CONGRESSIONAL BUDGET OFFICE
COST ESTIMATE

June 29, 2016

S. 1455
Recovery Enhancement for Addiction Treatment (TREAT) Act

As reported by the Senate Committee on Health, Education, Labor, and Pensions on April 27, 2016

SUMMARY

Under current law, physicians must obtain a waiver from the Substance Abuse and Mental Health Services Administration (SAMHSA) to prescribe buprenorphine to patients with opioid dependency. Those waivers permit the physician to treat up to 30 patients initially; after one year, a physician may apply to increase that cap to 100 patients. S. 1455 would increase the caps to 100 in the first year and 500 in subsequent years. The bill also would permit nurse practitioners and physician assistants who meet certain criteria to apply for those waivers. However, the bill would not preempt state laws that place stricter controls on the provision of treatments for opioid dependency than would be established by S. 1455.

Over the 2017-2026 period, CBO estimates that enacting S. 1455 would increase net direct spending by $2.3 billion and reduce revenues by $0.7 billion, resulting in a $3.1 billion increase in federal deficits. (Of that increase, $2.9 billion would be on-budget.) Implementing S. 1455 also would have a discretionary cost of about $4 million over the 2017-2021 period; any such spending would be subject to the availability of appropriated funds. Pay-as-you-go procedures apply to the bill because enacting it would affect direct spending and revenues.

CBO estimates that enacting the legislation would not increase net direct spending or on-budget deficits by more than $5 billion in any of the four consecutive 10-year periods beginning in 2027.

S. 1455 contains no intergovernmental or private sector-mandates as defined in the Unfunded Mandates Reform Act (UMRA).

ESTIMATED COST TO THE FEDERAL GOVERNMENT

The estimated budgetary effect of S. 1455 is shown in the following table. The costs of this legislation fall within budget functions 550 (health), 570 (Medicare), and 750 (administration of justice).

	By Fiscal Year, in Millions of Dollars											
	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026	2017-2021	2017-2026
CHANGES IN DIRECT SPENDING												
Marketplace Subsidies												
Estimated Budget Authority	0	15	40	67	96	108	111	109	106	103	218	754
Estimated Outlays	0	15	40	67	96	108	111	109	106	103	218	754
Medicaid												
Estimated Budget Authority	0	23	43	59	75	55	33	11	-12	-36	199	251
Estimated Outlays	0	23	43	59	75	55	33	11	-12	-36	199	251
Medicare												
Estimated Budget Authority	0	33	72	116	165	174	179	180	181	180	386	1,280
Estimated Outlays	0	33	72	116	165	174	179	180	181	180	386	1,280
Other												
Estimated Budget Authority	0	1	2	4	5	6	6	6	6	6	13	43
Estimated Outlays	0	1	2	4	5	6	6	6	6	6	13	43
Total Direct Spending Effects												
Estimated Budget Authority	0	71	156	246	341	343	329	307	282	252	815	2,328
Estimated Outlays	0	71	156	246	341	343	329	307	282	252	815	2,328
CHANGES IN REVENUES												
Estimated Revenues	0	-14	-37	-62	-91	-103	-107	-108	-109	-110	-204	-741
On-Budget	0	-11	-28	-47	-68	-78	-80	-81	-82	-82	-154	-558
Off-Budget	0	-4	-9	-15	-22	-25	-26	-27	-27	-27	-50	-183
NET INCREASE IN THE DEFICIT												
Impact on Deficit	0	86	193	308	432	446	435	415	391	362	1,019	3,068
On-Budget	0	82	184	293	409	421	409	388	364	335	969	2,886
Off-Budget	0	4	9	15	22	25	26	27	27	27	50	183

Source: Congressional Budget Office.

Notes: Components may not add to totals because of rounding; CBO estimates that implementing S. 1455 would result in administrative costs for the Department of Health and Human Services and the Department of Justice totaling about $4 million over the 2017-2021 period, subject to the availability of appropriated funds.

