CONGRESSIONAL BUDGET OFFICE
COST ESTIMATE

May 23, 2011

H.R. 5
Help Efficient, Accessible, Low-cost, Timely Healthcare (HEALTH) Act of 2011

As ordered reported by the House Committee on the Energy and Commerce on May 11, 2011

SUMMARY

H.R. 5 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.

CBO expects that those changes would, on balance, lower costs for health care both directly and indirectly: directly, by lowering premiums for medical liability insurance; and indirectly, by reducing the use of health care services prescribed by providers when faced with less pressure from potential malpractice suits. Those reductions in costs would, in turn, lead to lower spending in federal health programs and to lower private health insurance premiums.

Because employers would pay less for health insurance for employees, more of their employees' compensation would be in the form of taxable wages and other fringe benefits. As discussed below, the bill also would increase revenues because it would result in lower subsidies for health insurance. In total, CBO and the staff of the Joint Committee on Taxation (JCT) estimate that enacting H.R. 5 would increase federal revenues by almost $10 billion over the 2012-2021 period.

Enacting H.R. 5 would reduce federal direct spending for Medicare, Medicaid, the government's share of premiums for annuitants under the Federal Employees Health Benefits (FEHB) program, and other federal health benefits programs. CBO estimates that direct spending would decline by about $48 billion over the 2012-2021 period.

Because enacting the legislation would affect direct spending and revenues, pay-as-you-go procedures apply. In total, CBO estimates that enacting H.R. 5 would reduce deficits by almost $14 billion over the 2011-2016 period and by about $57 billion over the 2012-2021 period.

Federal spending for active workers participating in the FEHB program is included in the appropriations for federal agencies, and is therefore discretionary. H.R. 5 would also affect discretionary spending for health care services paid by the Departments of Defense (DoD) and Veterans Affairs (VA). CBO estimates that implementing H.R. 5 would reduce discretionary spending by about $2 billion over the 2012-2021 period, assuming appropriations actions consistent with the legislation.

H.R. 5 contains an intergovernmental mandate as defined in the Unfunded Mandates Reform Act (UMRA) because it would preempt state laws that provide less protection for health care providers and organizations from liability, loss, or damages (other than caps on awards for 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 ($71 million in 2011, adjusted annually for inflation).

H.R. 5 contains several mandates on the private sector, including caps on damages and on attorney fees, a more restrictive statute of limitations, and the fair share rule. The cost of those mandates would exceed the threshold established in UMRA for private-sector mandates ($142 million in 2011, adjusted annually for inflation) in four of the first five years in which the mandates were effective, rising to $1.4 billion per year in 2016, and totaling $3.3 billion over the 2012-2016 period.

ESTIMATED COST TO THE FEDERAL GOVERNMENT

The estimated budgetary impact of H.R. 5 is shown in the following table. The costs of this legislation fall within multiple budget functions, primarily 550 (health) and 570 (Medicare).

	By Fiscal Year, in Billions of Dollars											
	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	2012-2016	2012-2021
CHANGES IN REVENUES												
Estimated Revenues												
On-budget	*	0.1	0.3	0.6	0.8	0.9	1.0	1.0	1.1	1.2	1.8	7.0
Off-budget	*	*	0.1	0.2	0.3	0.3	0.3	0.4	0.4	0.4	0.7	2.5
Total	*	0.1	0.4	0.8	1.1	1.2	1.3	1.4	1.5	1.6	2.5	9.6
CHANGES IN DIRECT SPENDING												
Estimated Budget Authority	-0.1	-0.5	-1.8	-3.6	-5.3	-6.2	-6.7	-7.3	-7.9	-8.4	-11.3	-47.8
Estimated Outlays	-0.1	-0.5	-1.8	-3.6	-5.3	-6.2	-6.7	-7.3	-7.9	-8.4	-11.3	-47.8
NET INCREASE OR DECREASE (-) IN THE DEFICIT FROM CHANGES IN REVENUES AND DIRECT SPENDING												
Impact on the Deficit												
On-budget	-0.1	-0.6	-2.1	-4.2	-6.1	-7.1	-7.7	-8.3	-9.0	-9.6	-13.1	-54.8
Off-budget	*	*	-0.1	-0.2	-0.3	-0.3	-0.3	-0.4	-0.4	-0.4	-0.7	-2.5
Total	-0.1	-0.6	-2.2	-4.4	-6.4	-7.4	-8.0	-8.7	-9.4	-10.0	-13.8	-57.4
CHANGES IN SPENDING SUBJECT TO APPROPRIATION												
Estimated Authorization Level	0	*	-0.1	-0.1	-0.2	-0.2	-0.2	-0.3	-0.3	-0.3	-0.4	-1.6
Estimated Outlays	0	*	-0.1	-0.1	-0.2	-0.2	-0.2	-0.3	-0.3	-0.3	-0.4	-1.6

Notes: Components may not add to totals because of rounding.

* = increase in revenues, reduction in spending, or reduction in deficits of less than $50 million.

BASIS OF ESTIMATE

H.R. 5 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 FDA safety requirements; and

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

Over the 2012-2021 period, CBO and the staff of the Joint Committee on Taxation estimate that enacting H.R. 5 would reduce direct spending by about $48 billion and increase federal revenues by almost $10 billion. The combined effect of those changes in direct spending and revenues would reduce federal deficits by $57 billion over that period, with changes in off-budget revenues accounting for about $3 billion of that reduction in deficits. (Because those estimates assume enactment of H.R. 5 near the end of fiscal year 2011, no budgetary effects are expected in that year.)

