Congressional Budget Office
Cost Estimate

September 30, 2019

At a Glance

H.R. 3417, Beneficiary Education Tools, Telehealth, and Extenders Reauthorization Act of 2019

As ordered reported by the House Committee on Ways and Means on June 26, 2019

By Fiscal Year, Millions of Dollars	2020	2020-2024	2020-2029
Direct Spending (Outlays)	304	2,220	3,605
Revenues	0	0	0
Deficit Effect	304	2,220	3,605
Spending Subject to Appropriation (Outlays)	0	10	not estimated

Statutory pay-as-you-go procedures apply?	Yes
Increases on-budget deficits in any of the four consecutive 10-year periods beginning in 2030?	> $5 billion

Mandate Effects

Contains intergovernmental mandate?	No
Contains private-sector mandate?	No

The bill would

- Accelerate the starting date for coverage of some new Medicare enrollees
- Expand the availability of telehealth services for mental health care
- Allow certain hospitals to reset their graduate medical education (GME) caps
- Provide higher payments to Medicare physicians in rural areas

Estimated budgetary effects would primarily stem from

- Increased costs for new Medicare enrollees
- Expansion of telehealth services
- Increased numbers of GME positions at certain hospitals
- Higher Medicare payments to physicians in rural areas

Areas of significant uncertainty include

- Estimating the increased demand for telehealth mental health care services and projecting the number of providers available to meet that need
- Projecting the number of GME positions created under the new caps

Detailed estimate begins on the next page.

Bill Summary

H.R. 3417 would accelerate the start date for coverage of certain new enrollees; expand the availability of certain telehealth services; allow certain hospitals to increase the number of residents in graduate medical education programs for which Medicare provides funding; increase Medicare payments to physicians in rural areas; and extend several expiring programs under Medicare.

Estimated Federal Cost

The estimated budgetary effect of H.R. 3417 is shown in Table 1. The costs of the legislation fall within budget function 570 (Medicare).

Table 1.
Estimated Budgetary Effects of H.R. 3417

	By Fiscal Year, Millions of Dollars											
	2020	2021	2022	2023	2024	2025	2026	2027	2028	2029	2020-2024	2020-2029
Increases in Direct Spending												
Title I, Patient Improvements												
Section 101. Beneficiary Enrollment Notification and Eligibility Simplification												
Estimated Budget Authority	0	20	35	40	40	45	45	50	55	50	135	375
Estimated Outlays	0	20	35	40	40	45	45	50	55	50	135	375
Section 102. Extension of Funding Outreach and Assistance for Low-Income Programs												
Estimated Budget Authority	50	50	50	0	0	0	0	0	0	0	150	150
Estimated Outlays	45	50	50	5	0	0	0	0	0	0	150	150
Section 103. Medicare Coverage of Certain Mental Health Telehealth Services												
Estimated Budget Authority	0	5	15	30	55	105	145	185	235	250	105	1,025
Estimated Outlays	0	5	15	30	55	105	145	185	235	250	105	1,025
Title II, Rural and Quality Improvements												
Section 201. Medicare GME Treatment of Hospitals Establishing New Medical Residency Training Programs After Hosting Medical Resident Rotators for Short Durations												
Estimated Budget Authority	0	0	1	5	14	29	42	44	47	49	20	230
Estimated Outlays	0	0	1	5	14	29	42	44	47	49	20	230

(Continued)

Table 1.
Continued

	By Fiscal Year, Millions of Dollars											
	2020	2021	2022	2023	2024	2025	2026	2027	2028	2029	2020-2024	2020-2029
Increases in Direct Spending												
Section 202. Extension of the Work Geographic Index Floor Under the Medicare Program												
Estimated Budget Authority	230	590	655	235	0	0	0	0	0	0	1,710	1,710
Estimated Outlays	230	590	655	235	0	0	0	0	0	0	1,710	1,710
Section 203. Extension of Funding for Quality Measure Endorsement, Input, and Selection Under Medicare Program												
Estimated Budget Authority	30	30	30	0	0	0	0	0	0	0	90	90
Estimated Outlays	29	30	30	1	0	0	0	0	0	0	90	90
Total Changes in Direct Spending												
Estimated Budget Authority	304	695	791	316	114	179	237	279	337	354	2,220	3,605
Estimated Outlays	304	695	791	316	114	179	237	279	337	354	2,220	3,605

Components may not sum to totals because of rounding; GME = graduate medical education.

