CONGRESSIONAL BUDGET OFFICE
COST ESTIMATE

March 22, 2017

H.R. 1215
Protecting Access to Care Act of 2017

As ordered reported by the House Committee on the Judiciary
on February 28, 2017

SUMMARY

H.R. 1215 would impose limits on medical malpractice litigation in state and federal courts by capping awards and attorney fees, modifying the statute of limitations, and eliminating joint and several liability.

CBO expects that enacting H.R. 1215 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 premiums for private health insurance.

In total, CBO and the staff of the Joint Committee on Taxation (JCT) estimate that enacting the legislation would reduce deficits by about $14 billion over the 2017-2022 period, and almost $50 billion over the 2017-2027 period. Off-budget revenues account for about $2 billion of that reduction. CBO estimates that implementing the legislation would reduce discretionary costs by about $1.5 billion over the 2017-2027 period, assuming appropriations actions consistent with the legislation.

CBO estimates that enacting the legislation would not increase net direct spending or on-budget deficits in any of the four consecutive 10-year periods beginning in 2028.

H.R. 1215 would preempt state laws governing health care lawsuits in the areas of statutes of limitation, joint and several liability, product liability, and contingency fees. Those preemptions would be intergovernmental mandates as defined in the Unfunded Mandates Reform Act (UMRA). The bill also would require courts (including state courts) to direct periodic payments of damages in some circumstances. CBO estimates that the costs of complying with those mandates would be insignificant and well below the threshold established in UMRA ($78 million in 2017, as adjusted for inflation).

This bill would impose private-sector mandates as defined in UMRA, on plaintiffs who file medical malpractice claims or medical product liability claims and on attorneys. CBO estimates that the aggregate cost of the mandates would exceed the annual threshold established in UMRA for private-sector mandates ($156 million in 2017, adjusted annually for inflation) in at least four of the first five years the mandates are in effect.

ESTIMATED COST TO THE FEDERAL GOVERNMENT

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

These estimates are based on CBO's assumption that the legislation will be enacted near the beginning of fiscal year 2018. Assuming an earlier enactment date would not change CBO's estimate of the budgetary effects of the legislation.

	By Fiscal Year, in Millions of Dollars												
	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026	2027	2017-2022	2017-2027
CHANGES IN DIRECT SPENDING													
Estimated Budget Authority[a]	0	-30	-570	-2,440	-4,280	-5,290	-5,500	-5,710	-6,220	-6,690	-7,140	-12,610	-43,870
Estimated Outlays	0	-30	-570	-2,440	-4,280	-5,290	-5,500	-5,710	-6,220	-6,690	-7,140	-12,610	-43,870
CHANGES IN DIRECT SPENDING													
Estimated Revenues[b]	0	-9	83	240	516	691	764	816	875	935	999	1,521	5,909
On-budget	*0*	*-13*	*49*	*138*	*342*	*470*	*523*	*562*	*606*	*651*	*700*	*985*	*4,026*
Off-budget[c]	*0*	*4*	*34*	*102*	*174*	*221*	*241*	*255*	*269*	*284*	*300*	*535*	*1,883*
NET INCREASE OR DECREASE (-) IN THE DEFICIT FROM CHANGES IN DIRECT SPENDING AND RECEIPTS													
Impact on the Deficit	0	-21	-653	-2,680	-4,796	-5,981	-6,264	-6,526	-7,095	-7,625	-8,139	-14,131	-49,779
On-budget	*0*	*-17*	*-619*	*-2,578*	*-4,622*	*-5,760*	*-6,023*	*-6,272*	*-6,826*	*-7,341*	*-7,840*	*-13,595*	*-47,896*
Off-budget[c]	*0*	*-4*	*-34*	*-102*	*-174*	*-221*	*-241*	*-255*	*-269*	*-284*	*-300*	*-535*	*-1,883*
CHANGES IN SPENDING SUBJECT TO APPROPRIATION													
Estimated Authorization Level	0	-1	-20	-90	-150	-180	-190	-200	-210	-220	-230	-441	-1,491
Estimated Outlays	0	-1	-20	-90	-150	-180	-190	-200	-210	-220	-230	-441	-1,491

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

a. Includes estimated savings by the Postal Service, whose spending is classified as off-budget.

b. For revenues, positive numbers indicate a decrease in the deficit and negative numbers indicate an increase in the deficit.

c. Off-budget effects indicate a change in Social Security payroll tax revenues.

BASIS OF ESTIMATE

The legislation would establish:

- A three-year statute of limitations for medical malpractice claims, with certain exceptions, from the date of an injury;
- A cap of $250,000 on awards for noneconomic damages;
- 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; and
- A safe harbor from product liability litigation for health care providers who prescribe or dispense products approved by the Food and Drug Administration.

