118TH CONGRESS
2d Session
HOUSE OF REPRESENTATIVES
REPT. 118–875
Part 1

HEALTHY COMPETITION FOR BETTER CARE ACT

DECEMBER 16, 2024.—Ordered to be printed

Ms. FOXX, from the Committee on Education and the Workforce, submitted the following

R E P O R T

together with

ADDITIONAL VIEWS

[To accompany H.R. 3120]

[Including cost estimate of the Congressional Budget Office]

The Committee on Education and the Workforce, to whom was referred the bill (H.R. 3120) to ban anticompetitive terms in facility and insurance contracts that limit access to higher quality, lower cost care, having considered the same, reports favorably thereon with an amendment and recommends that the bill as amended do pass.

The amendment is as follows:

Strike all after the enacting clause and insert the following:

SECTION 1. SHORT TITLE.

This Act may be cited as the "Healthy Competition for Better Care Act".

SEC. 2. BANNING ANTICOMPETITIVE TERMS IN FACILITY AND INSURANCE CONTRACTS THAT LIMIT ACCESS TO HIGHER QUALITY, LOWER COST CARE.

(a) IN GENERAL.—

(1) PHSA.—Section 2799A–9 of the Public Health Service Act (42 U.S.C. 300gg–119) is amended by adding at the end the following:

"(b) PROTECTING HEALTH PLANS NETWORK DESIGN FLEXIBILITY.—

"(1) IN GENERAL.—A group health plan or a health insurance issuer offering group or individual health insurance coverage shall not enter into an agreement with a provider, network or association of providers, or other service provider offering access to a network of service providers if such agreement, directly or indirectly—

"(A) restricts the group health plan or health insurance issuer from—

"(i) directing or steering enrollees to other health care providers; or

"(ii) offering incentives to encourage enrollees to utilize specific health care providers;

"(B) requires the group health plan or health insurance issuer to enter into any additional contract with an affiliate of the provider as a condition of entering into a contract with such provider;

"(C) requires the group health plan or health insurance issuer to agree to payment rates or other terms for any affiliate not party to the contract of the provider involved; or

"(D) restricts other group health plans or health insurance issuers not party to the contract, from paying a lower rate for items or services than the contracting plan or issuer pays for such items or services.

"(2) ADDITIONAL REQUIREMENT FOR SELF-INSURED PLANS.—A self-insured group health plan shall not enter into an agreement with a provider, network or association of providers, third-party administrator, or other service provider offering access to a network of providers if such agreement directly or indirectly requires the group health plan to certify, attest, or otherwise confirm in writing that the group health plan is bound by restrictive contracting terms between the service provider and a third-party administrator that the group health plan is not party to, without a disclosure that such terms exist.

"(3) EXCEPTION FOR CERTAIN GROUP MODEL ISSUERS.—Paragraph (1)(A) shall not apply to a group health plan or health insurance issuer offering group or individual health insurance coverage with respect to—

"(A) a health maintenance organization (as defined in section 2791(b)(3)), if such health maintenance organization operates primarily through exclusive contracts with multi-specialty physician groups, nor to any arrangement between such a health maintenance organization and its affiliates; or

"(B) a value-based network arrangement, such as an exclusive provider network, accountable care organization or other alternative payment model, center of excellence, a provider sponsored health insurance issuer that operates primarily through aligned multi-specialty physician group practices or integrated health systems, or such other similar network arrangements as determined by the Secretary through rulemaking.

"(4) ATTESTATION.—A group health plan or health insurance issuer offering group or individual health insurance coverage shall annually submit to, as applicable, the applicable authority described in section 2723 or the Secretary of Labor, an attestation that such plan or issuer is in compliance with the requirements of this subsection.

"(c) MAINTENANCE OF EXISTING HIPAA, GINA, AND ADA PROTECTIONS.—Nothing in this section shall modify, reduce, or eliminate the existing privacy protections and standards provided by reason of State and Federal law, including the requirements of parts 160 and 164 of title 45, Code of Federal Regulations (or any successor regulations).

"(d) REGULATIONS.—The Secretary, in consultation with the Secretary of Labor and the Secretary of the Treasury, not later than 1 year after the date of enactment of this section, shall promulgate regulations to carry out this section.

"(e) RULE OF CONSTRUCTION.—Nothing in this section shall be construed to limit network design or cost or quality initiatives by a group health plan or health insurance issuer, including accountable care organizations, exclusive provider organizations, networks that tier providers by cost or quality or steer enrollees to centers of excellence, or other pay-for-performance programs.

"(f) CLARIFICATION WITH RESPECT TO ANTITRUST LAWS.—Compliance with this section does not constitute compliance with the antitrust laws, as defined in subsection (a) of the first section of the Clayton Act (15 U.S.C. 12(a))."

(2) EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974.—

(A) IN GENERAL.—Section 724 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1185m) is amended—

(i) in the header, by striking "**BY REMOVING**" and all that follows through "**INFORMATION**" and inserting "**; PROHIBITION ON ANTI-COMPETITIVE AGREEMENTS**";

(ii) in subsection (a)(4), in the first sentence, by striking "section" and inserting "subsection"; and

(iii) by adding at the end the following:

"(b) PROTECTING HEALTH PLANS NETWORK DESIGN FLEXIBILITY.—

"(1) IN GENERAL.—A group health plan or a health insurance issuer offering group health insurance coverage may not enter into an agreement with a covered entity (as defined in paragraph (3)) if such agreement, directly or indirectly—

"(A) restricts (including by operation of any agreement in effect between such covered entity and another covered entity) the group health plan (whether self-insured or fully-insured) or health insurance issuer from—

"(i) directing or steering participants or beneficiaries to other health care providers who are not subject to such agreement; or

"(ii) offering incentives to encourage participants or beneficiaries to utilize specific health care providers;

"(B) requires the group health plan or health insurance issuer to enter into any additional agreement with an affiliate of the covered entity;

"(C) requires the group health plan or health insurance issuer to agree to payment rates or other terms for any affiliate of the covered entity not party to the agreement; or

"(D) restricts other group health plans or health insurance issuers not party to the agreement from paying a lower rate for items or services than the plan or issuer involved in the agreement pays for such items or services.

"(2) EXCEPTIONS FOR CERTAIN PROVIDER GROUP AND VALUE-BASED NETWORK DESIGNS.—Paragraph (1)(A) shall not apply to a group health plan or health insurance issuer offering group health insurance coverage with respect to—

"(A) a health maintenance organization (as defined in section 733(b)(3)), if such health maintenance organization operates primarily through exclusive contracts with multi-specialty physician groups, nor to any arrangement between such a health maintenance organization and its affiliates; or

"(B) a value-based network arrangement, such as an exclusive provider network, accountable care organization, center of excellence, a provider sponsored health insurance issuer that operates primarily through aligned multi-specialty physician group practices or integrated health systems, or such other similar network arrangements as determined by the Secretary through guidance or rulemaking.

"(3) COVERED ENTITY DEFINED.—For purposes of this subsection, the term 'covered entity' means a health care provider, network or association of providers, third-party administrator, or other service provider offering access to a network of providers.

"(4) STATE GRANDFATHERING OPTION.—An applicable State authority may make a determination that the prohibitions under paragraph (1)(A) (relating to conditions that would direct or steer enrollees to, or offer incentives to encourage enrollees to use, other health care providers) will not apply in the State with respect to any specified agreement executed on June 19, 2019, and any agreements related to such specified agreement executed on or before December 31, 2020, for a maximum length of nonapplicability of up to 10 years from the date of execution of the contract if the applicable State authority determines that the contract is unlikely to significantly lessen competition. With respect to a specified agreement for which an applicable State authority has made a determination under the preceding sentence, an applicable State authority may determine whether renewal of the contract, within the applicable 10-year period, is allowed.

