CONGRESSIONAL BUDGET OFFICE
COST ESTIMATE

April 27, 2012

Reconciliation Recommendations of the House Committee on Energy and Commerce

As approved by the House Committee on Energy and Commerce on April 25, 2012

SUMMARY

H. Con. Res. 112, the Concurrent Budget Resolution for fiscal year 2013, as passed by the House of Representatives on March 29, 2012, instructed several committees of the House to recommend legislative changes that would reduce deficits over the 2012-2022 period. As part of this process, the House Committee on Energy and Commerce approved legislation on April 25, 2012, with a number of provisions that would reduce deficits.

In total, CBO and the staff of the Joint Committee on Taxation (JCT) estimate that enacting the legislation would reduce deficits by about $2.9 billion over the 2012-2013 period, by $45.9 billion between 2012 and 2017, and by $113.4 billion over the 2012-2022 period, assuming enactment on or near October 1, 2012. These figures represent the net effect of changes in direct spending and revenues as a result of the legislation. About $1.4 billion of the reduction for 2012 through 2022 would be off-budget, from net increases in Social Security tax receipts.

In addition, the Chairman of the House Committee on the Budget has directed CBO to prepare estimates assuming a July 1, 2012, enactment date for this year's reconciliation proposals. If the legislation were enacted by that earlier date, some of the provisions would result in greater reductions in direct spending than those estimated assuming enactment on or near October 1, 2012. Under the alternative assumption of a July 1 enactment date, CBO and JCT estimate that the legislation would reduce deficits by $3.9 billion over the 2012-2013 period, by $48.0 billion between 2012 and 2017, and by $115.5 billion over the 2012-2022 period.

The Committee's recommendations would make the following changes:

- Title I would eliminate funding for certain provisions of the Affordable Care Act (ACA), by repealing the authority for the Secretary of Health and Human Services (HHS) to provide grants to states for establishing health insurance exchanges, repealing the Prevention and Public Health Fund, and rescinding funding for loans for the Consumer Operated and Oriented Plan (CO-OP) program.

- Title II would make changes to Medicaid and the Children's Health Insurance Program (CHIP) by limiting states' ability to tax health care providers, reducing Medicaid payments to states for hospitals that serve a disproportionate share of poor and uninsured patients, repealing certain requirements that states maintain Medicaid and CHIP eligibility rules and procedures, limiting Medicaid payments to U.S. territories, and repealing performance bonuses under CHIP.

- Title III would impose limits on medical malpractice litigation in state and federal courts by capping awards and attorney fees, modifying the statute of limitations and the "collateral source" rule, and eliminating joint and several liability.

The legislation contains an intergovernmental mandate as defined in the Unfunded Mandates Reform Act (UMRA) because it would preempt state laws that provide health care providers and organizations less protection from liability, loss, or damages. CBO estimates the cost of complying with the mandate would be small and would fall well below the threshold established in UMRA for intergovernmental mandates ($73 million in 2012, adjusted annually for inflation).

The legislation contains several mandates on the private sector, including caps on damages and on attorney fees, the statute of limitations, and the fair share rule. The cost of those mandates would exceed the threshold established in UMRA for private-sector mandates ($146 million in 2012, adjusted annually for inflation) in four of the first five years in which the mandates were effective.

ESTIMATED COST TO THE FEDERAL GOVERNMENT

The estimated budgetary impact of the legislation is shown in the following tables. The spending effects of this legislation fall mostly within budget functions 550 (health) and 570 (Medicare).

For purposes of this estimate, CBO assumes that the legislation will be enacted on or near October 1, 2012, as shown in Table 1. As directed by the Chairman of the House Budget Committee, CBO has also prepared a set of estimates based on the assumption that the legislation is enacted by July 1, 2012. Those alternative estimates are presented in Table 2.

