CONGRESSIONAL BUDGET OFFICE
COST ESTIMATE

April 21, 1999

S. 326
Patients' Bill of Rights Act

As ordered reported by the Committee on Health, Education, Labor, and Pensions on March 18, 1999

SUMMARY

Title I of the Patients' Bill of Rights Act would amend the Employee Retirement Income Security Act (ERISA) to give members of self-insured health plans rights to obtain certain services, require group health plans and health insurance issuers to provide certain information to enrollees and potential enrollees, and establish internal and external review procedures for group health plans and health insurance issuers. Title II would prohibit health plans from discriminating on the basis of genetic information. Title III would redesignate the Agency for Health Care Policy and Research as the Agency for Healthcare Research and Quality and would reauthorize the agency.

The proposed patient protections and grievance procedures would increase the premiums for employer-sponsored health insurance, substitute nontaxable fringe benefits for taxable wages, and reduce federal receipts from income and payroll taxes. The Congressional Budget Office (CBO) estimates that these provisions would reduce federal tax revenues by $15 million in 2000 and by $1.0 billion over the 2000-2004 period.

S. 326 contains no intergovernmental mandates as defined in the Unfunded Mandates Reform Act (UMRA). State, local, and tribal governments either would be exempt from the bill's requirements governing health care benefits and insurance or would be able to opt out of the requirements.

ESTIMATED COST TO THE FEDERAL GOVERNMENT

The estimated effect of the bill on direct spending and receipts is shown in Table 1. The costs of this legislation fall within budget function 550 (health).

Table 1. Estimate of the Budgetary Effects of the Patients' Bill of Rights Act

	By Fiscal Year, in Millions of Dollars									
	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009
Revenues										
Income and HI Payroll Taxes	-10	-70	-140	-210	-260	-290	-310	-320	-340	-360
Social Security Payroll Taxes	-5	-30	-65	-90	-110	-130	-130	-140	-150	-160
Total	-15	-100	-205	-300	-370	-420	-440	-460	-490	-520
Authorizations of Appropriations										
Study of Access to Clinical Trials	1	a	0	0	0	0	0	0	0	0
Healthcare Research and Quality	25	138	217	247	261	267	272	250	123	37
Total	26	138	217	247	261	267	272	250	123	37

SOURCE: Congressional Budget Office.
NOTE: HI = Hospital Insurance.

a. Less than $500,000.

BASIS OF ESTIMATE

Revenues

The proposed rights to medical care and advice, informational requirements, and grievance procedures would affect the federal budget through their effect on premiums for employer-sponsored health insurance. Although the rights to medical advice and care would apply only to self-insured ERISA plans, other plans are likely to be affected by them as well. Federal legislation to regulate a significant part of the health insurance market could stimulate action by states and health plans to develop consistent policies on coverage. Taking such spillover effects into account, CBO estimates that the provisions for medical

care and advice, patient information, grievance procedures, and confidentiality of patient information would raise average premiums by about 0.8 percent. Table 2 shows the estimated effect of each provision on premiums, before employers modify their behavior to offset some of the increase. The effects are expressed as a percentage of total premiums for all nonfederal employer-sponsored plans, including plans that would face no increase in costs.

TABLE 2. ESTIMATED EFFECT OF THE PATIENTS' BILL OF RIGHTS ACT ON PREMIUMS FOR EMPLOYER-SPONSORED HEALTH INSURANCE (In percent)

Provision	Increase in Premiums
Title I	
Subtitle A—Right to Medical Advice and Care	
Access to emergency care	0.2
Offering choice of coverage options	a
Access to obstetric and gynecological care	a
Access to pediatric care	a
Access to specialists	a
Continuity of care	0.2
Protection of patient-provider communications	a
Right to prescription drugs	a
Self-payment for behavioral health care services	a
Subtitle B—Right to Information About Plans and Providers	0.1
Subtitle C—Right to Hold Health Plans Accountable	0.3
Title II	
Genetic Information and Services	a
Total	0.8

a. Less than 0.05 percent.

