

**Health Information Security and Privacy Collaboration
Harmonizing State Privacy Law Collaborative**

*Update to October 9, 2007 Report on State Privacy & Security Laws
Related to
Electronic Health Records and
Electronic Health Information Exchange*

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I. Background.

The Health Information Security and Privacy Collaboration (HISPC) is a project involving 42 states and territories funded by the Office of the National Coordinator for Health Information Technology of the U.S. Department of Health and Human Services. Its purpose is to address privacy and security challenges presented by electronic health information exchange.

Under the current phase of the HISPC project, seven multistate collaborative projects are analyzing specific high-priority areas to develop common, replicable solutions for barriers to electronic health information exchange.¹

In previous phases of the HISPC project, many states identified fragmented and outdated state laws as a significant barrier to the adoption and effective operation of interoperable health information exchange. In addition, although the HIPAA regulations² provide, among other matters, a comprehensive set of rules for the use and disclosure of protected health information by covered entities, the HIPAA regulations do not preempt more stringent state laws.³ Many states have laws more stringent than the requirements of the HIPAA regulations, such as laws requiring patient consent for the disclosure of sensitive information for treatment purposes.⁴ These requirements pose barriers to the effective operation of health information exchange, particularly with respect to interstate disclosures.

The goal of the Harmonizing State Privacy Law Collaborative is to advance the ability of states and territories to analyze and reform, if appropriate, their existing laws to facilitate interoperable health information exchange. The collaborative will develop a common subject-matter taxonomy (a classification of laws based on subject matter categories) to be used by states to analyze their existing legal framework and identify key areas that may require revision or new legislation. The common taxonomy will provide a means for comparison, analysis, and where appropriate, revision of state law as it pertains to health information exchange.

Seven states participate in the Harmonizing State Privacy Law Collaborative; namely Florida, Kentucky, Kansas, Michigan, Missouri, New Mexico, and Texas. Additional information on each state participating in the Harmonizing State Privacy Law Collaborative is included at [Appendix A](#).

¹ The initial phase of the HISPC project involved 34 states and territories. Each state focused on an assessment of barriers to electronic health information exchange in the state and the development of an implementation plan to address the barriers. In the second phase, each of the 34 states identified and worked toward completion of a foundational component of its implementation plan to be completed within a six-month time frame. Additional information regarding the HISPC project may be obtained at <http://privacysecurity.rti.org>.

² The regulations promulgated by the U.S. Department of Health and Human Services under the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164.

³ 45 C.F.R. §§ 160.201 – 160.205.

⁴ Many states impose heightened privacy requirements for HIV/AIDS, mental health, genetic, sexually-transmitted disease, and other types of sensitive medical information.

The Harmonizing State Privacy Law Collaborative initiated two steps to begin development of the taxonomy.

First, the collaborative determined that although it was not feasible to undertake a comprehensive review and analysis of the health privacy laws of every state, valuable information regarding state health laws already existed. As noted above, the HIPAA regulations preempt state law with respect to uses and disclosures of protected health information, except to the extent that the state law is more stringent. As a result, upon the adoption of the HIPAA regulations public and private entities in many states undertook an analysis of their state laws to ascertain those circumstances where their state law imposed requirements more stringent than the HIPAA regulations. The Harmonizing State Privacy Law Collaborative gathered existing preemption analysis information (and where available, other related information) from or about 42 states and territories. The comprehensiveness of the analyses varies from state to state. That information, together with this report and supplementary information is being reviewed and analyzed to begin the development of relevant categories for the taxonomy.

Second, in connection with the earlier phase of the HISPC project, the New Mexico HISPC project prepared a report on existing privacy- and security-related laws and proposed legislation in other states specifically authorizing the creation, maintenance, transmission, and use of electronic health records and electronic health information exchange (the “October 2007 Report”).⁵ The Harmonizing State Privacy Law Collaborative undertook to prepare this update to the October 2007 Report to ascertain the current trends in state legislation, to obtain additional information for the development of the taxonomy, and to uncover possible models for future legislation.

This report has been prepared in furtherance of the goals of the Harmonizing State Privacy Law Collaborative and to meet the obligations under the contracts between each of the Harmonizing State Privacy Law Collaborative states and RTI International. Specifically, this report is Deliverable No. 1 for the collaborative.

II. Summary of the October 2007 Report.

The October 2007 Report revealed that despite considerable activity in the private sector and at the federal government level, there was very little state activity directed at changing laws for the purpose of eliminating of barriers to interoperable health information exchange. Many states had engaged in some form in the study of issues related to electronic health records and health information exchange, such as through the creation of commissions, initiatives, and pilot programs, including funding for studies and implementation of health information exchange at various levels. Few states, however, had enacted or considered specific legislation aimed at reducing or eliminating barriers to health information exchange arising out of the existing legal framework.

⁵ New Mexico Privacy & Security Project, *Report On State Laws Related to Electronic Health Records and Electronic Health Information Exchange*, October 9, 2007.

