Congressional Budget Office
Cost Estimate

February 6, 2024

At a Glance

S. 2840, Bipartisan Primary Care and Health Workforce Act

As reported by the Senate Committee on Health, Education, Labor, and Pensions on November 8, 2023

By Fiscal Year, Millions of Dollars	2024	2024-2028	2024-2033
Direct Spending (Outlays)	3,897	22,904	23,095
Revenues	0	1,884	7,025
Increase in the Deficit	3,897	21,020	16,070
Spending Subject to Appropriation (Outlays)	142	1,029	not estimated

Increases *net direct spending* in any of the four consecutive 10-year periods beginning in 2034?	No	Statutory pay-as-you-go procedures apply?	Yes
Increases *on-budget deficits* in any of the four consecutive 10-year periods beginning in 2034?	No	**Mandate Effects**	
		Contains intergovernmental mandate?	Yes, Over Threshold
		Contains private-sector mandate?	Yes, Over Threshold

The bill would

- Extend funding for the Teaching Health Center Graduate Medical Education Program, community health centers, and the National Health Service Corps
- Authorize appropriations for new and existing health workforce programs
- Prohibit private health insurers from using certain anticompetitive terms in their contracts and impose new billing requirements on health care providers
- Reduce budget authority provided to the Prevention and Public Health Fund
- Impose intergovernmental and private-sector mandates by restricting insurance contracting terms and limiting the collection of facility fees

Estimated budgetary effects would mainly stem from

- Increased direct spending for graduate medical education programs, community health centers, and the National Health Service Corps
- Reduced federal subsidies for private health insurance because lower average payments to health care providers would result in reduced premiums

Areas of significant uncertainty include

- Forecasting the responses of providers, insurers, state governments, and enrollees to the bill's provisions
- Pinpointing the effects on private insurers' billing and how new anticompetitive contracting terms would affect enrollment in private health insurance plans and spending by private insurers

Detailed estimate begins on the next page.

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

Bill Summary

S. 2840 contains provisions related to access to and quality of primary health care, expanding the health workforce, and reducing the costs of private health insurance. In particular, the legislation would:

- Extend funding for the Teaching Health Center Graduate Medical Education Program, community health centers, and the National Health Service Corps;
- Authorize funding for new and existing health workforce programs; and
- Prohibit the use of certain anticompetitive terms in private health insurance contracts, modify certain billing requirements of health care providers, reduce the amount of budget authority provided to the Prevention and Public Health Fund (PPHF), and require broader publication of prices for items and services.

Estimated Federal Cost

The estimated budgetary effect of S. 2840 is shown in Table 1. The costs of the legislation fall within budget functions 550 (health) and 570 (Medicare).

Basis of Estimate

For this estimate, CBO assumes that S. 2840 will be enacted early in calendar year 2024 and that the estimated and authorized amounts will be appropriated each year.

Direct Spending and Revenues

Several provisions in S. 2840 would provide funding to public health programs aimed at improving primary care and expanding the health workforce. CBO and the staff of the Joint Committee on Taxation (JCT) also estimate that some of the bill's provisions would reduce federal subsidies for employment-based health insurance or for private health insurance obtained through the health insurance marketplaces established by the Affordable Care Act. A reduction in private health insurance premiums would reduce federal subsidies for insurance purchased through those marketplaces and would shift a portion of some employees' compensation from tax-favored health insurance to taxable wages.

CBO and JCT estimate that, on net, enacting S. 2840 would increase direct spending by $23.1 billion and increase revenues by $7.0 billion over the 2024-2033 period, for a net increase in the deficit of $16.1 billion.

