AUTHORIZE THIS!: THE CASE FOR HIPAA PREEMPTION OF STATE AND FEDERAL PROTECTION OF BEHAVIORAL HEALTH INFORMATION

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I. INTRODUCTION

The sharing of patient information is integral to health care reform. New models of health care delivery depend upon the exchange of health information across the continuum of care. Following patients from first encounter to appropriate after-care, creating quality metrics, monitoring provider performance and clinical outcomes, the development of clinical protocols, etc., are all critical to reform efforts and require access to patient information. The best-known health privacy regulation—the Health Insurance Portability and Accountability Act (HIPAA)[1]—for the most part accommodates this access.

Older privacy laws, however, like those regulating alcohol and drug-treatment or mental health records, are not so accommodating.[2]

do not adopt certified electronic medical records.[7] At the same time, however, federal and state laws preserve privacy protections guaranteed to frustrate the purpose of such technology: affording healthcare providers access to information when and where it is needed 24 hours a day, 7 days a week, 365 days a year.

These issues are particularly important in Oregon. Coordinated Care Organizations (CCO) deliver Medicaid services to a burgeoning population of medically indigent Oregonians. But CCOs are frustrated in their efforts to connect the addiction and mental health treatment of Medicaid beneficiaries to their medical, dental, and hospital care. The behavioral health patient population accounts for a disproportionate share of health care costs, and thus identifying and delivering appropriate services to these patients is critical to bending the cost curve.[8] Well-intended but vestigial700.081 T012 T2d143i.48uNechibigi

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ty assurance, credentialing, and peer review.[12] Calls for Part 2's amendment have focused on this requirement for patient consent to disclosure.[13]

This article also suggests a single, federal standard to govern the privacy of health information and health care data breach response: HIPAA's Privacy Rule. While reasonable people can disagree about appropriate privacy standards, one thing is certain: our current health care system is financially unsustainable.[14] Clinical integration and harnessing the power of Big Data are the two leading contenders for bending the health care cost curve and delivering better care for the buck.[15] Both strategies require widely shared patient health information, and both are currently hampered by an outdated framework of state and federal privacy laws specific to behavioral health that obstruct data-sharing across the continuum of care.

Appreciating the legal barriers to information exchange begins, first, with a description of the authorization requirements of Part 2 and the HIPAA Privacy Rule and, second, with a discussion of the exceptions to the authorization requirement for those two laws. Third, this article will address the key role federal preemption plays in determining what law governs access to BHI.[16] Fourth, this article will briefly discuss "special cases" of health information and their differing treatment by HIPAA and Part 2. Fifth, it will examine BHI that is not subject to Part 2, and the role that state law plays in its regulation. Sixth, and finally, this article will propose reforming of the laws protecting the privacy of BHI.

II. FEDERAL AUTHORIZATION REQUIREMENTS

In order to appreciate the obstacles to information sharing posed by patient authorization requirements, this article compares those requirements in Part 2 and HIPAA's Privacy Rule. Keep in mind that

12. *See* 45 C.F.R. § 164.501 (2013) (definition of "health care operations").

13. *See* Confidentiality of Substance Use Disorder Patient Records, 81 Fed. Reg. 6988-01 (proposed Feb. 9, 2016).

14. *Healthcare Costs Unsustainable in Advanced Economies Without Reform*, ORGANIZATION FOR ECONOMIC CO-OPERATION AND DEVELOPMENT (Sept. 24, 2015), http://www.oecd.org/health/healthcarecostsunsustainableinadvancedeconomieswithoutreform.htm.

15. *See, e.g.*, Keith D. Moore et al., *The Big Deal About Big Data*, HEALTHCARE FINANCIAL MGMT. (Aug. 2013), http://www.hfma.org/Content.aspx?id=18550.

16. Patient-identifying information relating to substance abuse and mental health treatment is lumped together under the phrase "behavioral health information" or "BHI."

the following is an illustrative, not exhaustive, sampling of authorization rules; there are additional privacy regimens, both federal and state, which provider organizations must contend with. In particular, this article illustrates the uneasy relationship between state and federal law pertaining to mental health records in light of the authorization requirements of ORS § 179.505 in section V.B., *infra*.

