues	0	6,631	20,938
Increase or Decrease (-) in the Deficit	0	33,764	20,090
Spending Subject to Appropriation (Outlays)	0	67	not estimated

Statutory pay-as-you-go procedures apply?	Yes
Increases on-budget deficits in any of the four consecutive 10-year periods beginning in 2030?	No

Mandate Effects

Contains intergovernmental mandate?	Yes, Over Threshold
Contains private-sector mandate?	Yes, Over Threshold

The bill would

- Extend funding for public health programs including those that support health centers and health education
- Extend funding for several programs financed through the Medicare trust funds, change some other aspects of Medicare, and change supplemental coverage for some military retirees
- Reduce scheduled funding cuts to state allotments to hospitals that treat a disproportionate share of uninsured and Medicaid patients
- Protect patients from surprise medical billing and reduce payments to some health care providers working in facilities where surprise bills are likely
- Increase funding for Medicaid in the U.S. territories
- Impose intergovernmental and private-sector mandates by prohibiting surprise medical billing

Estimated budgetary effects would primarily stem from

- Increased funding for public health programs
- Changes to Medicare coverage and payment rules
- Increased Medicaid spending on payments to hospitals and to the U.S. territories
- Reduced federal subsidies for health care and health insurance

Areas of significant uncertainty include

- Estimating coverage choices for military retirees and trends in prostate cancer testing and treatment
- Accurately projecting how states would respond to scheduled reductions in funding for hospital payments
- Accurately anticipating the nature and effects of provider and insurer responses to the bill's provisions that address surprise bills
- Estimating what the U.S. territories would spend on Medicaid

Detailed estimate begins on the next page.

Bill Summary

H.R. 2328 would extend funding for several federal public health programs, change portions of Medicare, and reduce scheduled cuts to allotments for Medicaid disproportionate share hospitals (DSH) that defray the costs of treating uninsured and Medicaid patients. In addition, H.R. 2328 would protect patients from surprise medical bills, and it would reduce payments to health care providers who work in facilities where surprise bills are likely, particularly providers of emergency care and ancillary services such as anesthesia. The bill also would increase federal funding for Medicaid in the U.S. territories.

Estimated Federal Cost

The estimated budgetary effect of H.R. 2328 is shown in Table 1. The costs of the legislation fall within budget functions 500 (education, training, employment, and social services), 550 (health), and 570 (Medicare).

Basis of Estimate

For this estimate, CBO assumes that the bill will be enacted near the end of 2019 and that the specified and estimated authorization of appropriations will be provided each year. Outlay estimates are based mainly on historical spending patterns for affected programs.

Direct Spending and Revenues

CBO and the staff of the Joint Committee on Taxation (JCT) estimate that enacting H.R. 2328 would increase direct spending by about $41.0 billion and increase revenues by $20.9 billion over the 2019-2029 period, for a net increase in the deficit of $20.1 billion.

Title I, Public Health Extenders. Title I would extend funding for several federal health care programs. CBO estimates that over the 2019-2029 period, title I would increase direct spending by $19.5 billion.

Section 101, 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 2023, section 101 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. CBO estimates that enacting section 101 would increase direct spending by $17.7 billion over the 2019-2029 period.

