

The role of government in health care in the United States has historically recognized the market system as the most appropriate setting for the exchange of health services but has generally stepped in to meet perceived needs when they are not being met by the private sector. Furthermore, the federal government steps in only after state and local governments have failed to meet those needs as well. After exploring the policy making process at the federal level, it is no wonder that they miss the mark so often even when approaching a problem with the best of intentions. The Health Insurance Portability and Accountability Act (HIPAA) is another example of Congress leaving lawmaking to the administrators. When Congress failed to pass laws establishing privacy standards for the handling and transmission of personal health information by a preset deadline, the Secretary of Health and Human Services was then authorized to provide such standards. Among other provisions, this act provides for administrative simplification and preservation of privacy and confidentiality. These two areas have impacts upon health care providers, administrators, and consumers. They also pose challenges in terms of managing health systems.

One of the original intents of HIPAA was to create administrative simplification by establishing standards that would enable most health and financial records to be exchanged electronically. This would include unique identifiers for users, purchasers and suppliers that would be set by a national standard setting group. It would also allow for electronic signatures, yet imply system security and impose strict penalties on those in non-compliance starting eighteen months after enactment. As with most government programs, this started with good intentions and even projected estimated savings between nine and forty-two billion dollars. However, the execution has proven to be far more complicated than anticipated and the cost savings are just not there.

For health care providers, the promise of instantaneous access to more accurate, reliable and useful health information must be balanced with the initial costs of converting to such a new system of handling health information. These costs would include training administrative and health care personnel as well as any computer hardware and software upgrades necessary. On the administrative side, again, the improved accuracy and reliability of information would prove useful. In fact, administrators perhaps stand to benefit the most from these provisions, as streamlined processes would make it easier for them to share required information between payers and suppliers. Improved efficiency should ultimately lead to improved quality of care at decreased cost. For consumers, theoretically these cost savings would be passed on to them. Another advantage they would see would be reduced paperwork and fewer hassles with access and payment. However, the reality is that these costs, to cover the increased burden on the health care system, would be passed on to the consumer as higher health care insurance premiums and increased taxes. The biggest foreseeable challenge with these administrative simplification provisions would be reconciling the real start-up costs with the “estimated” savings. Such a consolidated, universal system would be likely to develop in a market economy anyway as organizations sought to streamline their own systems for efficiency and profit. However, to force these changes with a deadline and impose severe penalties for non-compliance is more bureaucratic involvement than most private businesses want to see.

The privacy and confidentiality provisions raise even more questions and debate. These provisions were in fact the first comprehensive federal protection for the privacy of health information. Their roots probably lie in the 1980 change to the American Medical Association code of ethics. For decades prior, confidences could be revealed if: 1.) required by law; 2.) necessary to protect the welfare of the individual; and 3.) necessary to protect the welfare of

society. In 1980, these second and third exceptions were eliminated, removing all discretion in such matters from the medical profession and placing it in the hands of legislators and lawyers even less qualified to deal with matters of medical ethics than those providers who must live every day with the consequences of their decisions (Bioethics, 78-79). Policy makers and health care providers and administrators were in general agreement that this protection must not interfere with access to, or quality of, health care. The need for such complex privacy legislation stems from the complexity of today's health care system and the involvement of so many more players than the fee-for-service days of old. Some of the provisions include electronic, paper, or verbal consent which must be obtained for TPO described in organizations' Notice of Privacy Practices as well as a "minimum necessary" standard applied to all information sharing except that involving actual treatment from a health care provider. The punishment for violations of these provisions is very severe and does not distinguish well between mistakes and malfeasance. These provisions would also become a new IRB standard after informed consent.

The impact of the privacy and confidentiality provisions on providers would be profound. There would be an increased burden on an already over-worked system. The heightened anxiety of litigation would also lead to reluctance of providers to give any information to researchers for fear that some small piece of personally identifiable information might not have been removed. There are also concerns that medical student training would be impeded by the lack of access to complete patient health records. Also medical research could be stymied because information that might finally be obtained from reluctant providers would be so watered down as to be of little practical use. On the positive side, these provisions might lead to increased trust between patients and providers that would improve disclosure and ultimately quality of care.

For administrators, there would be a host of implied tasks including reviewing current patient information flow, doing gap analyses, adjusting policies as necessary, and re-training the work force. As with administrative simplification, the changes could greatly streamline processes; however, these gains must all be balanced with the increased cost, burden of regulations and potential for penalties and litigation.

Consumers, as always, stand to be the ultimate losers. Costs would be passed on, as above, with higher premiums and increased taxes. The impact on research could ultimately decrease the quality of health care they receive. Obviously, the provisions provide the consumer with a number of “rights” and protections increasing control over health information, but what the consumer would be more likely to notice would be the incessant requests for consent to release their information. Their rights would include written notice of information practices, access to inspect and receive a copy of their personal health information, requests for amendments or corrections to their records and requests to restrict the use or disclosure of their records in any form to anyone. Whether such considerations of confidentiality would impact at all on patients’ use or willingness to use healthcare services is subject to considerable debate. If one were to discover that 75 or more medical, administrative, and support staff have access to any one individual medical record in a typical hospital (NEJM, Dec. 9, 1982), would it deter that person from seeking hospital care when needed? Only the consumer can and should decide this.

So again, the greatest challenge to the privacy and confidentiality provisions of HIPAA, as with the administration simplification ones, is cost. At some point society, at one level or another, will be forced to decide upon the real value of privacy when compared to the other competitors of scarce resources in health care. Other challenges in this area, such as ensuring the security of electronic information, pale in comparison to this. Ultimately, you may get that

privacy for which you are willing to pay. It may be inherent to an insurance policy in which higher premiums are paid for better guarantees of privacy, or perhaps such decisions will be made on an individual basis. Every time a patient is presented with a consent form for release of personal health information, it will be accompanied by a billing alternative, in other words, what it would cost to keep that particular health transaction private. Of course, just as there would be a certain level of equitable health care provided to all (though heretofore undecided upon by anyone), confidentiality would be preserved to a reasonable extent within the confines of the health care system. But beyond that basic standard of care, premium insurance or out-of-pocket expense would have to cover the differential we will inevitably come upon if we continue to invent “rights” that increasingly impose on or require the services of others.

HIPAA provisions in the areas of administrative simplification, and more specifically privacy and confidentiality, have had, and promise to continue to have, striking impact on providers, administrators, and consumers of health services. Regardless of intent, such legislation tends to create so many bureaucratic obstacles as to create more problems than it fixes. The longer we take as a society and a people to make real decisions regarding the fundamental values involved in health care and its universal provision, the more piecemeal legislation such as HIPAA we will subject ourselves to. By the very nature of the process through which it is produced, such legislation will continue to provide temporary, painful remedies to wounds which really need definitive treatment from a well-defined standard of care and a distinct, acceptable funding mechanism.