



**Legislative Bulletin.....July 27, 2006**

**Contents:**

**H.R. 4157** — Better Health Information System Act of 2006

**Summary of the Bills Under Consideration Today:**

**Total Number of New Government Programs:** 2

**Total Cost of Discretionary Authorizations:** \$20 million in FY07, and \$40 million over two years

**Effect on Revenue:** \$0

**Total Change in Mandatory Spending:** See Cost to Taxpayers Section

**Total New State & Local Government Mandates:** at least 1

**Total New Private Sector Mandates:** at least 1

**Number of Bills Without Committee Reports:** 1

**Number of Reported Bills that Don't Cite Specific Clauses of Constitutional Authority:** 0

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**H.R. 4157 — Better Health Information System Act of 2006 — *as amended*  
(Johnson, R-CT)**

**Order of Business:** The bill is scheduled for consideration on Thursday, July 27, 2006, likely subject to a structured rule. Amendments made in order under the rule will be summarized in a separate RSC document.

**Summary by Title:**

**Title I — Coordination for, Planning for, and Interoperability of Health Information Technology**

- Provides that nothing in the Act should be construed to affect the scope, substance, or applicability of privacy and security regulations under the Health Insurance Portability and Accountability Act (HIPA).

- Establishes at the Department of Health and Human Services (HHS), an Office of the National Coordinator for Health Information Technology (ONCHIT) to be headed by a National Coordinator for HIT. The National Coordinator would be appointed by the HHS Secretary, and compensation would be at the basic pay for level IV of the Executive Schedule. According to the Office of Personnel Management, the 2006 basic pay for a level IV employee is \$143,000 annually. The bill authorizes such sums as necessary for the FY06-2010 period to create and sustain this office and the duties thereof. In addition, the Office of the National Coordinator for HIT was originally established by Executive Order 13335. H.R. 4157 essentially codifies this executive order (EO) and also provides that the EO now has not force or effect after enactment of this Act. To read EO 13335, please click here:  
<http://www.whitehouse.gov/news/releases/2004/04/20040427-4.html>.

**Note:** The bill does not specify authorization levels for the Office of HIT. However, CBO reports that, “Funding for ONCHIT totaled \$62 million for 2006: \$43 million was appropriated to ONCHIT, and \$19 million was reprogrammed from other activities. The President requested \$116 million for ONCHIT for 2007.”

- Specifies 12 “Goals of Nationwide Interoperable HIT Infrastructure.” Some of these goals include the following:
  - “improves health care quality, promotes data accuracy, reduces medical errors, increases the efficiency of care, and advances the delivery of appropriate, evidence-based health care services;
  - “promotes wellness, disease prevention, and management of chronic illnesses by increasing the availability and transparency of information related to the health care needs of an individual for such individual;
  - “promotes a more effective marketplace, greater competition, greater systems analysis, increased consumer choice, enhanced quality, and improved outcomes in health care services; and
  - “promotes the creation and maintenance of transportable, secure, Internet-based personal health records, including promoting the efforts of health care payers and health plan administrators for a health plan, such as Federal agencies, private health plans, and third party administrators, to provide for such records on behalf of members of such a plan.”
- Outlines the duties of the National Coordinator. Some of these duties include the following:
  - To provide for a strategic plan for the nationwide implementation of interoperable HIT in both the public and private health care sectors, consistent with the goals of HIT infrastructure listed above.
  - To serve as the principle advisor to the Secretary of HHS on the development, application, and use of health information technology, and to coordinate the policies and programs at HHS for promoting the use of HIT.
  - To ensure that HIT policies and programs at HSS are coordinated with those of relevant executive branch agencies and departments with a goal to avoid duplication of effort and to align the health information architecture of each agency or department toward a common approach.

- To provide to the Director of the Office of Management and Budget comments and advice with respect to specific federal health information technology programs.
  - To identify sources of funds that will be made available to promote and support the planning and adoption of HIT in medically underserved communities, including in urban and rural areas, either through grants or technical assistance.
  - To coordinate with the funding sources to help such communities connect to identified funding.
  - To collaborate with the Agency for Healthcare Research and Quality and the Health Services Resources Administration and other federal agencies to support technical assistance, knowledge dissemination, and resource development, to medically underserved communities seeking to plan for and adopt technology and establish electronic health information networks across providers.
- Directs HHS to submit to Congress a report on the work conducted by the American Health Information Community (AHIC), outlining a description of accomplishments with respect to the promotion of the development of national guidelines and increased adoption of HIT, information on how model privacy and security policies may be used to protect confidentiality health information, and recommendations for the transition of AHIC to a longer-term advisory and facilitation entity. This recommendation is to include a schedule for the transition, options for structuring the entity as either a public-private or private sector entity, and the role of the federal government in the entity.

