Bill as Introduced

SB 369- AS AMENDED BY THE SENATE

2/3/00 3071s

2000 SESSION

00-2472

01/10

SENATE BILL ***369***

AN ACT establishing a committee to conduct a study on the need for standards to protect health information privacy.

SPONSORS: Sen. Wheeler, Dist 21; Rep. M. Fuller Clark, Rock 36; Rep. Taylor, Straf 11

COMMITTEE: Insurance

AMENDED ANALYSIS

This bill establishes a committee to conduct a study on the need for standards to protect health information privacy.

Explanation: Matter added to current law appears in ***bold italics.***

Matter removed from current law appears [~~in brackets and struckthrough.~~]

Matter which is either (a) all new or (b) repealed and reenacted appears in regular type.

2/3/00 3071s

00-2472

01/10

STATE OF NEW HAMPSHIRE

In the Year of Our Lord Two Thousand

AN ACT establishing a committee to conduct a study on the need for standards to protect health information privacy.

Be it Enacted by the Senate and House of Representatives in General Court convened:

1 Committee Established. There is established a committee to conduct a study on the need for standards to protect health information privacy.

2 Membership and Compensation.

I. The members of the committee shall be as follows:

(a) Five members of the senate, appointed by the president of the senate.

(b) Five members of the house of representatives, appointed by the speaker of the house.

II. The committee shall solicit information and participation from representatives of affected groups, organizations, or agencies, including, but not limited to:

(a) The commissioner of insurance.

(b) The commissioner of health and human services.

(c) Health care consumers.

(d) Health care providers.

(e) Health insurers.

(f) The New Hampshire Health Information Management Association.

(g) The New Hampshire Hospital Association.

(h) Property and casualty insurers.

III. Members of the committee shall receive mileage at the legislative rate when attending to the duties of the committee.

3 Duties.

I. The committee shall study the need for standards to protect health information privacy .

II. The committee shall consider existing proposals that set standards for the protection of health information privacy, including, but not limited to:

(a) The Health Information Privacy Model Act established by the National Association of Insurance Commissioners.

(b) Recommendations developed by the United States Department of Health and Human Services on Privacy of Medical Information.

4 Chairperson; Quorum. The members of the study committee shall elect a chairperson from among the members. The first meeting of the committee shall be called by the first-named senate member. The first meeting of the committee shall be held within 45 days of the effective date of this section. Four members of the committee shall constitute a quorum.

5 Report. The committee shall make an interim report on its findings together with any recommendations for proposed legislation to the senate president, the speaker of the house of representatives, the senate clerk, the house clerk, the governor, and the state library on or before November 1, 2000 and shall make a final report on or before November 1, 2001.

6 Effective Date. This act shall take effect upon its passage.

Amendments

Insurance
January 12, 2000
2000-3071s
01/09

Amendment to SB 369

Amend the bill by replacing section 2 with the following:

2 Membership and Compensation.

I. The members of the committee shall be as follows:

(a) Five members of the senate, appointed by the president of the senate.

(b) Five members of the house of representatives, appointed by the speaker of the house.

II. The committee shall solicit information and participation from representatives of affected groups, organizations, or agencies, including, but not limited to:

(a) The commissioner of insurance.

(b) The commissioner of health and human services.

(c) Health care consumers.

(d) Health care providers.

(e) Health insurers.

(f) The New Hampshire Health Information Management Association.

(g) The New Hampshire Hospital Association.

(h) Property and casualty insurers.

III. Members of the committee shall receive mileage at the legislative rate when attending to the duties of the committee.

Amend the bill by replacing sections 5 and 6 with the following:

5 Report. The committee shall make an interim report on its findings together with any recommendations for proposed legislation to the senate president, the speaker of the house of representatives, the senate clerk, the house clerk, the governor, and the state library on or before November 1, 2000 and shall make a final report on or before November 1, 2001.

6 Effective Date. This act shall take effect upon its passage.

2000-3071s

AMENDED ANALYSIS

This bill establishes a committee to conduct a study on the need for standards to protect health information privacy.

Committee Minutes

Date: January 11, 2000
Time: 9:40AM
Room: State House, Room 103

The Senate Committee on **Insurance** held a hearing on the following:

SB369 *establishing a committee to conduct a study on the need for standards to protect health information privacy.*

Members of Committee present:

Senator Wheeler, Chairman
Senator Eaton
Senator Fraser
Senator Squires

The Chair, Senator **Katie Wheeler**, opened the hearing.

Senator Katherine W. Wheeler, D. 21:
I'm going to open the Insurance Committee meeting this morning and welcome our new committee member, Senator Eaton. We are delighted to have him with us. And just for the record I want to say that we will always miss Senator Blaisdell. He was such an intricate part of this committee for so many years that his absence will be felt.

But we're looking forward to a new session with Senator Eaton, with our new Vice Chair, Senator Francoeur, who's not able to be here right now but I hope will be coming in a little later. Senator's King and McCarley are unable to be with us this morning but we do have Senator Fraser and Senator Squires. I am looking forward to a very productive session. I've asked Senator Fraser to open the hearing on the first bill since I'm the Sponsor.

Senator Leo W. Fraser, Jr., D. 4:
Good Morning, I would like to open the public hearing on **SB369**, *"establishing a committee to conduct a study on the need for standards to protect health information privacy."* The Chair recognizes the Prime Sponsor Senator Katie Wheeler from District 21.

Senator Katherine W. Wheeler, D. 21:
Thank you Senator Fraser. I am Senator Katie Wheeler and I am the Prime Sponsor of SB369, which was a request of the Insurance Department. The whole issue of health information privacy is becoming increasingly important at all levels. The only changes that I might suggest, in the bill that we will listen to as people testify, is perhaps increasing the number of Representatives and Senators on it, as we will have a lot of work to do.

And I know that there are other people who want to be consulted. Other groups, so we will take those into account to. So, I think it's a very important topic and I hope the Committee will look favorable upon it and I will defer any other remarks of mine until after others have spoken.

Senator Leo W. Fraser, Jr., D. 4:
Thank you Madame Chairman and I would appreciate it if you would take the chair.

Senator Katherine W. Wheeler, D. 21:
Thank you very much Senator Fraser. I will call you in the order on which you've signed up unless there's a reason to change. Sheila Evans is the first person on the list. *(Someone says something).* Martha, oh, go away for awhile and you forget what you should do. I'm sorry. I will call on the other sponsors first, that is the normal procedure. Representative Martha Fuller-Clark.

Representative Martha Fuller-Clark:
Thank you very much Chairman Wheeler, I appreciate the courtesy. For the record my name is Martha Fuller-Clark, I represent Ward 2, Ward 5 and the City of Portsmouth. As you heard from Senator Wheeler this is a bill that was requested by the Insurance Department on the need to conduct a study to protect health information privacy. I do have some information to share with you from NCSL.

(See attached, Document #1)

So one of the challenges, I think, of this committee will be to look at if there's any possible way to be able to prevent that access to unauthorized and inappropriate parties. So clearly the issue is to protect individual privacy and at the same time allowing for justified access and research personal health data.

(Representative Martha Fuller-Clark continues)

I think it's clear that this is a complex issue. Many of you will remember that 2 years ago that main passed a patients privacy bill that turned out to be completely unworkable and had to be rescinded by the Governor. It's not something that's going to be easy to work out. I think it is clear that it needs a committee. I think it's true also that it may make sense to expand that committee.

Legislation has passed in 6 or 7 other States that we need to look at. And we need to be talking to as many interested parties as possible. And I hope that we will find a way to be able to hear from patients as well as from the other interested groups that have been mentioned in my previous testimony. I would be happy to answer and I do think this is important that New Hampshire devise a mechanism to solve this problem.

Senator Katherine W. Wheeler, D. 21:
Thank you very much for your testimony. Are there any questions? See none. Representative Kathy Taylor, also a sponsor.

Representative Kathy Taylor:
Thank you Madame Chair, for the record I'm Kathy Taylor, Strafford, District 11 from Dover. I think that almost all my testimony has been given. I would second that we perhaps would need a larger committee, as this is a vast amount of information to be gathered and worked on. I know that Rhode Island, Connecticut and Maine have all been working for years on this and Maine has just implemented its second law after the first one was rescinded. That went into effect as of January 1, 20000.

So I think that's about it. I would be happy to answer any questions.

Senator Katherine W. Wheeler, D. 21:
Thank you very much. Are there any questions for Representative Taylor? See none, thank you very much. I am going to call on Alex Feldvebel from the New Hampshire Insurance Department since it was their request.

Alex Feldvebel - New Hampshire Department of Insurance:
Thank you Madame Chairman, Members of the Committee, my name is Alex Feldvebel, I am here on behalf of the Insurance Department. I'd like to just say a few words in terms of setting context for this bill.

(Alex Feldvebel continues)

One of the reasons I think it's appropriate to go ahead now, expeditiously with this study committee is that there is a lot happening on the Federal level as well as the State level around health information privacy legislation or rule making.

On the Federal level the Department of Health and Human Services is required under the Health Insurance Portability and Accountability Act, has promulgated a proposed rule on Health Information Privacy. Which is quite detailed, I was just looking it over yesterday its 149 pages in small print. And it provided basic standards for health information privacy and for access to information for certain purposes such as, research and public health.

But it also is designed to basically set a floor, so that it would preempt State law, only to the extent that State law might not include standards that are up to the floor set by these Federal rules. It doesn't preempt State law in terms of going above the floor for providing protections. It also limited in a number of ways, which the New Hampshire Legislature might not want to limit itself.

It applies only to electronic information, so it doesn't apply to paper information. It applies only to providers and health insurance carriers not to other insurers. And it does not apply to downstream users of the health information.

So, it shouldn't be viewed as necessarily as solving all the problems with the respect to health information privacy. In fact, at the same time these rules are being promulgated, Congress is considering further legislation on health information privacy.

There were 3 bills in the last session and some of them would have provided for stronger preemption of State law. One of them actually would have completely preempted State law in less the State had some law in effect, within 18 months of the effective date of the Legislation.

So I think that's even more reason for us to be looking at the issue and figuring out whether we want our own standard and what that standard should be. Because it's possible at the Federal level there might be Legislation that would preempt States that have not acted.

(Alex Feldvebel continues)

A side from that we have the model developed by the NAIC, the Health Information Privacy Model Act, which is an important thing to look at. We felt the Insurance Department did, it would be inappropriate just to put that in a proposed piece of Legislation. This issue is so complex and the whole situation is even more complex with this activity at the Federal level. It made more sense to have a study committee than to just propose this NAIC model law. So that's all I had to say.

Senator Katherine W. Wheeler, D. 21:
Thank you. Any questions? Senator Fraser.

Senator Leo W. Fraser, Jr., D. 4:
Thank you Madame Chairman. Alex, you heard both Senator Wheeler and Representative Fuller-Clark talk about increasing the size of the committee?

Alex Feldvebel:
Yes, that makes sense. I think its issue of great importance and great concern to our factors. And I was also concerned that the initial draft, that the other section, where we sort of list the stakeholders that need to be consulted, that list maybe to short as well. So, I think it would be very well to sort of consider both those factors, whether the committee should be enlarged and whether the list of stakeholders that need to be consulted should be enlarged as well.

Senator Leo W. Fraser, Jr., D. 4:
Follow-up, Madame Chair?

Senator Katherine W. Wheeler, D. 21:
Yes, Senator.

Senator Leo W. Fraser, Jr., D. 4:
Would you be kind enough to give the Chair any additional interested parties that you think should be in the bill?

Alex Feldvebel:
Well one thing that occurred to me is that sort of the whole research community isn't sort of represented on the list of parties that need to be consulted. But I am sure we will hear more suggestions.

Senator Katherine W. Wheeler, D. 21:
Any more questions for Alex? See none, thank you very much. Sheila Evans representing New Hampshire Women's Lobby.

Sheila Evans - New Hampshire Women's Lobby:
Yes, Good Morning, my name is Sheila Evans from the New Hampshire Women's Lobby and the Women's Lobby is in full support of this bill. They specifically, the board meet and looked at all the bills that were filed, and specifically felt this was a very important issue for women and families of New Hampshire.

The only emphasis, which would echo what Alex and others had said, is that we thought that inclusion of healthcare consumers should have a diversity of people from different aspects of health experiences.

Because we find that different stories that people have, help raise the awareness of where and how privacy can be invaded. So we were hoping that it would be expanded not just generic consumers but people with different interests in different areas.

Senator Katherine W. Wheeler, D. 21:
Thank you very much. Any questions from the Committee? I would just like to make it clear that I think we all know that if a Committee such as this is established that it's a very good idea to have as many suggests in the Legislation as possible. But if somebody is inadvertently left out there will be plenty of opportunities for those voices to be heard. Kathy Bizarro from the New Hampshire Hospital Association.

Kathy Bizarro - New Hampshire Hospital Association:
Good Morning Madame Chair, Members of the Committee.

(See document handed out in the hearing or attached to the original copy, written testimony, Document #2).

(Kathy Bizarro continues)

One of the questions I was asked earlier was for potential additional members for the study committee. I would suggest that the Hospital Association would be more than happy to be involved.

But also there is a group called the New Hampshire Health Information Management Association, they are a professional organization of medical record professionals. They are very well versed in this area, so I would suggest they would be a great group to include.

Senator Katherine W. Wheeler, D. 21:
Thank you very much. Are there questions? Senator Fraser.

Senator Leo W. Fraser, Jr., D. 4:
Kathy, is this a New Hampshire, are they here in Concord or where are they located?

Kathy Bizarro:
They are a voluntary professional organization that we work closely with them through the Hospital Association and they have a current board that we can work with, to draw upon.

Senator Leo W. Fraser, Jr., D. 4:
So you will be able to get them?

Kathy Bizarro:
Yes.

Senator Katherine W. Wheeler, D. 21:
Any further questions? See none, thank you very much for your testimony. Jim Hatem, representing State Farm.

Jim Hatem – State Farm:
Madame Chair, Members of the Committee, my name is Jim Hatem representing State Farm Insurance. Just a follow-up, I think it's been mentioned before.

