

Congress to Gut State Privacy Laws? Build National Health Data System?

HR 4157 – Health Information Technology Promotion Act of 2005

A CCHC ANALYSIS

Sponsor: Rep. Nancy Johnson (R-CT)

“This legislation will make sure the national health IT coordinator’s post is a permanent one, and it will overcome some of the key obstacles that have slowed our progress toward adoption of a national, interoperable electronic system.” (Rep. Nancy Johnson, Press Release, October 27, 2005)

Sec.	Bill Language	Implications for the Public	Page
2	“There is established within the Department of Health and Human Services an Office of the National Coordinator for Health Information Technology” [OHCHIT]... “All functions personnel, assets, liabilities, administrative actions, and statutory reporting requirement applicable to the old national Coordinator or the Office of the old National Coordinator on the date before the date of the enactment of this Act shall be transferred, and applied in the same manner and under the same terms and conditions, to the new National Coordinator and the Office of the new National Coordinator as of the date of the enactment of this Act.”	New federal bureaucracy established. The Office of the National Coordinator for Health Information Technology, temporarily established by an April 2004 Executive Order from President Bush, is made permanent.	2, 7
2	“The National Coordinator shall be paid at a rate equal to the rate of basic pay for level IV of the Executive Schedule”... “There are authorized to be appropriated such sums as may be necessary to carry out this section for each of fiscal years 2006 through 2010.”	Taxpayers forced to pay for a new bureaucracy... and an online health data system that will disclose their private medical record information broadly over the Internet without their knowledge or consent (<i>see below</i>).	3, 7
2	The National Coordinator shall develop “a nationwide interoperable health information technology infrastructure that <ol style="list-style-type: none"> (1) improves healthcare quality, reduces medical errors, increases the efficiency of care and advances the delivery of <i>appropriate, evidence-based</i> health care services <i>[our emphasis]</i> (2) promotes wellness, disease prevention, and management of chronic illnesses by increasing the availability and transparency of information related to the health care needs of an individual for such individual (3) ensures that appropriate information necessary to make medical decisions is available in a useable form at the time and in the location that the medical service involved is provided (4) produces greater value for health care expenditures by reducing health care costs that result from inefficiency, medical errors, <i>inappropriate care</i>, and incomplete information <i>[our emphasis]</i> 	<p>National Patient ID: is a national patient ID number in the works?</p> <p>Privacy Intrusion: Loss of medical privacy and personal control through ongoing Internet-based surveillance and data-sharing activities.</p> <p>Less Access to Care? Who defines “evidence-based”? The health plan? How is “appropriate” defined? How will the definitions, combined with outside surveillance and analysis, impact patient access to care?</p> <p>Quality?: Computerized data systems decrease quality of care when the health care practitioner focuses on the computer, not the patient; on the health insurer’s treatment protocol shown on the computer screen, not on the concerns, preferences, and needs of unique patients.</p> <p>No Escape: Patients will be unable to prevent the spread of inaccurate, biased, or judgmental data written about them in their medical records. Patients will no longer have the right to obtain a fresh second opinion, or to prevent profiling by government agencies, insurers, and others.</p>	3-4

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	<p>(5) promotes a more effective marketplace, greater competition, greater systems analysis, increased choice, enhanced quality, and improved outcomes in health care services</p> <p>(6) improves the coordination of information and the provision of such services through an effective infrastructure for the secure and authorized exchange and use of health care information; and</p> <p>(7) ensures that the confidentiality of individually identifiable health information of a patient is secure and protected”</p>	<p>Increased Death? A recent study on computerized physician order entry systems found increased mortality. (<i>PEDIATRICS</i>. Vol. 116 no. 6, 12/05)</p> <p>No Patient Control: A single, standardized, computerized, data-sharing system facilitates broad dissemination and collection of private medical data—with a simple click of a mouse.</p> <p>No Patient Consent: The 2003 so-called federal medical privacy rule (HIPAA) eliminated patient consent requirements for disclosure and access to private patient data. Numerous companies and government agencies can now obtain private data without the consent of the patient.</p>	
2	“The National Coordinator shall maintain, direct, and oversee the continuous improvement of a strategic plan to guide the nationwide implementation of interoperable health information technology in both the public and private health care sectors...”	Federal government authorized to interfere in the private sector to build the national health information system.	4
2	“A standard approved...for use in the electronic creation, maintenance, or exchange of health information shall preempt a standard adopted under State law, regulation, or rule for such a use.”	Gutting of state laws and rules that hinder implementation of a national health information system. This is a violation of State’s rights, and the authority of state legislators to protect their own constituents.	6
2	“The National Coordinator shall ensure that health information technology policies and programs of the Department of Health and Human Services are coordinated with those of relevant executive branch agencies and departments with a goal to...ensure that each agency or department conducts programs within the areas of its greatest expertise and its mission in order to create a national interoperable health information system capable of meeting national public health needs effectively and efficiently.”	Federal coordination with government health departments for broad health data collection and ongoing health surveillance of the American public.	6
3	<p>“Any nonmonetary remuneration (in the form of health information technology and related training services) made by an entity to a physician” must conform to standards of the Public Health Service Act and criteria of the Health Information Technology Promotion Act of 2005.</p> <p>“[T]he term ‘health information technology’ means hardware, software, license, right, intellectual property, equipment, or other information technology used primarily for the electronic creation, maintenance, and exchange of <i>clinical health information</i> to improve health care quality or efficiency.” <i>[our emphasis]</i></p>	Expanding allowable nonmonetary remuneration (essentially, gifts) to health information technology, but restricting allowance to only those technologies that will build a national health information system —and will be most useful for sharing private <i>diagnosis and treatment data</i> .	9-10