According to the HHS website, “AHIC is being formed to help advance efforts to reach President Bush’s call for most Americans to have electronic health records within ten years. The Community is a federally-chartered commission and will provide input and recommendations to HHS on how to make health records digital and interoperable, and assure that the privacy and security of those records are protected, in a smooth, market-led way. The Community will have a total of 17 members including Secretary Leavitt who will serve as the Chair. The remaining 16 members selected by Secretary Leavitt represent a combination of key leaders in the public and private sectors.” (<http://www.hhs.gov/healthit/ahic.html>)

- Directs the National Coordinator to publish a strategic plan for the assessment and endorsement of core interoperability guidelines for significant use cases. The bill defines interoperability guidelines as “a guideline to improve and promote the interoperability of health information technology for purposes of electronically accessing and exchanging health information.” The term includes “named standards, architectures, software schemes for identification, authentication, and security, and other information needed to ensure the reproducible development of common solutions across disparate entities.” In addition, a “significant use case” is a category, as specified by the National Coordinator, which identifies a significant use or purpose for the interoperability of HIT, such as for the exchange of laboratory information, drug prescribing, clinical research, and electronic health records.
- Directs the National Coordinator to conduct one or more surveys designed to measure the capability of entities (including federal agencies, state and local government agencies, and private sector entities) to exchange electronic health information by appropriate significant use case. The surveys would identify the extent to which the type of health information, the use for such information, or any other appropriate characterization of such information may relate to the capability of such entities to exchange health information.

- Directs the President, in consultation with HHS, to take measures to ensure that federal activities involving the broad collection and submission of health information are consistent with guidelines established by the National Coordinator, within three years after the date of the endorsement by the National Coordinator of the guidelines.
- Directs the National Coordinator to, for five years following enactment of the Act, review and make recommendations regarding the operation of health information collection and exchange in the federal government and the proposed purchasing plans of federal agencies.
- **Authorizes \$30 million over two years for HHS to establish a new grant program.** Through the new program, HHS would make grants to integrated health care systems for projects to better coordinate the provision of health care through the adoption of new HIT, or the significant improvement of existing HIT. An integrated health care system is defined by the bill as “a system of health care providers that is organized to provide care in a coordinated fashion and has a demonstrated commitment to provide uninsured, underinsured, and medically underserved individuals with access to such care.” None of the funds provided through this program may be used for a project providing for the adoption or improvement of HIT that are used exclusively from financial record keeping, billing, or other non-clinical applications. Finally, the Act requires that those receiving a grant through this program make non-federal financial contributions toward the costs of carrying out their projects, equal to \$1 for each \$5 of federal funds provided under the grant.
- **Authorizes \$10 million over two years for HHS to establish a new demonstration grant program.** Through the new program, HHS would make grants to small physician practices that are located in rural areas or medically underserved urban areas for the purchase and support of health information technology. In addition, HHS would be required to, no later than January 2009, submit to Congress a report detailing the results of the demonstration program.

## **Title II — Transaction Standards, Codes, and Information**

- Directs HHS to publish in the Federal Register, a notice for the replacement of the International Classification of Diseases, 9<sup>th</sup> revision, Clinical Modification (ICD-9-CM) and the International Classification of Diseases, 9<sup>th</sup> revision, Procedure Coding System (ICD-9-PCS) with the International Classification of Diseases, 10<sup>th</sup> revision, Clinical Modification (ICD-10-CM) and the International Classification of Diseases, 10<sup>th</sup> revision, Procedure Coding System (ICD-10-PCS). This change would apply to services provided on or after October 1, 2010.

ICD-9-CM is the official system of assigning codes to medical diagnoses (such as the flu), and ICD-9-PCS is the official system of assigning codes to medical procedures (such as brain surgery). These codes are used by physician practices and hospitals in billing health plans, Medicare, Medicaid, and others. For example, if Mrs. Smith was diagnosed with appendicitis (inflammation of the appendix), that condition would be coded as 540.0 for billing purposes. If an appendectomy (removing the appendix) was performed on Mrs. Smith, that procedure would be coded as 47.0 for billing purposes. ICD-10-CM is the next version of this coding system, and is reportedly much more detailed in scope, providing many more codes for various diagnoses and procedures currently consolidated in the ICD-9.

