

109TH CONGRESS  
1ST SESSION

# H. R. 4157

To amend the Social Security Act to encourage the dissemination, security, confidentiality, and usefulness of health information technology.

---

## IN THE HOUSE OF REPRESENTATIVES

OCTOBER 27, 2005

Mrs. JOHNSON of Connecticut (for herself, Mr. DEAL of Georgia, Mr. BLUNT, Mr. CANTOR, Mr. McCRERY, Mr. SAM JOHNSON of Texas, Mr. CAMP, Mr. RAMSTAD, Mr. ENGLISH of Pennsylvania, Mr. HAYWORTH, Mr. HULSHOF, Mr. HERGER, Mr. LEWIS of Kentucky, Mr. WELLER, Mr. RYAN of Wisconsin, Mr. BEAUPREZ, Mr. UPTON, Mrs. WILSON of New Mexico, Mr. BASS, Mr. TERRY, Mr. MURPHY, Mr. BRADLEY of New Hampshire, Mr. BOEHLERT, Mr. CASTLE, Mrs. EMERSON, Mr. GERLACH, Mr. HOBSON, Mrs. KELLY, Mr. JINDAL, Mr. SCHWARZ of Michigan, Mr. SHAYS, and Mr. SIMMONS) 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

---

## A BILL

To amend the Social Security Act to encourage the dissemination, security, confidentiality, and usefulness of health information technology.

1       *Be it enacted by the Senate and House of Representa-*  
2       *tives of the United States of America in Congress assembled,*

1 **SECTION 1. SHORT TITLE AND TABLE OF CONTENTS.**

2 (a) SHORT TITLE.—This Act may be cited as the  
3 “Health Information Technology Promotion Act of 2005”.

4 (b) TABLE OF CONTENTS.—The table of contents of  
5 this Act is as follows:

Sec. 1. Short title and table of contents.

Sec. 2. Office of the National Coordinator for Health Information Technology.

Sec. 3. Safe harbors for provision of health information technology and training  
services to health care professionals.

Sec. 4. Uniform health information laws and regulations.

Sec. 5. Rulemaking to upgrade ASC X12 and NCPDP standards and ICD  
codes.

Sec. 6. Report on the American Health Information Community.

Sec. 7. Strategic plan for coordinating implementation of health information  
technology.

6 **SEC. 2. OFFICE OF THE NATIONAL COORDINATOR FOR**  
7 **HEALTH INFORMATION TECHNOLOGY.**

8 (a) IN GENERAL.—Title II of the Public Health Serv-  
9 ice Act is amended by adding at the end the following new  
10 part:

11 “PART D—HEALTH INFORMATION TECHNOLOGY

12 “OFFICE OF THE NATIONAL COORDINATOR FOR HEALTH  
13 INFORMATION TECHNOLOGY

14 “SEC. 271.

15 “(a) ESTABLISHMENT.—There is established within  
16 the Department of Health and Human Services an Office  
17 of the National Coordinator for Health Information Tech-  
18 nology that shall be headed by the National Coordinator  
19 for Health Information Technology (referred to in this  
20 section as the ‘National Coordinator’). The National Coor-  
21 dinator shall be appointed by the President and shall re-

1 port directly to the Secretary. The National Coordinator  
2 shall be paid at a rate equal to the rate of basic pay for  
3 level IV of the Executive Schedule.

4 “(b) GOALS OF NATIONWIDE INTEROPERABLE  
5 HEALTH INFORMATION TECHNOLOGY INFRASTRUC-  
6 TURE.—The National Coordinator shall perform the du-  
7 ties under subsection (c) in a manner consistent with the  
8 development of a nationwide interoperable health informa-  
9 tion technology infrastructure that—

10 “(1) improves health care quality, reduces med-  
11 ical errors, increases the efficiency of care, and ad-  
12 vances the delivery of appropriate, evidence-based  
13 health care services;

14 “(2) promotes wellness, disease prevention, and  
15 management of chronic illnesses by increasing the  
16 availability and transparency of information related  
17 to the health care needs of an individual for such in-  
18 dividual;

19 “(3) ensures that appropriate information nec-  
20 essary to make medical decisions is available in a us-  
21 able form at the time and in the location that the  
22 medical service involved is provided;

23 “(4) produces greater value for health care ex-  
24 penditures by reducing health care costs that result

1 from inefficiency, medical errors, inappropriate care,  
2 and incomplete information;

3 “(5) promotes a more effective marketplace,  
4 greater competition, greater systems analysis, in-  
5 creased choice, enhanced quality, and improved out-  
6 comes in health care services;

7 “(6) improves the coordination of information  
8 and the provision of such services through an effec-  
9 tive infrastructure for the secure and authorized ex-  
10 change and use of health care information; and

11 “(7) ensures that the confidentiality of individ-  
12 ually identifiable health information of a patient is  
13 secure and protected.

