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109TH CONGRESS
1ST SESSION

H. R. 747

To amend title XI of the Social Security Act to achieve a national health information infrastructure, and to amend the Internal Revenue Code of 1986 to establish a refundable credit for expenditures of health care providers implementing such infrastructure.

IN THE HOUSE OF REPRESENTATIVES

FEBRUARY 10, 2005

Mr. GONZALEZ (for himself, Mr. MCHUGH, Ms. JACKSON-LEE of Texas, Mr. TOWNS, Mr. LIPINSKI, Mr. HINOJOSA, Mr. CROWLEY, Mrs. CHRISTENSEN, Mr. MOORE of Kansas, and Mr. MILLER of North Carolina) introduced the following bill; which was referred to the Committee on Energy and Commerce, and in addition to the Committee on Ways and Means, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned

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A BILL

To amend title XI of the Social Security Act to achieve a national health information infrastructure, and to amend the Internal Revenue Code of 1986 to establish a refundable credit for expenditures of health care providers implementing such infrastructure.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as ''National Health Information Incentive Act of 2005''.

SEC. 2. FINDINGS AND PURPOSE.

(a) FINDINGS.—The Congress finds as follows:

(1) A March 2001 Institute of Medicine (''IOM'') study concludes that in order to improve quality, the nation must have a national commitment to building an information infrastructure to support healthcare delivery, consumer health, quality measurement and improvement, public accountability, clinical and health services research, and clinical education.

(2) A November 2001 National Committee on Vital Health Statistics study lauds the importance of a national health information infrastructure to improve patient safety, improve healthcare quality, improve bioterrorism detection, better inform and empower healthcare consumers regarding their own personal health information, and to better understand healthcare costs.

(3) An October 2002 IOM report calls on the federal government to take steps to encourage and facilitate development in the information technology infrastructure that is critical to healthcare quality and safety enhancement.

(4) A General Accounting Office October 2003 report found that the benefits of an electronic healthcare information system included improved quality of care, reduced costs associated with medication errors, more accurate and complete medical documentation, more accurate capture of codes and charges, and improved communication among providers enabling them to respond more quickly to patients' needs.

(5) Other studies and surveys show that cultivating a national healthcare information infrastructure and improving patient care will depend crucially on adoption of uniform medical data standards and interoperability.

(6) Acquisition costs, physician and staff time required to transition from paper-based offices to electronic health systems, and the lack of industry standards on interoperability are the principle barriers to creating a national health information infrastructure.

(7) The success of a national health information infrastructure depends on the widespread use and acceptance of electronic health records in physician offices.

(b) PURPOSES.—The purposes of this Act are as follows:

(1) To facilitate the development of standards and to create incentives that encourage physicians and other health professionals to adopt interoperable electronic health records, electronic prescribing systems, evidence-based clinical support tools, patient registries, and other health information technology as a key component of a national health care information infrastructure in the United States to ensure the rapid flow of secure, private and digitized information relevant to all facets of patient care.

(2) To do so in a voluntary manner that does not become an unfunded mandate on small physician practices.

(3) To do so in a manner that does not compromise the health care provider's ability to make patient care decisions based solely on his or her clinical expertise and experience, and what the provider concludes is the best for a particular patient based upon scientific evidence and knowledge of the patient's medical history.

SEC. 3. OFFICE OF THE NATIONAL COORDINATOR FOR HEALTH INFORMATION TECHNOLOGY.

(a) ESTABLISHMENT.—There is established within the executive office of the President an Office of the National Coordinator for Health Information Technology (referred to in this section as the ''Office''). The Office shall be headed by a Director appointed by the President. The Director of the Office shall report directly to the President.

(b) RESOURCES.—The President shall make available to the Office the resources, both financial and otherwise, necessary to enable the Director of the Office to carry out the purposes of, and perform the duties and responsibilities of, the Office.

SEC. 4. STANDARDS FOR BUILDING THE NATIONAL HEALTH INFORMATION INFRASTRUCTURE.