"(5) RULE OF CONSTRUCTION.—Except as provided in paragraph (1), nothing in this subsection shall be construed to limit network design or cost or quality initiatives by a group health plan or health insurance issuer, including accountable care organizations, exclusive provider organizations, networks that tier providers by cost or quality or steer enrollees to centers of excellence, or other pay-for-performance programs.".

(B) REGULATIONS.—Not later than 1 year after the date of the enactment of this Act, the Secretary of Labor, in consultation with the Secretary of Health and Human Services and the Secretary of the Treasury, shall promulgate regulations to carry out the amendments made by this paragraph.

(C) CLERICAL AMENDMENT.—The table of contents in section 1 of such Act is amended, in the entry relating to section 724, by amending such entry to read as follows:

"Sec. 724. Increasing transparency; prohibition on anticompetitive agreements.".

(3) IRC.—Section 9824 of the Internal Revenue Code of 1986 is amended by adding at the end the following:

"(b) PROTECTING HEALTH PLANS NETWORK DESIGN FLEXIBILITY.—

"(1) IN GENERAL.—A group health plan shall not enter into an agreement with a provider, network or association of providers, or other service provider offering access to a network of service providers if such agreement, directly or indirectly—

"(A) restricts the group health plan from—

"(i) directing or steering enrollees to other health care providers; or

"(ii) offering incentives to encourage enrollees to utilize specific health care providers;

"(B) requires the group health plan to enter into any additional contract with an affiliate of the provider as a condition of entering into a contract with such provider;

"(C) requires the group health plan to agree to payment rates or other terms for any affiliate not party to the contract of the provider involved; or

"(D) restricts other group health plans not party to the contract, from paying a lower rate for items or services than the contracting plan pays for such items or services.

"(2) ADDITIONAL REQUIREMENT FOR SELF-INSURED PLANS.—A self-insured group health plan shall not enter into an agreement with a provider, network or association of providers, third-party administrator, or other service provider offering access to a network of providers if such agreement directly or indirectly requires the group health plan to certify, attest, or otherwise confirm in writing that the group health plan is bound by restrictive contracting terms between the service provider and a third-party administrator that the group health plan is not party to, without a disclosure that such terms exist.

"(3) EXCEPTION FOR CERTAIN GROUP MODEL ISSUERS.—Paragraph (1)(A) shall not apply to a group health plan with respect to—

"(A) a health maintenance organization (as defined in section 9832(b)(3)), if such health maintenance organization operates primarily through exclusive contracts with multi-specialty physician groups, nor to any arrangement between such a health maintenance organization and its affiliates; or

"(B) a value-based network arrangement, such as an exclusive provider network, accountable care organization or other alternative payment model, center of excellence, a provider sponsored health insurance issuer that operates primarily through aligned multi-specialty physician group practices or integrated health systems, or such other similar network arrangements as determined by the Secretary through rulemaking.

"(4) ATTESTATION.—A group health plan shall annually submit to the Secretary of Labor an attestation that such plan is in compliance with the requirements of this subsection.

"(c) MAINTENANCE OF EXISTING HIPAA, GINA, AND ADA PROTECTIONS.—Nothing in this section shall modify, reduce, or eliminate the existing privacy protections and standards provided by reason of State and Federal law, including the requirements of parts 160 and 164 of title 45, Code of Federal Regulations (or any successor regulations).

"(d) REGULATIONS.—The Secretary, in consultation with the Secretary of Health and Human Services and the Secretary of Labor, not later than 1 year after the date of enactment of this section, shall promulgate regulations to carry out this section.

"(e) RULE OF CONSTRUCTION.—Nothing in this section shall be construed to limit network design or cost or quality initiatives by a group health plan, including accountable care organizations, exclusive provider organizations, networks that tier providers by cost or quality or steer enrollees to centers of excellence, or other pay-for-performance programs.

"(f) CLARIFICATION WITH RESPECT TO ANTITRUST LAWS.—Compliance with this section does not constitute compliance with the antitrust laws, as defined in subsection (a) of the first section of the Clayton Act (15 U.S.C. 12(a))."

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall apply with respect to any contract entered into, amended, or renewed on or after the date that is 18 months after the date of enactment of this Act.

PURPOSE

H.R. 3120, the *Healthy Competition for Better Care Act*, amends the *Employee Retirement Income Security Act of 1974* (ERISA), the *Public Health Service Act* (PHSA), and the Internal Revenue Code (IRC) to ban anticompetitive terms in facility and insurance contracts that limit access to higher quality, lower cost health care. The bill gives employer-sponsored health plans the protections they need to negotiate lower rates and obtain higher quality in their networks, lowering premiums and improving the health of their employees.

COMMITTEE ACTION

118TH CONGRESS

First Session—Hearing

On April 26, 2023, the Subcommittee on Health, Employment, Labor, and Pensions (HELP) held a hearing entitled "Reducing Health Care Costs for Working Americans and Their Families," which examined, among other topics, anticompetitive behavior such as provider payer contracts that result in increased health costs. Witnesses were Mr. Joel White, President, Council for Affordable Health Coverage (CAHC), Washington, D.C.; Mrs. Tracy Watts, Senior Partner, Mercer, Washington, D.C.; Ms. Marcie Strouse, Partner, Capitol Benefits Group, Des Moines, Iowa; and Ms. Sabrina Corlette, Senior Research Professor, Center on Health Insurance Reforms, Georgetown University's Health Policy Institute, Washington, D.C.

On June 21, 2023, the HELP Subcommittee held a hearing entitled "Competition and Transparency: The Pathway Forward for a Stronger Health Care Market," which discussed, among other topics, the prevalence of anticompetitive clauses found in contracts employed by insurers and their impact on creating higher costs. Witnesses were Dr. Gloria Sachdev, President and CEO, Employers' Forum of Indiana, Carmel, Indiana; Ms. Sophia Tripoli, Director of Health Care Innovation, Families USA, Washington, D.C.; Mr. Greg Baker, CEO, Affirmed RX, Louisville, Kentucky; Ms. Christine Monahan, Assistant Research Professor, Georgetown University Center on Health Insurance Reforms, Washington, D.C.; and Mr. JC Scott, President and CEO, Pharmaceutical Care Management Association, Washington, D.C.

Second Session—Hearing

On April 16, 2024, the HELP Subcommittee held a hearing entitled "ERISA's 50th Anniversary: The Path to Higher Quality, Lower Cost Healthcare," which discussed, among other topics, the use of contracting terms by hospitals and payers to inhibit competition in health care. Witnesses were Mr. Russell Dubose, Vice President of Human Resources, Phifer Inc., Tuscaloosa, Alabama; Mr. Scott Behrens, Senior Vice President, Director of Government Relations, Lockton Companies, Kansas City, Missouri; Ms. Mairin Mancino, Senior Advisor, Policy, Peterson Center on Healthcare, New York, New York; and Ms. Karen L. Handorf, Senior Counsel, Berger Montague, Washington, D.C.

On September 10, 2024, the HELP Subcommittee held a hearing entitled "ERISA's 50th Anniversary: The Value of Employer-Sponsored Health Benefits," which discussed, among other topics, anticompetitive terms in contracts between providers and employer-sponsored health plans. Witnesses were Ms. Ilyse Schuman, Senior Vice President, Health and Paid Leave Policy, American Benefits Council, Washington, D.C.; Ms. Holly Wade, Executive Director, National Federation of Independent Business Research Center, Washington, D.C.; Dr. Paul Fronstin, Director, Health Benefits Research, Employee Benefit Research Institute, Washington, D.C.; and Mr. Anthony Wright, Executive Director, Families USA, Washington, D.C.

Legislative Action

On May 5, 2023, Representative Michelle Steel (R–CA) introduced H.R. 3120, the *Healthy Competition for Better Care Act*, with Representative Don Davis (D–NC). The bill was referred to the Committee on Energy and Commerce, the Committee on Education and the Workforce, and the Committee on Ways and Means.