The October 2007 Report reflected only Minnesota and Nevada as having enacted, at that time, legislation that specifically addressed state law barriers to interoperable health information exchange.⁶

The October 2007 Report reached several conclusions, including the following:⁷

1. Issues as to whether the creation, maintenance, and use of electronic health records are legally permissible do not appear to be a significant concern, as very few states have adopted or were considering legislation in that area.
2. A comprehensive approach addressing all health records, in whatever form or medium, drafted with health information exchange specific provisions may be the preferred approach.
3. A simple approach, providing a blanket exemption for the transmission of electronic protected health information done in compliance with the HIPAA regulations, which was successfully passed in Nevada, may not be acceptable in other states.⁸
4. The Minnesota Health Records Act⁹ and the Uniform Health-Care Information Act¹⁰ provide guidance as to the elements that a comprehensive act might include.
5. Many states have adopted laws, in various forms, requiring notification in the event of the breach of the security of electronic data. Some of these laws specifically include health records within their scope. It may be preferable to not try to address security breach notification in an act focused on health records.
6. Despite the need for uniformity across state lines, there will always be differences in state law, and additional options for facilitating interstate interoperable health information exchange need to be developed.

III. Executive Summary of Update to October 2007 Report.

The project involved a review of statutory enactments and pending legislation throughout the 50 states and the territories of Puerto Rico and Guam since September 1, 2007.

Each of the states in the Harmonizing State Privacy Law Collaborative reviewed legislative activity in the health information exchange area occurring in specifically-assigned states. Among other resources, the states reviewed state legislative websites, and those information sources identified on Appendix B.

⁶ Id., p. 7.

⁷ Id., pp. 31, 32.

⁸ See, NEV. REV. STAT. ANN. § 439.538.

⁹ MINN. STAT. ANN. §§ 144.291 to 144.298.

¹⁰ The 1985 Proposed Revisions of the Uniform Health Care Information Act may be accessed at: <http://www.law.upenn.edu/bll/archives/ulc/fnact99/1980s/uhcia85.htm>.

Between September of 2007 and the date of this report, significant legislative activity related to health information exchange occurred in nine states; namely Florida, Illinois, Louisiana, New Mexico, Oklahoma, Rhode Island, Utah, New Hampshire, and Wisconsin. Although no legislation was introduced in Arizona, Arizona has engaged in significant efforts toward the introduction of legislation in January of 2009.

Of the nine states where legislation was proposed, legislation was enacted only in Oklahoma, Utah, and Wisconsin. Legislation has also passed in Rhode Island, but it has not yet been signed into law.

Of the nine states where legislation was proposed, comprehensive, detailed health information exchange legislation was proposed in six states. With the possible exception of Rhode Island, attempts to pass comprehensive health information exchange legislation failed. The legislation that did pass in Oklahoma, Utah, and Wisconsin was more narrowly drawn.

In Utah, the legislature gave the Department of Health authority to promulgate rules adopting standards for the exchange of health information in accordance with the HIPAA regulations. In Wisconsin, the successful legislation was focused on the elimination of specific barriers to health information exchange caused by stricter-than-HIPAA authorization requirements in several statutes. Finally, Oklahoma passed legislation requiring the development of standardized authorization forms as a means of facilitating the exchange of health information.

A description of the legislative activities in various states since September of 2007, both successful and unsuccessful, are set out below, as are conclusions drawn from the review of those activities.

The scope of this report is limited to identification of existing state law and recently-proposed legislation that specifically relates to privacy and security in connection with the use of electronic health records or electronic exchange of health information. This report is not a comprehensive survey of all electronic health records and health information exchange activity throughout the states. Many states have embarked on studies to address issues related to electronic health records and health information exchange, including possible revisions of state law, and those efforts are not addressed in this report. Likewise, many states have adopted or are considering the adoption of statutes related to electronic prescribing, but we have not included that area in this report. Rather, our goal is to identify existing laws and recently-proposed legislation designed to provide current comprehensive rules related to electronic health records and health information exchange.

Identification of proposed legislation is challenging, as legislation changes significantly as it proceeds through the legislative process. In addition, although every effort was made to identify relevant enacted laws, because of time and resource constraints, relevant law in some states may not be reflected in this report. Finally, any analysis and interpretation of the laws and proposed legislation is based only on a plain reading of the language, and no research as to the

actual interpretations in practice of any specific state statute has been undertaken. Likewise, no research was undertaken with respect to state administrative rules or regulations that may have been adopted or proposed governing electronic health records or health information exchange.

IV. State Laws and Proposed Legislation Since September 1, 2007.

a. Enacted State Laws and Proposed Legislation Specifically Directed to Electronic Health Records and Health Information Exchange.

(i) Enacted Laws.

Our review reflects that there are still very few states that have enacted laws specifically designed to affect interoperable health information exchange and electronic health records. In addition to Minnesota and Nevada cited in the October 2007 Report, as of June 30, 2008, only Oklahoma, Utah, and Wisconsin appear to have enacted legislation that was directed specifically to addressing state law barriers to health information exchange.

Oklahoma Health Information Exchange Act

On June 2, 2008, the Governor of Oklahoma signed into law the Oklahoma Health Information Exchange Act.¹¹ While the title of the act implies comprehensive legislation, the scope of the act is limited to development and use of a standardized authorization form. The stated purposes of the act are to: (1) set forth a standard process for authorizing the exchange of health information in compliance with federal and state law; and, (2) ensure immunity from liability under state law for exchanges of information done in accordance with the standardized process.¹²

The act requires the Oklahoma State Board of Health to adopt and distribute a standard authorization form and accompanying instructions for use in obtaining authorization for the exchange of health information. The form adopted is required to be in compliance with all applicable federal and state privacy and privilege laws.¹³

Health care entities are required to accept the standardized form as a valid authorization for the exchange of health information, but health care entities are not required to use the standardized form as opposed to other forms of authorization.¹⁴ Use of the standardized form, however, provides the persons exchanging information pursuant to the standard form authorization immunity from lawsuits in actions based upon state privacy or privilege laws that may be claimed to arise from the exchange of such information.¹⁵

¹¹ OKLAHOMA SB 1420 (2008).

