CONGRESSIONAL BUDGET OFFICE
COST ESTIMATE

October 20, 2017

H.R. 1148
Furthering Access to Stroke Telemedicine Act of 2017

As ordered reported by the House Committee on Energy and Commerce on October 4, 2017

SUMMARY

H.R. 1148 would expand the use of remote (telehealth) services for Medicare stroke patients located in non-rural areas. CBO estimates that enacting H.R. 1148 would increase direct spending by $180 million over the 2018-2027 period.

Enacting H.R. 1148 would affect direct spending; therefore, pay-as-you-go procedures apply. The legislation would not affect revenues.

CBO estimates that enacting H.R. 1148 would not increase net direct spending or on-budget deficits by more than $5 billion in one or more of the four consecutive 10-year periods beginning in 2028.

H.R. 1148 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 H.R. 1148 is shown in the following table. The costs of this legislation fall within budget function 570 (Medicare).

	By Fiscal Year, in Millions of Dollars											
	2018	2019	2020	2021	2022	2023	2024	2025	2026	2027	2018-2022	2018-2027
INCREASES IN DIRECT SPENDING												
Estimated Budget Authority	0	0	0	10	15	20	25	30	35	45	25	180
Estimated Outlays	0	0	0	10	15	20	25	30	35	45	25	180

BASIS OF ESTIMATE

Under current law, coverage of telehealth services is restricted to Medicare beneficiaries in rural areas. Beginning on January 1, 2021, H.R. 1148 would remove that geographic restriction for telestroke services (a subset of telehealth services that involves consultation with a neurologist for a patient suspected of having had a stroke).

There are two types of stroke: bleeding in the brain (hemorrhagic) and clotting in the brain (ischemic). Use of a clot-dissolving drug to treat clotting strokes within three to four-and-a-half hours of the onset of symptoms substantially improves outcomes, both by increasing survival rates and by reducing the likelihood that a stroke patient will be moderately or severely disabled. However, administering the clot-dissolving drug to a patient with a bleeding stroke is likely to cause death. Therefore, a timely neurological evaluation is essential to determine whether to administer the clot-dissolving drug to a patient with stroke symptoms.

Emergency medical services in most urban and suburban areas have protocols to identify patients with stroke symptoms and transport those patients directly to a hospital that is a "stroke center." As a result, a large majority of stroke patients in those areas are taken directly to a stroke center. Such a facility always has a neurologist available—either onsite or via telehealth—to determine which drugs to administer to a stroke patient, so enacting H.R. 1148 would not affect outcomes for such patients.

On the basis of an analysis of Medicare claims data, a review of the relevant literature, and discussions with experts, CBO estimates that about 550,000 strokes occur in the Medicare population in non-rural settings each year. Under H.R. 1148, by CBO's estimates, the proportion of those cases that is handled using telestroke services would increase from about 6 percent in 2021 to 14 percent in 2027.

To develop spending estimates for the bill's extension of telestroke services, CBO focused on cohorts of Medicare patients who receive a telestroke consultation in a given year. That approach, which tracks groups of patients over a span, is particularly appropriate when spending is changeable over time. On the basis of a review of the relevant literature and discussions with experts, CBO concluded that spending—by the federal government and nonfederal providers combined—for a cohort would increase in the year in which the telestroke consultation occurs and then decline in subsequent years.

Higher spending in the first year would be the result of: additional consultations, more medications, additional treatment, and—for patients who otherwise would not have survived—more spending for post–acute-care services during the 90 days after a hospital stay. Annual spending would be lower in subsequent years largely because the number of

patients who are discharged from the hospital with moderate or severe disability would decline significantly as would spending for long-term care.

Because Medicare does not cover long-term care services such as nursing home care, much of the savings from avoided long-term-care services would accrue to beneficiaries, other private payers, and state Medicaid programs—and not to the federal government. The federal government would share in the savings that accrue to state Medicaid programs.

For a given cohort, CBO estimates that cumulative spending—including spending by nonfederal payers—would be reduced beginning in the fourth year after the telestroke consultation. Federal spending would follow the same basic pattern but with a lag because much of the savings would accrue to nonfederal payers. CBO estimates that federal spending would be reduced beginning in the sixth year after the telestroke consultation.

Taking into account that pattern of an initial increase in spending and a reduction over time for each cohort of patients each year, CBO expects that expanding Medicare coverage of telestroke services ultimately would reduce Medicare spending. Over the 2018-2027 period, however, CBO estimates the expansion of telestroke services would increase direct spending by $180 million.

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. 1148, as ordered reported by the House Committee on Energy and Commerce on October 4, 2017

	By Fiscal Year, in Millions of Dollars											
	2018	2019	2020	2021	2022	2023	2024	2025	2026	2027	2018-2022	2018-2027
NET INCREASE IN THE DEFICIT												
Statutory Pay-As-You-Go Impact	0	0	0	10	15	20	25	30	35	45	25	180

INCREASE IN LONG-TERM DIRECT SPENDING AND DEFICITS

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 2028.

INTERGOVERNMENTAL AND PRIVATE-SECTOR IMPACT

H.R. 1148 contains no intergovernmental or private-sector mandates as defined in UMRA.

PREVIOUS CBO ESTIMATE

On August 1, 2017, CBO produced an estimate for S. 870, the Creating High-Quality Results and Outcomes Necessary to Improve Chronic (CHRONIC) Care Act of 2017, as ordered reported by the Senate Committee on Finance on May 18, 2017. H.R. 1148 and the telestroke provision in S. 870 are substantially similar, and the estimated budgetary effects are the same.

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