Conduct a thorough review of all federal programs and services designed to assist seniors with their housing needs

Facilitate the ''aging in place'' of seniors

Make recommendations about how to reduce duplication among programs and how to more effectively coordinate programs and services

Collect and disseminate data and information on seniors and their needs

Maintain an updated website with information on how seniors can access housing and services that fit their needs

Work with States to coordinate programs and services at the State and local level

Implement the recommendation of the 1999 Congressionally established Seniors Commission that the federal government streamline and consolidate its programs and services for seniors

This Interagency Council will be comprised of the Secretaries (or designees) of the agencies which operate programs for seniors: HUD, HHS, DOT, Agriculture, Treasury, Labor, Veterans Affairs, as well as the Commissioner of the Social Security Administration, the Administrator of the Centers for Medicare and Medicaid Services and the Administrator of the Administration on Aging.

The legislation authorizes $1.5 million per year for 5 years to pay for staff and other expenses. .

The legislation is supported by many organizations involved in housing and services for seniors, including: AARP (American Association of Retired Persons), NAHRO (the National Association of Housing and Redevelopment Officials), AAHSA (American Association of Homes and Services for the Aging), the Elderly Housing Coalition, and the National Low Income Housing Coalition.

AGING NEEDS IN THE UNITED STATES

Our Nation's Senior Population is Rapidly Growing, and Americans are Living Longer Than Ever Before.

The senior population (age 65 and older) is expected to double by 2030, from 36 million to 70 million, one-fifth of the Nation's population.

By 2050 there will be over 86 million seniors, an increase of 147% since 2000.

The average American life expectancy is anticipated to increase from 76 to 81 by 2060.

By 2020 the number of seniors over age 85 is expected to double to 7 million and then double again to 14 million by 2040.

Seniors Want to Age in Place.

82% of Americans age 45 and older say that even if they need help caring for themselves, they prefer receiving services that allow them to stay in their current home.

89% of those 55 and older desire to age in place, up from 84% in 1992.

To Facilitate Aging in Place, Services Must Be Connected to Housing.

While many seniors want to remain at home, over 18% of seniors (over 5.8 million) who do not reside in nursing facilities have difficulty performing their daily activities without assistance, and over one million of these seniors are severely impaired, requiring assistance with many of their basic tasks.

Many other seniors, those that can perform their daily functions, still require access to health care, transportation and other services.

In fact, nearly 20% of seniors have significant long-term care needs.

It is predicted that both shrinking family size and increasing workforce participation by women could make informal care less available (women currently provide the majority of such care), leading to a greater reliance on care from other sources.

In 2005, $129 billion will be spent on paid care for seniors; roughly $15,000 per senior.

To pay for long-term care, many seniors rely on government funding—Medicaid (39%) and Medicare (20%), while 36% of seniors pay out-of-pocket expenses.

Today, approximately one-third of all Medicaid spending pays for long-term care, making Medicaid our Nation's largest source of payment for such services and supports.

Medicaid spent a total of $83.8 billion for long-term care services in 2003.

Of those over age 85, roughly 55% are impaired and require long-term care.

A Florida study showed that more than 34% of seniors in government-assisted housing have no family to turn to if sick or disabled.

Many Seniors Are Not in a Financial Position to Pay for the Housing and/or Services They Need.

There are nearly six times as many seniors in need of affordable housing as are currently served in rent-assisted housing.

81% of seniors are homeowners, but: 44% of those have incomes of less than 50% of Area Median Income; 40% have no savings; 26% have less than $25,000 saved.

35% of senior renters are severely rent burdened and pay more than 50% of their income for rent.

The median income of older persons in 2002 was $19,436 for males and $11,406 for females.

In home support services are expensive and can cost from $140–$200 per day, or up to $73,000 per year.

Roughly one-third of seniors who enter a nursing home are eligible for Medicaid upon admission; another third deplete their assets paying for care and then turn to Medicaid to pay for the portion of care that exceeds their income.

Nuring Homes: Without services, seniors find it difficult to remain outside of nursing homes or other institutional settings.

One third of seniors leave their homes to go to nursing homes.

Nursing home costs average $60,000 per year; these costs are expected to rise at least 5% annually.

Almost 20% of seniors over age 85 live in nursing homes, compared with less than 2% of seniors age 65–84.

65% of nursing home admissions are directly from hospitals, giving families little time to explore other options.

The Congressionally established Seniors Commission found in their 2002 report that the unsynchronized federal housing and health policies often lead to premature institutionalization.

Assisted Living Facilities: Many seniors could be well served in assisted living facilities, an immediate step between aging in place and nursing homes.

Assisted living is the fastest growing type of senior housing in the United States, accounting for roughly 75% of all new senior housing produced in recent years.

The typical assisted living resident is a widowed White woman, age 85.

Roughly 50% of assisted living residents have Alzheimer's disease or other cognitive impairment.

In 2002, over 36,000 assisted living facilities served approximately 910,000 residents.

Assisted living costs between $2,100 and $2,900 a month, and is primarily private pay. Few people have private insurance coverage, and public subsidies are limited.

In 2002, 41 states provided at least some Medicaid coverage for assisted living (serving about 102,000 elderly Medicaid beneficiaries), but this covered personal care services, not room and board.

Programs and Services for Seniors are Fragmented: Regardless of where seniors live, it is clear that housing and services must be linked.

The 1999 Congressionally established Seniors Commission found that ''the most striking characteristic of seniors' housing and health care in this country is the disconnection of one field from another.''

The Seniors Commission also found that ''the time has come for coordination among Federal and State agencies and administrators.''

What these facts illustrate is that there is tremendous stress on seniors and on their families to find, maintain and afford housing; to acquire and pay for personal care assistance or long term care; and to access other needed services that can keep them independent and enable them to stay connected to their communities and age in place.

Senator Sarbanes has introduced an Interagency Council on Meeting the Housing and Service Needs of Seniors, to better coordinate housing programs and related services so that seniors can age in place and access needed services.

Mr. GRASSLEY. I ask unanimous consent that the committee-reported amendment be agreed to, the bill as amended be read a third time and passed, the motion to reconsider be laid on the table, and any statements be printed in the RECORD.

The PRESIDING OFFICER. Without objection, it is so ordered.

The committee amendment in the nature of a substitute was agreed to.

The bill (S. 705), as amended, was read the third time and passed.

UNANIMOUS CONSENT AGREEMENT—H.J. RES. 72

Mr. FRIST. Mr. President, I ask unanimous consent that when the Senate proceeds to H.J. Res. 72 on Friday, that Senator HARKIN be recognized in order to offer an amendment related to CSBG, which is at the desk. I further ask consent that there be 20 minutes for debate in relation to the amendment, no other amendments be in order, and that following that debate the Senate proceed to a vote in relation to the Harkin amendment; further, that following that vote, the joint resolution be read a third time and the Senate proceed to a vote on the joint resolution, with no intervening action or debate.

The PRESIDING OFFICER. Without objection, it is so ordered.

WIRED FOR HEALTH CARE QUALITY ACT

Mr. FRIST. Mr. President, I ask unanimous consent that the Senate proceed to the immediate consideration of Calendar No. 178, S. 1418.

The PRESIDING OFFICER. The clerk will report the bill by title.

The legislative clerk read as follows:

A bill (S. 1418) to enhance the adoption of a nationwide interoperable health information technology system and to improve the quality and reduce the costs of health care in the United States.

There being no objection, the Senate proceeded to consider the bill, which had been reported from the Committee on Health, Education, Labor, and Pensions, with an amendment.

(Strike the part shown in black brackets and insert the part shown in italic.)

S. 1418

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 ''Wired for Health Care Quality Act''.

[SEC. 2. IMPROVING HEALTH CARE, QUALITY, SAFETY, AND EFFICIENCY.

[The Public Health Service Act (42 U.S.C. 201 et seq.) is amended by adding at the end the following:

''TITLE XXIX—HEALTH INFORMATION TECHNOLOGY

[''SEC. 2901. DEFINITIONS.

[''In this title:

[''(1) HEALTH CARE PROVIDER.—The term 'health care provider' means a hospital, skilled nursing facility, home health entity, health care clinic, federally qualified health center, group practice (as defined in section 1877(h)(4) of the Social Security Act), a pharmacist, a pharmacy, a laboratory, a physician (as defined in section 1861(r) of the Social Security Act), a health facility operated by or pursuant to a contract with the Indian Health Service, a rural health clinic, and any other category of facility or clinician determined appropriate by the Secretary.

[''(2) HEALTH INFORMATION.—The term 'health information' has the meaning given such term in section 1171(4) of the Social Security Act.

[''(3) HEALTH INSURANCE PLAN.—The term 'health insurance plan' means—

[''(A) a health insurance issuer (as defined in section 2791(b)(2));

[''(B) a group health plan (as defined in section 2791(a)(1)); and

[''(C) a health maintenance organization (as defined in section 2791(b)(3)).

[''(4) LABORATORY.—The term 'laboratory' has the meaning given that term in section 353.

[''(5) PHARMACIST.—The term 'pharmacist' has the meaning given that term in section 804 of the Federal Food, Drug, and Cosmetic Act.

[''(6) QUALIFIED HEALTH INFORMATION TECHNOLOGY.—The term 'qualified health information technology' means a computerized system (including hardware, software, and training) that—

[''(A) protects the privacy and security of health information;

[''(B) maintains and provides permitted access to health information in an electronic format;

[''(C) incorporates decision support to reduce medical errors and enhance health care quality;

[''(D) complies with the standards adopted by the Federal Government under section 2903; and

[''(E) allows for the reporting of quality measures under section 2908.

[''(7) STATE.—The term 'State' means each of the several States, the District of Columbia, Puerto Rico, the Virgin Islands, Guam, American Samoa, and the Northern Mariana Islands.

[''SEC. 2902. OFFICE OF THE NATIONAL COORDINATOR OF HEALTH INFORMATION TECHNOLOGY.

[''(a) OFFICE OF NATIONAL HEALTH INFORMATION TECHNOLOGY.—There is established within the Office of the Secretary an Office of the National Coordinator of Health Information Technology (referred to in this section as the 'Office'). The Office shall be headed by a National Coordinator who shall be appointed by the President, in consultation with the Secretary, and shall report directly to the Secretary.

[''(b) PURPOSE.—It shall be the purpose of the Office to carry out programs and activities to develop a nationwide interoperable health information technology infrastructure that—

[''(1) ensures that patients' health information is secure and protected;

[''(2) improves health care quality, reduces medical errors, and advances the delivery of patient-centered medical care;

[''(3) reduces health care costs resulting from inefficiency, medical errors, inappropriate care, and incomplete information;

[''(4) ensures that appropriate information to help guide medical decisions is available at the time and place of care;

[''(5) promotes a more effective marketplace, greater competition, and increased choice through the wider availability of accurate information on health care costs, quality, and outcomes;

[''(6) improves the coordination of care and information among hospitals, laboratories, physician offices, and other entities through an effective infrastructure for the secure and authorized exchange of health care information;

[''(7) improves public health reporting and facilitates the early identification and rapid response to public health threats and emergencies, including bioterror events and infectious disease outbreaks;

[''(8) facilitates health research; and

[''(9) promotes prevention of chronic diseases.

[''(c) DUTIES OF THE NATIONAL COORDINATOR.—The National Coordinator shall—

[''(1) serve as a member of the public-private American Health Information Collaborative established under section 2903;

[''(2) serve as the principal advisor to the Secretary concerning the development, application, and use of health information technology, and coordinate and oversee the health information technology programs of the Department;

[''(3) facilitate the adoption of a nationwide, interoperable system for the electronic exchange of health information;

[''(4) ensure the adoption and implementation of standards for the electronic exchange of health information to reduce cost and improve health care quality;

[''(5) ensure that health information technology policy and programs of the Department are coordinated with those of relevant executive branch agencies (including Federal commissions) with a goal of avoiding duplication of efforts and of helping to ensure that each agency undertakes health information technology activities primarily within the areas of its greatest expertise and technical capability;

[''(6) to the extent permitted by law, coordinate outreach and consultation by the relevant executive branch agencies (including Federal commissions) with public and private parties of interest, including consumers, payers, employers, hospitals and other health care providers, physicians, community health centers, laboratories, vendors and other stakeholders;

[''(7) advise the President regarding specific Federal health information technology programs; and

[''(8) submit the reports described under section 2903(i) (excluding paragraph (4) of such section).

[''(d) DETAIL OF FEDERAL EMPLOYEES.—

[''(1) IN GENERAL.—Upon the request of the National Coordinator, the head of any Federal agency is authorized to detail, with or without reimbursement from the Office, any of the personnel of such agency to the Office to assist it in carrying out its duties under this section.

[''(2) EFFECT OF DETAIL.—Any detail of personnel under paragraph (1) shall—

[''(A) not interrupt or otherwise affect the civil service status or privileges of the Federal employee; and

[''(B) be in addition to any other staff of the Department employed by the National Coordinator.

[''(3) ACCEPTANCE OF DETAILEES.—Notwithstanding any other provision of law, the Office may accept detailed personnel from other Federal agencies without regard to whether the agency described under paragraph (1) is reimbursed.

[''(e) RULE OF CONSTRUCTION.—Nothing in this section shall be construed to require the duplication of Federal efforts with respect to the establishment of the Office, regardless of whether such efforts were carried out prior to or after the enactment of this title.

[''(f) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated such sums as may be necessary to carry out the activities of the Office under this section for each of fiscal years 2006 through 2010.

[''SEC. 2903. AMERICAN HEALTH INFORMATION COLLABORATIVE.

[''(a) PURPOSE.—The Secretary shall establish the public-private American Health Information Collaborative (referred to in this section as the 'Collaborative') to—

[''(1) advise the Secretary and recommend specific actions to achieve a nationwide interoperable health information technology infrastructure;

[''(2) serve as a forum for the participation of a broad range of stakeholders to provide input on achieving the interoperability of health information technology; and

[''(3) recommend standards (including content, communication, and security standards) for the electronic exchange of health information for adoption by the Federal Government and voluntary adoption by private entities.

[''(b) COMPOSITION.—

[''(1) IN GENERAL.—The Collaborative shall be composed of—

[''(A) the Secretary, who shall serve as the chairperson of the Collaborative;

[''(B) the Secretary of Defense, or his or her designee;

[''(C) the Secretary of Veterans Affairs, or his or her designee;

[''(D) the Secretary of Commerce, or his or her designee;

[''(E) the National Coordinator for Health Information Technology;

[''(F) representatives of other relevant Federal agencies, as determined appropriate by the Secretary; and

[''(G) representatives from each of the following categories to be appointed by the Secretary from nominations submitted by the public—

[''(i) consumer and patient organizations;

[''(ii) experts in health information privacy and security;

[''(iii) health care providers;

[''(iv) health insurance plans or other third party payors;

[''(v) standards development organizations;

[''(vi) information technology vendors;

[''(vii) purchasers or employers; and

[''(viii) State or local government agencies or Indian tribe or tribal organizations.

[''(2) CONSIDERATIONS.—In appointing members under paragraph (1)(G), the Secretary shall select individuals with expertise in—

[''(A) health information privacy;

[''(B) health information security;

[''(C) health care quality and patient safety, including those individuals with experience in utilizing health information technology to improve health care quality and patient safety;

[''(D) data exchange; and

[''(E) developing health information technology standards and new health information technology.

[''(3) TERMS.—Members appointed under paragraph (1)(G) shall serve for 2 year terms, except that any member appointed to fill a vacancy for an unexpired term shall be appointed for the remainder of such term. A member may serve for not to exceed 180 days after the expiration of such member's term or until a successor has been appointed.

[''(c) RECOMMENDATIONS AND POLICIES.—The Collaborative shall make recommendations to identify uniform national policies for adoption by the Federal Government and voluntary adoption by private entities to support the widespread adoption of health information technology, including—

[''(1) protection of health information through privacy and security practices;

[''(2) measures to prevent unauthorized access to health information;

[''(3) methods to facilitate secure patient access to health information;

[''(4) the ongoing harmonization of industry-wide health information technology standards;

[''(5) recommendations for a nationwide interoperable health information technology infrastructure;

[''(6) the identification and prioritization of specific use cases for which heath information technology is valuable, beneficial, and feasible;

[''(7) recommendations for the establishment of an entity to ensure the continuation of the functions of the Collaborative; and

[''(8) other policies determined to be necessary by the Collaborative.

[''(d) STANDARDS.—

[''(1) EXISTING STANDARDS.—The standards adopted by the Consolidated Health Informatics Initiative shall be deemed to have been recommended by the Collaborative under this section.

