



***NEW LAW RELATING TO HEALTH CARE INFORMATION
(1997 WISCONSIN ACT 231)***

Information Memorandum 98-5

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INTRODUCTION

This Information memorandum describes 1997 Wisconsin Act 231, which relates to the collection, analysis and dissemination of health care information by the Department of Health Family Services (DHFS). Part I. provides background information and Part II. describes changes made by Act 231.

Act 231 originated as 1997 Senate Bill 315, which was introduced by the Joint Legislative Council on the recommendation of the Council's Special Committee on Health Care Information.

Act 231 makes modifications in ch. 153, Stats., which governs collection, analysis and dissemination of health care information by DHFS's Office of Health Care Information (OHCI). Generally, DHFS currently undertakes these functions only for information from hospitals and ambulatory surgery centers. In addition, Act 231 includes provisions relating to confidentiality of patient information, including statutes governing DHFS and statutes governing insurers. In signing Act 231, the Governor partially vetoed certain portions of the Enrolled Bill, including provisions relating to disposal by businesses of records containing personal information.

The general effective date of Act 231 is **May 14, 1998**. However, the provisions on disclosure of personal medical information by insurers take effect on June 1, 1999.

A copy of 1997 Wisconsin Act 231 may be obtained from the Documents Room, Lower Level, One East Main Street, Madison, Wisconsin 53702; telephone: (608) 266-2400.

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I. BACKGROUND

This Part of the Information Memorandum describes the history and the powers and duties of OHCI and DHFS before enactment of Act 231. OHCI is the entity within DHFS that collects health care information and prepares specified reports under ch. 153, Stats.

A. HISTORY AND CURRENT STATUS OF OHCI AND RELATED ENTITIES

OHCI was established by 1987 Wisconsin Act 399 (the 1988 Annual Budget Act) as a bureau-level office within the Division of Health in the Department of Health and Social Services, the predecessor agency to DHFS. In addition to creating OHCI, 1987 Wisconsin Act 399 created the Board on Health Care Information, which was attached for administrative purposes to the department and consisted of seven members, a majority of whom could neither be nor represent health care providers.

Act 399 also created ch. 153, Stats., with many of the same provisions that existed in the statutes prior to enactment of 1997 Wisconsin Act 231, including provisions for required reports, data verification, patient confidentiality and assessments to fund the operations of OHCI and the board. Chapter 153, Stats., is described in greater detail in the next portion of this Information Memorandum.

In 1993, OHCI and the Board on Health Care Information were transferred to the Office of the Commissioner of Insurance by 1993 Wisconsin Act 16 (the 1993-95 Biennial Budget Act). However, a September 1996 memorandum of understanding entered into between the Office of the Commissioner of Insurance and DHFS “effects the interchange” between the Office of the Commissioner of Insurance and DHFS of the services of all OHCI employees under ch. 153, Stats. Under the memorandum of understanding, the interchanged employees were “on detail” to DHFS and were solely responsible to DHFS for performance of their assigned duties and responsibilities. In 1997 Wisconsin Act 27 (the 1997-99 Biennial Budget Act), this interchange was statutorily codified and OHCI’s powers and duties were transferred to DHFS.

OHCI’s budget has been funded primarily through assessments on hospitals and ambulatory surgery centers. Under the statutes, OHCI is required to estimate, by each October 1, the total amount of expenditures for OHCI and the board for the fiscal year. Hospitals are assessed in proportion to each hospital’s respective gross private-pay patient revenues and must pay the assessment on or before December 1. The remainder of OHCI’s budget is funded through other program revenue sources.

The **Board on Health Care Information** was increased by 1995 Wisconsin Act 433 from seven to nine members. Under s. 153.07, Stats., the board is given the duty to do the following: (1) advise the director of OHCI with regard to the collection, analysis and dissemination of health care information; (2) upon the advice of OHCI, determine whether to contract for services; and (3) approve all rules that are proposed for promulgation to implement ch. 153, Stats.

In addition, 1995 Wisconsin Act 433 created an *Interagency Coordinating Council* in the Department of Administration (DOA). The council consists of the following: (a) the Secretary of Employee Trust Funds or his or her designee; (b) a representative of the unit in DHFS that deals with health statistics; (c) a representative of the unit in DHFS that deals with the Medical Assistance program; (d) a representative of the unit in DHFS that deals with health care information; (e) a representative of the unit in the University of Wisconsin (UW) System that deals with health statistics and research analysis; and (f) a representative of the unit in DOA that deals with information technology.

