

**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 Enacted before transformative health information technology like electronic health records (EHR), these privacy laws obstruct access by caregivers to patient information and medical decision-making support. Since 1975, federal rules have protected the identity and clinical information of persons seeking treatment for addiction.³ Oregon law has protected information pertaining to mental health treatment since about the same time.⁴ Written releases of information signed by the patient remain the gold standard of privacy protection under these laws.⁵

But obtaining written authorization from individual patients for each and every disclosure of health information within an electronically connected network of providers is cumbersome at best. Federal healthcare programs have relentlessly promoted electronic health information exchange. For example, the federal Meaningful Use program is being consolidated into the merit-based Incentive Payment Program and is moving from reimbursement incentives for the use of electronic health exchange to punitive reimbursement penalties for failing to so.⁶ In addition, Medicare will soon penalize providers who

1. Pub. L. No. 104–191, 110 Stat. 1936 (1996).

2. Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act of 1970, Pub. L. No. 91–616, 84 Stat. 1848 (1970), *amended by* Pub. L. No. 92–255, 86 Stat. 65 (1972).

3. Confidentiality of Alcohol and Drug Abuse Patient Records, 40 Fed. Reg. 27802 (July 1, 1975).

4. 1973 Or. Laws, Ch. 736.

5. *See* OR. REV. STAT. § 179.505(3) (2015); 42 C.F.R. § 2.23 (1995).

6. *See* Medicare Program: Merit-Based Incentive Payment System and Alternative Payment Model Incentive Under the Physician Fee Schedule, and Criteria for Physician-Focused

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 vestigial privacy protections now prohibit the communication of medically relevant information to other health care providers without a patient's written consent.⁹

This article recommends liberalizing privacy regulations, and in particular 42 C.F.R. Part 2 (Part 2), to permit sharing clinical information among providers for treatment, payment, and health care operations. Part 2 regulates the use and disclosure of information concerning treatment of alcohol or drug addiction and is very restrictive, prohibiting even acknowledging treatment of an individual.¹⁰ There are effectively only two circumstances under which disclosure is permitted: with the patient's written consent or pursuant to a court order.¹¹ As a practical matter, patient consent is the only means for sharing Part 2 behavioral health information (BHI) for purposes of treatment, payment, or internal administrative functions such as quali-

Payment Models, 81 Fed. Reg. 28161 (May 9, 2016).

7. Stephen P. Melek et al., *Economic Impact of Integrated Medical-Behavioral Healthcare: Implications for Psychiatry*, MILLIMAN AM. PSYCHIATRIC ASS'N REPORT (2014).

8. Sarah Klein & Martha Hostetter, *In Focus: Integrating Behavioral Health and Primary Care*, THE COMMONWEALTH FUND (Aug.-Sept. 2014), <http://www.commonwealthfund.org/publications/newsletters/quality-matters/2014/august-september/in-focus> ("Spending for patients with comorbid mental health or substance abuse problems is 2.5 to 3.5 times higher than for those without such problems—with the vast majority of spending going to general medical services, not behavioral health.").

9. See Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act of 1970, Pub. L. No. 91-616, 84 Stat. 1848 (1970), *amended by* Pub. L. No. 92-255, 86 Stat. 65 (1972).

10. 42 C.F.R. § 2.13(c) (1995).

11. *Id.* §§ 2.23, 2.61.

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."

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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.”²²

Part 2 requires the patient’s consent to disclosure be accompanied by the following written prohibition against redisclosure:

This information has been disclosed to you from records protected by Federal confidentiality rules (42 C.F.R Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 C.F.R part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.²³

The program may disclose Part 2 BHI in accordance with the terms of the patient’s written consent, except for disclosures to “central registries and in connection with criminal justice referrals.”²⁴ Even with the patient’s written consent, these latter disclosures must meet detailed requirements.²⁵

The program is not required to obtain the patient’s written consent when it discloses Part 2 BHI to the patient at the patient’s request.²⁶ Even then, however, the program is subject to the restrictions

18. *Id.* § 2.31(b).