The estimate assumes that about 60 percent of the increase in premiums would be offset through decreases in fringe benefits and that about 40 percent would be passed on to employees as lower wages. CBO estimates that the increase in premiums would reduce federal tax revenues by $15 million in 2000 and by $1.0 billion over the 2000-2004 period. Social Security payroll taxes, which are off-budget, account for $300 million of the five-year total.

Right to Medical Advice and Care. Subtitle A of title I contains a number of patient protections for enrollees in self-insured ERISA health plans. Those provisions include:

- a prohibition of interference by health plans with medical communications between physicians and their patients;

- a requirement that plans pay for hospital emergency services—until the patient is stabilized—when the prudent layperson standard is met, and that beneficiaries be charged no more than would be required if such services were furnished by a participating provider;

- a requirement for direct access to an obstetrical and gynecological specialist for covered routine obstetrical and gynecological care;

- a requirement for direct access to pediatricians for covered routine pediatric services;

- a requirement that beneficiaries have access to specialty care when such care is covered by the plan;

- the right to continue care for 90 days with a provider whose contract has been terminated by a health plan;

- a requirement that plans with a formulary for prescription drugs involve physicians and pharmacists in the development of the formulary and provide for exceptions from the formulary limitation;

- prohibitions on discouraging beneficiaries from paying for behavioral health care services not covered by the plan and terminating providers because they permit beneficiaries to pay for such services; and

- a requirement that health plans offer employees a point-of-service option when the existing health plan offerings do not provide choice among provider groups.

CBO estimates that those rights to medical care and advice would ultimately increase costs across all nonfederal employer-sponsored health plans by about 0.4 percent.

Right to Information About Plans and Providers. Subtitle B of title I would require all ERISA group health plans to provide certain kinds of information on plan provisions to enrollees and to make other kinds available on request. Most of the required information is

typically provided now as part of a plan's handbook or could easily be incorporated into that document. Although some documents would have to be amended to meet the requirements of this provision, such documents are continually changed to reflect new terms. Plans would be responsible for making available to participants any data on quality or performance that they collect, but they would not be required to collect such data. Plans would have to make minor investments in personnel and systems to assure and monitor compliance with those requirements. CBO estimates that the informational requirements would increase costs across all nonfederal employee-sponsored health plans by 0.1 percent.

Right to Hold Health Plans Accountable. Subtitle C of title I would require all ERISA group health plans to abide by specific time limits for making coverage determinations and to have an internal review process for reconsidering coverage decisions within defined time limits at the request of the enrollee. For those coverage decisions involving medical necessity or investigational treatments, a physician with the appropriate expertise would have to conduct the internal review. Plans would also have to provide for external review of medical necessity decisions involving claims exceeding a significant dollar threshold or investigational treatments for life threatening illnesses. The findings of the external review would be binding on the health plan.

Most plans today have a functioning internal appeals process, but they operate with more flexibility on timing than they might have under this provision. Consequently, a few plans would have to invest in more review personnel to meet the specified time limits. Costs would also increase because of the requirement for external review, which would be new to most plans. CBO estimates that the net cost of this subtitle would be about 0.3 percent of employer-sponsored health plan costs.

Genetic Information and Services. Title II would prohibit all health plans and health insurers from using predictive genetic information in setting premiums for groups or individuals. It would also prohibit plans from requesting such information except when the information was needed for diagnosis, treatment, or payment relating to the provision of health services. Even then, plans could not require such information and would have to provide the individual with a description of the procedures in place for protecting the confidentiality of such information. Although this provision would keep health insurers and health plans from reducing their costs through favorable risk selection based on genetic information, its cost to private employer-sponsored health plans as a whole would be negligible.

Authorizations of Appropriations

Clinical Trials. Title I would require the Secretary of Health and Human Services to contract with the Institute of Medicine to conduct a study of access by patients to clinical trials and the coverage of routine health care costs by private health plans and insurers. CBO estimates that this provision would increase discretionary spending by $1 million in 2000.

