CONGRESSIONAL BUDGET OFFICE
COST ESTIMATE

October 17, 2001

S. 1533
Health Care Safety Net Amendments of 2001

As reported by the Senate Committee on Health, Education, Labor, and Pensions on October 11, 2001

SUMMARY

S. 1533 would extend expiring provisions and authorizations for appropriations in title III of the Public Health Service Act (PHSA). The bill would reauthorize and expand the Health Centers and National Health Service Corps programs, and establish the Community Access Program in statute. It also would create several new grant programs and demonstrations. The provisions in this bill would be administered by the Health Resources and Services Administration (HRSA).

Assuming the appropriation of the necessary amounts, CBO estimates that implementing S. 1533 would cost about $1 billion in 2002 and between $8 billion and $9 billion over the 2002-2006 period.

The bill would increase spending by the Medicare program for rural health clinic services, and reduce Medicaid spending for certain beneficiaries who use those clinics. In total, direct spending would increase by $146 million over the 2002-2011 period. Because enacting S. 1533 would affect direct spending, pay-as-you-go procedures would apply.

S. 1533 contains an intergovernmental mandate as defined in the Unfunded Mandates Reform Act (UMRA), but CBO estimates that the mandate would not affect the budgets of state, local, or tribal governments. Those governments may also benefit either directly or indirectly from some of the grant programs authorized in the bill, but their participation in those programs would be voluntary. S. 1533 contains no private-sector mandates as defined in UMRA.

ESTIMATED COST TO THE FEDERAL GOVERNMENT

The estimated budgetary impact of S. 1533 is shown in the following table. For the purposes of this estimate, CBO assumes that the bill will be enacted this fall and that the necessary

appropriations will be provided for each fiscal year. The table summarizes the budgetary impact on discretionary spending of the legislation under two different sets of assumptions. In cases where the bill would authorize the appropriation of such sums as may be necessary, the first set of figures provides the estimated levels of authorizations assuming annual adjustments for anticipated inflation after fiscal year 2002. The second set of assumptions does not include any such inflation adjustments. The costs of this legislation would fall within budget functions 550 (health) and 570 (Medicare).

	By Fiscal Year, in Millions of Dollars					
	2001	2002	2003	2004	2005	2006
SPENDING SUBJECT TO APPROPRIATION						
With Adjustments for Inflation						
Spending Under Current Law						
Budget Authority [a]	1,513	0	0	0	0	0
Estimated Outlays	1,368	662	60	7	0	0
Proposed Changes						
Estimated Authorization Level	0	1,887	1,878	1,914	1,953	1,989
Estimated Outlays	0	1,004	1,776	1,886	1,923	1,961
Spending Under S. 1533						
Estimated Authorization Level	1,513	1,887	1,878	1,914	1,953	1,989
Estimated Outlays	1,368	1,665	1,835	1,893	1,923	1,961
Without Adjustments for Inflation						
Spending Under Current Law						
Budget Authority [a]	1,513	0	0	0	0	0
Estimated Outlays	1,368	662	60	7	0	0
Proposed Changes						
Estimated Authorization Level	0	1,887	1,836	1,834	1,833	1,833
Estimated Outlays	0	1,003	1,753	1,826	1,824	1,825
Spending Under S. 1533						
Estimated Authorization Level	1,513	1,887	1,836	1,834	1,833	1,833
Estimated Outlays	1,368	1,665	1,813	1,832	1,824	1,825
CHANGES IN DIRECT SPENDING						
Estimated Budget Authority	0	9	15	15	15	15
Estimated Outlays	0	9	15	15	15	15

a. The 2001 level includes the amount appropriated for that year for the programs.

