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Confidentiality,
Third-Party Billing,
& the Health Insurance
Claims Process:
Implications for Title X

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Executive Summary

The Title X family planning program provides access to confidential family planning services for millions of individuals. Increasingly, patients seen in Title X-funded settings are gaining health insurance coverage through Medicaid or commercial health plans, at the same time that insurance coverage for contraceptive services has expanded. An increase in insured patients presents an opportunity for family planning providers to access new revenue streams for previously uncompensated care, but also poses challenges for providers seeking to maintain Title X's strong patient confidentiality protections while maximizing reimbursement from third-party payers for services and supplies provided in Title X settings.

Overview

This white paper provides background on the importance of confidentiality in family planning settings, the role of Title X, and the health care delivery environment, particularly as a result of the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule and the Affordable Care Act (ACA). Federal and state laws also contain numerous confidentiality protections, which vary widely in terms of what information they protect, who can access that information, when the patient's permission is required for disclosure, and many other factors. However, many requirements of state and federal law can lead to the disclosure of confidential health information. This white paper discusses disclosure requirements and confidentiality protections in the HIPAA Privacy Rule and state medical privacy laws as well as in the laws related to the primary sources of revenue for Title X-funded health centers—the Ryan White HIV/AIDS Program, Section 330 Federally Qualified Health Centers (FQHCs) program, Medicaid, and commercial health insurance. It also highlights examples of targeted approaches that have been adopted in several states to provide confidentiality protection in the billing and health insurance claims process.

HIPAA Privacy Rule

The HIPAA Privacy Rule contains many provisions that protect individuals' confidential medical information, which is referred to as "Protected Health Information" or "PHI." However, the HIPAA Privacy Rule contains a key provision that can and does lead to the disclosure of individuals' PHI, with or without their permission, but often without their clear understanding that the disclosure may occur or of its implications. The HIPAA Privacy Rule also contains important confidentiality protections of particular relevance for Title X providers. These include specific protections for the rights of minors and two special confidentiality protections that allow patients to request restrictions on disclosure of their PHI and to request that communications of their PHI occur in a confidential way. While all states have adopted laws to implement the HIPAA Privacy Rule, states have numerous other laws that protect confidentiality of health information.

Title X, Ryan White, and Federally Qualified Health Centers

Two other federally funded programs, Ryan White HIV/AIDS and Section 330 FQHCs, share characteristics with Title X. Title X law contains both strong confidentiality protections and a requirement that reimbursement be sought from potentially liable third parties, such as Medicaid and commercial health insurers. Ryan White is by law a payer of last resort and also contains strong confidentiality requirements. The confidentiality regulation for Section 330 FQHCs is virtually identical to Title X's and, as with Title X health centers, FQHCs are obligated to seek reimbursement from third parties who may be financially liable for services that patients receive. Thus Title X, Ryan White providers, and FQHCs may all potentially benefit in similar ways from states' efforts to reconcile the tension between the need to provide confidentiality protection and the necessity of billing public or commercial insurance.

Medicaid

Title X serves many low-income patients who increasingly may be or may become eligible for Medicaid. Therefore, understanding Medicaid's protections, as well as its requirements that can result in the disclosure of confidential patient information, is crucial for Title X providers. There are three key areas of federal and state Medicaid law and policy affecting the disclosure of confidential patient information: patient records, enrollment, and decision-making; Medicaid program communications; and third-party payment requirements.

The potential release of patient records to parents, spouses, and others, and the potential for interference with patient decision-making, carries a risk of harm for some patients. Federal Medicaid law safeguards against disclosure of confidential information and requires that enrollees be able to choose freely among family planning providers. This allows them to choose providers, like Title X, offering heightened confidentiality protection. State Medicaid laws and policies contain both general confidentiality protections and ones that are specific to family planning.

Federal Medicaid law does not require that explanations of benefits (EOBs) always be sent, but does require Medicaid managed care organizations (MCOs) to send notices when claims are denied in whole or in part. State Medicaid policies vary widely in the frequency with which they require EOBs to be sent and the mechanisms used to comply with the federal notice of denial requirement.

Medicaid serves as a payer of last resort and reimbursement must be sought from liable third parties before Medicaid is billed. There is a significant risk that confidentiality could be breached through the Medicaid eligibility and enrollment process and the billing of third parties such as commercial insurers. Federal law provides a good-cause exception when seeking third-party payment could cause harm to the patient. State laws and policies vary in

the ways they implement third-party liability and the good-cause exception.

Commercial Health Insurance

Title X health centers are beginning to see more patients who are covered by commercial health insurance, particularly young adults who remain on their parents' policies and individuals who have purchased insurance in the Marketplace. Myriad requirements of federal and state law lead to the disclosure of confidential health information by commercial health insurers and health plans throughout the billing and insurance claims process. Although state law, together with insurance policies and contracts, contains most of the communication requirements that result in confidentiality breaches, federal law contains a few key provisions.

In particular federal law requires insurers to send notices when claims are denied. Virtually all states have incorporated this requirement into state law, along with requirements for a range of other communications and practices related to claims and payment processing. Confidentiality breaches are likely as a result of these communications, particularly if they are sent to or seen by a parent, spouse, other family member, or domestic partner. In addition, other laws pertain to EOBs, requests for additional information, notices of payment of claims, and other communications, all of which risk breaching confidentiality.

Evolving Approaches to Protecting Confidentiality

Awareness of the potential for conflict between insurance coverage and confidentiality protections has existed for decades, particularly with respect to adolescents. More recently, the implications of this challenge have come into sharper focus as more adults—such as victims of intimate partner violence covered under a perpetrator's policy and young adults remaining on a parent's policy—gain access to public and

commercial health insurance coverage through Medicaid expansions and the ACA. Consequently, an increasing number of states are working to find solutions by exploring approaches designed to mitigate the problem.

These state-level efforts began in conjunction with and following the promulgation of the HIPAA Privacy Rule and have accelerated with the advent of the ACA; some have been in existence for a decade or more, while others are new or contained in pending legislation. The state laws and policies that represent at least partial solutions include strategies that implicate both Medicaid and commercial insurance. They include:

- Medicaid's good-cause exception;
- Management of EOBs, denials, and other communications;
- Restrictions on disclosure;
- Confidentiality protections for minor or adult dependents; and
- Implementation strategies.

This white paper highlights examples of each of these strategies. If fully implemented, they would likely result in significant progress toward protecting the confidential information of patients receiving family planning services from Title X providers. Ongoing efforts to promote adoption of similar measures in other states, as well as monitoring and evaluation of efforts taking place in all states, will be key to ensuring that they achieve maximum effectiveness.

Part I: Introduction

The Title X family planning program¹ has offered confidential services since it was enacted more than four decades ago. Title X confidentiality protections support access to essential family planning services for millions of adults and adolescents, with priority given to low-income individuals. Increasingly, and especially with the advent of the Affordable Care Act (ACA), Title X patients have health insurance coverage through Medicaid or commercial health plans, while insurance coverage for contraceptive services has also expanded. An increase in insured patients, while presenting an opportunity for family planning providers to access new revenue streams for previously uncompensated care, also poses challenges for providers seeking to maintain Title X's strong patient confidentiality protections while maximizing reimbursement from third-party payers for services and supplies provided in Title X settings.

This white paper provides background on the importance of confidentiality in family planning settings; the scope of Title X confidentiality protections; the health care delivery environment associated with the ACA; and the challenges associated with confidentiality, billing, and the insurance claims process. It details some of the key federal and state laws relevant for family planning that can lead to disclosure of confidential information via billing and insurance claims and that provide confidentiality protections. It also highlights some of the recent legal and policy developments in several states that provide targeted protections for confidential health information in the context of billing and health insurance claims.

Part II: Background

Importance of Confidentiality

Privacy has long been a concern of patients seeking and receiving medical care. Dating back to the Hippocratic Oath, physicians have had the obligation to maintain the confidentiality of their patients' information. More recently, the protection of confidential information has been a tenet of ethical principles in health and medicine, with medical codes of ethics and the policies of health care professionals' organizations incorporating strong privacy protections.² Federal and state laws also have established detailed confidentiality requirements.

Privacy requires protection in all health care settings and for all health services. Certain populations experience heightened concerns and certain services require particularly strong protections. Family planning services, which address some of the most sensitive and personal issues in health care, are among those that require the strongest protections; other sensitive services include care related to sexually transmitted diseases (STD) including HIV, substance use, and mental health concerns. Patients seeking family planning services, and therefore generally requiring strong confidentiality protections, encompass a broad spectrum of patient populations: women and men of reproductive age; individuals who are married, estranged, or divorced and insured under a spouse's policy; and children of separated and divorced couples.³ Research has documented the special privacy concerns of certain populations, including adolescents and young adults,⁴ and victims of domestic or intimate partner violence.⁵ The extensive research findings about the importance of patients' privacy concerns and the consequences of confidentiality breaches have provided the foundation for the confidentiality requirements that have been established in federal and state laws.

