

**The Honorable Pete Stark, Chairman, Committee on Ways and Means  
Subcommittee on Health  
Extension of Remarks  
September 15, 2008**

**Introduction Statement  
The Health-e Information Technology Act of 2008**

Madam Speaker, I rise to introduce the Health-e Information Technology Act of 2008, a bill to stimulate the development of a uniform, interoperable health information technology system for America. Such a system would enable every hospital and doctor to input a patients' information and pull up their medical record—all on-line and readily available. It would also make data available to researchers so that we could improve the practice of medicine.

Health Information Technology (HIT) is the key to improving quality, gaining efficiencies, and reducing cost in the US health care system. That's something that even people ranging from President Bush to Barack Obama can agree on.

If the United States had such a system, we would be able to provide the right care, to the patient, at the right time. A nationwide HIT system would:

- Ensure that every hospital could access an emergency room patient's medical record to appropriately treat them.
- Reduce duplicative lab tests. One study found that 9% of all lab tests were redundant<sup>1</sup> and that physicians canceled 69% of lab tests when their HIT systems alerted them to the redundancy.<sup>2</sup>
- More quickly eradicate outbreaks of disease because the HIT system would allow us to analyze where people were sick and what they had in common.
- More effectively conduct post-market surveillance on drugs approved by the FDA to ensure that they really are safe and effective once they are on the market. According to the FDA, Vioxx may have contributed to 27,785 heart attacks and sudden cardiac deaths between 1999 and 2003. Providers with health IT systems were able to closely monitor their Vioxx patients and take them off Vioxx at the first sign of harm.
- Dramatically reduce the use of paper records which—on top of being cumbersome and environmentally unfriendly—also causes medical errors because of difficulty interpreting handwriting and an inability to easily detect orders that are inappropriate for the patient, given their age, allergies, health conditions, and other drugs they may be taking. One study found that 1.4% of hospital admissions

---

<sup>1</sup> Bates et al. (1998) "What Proportion of Common Diagnostic Tests Appear Redundant?" *American Journal of Medicine*, vol. 104, no. 4 (April), pp 361-368.

<sup>2</sup> Bates et al. (1999). "Randomized Trial of a Computer-Based Intervention to Reduce Utilization of Redundant Laboratory Tests." *American Journal of Medicine*, vol. 106, no. 2 (February), pp. 144-150.

were caused by adverse drug events, 28% of which were preventable, and at a cost of \$10,000 per preventable event.<sup>3</sup>

There is no debate over whether we need such an HIT system in America. The debate is over the right role for government to foster the widespread adoption of such an interoperable, seamless HIT system. In this debate, it is vitally important to ensure that such a system has strong privacy protections and security requirements.

Some might say let the private sector do it. I'd respond that we've tried that and it's failed. Currently only 20-30% of hospitals and 10-20% of physician's offices have comprehensive health information systems. Even where systems are in place, they operate in silos and do not provide the aggregate data needed to improve quality of care. One reason for this failure is that private industry has spawned the development of unique proprietary systems. These systems may work well for the doctor's office or hospital system that purchases it, but they are unable to perform outside of their own network and therefore fail to meet the need of integrating our disparate health care system. This lack of progress is costing US tax payers millions of dollars. Studies have indicated that widespread adoption of HIT could reduce health care spending by \$80 million annually.

Just last week at a hearing before the Ways and Means Health Subcommittee, a representative for the California Association of Physician Groups (which represents large physician group practices in California) acknowledged that, while each of their member groups had adopted HIT, those systems were unable to talk to each other. The groups had each spent millions of dollars and suffered through reduced productivity during the transition, but their systems still cannot advance the practice of medicine in the United States or engage in other activities to achieve broader system efficiencies and quality improvements.

That's why, in my mind, it is so important for the federal government to step into the arena of HIT. Not because I think government is better than the private sector. But, because I think that if our government has decided that a uniform, interoperable HIT system is a priority, we should step up to the plate to create the standards and help pay for its adoption. That's precisely what the Health-e Information Technology Act does.

The Health-e Information Technology Act would codify the Office of the National Coordinator for Health Information Technology within the Department of Health and Human Services. The National Coordinator—with the assistance of an advisory committee representing private stakeholders and other appropriate public agencies—would be responsible for establishing and implementing a plan to achieve widespread adoption and use of interoperable, secure, and clinically useful electronic health records. In addition, the Coordinator would develop an open source health information technology system that is certified to meet the standards and would be available to health care providers at little or no cost in 2012, after the standards are established in 2011. Private

---

<sup>3</sup> Jha et al. (2001) "Identifying Hospital Admissions Due to Adverse Drug Events Using a Computer-Based Monitor." *Pharmacoepidemiology and Drug Safety*, vol 10, pp. 113-119.

vendors would be part of the process and would be encouraged to ensure that their products meet the new federal standards as well.

The bill would utilize the strength and size of the Medicare program as a tool to assure the adoption of these standards. Starting by 2013, Medicare would provide supplementary payments to doctors and hospitals (each up to a capped amount) to help offset the cost of purchasing new HIT equipment, transitioning to its use, and training personnel. These incentive payments would phase-out on a sliding scale over a four or five year period, for hospitals and doctors respectively. After that timeframe, if doctors or hospitals failed to use an HIT system that meets the defined standards, they would be penalized by a reduction in their Medicare reimbursements. As not all health care providers are reimbursed by Medicare, there are grant programs to assure assistance to them as well.

Maintaining the privacy and security of people's electronic health records is of vital importance. The Health-e Information Technology Act takes the protections afforded by the Health Insurance Portability and Accountability Act (HIPAA) of 1996, and updates them for the 21st century. It provides for protections to reach new entities in the e-health environment that were not envisaged by HIPAA, such as e-prescribing gateways and regional health information organizations, and addresses the increased migration of personal health information out of the traditional medical system through business associates. It shuts down the secondary market that has emerged around the sale and mining of patient health information by prohibiting the sale of patient information and applying stiff penalties to any individual or entity that uses or discloses health information in an unauthorized way. The bill also develops a culture of privacy protection through tough enforcement. To date, the Secretary has not levied a single penalty against a HIPAA covered entity, despite numerous privacy and security violations. This bill strengthens the enforcement of privacy and security protections by increasing the amount of civil monetary penalties that may be levied, requiring the Secretary to levy penalties in cases where violations rise to the level of willful neglect, and holding the Secretary accountable for actively enforcing the provisions through period audits and reports.

I recently sat down with the chairman of a major medical association, the head of a physician group practice organization, and two former Medicare and Medicaid administrators—one for a Democratic president and the other for a Republican president. All four of them agreed that without a date certain in law by which a uniform, interoperable HIT system must be used by all of America's doctors and hospitals, it simply won't happen. They also agreed that, while it won't be easy, it is vital that we form consensus around such legislation. They, too, acknowledged that a system that provides financial incentives for adoption, with eventual penalties for failure to adopt, is a sensible way to proceed.

With introduction of the Health-e Information Technology Act, I hope that we can move from the realm of private discussions to public endorsements. I am under no illusions that it will be easy to enact a bill like this. While the Congressional Budget Office has not yet provided a score for the legislation, we know that it will have significant costs. But

down-payments are required to achieve yield on long-term investments. I am confident that a uniform HIT system will ultimately lead to dramatic improvements in the delivery system and reap great savings once it is in place.

I look forward to working with my colleagues on both sides of the aisle, as well as physician and hospital organizations, to enact legislation to require the development and adoption of a uniform HIT system. We've been talking about this for decades. It is now time to act.