14 “(c) DUTIES OF NATIONAL COORDINATOR.—

15 “(1) STRATEGIC PLANNER FOR INTEROPER-  
16 ABLE HEALTH INFORMATION TECHNOLOGY.—The  
17 National Coordinator shall maintain, direct, and  
18 oversee the continuous improvement of a strategic  
19 plan to guide the nationwide implementation of  
20 interoperable health information technology in both  
21 the public and private health care sectors consistent  
22 with subsection (b).

23 “(2) PRINCIPAL ADVISOR TO HHS.—The Na-  
24 tional Coordinator shall serve as the principal advi-  
25 sor of the Secretary on the development, application,

1 and use of health information technology, and co-  
2 ordinate the health information technology programs  
3 of the Department of Health and Human Services.

4 “(3) COORDINATOR OF FEDERAL GOVERNMENT  
5 ACTIVITIES.—

6 “(A) IN GENERAL.—The National Coordi-  
7 nator shall serve as the coordinator of Federal  
8 Government activities relating to health infor-  
9 mation technology.

10 “(B) SPECIFIC COORDINATION FUNC-  
11 TIONS.—In carrying out subparagraph (A), the  
12 National Coordinator shall provide for—

13 “(i) the development and approval of  
14 standards used in the electronic creation,  
15 maintenance, or exchange of health infor-  
16 mation; and

17 “(ii) the certification and inspection of  
18 health information technology products, ex-  
19 changes, and architectures to ensure that  
20 such products, exchanges, and architec-  
21 tures conform to the applicable standards  
22 approved under clause (i).

23 “(C) USE OF PRIVATE ENTITIES.—The  
24 National Coordinator shall, to the maximum ex-

1           tent possible, contract with or recognize private  
2           entities in carrying out subparagraph (B).

3           “(D) UNIFORM APPLICATION OF STAND-  
4           ARDS.—A standard approved under subpara-  
5           graph (B)(i) for use in the electronic creation,  
6           maintenance, or exchange of health information  
7           shall preempt a standard adopted under State  
8           law, regulation, or rule for such a use.

9           “(4) INTRAGOVERNMENTAL COORDINATOR.—  
10          The National Coordinator shall ensure that health  
11          information technology policies and programs of the  
12          Department of Health and Human Services are co-  
13          ordinated with those of relevant executive branch  
14          agencies and departments with a goal to avoid dupli-  
15          cation of effort and to ensure that each agency or  
16          department conducts programs within the areas of  
17          its greatest expertise and its mission in order to cre-  
18          ate a national interoperable health information sys-  
19          tem capable of meeting national public health needs  
20          effectively and efficiently.

21          “(5) ADVISOR TO OMB.—The National Coordi-  
22          nator shall provide to the Director of the Office of  
23          Management and Budget comments and advice with  
24          respect to specific Federal health information tech-  
25          nology programs.

1       “(d) AUTHORIZATION OF APPROPRIATIONS.—There  
2 are authorized to be appropriated such sums as may be  
3 necessary to carry out this section for each of fiscal years  
4 2006 through 2010.”.

5       (b) TREATMENT OF EXECUTIVE ORDER 13335.—Ex-  
6 ecutive Order 13335 shall not have any force or effect  
7 after the date of the enactment of this Act.

8       (c) TRANSITION FROM ONCHIT UNDER EXECUTIVE  
9 ORDER.—

10           (1) IN GENERAL.—All functions, personnel, as-  
11 sets, liabilities, administrative actions, and statutory  
12 reporting requirements applicable to the old Na-  
13 tional Coordinator or the Office of the old National  
14 Coordinator on the date before the date of the enact-  
15 ment of this Act shall be transferred, and applied in  
16 the same manner and under the same terms and  
17 conditions, to the new National Coordinator and the  
18 Office of the new National Coordinator as of the  
19 date of the enactment of this Act.

20           (2) ACTING NATIONAL COORDINATOR.—Before  
21 the appointment of the new National Coordinator,  
22 the old National Coordinator shall act as the Na-  
23 tional Coordinator for Health Information Tech-  
24 nology until the office is filled as provided in section  
25 271(a) of the Public Health Service Act, as added

1 by subsection (a). The President may appoint the  
2 old National Coordinator as the new National Coor-  
3 dinator.