Title X Confidentiality Protections

The Title X confidentiality regulations⁶ are among the strongest in current law, and these confidentiality protections are one of the reasons individuals choose to seek care at Title X sites.⁷ Title X-funded health centers must follow the requirement that all information concerning the personal facts and circumstances of a patient be held confidential and not disclosed without the documented consent of the individual. The regulations contain exceptions that allow health providers to disclose patient information without documented consent if necessary to provide services to the patient or if the disclosure is required by law; but even then appropriate safeguards for confidentiality must be in place. These regulatory requirements have been incorporated into Title X program guidance.⁸ The regulations and implementing program guidance can be viewed as a gold standard in confidentiality protection and have withstood numerous attempts to alter or weaken them.⁹

Changing Health Care Delivery Environment

Title X providers are working in a rapidly changing health care delivery environment. Key drivers of change have been the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA),¹⁰ the privacy regulations pursuant to HIPAA (the HIPAA Privacy Rule),¹¹ and the Affordable Care Act (ACA).¹² At the same time, Title X grantees have felt increasing pressure to identify new revenue streams as federal funding for the Title X program has been reduced by 12.3% from 2010 to 2013.¹³

The HIPAA Privacy Rule has both strengthened confidentiality protections and created some opportunities for private information to be disclosed. The Rule imposes detailed obligations on health care providers and confers new rights on patients, including the right to request special confidentiality protections that could limit disclosures,¹⁴ especially when the disclosures would place patients in danger. The Rule also allows for certain disclosures in connection with billing and payment in ways that have the potential to undermine confidentiality.¹⁵

The ACA has enabled millions of uninsured individuals to gain coverage and sets standards for the services they must be able to receive with that coverage.¹⁶ Significantly, the ACA allows young adults to remain on a parent's health insurance plan until the age of 26.¹⁷ The increased number of young adults and victims of intimate partner violence with insurance has raised the visibility and urgency of the confidentiality challenges associated with insurance claims.¹⁸ Also of critical importance, the ACA requires most commercial health insurance plans to provide coverage for certain preventive services without cost-sharing.¹⁹ The scope of services covered under this requirement include many that are provided at Title X sites, such as all FDA-approved contraceptive methods,²⁰ associated counseling and well-woman visits; screening and counseling for STDs including HIV, and intimate partner violence; and some vaccines (such as HPV).²¹

Emerging Confidentiality Challenges

Protecting confidentiality is complex and has long been challenging in the health insurance arena.²² Some federal standards have been established to safeguard patient privacy, but apart from the HIPAA Privacy Rule there is no single overarching standard for confidentiality protections that applies across payer sources, which creates apparent conflicts between state and federal laws and even among federal laws. The landscape is replete with opportunities for disclosure of private information, some of which are the result of explicit legal requirements, such as the sending of explanations of benefits (EOBs). Meanwhile, others are inadvertent or unintended consequences of systems, such as web portals and electronic health records (EHRs), established to benefit health care providers and patients.²³ While Title X has strong confidentiality protections, the expansion of insurance coverage to previously uninsured populations has complicated the system.²⁴ Historically, Title X has served very few patients with commercial insurance, and Medicaid eligibility has been largely limited outside of family planning expansion programs, so providers have had little need to bill third-party payers. Now, however, a growing number of Title X patients have coverage, which means there are third parties from whom payment can and should be sought. Although other health care sectors are also grappling with similar confidentiality issues, the challenge is particularly acute in Title X settings because of both the heightened risk of harm from disclosure associated with the sensitivity of the services and the pressure to maximize revenue sources in a time of declining Title X and other public family planning dollars.

Part III: Purpose and Methodology

The purpose of this white paper is to shed light on the challenges that currently exist with respect to confidentiality, third-party billing, and insurance claims. First, the paper identifies the federal and state laws and policies that can result in breaches of confidential information in the billing and insurance claims process as well as those that protect the confidentiality of health information. The paper offers analysis of the implications of both sets of laws and policies for Title X and family planning providers. Second, the paper highlights examples of some of the approaches that have been adopted in a small but growing number of states to resolve the existing conflict between protecting confidentiality and using health insurance coverage.

To identify relevant laws and policies, a search was conducted of sources related to the HIPAA Privacy Rule; state confidentiality requirements; Title X; Ryan White HIV/AIDS Program; Section 330 Federally Qualified Health Centers; Medicaid; and commercial health insurance. Relevant sources were identified using LexisNexis and the Internet. A literature review of secondary sources included journal articles, monographs and reports, websites, and other electronic databases. Primary sources identified and analyzed included statutes, regulations, sub-regulatory guidance, and court decisions.

Extensive searches were conducted to identify primary sources in federal law. Searches also were conducted for state laws and policies in eight states. The criteria used to select states included: whether a state had laws requiring commercial health insurers to disclose confidential information as part of the claims process, e.g. via EOBs; whether a state had new or specific laws providing confidentiality protection for dependents insured on a family member's health insurance policy; the state's status with respect to Medicaid expansion under the ACA; the state's status with respect to the expansion of Medicaid eligibility for family planning services via waiver or a state plan amendment; other Medicaid factors, including Medicaid managed care implementation and any known Medicaid policies with respect to the "good-cause" exception;²⁵ geographic distribution; and the family planning policy environment in the state.

Through the application of these criteria, a non-representative but diverse group of states was selected, including Alabama, California, Colorado, Illinois, Iowa, New York, Texas, and Washington. The research conducted in these states was not designed to create a complete legal profile of each state but rather to identify some examples of different legal and policy approaches to disclosure requirements and confidentiality protections in the billing and insurance claims process.

Part IV: Required Disclosures & Confidentiality Protections in Current Laws & Policies

Many requirements of state and federal law can lead, directly or indirectly, to the disclosure of confidential health information that an individual would prefer remain private, sometimes for urgent and compelling reasons. Federal and state laws also contain numerous confidentiality protections for health care information. These laws vary widely in terms of what information they protect, who can access the information, when the patient's permission is required for disclosure, and many other factors. Although electronic health records (EHRs) constitute an extremely important component of the management of patients' health information, including the degree of confidentiality protection, a detailed exploration of the laws and policies that are specifically related to EHRs is beyond the scope of this white paper. The following discussion addresses disclosure requirements and confidentiality protections in the HIPAA Privacy Rule, state medical privacy laws, Title X, the Ryan White HIV/AIDS Program, Section 330 Federally Qualified Health Centers (FQHCs), Medicaid, and commercial health insurance.

HIPAA Privacy Rule

The HIPAA Privacy Rule contains many provisions that protect individuals' confidential medical information, which is referred to as "Protected Health Information" or "PHI." However, the HIPAA Privacy Rule also contains a key provision that leads to the disclosure of individuals' PHI, often with their permission but without their clear understanding that the disclosure may occur.

Disclosure of PHI Under the HIPAA Privacy Rule

Although an individual's authorization is generally required in order for "covered entities"—which include health plans and insurers as well as health care providers—to disclose PHI, there are exceptions, such as when disclosures are required by law, as in child abuse reporting, or for certain public health purposes. Also, there is one overarching exception to the authorization requirement,²⁶ which is that health care providers, health plans, and insurers are permitted to disclose otherwise protected confidential information for "treatment, payment, or health care operations" without the express authorization of the individual.²⁷ This covers a broad range of communications that occur within the billing and health insurance claims process.

Most covered entities do obtain authorization from individuals to disclose their PHI even when those disclosures will occur for treatment, payment, or health care operations purposes. For example, when seeking care from a health care provider in an inpatient or outpatient setting, individuals are almost always asked—and, in effect, required—to sign a document authorizing the provider to disclose whatever confidential health information is necessary to submit claims and receive payment from their health insurer. The signing of these documents is routine, and patients may not understand the full implications of what they are signing.²⁸ Even without that authorization from the individual, however, the health care

provider would likely be able to disclose the information under the rubric of the "treatment, payment, or health care operations" regulation. The reach of the HIPAA Privacy Rule is so broad, and the implementation of its requirements in virtually all health care settings has become so routine, that the implications of the disclosures that may occur are rarely made clear to patients.

Some states have statutory provisions authorizing these disclosures without the patient's authorization. In other states, the policy may be embodied in insurance contracts or plan documents. For example, in California, the "Confidentiality of Medical Information Act" provides:

A provider of health care or a health care service plan may disclose [without authorization of the patient] medical information as follows:... to an insurer, employer, health care service plan, hospital service plan, employee benefit plan, governmental authority, contractor, or other person or entity responsible for paying for health care services rendered to the patient, to the extent necessary to allow responsibility for payment to be determined and payment to be made [emphasis added].²⁹

Another example of the way in which insured individuals may have authorized disclosure of their confidential information without realizing it is contained in the standard "Summary Description" of one group health insurance plan in Alabama:

To administer this plan we need your medical information from physicians, hospitals and others. To decide if your claim should be paid or denied or whether other parties are legally responsible for some or all of your expenses, we need records from health care providers and other plan administrators. By applying for coverage and participating in this plan, you agree that we may obtain, use and release all records about you and your minor dependents that we need [emphasis added] in order to administer this plan or to perform any function authorized or permitted by law. You further direct all other persons to release all records to us about your minor dependents that we need to administer this plan. If you or any provider refuses to provide records, information or evidence we request within reason, we may deny your benefit payments. . . . Additionally, we may use or disclose your personal health information for treatment, payment or health care operations, or as permitted or authorized by law pursuant to the privacy regulations under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) [emphasis added].³⁰

Confidentiality Protections Under the HIPAA Privacy Rule

In addition to the provision that can lead to disclosures of patients' PHI, the HIPAA Privacy Rule also contains important confidentiality protections of particular relevance for Title X providers. These include specific protections for the rights of minors and two special confidentiality protections that allow patients to request restrictions on disclosure of their PHI and request that communications of their PHI be confidential.

Minors' Rights

The HIPAA Privacy Rule contains specific protections for minors and provides them with important rights.³¹ Generally, the

parent of an unemancipated minor is considered the authorized representative of the minor. However, in specific circumstances the Rule treats minors as individuals who can exercise rights for themselves. In particular, this occurs when minors are authorized to give consent for their own health care,³² or when parents accede to a confidentiality agreement between a minor and a health care provider. Parents' access to their minor child's PHI in these circumstances depends on "state or other law, including applicable case law."³³ Title X provides minors with confidentiality protection that also allows them to obtain services based on their own consent.³⁴ Therefore, in the Title X setting, parents should not have access to a minor's PHI unless the minor agrees, and the minor would provide authorization for disclosure whenever authorization is required or sought.

Requests for Special Confidentiality Protections

Two critically important provisions of the HIPAA Privacy Rule allow individuals to request special confidentiality protections for their PHI and the way in which it is handled by health care providers and health insurers. These provisions have provided the basis for the efforts of several states to provide confidentiality protections in the context of billing and health insurance claims.