Table 1.
Estimated Budgetary Effects of H.R. 2328

	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, Public Health Extenders													
Budget Authority	0	4,887	4,887	4,887	4,887	0	0	0	0	0	0	19,546	19,546
Estimated Outlays	0	1,892	3,887	4,833	4,868	2,981	985	40	6	0	0	18,461	19,491
Title II, Medicare Extenders													
Estimated Budget Authority	0	1,005	1,402	1,476	240	-6	-14	-7	9	11	21	4,117	4,137
Estimated Outlays	0	1,004	1,402	1,476	241	-6	-14	-7	9	11	21	4,117	4,137
Title III, Medicaid Provisions													
Estimated Budget Authority	0	1,385	3,201	1,790	0	0	0	0	0	0	0	6,375	6,375
Estimated Outlays	0	1,385	3,201	1,790	0	0	0	0	0	0	0	6,375	6,375
Title IV, No Surprises Act													
Estimated Budget Authority	0	1	-45	-91	-103	-106	-114	-122	-126	-131	-137	-345	-976
Estimated Outlays	0	1	-45	-91	-103	-106	-114	-122	-126	-131	-137	-345	-976
Title V, Territories Health Care Improvement Act													
Estimated Budget Authority	0	2,759	2,829	2,896	2,981	321	214	0	0	0	0	11,786	12,000
Estimated Outlays	0	2,759	2,829	2,896	2,981	321	214	0	0	0	0	11,786	12,000
Total Changes in Direct Spending													
Estimated Budget Authority	0	10,036	12,273	10,958	8,004	209	86	-129	-117	-120	-116	41,480	41,082
Estimated Outlays	0	7,040	11,274	10,904	7,986	3,190	1,071	-89	-112	-120	-116	40,394	41,027
Increases or Decreases (-) in Revenues													
Title IV, No Surprises Act													
Estimated Change in Revenues	0	-2	849	1,675	1,972	2,137	2,300	2,651	2,903	3,110	3,342	6,631	20,938
On-budget revenues	0	-1	603	1,189	1,399	1,521	1,639	1,942	2,146	2,303	2,477	4,711	15,218
Off-budget revenues	0	-1	246	486	572	616	661	709	757	807	865	1,920	5,719
Net Increase or Decrease (-) in the Deficit from Changes in Direct Spending and Revenues													
Total Effect on the Deficit	0	7,042	10,425	9,230	6,015	1,052	-1,230	-2,741	-3,015	-3,230	-3,459	33,764	20,090
On-budget deficits	0	7,042	10,671	9,716	6,587	1,668	-569	-2,031	-2,258	-2,423	-2,594	35,683	25,809
Off-budget deficits	0	1	-246	-486	-572	-616	-661	-709	-757	-807	-865	-1,920	-5,719
Increases in Spending Subject to Appropriation													
Estimated Authorization	0	58	8	2	1	1	n.e.	n.e.	n.e.	n.e.	n.e.	70	n.e.
Estimated Outlays	0	14	28	20	4	1	n.e.	n.e.	n.e.	n.e.	n.e.	67	n.e.

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

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

Section 102, Extension of the Special Diabetes Programs for the National Institutes of Health and the Indian Health Service. For each fiscal year from 2020 through 2023, section 102 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. CBO estimates that enacting section 102 would increase direct spending by $1.2 billion over the 2019-2029 period.

Section 104, Extension of the Personal Responsibility Education Program. Section 104 would appropriate $75 million per year for each year from 2020 through 2023 for the Personal Responsibility Education Program, which funds youth education about abstinence from sexual activity as well as about contraception and other topics. CBO estimates that enacting this provision would cost $288 million over the 2019-2029 period.

Section 105, Extension of the Sexual Risk Avoidance Education Program. Section 105 would appropriate $75 million per year for each year from 2020 through 2023 for the Sexual Risk Avoidance Education Program, which funds youth education about abstinence. CBO estimates that enacting this provision would cost $280 million over the 2019-2029 period.

Title II, Medicare Extenders. Title II would extend and increase funding for several programs that are financed through the Medicare trust funds. The title also would change military retirees' health care options and change some aspects of Medicare. CBO estimates that over the 2019-2029 period, title II would increase direct spending by $4.1 billion.

Section 201, Extension of the Work Geographic Index Floor Under the Medicare Program. Section 201 would extend a provision of current law that increases payments to rural physicians through calendar year 2022. Those increased payments are currently set to expire on December 31, 2019. Based on current spending for the physician fee schedule in those rural areas, CBO estimates that enacting section 201 would cost $1.7 billion over the 2019-2029 period.

Section 202, Extension of Funding Outreach and Assistance for Low-Income Programs. Section 202 would extend and increase funding for some entities that provide education and support to Medicare beneficiaries who are eligible for low-income assistance through fiscal year 2022. Those entities are the State Health Insurance Assistance Programs, Area Agencies on Aging, Aging and Disability Resource Centers, and the National Center for Benefits Outreach and Enrollment, and their funding is currently set to expire on September 30, 2019. CBO estimates that enacting section 202 would cost $150 million over the 2019-2029 period.