(Jim Hatem continues)

Our only comment is that property and casualty insurers have interest in health information and we would like to make sure; or that we would request that they be included in the members, the people who'll be providing information and participating in the Committee.

Senator Katherine W. Wheeler, D. 21:
Thank you. Are there any questions for Mr. Hatem? See none, thank you very much. Janet Monahan, representing the New Hampshire Medical Society.

Janet Monahan - New Hampshire Medical Society:
Good Morning, for the record my name is Janet Monahan I'm representing the New Hampshire Medical Society today. I think that previous speakers have covered a lot of what I was going to mention. But I am handing out an article; ***(See document handed out in the hearing or attached to the original copy, Document #3)*** it's interesting it's on medical records and health information privacy. I got it out of Kiplinger's Financial Magazine, so I thought it was interesting that this issue is important even to the financial community.

Recently, President Clinton gave a speech and he said in that 1/3 of all Fortune 500 companies check medical records before they hire or promote. I think that's a little bit scary. But in the article you'll see that health insurers will look at employers as the customer. There buying health insurance for their employees, they will give them accessed information.

And what I found very interesting, I was a meeting at the Medical Society last night, we were talking about the health insurance program that we offer to physician members. And Palmer Jones, my boss had said that our rates are going up because of pharmaceuticals and two particular cases that were expensive. So I asked him today, those 2 cases did the insurance company give you the name of those people? He said yes.

And here Palmer's not their employer that's really scary. I don't think those physicians who used the services would necessarily want everyone to know that. And I think that you really need to a handle on this to find out what is appropriate to share with pharmaceutical companies, for example. Because you know PBM's that handle a lot of the mail order drugs have access to a tremendous amount of information.

(Janet Monahan continues)

Just recently the State was about to sign a contract with a company; a PBM that was going to provide lower cost drugs to low income people of New Hampshire. And as part of that they said right in their materials that we're going to deduce the person's diagnosis from what drugs we sell to them. And then we're going to market over the counter products to these folks. I don't know that as people signed up for this program that they understand that they're releasing a lot of their privacy.

So, this is very important and we are certainly willing to work with you folks on this.

Senator Katherine W. Wheeler, D. 21:
Thank you. Are there any questions? See none, thank you very much for your testimony. That concludes the list of those who've signed up. Is there anyone else in the room who would like to testify on SB369? Seeing none I will close the hearing on **SB369**.

Hearing on SB369 closed at 10:00am.

Respectfully submitted,
Linda Brosseau, Senate Secretary

Document #1
SB369

Health Policy Tracking Service

Subject:	Pharmaceuticals, Finance, Providers	Date: 09/22/99
Title:	Medical Records	

By: Author: Jacob Herstok
Updated by: Nicole Kendell
Federal Section Updated by: Maria Rothouse Esq.

In 1999, at least 35 state legislatures looked to enact laws clarifying the boundaries between confidentiality and privacy of medical records and rightful access to computerized health information by qualified medical researchers, insurers and employers.

In today's streamlined managed care environment, confidential health and medical data are collected, analyzed, distributed and accessed in unprecedented quantities. Health care providers access records to diagnose illnesses, coordinate treatment and obtain payment for services rendered, and monitor other health care providers in an attempt to hold health care costs to a minimum. Clinical researchers use medical records to gather valuable data on the course of a disease and how it responds to treatment. Insurers refer to medical records to determine coverage, make payments on claims, conduct utilization reviews, and for underwriting purposes. An employer may use employee health care data to track worker compensation claims and overall health care costs.

The fact that these diverse, yet interested, parties are able to obtain and use this confidential information for so many different purposes has made the issue of access to medical records of paramount concern in today's health care debate.

Confidential health care information can include an individual's medical, psychiatric, or psychological history, diagnosis, condition, treatment, evaluation, or drug prescriptions. This information commonly is maintained in written, auditory, visual, electronic, and other physical forms. Consumers and legislators agree that it is necessary to keep patient health care information confidential and free from unauthorized access, regardless of whether the records are kept on paper, preserved on microfilm, or stored in computer-retrievable form.

Key Issues

The single most pressing issue fueling the debate about access to medical records is how to protect an individual's privacy while, at the same time, allowing justified research access to personal health data.

The proliferation of managed care organizations has, in effect, created virtual storehouses of medical records information. This information, increasingly, is stored on computers and networked databases. This has proven extremely helpful to medical researchers who seek access to patient records. Computerization has allowed for new, elaborate analyses of large multipurpose health databases. Although ease of access to this information is beneficial for researchers, it is potentially intrusive to individual patients whose medical records may be accessible without their consent or knowledge.

Because of the demand for health care data, patients and providers are growing uneasy about the erosion of medical privacy. Anecdotal information in the print and electronic media have told stories that expose the vulnerability of the security of computerized health records. This gives patients a justified reason to be

Rep. Martha Fuller Clark

worried about unwarranted disclosure and, in some cases, outright abuse of personal medical records.

Threats to Medical Record Privacy

Computerization. While encryption technology is available to ensure privacy and anonymity, the computerization of medical records actually may serve to decrease privacy by compiling information that can be accessed by both authorized and unauthorized users. Computerization ultimately may increase the amount of accessible information as well as the risks of unauthorized modification and dissemination.

- **Information:** Computers have the potential to store virtually a limitless amount of data. Anyone with access to medical records or the ability to breach security measures is likely to be able to obtain important personal information such as a social security numbers, relevant addresses and dates of birth.

- **Access:** Unlike printed data, networked information is accessible from any location, by any competent computer user, at any time. This allows access to a large number of people and increases the possibility of mistakes or misuse.

- **Modification:** Computer databases can be modified by skilled users. Security can be breached and records could be misused, changed or deleted.

- **Dissemination:** Collecting, exchanging and transmitting information can occur much faster by computer, thereby increasing the possibility that medical information may be widely disseminated in a short period of time.

Parties Interested in medical records

- **Insurance companies:** Insurers use information contained in medical records before approving treatment and/or extending coverage.

- **Drug companies:** Pharmaceutical companies may have partnerships with doctors and hospitals that allow prescription records to be used for marketing.

- **Court subpoenas:** Patients sometimes are unaware that their medical record history will be used in court. Furthermore, unnecessary information can be included when the records are not adequately screened.

- **Employers:** Sensitive health data may become available to employers that offer their own health plans.

Health Insurance Portability and Accountability Act of 1996

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the U.S. Department of Health and Human Services (HHS) was asked to develop recommendations to protect the privacy and confidentiality of health care records. Secretary Donna Shalala presented the recommendations to Congress in September 1997.

Secretary Shalala urged Congress to enact federal legislation that would provide new rights for patients and define responsibilities and limitations for those who need access to medical records. According to Secretary Shalala, by establishing a basic national standard of protection, there will be clear guidance and significant incentives for the fair treatment of personal information by those in the health care field, and there will be real penalties for misuse. Among the provisions proposed in the secretary's report:

- Organizations that are entrusted with health information must protect it against deliberate or inadvertent misuse or disclosure. Security measures should be required to protect the information against improper use by employees, or threats from outside. Organizations hired by providers and payers to process information and complete other tasks also should be bound.

- Those who provide and pay for health care should be required to give patients a clear, written explanation of how they will use, keep and disclose information. Patients would be able to see and obtain copies of their records and propose corrections. A history of most disclosures would have to be maintained and be made accessible to patients.

- There should be punishment for the misuse of personal health information and redress for people who are harmed by its misuse.

- The federal health privacy legislation should supersede state law that is less protective than the federal law. If either the federal or state law forbids a disclosure, the disclosure should not be made. Thus, the confidentiality protections should be cumulative, and the federal legislation should provide "floor preemption."

- Privacy protections must be balanced with the public responsibility to support national priorities--like public health, research, quality care and the fight against health care fraud and abuse.

If Congress does not legislate on confidentiality by August 1999, then HIPAA calls for Secretary Shalala to impose confidentiality controls on electronic transaction systems.

1999 Federal Activity

With Congress' self-imposed August 21st deadline to pass a medical records privacy bill passed, the Department of Health and Human Services' Office of the Assistant Secretary for Planning and Evaluation (ASPE) is busy drafting regulations. ASPE has until February 2000 to publish medical records privacy regulations. A notice of proposed rulemaking is expected sometime in the fall. These regulations will address privacy of electronically transmitted medical information only. The underlying provision in the Health Insurance Portability and Accountability Act (P.L. 104-191) does not authorize the Secretary to develop regulations on broader issues of medical records privacy. Due to the limitations on the Department in the law, the Administration continues to press Congress to enact comprehensive medical records privacy legislation. No bills have been reported from committee in either the House or Senate.

Pending in the Senate Health, Education, Labor and Pensions (HELP) Committee is S. 578, sponsored by committee chair, Senator Jim Jeffords (R-VT) and pending in the House Commerce Committee are two bills, H.R. 1941 sponsored by Representatives Henry Waxman (D-CA), Gary Condit (D-CA) and Edward Markey (D-MA) and H.R. 2470, sponsored by Congressman Greenwood (R-PA). A side-by-side comparison of the House bills is available on the AFI Health Committee website at http://www.ncsl.org/statefed/afihlth.htm.

Medical Record Laws

A case study in the difficulty of the implementation of state medical records laws is exemplified by a 1996 **Minnesota** law. The law, which has received much scrutiny, requires researchers that use medical records to:

- Notify, in writing, all patients seeking medical care that medical records may be released for research and that the patient may object;
- Obtain the patient's general authorization for the release of records for research, which does not expire but may be revoked; and

- On request, inform patients whose records were released and tell them how they can contact the investigators.

A *New England Journal of Medicine* article dated November 13, 1997, disputed the law for the difficulties it created for providers and the research community when trying to access medical information for research purposes.

The author of the article, L. Joseph Melton III, M.D., uses the following example to illustrate some of the difficulties created by the law at the Mayo Clinic in Rochester, Minnesota.

> *Increasing patients' control over medical data is a laudable goal, but what has been the result in actual practice? A quarter of a million patients will be seen at the Mayo Clinic in 1997. For practical reasons, the clinic has chosen to comply with the new law through an appointment-based system. Patients with an appointment are sent an authorization form to sign, along with an explanatory letter and an informational brochure describing the importance of medical-records research to patient care. Patients without appointments must be approached directly when they appear for care. As of October 1997, 96 percent of the 214,000 patients who returned forms have provided this general authorization for the Mayo Clinic to use their medical-records information for research if needed. At Olmsted Medical Center, Mayo's main partner in the Rochester Epidemiology Project, 97 percent have provided the research authorization. Because of logistic difficulties inherent in a large tertiary referral center with many access points, other patients did not receive or have not returned their authorization forms, thereby necessitating the additional expense of follow-up letters. Superimposed on this considerable effort is the need to develop an elaborate system to track the use of medical records in research. Since the vast majority of patients agree to the broad use of their medical-records data for research, one has to question this expenditure of scarce health care resources. Indeed, the overwhelming preponderance of agreement is consistent with the notion of "constructed consent" from the whole patient population.*

The complexity and sheer volume of state medical record laws renders a comprehensive overview difficult. In its effort to establish baseline information on state medical record laws, the National Conference of State Legislatures has been working closely with the Health Privacy Project at Georgetown University to help compile a complete picture of existing state laws. The Health Privacy Project has found this to be a massive undertaking, but still hopes to have the report complete sometime in late spring.

In an attempt to provide the most information in a timely manner, the Health Policy Tracking Service at the National Conference of State Legislatures surveyed all 50 states last November. The survey consisted of the Georgetown University Law Center, *Legislative Survey of State Confidentiality Laws, with Specific Emphasis on HIV and* Immunization written by Larry Gostin, et al. in 1996 as a baseline. The Health Policy Tracking Service asked its state contacts to help update the Georgetown report and the results are listed below.

Table 1.

Medical Record Laws

State	Duty to Maintain Confidentiality of Medical Records				Duty to Maintain Confidentiality of Computerized Records
	Physicians	Other Providers	Health care Institutions	Insurers	
Alabama					
Alaska	X				
Arizona					
Arkansas	X	X	X	X	X
California	X	X	X	X	
Colorado	X	X	X		X
Connecticut	X	X	X		

Delaware	X		X		
Florida	X	X	X		X
Georgia					
Hawaii					
Idaho					
Illinois	X	X	X		X
Indiana	X	X	X		
Iowa					
Kansas					
Kentucky					X
Louisiana	X	X	X		X
Maine	X	X	X	X	X
Maryland	X	X	X		X
Massachusetts	X		X		X
Michigan					
Minnesota	X	X	X		
Mississippi	X	X	X		
Missouri					
Montana	X	X	X		X
Nebraska			X		
Nevada	X	X	X		X
New Hampshire	X	X	X		X
New Jersey	X		X		
New Mexico	X	X	X		X
New York	X	X	X	X	X
North Carolina	X				
North Dakota	X	X	X		X
Ohio					
Oklahoma	X		X		X
Oregon	X	X	X	X	X
Pennsylvania	X	X	X		X
Rhode Island	X	X	X		X
South Carolina	X				X
South Dakota	X		X		
Tennessee	X	X	X		X
Texas	X	X	X		X
Utah	X	X	X		X
Vermont	X	X	X		X
Virginia	X				
Washington	X	X	X		X
West Virginia	X				X
Wisconsin	X	X	X		X
Wyoming	X	X	X		X

Source: Health Policy Tracking Service, National Conference of State Legislatures, December 1998.

Table 2.