First, health care providers and insurers must allow individuals to request *restrictions on the disclosure of their PHI* that would otherwise be permitted for the purpose of treatment, payment, or health care operations.³⁵ Health care providers and health plans ("covered entities") are not generally required to agree to such restrictions, but if they agree to comply they must do so, except in emergencies. However, a covered entity must agree to a request not to disclose an individual's PHI without the individual's authorization if the disclosure is for the purpose of treatment, payment, or health care operations and is not otherwise required by law and *if the health care item or service has been paid for in full* by the patient or someone other than the health plan.³⁶

Second, individuals must be allowed to make requests to both health care providers and health plans that they "receive communications of protected health information... by alternative means or at alternative locations."³⁷ *Health care providers* are required to accommodate reasonable requests and may not require patients to make a statement that that they would be endangered by disclosure. *Health plans* are required to accommodate reasonable requests, but only "if the individual clearly states that the disclosure of all or part of [the] information could endanger the individual [emphasis added]."³⁸ Health care providers and health plans may require an individual to put the request in writing; provide information about how payment, if any, will be handled; and specify an alternative address or other method of contact.

Both of these provisions of the HIPAA Privacy Rule have been key elements in the efforts states are making to address the confidentiality challenges that are part of the billing and health insurance claims process. The right to request communications about confidential information by alternative means or at alternate locations has had particular prominence in these efforts.

State Medical Privacy and Confidentiality Laws

States have many laws and policies that protect the privacy of patients and the confidentiality of their health care information. These protections are found in state laws implementing the HIPAA Privacy Rule; general medical confidentiality laws; laws providing patients with access to their medical records; general patients' rights laws requiring privacy protections in outpatient and inpatient settings; protections for information related to specific health issues such as substance use, mental health problems, and HIV; professional licensing laws and evidentiary privileges; state funding programs; and minor consent laws. Most

of these laws are relevant in the Title X setting and many of them are relevant to the intersection of confidentiality laws with laws governing the health care billing and insurance claims process. A few examples of these state medical privacy and confidentiality laws are included here.

State Implementation of HIPAA Privacy Rule

The requirements of the federal HIPAA Privacy Rule are applicable to health care providers and health insurers in every state. The Rule sets the floor for privacy protections, but states are free to provide more stringent protections if they so choose. Most states have enacted statutes or promulgated rules to incorporate at least some of the provisions of the HIPAA Privacy Rule into state law; some have adopted comprehensive statutory or regulatory schemes to reflect or go beyond the HIPAA requirements. Examples of states with detailed laws implementing HIPAA include California, Colorado, New York, Texas, and Washington. Four of these states—California, Colorado, New York, and Washington—have relied on the HIPAA privacy framework to begin to limit confidentiality breaches in the insurance claims process. These approaches are discussed in detail in the last section of this white paper. Texas has numerous statutory and regulatory protections for confidentiality and medical privacy. In particular, the Texas Medical Records Privacy Act contains several provisions that are more stringent than the HIPAA Privacy Rule.³⁹

General Medical Privacy and Confidentiality Laws

Although a comprehensive survey of the full range of medical privacy and confidentiality laws adopted by the eight states examined for this white paper is beyond this paper's scope, some salient examples of the various types of laws found in these states are highlighted here. California has long-standing and particularly detailed laws that pre-dated

HIPAA but have been updated and amended since the HIPAA Privacy Rule was promulgated—such as the Confidentiality of Medical Information Act⁴⁰ and the Patient Access to Health Records Act,⁴¹ both of which contain detailed provisions specifying when a patient's consent is required to release or access his or her medical records. Some state confidentiality laws pertain to the handling of medical information and records by specific types of health care providers or insurers. For example, laws in Alabama and Colorado obligate health maintenance organizations (HMOs) to protect from unauthorized disclosure any information or data about the “diagnosis, treatment, or health” of any enrollee or applicant.⁴² Many states also have laws that address the confidentiality of information related to a particular health condition, such as HIV infection, or a specific type of care, such as substance abuse or mental health treatment. The George Washington University's Hirsh Health Law & Policy Program and the Robert Wood Johnson Foundation have created an online legal database that contains summaries and citations of many of these laws.⁴³

Confidentiality for Minors

Every state has laws that allow minors to consent for their own health care in certain situations, based either on the status of the minor or services they are seeking.⁴⁴ Some states explicitly prohibit disclosure of information or records pertaining to the services for which minors may consent unless the minor gives permission for disclosure.⁴⁵ Some states explicitly grant discretion to health care professionals to disclose information to parents in specific circumstances, even when the minor has consented to care and may be objecting to the disclosure.⁴⁶ When neither state nor federal laws address the question of whether or when a minor's confidential information can be released to parents, the HIPAA Privacy Rule grants discretion to a health care provider (which includes a health insurance plan) exercising medical judgment to determine whether to grant access to parents. Many states'

minor consent laws are partially or mostly silent on this issue of parents' access.⁴⁷ However, federal Title X law is not. Title X providers may not disclose minors' confidential information without their permission unless required to do so by some other federal law or a state law such as a child abuse reporting requirement.⁴⁸

Beyond the confidentiality protections contained in minor consent laws, some states include specific protections for minors in their general medical privacy and confidentiality laws.⁴⁹ Protections for minors may also be included in the contract language for health insurance policies and managed care organizations (MCOs), but this varies widely by plan.

Title X

The Title X statute and regulations not only protect confidentiality, they also contain requirements that could create confidentiality challenges. Specifically, the regulations require that efforts be made to collect payments from third parties, including government agencies such as Medicaid, when those third parties are authorized or obligated to pay for the services a patient is receiving from a Title X-funded provider.⁵⁰

Title X Confidentiality Protections

The Title X confidentiality regulations are exceptionally strong. The regulations provide that:

All information as to personal facts and circumstances obtained by the project staff about individuals receiving services must be held confidential and must not be disclosed without the individual's documented consent, except as may be necessary to provide services to the patient or as required by law, with appropriate safeguards for confidentiality. Otherwise, information may be disclosed only in summary, statistical, or other form which does not identify particular individuals.⁵¹

These regulatory requirements have been incorporated into the guidance for the Title X program.⁵²

Of major current and historical significance, the Title X confidentiality regulations protect adolescents as well as adults;⁵³ this protection is supported by the requirement to determine a minor's financial eligibility for discounts based on his or her own resources rather than those of his or her families.⁵⁴ When documented consent is not obtained because disclosure is necessary to provide services to the patient or is required by law, appropriate safeguards for confidentiality must still be in place. Examples of disclosures that are required by law include mandatory reporting of child abuse,⁵⁵ intimate partner violence,⁵⁶ and STDs.⁵⁷ For a more detailed discussion of the history and current status of the Title X confidentiality regulations see "Adolescent Confidentiality Protections in Title X."⁵⁸

Risks of Disclosure in Title X

Generally, Title X law provides that individuals from low-income families—defined as having incomes at or below 100% of the federal poverty level (FPL) or a family with a higher income but unable to pay for family planning services—must not be charged for services unless the charges will be paid by a third party, including a government agency such as Medicaid that is authorized or legally obligated to pay.⁵⁹ Unemancipated minors who wish to receive confidential services must have their ability to pay considered on the basis of their own resources.⁶⁰ Individuals from families who do not meet the definition of "low-income" but whose income is at or below 250% FPL are to be charged according to a schedule of discounts, often referred to as a sliding fee scale.⁶¹

Title X providers are required to engage in reasonable efforts to secure third-party payment without application of discounts for low-income individuals.⁶² Third-party sources from which payments should be sought might

include public or commercial health insurance coverage through Medicaid, the Children's Health Insurance Program (CHIP), employer-based plans, the Federal Employee Benefit Program, TRICARE coverage for military personnel and families, and ACA Marketplace plans. Other publicly funded third-party sources that are important in the Title X context include FQHCs⁶³ and the Ryan White HIV/AIDS Program.⁶⁴ For Title X patients who are insured and who are subject to charges for Title X services, the copayments and other cost sharing for individuals with family incomes under 250% FPL cannot exceed what they would pay if Title X discounts were applied.⁶⁵

Although billing Medicaid or commercial health insurers and the steps involved in the insurance claims and payment process can result in breaches of confidentiality, especially if a patient is a dependent on a family member's policy, it is essential to identify approaches that allow Title X providers to secure revenues from third parties while honoring patient confidentiality. Some possibilities for doing this are highlighted in the last section of this paper. Ultimately, the Title X program requirements specify that reasonable efforts are required to collect charges *without* jeopardizing patient confidentiality.⁶⁶ This is an important failsafe for Title X patients that providers have used to not seek third-party reimbursement when the provider has ascertained that seeking reimbursement would jeopardize patient confidentiality and the patient has indicated a need for confidentiality protection.

Other Federal Funding Programs

Title X health centers often rely on funds from other federal programs to pay for services, and other federally funded health care service delivery sites sometimes receive Title X funds to subsidize family planning services. Therefore, it is important for Title X providers to understand whether any

of the requirements for these programs, such as the Ryan White HIV/AIDS Program or Section 330 Federally Qualified Health Centers, could lead to disclosures of patients' information in ways that are inconsistent with Title X confidentiality regulations and what specific confidentiality protections are part of these programs.