Section 203, Extension of Funding for Quality Measure Endorsement, Input, and Selection Under the Medicare Program. For each fiscal year from 2020 through 2022, section 203 would appropriate $30 million for a contract between the Department of Health and Human Services (HHS) and a consensus-based entity that would endorse standardized measures of

performance in health care. CBO estimates that enacting section 203 would increase direct spending by $90 million over the 2019-2029 period.

Section 204, Extension of the Independence at Home Medical Practice Demonstration Program Under the Medicare Program. Section 204 would extend the Independence at Home demonstration through calendar year 2023. Funding for the demonstration is currently set to expire on December 31, 2019. Based on the additional payments made in 2018 to participants in the demonstration, CBO estimates that enacting section 204 would cost $40 million over the 2019-2029 period.

Section 205, Extension of Appropriations and Transfers to the Patient-Centered Outcomes Research Trust Fund and of Certain Health Insurance Fees. Under current law, amounts collected by the Patient-Centered Outcomes Research Trust Fund are spent as they are collected; however, the authority of the trust fund to collect funds will expire on September 30, 2019. Section 205 would extend through fiscal year 2022 all three current sources of funding to the Patient-Centered Outcomes Research Trust Fund: transfers from the Medicare trust funds, fees on certain health insurance policies, and other mandatory appropriations, which are set to expire on September 30, 2019. CBO estimates that enacting section 205 would increase direct spending by $2.1 billion over the 2019-2029 period. Those changes and the basis of CBO's estimate are explained in more detail in CBO's estimate for H.R. 3439, the PATIENTS Act, as ordered reported by the House Committee on Ways and Means on June 26, 2019, which CBO transmitted on September 12, 2019.

Section 207, the Health Equity and Access for Returning Troops and Servicemembers Act of 2019. The HEARTS Act would make several changes to health care programs for military retirees and to the Medicare program. CBO estimates that enacting section 207 would decrease net direct spending by $63 million over the 2019-2029 period. Those changes and the basis of CBO's estimate are explained in more detail in CBO's estimate for H.R. 3429, the HEARTS and Rural Relief Act, as ordered reported by the House Committee on Ways and Means on June 26, 2019, which CBO transmitted on September 10, 2019.

In brief, Section 207 would modify the rules under which TRICARE, the health benefits plan for retirees of the armed forces and their families, coordinates with Medicare. Section 207 also would require Medicare coverage of the DNA specimen provenance assay test for men who test positive for prostate cancer, and would provide $5 million for certain improvements to the Medicare fee-for-service program in fiscal year 2024.

Section 208, Exclusion of Complex Rehabilitative Manual Wheelchairs From Medicare Competitive Acquisition Program; Non-Application of Medicare Fee-Schedule Adjustments for Certain Wheelchair Accessories and Cushions. Section 208 would modify payments for specific wheelchairs and wheelchair accessories covered by Medicare. CBO estimates that enacting the provision would increase direct spending by about $100 million over the 2020-2029 period. Section 208 is identical to a provision included in H.R. 3429, the

HEARTS and Rural Relief Act of 2019, and CBO's estimating methodology is explained in detail in that estimate.

Title III, Medicaid Provisions. Each year, states receive DSH allotments to cover payments to hospitals that treat a disproportionate share of uninsured and Medicaid patients (in 2018 the allotments totaled $12 billion). Under current law, those allotments will be cut by $4 billion in 2020 and by $8 billion in each year over the 2021-2025 period. Section 301 would eliminate the reductions for 2020 and 2021 and decrease the reduction in 2022 to $4 billion. CBO estimates that enacting this provision would increase net direct spending by $6.4 billion over the 2020-2029 period.

That estimated increase in outlays is smaller than the total change to the DSH allotments ($16 billion) for two main reasons. First, some states do not spend all of their allotments. Second, CBO expects that under current law states will respond to reduced DSH allotments starting in 2020 by increasing hospital payments either in the form of higher payments for services or in other supplemental payments. In its baseline projections, CBO estimates that increases in those types of payments would mean that the decline in spending for Medicaid payments to hospitals would be smaller than the actual reductions to DSH allotments.

Title IV, No Surprises Act. Title IV would establish patient protections from surprise medical billing and reduce payments to some health care providers who work in facilities where surprise bills are likely. CBO and JCT estimate that lower payments to some providers would reduce the cost of health insurance subsidized by the federal government—through the health insurance marketplaces established under the Affordable Care Act (ACA) and employment-based plans. Because lower premiums for private health insurance affect outlays and revenues alike, 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, over the 2019-2029 period, enacting title IV would increase revenues by $20.9 billion and reduce direct spending by $1.0 billion, for a total reduction in the deficit of about $21.9 billion over that period.

