CONGRESSIONAL BUDGET OFFICE
COST ESTIMATE

July 26, 2001

H.R. 2563
Bipartisan Patient Protection Act

As introduced on July 19, 2001

SUMMARY

H.R. 2563 would impose new requirements on the structure and operation of group health plans and issuers of health insurance and would provide members of health plans and insured individuals with new rights to obtain certain health care services. Those new rights include coverage of routine patient-care costs in clinical trials funded by the National Institutes of Health or approved by the Food and Drug Administration; access to out-of-network providers, including hospital emergency departments; and access to pediatricians, obstetricians, gynecologists, and other specialists.

The bill would require both internal and external review processes for members to appeal claims denied by health plans and insurers. It would also amend the Employee Retirement Income Security Act to allow individuals to sue health plans and insurers for personal injury or wrongful death—in federal court for failure to comply with terms of the plan and in state court under state tort laws.

The requirements on the structure and operation of group health plans would apply to plans offered by state, local, and tribal governments. These provisions would take effect beginning October 1, 2002.

H.R. 2563 would expand the availability of medical savings accounts (MSAs), increase the deduction for health insurance purchased by self-employed individuals, and provide tax credits for small businesses that purchase health insurance.

H.R. 2563 would also shift certain outlays for Part B of Medicare from fiscal year 2002 to 2003, extend certain user fees charged by the Customs Service, and transfer amounts from general revenues to the Social Security trust funds to offset reductions in revenue from Social Security payroll taxes.

CBO and the Joint Committee on Taxation estimate that federal tax revenues would fall by $269 million in 2002 and by $22 billion over the 2002-2011 period if H.R. 2563 were enacted. Social Security payroll taxes, which are off-budget, account for about $6 billion of that total. Direct spending would decline by an estimated $235 million in 2002 and by $7.2 billion over the 2002-2011 period. That total includes:

- an increase of almost $0.2 billion in spending for annuitants covered by the Federal Employees Health Benefits program;

- a decrease of $7.3 billion resulting from extending certain customs fees; and

- transfers of $5.9 billion from the general fund to the Social Security trust funds; although the outlays from the general fund are on-budget and the receipts by the trust funds are off-budget, those transfers would have no net effect on the unified budget.

Thus, the bill would reduce on-budget direct spending by $1.2 billion, and decrease off-budget direct spending by $5.9 billion over the 2002-2011 period. The changes in revenues and direct spending would, in total, reduce prospective surpluses by about $15 billion over the next 10 years, all of which would be on-budget. (The changes in off-budget revenues and outlays would offset each other.) Because the bill would affect both revenues and direct spending, pay-as-you-go procedures would apply.

H.R. 2563 would also affect discretionary spending for health care programs for federal civilian employees and for development and administration of regulations for the patient protections. CBO has not completed its estimate of these costs, which would be funded through appropriations. Our preliminary judgment is that discretionary spending would increase by less than $500 million over the 2002-2011 period, assuming appropriation of the necessary amounts.

The bill would establish several private-sector and intergovernmental mandates as defined in the Unfunded Mandates Reform Act (UMRA). CBO estimates that the direct costs of complying with those mandates would far exceed the thresholds established in UMRA in each of the years after enactment. (Those thresholds, which are adjusted annually for inflation, are $113 million for the private sector and $56 million for intergovernmental mandates in 2001.) By 2007, when the full costs of the bill would first be realized, the estimated costs of the mandates would be about $22 billion for the private sector and $2 billion for state and local governments.

ESTIMATED COST TO THE FEDERAL GOVERNMENT

The estimated budgetary impact of H.R. 2563 is shown in Table 1. The costs of this legislation fall within several budget functions. The estimate assumes enactment before October 1, 2001.

