I

103D CONGRESS
1ST SESSION

H. R. 2261

To contain the rate of growth in health care costs and enhance the quality of health care by improving and making more efficient the provision of medical and health insurance information, and for other purposes.

IN THE HOUSE OF REPRESENTATIVES

MAY 25, 1993

Mr. THOMAS of California (for himself, Mrs. JOHNSON of Connecticut, Mr. GRANDY, and Mr. MCCRERY) introduced the following bill; which was referred jointly to the Committees on Energy and Commerce, Ways and Means, Education and Labor, and Veterans' Affairs

---

A BILL

To contain the rate of growth in health care costs and enhance the quality of health care by improving and making more efficient the provision of medical and health insurance information, and for other purposes.

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

SECTION 1. TABLE OF CONTENTS.

The table of contents of this Act is as follows:

Sec. 1. Table of contents.
Sec. 2. Definitions.

TITLE I—STANDARDIZATION OF CLAIMS PROCESSING

Sec. 101. Adoption of data elements, uniform claims, and uniform electronic transmission standards.
Sec. 102. Application of standards.

Sec. 103. Periodic review and revision of standards.

TITLE II—ELECTRONIC MEDICAL DATA STANDARDS

Sec. 201. Medical data standards for hospitals and other providers.
Sec. 202. Application of electronic data standards to certain hospitals.
Sec. 203. Electronic transmission to Federal agencies.
Sec. 204. Limitation on data requirements where standards in effect.
Sec. 205. Advisory commission.

TITLE III—DEVELOPMENT AND DISTRIBUTION OF COMPARATIVE VALUE INFORMATION

Sec. 301. State comparative value information programs for health care purchasing.
Sec. 302. Federal implementation.
Sec. 303. Comparative value information concerning Federal programs.
Sec. 304. Development of model systems.

TITLE IV—ADDITIONAL STANDARDS AND REQUIREMENTS; RESEARCH AND DEMONSTRATIONS

Sec. 401. Standards relating to use of medicare and medicaid magnetized health benefit cards; secondary payor data bank.
Sec. 402. Preemption of State quill pen laws.
Sec. 403. Use of standard identification numbers.
Sec. 404. Coordination of benefit standards.
Sec. 405. Research and demonstrations.

SEC. 2. DEFINITIONS.

For purposes of this Act:

(1) HEALTH BENEFIT PLAN.—The term ''health benefit plan'' means any hospital or medical expense incurred policy or certificate, hospital or medical service plan contract, or health maintenance subscriber contract, or a multiple employer welfare arrangement or employee benefit plan (as defined under the Employee Retirement Income Security Act of 1974) which provides benefits with respect to health care services. The term includes the medicare program (under title XVIII of the Social Security Act), medicare supplemental health insurance, and a

State medicaid plan (approved under title XIX of such Act). The term does not include—

(A) coverage only for accident, dental, vision, disability income, or long-term care insurance, or any combination thereof,

(B) coverage issued as a supplement to liability insurance,

(C) worker's compensation or similar insurance, or

(D) automobile medical-payment insurance,

or any combination thereof.

(2) SECRETARY.—The term ''Secretary'' means the Secretary of Health and Human Services.

(3) STATE.—The term ''State'' means any of the several States, the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, Guam, and American Samoa.

TITLE I—STANDARDIZATION OF CLAIMS PROCESSING

SEC. 101. ADOPTION OF DATA ELEMENTS, UNIFORM CLAIMS, AND UNIFORM ELECTRONIC TRANSMISSION STANDARDS.

(a) IN GENERAL.—The Secretary of Health and Human Services shall adopt standards relating to each of the following:

(1) Data elements for use in paper and electronic claims processing under health benefit plans, as well as for use in utilization review and management of care (including data fields, formats, and medical nomenclature, and including plan benefit and insurance information).

(2) Uniform claims forms (including uniform procedure and billing codes for uses with such forms and including information on other health benefit plans that may be liable for benefits).

(3) Uniform electronic transmission of the data elements (for purposes of billing and utilization review).

Standards under paragraph (3) relating to electronic transmission of data elements for claims for services shall supersede (to the extent specified in such standards) the standards adopted under paragraph (2) relating to the

submission of paper claims for such services. Standards under paragraph (3) shall include protections to assure the confidentiality of patient-specific information and to protect against the unauthorized use and disclosure of information.