4 (3) DEFINITIONS.—For purposes of this sub-  
5 section:

6 (A) NEW NATIONAL COORDINATOR.—The  
7 term “new National Coordinator” means the  
8 National Coordinator for Health Information  
9 Technology appointed under section 271(a) of  
10 the Public Health Service Act, as added by sub-  
11 section (a).

12 (B) OLD NATIONAL COORDINATOR.—The  
13 term “old National Coordinator” means the  
14 National Coordinator for Health Information  
15 Technology appointed under Executive Order  
16 13335.

17 **SEC. 3. SAFE HARBORS FOR PROVISION OF HEALTH INFOR-**  
18 **MATION TECHNOLOGY AND TRAINING SERV-**  
19 **ICES TO HEALTH CARE PROFESSIONALS.**

20 (a) FOR CIVIL PENALTIES.—Section 1128A(b) of the  
21 Social Security Act (42 U.S.C. 1320a–7a(b)) is amended  
22 by adding at the end the following new paragraph:

23 “(4)(A) For purposes of this subsection, a payment  
24 described in paragraph (1) does not include any nonmone-  
25 tary remuneration (in the form of health information tech-

1 nology and related training services) made by an entity  
2 to a physician if—

3 “(i) such remuneration is made without a con-  
4 dition that—

5 “(I) limits or restricts the use of the health  
6 information technology to services provided by  
7 the physician to individuals receiving services at  
8 the entity;

9 “(II) limits or restricts the use of the  
10 health information technology in conjunction  
11 with other health information technology; or

12 “(III) takes into account the volume or  
13 value of referrals (or other business generated)  
14 by the physician to the entity;

15 “(ii) in the case of such remuneration made on  
16 a date that is on or after the date described in sec-  
17 tion 3(d)(2) of the Health Information Technology  
18 Promotion Act of 2005, to the extent the National  
19 Coordinator of Health Information Technology has  
20 approved a standard under section 271(c)(3)(B)(i)  
21 of the Public Health Service Act, the health infor-  
22 mation technology provided conforms to such stand-  
23 ard;

24 “(iii) in the case of such remuneration made on  
25 or after the date that is three years after the date

1 described in section 3(d)(2) of the Health Informa-  
2 tion Technology Promotion Act of 2005, if the Sec-  
3 retary establishes criteria under section 3(e)(3) of  
4 such Act, such remuneration is made in accordance  
5 with such criteria; and

6 “(iv) such remuneration is arranged for in a  
7 written agreement that is signed by a representative  
8 of the entity and by the physician and that specifies  
9 the remuneration made.

10 “(B) For purposes of subparagraph (A) and sections  
11 1128B(b)(3)(J) and 1877(e)(9), the term ‘health informa-  
12 tion technology’ means hardware, software, license, right,  
13 intellectual property, equipment, or other information  
14 technology used primarily for the electronic creation,  
15 maintenance, and exchange of clinical health information  
16 to improve health care quality or efficiency.”.

17 (b) FOR CRIMINAL PENALTIES.—Section  
18 1128B(b)(3) of such Act (42 U.S.C. 1320a–7b(b)(3)) is  
19 amended—

20 (1) in subparagraph (G), by striking “and” at  
21 the end;

22 (2) in the subparagraph (H) added by section  
23 237(d) of the Medicare Prescription Drug, Improve-  
24 ment, and Modernization Act of 2003 (Public Law  
25 108–173; 117 Stat. 2213)—

1 (A) by moving such subparagraph 2 ems to  
2 the left; and

3 (B) by striking the period at the end and  
4 inserting a semicolon;

5 (3) in the subparagraph (H) added by section  
6 431(a) of such Act (117 Stat. 2287)—

7 (A) by redesignating such subparagraph as  
8 subparagraph (I);

9 (B) by moving such subparagraph 2 ems  
10 to the left; and

11 (C) by striking the period at the end and  
12 inserting “; and”; and

13 (4) by adding at the end the following new sub-  
14 paragraph:

15 “(J) any nonmonetary remuneration (in the  
16 form of health information technology, as defined in  
17 section 1128A(b)(4)(B), and related training serv-  
18 ices) made to a person if—

19 “(i) such remuneration is solicited or re-  
20 ceived (or offered or paid) without a condition  
21 that—

22 “(I) limits or restricts the use of the  
23 health information technology to services  
24 provided by the person to individuals re-

1           ceiving services at the location of the entity  
2           providing such technology;