Table 1.
Estimated Budgetary Effects of S. 2840

	By Fiscal Year, Millions of Dollars											
	2024	2025	2026	2027	2028	2029	2030	2031	2032	2033	2024-2028	2024-2033
Increases or Decreases (-) in Direct Spending												
Estimated Budget Authority	10,050	7,050	6,927	142	-12	-338	-422	-110	-98	-84	24,157	23,105
Estimated Outlays	3,897	6,744	5,200	4,351	2,712	1,041	-203	-290	-235	-122	22,904	23,095
Increases in Revenues												
Estimated Revenues	0	48	332	634	870	1,049	1,077	1,044	1,008	963	1,884	7,025
On-Budget	*0*	*34*	*245*	*469*	*643*	*777*	*797*	*773*	*746*	*713*	*1,391*	*5,197*
Off-Budget	*0*	*14*	*87*	*165*	*227*	*272*	*280*	*271*	*262*	*250*	*493*	*1,828*
Net Increase or Decrease (-) in the Deficit From Changes in Direct Spending and Revenues												
Effect on the Deficit	3,897	6,696	4,868	3,717	1,842	-8	-1,280	-1,334	-1,243	-1,085	21,020	16,070
On-Budget	*3,897*	*6,710*	*4,955*	*3,882*	*2,069*	*264*	*-1,000*	*-1,063*	*-981*	*-835*	*21,513*	*17,898*
Off-Budget	*0*	*-14*	*-87*	*-165*	*-227*	*-272*	*-280*	*-271*	*-262*	*-250*	*-493*	*-1,828*
Increases in Spending Subject to Appropriation												
Estimated Authorization	359	363	365	11	11	n.e.	n.e.	n.e.	n.e.	n.e.	1,108	n.e.
Estimated Outlays	142	270	324	208	84	n.e.	n.e.	n.e.	n.e.	n.e.	1,029	n.e.
Memorandum: Nonscorable Changes in Direct Spending[a]												
Section 102, Community Health Centers	-2,637	-1,871	-1,385	1,503	701	200	41	0	0	0	-3,689	-3,448

Sources: Congressional Budget Office; staff of the Joint Committee on Taxation.

Components may not sum to totals because of rounding; off-budget effects would come from changes in Social Security revenues; n.e. = not estimated.

a. CBO expects that a provision in section 102 that would provide community health center funding would reduce direct spending for federally subsidized health insurance because those centers could provide more cost-effective patient care. Under the scorekeeping guidelines agreed to by the legislative and executive branches, those changes are not included in effects attributed to this legislation; however, they would be reflected in CBO's baseline budget projections after enactment. (For more information on the guidelines, see Congressional Budget Office, *CBO Explains Budgetary Scorekeeping Guidelines*, January 2021, www.cbo.gov/publication/56507.) CBO estimates that as a result of that funding, direct spending would decrease by $3.4 billion over the 2024-2033 period.

The estimated budgetary effects of the sections that would affect direct spending or revenues are shown in Table 2. CBO estimates that sections 104, 105, 106, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 305, and 306 would have no direct spending or revenue effects.

Table 2.
Estimated Effect of S. 2840 on Direct Spending and Revenues

	By Fiscal Year, Millions of Dollars											
	2024	2025	2026	2027	2028	2029	2030	2031	2032	2033	2024-2028	2024-2033
Increases or Decreases (-) in Direct Spending												
Title I. Extension for Community Health Centers, the National Health Service Corps, and Teaching Health Centers That Operate Medical Education Programs												
Section 101. Programs of Payments to Teaching Health Centers That Operate Graduate Medical Education Programs												
Budget Authority	300	300	300	300	300	0	0	0	0	0	1,500	1,500
Estimated Outlays	102	221	282	296	297	195	76	15	1	0	1,198	1,485
Section 102. Community Health Centers												
Budget Authority	8,800	5,800	5,800	0	0	0	0	0	0	0	20,400	20,400
Estimated Outlays	3,437	5,785	4,036	3,576	2,405	1,103	58	0	0	0	19,239	20,400
Section 103. National Health Service Corps												
Budget Authority	950	950	950	0	0	0	0	0	0	0	2,850	2,850
Estimated Outlays	358	738	930	591	212	20	1	0	0	0	2,829	2,850
Title III. Reducing Health Care Costs for Patients												
Section 302. Honest Billing Requirements Applicable to Providers[a]												
Estimated Budget Authority	0	0	-16	-35	-52	-67	-66	-62	-56	-49	-103	-403
Estimated Outlays	0	0	-16	-35	-52	-67	-66	-62	-56	-49	-103	-403
Section 303. Banning Facility Fees for Certain Services[a]												
Estimated Budget Authority	0	0	-13	-29	-43	-54	-54	-48	-42	-35	-85	-318
Estimated Outlays	0	0	-13	-29	-43	-54	-54	-48	-42	-35	-85	-318
Section 304. Prevention and Public Health Fund												
Estimated Budget Authority	0	0	-94	-94	-217	-217	-302	0	0	0	-405	-924
Estimated Outlays	0	0	-19	-48	-107	-156	-218	-195	-138	-38	-174	-919
Total Changes in Direct Spending												
Estimated Budget Authority	10,050	7,050	6,927	142	-12	-338	-422	-110	-98	-84	24,157	23,105
Estimated Outlays	3,897	6,744	5,200	4,351	2,712	1,041	-203	-290	-235	-122	22,904	23,095

