CONGRESSIONAL BUDGET OFFICE
COST ESTIMATE

July 5, 2006

H.R. 4157
Better Health Information System Act of 2006

As ordered reported by the House Committee on Energy and Commerce on June 15, 2006

SUMMARY

CBO estimates that implementing H.R. 4157 would cost $4 million in 2007 and $38 million over the 2007-2011 period, assuming appropriation of the authorized amounts. Enacting the bill would have no effect on direct spending or revenues.

H.R. 4157 would amend the Public Health Service Act (PHSA) to codify the establishment and responsibilities of the Office of the National Coordinator for Health Information Technology. The bill also would require the Secretary to conduct several studies on programs to promote the development and adoption of health information technology, and would authorize the appropriation of $20 million a year for 2007 and 2008 for grants to facilitate the adoption of certain health information technology.

In addition, H.R. 4157 would modify the Social Security Act to:

- Specify procedures for adopting updated standards for the electronic exchange of health data, and require that certain updated standards be implemented in 2009; and

- Establish "safe harbors" for donations of health information technology that might otherwise be subject to civil monetary penalties, criminal penalties, or sanctions for violating the prohibitions on certain physician referrals.

H.R. 4157 would preempt, in some circumstances, state laws that govern record-keeping requirements and that establish civil or criminal penalties for the exchange of health information technology. Because those preemptions would limit the application of state laws, they would be intergovernmental mandates as defined in the Unfunded Mandates Reform Act (UMRA). CBO estimates, however, that the costs of the mandates to states would be small and, thus, would not exceed the threshold established in UMRA ($64 million in 2006, adjusted annually for inflation).

The bill would impose a private-sector mandate on health plans, providers, and clearing houses by requiring them to adopt updated standards for claims transactions by 2009. CBO assumes that this deadline would be met under current law, however, so the mandate would impose no additional cost on those private-sector entities.

ESTIMATED COST TO THE FEDERAL GOVERNMENT

The estimated cost of H.R. 4157 is shown in the following table. The costs of this legislation fall within budget function 550 (health).

	By Fiscal Year, in Millions of Dollars				
	2007	2008	2009	2010	2011
CHANGES IN SPENDING SUBJECT TO APPROPRIATION					
Authorization Level	20	20	0	0	0
Estimated Outlays	4	14	14	5	1

BASIS OF ESTIMATE

On April 27, 2004, the President issued Executive Order 13335, which established within the Office of the Secretary of Health and Human Services (HHS) the position of National Health Information Technology Coordinator. The Secretary subsequently established the Office of the National Coordinator of Health Information Technology (ONCHIT) to support the adoption of interoperable health information technology. Funding for ONCHIT totaled $62 million for 2006: $43 million was appropriated to ONCHIT, and $19 million was reprogrammed from other activities. The President requested $116 million for ONCHIT for 2007.

H.R. 4157 would amend the Public Health Service act to codify the establishment and responsibilities of the Office of the National Coordinator for Health Information Technology, specify procedures for adopting updated standards for the electronic exchange of health data, and establish safe harbors for donations of health information technology.

For this estimate, CBO assumes that H.R. 4157 will be enacted near the end of fiscal year 2006, that the authorized amounts will be appropriated each year, and that outlays will follow historical patterns for similar activities of the Department of Health and Human Services.

Health Information Technology and Quality

The National Coordinator for Health Information Technology serves as the senior advisor to the Secretary of HHS and the President on all health information technology programs and initiatives, and is responsible for:

- Developing and maintaining a strategic plan to guide the nationwide implementation of electronic health records in both the public and private health care sectors;

- Coordinating spending by federal agencies for health information technology programs and initiatives; and

- Coordinating outreach activities to the private sector on health information technology matters.

H.R. 4157 would codify the establishment and responsibilities of the Office of the National Coordinator for Health Information Technology. The bill would require the Secretary of HHS to prepare reports on certain activities initiated pursuant to the Executive Order to promote the development of a nationwide health information network and on issues related to the development, operation, and implementation of state, regional, and community organizations that share and coordinate the deployment and use of health information technology (so-called health information exchanges). CBO estimates that implementing those provisions would not change the cost of ONCHIT's activities.

