# CONGRESSIONAL BUDGET OFFICE
# COST ESTIMATE

July 26, 2005

# S. 1418
## Wired for Health Care Quality Act

*As ordered reported by the Senate Committee on Health, Education, Labor, and Pensions on July 20, 2005*

## SUMMARY

CBO estimates that implementing S. 1418 would cost $40 million in 2006 and $652 million over the 2006-2010 period, assuming appropriation of the necessary amounts. Enacting the bill would have no effect on direct spending or revenues.

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) and the American Health Information Community (AHIC) to support the adoption of health information technology. S. 1418 would amend the Public Health Service Act (PHSA) to codify the establishment and responsibilities of those entities. In addition, the bill would authorize appropriation of funding for grants to facilitate the widespread adoption of certain health information technology. S. 1418 would authorize the appropriation of $125 million in 2006, $155 million in 2007, and such sums as necessary for 2008 through 2010 for those activities.

S. 1418 also would require the Agency for Healthcare Research and Quality (AHRQ) to establish a Center for Best Practices to provide technical assistance to support the adoption of health information technology, and it would extend through 2010 authorization for a program to provide telemedicine grants.

S. 1418 contains no intergovernmental or private-sector mandates as defined in the Unfunded Mandates Reform Act (UMRA). Any costs to state, local, or tribal governments as a result of participating in the grant programs would be incurred voluntarily.

## ESTIMATED COST TO THE FEDERAL GOVERNMENT

The estimated cost of S. 1418 is shown in the following table. The costs of this legislation fall within budget function 550 (health).

| | By Fiscal Year, in Millions of Dollars | | | | | |
|---|---|---|---|---|---|---|
| | 2005 | 2006 | 2007 | 2008 | 2009 | 2010 |
| **SPENDING SUBJECT TO APPROPRIATION** | | | | | | |
| Spending under Current Law | | | | | | |
| Estimated Budget Authority[a] | 20 | 0 | 0 | 0 | 0 | 0 |
| Estimated Outlays | 4 | 14 | 2 | 0 | 0 | 0 |
| Proposed Changes | | | | | | |
| Estimated Authorization Level | 0 | 133 | 163 | 166 | 169 | 172 |
| Estimated Outlays | 0 | 40 | 125 | 156 | 164 | 167 |
| Spending under S. 1418 | | | | | | |
| Estimated Authorization Level[a] | 20 | 133 | 163 | 166 | 169 | 172 |
| Estimated Outlays | 4 | 54 | 127 | 156 | 164 | 167 |

a. The 2005 level is CBO's estimate of the funding for the activities of the Office of the National Coordinator of Health Information Technology and the American Health Information Community, including funds reprogrammed by the Secretary of Health and Human Services from other activities.

## BASIS OF ESTIMATE

S. 1418 would amend the Public Health Service act to add title 29—which would deal with health information technology and quality—and to create a Center for Best Practices and extend authorization for a program to provide telemedicine grants. For this estimate, CBO assumes that S. 1418 will be enacted near the end of fiscal year 2005, that the necessary amounts will be appropriated each year, and that outlays will follow historical patterns for similar activities of the Department of Health and Human Services. CBO estimates that implementing those provisions would cost $40 million in 2006 and $652 over the 2006-2010 period.

**Health Information Technology and Quality**

The National Coordinator of 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 private industry and serving as the catalyst for change in the health care industry.

In June 2005, the Secretary announced the creation of the American Health Information Community a public-private collaboration to provide a forum for public and private interests to recommend specific actions that will accelerate the widespread adoption of electronic records and other health information technology. Based on information provided by the Department of Health and Human Services, CBO estimates that $20 million is available in 2005 for the activities of ONCHIT and AHIC ($3 million from funds appropriated to the Secretary and $17 million from funds reprogrammed from other activities).

S. 1418 would add title 29 to the Public Health Service Act to codify the establishment and responsibilities of ONCHIT and AHIC. (It would change the name of the latter organization to the American Health Information Collaborative.) The bill would establish several grant programs to promote the adoption of health information technology.

For activities under title 29, S. 1418 would authorize the appropriation of $125 million in 2006, $155 million in 2007, and such sums as necessary in 2008 through 2010. Of the amounts specified in 2006 and 2007, $5 million would be for ONCHIT in each year; $4 million a year would be for AHIC; and the remaining $116 million in 2006 and $146 million in 2007 would be for the grant programs.

The bill would establish three grant programs—for health care providers, states, and to implement regional or local plans for the exchange of health information—to facilitate the adoption of health information technology and a fourth grant program to develop academic curricula integrating health information technology systems into the clinical education of health professionals.

The bill would limit eligibility for the grants to health care providers to providers that demonstrate significant financial need. Those providers would be required to provide $1 of matching funds for every $3 of federal grant funds, and they could use the funds to purchase and enhance the utilization of health information technology and for training personnel in the use of the technology.

States would be eligible for grants that would fund the establishment of state programs for loans to health care providers to facilitate the purchase and use of health information technology. States would have to provide $1 of matching funds for every $1 of federal grant funds.

The grants to implement regional or local plans for the exchange of health information would require $1 of matching funds for every $2 of federal grant funds. The President's budget request for fiscal year 2006 included $50 million for a similar program. That program, which is in the request-for-proposal stage, would provide funding and oversight through contracts, rather than grants.

### Other Provisions

In addition to adding title 29 to the Public Health Service Act, S. 1418 would amend that act to establish a Center for Best Practices to provide technical assistance to support the adoption of health information technology, and it would extend through 2010 authorization for a program to provide telemedicine grants. The Center would be administered by AHRQ, and the telemedicine grants would be administered by the Health Resources and Services Administration (HRSA). Based on information provided by the Department of Health and Human Services, CBO estimates that implementing those provisions would require additional appropriations in 2006 through 2010 of $3 million a year for the Center and $5 million a year for HRSA.

## INTERGOVERNMENTAL AND PRIVATE-SECTOR IMPACT

S. 1418 contains no intergovernmental or private-sector mandates as defined in UMRA. The bill would not require any action on the part of state, local, or tribal governments, but it would provide grant money to public health entities that wish to implement health record transfer systems. Therefore, CBO assumes that any costs to those entities as a result of participating in the grant programs would be incurred voluntarily.

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