Medical Record Laws Continued

State	Permitted Disclosures to:			Penalties for Impermissible Disclosure	
	Health Care Providers	Researchers	Court Order	Civil	Criminal
Alabama			X		
Alaska					
Arizona	X			X	
Arkansas				X	
California	X	X	X	X	X
Colorado	X		X		X
Connecticut					
Delaware			X		
Florida	X	X	X		X
Georgia		X	X		
Hawaii			X		

Indiana						
Iowa						
Kansas						
Kentucky					X	
Louisiana	X		X	X		
Maine	X		X	X	X	
Maryland	X		X	X	X	X
Massachusetts					X	
Michigan						
Minnesota	X				X	
Mississippi	X			X		X
Missouri						
Montana	X		X	X		X
Nebraska			X			
Nevada				X		
New Hampshire			X			
New Jersey	X			X	X	
New Mexico					X	
New York	X		X	X	X	
North Carolina				X		
North Dakota				X	X	
Ohio	X		X	X	X	
Oklahoma					X	
Oregon	X			X		
Pennsylvania	X			X	X	X
Rhode Island	X		X	X	X	X
South Carolina					X	
South Dakota	X					
Tennessee	X		X	X	X	
Texas	X		X	X	X	
Utah			X			X
Vermont				X		X
Virginia	X		X			
Washington	X		X		X	
West Virginia						X
Wisconsin	X		X	X	X	X
Wyoming	X					X

Source: Health Policy Tracking Service, National Conference of State Legislatures, December 1998.

Current State Activity

In 1998, **Maine** was the only state to enact a broad-based comprehensive medical records law that was designed to protect the privacy of medical records by restricting what types of information can be released, and to whom. The law was short lived however. Concerns voiced by the media, relatives of hospital patients and by the clergy, as well as cautious interpretation by some hospitals led legislators to suspend the law in a unanimous House and Senate vote when the session began in January. Governor Angus King (R) signed the suspension into law soon thereafter, effective immediately.

In March of this year, Representative Elaine Fuller (D), the sponsor of the 1998 law, introduced an amendment to her bill (H 1156) that was enacted into law in June. The law will take effect February 1, 2000. Some key provisions of the measure include expanding the list of parties to whom health providers may disclose information. As originally worded, the law restricted information that some family members could get without written patient authorization. In cases where a patient is unconscious and unable to authorize disclosure, H 1156 will give health providers the authority to disclose patient information to the spouses, parents, adult children, adult grandchildren, siblings, aunts, uncles and other adults familiar with the patient. The law also lists non-family entities to whom limited information may be disclosed. Among them are schools and jails regarding immunization information; anyone needing to set or confirm

appointments for a third party; anyone who is picking up a drug prescription for a third party; clergy asking about room information and religious affiliation; media outlets asking to confirm the presence and general health status of a patient; and members of the public asking for a room number and health status of a patient. With the April Congressional deadline looming for federal action, states have made medical records confidentiality a top priority. Over 300 bills have been introduced and more than 100 have already passed through at least one chamber. Like last year, many of the proposals simply make technical changes to existing law. In 1999, however, states have followed **Maine's** lead in 1998, as there have been notably more comprehensive efforts in dealing with medical record confidentiality.

Montana was the first state to enact a broad medical records confidentiality law in 1999. Senate bill 103, signed into law on March 30, enacts the National Association of Insurance Commissioners (NAIC) Model Act. The law sets standards for the use of medical information by insurers. **Texas** also enacted a law (S 1237) that applies the state's existing privacy laws to pharmaceutical benefits managers (PBMs) and insurers. Prior to 1999, only five other states--**Arkansas, California, Maine, New York** and **Oregon**--regulate how insurers use medical records.

After several years of debate, **Hawaii** enacted a comprehensive medical record law (H 351) in June. The detailed law sets standards for the use and disclosure of both private and public health information. The measure uses specific language to establish mechanisms to protect against the unauthorized and inappropriate use of protected health information that is maintained as part of health care treatment, diagnosis, enrollment, payment, plan administration, testing or research processes. The law creates incentives to turn personal health information into non-identifiable health information for oversight, health research, public health, law enforcement, judicial, and administrative purposes. Finally, the law enacts penalties.

Finally, **North Dakota** enacted a comprehensive law (S 2166) dealing with public health medical information. The law sets standards and circumstances for the disclosure of individuals' medical records when it contains pertinent public health information.

Table 3.

1999 Medical Record Legislation

Note: Since more than 300 bills that reference medical records have been introduced in 1999, this update includes only those measures that have enacted and designates if a state has introduced a bill on this topic.

State	Laws	Provisions	State has introduced a Bill
Alabama	–	–	–
Alaska	–	–	–
Arizona	–	–	X
Arkansas	H 1070	Access to medical records for legal proceedings.	X
	S 527	Allows for a health facility to disclose medical records under the order of a subpoena.	
	S 773	Confidentiality of drug-free workplace program.	
California	–	–	X
Colorado	H 1214	Makes state trauma system records confidential.	X

Connecticut	S 1100	Applies the state's medical record law to pharmacy records.	X
	S 1019	Allows the Department of Mental Health and Addiction Services to have access to the records of individuals that they provide care to.	
	H 7501a	Information to obtained in medical records about HIV/AIDS testing of pregnant women.	
	H 7032	Requires MCOs to establish procedures to maintain the confidentiality of medical records.	
Delaware	--	--	--
Florida	H 2125	Allows the Department of Health to obtain patient records and insurance information pursuant to a subpoena without written authorization from the patient if the department and the probable cause panel of the appropriate board, if any, find reasonable cause to believe that a health care practitioner has provided inadequate medical care based on termination of insurance and also find that appropriate, reasonable attempts were made to obtain a patient release.	X
Georgia	H 199	Confidentiality of pharmacy and insurance records.	X
	H 660	Confidentiality of 'raw research' data.	
Hawaii	H 351	Comprehensive medical records privacy bill.	X
	H 1138	In conducting investigations that relate to the threat of public health, allows an authorized representative to view the limited portion of the patient's medical record directly relevant in time and scope to the disease incidence under investigation.	
	S 588	Allows any agency to provide medical records at the request of any other participating agency, of any offender receiving supervision or treatment while under custody of the state for purposes of sex offender treatment and community supervision.	

Idaho	S 1183	Establishes immunization registry.	X
Illinois	H 423	Provides that confidential medical information identifying a patient will not be available for public inspection in a way that identifies a patient.	X
	S 387	Optometrists medical records.	
	S 541	Hospital use and disclosure of medical records.	
	S 721	Confidentiality of dentists records.	
Indiana	H 1001	Children's health insurance medical records.	X
	H 2035	Establishes a state immunization registry.	
Iowa	S 248	Provides for strict confidentiality relating to a patient's HIV status. Contains provisions when disclosure is permitted.	X
Kansas	--	--	X
Kentucky	--	--	--
Louisiana	H 174	Provides protection from civil and criminal liability for the coroner and his agents when conducting any investigation, or review of any relevant medical records without the necessity of authorization, subpoena, or court order.	X
	H 620	Maintenance of electronic prescription records and pharmacists handling of medical records.	
	H 1552	Disclosure of minor's medical and genetic records.	
	S 870	Social workers handling and use of medical records.	
	S 709	Access to medical records owned by state departments for research and other statistical purposes.	

Maine	H 518	Establishes a study the confidentiality of information regarding persons receiving services funded in whole or in part by the Mental Health, Mental Retardation and Substance Abuse Services Department.	X
	H 1150	Amends and clarifies comprehensive medical record law enacted last year.	
Maryland	--	--	X
Massachusetts	--	--	X
Michigan	--	--	X
Minnesota	--	--	X
Mississippi	S 3016	Chiropractors' medical records.	X
Missouri	--	--	X
Montana	H 607	Permits the DOH to promulgate rules to ensure the confidentiality of health information.	X
	S 103	Comprehensive medical records privacy bill targeted at insurers.	
	S 309	Defines reasonable fee for the purposes of charging those authorized who request copies of theirs or others medical records.	
Nebraska	L 17	Permits a patient's representative to request release of medical records in certain circumstances. Sets fees to obtain costs of medical records.	X
Nevada	A 80	Disclosure of medical records of abused children.	X
	A 230	Establishes a system for the collection of information concerning adverse birth outcomes.	
	S 163	Establishes that if a person receiving services in a home for individual residential care is transferred to another home, the home must forward a copy of his or her medical records to the other home.	
New Hampshire	--	--	X
New Jersey	--	--	X

New Mexico	HJM 20	Calls for a study of the protection, access, use, disclosure and electronic transmission security standards of personal health data.	X
	H 497	Allows access to medical records for patients applying for disability benefits.	
New York	--	--	X
North Carolina	H 957	Establishes procedures for maintaining a electronic copy and paper copy of a patients medical records.	X
	H 958	Confidential information obtained by HMO's or other provider sponsored organizations may be disclosed pursuant to a court order.	
North Dakota	H 1143	Sets fees for copies of medical records.	X
	S 2400	Permits MCOs to put procedures in place to ensure the confidentiality of medical records.	
	S 2166	Sets comprehensive public health confidentiality standards.	
Ohio	H 283	Fees for copies of vital records.	X
Oklahoma	H 1368	Requires informed consent for disclosure of tissue samples for research purposes.	X
Oregon	H 2146	Contents of 'abstract records.'	X
	H 2179	Subpoena of medical records.	
Pennsylvania	--	--	X
Rhode Island	--	--	X
South Carolina	H 3498	No patient prescription drug information may be transferred without the written consent of the patient.	X
South Dakota	S 126	Provides that any patient information received by an ambulance service is confidential.	X
	S 236	MCO procedures for handling and disclosing medical records.	
	H 1223	Access to records by kin of deceased.	
Tennessee	H 570	Provides immunity from liability to a pharmacist for disclosing patient information in certain circumstances.	X
	H 1145	Allows a hospital to charge the actual costs of postage when sending medical records to patient who requests them.	

Texas	H 27	Access to medical records upon the death of a provider.	X
	S 1237	Applies state's privacy laws for insurers to PBMs.	
	S 1906	Confidentiality of dental records.	
	H 2702	Access and use of medical records by school based health centers.	
	H 2455	Access to medical records of a child by guardians.	
Utah	S 41	Confidentiality of HIV/AIDS patients' records.	X
Vermont	–	–	X
Virginia	H 2107	Deems a minor an adult to consent for release of medical records in certain circumstances.	X
	H 2131	Requires all providers to disclose medical records upon request of an injured employee.	
	S 1010 same as H 2427	Provider cannot disclose medical records for any other reason than what was consented.	
	S 1064	Disclosure of mental health records.	
	S 1199	Disclosure of minor's medical records for participation in medical assistance services.	
	S 1158	Disclosure of medical records for review for organ donation potential.	
Washington	–	–	X
West Virginia	S 90	Allows indigent persons free copies of their medical records under certain circumstances.	X
Wisconsin	–	–	–
Wyoming	H 227	Requires the confidentiality of medical records in professional assistance programs.	X
	S 95	Disclosure of medical records during judicial proceedings.	

Source: Health Policy Tracking Service, National Conference of State Legislatures, June 1999.

Publish? ● Yes ○ No

Comments:

Analyst: Nicole Kendall

July - 1999

HEALTH PRIVACY PROJECT

INSTITUTE FOR HEALTH CARE RESEARCH AND POLICY
GEORGETOWN UNIVERSITY

The State of Health Privacy: An Uneven Terrain

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Document #2

New Hampshire Hospital Association

TESTIMONY IN SUPPORT OF SB 369

ESTABLISHING A COMMITTEE TO CONDUCT A STUDY ON THE NEED FOR STANDARDS TO PROTECT HEALTH INFORMATION PRIVACY

SENATE INSURANCE COMMITTEE
JANUARY 11, 2000

Good Morning Madam Chair and members of the committee. My name is Kathy Bizarro and I am the Vice President for Strategic Information Services at the New Hampshire Hospital Association. I would like to provide testimony in support of Senate Bill 369.

The need for standardization of health information privacy is clearly needed. This is a complex and wide-ranging issue - even trying to define what constitutes health information is tricky. As mentioned in the Senate bill language, there are attempts currently underway at the national level to develop standards, but there has also been work in this area at the state level.

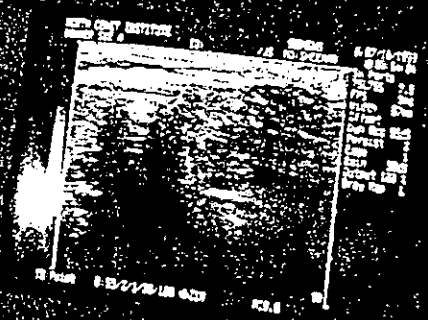
Nationally, Congress passed a law in 1996, called the Health Insurance and Portability Accountability Act (HIPAA), requiring that standards be developed to ensure proper security of health information. The New Hampshire Hospital Association is working with other state hospital associations and the American Hospital Association in formulating a response to the US Department of Health and Human Services' "Proposed Standards for Privacy of Individually Identifiable Health Information". The US DHHS' proposal focuses on personally identifiable electronic health information, which affects all healthcare providers, insurers and healthcare clearinghouses. This primarily involves medical record information.

At the state level, the New Hampshire Public Health Association received a Robert Wood Johnson grant two years ago called "Turning Point" which involved an evaluation of the public health infrastructure in the State of New Hampshire. There were several workgroups established, including one to look at public health data availability. One critical issue that arose was that there were different confidentiality standards for different public health data sets (such as vital records and hospital discharge data). A subgroup of public and private partners got together to develop language that would streamline the privacy standards for all public health data sets. We are in our final stages of development.

I urge you to consider all of the national and state initiatives currently underway. I'm available to the committee if you'd like more detailed information. Thank you for the opportunity to present my comments this morning.

