



Fiscal Score S. 1140 / H.R. 6100

Health Accelerating Customer's Care by Expediting Self-Schedule (ACCESS) Act

The Fiscal Lab has examined the fiscal effects of the Health ACCESS Act (S. 1140 and H.R. 6100), introduced in the 119th Congress. S. 1140, sponsored by Senator Cassidy, and H.R. 6100, sponsored by Representative Moore, is legislation that would allow healthcare providers and suppliers to pay for web-based platforms that would help consumers book appointments. It amends federal anti-kickback statutes but incorporates guardrails against steering, leading, and payment-based rankings.

The Fiscal Lab's analysis of this provision finds that the expected cost to the federal government is below the Fiscal Lab's de minimis threshold and would likely have a minimal budgetary cost using conventional scoring methods. The primary cost is administrative costs that would be necessary to ensure agencies are evaluating the statutory exemption of the anti-kickback statutes and ensuring compliance of the guardrails outlined by the legislation.

 Thursday, July 16, 2026	S. 1149/H.R. 6100		Fiscal Years (Millions of dollars)									
	2026	2027	2028	2029	2030	2031	2032	2033	2034	2035	2026 – 2030	2026 – 2035
Total Increase or Decrease (-) in Deficit	~ 0	~ 0	~ 0	~ 0	~ 0	~ 0	~ 0	~ 0	~ 0	~ 0	~ 0	~ 0
On Budget	~ 0	~ 0	~ 0	~ 0	~ 0	~ 0	~ 0	~ 0	~ 0	~ 0	~ 0	~ 0
Off Budget	~ 0	~ 0	~ 0	~ 0	~ 0	~ 0	~ 0	~ 0	~ 0	~ 0	~ 0	~ 0
Direct Spending (Outlays)	~ 0	~ 0	~ 0	~ 0	~ 0	~ 0	~ 0	~ 0	~ 0	~ 0	~ 0	~ 0
Revenues	~ 0	~ 0	~ 0	~ 0	~ 0	~ 0	~ 0	~ 0	~ 0	~ 0	~ 0	~ 0

Notes: At this time the Fiscal Lab does not believe the value will exceed \$1 billion for a 10-year window.

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To amend Title XI of the Social Security Act to lower barriers to increase patient access to healthcare.

Final Score: Under \$1 billion—for 2026 to 2035

Summary: The conventional score associated with the regulatory change of the Health ACCESS Act would be additional staffing needed by numerous agencies that would ensure regulatory compliance. The legislation would amend Section 1128B(b) of the Social Security Act which is the Anti-Kickback Statute. Current law makes it illegal to knowingly and willfully pay for the purpose of inducing rewards, purchases, leases, recommendations etc. to a federal healthcare program, such as Medicare or Medicaid. H.R. 6100 would provide narrow exceptions that would allow payments to online scheduling platforms as long as they follow the guardrails associated with the legislation. These guardrails ensure that there is:

- No payment-based steering – where the payment would steer or lead a consumer to a particular provider or supplier based upon the amount they pay the information service provider
- No medical services – the information service provider may not provide or represent itself as providing any medical services or background
- No broad lead sharing – the information service provider cannot share contact information of consumers
- No transportation agreement – the information service provider cannot arrange or provide transportation of a customer to a service provider or supplier
- No beneficiary remuneration – the information service provider can only provide the convenience of information service and cannot provide or arrange any other remuneration to a federal healthcare program
- No target marking – the information service provider cannot engage in targeted marking of a service provider or supplier
- Compensation structure – the methodology for determining compensation to the information service provider must be defined in advance, cannot exceed fair market value, outlined for specific services in writing, and cannot be tied to a federal healthcare program value
- Disclosure – the financial arrangement must be disclosed to consumers, information provided to consumers is based upon objective consumer-centric criteria, and participation must be objective and non-exclusionary

As noted, the legislation will require staffing changes by many federal agencies to ensure compliance and review of the guardrails and anti-kickback statute. The most likely agencies involved would include Health and Human Services (HHS) Office of Inspector General (OIG) and various operating divisions within HHS, Centers for Medicare & Medicaid Services (CMS), Department of Justice (DOJ), and potentially the Federal Trade Commission (FTC). HHS involvement is the clearest place where increased staffing and need for higher administrative costs would arise. The OIG of HHS may need to issue

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guidance, update compliance materials, review advisory opinion requests, investigate complaints, and train staff on the new exception.