On September 11, 2024, the Committee considered H.R. 3120 in legislative session and reported it favorably, as amended, to the House of Representatives by voice vote. The Committee adopted an amendment in the nature of a substitute (ANS) offered by Representative Steel, which made substantive changes to the bill's ERISA provisions. The ANS made the following changes: (1) removed requirements for group health plans to attest to DOL their compliance with the ERISA requirements in the bill; (2) removed extraneous clarifications regarding antitrust and health privacy law which do not impact the legislation's requirements or enforceability; (3) added a grandfather provision regarding the University of Pittsburgh Medical Center and Highmark contract, which has a unique structure that the bill's requirements would negate in the absence of a grandfather provision; and (4) incorporated technical assistance from the Department of Labor (DOL) regarding the rule of construction and the requirement that DOL issue regulations to implement the bill.

COMMITTEE VIEWS

INTRODUCTION

Unlike most industries in America, health care in this country rarely operates as a true free market. The health care system, especially among hospitals and providers, is increasingly consolidated. This consolidation weakens competition and undermines the free-market ideals that lead to higher quality and lower costs. Consolidated hospital and provider systems use their size and scale as leverage over the purchasers of health care services, namely employer-sponsored health plans. Legislation is needed to level the playing field to prevent consolidated hospital and provider systems from using anticompetitive terms in contracts to force employers into bad deals with high costs and low quality. With increased competition, employees and employers will benefit.

BACKGROUND ON EMPLOYER-SPONSORED HEALTH INSURANCE

The Committee on Education and the Workforce has jurisdiction over employer-sponsored health coverage. Employer-sponsored insurance (ESI) covers over half of the non-elderly population—an estimated 153 million employees and their dependents.[1] Employer-sponsored health benefits are governed by several laws, including ERISA, which is the foundation of employer-sponsored health care.

ERISA establishes federal guidelines governing the conduct of employee benefit plans, including employer-sponsored group health plans. Private employers that implement group health plans may implement uniform benefit plans because ERISA preempts state regulation of such plans. Approximately 99 million employees and family members have coverage from employers that self-insure

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

their own health plans, making them subject to regulation only under ERISA and the IRC.[2] The remainder of private employers offering health benefits purchase fully insured coverage from traditional insurance companies, which is generally governed by ERISA, the IRC, the PHSA, and state insurance laws.

ESI is the core of America's health care system. Employers have historically been at the forefront of creating innovative, market-driven approaches to providing health benefits. Ninety-three percent of Americans covered by ESI are satisfied with their employer-sponsored coverage.[3] Fifty-three percent of small firms (firms with 3–199 workers) and 98 percent of large firms (firms with 200 or more workers) offered health benefits to their workers in 2023.[4] When employees can participate in ESI, 75 percent enroll.[5]

PROVIDER CONSOLIDATION DRIVES UP PRICES

Competition drives innovation, improves quality, and lowers prices. Unfortunately, the health care system has become increasingly consolidated in recent decades. Three pharmacy benefit manager (PBM) companies control nearly 90 percent of the market,[6] health plans are becoming vertically integrated, primary and specialty care offices are being purchased,[7] and hospitals are consolidating at a rapid rate. From 1998 to 2021, 1,887 hospitals merged,[8] and 90 percent of metropolitan statistical areas are considered consolidated for hospital services.[9] The percentage of physicians' practices owned by or affiliated with hospitals has also increased.[10] One hundred seventeen million Americans reside in a concentrated hospital market,[11] with highly concentrated markets found in 90 percent of metropolitan statistical areas.[12] Commercial insurers and private payers are thus not keeping pace with consolidation in the hospital market.

Consolidation in health care has contributed to significantly higher prices in the commercial market compared to Medicare. A recent Congressional Budget Office report found that commercial insurers' prices were 240 percent of Medicare fee-for-service prices for outpatient services and 182 percent for inpatient services.[13] Researchers have found that insurers paid through administrative services only (ASO) contracts may have little incentive to obtain low health care prices and may have a disincentive to lower prices when an ASO contract is paid as a percentage of overall claims.[14]

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

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

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

[5] *Id.*

[6] https://content.naic.org/cipr-topics/pharmacy-benefit-managers.

[7] https://www.reuters.com/business/healthcare-pharmaceuticals/which-cvs-rivals-also-own-primary-care-services-2023-02-08/.

[8] https://ldi.upenn.edu/our-work/research-updates/hospital-consolidation-continues-to-boost-costs-narrow-access-and-impact-care-quality/:~:text=There%20were%201%2C887%20hospital%20mergers,to%20around%20just%20over%206%2C000.%E2%80%9D.

[9] https://www.aei.org/research-products/report/policy-solutions-for-hospital-consolidation/.

[10] https://www.cbo.gov/publication/57778.

[11] https://www.urban.org/sites/default/files/publication/101508/addressing_health_care_market_consolidation_and_high_prices_1.pdf.

[12] https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2017.0556.

[13] *Id.*

[14] https://www.nber.org/papers/w25190.

Additionally, the prices that commercial insurers pay hospitals are much higher than hospitals' costs.[15] The National Bureau of Economic Research reports that hospital mergers lessening competition is correlated with higher hospital price increases.[16]

CONSOLIDATED PROVIDERS DISADVANTAGE EMPLOYER-SPONSORED HEALTH PLANS WITH ANTI-COMPETITIVE CONTRACTS

Employers are often at a disadvantage negotiating with hospitals and providers when designing their networks, leading to increased costs for plans and enrollees. Even large employers often lack the resources, staffing, or expertise needed to negotiate favorable terms with hospitals and providers, especially highly resourced consolidated hospital and provider systems.[17] Due to this imbalance, employers are often forced to agree to anticompetitive contracting terms in their contracts with providers and hospitals, which reduces their flexibility to design networks that best meet the needs of their employees and keep costs down.[18] Employers would benefit from increased ability to steer patients towards higher quality or lower cost provider options and not be subject to mandated inflated reimbursement rates.

Large, self-insured companies such as Boeing, JPMorgan Chase, and General Motors have begun to negotiate prices with providers directly, using their large number of employees as leverage in their negotiations. However, the success of these efforts is typically a function of a given company's market power, and the vast majority of employers do not have the market power needed to negotiate lower prices or favorable contract terms with providers.[19]

During the HELP Subcommittee's April 16, 2024, hearing, Ms. Mairin Mancino from the Peterson Center on Healthcare testified about anti-competitive contracts:

> Lawmakers can help promote greater competition within the employer healthcare market, as well as individual and commercial health insurance markets, by more directly addressing anticompetitive practices that arise in consolidated markets. Anti-tiering and anti-steering clauses require that an insurer place physicians, hospitals, and other facilities associated with a particular system in the most favorable tier of providers or at the lowest cost-sharing level regardless of whether they meet cost and quality requirements to be in that tier or if other providers have better value. All-or-nothing clauses require insurers to include all of a health system's providers and facilities in their network, regardless of cost or quality differences. Most favored nation clauses also limit competition by guaranteeing that an insurer receives terms from providers that are at least as favorable as those provided to any other insurer, which prevents other insurers from offering new products at a lower rate. These clauses give dominant

[15] *Id.*
[16] https://www.nber.org/papers/w32613.
[17] https://www.ajmc.com/view/large-self-insured-employers-lack-power-to-effectively-negotiate-hospital-prices.
[18] https://republicans-edlabor.house.gov/UploadedFiles/9.10.24_HELP_Hearing_on_ERISA_Anniversary_Schuman_Testimony.pdf.
[19] https://www.ajmc.com/view/large-self-insured-employers-lack-power-to-effectively-negotiate-hospital-prices.