[''(2) FIRST YEAR REVIEW.—Not later than 1 year after the date of enactment of this title, the Collaborative shall—

[''(A) review existing standards (including content, communication, and security standards) for the electronic exchange of health information, including such standards adopted by the Secretary under paragraph (2)(A);

[''(B) identify deficiencies and omissions in such existing standards; and

[''(C) identify duplication and overlap in such existing standards;
and recommend modifications to such standards as necessary.

[''(3) ONGOING REVIEW.—Beginning 1 year after the date of enactment of this title, and annually thereafter, the Collaborative shall—

[''(A) review existing standards (including content, communication, and security standards) for the electronic exchange of health information, including such standards adopted by the Secretary under paragraph (2)(A);

[''(B) identify deficiencies and omissions in such existing standards; and

[''(C) identify duplication and overlap in such existing standards;
and recommend modifications to such standards as necessary.

[''(4) LIMITATION.—The standards described in this section shall be consistent with any standards developed pursuant to the Health Insurance Portability and Accountability Act of 1996.

[''(e) FEDERAL ACTION.—Not later than 60 days after the issuance of a recommendation from the Collaborative under subsection (d)(2), the Secretary of Health and Human Services, the Secretary of Veterans Affairs, and the Secretary of Defense, in collaboration with representatives of other relevant Federal agencies, as determined appropriate by the Secretary, shall jointly review such recommendations. The Secretary shall provide for the adoption by the Federal Government of any standard or standards contained in such recommendation.

[''(f) COORDINATION OF FEDERAL SPENDING.—Not later than 1 year after the adoption by the Federal Government of a recommendation as provided for in subsection (e), and in compliance with chapter 113 of title 40, United States Code, no Federal agency shall expend Federal funds for the purchase of any form of health information technology or health information technology system for clinical care or for the electronic retrieval, storage, or exchange of health information that is not consistent with applicable standards adopted by the Federal Government under subsection (e).

[''(g) COORDINATION OF FEDERAL DATA COLLECTION.—Not later than 3 years after the adoption by the Federal Government of a recommendation as provided for in subsection (e), all Federal agencies collecting health data for the purposes of surveillance, epidemiology, adverse event reporting, research, or for other purposes determined appropriate by the Secretary shall comply with standards adopted under subsection (e).

[''(h) VOLUNTARY ADOPTION.—Any standards adopted by the Federal Government under subsection (e) shall be voluntary with respect to private entities.

[''(i) REPORTS.—The Secretary shall submit to the Committee on Health, Education, Labor, and Pensions and the Committee on Finance of the Senate and the Committee on Energy and Commerce and the Committee on Ways and Means of the House of Representatives, on an annual basis, a report that—

[''(1) describes the specific actions that have been taken by the Federal Government and private entities to facilitate the adoption of an interoperable nationwide system for the electronic exchange of health information;

[''(2) describes barriers to the adoption of such a nationwide system;

[''(3) contains recommendations to achieve full implementation of such a nationwide system; and

[''(4) contains a plan and progress toward the establishment of an entity to ensure the continuation of the functions of the Collaborative.

[''(j) APPLICATION OF FACA.—The Federal Advisory Committee Act (5 U.S.C. App.) shall apply to the Collaborative, except that the term provided for under section 14(a)(2) shall be 5 years.

[''(k) RULE OF CONSTRUCTION.—Nothing in this section shall be construed to require the duplication of Federal efforts with respect to the establishment of the Collaborative, regardless of whether such efforts were carried out prior to or after the enactment of this title.

[''(l) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated such sums as may be necessary to carry out this section for each of fiscal years 2006 through 2010.

[''SEC. 2904. IMPLEMENTATION AND CERTIFICATION OF HEALTH INFORMATION STANDARDS.

[''(a) IMPLEMENTATION.—

[''(1) IN GENERAL.—The Secretary, based upon the recommendations of the Collaborative, shall develop criteria to ensure uniform and consistent implementation of any standards for the electronic exchange of health information voluntarily adopted by private entities in technical conformance with such standards adopted under this title.

[''(2) IMPLEMENTATION ASSISTANCE.—The Secretary may recognize a private entity or entities to assist private entities in the implementation of the standards adopted under this title using the criteria developed by the Secretary under this section.

[''(b) CERTIFICATION.—

[''(1) IN GENERAL.—The Secretary, based upon the recommendations of the Collaborative, shall develop criteria to ensure and certify that hardware, software, and support services that claim to be in compliance with any standard for the electronic exchange of health information adopted under this title have established and maintained such compliance in technical conformance with such standards.

[''(2) CERTIFICATION ASSISTANCE.—The Secretary may recognize a private entity or entities to assist in the certification described under paragraph (1) using the criteria developed by the Secretary under this section.

[''(c) DELEGATION AUTHORITY.—The Secretary, through consultation with the Collaborative, may delegate the development of the criteria under subsections (a) and (b) to a private entity.

[''SEC. 2905. GRANTS TO FACILITATE THE WIDESPREAD ADOPTION OF INTEROPERABLE HEALTH INFORMATION TECHNOLOGY.

[''(a) COMPETITIVE GRANTS TO FACILITATE THE WIDESPREAD ADOPTION OF HEALTH INFORMATION TECHNOLOGY.—

[''(1) IN GENERAL.—The Secretary may award competitive grants to eligible entities to facilitate the purchase and enhance the utilization of qualified health information technology systems to improve the quality and efficiency of health care.

[''(2) ELIGIBILITY.—To be eligible to receive a grant under paragraph (1) an entity shall—

[''(A) submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require;

[''(B) submit to the Secretary a strategic plan for the implementation of data sharing and interoperability measures;

[''(C) be a—

[''(i) not for profit hospital;

[''(ii) group practice (including a single physician); or

[''(iii) another health care provider not described in clause (i) or (ii);

[''(D) adopt the standards adopted by the Federal Government under section 2903;

[''(E) require that health care providers receiving such grants implement the measurement system adopted under section 2908 and report to the Secretary on such measures;

[''(F) demonstrate significant financial need; and

[''(G) provide matching funds in accordance with paragraph (4).

[''(3) USE OF FUNDS.—Amounts received under a grant under this subsection shall be used to facilitate the purchase and enhance the utilization of qualified health information technology systems.

[''(4) MATCHING REQUIREMENT.—To be eligible for a grant under this subsection an entity shall contribute non-Federal contributions to the costs of carrying out the activities for which the grant is awarded in an amount equal to $1 for each $3 of Federal funds provided under the grant.

[''(5) PREFERENCE IN AWARDING GRANTS.—In awarding grants under this subsection the Secretary shall give preference to—

[''(A) eligible entities that are located in rural, frontier, and other underserved areas as determined by the Secretary; and

[''(B) eligible entities that will link, to the extent practicable, the qualified health information system to local or regional health information networks.

[''(b) COMPETITIVE GRANTS TO STATES FOR THE DEVELOPMENT OF STATE LOAN PROGRAMS TO FACILITATE THE WIDESPREAD ADOPTION OF HEALTH INFORMATION TECHNOLOGY.—

[''(1) IN GENERAL.—The Secretary may award competitive grants to States for the establishment of State programs for loans to

health care providers to facilitate the purchase and enhance the utilization of qualified health information technology.

''(2) ESTABLISHMENT OF FUND.—To be eligible to receive a competitive grant under this subsection, a State shall establish a qualified health information technology loan fund (referred to in this subsection as a 'State loan fund') and comply with the other requirements contained in this section. A grant to a State under this subsection shall be deposited in the State loan fund established by the State. No funds authorized by other provisions of this title to be used for other purposes specified in this title shall be deposited in any State loan fund.

''(3) ELIGIBILITY.—To be eligible to receive a grant under paragraph (1) a State shall—

''(A) submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require;

''(B) submit to the Secretary a strategic plan in accordance with paragraph (4);

''(C) establish a qualified health information technology loan fund in accordance with paragraph (2);

''(D) require that health care providers receiving such loans—

''(i) link, to the extent practicable, the qualified health information system to a local or regional health information network; and

''(ii) consult with the Center for Best Practices established in section 914(d) to access the knowledge and experience of existing initiatives regarding the successful implementation and effective use of health information technology;

''(E) require that health care providers receiving such loans adopt the standards adopted by the Federal Government under section 2903(d);

''(F) require that health care providers receiving such loans implement the measurement system adopted under section 2908 and report to the Secretary on such measures; and

''(G) provide matching funds in accordance with paragraph (8).

''(4) STRATEGIC PLAN.—

''(A) IN GENERAL.—A State that receives a grant under this subsection shall annually prepare a strategic plan that identifies the intended uses of amounts available to the State loan fund of the State.

''(B) CONTENTS.—A strategic plan under subparagraph (A) shall include—

''(i) a list of the projects to be assisted through the State loan fund in the first fiscal year that begins after the date on which the plan is submitted;

''(ii) a description of the criteria and methods established for the distribution of funds from the State loan fund; and

''(iii) a description of the financial status of the State loan fund and the short-term and long-term goals of the State loan fund.

''(5) USE OF FUNDS.—

''(A) IN GENERAL.—Amounts deposited in a State loan fund, including loan repayments and interest earned on such amounts, shall be used only for awarding loans or loan guarantees, or as a source of reserve and security for leveraged loans, the proceeds of which are deposited in the State loan fund established under paragraph (1). Loans under this section may be used by a health care provider to facilitate the purchase and enhance the utilization of qualified health information technology.

''(B) LIMITATION.—Amounts received by a State under this subsection may not be used—

''(i) for the purchase or other acquisition of any health information technology system that is not a qualified health information technology system;

''(ii) to conduct activities for which Federal funds are expended under this title, or the amendments made by the Wired for Health Care Quality Act; or

''(iii) for any purpose other than making loans to eligible entities under this section.

''(6) TYPES OF ASSISTANCE.—Except as otherwise limited by applicable State law, amounts deposited into a State loan fund under this subsection may only be used for the following:

''(A) To award loans that comply with the following:

''(i) The interest rate for each loan shall be less than or equal to the market interest rate.

''(ii) The principal and interest payments on each loan shall commence not later than 1 year after the loan was awarded, and each loan shall be fully amortized not later than 10 years after the date of the loan.

''(iii) The State loan fund shall be credited with all payments of principal and interest on each loan awarded from the fund.

''(B) To guarantee, or purchase insurance for, a local obligation (all of the proceeds of which finance a project eligible for assistance under this subsection) if the guarantee or purchase would improve credit market access or reduce the interest rate applicable to the obligation involved.

''(C) As a source of revenue or security for the payment of principal and interest on revenue or general obligation bonds issued by the State if the proceeds of the sale of the bonds will be deposited into the State loan fund.

''(D) To earn interest on the amounts deposited into the State loan fund.

''(7) ADMINISTRATION OF STATE LOAN FUNDS.—

''(A) COMBINED FINANCIAL ADMINISTRATION.—A State may (as a convenience and to avoid unnecessary administrative costs) combine, in accordance with State law, the financial administration of a State loan fund established under this subsection with the financial administration of any other revolving fund established by the State if otherwise not prohibited by the law under which the State loan fund was established.

''(B) COST OF ADMINISTERING FUND.—Each State may annually use not to exceed 4 percent of the funds provided to the State under a grant under this subsection to pay the reasonable costs of the administration of the programs under this section, including the recovery of reasonable costs expended to establish a State loan fund which are incurred after the date of enactment of this title.

''(C) GUIDANCE AND REGULATIONS.—The Secretary shall publish guidance and promulgate regulations as may be necessary to carry out the provisions of this subsection, including—

''(i) provisions to ensure that each State commits and expends funds allotted to the State under this subsection as efficiently as possible in accordance with this title and applicable State laws; and

''(ii) guidance to prevent waste, fraud, and abuse.

''(D) PRIVATE SECTOR CONTRIBUTIONS.—

''(i) IN GENERAL.—A State loan fund established under this subsection may accept contributions from private sector entities, except that such entities may not specify the recipient or recipients of any loan issued under this subsection.

''(ii) AVAILABILITY OF INFORMATION.—A State shall make publically available the identity of, and amount contributed by, any private sector entity under clause (i) and may issue letters of commendation or make other awards (that have no financial value) to any such entity.

''(8) MATCHING REQUIREMENTS.—

''(A) IN GENERAL.—The Secretary may not make a grant under paragraph (1) to a State unless the State agrees to make available (directly or through donations from public or private entities) non-Federal contributions in cash toward the costs of the State program to be implemented under the grant in an amount equal to not less than $1 for each $1 of Federal funds provided under the grant.

''(B) DETERMINATION OF AMOUNT OF NON-FEDERAL CONTRIBUTION.—In determining the amount of non-Federal contributions that a State has provided pursuant to subparagraph (A), the Secretary may not include any amounts provided to the State by the Federal Government.

''(9) PREFERENCE IN AWARDING GRANTS.—The Secretary may give a preference in awarding grants under this subsection to States that adopt value-based purchasing programs to improve health care quality.

''(10) REPORTS.—The Secretary shall annually submit to the Committee on Health, Education, Labor, and Pensions and the Committee on Finance of the Senate, and the Committee on Energy and Commerce and the Committee on Ways and Means of the House of Representatives, a report summarizing the reports received by the Secretary from each State that receives a grant under this subsection.

''(c) GRANTS FOR THE IMPLEMENTATION OF REGIONAL OR LOCAL HEALTH INFORMATION TECHNOLOGY PLANS.—

''(1) IN GENERAL.—The Secretary may award competitive grants to eligible entities to implement regional or local health information plans to improve health care quality and efficiency through the electronic exchange of health information pursuant to the standards, protocols, and other requirements adopted by the Secretary under sections 2903 and 2908.

''(2) ELIGIBILITY.—To be eligible to receive a grant under paragraph (1) an entity shall—

''(A) demonstrate financial need to the Secretary;

''(B) demonstrate that one of its principal missions or purposes is to use information technology to improve health care quality and efficiency;

''(C) adopt bylaws, memoranda of understanding, or other charter documents that demonstrate that the governance structure and decisionmaking processes of such entity allow for participation on an ongoing basis by multiple stakeholders within a community, including—

''(i) physicians (as defined in section 1861(r) of the Social Security Act), including physicians that provide services to low income and underserved populations;

''(ii) hospitals (including hospitals that provide services to low income and underserved populations);

''(iii) pharmacists or pharmacies;

''(iv) health insurance plans;

''(v) health centers (as defined in section 330(b)) and Federally qualified health centers (as defined in section 1861(aa)(4) of the Social Security Act);

''(vi) rural health clinics (as defined in section 1861(aa) of the Social Security Act);

''(vii) patient or consumer organizations;

''(viii) employers; and

''(ix) any other health care providers or other entities, as determined appropriate by the Secretary;

''(D) adopt nondiscrimination and conflict of interest policies that demonstrate a commitment to open, fair, and nondiscriminatory participation in the health information plan by all stakeholders;

''(E) adopt the standards adopted by the Secretary under section 2903;

[''(F) require that health care providers receiving such loans implement the measurement system adopted under section 2908 and report to the Secretary on such measures;

[''(G) facilitate the electronic exchange of health information within the local or regional area and among local and regional areas;

[''(H) prepare and submit to the Secretary an application in accordance with paragraph (3); and

[''(I) agree to provide matching funds in accordance with paragraph (5).

[''(3) APPLICATION.—

[''(A) IN GENERAL.—To be eligible to receive a grant under paragraph (1), an entity shall submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require.

[''(B) REQUIRED INFORMATION.—At a minimum, an application submitted under this paragraph shall include—

[''(i) clearly identified short-term and long-term objectives of the regional or local health information plan;

[''(ii) a technology plan that complies with the standards adopted under section 2903 and that includes a descriptive and reasoned estimate of costs of the hardware, software, training, and consulting services necessary to implement the regional or local health information plan;

[''(iii) a strategy that includes initiatives to improve health care quality and efficiency, including the use and reporting of health care quality measures adopted under section 2908;

[''(iv) a plan that describes provisions to encourage the implementation of the electronic exchange of health information by all physicians, including single physician practices and small physician groups participating in the health information plan;

[''(v) a plan to ensure the privacy and security of personal health information that is consistent with Federal and State law;

[''(vi) a governance plan that defines the manner in which the stakeholders shall jointly make policy and operational decisions on an ongoing basis; and

[''(vii) a financial or business plan that describes—

['''(I) the sustainability of the plan;

['''(II) the financial costs and benefits of the plan; and

['''(III) the entities to which such costs and benefits will accrue.

[''(4) USE OF FUNDS.—Amounts received under a grant under paragraph (1) shall be used to establish and implement a regional or local health information plan in accordance with this subsection.

[''(5) MATCHING REQUIREMENT.—

[''(A) IN GENERAL.—The Secretary may not make a grant under this subsection to an entity unless the entity agrees that, with respect to the costs to be incurred by the entity in carrying out the infrastructure program for which the grant was 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 not less than 50 percent of such costs ($1 for each $2 of Federal funds provided under the grant).

