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To encourage health care facilities, group health plans, and health insurance issuers to reduce administrative costs, and to improve access, convenience, quality, and safety, and for other purposes.

IN THE SENATE OF THE UNITED STATES

JUNE 18, 2002

Mr. KENNEDY introduced the following bill; which was read twice and referred to the Committee on Health, Education, Labor, and Pensions

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A BILL

To encourage health care facilities, group health plans, and health insurance issuers to reduce administrative costs, and to improve access, convenience, quality, and safety, 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. SHORT TITLE.

This Act may be cited as the ''Efficiency in Health Care (eHealth) Act of 2002''.

SEC. 2. DEFINITIONS.

In this Act:

(1) CLAIM.—The term ''claim'' means any request for coverage (including authorization of coverage), for eligibility, or for payment in whole or in part, for an item or service under a group health plan or health insurance coverage.

(2) COST SHARING.—The term ''cost-sharing'' means any deductibles, coinsurance, copayment amounts, and liability for balance billing, for which the participant, beneficiary, or enrollee will be responsible.

(3) ENROLLEE.—The term ''enrollee'' means, with respect to health insurance coverage offered by a health insurance issuer, an individual enrolled with the issuer to receive such coverage.

(4) GROUP HEALTH PLAN.—The term ''group health plan'' has the meaning given such term in section 733(a) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1191b(a)).

(5) HEALTH CARE PROVIDER.—The term ''health care provider'' means a physician or other health care professional, as well as an institutional or other facility or agency that provides health care services and that is licensed, accredited, or certified to provide health care items and services under applicable State law.

(6) HEALTH INSURANCE ISSUER.—The term ''health insurance issuer'' has the meaning given such term in section 733(b) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1191b(b)).

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

TITLE I—INCENTIVES AND REQUIREMENTS FOR HEALTH CARE FACILITIES

SEC. 101. GRANTS TO HEALTH CARE FACILITIES.

(a) GRANTS AUTHORIZED.—The Secretary is authorized to award grants to health care facilities that submit applications under subsection (b).

(b) APPLICATION.—

(1) IN GENERAL.—Each health care facility desiring a grant under this section shall submit an application to the Secretary at such time, in such manner, and containing such information as the Secretary may reasonably require.

(2) ASSURANCES.— Each application submitted under paragraph (1) shall include an assurance that the health care facility will use funds provided under subsection (a) to enhance compliance with the requirement of subsection (c).

(3) PREFERENCE.—In awarding grants under subsection (a), the Secretary shall give preference to applications submitted by health care facilities that—

(A) are located in rural areas;

(B) provide care for large numbers of uninsured individuals; or

(C) in the determination of the Secretary have special needs for awards.

(c) REQUIREMENT.—

(1) IN GENERAL.—A health care facility shall have in effect an electronic system for the purpose of providing the information described in paragraph (2) to a participant, beneficiary, or enrollee of a group health plan or health insurance coverage.

(2) REQUIRED INFORMATION.—The information provided under paragraph (1) shall include, with regard to bills for services or products provided by or at the health care facility, information on—

(A) whether such bills were submitted to the applicable group health plan or health insurance issuer and if so, the date of submission;

(B) whether such bills were paid by the plan or issuer, and if so, the date of payment; and

(C) whether payments were denied by the plan or issuer, and if so, the date of denial and the reason for such denial.

(d) AUTHORIZATION OF APPROPRIATIONS.—

(1) IN GENERAL.—There is authorized to be appropriated to carry out this section $250,000,000 for fiscal year 2003 and such sums as may be necessary for each of fiscal years 2004 through 2007.

(2) AVAILABILITY.—Any amount appropriated under the authority of paragraph (1) shall remain available until expended.

SEC. 102. REQUIREMENTS FOR PROVIDERS.

(a) HEALTH CARE FACILITIES ANNUALLY ADMITTING 20,000 OR MORE INDIVIDUALS.—Beginning in the fiscal year that begins 5 years after the date of enactment of this Act, and in each fiscal year thereafter, a health care facility that admitted 20,000 or more individuals in the prior fiscal year shall not receive payments from Federal health plans for such fiscal year unless the health care facility complies with the requirements described in section 101(c), as determined by the Secretary.

(b) OTHER HEALTH CARE FACILITIES.—Beginning in the fiscal year that begins 10 years after the date of enactment of this Act, and in each fiscal year thereafter, no health care facility shall receive payments from Federal

health plans for such fiscal year unless the health care facility complies with the requirements described in section 101(c), as determined by the Secretary.

SEC. 103. REGULATIONS.

The Secretary shall issue such regulations as may be necessary or appropriate to carry out this title.

