was severed, again disrupting the lives and livelihoods of tens of thousands of residents and businesses.

Mr. Speaker, after decades of debate and lawsuits, the voters of San Mateo County have put an end to the battle with CALTRANS over how to resolve the problem of Devil's Slide. Voters decided overwhelmingly in favor of a local referendum to approve a mile-long tunnel at Devil's Slide instead of a bypass which would involve extensive cutting and filling of Montara Mountain. The referendum amends the local coastal plan, substituting a tunnel as the preferred permanent repair alternative for Highway 1 at Devil's Slide, and prohibits any other alternative unless approved by the voters. Following the release of a Federal Highway Administration sponsored study which found that the tunnel is environmentally feasible and its costs would not differ significantly from the costs of a bypass, CALTRANS reversed it opposition to a tunnel at Devil's Slide.

Mr. Speaker, today I am introducing important legislation to ensure that funds already appropriated and obligated for Devil's Slide will remain available to CALTRANS to build the tunnel at Devil's Slide. This legislation, entitled the ''Devil's Slide Tunnel Act,'' will provide greater flexibility to State transportation officials to use Federal funds already appropriated by Congress to fix this vital transportation link. Joining me as cosponsors of this legislation are bipartisan members of the bay area congressional delegation whose constituents are most affected by the Devil's Slide highway problem—my colleagues, TOM CAMPBELL, of San Jose, ANNA ESHOO of Atherton, and NANCY PELOSI of San Francisco.

Mr. Speaker, if local and State agencies and the citizens of a region determine that a better transportation alternative exists than the alternative for which funds have been obligated, then the Federal Government should grant greater funding flexibility, as long as all other Federal laws are compiled with. It is important that we not permit these funds to lapse. The rebuilding of a severely damaged highway in its existing location may no longer be feasible, and in such cases funds already available to a community should continue to be available.

History tell us that Devil's Slide will wash out again—it is only a matter of time. It is my hope that swift enactment of this legislation will ensure a permanent solution to the residents of the Coastside. I urge my colleagues to support the ''Devil's Slide Tunnel Act.''

STATEMENT OF THOMAS M. DAVIS IN HONOR OF MR. EVANS RICHARDSON, III

HON. THOMAS M. DAVIS

OF VIRGINIA

IN THE HOUSE OF REPRESENTATIVES

Tuesday, January 7, 1997

Mr. DAVIS of Virginia. Mr. Speaker, I rise today to express my deep appreciation for the invaluable service Mr. Evans Richardson III has provided to me and the constituents of the 11th District of Virginia over the past 11 months. An executive manager with McDonnell Douglas in St. Louis, MO, Evans brought a unique and thoughtful perspective to my office in working on legislative and constituent matters as a 1996 Brookings Congressional Fellow. Almost immediately after he joined my personal staff, he took on a great deal of responsibility, focusing on several key issues such as transportation, environment, affirmative action, and banking. Evans performed his duties with admirable dedication and enthusiasm.

Evans lives in St. Louis, MO, with his wife, Betty and their son Evans IV. He is a graduate of Washington University, and has worked for McDonnell Douglas for 12 years.

Taking an active role in one's community is a responsibility we all share, but which few of us fulfill. Evans actively works for the betterment of his community by serving on the board of directors of several community organizations, including the St. Charles Chamber of Commerce, Herbert Hoover Boys and Girls Club, and the Marygrove Catholic Home for Children.

It has been an honor and a privilege to have Evans Richardson on my staff. I have not only looked to him for legislative counsel, but I trust him as a valued confidante. His candid advice and opinion is always appreciated. I know that my staff and I will dearly miss him. Mr. Speaker, I know my colleagues will join me in thanking Evans for his service to the 104th Congress and wish him continued success in his future endeavors.

FAIR HEALTH INFORMATION PRACTICES ACT OF 1997

HON. GARY A. CONDIT

OF CALIFORNIA

IN THE HOUSE OF REPRESENTATIVES

Tuesday, January 7, 1997

Mr. CONDIT. Mr. Speaker, I have today introduced the Fair Health Information Practices Act of 1997. The purpose of this bill is to establish a uniform Federal code of fair information practices for individually identifiable health information that originates or is used in the health treatment and payment process.

This is the third time that I have introduced a health privacy bill, and I hope that the third time is the charm. In the 103d Congress, I introduced H.R. 4077. The bill was the subject of several days of hearings in 1994. In August 1994, the bill was reported by the Committee on Government Operations and became the confidentiality part of the overall health care reform effort. While my bill died along with the rest of health care reform, it was one of the only noncontroversial parts of health reform. In the 104th Congress, I introduced H.R. 435, a bill that was identical to the version reported by the Committee on Government Operations in 1994. A lengthy explanation of the bill can be found in the Government Operations Committee report, House Report 103–601 part V. That report remains highly relevant to this year's bill as well.