Ryan White HIV/AIDS Program

Some Title X health centers receive funds from the Ryan White HIV/AIDS program (Ryan White) to support medical services they provide for patients with HIV. By statute, Ryan White is a payer of last resort and Ryan White funds cannot be used if payment has been made, or can reasonably be expected to be made, by any other payer.⁶⁷ Ryan White fills the gaps for individuals with HIV who have no other source of coverage or face coverage limits.⁶⁸

Ryan White grantees and their contractors are expected to vigorously pursue Medicaid enrollment as well as other funding sources such as state-funded HIV/AIDS Programs, employer-sponsored health plans, and other public and commercial health insurance coverage.⁶⁹ They also should conduct eligibility determinations, perform insurance verification, make every effort to identify primary payers, and coordinate their services with other payers.⁷⁰ Thus the payer of last resort status of Ryan White and the obligation for recipients of Ryan White funds to seek other sources of payment available for individuals to whom services are being provided raises the possibility of disclosure similar to that which exists in the Title X setting. As in Title X, Ryan White service providers and patients have significant concerns about confidentiality that can complicate the process of sharing data to secure third-party payments,⁷¹ but also like Title X, the Ryan White law includes strong and explicit confidentiality protections.⁷²

Section 330 “Health Centers”

Federally qualified health centers (FQHCs) funded under Section 330 of the Public Health Service Act, also frequently referred to as community health centers, are required to provide voluntary family planning services and supplies.⁷³ Some FQHCs receive Title X funds to help provide family planning services. FQHCs are required to maintain the confidentiality of patient records⁷⁴ but they are also required to make every reasonable effort to collect reimbursement for costs of providing health services to patients who are entitled to medical assistance under Medicaid or under any other public assistance program or commercial health insurance program.⁷⁵ Centers are required to maintain a schedule of fees, with discounts applicable to patients based on their ability to pay, but are not allowed to deny services to anyone based on inability to pay.⁷⁶ The confidentiality regulation for FQHCs contains language almost identical to the Title X confidentiality regulations.⁷⁷ Thus Title X providers and FQHCs are in similar positions, with strong confidentiality requirements in place but also clear obligations to seek revenues from third-party payers. Consequently, the evolving approaches discussed later in this white paper would likely benefit both Title X providers and FQHCs in similar ways.

Medicaid

Title X serves many low-income patients who increasingly may be eligible for Medicaid. Therefore, understanding Medicaid’s protections, and its requirements that can result in the disclosure of confidential patient information, is crucial for Title X providers. There are three key areas of federal and state Medicaid law and policy affecting the disclosure of confidential patient information: patient records, enrollment, and decision-making; Medicaid program communications; and third-party payment requirements.

Patient Records, Enrollment, and Decision-making

The potential release of patient records to parents, spouses, and others, and the subsequent interference with patient decision-making, carries a risk of harm for some patients. Federal Medicaid law safeguards against disclosure of confidential information.⁷⁸ It also requires that Medicaid cover family planning “services and supplies” for all Medicaid enrollees of childbearing age, including “minors who can be considered to be sexually active.”⁷⁹ Combined with federal requirements that states ensure beneficiaries eligible for family planning services are “free from coercion or mental pressure and free to choose the method of family planning to be used,”⁸⁰ these protections have been interpreted to provide significant protection for patient records and decision-making, including for minors.⁸¹

In addition to confidentiality protections for Medicaid services, federal Medicaid law requires that enrollees be able to choose freely among family planning providers.⁸² This “freedom of choice” protection enables them to choose to receive services from providers, such as Title X sites, that adhere to a high standard of confidentiality protection, even if those providers are outside of the patient’s managed care network.

State laws and policies contain varied provisions that help to protect the privacy of Medicaid applicants and enrollees and their confidential health information.⁸³ These methods include both general confidentiality requirements⁸⁴ and specific confidentiality protections for information related to family planning services.⁸⁵

Additionally, the release of information about a patient’s enrollment in a Medicaid family planning expansion could cause harm. Some states have taken steps to protect this information, particularly as states have invested in technology to better use enrollment data and diverse databases containing information about patients become more linked, increasing the risk that

confidential information will be released. For example, in an analysis of state Medicaid family planning expansions, the Guttmacher Institute found that:

As data for many different state programs are linked together (with the advantage of easing enrollment and renewal, and improving customer service), situations may occur in which another family member may inadvertently be informed that a woman is enrolled in the family planning expansion program. Some states (six of the 19) have responded to this potential problem by creating electronic “flags” for client records, such as messages reminding state caseworkers and health care providers when a woman has requested confidentiality or when changes to the client’s record may affect her privacy [emphasis added].⁸⁶

Medicaid Program Communications

A significant concern for providers seeking to protect patient confidentiality arises from the use of EOBs and other forms of communication to convey information on Medicaid payment for services to enrollees. When information concerning Medicaid claims is communicated to patients, particularly through EOBs or similar notices, such communications may inadvertently reveal to parents, spouses, or other family members that a patient has sought or received family planning services, putting the patient at risk of harm.

Federal law does not explicitly require that state Medicaid programs always send EOBs when services are provided to beneficiaries or paid for by Medicaid. Instead, federal regulations require that, in order to combat fraud, state Medicaid agencies “have a method for verifying with beneficiaries [emphasis added] whether services billed by providers were received.”⁸⁷ Federal regulations, adopted pursuant

to the Balanced Budget Act of 1997, also specify that state Medicaid program contracts with Medicaid managed care organizations (MCOs) must require them to “give the enrollee written notice of any decision by the MCO . . . to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested.”⁸⁸ Thus some form of written notice to Medicaid enrollees is required by federal law when services are denied in whole or in part by a Medicaid MCO.⁸⁹ The extent to which an EOB is the specific mechanism used to comply with this requirement is not clear, although even if the written notice is not an EOB it nevertheless can result in a breach of confidentiality.

State policies vary widely when it comes to the use of EOBs and, within states, between fee-for-service Medicaid and Medicaid MCOs. Some states do not send EOBs at all, others send them only when a claim is denied, and others send them on a monthly or quarterly basis as opposed to on a per-service basis.⁹⁰ Research by the National Alliance to Advance Adolescent Health indicates that for patients not enrolled in MCOs the majority of state Medicaid agencies do utilize EOBs in some form—EOB, REOMB (Recipient Explanation of Medical Benefits), or Medical Service Verification letter.⁹¹ Interviews with 12 of the largest Medicaid MCOs serving the Medicaid population indicated that EOBs are viewed by states as a simple and inexpensive method of verifying services.⁹²

In contrast, Medicaid MCOs typically have broad discretion in setting their policies regarding the use of EOBs, and most MCOs do not send EOBs except as required by states.⁹³ Notably, CMS, the federal agency that oversees Medicaid, recently posted a sample EOB online to explain to beneficiaries that they might receive an EOB and what it would contain,⁹⁴ suggesting that use of EOBs in the Medicaid context is continuing, even if not federally mandated.

Beyond how frequently and for what reason EOBs are sent, other state policies

regarding EOBs—such as whether the patient can designate an alternate address for EOBs to be sent, or whether EOBs are sent to a minor receiving services or their parent or head of household—can impact confidentiality. In an effort to mitigate the problems that EOBs and other Medicaid communications can cause with regard to confidentiality, some states exclude information about family planning and other sensitive services when they send EOBs.⁹⁵ Also, to protect adolescents who need confidential Medicaid services, some states that do send EOBs, REOMBs, or Medical Service Verification Letters send them directly to the adolescent. The National Alliance to Advance Adolescent Health’s analysis showed that among 42 states that send EOBs or verification letters in Medicaid, “while about half . . . reported sending the statements directly to the adolescent, the other half reported sending them to the parent or head of household.”⁹⁶ Specific protective language related to Medicaid program communications in state laws or policies include some that are based on HIPAA⁹⁷ and others that pertain to communications in the state’s family planning waiver.⁹⁸

Medicaid Third-Party Liability

Medicaid is a payer of last resort, meaning that states are obligated to implement practices to secure payments from any liable third parties.⁹⁹ State Medicaid agencies are required to “take reasonable measures to determine the legal liability of the third parties who are obligated to pay for services furnished under the [Medicaid state] plan.”¹⁰⁰ The steps to determine the liability of third parties include obtaining health insurance information during the Medicaid initial application and redetermination processes.¹⁰¹ The type of information that is obtained from applicants for Medicaid “may include, but is not limited to, the name of the policy holder, his or her relationship to the applicant or beneficiary, the social security number (SSN) of the policy holder, and the name

and address of insurance company and policy number.”¹⁰² Medicaid regulations specify detailed procedures for ensuring that payment from liable third parties is collected, usually before Medicaid can issue payment on a claim.¹⁰³ They also require applicants to assign any rights they may have for medical support to the state Medicaid agency and to cooperate with collection efforts.¹⁰⁴ This is affirmed on the Medicaid website, which states: “By law, all other available third-party resources must meet their legal obligation to pay claims before the Medicaid program pays for the care of an individual eligible for Medicaid.”¹⁰⁵

Most states have adopted statutes, regulations, or state Medicaid agency policies to implement the third-party liability requirements of federal Medicaid law, although variations exist among the states. Alabama, for example, requires all providers to file claims and receive responses from liable third parties before seeking payment from Medicaid.¹⁰⁶ Colorado requires Medicaid enrollees to use “primary” third-party coverage before using Medicaid services, and requires counties to obtain information about that third-party coverage when the individual applies for or is predetermined to be eligible for Medicaid.¹⁰⁷ Illinois requires Medicaid beneficiaries to tell the Medicaid agency about medical benefits they receive or should receive.¹⁰⁸ New York requires recipients of services from the state’s Family Planning Benefit Program to assign their rights to medical support or insurance coverage for family planning services to the Medicaid agency unless “good cause” exists for them not to do so.¹⁰⁹

Federal statutes and regulations provide a good-cause exception to the requirement that individuals identify and provide information to assist in the pursuit of third parties who may be liable to pay for care and services under the plan when “it is anticipated that cooperation will result in reprisal against, and cause physical or emotional harm to, the individual or other person.”¹¹⁰ This exception, which has allowed patients to

seek health services without jeopardizing the confidentiality of their information, has been critical to protecting a patient's safety and ensuring access to family planning services.