The Interagency Coordinating Council is required to report at least twice annually concerning its activities to the Board on Health Care Information. The statutes give the council the duty to “. . . serve as a means of increasing the efficiency and utility and facilitating the effective functioning of state agencies in activities related to health care data collection.” The council is required to advise and assist state agencies in the coordination of health care data collection programs and the exchange of information related to health care data collection and dissemination, including agency budgets for health care data collection programs, health care data monitoring and management, public information and education, health care data analysis and facilities, research activities and the appropriation and allocation of state funds for health care data collection.

B. RELEVANT POWERS AND DUTIES OF DHFS BEFORE ACT 231

Chapter 153, Stats., states that “(i)n order to provide hospitals, health care providers, insurers, consumers, governmental agencies and others information concerning hospital service utilization, charges, revenues, expenditures, mortality and morbidity rates and uncompensated health care services, and in order to provide information to assist in peer review for the purpose of quality assurance . . . [DHFS] is required to collect, analyze and disseminate, in language that is understandable to lay persons, health care information . . .” from five specified data sources.

The statutes provide that prior to data submission, hospitals, ambulatory surgery centers or other health care providers must review discharge data for accuracy and obtain verification by the physician of the principal and secondary diagnoses and primary and secondary procedures. DHFS is responsible for assuring that appropriate editing is conducted for all submitted data. After completion of data verification and review procedures, DHFS is required to release data in specified forms.

The statutes provide that patient-identifiable data obtained under ch. 153, Stats., and contained in the discharge database of DHFS is not subject to inspection, copying or receipt under the Open Records Law and may not be released by DHFS, except to the patient or person granted permission for release by the patient. In addition, a hospital, a physician or the agent of a hospital or physician may have access to patient-identifiable data to ensure the accuracy of the information in the discharge database. Administrative rules provide that certain data elements from the uniform patient billing form are considered confidential. The rules also provide that, to ensure protection of the identity of patients when information generated by DHFS is released,

any data element category containing a small number of data elements must be aggregated using procedures developed by DHFS and approved by the Board on Health Care Information.

The statutes provide that any person violating the confidentiality statute or rules promulgated under the statute is liable to the patient for actual damages and costs, plus exemplary damages (punitive damages) of up to \$1,000 for a negligent violation and up to \$5,000 for an intentional violation. In addition, whoever intentionally violates that statute or the rules promulgated under the statute may be fined not more than \$10,000, imprisoned for not more than nine months, or both.

Prior to enactment of Act 231, the statutes listed a number of reports that DHFS is responsible for preparing. Those reports are: quarterly and annual health care data reports; an annual small area analysis report; an annual mortality and morbidity report and an annual hospital report relating to charge elements and comparisons between hospitals. In addition to these required reports, DHFS was given authority to prepare an annual report on health insurance coverage.

Finally, the statutes require DHFS to prepare an annual report setting forth the number of patients to whom uncompensated health care services were provided by each hospital and the total charges for the uncompensated health care services provided to the patients for the preceding year, together with the number of patients and total charges that were projected by the hospital for that year. Every hospital is required to file with DHFS an annual report setting forth the projected number of patients to whom uncompensated health care services will be provided by the hospital and the projected total charges for the uncompensated health care services to be provided to the patients for the ensuing year.

Although the statutes do not define “uncompensated health care services,” administrative rules define “uncompensated health care services” as charity care and bad debts. The terms “charity care” and “bad debt” are also defined by rule.

II. PROVISIONS OF 1997 WISCONSIN ACT 231

This Part of the Information Memorandum describes how Act 231 changes the laws described above with respect to collection, analysis and dissemination of health care information.

A. INFORMATION SOURCES; REQUIRED REPORTS

Act 231 deletes from the statutes the specific sources of health care information collected for purposes of ch. 153, Stats., and the specific reports DHFS is required to prepare periodically, except the annual report on uncompensated health care services provided by hospitals. These provisions are replaced by provisions requiring DHFS to specify by rule the standard reports that it will issue and the uniform data set of health care information to be collected and other details relating to collecting, using and disseminating data. As with other rules under ch. 153, Stats., these rules have to be approved by the Board on Health Care Information. Information about additional rules required by Act 231 is set forth below in Section C.

In addition to the report on uncompensated health care services, which is retained from current law, the Act requires DHFS to prepare an annual consumer guide to assist consumers in selecting health care providers and health care plans. The Act also requires DHFS to prepare a report on the feasibility of requiring annual reports and plans on uncompensated health care services (i.e., charity care and bad debt services) from major health care providers other than hospitals, which are already required to prepare these reports and plans.

B. ASSESSMENTS ON HEALTH CARE PROVIDERS

Act 231 modifies the current law on assessments on hospitals and ambulatory surgery centers to fund activities under ch. 153, Stats., by instead requiring assessments on health care providers who are in a class of health providers from whom DHFS collects data under ch. 153, Stats. The classes of health care providers from whom claims data and other health care information is collected and the methods and criteria for assessing those health care providers must be specified by DHFS by rule. The actual amounts of the assessments would not be set by rule, but for health care providers other than hospitals and ambulatory surgery centers, the amounts must be approved by the Board on Health Care Information. A health care provider that is not a facility may not be assessed more than \$75 annually.

