CONGRESSIONAL BUDGET OFFICE
COST ESTIMATE

March 10, 2003

H.R. 5
Help Efficient, Accessible, Low-cost, Timely Healthcare (HEALTH) Act of 2003

As ordered reported by the House Committee on the Judiciary on March 5, 2003

SUMMARY

H.R. 5 would impose limits on medical malpractice litigation in state and federal courts by capping awards and attorney fees, modifying the statute of limitations, eliminating joint and several liability, and changing the way collateral-source benefits are treated.

Those changes would lower the cost of malpractice insurance for physicians, hospitals, and other health care providers and organizations. That reduction in insurance costs would, in turn, lead to lower charges for health care services and procedures, and ultimately, to a decrease in rates for health insurance premiums.

Because employers would pay less for health insurance for employees, more of their employees' compensation would be in the form of taxable wages and other fringe benefits. As a result, CBO estimates that enacting H.R. 5 would increase federal revenues by $15 million in 2004 and by $3 billion over the 2004-2013 period.

Enacting H.R. 5 also would reduce federal direct spending for Medicare, Medicaid, the government's share of premiums for annuitants under the Federal Employees Health Benefits (FEHB) program, and other federal health benefits programs. CBO estimates that direct spending would decline by $14.9 billion over the 2004-2013 period.

Federal spending for active workers participating in the FEHB program is included in the appropriations for federal agencies, and therefore is discretionary. CBO estimates that enactment of H.R. 5 would reduce discretionary spending for the FEHB program by about $230 million over the 2004-2013 period.

The bill would preempt state laws that provide less protection for health care providers and organizations from liability, loss, or damages (other than caps on awards for damages). That preemption would be an intergovernmental mandate as defined in the Unfunded Mandates

Reform Act (UMRA). Such a preemption would limit the application of state law, but it would require no action by states that would result in additional spending or a loss of revenue. Thus, the threshold established by UMRA for intergovernmental mandates ($59 million in 2003, adjusted annually for inflation) would not be exceeded.

H.R. 5 would impose a private-sector mandate on attorneys in malpractice cases by limiting the size of the awards they could receive. CBO estimates that the direct cost of that mandate would exceed the annual threshold specified in UMRA ($117 million in 2003, adjusted annually for inflation) in all but the first year the mandate would be effective.

ESTIMATED COST TO THE FEDERAL GOVERNMENT

The estimated budgetary impact of H.R. 5 is shown in the following table. The effects of this legislation on direct spending fall within budget functions 550 (health) and 570 (Medicare). The effects on spending subject to appropriation fall within multiple budget functions.

	By Fiscal Year, in Millions of Dollars										
	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2004 - 2013
CHANGES IN REVENUES											
Income and HI Payroll Taxes (on-budget)	10	70	170	210	220	230	250	270	290	330	2,050
Social Security Payroll Taxes (off-budget)	5	20	60	90	100	110	120	130	140	150	925
Total	15	90	230	300	320	340	370	400	430	480	2,975
CHANGES IN DIRECT SPENDING											
Estimated Budget Authority	-170	-480	-910	-1,250	-1,570	-1,820	-1,990	-2,130	-2,220	-2,350	-14,900
Estimated Outlays	-170	-480	-910	-1,250	-1,570	-1,820	-1,990	-2,130	-2,220	-2,350	-14,900
CHANGES IN SPENDING SUBJECT TO APPROPRIATION											
Estimated Authorization Level	-2	-10	-20	-20	-20	-30	-30	-30	-30	-30	-230
Estimated Outlays	-2	-10	-20	-20	-20	-30	-30	-30	-30	-30	-230

NOTE: HI = Medicare Hospital Insurance program.

BASIS OF ESTIMATE

This estimate assumes that H.R. 5 will be enacted in July 2003. It would apply to lawsuits initiated on or after the date of enactment.

Major Provisions of the Bill

H.R. 5 would place caps on awards by limiting non-economic damages, such as pain and suffering, to $250,000, and punitive damages to twice the amount of economic damages or $250,000, whichever is greater. Punitive damages would be further constrained by limiting the circumstances under which they may be sought. Economic, or compensatory, damages would not be limited. Attorney fees would be restricted as follows: 40 percent of the first $50,000 of the award, 33.3 percent of the next $50,000 of the award, 25 percent of the next $500,000, and 15 percent of that portion of the award in excess of $600,000. The caps on attorney fees would apply regardless of whether the award was determined in the courts or settled privately, and could be reduced further at the discretion of the court. (The court could not, however, increase attorney fees beyond the caps.) For awards of future damages equal to or exceeding $50,000, any party to the lawsuit could request that future damages be paid by periodic payments.