In spite of its importance, the good-cause exception was written at a time when the primary means for a state Medicaid program to identify potentially liable third-party payers was through information provided by the patient; if a patient claimed the exemption and did not turn over their health insurance information, they could be reasonably assured that other payers—which may send EOBs or other communications that could breach the patients' confidentiality—would not be billed, and therefore their privacy would be protected. However, in today's age of electronic records and databases, and with the expansion of commercial health insurance coverage through the ACA marketplaces, many states now have alternate ways to identify and bill potential third-party payers. According to the Medicaid website:

States conduct data matches to identify third-party resources. States must have laws in place that require health insurers to provide their plan eligibility and coverage information to Medicaid programs. For example, states conduct data matches with public entities, such as the Department of Defense, to identify Medicaid enrollees and/or their dependents that have coverage through the Military Health Services system and the TRICARE program.¹¹¹

Further, there is significant variance from state to state about how the good-cause exception is operationalized, if at all. A number of states do not appear to have any statute or regulations pertaining to the good-cause exception, so it is unclear how it is operationalized in those states. This has led patients and providers in some states to be concerned about “losing control” of the process once Medicaid is billed, putting patients at

potential risk of harm. Such providers may therefore be choosing to forgo billing Medicaid to assure that the patient's confidentiality is fully protected, even when the state's Medicaid EOB and other communications policies would not put the patient's confidentiality at risk.

Other states have language regulating the use of the good-cause exception, but operationalize it differently. For example, Iowa provides that: “A woman eligible under the Iowa Family Planning Network coverage group can claim good cause for not cooperating with the Third-Party Liability Unit due to confidentiality if she is fearful of the consequences of a parent or spouse discovering that she is receiving family planning services.”¹¹² Texas Medicaid policy states: “Federal and state regulations mandate that family planning client information be kept confidential. Because seeking information from third-party insurance may jeopardize the client's confidentiality, prior insurance billing is not a requirement for billing family planning for [Medicaid].”¹¹³ Some states, such as Louisiana, make clear that the Medicaid agency has the right to pursue third-party benefits even when good cause exists for the Medicaid applicant or enrollee not to cooperate in doing so,¹¹⁴ potentially limiting the protection provided by the good-cause exception.

Commercial Health Insurance

Myriad requirements of federal and state law lead to the disclosure of confidential health information by commercial health insurers and health plans throughout the billing and insurance claims process. Although state law, together with insurance policies and contracts, contains most of the communication requirements that result in confidentiality breaches, federal law contains a few key provisions as well. In particular, federal law requires insurers to send notices when claims are denied. Virtually all states have incorporated this requirement into state law, along with requirements

for a range of other communications and practices related to claims and payment processing. Confidentiality breaches are likely a result of these communications, particularly if they are sent to or seen by a parent, spouse, other family member, or domestic partner.

Federal Disclosure Requirements

A key provision of the Employee Retirement Insurance Security Act (ERISA) requires most commercial health insurance plans¹¹⁵ to “provide adequate notice in writing to any participant or beneficiary whose claim for benefits under the plan has been denied, setting forth the specific reasons for such denial, written in a manner calculated to be understood by the participant,” and to provide an opportunity for a “full and fair review” of the denial.¹¹⁶ The federal regulations issued by the Department of Labor require ERISA plans to “establish and maintain reasonable procedures governing the filing of benefit claims, notification of benefit determinations, and appeal of adverse benefit determinations....”¹¹⁷ The ERISA definitions of “participant” and “beneficiary” suggest that these notices could be sent either to the employee/policyholder or to another individual who is covered and entitled to benefits under the plan.¹¹⁸ The regulations also state that the denial—or “adverse benefit determination”—may be sent either in writing or electronically.¹¹⁹

Regulations issued to implement ACA requirements related to group health plans and health insurers include procedures for claims and appeals. Pertinent requirements relating to denial of claims were issued jointly by the US Treasury Department, the Department of Labor, and the Department of Health and Human Services.¹²⁰ These regulations require most commercial health plans and insurers to comply with the same requirements regarding notices when claims are denied and added greater specificity to the content of the notices

required by the previous Department of Labor regulation.

As explained in the Preamble to the joint regulations:

Plans and issuers must comply with the requirements of paragraphs (g) and (j) of the DOL claims procedure regulation, which detail requirements regarding the issuance of a notice of adverse benefit determination. Moreover, for purposes of these interim final regulations, additional content requirements apply for these notices. A plan or issuer must ensure that any notice of adverse benefit determination... includes information sufficient to identify the claim involved. This includes the date of service, the health care provider, and the claim amount (if applicable), as well as the diagnosis code (such as an ICD-9 code, ICD-10 code, or DSM-IV code), the treatment code (such as a CPT code), and the corresponding meanings of these codes. A plan or issuer must also ensure that the reason or reasons for the adverse benefit determination or final internal adverse benefit determination includes the denial code (such as a CARC and RARC) and its corresponding meaning. It must also include a description of the plan or issuer's standard, if any, that was used in denying the claim (for example, if a plan applies a medical necessity standard in denying a claim, the notice must include a description of the medical necessity standard).¹²¹

The Preamble to the regulations also states:

A denial, reduction, or termination of, or a failure to provide or make a payment (in whole or in part) for a benefit can include both pre-service claims (for example, a claim resulting from the application of any utilization review), as well as post-service claims. Failure to make

a payment in whole or in part includes any instance where a plan pays less than the total amount of expenses submitted with regard to a claim, including a denial of part of the claim due to the terms of a plan or health insurance coverage regarding copayments, deductibles, or other costsharing [sic] requirements [emphasis added].¹²²

This means that virtually all benefit determinations made by health insurers are likely to be considered a denial, because the full amount of the charges submitted by health care providers is rarely paid by insurers due to a combination of the contractual discounts negotiated between the insurer and the provider and the terms of the covered individual's health insurance policy with respect to deductibles, copayments, and coinsurance. Thus Title X providers need to be aware that whether the notice is specifically titled an EOB or not, when claims are filed with their patients' commercial insurers or health plans, a notice regarding determination of benefits claimed and paid or not paid will almost certainly be sent in compliance with the requirements of federal law.

State Disclosure Requirements

Every state has numerous laws that explicitly require or indirectly result in disclosure of confidential health information as part of the health care billing and health insurance claims process. Two leading types of communications that are addressed in these statutes, regulations, and policies are EOBs and denials of claims; others include communications related to acknowledgment of claims, requests for additional information, and payment of claims. The Guttmacher Institute and the Center for Adolescent Health & the Law conducted a detailed review and analysis of these laws in all 50 states and the District of Columbia in 2012.¹²³

In addition to the requirements contained in laws and policies, various practices that are part of the insurance claims process may result in the disclosure of confidential health information to people other than the patient. For example, a policyholder may be able to view the claims history under the policy online, so that even if an EOB has been suppressed or sent to the patient rather than the policyholder, the policyholder may learn confidential information when reviewing the claims history.

Although not every state has a statute or regulation that explicitly requires the sending of an EOB for all insurance claims, the use of EOBs is ubiquitous in the health system. There are several possible reasons for this. First, about half of states do have laws specifically addressing EOBs.¹²⁴ Second, the sending of EOBs may be required in insurance contracts and policies rather than in state statutes and regulations.¹²⁵ Third, states without an explicit requirement to send a communication titled EOB almost certainly have a law requiring that a notice be sent when a claim is denied in whole or in part.¹²⁶ In light of the broad scope of how denials are understood in federal law—as described in the Preamble to the regulations regarding “adverse benefit determinations”¹²⁷—it is likely that laws requiring notices of denial are resulting in the issuance of EOBs, regardless of the specific terminology used to identify them.

Variations appear in the specific provisions of EOB laws in different states. For example, some laws specify the recipient or the content of the EOB or require information about specific services, but others do not. Detailed review of the laws in eight specific states yielded examples of these variations. For example, Alabama requires that an EOB be sent to the “insured” or “beneficiary;”¹²⁸ California requires that an EOB be sent to the “claimant and assignee;”¹²⁹ New York requires that an EOB be sent to the “insured” or “subscriber.”¹³⁰ Other states, such as Illinois,¹³¹ and Texas¹³² do not appear to

have an explicit requirement for sending EOBs but related language appears to presume that one will be sent. According to the state insurance commissioner, Washington requires that an EOB be sent upon the request of an enrollee of a health plan.¹³³

Those laws that specify the content of an EOB illustrate how confidentiality could be breached. For example, a New York statute requires HMOs and health insurers to:

...provide the insured or subscriber with an explanation of benefits form... The explanation of benefits form must include at least the following: (1) the name of the provider of service and the admission or financial control number, if applicable; (2) the date of service; (3) an identification of the service for which the claim is made; (4) the provider's charge or rate; (5) the amount or percentage payable under the policy or certificate after deductibles, co-payments, and any other reduction of the amount claimed; (6) a specific explanation of any denial, reduction, or other reason, including any other third-party payor [sic] coverage, for not providing full reimbursement for the amount claimed...¹³⁴

Similarly, in Colorado, a regulation requires that an EOB include the following information:

A. Name of member. B. Relationship of member to subscriber. C. Subscriber/member's claim number. D. Name of subscriber. E. Provider name and whether the provider is in or out of network. F. Date of service. G. Type of service (emergency, inpatient, outpatient, etc.).¹³⁵

The degree to which these requirements result in confidentiality breaches depends in part on the degree of detail included on an EOB with respect to such issues as the name of the provider and the description of the service. However, vague or general descriptions cannot be relied on as the means of protecting sensitive confidential information when the possibility exists of greater specificity resulting in breach.

Every state has a statute or regulation requiring that a notice be sent when a claim is denied partially or completely by a health plan or insurer, as mandated by federal law—ERISA and the ACA.¹³⁶ The specific information to be included in these notices of denial—or adverse benefit determinations—as set forth explicitly in both federal law and the laws of many states could easily breach confidentiality for the person receiving the services. As with EOBs, there is variation among states with respect to the recipient of the notice, and whether one is specified. The recipient is variously designated as the insured, beneficiary, legal representative, designated adult family member, enrollee, covered person, subscriber, or certificate holder.¹³⁷ There are not always clear definitions of these terms and it is not always discernable whether the denial could be sent to the patient rather than to the family member on whose policy the patient is insured.