Basis of Estimate

For this estimate, CBO assumes that the bill will be enacted near the end of 2019.

Direct Spending

CBO estimates that enacting H.R. 3417 would increase direct spending for Medicare by $3.6 billion over the 2020-2029 period.

Title I, Patient Improvements. Title I would accelerate the start date for certain new enrollees, provide funding for certain agencies and programs that provide education and support to Medicare beneficiaries with low income, and expand coverage of mental health services furnished via telehealth.

Section 101, Beneficiary Enrollment Notification and Eligibility Simplification. Section 101 would accelerate the start date for coverage of beneficiaries who enroll in the program during the general enrollment period (January through March of each year) or during the final three months of the initial enrollment period (when a beneficiary first becomes eligible to enroll); some of those enrollees would receive services sooner than is possible under current law. Based on historical enrollment data, CBO estimates that about 3 percent of new enrollees would receive Medicare benefits sooner than under current law. These additional months of

Medicare coverage would increase direct spending by $375 million over the 2019-2029 period.

Section 102, Extension of Funding Outreach and Assistance for Low-Income Programs. Section 102 would provide $50 million in annual funding for fiscal years 2020 through 2022 for certain agencies and programs that provide education and support to Medicare beneficiaries with low income. Those entities are the State Health Insurance Assistance Programs, Area Agencies on Aging, Aging and Disability Resource Centers, and the National Center for Benefits and Outreach Enrollment. CBO estimates that enacting this section would cost $150 million over the 2019-2029 period.

Section 103, Medicare Coverage of Certain Mental Health Telehealth Services. Current law limits provision of covered telehealth mental health services to people in rural areas, and those beneficiaries must receive such services onsite in a medical facility. Section 103 would eliminate the geographic and originating-site requirements for providing mental health telehealth services. The bill would require an initial face-to-face assessment by a provider before telehealth psychotherapy could begin, and it would mandate periodic in-person reassessments. Under section 103, beneficiaries could receive telehealth mental health services at home.

Under current law, since the use of mental health telehealth services is limited to rural areas and provided in a medical facility, the current use of these services is low. Because the provision would allow rural and urban beneficiaries to access services at home, CBO estimates that demand could increase substantially over the next five years. However, the ability to meet the demand for those services would depend on the supply of mental health practitioners. The Bureau of Labor Statistics projects growth in the mental health professions over the next few years, but CBO estimates that demand for services would still outstrip supply. Given those constraints, CBO estimates that expanding mental health telehealth to urban and rural beneficiaries at home would add an additional 150,000 visits in 2021 and Medicare would pay $73 per visit on average, depending on the length of the visit and the type of provider. CBO estimates that enacting section 103 would increase direct spending by $1 billion over the 2019-2029 period.

Title II, Rural and Quality Improvements. Title II would increase the number of residents trained in GME programs for which Medicare provides funding, increase payment rates for physicians in rural areas, and extend several expiring programs.

Section 201, Medicare GME Treatment of Hospitals Establishing New Medical Residency Training Programs After Hosting Medical Resident Rotators for Short Durations. After the Medicare residency caps were established in the Balanced Budget Act of 1997, some non-teaching hospitals were assigned such caps based on the presence of residents who rotated from teaching hospitals that year. But the caps also limit the number of residents in teaching

programs that can be used to calculate Medicare funding for those hospitals. Section 201 would allow them to receive funding for a higher number of residents trained in GME programs. Hospitals would be eligible: if the current cap on full-time-equivalent slots for resident physicians is less than 1 (based on cost-reporting periods before October 1, 1997) or no greater than 3 (based on cost-reporting periods between October 1, 1997, and the date of the bill's enactment).

