CONGRESSIONAL BUDGET OFFICE
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Washington, DC 20515

Peter R. Orszag, Director

September 5, 2007

Honorable Pete Stark
Chairman
Subcommittee on Health
Committee on Ways and Means
U.S. House of Representatives
Washington, DC 20515

Dear Mr. Chairman:

I am writing in response to your questions about how the Congressional Budget Office (CBO) evaluated the provisions regarding comparative effectiveness research that were contained in section 904 of H.R. 3162, the Children's Health and Medicare Protection Act of 2007, as reported by the Committee on Ways and Means and passed by the House of Representatives on August 1, 2007.

Section 904 would create a Center for Comparative Effectiveness Research; establish a Health Care Comparative Effectiveness Research Trust Fund; impose a fee on issuers of health insurance policies and sponsors of self-insured health plans; and authorize the center to spend moneys in the trust fund for research on the comparative effectiveness of medical treatments and procedures. The information generated by that research would tend to expand the scope of available evidence about what medical treatments work best for which patients. As a result, CBO estimates, spending on health care services would be reduced, but the effect on such spending over the next 10 years would be modest.

The Potential Value of Research on Comparative Effectiveness

The central fiscal challenge facing the nation involves rising health care costs. Over the past four decades, costs per beneficiary in Medicare and Medicaid have increased about 2.5 percentage points faster per year than has per capita GDP. If costs per beneficiary were to continue growing that much faster than income per capita over the next four decades, federal spending on Medicare and Medicaid would rise from about 4.5 percent of gross domestic product (GDP) today to roughly 20 percent of GDP by 2050. The rate at which health care costs grow relative to income is the most important determinant of the nation's long-term fiscal balance; it exerts a significantly larger influence on the budget over the long term than other commonly cited factors, such as the aging of the population.

A variety of evidence suggests opportunities to constrain health care costs in both public programs and the rest of the health system without adverse health consequences. Perhaps the most compelling evidence of that opportunity involves the substantial geographic differences in spending on health care—both across countries and within the United States—which do not translate into higher life expectancy or measured improvements in other health statistics in the higher-spending regions.

In the Medicare program, for example, costs per beneficiary vary significantly in different regions of the United States. Research has shown that much of the variation cannot be explained by the underlying characteristics of the populations in different areas and that the higher-spending regions do not generate better health outcomes than the lower-spending regions.

Furthermore, little evidence often exists about which treatments work best for which patients, or whether the added benefits of more effective but more expensive services are sufficient to warrant their added costs. In many cases, the extent of the variation in treatments is greatest for those types of care for which evidence about their relative effectiveness is not available. Together, those findings suggest that better information about the costs and benefits of different treatment options, especially if combined with new incentive structures reflecting the information, could eventually yield lower health care spending without having adverse effects on health—and that the potential reduction in spending below projected levels is substantial.

Getting to the point where additional research on comparative effectiveness could have a significant impact on health spending would probably take many years. In addition to the time required to get such research under way, a lag would exist before results were generated—particularly if they depended upon new clinical trials. Initially, the available results would probably address a relatively small number of medical treatments and procedures; more time would have to elapse before a substantial body of results was amassed. And in areas of medicine that involve significant amounts of spending, several studies might be needed before a consensus emerged about the appropriate conclusions to be drawn—even if those studies did not generate conflicting results. (CBO discussed the types of research that could be involved and the options for organizing it in testimony presented to the Subcommittee on June 12, 2007.) For all of those reasons, it would probably be a decade or more before new research on comparative effectiveness had the potential to reduce health care spending in a significant way.

CBO's Estimate of the Budgetary Impact of Section 904

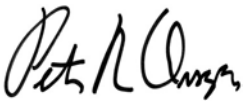
Under H.R. 3162, budget authority for the Center for Comparative Effectiveness Research would be $1.1 billion over the 2008-2012 period and $2.9 billion over the 2008-2017 period; CBO estimates that outlays would amount to about $600 million over five years and $2.4 billion over 10 years.

CBO estimates that the information produced by enacting section 904 would reduce total spending for health care services. Specifically, total spending—by public and private purchasers—would be reduced by about $0.5 billion over the 2008-2012 period and by about $6 billion over the 2008-2017 period. Direct spending by the federal government—mostly for Medicare, Medicaid, and the Federal Employees Health Benefits program—would be reduced by $0.1 billion over the 2008-2012 period and $1.3 billion over the 2008-2017 period. (Those amounts would constitute a very small fraction of overall federal outlays for those programs.) Thus, enacting section 904 would increase federal direct spending by $0.5 billion over five years and $1.1 billion over 10 years, CBO estimates.

That estimate assumes that better information about which health care services and procedures are ineffective or less effective than alternative services would lead to federal savings primarily through changes in physicians' practice patterns. To a lesser extent, some savings might also occur through changes in coverage rules that can be implemented under current law, although CBO did not make explicit assumptions about what those changes would be.

If you have any further questions, please feel free to contact me directly at (202) 226-2700.

Sincerely,



Peter R. Orszag
Director

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

Honorable Jim McCrery
Ranking Member

Honorable Dave Camp
Ranking Member
Subcommittee on Health
Committee on Ways and Means