Part V: Protections to Limit Confidentiality Breaches in Third-Party Billing and Insurance Claims

Awareness of the potential for conflict between insurance coverage and confidentiality protections has existed for decades, particularly with respect to adolescents.¹³⁸ More recently, the implications of this challenge have come into sharper focus as more adults—such as victims of intimate partner violence covered under a perpetrator’s policy and young adults remaining on a parent’s policy into their mid-20s—gain access to public and commercial health insurance coverage through Medicaid expansions and the ACA.¹³⁹ Consequently, an increasing number of states are working to find solutions by exploring approaches designed to mitigate the problem. These state-level efforts began in conjunction with and following the promulgation of the HIPAA Privacy Rule and have accelerated with the advent of the ACA. Some protections have been in existence for a decade or more, while others are brand new or contained in pending legislation.

The state laws and policies that represent at least partial solutions include strategies that implicate both Medicaid and commercial insurance. They include:

- Medicaid’s good-cause exception;
- Management of EOBs, denials, and other communications;
- Restrictions on disclosure;
- Confidentiality protections for minor or adult dependents; and
- Implementation strategies.

The following section includes examples of strategies contained in statutes, regulations, and pending legislation from California, Colorado, Maryland, Massachusetts, Oregon, New York, Texas, and Washington.¹⁴⁰ Ultimately, these strategies are linked in ways that underscore the need for seamless insurance protections. If, for example, commercial insurance protected patient confidentiality more effectively, avoiding breaches via EOBs and other mechanisms, then Medicaid’s third-party liability requirement would be less problematic and Medicaid’s good-cause exception would be less necessary. Also, the effectiveness of these strategies in protecting the confidentiality of individuals with health insurance, particularly dependents insured on a family member’s policy, depends on whether and how they are implemented; an assessment of this is beyond the scope of the legal analysis in this white paper and will require further research.¹⁴¹

Medicaid’s Good-Cause Exception

Some states have implemented the Medicaid good-cause exception in ways that are particularly beneficial to enrollees. For example, New York has operationalized the good-cause exception across its Medicaid program. Questions concerning whether patients have a good-cause reason third-party payers should not be billed appear on a number of checklists and application forms, such as the application for the state’s family planning state planning amendment

(SPA).¹⁴² Anecdotal information indicates that New York utilizes a 1-800 number providers can call to denote a patient’s need for confidentiality, which then flags that patient in the state Medicaid agency’s system so the state does not bill any third-party payers.¹⁴³ Texas requires compliance with federal third-party liability requirements, but has also incorporated language into its Medicaid Provider Procedures Manual directing providers to protect patient confidentiality in family planning:

Federal and state regulations mandate that family planning client information be kept confidential. Because seeking information from third party insurance may jeopardize the client’s confidentiality, prior insurance billing is not a requirement for billing family planning for any [Medicaid program] [emphasis added].¹⁴⁴

Washington implements the good-cause exception in Take Charge, its Medicaid family planning waiver program, with particularly detailed protections that explicitly apply to adolescents and victims of intimate partner violence:

“Two groups of clients may request an exemption from the Medicaid requirement to bill third-party insurance due to ‘good cause.’ The two groups are: . . . applicants who meet all the following criteria: are 18 years of age or younger;

are covered under their parent's health insurance; do not want their parents to know that they are seeking and/or receiving family planning services" and "individuals who are domestic violence victims and are covered under their perpetrator's health insurance"... 'Good cause' means that use of the third-party coverage would violate a client's confidentiality because the third party: routinely sends verification of services to the third-party subscriber and that subscriber is someone other than the applicant; requires the applicant to use a primary care provider who is likely to report the applicant's request for family planning services to another subscriber. If either of these conditions apply, the applicant is considered...without regard to the available third-party family planning coverage. At the time of application, providers must make a determination about 'good cause' on a case-by-case basis."¹⁴⁵

This provision does not appear to apply to young adults who, under the ACA, may be covered on a parent's health insurance until the age of 26 and whose need for confidentiality may be equal to that of adolescents. It also does not mention other adults who are not intimate partner violence victims but are covered under a subscriber's coverage when the subscriber is someone other than the Medicaid applicant; many of these adults also might have a compelling need for confidentiality protection.

Management of EOBs, Denials, and Other Communications

One of the strategies that states are beginning to use to protect confidentiality in the health insurance context involves policies that apply to the sending of EOBs, denials, and other related communications. Barriers do exist to limiting the use of EOBs. To the extent that they serve the purpose of providing enrollees and policyholders with the "adverse benefit determination" or service denial notices required by federal law, some mechanism must be found to ensure compliance with that federal law and the corresponding requirements incorporated into state laws. Additionally, EOBs have been designed at least in part to further benign purposes: deterring fraud and providing transparency in the claims process.¹⁴⁶ So, for example, informing policyholders of the degree to which they have met their cost-sharing obligations—copayments, deductibles, and coinsurance—as well as the amount of any remaining financial liability, is an important function of EOBs that must be served in some way.

In spite of these barriers, states have begun to put in place some tools for the management of EOBs and other communications that can enhance confidentiality for patients, particularly those who are insured as dependents on a family member's policy.¹⁴⁷ Some of these approaches include honoring requests for confidential communications; redirecting EOBs to the patient rather than the policyholder; controlling the level of detail in EOBs when sensitive services are involved; and suppressing or waiving the necessity for EOBs when the policyholder has no residual financial liability.

Requests for Confidential Communications

One of the leading strategies that is being adopted by states and discussed by health care professionals and advocates to reconcile the need for confidentiality with legal requirements, policies, and practices for insurance communications is to implement the HIPAA requirement of allowing individuals to request “confidential communications,” the phrase that is used to refer to requests that communications be sent to an alternative location or by alternate means.¹⁴⁸ Health care providers are required to accommodate reasonable requests of this type and may not require patients to state the basis of their request. Health insurers must accommodate reasonable requests but may require a statement of endangerment. This requirement is widely reflected in state Medicaid agency policies and insurance contracts, as well as notices of privacy practices issued to patients in compliance with HIPAA.

For example, California tells Medi-Cal enrollees: “You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. We will consider all reasonable requests, and must say “yes” if you tell us you would be in danger if we do not.”¹⁴⁹ California also has created a form for Medi-Cal enrollees to use in making such requests.¹⁵⁰

A leading state law to address the problem of confidentiality breaches in the health insurance claims process is California’s SB 138, which was enacted in late 2013 and went into effect in January of 2015. This legislation was enacted with the following explicit purpose: “Therefore, it is the intent of the Legislature in enacting this act to incorporate HIPAA standards [emphasis added] into state law and to clarify the standards for protecting the confidentiality of medical information in insurance transactions.”¹⁵¹

SB 138 contains both a detailed set of findings about the importance of privacy and confidentiality¹⁵² and a series of

definitions of key terms. “Endanger” is defined to mean that a “subscriber or enrollee fears that disclosure of his or her medical information could subject the subscriber or enrollee to harassment or abuse.”¹⁵³ A similar provision in pending legislation in Oregon defines endangerment to include fear that disclosure would lead to harassment or abuse or *undermine access to health care*.¹⁵⁴ California’s SB 138 defines “sensitive services” to include those that minors are able to consent for independently under state law—including among other services, mental health counseling, reproductive health services, STD testing and care, sexual assault services, and drug treatment.¹⁵⁵ Oregon’s pending legislation contains a similar definition of sensitive services.¹⁵⁶

Based upon these findings and definitions, SB 138 requires that:

A health care service plan shall permit subscribers and enrollees to request, and shall accommodate requests for, communication in the form and format requested by the individual, ...or at alternative locations [emphasis added], if the subscriber or enrollee clearly states either that the communication discloses medical information or provider name and address relating to receipt of sensitive services [emphasis added] or that disclosure of all or part of the medical information or provider name and address could endanger [emphasis added] the subscriber or enrollee.¹⁵⁷

This provision goes beyond the requirements of HIPAA in requiring insurers to accommodate requests for confidential communications related to sensitive services even if the enrollee does not claim endangerment. The law also makes clear that when an enrollee does claim endangerment, “the health care service plan shall not require an explanation as to the basis for a subscriber’s or enrollee’s statement that disclosure could endanger the subscriber or enrollee [emphasis added].”¹⁵⁸

California’s SB 138 is being looked to as a possible model for other states to consider as they move forward with efforts to address the problem of confidentiality and insurance. SB 138 contains some excellent elements that are protective of patients’ privacy interests. It also was enacted in the context of pre-existing California law, which already contained comprehensive protections for patients’ medical records and detailed minor consent laws that provided the foundation for the new protections contained in SB 138.

Maryland, Massachusetts, and Oregon appear to be following California’s lead with respect to confidential communications. Maryland recently enacted a law that requires the development of a form to use for requests for confidential communications in compliance with the HIPAA Privacy Rule.¹⁵⁹ The legislation pending in Massachusetts and Oregon would not allow insurers to require an explanation as to the basis for an insured’s confidential communications request.¹⁶⁰

Redirection of EOBs to the Patient

A similar strategy to the HIPAA-based request for confidential communications approach embodied in California’s SB 138 is redirection of EOBs, in which the EOB is sent directly to the patient or to a location the patient designates. Such redirection does sometimes occur, at least in the Medicaid context.¹⁶¹ However, few, if any, current laws and policies appear to explicitly require this approach in commercial insurance, although anecdotal reports suggest that some commercial insurers have adopted the practice, at least for adult patients who are insured as dependents. Redirection has the advantage of avoiding the same problems with respect to providing notice of certain rights, such as grievances and appeals, that would be associated with complete suppression of EOBs; however, it does remain potentially problematic when there is residual financial liability, which is ultimately the responsibility of

the policyholder rather than the patient. Redirection policies are evolving, so it is unclear at this time how, or even if, financial liability concerns conflict with redirection policies.