Additionally, other operating divisions within HHS would need to have time for policy development, legal review, guidance, and rulemaking. This is because the legislation gives the secretary an active role in setting conditions that could require further review. CMS would need to build monitoring routines, update manuals, coordinate with contractors, and analyze any claims that could align to payments on scheduling platforms. The DOJ would remain relevant for criminal enforcement and additional efforts would be dependent upon the volume of disputes or litigation under the legal changes. The FTC may need to also evaluate any deceptive rankings or advertising by healthcare providers or suppliers on the information service providers.

Outside of federal costs, there is the potential impact to state-level programs that administer Medicaid. As noted, with the increased administrative burdens, there may be the need for additional staff, training, revisions of existing compliance materials, and monitoring of compliance to new guardrails. The secretary also has the ability to impose additional conditions that could require further oversight and review.

To address request from the office it should be noted that:

- The literature supports a careful framing: Preventive care can produce savings, but broad claims of automatic savings are not well supported.
- The guardrails do not regulate the platform's speech; they regulate whether provider payments may receive safe harbor protection.

Overall, even if the cost requires staffing of a couple dozen new employees and the need for supplemental training and review, this legislation would likely fall below \$10 million per year with a cost below \$100 million for a 10-year window.

Additional Notes: Outside the conventional score there are two larger issues at play. First is the impact of dynamic scoring, such as how improved access and scheduling may allow for more preventative care and reduce the need for emergency care, a potential cost-savings measure. Based upon the data from Zocdoc, there is the potential for federal savings through preventative care and reducing Medicare and Medicaid patients' reliance on emergency department (ED) visits for healthcare. Though Zocdoc highlights potential cost savings from fewer ED visits, the current literature on this topic, discussed below, addresses potential concerns with this conclusion and how preventative care, though it can improve health quality, may not directly reduce healthcare costs. Second is the concern of money as speech, where larger healthcare providers and suppliers are able to afford information service platforms while smaller providers and suppliers may not be, and how that impacts their ability to connect with patients. Both of these will be addressed in greater detail below.

Impact of Preventative Care Versus Emergency Care

The Fiscal Lab received Zocdoc data from Senator Cassidy's office that highlight the potential cost savings to individuals, or federal health care programs, by having access to online booking for preventative care. The Fiscal Lab spoke with representatives from Zocdoc to review the data provided and

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examine the potential cost savings highlighted by the model. There is some question as to prior literature on the impact of preventative medicine on cost savings reductions, but Zocdoc notes that their data are primarily focused on Medicaid and Medicare recipients who may have a lower quality of health relative to the general population, and therefore would generate a greater cost savings for that subset of the population compared to the population as a whole.

Zocdoc highlights potential savings of almost \$3 billion in the 10th year by expanding the number of Medicare and Medicaid patients who would have access to preventative care through online booking. Based upon an internal survey, Zocdoc found that 25–28 percent of government-insured patients would have used the ED for care if they had not booked on Zocdoc. ED visits have a substantially higher cost relative to preventative care. Zocdoc calculates an estimated \$1,700 cost savings per individual accessing preventative care as opposed to an emergency room visit. This savings is also based upon the subset of the population that use government-funded healthcare: the elderly, with Medicare, and the disadvantaged, with Medicaid. Relative to the US population at large, Zocdoc notes the potential for greater savings from preventative care for those with more severe health issues associated with aging or those with income constraints. Table 1 notes the total savings and breaks it out based upon Medicaid and Medicare. However, Medicaid savings needs to be evaluated as the difference between federal- and state-level savings.