BASIS OF ESTIMATE

For this estimate, CBO assumes that S. 1455 will be enacted near the end of fiscal year 2016.

Background

An opioid is a type of drug that has a high potential for addiction and abuse. Opioids include heroin and certain prescription drugs that treat pain, such as oxycodone or morphine. Buprenorphine is a type of opioid used in medication-assisted treatment (MAT) to help people who are addicted to opioids reduce or stop using those drugs. Buprenorphine is one component of MAT, which typically also includes intensive medical and social services.

Current law places substantial limits on the ability of medical professionals to prescribe buprenorphine products for the treatment of opioid addiction. Physicians who meet certain training requirements must apply to SAMHSA for a waiver to prescribe buprenorphine. A physician who receives a waiver is permitted to prescribe the drug to a maximum of 30 patients at a time during the first year after receiving a waiver. After one year, the physician may apply for an increase to 100 patients. (SAMHSA has published a proposed rule that, if made final, would increase that limit to 200 patients.) As of June 2016, about 33,000 physicians were approved to prescribe buprenorphine. Nurse practitioners (NPs) and physician assistants (PAs) are not currently permitted to apply for waivers to prescribe buprenorphine.

Based on a review of available information, CBO estimates that about 850,000 people are being treated for opioid addiction with buprenorphine in 2016 and that an additional 1.5 million people could benefit from such treatment. Survey data from SAMHSA published in 2014 highlight several significant barriers to receiving treatment for substance abuse that are not directly related to the number of providers available to provide such treatment. Those barriers include:

- Inability to pay for treatment if uninsured or if health insurers impose coverage limitations;
- Not feeling ready to seek treatment; and
- Not knowing where to look to find the necessary treatment.

Given these barriers to accessing treatment, CBO expects that even if there were no constraints on the supply of MAT providers, most of the 1.5 million people who currently do not receive buprenorphine treatment for opioid addiction would remain untreated. In CBO's judgment, the greatest number of people who might take advantage of

buprenorphine-based MAT if it were available is about 1.3 million people, about 50 percent more than the estimated number currently receiving treatment.

Direct Spending

S. 1455 would allow qualified physicians to increase their patient limits from 30 to 100 in the first year and from 100 to 500 patients in subsequent years. In addition, the bill would permit NPs and PAs who meet certain criteria to apply for waivers to prescribe buprenorphine products to patients dependent on opioid drugs. Those practitioners would be required to receive 24 hours of specialized training or meet other training requirements set forth by the Secretary of Health and Human Services (HHS). The bill would not preempt state laws that set the patient limit to some amount between 30 and 500 or that place additional requirements on qualifying practitioners.

CBO estimates that enacting S. 1455 would increase the number of people who receive buprenorphine-based MAT services. By 2021, CBO expects that the number of additional people would reach 390,000 and estimates that enacting S. 1455 would increase net direct spending by about $2.3 billion over the 2017-2026 period. That estimate reflects net changes in federal spending for people enrolled in Medicare, Medicaid, and other federal health programs, as well as for people who receive subsidies for health insurance purchased through marketplaces (sometimes called exchanges).

To develop that estimate, CBO consulted with experts and analyzed administrative data to assess the effects of expanding the availability of waivers and increasing patient limits on the number of people who would newly receive treatment under the legislation. After adjusting the estimate to reflect the proposed rule, CBO estimated the share that would be enrolled in federally funded health care programs or private health insurance coverage and the per-person spending for MAT services for each type of coverage. CBO also accounted for the reduction in overall health care spending and the additional costs from reduced mortality rates for people who comply with buprenorphine MAT. Finally, CBO adjusted the estimates to take account of the time it would take for the legislation to be fully implemented.