(b) USE OF TASK FORCES.—In adopting standards under this section—

(1) the Secretary shall take into account the recommendations of current task forces, including at least the Workgroup on Electronic Data Interchange, National Uniform Billing Committee, the Uniform Claim Task Force, and the Computer-based Patient Record Institute;

(2) the Secretary shall consult with the National Association of Insurance Commissioners (and, with respect to standards under subsection (a)(3), the American National Standards Institute); and

(3) the Secretary shall, to the maximum extent practicable, seek to make the standards consistent with any uniform clinical data sets which have been adopted and are widely recognized.

(c) DEADLINES FOR PROMULGATION.—The Secretary shall promulgate the standards under—

(1) subsection (a)(1) relating to claims processing data, by not later than 12 months after the date of the enactment of this Act;

(2) subsection (a)(2) (relating to uniform claims forms) by not later than 12 months after the date of the enactment of this Act; and

(3)(A) subsection (a)(3) relating to transmission of information concerning hospital and physicians services, by not later than 24 months after the date of the enactment of this Act, and

(B) subsection (a)(3) relating to transmission of information on other services, by such later date as the Secretary may determine it to be feasible.

(d) REPORT TO CONGRESS.—Not later than 3 years after the date of the enactment of this Act, the Secretary shall report to Congress recommendations regarding restructuring the medicare peer review quality assurance program given the availability of hospital data in electronic form.

SEC. 102. APPLICATION OF STANDARDS.

(a) IN GENERAL.—If the Secretary determines, at the end of the 2-year period beginning on the date that standards are adopted under section 101 with respect to classes of services, that a significant number of claims for benefits for such services under health benefit plans are

not being submitted in accordance with such standards, the Secretary may require, after notice in the Federal Register of not less than 6 months, that all providers of such services must submit claims to health benefit plans in accordance with such standards. The Secretary may waive the application of such a requirement in such cases as the Secretary finds that the imposition of the requirement would not be economically practicable.

(b) SIGNIFICANT NUMBER.—The Secretary shall make an affirmative determination described in subsection (a) for a class of services only if the Secretary finds that there would be a significant, measurable additional gain in efficiencies in the health care system that would be obtained by imposing the requirement described in such paragraph with respect to such services.

(c) APPLICATION OF REQUIREMENT.—

(1) IN GENERAL.—If the Secretary imposes the requirement under subsection (a)—

(A) in the case of a requirement that imposes the standards relating to electronic transmission of claims for a class of services, each health care provider that furnishes such services for which benefits are payable under a health benefit plan shall transmit electronically and directly to the plan on behalf of the beneficiary

involved a claim for such services in accordance with such standards;

(B) any health benefit plan may reject any claim subject to the standards adopted under section 101 but which is not submitted in accordance with such standards;

(C) it is unlawful for a health benefit plan (i) to reject any such claim on the basis of the form in which it is submitted if it is submitted in accordance with such standards or (ii) to require, for the purpose of utilization review or as a condition of providing benefits under the plan, a provider to transmit medical data elements that are inconsistent with the standards established under section 101(a)(1); and

(D) the Secretary may impose a civil money penalty on any provider that knowingly and repeatedly submits claims in violation of such standards or on any health benefit plan (other than a health benefit plan described in paragraph (2)) that knowingly and repeatedly rejects claims in violation of subparagraph (B), in an amount not to exceed $100 for each such claim.

The provisions of section 1128A of the Social Security Act (other than the first sentence of subsection (a) and other than subsection (b)) shall apply to a civil money penalty under subparagraph (D) in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a) of such Act.

(2) PLANS SUBJECT TO EFFECTIVE STATE REGULATION.—A plan described in this paragraph is a health benefit plan—

(A) that is subject to regulation by a State, and

(B) with respect to which the Secretary finds that—

(i) the State provides for application of the standards established under section 101, and

(ii) the State regulatory program provides for the appropriate and effective enforcement of such standards.

