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Center for Information Technology Leadership

A Rebuttal to the Congressional Budget Office's Report on the Costs and Benefits of Health Information Technology

In May 2008, the Congressional Budget Office (CBO) published a report on the *Evidence on the Costs and Benefits of Health Information Technology*. This report, conducted in response to a request by the Senate Budget Committee Chairman, reviewed and summarized the literature on health information technology (IT) impact and value. The Senate Committee asked the CBO to assess the likely impact of federal intervention in health IT, specifically legislation, on healthcare costs. The questions of primary concern to the CBO were: If the federal government took steps to stimulate health IT adoption, what would be the likely impact? Would such steps ultimately reduce healthcare costs and, if so, by how much?

In 2004, the Center for Information Technology Leadership (CITL), a nonprofit health IT research organization based at Partners HealthCare System in Boston, MA, published a study on the *Value of Healthcare Information Exchange and Interoperability*. This report, conducted in response to recommendations from our advisory board, examines the potential value about a key issue in health IT: the ability for information systems to exchange data in a standardized fashion. The question we set out to answer was: What would be the potential value of fully standardized healthcare information exchange to the United States?

Relative to its central task of understanding the impact of federal intervention in health IT, the CBO report offers a brief assessment of CITL's study of healthcare information exchange. The CBO states that our projections of potential impact could not be used to estimate what likely savings would come from federal intervention and investment in health IT. We believe that is inaccurate—we think that they could be used this way, although caution should be exercised since our analysis focused on a narrower swath of health IT than the CBO.

In addition, it is important to point out that the CBO missed a central finding in our work, key to the debate on health IT. Our calculations predict that unstandardized data exchange will be vastly more costly, less efficient, and therefore inferior to standardized data exchange. Our report is not an assessment of electronic medical record adoption, nor does it purport to quantify the value of health IT generally. CITL's work has at least two important messages for Congress. First, standardized data exchange using encoded data is a great investment and would deliver substantial value to the healthcare system. Second, federal lawmakers should consider standardization in healthcare information exchange as a key component of the value, specifically cost savings, which would result from their investments in health IT.

The CBO also stated that we failed to account for the current health IT context in our evaluation. In fact, our analysis included then current estimates of adoption of electronic

data exchange between providers and payers as well as adoption of information systems in lab, radiology, and pharmacy settings. We assumed, though, that all provider organizations would have to replace or purchase new information systems (electronic medical records and IT infrastructure) to achieve full interoperability. This assumption was made, in part, to conservatively project net gains resulting from standardized healthcare information exchange and to ensure that we not underestimate costs of health IT adoption by providers.

Further, the CBO focused parts of its criticism on minor aspects of our analysis. The CBO cited criticisms that certain inputs into our calculations – administrative costs for lab tests, rates of avoidable tests, and phone call rates related to prescriptions – were "overly optimistic" or unrealistic. The CBO failed to recognize that all of these inputs were *not* key determinants of value in our projections; changing them greatly would not have affected the overall results. Other inputs such as lab and radiology charges and lab and radiology costs per person per year were much more important to determining overall potential cost savings.

Lastly, the CBO neglected to include any of CITL's discussion of the limitations of our analysis. We state in our 2004 report that our analysis did not model or consider potential clinical benefits from standardized data exchange; we noted that savings may be realized as quality improvements rather than hard financial returns. We stressed that we did not include all possible costs associated with healthcare information exchange, nor did we quantify all potential financial benefits. CITL recognizes the inherent uncertainty in assessing the value of emerging information technologies in healthcare, and our analysis on the *Value of Healthcare Information Exchange and Interoperability* incorporated and accounted for this uncertainty. Where we could not defensibly assess an aspect of healthcare information exchange, we noted so.

We commend the CBO for its broad analysis of a challenging and highly varied area, but were disappointed in its explication of our analysis and its relevance to the national debate on health IT adoption. CITL produced a rigorous, seminal report in the value of healthcare information exchange. We stand by our methods and projections, and look forward to working with the CBO and others to appropriately frame and interpret the evidence on health IT's costs and benefits. Analyses of health IT's potential impact is critical to informing public policy and, ultimately, enabling health system transformation.