> organizations an unfair advantage over competitors, and the lack of competition prevents employers from being able to prudently fulfill their fiduciary obligations.[20]

During the HELP Subcommittee's September 10, 2024, hearing, Ms. Ilyse Schuman from the American Benefits Council also testified about anti-competitive contracts:

> With growing market power, large hospital systems are able to demand higher prices and impose anti-competitive contracting terms on employer-sponsored health plans and third-party administrators or insurers negotiating on their behalf. These restrictive terms that appear in contracts the hospital system negotiates with insurers, third-party administrators or group health plans further solidify the hospital system's dominance in the region, reduce competition, and ultimately increase costs. Large hospital systems in highly concentrated markets use their leverage in contract negotiations to include terms that limit access to lower-cost, higher-quality health care. These anti-competitive contracting terms come in several forms: (1) "anti-steering" or "anti-tiering" provisions that prevent employers from utilizing value-based designs to direct employees toward lower-cost, higher-quality providers, (2) "all-or-nothing" clauses that require the health plan to contract with all affiliated facilities and providers, including lower-quality ones, or (3) "most-favored nation" clauses that restrict other health plans that are not even a party to the contract from paying lower rates.[21]
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> . . . .
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> With such contracting terms in place, the employer's hands are tied in their efforts to promote higher-value health care and employees are bound more tightly to higher-cost and/or lower quality providers . . . The Council urges the committee to pass the *Healthy Competition for Better Care Act* (H.R. 3120) that would increase competition and promote lower costs by restricting such anti-competitive contract terms.[22]

H.R. 3120, HEALTHY COMPETITION FOR BETTER CARE ACT

H.R. 3120 amends ERISA, the PHSA, and the IRC to ban anti-competitive terms in facility and insurance contracts that limit access to higher quality, lower cost care. Specifically, the bill requires that a group health plan or a health insurance issuer may not enter into an agreement with a health care provider, network or association of providers, third-party administrator, or other service provider offering access to a network of providers if such an agreement includes restrictive contracting terms. Restrictive contracting terms include terms that, directly or indirectly, (1) restrict the group health plan from directing or steering participants to other

[20] https://republicans-edlabor.house.gov/UploadedFiles/Mancino_Testimony.pdf.
[21] https://republicans-edlabor.house.gov/UploadedFiles/9.10.24_HELP_Hearing_on_ERISA_Anniversary_Schuman_Testimony.pdf.
[22] https://republicans-edlabor.house.gov/UploadedFiles/9.10.24_HELP_Hearing_on_ERISA_Anniversary_Schuman_Testimony.pdf.

health care providers, (2) restrict the group health plan from offering incentives to encourage participants to use specific health care providers, (3) require the group health plan to enter into additional agreements with an affiliate of the provider, (4) require the group health plan to agree to payment rates for any affiliate of the provider not party to the contract, or (5) restrict other group health plans from paying a lower rate for services than the plan would pay under the agreement. The bill also provides exceptions for health maintenance organizations and value-based network arrangements; it is not the Committee's intention to restrict employers' ability to design innovative, patient-centered payment models.

SUPPORT FOR H.R. 3120

The following organizations have endorsed or support H.R. 3120: the American Benefits Council, the Bipartisan Policy Center, the Blue Cross Blue Shield Association, the Colorado Consumer Health Initiative, the Consumers for Quality Care, the ERISA Industry Committee, Families USA, Health Access California, Nomi Health, the Pennsylvania Health Access Network, and the U.S. Public Interest Research Group.

CONCLUSION

H.R. 3120 helps level the playing field between highly consolidated providers and employer- sponsored health plans. The bill protects employer-sponsored health plans from anticompetitive contracting terms, giving them more control over their own health plans' networks. As such, this improved leverage will help employers fulfill their fiduciary duties to their employees, delivering high-quality health insurance at low costs.

SUMMARY

H.R. 3120 SECTION-BY-SECTION SUMMARY

Section 1. Short title

Section 1 provides that the short title is "Healthy Competition for Better Care Act."

Section 2. Banning anticompetitive terms in facility and insurance contracts that limit access to higher quality, lower cost care

Section 2 amends section 724 of ERISA, the PHSA, and the IRC to ban anticompetitive terms in facility and insurance contracts that limit access to higher quality, lower cost care. This summary only explains the ERISA provisions of Section 2, which are in the Committee's jurisdiction.

Section 2 prohibits a group health plan or a health insurance issuer (plan) from entering into an agreement with a covered entity, if such agreement directly or directly: (A) restricts the plan from directing or steering participants to other health providers or offering incentives to encourage participants to utilize specific health providers; (B) requires the plan to enter into an additional agreement with an affiliate of the covered entity; (C) requires the plan to agree to payment rates or other terms for an affiliate of the covered entity not party to the agreements; or (D) restricts other plans

not party to the agreement from paying a lower rate for items or services than the plan involved in the agreement pays.

With respect to such payment models, section 2 exempts plans employing the following types of payment models from the requirements under section 2: (A) a health maintenance organization, if it operates primarily through exclusive contracts with multi-specialty physician groups; or (B) a value-based network arrangement, such as an exclusive provider network, accountable care organization, center of excellence, a provider sponsored health insurance issuer operating primarily with multi-specialty physician groups or integrated health systems, or similar network arrangements as determined by the Secretary of Labor through guidance or rulemaking.

Section 2 defines a "covered entity" as a health care provider, network or association of providers, third-party administrator, or other service provider offering access to a network of providers.

Section 2 includes a "State Grandfathering Option," which permits an applicable state authority to determine that the provisions in section 2 would not apply in the state for a specified contract executed on June 19, 2019, and the contracts pursuant to that agreement executed on or before December 31, 2020, for a length of up to 10 years, with an opportunity for renewal. As drafted, this provision only pertains to one existing contract in Pennsylvania entered by the University of Pittsburgh Medical Center (UPMC) and Highmark. The UPMC Highmark contract is unique in that both entities operate insurers and hospital systems. To ensure that patients do not lose health care access, this grandfather clause is narrowly constructed to incorporate only this contract and not to set a precedent or loophole for other contracts.

Section 2 includes a rule of construction clarifying that section 2 shall not be construed to limit network design or cost of quality initiatives by plans beyond the strict terms in the section.

Section 2 directs the Secretary of Labor, in consultation with the Secretaries of Health and Human Services and the Treasury, to promulgate regulations to implement the legislation within one year of enactment.

Section 2 applies its requirements to any contract entered, amended, or renewed on or after the date that is 18 months after the date of enactment of the bill.

EXPLANATION OF AMENDMENTS

The amendments, including the amendment in the nature of a substitute, are explained in the body of this report.

APPLICATION OF LAW TO THE LEGISLATIVE BRANCH

Section 102(b)(3) of Public Law 104–1 requires a description of the application of this bill to the legislative branch. H.R. 3120. H.R. 3120 is applicable to health care facility and insurance contracts and therefore does not apply to the Legislative Branch.

UNFUNDED MANDATE STATEMENT

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

mate prepared by the Director of the Congressional Budget Office (CBO) pursuant to section 402 of the Congressional Budget and Impoundment Control Act of 1974.

EARMARK STATEMENT

H.R. 3120 does not contain any congressional earmarks, limited tax benefits, or limited tariff benefits as defined in clause 9 of House rule XXI.

ROLL CALL VOTES

Clause 3(b) of rule XIII of the Rules of the House of Representatives requires the Committee Report to include for each record vote on a motion to report the measure or matter and on any amendments offered to the measure or matter the total number of votes for and against and the names of the Members voting for and against. The Committee adopted an amendment in the nature of a substitute (ANS) offered by Representative Steel by voice vote. H.R. 3120, as amended, was ordered favorably reported to the House by voice vote.

STATEMENT OF GENERAL PERFORMANCE GOALS AND OBJECTIVES

In accordance with clause (3)(c) of House rule XIII, the goal of H.R. 3120 is to ban anticompetitive terms in facility and insurance contracts that limit access to higher quality, lower cost health care.

DUPLICATION OF FEDERAL PROGRAMS

No provision of H.R. 3120 establishes or reauthorizes a program of the Federal Government known to be duplicative of another Federal program, a program that was included in any report from the Government Accountability Office to Congress pursuant to section 21 of Public Law 111–139, or a program related to a program identified in the most recent Catalog of Federal Domestic Assistance.