The bill also would authorize the appropriation of $15 million a year for 2007 and 2008 for grants to integrated health systems to promote the adoption and use of health information technology for the purpose of improving coordination of care for uninsured and underserved populations. In addition, it would authorize the appropriation of $5 million a year for 2007 and 2008 for grants to small physician practices located in rural or medically underserved areas for the purchase and support of health information technology. Based on spending patterns for similar programs that provide grants to health care providers, CBO estimates that implementing those grant programs would cost $4 million in 2007 and $38 million over the 2007-2011 period, assuming appropriation of the specified amounts.

Standards for the Electronic Exchange of Health Data

H.R. 4157 would require the Secretary of HHS to establish expedited procedures for adopting updates to standards that enable the electronic exchange of health data. The bill also would require that two sets of standards apply to certain health information transactions

by April 1, 2009: the “X12" standards developed by the Accredited Standards Committee for electronic data interchange, and the updated telecommunication standards adopted by the National Council for Prescription Drug Programs. CBO estimates that implementing those provisions would not have a significant effect on federal spending.

Safe Harbors for Donations of Health Information Technology

H.R. 4157 would establish "safe harbors" for donations of health information technology that might otherwise be subject to civil monetary penalties, criminal penalties, or sanctions for violating the prohibitions on certain physician referrals. The bill would permit certain entities (hospitals, group practices, Medicare Advantage plans, and prescription drug plans) to donate health information technology (hardware; software; or related maintenance, support, or training services) to physicians.

The Administration has identified the current application of those penalties and sanctions as an impediment to the success of efforts to promote the widespread adoption of interoperable health information technology. Accordingly, the HHS Office of the Inspector General and the Centers for Medicare & Medicaid Services, under authority existing in current law, are engaged in a rule-making process to establish safe harbors for donations of health information technology that would balance enforcement of program-integrity rules with promotion of the adoption of interoperable health information technology. In the preliminary stage of the rule-making process, those offices described a framework that would limit:

- Entities eligible for the safe harbor (a hospital may donate to members of its medical staff; a group practice may donate to physicians who are members of the group practice; and Medicare Advantage plans and prescription drug plans may donate to their prescribing physicians), and

- Eligible donations (software and related training).

CBO anticipates that the final rules will establish a set of eligible entities and donations similar to those specified in the bill. Therefore, CBO estimates that enacting the safe-harbor provisions in H.R. 4157 would not have a significant effect on federal spending.

Budgetary Effects of Health Information Technology

CBO expects that the use of information technology in the health care sector will continue to grow under current law, and that expanded use of such technology will likely produce improvements in the quality of the health care provided to U.S. residents. In some cases, that

improvement in the quality of health care might mean less use of medical services; in other cases, it might mean an increase in utilization.

Under current law, CBO also expects that the expanded use of health information technology will likely result in increased efficiency in the health care system. That is, the use of information technology will result in more health benefits per dollar of spending than would otherwise be realized.

Experts caution, however, that the evidence is mixed concerning whether those improvements in quality and efficiency will also result in lower spending for health care, either in the private sector or for government programs.[1] In her recent testimony to the Senate Subcommittee on Technology, Innovation, and Competitiveness, Dr. Carolyn Clancy (Director of the Agency for Health Research and Quality) noted that, if poorly designed or implemented, health information technology will not bring those benefits, and in some cases may even lead to new medical errors and potential costs. She also noted that achieving improvements in health care and realizing potential cost savings will require real process change and will not result from simply acquiring and deploying hardware and software.