Table 1. Estimated Effect on Revenues and Direct Spending of H.R. 2563, the Bipartisan Patient Protection Act

	By Fiscal Year, in Millions of Dollars										
	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2002 - 2011
CHANGES IN REVENUES											
Income and HI Payroll Taxes (on-budget)											
Patient Protections	-20	-210	-600	-1,100	-1,400	-1,700	-1,900	-2,000	-2,200	-2,300	-13,430
Medical Savings Accounts	-1	-4	-7	-9	-8	-8	-7	-7	-7	-6	-64
Deductions for Self-employed	-214	-641	0	0	0	0	0	0	0	0	-855
Credit for Small Businesses	-24	-71	-125	-178	-209	-217	-220	-224	-214	-178	-1,660
Subtotal, on-budget	-259	-926	-732	-1,287	-1,617	-1,925	-2,127	-2,231	-2,421	-2,484	-16,009
Social Security Payroll Taxes (off-budget)	-10	-90	-270	-470	-630	-760	-830	-890	-960	-1,000	-5,910
Total	-269	-1,016	-1,002	-1,757	-2,247	-2,685	-2,957	-3,121	-3,381	-3,484	-21,919
CHANGES IN DIRECT SPENDING											
Increased FEHB Costs for Annuitants	0	5	10	10	20	25	25	30	30	30	185
Delay in Payments by Medicare Carriers	-235	235	0	0	0	0	0	0	0	0	0
Customs User Fees	0	0	-1,485	-1,675	-1,130	-530	-565	-605	-650	-695	-7,335
Transfer to Social Security: on-budget	10	90	270	470	630	760	830	890	960	1,000	5,910
off-budget	-10	-90	-270	-470	-630	-760	-830	-890	-960	-1,000	-5,910
Total	-235	240	-1,475	-1,665	-1,110	-505	-540	-575	-620	-665	-7,150

NOTE: HI = Medicare Hospital Insurance program; FEHB = Federal Employees Health Benefits program.

BASIS OF ESTIMATE

Revenues

Patient Protections. CBO estimates that H.R. 2563, if enacted, would ultimately increase the premiums for health plans sponsored by private employers (including self-employed individuals) and by state, local, or tribal governments by an average of 4.0 percent, before accounting for the responses of plans, employers, and workers to the higher prices (see

Table 2). We estimate that the increase in premiums would be phased in over a period of five years after the effective date.

CBO assumes that 60 percent of that increase would be offset by changes in profits and by purchasers switching to less expensive plans, cutting back on benefits, or dropping coverage.

Table 2. Estimated Ultimate Effect of H.R. 2563, The Bipartisan Patient Protection Act, on Premiums for Employer-Sponsored Health Insurance (In Percent)

Provision	Increase in Premiums
Subtitle A—Utilization Review, Claims, and Appeals	
Utilization review activities	0.2
Procedures for initial claims and prior authorization	a
Internal and external appeals	0.9
Subtitle B—Access to Care	
Consumer choice	0.1
Choice of health care professional	a
Access to emergency care	0.4
Access to specialty care	0.3
Access to obstetric and gynecological care	0.1
Access to pediatric care	a
Continuity of care	0.2
Access to needed drugs	a
Clinical trials	0.8
Treatment of breast cancer and second opinions	0.2
Subtitle C—Access to Information	0.1
Subtitle D—Protecting the Doctor-Patient Relationship	a
Subtitle E—Definitions	
Coverage of limited scope plans	a
Title IV—Availability of Civil Remedies	0.7
Total	4.0

SOURCE: Congressional Budget Office.

a. Less than 0.05 percent.

Most of the remaining 40 percent of the increase, or about 1.6 percent of health insurance costs, would be passed through to workers, reducing both their taxable compensation and other fringe benefits. For employees of private firms, CBO assumes that all of that increase would ultimately be passed through to workers. In contrast, state, local, and tribal governments are assumed to absorb 75 percent of the increase and reduce their workers' taxable income and other fringe benefits to offset the remaining one-quarter of the increase. CBO estimates that the resulting reduction in taxable income would grow from about $100 million in calendar year 2002 to nearly $10 billion in 2011.

Those reductions in workers' taxable compensation would lead to lower federal and state tax revenues. The estimate assumes a marginal rate of 21 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 fall by $30 million in 2002 and by $19 billion over the 2002-2011 period if H.R. 2563 were enacted. Social Security payroll taxes, which are off-budget, account for about 30 percent of those totals.