Act 231 requires DHFS and the Department of Regulation and Licensing to work together to develop a mechanism for collecting assessments from health care providers other than hospitals and ambulatory surgery centers.

A later legislative enactment, 1997 Wisconsin Act 237 (the 1998 Budget Adjustment Act), appropriated \$250,000 general purpose revenue for fiscal year 1998-99 for the collection of physician encounter data. This appropriation is "sunsetting" as of July 1, 1999.

C. RULE PROMULGATION

Act 231 requires DHFS to promulgate rules that do all of the following:

1. Specify the classes of health care providers from whom claims data and other health care information will be collected.
2. Specify the uniform data set of health care information, as adjusted for case mix and severity, to be collected.
3. Specify the means by which information will be collected, including procedures for submission of data by electronic means.
4. Specify the methods for using and disseminating health care data in order for health care providers to provide health care that is effective and economically efficient and for consumers and purchasers to make informed decisions in selecting health care plans and health care providers.
5. Specify the information to be provided in the annual consumer guide required under the Act.
6. Specify the standard reports that will be issued by DHFS in addition to the required report on uncompensated health care services provided by hospitals and the annual consumer guide.
7. Define “individual data elements” for purposes of the new statute that requires DHFS to prohibit purchasers of data from rereleasing individual data elements of data files.
8. Establish standards for determining if a requirement to submit health care information is burdensome for a health care provider.
9. Specify the methods for adjusting health care information for case mix and severity.

In addition, as described above, Act 231 modifies the provision in prior law that requires DHFS to promulgate rules establishing methods and criteria for assessing hospitals and ambulatory surgery centers for DHFS activities under ch. 153, Stats. The reference to “hospitals and ambulatory surgery centers” is changed to “health care providers.”

As with rules required under prior law, the above rules may be promulgated by DHFS only if they are approved by the Board on Health Care Information.

D. BOARD ON HEALTH CARE INFORMATION--COMPOSITION; DUTIES

Act 231 modifies the composition of the Board on Health Care Information. Under the Act, the board consists of 11 members, one of whom is a record administrator and five of whom must be or represent health care providers, including one registered nurse and two physicians.

The State Medical Society may recommend board membership for five physicians, one of whom the Governor must appoint.

The Act requires the board and DHFS jointly to: (1) provide oversight on standard reports; (2) develop the overall strategy and direction for implementation of ch. 153, Stats.; and (3) provide information on their activities to the Interagency Coordinating Council. In addition, the Act 231 repeals the required approval of the board for contracts under ch. 153, Stats.

E. INTERAGENCY COORDINATING COUNCIL

Act 231 changes the membership of the Interagency Coordinating Council to add a representative from the Office of the Commissioner of Insurance. In addition, the Act requires the Interagency Coordinating Council to establish methods and criteria for analyzing and comparing complaints filed against health care plans and grievances filed with health maintenance organizations, without requiring the collection of information in addition to what is already collected by state agencies.

F. CONFIDENTIALITY OF PATIENT INFORMATION

Act 231 repeals and recreates the statute on patient confidentiality. Under the Act, patient-identifiable data are not subject to inspection, copying or receipt under the Open Records Law. “*Patient-identifiable data*” are defined as patient medical record or chart number, patient control number, patient date of birth, date of patient admission, date of patient discharge, date of patient’s principal procedure, encrypted case identifier, insured’s policy number, patient’s employer’s name, insured’s date of birth, insured’s identification number, Medicaid resubmission code and Medicaid prior authorization number.

The Act provides that patient-identifiable data, as described in the previous paragraph, may be released only to the following:

1. The patient or a person granted written permission by the patient.
2. An agent of DHFS who is responsible for the data, in order to store it or ensure the accuracy of the information in DHFS’s data base.
3. A health care provider or the provider’s agent, to ensure the accuracy of the information in DHFS’s data base.
4. DHFS, for purposes of epidemiological investigation or to eliminate the need for duplicative data bases.
5. An entity that is required by federal or state statute to obtain patient-identifiable data for purposes of epidemiological investigation or to eliminate the need for duplicative data bases.

The Act specifies a procedure for the above authorized persons or entities to request release of patient-identifiable data. The Act specifies what such a request must include.

The Act also requires DHFS to undertake certain activities to ensure that the identity of patients is protected when information is disseminated. First, DHFS must aggregate any data element category containing "small numbers," as defined in the Act. Second, DHFS must remove and destroy the following data elements on uniform patient billing forms: the patient's name and street address; the insured's name, address and telephone number; any other insured's name, employer name and date of birth; the signature of the patient or other authorized signature; the signature of the insured or other authorized signature; and the signature of the physician.