STATEMENT OF OVERSIGHT FINDINGS AND RECOMMENDATIONS OF THE COMMITTEE

In compliance with clause 3(c)(1) of rule XIII and clause 2(b)(1) of rule X of the Rules of the House of Representatives, the Committee's oversight findings and recommendations are reflected in the body of this report.

REQUIRED COMMITTEE HEARING

In compliance with clause 3(c)(6) of rule XIII the following hearing held during the 118th Congress was used to develop or consider H.R. 3120: On April 16, 2024, the Committee on Education and the Workforce, Subcommittee on Health, Employment, Labor, and Pensions held a hearing on "ERISA's 50th Anniversary: the Path to Higher Quality, Lower Cost Health Care."

NEW BUDGET AUTHORITY AND CBO COST ESTIMATE

With respect to the requirements of clause 3(c)(2) of rule XIII of the Rules of the House of Representatives and section 308(a) of the Congressional Budget Act of 1974 and with respect to requirements

of clause 3(c)(3) of rule XIII of the Rules of the House of Representatives and section 402 of the Congressional Budget Act of 1974, the Committee adopts as its own the cost estimate for the bill prepared by the Director of the Congressional Budget Office.

At a Glance

Health Care Legislation

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

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

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

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

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

* = between zero and $500,000.

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

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

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

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

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

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

Direct spending and revenues: CBO and the staff of the Joint Committee on Taxation (JCT) estimate that enacting two pieces of legislation in the group would affect direct spending over the 2025–

2034 period and that enacting all three pieces would affect revenues over that period (see Table 1).

H.J. Res. 181, providing for Congressional disapproval under chapter 8 of title 5, United States Code, of the rule submitted by the Department of Labor relating to "Definition of 'Employer'-Association Health Plans," would disapprove a final rule that took effect in July 2024, which rescinded a rule from 2018 that defined "employer" and established a pathway for groups of unrelated employers to form AHPs.[1] The 2018 final rule also loosened regulation of AHPs and broadened the definition of "small employer" to include self-employed people. Under H.J. Res. 181, disapproving the final 2024 rule would restore the 2018 rule in its entirety.

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

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

	By fiscal year, millions of dollars—											
	2025	2026	2027	2028	2029	2030	2031	2032	2033	2034	2025–2029	2025–2034
INCREASES OR DECREASES (−) IN DIRECT SPENDING												
H.J. Res. 181:												
Estimated Budget Authority	0	20	46	72	105	126	123	136	142	157	243	927
Estimated Outlays	0	20	46	72	105	126	123	136	142	157	243	927
H.R. 3120:												
Estimated Budget Authority	0	0	−16	−21	−26	−28	−29	−30	−32	−34	−63	−216
Estimated Outlays	0	0	−16	−21	−26	−28	−29	−30	−32	−34	−63	−216
On-Budget	*0*	*0*	*−14*	*−19*	*−23*	*−25*	*−26*	*−27*	*−29*	*−30*	*−56*	*−193*
Off-Budget	*0*	*0*	*−2*	*−2*	*−3*	*−3*	*−3*	*−3*	*−3*	*−4*	*−7*	*−23*
INCREASES OR DECREASES (−) IN REVENUES												
H.J. Res. 181:												
Estimated Revenues	0	−15	−89	−171	−247	−274	−281	−294	−307	−325	−522	−2,003
On-Budget	*0*	*−12*	*−81*	*−158*	*−229*	*−255*	*−261*	*−274*	*−287*	*−304*	*−480*	*−1,861*
Off-Budget	*0*	*−3*	*−8*	*−13*	*−18*	*−19*	*−20*	*−20*	*−20*	*−21*	*−42*	*−142*
H.R. 3120:												
Estimated Revenues	0	38	261	437	547	604	645	689	727	768	1,283	4,716
On-Budget	*0*	*28*	*193*	*323*	*405*	*447*	*478*	*512*	*540*	*570*	*949*	*3,496*
Off-Budget	*0*	*10*	*68*	*114*	*142*	*157*	*167*	*177*	*187*	*198*	*334*	*1,220*
H.R. 9457:												
Estimated Revenues	0	0	6	14	20	27	27	24	20	16	40	154
On-Budget	*0*	*0*	*4*	*10*	*15*	*20*	*20*	*18*	*15*	*12*	*29*	*114*
Off-Budget	*0*	*0*	*2*	*4*	*5*	*7*	*7*	*6*	*5*	*4*	*11*	*40*
NET INCREASE OR DECREASE (−) IN THE DEFICIT FROM CHANGES IN DIRECT SPENDING AND REVENUES												
H.J. Res. 181:												
Effect on the Deficit	0	35	135	243	352	400	404	430	449	482	765	2,930
On-Budget	*0*	*32*	*127*	*230*	*334*	*381*	*384*	*410*	*429*	*461*	*723*	*2,788*
Off-Budget	*0*	*3*	*8*	*13*	*18*	*19*	*20*	*20*	*20*	*21*	*42*	*142*
H.R. 3120:												
Effect on the Deficit	0	−38	−277	−458	−573	−632	−674	−719	−759	−802	−1,346	−4,932
On-Budget	*0*	*−28*	*−207*	*−342*	*−428*	*−472*	*−504*	*−539*	*−569*	*−600*	*−1,005*	*−3,689*
Off-Budget	*0*	*−10*	*−70*	*−116*	*−145*	*−160*	*−170*	*−180*	*−190*	*−202*	*−341*	*−1,243*

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

About 23 percent of all private health insurance spending is for hospital outpatient services; CBO scaled its estimate accordingly, making adjustments as follows:

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

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

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

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

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

* = between zero and $500,000.

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

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

Pay-As-You-Go considerations: The Statutory Pay-As-You-Go Act of 2010 establishes budget-reporting and enforcement procedures for legislation affecting direct spending or revenues. The net changes in outlays and revenues for the three pieces of legislation that are subject to pay-as-you-go procedures are shown in Table 1.

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

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

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

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

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

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

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

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

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

COMMITTEE COST ESTIMATE

Clause 3(d)(1) of rule XIII of the Rules of the House of Representatives requires an estimate and a comparison of the costs that would be incurred in carrying out H.R. 3120. However, clause 3(d)(2)(B) of that Rule provides that this requirement does not

apply when, as with the present report, the Committee adopts as its own the cost estimate for the bill prepared by the Director of the Congressional Budget Office.

CHANGES IN EXISTING LAW MADE BY THE BILL, AS REPORTED

In compliance with clause 3(e) of rule XIII of the Rules of the House of Representatives, changes in existing law made by the bill, as reported, are shown as follows (existing law proposed to be omitted is enclosed in black brackets, new matter is printed in italics, and existing law in which no change is proposed is shown in roman):

PUBLIC HEALTH SERVICE ACT

* * * * * * *

TITLE XXVII—REQUIREMENTS RELATING TO HEALTH INSURANCE COVERAGE

* * * * * * *

PART D—ADDITIONAL COVERAGE PROVISIONS

* * * * * * *

SEC. 2799A–9. INCREASING TRANSPARENCY BY REMOVING GAG CLAUSES ON PRICE AND QUALITY INFORMATION.

(a) INCREASING PRICE AND QUALITY TRANSPARENCY FOR PLAN SPONSORS AND GROUP AND INDIVIDUAL MARKET CONSUMERS.—

(1) GROUP HEALTH PLANS.—A group health plan or health insurance issuer offering group health insurance coverage may not enter into an agreement with a health care provider, network or association of providers, third-party administrator, or other service provider offering access to a network of providers that would directly or indirectly restrict a group health plan or health insurance issuer offering such coverage from—

(A) providing provider-specific cost or quality of care information or data, through a consumer engagement tool or any other means, to referring providers, the plan sponsor, enrollees, or individuals eligible to become enrollees of the plan or coverage;

(B) electronically accessing de-identified claims and encounter information or data for each enrollee in the plan or coverage, upon request and consistent with the privacy regulations promulgated pursuant to section 264(c) of the Health Insurance Portability and Accountability Act of 1996, the amendments made by the Genetic Information Nondiscrimination Act of 2008, and the Americans with Disabilities Act of 1990, including, on a per claim basis—

(i) financial information, such as the allowed amount, or any other claim-related financial obligations included in the provider contract;

(ii) provider information, including name and clinical designation;

(iii) service codes; or

(iv) any other data element included in claim or encounter transactions; or

(C) sharing information or data described in subparagraph (A) or (B), or directing that such data be shared, with a business associate as defined in section 160.103 of title 45, Code of Federal Regulations (or successor regulations), consistent with the privacy regulations promulgated pursuant to section 264(c) of the Health Insurance Portability and Accountability Act of 1996, the amendments made by the Genetic Information Nondiscrimination Act of 2008, and the Americans with Disabilities Act of 1990.