(d) TREATMENT OF REJECTIONS.—If a plan rejects a claim pursuant to subsection (c)(1), the plan shall permit the person submitting the claim a reasonable opportunity to resubmit the claim on a form or in an electronic manner that meets the requirements for acceptance of the claim under such subsection.

SEC. 103. PERIODIC REVIEW AND REVISION OF STANDARDS.

(a) IN GENERAL.—The Secretary shall—

(1) provide for the ongoing receipt and review of comments and suggestions for changes in the standards adopted and promulgated under section 101;

(2) establish a schedule for the periodic review of such standards; and

(3) based upon such comments, suggestions, and review, revise such standards and promulgate such revisions.

(b) APPLICATION OF REVISED STANDARDS.—If the Secretary under subsection (a) revises the standards described in 101, then, in the case of any claim for benefits submitted under a health benefit plan more than the minimum period (of not less than 6 months specified by the Secretary) after the date the revision is promulgated under subsection (a)(3), such standards shall apply under section 102 instead of the standards previously promulgated.

TITLE II—ELECTRONIC MEDICAL DATA STANDARDS

SEC. 201. MEDICAL DATA STANDARDS FOR HOSPITALS AND OTHER PROVIDERS.

(a) PROMULGATION OF HOSPITAL DATA STANDARDS.—

(1) IN GENERAL.—Between July 1, 1994, and January 1, 1995, the Secretary shall promulgate standards described in subsection (b) for hospitals concerning electronic medical data.

(2) REVISION.—The Secretary may from time to time revise the standards promulgated under this subsection.

(b) CONTENTS OF DATA STANDARDS.—The standards promulgated under subsection (a) shall include at least the following:

(1) A definition of a standard set of data elements for use by utilization and quality control peer review organizations.

(2) A definition of the set of comprehensive data elements, which set shall include for hospitals the standard set of data elements defined under paragraph (1).

(3) Standards for an electronic patient care information system with data obtained at the point of

care, including standards to protect against the unauthorized use and disclosure of information.

(4) A specification of, and manner of presentation of, the individual data elements of the sets and system under this subsection.

(5) Standards concerning the transmission of electronic medical data.

(6) Standards relating to confidentiality of patient-specific information.

The standards under this section shall be consistent with standards for data elements established under section 101.

(c) OPTIONAL DATA STANDARDS FOR OTHER PROVIDERS.—

(1) IN GENERAL.—The Secretary may promulgate standards described in paragraph (2) concerning electronic medical data for providers that are not hospitals. The Secretary may from time to time revise the standards promulgated under this subsection.

(2) CONTENTS OF DATA STANDARDS.—The standards promulgated under paragraph (1) for non-hospital providers may include standards comparable to the standards described in paragraphs (2), (4), and (5) of subsection (b) for hospitals.

(d) CONSULTATION.—In promulgating and revising standards under this section, the Secretary shall—

(1) consult with the American National Standards Institute, hospitals, with the advisory commission established under section 205, and with other affected providers, health benefit plans, and other interested parties, and

(2) take into consideration, in developing standards under subsection (b)(1), the data set used by the utilization and quality control peer review program under part B of title XI of the Social Security Act.

SEC. 202. APPLICATION OF ELECTRONIC DATA STANDARDS TO CERTAIN HOSPITALS.

(a) MEDICARE REQUIREMENT FOR SHARING OF HOSPITAL INFORMATION.—As of January 1, 1996, subject to paragraph (2), each hospital, as a requirement of each participation agreement under section 1866 of the Social Security Act, shall—

(1) maintain clinical data included in the set of comprehensive data elements under section 201(b)(2) in electronic form on all inpatients,

(2) upon request of the Secretary or of a utilization and quality control peer review organization (with which the Secretary has entered into a con-

tract under part B of title XI of such Act), transmit electronically the data set, and

(3) upon request of the Secretary, or of a fiscal intermediary or carrier, transmit electronically any data (with respect to a claim) from such data set, in accordance with the standards promulgated under section 201(a).

(b) WAIVER AUTHORITY.—Until January 1, 2000:

(1) The Secretary may waive the application of the requirements of subsection (a) for a hospital that is a small rural hospital, for such period as the hospital demonstrates compliance with such requirements would constitute an undue financial hardship.