Title XI of the Social Security Act (42 U.S.C. 1301 et seq.) is amended by adding at the end the following part:

''PART D—STANDARDS FOR BUILDING THE NATIONAL HEALTH INFORMATION INFRASTRUCTURE

''SEC. 1181. STANDARDS FOR BUILDING THE NATIONAL HEALTH INFORMATION INFRASTRUCTURE.

''(a) STANDARDS.—

''(1) DEVELOPMENT AND ADOPTION.—

"(A) IN GENERAL.—The Secretary, through the Office of the National Coordinator for Health Information Technology and in collaboration with the Committee on Systematic Interoperability, shall develop or adopt standards for transactions and data elements for such transactions (in this section referred to as 'standards') to enable the creation of a national health care information infrastructure.

"(B) ROLE OF STANDARD SETTING ORGANIZATIONS.—

"(i) IN GENERAL.—Except as provided in clause (ii), any standard adopted under this section shall be a standard that has been developed, adopted, or modified by a standard setting organization.

"(ii) STANDARD SETTING ORGANIZATION.—For purposes of this section, the term 'standard setting organization' means an organization accredited by the American National Standards Institute that develops standards for information transactions, data elements, or any other standard that is necessary to, or will facilitate, the implementation of this part.

"(C) CONSULTATION.—In developing and adopting standards, the Secretary shall consult with national organizations representing physicians in clinical practice, hospitals, pharmacists, pharmacies, pharmaceutical manufacturers, patients, standard setting organizations, pharmacy benefit managers, beneficiary information exchange networks, technology experts, and representatives of the Departments of Veterans Affairs and Defense and other interested parties.

"(D) ASSISTANCE TO THE SECRETARY.—In complying with the requirements under this section, the Secretary shall rely on the recommendations of the National Committee on Vital and Health Statistics established under section 306(k) of the Public Health Service Act (42 U.S.C. 242k(k)), and shall consult with appropriate Federal and State agencies and national organizations. The Secretary shall publish in the Federal Register any recommendations of the National Committee on Vital and Health Statistics regarding the adoption of a standard under this section.

''(2) OBJECTIVE.—Any standards developed or adopted under this section shall be consistent with the objectives of improving—

''(A) patient safety; and

''(B) the quality of care provided to patients.

''(3) REQUIREMENTS.—Any standards developed or adopted under this section shall comply with the following:

''(A) UNDUE BURDEN.—The standards shall be designed so that, to the extent practicable, the standards do not impose an undue administrative or financial burden on the practice of medicine, or any other health care profession, particularly on small physician practices and practices in rural areas.

''(B) COMPATIBILITY WITH ADMINISTRATIVE SIMPLIFICATION AND PRIVACY LAWS.—The standards shall be—

''(i) consistent with the Federal regulations (concerning the privacy and security of individually identifiable information) promulgated under section 264(c) of the Health Insurance Portability and Accountability Act of 1996, and any State privacy

laws preserved under the Federal regulations promulgated under section 1178; and

"(ii) compatible with the standards under section 3.

"(b) TIMETABLE FOR ADOPTION OF STANDARDS.—

"(1) IN GENERAL.—The Secretary shall adopt trial standards under this section two years after the date of the enactment of this part, or at a subsequent date determined by the Secretary, as may be required to complete development of the trial standards.

"(2) PILOT PROGRAM TO TEST TRIAL STANDARDS.—

"(A) PILOT PROGRAM.—In accordance with the development and adoption of standards, the Secretary shall conduct a pilot program to test the effectiveness and impact of trial standards for transaction and data elements as defined in subsection (a)(1)(A).

"(B) LOCATION OF PROGRAM.—The pilot program shall be conducted through various health care facilities, including small physician practices, throughout the country that capture both rural and urban settings.

"(C) DURATION OF THE PROGRAM.—The pilot program shall be conducted during the two-year period beginning on the date of adoption of the standards.

"(D) DESIGNATION AND SELECTION OF PROGRAM SITES.—In designing the pilot program and in selecting locations and sites for the pilot test, the Secretary shall consult with national organizations representing affected parties, as defined in subsection (a)(1)(C), and appropriate standard setting organizations, as defined in subsection (a)(1)(B).