In addition, CBO estimates that implementing H.R. 5 would reduce discretionary spending for the FEHB program, DoD, and VA by about $2 billion over the 2012-2021 period.

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 H.R. 5 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 H.R. 5, a significant fraction of the potential cost savings has already been realized. Moreover, the estimate assumes that the reduction of about 0.5 percent would be realized over a period of four years, as providers gradually change their practice patterns.

[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.

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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 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 H.R. 5 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 $9.6 billion over the 2012-2021 period, according to estimates by JCT. Social Security payroll taxes, which are off-budget, account for $2.5 billion of that increase in federal revenues.

Direct Spending

CBO estimates that enacting H.R. 5 would reduce direct spending for Medicare, Medicaid, the Children's Health Insurance Program, the Federal Employees Health Benefits program, the Defense Department's TRICARE for Life program, and subsidies for enrollees in health insurance exchanges by roughly $48 billion over the 2012-2021 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]

[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.

Spending Subject to Appropriation

CBO estimates that implementing H.R. 5 would reduce federal spending for health insurance for federal employees covered through the FEHB program by about 0.5 percent—in line with the estimated reductions in the private sector—and would reduce spending for health insurance and health care services paid for by the Departments of Defense and Veterans Affairs by lesser amounts. CBO expects that the impact on those agencies would be proportionally smaller than the impact on overall health spending because medical malpractice costs are already lower than average for entities covered by the Federal Tort Claims Act. In CBO's estimation, the cost of health insurance and health care services funded through appropriation acts would be reduced by $1.6 billion over the 2012-2021 period.

PAY-AS-YOU-GO CONSIDERATIONS

The Statutory Pay-As-You-Go Act of 2010 establishes budget reporting and enforcement procedures for legislation affecting direct spending or revenues. The net changes in outlays and revenues that are subject to those pay-as-you-go procedures are shown in the following table. Only on-budget changes to outlays or revenues are subject to pay-as-you-go procedures.

CBO Estimate of Pay-As-You-Go Effects for H.R. 5, as ordered reported by the House Committee on Energy and Commerce on May 11, 2011

	By Fiscal Year, in Millions of Dollars												
	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	2011-2016	2011-2021
NET INCREASE OR DECREASE (-) IN THE ON-BUDGET DEFICIT													
Statutory Pay-As-You-Go Impact	0	-108	-593	-2,112	-4,186	-6,131	-7,105	-7,672	-8,331	-9,002	-9,574	-13,129	-54,814
Memorandum:													
Direct spending	0	-100	-500	-1,800	-3,600	-5,300	-6,200	-6,700	-7,300	-7,900	-8,400	-11,300	-47,800
Revenues	0	8	93	312	586	831	905	972	1,031	1,102	1,174	1,829	7,014

ESTIMATED IMPACT ON STATE, LOCAL, AND TRIBAL GOVERNMENTS

Intergovernmental Mandates

The bill contains an intergovernmental mandate because it would preempt state laws that would prevent the application of any provision of the bill; however, it would not preempt any state law that provides greater protections for health care providers and organizations from liability, loss, or damages. While the preemption would limit the application of state and local laws, CBO estimates that it would not impose significant costs and would fall well below the threshold established in the Unfunded Mandates Reform Act for intergovernmental mandates ($71 million in 2011, adjusted annually for inflation).

Other Impacts

A decline in health care spending is expected to result in a decrease in rates for health insurance premiums. State, local, and tribal governments, as employers, would save money as a result of lower health insurance premiums precipitated by the bill. State, local, and tribal governments that collect income taxes also would realize increased tax revenues as a result of increases in workers' taxable income. State spending in Medicaid would decrease by over $4 billion over the 2012-2016 period, with additional saving in the subsequent years.

ESTIMATED IMPACT ON THE PRIVATE SECTOR

H.R. 5 contains several mandates on the private sector, because it would limit the amount of compensatory damages that a plaintiff can receive.

Compensatory damages are paid to compensate a claimant for loss, injury, or harm suffered by a defendant’s breach of duty. Laws that directly limit the right of plaintiffs to be compensated for losses that they incurred as a result of a defendant’s wrongful acts impose a mandate.

Applying this standard, the cap on non-economic damages, the statute of limitations, and the fair-share rule included in H.R. 5 would be considered mandates on the private sector, as defined by UMRA, because they would limit the ability of some claimants to recover the entire amount of compensatory damages that could be collected under current law. In addition, the cap on attorney fees is a mandate because it limits the fees that attorneys might otherwise be able to collect from their clients. The cost of those mandates would exceed the threshold established in UMRA for private-sector mandates ($142 million in 2011, adjusted annually for inflation) in four of the first five years in which the mandates

were effective, rising to $1.4 billion per year in 2016, and totaling $3.3 billion over the 2012-2016 period.

PREVIOUS CBO ESTIMATE

On March 10, 2011, CBO transmitted a cost estimate for the HEALTH Act as ordered reported by the House Committee on the Judiciary on February 16, 2011. The version of H.R. 5 approved by the Committee on Energy and Commerce would permit the introduction of evidence of income from collateral sources at trial. The version approved by the Committee on the Judiciary did not contain that provision. Differences in the CBO cost estimates primarily reflect that difference in the bills.

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