3           “(II) limits or restricts the use of the  
4           health information technology in conjunc-  
5           tion with other health information tech-  
6           nology; or

7           “(III) takes into account the volume  
8           or value of referrals (or other business  
9           generated) by the person to the entity pro-  
10          viding such technology;

11          “(ii) in the case of such remuneration  
12          made on a date that is on or after the date de-  
13          scribed in section 3(d)(2) of the Health Infor-  
14          mation Technology Promotion Act of 2005, to  
15          the extent the National Coordinator of Health  
16          Information Technology has approved a stand-  
17          ard under section 271(c)(3)(B)(i) of the Public  
18          Health Service Act, the health information tech-  
19          nology provided conforms to such standard;

20          “(iii) in the case of such remuneration  
21          made on or after the date that is three years  
22          after the date described in section 3(d)(2) of  
23          the Health Information Technology Promotion  
24          Act of 2005, if the Secretary establishes criteria  
25          under section 3(e)(3) of such Act, such remu-

1           neration is made in accordance with such cri-  
2           teria; and

3                   “(iv) such remuneration is arranged for in  
4           a written agreement that is signed by the par-  
5           ties involved and that specifies the remunera-  
6           tion solicited or received (or offered or paid).”.

7           (c) FOR LIMITATION ON CERTAIN PHYSICIAN RE-  
8   FERRALS.—Section 1877(e) of such Act (42 U.S.C.  
9   1395nn(e)) is amended by adding at the end the following  
10   new paragraph:

11                   “(9) INFORMATION TECHNOLOGY AND TRAIN-  
12           ING SERVICES.—Any nonmonetary remuneration (in  
13           the form of health information technology, as de-  
14           fined in section 1128A(b)(4)(B), and related train-  
15           ing services) made by an entity to a physician if—

16                           “(A) such remuneration is made without a  
17           condition that—

18                                   “(i) limits or restricts the use of the  
19           health information technology to services  
20           provided by the physician to individuals re-  
21           ceiving services at the location of the entity  
22           providing such technology;

23                                   “(ii) limits or restricts the use of the  
24           health information technology in conjunc-

1           tion with other health information tech-  
2           nology; or

3           “(iii) takes into account the volume or  
4           value of referrals (or other business gen-  
5           erated) by the physician to the entity pro-  
6           viding such technology;

7           “(B) in the case of such remuneration  
8           made on a date that is on or after the date de-  
9           scribed in section 3(d)(2) of the Health Infor-  
10          mation Technology Promotion Act of 2005, to  
11          the extent the National Coordinator of Health  
12          Information Technology has approved a stand-  
13          ard under section 271(c)(3)(B)(i) of the Public  
14          Health Service Act, the health information tech-  
15          nology provided conforms to such standard;

16          “(C) in the case of such remuneration  
17          made on or after the date that is three years  
18          after the date described in section 3(d)(2) of  
19          the Health Information Technology Promotion  
20          Act of 2005, if the Secretary establishes criteria  
21          under section 3(e)(3) of such Act, such remu-  
22          neration is made in accordance with such cri-  
23          teria; and

24          “(D) such remuneration is arranged for in  
25          a written agreement that is signed by a rep-

1           representative of the entity and by the physician  
2           and that specifies the remuneration made.”.

3           (d) REGULATION, EFFECTIVE DATE, AND EFFECT  
4 ON STATE LAWS.—

5           (1) REGULATIONS.—Not later than 180 days  
6           after the date of the enactment of this Act, the Sec-  
7           retary of Health and Human Services shall promul-  
8           gate such regulations as may be necessary to carry  
9           out the provisions of this section.

10           (2) EFFECTIVE DATE.—The amendments made  
11           by this section shall take effect on the date that is  
12           180 days after the date of the enactment of this Act.

13           (3) PREEMPTION OF STATE LAWS.—No State  
14           (as defined in section 4(a)(3)) shall have in effect a  
15           State law that imposes a criminal or civil penalty for  
16           a transaction described in section 1128A(b)(4);  
17           1128B(b)(3)(J); or 1877(e)(9) of the Social Security  
18           Act, as added by this section, if the conditions de-  
19           scribed in the respective section, with respect to such  
20           transaction, are met.

21           (e) STUDY AND REPORT TO ASSESS EFFECT OF  
22 SAFE HARBORS ON HEALTH SYSTEM.—

23           (1) IN GENERAL.—The Secretary of Health and  
24           Human Services shall conduct a study to determine  
25           the impact of each of the safe harbors described in

1 paragraph (4). In particular, the study shall examine  
2 the following:

3 (A) The effectiveness of each safe harbor  
4 in increasing the adoption of health information  
5 technology.