¹² Id., Section 2. B.

¹³ Id., Section 4.

¹⁴ Id., Section 5.

¹⁵ Id., Section 6.

The act further provides that the exchange of health information under the standardized form does not constitute a violation or waiver of any privilege protected under the statutory or common law of Oklahoma.¹⁶

Utah – Standards for Electronic Exchange of Clinical Health Information

On March 19, 2008, the Governor of Utah signed into law Utah House Bill 47, which requires the Utah Department of Health to adopt standards for the electronic exchange of clinical health information.¹⁷ Specifically, the Utah Department of Health is charged to promulgate rules: (1) defining “clinical health care information” and “health system arrangements between providers or organizations;” and, (2) adopting standards for the electronic exchange of clinical health information between health care providers and third party payers that are in compliance with the HIPAA regulations.¹⁸

The act defines “electronic exchange” to include: (1) the electronic transmission of clinical health data via internet or extranet; and (2) physically moving clinical health information from one location to another using magnetic tape, disk, or compact disc media, but does not include the exchange of information by telephone or fax.¹⁹ Health care providers and third party payers in Utah are required to comply with the standards adopted by the Utah Department of Health if they elect to engage in an electronic exchange of clinical health information with another health care provider or third party payer.²⁰

Wisconsin – Amendment of Patient Confidentiality Provisions

Under prior Wisconsin law, various provisions were identified as creating barriers to health information exchange. Specifically, the disclosure of mental health treatment records to another health care provider required the informed consent of the patient. In addition, certain provisions governing disclosure of information in a medical record imposed restrictions on the ability of the recipient to make further disclosure of the information. As of April 1, 2008, the law in Wisconsin was revised to address these barriers to health information exchange.²¹

With the passage and signing of Wisconsin Senate Bill 487, provisions of the Wisconsin State Alcohol, Drug Abuse, Developmental Disabilities, and Mental Health Act were revised to permit the disclosure of treatment records covered by that act to health care providers without the informed consent of the patient.²² Also eliminated by the passage of Senate Bill 487 were

¹⁶ Id., Section 7.

¹⁷ UTAH HB 47 (2008).

¹⁸ Id., Section 1, enacting UTAH CODE ANN. 1953 § 26-1-37(2)(a).

¹⁹ Id., Section 1, enacting UTAH CODE ANN. 1953 § 26-1-37(1).

²⁰ Id., Section 1, enacting UTAH CODE ANN. 1953 § 26-1-37(3).

²¹ 2007 Wisconsin Act 108.

²² Id., WIS. STAT. ANN. §51.30(4)(b) 8g. bm.

prohibitions against redisclosure, and Wisconsin law now allows redisclosure of information for a purpose for which release is otherwise permitted.²³

(ii) Proposed Legislation.

Arizona – Arizona Health –E- Connection 2009 Legislative Proposals

Although no legislation affecting electronic health information exchange is expected to be introduced in Arizona in 2008, Arizona Health-E-Connection (“AzHeC”), a not-for-profit organization whose mission is to lead Arizona's establishment of health information exchange and adoption of health information technology is preparing a package of legislation for introduction in January of 2009.²⁴

The package will include proposals with respect to the following issues:

1. **Communicable Diseases:** Under current Arizona law, healthcare providers are required to preserve the confidentiality of reportable communicable disease information and may release that information only for limited purposes.²⁵ By statute, any disclosure of such information made pursuant to an authorization is required to be accompanied by a written statement prohibiting redisclosure of the information without an additional authorization.²⁶ Also, when such information is disclosed to a person under a patient authorization, the person receiving the information must comply with the statute.²⁷ AzHeC will propose elimination of the written non- redisclosure statement requirement and the addition of a provision permitting disclosure to a health information exchange. They will also propose that the current 180-day limitation on the effectiveness of authorizations be eliminated.
2. **Mental Health Information.** The permitted statutory disclosures of mental health information do not include direct disclosure to a health information exchange.²⁸ AzHeC will propose amendments to the statute to permit disclosure to a health information exchange.
3. **Immunization Information.** Arizona law restricts the release of immunization information held by the Arizona Department of Health.²⁹ In addition, there are prohibitions against redisclosure by the recipient of such information. AzHeC

²³ 2007 Wisconsin Act 108.

²⁴ Information regarding Arizona was obtained from the Arizona Health-e Connection Legal Working Group, Kristen B. Rosati, Esq.

²⁵ A.R.S. § 36-664.

²⁶ A.R.S. § 36-661(4) and (5).

²⁷ A.R.S. § 36-664(H).

²⁸ A.R.S. § 36-509.

²⁹ A.R.S. § 36-135.

will propose elimination of the prohibition against redisclosure, and permitting direct disclosure of immunization information to a health information exchange.

4. Genetic Testing Information. Arizona law provides for significant restrictions on the disclosure of genetic testing and information derived from genetic testing.³⁰ AzHeC will propose legislation that: (1) clarifies the definition of the type of information that is protected to avoid overbroad interpretations; (2) removes prohibitions against redisclosure of protected information; (3) clarifies that disclosure to treating providers is permitted; and, (4) permits disclosures directly to a health information exchange.
5. Medical Records Subpoena Statutes. Current law governs how health care providers respond to subpoenas for medical records.³¹ AzHeC will propose: (1) changes to the definition of “medical record” so that it includes records from other sources only to the extent the provider uses those records to provide care to the patient; (2) extension of the statute to include health information exchanges; and (3) creation of a formal process for submission of an affidavit in support of the medical records.