BASIS OF ESTIMATE

Spending Subject to Appropriations

Title I: Consolidated Health Center Program. S. 1533 would reauthorize and expand the scope of the consolidated health centers program, which provides grants to entities that provide health care and other services to uninsured and underinsured populations. S. 1533 contains two new provisions: It would authorize the use of up to 5 percent of authorized funds for grants to health centers or networks for the construction and modernization of buildings, and it would permit HRSA to guarantee the refinancing of non-federal loans by health centers. The costs of these additional activities would be subsumed in the general authorization of appropriations for the health center program, which is $1,379 million in 2002 and such sums as necessary for 2003-2006. The bill also would establish a linguistic grant program, which would award grants to health centers for the provision of translation and interpretation services for clients for whom English is a second language. The bill would authorize the appropriation of $10 million for that grant program in 2002, and then such sums as necessary each year until 2006. CBO estimates that outlays for these programs would be $745 million in 2002 and $6.4 billion during the 2002-2006 period, assuming appropriation of the necessary funds.

Title II: Rural Health

Rural Health Grants. S. 1533 would reauthorize several grant programs administered through the Office of Rural Health Policy within HRSA: health care services outreach, health network development, and small provider quality improvement grants. The bill would not substantially change the activities of the existing program. The bill would authorize $40 million in 2002 and such sums as necessary in subsequent years through 2006. (The 2002 authorization level is less than the 2001 appropriation level, which included a one-time appropriation of $18 million for a special project.) Based on past spending for these activities, CBO estimates that this provision would cost $12 million in 2002 and $164 million during the 2002-2006 period.

Telehealth Grant Consolidation. S. 1533 would create a new section in the Public Health Service Act for this established program. The bill would authorize appropriations for telehealth network grants as well as for telehealth resource centers grants. Telehealth refers to health information and services that are communicated via telecommunications technologies. Telehealth network grants are provided to entities to expand access to services, to train providers, and to improve access to health care information. Grants to telehealth centers may fund projects that demonstrate the uses of telehealth technologies. The bill

stipulates that not less than 50 percent of funds for grants for networks shall be awarded to entities in rural areas, and that the total funds awarded for network grants in 2002 may not be less than the total awarded for such grants in fiscal year 2001. S. 1533 would authorize the appropriation of $60 million in 2002 (compared to the $36 million appropriated in 2001) and then such sums as necessary through 2006. CBO estimates that outlays for this program would be $19 million in 2002 and $245 million over the 2002-2006 period, assuming appropriation of the necessary funds.

TABLE 2. APPROPRIATIONS FOR FISCAL YEAR 2001 AND AMOUNTS AUTHORIZED IN S. 1533 ASSUMING ADJUSTMENTS FOR INFLATION

	By Fiscal Year, in Millions of Dollars					
	2001[a]	2002	2003	2004	2005	2006
Title I						
Health Centers	1,164	1,379	1,410	1,440	1,469	1,496
Title II						
Rural Health Grants	58	40	41	42	43	43
Telehealth Grants	36	60	61	63	64	65
Telehomecare Demonstration	0	4	2	b	b	b
Emergency Medical Services Grants	0	1	1	1	1	1
Mental Health Services Demonstration	0	20	20	21	21	22
School-Based Health Networks	0	5	5	5	5	5
Title III						
National Health Service Corps	130	202	207	211	216	220
Chiropractor and Pharmacist Demonstration	0	1	1	1	0	0
Title IV						
Community Access Program	125	125	128	130	133	136
Primary Dental Programs	0	50	0	0	0	0
Total [b]	1,513	1,887	1,878	1,914	1,953	1,989

a. The 2001 level includes the amount appropriated for that year for the programs.
b. Total includes Title VI study, with budget authority estimated at less than $500,000.

Telehomecare Demonstration Project. S. 1533 would authorize a demonstration project for the provision of telehomecare services for residents of rural areas. Telehomecare means the provision of health services by providers at a distant site to patients in the home via telemedicine technology. The bill would limit the number of grants to five entities and would fund grantees for no more than three years. The Office for the Advancement of Telehealth within HRSA currently funds a dozen grants to home health agencies, so this demonstration would not represent a substantially new activity for the administration. The bill also would require HRSA to submit an interim and final report to the Congress

describing the results of the demonstration. Based on historical patterns of spending for similar activities, CBO estimates the cost of this demonstration would be $4 million in 2002 and $7 million over the 2002-2006 period.