6 (B) The types of health information tech-  
7 nology provided under each safe harbor.

8 (C) The extent to which the financial or  
9 other business relationships between providers  
10 under each safe harbor have changed as a re-  
11 sult of the safe harbor in a way that adversely  
12 affects the health care system or choices avail-  
13 able to consumers.

14 (2) REPORT.—Not later than three years after  
15 the effective date described in subsection (d)(2), the  
16 Secretary of Health and Human Services shall sub-  
17 mit to Congress a report on the study under para-  
18 graph (1) and shall include such recommendations  
19 for changes in the safe harbors as the Secretary de-  
20 termines may be appropriate.

21 (3) UPDATED CRITERIA FOR PERMISSIBLE  
22 HEALTH INFORMATION TECHNOLOGY REMUNERA-  
23 TION UNDER SAFE HARBORS.—Not later than three  
24 years after the effective date described in subsection  
25 (d)(2), the Secretary of Health and Human Services

1 may issue regulations that establish updated criteria  
2 for nonmonetary remuneration (in the form of  
3 health information technology and related training  
4 services) for purposes of the safe harbors described  
5 in paragraph (4). Such criteria may be based on the  
6 extent to which the health information technology  
7 conforms to a standard developed under section  
8 271(c)(3)(B)(i) of the Public Health Service Act, as  
9 added by section 2, only to the extent that such  
10 standard is recognized by the National Coordinator  
11 of Health Information Technology under such sec-  
12 tion 271(c)(3)(B)(i).

13 (4) SAFE HARBORS DESCRIBED.—For purposes  
14 of paragraphs (1) and (3), the safe harbors de-  
15 scribed in this paragraph are—

16 (A) the safe harbor under section  
17 1128A(b)(4) of the Social Security Act (42  
18 U.S.C. 1320a–7a(b)(4)), as added by subsection  
19 (a);

20 (B) the safe harbor under section  
21 1128B(b)(3)(J) of such Act (42 U.S.C. 1320a–  
22 7b(b)(3)(J)), as added by subsection (b); and

23 (C) the safe harbor under section  
24 1877(e)(9) of such Act (42 U.S.C.  
25 1395nn(e)(9)), as added by subsection (c).

1 **SEC. 4. UNIFORM HEALTH INFORMATION LAWS AND REGU-**  
2 **LATIONS.**

3 (a) STUDY TO DETERMINE EXTENT OF VARIATION  
4 IN STATE HEALTH INFORMATION LAWS AND REGULA-  
5 TIONS.—

6 (1) IN GENERAL.—The Secretary of Health and  
7 Human Services shall conduct a study of State secu-  
8 rity and confidentiality laws and current Federal se-  
9 curity and confidentiality standards to determine—

10 (A) the degree to which such State laws  
11 vary among States, and between the States and  
12 such current Federal standards;

13 (B) how any such variation may adversely  
14 impact the security and confidentiality of indi-  
15 vidualy identifiable health information and the  
16 electronic exchange of clinical health informa-  
17 tion among States, the Federal government,  
18 and private entities; and

19 (C) the strengths and weaknesses of such  
20 State laws and of such current Federal stand-  
21 ards for purposes of protecting the security and  
22 confidentiality of individually identifiable health  
23 information while also taking into account the  
24 need for timely and efficient exchanges of  
25 health information to improve quality of care  
26 and ensure the availability of health informa-

1           tion necessary to make medical decisions at the  
2           the location in which the medical care involved  
3           is provided.

4           (2) REPORT.—Not later than 18 months after  
5           the date of the enactment of this Act, the Secretary  
6           of Health and Human Services shall submit to Con-  
7           gress a report on the study under paragraph (1) and  
8           shall include in such report—

9                   (A) a determination by the Secretary  
10                  whether State security and confidentiality laws  
11                  and current Federal security and confidentiality  
12                  standards should be conformed to create a sin-  
13                  gle set of national standards to preserve and  
14                  protect the security and confidentiality of pa-  
15                  tient health information in order to improve  
16                  health care quality and efficiency; and

17                  (B) if the Secretary determines such State  
18                  laws and such current Federal standards should  
19                  be conformed to create such a single set of na-  
20                  tional standards, what the single set of stand-  
21                  ards should be.