Florida – eHealth Initiative Act

Companion legislation was introduced in the Florida House and Senate to create the Florida eHealth Initiative Act.³² The proposed legislation failed to pass.

The intent of the proposed legislation was to promote and coordinate the establishment of a secure, privacy-protected, and interconnected statewide health information exchange.³³ Key health information exchange terms defined in the proposed legislation included “electronic medical record,” “electronic medical records system,” “health information exchange,” and “health information organization.”³⁴ The act would have created grant and loan programs to advance the development of statewide health information exchange.³⁵

In addition, the proposed legislation would have created the Florida Health Information Exchange Advisory Council, with, among other duties, the responsibility to develop recommendations to establish standards for state-funded health information exchange efforts, including policies and procedures to protect the privacy and security of electronic medical records, and the removal of barriers to participation in a health information exchange.³⁶

³⁰ A.R.S. §§ 12-2801 *et seq.*

³¹ A.R.S. § 12-2294.01.

³² FLORIDA HB 637, FLORIDA SB 1998 (2008).

³³ FLORIDA HB 637 (2008), § 2.

³⁴ *Id.*, § 3.

³⁵ *Id.*, §§ 4 and 5.

³⁶ *Id.*, § (6)(i)(1).

Florida – Internet Access to Patient Medication History

Florida Senate Bill 1550, introduced during the 2008 Florida legislative session, called for the Florida Agency for Health Care Administration to contract with a vendor for the design and operation of a secure, privacy-protected website that would provide health care practitioners, pharmacies, and pharmacists with access to a comprehensive patient medication history. The contracted vendor would be required to comply with all applicable state and federal privacy laws and to maintain the website within the United States.³⁷ The data could be accessed by health care practitioners, pharmacies, and pharmacists only for current treatment and with the written permission of the patient.³⁸ Health care practitioners, pharmacies, and pharmacists would have been immune from liability to patients for accessing or failure to access the information using the website, but a violation of the proposed act by such a party would constitute grounds for disciplinary action under the appropriate licensing statutes.³⁹ A contractor providing the services, however, would be liable for tort damages for the improper release of any information received, in addition to any contractual liability incurred.⁴⁰

Illinois – Illinois Health Information Network Act

The Illinois Health Information Act was a comprehensive health information exchange act that would have created a state-formed nonprofit corporation known as the Illinois Health Information Network.⁴¹ The proposed act passed both houses of the Illinois legislature, but died on October 5, 2007. The act was subject to an amendatory veto by the Illinois Governor, and died when the legislature failed to act upon the Governor's proposed changes.

Key provisions of the proposed legislation included: creation of the network; the requirement of patient consent (if the patient were able to give consent) for the disclosure of key health data to other providers; the establishment of minimum standards for access by health care providers; identification and mitigation of barriers to participation; and education of the general public.⁴² The amendments proposed by the Governor, which were not accepted by the legislature, would have generally converted the legislation from authorizing the creation of a health information exchange network to the creation of an advisory board, to advise the state with respect to the creation of a health information network.⁴³

³⁷ FLORIDA SB 1550 (2008).

³⁸ Id.

³⁹ Id.

⁴⁰ Id.

⁴¹ ILLINOIS HB 1254 (2007).

⁴² Id., § 10(a).

⁴³ Amendatory Veto Message of Illinois Governor Rod R. Blagojevich on HB 1254, dated August 21, 2007.

Illinois – Health Care for All Illinois Act

The Health Care for All Illinois Act is currently pending in the Illinois legislature.⁴⁴ The act is a comprehensive universal access to health care bill. Section 65 of the proposed act, however, addresses patient rights, and provides:

Patients rights. The Program shall protect the rights and privacy of the patients that it serves in accordance with all current State and federal statutes. **With the development of the electronic medical records, patients shall be afforded the right and option of keeping any portion of their medical records separate from the electronic medical records.** Patients have the right to access their medical records upon demand.⁴⁵

Emphasis added.

Louisiana – Privacy of Personal Health Information

In 2008, legislation that would have created strong privacy rights with respect to personal health information was introduced in the Louisiana House of Representatives.⁴⁶ The proposed legislation did not make it out of committee.

The proposed legislation provided that: (1) personal health information is the property of the individual; (2) personal health information privacy and confidentiality laws apply to all persons that create, compile, duplicate, store, transmit, or use such information in any form and in any setting; and (3) individuals are entitled to control access to their personal health information and to obtain an audit trail of who has accessed their personal information.⁴⁷

In general, the proposed legislation would have required the “informed and written authorization” of an individual prior to the disclosure of the individual’s personal health information.⁴⁸ Disclosures for treatment, payment, and essential health care operations would be permitted without patient authorization, but only after the patient has been given the opportunity to elect otherwise.⁴⁹ Detailed procedures for providing the patient an opportunity to opt-out are set out in the proposed legislation.⁵⁰

Specific provisions of the proposed act would have authorized disclosure of a person’s personal health information and information about the location of a person’s personal health information to a health information exchange.⁵¹ Only health care providers would be allowed to

⁴⁴ ILLINOIS HB 4445 (2008).

⁴⁵ Id., § 65.

⁴⁶ LOUISIANA HB 1073 (2008).

⁴⁷ Id., § 250.71.

⁴⁸ Id., § 250.73 B.

⁴⁹ Id., § 250.73 C.

⁵⁰ Id.