- Directs HHS to develop a strategic plan with respect to the need for coordination in the implementation of transaction standards and ICD codes.
- Requires HHS to conduct a study of the impact of variation in state security and confidentiality laws and current federal security and confidentiality standards on the timely exchanges of health information in order to ensure the availability of health information necessary to make medical decisions at the location in which the medical care involved is provided. The study is to examine the following:
  - the degree of variation and commonality among the requirements of such laws for states;
  - the degree of variation and commonality between the requirements of such laws and the current federal standards;
  - insofar as there is variation among and between such requirements, the strengths and weaknesses of such requirements; and
  - the extent to which such variation may adversely impact the secure, confidential, and timely exchange of health information among states, the federal government, and public and private entities, or may otherwise impact the reliability of such information.

In connection with the study detailed above, the bill directs HHS to submit to Congress, within 18 months of enactment, a report on the study, which is to include a determination by the Secretary on the extent to which there is a need for greater commonality of the requirements of state security and confidentiality laws and current federal security and confidentiality standards. In addition, the Secretary is to submit to Congress, specific recommendation for legislative changes on **how such standards should supersede state laws**, in order to “provide the commonality needed to better protect or strengthen the security and confidentiality of health information in the timely exchange of such information and legislative language in the form of a bill to effectuate these specific recommendations. The greater commonality bill submitted by HHS would be introduced in the House by the majority leader, for himself and the minority leader, or their designee, and in the Senate by the majority leader, for himself and minority leader, or their designee, and would be referred to the appropriate committees. According to the Act, the title of this bill would be, “A bill to provide the commonality needed to better protect, strengthen, or otherwise improve the secure, confidential, and timely exchange of health information,” and the text of the bill, as introduced, would include the HHS report explained above.

### **Title III — Promoting the Use of Health Information Technology to Better Coordinate Health Care**

- Current anti-kickback laws prohibit hospitals from giving anything of value to physician or a physician’s office in order to encourage the doctor to refer his/her patients to that hospital. However, H.R. 4157 would make an exception to current law, allowing hospitals to provide doctors offices with HIT software, computers, training, and the like, without being subject to penalties. The bill also specifies that “the practical or other advantages resulting from health information technology or related installation, maintenance, support, or training services” are not to be subject to current anti-kickback laws. For example, under H.R. 4157, a hospital that recently purchased 100 licenses for updated ICD software, could provide a local physician’s office with one of their licenses to use the software, and not be subject to penalties under current anti-kickback laws.

- Creates an exception to the Stark law, allowing physicians to refer their patients to “specified entities” (such as hospitals) that have provided that doctor with HIT software, training, or the like. The Stark law prohibits physicians with a “financial interest” in an entity, such as a hospital, from referring their patients to that entity. For example, under H.R. 4157, if on a certain day, a hospital provided Dr. Smith’s and his administrative staff with two hours of training on how to use updated ICD software, and on the following day, Dr. Smith had a patient in need of emergency heart surgery, Dr. Smith *would be allowed* to refer this patient to the same hospital that provided the training.

**Note:** H.R. 4157 defines “specified entity” as an entity that is a hospital, group practice, prescription drug plan sponsor, a Medicare Advantage organization, or any other such entity specified by the Secretary, considering the goals and objectives of this section, as well as the goals to better coordinate the delivery of health care and to promote the adoption and use of health information technology.” However, this definition for specified entity would only be in effect until September 30, 2010; and effective October 1, 2011, a specified entity would be defined as “any entity.”

According to CBO, provisions allowing any entity to donate HIT to physicians without penalty would increase direct spending by \$25 million in the first year and \$150 million over five years, with Medicaid and Medicare cost increases each accounting for half of the increased direct spending. Specifically, CBO estimates that, in aggregate, such donations by entities other than those included in the definition for the first five years would lead to an increase in the volume of services that Medicare and state Medicaid programs pay for, thus increasing costs. **Note:** Reportedly, this provision will be removed, and the bill will retain the definition for specified entity utilized in the first five years.

- Provides that nothing in this title is to be construed as preventing entities from forming a consortium to collectively purchase and donate health information technology.

#### **Title IV — Additional Provisions**

- Directs HHS to encourage and facilitate the adoption of state reciprocity agreements for practitioner licensure in order to expedite the provision across state lines of telehealth services, and to submit a report to Congress, within 18 months of enactment, on the actions taken to carry about this provision. Telehealth refers to the combining of health telecommunication, information technology, and health education in providing health care services.
- Directs HHS to conduct a study to determine the feasibility, advisability, and the costs of :
  - including coverage and payment for home health-related telehealth services as part of home health services; and
  - expanding the list of sites covered for telehealth services to include **county mental health clinics or other publicly funded mental health facilities.**

The findings of this study are to be submitted to Congress within 18 months of enactment, and should include recommendations for legislation or administration action.