Eligible hospitals would have five years from the date of enactment to begin training new residents and increase their residency caps. Based on CBO's analyses of Medicare cost-reporting data and considering the challenges hospitals would be likely to face in establishing or expanding residency programs within the period, CBO estimates that roughly 250 positions would be created during the five years after enactment. Those positions would remain in place for future calculations of Medicare GME for those hospitals. Based on a projection of costs per resident, CBO estimates that enacting this provision would increase direct spending by $230 million over the 2019-2029 period.

Section 202, Extension of the Work Geographic Index Floor Under the Medicare Program. Section 202 would extend through calendar year 2022 a provision that increases Medicare's payments to rural physicians. Based on current spending for the physician fee schedule in those areas (about $450 million in 2018), CBO estimates that enacting section 202 would cost $1.7 billion over the 2019-2029 period.

Section 203, Extension of Funding for Quality Measure Endorsement, Input, and Selection Under Medicare Program. For each fiscal year from 2020 through 2022, section 203 would appropriate $30 million for a contract between the Department of Health and Human Services and a consensus-based entity that would endorse standardized measures of health care performance. CBO estimates that enacting section 203 would cost $90 million over the 2019-2029 period.

Spending Subject to Appropriation

Section 101 would require a change in the notice of Medicare eligibility that is sent to people between the ages of 63 and 65. It also would require that a notice be sent to disabled individuals in the 24-month waiting period. Those individuals do not receive such notices under current law. In addition, it would require that the updated notice be posted on the websites of the Social Security Administration and the Centers for Medicare & Medicaid Services. Because of this notice, the Social Security Administration would face increased costs for postage and mailing, staff training, and responding to additional inquiries. Based on information from the Social Security Administration, CBO estimates that implementing that provision would cost $10 million over the 2020-2024 period.

Uncertainty

Section 103 would change the way telehealth services for mental health treatment are provided under Medicare. CBO cannot precisely estimate either the number of beneficiaries who would participate or whether enough providers would be available to meet the demand. Therefore, the cost of the section could be higher or lower than CBO estimates.

Another source of uncertainty is the number of GME positions that would be created by hospitals that currently have caps on training programs for resident physicians. If the number of positions created is larger or smaller than estimated, the costs of section 201 could differ from CBO's estimate.

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 Table 2.

Table 2.
CBO's Estimate of the Statutory Pay-As-You-Go Effects of H.R. 3417

	By Fiscal Year, Millions of Dollars											
	2020	2021	2022	2023	2024	2025	2026	2027	2028	2029	2020-2024	2020-2029
	Net Increase in the Deficit											
Statutory Pay-As-You-Go Effect	304	695	791	316	114	179	237	279	337	354	2,220	3,605

Increase in Long-Term Deficits

CBO estimates that enacting H.R. 3417 would increase on-budget deficits by more than $5 billion in at least one of the four consecutive 10-year periods beginning in 2030.

Mandates

H.R. 3417 contains no intergovernmental or private-sector mandates as defined in the Unfunded Mandates Reform Act (UMRA). Participation in Medicare is voluntary for private entities. Therefore, the requirements in the bill arising from participation in Medicare would not impose private-sector mandates as defined in UMRA.

Previous CBO Estimate

Section 202. On September 18, 2019, CBO transmitted a cost estimate for H.R. 2328, the Reauthorizing and Extending America's Community Health Act, as ordered reported by the House Committee on Energy and Commerce on July 17, 2019. Section 202 of H.R. 3417 is the same as section 201 of H.R. 2328. Both bills would extend through calendar year 2022 a

provision that increases payments to rural physicians. CBO's estimate for that provision is the same in both bills.

Section 203. On September 18, 2019, CBO transmitted a cost estimate for H.R. 2328, the Reauthorizing and Extending America's Community Health Act, as ordered reported by the House Committee on Energy and Commerce on July 17, 2019. Section 203 of H.R. 3417 is similar to section 203 of H.R. 2328. Both bills would appropriate $30 million for a contract between the Department of Health and Human Services and a consensus-based entity that would endorse standardized measures of performance in health care. CBO's estimate for that provision is the same in both bills.

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