22           (3) DEFINITIONS.—For purposes of this sub-  
23           section:

24                   (A) STATE SECURITY AND CONFIDEN-  
25                  TIALITY LAWS.—The term “State security and

1 confidentiality laws” means State laws and reg-  
2 ulations relating to the privacy and confiden-  
3 tiality of individually identifiable health infor-  
4 mation or to the security of such information.

5 (B) CURRENT FEDERAL SECURITY AND  
6 CONFIDENTIALITY STANDARDS.—The term  
7 “current Federal security and confidentiality  
8 standards” means the Federal privacy stand-  
9 ards established pursuant to section 264(c) of  
10 the Health Insurance Portability and Account-  
11 ability Act of 1996 (42 U.S.C. 1320d–2 note)  
12 and security standards established under sec-  
13 tion 1173(d) of the Social Security Act.

14 (C) STATE.—The term “State” has the  
15 meaning given such term when used in title XI  
16 of the Social Security Act, as provided under  
17 section 1101(a) of such Act (42 U.S.C.  
18 1301(a)).

19 (b) ESTABLISHMENT OF UNIFORM CONFIDEN-  
20 TIALITY AND SECURITY STANDARDS.—

21 (1) IN GENERAL.—Section 1178(a) of the So-  
22 cial Security Act (42 U.S.C. 1320d–7(a)), is amend-  
23 ed—

1 (A) in paragraph (1), by inserting after  
2 “Except as provided in paragraph (2)” the fol-  
3 lowing: “and subject to paragraph (3)”;

4 (B) in paragraph (2), by striking “A provi-  
5 sion” and inserting “Subject to paragraph  
6 (3)(B), a provision”; and

7 (C) by adding at the end the following new  
8 paragraph:

9 “(3) UNIFORM NATIONAL STANDARDS.—

10 “(A) IN GENERAL.—

11 “(i) CREATING UNIFORM NATIONAL  
12 STANDARDS.—If the conditions under  
13 clause (ii) are met, then the regulation and  
14 standards described in subparagraph (C)  
15 shall become the single set of national  
16 standards to preserve and protect the secu-  
17 rity and confidentiality of individually iden-  
18 tifiable patient health information in order  
19 to improve health care quality and effi-  
20 ciency and supersede the current Federal  
21 security and confidentiality standards and  
22 State security and confidentiality laws, as  
23 defined in section 4(a)(3) of the Health In-  
24 formation Technology Promotion Act of  
25 2005.

1           “(ii) CONDITIONS.—For purposes of  
2 clause (i), the conditions under this clause  
3 are the following:

4           “(I) DETERMINATION OF NEED  
5 FOR SINGLE SET OF STANDARDS.—

6           The Secretary determines under sec-  
7 tion 4(a)(2)(A) of the Health Infor-  
8 mation Technology Promotion Act of  
9 2005 that State security and con-  
10 fidentiality laws and current Federal  
11 security and confidentiality standards  
12 should be conformed to create a single  
13 set of national standards to preserve  
14 and protect the security and confiden-  
15 tiality of individually identifiable pa-  
16 tient health information in order to  
17 improve health care quality and effi-  
18 ciency.

19           “(II) SECRETARY SPECIFIES  
20 STANDARDS.—The Secretary specifies  
21 that the regulation and standards de-  
22 scribed in subparagraph (C) should be  
23 the single set of national standards.

24           “(III) NO LEGISLATION ESTAB-  
25 LISHING STANDARDS.—Legislation

1 creating a single set of national stand-  
2 ards and preempting State security  
3 and confidentiality laws is not enacted  
4 by the date that is 36 months after  
5 the date of the enactment of the  
6 Health Information Technology Pro-  
7 motion Act of 2005.

8 “(B) NARROWING OF PREEMPTION EXCEP-  
9 TIONS.—

10 “(i) SUBSEQUENT LEGISLATION.—If  
11 legislation described in subparagraph (A)  
12 is enacted by the date described in such  
13 subparagraph, as of the date of enactment  
14 of such legislation paragraph (2) shall be  
15 superseded by such exceptions as may be  
16 provided for in such legislation. It is the  
17 intent of Congress that such exceptions be  
18 as narrow as possible to maximize the uni-  
19 form application of the regulation and  
20 standards described in subparagraph (C).

21 “(ii) NO LEGISLATION.—If legislation  
22 described in subparagraph (A) is not en-  
23 acted by the date described in such sub-  
24 paragraph, paragraph (2) shall be super-  
25 seded by such exceptions as may be pro-

1           vided for by the Secretary by regulation  
2           issued in connection with the regulation  
3           and standards described in subparagraph  
4           (C). It is the intent of Congress that such  
5           exceptions be as narrow as possible to  
6           maximize the uniform application of the  
7           regulation and standards described in sub-  
8           paragraph (C).