The bill would impose a statute of limitations requiring that lawsuits begin within three years after the injury alleged to have happened as a result of malpractice occurs or one year after the claimant discovers, or should have discovered, the injury, whichever occurs first. Under the joint and several liability provisions of current law, defendants found negligent in a lawsuit are each liable for the full amount of damages, regardless of their proportionate share of responsibility for the injury. H.R. 5 would limit the liability of each defendant to the share of damages attributable to his or her responsibility.

The bill would allow evidence of collateral-source benefits to be introduced at trial by either claimants or defendants. Collateral-source benefits are other sources of compensation a claimant may have access to in the event of an injury. A common source of such benefits is the claimant's health insurance, which would likely pay for a portion of the medical costs arising from the injury. Other sources include disability insurance payments, workers' compensation, and life insurance payments. In addition, providers of collateral-source benefits would not be allowed to place a lien on the claimant's award or recover any amount from the claimant, whether or not the case goes to trial.

Impact on Medical Malpractice Insurance Premiums

CBO's estimate of the impact of this bill is based on a statistical analysis of historical premiums and claims data for medical malpractice insurance coverage in states that have and have not enacted laws that limit awards for medical malpractice torts. The data include information on malpractice awards and insurance premiums, the characteristics of state insurance markets, state laws regarding malpractice torts, and socioeconomic measures. Data were provided by several organizations including Medical Liability Monitor; Insurance Services Office, Inc.; Physician Insurers Association of America; National Association of State Insurance Commissioners; and the U.S. Census Bureau. CBO also considered the impact of factors not directly related to trends in malpractice claim payments that may have contributed to recent increases in medical malpractice premiums. Those factors include reduced investment income of insurers, the need of insurers to replenish depleted reserves for unpaid claims, changes in market structure in certain states, and increases in the price of reinsurance.

CBO's analysis indicated that certain tort limitations, primarily caps on awards and rules governing offsets from collateral-source benefits, effectively reduce average premiums for medical malpractice insurance. Consequently, CBO estimates that, in states that currently do not have controls on malpractice torts, H.R. 5 would significantly lower premiums for medical malpractice insurance from what they would otherwise be under current law. That effect would increase somewhat over the ten-year time horizon of this estimate because caps on awards would not be indexed to increase with inflation. As a result, the caps on awards would become more constraining in later years. CBO also took into consideration the likelihood that, in the future, some additional states would enact laws limiting malpractice torts in the absence of federal legislation.

CBO estimates that, under this bill, premiums for medical malpractice insurance ultimately would be an average of 25 percent to 30 percent lower than what they would be under current law. However, other factors noted above may affect future premiums, possibly obscuring the anticipated effect of the legislation. The effect of H.R. 5 would vary substantially across states, depending on the extent to which a state already limits malpractice litigation. There would be almost no effect on malpractice premiums in about one-fifth of the states, while reductions in premiums would be substantially larger than the overall average in about one-third of the states.

Impact on Health Insurance Premiums

The percentage effect of H.R. 5 on overall health insurance premiums would be far smaller than the percentage impact on medical malpractice insurance premiums. Malpractice costs

account for a very small fraction of total health care spending; even a very large reduction in malpractice costs would have a relatively small effect on total health plan premiums. In addition, some of the savings leading to lower medical malpractice premiums—those savings arising from changes in the treatment of collateral-source benefits—would represent a shift in costs from medical malpractice insurance to health insurance. Because providers of collateral-source benefits would be prevented from recovering their costs arising from the malpractice injury, some of the costs that would be borne by malpractice insurance under current law would instead be borne by the providers of collateral-source benefits. A substantial portion of collateral source benefits are provided by health insurers.

CBO's estimate does not include savings from reductions in the practice of defensive medicine—services and procedures that are provided largely or entirely to avoid potential liability. Estimating the amount of health care spending attributable to defensive medicine is difficult. Most estimates are speculative in nature, relying, for the most part, on surveys of physicians' responses to hypothetical clinical situations, and clinical studies of the effectiveness of certain intensive treatments. Compounding the uncertainty about the magnitude of spending for defensive medicine, there is little empirical evidence on the effect of medical malpractice tort controls on spending for defensive medicine and, more generally, on overall health care spending.