"(E) REPORT OF FINDINGS.—The Secretary, consistent and accordance with subsections (a)(1)(B) and (a)(1)(C), shall submit to Congress a report on the pilot program no earlier than one year following the completion of the pilot program. The Secretary shall include in the report the following:

"(i) The Secretary's assessment of the impact and effectiveness of the trial standards, as applied to a variety of clinical and geographic setting as described under this section.

''(ii) The Secretary's assessment of the effect of the pilot program and trial standards on patient safety, including the effect on delivery and the quality of health care, and on the typical costs incurred by providers in acquiring necessary technology systems, and the necessary training to comply with the trial standards.

''(iii) The Secretary's assessment of the clinical usefulness of health information technologies that meet the trial standards, including the amount of time required of physicians, other health professionals and other office staff in sending, receiving, updating, maintaining, and recording clinical information using such technologies.

''(iv) In consultation with appropriate standard setting organizations, as defined in subsection (a)(1)(B), and with national organizations representing affected parties, as defined in subsection (a)(1)(C), the findings and conclusions of the Secretary with respect to the pilot program and notice of adoption of a modified standard.

"(v) Any recommendations of the Secretary for continuation of the pilot program for further study or testing to other clinical or geographic service areas prior to full implementation.

"(3) ADDITIONS AND MODIFICATIONS TO STANDARDS.—The Secretary shall, in consultation with appropriate representatives of interested parties, as defined in subsection (a)(1)(C) of this section, and with standard setting organizations, as defined in subsection (a)(1)(B), review the standards developed or adopted under this section and adopt modifications to the standards (including additions to the standards), as determined appropriate. Any addition or modification to such standards shall be completed in a manner which minimizes the disruption and cost of compliance.

"(c) COMPLIANCE WITH STANDARDS.—

"(1) REQUIREMENT FOR ALL INDIVIDUALS AND ENTITIES THAT UTILIZE HEALTH INFORMATION TECHNOLOGY.—

"(A) IN GENERAL.—Individuals or entities that voluntarily utilize electronic health records, and other health information technology defined by the Secretary as being a key component of

a national health care information infrastructure shall comply with the standards adopted or modified under this section.

''(B) RELATION TO STATE LAWS.—Consistent with subsection (a)(3)(B), the standards adopted or modified under this section shall supersede any State law or regulations pertaining to the electronic transmission of patient history, eligibility, benefit and any other information.

''(2) TIMETABLE FOR COMPLIANCE.—

''(A) INITIAL COMPLIANCE.—

''(i) IN GENERAL.—Not later than 24 months after the date on which a modified standard is adopted under this section, each individual or entity to whom the standard applies shall comply with the standard.

''(ii) SPECIAL RULES FOR SMALL HEALTH PLANS.—In the case of a 'small health plan', as defined by the Secretary for purposes of section 1175(b)(1)(B), clause (i) shall be applied by substituting, '36 months' for '24 months'.

''(iii) SPECIAL RULE FOR SMALL PROVIDER OF SERVICES.—In the case of a

small provider of services, clause (i) shall be applied by substituting '36 months' for '24 months'.

''(iv) EXCEPTION.—In consultation with national organizations representing affected parties, as defined in subsection (a)(1)(C), the Secretary may delay initial compliance until such time as the Secretary deems appropriate to assure maximum compliance.

''(d) NO REQUIREMENT TO OBTAIN SPECIFIC TECHNOLOGIES OR PRODUCTS.—Nothing in this part shall be construed to require an individual or entity to obtain specific technologies or products to utilize a national health care information infrastructure.

''(e) PRESERVATION OF HEALTH CARE PROVIDER OR OTHER ENTITY TO MAKE UNBIASED PATIENT CARE DECISIONS.—Interoperable health care technology shall be designed to facilitate access to unbiased and evidence-based decision support tools. All patient care decisions shall be based solely on the provider's clinical expertise and experience, without outside influence.

''(f) SMALL HEALTH CARE PROVIDERS.—For purposes of this part, a health care provider or practice is

considered 'small' if it is small under the provisions of section 1862(h).

"SEC. 1182. FINANCIAL INCENTIVE TO SMALL HEALTH CARE PROVIDERS AND ENTITIES TO IMPLEMENT A NATIONAL HEALTH INFORMATION INFRASTRUCTURE.