(Continued)

Table 2.
Estimated Effect of S. 2840 on Direct Spending and Revenues

	By Fiscal Year, Millions of Dollars											
	2024	2025	2026	2027	2028	2029	2030	2031	2032	2033	2024-2028	2024-2033
Increases in Revenues												
Title III. Reducing Health Care Costs for Patients												
Section 301. Banning Anticompetitive Terms in Facility and Insurance Contracts That Limit Access to Higher Quality, Lower Cost Care												
Estimated Revenues	0	49	185	294	357	395	426	460	498	538	885	3,202
On-Budget	*0*	*34*	*136*	*217*	*264*	*291*	*315*	*340*	*368*	*398*	*651*	*2,363*
Off-Budget	*0*	*14*	*49*	*77*	*94*	*103*	*112*	*120*	*130*	*140*	*234*	*839*
Section 302. Honest Billing Requirements Applicable to Providers[a]												
Estimated Revenues	0	0	74	171	257	329	326	293	256	213	502	1,919
On-Budget	*0*	*0*	*55*	*127*	*190*	*244*	*242*	*217*	*190*	*158*	*372*	*1,423*
Off-Budget	*0*	*0*	*19*	*44*	*67*	*85*	*84*	*76*	*66*	*55*	*130*	*496*
Section 303. Banning Facility Fees for Certain Services[a]												
Estimated Revenues	0	0	73	169	255	326	324	291	254	212	497	1,904
On-Budget	*0*	*0*	*54*	*125*	*189*	*242*	*240*	*216*	*188*	*157*	*368*	*1,411*
Off-Budget	*0*	*0*	*19*	*44*	*66*	*84*	*84*	*75*	*66*	*55*	*129*	*493*
Total Changes in Revenues	0	48	332	634	870	1,049	1,077	1,044	1,008	963	1,884	7,025
On-Budget	*0*	*34*	*245*	*469*	*643*	*777*	*797*	*773*	*746*	*713*	*1,391*	*5,197*
Off-Budget	*0*	*14*	*87*	*165*	*227*	*272*	*280*	*271*	*262*	*250*	*493*	*1,828*
Memorandum: Nonscorable Changes in Direct Spending[b]												
Section 102. Community Health Centers	-2,637	-1,871	-1,385	1,503	701	200	41	0	0	0	-3,689	-3,448

Sources: Congressional Budget Office; staff of the Joint Committee on Taxation.

Components may not sum to totals because of rounding; off-budget effects would come from changes in Social Security revenues.

a. This section would affect direct spending and revenues, which are shown separately.

b. CBO expects that the provision in section 102 that would provide community health center funding would reduce direct spending for federally subsidized health insurance because those centers could provide more cost-effective patient care. Under the scorekeeping guidelines agreed to by the legislative and executive branches, those changes are not included in effects attributed to this legislation; however, they would be reflected in CBO's baseline budget projections after enactment. (For more information on the guidelines, see Congressional Budget Office, *CBO Explains Budgetary Scorekeeping Guidelines*, January 2021, www.cbo.gov/publication/56507.) CBO estimates that as a result of that funding, direct spending would decrease by $3.4 billion over the 2024-2033 period.

Title I, Extension for Community Health Centers, the National Health Service Corps, and Teaching Health Centers That Operate Graduate Medical Education Programs. Title I would extend funding for several federal health care programs administered by the Health Resources and Services Administration (HRSA). CBO estimates that enacting title I would increase direct spending by $24.7 billion over the 2024-2033 period.

Section 101, Programs of Payments to Teaching Health Centers That Operate Graduate Medical Education Programs. For each fiscal year from 2024 through 2028, section 101 would provide $300 million for HRSA's Teaching Health Center Graduate Medical

Education Program, which funds training for primary care physicians and dentists in community-based health care facilities. Section 101 also would require per person payment rates under the program to exceed the amount in the previous year and would prioritize funding for facilities in states that do not already have a qualified teaching center receiving such funding.