⁵¹ Id., § 250.76 A.

access information in a health information exchange, and only for treatment purposes.⁵² The health information exchange would be required to adhere to the personal health information requirements applicable to health care providers, and would have to maintain a detailed audit log of health care providers who accessed personal health information.⁵³ The health information exchange would be required to provide a mechanism allowing an individual to suppress his or her information from view if the individual elects not to allow disclosure of his or her information.⁵⁴

The proposed act would have made a violation of its provisions subject to investigation by the state attorney general, and an unfair trade practice under Louisiana law.⁵⁵

New Hampshire – Patient Health Care Information

House Bill 1587 introduced in New Hampshire in early 2008 would have enacted new rules with respect to the use and disclosure of protected health care information in that state. The proposed act was not passed, but has been made the subject of an interim study by the House Health, Human Services & Elderly Affairs Committee.

Key provisions of the proposed legislation included:

- Adoption of the HIPAA regulation definitions for numerous terms.⁵⁶
- Adoption of definitions for “audit trail,” “health information exchange,” “medical emergency,” and “medical record.”⁵⁷
- Medical information is deemed to be the property of the individual that is the subject of such information.⁵⁸
- An individual has the right to receive an audit trail regarding access to his or her electronic medical record.⁵⁹
- Individuals have the right to restrict disclosure of protected health information.⁶⁰ Health care providers would be required to inform individuals of such right at the initial encounter with the individual. If the individual elects to restrict disclosures at the time of the initial encounter, or any time thereafter, the health care provider would inform the individual of possible consequences. The election to restrict access would be in writing on a form to be developed by the Commissioner of the New Hampshire Department of Health and Human Services.⁶¹

⁵² Id.

⁵³ Id.

⁵⁴ Id., § 250.76 E.

⁵⁵ Id., § 250.77.

⁵⁶ NEW HAMPSHIRE HB 1587N – AS AMENDED BY THE HOUSE (2008), § 332-I:2.

⁵⁷ Id.

⁵⁸ Id., § 332-I:3(I).

⁵⁹ Id., § 332-I:3(III).

⁶⁰ Id., § 332-I:3(IV).

⁶¹ Id., § 332-I:4(III).

- Notwithstanding an individual's election to restrict disclosure, a health care provider, at its discretion, may send the individual's name and address to a health information exchange.⁶²
- An election to restrict disclosure would not prohibit disclosure during a medical emergency when the treating health care provider is unable to obtain the individual's authorization.⁶³
- Health care providers would be allowed to disclose information about the location of an individual's protected health information to a health information exchange. Only health care providers, for the purpose of treatment, would be allowed access to protected health information in a health information exchange.⁶⁴
- A health information exchange would be required to adhere to protected health information requirements for health care providers in state or federal law.⁶⁵
- A health information exchange would be required to maintain an audit log of health care providers that access information.⁶⁶
- A health information exchange would be required to be certified as being in compliance with nationally accepted interoperability standards and practices.⁶⁷

New Mexico – Electronic Medical Records Act

In New Mexico, legislation was introduced that would have: (1) clarified the legality of the creation and use of electronic medical records; (2) generally required patient authorization for the disclosure of medical records in other than certain specified circumstances; (3) specifically authorized disclosures to a health information exchange; and (4) permitted out-of-state disclosures to the extent that the disclosure would have been permissible with the state.⁶⁸

Significant provisions of the proposed act included:

- Definitions of “demographic information,” “electronic medical record,” “health information exchange,” “medical emergency,” and “record locator service.”⁶⁹
- Clear authorization for the creation and use of electronic medical records, and that electronic medical records satisfy any requirement that records be maintained or written.⁷⁰

⁶² Id., § 332-I:4(III)(c).

⁶³ Id., § 332-I:4(V).

⁶⁴ Id., Id., § 332-I:7.

⁶⁵ Id.

⁶⁶ Id.

⁶⁷ Id.

⁶⁸ New Mexico House Bill 37, 2008.

⁶⁹ New Mexico House Bill 37, 2008, Section 3.

⁷⁰ New Mexico House Bill 37, 2008, Sections 6 and 9.

- Generally requiring patient authorization for the disclosure of information in a medical record.⁷¹
- Placing a one-year time limit on the effectiveness of patient authorizations.⁷²
- Allowing disclosure without authorization in the case of a medical emergency.⁷³
- Allowing disclosure of demographic information to a record locator service or health information exchange, but allowing an individual to elect to not participate in the record locator service.⁷⁴
- Allowing out-of-state disclosures of information in an individual's medical record if the disclosure would have been permissible in-state under the act.⁷⁵

After amendments that eliminated any restrictions on disclosure that exceeded the requirements of the HIPAA regulations, the proposed legislation passed the New Mexico House, but failed to pass on the floor of the New Mexico Senate. The legislation may be reintroduced in a fall 2008 special session, or in the 2009 session of the New Mexico legislature.

Oklahoma Health Records Efficiency Act

The Oklahoma Health Records Efficiency Act was proposed as Oklahoma House Bill 2805. The act failed to pass the 2008 Oklahoma legislature, but would have directed the Oklahoma State Department of Health to adopt a standardized interoperable electronic data-sharing system with state-wide capabilities for intrastate and interstate exchange of health information.⁷⁶

The act would have required the system to include: (1) a web-based exchange structure that would not require a health care provider to have an internal electronic medical records system; (2) the ability to supplement existing internal electronic medical records systems with information from outside sources; and (3) the capacity to share demographics, medications, laboratory tests, immunizations, allergies and reactions, providers, procedures and diagnoses.⁷⁷ The system would also have been required to include, among other items, privacy and security protection measures in compliance with all federal and state laws, e-prescribing measures, and provisions for an electronic personal health record that would allow consumers to access their own health information.⁷⁸

⁷¹ New Mexico House Bill 37, 2008, Section 11.