In affected markets in most years, premiums would be about 1 percent lower than they are projected to be under current law. That decline 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.

Under H.R. 2328, CBO and JCT anticipate that 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 agencies also expect that over time, payment rates for affected providers would increase somewhat more slowly because changes in the median in-network rate would be tied to the rate of growth in the consumer price index for all urban consumers (CPI-U) and the pace of CPI-U growth lags behind that of payment rates for affected providers. Lower average payment rates combined with downward pressure on the growth of payment rates in future years would lower insurers' health care spending on services delivered in facilities where surprise bills are likely. That reduced spending would spur reductions in premiums for private health insurance.

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) and any increase in the use of health care resulting from improved out-of-network coverage.

The bill would create new administrative costs for insurers, most notably for participation in an independent dispute resolution (IDR) process to settle disagreements between providers and health plans concerning out-of-network medical bills.

In addition to creating new administrative costs, CBO and JCT expect that the IDR process would further offset the expected reductions in premiums stemming from H.R. 2328 by almost 25 percent (relative to a policy that was identical but did not include IDR). That estimated reduction in savings reflects the agencies' assessment that the IDR process would be likely to result in larger payment rates to providers.

In addition to projecting a net reduction in premiums for private health insurance, CBO and JCT anticipate that the number of people who claim the itemized medical tax deduction would decrease slightly, increasing federal revenues.

Surprise Medical Bills. Under H.R. 2328, 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 such practices 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 IV of H.R. 2328 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 IV 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.

Beginning in 2021, under H.R. 2328 an IDR process would be implemented by the Secretary of Health and Human Services in consultation with the Secretary of Labor for disputes over out-of-network bills above $1,250. That threshold would increase annually to keep pace with growth in the CPI-U. Under the process, if either party chose to pursue IDR, the provider and the health plan would each submit their final offers for reimbursement or payment, and the IDR entity would determine which was the more reasonable. Under title IV, the IDR entity would consider the median contracted rate for the disputed service and account for additional circumstances as reflected in information submitted by the provider or the health plan. Those conditions could include the extent of the provider's expertise and the severity and complexity of the patient's condition.

Effects on Private Insurance Premiums. CBO and JCT anticipate that title IV 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 exert downward pressure on the growth in payment rates for providers who practice in facilities where surprise bills are likely;
- It would require insurers to pay median in-network rates for most out-of-network care in situations involving surprise bills;
- It would require insurers to pay the amount determined by an IDR entity for the remainder of surprise bills for out-of-network care;
- 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 IV 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 government.

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 IV 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 IV of H.R. 2328, 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 markedly 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 IV 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 H.R. 2328. 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 addition to causing prices to converge at median in-network rates, H.R. 2328's implementation would exert downward pressure on the growth of payment rates for providers practicing in facilities where surprise bills are likely. That downward pressure would result from defining the median in-network rate as the 2019 rate and increasing that rate to keep pace with growth in the CPI-U. Data on the historical growth in provider payments suggests that for facility-based physicians over the past decade, payment rates generally have grown at nearly twice the rate of growth in the CPI-U.[2] CBO and JCT

2. See Zack Cooper and others, "Hospital Prices Grew Substantially Faster Than Physician Prices for Hospital-Based Care in 2007-14," *Health Affairs*, vol. 38, no. 2, pp. 184-189, https://doi.org/10.1377/hlthaff.2018.05424; and Erin Trish and others, "Physician Reimbursement in Medicare Advantage Compared With Traditional Medicare and Commercial Health Insurance," *JAMA Internal Medicine*, vol. 177, no. 9, pp. 1287-1295, September 2017, https://doi.org/10.1001/jamainternmed.2017.2679.

estimate that H.R. 2328 would slow the growth of in-network payments relative to current law by matching growth in out-of-network payment rates to the CPI-U.

