CONGRESSIONAL BUDGET OFFICE
COST ESTIMATE

September 5, 2008

H.R. 6357

Protecting Records, Optimizing Treatment, and Easing Communication through Healthcare Technology Act of 2008

As ordered reported by the House Committee on Energy and Commerce on July 23, 2008

SUMMARY

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 (HIT). H.R. 6357 would amend the Public Health Service Act to codify the establishment and responsibilities of those entities. In addition, the bill would authorize funding for programs to facilitate the development of HIT standards and the widespread adoption of qualified HIT, and to enhance the security of private health information.

H.R. 6357 would authorize the appropriation of $193 million in 2009 and $960 million over the 2009-2013 period. CBO estimates that implementing the bill would cost an additional $58 million in 2009 and $743 million over the 2009-2013 period, when compared to current law, assuming the appropriation of the authorized amounts. Enacting H.R. 6357 would not affect direct spending or revenues.

Over the long term, widespread adoption of health IT could facilitate cost savings in the health care system as a whole and thus for government programs. Research indicates that in certain settings, health IT appears to make it easier to reduce health spending if other steps in the broader health care system are also taken to alter incentives to promote savings. By itself, however, the adoption of more health IT is generally not sufficient to produce significant cost savings.

H.R. 6357 contains both intergovernmental and private-sector mandates as defined in the Unfunded Mandates Reform Act (UMRA) because it would require governmental and private-sector entities, as providers and insurers of health care, to comply with new federal

standards regarding protected health information. CBO believes that the costs to the private sector to comply with the new requirements would probably exceed the threshold established in UMRA for private-sector mandates ($136 million in 2008, adjusted for inflation) in the first year or two following enactment. The cost to state, local and tribal governments to comply with the mandates in the bill, however, would not exceed the threshold established in UMRA for intergovernmental mandates ($68 million in 2008, adjusted for inflation).

ESTIMATED COST TO THE FEDERAL GOVERNMENT

The estimated cost of H.R. 6357 is shown in the following table. The costs of this legislation fall within budget function 550 (health).

	By Fiscal Year, in Millions of Dollars					
	2008	2009	2010	2011	2012	2013
SPENDING SUBJECT TO APPROPRIATION						
Spending Under Current Law						
Budget Authority	68	0	0	0	0	0
Estimated Outlays	59	46	8	1	0	0
Proposed Changes						
Estimated Authorization Level	0	193	195	196	187	189
Estimated Outlays	0	58	141	177	184	183
Estimated Spending Under H.R. 6357						
Estimated Authorization Level	68	193	195	196	187	189
Estimated Outlays	59	104	150	179	184	183

BASIS OF ESTIMATE

H.R. 6357 would amend the Public Health Service Act to add title 30—which would specify the responsibilities of ONCHIT and related committees, as well as establish several grant and loan programs. The bill also would establish privacy and security provisions for certain health information. For this estimate, CBO assumes that H.R. 6357 will be enacted near the end of fiscal year 2008, 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 H.R. 6357 would cost $58 million in 2009 and $743 million over the 2009-2013 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 HIT programs and initiatives, and is responsible for:

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

- Coordinating HIT policy across federal agencies.

H.R. 6357 would add title 30 to the Public Health Service Act to further specify the responsibilities of ONCHIT and create two committees to assume the current functions of the AHIC–the HIT Policy Committee and the HIT Standards Committee.

This bill would require the National Coordinator to ensure that standards for the secure electronic exchange of information incorporate adequate privacy and security protections. The bill would also require the National Coordinator to develop a program for the voluntary certification of products as meeting the standards developed for the secure electronic exchange of health information. In addition, the National Coordinator would be responsible for:

- Reviewing and determining the endorsement of industry standards;

- Implementing specifications and certifying criteria for the electronic exchange and use of health information; and

- Evaluating and reporting progress toward implementation of electronic health records, barriers to access to technology, and the benefits and costs of HIT, including those in medically underserved communities.

The HIT Policy Committee would serve as a federal advisory committee comprised of public and private stakeholders to provide input and assistance to the National Coordinator. The committee would be responsible for recommending a policy framework and prioritizing the technical standards necessary for the development of an HIT infrastructure. The HIT Standards Committee would also serve as a federal advisory committee of public and private stakeholders and be responsible for developing, recognizing, or harmonizing the technical standards necessary for secure electronic exchange of health information.

This bill would require private entities contracting with the federal government to carry out health care activities to adopt the standards established in this bill for the electronic exchange of health care information.