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3	<p>“No State...shall have in effect a State law that imposes a criminal or civil penalty for” nonmonetary remuneration of health information technology. [IT]</p>	<p>State legislators forbidden to stop implementation of a national health information system.</p>	15
3	<p>Not later than three years after the effective date of the law, “The Secretary of Health and Human Services shall conduct a study to determine the impact of each of the safe harbors [kick-back charges not allowed for nonmonetary remuneration of health IT]...[including] the extent to which the financial or other business relationships between providers under each safe harbor have changed as a result of the safe harbor in a way that adversely affects the health care system or choices available to consumers.”</p> <p>Not later than three years after the effective date of the law, “the Secretary of HHS may issue regulations that establish updated criteria for nonmonetary remuneration...”</p>	<p>No real intent to protect patients:</p> <ul style="list-style-type: none"> ▪ Study of impact of remunerations provisions 3 years after the fact ▪ Updated changes in remuneration criteria to be made before results of study may even be released. ▪ Long after the changes have been made, and the surveillance system is set in place, the impact on care will be studied. 	15-16
4	<p>“The Secretary of Health and Human Services shall conduct a study of State security and confidentiality laws and current Federal security and confidentiality standards [the HIPAA rule] to determine...how any such variation [between State and federal laws] may adversely impact the security and confidentiality of individually identifiable health information and the electronic exchange of clinical health information among States, the Federal Government, and private entities.”</p> <p>The Secretary of HHS must also determine “the strengths and weaknesses of such State law and of such current Federal standards for purposes of protecting the security and confidentiality of individually identifiable health information <i>while also taking into account</i> the need for timely and efficient exchanges of health information to improve quality of care and ensure the availability of health information necessary to make medical decisions at the location in which the medical care involved is provided.”</p>	<p>Biased aim of study? – no language even suggesting that such variation (such as is currently in Minnesota’s strong privacy law) protects the privacy and confidentiality of individuals against the privacy infringements allowed by the federal “no privacy” rule (HIPAA).</p> <p><i>In 1996, Congress authorized state preemption to assure the public that their own legislators could protect them if politics in Washington didn’t. In 1998, over 52,000 comments were sent to HHS in response to the proposed federal HIPAA privacy rule—most of them demanding patient consent requirements—yet patient consent was not included in the final HIPAA “no privacy” rule. Thus, the public is dependent on their own state legislators for real medical privacy protection... by using the state preemption provision of the 1996 federal law.</i></p> <p>HHS is told to weigh privacy—citizen—interests against the data and surveillance interests of health plans, the data industry and government. HHS has unilateral authority to decide <i>against</i> constitutional and privacy interests—the clear intent of the legislation.</p>	18-19
4	<p>“Not later than 18 months after the date of the enactment of this Act, the Secretary of Health and Human Services shall submit to Congress a report on the study [of state laws and the federal rule] and shall include...a determination by the Secretary whether State security and confidentiality laws and current Federal security and</p>	<p>Federal government assumes complete control over patient data by gutting all State medical privacy laws and placing all private medical record data into a national health surveillance and data-sharing system.</p>	19-23

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	<p>confidentiality standards should be conformed to create a single set of national standards to preserve and protect the security and confidentiality of patient health information...and what the single set of standards should be.”</p> <p>If HHS determines that State laws and federal standards “should be conformed to create a single set of national standards”, and “the Secretary specifies that single standard...and Congress fails to create “a single set of national standards and preempting State security and confidentiality laws is not enacted” within 36 months after the bill becomes law, “then the regulation and standards described [by HHS] shall become the single set of national standards...and supersede the current Federal security and confidentiality standards and State security and confidentiality laws.”</p>		
5	“The final rules promulgated on [ICD-9 codes] shall not be subject to judicial review.”	National Coding System: HHS has authority to change and standardize diagnosis and treatment (medical procedure) codes nationwide.	27
6	“The Secretary of HHS shall submit to Congress a report on the work conducted by the American Health Information Community” [AHIC] including information on the progress in (A) establishing uniform industry-wide health information technology standards, (B) achieving an internet-based nationwide health information network; and (C) achieving interoperable electronic health record adoption across health care providers”	Elements of national health information system clarified	29
6	The HHS report shall include “Recommendations for the transition of the AHIC to a permanent advisory entity...[for] providing long-term governance for health care transformation.”	Building bureaucracy: The 17-member American Health Information Community becomes a permanent government committee to implement and oversee the national health information system.	28-29
7	The HHS, “in consultation with entities involved in the area of health information technology, shall develop a strategic plan related to the need for coordination in such area.”	In a public-private partnership , government, the health care industry, and data corporations will work together to build a national health information system that meets their corporate and data-sharing agendas.	29-30
7	The strategic plan must include actions taken by ONCHIT, AHIC, the office of Electronic Standards and Security of the Centers for Medicare and Medicaid Services, the National Committee on Vital Health Statistics, and “any other entity involved in the electronic exchange of health information that the Secretary determines appropriate.”	Lead decision-making authority given to federal government.	31