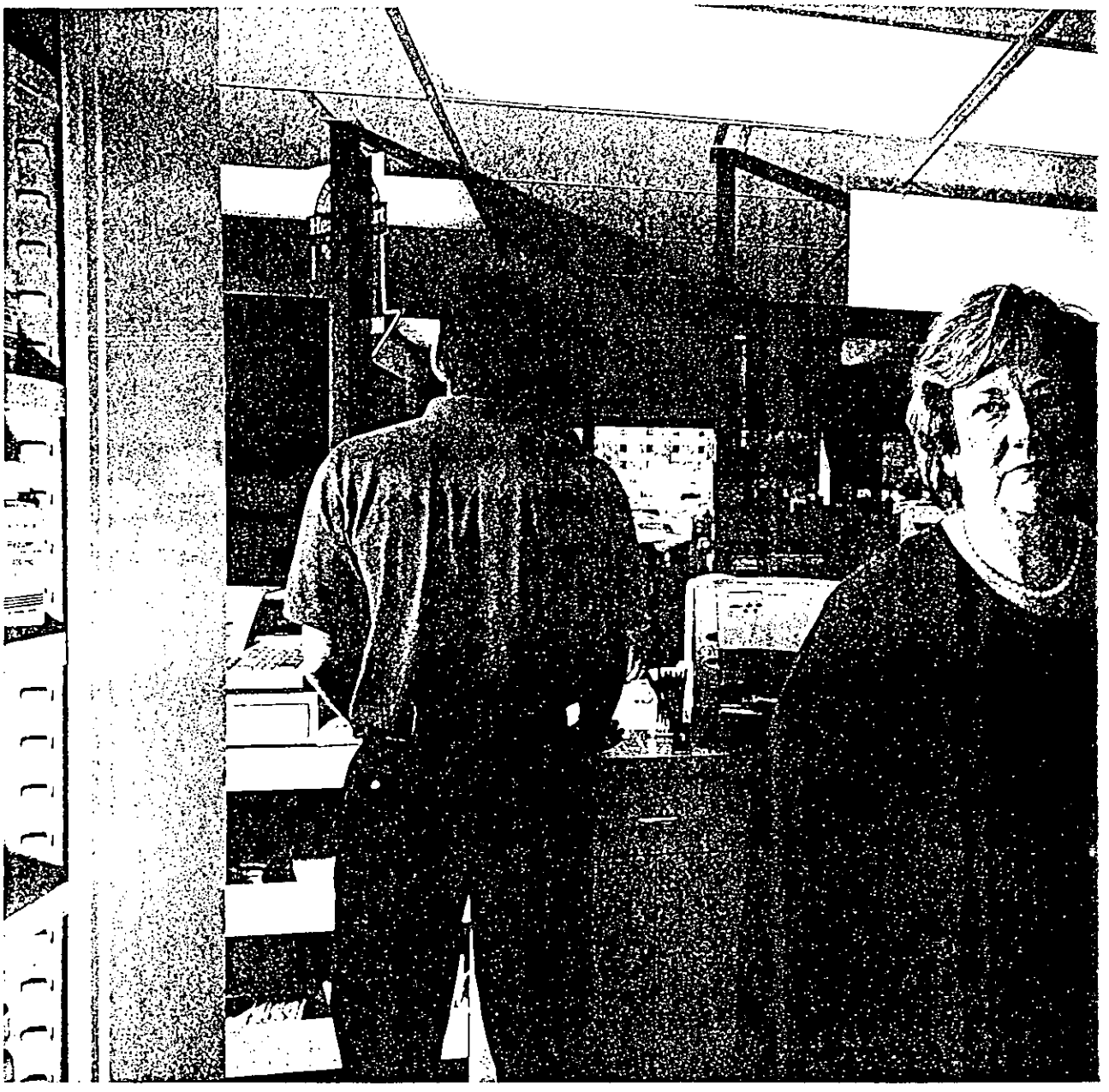
125 Airport Road ⊣ Concord, NH 03301-7300 ⊣ 603.225.0900 ⊣ Fax: 603.225.4846 ⊣ http://www.nhha.org

THE SALES REP came bearing doughnuts and muffins for the doctor's staff. But the message she delivered to Dr. John Sheehan, a Westlake, Ohio, endocrinologist, wasn't at all palatable. She opened a file that contained a listing of his postmenopausal patients and asked the doctor why he hadn't prescribed medication to prevent osteoporosis. The sales rep's goal: Get Sheehan to prescribe Evista, a drug made



John Sheehan found it offensive when a sales rep used information on his patients to pitch a drug.

Deposition #3. SR369



by Eli Lilly, her firm's parent company.

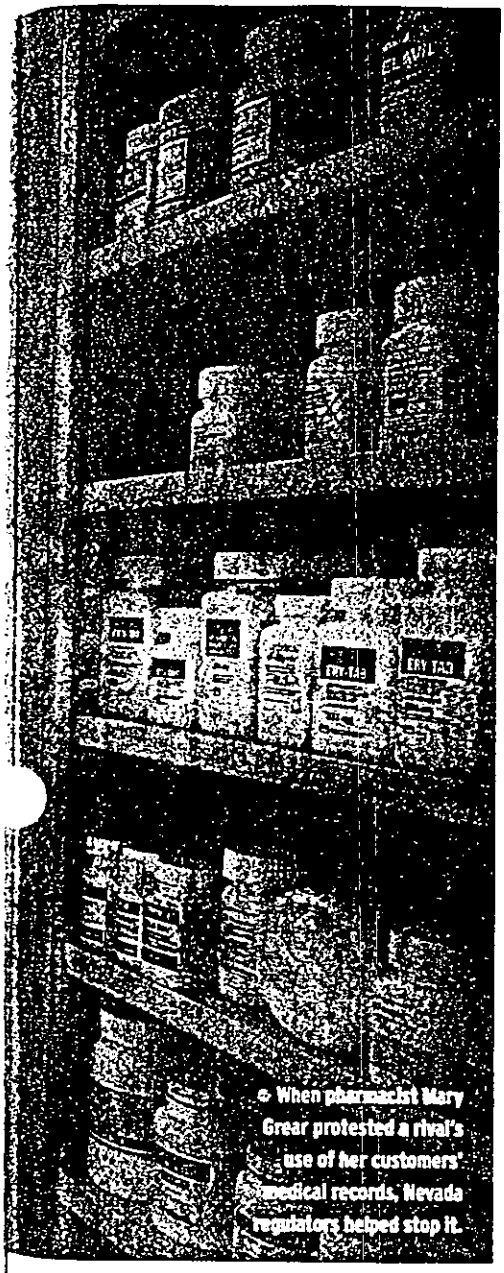
Shocked that an outsider would have access to his patients' records, and the audacity to question his medical judgment, Sheehan promptly sent the sales rep packing. "In my 25 years of practice, I had never experienced anything like that before," says Sheehan. "It was totally offensive."

Offensive, perhaps, but not unusual. While patients and doctors may assume their relationship is confidential, drug companies, insurers, employers and other outsiders know more about you and your medical history than you think.

Sometimes this knowledge can be annoying, as in the case of a drugstore that uses information on customers to sell you a particular medication or woo you away from your current pharmacy. Sometimes it can be embarrassing, as when your employer finds out that you're being treated for a particular medical condition.

But loss of confidentiality is more serious if it deters you from seeking health care. "If you eliminate privacy, you eliminate psychotherapy," says Jim Pyles, a lobbyist on behalf of the American Psychoanalytic Association. "Patients won't make disclosures unl they feel there is a confidential relati ship with the physician." Privacy adv cates worry that, taken to extremes, l of confidentiality could cost you your health insurance coverage, your job o the prospect of future employment.

Congress has been wrestling with several broad proposals to safeguard c confidentiality of medical informatio "If you have a medical record, you ha a privacy problem," says Sen. Patrick



When pharmacist Mary Grear protested a rival's use of her customers' medical records, Nevada regulators helped stop it.

Leahy (D–Vt.), who is sponsoring one of the bills. But chances of passage appear slim. Meanwhile, like Sheehan, you may be surprised at how far afield your medical history can go.

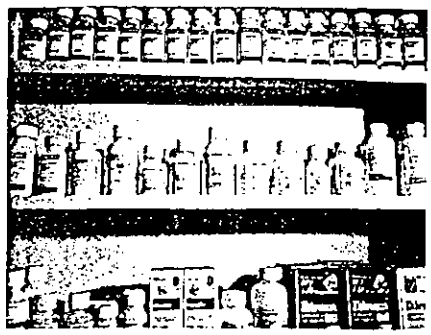
Sheehan discovered that it's easy for drug manufacturers to get patient information. In his case, the sales representative was from PCS Health Systems, one of the largest firms in pharmaceutical benefit management (PBMs). Insurers hire PBM companies to administer the prescription-benefit portion of health insurance plans because it's cost-effective. But because PBMs approve every drug a patient buys, they have access to an enormous amount of patient data. And there's no prohibition against a PBM sharing your information or selling it to drug manufacturers, researchers, marketers and other interested parties.

In fact, many PBMs are owned by drugstore chains or drug manufacturers. At the time of Sheehan's rude awakening in June 1998, PCS was owned by Eli Lilly, which has since sold it to Rite Aid. A company spokesman says PCS doesn't share patient data with Rite Aid, but there's no federal law that specifically prevents it.

In fact, Rx America, a PBM based in Utah, used patient data to solicit business for its owner, American Drug Stores. In 1997 American Drug Stores sent coupons and solicitation letters to customers of Health Mart, an independent drugstore chain in Las Vegas, suggesting that they switch to Sav-on, a local chain owned by American Drug Stores. Health Mart owner and pharmacist Mary Grear became suspicious when many of her customers received solicitations. When Grear investigated, she discovered that all of the customers were covered by an insurance company that used Rx America, the PBM owned by American Drug Stores.

Grear raised the issue with the Nevada Board of Pharmacy, which agreed that the practice was unethical, and Sav-on agreed to stop the mailings. But without a federal statute outlawing the practice, there's lots of incentive for firms to continue to do it. "There's so much going on with the sale of prescription information," says Grear. "It's become a very valuable commodity."

There's also nothing to stop PBMs from offering pharmacists incentives to suggest to customers that they switch to certain drugs. When a prescription is filled, the pharmacist sends a request by computer to the PBM to have it approved by the insurance company. If the medication is a brand name that isn't on the insurer's list of preferred drugs, the PBM may reply with an offer of a cheaper generic alternative or another brand-name drug that *is* on the insurer's preferred list.



The loss of privacy could cost you your insurance, your work, or the prospect of a job.

In many cases, however, the insurance company will pay for either brand-name drug. The pharmacist has the option of filling the original prescription, or getting the patient's permission to call his or her doctor and ask about switching. PCS offers pharmacists a commission of up to $12 per prescription if the prescription is changed. PCS spokesman Blair Jackson says the company is compensating pharmacists for their time. And sometimes PBMs are simply trying to save insurance companies money. But some in the pharmaceuticals industry question the practice, especially when a PBM is owned by a drug manufacturer.

Jeopardy on the job

PBMS AREN'T the only leak through which private medical information can become public without a patient's knowledge. Employers who self-insure not only have access to employee medical records so they can process claims, they technically own those records. And even when employers don't self-insure, "if they're paying for your coverage, the insurer

considers the *employer* the customer, not the patient," says Zoe Hudson, a policy analyst with the Health Privacy Project at Georgetown University, in Washington, D.C. "If employers ask for something, they're likely to get it."

Sometimes insurers automatically send copies of benefit claims, complete with diagnoses and treatment plans, directly to an employer. Or if an employer asks why its costs are rising, an insurer may disclose that certain employees are undergoing expensive treatments for AIDS or cancer.

No federal law specifically bars employers from using medical records when making decisions about promotions, hiring and firing. A study published in the *Employment Rights and Employment Policy Journal* reported that 35% of the largest employers in the U.S. consider medical information when making employment decisions.

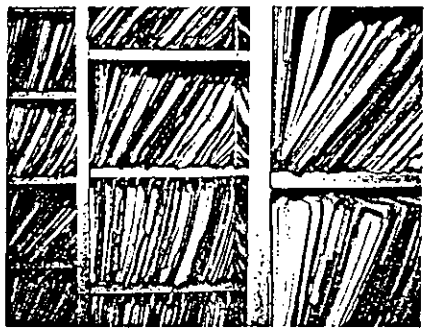
In one case, an administrative assistant at an international machinery firm mentioned in casual conversation with two co-workers that ten years earlier she had been exposed to hepatitis, although she had never become ill. When the conversation was reported to the company's director of human resources, the woman agreed to allow the company to perform a blood test but refused to sign a blanket medical release. As a result, she was suspended for three days.

Reinstated after the test proved negative, the woman was nevertheless embarrassed when she was asked to wear rubber gloves while serving food at meetings and told not to come in contact with the company president's secretary. She eventually left her job for another, taking a pay cut in the process.

Other conduits

INSURANCE COMPANIES can share your private medical information with lots of outside organizations, some of which you may not even know exist.

■ **Disease managers.** These firms are hired by insurance companies to monitor patients who have a specific condition, such as diabetes, asthma or congestive heart failure, and make sure they're following the prescribed treatment plan. Disease-management firms aren't required by law to keep patient medical histories confidential.



No federal law prohibits the sharing or selling of a patient's medical records.

■ **Accrediting organizations.** While conducting a routine review, an outside managed-care accrediting organization may ask to survey an insurance plan's patients. In response, the insurer may release hundreds of patient records.

"The problem is that whoever holds the information at any moment in time, whether it's the insurer or the pharmacy or the PBM, thinks that it's the owner of the information," says Hudson.

Even doctors can be unwittingly sloppy about keeping their patients' records confidential. Consider a physician who has contracts with several managed-care health insurance companies. To obtain a contract, the doctor may have had to agree to allow the plan to review all of his records—even those of patients not in that plan—to make sure the standard of care is consistent.

The goal may be worthwhile, but such reviews are done without the knowledge of patients. And not every physician goes along with the practice. Dr. Stephen Ducey, an internist in New London, Conn., refused to reveal his records to a representative of Physicians Health Service (PHS), a Connecticut-based insurance company. Instead, Ducey was willing to disclose only the records of PHS patients who had actually signed releases.

When one of Dr. Margo Goldman's psychotherapy patients applied for long-term-care insurance, the insurer hired a medical clearinghouse to review the patient's medical history. The clearinghouse immediately demanded that Goldman fax the patient's entire record. "This did not seem necessary or appropriate, given that they were evaluating him for long-term-care coverage," says Goldman, a psychiatrist in the Boston area. She persuaded the clearinghouse to accept a clinical summary instead.

Goldman is sensitive to confidentiality issues because she is director of policy development for the National Coalition for Patient Rights, but not all physicians are so vigilant. "If a physician found it more expedient, or just wasn't thinking about privacy, it would be easy to imagine that he would just fax the whole record," says Goldman.