[''(B) DETERMINATION OF AMOUNT CONTRIBUTED.—Non-Federal contributions required under subparagraph (A) may be in cash or in kind, fairly evaluated, including equipment, technology, or services. Amounts provided by the Federal Government, or services assisted or subsidized to any significant extent by the Federal Government, may not be included in determining the amount of such non-Federal contributions.

[''(d) REPORTS.—Not later than 1 year after the date on which the first grant is awarded under this section, and annually thereafter during the grant period, an entity that receives a grant under this section shall submit to the Secretary a report on the activities carried out under the grant involved. Each such report shall include—

[''(1) a description of the financial costs and benefits of the project involved and of the entities to which such costs and benefits accrue;

[''(2) an analysis of the impact of the project on health care quality and safety;

[''(3) a description of any reduction in duplicative or unnecessary care as a result of the project involved;

[''(4) a description of the efforts of recipients under this section to facilitate secure patient access to health information; and

[''(5) other information as required by the Secretary.

[''(e) AUTHORIZATION OF APPROPRIATIONS.—

[''(1) IN GENERAL.—For the purpose of carrying out this section, there is authorized to be appropriated $125,000,000 for fiscal year 2006, $150,000,000 for fiscal year 2007, and such sums as may be necessary for each of fiscal years 2008 through 2010.

[''(2) AVAILABILITY.—Amounts appropriated under paragraph (1) shall remain available through fiscal year 2010.

["SEC. 2906. DEMONSTRATION PROGRAM TO INTEGRATE INFORMATION TECHNOLOGY INTO CLINICAL EDUCATION.

[''(a) IN GENERAL.—The Secretary may award grants under this section to carry out demonstration projects to develop academic curricula integrating qualified health information technology systems in the clinical education of health professionals. Such awards shall be made on a competitive basis and pursuant to peer review.

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

[''(1) submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require;

[''(2) submit to the Secretary a strategic plan for integrating qualified health information technology in the clinical education of health professionals and for ensuring the consistent utilization of decision support software to reduce medical errors and enhance health care quality;

[''(3) be—

[''(A) a health professions school;

[''(B) a school of nursing; or

[''(C) a graduate medical education program;

[''(4) provide for the collection of data regarding the effectiveness of the demonstration project to be funded under the grant in improving the safety of patients, the efficiency of health care delivery, and in increasing the likelihood that graduates of the grantee will adopt and incorporate health information technology in the delivery of health care services; and

[''(5) provide matching funds in accordance with subsection (c).

[''(c) USE OF FUNDS.—

[''(1) IN GENERAL.—With respect to a grant under subsection (a), an eligible entity shall—

[''(A) use grant funds in collaboration with 2 or more disciplines; and

[''(B) use grant funds to integrate qualified health information technology into community-based clinical education.

[''(2) LIMITATION.—An eligible entity shall not use amounts received under a grant under subsection (a) to purchase hardware, software, or services.

[''(d) MATCHING FUNDS.—

[''(1) IN GENERAL.—The Secretary may award a grant to an entity under this section only if the entity agrees to make available non-Federal contributions toward the costs of the program to be funded under the grant in an amount that is not less than $1 for each $2 of Federal funds provided under the grant.

[''(2) DETERMINATION OF AMOUNT CONTRIBUTED.—Non-Federal contributions under paragraph (1) may be in cash or in kind, fairly evaluated, including equipment or services. Amounts provided by the Federal Government, or services assisted or subsidized to any significant extent by the Federal Government, may not be included in determining the amount of such contributions.

[''(e) EVALUATION.—The Secretary shall take such action as may be necessary to evaluate the projects funded under this section and publish, make available, and disseminate the results of such evaluations on as wide a basis as is practicable.

[''(f) REPORTS.—Not later than 1 year after the date of enactment of this title, and annually thereafter, the Secretary shall submit to the Committee on Health, Education, Labor, and Pensions and the Committee on Finance of the Senate, and the Committee on Energy and Commerce and the Committee on Ways and Means of the House of Representatives a report that—

[''(1) describes the specific projects established under this section; and

[''(2) contains recommendations for Congress based on the evaluation conducted under subsection (e).

[''(g) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this section, $5,000,000 for fiscal year 2007, and such sums as may be necessary for each of fiscal years 2008 through 2010.

[''(h) SUNSET.—This section shall not apply after September 30, 2010.

["SEC. 2907. LICENSURE AND THE ELECTRONIC EXCHANGE OF HEALTH INFORMATION.

[''(a) IN GENERAL.—The Secretary shall carry out, or contract with a private entity to carry out, a study that examines—

[''(1) the variation among State laws that relate to the licensure, registration, and certification of medical professionals; and

[''(2) how such variation among State laws impacts the secure electronic exchange of health information—

[''(A) among the States; and

[''(B) between the States and the Federal Government.

[''(b) REPORT AND RECOMMENDATIONS.—Not later than 1 year after the date of enactment of this title, the Secretary shall publish a report that—

[''(1) describes the results of the study carried out under subsection (a); and

[''(2) makes recommendations to States regarding the harmonization of State laws based on the results of such study.

["SEC. 2908. QUALITY MEASUREMENT SYSTEMS.

[''(a) IN GENERAL.—The Secretary of Health and Human Services, the Secretary of Veterans Affairs, the Secretary of Defense, and representatives of other relevant Federal agencies, as determined appropriate by the Secretary, (referred to in the section as the 'Secretaries') shall jointly develop a quality measurement system for the purpose of measuring the quality of care patients receive.

[''(b) REQUIREMENTS.—The Secretaries shall ensure that the quality measurement system developed under subsection (a) comply with the following:

[''(1) MEASURES.—

[''(A) IN GENERAL.—Subject to subparagraph (B), the Secretaries shall select measures of quality to be used by the Secretaries under the systems.

[''(B) REQUIREMENTS.—In selecting the measures to be used under each system pursuant to subparagraph (A), the Secretaries shall, to the extent feasible, ensure that—

[''(i) such measures are evidence based, reliable and valid;

[''(ii) such measures include measures of process, structure, patient experience, efficiency, and equity; and

[''(iii) such measures include measures of overuse, underuse, and misuse of health care items and services.

[''(2) PRIORITIES.—In developing the system under subsection (a), the Secretaries shall ensure that priority is given to—

[''(A) measures with the greatest potential impact for improving the quality and efficiency of care provided under Federal programs;

[''(B) measures that may be rapidly implemented by group health plans, health insurance issuers, physicians, hospitals, nursing homes, long-term care providers, and other providers; and

[''(C) measures which may inform health care decisions made by consumers and patients.

[''(3) WEIGHTS OF MEASURES.—The Secretaries shall assign weights to the measures used by the Secretaries under each system established under subsection (a).

[''(4) RISK ADJUSTMENT.—The Secretaries shall establish procedures to account for differences in patient health status, patient characteristics, and geographic location. To the extent practicable, such procedures shall recognize existing procedures.

[''(5) MAINTENANCE.—The Secretaries shall, as determined appropriate, but in no case more often than once during each 12-month period, update the quality measurement systems developed under subsection (a), including through—

[''(A) the addition of more accurate and precise measures under the systems and the retirement of existing outdated measures under the systems; and

[''(B) the refinement of the weights assigned to measures under the systems.

[''(c) REQUIRED CONSIDERATIONS IN DEVELOPING AND UPDATING THE SYSTEMS.—In developing and updating the quality measurement systems under this section, the Secretaries shall—

[''(1) consult with, and take into account the recommendations of, the entity that the Secretaries has an arrangement with under subsection (e);

[''(2) consult with representatives of health care providers, consumers, employers, and other individuals and groups that are interested in the quality of health care; and

[''(3) take into account—

[''(A) any demonstration or pilot program conducted by the Secretaries relating to measuring and rewarding quality and efficiency of care;

[''(B) any existing activities conducted by the Secretaries relating to measuring and rewarding quality and efficiency;

[''(C) any existing activities conducted by private entities including health insurance plans and payors; and

[''(D) the report by the Institute of Medicine of the National Academy of Sciences under section 238(b) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003.

[''(d) REQUIRED CONSIDERATIONS IN IMPLEMENTING THE SYSTEMS.—In implementing the quality measurement systems under this section, the Secretaries shall take into account the recommendations of public-private entities—

[''(1) that are established to examine issues of data collection and reporting, including the feasibility of collecting and reporting data on measures; and

[''(2) that involve representatives of health care providers, consumers, employers, and other individuals and groups that are interested in quality of care.

[''(e) ARRANGEMENT WITH AN ENTITY TO PROVIDE ADVICE AND RECOMMENDATIONS.—

[''(1) ARRANGEMENT.—On and after July 1, 2006, the Secretaries shall have in place an arrangement with an entity that meets the requirements described in paragraph (2) under which such entity provides the Secretaries with advice on, and recommendations with respect to, the development and updating of the quality measurement systems under this section, including the assigning of weights to the measures under subsection (b)(2).

[''(2) REQUIREMENTS DESCRIBED.—The requirements described in this paragraph are the following:

[''(A) The entity is a private nonprofit entity governed by an executive director and a board.

[''(B) The members of the entity include representatives of—

[''(i) health insurance plans and providers with experience in the care of individuals with multiple complex chronic conditions or groups representing such health insurance plans and providers;

[''(ii) groups representing patients and consumers;

[''(iii) purchasers and employers or groups representing purchasers or employers;

[''(iv) organizations that focus on quality improvement as well as the measurement and reporting of quality measures;

[''(v) State government health programs;

[''(vi) individuals or entities skilled in the conduct and interpretation of biomedical, health services, and health economics research and with expertise in outcomes and effectiveness research and technology assessment; and

[''(vii) individuals or entities involved in the development and establishment of standards and certification for health information technology systems and clinical data.

[''(C) The membership of the entity is representative of individuals with experience with urban health care issues and individuals with experience with rural and frontier health care issues.

[''(D) If the entity requires a fee for membership, the entity shall provide assurances to the Secretaries that such fees are not a substantial barrier to participation in the entity's activities related to the arrangement with the Secretaries.

[''(E) The entity—

[''(i) permits any member described in subparagraph (B) to vote on matters of the entity related to the arrangement with the Secretary under paragraph (1); and

[''(ii) ensures that member voting provides a balance among disparate stakeholders, so that no member organization described in subparagraph (B) unduly influences the outcome.

[''(F) With respect to matters related to the arrangement with the Secretary under paragraph (1), the entity conducts its business in an open and transparent manner and provides the opportunity for public comment.

[''(G) The entity operates as a voluntary consensus standards setting organization as defined for purposes of section 12(d) of the National Technology Transfer and Advancement Act of 1995 (Public Law 104–113) and Office of Management and Budget Revised Circular A–119 (published in the Federal Register on February 10, 1998).

[''(f) USE OF QUALITY MEASUREMENT SYSTEM.—

[''(1) IN GENERAL.—For purposes of activities conducted or supported by the Secretary under this Act, the Secretary shall, to the extent practicable, adopt and utilize the measurement system developed under this section.

[''(2) COLLABORATIVE AGREEMENTS.—With respect to activities conducted or supported by the Secretary under this Act, the Secretary may establish collaborative agreements with private entities, including group health plans and health insurance issuers, providers, purchasers, consumer organizations, and entities receiving a grant under section 2908, to—

[''(A) encourage the use of the health care quality measures adopted by the Secretary under this section; and

[''(B) foster uniformity between the health care quality measures utilized by private entities.

[''(g) DISSEMINATION OF INFORMATION.—Beginning on January 1, 2008, in order to make comparative quality information available to health care consumers, health professionals, public health officials, researchers, and other appropriate individuals and entities, the Secretary shall provide for the aggregation and analysis of quality measures collected under section 2905 and the dissemination of recommendations and best practices derived in part from such analysis.

[''(h) TECHNICAL ASSISTANCE.—The Secretary shall provide technical assistance to public and private entities to enable such entities to—

[''(1) implement and use evidence-based guidelines with the greatest potential to improve health care quality, efficiency, and patient safety; and

[''(2) establish mechanisms for the rapid dissemination of information regarding evidence-based guidelines with the greatest potential to improve health care quality, efficiency, and patient safety.

['SEC. 2909. APPLICABILITY OF PRIVACY AND SECURITY REGULATIONS.

[''The regulations promulgated by the Secretary under part C of title XI of the Social Security Act and sections 261, 262, 263, and 264 of the Health Insurance Portability and Accountability Act of 1996 with respect to the privacy, confidentiality, and security of health information shall—

[''(1) apply to any health information stored or transmitted in an electronic format on or after the date of enactment of this title; and

[''(2) apply to the implementation of standards, programs, and activities under this title.

['SEC. 2910. STUDY OF REIMBURSEMENT INCENTIVES.

[''The Secretary shall carry out, or contract with a private entity to carry out, a study that examines methods to create efficient reimbursement incentives for improving health care quality in Federally qualified health centers, rural health clinics, and free clinics.''.

[SEC. 3. HEALTH INFORMATION TECHNOLOGY RESOURCE CENTER.

[Section 914 of the Public Health Service Act (42 U.S.C. 299b–3) is amended by adding at the end the following:

[''(d) CENTER FOR BEST PRACTICES.—

[''(1) IN GENERAL.—The Secretary, acting through the Director, shall develop a Center for Best Practices to provide technical assistance and develop best practices to support and accelerate efforts to adopt, implement, and effectively use interoperable health information technology in compliance with section 2903 and 2908.

[''(2) CENTER FOR BEST PRACTICES.—

[''(A) IN GENERAL.—The Center shall support activities to meet goals, including—

[''(i) providing for the widespread adoption of interoperable health information technology;

[''(ii) providing for the establishment of regional and local health information networks to facilitate the development of interoperability across health care settings and improve the quality of health care;

[''(iii) the development of solutions to barriers to the exchange of electronic health information; or

[''(iv) other activities identified by the States, local or regional health information networks, or health care stakeholders as a focus for developing and sharing best practices.

[''(B) PURPOSES.—The purpose of the Center is to—

[''(i) provide a forum for the exchange of knowledge and experience;

[''(ii) accelerate the transfer of lessons learned from existing public and private sector initiatives, including those currently receiving Federal financial support;

[''(iii) assemble, analyze, and widely disseminate evidence and experience related to the adoption, implementation, and effective use of interoperable health information technology; and

[''(iv) assure the timely provision of technical and expert assistance from the Agency and its contractors.

[''(C) SUPPORT FOR ACTIVITIES.—To provide support for the activities of the Center, the Director shall modify the requirements, if necessary, that apply to the National Resource Center for Health Information Technology to provide the necessary infrastructure to support the duties and activities of the Center and facilitate information exchange across the public and private sectors.

[''(3) TECHNICAL ASSISTANCE TELEPHONE NUMBER OR WEBSITE.—The Secretary shall establish a toll-free telephone number or Internet website to provide health care providers and patients with a single point of contact to—

[''(A) learn about Federal grants and technical assistance services related to interoperable health information technology;

[''(B) learn about qualified health information technology and the quality measurement system adopted by the Federal Government under sections 2903 and 2908;

[''(C) learn about regional and local health information networks for assistance with health information technology; and

[''(D) disseminate additional information determined by the Secretary.

[''(4) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this subsection, such sums as may be necessary for each of fiscal years 2006 through 2010.''.

[SEC. 4. REAUTHORIZATION OF INCENTIVE GRANTS REGARDING TELEMEDICINE.

[Section 330L(b) of the Public Health Service Act (42 U.S.C. 254c–18(b)) is amended by striking ''2002 through 2006'' and inserting ''2006 through 2010''.]

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Wired for Health Care Quality Act''.

SEC. 2. IMPROVING HEALTH CARE QUALITY, SAFETY, AND EFFICIENCY.

The Public Health Service Act (42 U.S.C. 201 et seq.) is amended by adding at the end the following:

''TITLE XXIX—HEALTH INFORMATION TECHNOLOGY AND QUALITY

''SEC. 2901. DEFINITIONS.

''In this title:

''(1) HEALTH CARE PROVIDER.—The term 'health care provider' means a hospital, skilled nursing facility, home health entity, health care clinic, federally qualified health center, group practice (as defined in section 1877(h)(4) of the Social Security Act), a pharmacist, a pharmacy, a laboratory, a physician (as defined in section 1861(r) of the Social Security Act), a health facility operated by or pursuant to a contract with the Indian Health Service, a rural health clinic, and any other category of facility or clinician determined appropriate by the Secretary.

''(2) HEALTH INFORMATION.—The term 'health information' has the meaning given such term in section 1171(4) of the Social Security Act.

''(3) HEALTH INSURANCE PLAN.—The term 'health insurance plan' means—

''(A) a health insurance issuer (as defined in section 2791(b)(2));

''(B) a group health plan (as defined in section 2791(a)(1)); and

''(C) a health maintenance organization (as defined in section 2791(b)(3)).