TITLE II—INCREASING THE EFFICIENCY AND EFFECTIVENESS OF CLAIMS PROCESSING

SEC. 201. AUTOMATED INTEGRATED SYSTEM.

Not later than 7 years after the date of enactment of this Act, each group health plan and health insurance issuer offering health insurance coverage shall have in effect an automated, integrated system that allows for efficient and effective adjudication of claims and the detection of fraud and abuse in accordance with this title.

SEC. 202. ADJUDICATION OF CLAIMS.

(a) IN GENERAL.—Not later than 7 years after the date of enactment of this Act, each group health plan and health insurance issuer offering health insurance coverage shall use the system described in section 201 to provide for the prompt and accurate adjudication of claims upon receipt of such claims.

(b) ELEMENTS OF ADJUDICATION.—The adjudication described in subsection (a) shall include determinations concerning payments and coverage for items or services under the terms and conditions of the plan or coverage involved, including any cost-sharing amount that the participant, beneficiary, or enrollee is required to pay with respect to such claim.

(c) TIMEFRAME.—The plan or issuer shall complete the adjudication of claims under this section immediately after the plan or issuer receives—

(1) the claim; and

(2) any additional information requested by the plan or issuer that is necessary to make a determination relating to the claim.

(d) ACCURACY.—In adjudicating claims under this section the plan or issuer shall ensure that—

(1) such claims are adjudicated with an accuracy of at least 99 percent;

(2) the plan or issuer has the ability to accept claims submitted via the Internet; and

(3) the plan or issuer has the ability to issue denials where necessary instantaneously via the Internet, and to provide an opportunity for challenge to and resolution of such denials (except in cases of dispute over medical necessity) via the Internet.

SEC. 203. DETECTION SYSTEM.

Not later than 2 years after the date of enactment of this Act, each group health plan and health insurance issuer offering health insurance coverage shall use the system described in section 201 to detect fraud and abuse in real-time as part of the adjudication of claims under section 202.

SEC. 204. REGULATIONS.

The Secretary shall issue such regulations as may be necessary or appropriate to carry out this title.

TITLE III—MAKING HEALTH CARE MORE RESPONSIVE TO THE CONSUMER

SEC. 301. MAKING HEALTH CARE MORE RESPONSIVE TO THE CONSUMER.

Not later than 7 years after the date of enactment of this Act, each group health plan and health insurance issuer offering health insurance coverage shall have in effect a system to provide the services described in this title.

SEC. 302. STATEMENT OF ACCOUNT FOR PATIENTS.

(a) IN GENERAL.—Each group health plan and health insurance issuer shall provide a participant, beneficiary, or enrollee with a statement of account that—

(1) includes information, with respect to the participant, beneficiary, or enrollee, on—

(A) claims received, claims denied, and the reasons for any denials;

(B) status of coverage; and

(C) deductible information; and

(2) is issued quarterly.

(b) INTERNET ACCESS.—The plan or issuer may comply with this section by making the quarterly statements available on the Internet 24 hours a day, 7 days a week, through a secure website.

SEC. 303. STATEMENT OF ACCOUNT FOR EMPLOYERS AND PURCHASES.

Each group health plan and health insurance issuer shall provide to employers and other purchasers of health insurance products a statement of account that—

(1) includes—

(A) current information on coverage status; and

(B) reports of customer satisfaction that are updated annually; and

(2) is available 24 hours a day, 7 days a week, through—

(A) the Internet through a secure website; or

(B) a toll-free telephone number.

SEC. 304. INTERNET ENROLLMENT.

(a) IN GENERAL.—Each group health plan and health insurance issuer shall provide to employers and other purchasers of health insurance products an option to enroll for coverage under such health insurance products on the Internet through a secure website.

(b) ELIGIBILITY REQUIREMENTS.—The Internet website described in subsection (a) shall include information on eligibility requirements for coverage.

SEC. 305. CONSUMER EXPLANATION OF BENEFITS.

(a) IN GENERAL.—Each group health plan and health insurance issuer shall provide, to a participant, beneficiary, or enrollee—

(1) an explanation of benefits at the point of service or not later than 48 hours after the time that service is provided; and

(2) a description of the coverage and cost of each services provided to the participant, beneficiary, or enrollee under the plan or coverage.

(b) LANGUAGE.—Any explanation of benefits under this section shall be provided in a printed form and written in a manner calculated to be understood by the average participant, beneficiary, or enrollee.

SEC. 306. REFERRALS AND AUTHORIZATIONS.

(a) IN GENERAL.—Each group health plan and health insurance issuer shall establish an automated sys-

tem for making and checking referrals and pre-authorizations where such referrals and pre-authorizations are required under the plan or coverage.