(2) The Secretary may waive the application of the requirements of subsection (a) for a hospital that is in the process of developing a system to provide the required data set and executes agreements with its fiscal intermediary and its utilization and quality control peer review organization that the hospital will meet the requirements of subsection (a) by a specified date (not later than January 1, 2000).

(3) The Secretary may waive the application of the requirement of subsection (a)(1) for a hospital that agrees to obtain from its records the data elements that are needed to meet the requirements of

paragraphs (2) and (3) of subsection (a) and agrees to subject its data transfer process to a quality assurance program specified by the Secretary.

(c) APPLICATION TO HOSPITALS OF THE DEPARTMENT OF VETERANS AFFAIRS.—

(1) IN GENERAL.—The Secretary of Veterans Affairs shall provide that each hospital of the Department of Veterans Affairs shall comply with the requirements of subsection (a) in the same manner as such requirements would apply to the hospital if it were participating in the Medicare program.

(2) WAIVER.—Such Secretary may waive the application of such requirements to a hospital in the same manner as the Secretary of Health and Human Services may waive under subsection (b) the application of the requirements of subsection (a).

SEC. 203. ELECTRONIC TRANSMISSION TO FEDERAL AGENCIES.

(a) IN GENERAL.—Effective January 1, 2000, if a provider is required under a Federal program to transmit a data element that is subject to a presentation or transmission standard (as defined in subsection (b)), the head of the Federal agency responsible for such program (if not otherwise authorized) is authorized to require the provider

to present and transmit the data element electronically in accordance with such a standard.

(b) PRESENTATION OR TRANSMISSION STANDARD DEFINED.—In subsection (a), the term ''presentation or transmission standard'' means a standard, promulgated under subsection (b) or (c) of section 201, described in paragraph (4) or (5) of section 201(b).

SEC. 204. LIMITATION ON DATA REQUIREMENTS WHERE STANDARDS IN EFFECT.

(a) IN GENERAL.—If standards with respect to data elements are promulgated under section 201 with respect to a class of provider, a health benefit plan may not require, for the purpose of utilization review or as a condition of providing benefits under the plan, that a provider in the class—

(1) provide any data element not in the set of comprehensive data elements specified under such standards, or

(2) transmit or present any such data element in a manner inconsistent with the applicable standards for such transmission or presentation.

(b) COMPLIANCE.—

(1) IN GENERAL.—The Secretary may impose a civil money penalty on any health benefit plan (other than a health benefit plan described in paragraph

(2)) that fails to comply with subsection (a) in an amount not to exceed $100 for each such failure. The provisions of section 1128A of the Social Security Act (other than the first sentence of subsection (a) and other than subsection (b)) shall apply to a civil money penalty under this paragraph in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a) of such Act.

(2) PLANS SUBJECT TO EFFECTIVE STATE REGULATION.—A plan described in this paragraph is a health benefit plan that is subject to regulation by a State, if the Secretary finds that—

(A) the State provides for application of the requirement of subsection (a), and

(B) the State regulatory program provides for the appropriate and effective enforcement of such requirement with respect to such plans.

SEC. 205. ADVISORY COMMISSION.

(a) IN GENERAL.—The Secretary shall establish an advisory commission including hospital executives, hospital data base managers, physicians, health services researchers, and technical experts in collection and use of data and operation of data systems. Such commission shall include, as ex officio members, a representative of the Director of the National Institutes of Health, the Administrator

for Health Care Policy and Research, the Secretary of Veterans Affairs, and the Director of the Centers for Disease Control.

(b) FUNCTIONS.—The advisory commission shall monitor and advise the Secretary concerning—

(1) the standards established under this title, and

(2) operational concerns about the implementation of such standards under this part.

(c) STAFF.—From the amounts appropriated under subsection (d), the Secretary shall provide sufficient staff to assist the advisory commission in its activities under this section.

(d) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated $2,000,000 for each of fiscal years 1994 through 1999 to carry out this section.

TITLE III—DEVELOPMENT AND DISTRIBUTION OF COMPARATIVE VALUE INFORMATION

SEC. 301. STATE COMPARATIVE VALUE INFORMATION PROGRAMS FOR HEALTH CARE PURCHASING.