Rural Emergency Medical Services Program. S. 1533 would establish a program of grants, primarily to state and local entities, to pay up to 75 percent of the cost of recruiting and training emergency medical service (EMS) personnel in rural areas. It would authorize the appropriation of such sums as may be necessary for 2002 through 2006. The bill also would authorize grants for the acquisition of emergency medical equipment and for EMS training programs for the public. Based on information from HRSA staff about participation in similar programs, CBO assumes that about 20 states would participate in any given year. CBO estimates the cost of implementing this program would be about $1 million in 2002 and $6 million during the 2002-2006 period, assuming appropriation of the necessary funds.

Mental Health Services via Telehealth Grants. The bill would create a demonstration program to award grants to entities for the development of telehealth networks for the provision of mental health education and services in areas designated as mental health underserved areas. The grants would be directed to nursing homes and schools, with grants to be used for education about mental health issues, for the provision of mental health services, and for collaborative and other purposes. HRSA currently oversees more than 25 such grants. Appropriations at the authorized levels, which are $20 million in 2002 and such sums as necessary through 2006, would allow for 50 to 60 grants of similar size. Assuming appropriation of the authorized amounts, CBO estimates that outlays for this demonstration project would be about $7 million in 2002 and $93 million over the 2002-2006 period.

School-based Health Center Networks. S. 1533 would establish a new program to award grants to nonprofit organizations for the creation of state-wide technical assistance centers and for other purposes. The bill would authorize the appropriation of $5 million in 2002 and such sums as may be necessary for 2003-2006. Based on historical spending patterns for similar activities, CBO estimates this program would cost $2 million in 2002 and $23 million over the 2002-2006 period.

Title III: National Health Service Corps. S. 1533 would reauthorize the National Health Service Corps (NHSC) field, recruitment, and state loan repayment programs. The field and recruitment programs support activities to identify the health professional needs of underserved communities and to recruit and support providers in those communities. The state loan repayment program provides federal matching funds to state programs that repay the educational debts of health care providers practicing in underserved communities.

The bill would add new authority to the field program to establish a demonstration project to create a program of part-time corps members. The bill would allow the Secretary to change both the methodology and process of designating health professional shortage areas (HPSAs) and would instruct the Secretary to develop a plan to increase participation by dental health providers in the scholarship and loan repayment programs.

S. 1533 would authorize such sums as necessary for 2002-2006 for the field program, $146 million in 2002 and such sums as necessary through 2006 for the recruitment program, and $12 million in 2002 and such sums as may be necessary through 2006 for the state loan repayment program. While the authorization of appropriations for the recruitment program is substantially larger than the appropriation for fiscal year 2001, the demand for corps members in the community is strong. CBO assumes that the NHSC will be able to spend the proposed appropriations at current rates. The authorizations for the field and state loan repayment programs are not substantially larger than 2001 appropriation levels, and we therefore assume that the programs will spend funds at current rates. CBO estimates spending to implement all three programs would total $109 million in 2002 and $941 million during the 2002-2006 period, assuming appropriation of the necessary funds.

The bill would also establish a demonstration project that would allow chiropractors and pharmacists to participate in the NHSC loan repayment program. The determination of a HPSA would not be affected by the inclusion of these providers. The demonstration would be authorized for three years at such sums as may be necessary. Based on information from experts at HRSA and spending for similar activities within the NHSC loan repayment program, CBO estimates the demonstration would cost less than $500,000 in 2002 and about $3 million over the 2002-2004 period.