Right now there's not much you can do to ensure the privacy of your medical records. State laws cover various slices of medical privacy, but no federal statute prohibits the sharing or selling of medical information without the patient's consent. Even paying out of pocket won't protect you because your records may still be reviewed by outside insurance companies or other organizations if your doctor is a member of a managed-care plan.

The Department of Health and Human Services is working on final rules to safeguard the privacy of electronic medical records stored or transmitted by computer. But those rules won't take effect until 2002, and the bulk of medical records is still on paper. "If you give the public the impression that communications can't remain private, then the public loses confidence in the health care delivery system," says lobbyist Pyles. K —*Reporter:* JUSTIN WISER

Date: January 11, 2000
Time: 9:40AM
Room: State House, Room 103

The Senate Committee on **Insurance** held a hearing on the following:

SB369 *establishing a committee to conduct a study on the need for standards to protect health information privacy.*

Members of Committee present: *Senator Wheeler, Chairman*
Senator Eaton
Senator Fraser
Senator Squires

The Chair, Senator **Katie Wheeler**, opened the hearing.

Senator Katherine W. Wheeler, D. 21:
I'm going to open the Insurance Committee meeting this morning and welcome our new committee member, Senator Eaton. We are delighted to have him with us. And just for the record I want to say that we will always miss Senator Blaisdell. He was such an intricate part of this committee for so many years that his absence will be felt.

But we're looking forward to a new session with Senator Eaton, with our new Vice Chair, Senator Francoeur, who's not able to be here right now but I hope will be coming in a little later. Senator's King and McCarley are unable to be with us this morning but we do have Senator Fraser and Senator Squires. I am looking forward to a very productive session. I've asked Senator Fraser to open the hearing on the first bill since I'm the Sponsor.

Senator Leo W. Fraser, Jr., D. 4:
Good Morning, I would like to open the public hearing on **SB369**, *"establishing a committee to conduct a study on the need for standards to protect health information privacy."* The Chair recognizes the Prime Sponsor Senator Katie Wheeler from District 21.

Senator Katherine W. Wheeler, D. 21:
Thank you Senator Fraser. I am Senator Katie Wheeler and I am the Prime Sponsor of SB369, which was a request of the Insurance Department. The whole issue of health information privacy is becoming increasingly important at all levels. The only changes that I might suggest, in the bill that we will listen to as people testify, is perhaps increasing the number of Representatives and Senators on it, as we will have a lot of work to do.

And I know that there are other people who want to be consulted. Other groups, so we will take those into account to. So, I think it's a very important topic and I hope the Committee will look favorable upon it and I will defer any other remarks of mine until after others have spoken.

Senator Leo W. Fraser, Jr., D. 4:
Thank you Madame Chairman and I would appreciate it if you would take the chair.

Senator Katherine W. Wheeler, D. 21:
Thank you very much Senator Fraser. I will call you in the order on which you've signed up unless there's a reason to change. Sheila Evans is the first person on the list. *(Someone says something).* Martha, oh, go away for awhile and you forget what you should do. I'm sorry. I will call on the other sponsors first, that is the normal procedure. Representative Martha Fuller-Clark.

Representative Martha Fuller-Clark:
Thank you very much Chairman Wheeler, I appreciate the courtesy. For the record my name is Martha Fuller-Clark, I represent Ward 2, Ward 5 and the City of Portsmouth. As you heard from Senator Wheeler this is a bill that was requested by the Insurance Department on the need to conduct a study to protect health information privacy. I do have some information to share with you from NCSL.

(See attached, Document #1)

So one of the challenges, I think, of this committee will be to look at if there's any possible way to be able to prevent that access to unauthorized and inappropriate parties. So clearly the issue is to protect individual privacy and at the same time allowing for justified access and research personal health data.

(Representative Martha Fuller-Clark continues)

I think it's clear that this is a complex issue. Many of you will remember that 2 years ago that main passed a patients privacy bill that turned out to be completely unworkable and had to be rescinded by the Governor. It's not something that's going to be easy to work out. I think it is clear that it needs a committee. I think it's true also that it may make sense to expand that committee.

Legislation has passed in 6 or 7 other States that we need to look at. And we need to be talking to as many interested parties as possible. And I hope that we will find a way to be able to hear from patients as well as from the other interested groups that have been mentioned in my previous testimony. I would be happy to answer and I do think this is important that New Hampshire devise a mechanism to solve this problem.

Senator Katherine W. Wheeler, D. 21:
Thank you very much for your testimony. Are there any questions? See none. Representative Kathy Taylor, also a sponsor.

Representative Kathy Taylor:
Thank you Madame Chair, for the record I'm Kathy Taylor, Strafford, District 11 from Dover. I think that almost all my testimony has been given. I would second that we perhaps would need a larger committee, as this is a vast amount of information to be gathered and worked on. I know that Rhode Island, Connecticut and Maine have all been working for years on this and Maine has just implemented its second law after the first one was rescinded. That went into effect as of January 1, 20000.

So I think that's about it. I would be happy to answer any questions.

Senator Katherine W. Wheeler, D. 21:
Thank you very much. Are there any questions for Representative Taylor? See none, thank you very much. I am going to call on Alex Feldvebel from the New Hampshire Insurance Department since it was their request.

Alex Feldvebel - New Hampshire Department of Insurance:
Thank you Madame Chairman, Members of the Committee, my name is Alex Feldvebel, I am here on behalf of the Insurance Department. I'd like to just say a few words in terms of setting context for this bill.

(Alex Feldvebel continues)

One of the reasons I think it's appropriate to go ahead now, expeditiously with this study committee is that there is a lot happening on the Federal level as well as the State level around health information privacy legislation or rule making.

On the Federal level the Department of Health and Human Services is required under the Health Insurance Portability and Accountability Act, has promulgated a proposed rule on Health Information Privacy. Which is quite detailed, I was just looking it over yesterday its 149 pages in small print. And it provided basic standards for health information privacy and for access to information for certain purposes such as, research and public health.

But it also is designed to basically set a floor, so that it would preempt State law, only to the extent that State law might not include standards that are up to the floor set by these Federal rules. It doesn't preempt State law in terms of going above the floor for providing protections. It also limited in a number of ways, which the New Hampshire Legislature might not want to limit itself.

It applies only to electronic information, so it doesn't apply to paper information. It applies only to providers and health insurance carriers not to other insurers. And it does not apply to downstream users of the health information.

So, it shouldn't be viewed as necessarily as solving all the problems with the respect to health information privacy. In fact, at the same time these rules are being promulgated, Congress is considering further legislation on health information privacy.

There were 3 bills in the last session and some of them would have provided for stronger preemption of State law. One of them actually would have completely preempted State law in less the State had some law in effect, within 18 months of the effective date of the Legislation.

So I think that's even more reason for us to be looking at the issue and figuring out whether we want our own standard and what that standard should be. Because it's possible at the Federal level there might be Legislation that would preempt States that have not acted.

(Alex Feldvebel continues)

A side from that we have the model developed by the NAIC, the Health Information Privacy Model Act, which is an important thing to look at. We felt the Insurance Department did, it would be inappropriate just to put that in a proposed piece of Legislation. This issue is so complex and the whole situation is even more complex with this activity at the Federal level. It made more sense to have a study committee than to just propose this NAIC model law. So that's all I had to say.

Senator Katherine W. Wheeler, D. 21:
Thank you. Any questions? Senator Fraser.

Senator Leo W. Fraser, Jr., D. 4:
Thank you Madame Chairman. Alex, you heard both Senator Wheeler and Representative Fuller-Clark talk about increasing the size of the committee?

Alex Feldvebel:
Yes, that makes sense. I think its issue of great importance and great concern to our factors. And I was also concerned that the initial draft, that the other section, where we sort of list the stakeholders that need to be consulted, that list maybe to short as well. So, I think it would be very well to sort of consider both those factors, whether the committee should be enlarged and whether the list of stakeholders that need to be consulted should be enlarged as well.

Senator Leo W. Fraser, Jr., D. 4:
Follow-up, Madame Chair?

Senator Katherine W. Wheeler, D. 21:
Yes, Senator.

Senator Leo W. Fraser, Jr., D. 4:
Would you be kind enough to give the Chair any additional interested parties that you think should be in the bill?

Alex Feldvebel:
Well one thing that occurred to me is that sort of the whole research community isn't sort of represented on the list of parties that need to be consulted. But I am sure we will hear more suggestions.

Senator Katherine W. Wheeler, D. 21:
Any more questions for Alex? See none, thank you very much. Sheila Evans representing New Hampshire Women's Lobby.

Sheila Evans - New Hampshire Women's Lobby:
Yes, Good Morning, my name is Sheila Evans from the New Hampshire Women's Lobby and the Women's Lobby is in full support of this bill. They specifically, the board meet and looked at all the bills that were filed, and specifically felt this was a very important issue for women and families of New Hampshire.

The only emphasis, which would echo what Alex and others had said, is that we thought that inclusion of healthcare consumers should have a diversity of people from different aspects of health experiences.

Because we find that different stories that people have, help raise the awareness of where and how privacy can be invaded. So we were hoping that it would be expanded not just generic consumers but people with different interests in different areas.

Senator Katherine W. Wheeler, D. 21:
Thank you very much. Any questions from the Committee? I would just like to make it clear that I think we all know that if a Committee such as this is established that it's a very good idea to have as many suggests in the Legislation as possible. But if somebody is inadvertently left out there will be plenty of opportunities for those voices to be heard. Kathy Bizarro from the New Hampshire Hospital Association.

Kathy Bizarro - New Hampshire Hospital Association:
Good Morning Madame Chair, Members of the Committee.

(See document handed out in the hearing or attached to the original copy, written testimony, Document #2).

(Kathy Bizarro continues)

One of the questions I was asked earlier was for potential additional members for the study committee. I would suggest that the Hospital Association would be more than happy to be involved.

But also there is a group called the New Hampshire Health Information Management Association, they are a professional organization of medical record professionals. They are very well versed in this area, so I would suggest they would be a great group to include.

Senator Katherine W. Wheeler, D. 21:
Thank you very much. Are there questions? Senator Fraser.

Senator Leo W. Fraser, Jr., D. 4:
Kathy, is this a New Hampshire, are they here in Concord or where are they located?

Kathy Bizarro:
They are a voluntary professional organization that we work closely with them through the Hospital Association and they have a current board that we can work with, to draw upon.

Senator Leo W. Fraser, Jr., D. 4:
So you will be able to get them?

Kathy Bizarro:
Yes.

Senator Katherine W. Wheeler, D. 21:
Any further questions? See none, thank you very much for your testimony. Jim Hatem, representing State Farm.

Jim Hatem – State Farm:
Madame Chair, Members of the Committee, my name is Jim Hatem representing State Farm Insurance. Just a follow-up, I think it's been mentioned before.

(Jim Hatem continues)

Our only comment is that property and casualty insurers have interest in health information and we would like to make sure; or that we would request that they be included in the members, the people who'll be providing information and participating in the Committee.

Senator Katherine W. Wheeler, D. 21:
Thank you. Are there any questions for Mr. Hatem? See none, thank you very much. Janet Monahan, representing the New Hampshire Medical Society.

Janet Monahan - New Hampshire Medical Society:
Good Morning, for the record my name is Janet Monahan I'm representing the New Hampshire Medical Society today. I think that previous speakers have covered a lot of what I was going to mention. But I am handing out an article; ***(See document handed out in the hearing or attached to the original copy, Document #3)*** it's interesting it's on medical records and health information privacy. I got it out of Kiplinger's Financial Magazine, so I thought it was interesting that this issue is important even to the financial community.

Recently, President Clinton gave a speech and he said in that 1/3 of all Fortune 500 companies check medical records before they hire or promote. I think that's a little bit scary. But in the article you'll see that health insurers will look at employers as the customer. There buying health insurance for their employees, they will give them accessed information.

And what I found very interesting, I was a meeting at the Medical Society last night, we were talking about the health insurance program that we offer to physician members. And Palmer Jones, my boss had said that our rates are going up because of pharmaceuticals and two particular cases that were expensive. So I asked him today, those 2 cases did the insurance company give you the name of those people? He said yes.

And here Palmer's not their employer that's really scary. I don't think those physicians who used the services would necessarily want everyone to know that. And I think that you really need to a handle on this to find out what is appropriate to share with pharmaceutical companies, for example. Because you know PBM's that handle a lot of the mail order drugs have access to a tremendous amount of information.

(Janet Monahan continues)

Just recently the State was about to sign a contract with a company; a PBM that was going to provide lower cost drugs to low income people of New Hampshire. And as part of that they said right in their materials that we're going to deduce the person's diagnosis from what drugs we sell to them. And then we're going to market over the counter products to these folks. I don't know that as people signed up for this program that they understand that they're releasing a lot of their privacy.

So, this is very important and we are certainly willing to work with you folks on this.

Senator Katherine W. Wheeler, D. 21:
Thank you. Are there any questions? See none, thank you very much for your testimony. That concludes the list of those who've signed up. Is there anyone else in the room who would like to testify on SB369? Seeing none I will close the hearing on **SB369**.

Hearing on SB369 closed at 10:00am.

Respectfully submitted,
Linda Brosseau, Senate Secretary

Document #1
SB369

Health Policy Tracking Service

Subject:	**Pharmaceuticals, Finance, Providers**	**Date: 09/22/99**
Title:	**Medical Records**	

By: Author: Jacob Herstok
Updated by: Nicole Kendell
Federal Section Updated by: Maria Rothouse Esq.

In 1999, at least 35 state legislatures looked to enact laws clarifying the boundaries between confidentiality and privacy of medical records and rightful access to computerized health information by qualified medical researchers, insurers and employers.

In today's streamlined managed care environment, confidential health and medical data are collected, analyzed, distributed and accessed in unprecedented quantities. Health care providers access records to diagnose illnesses, coordinate treatment and obtain payment for services rendered, and monitor other health care providers in an attempt to hold health care costs to a minimum. Clinical researchers use medical records to gather valuable data on the course of a disease and how it responds to treatment. Insurers refer to medical records to determine coverage, make payments on claims, conduct utilization reviews, and for underwriting purposes. An employer may use employee health care data to track worker compensation claims and overall health care costs.