Table 1. Effects on Direct Spending and Revenues for Reconciliation Recommendations of the House Committee on Energy and Commerce, as approved by the Committee on April 25, 2012, assuming enactment around October 1, 2012

	By Fiscal Year, in Millions of Dollars												
	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	2012-2017	2012-2022
CHANGES IN DIRECT SPENDING ASSUMING ENACTMENT AROUND OCTOBER 1, 2012													
Title I – Repeal of Certain ACA Funding Provisions													
Estimated Budget Authority	0	-4,000	-3,860	-5,500	-5,460	-2,280	-1,250	-1,250	-1,500	-1,500	-2,000	-21,100	-28,600
Estimated Outlays	0	-630	-3,840	-5,960	-5,730	-2,380	-1,090	-1,200	-1,320	-1,450	-1,670	-18,540	-25,270
Title II – Medicaid													
Estimated Budget Authority	0	-9,990	-1,730	110	-1,900	-2,260	-2,050	-2,200	-1,330	-1,400	-5,710	-15,770	-28,460
Estimated Outlays	0	-2,140	-1,800	-3,190	-2,000	-1,690	-2,050	-2,090	-1,280	-1,400	-5,710	-10,820	-23,350
Title III – Liability Reform													
Estimated Budget Authority	0	-100	-880	-3,070	-5,240	-6,510	-6,980	-7,450	-8,000	-8,570	-9,160	-15,800	-55,960
Estimated Outlays	0	-100	-880	-3,070	-5,240	-6,510	-6,980	-7,450	-8,000	-8,570	-9,160	-15,800	-55,960
Total Changes in Direct Spending													
Estimated Budget Authority	0	-14,090	-6,470	-8,460	-12,600	-11,050	-10,280	-10,900	-10,830	-11,470	-16,870	-52,670	-113,020
Estimated Outlays	0	-2,870	-6,520	-12,220	-12,970	-10,580	-10,120	-10,740	-10,600	-11,420	-16,540	-45,160	-104,580
CHANGES IN REVENUES ASSUMING ENACTMENT AROUND OCTOBER 1, 2012													
Estimated Revenues [a]													
On-Budget	0	-10	0	-430	750	1,000	1,010	1,180	1,240	1,300	1,380	1,310	7,420
Off-Budget [b]	0	0	-190	-530	-100	210	330	390	400	420	440	-610	1,370
Total Changes	0	-10	-190	-960	650	1,210	1,340	1,570	1,640	1,720	1,820	700	8,790
INCREASE OR DECREASE (-) IN THE DEFICIT ASSUMING ENACTMENT AROUND OCTOBER 1, 2012													
Net Effect on Deficits													
On-Budget	0	-2,860	-6,520	-11,790	-13,720	-11,580	-11,130	-11,920	-11,840	-12,720	-17,920	-46,470	-112,000
Off-Budget [b]	0	0	190	530	100	-210	-330	-390	-400	-420	-440	610	-1,370
Total Changes	0	-2,860	-6,330	-11,260	-13,620	-11,790	-11,460	-12,310	-12,240	-13,140	-18,360	-45,860	-113,370

Source: CBO and the staff of the Joint Committee on Taxation.

Note: Components may not sum to totals because of rounding; ACA = the Affordable Care Act.

a. Negative numbers denote a reduction in revenues and positive numbers denote an increase in revenues.

b. All off-budget effects would come from changes in revenues. (Payroll taxes for Social Security are classified as off-budget.)

Table 2. Effects on Direct Spending and Revenues from Reconciliation Recommendations of the House Committee on Energy and Commerce, as approved by the Committee on April 25, 2012, assuming enactment by July 1, 2012, as directed by the Chairman of the House Committee on the Budget