Based on historical spending patterns for the programs, CBO estimates that enacting section 101 would increase direct spending by $1.5 billion over the 2024-2033 period.

Section 102, Community Health Centers. For each fiscal year from 2024 through 2026, section 102 would provide $5.8 billion for community health centers (CHCs). In addition, for fiscal year 2024, section 102 would provide $3.0 billion to CHCs to use for capital expenditures. The bill would require HRSA to allocate at least $245 million annually for programs that extend operating hours at CHCs and at least $55 million annually for school-based services. Section 102 also would require health centers to provide services related to nutrition, mental health, and substance use disorders.

Based on historical spending patterns for CHCs, CBO estimates that enacting section 102 would increase direct spending by $20.4 billion over the 2024-2033 period. CBO also estimates that the mandatory funding under section 102 would give rise to secondary effects in the form of federal savings stemming from more cost-effective patient care and federal costs associated with health insurance enrollment assistance provided by CHCs.

CBO expects that the provision in section 102 that would provide $5.8 billion annually over the 2024-2026 period for CHC funding would reduce net direct spending for federally subsidized health insurance because funding those centers would lead to more cost-effective patient care than the care that patients would otherwise receive. Under the scorekeeping guidelines agreed to by the legislative and executive branches, the net savings are not included in effects attributed to this legislation; however, they would be reflected in CBO's baseline budget projections after enactment.[1] CBO estimates that as a result of that funding, direct spending would decrease by $3.4 billion, on net, over the 2024-2033 period. Those effects are shown in the memorandum lines in Table 1 and Table 2.

CHCs provide primary care to low-income or underserved people, nearly 60 percent of whom are covered by Medicaid or Medicare. CBO estimates that the mandatory appropriations under section 102 would represent about 10 percent of annual revenues for those centers. Under current law, CBO estimates, about 30 percent of the centers' patients (or 9 million people) will lose access to care when the funding expires. CBO anticipates a smaller effect for centers that depend less on that funding and a larger effect for those that depend more on that funding to support their operations.

1. For more information on the guidelines, see Congressional Budget Office, *CBO Explains Budgetary Scorekeeping Guidelines* (January 2021), www.cbo.gov/publication/56507.

CBO estimates that enacting section 102 would maintain access to care at CHCs for those 9 million people and provide additional funding that would make it possible for CHCs to serve an additional 1 million patients. Evidence suggests that such care leads to more cost-effective care and ultimately to lower federal spending for the Medicaid and Medicare populations they serve; the use of health care provided by CHCs generally is associated with lower spending in emergency departments, in inpatient hospital settings, and for other outpatient services. CBO estimates that the funding provided under section 102 would reduce federal spending for health insurance by about $11.4 billion over the 2024-2033 period.

CBO estimates that enacting section 102 also would increase the number of people covered by health insurance and the amount provided in federal subsidies for such insurance. Nearly all CHCs have staff, known as enrollment assisters, who help uninsured patients gain access to health insurance, whether through subsidized plans obtained in the marketplaces established under the Affordable Care Act, through Medicaid, or through the Children's Health Insurance Program. Using information about the number of people who receive such assistance and about their enrollment rates in various plans, CBO estimates that about 200,000 more people would enroll in federally subsidized health insurance in each year in which the section 102 mandatory funding is provided. CBO estimates that the additional enrollment would cost the federal government about $8 billion over the 2024-2033 period.

Section 103, National Health Service Corps. For each fiscal year from 2024 through 2026, section 103 would provide $950 million in mandatory funding for the National Health Service Corps, which offers scholarships and loan repayment programs to workers in primary care medical, dental, and behavioral health.

Based on historical spending patterns for the program, CBO estimates that enacting section 103 would increase direct spending by $2.9 billion over the 2024-2033 period.

Title III, Reducing Health Care Costs for Patients. Title III would impose new contracting requirements on private health insurers and new billing requirements on health care providers. It also would reduce budget authority provided to the Prevention and Public Health Fund. CBO and JCT estimate that over the 2024-2033 period, enacting title III would decrease direct spending by $1.6 billion and increase revenues by $7.0 billion, for a total decrease in the deficit of $8.7 billion.

