Updating Privacy Laws to Facilitate Health Information Exchange

Consumer and provider concerns about privacy and security are inhibiting adoption of health IT. Consumers are concerned about the consequences of disclosure of sensitive health information related to dire or stigmatized diseases, such as the loss of health coverage or employment. Providers, concerned about varying interpretations of state and federal privacy laws and the liability for violations, often are reluctant to exchange data. State updates to health privacy laws can help alleviate these and other concerns. Trends identified in enacted legislation include the following.

Comprehensive Reform

Key policy decisions for states that want to update privacy laws to allow for health information exchange include structuring patient consent, addressing provider concerns and establishing accountability mechanisms.

Structuring Patient Consent

States face key questions on the issue of patient consent. Under what circumstances should patient consent be required? How should consent be structured (opt-in, opt-out)? Will patients have to choose between including all their information for exchange or none? Or will patients be able to choose specific information to share? As states set policy on consent, a number of competing issues must be balanced, including: patients' desire to control data, providers' concern about having access to all relevant information for treatment, and implementation costs for providers and health information exchanges.

Provider Concerns

Providers, understandably, want access to all relevant patient information at time of treatment. They are concerned about liability if they treat a patient based on incorrect or missing data obtained from a health information exchange. Providers also are concerned about the cost of implementing privacy rules and their effect on practice workflows.

Accountability

States need to structure regulations and penalties so that patient, provider and health information exchange needs are balanced.

Minnesota and Rhode Island passed health privacy updates as part of comprehensive health IT measures. A comparison of the privacy portion of the bills illustrates the differing paths states take as they attempt to capture the benefits of mobile health data and temper the associated risks (Table 1).

Table 1. Comparison of Privacy Provisions from Minnesota and Rhode Island

	Minnesota *Minnesota Health Records Act*	**Rhode Island** *Rhode Island Health Information Exchange Act of 2008*
Bill	2007 HB 1078	2008 HB 7409
Status	Enacted 5/25/07	Enacted 7/10/2008
Summary	Allows creation of record locator services (RLS). An RLS is an electronic index of patient identifying information that directs providers to the location of patient health records held by providers and group purchasers.	Establishes a statewide health information exchange (HIE) under state authority. Designates the Rhode Island Quality Institute as the governance body or regional health information organization (RHIO) for the HIE.
Putting Patient Data into the System	An RLS can be created without patient consent. Patients have the right to opt-out of the RLS in total or can exclude specific provider contacts from the system.	Patients must opt in for their data to be included in the HIE.
Consent for Access	Consent is required to search an RLS for the location of a patient's records except in an emergency. To facilitate the real-time exchange of data, one provider can electronically represent patient consent to another. To do so, a provider must have a signed and dated patient consent form authorizing the release. In addition, the provider releasing the record shall document: 1) the provider requesting the health records; 2) the identity of the patient; 3) the health records requested; and 4) the date the health records were requested.	Patients who opt in can choose which providers have access to their data. If a patient opts in their authorization is not required for release to: • public health authorities for specified functions; • health care providers for diagnosis or treatment in an emergency; and • the RHIO for operation and administrative oversight of the HIE.

Table 1. Comparison of Privacy Provisions from Minnesota and Rhode Island (continued)

	Minnesota *Minnesota Health Records Act*	Rhode Island *Rhode Island Health Information Exchange Act of 2008*
Audit Log	RLS must maintain an audit log of providers who access a patient's information. The log must contain at least the following: 1) the identity of the provider accessing the information; 2) the identity of the patient whose information was accessed by the provider; and 3) the date the information was accessed.	Patients have the following rights: (a) to obtain a copy of their health care information from the HIE; (b) to obtain a copy of the disclosure report pertaining to their health care information; (c) to be notified of a breach of the HIE security system; (d) to terminate participation in the HIE; and (e) to request to amend their information through the provider participant.
Provider Liability	(b) When requesting health records using consent, or a representation of holding a consent, a provider warrants that the request: 1) contains no information known to the provider to be false; 2) accurately states the patient's desire to have health records disclosed or that there is specific authorization in law; and 3) does not exceed any limits imposed by the patient in the consent.	Provides immunity to health care providers who rely in good faith upon information provided through the HIE in the treatment of a patient.
Penalties	An RLS is liable for inappropriate disclosures of information. Anyone who inappropriately discloses a patient's data is liable for compensatory damages caused by an unauthorized release, plus costs and reasonable attorneys' fees. Providers who violate the statute can face disciplinary action by the appropriate licensing board or agency.	The bill establishes civil and criminal penalties for violations of the statute. Attorneys' fees may be awarded by the court to the successful party in any action under this chapter.

