House
Legislative
Analysis
Section

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HEALTH CARE INFO ACT

House Bill 5217 as passed by the House
Sponsor: Rep. Michael J. Bennane

House Bill 5218 as passed by the House
Sponsor: Rep. Teola Hunter

House Bills 5219 and 5220 as passed by the House
Sponsor: Rep. Curtis Hertel

Second Analysis (1-13-93)

Committee: Public Health

THE APPARENT PROBLEM:

From a patient's point of view, two problems have existed with regard to medical records: sometimes patients have been refused access to their own medical records, and sometimes access to a patient's medical record is allowed (without the patient's knowledge) to those who should not necessarily have access. As an article in The Washington Monthly observed, "In dozens of states, patients are denied the critical, personal details in their medical records. Yet insurance companies, law-enforcement officials, medical professionals, intelligence agencies, and others have easy access to these records -- usually without the patients' knowledge. As a result of this injustice, some people have been denied jobs, demoted, or given inadequate medical care. Worse, these actions have been taken on the basis of medical records that -- without any input from the patient -- are often misleading and sometimes inaccurate."

THE CONTENT OF THE BILLS:

House Bill 5217 would create a new act, the health care information act, to require and regulate the disclosure of health care information to patients and others and to prescribe penalties for refusing to disclose such information and for unlawfully disclosing such information. Among other provisions, the bill would make the information in a patient's health care records the property of the patient, while leaving ownership of the physical files with the health care provider or facility, and would establish patients' right of access to their medical records. The other bills would amend the medical records part of the Public Health Code (House Bill 5218), the Insurance Code (House Bill 5219), and the Nonprofit Health Care Corporation Act (House Bill 5220) to conform with House Bill 5217.

House Bill 5217

Article 1: Definitions. The first article of the bill would name the proposed act (the "health care information act") and would define terms used in the bill, including "health care," "health care provider," "health care facility," and "health care information" or "medical record."

Article 2: Disclosure of Health Care Information. The second article of the bill would establish each patient's right to control access to the information contained in his or her medical record.

More specifically, the bill would, with certain exceptions, prohibit disclosure of health care information without written authorization from the patient, and would allow patients (or their legal guardians or patient advocates) to authorize health providers to disclose the patient's medical record. Providers and facilities generally would have to honor such requests for disclosure.

Health care providers and facilities would have to keep for a minimum of three years a record of everyone who had access to a patient's medical records. They could charge reasonable fees for providing the information (though not more than the actual costs involved, unless the request were for copies of the information, in which case the fee could not be more than 20 cents per page), and could withhold requested information until the copying and retrieval fees were paid. (Fees could not be charged for state audits or audits contracted with third party payers.) However, health care providers and facilities would not be able to withhold information in order to force payment of an unpaid fee for medical or health care services.

Disclosure authorizations. A disclosure authorization (including a written release or written waiver of confidentiality) would have to meet certain requirements: it would have to be in writing, identify the nature of the information to be disclosed and to whom, specify the purpose for which the information could be used, and contain a specific expiration date and a written explanation of the patient's right to copy or look at the disclosed information. Disclosure authorizations (and any revocations) would have to be kept with the patient's health care information (or at least be kept available for inspection).

Release of medical records to third party payers or auditors. Health care information released to a third party payer for purposes of reimbursement could be limited in certain ways and would last only for one year (unless specified otherwise). Third party requests for further information would have to say what more was needed and why. With certain exceptions (for claims adjudication, fraud investigation, posttreatment review, audit review, or peer review), third party payers could not release, without the patient's written consent, any information released to them.

Disclosure without the patient's authorization would be allowed to third party payers or outside auditors if the third party payer agreed to remove or destroy, at the earliest possible time, any information that would identify the patient and agreed to restrict disclosure of the information to do the audit or to report unlawful conduct (including fraud) by the health care provider or facility. Health care providers could disclose certain dental information to auditors (relating to fees for services) without prior patient authorization.

Disclosure revocation. Unless disclosure were necessary for payments for services rendered (or other legal action had been taken by the provider before receiving the revocation) patients could revoke, in writing and at any time, a disclosure authorization. The bill also would allow providers to release information "based upon a reasonable, good faith reliance" on a disclosure authorization if they did not have actual notice of the revocation when they released the information. Unless the disclosure authorization form had an expiration date, the authorization would expire when revoked by the patient.