(2) INDIVIDUAL HEALTH INSURANCE COVERAGE.—A health insurance issuer offering individual health insurance coverage may not enter into an agreement with a health care provider, network or association of providers, or other service provider offering access to a network of providers that would directly or indirectly restrict the health insurance issuer from—

(A) providing provider-specific price or quality of care information, through a consumer engagement tool or any other means, to referring providers, enrollees, or individuals eligible to become enrollees of the plan or coverage; or

(B) sharing, for plan design, plan administration, and plan, financial, legal, and quality improvement activities, data described in subparagraph (A) with a business associate as defined in section 160.103 of title 45, Code of Federal Regulations (or successor regulations), consistent with the privacy regulations promulgated pursuant to section 264(c) of the Health Insurance Portability and Accountability Act of 1996, the amendments made by the Genetic Information Nondiscrimination Act of 2008, and the Americans with Disabilities Act of 1990.

(3) CLARIFICATION REGARDING PUBLIC DISCLOSURE OF INFORMATION.—Nothing in paragraph (1)(A) or (2)(A) prevents a health care provider, network or association of providers, or other service provider from placing reasonable restrictions on the public disclosure of the information described in such paragraphs (1) and (2).

(4) ATTESTATION.—A group health plan or a health insurance issuer offering group or individual health insurance coverage shall annually submit to the Secretary an attestation that such plan or issuer of such coverage is in compliance with the requirements of this subsection.

(5) RULES OF CONSTRUCTION.—Nothing in this section shall be construed to modify or eliminate existing privacy protections and standards under State and Federal law. Nothing in this subsection shall be construed to otherwise limit access by a group health plan, plan sponsor, or health insurance issuer to data as permitted under the privacy regulations promulgated pursuant to section 264(c) of the Health Insurance Portability and Accountability Act of 1996, the amendments made by the Genetic Information Nondiscrimination Act of 2008, and the Americans with Disabilities Act of 1990.

(b) PROTECTING HEALTH PLANS NETWORK DESIGN FLEXIBILITY.—

(1) IN GENERAL.—A group health plan or a health insurance issuer offering group or individual health insurance coverage

shall not enter into an agreement with a provider, network or association of providers, or other service provider offering access to a network of service providers if such agreement, directly or indirectly—

(A) restricts the group health plan or health insurance issuer from—

(i) directing or steering enrollees to other health care providers; or

(ii) offering incentives to encourage enrollees to utilize specific health care providers;

(B) requires the group health plan or health insurance issuer to enter into any additional contract with an affiliate of the provider as a condition of entering into a contract with such provider;

(C) requires the group health plan or health insurance issuer to agree to payment rates or other terms for any affiliate not party to the contract of the provider involved; or

(D) restricts other group health plans or health insurance issuers not party to the contract, from paying a lower rate for items or services than the contracting plan or issuer pays for such items or services.

(2) ADDITIONAL REQUIREMENT FOR SELF-INSURED PLANS.—A self-insured group health plan shall not enter into an agreement with a provider, network or association of providers, third-party administrator, or other service provider offering access to a network of providers if such agreement directly or indirectly requires the group health plan to certify, attest, or otherwise confirm in writing that the group health plan is bound by restrictive contracting terms between the service provider and a third-party administrator that the group health plan is not party to, without a disclosure that such terms exist.

(3) EXCEPTION FOR CERTAIN GROUP MODEL ISSUERS.—Paragraph (1)(A) shall not apply to a group health plan or health insurance issuer offering group or individual health insurance coverage with respect to—

(A) a health maintenance organization (as defined in section 2791(b)(3)), if such health maintenance organization operates primarily through exclusive contracts with multi-specialty physician groups, nor to any arrangement between such a health maintenance organization and its affiliates; or

(B) a value-based network arrangement, such as an exclusive provider network, accountable care organization or other alternative payment model, center of excellence, a provider sponsored health insurance issuer that operates primarily through aligned multi-specialty physician group practices or integrated health systems, or such other similar network arrangements as determined by the Secretary through rulemaking.

(4) ATTESTATION.—A group health plan or health insurance issuer offering group or individual health insurance coverage shall annually submit to, as applicable, the applicable authority described in section 2723 or the Secretary of Labor, an attestation that such plan or issuer is in compliance with the requirements of this subsection.

(c) MAINTENANCE OF EXISTING HIPAA, GINA, AND ADA PROTECTIONS.—Nothing in this section shall modify, reduce, or eliminate the existing privacy protections and standards provided by reason of State and Federal law, including the requirements of parts 160 and 164 of title 45, Code of Federal Regulations (or any successor regulations).

(d) REGULATIONS.—The Secretary, in consultation with the Secretary of Labor and the Secretary of the Treasury, not later than 1 year after the date of enactment of this section, shall promulgate regulations to carry out this section.

(e) RULE OF CONSTRUCTION.—Nothing in this section shall be construed to limit network design or cost or quality initiatives by a group health plan or health insurance issuer, including accountable care organizations, exclusive provider organizations, networks that tier providers by cost or quality or steer enrollees to centers of excellence, or other pay-for-performance programs.

(f) CLARIFICATION WITH RESPECT TO ANTITRUST LAWS.—Compliance with this section does not constitute compliance with the antitrust laws, as defined in subsection (a) of the first section of the Clayton Act (15 U.S.C. 12(a)).

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EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974

SHORT TITLE AND TABLE OF CONTENTS

SECTION 1. This Act may be cited as the "Employee Retirement Income Security Act of 1974".

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SEC. 724. INCREASING TRANSPARENCY [BY REMOVING GAG CLAUSES ON PRICE AND QUALITY INFORMATION]*; PROHIBITION ON ANTICOMPETITIVE AGREEMENTS*.

(a) INCREASING PRICE AND QUALITY TRANSPARENCY FOR PLAN SPONSORS AND CONSUMERS.—

(1) IN GENERAL.—A group health plan (or an issuer of health insurance coverage offered in connection with such a plan) may not enter into an agreement with a health care provider, network or association of providers, third-party administrator, or other service provider offering access to a network of providers that would directly or indirectly restrict a group health plan or health insurance issuer offering such coverage from—

(A) providing provider-specific cost or quality of care information or data, through a consumer engagement tool or any other means, to referring providers, the plan sponsor, participants or beneficiaries, or individuals eligible to become participants or beneficiaries of the plan or coverage;

(B) electronically accessing de-identified claims and encounter information or data for each participant or beneficiary in the plan or coverage, upon request and consistent with the privacy regulations promulgated pursuant to section 264(c) of the Health Insurance Portability and Accountability Act of 1996, the amendments made by the Genetic Information Nondiscrimination Act of 2008, and the Americans with Disabilities Act of 1990, including, on a per claim basis—

(i) financial information, such as the allowed amount, or any other claim-related financial obligations included in the provider contract;

(ii) provider information, including name and clinical designation;

(iii) service codes; or

(iv) any other data element included in claim or encounter transactions; or

(C) sharing information or data described in subparagraph (A) or (B), or directing that such data be shared, with a business associate as defined in section 160.103 of title 45, Code of Federal Regulations (or successor regulations), consistent with the privacy regulations promulgated pursuant to section 264(c) of the Health Insurance Portability and Accountability Act of 1996, the amendments made by the Genetic Information Nondiscrimination Act of 2008, and the Americans with Disabilities Act of 1990.