Section 301, Banning Anticompetitive Terms in Facility and Insurance Contracts That Limit Access to Higher Quality, Lower Cost Care. Section 301 would generally prohibit private health insurers from entering into agreements with health care providers that restrict insurers from steering enrollees to specific health care providers or that require insurers to contract with affiliate providers as a condition of contracting with those providers. Compliance would be monitored through annual attestations submitted by private health insurers. States could

waive the requirements on agreements already in place for contracts that are determined to be unlikely to significantly lessen competition.

Banning such contract terms would allow more insurers to offer products with tiered networks and to steer patients to providers with lower costs, higher quality, or both. CBO and JCT estimate that enacting section 301 would reduce premiums by less than 0.1 percent once the policies have been fully implemented and all parties have fully adjusted to them. To arrive at that estimate, CBO first reviewed available evidence on the effects of tiered networks on spending for services provided by hospitals and physicians.[2] CBO then adjusted those estimates downward to account for the following:

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

Section 301 would apply to the nongroup market, but CBO and JCT do not anticipate a reduction in those premiums as an effect of enactment because that market already tends to use tiered networks to keep premiums low.

CBO and JCT estimate that enacting section 301 would increase revenues by $3.2 billion over the 2024-2033 period.

Section 302, Honest Billing Requirements Applicable to Providers. Section 302 would require every off-campus hospital outpatient department (HOPD) to use a unique billing identifier that is separate from the identifier they use for their main campus; failure to comply could result in the assessment of civil monetary penalties. The requirement would help insurers track payments to off-campus HOPDs and avoid paying facility fees if an insurer has a policy against doing so. (Facility fees are payments made to hospitals—in addition to physicians' direct charges—to cover operating and staffing costs, for example to continuously staff an emergency room. Facility fees paid to off-campus HOPDs, which can more closely resemble physicians' offices than hospitals in terms of overhead and labor costs, result in larger amounts being paid for services that otherwise are similar to services

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

delivered in a physician's office.) CBO expects that enacting the provision would encourage some insurers to adopt policies against paying facility fees for off-campus services.

Most of the estimated budgetary effects of section 302 would stem from the reduction in private health insurance premiums. CBO estimates that the effect of enacting section 302 would be largest in 2029, when premiums would decrease by less than 0.1 percent, but then would moderate by 2033, when premiums would decrease by less than 0.05 percent. On the basis of information from the Centers for Medicare & Medicaid's National Health Expenditures, the Health Care Costs Institute, and Medicare claims, CBO estimates that spending at off-campus HOPDs accounts for roughly 3 percent of total private health insurance spending.[3] CBO estimated the amount of off-campus hospital spending that would be affected under the bill by reducing estimated spending to account for the fact that some private health insurers already avoid off-campus facility fees and by estimating effects only for spending on services that have both a facility fee and a physician fee under Medicare. (Services that have a single fee are less likely to be affected by site-neutral payment policies.)

CBO further adjusted the estimates of commercial health insurance spending to reflect the increase in physician payments that would occur if services provided in HOPDs were billed at physician office rates, which are higher than rates for services performed in HOPDs. CBO estimated a slight decrease in savings that would occur because of the expectation that not all off-campus HOPDs would comply with the billing requirements and not all insurers would use transparency information to avoid paying facility fees. (For instance, insurers might lack the market leverage to use the information in contract negotiations with providers.) CBO also estimated a decrease in savings because the expected decline in insurers' costs would be partially reversed as health care providers found other ways to increase prices.

CBO estimates that enacting section 302 also would reduce the Medicare program's outlays by $81 million over the 2024-2033 period. Medicare tracks payments to off-campus HOPDs, but CBO expects that the section's requirements would make it easier to ensure that providers bill correctly and that Medicare's payments are accurate.

CBO and JCT estimate that enacting section 302 would decrease direct spending by $0.4 billion and increase revenues by $1.9 billion, for a total reduction in the deficit of $2.3 billion over the 2024-2033 period.