Unauthorized disclosure. Health care providers would be allowed to release information without written authorization from the patient under a number of specified circumstances. If the information released were limited to only that necessary to achieve the purpose of the party requesting the information, the bill would allow disclosure without authorization under the following circumstances:

(1) To other health care providers or facilities providing health care to the patient;

(2) For health care education and for general and legal services to the health care provider (e.g. for planning, quality assurance, risk management, peer review, utilization review, or administrative, financial, or actuarial services);

(3) For research, if no patient identifiers were used (if the research required patient identifiers, an institutional review board would have to have decided that the project was important enough to justify disclosure, that there were reasonable safeguards against re-disclosure, and that the identifiers would be destroyed as soon as possible); and

(4) For "directory information" (which the bill defines as information disclosing the presence and general health condition of a particular patient who is either an inpatient at a health care facility, receiving emergency health care, or an outpatient receiving care that involved a stay of more than eight hours), unless the patient had specified otherwise.

Health care providers or facilities would be required to disclose information without patient authorization under the following circumstances:

(1) To the Department of Licensing and Regulation (and successor agencies) for malpractice investigations;

(2) For Medicaid or Medicare requests;

(3) To the parents or legal guardians of minor patients; to patient advocates or agents (under durable power of attorney for health care) for health care decisions for the patient; to legal

guardians of adults (if the guardian had the power to make health care decisions for the patient); to licensed adult foster care providers if the patient had no legal guardian to make his or her health care decisions; to the patient's personal representative (under the Revised Probate Code); and to trustees under the following circumstances: there was no patient representative and the patient was dead, or the trustee was required to determine whether the patient was disabled ("due to a mental or physical disability");
(4) For audits;
(5) To state or county correctional officers, if the patient is in a correctional facility;
(6) To federal, state, or local public health authorities legally obligated or allowed to report health care information, or if needed to protect the public health;
(7) To federal, state, or local law enforcement officers;
(8) Under court order.

Court disclosure. Except for license investigations and state and federal medical assistance programs, health care providers would not be able to disclose information to the courts unless one of the following circumstances existed:
(1) The patient had given written consent (or executed a written waiver of his or her right to confidentiality);
(3) The patient's physical or mental condition was at issue (including to the execution or witnessing of wills or in inheritance claims or disputes);
(4) The patient's health care information was to be used in his or her commitment proceeding;
(5) The information was needed by a law enforcement agency to pursue charges against a health care provider;
(6) The information was relevant to a proceeding under the bill's provisions regarding civil remedies and criminal and administrative penalties; or
(7) A court order.

A health care provider or facility ordered by a court to provide health care information would have to be given -- and would have to keep as part of the patient's medical record -- a written certificate with certain kinds of information (such as the signature of the person seeking access to the information, the category under which the information was being sought, and assurance that all notification requirements had been met).

Article 3: Examination and copying of records. The bill would require that health providers and facilities respond "promptly" to patients' written requests to access to the patient's medical records, and specify that the information in the records was the property of the patient, while the physical records were the property of the provider or facility.

More specifically, a health care provider or facility would have 15 business days to respond to a written request from a patient to examine or copy all or part of his or her medical record. The health care provider or facility could:
(1) Make the information available for examination and provide a copy (if requested) during regular business hours;
(2) Tell the patient if the information was not available (for example, if it did not exist, or it could not be found, or if the provider or facility did not have the requested information), and where it could be found (if possible);
(3) Tell the patient if the information was being used or if "unusual circumstances" had delayed handling the request, explain in writing the reason for the delay, and specify when the information would be available; or
(5) Deny the request.

Health care providers would have to explain any codes or abbreviations in the medical records. They would not have to make new records or reformulate existing records to make it available in the form requested. If a health care provider were not available during the ten business days, as soon as he or she did become available he or she would have to immediately notify the patient and complete the request within ten business days.

Denial of patient requests for their medical records. A health provider or facility could deny a request for medical records if the requested information was being used for litigation, peer review, quality assurance, or administrative purposes. If a request for information were denied, the provider or facility would have to make available the part of the medical records not being used for these purposes and would have to let another health care provider or facility advising or caring for the patient see and copy the patient's record.