Although providers and health plans alike would be allowed to pursue the IDR process, CBO and JCT expect that providers would be more likely to initiate the process. That assessment is informed by conversations with stakeholders, language in H.R. 2328 that directs IDR entities to consider providers' expertise and patient characteristics, and the fact that default payment rates for out-of-network care are projected to be lower than the rate providers are paid under current law. The agencies expect that providers would initiate the IDR process if they believe they should be paid more than the median in-network rate for a particular service.

CBO and JCT expect that the availability of the IDR process would affect negotiations between providers and health plans. Some providers—now paid at higher-than-average rates because they have higher costs or provide more specialized services—might be able to negotiate larger payments from insurers under H.R. 2328 by threatening to initiate the IDR process for reimbursement of out-of-network bills. The agencies estimated the extent to which premiums would decrease under H.R. 2328 in the absence of the IDR process and then reduced that estimate by almost 25 percent to account for the higher payments to some providers resulting from the IDR process.

Other Effects on Premiums. Although the most significant budgetary effects of title IV 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 H.R. 2328, 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 IV 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 the expenses of calculating median in-network rates, submitting the required documentation about new rates to the applicable regulatory

authorities, acquiring external data to estimate median in-network rates in markets for which there are insufficient data to calculate rates, and complying with the IDR process. H.R. 2328 specifies that the party with the less reasonable offer in the judgment of the IDR entity would pay the costs of the process. CBO and JCT expect that those costs eventually would be passed on to enrollees in the form of higher premiums and estimate that, in total, administrative costs under the bill would increase the federal deficit by more than $100 million over the 2019-2029 period: Roughly 95 percent of that amount would be the costs associated with the IDR process.

Effects on the Medical Tax Deduction. By eliminating surprise bills, title IV would reduce the number of people who qualify for and claim the itemized medical tax deduction. Under current law, CBO and JCT estimate, 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 V, Territories Health Care Improvement Act. Title V would increase the amount of Medicaid funds available to the U.S. territories and increase the federal medical assistance percentage (FMAP) they receive under the program for the 2020-2025 period. Based on historical spending patterns in each territory, CBO estimates that over the 2019-2029 period, title V would increase direct spending by $12 billion.

Under current law, U.S. territories operate their Medicaid programs with federal assistance that is capped each year. Once spending by a territory has reached the cap, the program must be funded with local money. Despite that requirement, the Congress has provided temporary increases in the past. Before the enactment of the ACA, for example, the capped amount available to the U.S. territories in total was between $400 million and $475 million in each year over the 2011-2019 period. The ACA provided the U.S. territories with $7.3 billion in additional funds for the period from July 1, 2011, through September 30, 2019, which increased the cap for each year by $885 million. Those increases are scheduled to expire at the end of the current fiscal year.

Section 502 would raise the total annual cap for American Samoa, the Commonwealth of the Northern Mariana Islands, Guam, and the U.S. Virgin Islands by more than $300 million over the 2020-2025 period. That provision also would raise Puerto Rico’s cap by $2.4 billion, to $2.7 billion each year for the 2020-2024 period. Finally, the FMAP for each territory would be increased temporarily from about 55 percent to range between 76 percent and 100 percent, depending on the territory and the year. The enhanced FMAP would end when the territory’s annual cap reverted to its lower limit.

Spending Subject to Appropriation

CBO estimates that implementing H.R. 2328 would cost $67 million over the 2019-2024 period (see Table 2).

Table 2.
Estimated Increases in Spending Subject to Appropriation Under H.R. 2328

	By Fiscal Year, Millions of Dollars						
	2019	2020	2021	2022	2023	2024	2019-2024
Title III, Medicaid Provisions							
Sections 302 and 303, Public Availability of Hospital Upper Payment Limit Demonstrations, GAO Report							
Estimated Authorization	0	*	*	0	0	0	1
Estimated Outlays	0	*	*	0	0	0	1
Title IV, No Surprises Act							
HHS Regulation, Implementation, Enforcement, and Reporting Activities							
Estimated Authorization	0	4	4	1	1	1	11
Estimated Outlays	0	4	4	1	1	1	11
Department of Labor Regulation, Implementation, Enforcement, and Reporting Activities							
Estimated Authorization	0	2	2	*	*	*	5
Estimated Outlays	0	2	2	*	*	*	5
Section 404, State All-Payer Claims Databases							
Authorization	0	50	0	0	0	0	50
Estimated Outlays	0	6	20	19	2	0	47
Sections 403 and 408 GAO Reports							
Estimated Authorization	0	1	1	*	*	0	2
Estimated Outlays	0	1	1	*	*	0	2
Title V, Territories Health Care Improvement Act							
Section 504. Additional Program Integrity Requirements							
Estimated Authorization	0	*	*	0	0	0	1
Estimated Outlays	0	*	*	*	0	0	1
Total Changes							
Estimated Authorization	**0**	**58**	**8**	**2**	**1**	**1**	**70**
Estimated Outlays	**0**	**14**	**28**	**20**	**4**	**1**	**67**