	By Fiscal Year, in Millions of Dollars												
	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	2012-2017	2012-2022
CHANGES IN DIRECT SPENDING ASSUMING ENACTMENT BY JULY 1, 2012													
Title I – Repeal of Certain ACA Funding Provisions													
Estimated Budget Authority	-3,960	-1,980	-3,860	-5,500	-5,460	-2,280	-1,250	-1,250	-1,500	-1,500	-2,000	-23,040	-30,540
Estimated Outlays	-230	-1,230	-4,480	-6,260	-5,830	-2,440	-1,090	-1,200	-1,320	-1,450	-1,670	-20,470	-27,200
Title II – Medicaid													
Estimated Budget Authority	-8,480	-1,690	-1,730	110	-1,900	-2,260	-2,050	-2,200	-1,330	-1,400	-5,710	-15,950	-28,640
Estimated Outlays	-180	-2,140	-1,800	-3,190	-2,000	-1,690	-2,050	-2,090	-1,280	-1,400	-5,710	-11,000	-23,530
Title III – Liability Reform													
Estimated Budget Authority	0	-100	-880	-3,070	-5,240	-6,510	-6,980	-7,450	-8,000	-8,570	-9,160	-15,800	-55,960
Estimated Outlays	0	-100	-880	-3,070	-5,240	-6,510	-6,980	-7,450	-8,000	-8,570	-9,160	-15,800	-55,960
Total Changes in Direct Spending													
Estimated Budget Authority	-12,440	-3,770	-6,470	-8,460	-12,600	-11,050	-10,280	-10,900	-10,830	-11,470	-16,870	-54,790	-115,140
Estimated Outlays	-410	-3,470	-7,160	-12,520	-13,070	-10,640	-10,120	-10,740	-10,600	-11,420	-16,540	-47,270	-106,690
CHANGES IN REVENUES ASSUMING ENACTMENT BY JULY 1, 2012													
Estimated Revenues [a]													
On-Budget	0	-10	0	-430	750	1,000	1,010	1,180	1,240	1,300	1,380	1,310	7,420
Off-Budget [b]	0	0	-190	-530	-100	210	330	390	400	420	440	-610	1,370
Total Changes	0	-10	-190	-960	650	1,210	1,340	1,570	1,640	1,720	1,820	700	8,790
INCREASE OR DECREASE (-) IN THE DEFICIT ASSUMING ENACTMENT BY JULY 1, 2012													
Net Effect on Deficits													
On-Budget	-410	-3,460	-7,160	-12,090	-13,820	-11,640	-11,130	-11,920	-11,840	-12,720	-17,920	-48,580	-114,110
Off-Budget [b]	0	0	190	530	100	-210	-330	-390	-400	-420	-440	610	-1,370
Total Changes	-410	-3,460	-6,970	-11,560	-13,720	-11,850	-11,460	-12,310	-12,240	-13,140	-18,360	-47,970	-115,480

Source: CBO and the staff of the Joint Committee on Taxation.

Note: Components may not sum to totals because of rounding; ACA = the Affordable Care Act.

a. Negative numbers denote a reduction in revenues and positive numbers denote an increase in revenues.

b. All off-budget effects would come from changes in revenues. (Payroll taxes for Social Security are classified as off-budget.)

BASIS OF ESTIMATE

In total, CBO and JCT estimate that enacting the Energy and Commerce Committee's recommendations would reduce direct spending by $104.6 billion, increase revenues by $8.8 billion, and reduce deficits by about $113.4 billion over the 2012-2022 period, assuming enactment on or near October 1, 2012 (see Table 1). Assuming enactment by July 1, 2012, the committee's recommendations are estimated to reduce direct spending by $106.7 billion, increase revenues by $8.8 billion, and reduce deficits by about $115.5 billion over the 2012-2022 period (see Table 2).

Title I – Repeal of Certain ACA Funding Provisions

Title I of the legislation would repeal several provisions of the Affordable Care Act, including grant authority for state exchanges, the Prevention and Public Health Fund, and funding for loans for the CO-OP program. CBO estimates that enacting the provisions in title I would reduce direct spending by $25.3 billion over the 2012-2022 period, assuming enactment on or near October 1, 2012; and by $27.2 billion over the same period, assuming enactment by July 1, 2012. In addition, enacting title I would reduce revenues by approximately $0.9 billion over the 2012–2022 period for both October 1, 2012, and July 1, 2012, enactment dates.