Over the 2017-2027 period, CBO and the staff of the Joint Committee on Taxation estimate that enacting the legislation would reduce direct spending by about $44 billion and increase federal revenues by about $6 billion. The combined effect of those changes would be to reduce federal deficits by almost $50 billion over that period.

In addition, CBO estimates that implementing the legislation would reduce discretionary costs for the Federal Employees Health Benefits (FEHB) program, Department of Defense (DoD), and Department of Veterans Affairs (VA) by about $1.5 billion over the 2017-2027 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 the legislation would reduce national health spending by about 0.4 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

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. The estimated effect on national health spending reported in that letter is different from the estimated effect for this legislation because the two proposals would impose different limits on medical malpractice litigation.

estimate assumes that the spending reduction of about 0.4 percent would be phased in over a period of four years, as providers gradually change their practice patterns.

Direct Spending

Consistent with CBO's estimate of the bill's effect on national health spending, we estimate that enacting the legislation would reduce federal direct spending by about 0.4 percent for Medicare, Medicaid, FEHB, DoD's TRICARE-for-Life program, and subsidies for enrollees in health insurance marketplaces. Those reductions would total roughly $44 billion over the 2017-2027 period.

Revenues

Much of private-sector health care is paid for through employment-based insurance, which represents nontaxable compensation. In addition, since 2014, refundable tax credits have been available to certain individuals and families to subsidize health insurance purchased through health insurance marketplaces. (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 the legislation would lead to an increase in taxable compensation and a reduction in subsidies for health insurance purchased through a marketplace. Conversely, the limitation on attorney's fees would slightly reduce taxable income, causing a loss of revenues. In the first year, that revenue loss would exceed the gains from other increases in compensation. The net effect of those changes would be to increase federal tax revenues by an estimated $5.9 billion over the 2017-2027 period, according to estimates by JCT. Social Security payroll taxes, which are off-budget, account for $1.9 billion of that increase in revenues.

Spending Subject to Appropriation

CBO estimates that implementing the legislation also would reduce federal costs for health insurance for federal employees covered through the FEHB program by about 0.4 percent and would thus reduce costs for health insurance and health care services paid for by the Departments of Defense and Veterans Affairs. In CBO's estimation, the cost of health insurance and health care services funded through appropriation acts would be reduced by $1.5 billion over the 2017-2027 period, assuming appropriation actions consistent with the legislation.

ESTIMATED IMPACT ON STATE, LOCAL, AND TRIBAL GOVERNMENTS

H.R. 1215 would preempt state laws governing health care lawsuits in the areas of statutes of limitation, joint and several liability, product liability, and contingent fees. Those preemptions would be intergovernmental mandates as defined by UMRA. Although the preemptions would limit the application of state laws, they would impose no duty on states that would result in additional spending or a loss of revenues. The bill also would require courts (including state courts) to direct periodic payments of damages in some circumstances. That intergovernmental mandate would place administrative responsibilities on court officials, but CBO estimates that the costs would be insignificant and well below the threshold established in UMRA ($78 million in 2017, as adjusted for inflation).

ESTIMATED IMPACT ON THE PRIVATE SECTOR

H.R. 1215 contains private-sector mandates as defined in UMRA on plaintiffs and their attorneys in medical malpractice claims. By establishing a cap on noneconomic damages in medical malpractice claims, the bill would impose a mandate on plaintiffs as it would limit their ability to recover the entire amount of compensatory damages that could be collected under current law. Additionally, by imposing a cap on fees for attorneys representing plaintiffs in medical malpractice claims the bill would impose a mandate because it would restrict amounts that attorneys might otherwise be able to collect from their clients. The bill also would impose a mandate on plaintiffs who file medical product liability claims. Such claims may allege an injury caused by a defective or dangerous medical product (a drug, device, or biological product). The bill would eliminate a right to file such claims against health care providers by exempting those providers from liability if they prescribe or dispense a medical product that is approved by the Food and Drug Administration. Eliminating an existing right of action is a mandate on plaintiffs because their right to seek redress and recover damages is restricted or lost. The cost of a mandate that restricts or eliminates an existing right of action is the value of forgone awards and settlements in such cases.

CBO estimates the aggregate cost of the mandates in the bill would exceed the annual threshold established in UMRA for private-sector mandates ($156 million in 2017, adjusted annually for inflation) in four of the first five years the mandates are in effect. On the basis of evidence from studies on damages in malpractice cases, CBO estimates that the aggregate cost of the mandates would amount to more than $2.0 billion over the 2018-2022 period.

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