The fact that these diverse, yet interested, parties are able to obtain and use this confidential information for so many different purposes has made the issue of access to medical records of paramount concern in today's health care debate.

Confidential health care information can include an individual's medical, psychiatric, or psychological history, diagnosis, condition, treatment, evaluation, or drug prescriptions. This information commonly is maintained in written, auditory, visual, electronic, and other physical forms. Consumers and legislators agree that it is necessary to keep patient health care information confidential and free from unauthorized access, regardless of whether the records are kept on paper, preserved on microfilm, or stored in computer-retrievable form.

Key Issues

The single most pressing issue fueling the debate about access to medical records is how to protect an individual's privacy while, at the same time, allowing justified research access to personal health data.

The proliferation of managed care organizations has, in effect, created virtual storehouses of medical records information. This information, increasingly, is stored on computers and networked databases. This has proven extremely helpful to medical researchers who seek access to patient records. Computerization has allowed for new, elaborate analyses of large multipurpose health databases. Although ease of access to this information is beneficial for researchers, it is potentially intrusive to individual patients whose medical records may be accessible without their consent or knowledge.

Because of the demand for health care data, patients and providers are growing uneasy about the erosion of medical privacy. Anecdotal information in the print and electronic media have told stories that expose the vulnerability of the security of computerized health records. This gives patients a justified reason to be

Rep. Martha Fuller Clark

worried about unwarranted disclosure and, in some cases, outright abuse of personal medical records.

Threats to Medical Record Privacy

Computerization. While encryption technology is available to ensure privacy and anonymity, the computerization of medical records actually may serve to decrease privacy by compiling information that can be accessed by both authorized and unauthorized users. Computerization ultimately may increase the amount of accessible information as well as the risks of unauthorized modification and dissemination.

- **Information:** Computers have the potential to store virtually a limitless amount of data. Anyone with access to medical records or the ability to breach security measures is likely to be able to obtain important personal information such as a social security numbers, relevant addresses and dates of birth.

- **Access:** Unlike printed data, networked information is accessible from any location, by any competent computer user, at any time. This allows access to a large number of people and increases the possibility of mistakes or misuse.

- **Modification:** Computer databases can be modified by skilled users. Security can be breached and records could be misused, changed or deleted.

- **Dissemination:** Collecting, exchanging and transmitting information can occur much faster by computer, thereby increasing the possibility that medical information may be widely disseminated in a short period of time.

Parties interested in medical records

- **Insurance companies:** Insurers use information contained in medical records before approving treatment and/or extending coverage.

- **Drug companies:** Pharmaceutical companies may have partnerships with doctors and hospitals that allow prescription records to be used for marketing.

- **Court subpoenas:** Patients sometimes are unaware that their medical record history will be used in court. Furthermore, unnecessary information can be included when the records are not adequately screened.

- **Employers:** Sensitive health data may become available to employers that offer their own health plans.

Health Insurance Portability and Accountability Act of 1996

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the U.S. Department of Health and Human Services (HHS) was asked to develop recommendations to protect the privacy and confidentiality of health care records. Secretary Donna Shalala presented the recommendations to Congress in September 1997.

Secretary Shalala urged Congress to enact federal legislation that would provide new rights for patients and define responsibilities and limitations for those who need access to medical records. According to Secretary Shalala, by establishing a basic national standard of protection, there will be clear guidance and significant incentives for the fair treatment of personal information by those in the health care field, and there will be real penalties for misuse. Among the provisions proposed in the secretary's report:

- Organizations that are entrusted with health information must protect it against deliberate or inadvertent misuse or disclosure. Security measures should be required to protect the information against improper use by employees, or threats from outside. Organizations hired by providers and payers to process information and complete other tasks also should be bound.

- Those who provide and pay for health care should be required to give patients a clear, written explanation of how they will use, keep and disclose information. Patients would be able to see and obtain copies of their records and propose corrections. A history of most disclosures would have to be maintained and be made accessible to patients.

- There should be punishment for the misuse of personal health information and redress for people who are harmed by its misuse.

- The federal health privacy legislation should supersede state law that is less protective than the federal law. If either the federal or state law forbids a disclosure, the disclosure should not be made. Thus, the confidentiality protections should be cumulative, and the federal legislation should provide "floor preemption."

- Privacy protections must be balanced with the public responsibility to support national priorities--like public health, research, quality care and the fight against health care fraud and abuse.

If Congress does not legislate on confidentiality by August 1999, then HIPAA calls for Secretary Shalala to impose confidentiality controls on electronic transaction systems.

1999 Federal Activity

With Congress' self-imposed August 21st deadline to pass a medical records privacy bill passed, the Department of Health and Human Services' Office of the Assistant Secretary for Planning and Evaluation (ASPE) is busy drafting regulations. ASPE has until February 2000 to publish medical records privacy regulations. A notice of proposed rulemaking is expected sometime in the fall. These regulations will address privacy of electronically transmitted medical information only. The underlying provision in the Health Insurance Portability and Accountability Act (P.L. 104-191) does not authorize the Secretary to develop regulations on broader issues of medical records privacy. Due to the limitations on the Department in the law, the Administration continues to press Congress to enact comprehensive medical records privacy legislation. No bills have been reported from committee in either the House or Senate.

Pending in the Senate Health, Education, Labor and Pensions (HELP) Committee is S. 578, sponsored by committee chair, Senator Jim Jeffords (R-VT) and pending in the House Commerce Committee are two bills, H.R. 1941 sponsored by Representatives Henry Waxman (D-CA), Gary Condit (D-CA) and Edward Markey (D-MA) and H.R. 2470, sponsored by Congressman Greenwood (R-PA). A side-by-side comparison of the House bills is available on the AFI Health Committee website at http://www.ncsl.org/statefed/afihlth.htm.

Medical Record Laws

A case study in the difficulty of the implementation of state medical records laws is exemplified by a 1996 **Minnesota** law. The law, which has received much scrutiny, requires researchers that use medical records to:

- Notify, in writing, all patients seeking medical care that medical records may be released for research and that the patient may object;
- Obtain the patient's general authorization for the release of records for research, which does not expire but may be revoked; and

- On request, inform patients whose records were released and tell them how they can contact the investigators.

A *New England Journal of Medicine* article dated November 13, 1997, disputed the law for the difficulties it created for providers and the research community when trying to access medical information for research purposes.

The author of the article, L. Joseph Melton III, M.D., uses the following example to illustrate some of the difficulties created by the law at the Mayo Clinic in Rochester, Minnesota.

> *Increasing patients' control over medical data is a laudable goal, but what has been the result in actual practice? A quarter of a million patients will be seen at the Mayo Clinic in 1997. For practical reasons, the clinic has chosen to comply with the new law through an appointment-based system. Patients with an appointment are sent an authorization form to sign, along with an explanatory letter and an informational brochure describing the importance of medical-records research to patient care. Patients without appointments must be approached directly when they appear for care. As of October 1997, 96 percent of the 214,000 patients who returned forms have provided this general authorization for the Mayo Clinic to use their medical-records information for research if needed. At Olmsted Medical Center, Mayo's main partner in the Rochester Epidemiology Project, 97 percent have provided the research authorization. Because of logistic difficulties inherent in a large tertiary referral center with many access points, other patients did not receive or have not returned their authorization forms, thereby necessitating the additional expense of follow-up letters. Superimposed on this considerable effort is the need to develop an elaborate system to track the use of medical records in research. Since the vast majority of patients agree to the broad use of their medical-records data for research, one has to question this expenditure of scarce health care resources. Indeed, the overwhelming preponderance of agreement is consistent with the notion of "constructed consent" from the whole patient population.*

The complexity and sheer volume of state medical record laws renders a comprehensive overview difficult. In its effort to establish baseline information on state medical record laws, the National Conference of State Legislatures has been working closely with the Health Privacy Project at Georgetown University to help compile a complete picture of existing state laws. The Health Privacy Project has found this to be a massive undertaking, but still hopes to have the report complete sometime in late spring.

In an attempt to provide the most information in a timely manner, the Health Policy Tracking Service at the National Conference of State Legislatures surveyed all 50 states last November. The survey consisted of the Georgetown University Law Center, *Legislative Survey of State Confidentiality Laws, with Specific Emphasis on HIV and* Immunization written by Larry Gostin, et al. in 1996 as a baseline. The Health Policy Tracking Service asked its state contacts to help update the Georgetown report and the results are listed below.

Table 1.

Medical Record Laws

State	Duty to Maintain Confidentiality of Medical Records				Duty to Maintain Confidentiality of Computerized Records
	Physicians	Other Providers	Health care Institutions	Insurers	
Alabama					
Alaska	X				
Arizona					
Arkansas	X	X	X	X	X
California	X	X	X	X	
Colorado	X	X	X		X
Connecticut	X	X	X		

Delaware	X		X		
Florida	X	X	X		X
Georgia					
Hawaii					
Idaho					
Illinois	X	X	X		X
Indiana	X	X	X		
Iowa					
Kansas					
Kentucky					X
Louisiana	X	X	X		X
Maine	X	X	X	X	X
Maryland	X	X	X		X
Massachusetts	X		X		X
Michigan					
Minnesota	X	X	X		
Mississippi	X	X	X		
Missouri					
Montana	X	X	X		X
Nebraska			X		
Nevada	X	X	X		X
New Hampshire	X	X	X		X
New Jersey	X		X		
New Mexico	X	X	X		X
New York	X	X	X	X	X
North Carolina	X				
North Dakota	X	X	X		X
Ohio					
Oklahoma	X		X		X
Oregon	X	X	X	X	X
Pennsylvania	X	X	X		X
Rhode Island	X	X	X		X
South Carolina	X				X
South Dakota	X		X		
Tennessee	X	X	X		X
Texas	X	X	X		X
Utah	X	X	X		X
Vermont	X	X	X		X
Virginia	X				
Washington	X	X	X		X
West Virginia	X				X
Wisconsin	X	X	X		X
Wyoming	X	X	X		X

Source: Health Policy Tracking Service, National Conference of State Legislatures, December 1998.

Table 2.

Medical Record Laws Continued

	Permitted Disclosures to:			Penalties for Impermissible Disclosure	
State	Health Care Providers	Researchers	Court Order	Civil	Criminal
Alabama			X		
Alaska					
Arizona	X			X	
Arkansas				X	
California	X	X	X	X	X
Colorado	X		X		X
Connecticut					
Delaware			X		
Florida	X	X	X		X
Georgia		X	X		
Hawaii			X		

Indiana						
Iowa						
Kansas						
Kentucky					X	
Louisiana	X		X	X		
Maine	X		X	X	X	
Maryland	X		X	X	X	X
Massachusetts					X	
Michigan						
Minnesota	X				X	
Mississippi	X			X		X
Missouri						
Montana	X		X	X		X
Nebraska			X			
Nevada				X		
New Hampshire			X			
New Jersey	X			X	X	
New Mexico					X	
New York	X		X	X	X	
North Carolina				X		
North Dakota				X	X	
Ohio	X		X	X	X	
Oklahoma					X	
Oregon	X			X		
Pennsylvania	X			X	X	X
Rhode Island	X		X	X	X	X
South Carolina					X	
South Dakota	X					
Tennessee	X		X	X	X	
Texas	X		X	X	X	
Utah			X			X
Vermont				X		X
Virginia	X		X			
Washington	X		X		X	
West Virginia						X
Wisconsin	X		X	X	X	X
Wyoming	X					X

Source: Health Policy Tracking Service, National Conference of State Legislatures, December 1998.

Current State Activity

In 1998, **Maine** was the only state to enact a broad-based comprehensive medical records law that was designed to protect the privacy of medical records by restricting what types of information can be released, and to whom. The law was short lived however. Concerns voiced by the media, relatives of hospital patients and by the clergy, as well as cautious interpretation by some hospitals led legislators to suspend the law in a unanimous House and Senate vote when the session began in January. Governor Angus King (R) signed the suspension into law soon thereafter, effective immediately.

In March of this year, Representative Elaine Fuller (D), the sponsor of the 1998 law, introduced an amendment to her bill (H 1156) that was enacted into law in June. The law will take effect February 1, 2000. Some key provisions of the measure include expanding the list of parties to whom health providers may disclose information. As originally worded, the law restricted information that some family members could get without written patient authorization. In cases where a patient is unconscious and unable to authorize disclosure, H 1156 will give health providers the authority to disclose patient information to the spouses, parents, adult children, adult grandchildren, siblings, aunts, uncles and other adults familiar with the patient. The law also lists non-family entities to whom limited information may be disclosed. Among them are schools and jails regarding immunization information; anyone needing to set or confirm

appointments for a third party; anyone who is picking up a drug prescription for a third party; clergy asking about room information and religious affiliation; media outlets asking to confirm the presence and general health status of a patient; and members of the public asking for a room number and health status of a patient. With the August Congressional deadline looming for federal action, states have made medical records confidentiality a top priority. Over 300 bills have been introduced and more than 100 have already passed through at least one chamber. Like last year, many of the proposals simply make technical changes to existing law. In 1999, however, states have followed **Maine's** lead in 1998, as there have been notably more comprehensive efforts in dealing with medical record confidentiality.

Montana was the first state to enact a broad medical records confidentiality law in 1999. Senate bill 103, signed into law on March 30, enacts the National Association of Insurance Commissioners (NAIC) Model Act. The law sets standards for the use of medical information by insurers. **Texas** also enacted a law (S 1237) that applies the state's existing privacy laws to pharmaceutical benefits managers (PBMs) and insurers. Prior to 1999, only five other states--**Arkansas, California, Maine, New York** and **Oregon**--regulate how insurers use medical records.

After several years of debate, **Hawaii** enacted a comprehensive medical record law (H 351) in June. The detailed law sets standards for the use and disclosure of both private and public health information. The measure uses specific language to establish mechanisms to protect against the unauthorized and inappropriate use of protected health information that is maintained as part of health care treatment, diagnosis, enrollment, payment, plan administration, testing or research processes. The law creates incentives to turn personal health information into non-identifiable health information for oversight, health research, public health, law enforcement, judicial, and administrative purposes. Finally, the law enacts penalties.