19. OR. REV. STAT. § 192.566 (2015).

20. 42 C.F.R. § 2.31(a)(1) (emphasis added).

21. *Id.* § 2.31(a)(2).

22. *See* Confidentiality of Substance Use Disorder Patient Records, 81 Fed. Reg. at 7005.

23. 42 C.F.R. § 2.32 (1995).

24. *Id.* § 2.33.

25. *Id.* § 2.34.

26. *Id.* § 2.23(a).

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

B. HIPAA Authorization

HIPAA's authorization requirements are much like Part 2's but impose additional requirements. HIPAA requires statements concerning the conditioning of care or insurance coverage upon the granting of authorization, and emphasizing the potential for redisclosure.²⁸ When the authorization concerns psychotherapy notes, a specific and separate authorization for disclosure is required.²⁹ With respect to the use of psychotherapy notes, the HIPAA Privacy Rule requires specific authorization for all uses except for treatment or for other limited purposes.³⁰

III. EXCEPTIONS TO THE AUTHORIZATION REQUIREMENT

Exceptions to the authorization requirement are contained in both HIPAA and Part 2. HIPAA is by far the more permissive scheme, and the better vehicle for overcoming the authorization obstacle to sharing BHI.

A. HIPAA Exceptions

1. Treatment, Payment, and Health Care Operations

HIPAA permits health care providers to share protected health information (PHI), without patient authorization, for purposes of treatment, payment, and health care operations.³¹ These uses easily account for the vast majority of the disclosures occurring between covered entities. These exceptions promote therapeutic benefit to the patient, provide a basis for payment to the provider, and permit critical administrative uses of PHI.³²

27. *Id.* §§ 2.23(b), 2.12(d)(1).

28. 45 C.F.R. §§ 164.508(c)(2)(ii), (iii) (2013).

29. *Id.* § 164.508(a)(2).

30. 45 C.F.R. § 164.508(a)(2).

31. 45 C.F.R. § 164.506(c).

32. 45 C.F.R. § 164.501 ("Health care operations" include credentialing, quality assurance and peer review, internal business processes, and other administrative uses).

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 treatment⁴⁰ 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.

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 some form of consumer data protection law.⁴⁷ States may also have

42. See 45 C.F.R. §§ 160.202, 160.203(b).

43. 45 C.F.R. § 160.202.

44. *Id.*

45. *Id.* § 160.203(b).

46. *Id.*

47. *E.g.*, OR. REV. STAT. §§ 646A.600–.628 (2015); see also *Security Breach Notification Laws*, NAT’L CONFERENCE OF STATE LEGISLATURES (Jan. 4, 2016), <http://www.ncsl.org/research/telecommunications-and-information-technology/security-breach-notification->

laws specific to different kinds of health information.⁴⁸ This “patchwork quilt” of state laws and the federal “floor” established by the HIPAA Privacy Rule and Part 2 often makes for complex legal analysis. Too often covered entities find themselves obligated to comply with multiple and varying requirements or prohibitions.

B. 42 C.F.R Part 2

The Part 2 preemption rule is more unqualified than HIPAA’s:

The statutes authorizing these regulations (42 U.S.C. § 290ee-3 and 42 U.S.C. § 290dd-3) do not preempt the field of law that they cover to the exclusion of all State laws in that field. If a disclosure permitted under these regulations is prohibited under State law, neither these regulations nor the authorizing statutes may be construed to authorize any violation of that State law. However, no State law may either authorize or compel any disclosure prohibited by these regulations.⁴⁹

Like HIPAA, Part 2 gives way to more stringent state law. But the punch line is that “no State law may either authorize or compel any disclosure prohibited by these regulations.”⁵⁰ There is no provision analogous to HIPAA’s “required by law” exception,⁵¹ making Part 2 the final word with respect to Part 2 BHI. Generally speaking, that word is “no.”