9           “(C) APPLICATION OF UNIFORM STAND-  
10          ARDS.—The regulation and standards described  
11          in this subparagraph are the regulation promul-  
12          gated under section 264(c)(1) of the Health In-  
13          surance Portability and Accountability Act of  
14          1996 (42 U.S.C. 1320d–2 note) and standards  
15          under section 1173(d), as modified by the Sec-  
16          retary to the extent the Secretary determines,  
17          after consideration of the results of the study  
18          conducted under section 4(a) of the Health In-  
19          formation Technology Promotion Act of 2005,  
20          necessary to promote uniformity and efficiency  
21          in the application of confidentiality and security  
22          standards with respect to individually identifi-  
23          able health information.”.

24          (2) HIPAA CONFORMING AMENDMENT.—Sec-  
25          tion 264(c)(2) of the Health Insurance Portability

1 and Accountability Act of 1996 (42 U.S.C. 1320d–  
2 2 note) is amended by striking “A regulation” and  
3 inserting “(A) Subject to section 1178(a)(3) of the  
4 Social Security Act, a regulation”.

5 **SEC. 5. RULEMAKING TO UPGRADE ASC X12 AND NCPDP**  
6 **STANDARDS AND ICD CODES.**

7 (a) IN GENERAL.—Not later than April 1, 2007, the  
8 Secretary of Health and Human Services shall promulgate  
9 a final rule under section 1174(b) of the Social Security  
10 Act (42 U.S.C. 1320d–3(b)) to provide for the following  
11 modification of standards:

12 (1) ACCREDITED STANDARDS COMMITTEE X12  
13 (ASC X12) STANDARD.—The replacement of the Ac-  
14 credited Standards Committee X12 (ASC X12)  
15 version 4010 adopted under section 1173(a) of such  
16 Act (42 U.S.C. 1320d–2(a)), including for purposes  
17 of part A of title XVIII of such Act, with the ASC  
18 X12 version 5010, as reviewed by the National Com-  
19 mittee on Vital Health Statistics.

20 (2) NATIONAL COUNCIL FOR PRESCRIPTION  
21 DRUG PROGRAMS (NCPDP) TELECOMMUNICATIONS  
22 STANDARDS.—The replacement of the National  
23 Council for Prescription Drug Programs (NCPDP)  
24 Telecommunications Standards version 5.1 adopted  
25 under section 1173(a) of such Act (42 U.S.C.

1 1320d–2(a)), including for purposes of part A of  
2 title XVIII of such Act, with NCPDP Telecommuni-  
3 cations Standards version C.3, as approved by such  
4 Council and reviewed by the National Committee on  
5 Vital Health Statistics.

6 (3) ICD CODES.—The replacement of the Inter-  
7 national Statistical Classification of Diseases and  
8 Related Health Problems, 9th revision, Clinical  
9 Modification (ICD–9–CM) under the regulation pro-  
10 mulgated under section 1173(c) of such Act (42  
11 U.S.C. 1320d–2(e)), including for purposes of part  
12 A of title XVIII of such Act, with both of the fol-  
13 lowing:

14 (A) The International Statistical Classi-  
15 fication of Diseases and Related Health Prob-  
16 lems, 10th revision, Clinical Modification (ICD–  
17 10–CM).

18 (B) The International Statistical Classi-  
19 fication of Diseases and Related Health Prob-  
20 lems, 10th revision, Procedure Coding System  
21 (ICD–10–PCS).

22 (b) RULE OF CONSTRUCTION.—Nothing in sub-  
23 section (a)(3) shall be construed as affecting the applica-  
24 tion of classification methodologies or codes, such as CPT  
25 or HCPCS codes, other than under the International Sta-

1 tistical Classification of Diseases and Related Health  
2 Problems (ICD).

3 (c) NOTICE.—Not later than 30 days after the date  
4 of the enactment of this Act, the Secretary of Health and  
5 Human Services shall publish in the Federal Register a  
6 notice of the requirements to promulgate final rules under  
7 subsection (a). Such notice shall include—

8 (1) the respective date by which each such rule  
9 must be promulgated under such subsection;

10 (2) the respective compliance date described in  
11 subsection (e) for each such rule; and

12 (3) a statement that entities covered under the  
13 Health Insurance Portability and Accountability Act  
14 of 1996 and health information technology vendors  
15 should plan for the implementation of upgraded ASC  
16 X12, NCPDP, and ICD codes under such sub-  
17 section.

