CONGRESSIONAL BUDGET OFFICE
COST ESTIMATE

July 20, 2001

H.R. 2315
Patients' Bill of Rights Act of 2001

As introduced in the House on June 26, 2001

SUMMARY

H.R. 2315 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 and in cancer clinical trials 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 amend the Employee Retirement Income Security Act (ERISA) to require both internal and external review processes for members to appeal claims denied by plans and insurers. It would also amend ERISA to allow individuals to sue health plans and insurers in federal court for personal injury or wrongful death resulting from failure to comply with terms of the plan. Those amendments to ERISA would not apply to plans regulated by states under current law.

Those provisions would take effect 18 months after the Secretaries of Health and Human Services and Labor issue final regulations to carry out the provisions of the act. The estimate assumes enactment before October 1, 2001, with an effective date of January 1, 2004.

H.R. 2315 would also expand the availability of medical savings accounts (MSAs) and establish rules governing federally-certified association health plans (AHPs).

CBO estimates that federal tax revenues would fall by $120 million in 2002 and by $16 billion over the 2002-2011 period if H.R. 2315 were enacted. Social Security payroll taxes, which are off-budget, account for about 20 percent of those totals. Direct spending by the Federal Employees Health Benefits (FEHB) program would increase by about $80 million over the 2002-2011 period. In total, the changes in revenues and direct spending

would reduce prospective surpluses by $16.4 billion over the 2002-2011 period—$12.8 billion on-budget and $3.6 billion off-budget. Because the bill would affect revenues and direct spending, pay-as-you-go procedures would apply.

H.R. 2315 would also affect discretionary spending for health care programs for federal civilian employees and for development and administration of regulations for the patient protections and association health plans. 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 2008, when the full costs of the bill would first be realized, the estimated costs of the mandates would be about $15 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. 2315 is shown in the Table 1. The direct spending costs of this legislation fall within budget function 550 (health).

BASIS OF ESTIMATE

Revenues

Three components of H.R. 2315 would affect federal revenues:

- The patient protections established by the Patients' Bill of Rights in title I;
- Expansion of medical savings accounts in subtitle A of title VI;
- Establishment of rules governing association health plans in subtitle B of title VI.

Table 1. Estimated Effect on Revenues and Direct Spending of H.R. 2315, The Patients' Bill of Rights 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)											
Patients' Bill of Rights	0	-10	-170	-450	-730	-960	-1,200	-1,300	-1,400	-1,500	-7,720
Medical Savings Accounts	-120	-358	-397	-431	-467	-497	-537	-578	-616	-681	-4,684
Association Health Plans	*	-5	-15	-25	-40	-50	-55	-60	-65	-70	-385
Subtotal, On-budget	-120	-373	-582	-906	-1,237	-1,507	-1,792	-1,938	-2,081	-2,251	-12,789
Social Security Payroll Taxes (off-budget)											
Patients' Bill of Rights	0	-10	-70	-200	-320	-420	-530	-590	-630	-680	-3,450
Association Health Plans	*	-5	-5	-10	-15	-20	-25	-25	-30	-30	-165
Subtotal, Off-budget	0	-15	-75	-210	-335	-440	-555	-615	-660	-710	-3,615
Total	-120	-388	-657	-1,116	-1,572	-1,947	-2,347	-2,553	-2,741	-2,961	-16,402
CHANGES IN DIRECT SPENDING											
Outlays for Federal Health Care Programs	0	0	2	5	5	10	15	15	15	15	82

NOTES: HI = Medicare Hospital Insurance program.

* = Revenue loss of less than $500,000.

The Congressional Budget Office estimated the budgetary effects of provisions that would affect the level of health insurance premiums and spending by federal health programs—specifically, the patient protections in title I and the rules governing association health plans in subtitle B of title VI. The Joint Committee on Taxation estimated the budgetary effects of the provision that would modify the tax treatment of health care and health insurance programs— specifically, subtitle A of title VI, which would expand the availability of medical savings accounts.

CBO and the Joint Committee on Taxation estimate that those provisions would reduce federal tax revenues by $120 million in 2002 and by $16 billion over the 2002-2011 period. Social Security payroll taxes, which are off-budget, account for about 20 percent of those totals.