The Act specifies that DHFS may not require a health care provider submitting health care information under ch. 153, Stats., to include the patient's name, street address or Social Security number.

In addition, the Act requires DHFS to prohibit purchasers of data from rereleasing individual data elements (as defined by rule) of health care data files.

G. DISCLOSURE OF PERSONAL MEDICAL INFORMATION BY INSURERS

Act 231 creates a provision relating to disclosure of personal medical information by insurers. A form that is used in connection with an insurance transaction and that authorizes the disclosure of personal medical information must comply with specified requirements. The Act specifies the maximum length of time that a disclosure authorization may be in effect.

The Act also sets forth requirements for access by an individual to his or her personal medical information held by an insurer. A procedure is set forth by which a person may make a request to correct, amend or delete certain personal medical information held by an insurer.

The Act also contains provisions regarding when disclosure by an insurer of personal medical information is permitted. Immunity is provided for persons who disclose personal medical information in accordance with the statutes or furnish personal medical information to an insurer or insurance support organization in accordance with the statutes, unless the person discloses or furnishes false information with malice or intent to injure a person. Criminal penalties are provided for any person who knowingly and wilfully obtains information about an individual from an insurer or insurance support organization under false pretenses; such a person may be fined not more than \$10,000, imprisoned for not more than one year in the county jail or both.

H. CRIMINAL PROVISIONS

Act 231 creates two other new crimes in addition to the new crime described in the previous paragraph:

1. The Act prohibits DHFS from releasing any health care information that is subject to the department's rules on review, verification and comment until those rules have been complied with. Whoever intentionally violates this prohibition may be fined not more than \$10,000, imprisoned for not more than nine months, or both.

2. The Act creates a new crime in the criminal extortion statute, relating to maliciously using or threatening to use patient health care records for purposes of extortion or to compel a person to do an act against his or her will or omit to do any lawful act. A violator is subject to a Class D felony, punishable by a fine of not more than \$10,000, imprisonment for not more than five years, or both.

I. OTHER PROVISIONS RELATING TO PROVIDER INFORMATION

Act 231 contains a number of other provisions relating to health care provider information, including the following:

1. DHFS may waive data submission requirements for a health care provider who requests a waiver and presents evidence to DHFS that the requirements are burdensome, under standards established by DHFS by rule. DHFS is required to develop a waiver request form.

2. Health care provider-identifiable data obtained under ch. 153, Stats., is not subject to inspection, copying or receipt under the Open Records Law.

3. DHFS is allowed to provide and release special data compilations, but is not required to do so.

4. The information under ch. 153, Stats., must be adjusted for case mix and severity. DHFS is required to specify by rule the methods for adjusting health care information for case mix and severity.

5. Several references in current law regarding data verification and review procedures are changed to refer instead to data verification, comment and review procedures, thereby providing for provider comment on data before release. Data that are released would include the comments.

6. DHFS is required to develop a plan for the correction of erroneous data collected under ch. 153, Stats. DHFS may not implement procedures under the plan unless the plan is approved by the Board on Health Care Information. DHFS is required to implement the procedures at the time data are first collected from health care providers.

7. DHFS is required to report on whether health care information that is collected under ch. 153, Stats., from a physician who is a member of the faculty of a medical school should be adjusted to reflect services rendered by residents or fellows in medical education who are under the supervision of the physician. The report must be submitted to the Legislature and

the Governor by July 1, 1999. The appropriation to DHFS is increased by \$5,200 for fiscal year 1998-99 to contract for the preparation of the report.

J. HEALTH PLAN REPORTING

Act 231 requires DHFS to study a voluntary system of health plan reporting and allows DHFS, based on the results of the study, to develop and implement a system that enables purchasers and consumers to assess the performance of health care plans and the health care providers that are employed or reimbursed by the health care plans. DHFS is required to undertake the study and any development and implementation in cooperation with private health care purchasers, the Board on Health Care Information, the Department of Employee Trust Funds, the Office of the Commissioner of Insurance, the Interagency Coordinating Council, major associations of health care providers, health care plans and consumers.

If DHFS collects health care provider-specific data from health care plans, it must attempt to avoid collecting the same data from health care providers.

K. HOSPITAL RATE INCREASES

Act 231 modifies the current law that requires that before a hospital increases its rates by more than the increase in the Consumer Price Index, it must publish a notice and hold a public hearing. The Act eliminates the requirement that a public hearing be held. In addition, the Act requires that the notice be published in the area where the hospital is located and eliminates the alternative of publishing the notice in the official state newspaper.

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