Costs of obtaining records. Health care providers could charge retrieval fees and copying fees. Retrieval fees could not be more than the actual cost of retrieval. Copying costs to patients could not be more than 20 cents per page, though providers and facilities could charge the actual cost of copying "imaging records" (such as X-rays and electroencephalogram tracings). The bill would recognize that the 20-cent-per-page fee would represent a subsidized rate that was below cost, but would say that the state had an interest in protecting patients' right to access to their medical records. Health care providers and facilities could charge "reasonable fees" to all others requesting copies of medical records and prohibit copying until the fee was paid, but could charge only for those parts of the records actually provided. People could bring their own copying equipment and pay only a retrieval fee that reflected the cost of supervising the examination and copying of the medical records. Third party payers could charge a retrieval and copying fee of up to $2 per page for health care information they provided upon request or under subpoena in civil suits to which they were not a party.

Article 4: Additions to Medical Record. Patients could ask, in writing, to have their medical records "appended" both for accuracy and for completeness. Health care providers and facilities would have to respond to such requests "as promptly as required under the circumstances," but at least within 15 business days of the request. As in the case of requests to examine or copy records, health care providers and facilities could take a number of actions.

(1) They could make the requested addition to the medical record, so inform the patient, and tell the patient of his or her right to have the addition sent, within 14 days, to whomever had copies of the uncorrected medical record.

(2) They could tell the patient if they couldn't find the record or if it no longer existed.

(3) If they didn't have the record, they could tell the patient, as well as telling who did have it (if they knew).

(4) If the record were in use or "unusual circumstances" delayed the handling of the request, the health care provider or facility could notify the patient and explain in writing why and when the addition would be made (or when the request would otherwise be taken care of).

(5) Finally, they could refuse to make the addition, in which case they would have to explain why (in writing), and tell the patient of his or her right to have a "statement of disagreement" added to his or her records and sent to anyone who had copies of the record.

When a health provider or facility added corrective or missing information to a medical record, they would have to both make the additional information part of the medical record and mark the entries in question (and indicate where the appended information was located). If the provider or facility refused to make the requested addition, they would have to let the patient file with his or her record a statement of the requested addition and why the addition had been requested. The provider or facility also would have to mark the challenged parts of the record.

When patients so requested in writing, health providers or facilities would have to take "reasonable steps" to provide copies of additional information (or a statement of disagreement) to everyone designated by the patient who are identified in the health care information as having seen or received copies of the additional information. Unless the health provider or facility had made an error that made the additional information necessary, providers or facilities could charge the patient a "reasonable fee" of up to 20 cents a page for distributing additional information (or statements of disagreement).

Article 5: Notice of Information Practices. Health care providers and facilities that kept medical records would have to create and post a "notice of information practices" which included information about any administrative costs for getting a copy of a medical record as well as substantially the following information:

"We keep a record of the health care we provide you. You may ask us to see and copy that record. The cost to you of copying that record is 20 cents per page plus a retrieval fee. You may also ask us to append that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may see your record or get more information about it at _______________________."

The Department of Licensing and Regulation or its successor agencies would enforce this section with regard to health care providers, while the Department of Public Health would enforce it with regard to health care facilities. Both departments could impose administrative penalties for violations.

Article 6: Persons authorized to act for patient. People authorized to act for a patient would be able to exercise the patient's rights necessary to carry out their duties and would be required to "act in good faith to represent the best interests of the patient." In the case of emancipated minors (and others less than 18 who were authorized to consent to health care without parental consent), only the minor would be able to make decisions about his or her health care information. In the case of dead patients, the dead patient's personal representative could exercise all of the patient's rights under the bill. If there were no personal representative, anyone legally authorized to act for the dead patient could also exercise the patient's rights under the bill.

Article 7: Security safeguards and record retention. Health care providers and facilities would have to use "reasonable safeguards" for the security of all of the health care records they kept. Providers and facilities would not have to keep medical records (including imaging records, such as X-rays, and their interpretations) for more than 7 years after the care had been given (in the case of minors, for at least 7 years or until the minor turned 18, whichever were longer).

Abbreviated medical records. After 7 years, a provider or facility could either destroy the medical records (by shredding, burning, or other approved means) or keep them. If they destroyed records, they would still have to keep certain information in one of two forms: as certain specified "basic" information or as abstracts containing information similar to the specified basic information. Providers and facilities would have to keep abbreviated information from each record for at least 25 years (in the case of minors, 25 years after the minor turned 18). The abbreviated information required to be kept by health care providers would include the patient's name, birth date, social security number, and list of diagnoses and invasive procedures (including dates), chronic illnesses (including mental illness), and genetic diseases. For health care facilities, this basic information would consist of the patient's name, birth date, social security number, dates of admission and discharge, name of attending physician, operative reports, surgical pathology reports, and discharge summaries.

