CONGRESSIONAL BUDGET OFFICE
COST ESTIMATE

July 24, 2017

H.R. 3178
Medicare Part B Improvement Act of 2017

As ordered reported by the House Committee on Ways and Means on July 13, 2017

SUMMARY

H.R. 3178 would modify several Medicare policies related to coverage and payment for services under Part B of the program. CBO estimates that enacting H.R. 3178 would reduce direct spending by $4 million over the 2018-2027 period.

Pay-as-you-go procedures apply because enacting the legislation would affect direct spending. The legislation would not affect revenues.

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. 3178 contains no intergovernmental or private-sector mandates as defined in the Unfunded Mandates Reform Act (UMRA) and would impose no costs on state, local, or tribal governments.

ESTIMATED COST TO THE FEDERAL GOVERNMENT

The estimated budgetary effect of H.R. 3178 is shown in the following table. The costs of this legislation fall within budget function 570 (Medicare).

	By Fiscal Year, in Millions of Dollars												
	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026	2027	2017-2022	2017-2027
INCREASES OR DECREASES (-) IN DIRECT SPENDING													
Estimated Budget Authority	0	3	77	-17	-55	-12	0	0	0	0	0	-4	-4
Estimated Outlays	0	3	77	-17	-55	-12	0	0	0	0	0	-4	-4

BASIS OF ESTIMATE

For this estimate, CBO assumes that H.R. 3178 will be enacted near the end of fiscal year 2017. CBO estimates that enacting H.R. 3178 would affect direct spending in fiscal years 2018 through 2022 and would decrease direct spending by $4 million over that period. The bill would make a number of changes to Medicare, including changes to rules related to self-referral by physicians and modifications to telehealth utilization by beneficiaries with end-stage renal disease. The provisions that would affect direct spending are discussed below.

Transitional payment for home infusion therapy services. Currently, the Medicare program does not pay for nursing and administration services when beneficiaries receive a drug infusion in the home setting. Many drugs that beneficiaries receive in that setting are delivered via a pump, which Medicare does cover as part of the durable medical equipment (DME) benefit. Medicare also pays for covered drugs administered through a pump for beneficiaries in the home setting.

The 21st Century Cures Act of 2016 (Public Law 114-255) added a home infusion benefit to Medicare, but that benefit will not become available until January 1, 2021. That act also modified, as of January 1, 2017, the payment rate for drugs delivered through DME, which lowered the payment rate significantly for several infused drugs. According to stakeholders, suppliers had used the difference between their cost to purchase infused drugs and the Medicare payment rate to pay for administration services for beneficiaries receiving infused drugs in the home setting. After that reduction in payment rates for drugs administered through DME was implemented, evidence suggests that many beneficiaries now receive their infusions in physicians' offices or hospital outpatient departments instead of at home.

H.R. 3178 would add a temporary home infusion benefit to Medicare, beginning on January 1, 2019, and ending on December 31, 2020. Payment for home infusion services under the new benefit would be based on payment rates for infusion services under the Medicare physician fee schedule (PFS). The payment would vary depending on the drug being administered, and would be set based on the PFS rate for a five-hour infusion.

CBO analyzed how drugs that would be included in the temporary benefit were utilized across settings prior to the enactment of the 21st Century Cures Act, to understand where beneficiaries typically had received drug infusions. CBO also assessed how those utilization patterns likely changed since the enactment of the 21st Century Cures Act and how the distribution across settings would change if H.R. 3178 is enacted.

Some beneficiaries who now receive infusions at home would continue to do so if the legislation is enacted. For those beneficiaries, the bill would increase Medicare spending

for drug administration services. Other beneficiaries currently receive infusion services in the physician office setting and some would choose to receive infusions at home if H.R. 3178 becomes law. In that case, Medicare spending would increase slightly, because CBO estimates that the average duration of a physician-administered infusion is shorter than the five hours allowed for in H.R. 3178. For beneficiaries currently receiving infusions in the hospital outpatient setting who would switch to the home setting, H.R. 3178 would reduce spending, as the temporary rate would be lower than the equivalent rate in the outpatient setting.

Based on CBO's expectation that Medicare would pay for about 25 million infusions per year in the home setting, CBO estimates that on net, the home infusion provision would increase direct spending by $15 million over the 2018-2027 period.

Extension of Medicare Patient IVIG Access Demonstration Project. The Medicare IVIG Access and Strengthening Medicare and Repaying Taxpayers Act of 2012 (Public Law 112-242) authorized a three-year demonstration project under which Medicare pays for services related to the infusion of intravenous immune globulin (IVIG) to certain beneficiaries. Under the demonstration Medicare makes a per-visit payment for items and services needed for the in-home administration of IVIG. The demonstration is scheduled to end on September 30, 2017.

H.R. 3178 would extend the existing demonstration through December 31, 2020. Public Law 112-242 appropriated $45 million for the project; as of January 2017, about $5 million has been spent. Although the funding made available for the demonstration has not been exhausted, the authority to spend that money will lapse as of October 1, 2017. As a result, extending the demonstration would result in new direct spending. Based on historical enrollment and spending patterns for the demonstration, CBO estimates that the extension in H.R. 3178 would increase direct spending by about $16 million over the 2018-2027 period.

Rescission. H.R. 3178 would rescind $25 million earmarked under current law for making improvements to the Medicare fee-for-service program. Changes in spending in the fee-for-service sector affect both payment to Medicare Advantage plans and collections of Part B premiums. Taking those effects into account, CBO estimates that rescission would reduce direct spending for Medicare by $35 million over the 2017-2027 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 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 H.R. 3178, as ordered reported by the House Committee on Ways and Means on July 13, 2017

	By Fiscal Year, in Millions of Dollars												
	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026	2027	2017-2022	2017-2027
NET DECREASE (-) IN THE DEFICIT													
Statutory Pay-As-You-Go Impact	0	3	77	-17	-55	-12	0	0	0	0	0	-4	-4

INCREASE IN LONG-TERM DIRECT SPENDING AND DEFICITS

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.

INTERGOVERNMENTAL AND PRIVATE-SECTOR IMPACT

H.R. 3178 contains no intergovernmental or private-sector mandates as defined in UMRA and would impose no costs on state, local, or tribal governments.

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