

Blues: House I.T Bill Needs Fixes

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The Blue Cross and Blue Shield Association has sent a letter to members of the House Energy & Commerce Committee expressing significant concerns with privacy provisions in health information technology legislation being considered.

The letter from Mary Nell Lehnhard, senior vice president of the association, went to Reps. John Dingell (D-Mich.), committee chair; Joe Barton (R-Texas), committee ranking member; Frank Pallone (D-N.J.), health subcommittee chair; and Nathan Deal (R-Ga.), health subcommittee ranking member. Dingell and Barton are the prime sponsors of H.R. 6357. What follows is full text of the association's letter:

"On behalf of the Blue Cross and Blue Shield Association (BCBSA) – a national federation of 39 independent, community-based and locally operated Blue Cross and Blue Shield companies that collectively provide healthcare coverage for more than 100 million Americans – I would like to commend the Committee for seeking to advance health information technology (HIT) with the "Protecting Records, Optimizing Treatment, and Communication through Healthcare Technology Act of 2008" (H.R. 6357).

"BCBSA is committed to a health care system that delivers safe, efficient, and high-quality care for consumers. As part of that commitment, BCBSA has been on the leading edge of national efforts to advance health IT, developing national standards for personal health records (PHRs), encouraging providers to use electronic prescribing, and promoting the adoption of inter-operable health information technology. We believe that H.R. 6357 has the potential to strengthen such efforts, bringing us closer to the overall goal of safer, more efficient, and higher quality care.

"Payers and providers have embraced the national movement to encourage and reward high quality care through vital quality initiatives such as increased care coordination for patients with chronic conditions, infection reduction programs for hospital ICUs, and an overall greater focus on prevention. However, contrary to its overall goal of improving health care, Title III of H.R. 6357 includes a number of problematic provisions that would set back this national movement by: (1) slowing or freezing adoption of HIT, (2) weakening – not strengthening – consumer protections, (3) crippling health plans' efforts to promote quality, encourage use of health IT, increase efficiency, and fight fraud, and (4) undermining the move to pay for outcomes. In addition, Title III includes a provision regarding non-disclosure of self-paid services that Congress should consider as part of broader health care reform, not as part of privacy.

"Freeze HIT Adoption – Provider adoption of HIT is already lagging because of concerns about costs. H.R. 6357 would exacerbate these concerns by requiring providers: (1) to get

consent whenever they use patients' information for vital quality and management functions, such as medical reviews to pinpoint and fix safety problems, and (2) to track and store for three years every time they send information to another provider.

“The additional costs of getting, verifying, and retaining consent for every vital quality and management function will be a huge disincentive to building and using Electronic Medical Records (EMRs). And there is a strong industry consensus that the requirement to track and retrieve huge amounts of information is not currently workable – the technology does not fully exist – and will only add further to driving down adoption.

“Weaken Protections – Following two years of hearings, the National Committee on Vital and Health Statistics (NCVHS) recommended to the Secretary on June 21, 2007 that, at a minimum, all companies that offer personal health records (PHR) should be treated as covered entities under HIPAA.

“However, the bill generally exempts HIPAA non-covered entities that offer or maintain PHRs from any rules, instead calling for yet more study of what privacy and security rules should apply. We agree with NCVHS that Congress should require all entities that handle personal health information to have the same consumer protection rules. Otherwise, consumers could tell payers and providers to turn over their information to these vendors, not understanding that the vendors do not offer the same privacy protections.

“Cripple Health Plan Efforts – A new addition to the bill would require providers – on a claim by claim basis – to tell the health plan whether the provider has the patient's consent to use the patient's information for quality or management functions. If providers do not obtain consent, then health plans would not be able to use claims information for their own vital quality and management functions.

“Health plans use claims information for a wide range of functions from investigating fraud and abuse to supporting patient-centered medical homes to providing consumers personal health records. These functions would be crippled if patients withheld consent from providers. For example, health plans look for patterns in claims to identify potential fraud and abuse activities. However, a health plan would have to exclude any claim where the provider did not have his or her patient's consent. While some argue the regulatory process could avoid these problems by allowing HHS to exempt certain functions, it won't because vital quality and management functions involve all health care operations.

“Undermine Paying for Outcomes – To rein in costs and improve quality, payers are changing financial incentives to advance the best possible care, not just more services. Yet H.R. 6357 would prevent providers with EMRs from sending health plans needed information to support pay-for-quality programs unless providers have their patients' consent.

“This consent requirement would jeopardize innovative quality programs because it would be impossible for providers with EMRs to get 100 percent consent and, therefore, the information supplied would be neither complete nor accurate. Moreover, lower adoption of EMRs would mean that more providers continue to use paper.

“Insurance Reform – Title III also includes a significant insurance reform that belongs in a broader debate over health care reform, not privacy. For the first time, patients would be able to direct their physicians to withhold information from health plans about services for which they self pay.

“This is a significant insurance reform because it would encourage people to hide information from their health plan to avoid current underwriting and rating rules. This would result in higher premiums, and would raise fraud and abuse issues. This has broad implications for access and affordability issues that should be debated in the larger context of health care reform.

“As the full Committee considers H.R. 6357, we hope that you can remedy the four major concerns that we have raised. We appreciate the opportunity to voice these concerns and look forward to working with you as the bill moves through the legislative process.”

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