''(4) LABORATORY.—The term 'laboratory' has the meaning given that term in section 353.

''(5) PHARMACIST.—The term 'pharmacist' has the meaning given that term in section 804 of the Federal Food, Drug, and Cosmetic Act.

''(6) QUALIFIED HEALTH INFORMATION TECHNOLOGY.—The term 'qualified health information technology' means a computerized system (including hardware and software) that—

''(A) protects the privacy and security of health information;

''(B) maintains and provides permitted access to health information in an electronic format;

''(C) incorporates decision support to reduce medical errors and enhance health care quality;

''(D) complies with the standards adopted by the Federal Government under section 2903; and

''(E) allows for the reporting of quality measures under section 2908.

''(7) STATE.—The term 'State' means each of the several States, the District of Columbia, Puerto Rico, the Virgin Islands, Guam, American Samoa, and the Northern Mariana Islands.

''SEC. 2902. OFFICE OF THE NATIONAL COORDINATOR OF HEALTH INFORMATION TECHNOLOGY.

''(a) OFFICE OF NATIONAL HEALTH INFORMATION TECHNOLOGY.—There is established within the Office of the Secretary an Office of the National Coordinator of Health Information Technology (referred to in this section as the 'Office'). The Office shall be headed by a National Coordinator who shall be appointed by the President, in consultation with the Secretary, and shall report directly to the Secretary.

''(b) PURPOSE.—It shall be the purpose of the Office to coordinate and oversee programs and activities to develop a nationwide interoperable health information technology infrastructure that—

''(1) ensures that patients' health information is secure and protected;

''(2) improves health care quality, reduces medical errors, and advances the delivery of patient-centered medical care;

''(3) reduces health care costs resulting from inefficiency, medical errors, inappropriate care, and incomplete information;

''(4) ensures that appropriate information to help guide medical decisions is available at the time and place of care;

''(5) promotes a more effective marketplace, greater competition, and increased choice through the wider availability of accurate information on health care costs, quality, and outcomes;

''(6) improves the coordination of care and information among hospitals, laboratories, physician offices, and other entities through an effective infrastructure for the secure and authorized exchange of health care information;

''(7) improves public health reporting and facilitates the early identification and rapid response to public health threats and emergencies, including bioterror events and infectious disease outbreaks;

''(8) facilitates health research; and

''(9) promotes prevention of chronic diseases.

''(c) DUTIES OF THE NATIONAL COORDINATOR.—The National Coordinator shall—

''(1) serve as a member of the public-private American Health Information Collaborative established under section 2903;

''(2) serve as the principal advisor to the Secretary concerning the development, application, and use of health information technology, and coordinate and oversee the health information technology programs of the Department;

''(3) facilitate the adoption of a nationwide, interoperable system for the electronic exchange of health information;

''(4) ensure the adoption and implementation of standards for the electronic exchange of health information to reduce cost and improve health care quality;

''(5) ensure that health information technology policy and programs of the Department are coordinated with those of relevant executive branch agencies (including Federal commissions) with a goal of avoiding duplication of efforts and of helping to ensure that each agency undertakes health information technology activities primarily within the areas of its greatest expertise and technical capability;

''(6) to the extent permitted by law, coordinate outreach and consultation by the relevant executive branch agencies (including Federal commissions) with public and private parties of interest, including consumers, payers, employers, hospitals and other health care providers, physicians, community health centers, laboratories, vendors and other stakeholders;

''(7) advise the President regarding specific Federal health information technology programs; and

''(8) submit the reports described under section 2903(i) (excluding paragraph (4) of such section).

''(d) DETAIL OF FEDERAL EMPLOYEES.—

''(1) IN GENERAL.—Upon the request of the National Coordinator, the head of any Federal agency is authorized to detail, with or without reimbursement from the Office, any of the personnel of such agency to the Office to assist it in carrying out its duties under this section.

''(2) EFFECT OF DETAIL.—Any detail of personnel under paragraph (1) shall—

''(A) not interrupt or otherwise affect the civil service status or privileges of the Federal employee; and

''(B) be in addition to any other staff of the Department employed by the National Coordinator.

''(3) ACCEPTANCE OF DETAILEES.—Notwithstanding any other provision of law, the Office may accept detailed personnel from other Federal agencies without regard to whether the agency described under paragraph (1) is reimbursed.

''(e) RULE OF CONSTRUCTION.—Nothing in this section shall be construed to require the duplication of Federal efforts with respect to the establishment of the Office, regardless of whether such efforts were carried out prior to or after the enactment of this title.

''(f) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section, $5,000,000 for fiscal year 2006, $5,000,000 for fiscal year 2007, and such sums as may be necessary for each of fiscal years 2008 through 2010.

''SEC. 2903. AMERICAN HEALTH INFORMATION COLLABORATIVE.

''(a) PURPOSE.—The Secretary shall establish the public-private American Health Information Collaborative (referred to in this section as the 'Collaborative') to—

''(1) advise the Secretary and recommend specific actions to achieve a nationwide interoperable health information technology infrastructure;

''(2) serve as a forum for the participation of a broad range of stakeholders to provide input on achieving the interoperability of health information technology; and

''(3) recommend standards (including content, communication, and security standards) for the electronic exchange of health information (including for the reporting of quality data under section 2908) for adoption by the Federal Government and voluntary adoption by private entities.

''(b) COMPOSITION.—

''(1) IN GENERAL.—The Collaborative shall be composed of—

''(A) the Secretary, who shall serve as the chairperson of the Collaborative;

''(B) the Secretary of Defense, or his or her designee;

''(C) the Secretary of Veterans Affairs, or his or her designee;

''(D) the Secretary of Commerce, or his or her designee;

''(E) the National Coordinator for Health Information Technology;

''(F) representatives of other relevant Federal agencies, as determined appropriate by the Secretary; and

''(G) representatives from each of the following categories to be appointed by the Secretary from nominations submitted by the public—

''(i) consumer and patient organizations;

''(ii) experts in health information privacy and security;

''(iii) health care providers;

''(iv) health insurance plans or other third party payors;

''(v) standards development organizations;

''(vi) information technology vendors;

''(vii) purchasers or employers; and

''(viii) State or local government agencies or Indian tribe or tribal organizations.

''(2) CONSIDERATIONS.—In appointing members under paragraph (1)(G), the Secretary shall select individuals with expertise in—

''(A) health information privacy;

''(B) health information security;

''(C) health care quality and patient safety, including those individuals with expertise in utilizing health information technology to improve health care quality and patient safety;

''(D) data exchange; and

''(E) developing health information technology standards and new health information technology.

''(3) PARTICIPATION.—Membership and procedures of the Collaborative shall ensure a balance among various sectors of the healthcare system so that no single sector unduly influences the recommendations of the Collaborative.

''(4) TERMS.—Members appointed under paragraph (1)(G) shall serve for 2 year terms, except that any member appointed to fill a vacancy for an unexpired term shall be appointed for the remainder of such term. A member may serve for not to exceed 180 days after the expiration of such member's term or until a successor has been appointed.

''(c) RECOMMENDATIONS AND POLICIES.—Not later than 1 year after the date of enactment of this title, and annually thereafter, the Collaborative shall recommend to the Secretary uniform national policies for adoption by the Federal Government and voluntary adoption by private entities to support the widespread adoption of health information technology, including—

''(1) protection of health information through privacy and security practices;

''(2) measures to prevent unauthorized access to health information;

''(3) methods to facilitate secure patient access to health information;

''(4) fostering the public understanding of health information technology;

''(5) the ongoing harmonization of industry-wide health information technology standards;

''(6) recommendations for a nationwide interoperable health information technology infrastructure;

''(7) the identification and prioritization of specific use cases for which health information technology is valuable, beneficial, and feasible;

''(8) recommendations for the establishment of an entity to ensure the continuation of the functions of the Collaborative; and

''(9) other policies (including recommendations for incorporating health information technology into the provision of care and the organization of the health care workplace) determined to be necessary by the Collaborative.

''(d) STANDARDS.—

''(1) EXISTING STANDARDS.—The standards adopted by the Consolidated Health Informatics Initiative shall be deemed to have been recommended by the Collaborative under this section.

''(2) FIRST YEAR REVIEW.—Not later than 1 year after the date of enactment of this title, the Collaborative shall—

''(A) review existing standards (including content, communication, and security standards) for the electronic exchange of health information, including such standards adopted by the Secretary under paragraph (2)(A);

''(B) identify deficiencies and omissions in such existing standards; and

''(C) identify duplication and overlap in such existing standards;

and recommend new standards and modifications to such existing standards as necessary.

''(3) ONGOING REVIEW.—Beginning 1 year after the date of enactment of this title, and annually thereafter, the Collaborative shall—

''(A) review existing standards (including content, communication, and security standards) for the electronic exchange of health information, including such standards adopted by the Secretary under paragraph (2)(A);

''(B) identify deficiencies and omissions in such existing standards; and

''(C) identify duplication and overlap in such existing standards;

and recommend new standards and modifications to such existing standards as necessary.

''(4) LIMITATION.—The standards and timeframe for adoption described in this section shall be consistent with any standards developed pursuant to the Health Insurance Portability and Accountability Act of 1996.

''(e) FEDERAL ACTION.—Not later than 60 days after the issuance of a recommendation from the Collaborative under subsection (d)(2), the Secretary of Health and Human Services, the Secretary of Veterans Affairs, and the Secretary of Defense, in collaboration with representatives of other relevant Federal agencies, as determined appropriate by the Secretary, shall jointly review such recommendations. The Secretary shall provide for the adoption by the Federal Government of any standard or standards contained in such recommendation.

''(f) COORDINATION OF FEDERAL SPENDING.—Not later than 1 year after the adoption by the Federal Government of a recommendation as provided for in subsection (e), and in compliance with chapter 113 of title 40, United States Code, no Federal agency shall expend Federal funds for the purchase of any form of health information technology or health information technology system for clinical care or for the electronic retrieval, storage, or exchange of health information that is not consistent with applicable standards adopted by the Federal Government under subsection (e).

''(g) COORDINATION OF FEDERAL DATA COLLECTION.—Not later than 3 years after the adoption by the Federal Government of a recommendation as provided for in subsection (e), all Federal agencies collecting health data for the purposes of quality reporting, surveillance, epidemiology, adverse event reporting, research, or for other purposes determined appropriate by the Secretary, shall comply with standards adopted under subsection (e).

''(h) VOLUNTARY ADOPTION.—

''(1) IN GENERAL.—Any standards adopted by the Federal Government under subsection (e) shall be voluntary with respect to private entities.

''(2) RULE OF CONSTRUCTION.—Nothing in this section shall be construed to require that a private entity that enters into a contract with the Federal Government adopt the standards adopted by the Federal Government under section 2903 with respect to activities not related to the contract.

''(3) LIMITATION.—Private entities that enter into a contract with the Federal Government shall adopt the standards adopted by the Federal Government under section 2903 for the purpose of activities under such Federal contract.

''(i) REPORTS.—The Secretary shall submit to the Committee on Health, Education, Labor, and Pensions and the Committee on Finance of the Senate and the Committee on Energy and Commerce and the Committee on Ways and Means of the House of Representatives, on an annual basis, a report that—

''(1) describes the specific actions that have been taken by the Federal Government and private entities to facilitate the adoption of an interoperable nationwide system for the electronic exchange of health information;

''(2) describes barriers to the adoption of such a nationwide system;

''(3) contains recommendations to achieve full implementation of such a nationwide system; and

''(4) contains a plan and progress toward the establishment of an entity to ensure the continuation of the functions of the Collaborative.

''(j) APPLICATION OF FACA.—The Federal Advisory Committee Act (5 U.S.C. App.) shall apply to the Collaborative, except that the term provided for under section 14(a)(2) shall be 5 years.

''(k) RULE OF CONSTRUCTION.—Nothing in this section shall be construed to require the duplication of Federal efforts with respect to the establishment of the Collaborative, regardless of whether such efforts were carried out prior to or after the enactment of this title.

''(l) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section, $4,000,000 for fiscal year 2006, $4,000,000 for fiscal year 2007, and such sums as may be necessary for each of fiscal years 2008 through 2010.

''SEC. 2904. IMPLEMENTATION AND CERTIFICATION OF HEALTH INFORMATION STANDARDS.

''(a) IMPLEMENTATION.—

''(1) IN GENERAL.—The Secretary, based upon the recommendations of the Collaborative, shall develop criteria to ensure uniform and consistent implementation of any standards for the electronic exchange of health information voluntarily adopted by private entities in technical conformance with such standards adopted under this title.

''(2) IMPLEMENTATION ASSISTANCE.—The Secretary may recognize a private entity or entities to assist private entities in the implementation of the standards adopted under this title using the criteria developed by the Secretary under this section.

''(b) CERTIFICATION.—

''(1) IN GENERAL.—The Secretary, based upon the recommendations of the Collaborative, shall develop criteria to ensure and certify that hardware and software that claim to be in compliance with any standard for the electronic exchange of health information adopted under this title have established and maintained such compliance in technical conformance with such standards.

''(2) CERTIFICATION ASSISTANCE.—The Secretary may recognize a private entity or entities to assist in the certification described under paragraph (1) using the criteria developed by the Secretary under this section.

''(c) DELEGATION AUTHORITY.—The Secretary, through consultation with the Collaborative, may accept recommendations on the development of the criteria under subsections (a) and (b) from a Federal agency or private entity.

"SEC. 2905. GRANTS TO FACILITATE THE WIDESPREAD ADOPTION OF INTEROPERABLE HEALTH INFORMATION TECHNOLOGY.

''(a) COMPETITIVE GRANTS TO FACILITATE THE WIDESPREAD ADOPTION OF HEALTH INFORMATION TECHNOLOGY.—

''(1) IN GENERAL.—The Secretary may award competitive grants to eligible entities to facilitate the purchase and enhance the utilization of qualified health information technology systems to improve the quality and efficiency of health care.

''(2) ELIGIBILITY.—To be eligible to receive a grant under paragraph (1) an entity shall—

''(A) submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require;

''(B) submit to the Secretary a strategic plan for the implementation of data sharing and interoperability measures;

''(C) be a—

''(i) not for profit hospital;

''(ii) individual or group practice; or

''(iii) another health care provider not described in clause (i) or (ii);

''(D) adopt the standards adopted by the Federal Government under section 2903;

''(E) implement the measurement system adopted under section 2908 and report to the Secretary on such measures;

''(F) demonstrate significant financial need; and

''(G) provide matching funds in accordance with paragraph (4).

''(3) USE OF FUNDS.—Amounts received under a grant under this subsection shall be used to facilitate the purchase and enhance the utilization of qualified health information technology systems and training personnel in the use of such technology.

''(4) MATCHING REQUIREMENT.—To be eligible for a grant under this subsection an entity shall contribute non-Federal contributions to the costs of carrying out the activities for which the grant is awarded in an amount equal to $1 for each $3 of Federal funds provided under the grant.

''(5) PREFERENCE IN AWARDING GRANTS.—In awarding grants under this subsection the Secretary shall give preference to—

''(A) eligible entities that are located in rural, frontier, and other underserved areas as determined by the Secretary;

''(B) eligible entities that will link, to the extent practicable, the qualified health information system to local or regional health information plan or plans; and

''(C) with respect to an entity described in subsection (a)(2)(C)(iii), a nonprofit health care provider.

''(b) COMPETITIVE GRANTS TO STATES FOR THE DEVELOPMENT OF STATE LOAN PROGRAMS TO FACILITATE THE WIDESPREAD ADOPTION OF HEALTH INFORMATION TECHNOLOGY.—

''(1) IN GENERAL.—The Secretary may award competitive grants to States for the establishment of State programs for loans to health care providers to facilitate the purchase and enhance the utilization of qualified health information technology.

''(2) ESTABLISHMENT OF FUND.—To be eligible to receive a competitive grant under this subsection, a State shall establish a qualified health information technology loan fund (referred to in this subsection as a 'State loan fund') and comply with the other requirements contained in this section. A grant to a State under this subsection shall be deposited in the State loan fund established by the State. No funds authorized by other provisions of this title to be used for other purposes specified in this title shall be deposited in any State loan fund.

''(3) ELIGIBILITY.—To be eligible to receive a grant under paragraph (1) a State shall—

''(A) submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require;

''(B) submit to the Secretary a strategic plan in accordance with paragraph (4);

''(C) establish a qualified health information technology loan fund in accordance with paragraph (2);

''(D) require that health care providers receiving such loans—

''(i) link, to the extent practicable, the qualified health information system to a local or regional health information network; and

''(ii) consult with the Health Information Technology Resource Center established in section 914(d) to access the knowledge and experience of existing initiatives regarding the successful implementation and effective use of health information technology;

''(E) require that health care providers receiving such loans adopt the standards adopted by the Federal Government under section 2903;

''(F) require that health care providers receiving such loans implement the measurement system adopted under section 2908 and report to the Secretary on such measures; and

''(G) provide matching funds in accordance with paragraph (8).