⁷² Id.

⁷³ Id.

⁷⁴ Id, Section 11(H).

⁷⁵ Id., Section 12.

⁷⁶ OKLAHOMA HB 2805 (2008).

⁷⁷ Id., § 3..

⁷⁸ Id.

The system would be allowed to share health information with other health networks for subsequent distribution, if the other systems were nonprofit, publicly managed, and met state and federal privacy standards.⁷⁹ The Oklahoma Department of Health would have promulgated rules for implementation of the act.

Rhode Island – Rhode Island Health Information Exchange Act of 2008.

Rhode Island Senate Bill 2679 would enact the Rhode Island Health Information Exchange Act of 2008. As of June 20, 2008, the act had passed both houses of the Rhode Island legislature. The purpose of the act is to establish safeguards and confidentiality protections for health information exchange in order to improve the quality, safety, and value of health care, keep confidential health information secure and confidential and use the health information exchange to progress toward meeting public health goals.⁸⁰

The act would establish a statewide health information exchange under state authority, and confidential health information may only be accessed, released, or transferred from the health information exchange in accordance with the act.⁸¹ The act provides comprehensive provisions related to participation in the health information exchange, privacy and security of confidential health care information, patient rights, and disclosures. Key provisions include the following:

- Definitions of health information exchange related terms, including “confidential health care information,” “emergency,” “health information exchange,” “regional health information organization,” and various types of participants.⁸²
- Patients and health care providers have the choice to participate or not participate in the health information exchange. Except for cases of disclosure to a health care provider for the treatment of an individual in an emergency, disclosure to public health authorities to carry out their duties, or use by the regional health information organization for operations and oversight of the health information exchange, a patient participant’s confidential health care information may only be accessed, released or transferred from the health information exchange with a signed authorization from the patient.⁸³
- The patient authorization must include, at a minimum: a statement of the need for and proposed uses of the information; a statement that the authorization may be revoked or amended at any time; that the patient has

⁷⁹ Id.

⁸⁰ RHODE ISLAND S 2679 SUBSTITUTE A AS AMENDED (2008), § 5-37.7.1.

⁸¹ Id., § 5-37.7.4.

⁸² Id., § 5-37.7.3.

⁸³ Id., § 5-37.7.7(a) and (b).

the right not to participate in the health information exchange; and, the patient's right to choose to enroll and participate fully in the health information exchange or to designate only specific health care providers that may access the patient's confidential health care information.⁸⁴

- Patients that participate in the health information exchange have the right to: obtain a copy of his or her confidential health care information from the health information exchange; obtain a copy of a disclosure report pertaining to his or her information that is a record of access to, review of, or disclosure of the patient's information; to be notified in the case of a breach of security; to terminate participation in the health information exchange; and to request to amend his or her information through his or her provider.⁸⁵
- Health care providers that rely in good faith on information provided through the health information exchange are immune from criminal or civil liability for damages caused by such good faith reliance.⁸⁶
- Violations of the act may subject the violator to: civil penalties, including exemplary damages; criminal penalties; and payment of attorney's fees.⁸⁷

b. Miscellaneous State Laws and Proposed Legislation Related to Electronic Health Records and Health Information Exchange.

Alaska – Disposal of Records of Medical Information

In June of 2008, the Alaska Personal Information Protection Act became law.⁸⁸ It can be generally characterized as a notification of security breach law. The breach-notification provisions do not specifically include medical information within the type of personal information that is protected under the act. Article 4 of the act, however, is directed to the disposal of records containing personal information. For the purposes of Article 4, the definition of "personal information" specifically includes the combination of a person's name and medical information.⁸⁹

Article 4 of the act requires a person disposing of records that contain personal information to take all reasonable measures necessary to protect against the unauthorized access or use of the records.⁹⁰ With respect to electronic information, measures that would meet that requirement include the implementation of policies and procedures that require the destruction or erasure of electronic media containing personal information so that the personal information cannot practicably be read or reconstructed.⁹¹

⁸⁴ Id., § 5-37.7.7(c).

⁸⁵ Id., § 5-37.7.10.

⁸⁶ Id., § 5-37.7.11.

⁸⁷ Id., § 5-37.7.13.

⁸⁸ AK. STAT. ANN. § 45.48.010 et. seq.

⁸⁹ AK STAT. ANN.. § 45.48.590.

⁹⁰ AK STAT. ANN.. § 45.48.500(a).

⁹¹ AK STAT. ANN. § 45.48.510(2)..

Violations of Article 4 of the act can result in civil penalties, and a private right of action is allowed under which a person damaged by a violation may recover actual economic damages, costs, and attorneys fees.⁹²

California – Access to Electronic Medical Data for Public Health

California Assembly Bill 211, introduced in 2007, but currently being heard by the California Senate Committee on health would generally create a grant program for local city and county health departments.⁹³ Part 8 of the proposed legislation would grant the California Department of Public Health and local health departments access to electronic medical data for the purposes of carrying out mandated public health activities, including surveillance, monitoring of community health status, and implementation and evaluation of public health interventions to prevent and control disease.⁹⁴ The California Department of Public Health is obligated to view and use such data in full compliance with all applicable state and federal laws regarding the protection of confidentiality of personal health information.⁹⁵

Florida – Ownership and Control of Patient Records

Section 456.057 of the Florida statutes includes provisions enacted prior to September 1 of 2007 that apply to custodians of medical records. Specifically a “records custodian” under Florida law is a person or entity that: (1) is specifically authorized by the statute to maintain medical records or obtains medical records from a records owner.⁹⁶ Custodians of medical records are required to maintain records or documents as provided under the confidentiality provisions applicable to the licensed or regulated health care practitioner that created the medical records.⁹⁷

V. Conclusions.

The Harmonizing State Privacy Law Collaborative has not yet had the opportunity to fully assess the impact of the recent legislative activities. However, certain things stand out upon a preliminary review.