Section 303, Banning Facility Fees for Certain Services. Section 303 would prohibit providers from charging private health insurance plans and enrollees facility fees for three types of services—office and other office-based outpatient evaluation and management services, outpatient-office-based behavioral health services, and telehealth services. Those

3. See Centers for Medicare & Medicaid Services, "National Health Expenditure Data" (September 6, 2023), http://tinyurl.com/4mhh3bhh; and Health Care Cost Institute, *HCCUR Data Point: Use and Spending on Clinician Services in Hospital and Non-Hospital Settings* (August 23, 2022), http://tinyurl.com/sjnhw74s.

services together account for roughly 2 percent of private health insurance spending on outpatient services. Unlike section 302, section 303 would apply to all hospital outpatient providers, not just off-campus HOPDs.

CBO estimates that the effect of enacting section 303 would be largest in 2029, when premiums would decrease by less than 0.1 percent, but then would moderate by 2033, when premiums would decrease by less than 0.05 percent. That projection is based on the estimate that 2 percent of private health insurance spending on hospital outpatient services would be affected by prohibiting providers from charging facility fees for the specified services; that 2 percent share was calculated from commercial claims that identify hospital outpatient spending for the specified services. CBO scaled that amount to reflect the fact that about 23 percent of all private health insurance spending is for hospital outpatient services.[4]

CBO made adjustments to the health insurance spending estimates for section 303 that were similar to those made to the estimate for section 302: reducing the amount of affected spending to account for the fact that some private health insurers' already avoid paying off-campus facility fees, including an offsetting increase in physician payments to reflect a shift toward office-based billing for services performed in HOPDs, and incorporating the expectation that savings erode over time as providers find ways to raise the amounts they charge.

CBO also accounted for the expectation that not all HOPDs would comply with the new billing requirements and that some insurers would lack the market leverage to negotiate lower rates in their contracts with providers. Those adjustments are smaller than the adjustments for section 302 because section 303 prohibits providers from billing for facility fees, rather than providing insurers with additional information to help them avoid paying those fees.

CBO's estimate for section 303 also accounts for interactions with section 302. For off-campus providers, the three service types specified in section 303 also would be affected by requirements in section 302.

CBO and JCT estimate that, over the 2024-2033 period, enacting section 303 would decrease direct spending by $0.3 billion and increase revenues by $1.9 billion, for a total reduction in the deficit of $2.2 billion over that period.

Section 304, Prevention and Public Health Fund. Enacting section 304 would reduce the funding provided to the PPHF under the Affordable Care Act by $100 million (from $1.525 billion to $1.425 billion) in 2026 and 2027, by $230 million (from $1.725 billion to

4. See Centers for Medicare & Medicaid Services, "National Health Expenditure Data" (September 6, 2023), http://tinyurl.com/4mhh3bhh; and Health Care Cost Institute, *HCCUR Data Point: Use and Spending on Clinician Services in Hospital and Non-Hospital Settings* (August 23, 2022), http://tinyurl.com/sjnhw74s.

$1.495 billion) in 2028 and 2029, and by $320 million (from $2.000 billion to $1.680 billion) in 2030. Amounts provided to the PPHF in each of those years are subject to sequestration under the Balanced Budget and Emergency Deficit Control Act of 1985, meaning that the amount of budget authority available for obligation is 5.7 percent less than the amount provided in statute. Accounting for the effects of sequestration, CBO estimates that enacting section 304 would reduce the mandatory budget authority available to the PPHF by $94 million (from $1.438 billion to $1.344 billion) in 2026 and 2027, by $217 million (from $1.627 billion to $1.410 billion) in 2028 and 2029, and by $302 million (from $1.886 billion to $1.584 billion) in 2030.

After accounting for historical spending patterns, CBO estimates that enacting the reduction in budget authority would reduce direct spending by $919 million over the 2024-2033 period.

Spending Subject to Appropriation

CBO estimates that S. 2840 would authorize the appropriation of $1.1 billion for various programs over the 2024-2028 period. CBO estimates that implementing the bill would cost $1.0 billion over the same period (see Table 3), assuming appropriation of the specified and estimated amounts. The estimate includes specified authorizations of appropriations as well as estimated authorizations for sections authorizing such sums as may be necessary or authorizing activities that normally would be funded with discretionary appropriations. The outlay estimates are based on historical spending patterns for the affected programs.