V. SPECIAL CASES

A. Minors

A recurring issue is the authority of minors to control the use and disclosure of their own health information. In the case of Part 2 BHI, the minor’s written consent is required, regardless of age.⁵² While

laws.aspx.

48. *E.g.*, OR. REV. STAT. §§ 192.515, 192.517 (2015) (Records of Individual Disability or Mental Illness); OR. REV. STAT. §§ 192.531–.549 (2015) (Genetic Privacy); OR. REV. STAT. §§ 192.553–.581 (2015) (Protected Health Information).

49. 42 C.F.R. § 2.20.

50. *Id.*

51. 45 C.F.R. § 164.512(a).

52. 42 C.F.R. § 2.14.

one might hope for a common sense limitation on this deference to very young minors, a court order is the sole alternative under Part 2.⁵³ Under HIPAA, however, the minor's confidentiality rights may vary with state law.⁵⁴ Parents presumptively control a minor's PHI and may authorize disclosures to third parties.⁵⁵ However, there are exceptions to this presumption: the parent may agree to a confidential relationship between the practitioner and the minor, or state law grants the minor the power of informed consent and the minor consents to his or her own care. In both cases, control over disclosure of PHI to third parties passes to the minor.⁵⁶

Under HIPAA, when state law is silent on parental access to a minor's PHI but the minor may consent to treatment,⁵⁷ professional judgment controls.⁵⁸ Thus, parental access to PHI, as opposed to Part 2 BHI, is usually left to the discretion of the treating practitioner or covered entity even when the minor may consent to treatment. The Office of Civil Rights (OCR) has said:

In cases in which State or other applicable law is silent concerning parental access to the minor's protected health information, and a parent is not the personal representative of a minor child . . . a covered entity has discretion to provide or deny a parent with access under 45 C.F.R. § 164.524 to the minor's health information, if doing so is consistent with State or other applicable law, and provided the decision is made by a licensed health care professional in the exercise of professional judgment.⁵⁹

Where state law is permissive or mandatory with respect to disclosure to parents, HIPAA provides for the exercise of professional

53. See 42 C.F.R. § 2.64.

54. 45 C.F.R. § 164.502(g).

55. *Id.* § 164.502(g)(2); see *Summary of the HIPAA Privacy Rule*, UNITED STATES DEP'T OF HEALTH & HUMAN SERV. OFFICE OF CIVIL RIGHTS (2003), <http://www.hhs.gov/hipaa/for-professionals/privacy/laws-regulations/index.html>; *Guidance: Personal Representatives*, UNITED STATES DEP'T OF HEALTH & HUMAN SERV. OFFICE OF CIVIL RIGHTS (2003), <http://www.hhs.gov/hipaa/for-professionals/privacy/guidance/personal-representatives/index.html>.

56. 45 C.F.R. § 164.502(g)(3)(i).

57. *E.g.*, OR. REV. STAT. § 109.610 (2015).

58. Moore, *supra* note 15.

59. *Guidance: Personal Representatives*, *supra* note 55.

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 end of treatment absent parental refusal, sexual abuse, or the emancipation of the minor. Under ORS 109.695, the OHA must adopt rules requiring community mental health programs authorized to do so to provide for the earliest feasible involvement of parents or guardians in the treatment plan consistent with clinical requirements of the minor. HIPAA would permit parental access subject to professional discretion. But if the information is Part 2 BHI, federal law preempts any state law or rule permitting parental access without a minor patient's consent.

B. Disclosures Within Organizations

As a general rule, the sharing of information within an organization is not a disclosure and, therefore, is permissible.⁶¹ However, there are exceptions to this general rule.