During the last 2 years, most of the action on health privacy took place on the Senate side. The leading Senate bill was S. 1360 which was introduced by Senator BENNETT. His bill and mine have many similarities in language and structure, but there are also numerous smaller but significant differences. In addition, my bill covers several aspects of health privacy that were not included in Senator BENNETT'S original bill. I am aware that several interim drafts were developed by Senator BENNETT during the course of the Congress, and these drafts narrowed some of the differences between our two bills. I look forward to the new version of the Senate bill. My bill is largely similar to H.R. 435, but I have made several changes based on new ideas and developments that emerged in the last 2 years. The substantive changes in this year's proposal are:

(1) References to health information service organizations have been dropped. This was a place holder for other institutions that were being developed in the context of broad health care reform. The references are no longer meaningful.

(2) The section on ''Accounting for Disclosures'' has been retitled as ''Disclosure History.'' Nothing substantive was changed, but the new language is more descriptive.

(3) In section 1.01, I added language to the patient access section making it clear that copies of records have to be provided to the patient in any form or format requested by the patient if the record is readily reproducible by the trustee in that form or format. The language was inspired in part by the recently passed Electronic Freedom of Information Amendments. The purpose is to make sure that a patient can have a record in a format that will be meaningful to the patient or useful to other health care providers.

(4) Also in section 1.01, the exception to patient access for mental health treatment notes has been eliminated. The policy of the bill is that a patient should have broad access to his or her health record. Exceptions are provided only when there is a direct conflict with another interest or when access is meaningless or pointless. The only substantive exception had been for mental health treatment notes. Given the broad sweep of the access provision, I am not sure that this exception can be justified any more. I left it out this year so that the advocates of the exception would have to come forward to argue for its inclusion and make their case on the public record.

(5) New language in section 301(d) creates an Office of Information Privacy in the Department of Health and Human Services. The head of the office is the Privacy Advisor to the Department. This is not really a new office. The Department recently established a private Advocate. The purpose of the new legislative language is to define the health privacy functions of this office with more precision and permanence.

(6) Section 304 of the bill deals with preemption of State laws. This is a difficult subject that clearly need more work and thought. I added one new idea this year. New language provides that the States may impose additional requirements on its own agencies with respect to the use or disclosure of protected health information. The idea is a simple one. If a State wants to impose more stringent restrictions on the ability of State police, State fraud investigators, or other State offices to use or disclose protected health information, it may do so.

In this instance, higher standards will not interfere with access to or use of information by other authorized users or by the Federal Government. The goal is to allow States to set as high a floor as they choose with respect to their own activities. This will not undermine the uniformity principle otherwise reflected in the bill, and it will not affect the drive for administrative simplification or uniform technical standards. Only State agencies will be affected by my new language. I thought that this

idea was worth including so that it would attract comment. The language itself may need further tweaking.

The need for uniform Federal health confidentiality legislation is clear. In a report titled ''Protecting Privacy in Computerized Medical Information,'' the Office of Technology Assessment found that the present system of protecting health care information is based on a patchwork quilt of laws. State laws vary significantly in scope and Federal laws are applicable only to limited kinds of information or to information maintained only by the Federal Government. Overall, OTA found that the present legal scheme does not provide consistent, comprehensive protection for privacy in health care information, whether that information exists in a paper or computerized environment. A similar finding was made by the Institute of Medicine in a report titled ''Health Data in the Information Age.''

A public opinion poll sponsored by Equifax and conducted by Louis Harris and Associates documents the importance of privacy to the American public. Eighty-five percent agree that protecting the confidentiality of people's medical records is absolutely essential or very important in national health care reform. The poll shows that most Americans believe protecting confidentiality is a higher priority than providing health insurance to those who do not have it today, reducing paperwork burdens, or providing better data for research. The poll also showed that 96 percent of the public agrees that it is important for an individual to have the right to obtain a copy of their own medical record.

Health information is a key asset in the health care delivery and payment system. Identifiable health information is heavily used in research and cost containment, and this usage will only grow over time. The Health Insurance Portability and Accountability Act of 1996 passed in the last Congress recognized that confidentiality legislation was essential to the fair management of health information. The law established a 3-year timetable for congressional action on confidentiality. That clock is ticking already, and we don't have much time to waste.

By establishing fair information practices in statute, the long-term costs of implementation will be reduced, and necessary protections will be uniform. This will assure patients and health professionals that fair treatment of health information is a fundamental element of the health care system. Uniform privacy rules will also assist in restraining costs by supporting increased automation, simplifying the use of electronic data interchange, and facilitating the portability of health coverage.