(a) PURPOSE.—In order to assure the availability of comparative value information to purchasers of health care in each State, the Secretary shall determine whether each State is developing and implementing a health care

value information program that meets the criteria and schedule set forth in subsection (b).

(b) CRITERIA AND SCHEDULE FOR STATE PROGRAMS.—The criteria and schedule for a State health care value information program in this subsection shall be specified by the Secretary as follows:

(1) The State begins promptly after enactment of this Act to develop (directly or through contractual or other arrangements with one or more States, coalitions of health insurance purchasers, other entities, or any combination of such arrangements) information systems regarding comparative health values.

(2) The information contained in such systems covers at least the average prices of common health care services (as defined in subsection (d)) and health insurance plans, and, where available, measures of the variability of these prices within a State or other market areas.

(3) The information described in paragraph (2) is made available within the State beginning not later than 1 year after the date of the enactment of this Act, and is revised as frequently as reasonably necessary, but at intervals of no greater than 1 year.

(4) Not later than 6 years after the date of the enactment of this Act the State has developed information systems that provide comparative costs, quality, and outcomes data with respect to health insurance plans and hospitals and made the information broadly available within the relevant market areas.

Nothing in this section shall preclude a State from providing additional information, such as information on prices and benefits of different health benefit plans, available.

(c) GRANTS TO STATES FOR THE DEVELOPMENT OF STATE PROGRAMS.—

(1) GRANT AUTHORITY.—The Secretary may make grants to each State to enable such State to plan the development of its health care value information program and, if necessary, to initiate the implementation of such program. Each State seeking such a grant shall submit an application therefore, containing such information as the Secretary finds necessary to assure that the State is likely to develop and implement a program in accordance with the criteria and schedule in subsection (b).

(2) OFFSET AUTHORITY.—If, at any time within the 3-year period following the receipt by a State of a grant under this subsection, the Secretary is required by section 302 to implement a health care in-

formation program in the State, the Secretary may recover the amount of the grant under this subsection by offset against any other amount payable to the State under the Social Security Act. The amount of the offset shall be made available (from the appropriation account with respect to which the offset was taken) to the Secretary to carry out such section.

(3) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated such sums as are necessary to make grants under this subsection, to remain available until expended.

(d) COMMON HEALTH CARE SERVICES DEFINED.—In this section, the term ''common health care services'' includes such procedures as the Secretary may specify and any additional health care services which a State may wish to include in its comparative value information program.

SEC. 302. FEDERAL IMPLEMENTATION.

(a) IN GENERAL.—If the Secretary finds, at any time, that a State has failed to develop or to continue to implement a health care value information program in accordance with the criteria and schedule in section 301(b), the Secretary shall take the actions necessary, directly or through grants or contract, to implement a comparable program in the State.

(b) FEES.—Fees may be charged by the Secretary for the information materials provided pursuant to a program under this section. Any amounts so collected shall be deposited in the appropriation account from which the Secretary's costs of providing such materials were met, and shall remain available for such purposes until expended.

SEC. 303. COMPARATIVE VALUE INFORMATION CONCERNING FEDERAL PROGRAMS.

(a) DEVELOPMENT.—The head of each Federal agency with responsibility for the provision of health insurance or of health care services to individuals shall promptly develop health care value information relating to each program that such head administers and covering the same types of data that a State program meeting the criteria of section 301(b) would provide.

(b) DISSEMINATION OF INFORMATION.—Such information shall be made generally available to States and to providers and consumers of health care services.

SEC. 304. DEVELOPMENT OF MODEL SYSTEMS.

(a) IN GENERAL.—The Secretary shall, directly or through grant or contract, develop model systems to facilitate—

(1) the gathering of data on health care cost, quality, and outcome described in section 301(b)(4), and

(2) analyzing such data in a manner that will permit the valid comparison of such data among providers and among health plans.

(b) EXPERIMENTATION.—The Secretary shall support experimentation with different approaches to achieve the objectives of subsection (a) in the most cost effective manner (relative to the accuracy and timeliness of the data secured) and shall evaluate the various methods to determine their relative success.

(c) STANDARDS.—When the Secretary considers it appropriate, the Secretary may establish standards for the collection and reporting of data on health care cost, quality and outcomes in order to facilitate analysis and comparisons among States and nationally.