Source: National Conference of State Legislatures, 2008.

Other Strategies

Make HIPAA the Rule

Nevada specifies that the Health Insurance Portability and Accountability Act (HIPAA) shall preempt any more stringent state laws related to the electronic exchange of health information by covered entities. The bill allows patients to not participate in electronic transmission of individually identifiable health information, with an exception for Medicaid and SCHIP patients and when required by HIPAA or state law.

Nevada SB 536 *Section 1 1. "If a covered entity transmits electronically individually identifiable health information in compliance with the provisions of the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191, which govern the electronic transmission of such information, the covered entity is, for purposes of the electronic transmission, exempt from any state law that contains more stringent requirements or provisions concerning the privacy or confidentiality of individually identifiable health information."*

Address Varying Interpretations of State and Federal Privacy Laws

To address differing interpretations and application of federal and state privacy laws, the Oklahoma Legislature ordered the State Board of Health to create a standard authorization form for exchange of health information. Providers who use the form and follow the board's instructions are immunized from liability under state privacy laws that may arise from the exchange of health information. Use of the form is not required. (Oklahoma SB 1420)

Data Breach Notification

California AB 1298 expands the state's data breach notification law to include unencrypted medical information and health insurance information. The bill also expands the definition of provider of health care under the state's Confidentiality of Medical Information Act to cover third-party vendors of personal health records such as Google and Microsoft. HIPAA and most state health privacy laws do not cover personal health records maintained by third-party vendors.

E-prescribing

A few states prohibit e-prescribing systems from influencing provider prescribing practices. New Hampshire passed the most comprehensive of these bills, which included the following language to prohibit use of prescription information by certain parties:

New Hampshire HB 134 *"(e) No person who has access to electronic prescription information solely by transmitting or facilitating the transmission of prescriptions between the licensed prescriber generating the prescription and the pharmacy receiving the prescription, or any intermediary, shall retain the prescription or any information it contains for longer than is mandated by federal or state law, after which time the prescription information shall be destroyed. No such person shall sell, use, or otherwise make available the prescription information for any purpose other than transmission of prescriptions, prescription refills, and clinical information displayed to the prescriber or pharmacist."*

Promoting Health Information Exchange

States are working to advance health information exchange by promoting interoperable health IT tools and by establishing and sustaining health information exchange organizations and infrastructure. Interoperability, combined with state initiatives to create health information exchange organizations is essential to states efforts to achieve quality improvements and reduce duplicative tests. Trends identified in the enacted legislation include the following.

Interoperability

Interoperability allows different systems to share information in an understandable format. Uniform data standards are essential to achieving this capability among health IT systems. At the national level, the Healthcare Information Technology Standards Panel is establishing standards, and the Certification Commission for Healthcare Information Technology certifying products. State approaches to encourage interoperability vary. Some states adopted these standards by reference, while others designated a state agency or outside group to establish standards. To encourage use of the standards, states can require agencies to purchase only standards-based systems. States also can require specific functions for health IT systems sold within their borders.

Require Purchase of Certified Systems

Minnesota mandated interoperable electronic health records by 2015 for all hospital and health care providers. To meet the interoperability standards set by statute, providers must use an electronic health records system certified by the Certification Commission for Healthcare Information Technology or its successor. An exception is included in the legislation for specialists whose practice setting the Certification Commission for Healthcare Information Technology doesn't certify electronic health records for. (Minnesota SB 3780)

Use State Agency Purchasing Requirements

Virginia HB 2198 requires that electronic health records systems or other tools that interact with electronic patient information purchased by state agencies meet interoperability standards or be certified by a recognized certification body. The bill also requires state agencies that provide grants available to other entities for such systems ensure that the systems meet interoperability standards or be certified by a recognized certification body.

Create Standards and Require Use to Exchange Data

Utah HB 47 authorizes the Department of Health to adopt standards for electronic health information exchange. Payers and providers must use the standards adopted by the department to electronically exchange health information between health care systems. Payers and providers are not required to use the standards if they electronically exchange health information within a health care system.

Require Certain Functions

Texas SB 204 requires that electronic medical record systems sold to Texas health care providers who administer immunizations be able to interface with the state immunization registry.