Ten sections in title II contain specified authorizations of appropriations:

- $41 million under section 201 for the 2024-2026 period for a rural residency planning and development program,
- $51 million under section 202 for the 2024-2026 period for a primary care training and enhancement program,
- $23 million under section 203 for the 2026-2028 period for a telehealth technology-enabled learning program,
- $86 million under section 205 for the 2024-2026 period for a nurse faculty loan program,
- $30 million under section 206 for the 2024-2025 period for a demonstration grant program to increase recruitment and retention of faculty at nursing schools,
- $284 million under section 207 for the 2024-2026 period for a nurse corps scholarship and loan repayment program,
- $90 million under section 208 for the 2024-2026 period for grants for primary care nurse residency training programs,

- $47 million under section 209 for the 2024-2026 period for a grant program to increase states' oral health workforces,
- $29 million under section 210 for 2026 for oral health training programs, and
- $300 million under section 211 for the 2024-2026 period for allied health workforce programs.

In addition, section 204 would establish a two-year pilot grant program to help certain health professionals become registered nurses. Based on the cost of similar programs, CBO estimates that implementing the program would cost $118 million for the 2024-2028 period; any spending would be subject to appropriation.

Five sections of the bill contain reporting requirements that also would be subject to appropriation:

- Section 104 would direct the Government Accountability Office to report on the effectiveness of the National Health Service Corps for increasing the number of workers in areas designated by HRSA as having shortages of health professionals,
- Section 105 would require the Office of Inspector General to report on HRSA's efforts to ensure quality and continuity of care in underserved areas and on that agency's oversight of funding for health centers,
- Section 212 would require the Departments of Health and Human Services (HHS) and Labor to review grant programs that support the nurse workforce and to provide recommendations to the Congress concerning those programs,
- Section 213 would direct HHS to report on the effects of title II on community health centers, and
- Section 306 would direct HHS to report annually to the Congress and also require the Government Accountability Office to report to the Congress on violations and enforcement activities related to hospital price transparency rules in the Public Health Service Act.

CBO estimates that implementing each of those sections individually would increase federal spending by an insignificant amount; combined, the total would be about $3 million over the 2024-2028 period. Any spending would be subject to the availability of appropriated funds.

Table 3.
Estimated Increases in Spending Subject to Appropriation Under S. 2840

	By Fiscal Year, Millions of Dollars					
	2024	2025	2026	2027	2028	2024-2028
Title II. Supporting the Health Care Workforce						
Section 201. Rural Residency Planning and Development Program						
Authorization	13	14	14	0	0	41
Estimated Outlays	5	10	12	8	3	38
Section 202. Primary Care Training and Enhancement Program						
Authorization	*	1	50	0	0	51
Estimated Outlays	0	0	20	18	8	46
Section 203. Telehealth Technology-Enabled Learning Program						
Authorization	0	0	1	11	11	23
Estimated Outlays	0	0	0	5	8	13
Section 204. Nurse Education, Practice, Quality, and Retention Grants and Contracts						
Estimated Authorization	61	63	0	0	0	124
Estimated Outlays	24	46	31	13	4	118
Section 205. Nurse Faculty Loan Program						
Authorization	29	29	29	0	0	86
Estimated Outlays	11	21	26	16	6	80
Section 206. Nurse Faculty Demonstration Program						
Authorization	15	15	0	0	0	30
Estimated Outlays	6	11	8	3	1	29
Section 207. Nurse Corps Scholarship and Loan Repayment Program						
Authorization	94	95	96	0	0	284
Estimated Outlays	37	71	85	53	20	266
Section 208. Grants for Primary Care Nurse Residency Training Programs						
Authorization	30	30	30	0	0	90
Estimated Outlays	12	23	27	17	6	85
Section 209. State Oral Health Workforce Improvement Grant Program						
Authorization	15	16	16	0	0	47
Estimated Outlays	6	12	14	9	3	44
Section 210. Oral Health Training Programs						
Authorization	0	0	29	0	0	29
Estimated Outlays	0	0	11	10	4	25
Section 211. Allied Health Professionals						
Authorization	100	100	100	0	0	300
Estimated Outlays	40	75	90	56	21	282
Reporting Requirements[a]						
Estimated Authorization	1	1	*	1	*	3
Estimated Outlays	1	1	*	1	*	3
Total Changes						
Estimated Authorization	359	363	365	11	11	1,108
Estimated Outlays	142	270	324	208	84	1,029

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

a. Amounts are for sections 104, 105, 212, 213, and 306, combined.

