



# **Statement**

**of the**

**American Medical Association**

**to the**

**Committee on Energy and Commerce**

**Subcommittee on Health**

**U.S. House of Representatives**

**Re: Discussion Draft of Health  
Information Technology and Privacy  
Legislation**

**June 4, 2008**

**Division of Legislative Counsel  
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**RE: “Discussion Draft of Health Information Technology and Privacy Legislation”**

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Thank you Chairman Pallone, Ranking Member Deal, and Members of the Subcommittee on Health for inviting me to provide comments on three primary elements being considered as part of the Committee’s draft legislation on health information technology (HIT) and privacy. On behalf of our physician and medical student members, the American Medical Association (AMA) appreciates the opportunity to submit our statement on HIT. We hope our comments provide you with further guidance on legislative mechanisms needed to incentivize the rapid adoption of HIT. We commend the Subcommittee for recognizing the importance of moving toward an interoperable, nationwide HIT infrastructure and the crucial role the federal government plays in assisting the health care industry to accelerate the adoption and implementation of HIT systems and tools. When implemented properly in a connected environment, widespread HIT adoption will transform the practice of medicine and provide physicians with a powerful tool by putting real-time, clinically relevant patient information and up-to-date clinical decision

support tools in practitioners' hands at the point of care. Physicians agree that HIT is a means to improve patient safety, advance care coordination, and increase administrative efficiency. In order to achieve this reality, a coherent HIT environment will need to be highly connected, secure, affordable, and be integrated into the typical workflow of medical practices as diverse as those in large hospitals, community health centers, and among rural solo practitioners.

The AMA urges policymakers to give careful consideration to several points. HIT systems must operate in a robust network, which enables data to flow smoothly among health professionals and the differing HIT systems they rely upon. At present, the lack of connectivity among HIT systems presents a serious barrier to the effectiveness of HIT to significantly improve health care delivery. In addition, privacy and security of patients' confidential medical information should be of paramount concern. In an era when a patient's private, sensitive health care information can be made public with the touch of a button, it is imperative that strong privacy and security standards and protections be in place and be enforced against all parties that exchange, use, disclose, store, or otherwise handle patient health information. All sectors of the health care industry will benefit from physician HIT adoption, including the federal government, private payers, and consumers. Thus, any legislative proposal intended to promote widespread HIT must provide financial incentives that address true direct and indirect costs of adoption. Accordingly, the AMA urges Congress to provide direct financial assistance for physicians to adopt HIT, especially since physicians continue to face shrinking payer revenues that have failed to keep pace with the costs of their practices. We appreciate your consideration of our

comments and welcome the opportunity to work closely with you to promote HIT during this important and pivotal time for our health care delivery system.

### **A Connected HIT Environment**

Perhaps the largest impediment to the effectiveness of HIT is the lack of connectivity of health care data among health care providers. Currently, most health care data, whether on paper or electronic, are trapped in "silos." As a result, a patient may have a physician or health system that uses HIT, but if that patient requires care elsewhere, the information from that system may not be accessible. A report from the Institute of Medicine has noted that "health information exchange," the anytime, anywhere access to clinical care information across traditional business boundaries, is essential for improving health care quality. HIT is simply a tool that enables users to more effectively store and manage data. However, without the necessary data, the value of HIT is significantly constrained. Therefore, the real benefits of HIT will only be realized in a highly networked environment in which data is liberated from those silos and shared appropriately with health care providers.

According to a February 2008 Government Accountability Office (GAO) Report, the U.S. Department of Health and Human Services (HHS) has not yet developed a national strategy that defines plans, milestones, and performance measures for reaching the President's goal of interoperable electronic health records by 2014. The GAO recommends that HHS establish detailed plans and milestones for the development of a national HIT strategy and take steps to ensure that its plans are followed and that milestones are met. A national strategic plan for developing HIT policies, standards,

implementation and interoperability specifications for an interoperable nationwide HIT infrastructure, which sets milestones and performance measures is needed. Currently, there are multiple government initiatives involved with HIT, including the Certification Commission for Healthcare Information Technology (CCHIT), the Healthcare Information Technology Standards Panel (HITSP), the National Institute of Standards and Technology (NIST), and the federal advisory committee known as the American Health Information Community (AHIC) and its future successor (AHIC 2.0). It is essential that this myriad of federal initiatives be coordinated to avoid conflicts and the duplication of efforts and that each agency focuses on areas of its greatest expertise and technical capability. Moreover, appropriate input from expert stakeholders into the development of interoperable, technical standards, implementation specifications, and certification criteria for health information exchange is critical. Expert stakeholders must be involved throughout the standard development process, including physicians who will use and are expected to invest most heavily in these advanced systems. Current government initiatives and advisory committees should incorporate greater physician representation and involvement, especially representation from small medical practices.

### **Privacy and Security of Patient Health Information**

The AMA urges policymakers to make privacy and security of patient medical information a top priority. Privacy and security of patient information is a principle that physicians take very seriously. Information disclosed to a physician during the course of the patient-physician relationship is confidential to the greatest possible degree. Respect for patient

privacy is a fundamental expression of patient autonomy and is a prerequisite to building the trust that is at the core of the patient-physician relationship.