Today, few professionals and fewer patients know the rules that govern the use and disclosure of medical information. In a society where patients, providers, and records routinely cross State borders, it is rarely worth anyone's time to attempt to learn the rules of any one jurisdiction, let alone several jurisdictions. One goal of my bill is to change the culture of health records so that everyone will be able to understand the rights and responsibilities of all participants. Common rules and a common language will facilitate broader understanding and better protection. Physicians will be able to learn the rules once with the confidence that the same rules will apply wherever they practice. Patients will learn that they have the same rights in every State and in every doctor's office.

There are two basic concepts that are essential to an understanding of the bill. First, identifiable health information that is created or used during the health care treatment or payment process becomes protected health information, or individually identifiable patient information relating to the provision of health care or payment for health care. This new terminology emphasizes the sensitivity of the information and connotes an obligation to safeguard the data. Protected health information generally remains subject to statutory restriction no matter how it is used or disclosed.

The second basic concept is that of a health information trustee. Anyone who obtains access to protected health information under the bill's procedures becomes a health information trustee. Trustees have different sets of responsibilities and authorities depending on their functions. The authorities and responsibilities have been carefully defined to balance legitimate societal needs for data against each patient's right to privacy and the need for confidentiality in the health treatment process. Of course, every health information trustee has an obligation to maintain adequate security for protected health information.

The term trustee was selected in order to underscore that those in possession of identifiable health information have obligations that go beyond their own needs and interests. A physician who possesses information about a patient does not own that information. It is more accurate to say that both the record subject and the record keeper have rights and responsibilities with respect to the information. My legislation defines those rights and responsibilities. The concept of ownership of personal information maintained by third-party record keepers is not particularly useful in today's complex world.

A key element of this system is the specification of the rights of patients. Each patient will have a bundle of rights with respect to protected health care information about himself or herself that is maintained by a health information trustee. A patient will have the right to seek correction of information that is not timely, accurate, relevant, or complete. A patient will also have the right to expect that every trustee will use and maintain information in accordance with the rules in the Act. A patient will have a right to receive a notice of information practices. The bill establishes standards and procedures to make these rights meaningful and effective.

I want to emphasize that I have not proposed a pie-in-the-sky privacy code. This is a realistic bill for the real world. I have borrowed ideas from others concerned about health records, including the American Health Information Management Association, the Workgroup for Electronic Data Interchange, and the National Conference of Commissioners on Uniform State Laws. Assistance provided by the American Health Information Management Association [AHIMA] was especially helpful in the development of this legislation several years ago. AHIMA remains a valuable source of knowledge on health records policies and an ardent supporter of Federal health privacy legislation.

I believe that we do not have the luxury of elevating each patient's privacy interest above every other societal interest. Such a result would be impractical, unrealistic, and expensive. The right answer is to strike an appropriate balance that protects each patient's interests while permitting essential uses of data under controlled conditions. This should be happening today, but record keepers do not know their responsibilities, patients rights are not always clearly defined, and there are large gaps in legal protections for health information.

My bill recognizes necessary patterns of usage and combines it with comprehensive protections for patients. There will be no loopholes in protection for information originating in the health treatment or payment process. As the data moves to other parts of the health care system and beyond, it will remain subject to the Fair Health Information Practices Act of 1997. This may be the single most important feature of the bill.

The legislation includes several remedies that will help to enforce the new standards. For those who willfully ignore the rules, there are strong criminal penalties. For patients whose rights have been ignored or violated by others, there are civil remedies. There will also be administrative sanctions and arbitration to provide alternative, less expensive, and more accessible remedies.

The Fair Health Information Practices Act of 1997 offers a complete and comprehensive plan for the protection of the interests of patients and the needs of the health care system in the complex modern world of health care. More work still needs to be done, and I am committed to working with every group and institution that will be affected by the new health information rules. I remain open to new ideas that will improve the bill.

In closing, I want to acknowledge the limits of legislation. We must recognize and accept the reality that health information is not completely confidential. It would be wonderful if we could restore the old notion that what you tell your doctor in confidence remains absolutely secret. In today's complex health care environment, characterized by third party payers, medical specialization, high-cost care, and increasing computerization, this is simply not possible. My legislation does not and cannot promise absolute privacy. What it does not offer is a code of fair information practices for health information.

The promise of that code to professionals and patients alike is that identifiable health information will be fairly treated according to a clear set of rules that protect the confidentiality interests of each patient to the greatest extent possible. While we may not realistically be able to offer any more than this, we surely can do no less for the American public.

THE COMMUNITY PROTECTION ACT OF 1997

HON. RANDY ''DUKE'' CUNNINGHAM

OF CALIFORNIA

IN THE HOUSE OF REPRESENTATIVES

Tuesday, January 7, 1997

Mr. CUNNINGHAM. Mr. Speaker, Americans want us to work together to sensibly combat crime. Putting more, better-equipped and fully trained cops on the beat can be a strong part of any anticrime effort. It is for that very reason that today I am introducing the Community Protection Act of 1997.

The bill will allow qualified, properly trained active and retired law enforcement officers to carry concealed handguns. Too often State