Utilization Review, Claims, and Internal and External Appeals. Subtitle A of title I sets out requirements for the conduct of utilization reviews and for appeals of decisions to deny coverage or payment of claims. Plans would have to specify clinical review criteria developed with input from appropriate health care professionals and, to the extent feasible, based on outcomes of care.

The bill would also require all group health plans and insurers to establish a system for handling enrollees' grievances, which would include a two-tier process for reviewing appeals of plans' decisions. The first stage would involve appeals to professionals within the plan. Enrollees who were not satisfied with that internal decision could then appeal grievances to an external appeals board.

CBO estimates that these provisions, which are closely interrelated, would jointly raise premiums by 1.1 percent.

Access to Care. Subtitle B of title I contains a number of patient protections for enrollees covered by group health plans or by issuers of health insurance. Those provisions include:

- 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;

- a requirement that plans that require or provide for designation of a participating primary care provider permit enrollees to designate any participating primary care

provider who is available; enrollees in such plans may designate a participating and available pediatrician as the primary care provider for a child;

- a requirement that plans pay for hospital emergency services—including certain post-stabilization and maintenance services—and for emergency ambulance services, 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 that beneficiaries have access to appropriate and accessible specialty care when such care is covered by the plan;

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

- the right to continue care for specified periods 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 with the same cost sharing as a drug on the formulary[1];

- a requirement that plans cover routine patient costs for enrollees participating in certain clinical trials approved by the Food and Drug Administration or funded by the National Institutes of Health (NIH), a cooperative group or center of NIH, the Department of Veterans Affairs, or the Department of Defense;

- a requirement that plans that cover medical and surgical benefits provide coverage of inpatient care for the period determined by the attending physician in the case of a patient receiving a mastectomy or lymph node dissection for treatment of breast cancer; and

- a requirement that plans cover secondary consultations for patients diagnosed with or being treated for cancer.

CBO estimates those provisions would increase premiums by 2.1 percent.

1. CBO assumes that some plans with a closed formulary (that is, some brands of drugs are not covered) would establish an open formulary which would minimize the plan's share of the cost of drugs previously not covered.

Access to Information. Subtitle C of title I would require group health plans and issuers of health insurance to provide certain information to enrollees on their plan's provisions and to make other information available on request. CBO estimates those requirements would increase premiums by 0.1 percent.

Protecting the Doctor-Patient Relationship. Subtitle D of title I contains five provisions governing plans' contracts with providers. Those provisions would:

- void any provision of a contract that limited a provider's freedom to discuss or communicate with a patient about aspects of his or her care;

- prohibit discrimination with respect to participation or indemnification against a provider on the basis of licensure or certification if that provider is acting within the scope of his or her license or certification;

- prohibit provisions in contracts between health plans and providers that transfer liability for decisions of the plan to the provider or reward the provider for medical decisions regarding specific payments;

- require that 95 percent of claims be paid within 30 days of the receipt of information needed to establish that the claim is for a covered service; and

- protect providers (and enrollees) from retaliation for participating in the appeals and grievance process or for disclosing information on the quality of care to a plan or regulatory agency.

CBO estimates those provisions would have a negligible effect on premiums because those requirements are largely met already.

Definitions. Subtitle E of title I would apply these patient protections to "limited scope" plans, such as plans that cover only dental benefits or eye care. CBO estimates that provision would have a negligible effect.

Availability of Civil Remedies. Title IV would alter the legal liability of group health plans and issuers of health insurance under the Employee Retirement Income Security Act of 1974 (ERISA). The bill would amend ERISA to permit enrollees in employer-sponsored plans to sue plans in state court for cases of injury or death involving medically reviewable decisions; suits for cases involving injury or death resulting from administrative decisions would be tried in federal court. It would prevent any recovery by plans from doctors or hospitals for the medical costs resulting from medical malpractice. CBO estimates those provisions would increase premiums by 0.7 percent.

Tax Provisions. H.R. 2563 would expand the availability of medical savings accounts, increase the deduction for health insurance purchased by self-employed individuals, and provide tax credits for small businesses that purchase health insurance. The Joint Committee on Taxation estimates that those provisions would reduce federal tax revenues by about $2.6 billion over the 2002-2011 period. The credits for small businesses would account for $1.7 billion of that amount.