- Directs HHS to conduct a study on the use of store and forward technologies in the provision of telehealth services. The study is to assess the feasibility, advisability, and the costs of examining the use of these technologies for use in the diagnosis and treatment of certain conditions.
- Requires HHS to develop a method for the reporting of uniform price data for inpatient and outpatient hospital services. The bill requires the method to provide for the reporting by each hospital of such data for selected procedures or services based on a range of charges and a range of prices actually paid for inpatient and outpatient hospital services grouped by type of payer, with each of the following treated as a separate type of payer: the Medicare program, the Medicaid program, other public health insurance coverage (including public group health plan coverage), private health insurance coverage (including private group health plan coverage), other insurance coverage, and self-pay. In addition, the bill would direct GAO to conduct a study to assess the structure and methodology for permanent uniform reporting of price data for health care services, and submit to Congress recommendations on a structure and methodology for timely reporting of charges and prices actually paid for health care services.  
**Note:** Reportedly, this provision (Section 404) will be removed from the bill.
- Requires hospitals not submitting certain specified inpatient pricing information in accordance with the methodology described above, to have the applicable market basket percentage (an inflationary type increase) reduced by two percentage points. **Note:** Reportedly, this provision (Section 405) will be removed from the bill.
- Directs HHS to conduct a study on issues relating to the development, operation, and implementation of state, regional, and community health information exchanges.

**Committee Action:** H.R. 4157 was introduced on October 27, 2006, and was referred to the Committee on Energy and Commerce, which considered it, held a mark-up, and reported the bill, as amended, by voice vote on June 15, 2006. The bill was also referred to Committee on Ways and Means, which considered it and held a mark-up.

**Cost to Taxpayers:** There is no CBO score available for H.R. 4157, as amended. However, a CBO score for the Energy and Commerce-reported version of the bill confirms that the bill authorizes \$20 million in FY07, and \$40 million over five years. This score also includes an extensive discussion on the budgetary impacts of implementing H.R. 4157, specifically the possible impacts on Medicare. To read this discussion, please view this CBO estimate: <http://cbo.gov/ftpdocs/73xx/doc7358/hr4157.pdf>.

In addition, a preliminary score, which detailed the costs of requiring health plans and providers to transition from ICD-9 to ICD-10, estimates that “implementing the ICD-10 system will result in costs to providers and health plans in the first few years, with benefits beginning later.” Initial costs would be incurred from purchasing new equipment or providing training on the new system, while in the later years, according to CBO, “increased specificity and clinical detail of the new set of codes will reduce providers’ and plans’ costs.” Specifically, the federal government would see an increase in direct spending of \$5 million in FY07, and an increase of \$30 over the five years. However, over ten years, direct spending would be *reduced* by \$100 million. In other words, the policy change costs in the short-term but saves the federal government in the long-term. However, the bill violates the budget resolution by exceeding the allocations of the committees with jurisdiction. As a result, Members will be asked to waive a budget point of order (302(f)) lying against H.R. 4157 (and thus waiver the budget resolution) in voting for the rule giving consideration to the bill.

In addition, CBO estimates that direct spending in later years, outside the budget window, will increase as a result of the Stark safe harbor provision (detailed on page 6, in the summary section), which take effect on October 1, 2011. The provisions would cost roughly \$150 million over five years. According to the House Budget Committee, this provision violates Section 303(a) of the Budget Act, which prohibits the consideration of legislation providing new budget authority (an increase or decrease in direct spending) for a fiscal year until a concurrent resolution on the budget for that fiscal year has been agreed to. **Note:** Reportedly, this provision will be removed, thus lifting the direct spending cost concerns.

**Does the Bill Expand the Size and Scope of the Federal Government?:** The bill codifies the Office of the National Coordinator for Health Information Technology, which was originally established by an executive order.

**Does the Bill Contain Any New State-Government, Local-Government, or Private-Sector Mandates?:** Yes. According to CBO, “H.R. 4157 would preempt, in some circumstances, state laws that govern record-keeping requirements and that establish civil or criminal penalties for the exchange of health information technology. Because those preemptions would limit the application of state laws, they would be intergovernmental mandates as defined in the Unfunded Mandates Reform Act (UMRA). ...[but] would not exceed the threshold established in UMRA.”

In addition, CBO explains that the bill would also impose a private sector mandate “on health plans, providers, and clearing houses by requiring them to adopt updated standards for claims transactions by 2009. CBO assumes that this deadline would be met under current law, however, so the mandate would impose no additional cost on those private-sector entities.”

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