Components may not sum to totals because of rounding.
GAO = Government Accountability Office; HHS = Department of Health and Human Services; * = between zero and $500,000.

Several sections of H.R. 2328 would authorize activities subject to appropriations. Only one section specifies an authorization amount. That provision, section 404, would authorize the appropriation of $50 million for grants to states to establish and maintain state all-payer claims databases, which compile medical, pharmacy, and dental claims reported to states by insurers. That amount shows up as an authorization in 2020, which is the first year that CBO anticipates funding would be available. CBO estimates that enacting section 404 would cost $47 million over the 2019-2024 period.

CBO estimates that the other provisions would increase discretionary costs as follows:

- Section 302 would require the HHS Secretary to publish state Medicaid programs' reports on hospital services under the Upper Payment Limit demonstrations of the Centers for Medicare & Medicaid Services. CBO estimates that requirement would cost less than $500,000 over the 2019-2024 period.
- Various sections of the bill would direct the Government Accountability Office to report on policy considerations for establishing a formula for states' DSH allotments (section 303), on profit and revenue sharing in commercial health care markets (section 403), and on the effects of H.R. 2328 (section 408), at a total estimated cost of $2 million over the 2019-2024 period.
- Section 504 would require the HHS Office of Inspector General to provide the Congress with a plan for auditing and investigating contracts within Puerto Rico's Medicaid program and to audit any aspects of the program that are determined to be at high risk of waste, fraud, or abuse. CBO estimates that meeting those program integrity requirements would cost $1 million over the 2019-2024 period.
- Title IV 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 the costs would be $11 million for HHS and $5 million for the Department of Labor over the 2019-2024 period.

Uncertainty

Because H.R. 2328 would affect a wide swath of the nation's health care system, CBO's estimate of its budgetary effects is subject to uncertainty in many areas, particularly provisions that concern Medicare, Medicaid payments for hospitals, surprise medical billing, and Medicaid funding in the U.S. territories.

Title II, Medicare Extenders. The number of TRICARE beneficiaries who would choose to forgo enrollment in Medicare Part B under the new rules proposed by Title II could be different from CBO's estimate, and thus, the estimated federal cost of this provision could be higher or lower than CBO estimates.

CBO's estimate for the provision of section 207 that concerns testing for prostate cancer is based on recent trends in testing and treatment of that disease. Over time, treatment options could change and thus affect the costs of averting treatment.

Title III, Medicaid Provisions. The estimated cost under section 301 for decreasing reductions in Medicaid DSH allotments is subject to significant uncertainty because the response by states to the currently scheduled cuts is uncertain. CBO expects that some states will offset a portion of the reduced payments under current law by increasing payments for services or by increasing other lump-sum payments. However, the number of states that

make such offsetting increases and the degree to which they might do so are uncertain. If states increase other types of payments to hospitals either more or less than CBO anticipates, that would affect the reduction in hospital spending that CBO projects under current law. The uncertainty under current law is equally applicable to CBO's estimates of the effects of section 301.

Title IV, No Surprises Act. CBO and JCT's estimate of the surprise-billing provisions of H.R. 2328 is subject to significant uncertainty about payment rates for health care providers. The agencies expect that prices would converge around median in-network rates, but they cannot precisely estimate how close that convergence would be. The bill also could spur changes in provider and insurer consolidation and integration, which might dramatically affect payment rates.