A. Part 2 Consent

When no exception to the disclosure prohibition exists for Part 2 BHI, "[a] written consent to a disclosure under these regulations [is required and] must include":

> (1) The specific name or general designation of the program or person permitted to make the disclosure.
> (2) The name or title of the individual or the name of the organization to which disclosure is to be made.
> (3) The name of the patient.
> (4) The purpose of the disclosure.
> (5) How much and what kind of information is to be disclosed.
> (6) The signature of the patient and, when required for a patient who is a minor, the signature of a person authorized to give consent under § 2.14; or, when required for a patient who is incompetent or deceased, the signature of a person authorized to sign under § 2.15 in lieu of the patient.
> (7) The date on which the consent is signed.
> (8) A statement that the consent is subject to revocation at any time except to the extent that the program or person which is to make the disclosure has already acted in reliance on it. Acting in reliance includes the provision of treatment services in reliance on a valid consent to disclose information to a third party payer.
> (9) The date, event, or condition upon which the consent will expire if not revoked before. This date, event, or condition must insure that the consent will last no longer than reasonably necessary to serve the purpose for which it is given.[17]

17. 42 C.F.R. § 2.31 (1995).

A sample consent form is set out in Part 2.[18] Oregon has a statutory form designed to meet the requirements of Part 2 and HIPAA.[19]

Note that the party disclosing Part 2 BHI can be identified with a "specific name or *general designation* of the program or person."[20] By contrast, the form requires greater specificity with respect to the recipient: the authorization must designate "the name or title of the individual or the name of the organization to which disclosure is to be made."[21] Note that the proposed rule amending Part 2 significantly broadens the acceptable description of recipients of Part 2 BHI, permitting a "general designation.

against use of the information for purposes of initiating a criminal investigation or criminal charges against the patient.[27]

2. Other Exceptions

HIPAA provides a dozen exceptions for disclosure in less common situations: judicial proceedings, public health reporting, criminal investigations, and national security.[33] Of particular importance is HIPAA's exception for uses or disclosures "required by law."[34] Other HIPAA exceptions may arise under state law (*e.g.*, mandatory public health reporting, discovery of health care records in judicial proceedings, etc.), but the "required by law" exception is a catchall for state or federal mandatory disclosures. HIPAA itself requires disclosure only to individuals seeking access to their own records and to the Secretary of Health and Human Services.[35] Thus, unlike Part 2, contrary state law is not preempted if it mandates disclosure. Literally, such state law is not "contrary to" HIPAA for preemption purposes.[36] This exception is significant for CCOs, which are required to share certain information among organizational participants.[37]

B. Part 2 Exceptions

Part 2 provides for authorization exceptions, but they are few and narrowly drawn. Generally, they are limited to specific contractual or administrative relationships.[38] They do not include, for example, nonemergency treatment of a patient. Some disclosures for what HIPAA describes as "health care operations" are permitted, but not many.[39] Two common sense exceptions are permitted: emergency medical treatment[40] and reports of suspected child abuse required by state law.[41]

IV. PREEMPTION

Both Part 2 and HIPAA provide for preemption of state law: 45 C.F.R. § 160.203, the HIPAA preemption rule, and 42 C.F.R. § 2.20, the Part 2 preemption rule.

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33. 45 C.F.R. § 164.512.

34. *Id.* § 164.512(a).

35. *Id.* § 164.502(a)(2).

36. *See infra* III.A.

37. OR. REV. STAT § 192.561(a) (2015).

38. 42 C.F.R. § 2.12(c).

39. *Compare* 45 C.F.R. § 160.103 ("health care operations"), *with* 42 C.F.R. § 2.12(c)(3)-(4) (exceptions).

40. 42 C.F.R. § 2.51.

41. *Id.* §§ 2.12(c)(6), 2.51.

A. HIPAA

HIPAA preempts state law that is "contrary to" the Privacy Rule, unless it is "saved" by one of four exceptions: (1) state law determined to be necessary for specified reasons by the DHS Secretary; (2) state law that is "more stringent" than the Privacy Standards; (3) state law providing "for the reporting of disease, injury, child abuse, birth or death, or for the conduct of public health surveillance, investigation or intervention"; and (4) state law governing accessibility to, or the reporting of, information in the possession of health plans.[42] Exception one has never been invoked, and exception four is not relevant to sharing BHI among providers. This article will not discuss those two exceptions.

The threshold question for establishing preemption is whether a state law is "contrary to" the Privacy Rule. A state law is "contrary to" the Privacy Rule if *either* (1) it is impossible to comply with both state law and the Privacy Rule, *or* (2) the state law "stands as an obstacle to the accomplishment and execution of the full purposes and objectives of [the Privacy Rule]."[43] An example of an "obstacle" is a state law permitting, but not requiring, disclosure of information for which the Privacy Rule requires confidentiality. A permissive state law, while not necessarily in conflict with the Privacy Rule, is nonetheless less protective of privacy and is preempted.