(e) REPORT.—By not later than 3 years after the date of the enactment of this Act, the Secretary shall report to the Congress and the States on the models developed, and experiments conducted, under this section.

(e) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated such sums as are necessary for each fiscal year beginning with fiscal year 1993 to enable the Secretary to carry out this section, including

evaluation of the different approaches tested under subsection (b) and their relative cost effectiveness.

TITLE IV—ADDITIONAL STANDARDS AND REQUIREMENTS; RESEARCH AND DEMONSTRATIONS

SEC. 401. STANDARDS RELATING TO USE OF MEDICARE AND MEDICAID MAGNETIZED HEALTH BENEFIT CARDS; SECONDARY PAYOR DATA BANK.

(a) MAGNETIZED IDENTIFICATION CARDS UNDER MEDICARE PROGRAM.—The Secretary shall adopt standards relating to the design and use of magnetized medicare identification cards in order to assist health care providers providing medicare covered services to individuals—

(1) in determining whether individuals are eligible for benefits under the medicare program, and

(2) in billing the medicare program for such services provided to eligible individuals.

Such cards shall be designed to be compatible with machines currently employed to transmit information on credit cards. Such cards also shall be designed to be able to be used with respect to the provision of benefits under medicare supplemental policies.

(b) ADOPTION UNDER MEDICAID PLANS.—

(1) IN GENERAL.—The Secretary shall take such steps as may be necessary to encourage and assist States to design and use magnetized medicaid identification cards that meet such standards, for use under their medicaid plans.

(2) LIMITATION ON MMIS FUNDS.—In applying section 1903(a)(3) of the Social Security Act, the Secretary may determine that Federal financial participation is not available under that section to a State which has provided for a magnetized card system that is inconsistent with the standards adopted under subsection (a).

(c) MEDICARE AND MEDICAID SECONDARY PAYOR DATA BANK.—The Secretary shall establish a medicare and medicaid information system which is designed to provide information on those group health plans and other health benefit plans that are primary payors to the medicare program and medicaid program under section 1862(b) or section 1905(a)(25) of the Social Security Act.

(d) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated, in equal proportions from the Federal Hospital Insurance Trust Fund and from the Federal Supplementary Medical Insurance Trust Fund, a total of $25,000,000 to carry out subsections (a)

and (c), including the issuance of magnetized cards to medicare beneficiaries.

SEC. 402. PREEMPTION OF STATE QUILL PEN LAWS.

(a) IN GENERAL.—Effective January 1, 1994, no effect shall be given to any provision of State law that requires medical or health insurance records (including billing information) to be maintained in written, rather than electronic form.

(b) SECRETARIAL AUTHORITY.—The Secretary of Health and Human Services may issue regulations to carry out subsection (a). Such regulations may provide for such exceptions to subsection (a) as the Secretary determines to be necessary to prevent fraud and abuse, with respect to controlled substances, and in such other cases as the Secretary deems appropriate.

SEC. 403. USE OF STANDARD IDENTIFICATION NUMBERS.

(a) IN GENERAL.—Effective January 1, 1994, each health benefit plan shall—

(1) for each of its beneficiaries that has a social security account number, use that number as the personal identifier for claims processing and related purposes, and

(2) for each provider that has a unique identifier for purposes of title XVIII of the Social Security Act and that furnishes health care items or services

to a beneficiary under the plan, use that identifier as the identifier of that provider for claims processing and related purposes.

(b) COMPLIANCE.—

(1) IN GENERAL.—The Secretary may impose a civil money penalty on any health benefit plan (other than a health benefit plan described in paragraph (2)) that fails to comply with standards established under subsection (a) in an amount not to exceed $100 for each such failure. The provisions of section 1128A of the Social Security Act (other than the first sentence of subsection (a) and other than subsection (b)) shall apply to a civil money penalty under this paragraph in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a) of such Act.

(2) PLANS SUBJECT TO EFFECTIVE STATE REGULATION.—A plan described in this paragraph is a health benefit plan that is subject to regulation by a State, if the Secretary finds that—

(A) the State provides for application of the requirement of subsection (a), and

(B) the State regulatory program provides for the appropriate and effective enforcement of such requirement with respect to such plans.