''(4) STRATEGIC PLAN.—

''(A) IN GENERAL.—A State that receives a grant under this subsection shall annually prepare a strategic plan that identifies the intended uses of amounts available to the State loan fund of the State.

''(B) CONTENTS.—A strategic plan under subparagraph (A) shall include—

''(i) a list of the projects to be assisted through the State loan fund in the first fiscal year that begins after the date on which the plan is submitted;

''(ii) a description of the criteria and methods established for the distribution of funds from the State loan fund; and

''(iii) a description of the financial status of the State loan fund and the short-term and long-term goals of the State loan fund.

''(5) USE OF FUNDS.—

''(A) IN GENERAL.—Amounts deposited in a State loan fund, including loan repayments and interest earned on such amounts, shall be used only for awarding loans or loan guarantees, or as a source of reserve and security for leveraged loans, the proceeds of which are deposited in the State loan fund established under paragraph (1). Loans under this section may be used by a health care provider to facilitate the purchase and enhance the utilization of qualified health information technology and training of personnel in the use of such technology.

''(B) LIMITATION.—Amounts received by a State under this subsection may not be used—

''(i) for the purchase or other acquisition of any health information technology system that is not a qualified health information technology system;

''(ii) to conduct activities for which Federal funds are expended under this title, or the amendments made by the Wired for Health Care Quality Act; or

''(iii) for any purpose other than making loans to eligible entities under this section.

''(6) TYPES OF ASSISTANCE.—Except as otherwise limited by applicable State law, amounts deposited into a State loan fund under this subsection may only be used for the following:

''(A) To award loans that comply with the following:

''(i) The interest rate for each loan shall be less than or equal to the market interest rate.

''(ii) The principal and interest payments on each loan shall commence not later than 1 year after the loan was awarded, and each loan shall be fully amortized not later than 10 years after the date of the loan.

''(iii) The State loan fund shall be credited with all payments of principal and interest on each loan awarded from the fund.

''(B) To guarantee, or purchase insurance for, a local obligation (all of the proceeds of which finance a project eligible for assistance under this subsection) if the guarantee or purchase would improve credit market access or reduce the interest rate applicable to the obligation involved.

''(C) As a source of revenue or security for the payment of principal and interest on revenue or general obligation bonds issued by the State if the proceeds of the sale of the bonds will be deposited into the State loan fund.

''(D) To earn interest on the amounts deposited into the State loan fund.

''(7) ADMINISTRATION OF STATE LOAN FUNDS.—

''(A) COMBINED FINANCIAL ADMINISTRATION.—A State may (as a convenience and to avoid unnecessary administrative costs) combine, in accordance with State law, the financial administration of a State loan fund established under this subsection with the financial administration of any other revolving fund established by the State if otherwise not prohibited by the law under which the State loan fund was established.

''(B) COST OF ADMINISTERING FUND.—Each State may annually use not to exceed 4 percent of the funds provided to the State under a grant under this subsection to pay the reasonable costs of the administration of the programs under this section, including the recovery of reasonable costs expended to establish a State loan fund which are incurred after the date of enactment of this title.

''(C) GUIDANCE AND REGULATIONS.—The Secretary shall publish guidance and promulgate regulations as may be necessary to carry out the provisions of this subsection, including—

''(i) provisions to ensure that each State commits and expends funds allotted to the State under this subsection as efficiently as possible in accordance with this title and applicable State laws; and

''(ii) guidance to prevent waste, fraud, and abuse.

''(D) PRIVATE SECTOR CONTRIBUTIONS.—

''(i) IN GENERAL.—A State loan fund established under this subsection may accept contributions from private sector entities, except that such entities may not specify the recipient or recipients of any loan issued under this subsection.

''(ii) AVAILABILITY OF INFORMATION.—A State shall make publicly available the identity of, and amount contributed by, any private sector entity under clause (i) and may issue letters of commendation or make other awards (that have no financial value) to any such entity.

''(8) MATCHING REQUIREMENTS.—

''(A) IN GENERAL.—The Secretary may not make a grant under paragraph (1) to a State unless the State agrees to make available (directly or through donations from public or private entities) non-Federal contributions in cash toward the costs of the State program to be implemented under the grant in an amount equal to not less than $1 for each $1 of Federal funds provided under the grant.

''(B) DETERMINATION OF AMOUNT OF NON-FEDERAL CONTRIBUTION.—In determining the amount of non-Federal contributions that a State has provided pursuant to subparagraph (A), the Secretary may not include any amounts provided to the State by the Federal Government.

''(9) PREFERENCE IN AWARDING GRANTS.—The Secretary may give a preference in awarding grants under this subsection to States that adopt value-based purchasing programs to improve health care quality.

''(10) REPORTS.—The Secretary shall annually submit to the Committee on Health, Education, Labor, and Pensions and the Committee on Finance of the Senate, and the Committee on Energy and Commerce and the Committee on Ways and Means of the House of Representatives, a report summarizing the reports received by the Secretary from each State that receives a grant under this subsection.

''(c) COMPETITIVE GRANTS FOR THE IMPLEMENTATION OF REGIONAL OR LOCAL HEALTH INFORMATION TECHNOLOGY PLANS.—

''(1) IN GENERAL.—The Secretary may award competitive grants to eligible entities to implement regional or local health information plans to improve health care quality and efficiency through the electronic exchange of health information pursuant to the standards, protocols, and other requirements adopted by the Secretary under sections 2903 and 2908.

''(2) ELIGIBILITY.—To be eligible to receive a grant under paragraph (1) an entity shall—

''(A) demonstrate financial need to the Secretary;

''(B) demonstrate that one of its principal missions or purposes is to use information technology to improve health care quality and efficiency;

''(C) adopt bylaws, memoranda of understanding, or other charter documents that demonstrate that the governance structure and decisionmaking processes of such entity allow for participation on an ongoing basis by multiple stakeholders within a community, including—

''(i) physicians (as defined in section 1861(r) of the Social Security Act), including physicians that provide services to low income and underserved populations;

''(ii) hospitals (including hospitals that provide services to low income and underserved populations);

''(iii) pharmacists or pharmacies;

''(iv) health insurance plans;

''(v) health centers (as defined in section 330(b)) and Federally qualified health centers (as defined in section 1861(aa)(4) of the Social Security Act);

''(vi) rural health clinics (as defined in section 1861(aa) of the Social Security Act);

''(vii) patient or consumer organizations;

''(viii) employers; and

''(ix) any other health care providers or other entities, as determined appropriate by the Secretary;

''(D) demonstrate the participation, to the extent practicable, of stakeholders in the electronic exchange of health information within the local or regional plan pursuant to paragraph (2)(C);

''(E) adopt nondiscrimination and conflict of interest policies that demonstrate a commitment to open, fair, and nondiscriminatory participation in the health information plan by all stakeholders;

''(F) adopt the standards adopted by the Secretary under section 2903;

''(G) require that health care providers receiving such grants implement the measurement system adopted under section 2908 and report to the Secretary on such measures;

''(H) facilitate the electronic exchange of health information within the local or regional area and among local and regional areas;

''(I) prepare and submit to the Secretary an application in accordance with paragraph (3); and

''(J) agree to provide matching funds in accordance with paragraph (5).

''(3) APPLICATION.—

''(A) IN GENERAL.—To be eligible to receive a grant under paragraph (1), an entity shall submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require.

''(B) REQUIRED INFORMATION.—At a minimum, an application submitted under this paragraph shall include—

''(i) clearly identified short-term and long-term objectives of the regional or local health information plan;

''(ii) a technology plan that complies with the standards adopted under section 2903 and that includes a descriptive and reasoned estimate of costs of the hardware, software, training, and consulting services necessary to implement the regional or local health information plan;

''(iii) a strategy that includes initiatives to improve health care quality and efficiency, including the use and reporting of health care quality measures adopted under section 2908;

''(iv) a plan that describes provisions to encourage the implementation of the electronic exchange of health information by all physicians, including single physician practices and small physician groups participating in the health information plan;

''(v) a plan to ensure the privacy and security of personal health information that is consistent with Federal and State law;

''(vi) a governance plan that defines the manner in which the stakeholders shall jointly make policy and operational decisions on an ongoing basis;

''(vii) a financial or business plan that describes—

''(I) the sustainability of the plan;

''(II) the financial costs and benefits of the plan; and

''(III) the entities to which such costs and benefits will accrue; and

''(viii) if the case of an applicant entity that is unable to demonstrate the participation of all stakeholders pursuant to paragraph (2)(C), the justification from the entity for any such nonparticipation.

''(4) USE OF FUNDS.—Amounts received under a grant under paragraph (1) shall be used to establish and implement a regional or local health information plan in accordance with this subsection.

''(5) MATCHING REQUIREMENT.—

''(A) IN GENERAL.—The Secretary may not make a grant under this subsection to an entity unless the entity agrees that, with respect to the costs to be incurred by the entity in carrying out the infrastructure program for which the grant was 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 not less than 50 percent of such costs ($1 for each $2 of Federal funds provided under the grant).

''(B) DETERMINATION OF AMOUNT CONTRIBUTED.—Non-Federal contributions required under subparagraph (A) may be in cash or in kind, fairly evaluated, including equipment, technology, or services. Amounts provided by the Federal Government, or services assisted or subsidized to any significant extent by the Federal Government, may not be included in determining the amount of such non-Federal contributions.

''(d) REPORTS.—Not later than 1 year after the date on which the first grant is awarded under this section, and annually thereafter during the grant period, an entity that receives a grant under this section shall submit to the Secretary a report on the activities carried out under the grant involved. Each such report shall include—

''(1) a description of the financial costs and benefits of the project involved and of the entities to which such costs and benefits accrue;

''(2) an analysis of the impact of the project on health care quality and safety;

''(3) a description of any reduction in duplicative or unnecessary care as a result of the project involved;

''(4) a description of the efforts of recipients under this section to facilitate secure patient access to health information; and

''(5) other information as required by the Secretary.

''(e) REQUIREMENT TO ACHIEVE QUALITY IMPROVEMENT.—The Secretary shall annually evaluate the activities conducted under this section and shall, in awarding grants, implement the lessons learned from such evaluation in a manner so that awards made subsequent to each such evaluation are made in a manner that, in the determination of the Secretary, will result in the greatest improvement in quality measurement systems under section 2908.

''(f) LIMITATION.—An eligible entity may only receive one non-renewable grant under subsection (a), one non-renewable grant under subsection (b), and one non-renewable grant under subsection (c).

''(g) AUTHORIZATION OF APPROPRIATIONS.—

''(1) IN GENERAL.—For the purpose of carrying out this section, there is authorized to be appropriated $116,000,000 for fiscal year 2006, $141,000,000 for fiscal year 2007, and such sums as may be necessary for each of fiscal years 2008 through 2010.

''(2) AVAILABILITY.—Amounts appropriated under paragraph (1) shall remain available through fiscal year 2010.

''SEC. 2906. DEMONSTRATION PROGRAM TO INTEGRATE INFORMATION TECHNOLOGY INTO CLINICAL EDUCATION.

''(a) IN GENERAL.—The Secretary may award grants under this section to carry out demonstration projects to develop academic curricula integrating qualified health information technology systems in the clinical education of health professionals. Such awards shall be made on a competitive basis and pursuant to peer review.

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

''(1) submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require;

''(2) submit to the Secretary a strategic plan for integrating qualified health information technology in the clinical education of health professionals and for ensuring the consistent utilization of decision support software to reduce medical errors and enhance health care quality;

''(3) be—

''(A) a health professions school;

''(B) a school of nursing; or

''(C) an institution with a graduate medical education program;

''(4) provide for the collection of data regarding the effectiveness of the demonstration project to be funded under the grant in improving the safety of patients, the efficiency of health care delivery, and in increasing the likelihood that graduates of the grantee will adopt and incorporate health information technology, and implement the quality measurement system adopted under section 2908, in the delivery of health care services; and

''(5) provide matching funds in accordance with subsection (c).

''(c) USE OF FUNDS.—

''(1) IN GENERAL.—With respect to a grant under subsection (a), an eligible entity shall—

''(A) use grant funds in collaboration with 2 or more disciplines; and

''(B) use grant funds to integrate qualified health information technology into community-based clinical education.

''(2) LIMITATION.—An eligible entity shall not use amounts received under a grant under subsection (a) to purchase hardware, software, or services.

''(d) MATCHING FUNDS.—

''(1) IN GENERAL.—The Secretary may award a grant to an entity under this section only if the entity agrees to make available non-Federal contributions toward the costs of the program to be funded under the grant in an amount that is not less than $1 for each $2 of Federal funds provided under the grant.

''(2) DETERMINATION OF AMOUNT CONTRIBUTED.—Non-Federal contributions under paragraph (1) may be in cash or in kind, fairly evaluated, including equipment or services. Amounts provided by the Federal Government, or services assisted or subsidized to any significant extent by the Federal Government, may not be included in determining the amount of such contributions.

''(e) EVALUATION.—The Secretary shall take such action as may be necessary to evaluate the projects funded under this section and publish, make available, and disseminate the results of such evaluations on as wide a basis as is practicable.

''(f) REPORTS.—Not later than 1 year after the date of enactment of this title, and annually thereafter, the Secretary shall submit to the Committee on Health, Education, Labor, and Pensions and the Committee on Finance of the Senate, and the Committee on Energy and Commerce and the Committee on Ways and Means of the House of Representatives a report that—

''(1) describes the specific projects established under this section; and

''(2) contains recommendations for Congress based on the evaluation conducted under subsection (e).

''(g) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this section, $5,000,000 for fiscal year 2007, and such sums as may be necessary for each of fiscal years 2008 through 2010.

''(h) SUNSET.—This section shall not apply after September 30, 2010.

''SEC. 2907. LICENSURE AND THE ELECTRONIC EXCHANGE OF HEALTH INFORMATION.

''(a) IN GENERAL.—The Secretary shall carry out, or contract with a private entity to carry out, a study that examines—

''(1) the variation among State laws that relate to the licensure, registration, and certification of medical professionals; and

''(2) how such variation among State laws impacts the secure electronic exchange of health information—

''(A) among the States; and

''(B) between the States and the Federal Government.

''(b) REPORT AND RECOMMENDATIONS.—Not later than 1 year after the date of enactment of this title, the Secretary shall publish a report that—

''(1) describes the results of the study carried out under subsection (a); and

''(2) makes recommendations to States regarding the harmonization of State laws based on the results of such study.

''SEC. 2908. QUALITY MEASUREMENT SYSTEM.

''(a) IN GENERAL.—The Secretary, in consultation with the Secretary of Veterans Affairs, the Secretary of Defense, and representatives of other relevant Federal agencies, as determined appropriate by the Secretary, shall develop or adopt a quality measurement system, including measures to assess that effectiveness, timeliness, patient self-management, patient centeredness, efficiency, and safety, for the purpose of measuring the quality of care patients receive.

''(b) REQUIREMENTS.—The Secretary shall ensure that the quality measurement system developed under subsection (a) comply with the following:

''(1) MEASURES.—

''(A) IN GENERAL.—Subject to subparagraph (B), the Secretary shall select measures of quality to be used by the Secretary under the systems.

''(B) REQUIREMENTS.—In selecting the measures to be used under each system pursuant to subparagraph (A), the Secretary shall, to the extent feasible, ensure that—

''(i) such measures are evidence based, reliable and valid;

''(ii) such measures include measures of clinical processes and outcomes, patient experience, efficiency, and equity; and

''(iii) such measures include measures of overuse and underuse of health care items and services.

''(2) PRIORITIES.—In developing the system under subsection (a), the Secretary shall ensure that priority is given to—

''(A) measures with the greatest potential impact for improving the quality and efficiency of care provided under Federal programs;

''(B) measures that may be rapidly implemented by group health plans, health insurance issuers, physicians, hospitals, nursing homes, long-term care providers, and other providers; and

''(C) measures which may inform health care decisions made by consumers and patients.

''(3) WEIGHTS OF MEASURES.—The Secretary shall assign weights to the measures used by the Secretary under each system established under subsection (a).

''(4) RISK ADJUSTMENT.—The Secretary shall establish procedures to account for differences in patient health status, patient characteristics, and geographic location. To the extent practicable, such procedures shall recognize existing procedures.

''(5) MAINTENANCE.—The Secretary shall, as determined appropriate, but in no case more often than once during each 12-month period, update the quality measurement systems developed under subsection (a), including through—

''(A) the addition of more accurate and precise measures under the systems and the retirement of existing outdated measures under the systems; and

''(B) the refinement of the weights assigned to measures under the systems.