Direct Spending

H.R. 2563 would reduce direct spending by an estimated $235 million in 2002 and by about $7.2 billion over the 2002-2011 period. That total includes a $1.2 billion decrease in on-budget direct spending and a $5.9 billion decrease in off-budget direct spending.

The bill would impose additional costs on the Federal Employees' Health Benefits (FEHB) program, because most of the plans in that program are classified as issuers of health insurance. However, many of the patient protections in title I were extended to federal health care programs by an Executive Memorandum issued on February 20, 1998, which required those programs to comply with the recommendations of the Advisory Commission on Consumer Protection and Quality in the Health Care Industry. Nevertheless, several provisions were not addressed by the Advisory Commission, go beyond the commission's recommendations, or require changes in procedures to comply with the commission's recommendations. The provisions likely to have a significant effect on direct spending include:

- requirements concerning emergency care;
- requirements concerning continuity of care;
- requirements concerning access to specialty care;
- coverage of routine patient costs in clinical trials; and
- patient access to information.

CBO estimates that the patient protection provisions would ultimately increase spending for FEHB by 0.2 percent. Spending for FEHB for annuitants is direct spending; spending for active workers is subject to appropriation and is not included in this estimate. The increase in direct spending for FEHB would total about $185 million over the 2002-2011 period.

In addition, the bill would shift $235 million in spending for Medicare Part B from the last day of fiscal year 2002 to the first day of fiscal year 2003. H.R. 2563 would also extend expiring user fees charged by the Customs Service, beginning in 2004. That provision would result in offsetting receipts (which are negative outlays) totaling $7.3 billion through 2011. Finally, the bill would require the Secretary of the Treasury to transfer from general revenues amounts sufficient to ensure that the bill would not affect the balances of the Social Security trust funds. CBO estimates that the on-budget outlay and the off-budget receipt of those transfers by the Social Security trust funds would total $5.9 billion during the 2002-2011 period.

PAY-AS-YOU-GO CONSIDERATIONS

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

Table 3. Pay-As-You-Go Effects of H.R. 2563, the Bipartisan Patient Protection Act

	By Fiscal Year, in Millions of Dollars										
	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011
Changes in Revenues (on-budget)	0	-259	-926	-732	-1,287	-1,617	-1,925	-2,127	-2,231	-2,421	-2,484
Changes in Outlays (on-budget)	0	-225	330	-1,205	-1,195	-480	255	290	315	340	335

ESTIMATED IMPACT ON STATE, LOCAL, AND TRIBAL GOVERNMENTS

Mandates

Under current law, state and local government entities that operate group health plans for the benefit of their employees may opt out of the requirements of the Public Health Service Act that otherwise apply to health plans. Under subsection 201(b) of H.R. 2563, however, state and local government entities would not be allowed to take advantage of this opt-out provision with regard to the patient protection provisions in title I. Consequently, the patient care and advice requirements would be intergovernmental mandates as defined in UMRA and would affect the budgets of a significant number of state and local government entities.

In states where requirements for group health plans and health insurers under state law do not already substantially comply with the provisions of H.R. 2563, health plans operated by those governments would have to implement changes to comply with the new federal requirements. State and local governments that do not self-insure their benefit programs, but rather contract with private health insurers, also would face increased premium costs, but the requirements (and hence the mandates) included in the bill would fall on the private plans. However, significant costs would be passed on to the state and local governments that purchase the health care coverage.

Based on data from the Bureau of the Census and the Joint Committee on Taxation, and on information about existing state laws governing health care from the National Conference of State Legislatures, CBO estimates that state and local governments that self-insure would be directly responsible for implementing the changes and would face increased costs of about $4.6 billion over the first five years following enactment. This total is based on estimates of state and local spending for health care growing from about $80 billion in 2002 to $110 billion in 2006, an expectation that added costs would phase in over a five-year period, and an assumption that about two-thirds of the affected governmental employees are in self-insured plans.