State Exchange Grants. The legislation includes a provision to eliminate the authority of the Secretary of HHS to provide grants to states for setting up health insurance exchanges. Section 1311 of the ACA provided for such grants in the amounts necessary for planning and establishing health insurance exchanges until January 1, 2015. Under current law, CBO estimates that $2.7 billion in grants will be provided to states over the 2012-2022 period. CBO expects that some of those funds will be obligated by the time this legislation is enacted and will be disbursed over time even if the legislation is enacted. Therefore, eliminating the authority to provide grants after the enactment date would generate a reduction in the disbursement of grants of $1.4 billion over the 2012-2022 period, CBO estimates. In addition, the repeal would lead to some delay in the establishment of insurance exchanges, resulting in changes in insurance coverage and additional changes in federal spending primarily for subsidies provided through health insurance exchanges. After taking into account such changes in coverage, CBO and JCT estimate that enacting this provision would reduce direct spending by $14.1 billion over the 2012-2022 period and would reduce net revenues by $0.9 billion over the same period.

Prevention and Public Health Fund. The ACA established the Prevention and Public Health Fund and provided authority for federal agencies to award grants from the fund to public and private entities for prevention, wellness, and public health activities. Federal agencies can award annual grants that total $1.0 billion in 2012 rising to $2.0 billion in 2022 and beyond. Title I would repeal the Prevention and Public Health Fund and rescind

any unobligated balances. CBO estimates that enacting this provision would reduce direct spending by $10.9 billion over the 2012-2022 period.

Consumer Operated and Oriented Plan Program. Title I also would rescind unobligated balances of the CO-OP program. The CO-OP program was established by the ACA to provide loans to new nonprofit health insurance issuers so that they may offer health insurance plans in the individual and small group markets. CBO estimates that enacting this provision would reduce direct spending by $0.3 billion over the 2012-2022 period.

Title II – Medicaid and CHIP

Title II would make several changes to Medicaid and CHIP. It would limit states' ability to tax health care providers, reduce payments to hospitals that serve a disproportionate share of poor and uninsured patients (known as DSH payments), repeal Medicaid and CHIP maintenance of effort requirements, limit Medicaid payments to the U.S. territories, and repeal the authority for HHS to award CHIP performance bonuses.

CBO estimates that enacting title II would reduce direct spending by $23.4 billion over the 2012-2022 period, assuming enactment on or near October 1, 2012; and by $23.5 billion over the same period, assuming enactment by July 1, 2012. In addition, enacting title II would reduce revenues by $0.8 billion over the 2012-2022 period for both the October 1 and July 1 enactment assumptions.

Revise Provider Tax Threshold. Under current law, states may not tax health care providers and return the tax revenues to those same providers through higher Medicaid payment rates or through other offsets and guarantees (known as a "hold harmless" arrangement). An exception to this provision is that the federal government will not deem a hold harmless arrangement to exist if the provider taxes collected from given providers are less than 6 percent of the providers' revenues. The legislation would lower the allowable percentage threshold of provider revenues to 5.5 percent starting in 2013. CBO estimates that enacting this provision would reduce direct spending by $11.3 billion over the 2012-2022 period.

Reduce DSH Payments. Under current law, Medicaid provides for payments to hospitals that serve a disproportionate share of low-income and uninsured individuals. The ACA reduced those payments beginning in 2014 and continuing through 2021. Payments in 2022 were unaffected. This provision would reduce DSH payments in 2022 from $12.1 billion to $7.9 billion, bringing those amounts in line with 2021 payments. CBO estimates that enacting this provision would reduce direct spending by $4.2 billion in 2022.

Repeal Medicaid and CHIP Maintenance of Effort (MOE) Requirements. As a condition of receiving federal Medicaid and CHIP payments, states must maintain the eligibility standards, methodologies, and procedures that were in place prior to enactment of the ACA with respect to children and adults in Medicaid and CHIP. The requirements for adults remain in effect until state health insurance exchanges are operational while the requirements for children remain in effect until 2019. The legislation would repeal the MOE requirements for adults and children in Medicaid and CHIP. CBO assumes that individuals losing Medicaid or CHIP coverage as a result of this provision would take up employment-based health insurance, exchange coverage, or become uninsured. Those changes in enrollment in Medicaid, CHIP, exchanges, and employer-based health insurance together would reduce direct spending by approximately $1.4 billion and reduce revenues by $0.8 billion over the 2012-2022 period.