CBO first analyzed administrative data to determine the rate at which physicians currently apply for waivers and the average number of opioid-dependent patients each physician treats. Increasing the patient limit to 500 would increase the average caseload for physicians with waivers. If NPs and PAs also applied for waivers at the same rate as physicians, and treated the same number of patients on average as waivered physicians, CBO estimates that the number of additional people who would use MAT services for opioid use disorders would gradually increase to about 390,000 over several years. That estimate reflects CBO’s expectation that about 10 percent of potential patients with opioid dependency live in states that would place additional restrictions on providers beyond those included S. 1455. It also reflects CBO’s expectation that over two-thirds of that

increase in MAT utilization would be generated from expanding waiver authority to NPs and PAs.

The analysis described above is based on estimates of the number of people being treated with buprenorphine under current limits and on the number of patients a medical professional with a waiver may treat. It also takes into account that on March 30, 2016, SAMHSA published a proposed rule that would increase the patient limit from 100 patients to 200 patients. Like S. 1455, that proposed change would also have the effect of increasing the number of people treated with buprenorphine. CBO expects that there is substantial overlap between the people who would gain access to MAT services under that rule, if it were made final, and under S. 1455. In accordance with CBO's standard practice for incorporating the effects of proposed rules, this estimate reflects an assumption that there is a 50 percent chance that the rule will become final.[1] To incorporate that effect in this estimate, CBO reduced the estimated number of people who ultimately would receive MAT services as a result of enacting S. 1455.

CBO estimates that about a third of people treated for opioid addiction with buprenorphine have health care coverage through employment-based insurance, about 10 percent are enrolled in a plan purchased through a health insurance marketplace, and less than a third have health care coverage through other federal health programs such as Medicare or Medicaid. CBO further estimates that the same proportions would apply to the increase in the total number of people who would receive such treatment as a result of enacting S. 1455.

Based on data published in the proposed rule and on administrative data for the Medicaid and Medicare programs, CBO estimates that the cost to the federal government of MAT will average about $1,900 for people covered by Medicaid and about $4,600 for people covered by Medicare and other federal programs in 2018, the first year in which CBO expects new individuals would receive MAT under S. 1455. This estimate accounts for use of Probuphine, a buprenorphine implant that became available at the end of May 2016 and will increase the costs of MAT services for some recipients. CBO estimates that the insurer's share of costs for MAT services for people with private health insurance will average about $5,100, but the federal government bears only a portion of those costs.

CBO also reviewed published studies that compared spending on health care services for individuals treated with buprenorphine-based MAT with such spending for individuals who either receive other treatments or no treatment for opioid addiction. Most—but not all—of those studies concluded that there was a reduction in use of health care services

1. See Congressional Budget Office letter to the Honorable John M. Spratt about how CBO reflects anticipated administrative actions in its baseline projections and how it estimates the budgetary impact of legislation directing or prohibiting such actions (May 2, 2007): https://www.cbo.gov/sites/default/files/110th-congress-2007-2008/reports/05-02-letteronregs.pdf

such as emergency department visits and inpatient hospital stays within six months to a year of initiating treatment.

Based on that literature, CBO also expects that reduced spending on other health care services would be concentrated in the roughly one-quarter to one-third of patients treated with buprenorphine who adhered to the treatment protocol for at least three-quarters of the year. CBO estimates those savings would initially offset about one-quarter of the cost of buprenorphine treatment for both adherent and non-adherent patients. CBO expects those offsetting savings would increase in subsequent years and would offset about half of the cost of treatment with buprenorphine over the 2017-2026 period.

Based on that literature, CBO also anticipates that annual mortality rates for people who adhere to buprenorphine-based MAT would be reduced by about one percentage point. For this estimate, CBO projected that the annual federal costs for health care for the additional survivors would equal the average cost for other enrollees with similar coverage.

For this estimate, CBO assumes that the Attorney General and SAMHSA would issue final regulations implementing S. 1455 in fiscal year 2017. We expect SAMHSA would begin issuing waivers to NPs and PAs and increasing the patient limits in fiscal year 2018. Taking into account the gradual increase in the number of MAT users under the bill, CBO estimates that the number of newly treated people (390,000) would be fully phased-in by 2021.