Generally, the conclusions reached in the October 2007 Report hold true. However, at the present time incremental approaches addressed at eliminating specific barriers, such as the approach taken by Wisconsin, or process oriented approaches, such as that taken in Oklahoma to create a standard patient authorization form, appear to have greater success than attempts to enact comprehensive, detailed legislation. Whether this is a trend that will continue as legislators

⁹² AK STAT. ANN. §§ 45.48.550 and 45.48.560.

⁹³ CALIFORNIA ASSEMBLY BILL 211 (2008) PART 8, Healthy California.

⁹⁴ Id.

⁹⁵ Id.

⁹⁶ FLA. STAT. ANN. § 456.057(3)

⁹⁷ FLA. STAT. ANN. § 456.057(4).

become more educated about health information exchange remains to be seen, but clearly as of yet, comprehensive statutory revisions have been difficult to pass.

The approach taken by the Oklahoma legislature, creating a standardized authorization process, could serve as a first step towards future laws related to health information exchange. The uniform authorization form process does not affect areas of current law not preempted by HIPAA, and might allow states the option of changing specific authorization requirements to align with HIPAA (or evolving standards) where there is agreement to do so.

Language addressing provider liability could also be highly significant if it is successful in encouraging the adoption of a uniform process and use of electronic health information exchange.

Although no state succeeded in passage of comprehensive health information exchange legislation, the fact that comprehensive legislation was proposed in six states is significant. It is also important to consider the focus of the proposed comprehensive legislation, which in most cases appears to be directed at authorizing electronic health information exchange while at the same time providing significantly higher privacy protections to individuals with respect to their medical records. The proposed legislation would have a significant effect on interstate electronic health information exchange given that it appears highly variable. A piecemeal adoption of comprehensive state electronic health information exchange legislation, which may be coming in the near future, may create unnecessary barriers unless there is some uniformity or consistency in the new legislation.

Apart from the issues of patient authorization, the various proposed comprehensive acts included definitions of key terms (i.e. “health information exchange,” “medical emergency,” “medical record,” etc.). To the extent that the meaning of key terms differs from state to state, new legislation could create new barriers. This underscores the importance of the creation of a taxonomy and uniform definitions for use by the states in addressing changes to their existing state law.

It will be the goal of the Harmonizing State Privacy Law Collaborative to address these issues and to provide the states with tools and information that will promote consistency in state-law changes.

Appendix A

Harmonizing State Privacy Law Collaborative States

FLORIDA

Florida Center for Health Information and Policy Analysis
Agency for Health Care Administration

The Agency for Health Care Administration (Agency) is the state agency with legislative authority to develop a strategic plan for the adoption and use of electronic health records in Florida. The Agency is authorized to administer grants to advance the development of a health information network; integrate health care data from state agencies and make the data available to health care practitioners through the health information network; and provide technical assistance to support the statewide health information network. The Agency has supported the development of RHIOs and other health information organizations through grants, technical assistance and leadership that is facilitated by the Agency's participation in the Health Information Security and Privacy Collaboration. A strategic goal of the Agency is to develop clear and concise standards to facilitate health information exchange including legislation to reconcile barriers in law or regulation as recommended by the Florida HISPC Legal Work Group.

KANSAS

Currently, Kansas is in a state of transition with respect to the identification, evaluation, and adoption of policies and laws designed to support the widespread implementation of Health Information Exchange ("HIE") and Health Information Technology ("HIT") across the state. In 2008, the Kansas Health Information Exchange Commission, a body appointed by Governor Kathleen Sebelius to further HIE and HIT issues was sunsetted. At the request of the Governor, the Kansas Health Policy Authority ("KHPA"), the state agency responsible for coordinating a statewide health policy agenda that incorporates effective purchasing and administration with health promotion strategies, accepted the leadership for coordination of ongoing statewide health information exchange efforts. The staff and leadership of the Kansas Health Information Security and Privacy Collaboration ("HISPC") project believe that one of the most valuable benefits of participating in the HISPC projects, especially as HIT and HIE activities in Kansas continue to evolve, has been the opportunity to meet with and learn from counterparts in other states. The second phase of HISPC enabled Kansas to form multi-state collaborations to gain further leverage for efforts to harmonize state privacy and security laws and to educate consumers. As Kansas moves forward with the third phase of HISPC, these collaborations will enable Kansas to participate in the development of more effective HIE and HIT policy initiatives at the local, regional and national levels.

KENTUCKY

HISPC was one of the first projects undertaken by the Commonwealth of Kentucky after the passage of Senate Bill 2 which established the legislative basis for e-Health in Kentucky and resulted in the formation of the Kentucky e-Health Network (KeHN) Board. With oversight by the Kentucky Cabinet for Health and Family Services (CHFS), the HISPC Steering Committee was charged with examining the effect of privacy and security practices and policies on HIE in support of establishing efficient and effective interoperable health information exchange in Kentucky.