Limit Medicaid Payments to Territories. The legislation would repeal provisions enacted under the ACA that increased Medicaid payments to the U.S. territories by raising their federal matching percentage and their capped allotments under the program. Under current law, CBO estimates that total Medicaid payments to the U.S. territories will be $12.4 billion over the 2012-2022 period with the Commonwealth of Puerto Rico expected to receive the majority of those payments. CBO estimates that eliminating the increased funding provided in the ACA would reduce direct spending by $6.1 billion over the 2012-2022 period, assuming enactment around October 1, 2012. (Assuming enactment by July 1, 2012, savings from this provision would be $6.3 billion between 2012 and 2022.)

Repeal CHIP Performance Bonuses. Under the CHIP statute, the Secretary of HHS awards bonus payments to states that meet two criteria. First, states must adopt any 5 of 8 specified program changes that generally facilitate enrollment in, and retention of, Medicaid and CHIP coverage for children. Second, states that have made such program changes must achieve specified enrollment targets for children's coverage in Medicaid. The legislation would repeal the bonus payment program as of the date of enactment. In addition, this legislation would rescind any unobligated balance remaining in the performance bonus fund. CBO estimates that enacting this legislation would reduce direct spending by $0.4 billion in 2013 (with no effect in any other years).

Title III – Liability Reform

The legislation would establish:

- A three-year statute of limitations for medical malpractice claims, with certain exceptions, from the date of discovery of an injury;

- A cap of $250,000 on awards for noneconomic damages;

- A cap on awards for punitive damages that would be the larger of $250,000 or twice the economic damages, and restrictions on when punitive damages may be awarded;

- Replacement of joint and several liability with a fair-share rule, under which a defendant in a lawsuit would be liable only for the percentage of the final award that was equal to his or her share of responsibility for the injury;

- Sliding-scale limits on the contingency fees that lawyers can charge;

- A safe harbor from punitive damages for products that meet applicable safety requirements established by the Food and Drug Administration; and

- Permission to introduce evidence of income from collateral sources (such as life insurance payouts and health insurance) at trial.

Over the 2012-2022 period, CBO and JCT estimate that enacting title III would reduce direct spending by about $56 billion and increase federal revenues by about $10.5 billion. The combined effect of those changes in direct spending and revenues would reduce federal deficits by almost $66.5 billion over that period, with changes in off-budget revenues accounting for $2.6 billion of that reduction.

Effects on National Spending for Health Care. CBO reviewed recent research on the effects of proposals to limit costs related to medical malpractice ("tort reform"), and estimates that enacting title III would reduce national health spending by about 0.5 percent.[1] That figure comprises a direct reduction in spending for medical liability premiums and an additional indirect reduction from slightly less utilization of health care services. CBO's estimate takes into account the fact that, because many states have already implemented some elements of the legislation, a significant fraction of the potential cost savings has already been realized. Moreover, the estimate assumes that the spending reduction of about 0.5 percent would be realized over a period of four years, as providers gradually change their practice patterns.

Revenues. CBO estimates that private health spending would be reduced by about 0.5 percent. Much of private-sector health care is paid for through employment-based insurance that represents nontaxable compensation. In addition, beginning in 2014, refundable tax credits will be available to certain individuals and families to subsidize health insurance purchased through new health insurance exchanges. (The portion of

1. See Congressional Budget Office, letter to the Honorable Orrin G. Hatch regarding CBO's Analysis of the Effects of Proposals to Limit Costs Related to Medical Malpractice, (October 9, 2009). http://www.cbo.gov/ftpdocs/106xx/doc10641/10-09-Tort_Reform.pdf.

those tax credits that exceed taxpayers' liabilities are classified as outlays, while the portions that reduce taxpayers' liabilities are recorded as reductions in revenues.)