Revenues

CBO expects that under S. 1455, higher spending for some people with employment-based health insurance would lead to higher premiums. Those higher premiums, in turn, would result in more of an employee's compensation being received in the form of nontaxable employer-paid premiums, and less in the form of taxable wages. As a result of this shift, federal income and payroll tax revenues would decline. Premiums for people purchasing health insurance through the marketplaces would also be higher, reducing tax liability for some people who receive subsidies for such coverage. Overall, the agencies estimate that S. 1455 would decrease revenues by about $0.7 billion over the 2017-2026 period.

Spending Subject to Appropriation

CBO estimates that implementing S. 1455 would have discretionary costs of about $4 million over the 2017-2021 period. About $3 million of those costs would result from paying for administrative expenses associated with approving new waivers for providers and, subsequently, issuing Drug Enforcement Administration numbers. The remaining costs would be for HHS to submit a report to the Congress. Any such spending would be subject to the availability of appropriated funds.

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.

CBO Estimate of Pay-As-You-Go Effects for S. 1455, as ordered reported by the Senate Committee on Health, Education, Labor, and Pensions on March 16, 2016.

	By Fiscal Year, in Millions of Dollars												
	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026	2016-2021	2016-2026
NET INCREASE OR DECREASE (-) IN THE ON-BUDGET DEFICIT													
Statutory Pay-As-You-Go Impact	0	0	82	184	293	409	421	409	388	364	335	969	2,886
Memorandum:													
Changes in On-Budget Outlays	0	0	71	156	246	341	343	329	307	282	252	815	2,328
Changes in On-Budget Revenues[a]	0	0	-11	-28	-47	-68	-78	-80	-81	-82	-82	-154	-558

a. For revenues, a positive number indicates an increase (reducing the deficit) and a negative number indicates a decrease (adding to the deficit)

INCREASE IN LONG-TERM DIRECT SPENDING AND DEFICITS

CBO expects that the savings from reduced spending for overall health services would grow more rapidly than the cost of treatment with buprenorphine. As a result, CBO estimates that enacting the legislation would not increase net direct spending or on-budget deficits by more than $5 billion in any of the four consecutive 10-year periods beginning in 2027.

INTERGOVERNMENTAL AND PRIVATE-SECTOR IMPACT

S. 1455 contains no intergovernmental or private-sector mandates as defined in UMRA. Because the bill would increase the number of Medicaid beneficiaries who may receive medication-assisted treatment for opioid dependency, CBO estimates that Medicaid spending by states would increase by about $241 million over the 2017-2026 period.

PREVIOUS ESTIMATE

On May 31, 2016, CBO transmitted a cost estimate for H.R. 4981, the Opioid Use Disorder Treatment Expansion and Modernization Act, as passed by the House of Representatives on May 11, 2016. Section 3 of H.R. 4981 would preserve the patient caps at current law levels, but it is similar to S. 1455 in that it also would permit NPs and PAs to apply for waivers to prescribe buprenorphine products under the supervision of a physician. However, under H.R. 4981 the ability of NPs and PAs to receive those waivers would expire three years after the date of enactment.

CBO completed the estimate for section 3 of H.R. 4981 before the agency had completed the literature review and additional analysis underlying this estimate of S. 1455. Therefore, the estimate for that section of the bill did not account for the reduction in health care spending, the additional costs from reduced mortality rates for those people who comply with buprenorphine MAT, or for the effects of the bill on the costs of private health insurance coverage. After incorporating those effects, CBO estimates that enacting H.R. 4981 would reduce direct spending by $62 million and revenues by $22 million, resulting in a $40 million decrease in federal deficits.[2]

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2. See Congressional Budget Office table for the revised estimate of H.R. 4981, the Opioid Use Disorder Treatment Expansion and Modernization Act (June 29, 2016): https://www.cbo.gov/publication/51739