''(a) IN GENERAL.—The Secretary shall include additional Medicare payment incentives to assure small health care providers have the capability to move toward a national health care information infrastructure by acquiring electronic health record systems and other health information technologies that meet the standards adopted or modified under section 1181.

''(b) CONDITIONS FOR QUALIFICATION.—As a condition of qualifying for financial incentives described in this section, the Secretary, in consultation with national organizations representing affected parties, as defined in section 1181(a)(1)(C), and appropriate standards setting organizations, as defined in section 1181(a)(1)(B), shall grant the use of financial incentives to assure that such technologies are consistent with the goals of creation of a national health information infrastructure, such as—

''(1) voluntary participation in studies or demonstration projects to evaluate the use of such sys-

tems to measure and report quality data based on accepted clinical performance measures; and

''(2) voluntary participation in studies to demonstrate the impact of such technologies on improving patient care, reducing costs and increasing efficiencies.

''(c) ADDITIONAL MEDICARE PAYMENT TO SMALL HEALTH CARE PROVIDERS AND ENTITIES FOR EXPENDITURES RELATING TO THE IMPLEMENTATION OF A NATIONAL HEALTH INFORMATION INFRASTRUCTURE.—

''(1) IN GENERAL.—The Secretary shall provide for additional payment to small health care providers, including physicians and others in clinical practice, for the purpose of assisting such entities to implement, design, test, acquire, and adopt electronic health records and other health information technologies defined by the Secretary as a key component of a national health care information infrastructure that comply with the standards adopted or modified under section 1181.

''(2) TYPES OF REIMBURSEMENT INCENTIVES.—In developing the reimbursement incentives described in paragraph (1), the Secretary shall consider inclusion of one or more of the following types of incentives:

"(A) Adds-ons to payments for evaluation and management services.

"(B) Care management fees for physicians who use information technology to manage care of patients with chronic illnesses.

"(C) Payments for structured e-mail consults resulting in a separately identifiable medical service from other evaluation and management services.

"(D) Any other method deemed appropriate by the Secretary to encourage participation.

"(3) AMOUNT OF REIMBURSEMENT.—The amount of reimbursement made to small health care providers and entities to implement a national health care information infrastructure shall be in a manner determined by the Secretary, in accordance with section 1181(b)(2)(ii), that takes into account the costs of implementation, training, and complying with standards.

"(4) EXEMPTION FROM BUDGET NEUTRALITY UNDER THE PHYSICIAN FEE SCHEDULE.—Any increased expenditures pursuant to this section shall be treated as additional allowed expenditures for

purposes of computing any update under section 1848(d).

"SEC. 1183. OPTIONAL FINANCIAL INCENTIVES TO SMALL HEALTH CARE PROVIDERS AND ENTITIES TO IMPLEMENT A NATIONAL HEALTH INFORMATION INFRASTRUCTURE.

''(a) IN GENERAL.—The Secretary may utilize any, all, or a combination of financial incentives thereof, to assure small health care providers have the capability to move toward a national health care information infrastructure by acquiring electronic health record systems and other health information technologies that meet the standards adopted or modified under section 1181.

''(b) CONDITIONS FOR QUALIFICATION.—As a condition of qualifying for financial incentives described in this section, the Secretary, in consultation with national organizations representing affected parties, as defined in section 1181(a)(1)(C), and appropriate standards setting organizations, as defined in section 1181(a)(1)(B), shall grant the use of financial incentives to assure that such technologies are consistent with the goals of creation of a national health information infrastructure, such as—

''(1) voluntary participation in studies or demonstration projects to evaluate the use of such sys-

tems to measure and report quality data based on accepted clinical performance measures; and

''(2) voluntary participation in studies to demonstrate the impact of such technologies on improving patient care, reducing costs and increasing efficiencies.

''(c) GRANTS TO SMALL HEALTH CARE PROVIDERS AND ENTITIES FOR EXPENDITURES RELATING TO THE IMPLEMENTATION OF A NATIONAL HEALTH INFORMATION INFRASTRUCTURE.—

''(1) IN GENERAL.—The Secretary is authorized to make grants to small health care providers, including physicians and others in clinical practice, for the purpose of assisting such entities to implement, design, test, acquire, and adopt electronic health records and other health information technologies identified by the Secretary as a key component of a national health care information infrastructure that comply with the standards adopted or modified under section 1181.

