

CONSENT 2 – POLICY OPTIONS COLLABORATIVE INTERSTATE COMPACT – OHIO ANALYSIS

INTRODUCTION

One focus of the Consent 2 – Policy Options Collaborative is to explore the viability of four options that states could enact to resolve barriers to the exchange, including electronic, of protected health information (PHI) among states that have conflicting state laws governing consent to use or disclose PHI. These barriers can be summarized as the civil or criminal liability that may accrue to health information exchange (HIE) organizations or healthcare providers for using or disclosing PHI in contravention of state consent laws.

This analysis addresses whether an “interstate compact” could eliminate these barriers. An interstate compact may accomplish this goal by establishing a framework for resolving conflicts, which member states agree to adopt.

The Council of State Governments defines an interstate compact as “a contract between two or more states. It carries the force of statutory law and allows states to perform a certain action, observe a certain standard or cooperate in a critical policy area. Generally speaking, interstate compacts:

- establish a formal, legal relationship among states to address common problems or promote a common agenda;
- create independent, multistate governmental authorities (such as commissions) that can address issues more effectively than a state agency acting independently, or when no state has the authority to act unilaterally; and
- establish uniform guidelines, standards or procedures for agencies in the compact’s member states.”¹

DEFINITIONS/ASSUMPTIONS

To ensure consistency in the analysis of the four options, the collaborative has adopted a uniform set of definitions and assumptions.

Definitions:

- Authentication – means the method or methods to verify the identity of a person or entity authorized to access PHI.
- Authorization – means the level of access an individual or entity has to PHI and includes a management component—an individual or individuals must be designated to authorize access and manage access once access is approved.
- Consent – means the patient’s signed approval for the use or disclosure of PHI, which may also be referred to as an “authorization” or “permission” under HIPAA or other state laws.

¹ Fact Sheet, Council of State Governments, National Center for Interstate Compacts at www.csg.org (keyword: interstate compacts).

- Health - is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.²
- Health care - is the prevention, treatment, and management of illness and the preservation of mental and physical well being through the services offered by the [medical](#), [nursing](#), and [allied health](#) professions.³
- Health information exchange (HIE) – The electronic movement of health-related information among organizations according to nationally recognized standards.
- Requesting state – the state that is requesting medical information.
- Responding state – the state that has received the request for medical information and is responding.
- Protected health information (PHI) – is individually identifiable health information that is transmitted by, or maintained in, electronic media or any other form or medium. This information must relate to 1) the past, present, or future physical or mental health, or condition of an individual; 2) provision of health care to an individual; or 3) payment for the provision of health care to an individual. If the information identifies or provides a reasonable basis to believe it can be used to identify an individual, it is considered individually identifiable health information.

Assumptions: The purpose of these assumptions is to lay the framework for the analysis effort.

- For purposes of this initiative HIE represents the processes involved in the exchange of consent as defined by the Office of the National Coordinator and is not intended to represent a specific entity.
- The record holder of the responding state may release and have access to the patient's record in conformance with federal and state consent laws for the release PHI.
- The **responding state** and the **requesting state** will have an agreement that addresses:
 - The exchange of PHI regarding persons authorized to access PHI
 - The authentication of users
- The **responding state** has more stringent consent requirements for the release of PHI than the patient's **requesting state**. *[Assuming the reverse would not be relevant to this analysis in that the patient's PHI would not be available for exchange unless the patient had already executed the required - more expansive - consent.]*

PROCESS FOR DEVELOPING THE OPTION

Discussion

Development: The process would begin with a negotiated agreement between the participating

² World Health Organization, www.who.int/about/definition/en/

³ Wikipedia definition, http://en.wikipedia.org/wiki/Health_care

states. Initially, an advisory group composed of state officials, stakeholders, and issue experts will examine the issues and current policy. The group will work to identify best practices and alternative structures. Ultimately, the advisory group should establish recommendations for the content.

