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Privacy of Medical Records Under Kassebaum-Kennedy

by John S. Hoff

Despite the obstacles I described in this column in the July/August *Oncology Issues*, the Kassebaum-Kennedy bill passed Congress and was signed into law by President Clinton. The health care community already has noted with concern one part of the law that received scant attention during the bill's convoluted process through Congress.

The concern arises from a seemingly innocuous title of the bill dealing with "Administrative Simplification." The intent of this title, as it modestly states, is to improve the efficiency of the health care system. The legislation intends to do so by requiring the Department of Health and Human Services (DHHS) to issue standards for:

1. Electronic transmission of health care information for financial and administrative transactions. (This includes oral statements of health information. The provision evidently applies to transmission of health information by telephone as well as computer transmission of data. The idea of standards for oral communications raises intriguing possibilities.)
2. "Code sets" for the data involved in the transactions.
3. A "standard unique health identifier for each individual, employer, health plan, and health care provider for use in the health care system."
4. Security standards for persons handling health information.

In addition, the law requires any person who maintains or transmits health information to "ensure the integrity and confidentiality of the information" and to protect against "unauthorized uses or disclosures of the information," but does not specify what is or is not authorized. It is unclear to what extent this provision is independently effective or is tied to the standards to be issued by DHHS.

On its face, the legislation merely facilitates the exchange of data and requires that confidentiality be maintained. However, many consider it a threat to the confidentiality of medical records. This fear appears to be the result of several factors.

First, the legislation focuses attention on an issue that is otherwise in the shadows. Currently various state laws impose confidentiality requirements; the scope of those laws often is unclear, but little attention is paid to them except by people directly involved in a particular issue. Enactment of federal legislation tends to concentrate attention on an issue.

The legislation also is intended to facilitate the exchange of data by computers. If successful, the law will ease the transfer of and thus access to confidential data. To the extent confidentiality now depends on the current haphazard system of storing and accessing data, the legislation will increase the risk of inappropriate use. On the other hand, one could argue that the centralization and enhanced tracking mechanisms provided by an electronic system would introduce better security than a system that permits surreptitious examination of medical records.

Finally, the conference report includes a statement that has raised concern. The statement reads: "Certain uses of individually identifiable information are appropriate, and do not compromise the privacy of an individual." The report then supports this obvious statement by providing two examples that constitute appropriate use and do not compromise privacy: transfer of information accompanying a referral to a specialist and transfer of information to an organization "for the sole purpose of conducting health care-related research." It is unclear why individually identifiable information is needed in connection with research, and in fact the next sentence in the report refers to the need for aggregated data in research.

Most importantly, the statute greatly enhances the role of the federal government in regulating the treatment of confidential records. This is the most significant aspect of the new law with respect to the confidentiality of medical records.

The statute creates a new federal requirement that health information be kept confidential without spelling out what this means. It then directs DHHS to send to Congress in the next twelve months proposed standards with respect to the privacy of individually identifiable information, including the "uses and disclosures of such information that should be authorized or required." If Congress has not passed legislation by the summer of 1999, DHHS must issue the standards as regulations. Any state law that is more protective of confidentiality than those regulations would continue to be applicable.

Kassebaum-Kennedy, therefore, deals with the confidentiality of medical records in two ways. If the legislation is successful in facilitating electronic exchange of data, it has increased the risk that confidentiality will be compromised. Most clearly and most significantly, Kassebaum-Kennedy has involved the federal government in the murky area of determining the appropriate uses of confidential medical records by imposing a general but ambiguous requirement of confidentiality and then by requiring further legislation or DHHS regulation. The same people who brought you Stark I and Stark II soon will regulate, with equal precision and understanding of the health care system, the use of medical records.

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