Legislation proposed in Oregon would require that most communications from insurers, including EOBs and benefit denials, be sent directly to the patient, regardless of whether she or he had submitted a confidential communications request.¹⁶² The proposed Massachusetts legislation, if enacted, would require an EOB (referred to in Massachusetts as a “common summary of payment” form) to be sent to the patient if the insured patient requested it:

Carriers shall issue common summary of payments forms at the member level for all insureds. Carriers shall permit an insured who is legally authorized to consent to care, or a party legally authorized to consent to care for the insured, to choose his or her preferred method of receiving the common summary of payments form, which shall include, but not be limited to, the following: (1) sending the form to the address of the subscriber; (2) sending the form to the address of the insured dependent; (3) sending the form to an alternate address upon request of the insured; or (4) sending the form through electronic means when available. The preferred method of receipt shall be valid until the insured submits a new preferred method.¹⁶³

This is similar to the requirement in the HIPAA Privacy Rule that allows individuals to request confidential communications, as previously discussed. However, HIPAA allows an insurer to condition compliance on the individual stating that she or he would be endangered otherwise; the Massachusetts proposed bill does not appear to permit the insurer to require such a statement. A provision in legislation recently introduced in Oregon also would not allow insurers to require the insured

to provide the basis of their fear of harassment, abuse, or limitations in their access to health care that would result from disclosure.¹⁶⁴

Exclusion of Information about Sensitive Services

One strategy for providing confidentiality protection for a patient insured as a dependent, even if the EOB or similar communication were to reach the policyholder, is to limit the level of detail about sensitive services that is included in the EOB. Legislation recently proposed in Massachusetts would do that in the following way with respect to the common summary of payments form:

Carriers shall not identify the descriptions for sensitive health care services in a common summary of payments form. The division shall define by regulation sensitive health care services for purposes of this section. The division shall refer to the National Committee on Vital and Health Statistics and similar regulations in other states, and shall consult with experts in fields including, but not limited to, infectious disease, reproductive and sexual health, domestic violence and sexual assault, and mental health and substance use disorders, in promulgating the regulation.¹⁶⁵

Massachusetts law currently requires the Division of Insurance to develop a common summary of payments form and consult with stakeholders in so doing.¹⁶⁶ A broad coalition of stakeholders in Massachusetts submitted recommendations for the content and management of the common summary of payments form.¹⁶⁷

This strategy offers some clear advantages but also has inherent limitations. For example, limiting the level of detail about services is only effective if the policyholder already knows that the patient was going to a provider, but less

so if either the name of the provider is disclosed and reveals the type of services provided (e.g., family planning), or the policyholder did not know that the patient was seeking services. The mere fact of the EOB, rather than what it contains, triggers problematic questions.

Omission of EOBs When No Balance Due

Taking into consideration the important role of the EOB in informing policyholders of their residual financial liability, some states have adopted or are considering laws and policies that either suppress EOBs or remove the mandate to send them. For example, a New York statute provides:

Except on demand by the insured or subscriber, insurers, including health maintenance organizations ... shall not be required to provide the insured or subscriber with an explanation of benefits form in any case where the service is provided by a facility or provider participating in the insurer's program and full reimbursement for the claim, other than a co-payment that is ordinarily paid directly to the provider at the time the service is rendered, is paid by the insurer directly to the participating facility or provider [emphasis added].¹⁶⁸

Thus, if a patient has paid any copayments owed to the health care provider and the balance of any amount due to the provider will be paid directly by the insurer, it is not *required* under New York law for the insurer to send an EOB to the insured or subscriber unless one is demanded. This policy contains at least two potential gaps: the policyholder (insured or subscriber) can demand an EOB (if they have become aware by some means that the care has been obtained by an insured dependent); and the statute, while eliminating any requirement that an EOB be sent when no financial

liability remains for the policyholder, still permits insurers to send EOBs.

The legislation recently proposed in Massachusetts employs a similar approach. The Massachusetts bill provides that:

Unless specifically requested by the insured, a carrier shall not provide a common summary of payments form if the insured has no liability for payment for any procedure or service, including, but not limited to, the United States Preventive Services Taskforce recommended A and B preventive services.¹⁶⁹

“Insured” is defined in Massachusetts health insurance law as “an enrollee, covered person, insured, member, policyholder or subscriber of a carrier.”¹⁷⁰ Thus, as in New York, if the proposed legislation were enacted in Massachusetts, a policyholder would be able to request an EOB; but, unlike in New York, if no request were made, the insurer would not be permitted to send an EOB if there were no residual financial liability. The proposed Massachusetts bill also makes clear that the intention is to encompass preventive services that have no cost-sharing pursuant to the ACA.

Suppression of EOBs

Health care professionals, advocates, and researchers who have considered the challenge of aligning the insurance claims process with the need for confidentiality protection often have suggested the suppression of EOBs to protect patients from the disclosure to family members of information about sensitive services.¹⁷¹ To date, current laws and policies do not appear to have adopted this strategy, possibly because doing so might impact the requirement of notification of denials and appeal rights under federal law, a requirement that EOBs often fulfill. However, the legislation pending in Massachusetts would apparently make suppression possible, by providing:

Carriers shall permit all insureds who are legally authorized to

consent to care, or parties legally authorized to consent to care for the insured, to request suppression of summary of payments forms, in which case summary of payments forms shall not be issued unless and until the insured submits a revocation of the request.¹⁷²

This provision is unusual in its use of the term “suppression” with respect to a summary of payments form or EOB. It is, however, effectively the equivalent of the type of request to limit disclosure of PHI that is permitted under the HIPAA Privacy Rule, discussed below. It differs in one important respect. The Massachusetts bill would require the insurer to suppress the summary of payment form/EOB upon request, as long as the insured is legally authorized to consent to care and states that disclosure would endanger the insured.¹⁷³ Under the HIPAA Privacy Rule, the insurer would be permitted but not required to accede to such a request.¹⁷⁴

Restrictions on Disclosure

Apart from the specific management of EOBs and other communications, an important strategy is for insurers to restrict disclosure of information about sensitive services to anyone other than the patient. Once again, this is something that the HIPAA Privacy Rule allows individuals (i.e. patients) to request.¹⁷⁵ However, health insurers are not obligated to grant such requests, unless the care to which the information pertains has been paid for in full.¹⁷⁶ This HIPAA requirement, which is applicable in Medicaid, Medicaid managed care, and the commercial insurance context, has been widely implemented in statutes, regulations, policies, and insurance contracts. The details of implementation vary.

For example, California informs its Medicaid (known as Medi-Cal) enrollees that: “You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not

required to agree to your request, and we may say “no” if it would affect your care.”¹⁷⁷ California also informs Medi-Cal enrollees that:

You have the right to request the Department of Health Care Services (DHCS) to restrict the use and disclosure of your Medi-Cal information to carry out treatment, payment or operations. You also have the right to request DHCS not to disclose Medi-Cal information to a family member, relative, or friend involved with your care or payment for your health care. DHCS may not be able to agree with your request. This form must be accompanied by a photocopy of a form of identification and documentation of your address.¹⁷⁸

Thus the confidentiality protection afforded the patient is conditional rather than within the control of the patient.

Restrictions Based on Endangerment

The HIPAA Privacy Rule requirement to allow individuals to request restrictions on their PHI provides a floor of privacy protections below which states are not permitted to go. However, states are free to adopt more protective measures. One example of a state doing so is Washington’s regulation that requires insurers to grant individuals’ requests to limit disclosure, by providing that:

Notwithstanding other provisions of this chapter, a licensee shall limit disclosure of any information, including health information, about an individual who is the subject of the information if the individual clearly states in writing that disclosure to specified individuals of all or part of that information could jeopardize the safety of the individual [emphasis added]. Disclosure of information under this subsection

shall be limited consistent with the individual's request, such as a request for the licensee to not release any information to a spouse to prevent domestic violence [emphasis added].¹⁷⁹

Thus, Washington has allowed insurers to require individuals to state that they would be endangered by disclosure and, if that occurs, requires the insurer to limit disclosure as requested by the patient.

Restrictions on Disclosures about Sensitive Services

Washington goes further in its regulations pertaining to restrictions on disclosure by requiring that insurers—and other “licensees” including health care providers restrict disclosures about sensitive services based on a written request by the patient, regardless of whether the individual has made a statement of endangerment:

Notwithstanding any insurance law requiring the disclosure of information, a licensee shall not disclose nonpublic personal health information concerning health services related to reproductive health, sexually transmitted diseases, chemical dependency and mental health, including mailing appointment notices, calling the home to confirm appointments, or mailing a bill or explanation of benefits to a policyholder or certificateholder, if the individual who is the subject of the information makes a written request. In addition, a licensee shall not require an adult individual to obtain the policyholder's or other covered person's authorization to receive health care services or to submit a claim.¹⁸⁰

Washington further makes clear what the individual must include in a request for nondisclosure and what it is that the insurer must protect:

When requesting nondisclosure, the individual shall include in the request: (a) Their name and address; (b) Description of the type of information that should not be disclosed; (c) In the case of reproductive health information, the type of services subject to nondisclosure; (d) The identity or description of the types of persons from whom information should be withheld; (e) Information as to how payment will be made for any benefit cost sharing; (f) A phone number or e-mail address where the individual may be reached if additional information or clarification is necessary to satisfy the request.¹⁸¹

These Washington regulations, if fully implemented, would go a long way toward alleviating the conflict between the need to protect confidentiality without sacrificing insurance coverage.

Requirements to Protect Confidentiality for Adult or Minor Dependents

Some states have adopted statutes or regulations that contain specific provisions to protect confidentiality either for adults or minors who are insured as dependents. Although these approaches are similar to strategies discussed above, they are not identical and are highlighted here.

For example, a Colorado regulation requires that insurers:

Must take reasonable steps to ensure that the protected health information (PHI) of any adult child or adult dependent who is covered under the policy is protected [emphasis added]. This protection includes ensuring that any communications between the carrier and covered adult child remain confidential and private, [emphasis added] as required under the Health Insurance Portability

and Accountability Act (HIPAA). This protection of personal health information would include, but is not limited to, developing a means of communicating exclusively [emphasis added] with the covered adult child or adult dependent such that PHI would not be sent to the policyholder without prior consent of the covered adult child or adult dependent.¹⁸²

This regulation contains key protections, incorporating HIPAA Privacy Rule standards, but also making clear that communications must not be sent to the policyholder without the permission of the adult child or adult dependent. This would protect young adults who remain on their parents' plans as allowed by the ACA and victims of intimate partner violence who are insured as dependents on a perpetrator's policy.