18 (d) NO JUDICIAL REVIEW.—The final rules promul-  
19 gated under subsections (a) shall not be subject to judicial  
20 review.

21 (e) COMPLIANCE WITH UPGRADED STANDARDS.—  
22 For purposes of section 1175(b)(2) of the Social Security  
23 Act (42 U.S.C. 1320d–4(b)(2))—

24 (1) ASC X12 AND NCPDP STANDARDS.—The  
25 final rules promulgated under paragraphs (1) and

1 (2) of subsection (a) shall apply to transactions oc-  
2 ccurring on or after April 1, 2009.

3 (2) ICD CODES.—The final rule promulgated  
4 under paragraph (3) of subsection (a) shall apply to  
5 transactions occurring on or after October 1, 2009.

6 **SEC. 6. REPORT ON THE AMERICAN HEALTH INFORMATION**  
7 **COMMUNITY.**

8 Not later than two years after the date of the enact-  
9 ment of this Act, the Secretary of Health and Human  
10 Services shall submit to Congress a report on the work  
11 conducted by the American Health Information Commu-  
12 nity (in this section referred to as “AHIC”), as established  
13 by the Secretary. Such report shall include the following:

14 (1) A description of the accomplishments of  
15 AHIC, with respect to the promotion of the develop-  
16 ment of a nationwide health information network  
17 and the increased adoption of health information  
18 technology.

19 (2) Information identifying the practices that  
20 are used to protect health information and to guar-  
21 antee confidentiality and security of such informa-  
22 tion.

23 (3) Information on the progress in—

24 (A) establishing uniform industry-wide  
25 health information technology standards;

1 (B) achieving an internet-based nationwide  
2 health information network; and

3 (C) achieving interoperable electronic  
4 health record adoption across health care pro-  
5 viders.

6 (4) Recommendations for the transition of the  
7 AHIC to a permanent advisory entity, including—

8 (A) a schedule for such transition;

9 (B) options for structuring the entity as ei-  
10 ther a public-private or private sector entity;

11 (C) the role of the Federal Government in  
12 the entity; and

13 (D) the ongoing responsibilities of the enti-  
14 ty, such as in establishing standards, certifying  
15 health information technology, and providing  
16 long-term governance for health care trans-  
17 formation.

18 **SEC. 7. STRATEGIC PLAN FOR COORDINATING IMPLEMEN-**  
19 **TATION OF HEALTH INFORMATION TECH-**  
20 **NOLOGY.**

21 (a) IN GENERAL.—Not later than 180 days after the  
22 date of the enactment of this Act, the Secretary of Health  
23 and Human Services, in consultation with entities involved  
24 in the area of health information technology, shall develop

1 a strategic plan related to the need for coordination in  
2 such area.

3 (b) COORDINATION OF SPECIFIC IMPLEMENTATION  
4 PROCESSES.—The strategic plan under subsection (a)  
5 shall address the need for coordination in the implementa-  
6 tion of the following:

7 (1) HEALTH INFORMATION TECHNOLOGY  
8 STANDARDS.—Health information technology stand-  
9 ards approved under section 271(c)(3)(B)(i) of the  
10 Public Health Service Act, as added by section 2.

11 (2) HIPAA TRANSACTION STANDARDS.—Trans-  
12 action standards under section 1173(a) of the Social  
13 Security Act (42 U.S.C. 1320d–2(d)).

14 (3) UPDATED ICD CODES.—The International  
15 Statistical Classification of Diseases and Related  
16 Health Problems, 10th revision, Clinical Modifica-  
17 tion (ICD–10–CM) and the International Statistical  
18 Classification of Diseases and Related Health Prob-  
19 lems, 10th revision, Procedure Coding System  
20 (ICD–10–PCS) described in section 5.

21 (c) COORDINATION AMONG SPECIFIC FEDERAL EN-  
22 TITIES.—The strategic plan under subsection (a) shall ad-  
23 dress any methods to coordinate, with respect to the elec-  
24 tronic exchange of health information, actions taken by  
25 the following entities:

1           (1) The Office of the National Coordinator for  
2 Health Information Technology.

3           (2) The American Health Information Commu-  
4 nity.

5           (3) The Office of Electronic Standards and Se-  
6 curity of the Centers for Medicare and Medicaid  
7 Services.

8           (4) The National Committee on Vital Health  
9 Statistics.

10          (5) Any other entity involved in the electronic  
11 exchange of health information that the Secretary  
12 determines appropriate.

○