Thereafter, a drafting team composed of a smaller number of officials, stakeholders, and experts will draft a compact based upon the advisory board recommendations. The committee's draft agreement may be circulated to representatives of the states and stakeholders any number of times for review, comment, and revisions. At each round, the drafting team will consider and incorporate the comments it receives, and will eventually send its final product back to the advisory board before the compact is released to the States for consideration.

Common characteristics of an interstate compact which would have to be negotiated include: (a) the creation of an independent joint regulatory organization or body; (b) uniform guidelines, standards, or procedures conditioned on action by the other states involved; (c) the states are not free to modify or repeal their laws unilaterally; and (d) statutes requiring reciprocity.

Lastly, consideration will have to be given to whether the interstate compact would require Congressional approval. Article I, Section 10, Clause 3 of the U.S. Constitution provides that "No State shall, without the consent of Congress...enter into agreement or compact with another State..." This language appears to require that all interstate compacts require Congressional approval, but the United States Supreme Court has clarified that Congressional approval is *not* required in all instances. *Virginia v. Tennessee*, 148 U.S. 503, 518-522 (1893). Rather, to determine whether Congressional approval is necessary, courts typically look to determine (a) whether the agreement affects the balance of power between the federal government and the states; or (b) intrudes on an area reserved or of interest to the federal government. Based upon these criteria, it appears that Congressional approval would be necessary before the compact could take effect.

Congressional consent may take the form of an act or joint resolution of Congress stating that it consents. Or, Congress may consent in advance to the creation of an interstate compact. Alternatively, Congressional approval may be implied by its actions after the states have formally entered into the compact.

Congressional consent may have the effect of transforming the compact into federal law. In *Cuyler v. Adams*, 449 U.S. 433, 440 (1981), the U.S. Supreme Court concluded that "where Congress has authorized the States to enter into a cooperative agreement, and where the subject matter of that agreement is an appropriate subject for congressional legislation, the consent of Congress transforms the State's agreement into federal law under the Compact Clause."

Education and Enactment: The states will need to be educated on the necessity for and the terms of the compact. To that end, a comprehensive resource kit and other promotional materials, support documents, and internet resources will likely need to be developed. In addition, a national symposium or briefing to education state legislators and other key state officials may need to be convened.

State support will be created through a network of champions (officials, legislators, governors, etc.). Informational testimony will need to be offered to the state legislative committees considering the compact. Then, as each state enacts the compact, focus will need to shift toward transition and implementation of the compact.

Additional support and education efforts will also be required at the federal level if Congressional approval is determined to be required.

Transition and Operation: Once the enactment threshold is met, states should be notified that the compact has taken effect and an interim executive board of the interstate commission will need to be appointed. Information systems will likely need development at this point (including the creation of standards, establishment of security procedures, and selection of vendors).

Once the compact is fully up and running, an eye must be kept on technological advancements, law changes, or other issues that may require reconvening the advisory committees and revising the compact language.

Pros

Allows the states (as opposed to the federal government) to draw the parameters, not only for participation in the compact, but also for developing dispute resolution procedures. This can lead to increased effectiveness and efficiency, as well as flexibility and autonomy. While the threat of federal preemption or mandates is lessened, it is important to note (as set forth below), that Congressional consent will likely transform the final product into federal law.

Cons

Congressional approval may have the effect of transforming the interstate compact into federal law. Accordingly, the compact's language and interpretation could be at the mercy of the federal government, including the federal courts. Courts could hold unenforceable state laws that are inconsistent with federal and interstate interests.

LENGTH OF TIME REQUIRED TO FORMULATE

Discussion

Unfortunately, there is no clear answer regarding the length of time required to formulate a compact, but based upon past Ohio experience, it appears that from the initial meeting of the advisory committee to the time the compact takes effect could take several years.

Pros

While formulating an effective interstate compact is expected to be a lengthy process, the end result will be a negotiated agreement among the participating states, which would hopefully offset later delays occasioned by individual states' objections to the provisions of the compact. In other words, presumably the states that agree to and execute the compact will not thereafter seek to challenge its terms.

