CONGRESSIONAL BUDGET OFFICE
COST ESTIMATE

July 20, 2001

S. 1052
Bipartisan Patients' Bill of Rights Act

As passed by the Senate on June 29, 2001

SUMMARY

S. 1052 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 act 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.

Those requirements on the structure and operation of group health plans would be applied to federal health care programs and to plans offered by state, local, and tribal governments. In addition, the act would permit individuals to sue federal health care programs in federal court when a federal health care program is negligent in denying a claim for benefits because of a non-medical reason, if the denial resulted in personal injury or death.

These provisions would take effect beginning October 1, 2002.

S. 1052 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 estimates that federal tax revenues would fall by $30 million in 2002 and by $19 billion over the 2002-2011 period if S. 1052 were enacted. Social Security payroll taxes, which are off-budget, account for about 30 percent of those totals. Direct spending would decline by an estimated $235 million in 2002 and by $1.2 billion over the 2002-2011 period. That total includes:

- an increase of $6.1 billion from applying the patient protection provisions and certain liability provisions to federal health care programs;

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

- 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 act would increase on-budget direct spending by $4.7 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 $18 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 act would affect both revenues and direct spending, pay-as-you-go procedures would apply.

S. 1052 would also affect discretionary spending for administrative costs of the Medicare program, for health care programs for federal civilian employees, members of the armed forces and veterans, and for a number of other federal programs. CBO has not completed its estimate of those costs, which would be funded through appropriations. Our preliminary judgment is that discretionary spending would increase by $1 billion to $3 billion over the 2002-2011 period, assuming appropriation of the necessary amounts.

The act 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 S. 1052 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 S. 1052, 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)	-20	-210	-600	-1,100	-1,400	-1,700	-1,900	-2,000	-2,200	-2,300	-13,430
Social Security Payroll Taxes (off-budget)	-10	-90	-270	-470	-630	-760	-830	-890	-960	-1,000	-5,910
Total	-30	-300	-870	-1,570	-2,030	-2,460	-2,730	-2,890	-3,160	-3,300	-19,340
CHANGES IN DIRECT SPENDING											
Federal Health Care Programs:											
Patient Protections	0	90	200	340	400	440	480	520	570	620	3,660
Liability	0	50	100	160	230	320	350	370	410	440	2,430
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	375	-1,185	-1,175	-500	230	265	285	330	365	-1,245

NOTE: HI = Medicare Hospital Insurance program.

BASIS OF ESTIMATE

Revenues

CBO estimates that S. 1052, 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 S. 1052, 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 10.5 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 S. 1052 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 act 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;

- 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.

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. The act would also prohibit plans from using predictive genetic information in setting premiums or deciding whether to offer health insurance. CBO estimates those provisions 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 act 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. CBO estimates those provisions would increase premiums by 0.7 percent.

Direct Spending

S. 1052 would reduce direct spending by an estimated $235 million in 2002 and by $1.2 billion over the 2002-2011 period. That total includes a $4.7 billion increase in on-budget direct spending and a $5.9 billion decrease in off-budget direct spending.

Federal Health Care Programs. Title III would require federal health care programs to comply with the patient protection provisions of title I. It would also define the federal government as the plan sponsor for federal health care programs, and subject the federal government to liability in cases involving injury or death that result from administrative

decisions. Those cases would be tried in federal court. The act would not change current law with regard to the liability of the federal government in cases involving medically-reviewable decisions.

Patient protections. S. 1052 would apply the requirements of title I to any plan or program that provides health benefits, whether directly, through insurance, or otherwise, and that is funded directly, in whole or in part, by the federal government. That definition of a federal health care program includes the large federal health insurance programs (such as Medicare, the Federal Employees Health Benefits (FEHB) program, and Tricare). It also includes programs that directly provide comprehensive health care services (such as the military and veterans health programs), as well as many programs that provide a narrower scope of benefits (such as the Ryan White program, which provides grants to state and local governments and private organizations to provide health and social services to individuals infected with the Human Immunodeficiency Virus). In addition, the act would apply the requirements of title I to several state programs established by the Social Security Act—Medicaid, the State Children's Health Insurance Program (SCHIP), Maternal and Child Health Services Block Grants, and Social Services Block Grants.

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. The President also issued an Executive Memorandum on June 7, 2000, which required Medicare to cover the routine costs of clinical trials. Nevertheless, several provisions were not addressed by the Advisory Commission, go beyond the commission's recommendations, or require changes in procedures used by federal plans to comply with the commission's recommendations. The provisions likely to have a significant effect on direct spending include:

- procedures for internal and external appeals;
- 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 increase direct spending for Medicare, Medicaid, FEHB, Tricare and military treatment facilities by $3.7 billion over the 2002-2011 period. Spending by FEHB for annuitants and by Tricare and military treatment facilities for military retirees age 65 and over (and for their survivors and dependents) is direct spending; spending by those programs for active workers and for military retirees under age 65 is subject to appropriation and is not included in the above figure.