(2) CLARIFICATION REGARDING PUBLIC DISCLOSURE OF INFORMATION.—Nothing in paragraph (1)(A) prevents a health care provider, network or association of providers, or other service provider from placing reasonable restrictions on the public disclosure of the information described in such paragraph (1).

(3) ATTESTATION.—A group health plan (or health insurance coverage offered in connection with such a plan) shall annually submit to the Secretary an attestation that such plan or issuer of such coverage is in compliance with the requirements of this subsection.

(4) RULES OF CONSTRUCTION.—Nothing in this [section] *subsection* shall be construed to modify or eliminate existing privacy protections and standards under State and Federal law. Nothing in this subsection shall be construed to otherwise limit access by a group health plan, plan sponsor, or health insurance issuer to data as permitted under the privacy regulations promulgated pursuant to section 264(c) of the Health Insurance Portability and Accountability Act of 1996, the amendments made by the Genetic Information Nondiscrimination Act of 2008, and the Americans with Disabilities Act of 1990.

(b) PROTECTING HEALTH PLANS NETWORK DESIGN FLEXIBILITY.—

(1) IN GENERAL.—A group health plan or a health insurance issuer offering group health insurance coverage may not enter into an agreement with a covered entity (as defined in paragraph (3)) if such agreement, directly or indirectly—

(A) restricts (including by operation of any agreement in effect between such covered entity and another covered entity) the group health plan (whether self-insured or fully-insured) or health insurance issuer from—

(i) directing or steering participants or beneficiaries to other health care providers who are not subject to such agreement; or

(ii) offering incentives to encourage participants or beneficiaries to utilize specific health care providers;

(B) requires the group health plan or health insurance issuer to enter into any additional agreement with an affiliate of the covered entity;

(C) requires the group health plan or health insurance issuer to agree to payment rates or other terms for any affiliate of the covered entity not party to the agreement; or

(D) restricts other group health plans or health insurance issuers not party to the agreement from paying a lower rate for items or services than the plan or issuer involved in the agreement pays for such items or services.

(2) EXCEPTIONS FOR CERTAIN PROVIDER GROUP AND VALUE-BASED NETWORK DESIGNS.—Paragraph (1)(A) shall not apply to a group health plan or health insurance issuer offering group health insurance coverage with respect to—

(A) a health maintenance organization (as defined in section 733(b)(3)), if such health maintenance organization operates primarily through exclusive contracts with multi-specialty physician groups, nor to any arrangement between such a health maintenance organization and its affiliates; or

(B) a value-based network arrangement, such as an exclusive provider network, accountable care organization, center of excellence, a provider sponsored health insurance issuer that operates primarily through aligned multi-specialty physician group practices or integrated health sys-

tems, or such other similar network arrangements as determined by the Secretary through guidance or rulemaking.

(3) COVERED ENTITY DEFINED.—For purposes of this subsection, the term "covered entity" means a health care provider, network or association of providers, third-party administrator, or other service provider offering access to a network of providers.

(4) STATE GRANDFATHERING OPTION.—An applicable State authority may make a determination that the prohibitions under paragraph (1)(A) (relating to conditions that would direct or steer enrollees to, or offer incentives to encourage enrollees to use, other health care providers) will not apply in the State with respect to any specified agreement executed on June 19, 2019, and any agreements related to such specified agreement executed on or before December 31, 2020, for a maximum length of nonapplicability of up to 10 years from the date of execution of the contract if the applicable State authority determines that the contract is unlikely to significantly lessen competition. With respect to a specified agreement for which an applicable State authority has made a determination under the preceding sentence, an applicable State authority may determine whether renewal of the contract, within the applicable 10-year period, is allowed.

(5) RULE OF CONSTRUCTION.—Except as provided in paragraph (1), nothing in this subsection shall be construed to limit network design or cost or quality initiatives by a group health plan or health insurance issuer, including accountable care organizations, exclusive provider organizations, networks that tier providers by cost or quality or steer enrollees to centers of excellence, or other pay-for-performance programs.

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INTERNAL REVENUE CODE OF 1986

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Subtitle K—Group Health Plan Requirements

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CHAPTER 100—GROUP HEALTH PLAN REQUIREMENTS

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Subchapter B—OTHER REQUIREMENTS

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SEC. 9824. INCREASING TRANSPARENCY BY REMOVING GAG CLAUSES ON PRICE AND QUALITY INFORMATION.

(a) INCREASING PRICE AND QUALITY TRANSPARENCY FOR PLAN SPONSORS AND CONSUMERS.—

(1) IN GENERAL.—A group health plan may not enter into an agreement with a health care provider, network or association of providers, third-party administrator, or other service provider offering access to a network of providers that would directly or indirectly restrict a group health plan from—

(A) providing provider-specific cost or quality of care information or data, through a consumer engagement tool or any other means, to referring providers, the plan sponsor, participants or beneficiaries, or individuals eligible to become participants or beneficiaries of the plan;

(B) electronically accessing de-identified claims and encounter information or data for each participant or beneficiary in the plan, upon request and consistent with the privacy regulations promulgated pursuant to section 264(c) of the Health Insurance Portability and Accountability Act of 1996, the amendments made by the Genetic Information Nondiscrimination Act of 2008, and the Americans with Disabilities Act of 1990, including, on a per claim basis—

(i) financial information, such as the allowed amount, or any other claim-related financial obligations included in the provider contract;

(ii) provider information, including name and clinical designation;

(iii) service codes; or

(iv) any other data element included in claim or encounter transactions; or

(C) sharing information or data described in subparagraph (A) or (B), or directing that such data be shared, with a business associate as defined in section 160.103 of title 45, Code of Federal Regulations (or successor regulations), consistent with the privacy regulations promulgated pursuant to section 264(c) of the Health Insurance Portability and Accountability Act of 1996, the amendments made by the Genetic Information Nondiscrimination Act of 2008, and the Americans with Disabilities Act of 1990.

(2) CLARIFICATION REGARDING PUBLIC DISCLOSURE OF INFORMATION.—Nothing in paragraph (1)(A) prevents a health care provider, network or association of providers, or other service provider from placing reasonable restrictions on the public disclosure of the information described in such paragraph (1).

(3) ATTESTATION.—A group health plan shall annually submit to the Secretary an attestation that such plan is in compliance with the requirements of this subsection.

(4) RULES OF CONSTRUCTION.—Nothing in this section shall be construed to modify or eliminate existing privacy protections and standards under State and Federal law. Nothing in this subsection shall be construed to otherwise limit access by a group health plan or plan sponsor to data as permitted under the privacy regulations promulgated pursuant to section 264(c) of the Health Insurance Portability and Accountability Act of 1996, the amendments made by the Genetic Information Non-

discrimination Act of 2008, and the Americans with Disabilities Act of 1990.

(b) PROTECTING HEALTH PLANS NETWORK DESIGN FLEXIBILITY.—

(1) IN GENERAL.—A group health plan shall not enter into an agreement with a provider, network or association of providers, or other service provider offering access to a network of service providers if such agreement, directly or indirectly—

(A) restricts the group health plan from—

(i) directing or steering enrollees to other health care providers; or

(ii) offering incentives to encourage enrollees to utilize specific health care providers;

(B) requires the group health plan to enter into any additional contract with an affiliate of the provider as a condition of entering into a contract with such provider;

(C) requires the group health plan to agree to payment rates or other terms for any affiliate not party to the contract of the provider involved; or

(D) restricts other group health plans not party to the contract, from paying a lower rate for items or services than the contracting plan pays for such items or services.