A related source of uncertainty concerns implementation of title IV at both the federal and the state level: The bill does not specify a methodology for calculating current 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 those rates. Moreover, under title IV, 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 rates in a given area or for a given specialty. CBO and JCT could not determine how an 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 cannot accurately determine how often providers or health plans would enter into the IDR process, the final offers they would submit to the IDR entities, how often the IDR entities would side with providers or with insurers, or the effects that IDR outcomes would have on negotiated payment rates. Although CBO and JCT anticipate that the IDR provisions in title IV would create upward pressure on payment rates, the size of that effect is quite uncertain.

Title V, Territories Health Care Improvement Act. CBO's budgetary estimates for title V are uncertain because they rely on underlying projections that also are uncertain. Specifically, CBO's estimates of increased federal Medicaid assistance for the U.S. territories rely on projections of the amount of local funds that territories would provide in order to receive federal money. For example, CBO projects that, with the exception of Puerto Rico, the amount of matching funds provided by the territories in 2025 would be less than they would need in order to receive 100 percent of the federal funds that would be made available in that year under H.R. 2328. If the territories provided more in matching funds than CBO projects, outlays could be larger than CBO estimates. Conversely, if they provided less in matching funds than CBO projects, outlays could be smaller than CBO estimates.

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 3.

Table 3.
CBO's Estimate of Pay-As-You-Go Effects of H.R. 2328

	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	7,042	10,671	9,716	6,587	1,668	-569	-2,031	-2,258	-2,423	-2,594	35,683	25,809
Memorandum:													
Changes in Outlays	0	7,040	11,274	10,904	7,986	3,190	1,071	-89	-112	-120	-116	40,394	41,027
Changes in Revenues	0	-1	603	1,189	1,399	1,521	1,639	1,942	2,146	2,303	2,477	4,711	15,218

Increase in Long-Term Deficits

CBO estimates that enacting H.R. 2328 would not increase on-budget deficits by more than $5 billion in any of the four consecutive 10-year periods beginning in 2030.

Mandates

H.R. 2328 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 $90 million annually and that, in at least two 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 estimates that the cost of the bill's private-sector mandates would average $7.2 billion annually and that, in each of the first five years the mandates are in effect, those costs would far exceed the private sector-threshold established in UMRA ($164 million in 2019, adjusted annually for inflation).

Title IV, No Surprises Act

Title IV 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.

CBO and JCT estimate that the bill's requirements would lead to provider payment rates converging 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 currently command rates that are well above the median.

The bill would impose costs on providers in several ways, specifically by:

- Reducing the leverage of providers during negotiations with insurers;
- Requiring providers who remain out-of-network to accept median in-network rates for covered services as established by the bill; and
- Prohibiting providers from billing patients in excess of their cost-sharing amounts.

The cost of those mandates would include the receipts forgone from the prohibited billing practices and from lower negotiated in-network rates. The bill also would impose additional administrative costs on providers and insurers to comply with the new requirements. CBO estimates that, taken together, the cost of private-sector surprise billing mandates would average $6.7 billion annually over the first five years that the mandates are in effect.

The bill would establish an independent dispute resolution (IDR) process to settle disagreements between providers and health plans concerning out-of-network medical bills. CBO expects that the presence of the IDR process would likely result in more favorable negotiated rates for providers and higher payment rates for the remaining out-of-network bills. These effects would reduce the cost of the surprise billing mandates relative to a policy that was identical but did not include IDR.

Because public hospitals' emergency departments would be affected by the new billing restrictions, title IV 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 $90 million annually over the first five years the mandates are in effect.

Other Mandates

Title IV also would prohibit health care providers, facilities, or insurers from billing a patient more than one year after services have been performed. Since the duty would apply to hospital facilities, it would impose both an intergovernmental and a private sector mandate. The affected entities already have the procedures in place to bill patients and a clear incentive to do so in a timely manner; therefore, CBO expects that the mandate would impose small incremental costs to accelerate the bills currently issued with the greatest delay.

Finally, title IV would impose an intergovernmental and private-sector mandate by requiring operators of air ambulances to provide HHS with payment information and cost data related

to those services. Some air ambulances are operated by public entities, most commonly by state, county, or large city police and fire departments. CBO estimates that the mandate would impose small administrative costs related to compiling, aggregating, and reporting the required information.