Where state law is more protective of privacy than the Privacy Rule, it is "more stringent" for preemption purposes.[44] In this circumstance, the Privacy Rule must give way to state law.[45] The Privacy Rule sets out six scenarios in which the effect of state law is more protective of privacy, more permissive with respect to individual access, or more demanding with respect to accounting for disclosures.[46]

In summary, covered entities and their business associates must comply with the Privacy Rule in addition to, or as modified by, more stringent state law requirements. At least 47 states have adopted

discretion about whether to disclose to parents. For example, ORS section 109.675(1) gives minors fourteen years of age or older the power of informed consent to treatment of a mental or emotional disorder, or treatment of chemical dependency by a physician, psychologist, nurse practitioner, clinical social worker, professional counselor or marriage or family therapist, or a community health program approved by rule to do so by the Oregon Health Authority (OHA).[60] However, ORS 109.675(2), requires parental involvement before the

2. Segmented Organizations

HIPAA's Privacy Rule recognizes that a single legal entity may have divisions within it that perform different functions, some related to the provision of health care and some not, called "hybrid" organizations.[66] Hybrid organizations are organizations with multiple covered entities under the same corporate roof, such as a health care provider and a health insurer, which have a boundary between them. Sharing between distinct units of a larger organization is a disclosure under HIPPA.[67] A clinically integrated care setting such as a hospital, where a patient typically receives care from more than one provider, or an organized healthcare system in which multiple covered entities participate and hold themselves out to the public as conducting a common enterprise, may qualify as an Organized Health Care Arrangement (OHCA).[68] Disclosures among participants in an OHCA are permitted by HIPAA without patient authorization. This is not the case with Part 2.

C. Personal Representatives

A recurring issue in the delivery of behavioral health is the identity and authority of personal representatives. Patients may lack capacity at the time they originally seek or receive care, or at the time of transition between care providers. A Personal Representative (PR) plays an important role in these times. Under both Part 2 and the HIPAA Privacy Rule, state law largely defines who may be a PR and when a PR may act on a patient's behalf, including consent to Part 2 BHI disclosures.

1. Part 2

Part 2 contemplates PRs in three categories: (1) when the patient has been adjudicated incompetent; (2) when the patient has not been adjudicated incompetent but lacks capacity in the professional judgment of the program director; and (3) when the patient is deceased.[69] Personal representatives for minors are conspicuously absent.[70]

In the first case, a court declares the patient incompetent to han-

66. 45 C.F.R. §§ 164.103, 164.105 (2013).
67. *Id.* § 164.504(g).
68. *Id.* § 160.103.
69. 42 C.F.R. § 2.15 (1987).
70. *See id.* § 2.14.

> [O]utpatient facilities, inpatient facilities, and other facilities the [Oregon Health Authority] determines suitable and that provide services that meet minimum standards established under ORS 430.357, any of which may provide diagnosis and evaluation, medical care, detoxification, social services or rehabilitation for alcoholics or drug-dependent persons and which operate in the form of a general hospital, a state hospital, a foster home, a hostel, a clinic or other suitable form approved by the [Oregon Health Authority].[79]

ORS section 430.399 is, in some respects, even more unqualified in its prohibition of disclosure than Part 2. The Oregon statute impliedly distinguishes between "records of a person" and the fact of the admission of the patient for treatment, but it contains none of the exceptions found in Part 2:

> The records of a person at a treatment facility or sobering facility may not, without the person's consent, be revealed to any person other than the director and staff of the treatment facility or sobering facility. A person's request that no disclosure be made of admission to a treatment facility or sobering facility shall be honored unless the person is incapacitated or disclosure of admission is required by ORS 430.397.[80]

In practice, ORS 430.399(6) has been limited to health care facilities, such as hospitals or residential treatment facilities, where inpatient, long-term, or continuing outpatient care is provided. Health care providers and their legal counsel have operated under this assumption at least in part to avoid the unqualified prohibition of ORS 430.399(6) and the obstacles to information-sharing that a broader application would entail.[81]

79. OR. REV. STAT. § 430.306(9) (2015).

B. ORS § 179.505

Behavioral health information that is not subject to Part 2 or ORS 430.399 falls under HIPAA or, when it is "more stringent," ORS 179.505. Behavioral health information subject to ORS 179.505 is generally records of mental health and developmental disability services.