Uncertainty

CBO's estimate of the budgetary effects of S. 2840 is subject to significant uncertainty. In particular, data are limited for estimating the effects of sections 302 and 303, which would impose requirements on the private health insurance market. Because the details of contracts within those markets typically are proprietary, CBO cannot precisely predict the sections' budgetary effects without information about how many private health insurers currently do not pay facility fees. Therefore, on the basis of certain insurer characteristics, CBO estimated the share of insurers likely to have such policies. CBO supplemented some gaps in the data by using Medicare claims information, which provided detailed data about where health care services are performed. The Medicare data were adjusted to reflect patterns of care paid for by private health insurance, but trends or practices in private health insurance may not be fully captured in CBO's estimates.

CBO's estimate for section 301, which prohibits private health insurance contracts from using certain anticompetitive terms, also relies on limited but growing evidence to explain the effects of contracting arrangements. CBO's assessment is that banning use of contract clauses that are designed to steer enrollees to specific health care providers would increase the availability of and enrollment in tiered-network plans, but the extent to which those changes would affect private health insurance premiums or the federal deficit largely would depend on factors such as how many more people enrolled in those plans and what effects tiered-network plans' would have on spending for private health insurance.

Separately, CBO's estimate for section 301 accounts for the effects of states' waiving the requirements for insurance agreements that would be executed before the bill's enactment. To arrive at that estimate, CBO examined related state laws that regulate insurer and provider contracting to indicate the likelihood that states would waive those requirements. Such analyses add to the uncertainty in CBO's estimate because the enactment of state laws does not perfectly predict what will happen in those states.

It also is difficult to project which impediments would need to be overcome for implementation of and compliance with the requirements of sections 301, 302, and 303. Those factors could significantly change CBO's estimates, especially later in the 2024-2033 period. Private health insurance contracts are regularly renegotiated, and such renegotiations could offset the effects of the policies in those sections. In areas where providers' market power is stronger than that of the private health insurers, providers might be able to increase negotiated rates across all their lines of business to recoup the losses from requirements imposed by sections 301, 302, and 303. Alternatively, in areas where private health insurers have more market power than providers do, it is more likely that the policies would have their intended effects. Although CBO's estimates incorporate such market dynamics, for example by projecting that savings may erode over time, the full extent to which those dynamics would influence the actions of insurers and providers is highly uncertain.

Pay-As-You-Go Considerations

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

Table 4.
CBO's Estimate of the Statutory Pay-As-You-Go Effects of S. 2840, the Bipartisan Primary Care and Health Workforce Act, as Reported by the Senate Committee on Health, Education, Labor, and Pensions on November 8, 2023

	By Fiscal Year, Millions of Dollars											
	2024	2025	2026	2027	2028	2029	2030	2031	2032	2033	2024-2028	2024-2033
	Net Increase or Decrease (-) in the On-Budget Deficit											
Pay-As-You-Go Effect	3,897	6,710	4,955	3,882	2,069	264	-1,000	-1,063	-981	-835	21,513	17,898
Memorandum:												
Changes in Outlays	3,897	6,744	5,200	4,351	2,712	1,041	-203	-290	-235	-122	22,904	23,095
Changes in Revenues	0	34	245	469	643	777	797	773	746	713	1,391	5,197

Increase in Long-Term Net Direct Spending and Deficits

CBO estimates that enacting S. 2840 would not increase net direct spending or deficits in any of the four consecutive 10-year periods beginning in 2034.

Mandates

S. 2840 would impose intergovernmental and private-sector mandates as defined in the Unfunded Mandates Reform Act (UMRA). The bill would require hospitals and health care providers to use a unique billing identifier for off-campus departments, prohibit facilities from imposing fees for certain services, and require broader publication of prices for items and services. Because some hospitals are operated by state or local governments, the bill's requirements would impose intergovernmental and private-sector mandates. Additionally, the bill would impose a private-sector mandate by restricting the use of certain anticompetitive terms in contracts between health insurance plans and health care providers.

Based on the anticipated market and revenue effects of those provisions, CBO estimates that the cost of the mandates would exceed the intergovernmental and private-sector thresholds established in UMRA ($99 million and $198 million, respectively, in 2023, adjusted annually for inflation) in at least three of the first five years that the mandates are in effect.

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