Lower costs for health care arising from enactment of title III would lead to an increase in taxable compensation and a reduction in subsidies for health insurance purchased through an exchange. Those changes would increase federal tax revenues by an estimated $10.5 billion over the 2012-2022 period, according to estimates by JCT. Social Security payroll taxes, which are off-budget, account for $2.6 billion of that increase in revenues.

Direct Spending. CBO estimates that enacting title III would reduce direct spending for Medicare, Medicaid, the CHIP, the Federal Employees Health Benefits program, the Defense Department's TRICARE for Life program, and subsidies for enrollees in health insurance exchanges. We estimate those reductions would total roughly $56 billion over the 2012-2022 period.

For programs other than Parts A and B of Medicare, the estimate assumes that federal spending for acute care services would be reduced by about 0.5 percent, in line with the estimated reductions in the private sector.

CBO estimates that the reduction in federal spending for services covered under Parts A and B of Medicare would be larger—about 0.7 percent—than in the other programs or in national health spending in general. That estimate is based on empirical evidence showing that the impact of tort reform on the utilization of health care services is greater for Medicare than for the rest of the health care system.[2]

ESTIMATED IMPACT ON STATE, LOCAL, AND TRIBAL GOVERNMENTS

Intergovernmental Mandates

The bill contains an intergovernmental because it would preempt state laws that provide health care providers and organizations less protection from liability, loss, or damages. While the preemption would limit the application of state laws, it would impose no duty on states that would result in significant additional spending. Consequently, CBO estimates that any costs would fall well below the threshold established in UMRA for intergovernmental mandates ($73 million in 2012, adjusted annually for inflation).

2. One possible explanation for that disparity is that the bulk of Medicare's spending is on a fee-for-service basis, whereas most private health care spending occurs through plans that manage care to some degree. Such plans limit the use of services that have marginal or no benefit to patients (some of which might otherwise be provided as "defensive" medicine), thus leaving less potential for savings from the reduction of utilization in those plans than in fee-for-service systems.

Other Impacts

The bill would have mixed effects on the budgets of state, local, and tribal governments aside from the mandate effects noted above. CBO estimates that those governments, as employers, would save money as a result of lower health insurance premiums precipitated by the bill's liability reforms. In addition, state, local, and tribal governments that collect income taxes would realize increased tax revenues as a result of increases in workers' taxable income. CBO estimates that the bill's changes also would lead to reduced state spending in Medicaid by $20 billion over the 2012-2022 period. The legislation also would limit the amount that states would be able to raise through taxes on Medicaid providers, reducing one of the means by which states finance their share of Medicaid spending.

Other provisions in the bill would decrease the amount of resources that state, local, and tribal governments receive to establish health exchanges and to conduct prevention, wellness, and public health activities. In total, CBO estimates that the decrease in grant aid to states would exceed $12 billion over the 2012-2022 period. In addition, CBO estimates that enactment of the bill would reduce the amount of Medicaid payments that the U.S. territories receive by $6.1 billion over the same period.

ESTIMATED IMPACT ON THE PRIVATE SECTOR

The legislation contains several mandates on the private sector, including caps on damages and on attorney fees, the statute of limitations, and the fair share rule.[3] The cost of those mandates would exceed the threshold established in UMRA for private-sector mandates ($146 million in 2012, adjusted annually for inflation) in four of the first five years in which the mandates were effective.

PREVIOUS CBO ESTIMATE

On April 26, 2012, CBO transmitted a cost estimate for the Help Efficient, Accessible, Low-cost, Timely Healthcare Act as approved by the House Committee on the Judiciary on April 25, 2012. That legislation is substantially similar to title III of this legislation. However, this legislation would permit the introduction of evidence of income from collateral sources at trial. The version of medical liability reform approved by the Committee on the Judiciary did not contain that provision. Differences in the CBO cost estimates for title III of this legislation and the legislation approved by the Committee on the Judiciary reflect that difference in the two versions of such liability reform.

3. Under the fair share rule, a defendant in a lawsuit would be liable only for the percentage of the final award that was equal to his or her share of responsibility for the injury.

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