Cons

Resolution of the issue and effective transfer of health and medical information will not be immediate under this process. By way of example, the negotiation and approval of the Great Lakes-St. Lawrence River Basin Water Resources Compact took seven years from the initial stages through Congressional approval in August, 2008.

IMPLEMENTATION REQUIREMENTS

Discussion

A state enters into an enforceable and binding interstate compact when it follows the entry provisions set out in the compact. States need to explicitly follow the procedures for entry that are stated in the compact language.

In Ohio, there appears to be two mechanisms for approving an interstate compact. The General Assembly may authorize the Governor or other official to execute the compact. See, e.g., R.C. 2151.56 (Interstate Compact on Juveniles); R.C. 5101.141 (authorizing the director of the department of job and family services to enter into interstate compacts for the provision of medical assistance and other social services to children in certain circumstances).

More commonly, the General Assembly enacts the compact's language as Ohio law. See, e.g., R.C. 109.971 (National Crime Prevention and Privacy Compact); R.C. 921.60 (Pest Control Compact); R.C. 1503.41 (Middle Atlantic Interstate Forest Fire Protection Compact); R.C. 1514.30 (Interstate Mining Compact); R.C. 1522.01 (Great Lakes-St. Lawrence River Basin Water Resources Compact); R.C. 3301.48 (Interstate Compact for Education); R.C. 3747.01 (Midwest Interstate Compact and Commission on Low-level Radioactive Waste); R.C. 3915.16 (Interstate Insurance Product Regulation Compact); R.C. 5103.20 (Interstate Compact for the Placement of Children); R.C. 5119.50 (Interstate Compact on Mental Health); R.C. 5149.21 (Interstate Compact for Adult Offender Supervision). In either event, it appears the General Assembly has typically enacted the language of the compact, and required that the final version be "substantially" the same as the language it has enacted. And, the General Assembly may enact companion statutes at the same time as part of the legislation. See, e.g., R.C. 3747.02-.03 (related to the Midwest Interstate Compact and Commission on Low-level Radioactive Waste); R.C. 1522.02-.08 (related to the Great-Lakes-St. Lawrence River Basin Water Resources Compact).

In addition, the compact may include language setting forth many parameters, including: (a) the number of states that must agree to the compact before it will take effect; (b) the necessity for Congressional consent; (c) the method by which a state must consent to the compact (e.g., signature or legislative enactment).

Pros

Because the implementation process is set out as part of the compact language, participating states should be able to reach some consensus in advance as to the most effective way to get state participation as early as possible. However, it is likely that not each state will have the same preferred process, which may make ratification by some states more difficult than others.

Cons

Ohio's experience has been that even when the proper "champions" are on board with the compact's purpose and language, individual legislators can hold up the process by injecting their own concerns. For example, in considering the Great Lakes Water Compact, members of the Ohio Senate held up enactment of the compact in Ohio for months over concerns that the compact language could infringe upon private property rights. Thus, education efforts and support activities are critical at each stage of the process.

IMPACT ON STAKEHOLDER COMMUNITIES

Discussion

Interstate compacts have proven to be fairly effective in addressing a number of inconsistent policies among states, though their impact on stakeholders appears mixed at best. The range of problems stakeholders may experience, however, could ultimately deter support and participation.

Pros and Cons by Stakeholder Group

1. Consumer Interests - Consumers will be impacted by whatever “consensus” is reached, as some states currently provide greater protection than other states and the federal government (e.g., whether disclosures for the purposes of payment or health care operations require authorization, the treatment of sensitive information, and access rights of minors and their parents). Consumers which experience diminished protections and rights may consequently decide to forgo necessary treatment or seek treatment from more consumer friendly states/regions.

2. Health Care Providers – An interstate compact may offer health care providers with added certainty about what law to apply when exchanging information electronically across state lines. Such certainty could reduce disputes among providers, concerns surrounding liability and professional hesitation due to patient confidentiality obligations. The adaptive structure of interstate compacts may give health care providers a more immediate remedy than would a national solution, should modifications become necessary in light of their experience. Larger health care providers that offer their services across states or regions could realize more exponential gains by consistency in law.