In addition, H.R. 2563 would preempt patient protection requirements and appeals procedures under a wide range of state laws unless those requirements and procedures are "substantially compliant" with the new federal requirements. That preemption also would be an intergovernmental mandate, but because it would only prohibit the exercise of state regulatory authority, compliance would not result in direct costs to state, local, or tribal governments. States would be able to request that the Secretary of Health and Human Services certify that their laws meet the federal standard for substantial compliance.

The bill would allow private not-for-profit corporations to sell health insurance to employers if they meet requirements of the bill and become qualified health benefit purchasing coalitions. The bill would preempt state laws that would prevent such coalitions from passing on savings from administrative expenses in the form of lower premiums, and it would preempt any state laws that would impede the establishment and operation of these coalitions. Those preemptions would be intergovernmental mandates as defined in UMRA. It is possible that state premium taxes could be interpreted to impede the establishment or operation of the coalitions, and if so, state governments could realize a decrease in revenues as a result of this bill. CBO does not have sufficient information to estimate the potential impact of this provision on state budgets.

Other Impacts

State and local governments that purchase health insurance through private plans would face over $2 billion in increased premiums over the 2002-2006 period as a result of increased costs passed on to them by issuers of health insurance that would have to implement the new patient protection requirements. Those costs, however, would not result from intergovernmental mandates, and would be part of the mandate costs initially borne by the private sector.

ESTIMATED IMPACT ON THE PRIVATE SECTOR

The bill would establish several private-sector mandates as defined in the Unfunded Mandates Reform Act. CBO estimates that the direct cost of those requirements to private-sector entities would significantly exceed the threshold specified in UMRA ($113 million in 2001, adjusted annually for inflation) in each year the mandates would be effective.

CBO estimates that the provisions in title I and title IV of the bill ultimately would raise private health insurance premiums by 4.2 percent[2]. Under UMRA, most of the provisions in title I would constitute private-sector mandates because they would impose new requirements on private health plans and issuers of health insurance. The limitation on attorneys' fees in title IV also would constitute a private-sector mandate. Other provisions in title IV that would indirectly raise plans' costs, such as those giving members the right to sue their health plans, would not be considered mandates because they would simply convey a new right that members could exercise at their discretion. CBO estimates that the direct cost of the private-sector mandates in the bill would rise each year, so that in 2007 (the first year the full costs of the bill would be realized) the direct cost of the mandates would total about $22 billion.

PREVIOUS CBO ESTIMATE

On July 20, 2001, CBO provided an estimate of the budgetary impact of S. 1052, the Bipartisan Patients' Bill of Rights Act, as passed by the Senate on June 29, 2001. The estimate for the patient protection provisions in both bills is identical. Although the patient protection provisions of H.R. 2563 differ in a number of ways from S. 1052, CBO estimates that none of those differences would have a significant effect on the budgetary impact of the legislation. The estimated budgetary impact of H.R. 2563 differs from that of S. 1052

2. The 4.0 percent increase in premiums presented in Table 2 is the average for all nonfederal employers. CBO estimates that H.R. 2536 would increase premiums for plans sponsored by private employers by an average of 4.2 percent; the corresponding increase for plans sponsored by state, local, or tribal governments would be 2.6 percent.

primarily because, unlike H.R. 2563, S. 1052 (1) would require federal health care programs to comply with the patient protection provisions, (2) would subject the federal government to liability for cases involving injury or death that result from administrative decisions in federal health care programs, and (3) does not include changes in the tax code for medical savings accounts, deductions for health insurance purchased by self-employed individuals, and tax credits for small businesses.

Also on July 20, 2001, CBO prepared an estimate of the budgetary impact of H.R. 2315, the Patients' Bill of Rights Act of 2001, as introduced on June 26, 2001. That bill would result in a smaller increase in health insurance premiums and thus a smaller loss of tax revenues from the patient protection provisions. The estimated budgetary impact of H.R. 2563 also differs from that of H.R. 2315 primarily because H.R. 2315 (1) would establish rules governing the establishment of federally-certified association health plans, (2) would make different changes in the tax code for medical savings accounts, and (3) does not include changes in the tax code for deductions for health insurance purchased by self-employed individuals and for tax credits for small businesses.

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