Medicare, Medicaid, and FEHB account for nearly all of the effect of the patient protections on direct spending. CBO estimates that direct spending would ultimately increase by about one-quarter of a percent for Medicaid and by about one-third of a percent for FEHB. By contrast, direct spending for Medicare would increase by less than 0.05 percent. The estimated effect on Medicare spending is smaller for several reasons:

- Medicare substantially complies with the clinical trials provision, whereas Medicaid programs and FEHB plans may not;

- Administrative costs account for a substantial portion of the cost of complying with the patient protections, but funding for those costs in Medicare is subject to appropriations; and

- Changes in the cost of compliance with patient protections would be higher in the more-tightly managed parts of Medicare (that is, Medicare+Choice plans) than in the fee-for-service program. However, changes in costs incurred by Medicare+Choice plans do not significantly affect Medicare spending, because Medicare's payments to those plans are based on costs in the fee-for-service sector.

SCHIP is a capped entitlement, and will spend nearly all available funds during the 2002-2011 period. Therefore, applying the patient protection provisions to SCHIP would likely change year-by-year spending, but would have a negligible effect on cumulative spending over the coming decade.

Numerous other federal health programs would be affected by the provisions of title IV. However, spending by those programs, and for administrative spending by Medicare, depends on the amounts appropriated. CBO has not yet estimated the effect of enacting S. 1052 on funding for such programs.

*Federal liability***.** S. 1052 would subject the federal government to liability for cases involving injury or death that result from administrative decisions in federal health care programs. Judgments and settlements would be paid from the Treasury's permanent, indefinite Judgment Fund. Those payments are considered direct spending, regardless of whether the health program involved is an entitlement program or is subject to appropriation.

Nearly all of the estimated effect of the liability provision on premiums for employer-sponsored plans is attributable to cases involving medically-reviewable decisions or to the practice of more defensive medicine and other changes in behavior by plans to avoid being sued for such decisions, rather than to administrative decisions. The liability provision for federal programs appears to waive sovereign immunity only for denials of care based on non-medical reasons, and it provides standing to sue only if the individual received care from the federal health care program. Therefore, we expect that a very limited number of individuals would be eligible sue the federal government under this provision. CBO estimates that enacting S. 1052 would increase direct spending from the Judgment Fund by $2.4 billion over the 2002-2011 period.

Other Direct Spending. The act 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.

S. 1052 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 act would require the Secretary of the Treasury to transfer from general revenues amounts sufficient to ensure that the act 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 S. 1052, 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	-20	-210	-600	-1,100	-1,400	-1,700	-1,900	-2,000	-2,200	-2,300
Changes in Outlays (on-budget)	0	-225	465	-915	-705	130	990	1,095	1,175	1,290	1,365

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 S. 1052, 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 S. 1052, 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 act 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 $78 billion in 2002 to $111 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, the act 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.

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.

The act would apply the requirements of title I to any programs, including state and local programs, that provide health benefits directly or indirectly through the use of federal funding. The requirements would thus apply to large entitlement programs, such as Medicaid, with state costs that CBO estimates would total about $575 million over the 2002-2006 period. Because states have significant flexibility to adjust their programmatic and financial responsibilities to offset such additional costs, however, these costs would not result from an intergovernmental mandate as defined in UMRA. Numerous other grant programs (for example: community health centers, HIV prevention and care activities, and immunization programs) also would be affected by the provisions of title I. Because those requirements would be duties arising from participation in voluntary federal programs, however, they also would not be mandates as defined in UMRA. CBO has not estimated the potential costs to states for those grant programs.

ESTIMATED IMPACT ON THE PRIVATE SECTOR

The act 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 act ultimately would raise private health insurance premiums by 4.2 percent. 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 act 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 June 13, 2001, CBO provided an estimate of an earlier version of the Bipartisan Patients' Bill of Rights Act (S. 872). The estimate for S. 1052 reflects changes that have been made in the legislation and a correction involving application of the provisions of title I to plans offered by state, local, or tribal governments.

In the earlier estimate, CBO had assumed incorrectly that state, local, and tribal governments could elect not to have certain federal requirements apply to their own group health plans. However, section 201 of S. 1052 would prevent those governments from opting out of the patient protection requirements.

Plans offered by state, local, or tribal governments would not be affected by the liability provisions of title IV. In addition, because many states have already enacted some of the patient protections, those plans are more likely than plans sponsored by private employers to comply under current law with many of the requirements of S. 1052. CBO estimates that S. 1052 would ultimately increase premiums for plans sponsored by state, local, or tribal governments by 2.6 percent; the corresponding increase for plans sponsored by private employers would be 4.2 percent. The average increase for plans sponsored by nonfederal employers would be the 4.0 percent presented in Table 2.

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