The uncertainty that state courts would interpret the interstate compact consistently, however, may still deter interstate exchange. The time, expense and potential confusion experienced by health providers in complying with the interstate compact for interstate exchanges, in addition to state law for intrastate exchanges, would also be significant obstacle to interstate health information exchange. The negative aspects of interstate compacts may be experienced more acutely by smaller health care providers, whose resources, compliance programs and liability concerns would all highlight the level of uncertainty an interstate compact would still allow.

3. Health Plans and Other 3rd Party Payers - An interstate compact may similarly offer health plans and other third party payers some added certainty as to which law they might apply when exchange health information electronically between states. This may be especially beneficial to larger health plans that regularly do business in multiple, adjoining states and are otherwise subject to differing laws. Health plans and third party payers will also be impacted by time, resources and additional compliance requirements associated with an interstate compact for interstate exchange which may differ from intrastate exchange requirements. Larger health plans and third party payers may be less negatively impacted, however, as a result of their size.

4. State Government - State governments may retain some of their traditional sovereignty by developing an interstate compact that reflects the needs and experiences of their citizens, though some of that traditional sovereignty would necessarily be reduced in reaching the collective’s objectives. The range of stratification between participating states’ laws may make consensus more or less difficult to achieve. Governments which forgo their own state’s traditional sovereignty may find their actions to be later questioned and politically opposed.

Interstate compacts may also create some political tension between the various branches of state government. Tension may arise, for example, as a result of a participating state’s lost ability to pass new and dissimilar laws, absent a subsequent compact or repeal with Congress’ approval. Political tension may also result from executive branch appointments to the interstate council or advisory board which may be claimed by others to be unrepresentative of the State’s constituency at large.

The distribution of funding requirements among participating states, may be problematic and especially for those states with limited health care budgets. State agencies charged with the development and/or administration of an interstate compact would also require enhanced funding to take on the additional responsibilities associated with the interstate compact, and workforce investments would be required. State government health care providers and payers would likely experience the same advantages and frustrations with regard to resources, time and compliance requirements as would their private counterparts. Health care providers and health plans may also seek reimbursement increases by the state to offset their own additional compliance costs.

5. Employers - Employers may be financially impacted by the costs associated with an interstate compact through direct requests for contributions, an increase in taxes used by participating states to redistribute the costs and potential increases in the billing and premiums used by health care providers and health plans to offset their own additional expenses. Larger employers that self-insure or provide in-house health care services may experience more of the benefits associated with an interstate compact and less of the associated burdens.

FEASIBILITY

Discussion

Adoption of a health information exchange compact would engage state legislative and executive processes, which necessarily exist in a political context.

Cost considerations should not be an issue based upon historical data from the Council of State Governments showing modest expenditures, particularly when the federal government provides financial support (see 10 Frequently Asked Questions, National Center for Interstate Compacts, posted at www.csg.org/programs/ncic/documents/CompactFAQ.pdf). While Ohio's state budget picture is difficult, with recent state program cuts, Governor Strickland appears to recognize the return on investment for electronic HIE and is likely to find the modest funds necessary to facilitate development and implementation of an interstate HIE compact (see Executive Order 2007-30S, posted at www.governor.ohio.gov/Portals/0/Executive%20Orders/Executive%20Order%202007-30S.pdf).

It is difficult to predict how elected officials will respond to an interstate HIE compact. Issues such as the confidentiality of mental health and infectious disease status may challenge feasibility, but the history of adoption of controversial compact legislation such as the recent Great Lakes-St. Lawrence River Basic Water Resources Compact (Am. H.B. 416 posted at www.legislature.state.oh.us/bill_search.cfm?NUMBER=416&HOUSE=H) suggests bipartisan support would develop because of the recognized return on investment resulting from health information exchange between and among the states).