(2) ADDITIONAL REQUIREMENT FOR SELF-INSURED PLANS.—A self-insured group health plan shall not enter into an agreement with a provider, network or association of providers, third-party administrator, or other service provider offering access to a network of providers if such agreement directly or indirectly requires the group health plan to certify, attest, or otherwise confirm in writing that the group health plan is bound by restrictive contracting terms between the service provider and a third-party administrator that the group health plan is not party to, without a disclosure that such terms exist.

(3) EXCEPTION FOR CERTAIN GROUP MODEL ISSUERS.—Paragraph (1)(A) shall not apply to a group health plan with respect to—

(A) a health maintenance organization (as defined in section 9832(b)(3)), if such health maintenance organization operates primarily through exclusive contracts with multi-specialty physician groups, nor to any arrangement between such a health maintenance organization and its affiliates; or

(B) a value-based network arrangement, such as an exclusive provider network, accountable care organization or other alternative payment model, center of excellence, a provider sponsored health insurance issuer that operates primarily through aligned multi-specialty physician group practices or integrated health systems, or such other similar network arrangements as determined by the Secretary through rulemaking.

(4) ATTESTATION.—A group health plan shall annually submit to the Secretary of Labor an attestation that such plan is in compliance with the requirements of this subsection.

(c) MAINTENANCE OF EXISTING HIPAA, GINA, AND ADA PROTECTIONS.—Nothing in this section shall modify, reduce, or eliminate the existing privacy protections and standards provided by reason of State and Federal law, including the requirements of parts 160

and 164 of title 45, Code of Federal Regulations (or any successor regulations).

(d) REGULATIONS.—The Secretary, in consultation with the Secretary of Health and Human Services and the Secretary of Labor, not later than 1 year after the date of enactment of this section, shall promulgate regulations to carry out this section.

(e) RULE OF CONSTRUCTION.—Nothing in this section shall be construed to limit network design or cost or quality initiatives by a group health plan, including accountable care organizations, exclusive provider organizations, networks that tier providers by cost or quality or steer enrollees to centers of excellence, or other pay-for-performance programs.

(f) CLARIFICATION WITH RESPECT TO ANTITRUST LAWS.—Compliance with this section does not constitute compliance with the antitrust laws, as defined in subsection (a) of the first section of the Clayton Act (15 U.S.C. 12(a)).

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ADDITIONAL VIEWS

H.R. 3120, the *Healthy Competition for Better Care Act*, introduced by Rep. Michelle Steel (R–CA), prohibits certain terms in contracts entered into by group health plans and insurers, including "anti-tiering" and "anti-steering" clauses, "all-or-nothing" clauses, "most-favored-nation" clauses, and other anticompetitive terms. Prohibiting these contract terms in federal law could help counter the negative impacts that consolidation can have on plans and consumers alike, by preventing hospital monopolies from leveraging their market power to force sponsors into contracts that financially benefit the hospital and raise costs.[1] H.R. 3120 was reported favorably out of Committee on voice vote.

Consideration of the bill is timely, and the legislative intent is meritorious—to address the anticompetitive practices that disadvantage consumers of health care. Over the past three decades, there has been a steady increase in hospital consolidations[2] and this trend is expected to continue.[3] One study found that the hospital sector is highly concentrated in as many as 90 percent of urban areas.[4] Research shows that consolidation reduces competition and leads to increased prices[5]—as high as 65 percent according to one estimate.[6] Consolidation also can lead to lower wages for many health industry workers,[7] lower quality of care for patients,[8] and higher costs for the federal government.[9]

However, while well-intentioned, additional deliberation and refinements are needed. The bill includes exemptions for any contract that involves a health maintenance organization (HMO), center of excellence, or a "value-based network arrangement." Notably, 13 percent of workers with employer-sponsored health coverage were enrolled in an HMO in 2023.[10] In addition, although undefined in

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[1] Brot-Goldberg et al., *Who Pays for Rising Health Care Prices? Evidence from Hospital Mergers*, National Bureau of Economic Research (June 2024), https://www.nber.org/papers/w32613.

[2] Levinson et al., *Ten Things to Know About Consolidation in Health Care Provider Markets*, KFF (Apr. 19, 2024), https://www.kff.org/health-costs/issue-brief/ten-things-to-know-about-consolidation-in-health-care-provider-markets/.

[3] Ron Southwick, *Hospital merger activity is projected to increase in 2024*, Chief Healthcare Executive (Jan. 25, 2024), https://www.chiefhealthcareexecutive.com/view/hospital-merger-activity-is-projected-to-increase-in-2024.

[4] Brent D. Fulton, *Health Care Market Concentration Trends In The United States: Evidence And Policy Responses*, Health Affairs (Sep. 2017), https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2017.0556.

[5] Gaynor & Town, *The Impact of Hospital Consolidation—Update*, The Robert Wood Johnson Foundation (June 2012), DOI: 10.13140/RG.2.1.4294.0882; Brot-Goldberg et al., *supra* note 2.

[6] Liu et al., *Environmental Scan on Consolidation Trends and Impacts in Health Care Markets*, RAND (Sept. 30, 2022), https://www.rand.org/pubs/research_reports/RRA1820-1.html.

[7] Prager & Schmitt, *Employer Consolidation and Wages: Evidence from Hospitals*, American Economic Review (2021), https://pubs.aeaweb.org/doi/pdfplus/10.1257/aer.20190690.

[8] Martin Gaynor, *What to Do about Health-Care Markets? Policies to Make Health-Care Markets Work*, Brookings (Mar. 2020), https://www.brookings.edu/wp-content/uploads/2020/03/Gaynor_PP_FINAL.pdf.

[9] *Supra* note 2.

[10] *2023 Employer Health Benefits Survey*, KFF (Oct. 18, 2023), https://www.kff.org/health-costs/report/2023-employer-health-benefits-survey/.

this bill, the term Accountable Care Organizations (ACOs) are recognized as one type of "value-based network arrangement."[11] While ACOs were originally established as a payment model for Medicare, many private sector health plans across the country have launched their own ACO networks, and today the top 20 commercial ACOs by patient population represent more than 13 million patients.[12] While there may be policy merit in ensuring that certain arrangements focused on value and quality can continue, there should be ongoing dialogue on how to best achieve that goal without leaving consumers vulnerable to the behaviors the bill seeks to eliminate.[13] Furthermore, in addition to creating a loophole for certain existing contracts, the bill's state grandfathering option allows states to determine the applicability of federal law to employee health benefits plans, upending a longstanding practice regarding ERISA preemption and setting a dangerous precedent. Lastly, the Secretary is granted broad authority to exempt any "other similar network arrangements," further weakening the bill and leaving the door open for future loopholes or problematic interpretations.

It is necessary to close the loopholes and eliminate the exceptions in the bill adopted by the Committee. Doing so would bolster its strength and sufficiency to protect consumers from high health care costs. With these improvements, this legislation would be a stronger product and would warrant full support.

ROBERT C. "BOBBY" SCOTT,
Ranking Member.

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[11] *Value-Based Care*, Centers for Medicare and Medicaid Services, https://www.cms.gov/priorities/innovation/key-concepts/value-based-care (last visited Sept. 19, 2024); *Making the Most of Accountable Care Organizations (ACOs): What Advocates Need to Know*, Families USA (Feb. 2012), https://familiesusa.org/wp-content/uploads/2012/01/ACO-Basics.pdf.

[12] *Top 25 ACOs by patient population*, Definitive Healthcare (June 12, 2024), https://www.definitivehc.com/resources/healthcare-insights/top-acos-patient-population:~:text=Which%20ACO%20has%20the%20largest,and%20two%20 are%20Medicaid%20ACOs; *How many accountable care organizations (ACOs) are in each state?* Definitive Healthcare (May 6, 2024), https://www.definitivehc.com/ resources/healthcare-insights/accountable-care-organizations-by-state.

[13] *See, e.g.*, Letter from Consumers for Fair Hospital Pricing to Chair Virginia Foxx and Ranking Member Bobby Scott (Sept. 11, 2024), https://familiesusa.app.box.com/s/lt4fr3pxuekuqjdlvbjii1twt8334piz.