# CONGRESSIONAL BUDGET OFFICE
# COST ESTIMATE

July 25, 2007

# S. 1693
## Wired for Health Care Quality Act

*As ordered reported by the Senate Committee on Health, Education, Labor, and Pensions on June 27, 2007*

## SUMMARY

CBO estimates that implementing S. 1693 would cost $47 million in 2008 and $317 million over the 2008-2012 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. 1693 would amend the Public Health Service Act (PHSA) to codify the establishment and responsibilities of those entities. In addition, the bill would authorize funding for grants to facilitate the widespread adoption of certain health information technology. S. 1693 would authorize the appropriation of $150 million for 2008 and $150 million for 2009 for those activities.

S. 1693 also would require the Agency for Healthcare Research and Quality (AHRQ) to establish a Health Information Technology Resource Center to provide technical assistance to support the adoption of health information technology, authorize AHRQ to award grants to develop and test quality measures, and extend through 2009 authorization for a program to provide telemedicine grants. CBO estimates that implementing those provisions would require the appropriation of $11 million for 2008 and $25 million over the 2008-2012 period.

S. 1693 contains an intergovernmental mandate as defined in the Unfunded Mandates Reform Act (UMRA) because it would limit the application of state and local law. However, CBO estimates that the net costs of the mandate would be minimal and far below the threshold established in UMRA ($66 million in 2007, as adjusted for inflation). In general, the bill would benefit state, local, and tribal governments and any costs they incur as a result

of participating in the grant programs would result from complying with conditions of federal assistance. The bill contains no private-sector mandates as defined in UMRA.

## ESTIMATED COST TO THE FEDERAL GOVERNMENT

The estimated cost of S. 1693 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 | 2012 |
| **SPENDING SUBJECT TO APPROPRIATION** | | | | | | |
| Spending under Current Law | | | | | | |
| Estimated Budget Authority[a] | 61 | 0 | 0 | 0 | 0 | 0 |
| Estimated Outlays | 18 | 28 | 12 | 2 | 0 | 0 |
| Proposed Changes | | | | | | |
| Estimated Authorization Level | 0 | 161 | 161 | 1 | 1 | 1 |
| Estimated Outlays | 0 | 47 | 119 | 105 | 39 | 7 |
| Spending under S. 1693 | | | | | | |
| Estimated Authorization Level[a] | 61 | 161 | 161 | 1 | 1 | 1 |
| Estimated Outlays | 18 | 75 | 131 | 107 | 39 | 7 |

a. The 2007 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. 1693 would amend the Public Health Service Act to add title 30—which would deal with health information technology and quality—and to create a Health Information Technology Resource Center and extend authorization for a program to provide telemedicine grants. For this estimate, CBO assumes that S. 1693 will be enacted near the end of fiscal year 2007, 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 $47 million in 2008 and $317 million over the 2008-2012 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 $61 million is available in 2007 for the activities of ONCHIT and AHIC ($42 million from funds appropriated to the Secretary and $19 million from funds reprogrammed from other activities).

S. 1693 would add title 30 to the Public Health Service Act to specify the responsibilities of ONCHIT, AHIC, and a new organization—the Partnership for Health Care Improvement. The current responsibilities of AHIC would be divided between AHIC and the Partnership, with AHIC focusing on development of policy and the Partnership focusing on the technical aspects of developing and promoting the adoption of health information technology.

The bill also would establish several grant programs to promote the adoption of health information technology.

For most of the activities under title 30, S. 1693 would specify the amounts authorized to be appropriated for fiscal years 2008 and 2009: $5 million in each year for ONCHIT, $2 million in each year for the Partnership, $2 million in each year for AHIC, and $141 million in each year for grant programs. Those specified amounts total $150 million in each of fiscal years 2008 and 2009. In addition, the bill would authorize the Secretary, acting through AHRQ, to make grants to support the development and testing of quality measures. CBO estimates the necessary funding for those grants would amount to $1 million for 2008 and $5 million over the 2008-2012 period. Thus, CBO estimates that the necessary funding for activities

under title 30 would total $151 million for fiscal year 2008 and $305 million over the 2008-2012 period.

Of the $141 million in specified funding for grant programs in each of fiscal years 2008 and 2009, $139 million a year would be allocated to 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 $2 million a year would be allocated to 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.

**Other Provisions**

In addition to adding title 30 to the Public Health Service Act, S. 1693 would amend that act to establish a Health Information Technology Resource Center to provide technical assistance to support the adoption of health information technology, and it would extend through 2009 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). CBO estimates that implementing those provisions would require additional appropriations for 2008 and 2009 of $5 million a year for the Center and $5 million a year for HRSA.

## INTERGOVERNMENTAL AND PRIVATE-SECTOR IMPACT

S. 1693 would deem an operator of a health information electronic database a covered entity under the Health Insurance Portability and Accountability Act (HIPAA). With some exceptions HIPAA preempts state laws that impose standards less stringent than the federal standard. Therefore, state standards with respect to an operator of a health information database 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 because it would limit the application of state and local law. However, CBO estimates that the net costs of the mandate would be minimal and far below the threshold established in UMRA ($66 million in 2007, as adjusted for inflation).

The bill also would authorize grants to states and public health entities to assist them with purchasing information technology systems to improve the delivery of health care. Public institutions of higher education also would benefit from grants authorized in the bill to develop academic curricula or analyze data. Any costs those governments or institutions incur, including matching funds, would result from complying with conditions of federal assistance.

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

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