''(c) REQUIRED CONSIDERATIONS IN DEVELOPING AND UPDATING THE SYSTEMS.—In developing and updating the quality measurement systems under this section, the Secretary shall—

''(1) consult with, and take into account the recommendations of, the entity that the Secretary has an arrangement with under subsection (e);

''(2) consult with representatives of health care providers (including physicians, pharmacists, nurses, and other health care professionals), consumers, employers, and other individuals and groups that are interested in the quality of health care; and

''(3) take into account—

''(A) any demonstration or pilot program conducted by the Secretary relating to measuring and rewarding quality and efficiency of care;

''(B) any existing activities conducted by the Secretary relating to measuring and rewarding quality and efficiency;

''(C) any existing activities conducted by private entities including health insurance plans and payors; and

''(D) the report by the Institute of Medicine of the National Academy of Sciences under section 238(b) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003.

''(d) REQUIRED CONSIDERATIONS IN IMPLEMENTING THE SYSTEMS.—In implementing the quality measurement systems under this section, the Secretary shall take into account the recommendations of public-private entities—

''(1) that are established to examine issues of data collection and reporting, including the feasibility of collecting and reporting data on measures; and

''(2) that involve representatives of health care providers (including physicians, pharmacists, nurses, and other health care professionals), consumers, employers, and other individuals and groups that are interested in quality of care.

''(e) ARRANGEMENT WITH AN ENTITY TO PROVIDE ADVICE AND RECOMMENDATIONS.—

''(1) ARRANGEMENT.—On and after July 1, 2006, the Secretary shall have in place an arrangement with an entity that meets the requirements described in paragraph (2) under which such entity provides the Secretary with advice on, and recommendations with respect to, the development and updating of the quality measurement systems under this section, including the assigning of weights to the measures under subsection (b)(2).

''(2) REQUIREMENTS DESCRIBED.—The requirements described in this paragraph are the following:

''(A) The entity is a private nonprofit entity governed by an executive director and a board.

''(B) The members of the entity include representatives of—

''(i) health insurance plans and health care providers with experience in the care of individuals with multiple complex chronic conditions or groups representing such health insurance plans and providers;

''(ii) groups representing patients and consumers;

''(iii) purchasers and employers or groups representing purchasers or employers;

''(iv) organizations that focus on quality improvement as well as the measurement and reporting of quality measures;

''(v) State government health programs;

''(vi) individuals or entities skilled in the conduct and interpretation of biomedical, health services, and health economics research and with expertise in outcomes and effectiveness research and technology assessment; and

''(vii) individuals or entities involved in the development and establishment of standards and certification for health information technology systems and clinical data.

''(C) The membership of the entity is representative of individuals with experience with urban health care issues and individuals with experience with rural and frontier health care issues.

''(D) If the entity requires a fee for membership, the entity shall provide assurances to the Secretary that such fees are not a substantial barrier to participation in the entity's activities related to the arrangement with the Secretary.

''(E) The entity—

''(i) permits any member described in subparagraph (B) to vote on matters of the entity related to the arrangement with the Secretary under paragraph (1); and

''(ii) ensures that member voting provides a balance among disparate stakeholders, so that no member organization described in subparagraph (B) unduly influences the outcome.

''(F) With respect to matters related to the arrangement with the Secretary under paragraph (1), the entity conducts its business in an open and transparent manner and provides the opportunity for public comment.

''(G) The entity operates as a voluntary consensus standards setting organization as defined for purposes of section 12(d) of the National Technology Transfer and Advancement Act of 1995 (Public Law 104–113) and Office of Management and Budget Revised Circular A–119 (published in the Federal Register on February 10, 1998).

''(f) USE OF QUALITY MEASUREMENT SYSTEM.—

''(1) IN GENERAL.—For purposes of activities conducted or supported by the Secretary under this Act, the Secretary shall, to the extent practicable, adopt and utilize the measurement system developed under this section.

''(2) COLLABORATIVE AGREEMENTS.—With respect to activities conducted or supported by the Secretary under this Act, the Secretary may establish collaborative agreements with private entities, including group health plans and health insurance issuers, providers, purchasers, consumer organizations, and entities receiving a grant under section 2905, to—

''(A) encourage the use of the health care quality measures adopted by the Secretary under this section; and

''(B) foster uniformity between the health care quality measures utilized by private entities.

''(3) REPORTING.—The Secretary shall implement procedures to enable the Department of Health and Human Services to accept the electronic submission of data for purposes of quality measurement using the quality measurement system adopted under this section and using the standards adopted by the Federal Government under section 2903.

''(g) DISSEMINATION OF INFORMATION.—Beginning on January 1, 2008, in order to make comparative quality information available to health care consumers, health professionals, public health officials, researchers, and other appropriate individuals and entities, the Secretary shall provide for the dissemination, aggregation, and analysis of quality measures collected under section 2905 and the dissemination of recommendations and best practices derived in part from such analysis.

''(h) TECHNICAL ASSISTANCE.—The Secretary shall provide technical assistance to public and private entities to enable such entities to—

''(1) implement and use evidence-based guidelines with the greatest potential to improve health care quality, efficiency, and patient safety; and

''(2) establish mechanisms for the rapid dissemination of information regarding evidence-based guidelines with the greatest potential to improve health care quality, efficiency, and patient safety.

''SEC. 2909. ENSURING PRIVACY AND SECURITY.

''Nothing in this title shall be construed to affect the scope or substance of—

''(1) section 264 of the Health Insurance Portability and Accountability Act of 1996;

''(2) sections 1171 through 1179 of the Social Security Act; and

''(3) any regulation issued pursuant to any such section;

and such sections shall remain in effect.

''SEC. 2910. STUDY OF REIMBURSEMENT INCENTIVES.

''The Secretary shall carry out, or contract with a private entity to carry out, a study that examines methods to create efficient reimbursement incentives for improving health care quality in Federally qualified health centers, rural health clinics, and free clinics.''.

SEC. 3. HEALTH INFORMATION TECHNOLOGY RESOURCE CENTER.

Section 914 of the Public Health Service Act (42 U.S.C. 299b–3) is amended by adding at the end the following:

''(d) HEALTH INFORMATION TECHNOLOGY RESOURCE CENTER.—

''(1) IN GENERAL.—The Secretary, acting through the Director, shall develop a Health Information Technology Resource Center to provide technical assistance and develop best practices to support and accelerate efforts to adopt, implement, and effectively use interoperable health information technology in compliance with section 2903 and 2908.

''(2) HEALTH INFORMATION TECHNOLOGY RESOURCE CENTER.—

''(A) IN GENERAL.—The Center shall support activities to meet goals, including—

''(i) providing for the widespread adoption of interoperable health information technology;

''(ii) providing for the establishment of regional and local health information networks to facilitate the development of interoperability across health care settings and improve the quality of health care;

''(iii) the development of solutions to barriers to the exchange of electronic health information; or

''(iv) other activities identified by the States, local or regional health information networks, or health care stakeholders as a focus for developing and sharing best practices.

''(B) PURPOSES.—The purpose of the Center is to—

''(i) provide a forum for the exchange of knowledge and experience;

''(ii) accelerate the transfer of lessons learned from existing public and private sector initiatives, including those currently receiving Federal financial support; and

''(iii) assemble, analyze, and widely disseminate evidence and experience related to the adoption, implementation, and effective use of interoperable health information technology.

''(C) SUPPORT FOR ACTIVITIES.—To provide support for the activities of the Center, the Director shall modify the requirements, if necessary, that apply to the National Resource Center for Health Information Technology to provide the necessary infrastructure to support the duties and activities of the Center and facilitate information exchange across the public and private sectors.

''(3) TECHNICAL ASSISTANCE TELEPHONE NUMBER OR WEBSITE.—The Secretary shall establish a toll-free telephone number or Internet website to provide health care providers and patients with a single point of contact to—

''(A) learn about Federal grants and technical assistance services related to interoperable health information technology;

''(B) learn about qualified health information technology and the quality measurement system adopted by the Federal Government under sections 2903 and 2908;

''(C) learn about regional and local health information networks for assistance with health information technology; and

''(D) disseminate additional information determined by the Secretary.

''(4) RULE OF CONSTRUCTION.—Nothing in this subsection shall be construed to require the duplication of Federal efforts with respect to the establishment of the Center, regardless of whether such efforts were carried out prior to or after the enactment of this subsection.''.

SEC. 4. REAUTHORIZATION OF INCENTIVE GRANTS REGARDING TELEMEDICINE.

Section 330L(b) of the Public Health Service Act (42 U.S.C. 254c–18(b)) is amended by striking ''2002 through 2006'' and inserting ''2006 through 2010''.

Mr. FRIST. Mr. President, I ask unanimous consent that the Enzi substitute at the desk be agreed to, the committee-reported amendment, as amended, be agreed to, the bill, as amended, be read a third time and passed, the motion to reconsider be laid upon the table, and that any statements relating to the bill be printed in the RECORD.

The PRESIDING OFFICER. Without objection, it is so ordered.

The amendment (No. 2671) was agreed to.

(The amendment is printed in today's RECORD under ''Text of Amendments.'')

The committee amendment in the nature of a substitute, as amended, was agreed to.

The bill (S. 1418), as amended, was read the third time and passed.

Mr. FRIST. Mr. President, the Senate just passed a bill that takes a major step—major step—to bringing health care into the information age, finally. This bill, the Wired for Health Care Quality Act, reflects the hard work by Senator ENZI, to whom I will turn the floor over shortly, myself, Senator KENNEDY, Senator CLINTON, and many others.

This bill will do as much as anything we have done in this Congress and the last Congress and the Congress before that to cut waste and inefficiency out of our health care system. What the bill does is encourage the use of secure and interoperable health care records, electronic records, electronic medical records.

This has a huge benefit for every American. It reduces waste and inefficiency. It reduces medical errors. It improves the quality of health care. It reduces health care costs throughout the system, raising quality. When you lower costs and you raise quality, by definition, you improve access as well.

This bill will help empower patients to become full partners in what we all have as a vision; and that is, a patient-centered, provider-friendly, consumer-driven system that will be driven by information, and be driven by choice, and be driven by control.

Patient privacy is protected. This secure exchange of lifesaving information improves efficiency throughout the system. It will allow, for the first time, because there are interoperable standards that are set, the exchange of information, which will seamlessly help integrate health care delivery from the time a patient first presents to see a physician or a nurse to ultimate discharge and treatment.

So this really is a pivotal moment. I encourage the House to act quickly on the legislation.

Again, I thank Senator ENZI for his leadership. Without it, this moment simply would not be possible. I thank Senator CLINTON who has stressed, from day one, the importance of having quality injected into this bill, and Senator KENNEDY. I thank them all for their commitment to this effort.

I thank the staff who have worked many hours: Andrea Palm, Katy Barr, Steve Northrup, and David Bowen, and many others.

Mr. President, I do want to at least turn to my colleague to thank him and

so he can make a few comments because this is truly historic legislation. And although it is mighty early in the morning now—late at night or early in the morning—this really is a historic time for health care and health care delivery.

The PRESIDING OFFICER. The Senator from Wyoming.

Mr. ENZI. Mr. President, I thank the leader for his kind comments but much more so for his diligent work and leadership on this issue. As the heart doctor of the Senate, and the doctor with a lot of heart, he understands the need for health information technology and worked in a very bipartisan way with Senator CLINTON to come up with some of the precepts we have in this bill. Senator KENNEDY and I were working on some other aspects of it. And we merged those two to come up with a much more comprehensive health IT bill.

This will make a huge difference in the country. A RAND study that was recently released said this will save about $162 billion a year in medical costs. In my opinion, that is not even going to be the biggest benefit. The biggest benefit is that it is going to allow medical data to move with the people as they move.

When they go to the doctor's office, they will not have to take that little clipboard and fill out whatever it is they can remember about their health. And it will not matter because a lot more information will be available to the doctor so he can make the right kinds of decisions and choices.

It will also benefit travelers. If a tourist is out on the road and has a wreck and has to see a doctor, they will have their information with them. They will have access to it so the doctor will know what medications they are on, even if they are in a coma, and can make sure they are taken care of properly. And yes, it will reduce medical errors and eliminate some adverse reactions from medications or even missed medications.

So this will make a huge difference to the people of this country. The difficulty with doing something by unanimous consent is that a lot of times people think there is not much to it, or if there wasn't much controversy, that nothing really happened. But there has been controversy that has been taken care of behind the scenes, where people got together and actually realized how important this was. So they worked together to come up with solutions, and came up with a truly bipartisan solution in this instance.

So it is almost too bad that it has to go through unanimous consent, that we cannot have some very heated debates on the floor so people will realize the intensity and the interest in the bill.

But there is not anything bad about the bill. This was a teamwork effort from both sides of the aisle. I appreciate the leader mentioning a number of the people who were involved in this bill. This is a truly monumental piece of legislation we just passed, and I add the encouragement to have the House act on it quickly.

Mr. President, I rise today to applaud the Senate passage of S. 1418, the Wired for Health Care Quality Act. As chairman of the Committee on Health, Education, Labor, and Pensions, I have been working to improve the quality and reduce the cost of health care in this Nation.

Some of the most serious challenges facing health care today—medical errors, inconsistent quality, and rising costs—can be addressed through the effective application of available health information technology linking all elements of the health care system. Information-sharing networks have the potential to enable decision support anywhere at any time, thus improving the quality of health care and reducing costs.

Health IT allows medical data to move with people as they move. When they go to the doctor's office they won't have to take the clipboard and write down everything they can remember about themselves. This system also benefits travelers. If a tourist were to get in a car wreck or hurt in some other way, the doctor would be able to find out everything he or she needs to know. If in a coma this technology could save a person's life and if they happen to be on medications, it could prevent adverse drug reactions. This system could also cut down on medical errors with prescriptions—instead of deciphering the doctor's handwriting, the information could be given to the pharmacist electronically.

A RAND study recently released suggested that health IT has the potential to save $162 billion a year. In order for these savings to be realized, we must create an infrastructure for interoperability. S. 1418 is the first step in building that infrastructure.

Most folks agree that there are significant barriers to widespread adoption of interoperable health information technology. One of the primary barriers is the current lack of agreed-upon standards and common implementation guides and a certification process. This bill addresses those factors in a way that appropriately incorporates involvement of both the public and private sectors.

This legislation brings the government and the private sector together to make health care better, safer and more efficient by accelerating the widespread adoption of interoperable health information technology and quality measurement across our health care system. The legislation formalizes involvement of private entities in the standards and policy-setting process by directing the Secretary to establish and chair the public-private American Health Information Collaborative, which shall be composed of representatives of the public and private sectors. S. 1418 also codifies the Office of the National Coordinator for Health Information Technology. President Bush, Secretary Leavitt, and Dr. Brailer have done a lot to advance the health IT infrastructure, and I am glad that Congress is finally stepping up to the plate.

In order to address the health information technology ''adoption gap'' in the United States, S. 1418 authorizes three grant programs that will carefully target financial support to health care providers and consortia for the purpose of facilitating the adoption of interoperable health information technology. To maximize the Secretary of Health and Human Service's flexibility, the bill leaves to the discretion of the Secretary the allocation of the authorization among the three programs.

In addition, the greatest improvements in quality of health care and cost savings will be realized when all elements of the health care system are electronically connected and speak a common technical language—that is they are interoperable. For this reason, each grant program requires that each grant recipient acquire only qualified health information technology systems that are capable of supporting common technical standards adopted by the Federal Government.

Another barrier to widespread adoption of interoperable health information is cultural. I recognize that many physicians and hospitals are hesitant to move from paper-based systems to electronic systems. Some physicians have been writing prescriptions by hand for many years and may resist changing to electronic prescribing. One way to address this cultural barrier to the widespread adoption of health information technology is to support teaching hospitals and continuing education programs that integrate health information technology in the clinical education of health care professionals. Exposing students and residents to effective everyday uses of health IT will lead to a greater adoption by these students and residents when they graduate and begin practicing on their own. The bill authorizes the Secretary to award demonstration grants to health professions centers and academic health centers to integrate health IT into clinical education in community settings.

The issue of health IT is also critical for effective response in public health emergencies. Interoperable health IT systems will help to track infectious disease outbreaks and increase the Federal Government's rapid response in emergency situations.

I thank all of my Senate colleagues for their support of this very important legislation, which will help facilitate the widespread adoption of electronic health records to ultimately result in fewer mistakes, lower costs, better care, and greater patient participation in their health and well-being. This is a great stride forward in the journey to improve our Nation's health care system. I look forward to seeing meaningful health information technology legislation signed into law this Congress.