After 25 years, health care providers or facilities could either keep the information (medical record, basic information, or abstract) indefinitely or request the Department of Public Health take possession of the information. The department would have to take any such information as requested, and keep it indefinitely.

Original medical records. Before closing or otherwise stopping provision of health care to patients, providers and facilities would have to take a number of actions to ensure that their patients' medical records were appropriately stored by someone else and were accessible to patients. Closing providers and facilities would have to arrange to have their medical records kept in compliance with the bill's provisions, publish a newspaper notice containing certain information and at least one month before the pending closure, and contract with someone to store the medical records. If alternative storage could not be found, the provider or facility could ask the Department of Public Health to serve as the storage site, and the department would have to comply.

The Department of Public Health could promulgate rules to implement the bill's security and record retention provisions. The department also would be required, in consultation with the appropriate health care providers' and facilities' organizations, to do a study on the feasibility of a standardized numbering system to be used in cataloging medical records. One year after the bill took effect, the department would have to report to the legislature on this study.

Article 8: Civil remedies and criminal and administrative sanctions. In addition to the administrative fines allowed under the notification part of the bill (Article 5), the bill would allow civil lawsuits for violations of the bill's provisions.

Health care providers or facilities who denied allowable requests for health care information would be subject to administrative penalties under the Public Health Code, but would not be subject to civil, administrative, or criminal liability for allowable disclosure or denial of access to health care information. Health care providers and facilities would be prohibited from entering into any contracts that would alter the bill's provisions, and would not be liable for any good faith disclosures made in response to a certificate served as part of compulsory legal process or discovery requests.

Someone could sue health care providers and facilities for violations of the bill; if a patient alleged that health care information was improperly withheld when he or she had asked to see or copy it, the burden of proof would be on the health provider or facility to show that the information had properly been withheld.

Courts could order health providers and facilities to comply with the bill, assess reasonable attorney's fees and all other expenses to the prevailing party in litigation, and could order any other appropriate relief. If a court decided in a civil suit that a violation had occurred, the aggrieved person could recover damages for pecuniary losses and, in cases of willful or grossly negligent conduct, exemplary damages of up to $5,000.

House Bill 5218 would amend the Public Health Code (MCL 333.2619 et al.) to change confidentiality or record retention requirements that would conflict with the Health Care Information Act proposed in House Bill 5217. More specifically, it would apply the proposed act's requirements to the health code's:

* cancer registry;
* provisions for departmental data regulation (allowing the release of any medical information from registries or other sources held by the Department of Public Health so long as the release complied with the confidentiality and release requirements of House Bill 5217);
* spinal cord injury and traumatic brain injury registry;
* Alzheimer's registry;
* Agent Orange registry (and the "cause of death" study results that the DPH will compile from this registry);
* birth defects registry;
* provisions for inspections of health care facilities (including both scheduled annual inspections and unscheduled complaint investigations);
* provisions requiring health care facilities to have a patients rights and responsibilities document posted in the facility;
* provisions allowing the Bureau of Occupational and Professional Regulation access to medical records for the DPH;
* access by the public to nursing home records; and
* certificate of need requirements for short-term nursing care programs.

House Bill 5219 would amend the Insurance Code (MCL 500.3152 and 500.3158) to require all insurers to comply with the requirements of the Health Care Information Act proposed in House Bill 5217.

House Bill 5220 would amend the Nonprofit Health Care Corporation Act (MCL 550.1406 and 550.1604) to require Blue Cross and Blue Shield of Michigan to comply with the requirements of the Health Care Information Act proposed in House Bill 5217. More specifically, the act currently prohibits the disclosure of records containing identifying information or personal information about a member to anyone without the member's written permission -- except for claims adjudication or verification, as required by law, or as allowed to the insurance commissioner. The act also requires the commissioner to ensure the confidentiality of all records containing identifying information, and allows him or her to disclose such information only in compliance with a court order, for adjudication, or when required by law.

The bill would require that such information be disclosed as required under the Health Care Information Act.

Tie-bar. House Bills 5218, 5219, and 5220 are tie-barred to House Bill 5217.

FISCAL IMPLICATIONS:

Fiscal information is not available.