H.R. 6357 would authorize the appropriation of $66 million for fiscal year 2009 for those purposes. Because ONCHIT's responsibilities would be ongoing, the estimate assumes that amount, with adjustments for inflation, would be appropriated in subsequent years. Assuming the appropriation of the necessary amounts, CBO estimates that spending for those activities resulting from this bill would total $20 million in 2009 and $265 million over the 2009-2013 period.

Incentives for the Use of Health Information Technology

H.R. 6357 would also establish several grant and loan programs to promote the widespread adoption of qualified HIT, including programs for health care providers, states and Indian tribes, and local or regional organizations. The grant programs would require that recipients provide matching funds. Small health care providers, those in medically underserved or rural areas, and others who may have difficulty acquiring electronic health records without outside assistance would be given preference in awarding the grants. The bill also would create a demonstration program to integrate HIT in the clinical education of health professionals.

H.R. 6357 would authorize appropriations for the grant programs of $115 million a year for fiscal years 2009 through 2013. It would authorize the appropriation of $10 million a year for fiscal years 2009 through 2011 for the demonstration projects. Assuming appropriation of the authorized amounts, CBO estimates that implementing those programs would cost $38 million in 2009 and $470 million over the 2009-2013 period.

Privacy and Security Provisions

H.R. 6357 would establish federal standards regarding the privacy and security of protected health information (PHI), and would require health care providers and insurers to comply with those standards.

The bill also would require the Secretary of HHS to implement an education program to enhance public transparency regarding the uses of PHI, and would authorize the appropriation of $10 million during the 2009-2013 period for that purpose. Assuming the appropriation of the authorized amount, CBO estimates that implementing that provision would cost $8 million over the 2009-2013 period.

INTERGOVERNMENTAL AND PRIVATE-SECTOR IMPACT

H.R. 6357 contains both intergovernmental and private-sector mandates as defined in UMRA. In aggregate, CBO estimates that the cost to private-sector entities to comply with the mandates in the bill would probably exceed the UMRA threshold of $136 million per year (adjusted for inflation); the cost to state, local and tribal governments to comply with the mandates in the bill, however, would not exceed the UMRA threshold ($68 million per year, adjusted for inflation). Precise estimates are difficult given the lack of available data.

The bill would require providers and insurers of health care, both in the private sector and as operated by state, local, and tribal governments, to notify individuals whose health information has been, or is reasonably believed to have been, breached. Such a requirement would be an intergovernmental and private-sector mandate. CBO estimates, however, that few breaches of health information would occur that would require a notice as specified in the bill; thus, the cost of this provision would be small.

The bill also would impose intergovernmental and private-sector mandates by requiring providers and insurers to comply with a patient's request that they not disclose protected health information if the information pertains solely to a health care item or service that has been paid for completely out of pocket. Disclosures for purposes of carrying out treatment or as otherwise required by law would be exempt from this requirement.

Providers and insurers that use electronic medical record systems also would be prohibited from using or disclosing an individual's PHI for purposes of health care operations unless they obtain the consent of the individual. Such a requirement would constitute an intergovernmental and private-sector mandate as defined in UMRA. Due to the bill's relatively broad definition of an "electronic medical record," most health care entities, including pharmacies, physicians, ancillary service providers, and hospitals, would be considered to have electronic medical records. Thus, because of the large number of consents required by this provision, CBO believes that the cost would probably exceed the threshold for private-sector mandates established under UMRA in the first year or two following enactment. Because most health care providers are private entities, CBO does not believe that the cost to state, local and tribal governments would exceed the threshold.

H.R. 6357 also would require private-sector entities and state, local, and tribal governments with electronic medical records to maintain a six-year log of disclosures of an individual's PHI for treatment, payment, and health care operations. Covered entities would be required to provide a copy of the log to the individual upon request. CBO believes that the cost of this provision would be relatively small, however, because under the Health Insurance Portability and Accountability Act (HIPAA), providers already must provide logs of disclosures of PHI for purposes other than for treatment, payment, and health care operations, and therefore,

already must have capabilities for maintaining such logs. Indeed, most electronic medical record systems used by providers have audit trail capabilities that can maintain logs of disclosures and transactions. In addition, requests for such logs would probably be infrequent.

With some exceptions, HIPAA preempts state laws that impose standards less stringent than the federal standard. H.R. 6357 would apply HIPAA's criteria for preempting state laws. Therefore, state standards with respect to health information technology and the privacy of unsecured protected health information that are less stringent than the new federal standard would be preempted by the bill. That preemption would be an intergovernmental mandate as defined in UMRA. CBO estimates that the costs to state, local, and tribal government of this provision would be minimal.

Other provisions in the bill would benefit state, local, and tribal governments that participate in grant and loan programs to facilitate the adoption of health information technology; any costs they incur to comply with grant or loan conditions would be incurred voluntarily.

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