Table 1. Zocdoc model of savings breaking out Medicare and Medicaid

	Zocdoc Noted Savings (\$ millions)	Zocdoc Noted Medicaid Savings (\$ millions)	Zocdoc Noted Medicare Savings (\$ millions)
Year 1	137.90	87.56	50.34
Year 2	414.51	263.20	151.31
Year 3	668.99	424.79	244.20
Year 4	916.84	582.17	334.67
Year 5	1,170.65	743.33	427.32
Year 6	1,442.31	915.83	526.48
Year 7	1,740.72	1,105.31	635.41
Year 8	2,075.42	1,317.84	757.58
Year 9	2,458.04	1,560.79	897.24
Year 10	2,897.56	1,839.88	1,057.68

The potential Medicaid savings, addressed in Table 2, is based on the total reduction in costs that Zocdoc calculates of preventative care relative to ER visits. However, the federal government would only cover a portion of Medicaid expenditures with the balance falling on the individual states. To calculate an estimated federal government savings, because the Fiscal Lab does not have savings by state, a weighted average is calculated. This is based off the 2025 Census for state population and the reported FMAP percentages by HHS. This generates a weighted average FMAP of 58.07 percent, meaning the federal government will cover that percentage of costs with the individual states covering the remaining balance. Based on Zocdoc estimates and the weighted averages for FMAP, the potential savings over a 10-year window are \$5.13 billion from Medicaid savings.

Table 2. Zocdoc model for federal savings based on Medicaid

	Zocdoc Noted Medicaid Savings (\$ millions)	State Based Weighted Avg of FMAP	Zocdoc proposed Medicaid Savings (\$ millions)
Year 1	87.56	58.07%	50.85
Year 2	263.20	58.07%	152.84
Year 3	424.79	58.07%	246.68
Year 4	582.17	58.07%	338.07
Year 5	743.33	58.07%	431.65
Year 6	915.83	58.07%	531.82
Year 7	1,105.31	58.07%	641.86
Year 8	1,317.84	58.07%	765.27
Year 9	1,560.79	58.07%	906.35
Year 10	1,839.88	58.07%	1,068.42
Years 1-5	2,101.06	58.07%	1,220.09
Years 1-10	8,840.71	58.07%	5,133.80

Medicare is funded directly by the government and Part B care, under which preventative and ED visits fall, which are financed through premiums paid to the government. Overall, the savings measured by Zocdoc would be directly received by the federal government in the form of a reduction of healthcare costs. Through expanded access to online bookings, Zocdoc estimates that in the 10th year the savings could exceed \$1 billion because of the expansion of preventative care and the reduction of ED visits.

Overall, through Medicare and Medicaid savings, Zocdoc estimates that there is the potential for upwards of \$10 billion in federal savings that could be achieved over a 10-year window, as shown in Table 3. This savings is based upon a number of assumptions, such as the cost savings from preventative care in place of ED visits and that the Medicare and Medicaid population is significantly less healthy and more prone to ED visits than the general population. The Fiscal Lab has summarized articles below that potentially refute the claims of cost savings from preventative care. The articles note that access to preventative care significantly improves quality of life, which could create a healthier and more productive labor force, but does not note significant cost savings outside a couple of limited procedures.

Table 3. Zocdoc model for potential federal savings

	Zocdoc proposed Federal Medicaid Savings (millions)	Zocdoc proposed Federal Medicare Savings (millions)	Zocdoc proposed Total Federal Savings (millions)
Year 1	50.85	50.34	101.19
Year 2	152.84	151.31	304.15
Year 3	246.68	244.20	490.87
Year 4	338.07	334.67	672.74
Year 5	431.65	427.32	858.97
Year 6	531.82	526.48	1,058.30