A few studies have observed reductions in health care spending correlated with changes in tort law, but that research was based largely on a narrow part of the population and considered only spending for a small number of ailments. One study analyzed the impact of tort limits on Medicare hospital spending for patients suffering acute myocardial infarction or ischemic heart disease, and observed a significant reduction in spending in states with such laws. Other research examined the effect of tort limits on the proportion of births by Caesarean section. It also found savings in states with tort limits, albeit of a much smaller magnitude. Using a longitudinal database of Medicare spending for fee-for-service beneficiaries between 1989 and 1999, CBO found no effect of tort controls on medical spending in an analysis that considered a broader set of ailments. Moreover, using a different data set, CBO could find no statistically significant difference in per capita health care spending between states with and without malpractice tort limits. These findings are preliminary, however, and CBO continues to explore this issue.

Federal Revenues

CBO estimates that, over a three-year period, enacting H.R. 5 would lower the price employers, state and local governments, and individuals pay for health insurance by about 0.4 percent, before accounting for the responses of health plans, employers, and workers to the lower premiums. Those responses would include an increase in the number of employers

offering insurance to their employees and in the number of employees enrolling in employer-sponsored insurance, changes in the types of health plans that are offered, and increases in the scope or generosity of health insurance benefits. CBO assumes that these behavioral responses would offset 60 percent of the potential impact of the bill on the total costs of health plans.

The remaining 40 percent of the potential reduction in premium costs, or about 0.2 percent of group health insurance premiums, would occur in the form of lower spending for health insurance. In the short term, some of the savings would be retained by employers as higher profits, and would result in higher collections of income taxes from employers. Ultimately, however, those savings would be passed through to workers, increasing both their taxable compensation and other fringe benefits. For employees of private firms, CBO assumes that all of that savings would ultimately be passed through to workers. We assume that state, local, and tribal governments would absorb 75 percent of the decrease and would increase their workers' taxable income and other fringe benefits to offset the remaining one-quarter of the decrease. CBO estimates that the resulting increase in taxable income would grow from $65 million in calendar year 2004 to $1.4 billion in 2013.

Those increases in workers' taxable compensation would lead to more federal tax revenues. The estimate assumes an average marginal rate of about 20 percent for income taxes and the current-law rates for the Hospital Insurance and Social Security payroll taxes (2.9 percent and 12.4 percent, respectively). CBO further assumes that 15 percent of the change in taxable compensation would not be subject to the Social Security payroll tax. As a result, we estimate that federal tax revenues would increase by $15 million in 2004 and by a total of $3 billion over the 2004-2013 period if H.R. 5 were enacted. Social Security payroll taxes, which are off-budget, account for about 30 percent of those totals.

Federal Spending

CBO estimates that H.R. 5 would reduce direct spending for federal health insurance programs by $14.9 billion over the 2004-2013 period.

CBO estimates that premiums for the FEHB program would decline by the same 0.4 percent as the estimated average change in premiums for private health insurance. (That estimate includes the effects of H.R. 5 on both premiums for malpractice insurance and the collection of collateral-source benefits.) We assume that participants in the FEHB program would offset 60 percent of that reduction by choosing more expensive plans, so that spending for the FEHB program would decline by about 0.2 percent.

Federal spending for annuitants in the FEHB program is considered direct spending. CBO estimates that H.R. 5 would reduce direct spending for annuitants in FEHB by $230 million over the 2004-2013 period. Federal spending for active workers participating in the FEHB program is included in the appropriations for federal agencies, and therefore is discretionary. CBO estimates that enactment of H.R. 5 would reduce discretionary spending for FEHB by about $230 million over the 2004-2013 period. Spending for postal workers and postal annuitants participating in the FEHB program is off-budget. CBO estimates that changes in spending for Postal Service participants would be offset by changes in the prices of postal services, and therefore would net to zero.

Each year, the Centers for Medicare & Medicaid Services sets Medicare payment rates for physician services and hospital services that include explicit adjustments for changes in the cost of malpractice premiums. CBO estimates that H.R. 5 would have no effect on Medicare spending in 2003, because payment rates have already been set for hospital and physician services. CBO estimates that incorporating lower malpractice premiums in Medicare payment rates would reduce Medicare spending by $11.2 billion over the 2004-2013 period.