Create or Designate a State-level Health Information Exchange

Many early health information exchange efforts began in the private sector, and state governments were asked to join. The current wave of health information exchanges, by contrast, is as likely to originate at the state level. Texas and Indiana created bodies to run the state-level health information exchange; and Connecticut, Vermont and Rhode Island designated existing independent nonprofit entities. Whether they create new entities or bless existing activities, statutes that define a state-level health information exchange confer formal status and authority, charge the health information exchange to promote health IT in both private and public sectors, define governance to include state agencies, and determine that they may receive and disburse funds on behalf of statewide health IT initiatives. Beyond these broad elements, various models have been adopted, reflecting existing activity in the state. Statutes that create these entities typically are comprehensive measures that, among other things, include: start-up support for a designated group, a state governance role, ongoing funding, and unique state-level responsibilities.

Appendix A compares legislation from Indiana, Texas and Vermont that creates or designates a state-level health information exchange.

ADVANCING ADOPTION AND USE

States are drawing on a wide range of policy levers to expand the use of health IT. These include mandates, incentives and leveraging state purchasing power. Trends identified in the enacted legislation include the following.

Mandates

Minnesota and Massachusetts have enacted mandates for the use of health IT tools. A few other states considered such mandates but did not enact them.

Mandate Purchase

Minnesota enacted two mandates for the purchase of health IT systems. The first requires hospitals and health care providers to have interoperable electronic health records systems by 2015. (Minnesota HB 1078) The second requires that, by 2011, all providers, group purchasers, prescribers and dispensers establish and maintain e-prescribing systems. (Minnesota SB 3780)

Tie Facility Licensure to Health IT System Implementation

Massachusetts tied implementation of computerized physician order entry and electronic health records to facility licensure standards for hospitals and community health centers. The Department of Public Health is charged with adopting regulations to require implementation of computerized physician order entry by Oct. 1, 2012, and of electronic health records by Oct. 1, 2015. The systems are to be certified by the Certification Commission for Healthcare Information Technology or its successor. (Massachusetts SB 2863)

Require health IT competency for physician licensure.

> (Massachusetts SB 2863) *"The board shall require, as a standard of eligibility for licensure, that applicants show a predetermined level of competency in the use of computerized physician order entry, e-prescribing, electronic health records and other forms of health information technology, as determined by the board."*

Incentives

Link Medical School Loan Repayment to Health IT Competency

Massachusetts created a workforce loan repayment assistance program for graduates of medical or nursing schools who specialize in areas where practitioners are in short supply. Among other eligibility requirements for the program is demonstration of competency with certain health IT tools. (Massachusetts SB 2863)

Offer Tax Credits

Wisconsin SB 40 creates a tax credit for providers who purchase electronic medical records. Providers can claim up to 50 percent of the cost of the system, to a maximum of $10 million per year.

Leverage State Purchasing Power

States are leveraging their role as a purchaser and provider of care to drive adoption and use of health IT.

Offer Incentive Payments for Electronic Health Records Use

New York SB 6808 allows providers who meet certain standards set by the Department of Health to receive supplemental payments for the increased cost of using electronic health records. To receive the payments, a provider must have an operating electronic health records system, and a set percentage of patients must be on Medicaid or uninsured.

Provide Targeted Reimbursement

Colorado SB 196 provides medical assistance program reimbursement for home and community services delivered via telemedicine.

Leverage State Employee Health Plan

Minnesota HB 548 creates a pilot program to provide a consumer-owned portable personal health record to members of the state employee health plan.

Appendix A. Comparison of Health Information Exchange Legislation in Three States