DOES THE OPTION ADDRESS LIABILITY CONCERNS

Discussion

Since an interstate compact is enacted in statute by states participating in the compact, and assuming the language of the interstate compact statutes is sufficient, all liability concerns should be addressed in a satisfactory fashion. Such compact language must be carefully drafted so it protects health information exchange parties from civil and criminal liability as well as adverse administrative actions such as those related to provider (e.g., physician, nurse, hospital, nursing home) licensing and regulatory oversight from all pertinent state agencies (e.g., provider licensing boards, pharmacy board,

mental health and workers compensation agencies).

State constitutional issues also must be a consideration in addressing liability concerns. State court application of state constitutional provisions involving such issues as immunity, damage caps, and privacy rights are examples.

Attention must also be given to federal requirements (e.g., HIPAA) that preempt state and therefore interstate compact law. It may be determined that federal recognition through federal legislative enactment or resolution, or perhaps administrative rule promulgation will be necessary to ensure that liability does not arise from federal quarters.

Finally, cursory review of some interstate compact language suggests that liability has been addressed. Examples include the International Emergency Management Assistance Compact and Northeastern American/Canadian Emergency Management Assistance Compact (see W. Voit, N. Vickers, & T. Gavenonis, *Interstate Compacts & Agencies* 2003, pp. 188, 212, *The Council of State Governments* 2003).

Ohio is a member of more than 26 interstate compacts, some of which address liability exposure (*Id.*, p. 153). For example, the Middle Atlantic interstate forest fire protection compact recites in R.C. 1503.41, Article V:

“No member state or its officers or employees rendering outside aid pursuant to this compact shall be liable on account of any act or omission on the part of such forces while so engaged, or on account of the maintenance or use of any equipment or supplies in connection therewith.”

A second example of a compact addressing liability concerns is Ohio’s participation in the Interstate emergency management assistance compact. At R.C. 5502.40, Article VI, appears the following:

“Officers or employees of a party state rendering aid in another state pursuant to this compact shall be considered agents of the requesting state for tort liability and immunity purposes; and no party state or its officers or employees rendering aid in another state pursuant to this compact shall be liable on account of any act or omission in good faith on the part of such forces while so engaged or on account of the maintenance or use of any equipment or supplies in connection therewith. Good faith in this article shall not include willful misconduct, gross negligence, or recklessness.”

Pros

Momentum for decades, seemingly accelerating in recent years, has favored uniform state law on matters of regional or national importance. This momentum has been especially visible in the area of data exchange as a result of technological advances (e.g., computers, cell phones, internet, satellite communication). There appears to be a wide consensus that unimpeded but secure health information exchange has sufficient societal value to justify formation of an interstate compact—especially if the federal government is unable to act in a timely and appropriate manner.

These general comments are pertinent because they suggest that liability concerns would be appropriately addressed in order to accomplish higher ranked political and social goals.

Cons

It remains to be seen if there are local or state issues or constituencies that would prevent satisfactory standardized liability protection in multi-state compact language. Issues related to HIV, mental health

and substance abuse, or states with unreasonable privacy advocates or self-serving plaintiff attorney associations (without minimizing the legitimacy of mainstream privacy advocates and plaintiff attorney associations) might lead to compact language sufficiently unsatisfactory to defeat successful implementation of health information exchange.

RAMIFICATIONS OF ACCEPTANCE/REJECTION

Discussion

Acceptance

A number of beneficial ramifications arise from the enactment of an interstate compact. The major one is the establishment of a regulated and standardized system to secure patient consent for electronic exchange of PHI among compact member states regardless of varying consent requirements. Based on this process within the compact, PHI arguably can be exchanged by providers more confidently while protecting patients' privacy rights. This may result in an increase in the authorized interstate exchange of PHI among the member states. A favorable outcome has been realized through another healthcare related interstate compact. Specifically, an evaluation study of the Nurse Licensure Compact, sponsored by the National Council of State Boards of Nursing, reflected increases in active licenses based on the benefits offered through the compact. See National Council of State Boards of Nursing, Multi-state Licensure Compact Impact Evaluation (2003), www.ncsbn.org.