CBO assumes that the rates that state Medicaid programs pay for hospital and physician services would change in proportion to the changes in Medicare payments. In addition, lower Medicare payment rates would result in lower payments by beneficiaries for cost sharing and premiums. Therefore, H.R. 5 would reduce spending by federal programs that pay premiums and cost sharing for certain Medicare beneficiaries—Medicaid and the Tricare for Life program of the Department of Defense (DoD). CBO estimates that H.R. 5 would reduce direct spending for Medicaid and DoD by $3.5 billion over the 2004-2013 period.

INTERGOVERNMENTAL AND PRIVATE-SECTOR IMPACTS

The Unfunded Mandates Reform Act defines a mandate as legislation that "would impose an enforceable duty" upon the private sector or a state, local, or tribal government. CBO believes that UMRA's definition of a mandate does not include legislation that would impose requirements or limitations on recoveries, address burdens of proof, or modify evidentiary rules because such changes would be methods of enforcing existing duties, rather than new duties themselves as contemplated by UMRA. The provisions of H.R. 5 would not impose or change the underlying enforceable duties or standards of care applicable to those providing medical items and services under current law. Rather, they would address the enforcement of existing standards of professional behavior through tort litigation procedures.

Clearly, a cap on recoveries of damages from medical malpractice would lower recoveries by future plaintiffs while reducing the costs borne by potential defendants. This cost effect,

however, would not itself establish a new mandate. It would be more reasonably viewed as part of the process for enforcing the professional duties of medical providers, rather than an enforceable duty as defined by UMRA.

Intergovernmental Mandates and Other Public-Sector Impacts

Intergovernmental Mandates. The bill would preempt state laws that would prevent the application of any provisions of the bill, but it would not preempt any state law that provides greater protections for health care providers and organizations from liability, loss, or damages. Those that provide a lesser degree of protection would be preempted. (State laws governing damage awards would not be preempted, regardless of whether they were higher or lower than the caps provided for in the bill.) These preemptions would limit the application of state law, but they would require no action by states that would result in additional spending or a loss of revenue. Thus, the threshold established by UMRA for intergovernmental mandates ($59 million in 2003, adjusted annually for inflation) would not be exceeded.

Other Public-Sector Impacts. State, local, and tribal governments would realize net savings as a result of provisions of the bill. State, local, and tribal governments that assess income taxes also would realize increased tax revenues as a result of increases in workers' taxable income. CBO has not estimated the magnitude of those increased revenues.

State, local, and tribal governments would save money as a result of lower health insurance premiums precipitated by the bill. Based on information from the Bureau of the Census and the Joint Committee on Taxation and on our estimates of the effect of the bill on health care premiums, CBO estimates that state and local governments would save about $6 billion over the 2004-2013 period as a result of lower premiums for health care benefits they provide to their employees. That figure is based on estimates of state and local spending for health care growing from about $95 billion in 2004 to $185 billion in 2013 and an expectation that savings would phase in over a three-year period. The estimate accounts for some loss in receipts because state health, sickness, income-disability, accident, and workers' compensation programs would no longer be able to recover a share of malpractice damage awards.

State and local governments also would save Medicaid costs as a result of lower health care spending. CBO estimates that state spending for Medicaid would decrease by $2.5 billion over the 2004-2013 period.

Private-Sector Mandates and Other Impacts

The bill would impose a private-sector mandate on attorneys in malpractice cases by limiting the size of the awards they could receive. CBO estimates that the direct cost of that mandate to affected attorneys would be less than $100 million in 2003, and about $340 million peryear in 2004 through 2007. Those costs would exceed the annual threshold specified in UMRA ($117 million in 2003, adjusted annually for inflation) in all but the first year the mandate would be effective.

PREVIOUS COST ESTIMATE

On September 24, 2002, CBO provided a cost estimate for H.R. 4600 as ordered reported by the Committee on the Judiciary. The current estimate differs from the earlier estimate in three ways. It:

- Reflects the exclusion of the Medicare and Medicaid programs from the collateral-source benefits provision in the bill, thus allowing them to continue to be secondary payers in medical malpractice cases. This change increases the estimated savings to the Medicare and Medicaid programs.

- Corrects the previous estimate, which overstated on-budget savings in the FEHB program because it included off-budget effects related to the Postal Service.

- Reflects changes in projections under current law of tax-sheltered health expenditures, as well as changes in projections of spending under current law for the Medicare, Medicaid, and FEHB programs.

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