	Indiana *Indiana Health Informatics Corporation*	**Texas** *Texas Health Services Authority Corporation*	**Vermont** *Vermont Information Technology Leaders*
Bill	**2007 IN S 551**	**2007 TX H 1066**	**2007 VT H 229**
Status	Enacted 5/2/07	Enacted 6/15/07	Enacted 6/5/07
Project's Role within State Health IT Activities			
	Chapter 5. General Powers Sec. 1. The corporation shall encourage and facilitate the development of health informatics functions in Indiana. Sec. 2. The corporation is granted all powers necessary or appropriate to carry out the corporation's public and corporate purposes under this article. Chapter 7. Expiration Corporation will expire on June 30, 2015.	Section 182.051 (a) Created to promote the establishment of a voluntary statewide network for the communication of electronic health information and to foster a coordinated public-private initiative for the development and operation of the health information infrastructure in the state.	Amends the scope of work of the Vermont Information Technology Leaders (VITL, a non-profit organization incorporated in 2005). Section 903 (c) VITL shall develop the states health information technology plan. Designates VITL to operate the statewide health information exchange network.
Organizational Structure			
	Chapter 3. Indiana Health Informatics Corporation Sec. 2. (a) The corporation is a body politic and corporate, not a state agency but an independent instrumentality exercising essential public functions.	Sec.A182.051. Texas Health Services Authority; Purpose. … (b) The corporation is a public nonprofit corporation and, except as otherwise provided in this chapter, has all the powers and duties incident to a nonprofit corporation under the Business Organizations Code.	VITL is a nonprofit corporation.

Appendix A. Comparison of Health Information Exchange Legislation in Three States (continued)

	Indiana *Indiana Health Informatics Corporation*	**Texas** *Texas Health Services Authority Corporation*	**Vermont** *Vermont Information Technology Leaders*
Bill	**2007 IN S 551**	**2007 TX H 1066**	**2007 VT H 229**
Status	Enacted 5/2/07	Enacted 6/15/07	Enacted 6/5/07
Board Membership			
	Chapter 4. Corporation Board Sec. 1. The corporation shall be governed by a board. Sec. 2. (a) The board is composed of the following nine (9) members, none of whom may be a member of the general assembly: (1) The secretary of family and social services, or the secretary's designee. (2) The state health commissioner, or the state health commissioner's designee. (3) Seven (7) individuals appointed by the governor, of which at least: (A) one (1) individual must be a licensed physician who is actively engaged in the practice of medicine; and (B) one (1) individual must be engaged in the administration of a hospital licensed under IC 16-21.	Sec.A182.053.AA Composition Of Board Of Directors. (a) The corporation is governed by a board of 11 directors appointed by the governor, with the advice and consent of the senate. (b) The governor shall also appoint at least two ex officio, nonvoting members representing the Department of State Health Services. (c) The governor shall appoint as voting board members individuals who represent consumers, clinical laboratories, health benefit plans, hospitals, regional health information exchange initiatives, pharmacies, physicians, or rural health providers, or who possess expertise in any other area the governor finds necessary for the successful operation of the corporation.	Sec. 903. Health Information Technology (d) The following persons shall be members of VITL: (1) the commissioner, who shall advise the group on technology best practices and the state's information technology policies and procedures, including the need for a functionality assessment and feasibility study related to establishing an electronic health information infrastructure under this section; (2) the director of the office of Vermont health access or his or her designee; (3) the commissioner of health or his or her designee; and (4) the commissioner of banking, insurance, securities, and health care administration or his or her designee.

Appendix A. Comparison of Health Information Exchange Legislation in Three States (continued)			
	Indiana *Indiana Health Informatics Corporation*	**Texas** *Texas Health Services Authority Corporation*	**Vermont** *Vermont Information Technology Leaders*
Bill	**2007 IN S 551**	**2007 TX H 1066**	**2007 VT H 229**
Status	Enacted 5/2/07	Enacted 6/15/07	Enacted 6/5/07
Financing			
	Chapter 5. General Powers Section 11 The corporation may request appropriations from the general assembly to: 1) carry out the corporation's duties under this article; and 2) fund the effort to develop and operate a statewide health information network. Section 12. (a) The Indiana health informatics fund is established. ...the corporation shall deposit the following in the fund: (1) All appropriations made by the general assembly to the corporation (2) All funding received from nonprofit entities under IC 5-31-6-2(4). (3)All other contributions received by the corporation from a nonprofit entity, as long as the nonprofit entity does not otherwise have an interest in the decisions of the corporation or board.	Sec. 182.107 (a) The corporation may be funded through the General Appropriations Act and may request, accept, and use gifts and grants as necessary to implement its functions. (b) The corporation may assess transaction, convenience, or subscription fees to cover costs associated with implementing its functions. All fees must be voluntary but receipt of services provided by the corporation may be conditioned on payment of fees. (c) The corporation may participate in other revenue-generating activities that are consistent with the corporation's purposes.	Sec. 903 (a)(8)(g) By July 1, 2007, shall prepare a plan for achieving self-sustainable funding, including an analysis of the costs, benefits, and effectiveness of any pilot projects. (i) VITL is authorized to seek matching funds...In addition, it may accept any and all donations, gifts and grants of money, equipment, supplies, materials, and services from the federal or any local government, or any agency thereof, and from any person, firm or corporation for any of its purposes and functions under this section and may receive and use the same, subject to the terms, conditions, and regulations governing such donations, gifts, and grants.