I would like to commend various staff for the hard work they did in bringing this bill to fruition. First, I want to recognize my fine staff from the Senate HELP Committee, who have doggedly worked with many interested parties over many months—Stephen Northrup and Katy Barr. I would also like to recognize David Bowen from Senator KENNEDY's office for his dedication to this legislation. Elizabeth Hall of Senator FRIST's office did a good job providing leadership support throughout the process. I should also mention Andrea Palm from Senator CLINTON's office and Michelle Spence with Senator ENSIGN's office for ensuring that the health care quality provisions stayed strong. Secondly, I want to recognize the work of the Senate Finance Committee and the complementary bill supporting improvements in health care quality in the Medicaid and Medicare programs that has contributed to our success today. Mark Hayes and Ted Totman from the Senate Finance Committee were very dedicated to seeing this bill pass. And finally, without the dedication and patience of Bill Baird of Senate Legislative Counsel, we would not have the bill that will pass here today.

Mr. KENNEDY. Mr. President, today the Senate has passed legislation that can help transform our health care system and save lives. The Wired for Health Care Quality Act will improve the use of lifesaving health information technology in hospitals and doctors' offices across the country. In so doing, we will improve the quality of care, lower administrative costs, and reduce medical errors.

This legislation is being considered by the Senate because of the leadership and commitment of the chairman of our Health Committee, Senator ENZI. He made health information technology a priority for our committee, and he has guided this legislation to the Senate floor. Successful legislation takes creative thinking and hard work—and Senator ENZI has supplied an abundance of both to this measure.

I also thank our partners in this legislation, Senator FRIST and Senator CLINTON. As a surgeon, Senator FRIST knows firsthand the importance of making sure that doctors have the information they need to provide the best possible care for patients—and that they get that information in time for it to be of value. It is inconceivable that in the 21st century, doctors are asked to treat patients in life or death situations without knowing their medical histories or even the medications they are taking—but that happens every hour of every day in hospitals and emergency rooms around the country. Senator FRIST has been tireless in his commitment to correcting this unacceptable situation.

Senator CLINTON has done an excellent job as well. She has championed better studies of the comparative effectiveness of medications, she is dedicated to improving the quality of care for every patient, and this legislation owes much to her ability and commitment.

This legislation is urgently needed, because we live in a new era of medical miracles and rapid changes in medicine.

Modern electronics have given doctors implantable pacemakers to save patients from sudden cardiac failure.

The sequencing of the human genome offers extraordinary opportunities for new cures and better treatments.

But there is another medical miracle to add to the list.

Modern information technology can transform health care as profoundly as any of these discoveries.

We have a moral responsibility to make the miracles of modern medicine available to every American—but we have failed to meet that responsibility. Costs are crushing our health care system. Premiums are going through the roof. The ranks of the uninsured grow every day. Families are forced to choose between paying the cost of health care or paying for food, rent, and college tuition. That is not the American dream.

Information technology alone can't solve these problems, but it can help substantially. Electronic medical records. Software to warn if a treatment could harm a patient. Computer prescribing. These and many other applications of information technology can save lives and dramatically reduce costs.

Despite the wonders of modern medicine, too many patients today are harmed by preventable mishaps. They waste hours and face new risk when tests must be duplicated, because a crucial record is locked in another archive. Too many doctors only guess at the right course of treatment, because they don't know a patient's medical history. Millions of patients are needlessly put at risk, and billions of dollars are wasted.

When so many Americans are already struggling to afford health care for their families, it is profoundly wrong to squander more than half a trillion dollars each year on administrative expenses.

The Department of Health and Human Services estimates that better use of information technology will save $140 billion every year. Such savings would produce a technology dividend worth over $700 on the cost of an average family's insurance policy. That is like getting 1 month free every year.

Other nations are already using this extraordinary technology to cut costs and save lives—but America lags behind. We can't continue to allow the high cost of health care to price American goods and services out of the global marketplace.

The need to invest in this technology is urgent. In the words of Secretary Leavitt, ''Every day that we delay, lives are lost.'' The time to act is now. The bill before us will improve care, save lives and make health care more affordable for every American.

The need to reduce medical errors is especially urgent. It is already 6 years since the Institute of Medicine reported that medical errors cause 98,000 deaths every year. According to the National Patient Safety Foundation, 42 percent of Americans have been affected by a medical error, either personally or through a friend or relative. One out of every three of those affected said that the error had a permanent negative effect on the patient's health. The exact figures may be the subject of debate, but it is undeniable that preventable deaths occur in our health care system all too often. For even one patient to die needlessly in our health care system ought to be unacceptable.

Our response should be broad based. New technology, new ideas, aud new ways of practicing medicine all have a role in improving the quality of care and saving lives. We no longer expect airline pilots to navigate by looking at the stars or local landmarks. Engineers no longer rely on slide rules to design strong buildings. In virtually every field except medicine, professionals use computers to expand their skills. Yet in medicine, we expect doctors to keep in their heads the possible interactions of the dozens of medications that a patient may be receiving. Under these circumstances, the wonder is not that errors occur, but that they don't occur even more frequently.

The evidence that information technology can save lives is undeniable. In terms of drug safety alone, a recent analysis by the RAND Corporation estimates that by using computerized data, the nation could prevent 2.2 million adverse drug events, and 1 million additional days in the hospital.

What we have today, in the words of the Institute of Medicine, is a ''quality chasm.'' Doctors repeat tests that have already been performed. Residents take medical histories that have already been taken. Patients show up for doctor's appointments that are essentially a waste of time because the tests have been performed but the results have not yet been delivered.

Information technology can help close this gap by improving the coordination of care, providing guidance on the best methods of care and reminding busy physicians when it's time to schedule preventive screenings. The Veterans Administration is a national leader in using IT to improve quality, and patients get better preventive services there than almost any other patient group in America gets, especially in areas such as proper cholesterol screening, eye exams for diabetic patients, and proper immunization against pneumonia.

Electronic medical records improve the quality of care, and can also improve our ability to monitor drug safety, detect outbreaks of disease before they become epidemics and decide which treatments are most effective for patients.

Electronic medical records can be critical in a natural disaster. The devastation of Hurricane Katrina was

compounded because most hospitals kept their records on paper. As a result, medical histories of tens of thousands of hurricane survivors were irretrievably lost. It would be inexcusable if we didn't make the investments needed for the nation to benefit from these innovations.

Information technology doesn't simply improve the quality of care—it reduces costs as well. According to the Institute of Medicine, each prescription error that is prevented saves $4,000 in additional care. This isn't just a theory. Since 1996, when the Veterans Administration began investing significantly in information technology, its costs per patient have actually decreased by 7 percent while private sector costs per patient have increased by 62 percent.

Excessive administrative costs are weighing down our health care system. We are spending over $500 billion a year on such costs—nearly 33 cents out of every health care dollar. These already high costs are also growing 50 percent faster than other health costs. It can cost as much as $20 to process a single insurance claim using antiquated paper records—and nearly half the 18 billion insurance claims in America are still settled in this old-fashioned way every year. We know that paper-based records are prone to error. About one in four health insurance claims is initially rejected because of errors. By contrast, in the financial industry, only 1 in 10,000 ATM transactions has an error.

Despite clear evidence that health IT saves lives and cuts costs, its use is still scandalously low. Our health care system should be the envy of the world, but nations from Australia to Scandinavia are outpacing us in this technology. In Sweden and Holland, nine out of ten primary care physicians use electronic medical records. In Britain, Austria, Finland and many other nations, it is over half. But in the United States, less than a quarter of all doctors use electronic medical records.

Obviously, there are significant barriers to the adoption of health information technology that Congress should also address. Many providers don't have the financial ability to absorb the costs of buying the equipment, making the transition to computer systems, and training staff. It costs a physician's office $30,000 and significant aggravation to install the system. The savings from its use tend to come over the longer term, while the costs are immediate, which is a major financial barrier to hospitals, physicians, and nursing homes already drowning in red ink. Providers get savings over the long run, but the largest share of the savings goes to payers, not providers. If a diabetic is kept out of the hospital by better management of his condition as the result of information technology, that's a loss of revenue to the hospital.

This bipartisan legislation will help overcome these barriers. It requires the development of standards on interoperability and other technical measures for health information technology, and it establishes a public-private consultation to develop those standards.

But standards without Federal resources are not enough to achieve the goal of a modern health care system that we all share. That is why the legislation includes financial assistance to hard pressed providers to meet the technical standards. It provides this assistance in three ways in recognizing the fact that different health care providers and different communities will have different needs. It authorizes direct grants to needy providers. It authorizes financial assistance to establish regional networks. And it creates an innovative Federal-State, public-private partnership to modernize health care by enabling states to fund low interest loans to help health professionals in financial need to acquire the technology to improve the quality and efficiency of health care.

Getting the right hardware and software into the hands of doctors is only half the battle. It is also essential to see that doctors have access to the knowledge necessary to make the technology a success. The legislation establishes a Best Practices Center where technology users can learn from the experience of others who have established such networks. It sets up a Help line at the Department of Health and Human Services to answer technical questions and help meet technical requirements. To assist doctors in sorting through the confusing array of options for this technology, the legislation establishes a certification program, so that providers can quickly determine whether particular systems meet the applicable technical standards.

There are many Senate colleagues who deserve great credit for their thoughtful contributions to this legislation and for their leadership in getting to this moment.

Again, I commend the chairman of our Health Committee, Senator ENZI, for his impressive leadership on this issue. It has been a privilege to work closely with him and his staff since the beginning of this year and to deal with this priority.

The pending legislation combines the bill that Chairman ENZI and I introduced and the bill that Senator FRIST and Senator CLINTON introduced. We have also had broad input from many other committee members, and we have produced a better bill because of it.

Senator DODD was a leader on the issue in the last Congress as well, and our bill includes many of his ideas, especially on making sure that standards are widely available.

Senator ENSIGN made sure that best practices are front and center in implementing this technology.

Our subcommittee chairman, Senator BURR, has a strong interest in using information technology to improve our ability to respond to bioterrorist attacks or other disease emergencies, when lost hours can mean countless lost lives.

Senator REED of Rhode Island had the innovative idea of including a 1–800 number to help providers on technical questions. Senator HARKIN contributed important proposals to use the technology to improve the treatment of chronic diseases.

Senator REID of Nevada has shown impressive leadership in making sure technology improves the lives of American families, and I thank him for his strong support.

Senator SNOWE and Senator STABENOW have a major commitment to effective funding for this technology, and I look forward to working with them on this issue in the days to come. I also commend Senator SNOWE for her strong commitment to protecting the privacy of electronic medical data.

I also commend Steve Northrup and Katy Barr of Senator ENZI's staff, Andrea Palm of Senator CLINTON's staff, Liz Hall of Senator FRIST's staff, and my own health staff, for their effective work on this issue for so many months.

I thank these and all our Senate colleagues who contributed to the legislation we consider today. I look forward to working with all of you and with our colleagues in the House to see this needed measure signed into law as soon as possible.

Mr. ENZI. Mr. President, I rise today to speak about the passage of 1418, the Wired for Health Care Quality Act. As chairman of the Committee on Health, Education, Labor, and Pensions, I have been working to improve the quality and reduce the cost of health care in this Nation. I commend the ranking member of my committee for his dedication to this great cause.

I want to commend my colleague from Maine, Senator SNOWE, and my colleague from Michigan, Senator STABENOW, for their leadership on the issue of health information technology. They have made a major contribution to the debate, and I look forward to working with them as we continue to consider this important issue.

I see the legislation we consider today as the first step toward more effective use of information technology in health care. This proposal will provide the framework to improve the use of health IT. Senator SNOWE and Senator STABENOW have several thoughtful proposals on providing additional financial incentives through Medicare for the use of health information technology.

Providing adequate funding for health IT is a critically important issue, and I believe that it should be carefully considered in our committee and by the Senate. I look forward to working with my colleagues on the committee and with Senator SNOWE and Senator STABENOW to see that health IT receives an appropriate level of funding.

I also believe it is important to examine carefully the privacy protections that apply to individually identifiable health information maintained in electronic databases. The manager's amendment to S. 1418 contains several important provisions relating to privacy, including a GAO investigation on methods to enhance privacy protections for electronically stored and transmitted health information.

I believe it is important to examine the issues surrounding implementation and adoption of health IT systems carefully. To that end, I intend to hold a hearing by the Memorial Day recess next year on the essential issue of funding to promote wide adoption of health information technology. We will also examine the report of the GAO to address the critical issue of protections for the privacy of health information that must be part of health IT systems and practices. I will work closely with my colleagues, Senator SNOWE and Senator STABENOW, as well as with the ranking member on this hearing.

I will also work with the Finance Committee, the committee with jurisdiction over Medicare, and with Senators STABENOW and SNOWE on legislation to spur the widespread adoption of interoperable health information technology through such innovative financing mechanisms, and we will work to achieve passage of that legislation before the end of this Congress.

I happen to be an original sponsor of legislation in the Finance Committee to reward high-quality health care through value based purchasing under Medicare. By rewarding doctors and hospitals for the quality of care they provide, not just the quantity of care, we can improve health care quality in a fiscally responsible way.

I look forward to working with Senators KENNEDY, GRASSLEY, BAUCUS, SNOWE, STABENOW, FRIST, and CLINTON on these important proposals, and I commend them for their leadership on this important field of health IT.

Mr. KENNEDY. I thank the distinguished chairman of our Health Committee for his impressive leadership on the issue of health information technology. Health information technology can revolutionize health care, with lasting benefits in areas from improving quality to better detection of bioterrorist attacks and epidemics.

I also commend my colleagues, Senator STABENOW and Senator SNOWE, for their commitment to seeing that we provide adequate financial support for doctors and hospitals to use health information technology systems. I will work closely with them, and with our chairman and our colleagues on the health committee, to see that we build on the legislation under consideration today in order to assist health care providers to meet the cost of acquiring health IT.

Senator SNOWE and Senator STABENOW have made a major contribution to our debate, and I look forward to working with them on additional proposals on this important issue in the very near future.

Ms. SNOWE. Mr. President, I want to commend Senators ENZI, KENNEDY, FRIST, and CLINTON for their work in addressing the inadequate state of our individual health records today. The Wired for Health Care Quality Act will accelerate the development of essential standards to protect investment in health information technology. Very soon the Federal Government will require compliance with these standards for its purchases—a long overdue step in modernizing health care information management.

I began work with on this issue in the last Congress when we learned from the Institute of Medicine that an estimated 98,000 Americans die each year as a result of medical errors. Technology can help us prevent these deaths and injuries from medical mistakes. That is one reason I joined with Senator STABENOW to assure that we implement live saving technology.

A second reason for our work is that information technology, IT, will help us reduce the cost of health care. As health care costs increase far more rapidly than inflation, care becomes less affordable and the ranks of the uninsured grow. Each of us appreciates that technology will help us reduce that unsustainable trend. Recent reports demonstrate that the cost of implementing health IT is exceeded by a single year of savings. That is a remarkable return on investment, but since an estimated 89 percent of savings accrues to payers, not providers, standards alone will not spur adoption.

Since the rewards for adoption primarily accrue to payers and patients, it is wholly appropriate that payers—including the Federal Government—act in their best interest to reduce costs. That means we must ensure adoption not just by those providers for whom investment is relatively easy, but by those with lesser resources, such as the many who provide care for our Medicare, Medicaid, and SCHIP beneficiaries. I look forward to working with my colleagues to see that we implement financing—including grants and tax incentives—to allow all providers to adopt this promising technology. Otherwise we will see a two-tiered system develop.

If some patients do not receive the benefits of the electronic health record the President has set as a goal, their care will suffer. In fact, if their providers cannot adopt technology, their clinical data may not be not properly integrated in pay-for-performance methodologies. If the resulting criteria don't account for such patients, they then pose the risk of inadequate compensation to providers, and many may decline to serve them. So it is critical that we assure all providers can adopt health IT.

I thank Chairman ENZI and the Senator KENNEDY for their commitment to a hearing next spring on the adoption and financing issue. I also thank the majority leader for his assistance. The issue of adoption certainly multiple committees, and we appreciate his efforts in helping the full Senate to consider promising financing proposals to assure broad adoption.

As we move forward together, we should also remember to follow the physician's adage—certainly one the leader knows so well—to ''first do no harm''. We are all agreed that genetic information, which may indicate probability of disease, must be protected. One's medical record includes even more than probability—it is indisputable evidence of the presence of disease, the drugs one uses, your full physical and mental health history. Consequently, Americans are worried about their health records. A recent survey demonstrates that two-thirds of all consumers have substantial concerns about the privacy of their medical records. The same proportion say that recent reports of privacy breaches have actually increased these concerns. So it comes as no surprise that consumers engage in behaviors to avoid such data from even being created—such as paying out-of-pocket for medical expenses, using a different physician on occasion, or simply asking that vital information not be included in their chart. Patients even forgo treatment altogether in fear of disclosure. This compromises health, so we simply must provide Americans with confidence in the security of their health record.