JCT has determined that the tax provisions of H.R. 2328 would impose a private-sector mandate by extending fees on health insurance policies to fund transfers to the PCOR trust fund. The revenue from those fees are part of the CBO baseline because current law requires CBO to assume that excise taxes dedicated to a trust fund, if expiring, are extended. For private entities, however, paying the fees would extend an expiring duty, which is a mandate as defined in UMRA. Based on information from JCT, CBO estimates that the cost of the mandate would average $500 million annually in the three years authorized under the bill.

Other Effects

Title V would increase the amount of Medicaid funds available to the U.S. territories and increase the FMAP they receive under the program. The title also would require the territories to implement several program integrity measures with respect to their Medicaid programs. For large entitlement programs, including Medicaid, UMRA defines an increase in the stringency of conditions on states or territories as an intergovernmental mandate only if the affected governments lack authority to offset those costs while continuing to provide required services. Because the territories possess significant flexibility to alter their responsibilities within Medicaid, the duty to operate these programs would not be a mandate as defined in UMRA.

Previous CBO Estimates

S. 1895, the Lower Health Care Costs Act. On July 16, 2019, CBO transmitted a cost estimate for S. 1895 as ordered reported by the Senate Committee on Health, Education, Labor, and Pensions on June 26, 2019.

- Section 101 of H.R. 2328 is similar to section 411 of S. 1895: Both bills would extend funding for community health centers, the National Health Service Corps, and Teaching Health Centers that operate graduate medical education programs. The Senate bill would appropriate an additional year of funding for each program; the House bill would not.
- Section 102 of H.R. 2328 is similar to section 412 of S. 1895. Both bills would extend funding for the special diabetes programs. The Senate bill would appropriate an additional year of funding for each program; the House bill would not.
- Title IV of H.R. 2328 is similar to title I of S. 1895: Each aims to address surprise medical billing and includes the same protections for patients. Both would set the out-of-network payment rate to equal the median in-network payment rate.

However, two significant differences distinguish title IV of H.R. 2328 from title I of S. 1895. First, the House bill specifies that the median in-network rate would begin as the 2019 rate and increase annually to keep pace with growth in the CPI-U; the Senate bill does not specify a methodology for updating median in-network rates. Second, the House bill includes an IDR process that the Senate bill does not contain.

In CBO and JCT's estimates, those differences have offsetting effects. Indexing growth in median in-network rates to the CPI-U would increase the savings associated with addressing surprise medical bills, but the IDR process would reduce those savings. Specifically, CBO and JCT expect that using the CPI-U to increase the median-in network rate would exert additional downward pressure on insurers' payments to providers. For S. 1895, the agencies did not forecast net changes in the growth of median in-network rates relative to growth under current law. The IDR process reduces the agencies' estimate of savings associated with addressing surprise medical bills because, in general, insurers would be expected to pay higher rates to providers as a result of the IDR process, and those costs would be passed on to enrollees in the form of higher premiums. In total, CBO and JCT estimate, H.R. 2328 would reduce the deficit by $21.9 billion over the 2019-2029 period; that reduction is $3 billion less than the agencies estimated for S. 1895.

H.R. 3253, the Empowering Beneficiaries, Ensuring Access, and Strengthening Accountability Act of 2019. On June 19, 2019, CBO transmitted a cost estimate for H.R. 3253 as introduced on June 13, 2019. That bill was enacted on August 6, 2019, as Public Law 116-39, and it extended funding for family-to-family health information centers from 2020 through 2024. Section 103 of H.R. 2328 would extend that funding through 2023, but because funding has already been enacted, CBO has not estimated any costs associated with section 103.

H.R. 3439, the PATIENTS Act. On September 12, 2019, CBO transmitted a cost estimate for H.R. 3439 as ordered reported by the House Committee on Ways and Means on June 26, 2019. Similar to section 205 of H.R. 2328, that legislation would extend payments to the Patient-Centered Outcomes Research Trust Fund, but for a different period. CBO estimated both bills using a consistent methodology. A more detailed discussion is in the cost estimate for H.R. 3439.

H.R. 3429, the HEARTS and Rural Relief Act. On September 10, 2019, CBO transmitted a cost estimate for H.R. 3429 as ordered reported by the House Committee on Ways and Means on June 26, 2019. Two provisions of that legislation, the HEARTS Act and a provision related to payment for complex wheelchairs, are identical to sections 207 and 208 of H.R. 2328; CBO's estimates are the same in each case.

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