Finally, **North Dakota** enacted a comprehensive law (S 2166) dealing with public health medical information. The law sets standards and circumstances for the disclosure of individuals' medical records when it contains pertinent public health information.

Table 3.

1999 Medical Record Legislation

Note: Since more than 300 bills that reference medical records have been introduced in 1999, this update includes only those measures that have enacted and designates if a state has introduced a bill on this topic.

State	Laws	Provisions	State Has Introduced a Bill
Alabama	--	--	--
Alaska	--	--	--
Arizona	--	--	X
Arkansas	H 1070	Access to medical records for legal proceedings.	X
	S 527	Allows for a health facility to disclose medical records under the order of a subpoena.	
	S 773	Confidentiality of drug-free workplace program.	
California	--	--	X
Colorado	H 1214	Makes state trauma system records confidential.	X

Connecticut	S 1100	Applies the state's medical record law to pharmacy records.	X
	S 1019	Allows the Department of Mental Health and Addiction Services to have access to the records of individuals that they provide care to.	
	H 7501a	Information to obtained in medical records about HIV/AIDS testing of pregnant women.	
	H 7032	Requires MCOs to establish procedures to maintain the confidentiality of medical records.	
Delaware	--	--	--
Florida	H 2120	Allows the Department of Health to obtain patient records and insurance information pursuant to a subpoena without written authorization from the patient if the department and the probable cause panel of the appropriate board, if any, find reasonable cause to believe that a health care practitioner has provided inadequate medical care based on termination of insurance and also find that appropriate, reasonable attempts were made to obtain a patient release.	X
Georgia	H 159	Confidentiality of pharmacy and insurance records.	X
	H 660	Confidentiality of 'raw research' data.	
Hawaii	H 361	Comprehensive medical records privacy bill.	X
	H 1138	In conducting investigations that relate to the threat of public health, allows an authorized representative to view the limited portion of the patient's medical record directly relevant in time and scope to the disease incidence under investigation.	
	S 588	Allows any agency to provide medical records at the request of any other participating agency, of any offender receiving supervision or treatment while under custody of the state for purposes of sex offender treatment and community supervision.	

Idaho	S 1183	Establishes immunization registry.	X
Illinois	H 423	Provides that confidential medical information identifying a patient will not be available for public inspection in a way that identifies a patient.	X
	S 387	Optometrists medical records.	
	S 541	Hospital use and disclosure of medical records.	
	S 721	Confidentiality of dentists records.	
Indiana	H 1001	Children's health insurance medical records.	X
	H 2035	Establishes a state immunization registry.	
Iowa	S 248	Provides for strict confidentiality relating to a patient's HIV status. Contains provisions when disclosure is permitted.	X
Kansas	--	--	X
Kentucky	--	--	--
Louisiana	H 174	Provides protection from civil and criminal liability for the coroner and his agents when conducting any investigation, or review of any relevant medical records without the necessity of authorization, subpoena, or court order.	X
	H 620	Maintenance of electronic prescription records and pharmacists handling of medical records.	
	H 1352	Disclosure of minor's medical and genetic records.	
	S 870	Social workers handling and use of medical records.	
	S 709	Access to medical records owned by state departments for research and other statistical purposes.	

Maine	H 516	Establishes a study the confidentiality of information regarding persons receiving services funded in whole or in part by the Mental Health, Mental Retardation and Substance Abuse Services Department.	X
	H 1156	Amends and clarifies comprehensive medical record law enacted last year.	
Maryland	--	--	X
Massachusetts	--	--	X
Michigan	--	--	X
Minnesota	--	--	X
Mississippi	S 3016	Chiropractors' medical records.	X
Missouri	--	--	X
Montana	H 607	Permits the DOH to promulgate rules to ensure the confidentiality of health information.	X
	S 108	Comprehensive medical records privacy bill targeted at insurers.	
	S 309	Defines reasonable fee for the purposes of charging those authorized who request copies of theirs or others medical records.	
Nebraska	L 17	Permits a patient's representative to request release of medical records in certain circumstances. Sets fees to obtain costs of medical records.	X
Nevada	A 80	Disclosure of medical records of abused children.	X
	A 230	Establishes a system for the collection of information concerning adverse birth outcomes.	
	S 163	Establishes that if a person receiving services in a home for individual residential care is transferred to another home, the home must forward a copy of his or her medical records to the other home.	
New Hampshire	--	--	X
New Jersey	--	--	X

New Mexico	HJM 20	Calls for a study of the protection, access, use, disclosure and electronic transmission security standards of personal health data.	X
	H 497	Allows access to medical records for patients applying for disability benefits.	
New York	--	--	X
North Carolina	H 957	Establishes procedures for maintaining a electronic copy and paper copy of a patients medical records.	X
	H 858	Confidential information obtained by HMO's or other provider sponsored organizations may be disclosed pursuant to a court order.	
North Dakota	H 1143	Sets fees for copies of medical records.	X
	S 2400	Permits MCOs to put procedures in place to ensure the confidentiality of medical records.	
	S 2166	Sets comprehensive public health confidentiality standards.	
Ohio	H 283	Fees for copies of vital records.	X
Oklahoma	H 1368	Requires informed consent for disclosure of tissue samples for research purposes.	X
Oregon	H 2146	Contents of 'abstract records.'	X
	H 2179	Subpoena of medical records.	
Pennsylvania	--	--	X
Rhode Island	--	--	X
South Carolina	H 3488	No patient prescription drug information may be transferred without the written consent of the patient.	X
South Dakota	S 126	Provides that any patient information received by an ambulance service is confidential.	X
	S 238	MCO procedures for handling and disclosing medical records.	
	H 1223	Access to records by kin of deceased.	
Tennessee	H 570	Provides immunity from liability to a pharmacist for disclosing patient information in certain circumstances.	X
	H 1145	Allows a hospital to charge the actual costs of postage when sending medical records to patient who requests them.	

Texas	H 27	Access to medical records upon the death of a provider.	X
	S 1237	Applies state's privacy laws for insurers to PBMs.	
	S 1906	Confidentiality of dental records.	
	H 2702	Access and use of medical records by school based health centers.	
	H 2455	Access to medical records of a child by guardians.	
Utah	S 41	Confidentiality of HIV/AIDS patients' records.	X
Vermont	--	--	X
Virginia	H 2107	Deems a minor an adult to consent for release of medical records in certain circumstances.	X
	H 2131	Requires all providers to disclose medical records upon request of an injured employee.	
	S 1010 same as H 2427	Provider cannot disclose medical records for any other reason than what was consented.	
	S 1054	Disclosure of mental health records.	
	S 1199	Disclosure of minor's medical records for participation in medical assistance services.	
	S 1158	Disclosure of medical records for review for organ donation potential.	
Washington	--	--	X
West Virginia	S 90	Allows indigent persons free copies of their medical records under certain circumstances.	X
Wisconsin	--	--	--
Wyoming	H 227	Requires the confidentiality of medical records in professional assistance programs.	X
	S 95	Disclosure of medical records during judicial proceedings.	

Source: Health Policy Tracking Service, National Conference of State Legislatures, June 1999.

Publish? ● Yes ○ No

Comments:

Analyst: Nicole Kendall

July - 1999

HEALTH PRIVACY PROJECT

INSTITUTE FOR HEALTH CARE RESEARCH AND POLICY
GEORGETOWN UNIVERSITY

The State of Health Privacy: An Uneven Terrain

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Document #2

New Hampshire Hospital Association

TESTIMONY IN SUPPORT OF SB 369

ESTABLISHING A COMMITTEE TO CONDUCT A STUDY ON THE NEED FOR STANDARDS TO PROTECT HEALTH INFORMATION PRIVACY

SENATE INSURANCE COMMITTEE
JANUARY 11, 2000

Good Morning Madam Chair and members of the committee. My name is Kathy Bizarro and I am the Vice President for Strategic Information Services at the New Hampshire Hospital Association. I would like to provide testimony in support of Senate Bill 369.

The need for standardization of health information privacy is clearly needed. This is a complex and wide-ranging issue - even trying to define what constitutes health information is tricky. As mentioned in the Senate bill language, there are attempts currently underway at the national level to develop standards, but there has also been work in this area at the state level.

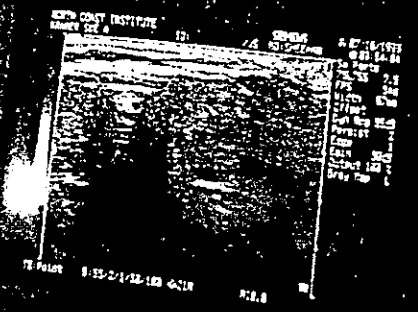
Nationally, Congress passed a law in 1996, called the Health Insurance and Portability Accountability Act (HIPAA), requiring that standards be developed to ensure proper security of health information. The New Hampshire Hospital Association is working with other state hospital associations and the American Hospital Association in formulating a response to the US Department of Health and Human Services' "Proposed Standards for Privacy of Individually Identifiable Health Information". The US DHHS' proposal focuses on personally identifiable electronic health information, which affects all healthcare providers, insurers and healthcare clearinghouses. This primarily involves medical record information.

At the state level, the New Hampshire Public Health Association received a Robert Wood Johnson grant two years ago called "Turning Point" which involved an evaluation of the public health infrastructure in the State of New Hampshire. There were several workgroups established, including one to look at public health data availability. One critical issue that arose was that there were different confidentiality standards for different public health data sets (such as vital records and hospital discharge data). A subgroup of public and private partners got together to develop language that would streamline the privacy standards for all public health data sets. We are in our final stages of development.

I urge you to consider all of the national and state initiatives currently underway. I'm available to the committee if you'd like more detailed information. Thank you for the opportunity to present my comments this morning.

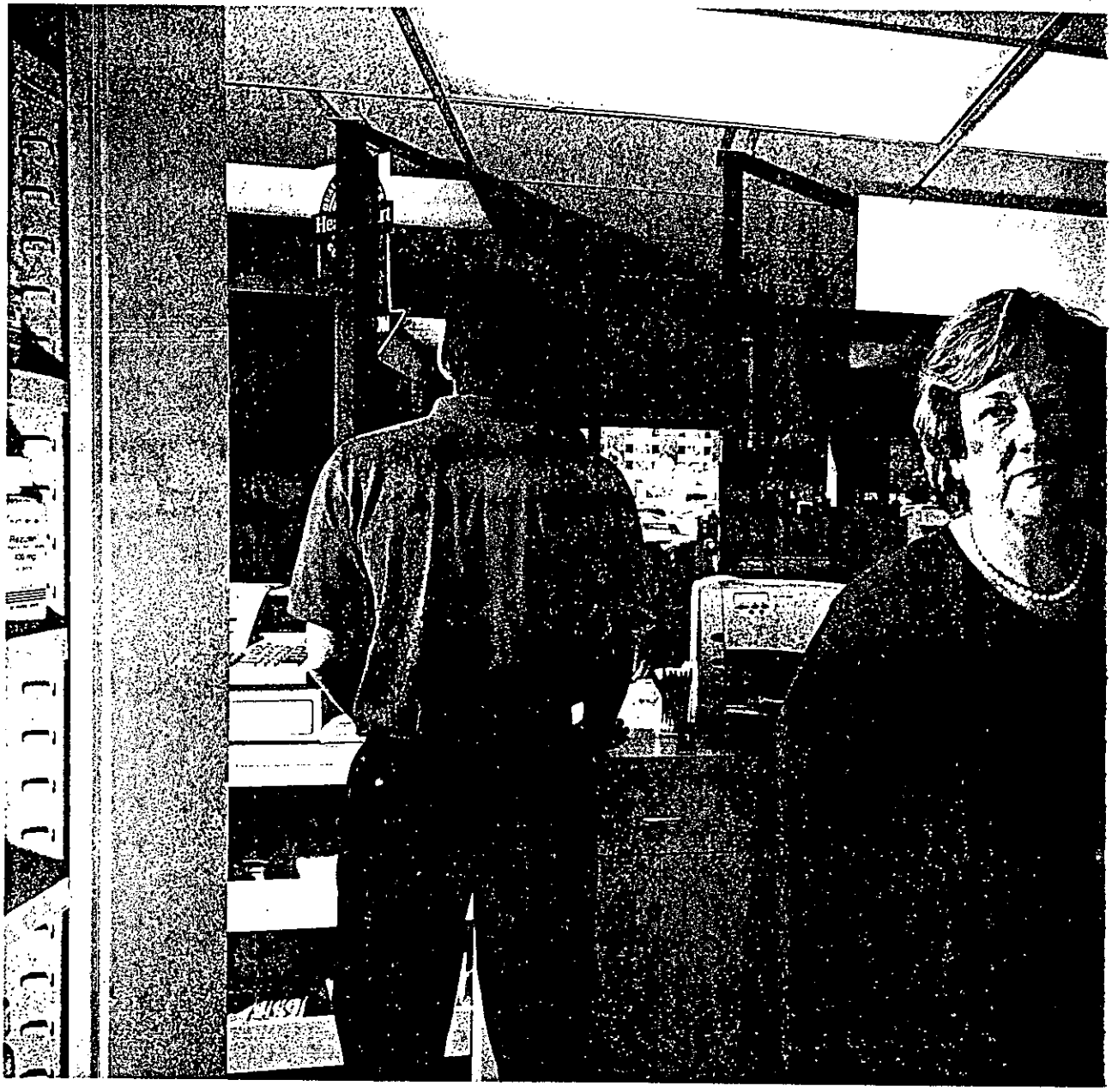
125 Airport Road ❑ Concord, NH 03301-7300 ❑ 603.225.0900 ❑ Fax: 603.225.4346 ❑ http://www.nhha.org

THE SALES REP came bearing doughnuts and muffins for the doctor's staff. But the message she delivered to Dr. John Sheehan, a Westlake, Ohio, endocrinologist, wasn't at all palatable. She opened a file that contained a listing of his postmenopausal patients and asked the doctor why he hadn't prescribed medication to prevent osteoporosis. The sales rep's goal: Get Sheehan to prescribe Evista, a drug made



John Sheehan found it offensive when a sales rep used information on his patients to pitch a drug.