We simply must have the highest levels of data security. So first we must see procedures established to assure that inappropriate disclosure does not occur. Next, if a data breach does occur, the patient must be informed. To do otherwise is unconscionable.

I am pleased to see that the managers amendment requires such notification for those handling data under the programs established by this legislation, and the bill also establishes a process to address concerns on medical data privacy by directing a GAO study to guide us in providing the assurance all Americans must have that their medical data is protected. I thank my colleagues for including these essential provisions.

Today marks the beginning of a process to offer all Americans a safer, more affordable system of health care. I look forward with Senator STABENOW to working with the majority leader and Senators ENZI, KENNEDY, and CLINTON, as well as Senators GRASSLEY and BAUCUS, as we move forward to realizing the full potential of health IT become reality for our constituents. The rewards in lives and dollars saved compels us to act promptly.

Ms. STABENOW. Mr. President, I want to commend the leadership of Senators ENZI, KENNEDY, FRIST, and CLINTON in this critically important arena. Their diligent work in introducing and passing S. 1418 establishes the groundwork necessary to begin to realize the promises of health information technology, IT.

The evidence showing the ability of health IT to reduce costs and improve quality of care is simply overwhelming. Dr. David Brailer's office attributes savings from widespread adoption of electronic health records in the range of 7.5 percent to 30 percent of annual health care spending that is between $135 and $540 billion annually.

Manufacturers in Michigan and across the country are struggling to remain competitive in a global market with skyrocketing health care costs. Health IT can, and should, play a key role in managing these costs.

Equally compelling is the promise health IT holds for improving the quality of our health care system by ensuring that patients get the care they need, at the right time, and in the best setting.

To realize these promises, however, Congress must enact legislation providing meaningful resources through Federal financial incentives, both mandatory grants and tax incentives, to physicians, hospitals, skilled nursing facilities, and community health and mental health centers for health information technology.

Health care providers are struggling to keep up with their daily needs at the same time they are anticipating cuts in their rates. A major barrier to widespread use of IT is the initial investment cost: the costs of procuring and implementing health IT can be staggering.

Every day we delay providing Federal seed money through a grant program and accelerated depreciation of health information technology expenses, we delay getting health information technology systems in place, and businesses, taxpayers and patients pay in both dollars and lives.

I appreciate the majority leader's commitment to encourage the chairman and ranking member of the Finance Committee and the chairman and ranking member of the HELP Committee to schedule, at the earliest opportunity, consideration of legislative proposals to ensure federal funding to accelerate adoption of health IT.

A meaning Federal investment must be robust, funded with mandatory, rather than discretionary, dollars, and available to individual providers and health care systems.

This is not the place to skimp on dollars; we know every dollar we spend will come back to us many times over. Federal investments, through grants and tax incentives, in health information technology will result in lower Medicare, Medicaid and SCHIP spending, reduced medical errors, and greater quality and efficiency in our health care system. We must provide a level of funding that will allow a significant percentage of our health care providers to adopt and use health IT systems. Additionally, funding must not be limited to authorizations of appropriations. We must actually provide the dollars needed to begin realizing the benefits of health IT.

Nor should we limit funds to providers in networks. We should work towards a system where all health care providers are linked, but we do not need to wait for those networks to be formed to see the benefits of health IT. Standalone e-prescribing systems could reduce medication errors by 50 percent; there is no reason to delay the quality, safety, and financial savings possible through immediate health IT adoption by individual providers.

In addition to funding, we must pay careful attention to privacy and confidentiality rights and concerns. A patient's right to health information privacy is paramount, and an essential component of the health care provider-patient relationship. According to a survey recently released by the California HealthCare Foundation, CHCF, 67 percent of Americans remain concerned about the privacy of their personal health information. The survey also reports that many consumers may be putting their health at risk by avoiding their regular doctor or forgoing needed tests over privacy concerns. Apprehension over privacy and confidentiality, if not addressed thoughtfully, could pose enormous barriers to the savings and health care improvements possible through adoption of health information technologies. Strong, enforceable privacy safeguards based on a patient's right to health information privacy are absolutely critical as we move towards a nationwide, interoperable electronic health care system.

I appreciate provisions included in the managers' amendment addressing the need for patients to be notified if their individually identifiable health information is wrongfully disclosed and a study by the General Accounting Office examining the issue as it relates to all Americans.

I look forward to working with the majority leader, and Senators SNOWE, ENZI, KENNEDY, and CLINTON, as well as Senator GRASSLEY and BAUCUS to ensure passage of legislation this Congress providing meaningful, substantial Federal financial incentives to accelerate adoption of life and dollar saving health information technologies.

Mr. FRIST. Mr. President, I am pleased to speak in support of S. 1418. I share an important goal with Senators ENZI, KENNEDY, SNOWE, STABENOW, and CLINTON—to improve health care quality and reduce costs through the use of health information technology tools.

I spent 20 years as a physician and heart surgeon before coming to the Senate. Like most physicians, I wanted the latest and best medical technology, anything that could make my patients healthier or more comfortable, while reducing health care costs and increasing efficiency.

But amidst the artificial heart assist devices, lasers, CT Scan machines, endoscopic devices, digital X-Rays, and digital thermometers, doctors today keep patient records the same way I did and the way my father did 50 years ago: on paper, in manila folders in file cabinets, in the basements of clinics and hospitals. Yet computers, and computer technology, is everywhere, both inside and outside the hospitals and clinics. From bedside monitors to massive MRI machines, computers power almost all of the diagnostic devices we rely on.

S. 1418 represents an important and crucial first step towards recognizing the importance of computers and the electronic medical record in contemporary health care. Establishing interoperability of the electronic medical record, an essential hurdle towards effective use of health information technology, is a priority. Proposals for providing Federal financial incentives for physicians, community health centers, community mental health centers, hospitals and skilled nursing facilities like that introduced by Senator SNOWE and Senator STABENOW need to be considered.

Assuring proper funding of health IT is an issue of major importance for the Senate to consider in the coming congressional session. I will work with the chairman and ranking member of the Finance Committee and the chairman and ranking member of the HELP committee as well as Senators SNOWE and STABENOW to encourage these committees to schedule, at the earliest opportunity, consideration of legislative proposals to ensure creative and reasonable Federal funding for such an important and relevant mission. I will also work with relevant committees to encourage consideration of legislation that would enable providers to connect to a secure, interoperable network for the electronic exchange of health information.

Mrs. CLINTON. I would like to commend Chairman ENZI and Senator KENNEDY for all of their work on this legislation. I would also like to recognize the commitment and leadership of the majority leader, who I have been working closely with on this issue. Today's passage of S. 1418, the Wired for Health Care Quality Act, is a fundamental first step in establishing a nationwide, interoperable health IT infrastructure.

Our legislation provides the framework and authorizes several grant programs to begin the process of funding health IT projects that are compliant with the framework established in the bill. The legislation introduced by Senators SNOWE and STABENOW and their work more broadly on this issue will be critical as we work on additional financing mechanisms. I am anxious to begin that work and am committed to working closely with them, and my colleagues on the HELP and Finance committees to ensure that physicians and hospitals are able to afford to participate in a 21st century health care system.

Mr. ENZI. I see this bill as the first step of many in improving the health care in the United States. I look forward to working with my friends on the Finance Committee as well as

working with Senators SNOWE and STABENOW to look at creative financing mechanisms to help doctors and hospitals go on line.

Mr. FRIST. Mr. President, in closing our comments on this bill, I also thank my staff who have been shepherding this for me for the last 3 years, Liz Hall, Jennifer Romans, and many others. The real significance is that patient care will be improved. It will get the waste and abuse out of the system. It makes the health care system more efficient. I am excited about it. Having interoperable standards that people begin to agree with means you will have an influx of private capital which will help with the spreading of this information technology infrastructure over time.

TERRORISM RISK INSURANCE EXTENSION ACT OF 2005

Mr. FRIST. Mr. President, I ask unanimous consent that the Senate proceed to the immediate consideration of Calendar No. 287, S. 467.

The PRESIDING OFFICER. The clerk will report the bill by title.

The legislative clerk read as follows:

A bill (S. 467) to extend the applicability of the Terrorism Risk Insurance Act of 2002.

There being no objection, the Senate proceeded to consider the bill which had been reported from the Committee on Banking, Housing, and Urban Affairs with an amendment, as follows:

(Strike the part shown in black brackets and insert the part shown in italic.)

S. 467

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 ''Terrorism Risk Insurance Extension Act of 2005.''.

[SEC. 2. EXTENSION OF TERRORISM RISK INSURANCE PROGRAM.

[(a) EXTENSION OF PROGRAM YEARS.—Section 108(a) of the Terrorism Risk Insurance Act of 2002 (15 U.S.C. 6701 note, 116 Stat. 2336) is amended by striking ''2005'' and inserting ''2007''.

[(b) CONTINUING AUTHORITY OF THE SECRETARY.—Section 108(b) of the Terrorism Risk Insurance Act of 2002 (15 U.S.C. 6701 note, 116 Stat. 2336) is amended by striking ''arising out of'' and all that follows through ''this title''.

[SEC. 3. CONFORMING AMENDMENTS.

[(a) DEFINITIONS.—

[(1) PROGRAM YEARS.—Section 102(11) of the Terrorism Risk Insurance Act of 2002 (15 U.S.C. 6701 note, 116 Stat. 2326) is amended by adding at the end the following:

''[(E) PROGRAM YEAR 4.—The term 'Program Year 4' means the period beginning on January 1, 2006 and ending on December 31, 2006.

''[(F) PROGRAM YEAR 5.—The term 'Program Year 5' means the period beginning on January 1, 2007 and ending on December 31, 2007.

''[(G) OTHER PROGRAM YEARS.—Except when used as provided in subparagraphs (B) through (F), the term 'Program Year' means, as the context requires, any of Program Year 1, Program Year 2, Program Year 3, Program Year 4, or Program Year 5.''.

[(2) INSURED LOSSES.—Section 102(5) of the Terrorism Risk Insurance Act of 2002 (15 U.S.C. 6701 note, 116 Stat. 2324) is amended—

[(A) by inserting ''on or before December 31, 2007, as required by this title,'' before ''if such loss'';

[(B) by striking ''(A) occurs within'' and inserting the following:

''[(A) occurs on or before the earlier of the expiration date of the insurance policy or December 31, 2008; and

''[(B) occurs—

''[(i) within''; and

[(C) by striking ''occurs to an air carrier'' and inserting the following:

''[(ii) to an air carrier''.

[(3) CONFORMING AMENDMENTS.—Section 102 of the Terrorism Risk Insurance Act of 2002 (15 U.S.C. 6701 note, 116 Stat. 2323) is amended—

[(A) in paragraph (1)(A)(iii)(I), by striking ''(5)(B)'' and inserting ''(5)(B)(ii)''; and

[(B) in paragraph (4), by striking ''subparagraphs (A) and (B)'' and inserting ''subparagraph (B)''.

[(b) APPLICABLE INSURER DEDUCTIBLES.—Section 102(7) of the Terrorism Risk Insurance Act of 2002 (15 U.S.C. 6701 note, 116 Stat. 2325) is amended—

[(1) in subparagraph (D)—

[(A) by inserting ''and each Program Year thereafter'' before '', the value''; and

[(B) by striking ''preceding Program Year 3'' and inserting ''preceding that Program Year''; and

[(2) in subparagraph (E), by striking ''for the Transition'' and all that follows through ''Program Year 3'' and inserting the following: ''for the Transition Period or any Program Year''.

[(c) CONTINUATION OF MANDATORY AVAILABILITY.—Section 103(c)(1) of the Terrorism Risk Insurance Act of 2002 (15 U.S.C. 6701 note, 116 Stat. 2327) is amended—

[(1) by striking ''last day of Program Year 2'' and inserting ''termination date established under section 108(a)''; and

[(2) by striking the paragraph heading and inserting ''IN GENERAL.—''.

[(d) DURATION OF POLICIES.—Section 103(c) of the Terrorism Risk Insurance Act of 2002 (15 U.S.C. 6701 note, 116 Stat. 2327) is amended—

[(1) by redesignating paragraph (2) as paragraph (3); and

[(2) by inserting after paragraph (1) the following:

''[(2) MANDATORY DURATION.—Coverage for insured losses required by paragraph (1) under a policy issued at any time during Program Year 5 shall remain in effect for not less than 1 year following the date of issuance of the policy, except that no loss occurring after the earlier of the expiration date of the subject insurance policy or December 31, 2008, shall be considered to be an insured loss for purposes of this title.''.

[(e) INSURED LOSS SHARED COMPENSATION.—Section 103(e) of the Terrorism Risk Insurance Act of 2002 (15 U.S.C. 6701 note, 116 Stat. 2328) is amended—

[(1) in paragraph (2)(A), by striking ''ending on'' and all that follows through ''Program Year 3'' and inserting ''ending on the termination date established under section 108(a)''; and

[(2) in paragraph (3), by striking ''ending on'' and all that follows through ''Program Year 3'' and inserting ''ending on the termination date established under section 108(a)''.

[(f) AGGREGATE RETENTION AMOUNT.—Section 103(e)(6) of the Terrorism Risk Insurance Act of 2002 (15 U.S.C. 6701 note, 116 Stat. 2328) is amended—

[(1) in subparagraph (B), by striking ''and'' at the end;

[(2) in subparagraph (C), by striking the period at the end and inserting a semicolon; and

[(3) by adding at the end the following:

''[(D) for Program Year 4, the lesser of—

''[(i) $17,500,000,000; and

''[(ii) the aggregate amount, for all insurers, of insured losses during such Program Year; and

''[(E) for Program Year 5, the lesser of—

''[(i) $20,000,000,000; and

''[(ii) the aggregate amount, for all insurers, of insured losses during such Program Year.''.

[SEC. 4. COVERAGE OF GROUP LIFE INSURANCE.

[Section 103 of the Terrorism Risk Insurance Act of 2002 (15 U.S.C. 6701 note, 116 Stat. 2327) is amended by striking subsection (h) and inserting the following:

[''(h) APPLICABILITY TO GROUP LIFE INSURANCE.—

[''(1) IN GENERAL.—The Secretary shall, by rule, apply the provisions of this title to providers of group life insurance, in the manner determined appropriate by the Secretary, consistent with the purposes of this title.

[''(2) CONSISTENT APPLICATION.—The rules of the Secretary under this subsection shall, to the extent practicable, apply the provisions of this title to providers of group life insurance in a similar manner as those provisions apply to an insurer otherwise under this title.

[''(3) CONSIDERATIONS.—In determining the applicability of this title to providers of group life insurance, and the manner of such application, the Secretary shall consider the overall group life insurance market size, and shall consider the establishment of separate retention amounts for such providers.

[''(4) RULEMAKING REQUIRED.—Not later than 90 days after the date of enactment of the Terrorism Risk Insurance Extension Act of 2005, the Secretary shall issue final regulations to carry out this subsection.

[''(5) RULE OF CONSTRUCTION.—Nothing in this subsection may be construed to affect or otherwise alter the applicability of this title to any insurer, as defined in section 102.

[''(6) DEFINITION.—As used in this subsection, the term 'group life insurance' means an insurance contract that provides term life insurance coverage, accidental death coverage, or a combination thereof, for a number of persons under a single contract, on the basis of a group selection of risks.''.

[SEC. 5. RECOMMENDATIONS FOR LONG-TERM SOLUTIONS.

[Section 108 of the Terrorism Risk Insurance Act of 2002 (15 U.S.C. 6701 note, 116 Stat. 2328) is amended by adding at the end the following:

[''(e) RECOMMENDATIONS FOR LONG-TERM SOLUTIONS.—The Presidential Working Group on Financial Markets shall, in consultation with the NAIC, representatives of the insurance industry, and representatives of policy holders, not later than June 30, 2006, submit a report to Congress containing recommendations for legislation to address the long-term availability and affordability of insurance for terrorism risk.''.

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Terrorism Risk Insurance Extension Act of 2005''.

SEC. 2. EXTENSION OF TERRORISM RISK INSURANCE PROGRAM.

(a) PROGRAM EXTENSION.—Section 108(a) of the Terrorism Risk Insurance Act of 2002 (15 U.S.C. 6701 note; 116 Stat. 2336) is amended by striking ''2005'' and inserting ''2007''.

(b) MANDATORY AVAILABILITY.—Section 103(c) of the Terrorism Risk Insurance Act of 2002 (15 U.S.C. 6701 note; 116 Stat. 2327) is amended—

(1) by striking paragraph (2);

(2) by striking ''AVAILABILITY.—'' and all that follows through ''each entity'' and inserting