With HISPC Phase 2 continuation funding, Kentucky chose to move forward with activities to address specific challenges to secure health information exchange on two fronts: educational and legal/regulatory. The development of a Privacy and Security Training Module and completion of a Kentucky HIPAA Pre-emption Analysis moved the Commonwealth further along in development of effective interoperable HIE.

Participation in the Harmonizing State Privacy Law Collaborative will provide an opportunity for the state to continue its focus on an area most critical to the successful development of Kentucky's statewide health information network, and to do it in concert with other states.

MICHIGAN

Created in 2007, the Michigan Health Information Network (MiHIN) Resource Center provides guidance, direction, and coordination to regional and statewide health information exchange (HIE) initiatives in the state, representing HIE regional efforts at the state and national levels, promoting the adoption of standards, and identifying resources to enable HIE organizations to achieve their goals. The Michigan Health Information Technology (HIT) Commission, created by PA 137-06, is housed within the Michigan Department of Community Health to facilitate and promote the design, implementation, operation, and maintenance of an interoperable health care information infrastructure in Michigan. The HIT Commission also serves as the Steering Committee for Michigan's HISPC projects. The HISPC Legal Work Group, also served as the Legal Work Group for the MiHIN Conduit to Care Project in 2006 and was reconvened in 2007 to identify any possible legislative barriers to HIE implementation. While Michigan continues to move forward with HIE, this third phase of HISPC continues to keep the State informed and connected with national and state-wide issues concerning the critical areas of privacy and security in HIE.

MISSOURI

In Missouri, improving electronic health information exchange (HIE) is a high priority for many stakeholder groups who work to improve the state's health care delivery system. The Governor's Healthcare Information Technology (HIT) Task Force was established in 2006-07 to assess the status of healthcare information technology adoption; identify technical, security, and privacy issues related to the electronic exchange of

healthcare information; and recommend best practices and policies for state government and private entities to promote the adoption of interoperable healthcare information technology by the Missouri healthcare delivery system. Identifying and removing the barriers to sharing health information is critical within the state and across state borders, particularly the Missouri/Kansas border. Participation in the Health Information Security and Privacy Collaboration (HISPC) will facilitate Missouri's efforts to provide safe, effective, and efficient patient care. Missouri will join the Harmonizing State Privacy Law (HSPL) Collaborative to achieve the objective of harmonizing state laws to facilitate health information exchange within and across state borders.

NEW MEXICO

The Lovelace Clinic Foundation (LCF), which implements the HISPC and the Nationwide Health Information Network (NHIN) contracts in New Mexico, is a 501(c)(3) nonprofit, tax-exempt applied health research institute. Created in 1990, LCF conducts health care delivery research, medical education, and is implementing the state's emerging statewide health information exchange. LCF has close research ties with New Mexico healthcare providers, and also collaborates with multiple public and private groups, both within New Mexico and nationwide. In New Mexico, LCF has collaborated successfully with the New Mexico Department of Health (NMDOH), the University of New Mexico (UNM), the Veterans' Administration (VA), and numerous other community stakeholders throughout its 17-year history, on such diverse projects as an initiative to establish an emergency department-based injury surveillance system, the Clinical Prevention Initiative co-sponsored by NM DOH and the NM Medical Society, and involvement in the Governor's Telehealth and Health Information Technology Commission. In 2004 LCF was awarded a 3 year implementation grant by AHRQ to address the use of HIT for the purposes of improving patient safety and quality of care and to encourage strategies for successful organizational and community-wide HIT planning and implementation. New Mexico Health Information Collaborative (NMHIC) initiated multiple constructive interactions with community stakeholders and the NM DOH. NMHIC, operated by LCF, is now recognized throughout much of the state as New Mexico's statewide health information exchange. One of the issues that NMHIC faced from its beginning was privacy and security of the electronic transmission of health information. This issue is of particular importance to the continued development of NMHIC and NHIN. A strategic goal for LCF is to promote health information exchange, which includes support of legislation that resolves barriers in the current law.

TEXAS

Although Texas is participating in the HISPC project for the first time, there are several major planning and policy initiatives underway in the state. The Texas Health Care Policy Council (HCPC), located within the Office of the Governor, is charged with coordinating and promoting health IT and HIE among the executive agencies of the state. The Texas Health Services

Authority (THSA), a legislative chartered, public-private partnership legally structured as a non-profit corporation, is charged with coordinating and promoting health IT and HIE among the state's private-sector providers. At the present time, the THSA is administered through the HCPC pending allocation of specific funding for their initiatives. Texas also has several regional health information exchange initiatives at different levels of development and maturity. However, health information exchange implementation is slow, partly because of the uncertainty about the legal landscape as it relates to privacy and security. Goals for Texas' participation in the HISPC project are to further promote the establishment of regional HIE initiatives, assist fledgling initiatives, and coordinate regional initiatives among each other and with the various federal IT and HIE initiatives. Texas further hopes to clarify ambiguities and conflicts in the state's existing medical privacy laws in order to eliminate statutory barriers inhibiting health IT and to identify additional statutory provisions to promote health IT and HIE.

Appendix B

Helpful Resources

1. National Conference of State Legislators, at:
<http://www.ncsl.org/programs/health/forum/hitch/>

and
http://www.ncsl.org/programs/health/forum/Hitch/HIT_database.cfm
2. The Healthcare Information and Management Systems Society (HIMSS) State Legislation Tracker.
3. National Association of State Chief Information Officers (NASCIO), Profiles of Progress – State Health IT Initiatives, September 2007 at
<http://www.nascio.org/publications/documents/NASCIO-ProfilesOfProgress2.pdf>
4. State Legislative Websites.