1. Minimum Necessity and the Need to Know

HIPAA's minimum necessary requirement restricts access to, and the use of, PHI to that which is minimally necessary to accomplish the intended purpose of the use or disclosure.⁶² Exceptions to the minimum necessity requirement exist, such as disclosures for purposes of treatment.⁶³ Similarly, a program may communicate Part 2 BHI within the program if there is a "need to know" the BHI in connection with job duties arising from the rendering of diagnosis, treatment, or referral for treatment.⁶⁴ Both HIPAA and Part 2 permit the communication of patient information in a medical emergency.⁶⁵

60. *E.g.*, OR. REV. STAT. § 430.620 (2015).

61. *See* 42 C.F.R. § 2.12(c)(3)(i) (1995); 45 C.F.R. § 160.103 ("Disclosure") (2013).

62. 45 C.F.R. § 164.502(b) (2013).

63. *Id.* § 164.502(b)(2)(i).

64. 42 C.F.R. § 2.12(c)(3)(i) (1995).

65. *Id.* § 2.51 (1995); 45 C.F.R. § 164.510(a)(3) (2013).

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 HIPAA.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.

dle his or her own affairs and appoints a specific person to act as PR. The court-appointed PR has the power to consent on the patient's behalf in all respects.⁷¹ In the second circumstance, the director of the drug treatment program may act as the PR for the limited purpose of consenting to disclosure of Part 2 BHI to a third party payer in order to obtain payment for services.⁷² In the third and final circumstance, Part 2 does not prohibit communicating facts for vital statistics purposes, such as the deceased's cause of death.⁷³ Additionally, Part 2 permits the PR to act for a deceased patient in other situations authorized by state law.⁷⁴ In the absence of an executor or other PR under state law, a spouse or, if there is no surviving spouse, a responsible family member may consent on behalf of the deceased.⁷⁵

2. HIPAA

The HIPAA Privacy Rule also defers to state law with respect to who may act as the patient's PR. Unlike Part 2, parents are presumptively PRs of their children under the Privacy Rule.⁷⁶ That presumption is rebutted, as described above, when the minor exercises the power of informed consent, or there are issues of abuse or neglect.⁷⁷ State law also governs in other circumstances, such as adult incapacity or the death of a patient.⁷⁸

VI. OREGON STATE LAW

A. ORS § 430.399

State law adds another layer of complexity to the privacy of BHI. Oregon has two statutes specifically applicable to disclosure of drug and alcohol treatment information: ORS sections 430.397 and 430.399, which apply to a drug and alcohol "treatment facility." A "treatment facility" includes:

71. *Id.* § 2.15(a)(1).

72. *Id.* § 2.15(a)(2).

73. *Id.* § 2.15(b)(1).

74. *Id.* § 2.15(b)(2).

75. *Id.*

76. 45 C.F.R. § 164.502(g)(2) (2013); see *Guidance: Personal Representatives*, *supra* note 55.

77. 45 C.F.R. §§ 164.502(g)(3), 164.503(g)(5) (2013).

78. *Id.* § 164.502(g)(4).

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[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).

80. 2015 Or. Laws. Ch. 730 § 4 (amending OR. REV. STAT. § 430.399, effective July 20, 2015).

81. See BENJAMIN D. KNAUPP ET AL., HEALTH LAW IN OREGON § 3.14-1(a) (OSB Legal Pubs BarBook 2014).

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 with respect to CCOs, that begin with, “notwithstanding ORS 179.505.”⁸⁸ ORS 192.561 *requires* disclosure among members of a CCO, and between members and the CCO entity, for purposes of

82. OR. REV. STAT. § 179.505(1)(b), (g) (2015).

83. *Id.* § 179.505(1)(h).

84. *Id.* § 179.505(3)(a).

85. *Id.* § 179.505(1)(d).

86. KNAUPP, *supra* note 81.

87. OR. REV. STAT. § 179.505(2) (2015) (the 2015 Oregon Legislature added paragraph (18), which permits disclosures in an ethical exercise of professional judgment for the protection of any person or the public); 2015 Or. Laws, Ch. 473 § 3.

