

H.R. 6703 would establish new rules for association health plans, modify requirements for individual and group health coverage, require contracts between plan sponsors and pharmacy benefit managers (PBMs) to meet certain standards, and appropriate funding for reductions in cost sharing. CBO and the staff of the Joint Committee on Taxation (JCT) estimate that enacting the bill would reduce the deficit by \$35.6 billion over the 2026-2035 period. CBO estimates that enacting the bill would decrease the number of people with health insurance by an average of 100,000 over the 2027-2035 period and reduce gross benchmark premiums by 11 percent, on average, through 2035.

**Estimated Budgetary Effects of H.R. 6703, the Lower Health Care Premiums for All Americans Act**  
 As introduced in the House of Representatives on December 12, 2025

	By Fiscal Year, Millions of Dollars										2026-2030	2026-2035	
	2026	2027	2028	2029	2030	2031	2032	2033	2034	2035			
<b>Increase or Decrease (-) in the Deficit</b>													
Section 101													
Association Health Plans	0	54	147	246	346	388	404	431	448	472	793	2,936	
<i>On-Budget</i>	0	50	136	230	324	363	378	405	422	445	740	2,753	
<i>Off-Budget</i>	0	4	11	16	22	25	26	26	26	27	53	183	
Section 102													
Stop-Loss Insurance	0	*	*	*	*	*	*	*	*	*	*	*	
<i>On-Budget</i>	0	*	*	*	*	*	*	*	*	*	*	*	
<i>Off-Budget</i>	0	*	*	*	*	*	*	*	*	*	*	*	
Section 103													
HRAs	**	**	2	4	6	8	9	10	10	10	11	59	
<i>On-Budget</i>	**	**	2	4	6	9	10	11	11	11	11	62	
<i>Off-Budget</i>	†	†	†	†	†	-1	-1	-1	-1	-1	†	-3	
Section 201													
PBM Services	0	0	0	-245	-327	-306	-286	-263	-235	-203	-572	-1,865	
<i>On-Budget</i>	0	0	0	-176	-233	-219	-205	-188	-169	-146	-409	-1,336	
<i>Off-Budget</i>	0	0	0	-69	-94	-87	-81	-75	-66	-57	-163	-529	
Section 202													
Cost-Sharing Reductions	0	-3,347	-3,504	-3,566	-3,793	-3,986	-4,194	-4,594	-4,833	-4,885	-14,210	-36,702	
<i>On-Budget</i>	0	-3,382	-3,596	-3,673	-3,934	-4,132	-4,379	-4,786	-5,041	-5,112	-14,585	-38,035	
<i>Off-Budget</i>	0	35	92	107	141	146	185	192	208	227	375	1,333	
Total Deficit Effect	**	-3,293	-3,355	3,561	-3,768	-3,896	-4,067	-4,416	-4,610	-4,606	-13,978	-35,572	
<i>On-Budget</i>	**	-3,332	-3,458	-3,615	-3,837	-3,979	-4,196	-4,558	-4,777	-4,802	-14,243	-36,556	
<i>Off-Budget</i>	†	39	103	54	69	83	129	142	167	196	265	984	

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

Components may not sum to totals because of rounding. HRA = health reimbursement account; PBM = pharmacy benefit manager; \* = between -\$500,000 and \$500,000; \*\* = between zero and \$500,000; † = between -\$500,000 and zero.

a. Off-budget effects would come from changes in Social Security revenues.

See also

[CBO's Cost Estimates Explained](#), [CBO Describes Its Cost-Estimating Process](#), [Glossary](#)

For this estimate, CBO assumes an enactment date in December 2025.

### **Section 101, Association Health Plans**

Section 101 would modify federal law by establishing rules for association health plans—group health plans sponsored by associations of employers.

CBO and JCT estimate that the number of people in association plans would increase by about 700,000 per year, on average, over the 2027-2035 period. The agencies estimate that under current law, about 200,000 of those people now have no insurance; the rest purchase insurance in the fully regulated nongroup or small-group markets.

CBO and JCT estimate that enacting section 101 would increase federal deficits by \$2.9 billion over the 2027-2035 period, primarily because of an increase among self-employed people taking up coverage through association health plans. That increase would be slightly offset by effects stemming from lower premiums by the movement into those plans of people who currently have insurance in the fully regulated nongroup or small-group markets.