''(2) AMOUNT OF GRANT.—The grant amount made to small health care providers and entities to implement a national health care information infrastructure shall be in a manner determined by the Secretary, in accordance with section 1181(b)(2)(ii),

that takes into account the costs of implementation, training, and complying with standards.

''(3) APPLICATION.—No grant may be made under this subsection except pursuant to a grant application that is submitted in a time, manner, and form approved by the Secretary.

''(4) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this subsection such sums as may be necessary for each fiscal year.

''(d) REVOLVING LOANS TO SMALL HEALTH CARE PROVIDERS AND ENTITIES FOR EXPENDITURES RELATING TO THE IMPLEMENTATION OF A NATIONAL HEALTH INFORMATION INFRASTRUCTURE.—

''(1) IN GENERAL.—The Secretary is authorized to make and guarantee loans to small health care providers, including physicians and others in clinical practice, for the purpose of assisting such entities to implement, design, test, acquire, and adopt electronic health records and other health information technologies identified by the Secretary as a key component of a national health care information infrastructure that comply with the standards adopted or modified under section 1181.

''(2) AMOUNT OF LOAN.—The loan amount made to small health care providers and entities to implement a national health care information infrastructure shall be in a manner determined by the Secretary, in accordance with section 1181(b)(2)(ii), that takes into account the costs of implementation, training, and complying with standards.

''(3) APPLICATION.—No loan may be made under this subsection except pursuant to a loan application that is submitted in a time, manner, and form approved by the Secretary.

''(4) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this subsection such sums as may be necessary for each fiscal year.''.

SEC. 5. REFUNDABLE CREDIT FOR HEALTH CARE INFORMATION INFRASTRUCTURE.

(a) IN GENERAL.—Subpart C of part IV of subchapter A of chapter 1 of the Internal Revenue Code of 1986 (relating to refundable credits) is amended by redesignating section 36 as section 37 and by inserting after section 35 the following new section:

''SEC. 36. HEALTH CARE INFORMATION INFRASTRUCTURE.

''(a) IN GENERAL.—In the case of a qualified health care provider, there shall be allowed as a credit against

the tax imposed by this chapter for the taxable year an amount equal to 10 percent of the amounts paid or incurred during the taxable year by the taxpayer for establishing a qualified health information technology system.

''(b) QUALIFIED HEALTH INFORMATION TECHNOLOGY SYSTEM.—For purposes of this section, the term 'qualified health information technology system' means a system which has been individually approved by the Secretary of Health and Human Services for purposes of this section and which consists of electronic health record systems and other health information technologies that meet the standards and conditions of qualification adopted or modified under sections 1181 and 1183 of the Social Security Act.

''(c) QUALIFIED HEALTH CARE PROVIDER.—For purposes of this section, the term 'qualified health care provider' means any person in the trade or business of providing health care.

''(d) TERMINATION.—This section shall not apply to amounts paid or incurred during taxable years beginning after December 31, 2014.''.

(b) DENIAL OF DOUBLE BENEFIT.—Section 280C of such Code is amended by adding at the end the following new subsection:

''(e) CREDIT FOR HEALTH CARE INFORMATION INFRASTRUCTURE.—No deduction shall be allowed for that portion of the expenses (otherwise allowable as a deduction) taken into account in determining the credit under section 36 for the taxable year which is equal to the amount of the credit determined for such taxable year under section 36(a).''.

(c) CONFORMING AMENDMENTS.—

(1) Paragraph (2) of section 1324(b) of title 31, United States Code, is amended by inserting ''or 36'' after ''section 35''.

(2) The table of sections for subpart C of part IV of subchapter A of chapter 1 of the Internal Revenue Code of 1986 is amended by striking the item relating to section 36 and inserting the following new items:

''Sec. 36. Health care information infrastructure.
''Sec. 37. Overpayment of taxes.''.

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to amounts paid or incurred during taxable years beginning after December 31, 2005.

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