Patients' Bill of Rights. CBO estimates that the patient protection provisions in title I of H.R. 2315, 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 2.6 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.

Most of the remaining 40 percent of the increase, or about 1.0 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 $7 million in 2002 to about $6.5 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, CBO estimates that federal revenues from income taxes and Hospital Insurance payroll taxes would fall by $7.7 billion over the 2002-2011 period if title I were enacted. Social Security payroll taxes, which are off-budget, would decline by $3.5 billion over the same period.

Table 2. Estimated Ultimate Effect of Title I of H.R. 2315, the Patients' Bill of Rights Act, on Premiums for Employer-Sponsored Health Insurance (In Percent)

Provision	Increase in Premiums
Subtitle A—Right to Advice and Care	
Access to emergency care	0.4
Choice of coverage options	0.1
Access to obstetric and gynecological care	0.1
Access to pediatric care	a
Access to specialists	a
Continuity of care	0.2
Patient-provider communications	a
Access to prescription drugs	a
Clinical trials	0.6
Prohibition of discrimination based on licensure	a
Subtitle B—Right to Information about Plans and Providers	0.1
Subtitle C—Right to Hold Health Plans Accountable	0.8
Subtitle D—Remedies	0.3
Subtitle F—Miscellaneous Provisions	
Coverage of limited scope plans	a
Total	2.6

SOURCE: Congressional Budget Office.

a. Less than 0.05 percent

Right to Advice and Care. Subtitle A of title I contains a number of patient protections for enrollees in group health plans and issuers of health insurance. Those provisions include:

- 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 health plans offered by employers with at least 25 employees provide a point-of-service option when the existing health plan offerings do not provide choice among provider groups;

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

- a requirement that plans that require or provide for designation of a participating primary care provider permit enrollees to designate any participating and available pediatrician as the primary care provider for a child;

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

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

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

- 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;

- a requirement that plans cover routine patient costs for enrollees participating in certain cancer clinical trials approved by the Food and Drug Administration or in certain clinical trials 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; and

- a prohibition of 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.

CBO estimates those provisions would increase premiums by 1.4 percent.

Right to Information About Plans and Providers. Subtitle B 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 that provision would increase premiums by 0.1 percent.

Right to Hold Health Plans Accountable. Subtitle C of title I sets out requirements that apply to group health plans and issuers of health insurance under ERISA concerning appeals of decisions to deny coverage or payment of claims. Plans would have to establish a system for handling enrollees' grievances that 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 independent external appeals board.

CBO estimates that these provisions, which are closely interrelated, would jointly raise premiums by 0.8 percent.

Remedies. Subtitle D of title I would alter the legal liability of group health plans and issuers of health insurance under ERISA. The bill would amend ERISA to permit enrollees in employer-sponsored plans to sue plans in federal court for cases of injury or death involving administrative decisions or medically-reviewable decisions. The bill would cap the award for noneconomic damages in such cases at $500,000. CBO estimates that provision would increase premiums by 0.3 percent.

Miscellaneous Provisions. Subtitle F 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.

Medical Savings Accounts. Subtitle A of title VI would amend the provisions of the Internal Revenue Code governing medical savings accounts to increase the amount of wages, benefits, and investment income given favorable tax treatment and to make these accounts more widely available. Under current law, contributions to an MSA by individuals covered by high-deductible health insurance plans are deductible, and contributions by employers on behalf of the covered individual are excludable for income and payroll tax purposes. Investment earnings of MSAs are excluded from taxable income in the year earned, and withdrawals from MSAs for medical expenses are tax-free.

The proposal would reduce the minimum annual deductible for a high-deductible health insurance policy from $1,500 to $1,000 for an individual policy and from $3,000 to $2,000 for a family policy; these amounts would be indexed for inflation. Currently, the amount of the tax deduction allowed for contributions to MSAs is limited to between 60 percent and 75 percent of the annual deductible. The bill would increase the tax deduction to the full amount of the insurance policy's deductible. H.R. 2315 would also remove the current limit on the number of MSAs and permit all employers to offer MSAs.

CBO and the Joint Committee on Taxation estimate that enactment of this provision would reduce income and payroll tax revenues by $120 million in 2002 and by $4.7 billion over the 2002-2011 period.