There are also several legal ramifications that stem from the utilization of the compact. These ramifications provide added protections for the compact and the compact member states. Of note, the interstate compact becomes statutory law when adopted by each of the member state legislators and has precedence over conflicting statutes of member states. *C.T. Hellmuth & Assoc. v. Wash. Metro. Area Transit Auth.* (D.Md. 1976), 414 F.Supp. 408, 409. Along these same lines, no unilateral action taken by member state that is in conflict with the compact terms and conditions can be imposed upon the other member states without the approval of the other member states. *Nebraska v. Cent. Interstate Low-Level Radioactive Waste Comm.* (C.A.8, 2000), 207 F.3d 1021, 1026. See Buenger and Masters, *The Interstate Compact on Adult Offender Supervision: Using Old Tools to Solve New Problems* (2003), 9 Roger Williams U.L. Rev. 71, 94.

Rejection

Without the use of the compact or adoption of standardized choice of law statutes, uniform laws or model acts, there would continue to be discordant requirements for sharing PHI, causing unnecessary burdens for the patient and health care system to determine when sharing of information is legally permitted.

CONFLICTS WITH STATE OR FEDERAL LAWS

Discussion

Once a state enters into a compact, the terms of the compact control over the laws of the state, regardless of whether those laws are statutory, regulatory or common law. In the case of medical records, Ohio has specific and detailed statutes regarding access to certain mental health records, certain records regarding AIDS and HIV tests, and drug and alcohol treatment records (Ohio Rev. Code §5122.3; Ohio Rev. Code §3701.243), regulations pertaining to drug and alcohol treatment

records (Oh. Admin. Code §3793:2-01-06), and regulations on the use of Medicaid and other public assistance information. R.C. 5101.27. In addition, by case law, Ohio has recognized a privacy right in general medical records and a cause of action for violation of that privacy right. *Biddle v. Warren General Hospital* (1999), 86 Ohio St.3d 395. The terms of a compact regarding access to medical records would take priority over these laws in any situation in which the compact applies (i.e., if the compact applies only to interstate access to medical records, then Ohio law would continue to apply to intrastate access, while the compact terms would supersede those laws and apply to interstate access).

A compact, however, cannot pre-empt federal law. Therefore, existing federal law regarding access to medical records, and any future federal laws, would apply rather than the terms of the compact. Specifically, federal regulations restrict the access to drug and alcohol treatment records from any entity receiving federal assistance. The federal assistance can be in any form, such as funding, reimbursement for services or federal tax-exempt status. 42 C.F.R. Part 2. These federal restrictions will apply regardless of any compact terms. Furthermore, the federal government could, particularly in connection with Medicare and Medicaid funding, enact or promulgate restrictions pertaining to other types of medical records. Any future laws at the federal level would also apply over the terms of a compact.

Pros

One of the primary benefits of a compact is the fact that it supersedes the application of contrary state laws. In other words, the benefit is that it makes the rules between the states to the compact uniform, thereby making it easier to access medical information across state lines. This, by nature, means that conflicting state laws must not apply. This results in a collaborative approach among the states to resolving issues created by conflicting state laws, and may encourage the federal government to also collaborative resolve differences with federal law.

In addition, the process of entering into a compact may result in individual states review and revising their current privacy laws and statutes.

Cons

The downside of a compact's pre-emption of state laws is the fact that it does not permit a state to enact policies that reflect unique cultures or climates that exist in that state.

LEGAL FRAMEWORK/RULES OF ENGAGEMENT

Discussion

Compacts between/among states were originally developed under common law. The US Constitution, in Art. I, § 10, Clause 3, addresses compacts in context of balance of powers [No state shall, without consent of Congress, enter into any . . . compact with another state]. Case law has established that Congressional approval is only necessary for those agreements affecting the power of the national government or "political balance" within the federal government.