Document #3 SB369



by Eli Lilly, her firm's parent company.

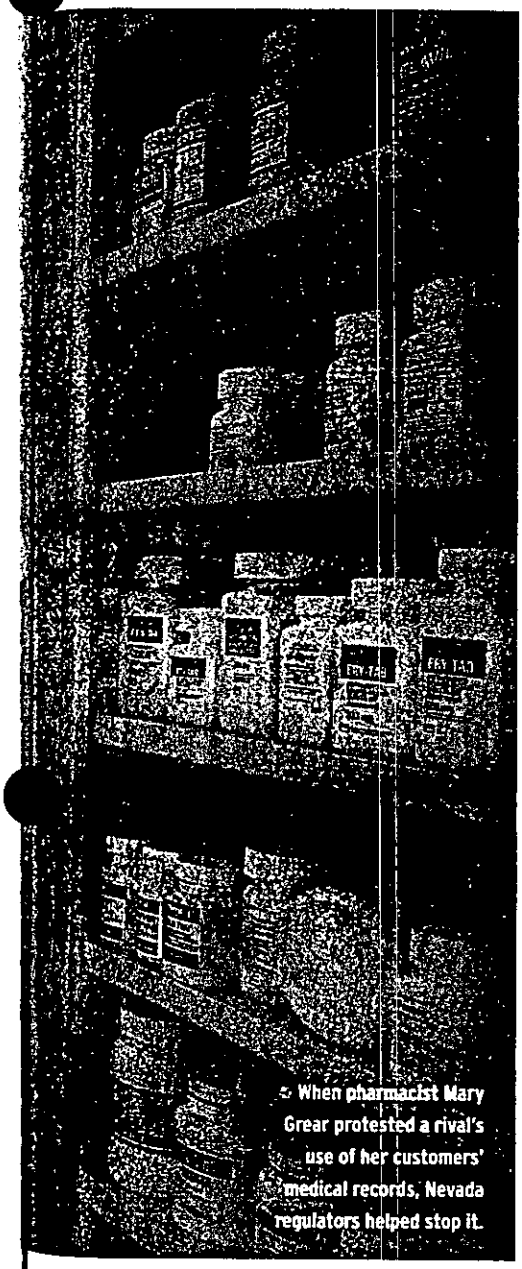
Shocked that an outsider would have access to his patients' records, and the audacity to question his medical judgment, Sheehan promptly sent the sales rep packing. "In my 25 years of practice, I had never experienced anything like that before," says Sheehan. "It was totally offensive."

Offensive, perhaps, but not unusual. While patients and doctors may assume their relationship is confidential, drug companies, insurers, employers and other outsiders know more about you and your medical history than you think.

Sometimes this knowledge can be annoying, as in the case of a drugstore that uses information on customers to sell you a particular medication or woo you away from your current pharmacy. Sometimes it can be embarrassing, as when your employer finds out that you're being treated for a particular medical condition.

But loss of confidentiality is more serious if it deters you from seeking health care. "If you eliminate privacy, you eliminate psychotherapy," says Jim Pyles, a lobbyist on behalf of the American Psychoanalytic Association. "Patients won't make disclosures unle they feel there is a confidential relatic ship with the physician." Privacy adv cates worry that, taken to extremes, l of confidentiality could cost you your health insurance coverage, your job o the prospect of future employment.

Congress has been wrestling with several broad proposals to safeguard t confidentiality of medical informatio "If you have a medical record, you ha a privacy problem," says Sen. Patrick



When pharmacist Mary Grear protested a rival's use of her customers' medical records, Nevada regulators helped stop it.

Leahy (D–Vt.), who is sponsoring one of the bills. But chances of passage appear slim. Meanwhile, like Sheehan, you may be surprised at how far afield your medical history can go.

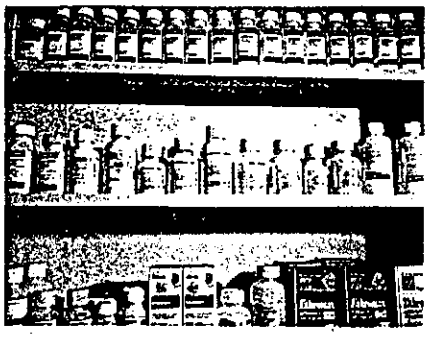
Sheehan discovered that it's easy for drug manufacturers to get patient information. In his case, the sales representative was from PCS Health Systems, one of the largest firms in pharmaceutical benefit management (PBM). Insurers hire PBM companies to administer the prescription-benefit portion of health insurance plans because it's cost-effective. But because PBMs approve every drug a patient buys, they have access to an enormous amount of patient data. And there's no prohibition against a PBM sharing your information or selling it to drug manufacturers, researchers, marketers and other interested parties.

In fact, many PBMs are owned by drugstore chains or drug manufacturers. At the time of Sheehan's rude awakening in June 1998, PCS was owned by Eli Lilly, which has since sold it to Rite Aid. A company spokesman says PCS doesn't share patient data with Rite Aid, but there's no federal law that specifically prevents it.

In fact, Rx America, a PBM based in Utah, used patient data to solicit business for its owner, American Drug Stores. In 1997 American Drug Stores sent coupons and solicitation letters to customers of Health Mart, an independent drugstore chain in Las Vegas, suggesting that they switch to Sav-on, a local chain owned by American Drug Stores. Health Mart owner and pharmacist Mary Grear became suspicious when many of her customers received solicitations. When Grear investigated, she discovered that all of the customers were covered by an insurance company that used Rx America, the PBM owned by American Drug Stores.

Grear raised the issue with the Nevada Board of Pharmacy, which agreed that the practice was unethical, and Sav-on agreed to stop the mailings. But without a federal statute outlawing the practice, there's lots of incentive for firms to continue to do it. "There's so much going on with the sale of prescription information," says Grear. "It's become a very valuable commodity."

There's also nothing to stop PBMs from offering pharmacists incentives to suggest to customers that they switch to certain drugs. When a prescription is filled, the pharmacist sends a request by computer to the PBM to have it approved by the insurance company. If the medication is a brand name that isn't on the insurer's list of preferred drugs, the PBM may reply with an offer of a cheaper generic alternative or another brand-name drug that *is* on the insurer's preferred list.



The loss of privacy could cost you your insurance, your work, or the prospect of a job.

In many cases, however, the insurance company will pay for either brand-name drug. The pharmacist has the option of filling the original prescription, or getting the patient's permission to call his or her doctor and ask about switching. PCS offers pharmacists a commission of up to $12 per prescription if the prescription is changed. PCS spokesman Blair Jackson says the company is compensating pharmacists for their time. And sometimes PBMs are simply trying to save insurance companies money. But some in the pharmaceuticals industry question the practice, especially when a PBM is owned by a drug manufacturer.

Jeopardy on the job

PBMs AREN'T the only leak through which private medical information can become public without a patient's knowledge. Employers who self-insure not only have access to employee medical records so they can process claims, they technically own those records. And even when employers don't self-insure, "if they're paying for your coverage, the insurer

considers the *employer* the customer, not the patient," says Zoe Hudson, a policy analyst with the Health Privacy Project at Georgetown University, in Washington, D.C. "If employers ask for something, they're likely to get it."

Sometimes insurers automatically send copies of benefit claims, complete with diagnoses and treatment plans, directly to an employer. Or if an employer asks why its costs are rising, an insurer may disclose that certain employees are undergoing expensive treatments for AIDS or cancer.

No federal law specifically bars employers from using medical records when making decisions about promotions, hiring and firing. A study published in the *Employment Rights and Employment Policy Journal* reported that 35% of the largest employers in the U.S. consider medical information when making employment decisions.

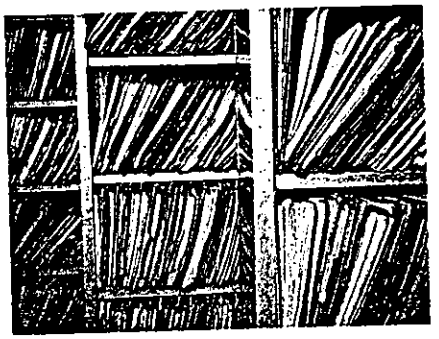
In one case, an administrative assistant at an international machinery firm mentioned in casual conversation with two co-workers that ten years earlier she had been exposed to hepatitis, although she had never become ill. When the conversation was reported to the company's director of human resources, the woman agreed to allow the company to perform a blood test but refused to sign a blanket medical release. As a result, she was suspended for three days.

Reinstated after the test proved negative, the woman was nevertheless embarrassed when she was asked to wear rubber gloves while serving food at meetings and told not to come in contact with the company president's secretary. She eventually left her job for another, taking a pay cut in the process.

Other conduits

INSURANCE COMPANIES can share your private medical information with lots of outside organizations, some of which you may not even know exist.

■ **Disease managers.** These firms are hired by insurance companies to monitor patients who have a specific condition, such as diabetes, asthma or congestive heart failure, and make sure they're following the prescribed treatment plan. Disease-management firms aren't required by law to keep patient medical histories confidential.



No federal law prohibits the sharing or selling of a patient's medical records.

■ **Accrediting organizations.** While conducting a routine review, an outside managed-care accrediting organization may ask to survey an insurance plan's patients. In response, the insurer may release hundreds of patient records.

"The problem is that whoever holds the information at any moment in time, whether it's the insurer or the pharmacy or the PBM, thinks that it's the owner of the information," says Hudson.

Even doctors can be unwittingly sloppy about keeping their patients' records confidential. Consider a physician who has contracts with several managed-care health insurance companies. To obtain a contract, the doctor may have had to agree to allow the plan to review all of his records—even those of patients not in that plan—to make sure the standard of care is consistent.

The goal may be worthwhile, but such reviews are done without the knowledge of patients. And not every physician goes along with the practice. Dr. Stephen Ducey, an internist in New London, Conn., refused to reveal his records to a representative of Physicians Health Service (PHS), a Connecticut-based insurance company. Instead, Ducey was willing to disclose only the records of PHS patients who had actually signed releases.

When one of Dr. Margo Goldman's psychotherapy patients applied for long-term-care insurance, the insurer hired a medical clearinghouse to review the patient's medical history. The clearinghouse immediately demanded that Goldman fax the patient's entire record. "This did not seem necessary or appropriate, given that they were evaluating him for long-term-care coverage," says Goldman, a psychiatrist in the Boston area. She persuaded the clearinghouse to accept a clinical summary instead.

Goldman is sensitive to confidentiality issues because she is director of policy development for the National Coalition for Patient Rights, but not all physicians are so vigilant. "If a physician found it more expedient, or just wasn't thinking about privacy, it would be easy to imagine that he would just fax the whole record," says Goldman.

Right now there's not much you can do to ensure the privacy of your medical records. State laws cover various slices of medical privacy, but no federal statute prohibits the sharing or selling of medical information without the patient's consent. Even paying out of pocket won't protect you because your records may still be reviewed by outside insurance companies or other organizations if your doctor is a member of a managed-care plan.

The Department of Health and Human Services is working on final rules to safeguard the privacy of electronic medical records stored or transmitted by computer. But those rules won't take effect until 2002, and the bulk of medical records is still on paper. "If you give the public the impression that communications can't remain private, then the public loses confidence in the health care delivery system," says lobbyist Pyles. K —*Reporter:* **JUSTIN WISER**

Speakers

SENATE INSURARNCE COMMITTEE

Date January 11, 2000 Time 9:30am Public Hearing on SB369

Appearing in FAVOR: (Please print) Please check box at left to speak.

Speaking?	Name	Address	Representing
✓ ☐	Sheila Evans	NH Women's Lobby	Concord
✓ ☒	KATHY BIZARRO	NH HOSPITAL ASSOCIATION,	CONCORD, NH
✓ ☒	Alex Feldvebel	NH DOT	DOT
✓ ☒	Kathy Taylor	Rep. Strafford #11	
☐	ANTHONY JULIANO	125 AIRPORT RD.	CONCORD NH ASSOC. OF HEALTH UNDER,
✓ ☒	Jim Hatem	889 Elm Street	Manchester NH State Farm
✓ ☑	Janet Monahan	7 N. State St,	Concord NH Medical Soc.
✓ ☑	M. J. Clark	State Rep.	Portsmouth
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Appearing in OPPOSITION: (Please Print) Please check box at left to speak.

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Committee Report

STATE OF NEW HAMPSHIRE

SENATE

REPORT OF THE COMMITTEE

Date:

THE COMMITTEE ON Insurance

to which was referred Senate Bill 369

AN ACT establishing a committee to conduct a study on the need for standards to protect health information privacy.

VOTE: 4-0

2000-3071s

Having considered the same, report the same with the following amendment and recommend that the bill: **AS AMENDED OUGHT TO PASS.**

Senator Katie Wheeler
For the Committee

SB369 Docket

Next|Previous|Results List|Bill Status

Bill Title: establishing a committee to conduct a study on the need for standards to protect health information privacy.

Date	Body	Description
1/5/00	**H**	Introduced and Ref. to Insurance; SJ Convening Day, Pg.10
1/6/00	**S**	Hearing, Jan. 11, 9:30 a.m., Room 103, SH; SC1, Pg.3
1/31/00	**S**	Committee Report , Ought to Pass with Amendment {3071} 2/3/2000 ; SC8, Pg.37
2/3/00	**S**	Ought to Pass with Amendment {3071}, AA, VV, OT3rdg, MA, VV; SJ 2, Pg.80-81
2/10/00	**H**	Introduced and ref to Commerce; HJ18, p479
2/15/00	**H**	Copy to Chairman on 2/15/2000
3/15/00	**H**	Hearing Apr 11 10:00 RM302,LOB
4/13/00	**H**	Subcom Work Session Apr 19 9:00 RM302,LOB
4/14/00	**H**	(Subcom: Reps Francoeur, Langley & Garrish)
4/27/00	**H**	Maj Report ITL for May 4 (vote 13-0;CC)
5/4/00	**H**	ITL Report Adopted; HJ39, p1208-1209

**Docket Abbreviation Explanations

Next|Previous|Results List|Bill Status