### **Section 102, Stop-Loss Insurance**

Section 102 would amend the Employee Retirement Income Security Act of 1974 (ERISA) to exclude stop-loss policies from that act's definition of health insurance coverage. Those policies insure against excess or unexpected losses and are obtained by self-insured group health plans or plan sponsors of a group health plan that self-insures. Excluding stop-loss policies from the definition of health insurance coverage would exempt those policies from regulation under ERISA. The bill also would preempt state laws that prohibit group health plans from obtaining stop-loss policies.

CBO and JCT estimate that enacting section 102 would have insignificant effects on direct spending, revenues, and the deficit over the 2026-2035 period. The agencies' analysis of state laws indicates that few states prohibit the sale of stop-loss coverage; thus, the bill's preemption of state laws would affect a small number of people.

### **Section 103, Health Reimbursement Arrangements**

Section 103 would codify and amend regulations for how certain health reimbursement arrangements (HRAs) that are paired with health insurance purchased in the individual market are treated for tax purposes. An HRA is an employer-funded account that reimburses employees for medical expenses.

JCT estimates that the use of HRAs would expand under section 103 and that enacting the section would decrease revenues by \$59 million over the 2026-2035 period.

### **Section 201, Oversight of Pharmacy Benefit Management Services**

Section 201 would require PBMs to disclose certain types of information to group health plans. For employers and plans with 100 or more employees or participants, PBMs would be directed to disclose data related to enrollees' use of prescription drugs, along with costs, rebates, fees, and cost-sharing amounts, to the group health plans. PBMs would be required to disclose only a subset of that information (excluding information related to the use and costs of specific prescription drugs) to group health plans with fewer than 100 participants that insure employers with fewer than 100 employees.

CBO expects that, in some cases, prescription drug costs would be reduced if private payers had more complete information about the operations of their PBMs, including the net drug prices that PBMs negotiate with drug manufacturers and pharmacies. CBO estimates that the reduction in drug costs would cause premiums charged in the group health insurance market in the first full year of implementation to fall by less than 0.1 percent, on average, and expects that those savings probably would erode over time. By 2035, CBO estimates, average premiums charged in the private insurance market would be less than 0.05 percent lower than under current law.

CBO and JCT estimate that enacting section 201 would increase federal revenues by \$1.8 billion and decrease direct spending by \$22 million, for a net decrease in the deficit of \$1.9 billion over the 2026-2035 period.

### **Section 202, Payments to Reduce Cost Sharing**

Section 202 would affect the cost-sharing reductions that the Affordable Care Act requires insurers to offer to eligible people who purchase silver plans through the marketplaces. Those reductions increase the actuarial value—the average share of covered medical expenses paid by the insurer—above the amount in other silver plans, resulting in lower out-of-pocket costs for eligible enrollees. To be eligible, an enrollee must have income that generally falls between 100 percent and 250 percent of the federal poverty level (FPL); the amount of the reduction varies with an enrollee's income.

Section 202 would appropriate funds for payments to reduce cost sharing and allow those payments to be made only for plans that limit any coverage of abortion services to when it is necessary to save the life of the mother or when a pregnancy is the result of rape or incest.

Because insurers must still offer cost-sharing reductions, and they bear that cost even without a direct payment from the government, most cover the costs by increasing premiums for silver plans offered through the marketplaces. That practice, called silver loading, results in a larger premium tax credit under current law because the credit is tied to the second-lowest-cost silver plan. The premium tax credit covers a greater share of premiums for enrollees in non-silver plans and, in CBO's estimation, primarily increases enrollment among people whose income is between 200 percent and 400 percent of the FPL. Silver loading would end if insurers were compensated for cost-sharing reductions through an appropriation, thereby reducing gross premiums for silver plans and reducing the premium tax credit.

CBO expects that enacting section 202 would end silver loading in the states where roughly 75 percent of marketplace enrollees reside. Because some states mandate coverage of certain abortion services, and marketplace plans still must offer cost-sharing reductions, CBO projects that the other 25 percent of enrollees would live in states where silver loading would continue, consistent with current conditions. In the absence of silver loading, CBO projects, enrollment would decline primarily among people whose income is between 200 percent and 400 percent of the FPL because the premium tax credit available to them would cover a smaller share of premiums for non-silver plans than under current law. CBO estimates that enacting section 202 would reduce the nation's gross benchmark premium by 11 percent and increase the number of people without health insurance by 300,000, on average, per year over the 2027-2035 period.

CBO and JCT estimate that enacting section 202 would decrease federal deficits, on net, by \$36.7 billion over the 2026-2035 period. That decrease is driven by a reduction in the premium tax credit of \$131.1 billion and an increase in outlays for cost-sharing reductions of \$91.8 billion, partially offset by \$2.6 billion in other effects.

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