Title IV: Healthy Communities Access Program

Community Access Program. S. 1533 would establish in statute the community access program (CAP), which has been funded since 1999. The program awards grants to consortiums to improve the efficiency, effectiveness, and the coordination of health services to uninsured and underinsured in their community. The bill would authorize the appropriation of $125 million for fiscal year 2002, and such sums as may be necessary for the subsequent four years. CBO estimates this provision would result in outlays of $94 million in 2002 and $613 million over the 2002-2006 period, assuming appropriation of the necessary funds.

Primary Dental Programs. S. 1533 would authorize the appropriation of $50 million in 2002, to be available for five years, for the development of a grant program to be administered by HRSA to respond to states' dental workforce needs. The grants would

provide federal matching funds to state programs for loan forgiveness, recruitment, practice expansion, dental residency programs, and for other purposes. The estimated cost of implementing this program is $10 million in 2002 and $50 million over the 2002-2006 period.

Title VI: Study

S. 1533 would require the Secretary of Health and Human Services to conduct a study to determine the ability of the department to provide for solvency for managed care networks whose member organizations are health centers receiving funds from the Consolidated Health Centers Program. The bill would direct the Secretary to submit a report to the Congress detailing the results of the study. CBO estimates the cost of implementing this provision would be less than $500,000 in 2002 and 2003.

Direct Spending Effects—Rural Health Clinics

Under current law, Medicare beneficiaries must pay for the first $100 of Part B services before the Medicare program will begin paying for such services. The bill would exempt certain low-income beneficiaries from the requirement that they satisfy that deductible before Medicare will pay for services furnished by a rural health clinic (RHC) at which a NHSC member is assigned. The proposal would affect Medicare spending for eligible patients of rural health clinics who receive nearly all of their Part B services from those clinics. (Medicare spending would not be affected for those beneficiaries who also receive at least $100 in Part B services from other providers.) CBO estimates that this provision would eliminate the deductible in calendar year 2002 for about 200,000 low-income beneficiaries who receive nearly all of their Part B services from qualifying RHCs.

Increasing Medicare spending to pay for the deductible for those beneficiaries would also have other effects on spending by the Medicare and Medicaid programs. Annual increases in payment rates for Medicare+Choice plans are tied to increases in per-capita spending in the fee-for-service sector, so this provision would increase payments to Medicare+Choice plans. Part B premiums would also rise, so about one-quarter of the increase in Medicare spending would be offset by higher premium receipts. Medicaid spending would be reduced because Medicaid would not have to pay the Medicare deductible for some patients at RHCs who are enrolled in both programs, although some of those savings would be offset by higher Medicaid spending for Part B premiums. Taking all those interactions into account, CBO estimates the provision would increase federal direct spending by $9 million in 2011 and by $146 million over the 2002-2011 period.

PAY-AS-YOU-GO CONSIDERATIONS

The Balanced Budget and Emergency Deficit Control Act sets up pay-as-you-go procedures for legislation affecting direct spending or receipts. The following table displays CBO's estimate of the direct spending effects of S. 1533. For the purposes of enforcing pay-as-you-go procedures, only the effects in the budget year and the succeeding four years are counted.

	By Fiscal Year, in Millions of Dollars									
	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011
Change in Outlays	9	15	15	15	15	15	15	15	16	16
Change in Revenues	Not applicable									

ESTIMATED IMPACT ON STATE, LOCAL, AND TRIBAL GOVERNMENTS

S. 1533 would preempt state laws governing statutes of limitations for cases against individuals who have breeched their contracts under the National Health Services Corps program. This preemption would be an intergovernmental mandate as defined in UMRA. However, CBO estimates that the preemption would not affect the budgets of state, local, or tribal governments because, while it would limit the application of state law, it would impose no duty on states that would result in additional spending.

The bill also would authorize a number of grant programs that could either directly or indirectly benefit state, local, or tribal governments through increased assistance for a variety of community and rural health programs. In some cases, those governments may be required to provide matching funds for the federal assistance, but their participation in the programs would be voluntary.

ESTIMATED IMPACT ON THE PRIVATE SECTOR

The bill contains no private-sector mandates as defined in UMRA.

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