To the extent that health information technology will result in lower spending for health care, much of those savings would not be passed through as a reduction in direct spending for federal programs—particularly Medicare—under current law. For example, two areas account for much of the potential savings reported in the literature: reductions in the cost of care during a hospital stay, and administrative savings for providers and claims processors. Under current law, Medicare's payment rates for hospital inpatient services are updated each year to reflect changes in general inflation rates, and do not reflect changes in the costs that hospitals incur (either for administrative activities or for providing health care services). Medicare might realize savings in the cost of processing claims. However, funding for

---

1. See, for example:

   Testimony of Carolyn Clancy, MD to the Subcommittee on Technology, Innovation and Competitiveness of the Senate Committee on Commerce, Science, and Transportation, June 21, 2006. (http://commerce.senate.gov/public/_files/Clancy062106.pdf)

   Clifford Goodman, "Savings In Electronic Medical Record Systems? Do It For The Quality", Health Affairs, Sept./Oct. 2005. (http://content.healthaffairs.org/cgi/content/full/24/5/1124)

   Paul B. Ginsburg, Ph.D., "Controlling Health Care Costs", NEJM , Oct 14, 2004. (http://content.nejm.org/cgi/content/full/351/16/1591)

   James Walker, "Electronic Medical Records And Health Care Transformation", Health Affairs, Sept./Oct. 2005. (http://content.healthaffairs.org/cgi/content/full/24/5/1118)

Medicare's claims-processing activities is subject to appropriation, so such savings could only be realized through the appropriations process.

In preparing an estimate of the budgetary effect of enacting this bill—or other legislation involving health information technology—CBO focuses on the extent to which the bill would change the rate at which the use of health technology will grow or how well that technology will be designed and implemented under current law. CBO then evaluates the extent to which those changes, in conjunction with other provisions in current law and in the proposed legislation, would affect direct spending.

CBO estimates that enacting H.R. 4157 would not significantly affect either the rate at which the use of health technology will grow or how well that technology will be designed and implemented. Therefore, CBO estimates enacting the bill would have no effect on spending by the federal government, other than the specific appropriations it would authorize.

ESTIMATED IMPACT ON STATE, LOCAL, AND TRIBAL GOVERNMENTS

H.R. 4157 would preempt, in some circumstances, state laws that govern record-keeping requirements and that establish civil or criminal penalties for the exchange of health information technology. While those preemptions would be intergovernmental mandates as defined in UMRA, CBO estimates that the costs of the mandates to states would be small and, thus, would not exceed the thresholds established in UMRA ($64 million in 2006, adjusted annually for inflation).

The bill would preempt state laws that require providers to maintain data in paper form, if those providers receive federal funds and maintains the data electronically. In most cases, such a preemption would be a condition of aid and thus not an intergovernmental mandate, as most federal assistance to health care providers comes through state governments as part of agreements with the federal government. However, some federal assistance goes directly to providers, independent of federal agreements with state governments, and in those cases the preemption of state laws requiring paper documentation would be an intergovernmental mandate. CBO estimates, however, that the preemption would not significantly affect the budgets of state, local, or tribal governments because it would impose no duty on those governments that would result in additional spending or a loss of revenues.

The bill also would change safe-harbor guidelines for the exchange of health information technology, and it would preempt state laws that would assess civil or criminal penalties on exchanges of information that the bill would allow. While this preemption could affect the ability of states to assess penalties and collect revenues, CBO estimates that any such losses would be small.

ESTIMATED IMPACT ON THE PRIVATE SECTOR

The bill would impose a private-sector mandate on health plans, providers, and clearing houses by requiring them to adopt updated standards for claims transactions by April 1, 2009. The bill would require them to move from version 4010 to version 5010 of the Accredited Standards Committee X12 standards. It would also require them to move from version 5.1 of the National Council for Prescription Drug Programs Telecommunication Standards to the most recent version approved as of April 1, 2008.

CBO assumes that this deadline would be met under current law. Thus, this mandate would impose no additional costs on private-sector entities.

ESTIMATE PREPARED BY:

Federal Costs: Tom Bradley, Jeanne De Sa, and Camile Williams
Impact on State, Local, and Tribal Governments: Leo Lex
Impact on the Private Sector: Stuart Hagen and Julie Lee

ESTIMATE APPROVED BY:

Peter H. Fontaine
Deputy Assistant Director for Budget Analysis