ORS 179.505 is directed at "public providers" and "health care services providers" that contract with them.[82] Given the dominant role of state and local agencies in behavioral healthcare delivery, most of the state's mental health providers are swept up in ORS 179.505. The records protected by ORS 179.505 are described as "written accounts," which contain "individually identifiable health information."[83]

ORS 179.505(3) generally requires written authorization for disclosure by the patient or the patient's personal representative, which must contain specified information.[84] A "personal representative" may be an appointee under a number of state statutes cited in ORS 179.505(1)(d), but "is not limited to" such appointed persons.[85] It is likely that other persons, such as parents, persons acting *in loco parentis*, or persons appointed under the laws of a different state, could be treated as "personal representatives."[86]

1. Interpreting ORS 179.505(2)

Access or disclosure of BHI without patient consent is authorized by the subsections listed in ORS 179.505(2), "or unless otherwise permitted or required by state or federal law or by order of the court."[87]

The legislature has enacted subsequent statutes, most recently

treatment, payment, and health care operations.[89] Presumably that prefatory phrase is unnecessary if an expansive interpretation of ORS 179.505(2) is correct. Basic statutory construction principles provide, "where there are several provisions or particulars such construction is, if possible, to be adopted as will give effect to all."[90] To facilitate information sharing among healthcare providers, the better argument may be to defer to the specific provisions of ORS 179.505(2) in the case of a "health care services provider" under contract with a "public provider" under ORS 179.505.[91]

Note that ORS 179.505(14), like Part 2, contains a prohibition against "redisclosure" of BHI obtained under the statute.[92] Subsection (14) permits "redisclosure" only in compliance with ORS 179.505(2).[93] Unlike HIPAA, which regulates PHI only in the hands of covered entities or business associates, the "redisclosure" prohibi-

the exchange of health information or a research institution."[104] This latter provision is intended to facilitate information sharing by health information exchanges (HIE), accountable care organizations (ACO), and CCOs.[105]

> The Department is concerned by the multitude of comments and examples demonstrating that the consent requirements result in unintended consequences that impede the provision of health care in many critical circumstances and that other such unintended consequences may exist which have yet to be brought to its attention.[113]

The proposed amendment of Part 2, of course, does not lift the consent requirement, it merely loosens it a bit. The requirement of consent remains a problem however prescribed. In combination with Part 2's sweeping preemption of state law, surviving state laws more stringent than even Part 2, and HIPAA's deference to other federal law and more stringent state law, integrated networks are either prohibited from sharing data when and where it is needed, or are unclear about what law controls.

The health care sector must be modernized, made more efficient, cost-effective, and integrated. Digital technology that is revolutionizing other sectors of the economy is absent or ineffective in health care. While by no means the only reason, the patchwork quilt of privacy regulation, and the fear of accompanying liability, is a significant obstacle to applying 20th century technology to our 21st century health care system. Compared to other obstacles to efficiency in the health care sector, conflicting and unnecessarily onerous privacy regulation is low hanging fruit.

Health care confidentiality is no longer a local concern best left to the states. Two developments argue for a single, federal standard. The first is the consolidation and vertical integration of insurance companies and health care systems. These larger and more complex organizations routinely cross state lines. Varying state privacy laws already impose a "highest common denominator" standard on interstate organizations; however, the highest common denominator strategy is unduly cumbersome when the denominator changes with new state laws and new federal preemption analysis. The most obvious example can be seen in the "mission creep" of state laws originally addressed to identify theft and remediation that have been given broader subject matter application and more demanding requirements.[116]

The second development is the need to integrate mental health and substance abuse treatment with primary, acute, and dental care. The behavioral health population utilizes health care services at the rate of $57 billion a year, the vast majority of which is medical and acute care, not behavioral health.[117] Appropriate utilization is a chronic problem with this population.[118] Population-level health strategies are difficult to implement in an uncertain and shifting legal environment. A single, federal standard governing all health information is both necessary and desirable.

HIPAA is the obvious platform for this single, federal standard. It brooks no carelessness with patient information, but it accounts for

When Does the Privacy Rule Allow Covered Entities to Disclose Protected Health Information to Law Enforcement Officials?, UNITED STATES DEPT. OF HEALTH & HUMAN SERVICES (2004), http://www.hhs.gov/ocr/privacy/hipaa/faq/disclosures_for_law_enforcement_purposes/505.html.

116. *E.g.*, 2015 Or. Laws ch. 357 (amending ORS 646A.600) (the Oregon Consumer Identity Theft Protection Act).

117. Klein & Hostetter, *supra* note 8.

118. *Id.*

404.