Association Health Plans. Subtitle B of title VI would establish a certification process and regulatory structure for AHPs. These entities, which would be regulated by the Department of Labor, could provide health plans to employers under different sets of rules than apply to

insurers or other health plan arrangements that fall under state insurance regulation. AHPs would not have to comply with many state benefit mandates and would not be subject to statewide availability rules. AHPs would have to make their plans available to all of their association's members.

Under subtitle B, CBO would expect a small net increase in total spending by employers on employer-sponsored health insurance. Spending would increase as otherwise uninsured employees became insured through the new entities. Spending would also increase for those employers who continued to offer traditional, state-regulated plans because of a disproportionate tendency for higher cost groups to remain with state-regulated plans, which are typically subject to rules that compress the range of premiums that can be charged across firms. Those spending increases would be partially offset by reduced spending among employers who found less expensive plans in the AHP market and chose to shift away from purchasing insurance in the traditional, state-regulated market to those new plans, and among employers who responded to higher premiums for policies in the traditional market by dropping coverage. Since the composition of the total compensation packages of employees would shift toward non-taxable health benefits and away from taxable wages and salaries, total federal revenues would decrease by an estimated $550 million over the 2002-2011 period.

Direct Spending

The bill would impose additional costs on the Federal Employees' Health Benefits program, most of whose plans are classed 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 by FEHB by 0.1 percent. Spending by 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 $80 million over 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 the following table. 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. 2315, The Patients' Bill of Rights Act

	By Fiscal Year, in Millions of Dollars										
	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2002 - 2011
Changes in Revenues (on-budget)	-120	-373	-582	-906	-1,237	-1,507	-1,792	-1,938	-2,081	-2,251	-12,789
Change in Outlays (on-budget)	0	0	2	5	5	10	15	15	15	15	82

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 the bill, 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 information 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 substantially equivalent requirements for group health plans are not already in place under state law, 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 on 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 billion over the 2004-2008 period, the first five years in which the act would be effective. This total is based on estimates of state and local spending for health care growing from $95 billion in 2004 to $128 billion in 2008, 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.

The bill's preemption of state laws governing patient protection requirements and appeals procedures unless those laws are "substantially equivalent" with federal requirements would be an intergovernmental mandate. However, this preemption would not result in direct costs to state, local, or tribal governments because the mandate would only prohibit the exercise of state regulatory authority. States would be able to request that the Secretary of Health and Human Services certify that their laws meet the federal standard for substantial equivalence.

The provisions of the bill governing the establishment of AHPs would preempt state laws that limit an AHP's ability to determine which services or items are part of their package of medical care benefits. (State laws prohibiting the exclusion of specific diseases would still apply.) This preemption would not result in additional direct costs to state, local, or tribal governments, but because it would limit the exercise of state authority, it also would be an intergovernmental mandate as defined in UMRA.

The bill also would limit the ability of states to tax AHPs that operated before the enactment of the bill, while allowing states to levy a contribution tax, similar to a premium tax, on new AHPs. On the one hand, state contribution taxes on new AHPs that become certified under the bill could increase state tax collections. On the other hand, existing multiple employer welfare arrangements (MEWAs) could similarly attain certification to operate as AHPs and it is not clear that states would be able to collect contribution taxes from them. States currently levy taxes on MEWAs, so if they are unable to collect the contribution tax from MEWAs that become certified AHPs, tax revenues would decrease. The combination of these changes would have mixed effects on state tax collections. CBO cannot determine which of these forces would be the stronger, and we therefore cannot estimate whether states would ultimately gain or lose revenues as a result of the AHP provisions.

Other Impacts

State and local governments that purchase health insurance through private plans would face $2 billion in increased premiums over the 2004-2008 period as a result of increased costs passed on to them by health insurance providers 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 of the bill ultimately would raise private health insurance premiums by about 2.6 percent. Under UMRA, most of those provisions would constitute private-sector mandates because they would impose new requirements on private health plans and issuers of health insurance. Provisions in subtitle D that would indirectly raise plan costs, such as those giving plan 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 2008 (the first year the provisions would be fully effective) the direct cost of the mandates would total about $15 billion.

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