The compact is formed as a contract – offer made by state adopting terms of the compact and acceptance given via other states' adoption of the necessary language. Entry requirements must be followed as set forth in the terms of the compact – usually adoption as statute by legislature (see e.g. ORC 5119.50 et seq, *Interstate Compact on Mental Health*), though may be by legislative authority for state to adopt by resolution or adherence by Governor (see e.g. ORC 3301.48-.49, *Interstate Compact on Education*). Terms may also address time frame for enactment, # of states' adoption required for

compact to become effective, administration issues, i.e. creation of compact administrative body/commission and powers conferred thereon, including dispute resolution authority (see e.g. ORC 5149.21, *Interstate Compact for Adult Offender Supervision, Art. IX*). Ohio is member to several compacts.

Pros

Superior in force and effect to prior and subsequent state statutes [see e.g. : *A Primer on the Relationship between an Interstate Compact and State Law*, Jeffrey B. Litwa, *Council of State Governments/Summit of the States, June 1, 2006*; ORC 5149.21, *Interstate Compact on Adult Offender Supervision, Art. XIV*]; contractually binding/not subject to unilateral renouncement; allows states to define remedy to address a perceived problem; option for alternative dispute resolution

Cons

Drafters must satisfy all potential adopters since terms must be consistent; administration must be defined in compact terms and well designed in order to be effective; length of time for necessary legislative action; potential need for Congressional approval

PROCESS FOR WITHDRAWAL

Discussion:

Withdrawal or modification may be accomplished only in compliance with the terms of the compact or by mutual consent and necessary (usually legislative) action by all members. Usually requires legislative enactment but compact terms may additionally provide for delay in effective date of withdrawal (i.e. two years) and require notice of withdrawal to all other member states. For example, the Interstate Compact on Mental Health, ORC 5119.50, allows for withdrawal by passing legislation repealing the compact, and provides that the withdrawal will become effective one year after formal notice to all other member states. Additionally, the withdrawal shall not change the status of patients previously transferred between states according to the terms of the compact.

Pros:

Not easily renounced by other members

Cons:

Complex and potentially lengthy process to modify terms or withdraw

STATE RESPONSIBILITIES

Discussion

State government officials and policymakers would have to promote the compact and enact legislation authorizing the state to join the compact. In the same legislation, the state legislature will have to

designate a lead governmental agency. The lead governmental agency and any subsequent statutes and administrative regulations will have to serve both to promote and educate potential users and other governmental entities as to the expectations created by the compact.

Pros

By serving as the primary driver of a compact, state government injects a higher level of stability and predictability into the expectations of health information exchange. This stability and predictability can be bolstered by the force of law as each member state insures compliance with the processes and mechanisms established through the compact. These efforts and any subsequent educational campaigns should have minimal fiscal impact in the long-term. Certainly, bodies such as the Governor's Ohio Health Information Partnership Advisory Board.

Cons

As with all governmental program or involvement, there will be a certain amount of bureaucracy accompanying compact sanctioned transactions. Additionally, due to variations in governmental structures from state-to-state, there will be some inconsistencies as to the specific governmental entity managing compact issues or concerns; however, the impact of these variations should be minimal.

STATE'S RIGHTS

Discussion

A compact is used in matters affecting the interests of multiple states or, in the case of access to medical records, the individual citizens of multiple states. As such, it permits states to work together to address the mutual practical and policies issues. This reinforces the rights of the state to address such issues. Nevertheless, because the compact supersedes the application of an individual state's laws, it also limits the ability of a state to unilaterally establish policy in the area covered by the compact. This later issue has proven not to be insurmountable in Ohio, which has entered into over twenty-six compacts.

Pros

The establishment of a compact makes it less likely that the federal government will enact or promulgate pre-emptive laws or regulations. In other words, an effective compact will lessen or eliminate the need for federal government intervention. Thus, a compact will assist in preserving the rights of the states to have control over the policies governing access to medical records.

Cons

At the same time, a compact will limit the rights of the individual compact states to alter the policies or procedures to access medical records. In other words, a state may enact new laws pertaining to privacy or access to specific health records, but the compact provisions will supersede those laws in any situation in which the compact applies. Thus a state cannot unilaterally alter the process for access to medical records in any situation in which the compact applies.

