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MICHIGAN HEALTH DATA INSTITUTE

House Bills 4363-4367
Sponsor: Rep. Keith Stallworth
Committee: Health Policy

Complete to 5-5-99

A SUMMARY OF HOUSE BILLS 4363-4367 AS INTRODUCED 3-3-99

House Bills 4363-4366 would add Part 29, entitled "Health Information", to the Public Health Code; create the Michigan Health Data Institute; establish a board of directors; develop the Michigan Comparative Health Database; create the Michigan Health Data Institute Fund and the Michigan Health Database Corporation; define terms; state the purpose of the database, components of the data plan, and types of information in the database; and establish confidentiality practices, access to the data, and penalties for violations. House Bill 4367 would amend the Administrative Procedures Act (MCL 24.207) to exclude the data plan created in House Bills 4363-4366 from the definition of administrative rule. The bills are tie-barred to each other. More specifically, the bills would do the following:

House Bill 4364 would amend the Public Health Code (MCL 333.2901, 333.2903, and 333.2905) to add Part 29, entitled "Health Information". Under the bill, the Michigan Health Data Institute would be created within the governor's office as a public body corporate, but would have to be reassigned to an executive branch agency within 90 days after the effective date of a data plan, but not later than two years after the bill's effective date, after which it would function independently of that agency.

The powers and duties of the institute would be vested in a 13-member board appointed by the governor with the advice and consent of the Senate. Membership on the board would have to broadly represent the interests of all the residents of the state. Members would be appointed within three months of the bill's effective date and again within 90 days of when the initial data plan took effect. Except for the initial board members and those members appointed after the initial data plan took effect, who would serve staggered terms from one to three years, members would serve for a term of three years. Appointments would have to assure representation of consumers, providers, and purchasers of health care, with neither providers nor purchasers being in the majority. Further, the provider members would have to represent the predominant sources of data. "Provider" would include state-licensed and registered health care professionals, associations representing health professionals or facilities, and officers and employees of health-related organizations. "Purchaser" would include insurers, Blue Cross/Blue Shield of Michigan, an organization that purchased or provided a health care payment or benefit plan, and a coalition or association of purchasers, and, presumably, would include HMOs and other managed care companies.

Bylaws that included voting procedures and that were in compliance with certain specified statutes would have to be adopted within one month of board members being appointed and confirmed. The board would have to elect a chairperson and vice-chairperson at the beginning of each calendar year. Meetings would have to be held in compliance with the Open Meetings Act, and could be held as often as necessary for members to fulfil their duties. Meetings could be called by the chair or by not less than five board members. A majority of the members would constitute a quorum, and members could not vote by proxy. Members could be removed for missing three consecutive meetings in a one-year period. Members would be reimbursed for expenses incurred in carrying out their duties. Writings prepared, owned, used, in the possession of, or retained by the board in conjunction with official business would be available to the public under the Freedom of Information Act.

House Bill 4363 would amend the Public Health Code (MCL 333.2907, 333.2909, and 333.2911) to establish the Michigan Health Data Institute Fund in the state treasury and to establish the Michigan Health Database Corporation, which would assist the Michigan Health Data Institute in developing and implementing the Michigan Comparative Health Database.

Funding for the Michigan Health Data Institute Fund would be broadly derived from providers and group purchasers, with access fees to the database set by the board of directors of the Michigan Health Data Institute and based on extent of use. The fund could also receive gifts and other revenue as provided by law, and the bill would not preclude legislative appropriations to cover the costs of developing a data plan. Expenditures from the fund would be restricted for the operation of the institute. Investments would be directed by the state treasurer. Interest and earnings would be credited to the fund and would not revert to the general fund at the close of a fiscal year.

Under the bill, a draft data plan for the database would have to incorporate the scope, content, format, use, timetable, and financing of the database, according to provisions contained in House Bill 4365. Data plans would have to be approved by the board and would have to specifically designate the data that would be submitted and its source. The board would have to hold public hearings on the first approved draft data plan, and would have to approve a proposed first data plan after considering information presented at the hearing.

Within nine months of the appointment and confirmation of all initial board members, the proposed first data plan would then be presented to the governor and to the standing committees of the House of Representatives and Senate that have jurisdiction over public health matters. The governor or legislature would have 90 days (nine of which must be legislative session days) in which to disapprove of the data plan. Legislative disapproval would have to be expressed in a concurrent resolution adopted by each house. If the data plan was not disapproved, it would become effective at the end of the 90-day period. If the first data plan were disapproved, a modified first data plan would have to be submitted to the governor and legislature within six months after the disapproval date. After a first data plan had been approved and implemented, the board would have to periodically submit proposed revised data plans to the governor and legislature no later than every three years. In revising a data plan, the board would have to follow the same procedure as the initial data plan, except the time period in which the governor and legislature could review and disapprove a data plan would be reduced from 90 days to 60 days.

Further, the bill would require the board to establish the Michigan Health Database Corporation, a nonprofit corporation that would assist the institute in the development and implementation of the Michigan Comparative Health Database. Board members would also act as the board of directors of the nonprofit corporation, and would contract with the nonprofit corporation and other parties to carry out the duties of the corporation. The contract between the board and the nonprofit data corporation would have to provide, at a minimum, all of the following:

-- A draft of each data plan prepared by the data corporation.

-- Subject to confidentiality provisions under House Bill 4366, arrangements for the development and distribution of publicly available, consistent, and standardized analyses of data in the database, along with the establishment of an appropriate process for computer access to the database.