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	Zocdoc proposed Federal Medicaid Savings (millions)	Zocdoc proposed Federal Medicare Savings (millions)	Zocdoc proposed Total Federal Savings (millions)
Year 7	641.86	635.41	1,277.26
Year 8	765.27	757.58	1,522.85
Year 9	906.35	897.24	1,803.60
Year 10	1,068.42	1,057.68	2,126.10
Years 1-5	1,220.09	1,207.83	2,427.91
Years 1-10	5,133.80	5,082.21	10,216.01

As noted, the Fiscal Lab examined several articles that examine the reasonability of the statement, “preventative care can produce cost savings.” Cohen et al. (2008) provide the strongest cautionary framing: Preventive care can improve health, but it should not be assumed to save money. They note that some preventive services, such as childhood vaccines, can produce clear cost savings, while others, such as colon cancer screening, are highly valuable and may prevent expensive downstream treatment but are not automatically budget-saving in every setting. Their main point is that prevention often adds upfront costs through screening, outreach, and follow-up treatment, and only becomes cost-saving when it prevents enough expensive downstream care to offset those upfront costs. The potential cost savings for older individuals with colon cancer screening could contribute toward the savings for Medicare recipients, and the benefits of childhood vaccines may significantly benefit those on Medicaid who may not otherwise schedule appointments for children.

David et al. (2015) offer a more targeted example where prevention and care coordination may reduce spending. Their study of patient-centered medical homes—a digital coordinated approach, not a physical home—found lower emergency department use among chronically ill patients, suggesting that savings are more plausible when interventions focus on high-risk populations rather than the general population. This analysis may support Zocdoc’s analysis for the greater at-risk populations like the elderly or those with less access to basic necessities.

Pourat et al. (2015) similarly show that continuity in primary care was associated with fewer emergency department visits and hospitalizations. This supports the idea that better routine care can help patients avoid costly acute care, but the savings case depends on whether the reduced hospital use is large enough to outweigh the cost of expanding or maintaining primary care access. If Zocdoc is able to provide greater continuity of care, there will be better health outcomes for individuals, but, as noted, there is a potential question of the amount of cost savings that may be achieved.

Baicker and Chandra (2025) reinforce the skeptical view that prevention should be evaluated like any other health intervention: Some preventive care is cost-saving, some is cost-effective but not cost-saving, and some may raise total spending while still improving health. Their broader takeaway is that prevention is most fiscally credible when it is low cost, well targeted, and aimed at patients most likely to generate avoidable high-cost care. This article provides a great summary that, though preventative care is beneficial, the cost-savings measure can vary greatly depending upon the treatment provided.

Alternatively, an Assistant Secretary for Planning and Evaluation (ASPE) report on emergency department utilization from 2009 to 2018 shows that ED use remains a major and costly part of the health

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system, with more than 143 million ED visits in 2018 and more than 20 million resulting in admission to the same hospital. The report is useful because it frames ED use as a broad system-cost issue, but it also supports a cautious interpretation: Not every ED visit is avoidable, and savings from prevention depends on whether better primary care, chronic disease management, or earlier intervention can reduce truly avoidable ED visits and admissions. This article notes that continuous ED use is expensive to the healthcare system as a whole, and not simply an avoidable cost to the government for federally insured patients.

Also, Allen et al. (2021) compare low-income adults covered by Medicaid with those covered by subsidized private insurance and show that coverage type can be associated with differences in utilization, spending, and quality. Their study highlights that insurance design and access pathways may shape how patients use care, including whether they rely more on routine care or higher-cost settings. However, the article should be examined carefully for cost-savings claims: It supports the idea that better access and coverage structure may influence downstream spending, but it does not by itself show that preventive care will generate net federal savings.

Overall, the literature supports a careful framing: Preventive care can produce savings, but broad claims of automatic savings are not well supported. The strongest cost-saving argument comes from targeted interventions for high-risk or chronically ill patients where there is evidence of reduced emergency department use, hospitalizations, or disease progression. For this reason, though the greater cost savings highlighted by Zocdoc focuses on the elderly and disadvantaged individuals, the results should be viewed conservatively, with appropriate caution, and by focusing on the measurable outcomes and not on assumed savings.

