CONGRESSIONAL BUDGET OFFICE
U.S. Congress
Washington, DC 20515

Douglas W. Elmendorf, Director

June 16, 2009

Honorable Dave Camp
Ranking Member
Committee on Ways and Means
U.S. House of Representatives
Washington, DC 20515

Dear Congressman:

You asked the Congressional Budget Office (CBO) to review the documents accompanying a letter to the President in which a group of health care industry stakeholders describe their commitments to reduce health care costs, strengthen quality, and improve access. In particular, you asked CBO to determine the level of savings that their proposals would yield for the federal government. The industry leaders' attention to these goals and agreement that significant savings can be obtained are no doubt welcome. However, most of the proposals are steps that do not require the involvement of the federal government or are not specified at a level of detail that would enable CBO to estimate budgetary savings.

Some of the initiatives would bolster good medical practice (for example, promoting improved hand hygiene to prevent infections and providing guidance to patients about their medications before they are discharged from the hospital) and would probably occur to a large degree in the absence of federal legislation. Others—like developing new medications to treat Alzheimer's disease—also would not necessarily involve the federal government.

As you know, a CBO cost estimate for a legislative proposal must report the savings that would occur because of the law. To the extent that certain practices would be adopted anyway, without legislation, they would not affect the budgetary scoring of a proposal, although they might affect CBO's baseline projections of the costs of federal programs.

Private or governmental initiatives that would affect the amount of spending that occurs in the private sector can have a muted effect on the federal budget by bringing about a change in the composition of compensation between tax-excluded health benefits and taxable wages. But often, reducing federal spending would require corresponding legislation. For example, the initiative to standardize administrative transactions in order to lower providers' administrative costs would have to be coupled with reductions in Medicare's payment rates for providers in order to reap savings for Medicare. Presumably, the providers would

be able to absorb those reductions because of the efficiencies gained from standardization.

Although the proposals generally are not specific enough for CBO to estimate their budgetary impact, several are similar to approaches that the agency has previously analyzed. They include the following:

- Reducing Medicare payments to hospitals with high readmission rates, which CBO has estimated could save between $5 billion and $10 billion over 10 years;[1]
- Capping the amounts of noneconomic and punitive damages that can be awarded in malpractice claims, which the agency has said could result in net federal savings of around $5 billion over the next decade;[2]
- Establishing a pathway for regulatory approval of so-called follow-on biologics, which, according to CBO's estimate, could yield federal savings of approximately $10 billion over that same span;[3]
- Extending prescription drug coverage to the entire population, which would probably increase the deficit significantly; and
- Expanding the use of home and community-based services in Medicaid, which would generally increase federal spending—depending on the details, from about $8 billion to almost $90 billion over 10 years, according to CBO's estimates.[4]

In sum, the industry documents describe a number of initiatives that may affect the quality and the cost of health care but sometimes would not involve the federal government at all. Only a subset of the initiatives could result in savings (or costs) that would be relevant for CBO's cost estimates for legislative proposals, but more specific legislative details would be required in order to prepare such estimates.

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[1] See Congressional Budget Office, *Budget Options, Volume 1: Health Care* (December 2008), Option 31.

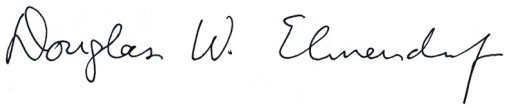
[2] Ibid., Option 8.

[3] Ibid., Option 68.

[4] Ibid., Options 99, 100, and 101.

I hope that you find this information helpful. I would be happy to answer any further questions you might have. The CBO staff contact on this topic is Jim Baumgardner.

Sincerely,



Douglas W. Elmendorf
Director

cc: Honorable Charles B. Rangel
Chairman, Committee on Ways and Means