88. OR. REV. STAT. § 192.561(1)(a) (2015).

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” prohibition in ORS 179.505(14) applies to anyone receiving BHI in compliance with that section.

2. Authorization Under ORS 179.505

Under ORS 179.505, a patient or the patient’s personal representative may authorize disclosure of mental health records.⁹⁴ Like Part 2 written consent, the authorization must be signed and dated by the patient⁹⁵ and be revocable by the patient.⁹⁶ The patient also must specify a date, event, or condition upon which the authorization expires without express revocation.⁹⁷ The authorization must contain:

- (1) The name of the provider directed to make the disclosure (except when the recipients of or applicants for public assistance for certain purposes give the authorization);
- (2) The name or title of the person or organization to which disclosure is to be made, or that the information

89. *Id.*

90. OR. REV. STAT. § 174.010 (2015); *see also* OR. REV. STAT. § 179.505(1)(b), (g) (2015).

91. *See* OR. REV. STAT. § 179.505(2) (the more liberal provisions of ORS 192.556 and HIPAA will control in the case of private practitioners not subject to ORS 179.505).

92. OR. REV. STAT. § 179.505(14) (2015).

93. *Id.* (the “redisclosure” limitation does not apply to the subject individual or that individual’s personal representative).

94. OR. REV. STAT. § 179.505(3) (2015).

95. *Id.*

96. *Id.* § 179.505(3)(e).

97. *Id.*

may be made public;

(3) The patient's name;

(4) The extent and nature of the information to be disclosed; and,

(5) A "[s]tatement that the authorization is subject to revocation at any time except to the extent action has been taken in reliance" upon it, and a specification of the event, date, or condition on which the authorization will expire without express revocation.⁹⁸

To the extent that these requirements are contrary to and more stringent than the authorization requirements in ORS 179.505(3), the state statute is preempted by HIPAA.⁹⁹

VII. PROPOSED AMENDMENT OF PART 2

On February 9, 2016, the Substance Abuse and Mental Health Services Administration (SAMHSA) proposed amendments to Part 2.¹⁰⁰ The amendments are intended

to modernize the 42 C.F.R. part 2 . . . rules by facilitating the electronic exchange of information for treatment and other legitimate health care purposes while ensuring appropriate confidentiality protections for records that might identify an individual, directly or indirectly, as having or having had a substance use disorder.¹⁰¹

The centerpiece of the proposed amendment is a change to consent requirements, permitting a less specific description of the recipient of Part 2 BHI under certain circumstances.¹⁰² Under the current rule, the consent form must specify the name or title of the recipient individual or organization.¹⁰³ The proposed change would permit a more general description if the recipient has a prior treatment relationship with the patient is an insurer or is "an entity that facilitates

98. *Id.* § 179.505(3).

99. *See* III.A. *supra*.

100. Confidentiality of Substance Use Disorder Patient Records, 81 Fed. Reg. 6988 (proposed Feb. 9, 2016) (to be codified at 42 C.F.R. § 2.13).

101. *Id.* at 6989.

102. *See* 42 C.F.R. § 2.31(a)(4) (proposed Feb. 9, 2016).

103. 42 C.F.R. § 2.31(a)(2).

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 More specifically, an expansive notion of “treatment provider relationship” and a “general designation” of a class of such providers, such as “my treatment providers,” would authorize disclosure of Part 2 BHI to network providers through an HIE, ACO, or CCO.¹⁰⁶ This is a concession to “reported burdens associated with the collection of updated consent forms whenever new participants join one of these organizations.”¹⁰⁷

The tradeoff for this liberalization is substantial. The description of the disclosing party must be more specific;¹⁰⁸ the description of the Part 2 BHI must be more than the “how much and what kind” description currently required¹⁰⁹ and must instead include “an explicit description of the substance use disorder information that may be disclosed.”¹¹⁰ Other new burdens are imposed, such as an accounting requirement for disclosures for whatever purpose to recipients generally described (*e.g.*, “my treatment providers”).¹¹¹