Money as Speech Concerns

S. 1140 and H.R. 6100 would create targeted exceptions to existing anti-kickback restrictions, while also including numerous guardrails intended to prevent pay-to-play referrals or payment-based rankings of healthcare providers and suppliers. These guardrails are designed to ensure that platforms do not become paid referral engines by prohibiting payment-based steering, requiring financial disclosure, and requiring provider-specific information to be based on objective, consumer-centric criteria.

However, the legislation does not expressly dictate what an online platform must display or how rankings must occur. As a result, larger providers or suppliers could potentially influence the general categories of information shown on a platform, such as requesting that platforms avoid displaying consumer reviews below a certain verification threshold, pending complaints, quality scores, wait times, or billing complaints. If applied uniformly across all providers, this would not necessarily amount to suppressing information for only paying providers, but it could still skew the information available to consumers in ways that benefit larger providers or suppliers with greater market leverage.

In that scenario, a platform could argue that its ranking, review, and display practices reflect protected editorial or commercial speech, rather than payment-based steering. The concern is not only that payment could be directly connected to suppressing negative information about a single provider, but also that broader platform-wide information policies could systematically benefit certain providers while remaining outside the clearest pay-to-play restrictions.

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That distinction is important. The guardrails do not regulate the platform’s speech; they regulate whether provider payments may receive safe harbor protection. A platform may retain broad discretion over how it presents information, but if payments directly influence rankings, suppress negative information, steer consumers, or otherwise change the treatment of participating providers in a way that is not based on objective, consumer-centered criteria, the arrangement may fall outside the protection created by S. 1140 and H.R. 6100.

Modeling Used: Documentation provided by Zocdoc identified the potential savings to Medicare and Medicaid through preventative care. To examine the potential federal savings a weighted average, based on state population, of Federal Medical Assistance Percentage (FMAP) was taken across all states. Weighting was based on the 2025 population from the US Census and the FMAP was taken from the HHS. The corresponding tables relating to the calculations are included in the additional notes below.

Source(s):

Senator Bill Cassidy, Health ACCESS Act, S. 1140, 119th Cong. (2025)

Rep. Blake D. Moore, Health ACCESS Act, H.R. 6100, 119th Cong. (2025).

USAFACTS, “How Much Money Do Federal Employees Make?,” November 28, 2023.

US Census Bureau, “State Population Totals and Components of Change: 2020–2025,” January 2026.

US Department of Health and Human Services, “Federal Financial Participation in State Assistance Expenditures; Federal Matching Shares for Medicaid, the Children’s Health Insurance Program, and Aid to Needy Aged, Blind, or Disabled Persons for October 1, 2025 Through September 30, 2026,” Federal Register 89, no. 230 (November 29, 2024): 94708–12.

Joshua T. Cohen, Peter J. Neumann, and Milton C. Weinstein, “Does Preventive Care Save Money? Health Economics and the Presidential Candidates,” *New England Journal of Medicine* 358, no. 7 (2008): 661–63.

Guy David et al., “Do Patient-Centered Medical Homes Reduce Emergency Department Visits?,” *Health Services Research* 50, no. 2 (2015): 418–39.

Naderreh Pourat et al., “In California, Primary Care Continuity Was Associated with Reduced Emergency Department Use and Fewer Hospitalizations,” *Health Affairs* 34, no. 7 (2015): 1113–20.

Katherine Baicker and Amitabh Chandra, “Can Prevention Save Money?,” *JAMA Health Forum* 6, no. 4 (2025).

Trends in the Utilization of Emergency Department Services, 2009–2018 (US Department of Health and Human Services, March 1, 2021).

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Heidi Allen et al., “Comparison of Utilization, Costs, and Quality of Medicaid vs Subsidized Private Health Insurance for Low-Income Adults,” JAMA Network Open 4, no. 1 (2021).

UnitedHealthcare, “What Are My Care Options and Their Costs?,” accessed June 26, 2026.

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