(b) ACCESS.—The system described in subsection (a) shall permit access by physicians and by participants, beneficiaries, and enrollees to information on the completion of referrals and pre-authorizations and whether health care services and products have been authorized, through—

(1) the Internet through a secure website; or

(2) a toll-free telephone number.

SEC. 307. PRESCRIPTIONS.

To the extent that a group health plan or health insurance coverage offered by a health insurance issuer, provides coverage for benefits with respect to prescription drugs, each plan and issuer shall establish a system for automated prescription posting and ordering that—

(1) is accessible to physicians and to participants, beneficiaries, and enrollees;

(2) is accessible through—

(A) the Internet through a secure website; or

(B) a toll-free telephone number; and

(3) does not require the use of paper for posting or ordering prescriptions.

SEC. 308. PATIENT CLAIM HISTORY.

Each group health plan and health insurance issuer shall establish a system—

(1) by which a health care provider may, with patient authorization, have access to the patient's statement of account, as described in section 302; and

(2) that is accessible through—

(A) the Internet through a secure website; or

(B) a toll-free telephone number.

SEC. 309. STATEMENT TO HEALTH CARE PROVIDERS.

Each group health plan and health insurance issuer shall establish a system under which the plan or issuer shall notify a health care provider who has provided items or services to a participant, beneficiary, or enrollee of the amount that such plan or issuer has paid on a claim with respect to such items or services. Such notice shall be provided to the health care provider within 48 hours of the receipt by the plan or issuer of a claim with respect to the items or services involved.

SEC. 310. REGULATIONS.

The Secretary shall issue such regulations as may be necessary or appropriate to carry out this title.

TITLE IV—MODERNIZING FINANCIAL TRANSACTIONS IN HEALTH CARE

SEC. 401. MODERNIZING FINANCIAL TRANSACTIONS IN HEALTH CARE.

Not later than 7 years after the date of enactment of this Act, each group health plan and health insurance issuer offering health insurance coverage shall have in effect a system to provide the financial transaction services described in this title.

SEC. 402. ELECTRONIC TRANSFER OF PAYMENTS.

Each group health plan and health insurance issuer shall establish a system that permits health care providers to receive claim payments through electronic transfer of funds.

SEC. 403. AUTOMATIC PAYMENTS.

Each group health plan and health insurance issuer shall establish a system that permits participants, beneficiaries, and enrollees to make payments for deductibles through electronic transfer of funds from bank accounts or pre-tax savings accounts.

SEC. 404. CONTROL SYSTEMS.

Each group health plan and health insurance issuer shall establish a system that provides automated, inte-

grated audit controls to monitor any duplicate payments or overpayments within the adjudication system.

TITLE V—ENHANCING PATIENT SAFETY

SEC. 501. PURPOSE.

It is the purpose of this title to reduce medication errors by facilitating and requiring the installation and use of computerized physician order entry systems by health care facilities.

SEC. 502. INFRASTRUCTURE FOR SAFE PRESCRIPTIONS.

Title VI of the Public Health Service Act (42 U.S.C. 291 et seq.) is amended by adding at the end thereof the following:

''PART E—INFRASTRUCTURE FOR SAFE PRESCRIPTIONS

''SEC. 651. GRANTS FOR COMPUTERIZED PHYSICIAN ORDER ENTRY SYSTEMS.

''(a) IN GENERAL.—The Secretary may award grants to eligible entities to enable such entities to develop, install, or train personnel in the use of, computerized physician order entry systems.

''(b) ELIGIBILITY.—To be eligible to receive a grant under subsection (a), an entity shall—

''(1) be a nonprofit hospital, health care clinic, community health center, skilled nursing facility, or

other nonprofit entity determined to be eligible by the Secretary;

''(2) prepare and submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require, including a description of the computerized medication prescribing system that the entity intends to implement using amounts received under the grant; and

''(3) provide assurances that are satisfactory to the Secretary that the computerized physician order entry system, for which amounts are to be expended under the grant, conforms to the technical standards established by the Secretary for such systems under section 652.

''(c) MATCHING REQUIREMENT.—The Secretary may not make a grant to an entity under subsection (a) unless that entity agrees that, with respect to the costs to be incurred by the entity in carrying out the activities for which the grant is being awarded, the entity will make available (directly or through donations from public or private entities) non-Federal contributions toward such costs in an amount equal to $1 for each $1 of Federal funds provided under the grant.

"SEC. 652. REQUIREMENTS FOR COMPUTERIZED PHYSICIAN ORDER ENTRY SYSTEMS.