Physicians and others in the health care industry have devoted substantial resources and staff time to retooling their privacy policies and daily work flow practices to comport with the demands of the Health Insurance Portability and Accountability Act of 1996 Privacy Rule (HIPAA). Physicians would be reluctant to revisit this issue again so soon without assurances that the highest possible privacy and security protections are implemented without impeding their office practices. The AMA cautions against restricting or imposing additional requirements on physicians for the use and disclosure of health information that is currently authorized under HIPAA for treatment, payment, and health care operations purposes. These current permitted uses and disclosures are critical for ensuring that patients' access to care is not impeded or delayed.

Currently, the HIPAA Privacy Rule applies only to health plans, health care clearinghouses, and health care providers—so-called “covered entities.” Yet, there are other parties that work with confidential health care records that are not required to comply with privacy rules. Examples of parties that may receive and use information and who are not covered by HIPAA include workers compensation carriers, researchers, life insurance issuers, employers, marketing firms, HIT and personal health record (PHR) vendors, and health information exchanges (HIEs). Many of the parties that covered entities contract with to perform administrative, legal, accounting, and similar services on their behalf, and that would obtain health information in order to perform their duties (called “business associates”), are beyond the law’s authority to directly regulate or sanction. These gaps in

federal privacy protection coverage leave large volumes of identifiable health information vulnerable to improper access and disclosure without meaningful enforcement mechanisms or remedies. Forming a national health information infrastructure without adequate federal privacy protections threatens not only the privacy of patients, but also the viability of such a system. Patients cannot be placed in the untenable situation of being forced to withhold sensitive information essential to their diagnosis and treatment out of fear it may be improperly disclosed. Patients must believe in the security of their records for any HIT system to work. As we continue to move toward the electronic exchange of health information, it is crucial that protecting the privacy of health information remain a central element. Federal law also should ensure that those who improperly obtain, use, or disclose health information are subject to civil and criminal penalties. Therefore, we appreciate your efforts to expand the HIPAA Rules to directly cover additional parties involved in the electronic exchange, storage, use, or handling of health information that are not currently covered by the HIPAA Privacy and Security Rules.

### **Financial Incentives to Spur HIT Adoption**

While physicians are optimistic about the promise that HIT holds to transform patient care through better access to patient records and improved office efficiencies, the adoption rate among physicians still remains relatively low. Approximately 20 percent of physicians in practices employing 21 or more physicians have some form of HIT, while adoption rates among smaller practices with 5 or fewer physicians range from 12 to 13 percent.

Significant adoption barriers remain—these include lack of financial incentives, training, and technical support. In fact, there may be significant first-mover disadvantages because

early adopters are likely to pay the initial costs without receiving the benefits that will accrue only when a truly networked HIT system exists. The Congressional Budget Office (CBO) reported last month that HIT will not produce the extraordinary savings originally claimed by many including widely-cited reports that estimated that the use of HIT would result in \$80 billion in net savings annually. CBO further stated that such reports “appear to significantly overstate the savings for the healthcare system as a whole—and by extension, for the federal budget—that would accrue from legislative proposals to bring about widespread adoption of health IT.”

Although lack of interoperability and cost savings, discussed above, are barriers to physician adoption as they significantly reduce the clinical and business case for physician HIT investment, direct and indirect HIT costs are also an impediment, particularly for physicians practicing in small office settings. A study by Robert H. Miller and others found that initial EMR costs were approximately \$44,000 per full-time equivalent (FTE) provider per year, and ongoing costs were about \$8,500 per FTE provider per year. (*Health Affairs*, September/October, 2005). Initial costs for 12 of the 14 solo or small practices surveyed ranged from \$37,056 to \$63,600 per FTE provider. These costs are difficult to absorb for the over 50 percent of physician practices in this country that have 5 or fewer physicians, and account for 80 percent of outpatient visits, especially as these practices struggle to implement existing HIPAA requirements, Medicare and other public and private payer mandates while facing shrinking public and private payer revenues. Direct financial incentives are especially critical for small physician and rural practices that face the greatest financial, technological, and operational challenges.

A 2007 AMA survey showed that with a 10 percent Medicare physician payment cut in 2008, two-thirds of physicians will defer investments in their practice, including the purchase of new medical equipment and information technology. If rates are cut by 40 percent by 2016, about 8 in 10 physicians will forgo these investments. For the majority of physicians dealing with multiple financial issues, ranging from low reimbursement under Medicare and Medicaid, declining revenue from managed care, professional liability insurance premiums, and the cost of complying with state and federal mandates, investing in HIT systems is challenging.

A variety of technical and workflow issues pose additional cost barriers to more widespread adoption of HIT. Implementing HIT in a clinical setting is much more complicated than connecting a computer to the Internet or installing software from a CD-ROM. Systems must conform to the workflow of a practice or the workflow must be modified so that the HIT system does not impede it. Physician offices, particularly small practices and those in rural or underserved areas, need simple and inexpensive solutions to obtain the benefits of HIT. Physicians will need time and money to effectively transform the workflow of their practices. The AMA strongly believes that meaningful grants, loans, and other financial incentives for accelerating widespread adoption of HIT systems and tools are essential for accelerating widespread adoption of HIT.

We commend you for your legislative proposal to establish an HIT Resource Center to provide technical assistance and serve as a forum to exchange knowledge and experience in order to support and accelerate efforts to adopt, implement, and effectively use interoperable HIT.

## **Conclusion**

Despite the complexity and cost of developing an interoperable, nationwide HIT infrastructure, physicians realize the transformative power that adoption of this technology promises for the future of patient care. The AMA appreciates the leadership of the Subcommittee and remains committed to working closely with you on further developing legislation in order to accelerate the widespread adoption and implementation of HIT.