Appendix A. Comparison of Health Information Exchange Legislation in Three States (continued)

	Indiana *Indiana Health Informatics Corporation*	**Texas** *Texas Health Services Authority Corporation*	**Vermont** *Vermont Information Technology Leaders*
Bill	**2007 IN S 551**	**2007 TX H 1066**	**2007 VT H 229**
Status	Enacted 5/2/07	Enacted 6/15/07	Enacted 6/5/07
Privacy and Security			
	Chapter 6. Duties Sec. 3. The corporation's plan to create the statewide health information exchange system must provide for procedures and security policies to ensure the following: (1) Compliance with the federal Health Insurance Portability and Accountability Act (HIPAA) (P.L. 104-191). (2) Protection of information privacy. (3) Use of information in the statewide health information exchange system only in accordance with the federal Health Insurance Portability and Accountability Act (HIPAA) (P.L.104-191) and as required by public health agencies.	Sec. 182.104.AASecurity Compliance. The corporation shall: (1) establish appropriate security standards to protect both the transmission and the receipt of individually identifiable health information or health care data; (2) establish appropriate security standards to protect access to any individually identifiable health information or health care data collected, assembled, or maintained by the corporation; (3) establish the highest levels of security and protection for access to and control of individually identifiable health information, including mental health care data and data relating to specific disease status, that is governed by more stringent state or federal privacy laws; and	Sec. 903. Health Information Technology (f) The standards and protocols developed by VITL shall be no less stringent than the "Standards for Privacy of Individually Identifiable Health Information" established under the Health Insurance Portability and Accountability Act of 1996 and contained in 45 C.F.R., Parts 160 and 164, and any subsequent amendments. In addition, the standards and protocols shall ensure that there are clear prohibitions against the out-of-state release of individually identifiable health information for purposes unrelated to treatment, payment, and health care operations, and that such information shall under no circumstances be used for marketing purposes. The standards and protocols shall require that access to individually identifiable health information is secure and traceable by an electronic audit trail.

Appendix A. Comparison of Health Information Exchange Legislation in Three States (continued)

	Indiana *Indiana Health Informatics Corporation*	**Texas** *Texas Health Services Authority Corporation*	**Vermont** *Vermont Information Technology Leaders*
Bill	**2007 IN S 551**	**2007 TX H 1066**	**2007 VT H 229**
Status	Enacted 5/2/07	Enacted 6/15/07	Enacted 6/5/07
Data Standards			
	Chapter 6. Duties Sec. 1. The corporation shall do the following:... (6) Promote the use of the statewide health information exchange system by doing the following: (A) Encouraging and facilitating users of the statewide health information exchange system and other interested parties in developing and adopting standards for the statewide health information exchange system. (B) Recommending policies and legislation that advance the development and efficient operation of the statewide health information exchange system.... (10) Encourage and endorse interoperability standards.	Sec.A182.103. Privacy of Information. (c) The corporation shall develop privacy, security, operational, and technical standards to assist health information networks in the state to ensure effective statewide privacy, data security, efficiency, and interoperability across networks. The network 's standards shall be guided by reference to the standards of the Certification Commission for Healthcare Information Technology or the Health Information Technology Standards Panel, or other federally approved certification standards, that exist on May 1, 2007, as to the process of implementation, acquisition, upgrade, or installation of electronic health information technology.	Sec. 903. Health Information Technology b) The health information technology plan shall: (3) promote the use of national standards for the development of an interoperable system, which shall include provisions relating to security, privacy, data content, structures and format, vocabulary, and transmission protocols;... (6) incorporate the existing health care information technology initiatives in order to avoid incompatible systems and duplicative efforts; (7) integrate the information technology components of the blueprint for health established in chapter 13 of Title 18, the global clinical record, and all other Medicaid management information systems being developed by the office of Vermont health access, information technology components of the quality assurance system, the program to capitalize with loans and grants electronic medical record systems in primary care practices, and any other information technology initiatives coordinated by the secretary of administration pursuant to section 2222a of Title 3;