"(a) INITIAL REQUIREMENT.—Beginning in the fiscal year that begins 5 years after the date of enactment of this Act, and in each fiscal year thereafter, a health care facility that admitted 20,000 or more individuals in the prior fiscal year shall not receive payments from Federal health plans unless the health care facility has in effect a computerized physician order entry system that meets the requirements of section 651.

"(b) SUBSEQUENT REQUIREMENT.—Beginning in the fiscal year that begins 10 years after the date of enactment of this Act, and in each fiscal year thereafter, no health care facility shall receive payments from Federal health plans unless that health care facility has in effect a computerized physician order entry system that meets the requirements of section 651.

"SEC. 653. GUIDELINES FOR COMPUTERIZED PHYSICIAN ORDER ENTRY SYSTEMS.

"(a) DEVELOPMENT.—The Secretary, acting through the Administrator of the Agency for Healthcare Research and Quality, shall establish technical standards for computerized physician order entry systems.

"(b) WORKING GROUP.—In carrying out subsection (a), the Secretary shall convene a working group of individuals with expertise in computer technology, the pre-

scribing of medication, and other appropriate fields, to provide the Secretary with advice for purposes of assisting the Secretary in the establishment of technical standards under such subsection. The working group shall be subject to the Federal Advisory Committee Act.

''(c) FOCUS OF TECHNICAL STANDARDS.—The standards developed under subsection (a) shall focus on—

''(1) the interoperability of a computerized physician order entry system with such other systems in common use;

''(2) the protection of the confidentiality of individually identifiable health information contained within such system from unauthorized access or dissemination;

''(3) procedures for issuing warnings when prescribing errors may be imminent;

''(4) procedures for ensuring that recommendations or warnings issued by such systems reflect good medical practice; and

''(5) other matters determined appropriate by the Secretary.

''(d) REVISIONS.—The Secretary, acting through the Administrator of the Agency for Healthcare Research and Quality, shall establish a working group to continually up-

date and revise the technical standards developed under subsection (a).

''(e) PUBLICATION.—Not later than 1 year after the date of enactment of this part, the Secretary shall publish the technical standards developed under this section in the Federal Register. The Secretary shall publish and make available any revisions to such guidelines within 30 days of the date on which such revisions are proposed under subsection (d).

''SEC. 654. AUTHORIZATION OF APPROPRIATIONS.

''There is authorized to be appropriated to carry out this part, $100,000,000 for fiscal year 2003, and such sums as may be necessary for each fiscal year thereafter.''.

TITLE VI—APPLICATION TO PUBLIC HEALTH SERVICE ACT AND EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974

SEC. 601. APPLICATION TO GROUP HEALTH PLANS AND GROUP HEALTH INSURANCE COVERAGE UNDER THE PUBLIC HEALTH SERVICE ACT.

(a) IN GENERAL.—Subpart 2 of part A of title XXVII of the Public Health Service Act is amended by adding at the end the following new section:

''SEC. 2707. HEALTH CARE MODERNIZATION STANDARDS.

''Each group health plan shall comply with health care modernization requirements under titles II and III of the Efficiency in Health Care (eHealth) Act, and each health insurance issuer shall comply with health care modernization requirements under such titles with respect to group health insurance coverage it offers, and such requirements shall be deemed to be incorporated into this subsection.''.

(b) CONFORMING AMENDMENT.—Section 2721(b)(2)(A) of such Act (42 U.S.C. 300gg–21(b)(2)(A)) is amended by inserting ''(other than section 2707)'' after ''requirements of such subparts''.

SEC. 602. APPLICATION TO INDIVIDUAL HEALTH INSURANCE COVERAGE UNDER THE PUBLIC HEALTH SERVICE ACT.

Part B of title XXVII of the Public Health Service Act is amended by inserting after section 2752 the following new section:

''SEC. 2753. HEALTH CARE MODERNIZATION STANDARDS.

''Each health insurance issuer shall comply with health care modernization requirements under titles II, III, and IV of the Efficiency in Health Care (eHealth) Act with respect to individual health insurance coverage it offers, and such requirements shall be deemed to be incorporated into this subsection.''.

SEC. 603. APPLICATION TO GROUP HEALTH PLANS AND GROUP HEALTH INSURANCE COVERAGE UNDER THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974.

Subpart B of part 7 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 is amended by adding at the end the following new section:

''SEC. 714. HEALTH CARE MODERNIZATION STANDARDS.

''A group health plan (and a health insurance issuer offering group health insurance coverage in connection with such a plan) shall comply with the requirements of titles II, III, and IV of the Efficiency in Health Care (eHealth) Act (as in effect as of the date of the enactment of such Act), and such requirements shall be deemed to be incorporated into this subsection.''.

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