ARGUMENTS:

For:

In dozens of states, patients are denied the critical, personal details in their medical records. Yet insurance companies, law-enforcement officials, medical professionals, intelligence agencies, and others have easy access to these records -- usually without the patients' knowledge. Lawyers can obtain subpoenas for medical records, police can simply walk into local hospitals and demand them, and insurance companies can withhold payment for their clients' medical treatment until they've read them. Such easy access has led to abuse. Some people have been denied jobs, demoted, or given inadequate medical care. Worse, these actions have been taken on the basis of medical records that -- without any input from the patient -- are often misleading and sometimes inaccurate.

Though the vast majority of doctors probably keep accurate records, many patients suffer hardship needlessly because of errors they could easily correct if they had access to their files. For example, a patient at the prestigious New York

University Medical Center underwent a successful lung-cancer operation, but in the diagnosis section of her discharge summary, along with the correct diagnosis, a resident physician reading from another doctor's notes added the diagnosis of paranoid schizophrenia. For three years afterwards the patient was unable to find a doctor who was willing to provide even the most basic treatment to a woman whose medical records indicated she was crazy. She learned of the misdiagnosis only after her frustrated search for a doctor lead her to ask for a copy of her medical records -- to which she was denied access until she threatened legal action. As upset as the patient remains over the misdiagnosis, she is equally angry that for three years neither the hospital nor the doctors who refused to treat her told her she had been diagnosed as mentally ill. Not treating her was bad enough, but the doctors who knew of her "diagnosis" yet did nothing didn't seem to care whether she got any treatment at all. They offered no referrals, no suggestions, and they didn't even tell her family.

Employees also have been victimized by their employers on the basis of incorrect medical records. For example, two years after he was hired as a customer-service representative for a computer manufacturer, a New York man found himself demoted to a dead-end job loading paper into printers. His misfortune, although he did not know it at the time, was the result of incorrect diagnoses made by a company doctor that he was a "possible manic depressive," and "possible schizophrenic." By sheer accident he saw his medical records on a desk while undergoing a compulsory hearing and vision exam six months after he had been demoted. Over the objections of the a nurse, he scanned his records and found the mistaken diagnosis. Subsequently he still was denied access to his records, but after finally threatening legal action he was promoted to a computer programming position and the company has apologized for the mistaken diagnosis.

The answer to the medical records mess is simple: give patients access to their records and restrict access to third parties.

Against:

Medical records are the property of the physician, created for his or her use and not for the eyes of the patient. Giving patients access to their medical records can be detrimental to both patients and doctors. If patients see their records, it will increase their anxiety and make them less likely to comply with their physicians' orders. In addition, giving patients access to their medical records will increase malpractice lawsuits. The litigious climate that prevails between doctors and patients would be fueled, to the detriment both of patients (by decreasing available health care) and doctors alike.

Response:

Most courts have ruled that while the doctor owns the physical record itself, the patient has an interest in, and a right to, the information in those records. After all, the records at issue are composed of information about the patient, provided by the patient, to a physician who is being paid by the patient or his or her representative. Patients' rights to see their medical records is just common sense.

With regard to causing higher patient anxiety and higher levels of patient noncompliance, studies have shown just the opposite. Certainly there may be cases where telling patients details of their illnesses would be more dangerous than not telling them, but that is why every patient access law that has been proposed or enacted leaves ample room for appeal. But in both the public and private sectors, patient access has proven beneficial. The federal Privacy Act of 1974 gave patients access to records at federally-run hospitals, and administrators at these hospitals have found few of the problems predicted by doctors -- even in the area of psychiatric care. Another study at a Vermont health care center, in which 100 patients were given copies of their own records, found that 84 percent were more careful about taking medicine prescribed for them, and 97 percent worried less about their health care. The time is long since past in which patients should be asked to blindly trust while their health care providers magically heal. The curious, well-informed patient has no need of out-moded paternalistic attitudes, and health care should move on to giving patients the right to participate knowledgeably in their own care.

Finally, it needs to be pointed out that malpractice suits have risen despite the current restrictions on patients' access to their records. It could even be argued that if doctors became more open with patients, an informed relationship would emerge that would lead to fewer, not more, malpractice claims. But even if it didn't, the only time open records would lead to a successful malpractice suit would be when there's something in the record that indicated negligence. Arresting the growth of malpractice claims by suppressing the evidence is ridiculous.

POSITIONS:

There are no positions on the bills.