SEC. 404. COORDINATION OF BENEFIT STANDARDS.

(a) REVIEW OF COORDINATION OF BENEFIT PROBLEMS.—Between July 1, 1994, and January 1, 1995, the Secretary shall determine whether problems relating to—

(1) the rules for determining the liability of health benefit plans when benefits are payable under 2 or more such plans, or

(2) the availability of information among such health benefit plans when benefits are so payable,

cause significant administrative costs.

(b) CONTINGENT PROMULGATION OF STANDARDS.—

(1) IN GENERAL.—If the Secretary determines that such problems do cause significant administrative costs that could be significantly reduced through the implementation of standards, the Secretary shall promulgate standards concerning—

(A) the liability of health benefit plans when benefits are payable under 2 or more such plans, and

(B) the transfer among health benefit plans of appropriate information (which may include standards for the use of unique identifiers, and for the listing of all individuals covered under a health benefit plan) in determining liability in cases when benefits are payable under 2 or more such plans.

(2) EFFECTIVE DATE.—The standards promulgated under paragraph (1) shall become effective on a date specified by the Secretary, which date shall be not earlier than 1 year after the date of promulgation of the standards.

(c) COMPLIANCE.—

(1) IN GENERAL.—The Secretary may impose a civil money penalty on any health benefit plan (other than a health benefit plan described in paragraph (2)) that fails to comply with standards promulgated under subsection (b) in an amount not to exceed $100 for each such failure. The provisions of section 1128A of the Social Security Act (other than the first sentence of subsection (a) and other than subsection (b)) shall apply to a civil money penalty under this paragraph in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a) of such Act.

(2) PLANS SUBJECT TO EFFECTIVE STATE REGULATION.—A plan described in this paragraph is a health benefit plan that is subject to regulation by a State, if the Secretary finds that—

(A) the State provides for application of the standards established under subsection (b), and

(B) the State regulatory program provides for the appropriate and effective enforcement of such standards with respect to such plans.

(d) REVISION OF STANDARDS.—If the Secretary establishes standards under subsection (b), the Secretary may revise such standards from time to time and such revised standards shall be applied under subsection (c) on or after such date (not earlier than 6 months after the date the revision is promulgated) as the Secretary shall specify.

SEC. 405. RESEARCH AND DEMONSTRATIONS.

(a) DEMONSTRATIONS AND RESEARCH ON MONITORING AND IMPROVING PATIENT CARE.—

(1) The Secretary shall provide grants to qualified entities to demonstrate (and conduct research concerning) the application of comprehensive information systems—

(A) in continuously monitoring patient care, and

(B) in improving patient care.

(2) To make grants under this subsection, there are authorized to be appropriated from the Federal Hospital Insurance Trust Fund $10,000,000 for each fiscal year (beginning with fiscal year 1994 and ending with fiscal year 1998).

(b) COMMUNICATION LINKS.—

(1) The Secretary may make grants to at least 2, but not more than 5, community organizations, or coalitions of health care providers, health benefit plans, and purchasers, to establish and document the efficacy of communication links between the information systems of health benefit plans and of health care providers.

(2) To make grants under this subsection, there are authorized to be appropriated such sums as may be necessary for fiscal year 1994, to remain available until expended.

(c) REGIONAL OR COMMUNITY BASED CLINICAL INFORMATION SYSTEMS.—

(1) The Secretary may make grants to at least 2, but not more than 5, public or private non-profit entities for the development of regional or community-based clinical information systems.

(2) To make grants under this subsection, there are authorized to be appropriated such sums as may be necessary for fiscal year 1994, to remain available until expended.

(d) AMBULATORY CARE DATA SETS.—

(1) The Secretary may make grants to public or private non-profit entities to develop and test, for

electronic medical data generated by physicians and other entities (other than hospitals) that provide health care services—

(A) the definition of a comprehensive set of data elements, and

(B) the specification of, and manner of presentation of, the individual data elements of the set under subparagraph (A).

(2) To make grants under this subsection, there are authorized to be appropriated such sums as may be necessary for fiscal year 1994, to remain available until expended.

○

HR 2261 IH——2

HR 2261 IH——3