-- Require the data corporation to rely on contracts with other private entities such as local and regional coalitions and other groups to perform all or part of the analyses required under the bills, including analyses on a regional basis. Contracts under this provision would have to be on an open and competitive bid process.

-- One or more reports analyzing and summarizing timely health care expenditure data, and timely data describing important variations in the delivery of health care and the health status characteristics of the population, would have to be issued annually by the data corporation.

House Bill 4365 would amend the Public Health Code (MCL 333.2913, 333.2915, and 333.2917) to specify the purpose of the Michigan Comparative Health Database, the components of the data plan, and the types of information stored in the database. The bill specifies that the objectives of the database and the data plans would be to obtain, process, analyze, and publicly disseminate statewide comparative data in a clear, usable, and standardized form regarding the cost, quality, and organization of health care services within the state and also on the health status of the state population as a whole and by geographic, demographic, and other appropriate categories.

The database would have to include clinical and financial data that could provide the means to evaluate health providers and health care payment and benefits plans on a comparative, provider-specific, plan-specific, and treatment-specific basis. Data would have to be severity-adjusted and risk-adjusted. The database would also have to include, at a minimum, data from the Michigan inpatient database or comparable data; data from the Medicaid program; data from uniform claim forms used by hospitals to submit bills; and, as needed to evaluate health care payment and benefit plans on a comparative basis, data from licensed health maintenance organizations, organizations offering prudent purchaser arrangements, insurers, and Blue Cross/Blue Shield of Michigan. The data collected for the database would have to be coordinated with information collected by the Department of Community Health for medical research projects and with other information required to be collected under the code, and would also have to be coordinated with information contained in the birth defects registry and in the occupational disease or health condition reports that health care providers, health facilities, and employers are currently required to file regarding occupational diseases or conditions of employees that are aggravated by workplace exposures.

An approved data plan would have to specify all of the following:

-- The database content, including such things as the clinical and financial detail specific to diagnoses, treatments or procedures, and providers (including plan performance, health settings, and practitioners); data related to the organization of health services; data characterizing the quality of health service outcomes; and the statistical adjustment of all data elements according to the health status of a patient.

-- Release of data analyses and reports promoting value for all users of the data system (including consumers, planners, policy makers, providers, purchasers, and researchers); continuous improvements in quality, appropriateness, and efficiency of health service delivery and in the health status of Michigan residents; and timely availability of information that met priority needs of the users of the database.

-- Appropriate recognition of administrative considerations such as implementation of each phased-in data plan based on determinations of priority needs of data users, value of data, and data availability and accessibility; data collection in a standardized manner; reliance on existing data sets; minimization of administrative cost and burden on those generating and those supplying data; promotion of the use of electronic information technology and uniform claims procedures; and availability of adequate resources to cover all incremental costs related to initiation and ongoing operation of the database, regardless of who incurred the costs.

House Bill 4366 would amend the Public Health Code (MCL 333.2919-333.2927) to establish policies and procedures regarding access to the data in the Michigan Comparative Health Database, confidentiality of data, and penalties for violations of the provisions added by the bill package. Under the bill, each data plan would have to include policies and procedures on confidentiality and access to the data that included, at a minimum, such things as who could obtain access to which data, access fees to the database, who could use which data, how accessible data could be used, and how patient confidentiality would be protected. Any data that identified an individual patient and any other information that could be expected to reveal the identity of an individual patient could not be publicly disclosed under the Freedom of Information Act (FOIA).

The policies and procedures of a data plan would also have to provide that any publicly available information from the database did not provide access to combinations of patient characteristic data elements that could reasonably be expected to reveal an individual's identity. Those with whom the nonprofit data corporation contracted to develop data analyses would be subject to the data plan's policies and procedures and would have access to patient-level data from the database only as necessary to develop data analyses; for example, linkage for outcome and other analyses. Once linkage occurred, patient-level data and analyses would have to be coded to prevent their use or display in any manner that could reveal a patient's identity. Unless expected to reveal the identity of a patient, data collected that contained the identity of individual providers, employers, and purchasers would not be confidential and would be considered public information. Health care information from a patient's medical record or supplied by a health care payment or benefits plan to the board or to the data corporation in order to enable either to perform its duties would have to be limited to only those data elements specified in the approved data plan that was in effect at the time the information was provided. Requests for data from the database that were not allowable under FOIA would have to be consistent with the data plan, and would have to state, with particularity, what information was needed and why. Data in the data base could only be disclosed if it met the confidentiality requirements of the bill.

A civil action could be brought by the attorney general, a county prosecutor, or any person aggrieved by a violation of Part 29. The court could order a provider, purchaser, or any other person to comply with the provisions of Part 29 and could also order any other appropriate relief, including damages for pecuniary losses sustained by a plaintiff as a result of the violation. If a violation involved willful or grossly negligent conduct that resulted in the disclosure of information that identified a patient, the court could award exemplary damages up to $5,000 (in addition to any pecuniary loss) for each data element disclosed that pertained to the patient. The court could also award reasonable attorney fees and costs to the prevailing party. A person who disclosed information in good faith in compliance with an approved data plan would not be subject to civil, administrative, or criminal liability for the disclosure.

House Bill 4367 would amend the Administrative Procedures Act (MCL 24.207) to exclude a data plan approved by the Michigan Health Data Institute and in effect under section 2909, which would be added by House Bill 4363, from the definition of an administrative rule.

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