Healthcare Research and Quality. Title III would redesignate the Agency for Healthcare Policy and Research as the Agency for Healthcare Research and Quality and respecify its mission. To support the activities of AHRQ, S. 326 would authorize $250 million in fiscal year 2000 and such sums as may be necessary for fiscal years 2001-2006. Assuming appropriations of the authorized amounts, CBO estimates that this title would increase discretionary spending by $25 million in fiscal year 2000 and $888 million over the 2000-2004 period.

PAY-AS-YOU-GO CONSIDERATIONS

Section 252 of the Balanced Budget and Emergency Deficit Control Act sets up pay-as-you-go procedures for legislation affecting direct spending and receipts. The net changes in outlays and governmental receipts that are subject to pay-as-you-go procedures are shown in Table 3. For purposes of enforcing pay-as-you-go procedures, only the effects in the current year, the budget year, and the succeeding four years are counted.

Table 3. Summary of Pay-As-You-Go Effects

	By Fiscal Year, in Millions of Dollars									
	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009
Change in outlays	0	0	0	0	0	0	0	0	0	0
Change in receipts	-10	-70	-140	-210	-260	-290	-310	-320	-340	-360

ESTIMATED IMPACT ON STATE, LOCAL, AND TRIBAL GOVERNMENTS

The bill's amendments to ERISA and to the Public Health Services Act would establish a number of new requirements governing health care benefits and insurance. However, plans offered by state, local, and tribal governments are exempt from the requirements of ERISA,

and they may opt out of the requirements of the Public Health Service Act. Consequently, the new provisions would not be intergovernmental mandates as defined by UMRA, and they would have an impact on the budgets of states, local, or tribal governments only if those governments chose to comply.

ESTIMATED IMPACT ON THE PRIVATE SECTOR

The bill would impose several private-sector mandates as defined in UMRA. They include the rights to medical care and advice and requirements for plans to establish appeals procedures for handling patients' grievances. CBO estimates that the direct costs of those mandates to private-sector entities would significantly exceed the threshold specified in UMRA ($100 million in 1996, adjusted annually for inflation) every year after 2000.

PREVIOUS CBO ESTIMATE

On March 17, 1999, CBO provided an estimate of S. 326, as introduced on January 28, 1999. This estimate reflects changes in the bill as reported by the committee on March 18, 1999, more recent information on the health care system, and reanalysis of the impact of certain provisions in light of new information. In total, the estimated effect on premiums for employer-sponsored health insurance has increased from 0.5 percent to 0.8 percent.

The committee added a new standard for external review of denials of coverage to subtitle C. That standard would require independent external reviewers to take into account information submitted by the patient's physician and the medical records as well as scientific and clinical literature. The standard would substitute those criteria for the plan's own definition of medical necessity and would therefore lead to more decisions favorable to patients. That change adds 0.2 percentage points to the estimate.

The estimate of the prudent layperson standard for emergency care has been increased by 0.1 percentage point because the committee added a new restriction on health plans' ability to charge patients higher copayments when they seek emergency care at nonparticipating providers.

New provisions involving prescription drugs and the right to receive behavioral health care at the participant's expense add little to the estimate. In addition, the title regarding privacy of medical records and access to medical records was removed.

New information obtained about the frequency with which employers, especially those with few employees, switch plans has led to a slight increase in the estimate of the effect of the provision involving continuity of care. New data also led to a slight decrease in the estimate of the costs of offering a choice of coverage options.

ESTIMATE PREPARED BY:

Federal Cost Estimate: Linda Bilheimer, Tom Bradley, Jeanne De Sa, and Judith Wagner

Impact on State, Local, and Tribal Governments: Leo Lex

Impact on the Private Sector: Judith Wagner

ESTIMATE APPROVED BY:

Paul N. Van de Water
Assistant Director for Budget Analysis