There are numerous other changes and additional requirements in the proposed 42 C.F.R. Part 2, but the critical problem remains: the demand for consent before Part 2 BHI may be disclosed for treatment, payment, or health care operations. Moreover, changes intended to liberalize the consent requirement weaken the case for such consent as fair notice to the patient of the recipients of Part 2 BHI. Open-ended “general designations” of downstream providers are at best abstract permissions. And there is more than a little wishful thinking involved when so simple a solution is prescribed for such a complex systematic problem. The Department of Health and Human Services came to the same conclusion when it recanted its requirement for consent to disclosure for treatment, payment, and health care operations in the first iteration of the HIPAA Privacy Rule:¹¹²

104. *Id.* § 2.31(a)(4)(iv).

105. *See* Confidentiality of Substance Use Disorder Patient Records, 81 Fed. Reg. at 7000.

106. *Id.*

107. *Id.*

108. *See generally* 42 C.F.R. § 2.31(a)(2) (proposed Feb. 9, 2016).

109. *Id.* § 2.31(a)(5).

110. *Id.* § 2.31(a)(3).

111. 42 C.F.R. § 2.13(d) (proposed Feb. 9, 2016).

112. *See* Standards for Privacy of Individually Identifiable Health Information, 67 Fed.

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.

A. *Proposal for Reform*

Attitudes toward addiction and mental illness have changed significantly over the past forty or fifty years. Addiction is now widely considered a disease, not a character flaw. Mental illness is generally attributed to neurochemical imbalances, genetic predisposition, or harsh environmental factors. Contemporary attitudes are shaped by campaigns against sexually transmitted diseases, the over-prescription of narcotics, and laws prohibiting the unnecessary segregation of the mentally ill or impaired.

The need for protection from social stigmas related to BHI has dramatically decreased since 1970, when the original legislation authorizing 42 C.F.R. Part 2 was enacted.¹¹⁴ It is difficult to argue that substance abuse treatment is any more stigmatizing now than other sensitive health information handled under the terms of HIPAA's Privacy Rule, for which HIPAA provides significant safeguards with respect to disclosures to law enforcement.¹¹⁵

Reg. 14776, 14778-83 (Mar. 27, 2002); compare 65 Fed. Reg. 82462 (Dec. 28, 2000), with former 45 C.F.R. § 164.506.

113. Standards for Privacy of Individually Identifiable Health Information, 67 Fed. Reg. at 14780.

114. Nat'l Institute on Alcohol Abuse and Alcoholism, Pub. L. No. 91-616, 845 Stat. 1852-53 (codified as amended in 42 U.S.C. § 2694).

115. 45 C.F.R. §§ 164.512(b)(1), 164.512(c), 164.512(f)(1)-(6), 164.512(j)(1)-(3). See

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.*

the numerous circumstances in which the need to share health information freely among providers and insurers is clear. If HIPAA can be amended to allow the identification of mental health patients to licensed sellers of firearms,¹¹⁹ then addiction and mental health treatment information should be available to licensed health care professionals coordinating and rendering care to these patients. In both cases, there are significant risks associated with keeping that information confidential.

HIPAA's Privacy Rule undoubtedly should be amended to better effectuate an expanded role. For example, protections may need to extend to Part 2 BHI even after it leaves the hands of HIPAA covered entities, business associates, and their agents or subcontractors. Contrary but more stringent state law can be preempted in favor of a HIPAA Privacy Rule occupying the field and addressing the entire spectrum of health care information. This proposal inevitably will generate debate and disagreement. That cannot and should not prevent the removal of legal obstacles to data sharing among health care providers and payors.

119. Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule and the Nat'l Instant Criminal Background Check System (NICS), 81 Fed. Reg. 382 (Jan. 6, 2016) (to be codified in 45 C.F.R. § 164.512(k)(7)).