ENFORCEMENT

Discussion

As an interstate compact is essentially a congressionally approved contract among the member states, with its remedies best set forth within the terms of compact. The enforceability compact is directly tied to congressional approval; without such approval, the compact is nonbinding and legally unenforceable upon the members. Thus, disputes within an approved compact are matters between the states and within federal subject-matter jurisdiction. However, federal courts are often reluctant to apply certain contract remedies as the parties and the compact are atypical. Waterfront Com'n of New York Harbor v. Construction and Marine Equipment Co., Inc., 928 F.Supp. 1388 (D.N.J. 1996). For example, federal courts will refrain from the equitable remedy of reforming the compact even in the face of unforeseen circumstances. Texas v. New Mexico, 462 U.S. 554, 103 S.Ct. 2558, 77 L.Ed.2d 1 (1983); New Jersey v. New York, 118 S.Ct. 1726 (1998). While the remedy of monetary damages is complicated by the Tenth Amendment, specific performance is a reasonable alternative. Texas v. New Mexico, 462 U.S. 554. However, when the terms of the compact set forth a dispute resolution mechanism, the courts generally prefer deference to that mechanism even when the mechanism is not efficient or necessarily effective. See Texas v. New Mexico, 462 U.S. 554; Waterfront Com'n of New York Harbor, 928 F.Supp. 1388.

A compact, in and of itself, does not directly alter the intrastate legal expectations. That is, a potential interstate compact on health information exchange across state boundaries can be limited only to the management of that exchange setting. It is only when the compact terms address the specific issue addressed by the compact that the effect of joining the compact serves to create a cognizable exception to the standard or usual expectations. However, even a well crafted compact term cannot create an exception to a constitutional expectation if the state legislature does not have specific authority to create the exception. Nevertheless, the pressure standardized interstate exchange expectations create on intrastate exchanges to match those expectations will be proportional to amount or reutilization of the interstate exchange through the established interstate compact protocols. In other words, the more the healthcare system uses the interstate compact mechanisms, the more likely the health care system will look to those mechanisms as the generalized standards for all exchange. For these reasons, the compact should carefully set out the enforcement mechanisms that arbitrate concerns and divergent understanding in a timely fashion; e.g., governing bodies, mediation board, dispute board, etc. Additionally, given the potential pressure to standardize intrastate health information exchange by the standardization of interstate health information exchange, it is potentially advisable for the compact to specifically address the matter in its construction and terms.

Pros

Some form of enforcement needs to be set forth within the terms of compact. By addressing enforcement, the compact remains the master of its own fate. Additionally, it fosters clear expectations among the member states if and when disputes arise.

Cons

Failing to address enforcement within the terms of the compact fosters litigation and ambiguity within the compact processes. Additionally, without a clearly defined enforcement provision, federal courts are confounded as to the appropriate remedies. However, it is important to note that Ohio cannot, under current law, agree to arbitration clauses.

OTHER CONSIDERATIONS

Must consider need for Congressional approval of compact and effect thereof – affects whether compact will be considered federal law, and aspects of jurisdiction and enforcement; should consider careful design of compact administration to be effective and efficient

A question for discussion is how will the standardized system to secure patient consent under the compact be effected when exchanging PHI with non-compact states?

CONCLUSION

An interstate compact is, by its very nature, a contract among the states. Typically, the compacts are narrowly drawn to a specific purpose but often have far reaching implications. A compact on HIE will be no exception. The scope of such a compact is could be unprecedented; however, the limits of its scope are not yet clear. While an interstate compact has both advantages and disadvantages, the most significant difference appears to be related to the forum in which the details of HIE would be addressed.

The details of model and uniform laws will require extensive vetting in various state legislatures. The details of an interstate compact will rely on government attorneys to lead state teams of negotiators. These negotiators will carry mandates from the stakeholders within their respective states; however, unless careful efforts are made to include a broad spectrum of stakeholders in the development of the mandates, the appearance of selectivity may be unavoidable. Accordingly, vetting will be as much of a necessary aspect in developing an interstate compact as in the other options. The difference will be the forum and process of that vetting.