Washington, which has regulations that restrict disclosure of sensitive information, extends to minors “who may obtain health care without the consent of a parent or legal guardian pursuant to state or federal law” the same rights it grants to adults, described above, and allows minors to exclusively exercise those rights.¹⁸³ Because minors are able to obtain Title X-funded family planning services without parental consent, the Washington regulation extends to them. Washington also makes clear that insurers “shall not require the minor to obtain the policyholder's or other covered person's authorization to receive health care services or to submit a claim as to health care which the minor may obtain without parental consent under state or federal law.”¹⁸⁴ The legislation pending in Massachusetts would similarly extend its protections to minors insured as dependents.¹⁸⁵

Another example of language protecting minors is contained in a New York Medicaid MCO contract: “The Contractor must ensure that any Enrollee's, including a minor's [emphasis added], use of Family Planning and Reproductive Health services remains

confidential and is not disclosed to family members or other unauthorized parties, without the Enrollee's consent to the disclosure."¹⁸⁶ Colorado also provides protection for minors receiving family planning services in one county service site, stating: "All services are confidential. Although we encourage open communication between parents and teens, by law, [emphasis added] parental permission is not required for teens to use our services. All of the clinic's services are completely confidential."¹⁸⁷

Implementation

None of the state protections will be of value unless they are implemented in ways that effectively shield individuals with insurance, particularly those insured as dependents. The status of implementation for these laws is far from clear, and anecdotal reports suggest that in most places it is in the early stages or has not yet begun.

For example, California's SB 138 took effect in January 2015, so it is too soon to assess its effect. Nevertheless, health care providers and advocates in California have worked hard with insurers to establish mechanisms for compliance, including the development of forms and the establishment of a website to communicate with patients and providers.¹⁸⁸

If the legislation pending in Massachusetts is enacted, it requires:

The division, in collaboration with the department of public health, shall develop and implement a plan to educate providers and consumers regarding the rights of insureds to promote compliance with this section. The plan shall include, but not be limited to, staff training and other education for hospitals, community health centers, school-based health centers, physicians, nurses and other licensed health care professionals, as well as administrative staff, which shall include all staff involved in patient registration and education about confidentiality, and billing

staff involved in processing of insurance claims. The plan shall be developed in consultation with groups representing health care insurers, providers, and consumers, including consumer organizations concerned with the provision of sensitive health services.¹⁸⁹

If carried out, these detailed specifications of an implementation strategy would likely result in significant progress toward protecting patients receiving sensitive services, including family planning services from Title X providers. Ongoing monitoring and evaluation of efforts taking place in all states will be key to ensuring that they achieve maximum effectiveness.

Part VI: Conclusion

For many years, even decades, awareness has been growing of the tension that exists between protecting the confidentiality of health information and receiving reimbursement from public and commercial health insurance. Title X providers are in the vanguard of addressing this challenge and seeking ways to resolve the tension. Recently, largely due to the ACA, increasing numbers of Title X patients are enrolled in Medicaid or have coverage through commercial health insurance plans, and insurance coverage of family planning services has expanded. Therefore, Title X providers have the opportunity to bill insurance when their patients have coverage, which they are also required to do by statute. Committed to safeguarding the confidentiality of their patients' sensitive information, and obligated to do so by the stringent Title X confidentiality rules, Title X providers have been seeking ways to reconcile their ostensibly conflicting requirements—to protect confidentiality while maximizing revenues from third parties.

A growing number of states are adopting numerous strategies to address the challenge, and Title X providers have played a key role in these evolving efforts. The research conducted for this white paper uncovered examples of promising approaches in five of the eight states targeted for in-depth research—California, Colorado, New York, Texas, and Washington—as well as in three other states that have recently enacted or proposed legislation—Massachusetts, Maryland, and Oregon. The state strategies have relied heavily on the HIPAA Privacy Rule, particularly the provisions that allow individuals to request special confidentiality protections: to restrict disclosure of their information or redirect communications to a different location or send it by alternative means. Each of the evolving strategies in these states has been highlighted and discussed in this white paper. Although they do not provide complete solutions, their full implementation could result in significant progress toward enabling

patients to receive sensitive services on a confidential basis while allowing their health care providers to bill and receive payment from the patients' public or commercial health insurance. A policy guide developed to complement this white paper explores ways in which existing state laws and policies can be implemented robustly or modified, and new ones can be adopted, to move toward reconciliation of the confidentiality challenges associated with health insurance billing and claims.¹⁹⁰

Endnotes

- 1 42 U.S.C. §§ 300 et seq.
- 2 See, e.g., Madlyn C. Morreale, Amy J. Stinnett, and Emily C. Dowling, eds., *Policy Compendium on Confidential Health Services for Adolescents, 2nd Ed.* (Chapel Hill, NC: Center for Adolescent Health & the Law, 2005). <http://www.cahl.org/policy-compendium-2nd-2005/>.
- 3 Rachel B. Gold, “A New Frontier in the Era of Health Reform: Protecting Confidentiality for Individuals Insured as Dependents,” *Guttmacher Policy Review* 16, no. 4 (2013): 2. <https://www.guttmacher.org/pubs/gpr/16/4/gpr160402.pdf>. According to the Kaiser Family Foundation, more women of reproductive age (27%) than men (20%) are insured as dependents. *Ibid.*
- 4 Research findings have shown that privacy concerns influence the behavior of adolescents and young adults with respect to whether they seek care, where they do so, which services they accept, and how candid they are with their health care providers. Carol A. Ford, Abigail English, and Garry Sigman, “Confidential Health Care for Adolescents: Position Paper of the Society for Adolescent Medicine,” *Journal of Adolescent Health* 35, no. 2 (2004): 160-167. <http://www.jahonline.org/article/S1054-139X%2804%2900086-2/fulltext>; Alina Salganicoff, Usha Ranji, Adara Beamesderfer, and Nisha Kuran, *Women and Health Care in the Early Years of the ACA: Key Findings from the 2013 Kaiser Women’s Health Survey* (Menlo Park, CA: Henry J. Kaiser Family Foundation, May 2014): 28, 38-39. <https://kaiserfamilyfoundation.files.wordpress.com/2014/05/8590-women-and-health-care-in-the-early-years-of-the-affordable-care-act.pdf>. Adolescents are especially concerned about disclosures to their parents of their use of family planning services, but young adults have similar concerns. Diane M. Reddy, Raymond Fleming, and Carolyn Swain, “Effect of Mandatory Parental Notification on Adolescent Girls’ Use of Sexual Health Care Services,” *JAMA* 288, no. 6 (2002): 710-714; Rachel K. Jones, et al., “Adolescents’ Reports of Parental Knowledge of Adolescents’ Use of Sexual Health Services and Their Reactions to Mandated Parental Notification for Prescription Contraception,” *JAMA* 293, no. 3 (2005): 340-348; Carol A. Ford, et al., “Young Adults’ Attitudes, Beliefs, and Feelings About Testing for Curable STDs Outside of Clinic Settings,” *Journal of Adolescent Health* 34, no. 4 (2004): 266-269.
- 5 Victims of intimate partner violence have heightened concerns about protecting their confidential information due to fears of serious physical and psychological danger from spouses or domestic partners as a result of disclosure. *National Consensus Guidelines on Identifying and Responding to Domestic Violence Victimization in Health Care Settings*. (San Francisco: Family Violence Prevention Fund, 2004). <http://www.futureswithoutviolence.org/userfiles/file/HealthCare/consensus.pdf>.
- 6 42 C.F.R. § 59.11.
- 7 Jennifer J. Frost, Rachel Benson Gold, and Amelia Bucek, “Specialized Family Planning Clinics in the United States: Why Women Choose Them and Their Role in Meeting Women’s Health Care Needs,” *Women’s Health Issues* 22 (November 2012): e519-e525.
- 8 Office of Population Affairs, Program Requirements for Title X Funded Family Planning Projects. (April 2014), Sec. 10. <http://www.hhs.gov/opa/pdfs/ogc-cleared-final-april.pdf>.
- 9 Abigail English, Center for Adolescent Health & the Law, and National Family Planning & Reproductive Health Association, Adolescent Confidentiality Protections in Title X, June 5, 2014. <http://www.nationalfamilyplanning.org/document.doc?id=1559>.
- 10 Health Insurance Portability and Accountability Act of 1996 (HIPAA), Pub. L. No. 104-191, 110 Stat. 1936 (codified as amended in scattered sections of titles 18, 26, 29, and 42 of the U.S. Code).
- 11 45 C.F.R. Part 160 and Part 164, Subparts A and E.
- 12 Patient Protection and Affordable Care Act (H.R. 3590), Pub. L. No. 111-148, 124 Stat. 119 (signed into law March 23, 2010), and amended by the Health Care and Education Affordability Reconciliation Act of 2010 (H.R. 4872), Pub. L. No. 111-1522 (signed into law March 30, 2010).
- 13 “Title X Funding History,” Office of Population Affairs, accessed April 2, 2015, <http://www.hhs.gov/opa/about-opa-and-initiatives/funding-history/>.
- 14 45 C.F.R. § 164.522(a) and (b).
- 15 45 C.F.R. §§ 164.502(a)(1)(ii) and 164.506.
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- 17 Abigail English and M. Jane Park, *Access to Health Care for Young Adults: The Affordable Care Act is Making a Difference* (Chapel Hill, NC: Center for Adolescent Health & the Law; and San Francisco: CA: National Adolescent Health Information and Innovation Center, 2012). <http://nahic.ucsf.edu/download/access-to-health-care-for-young-adults-the-affordable-care-act-of-2010-is-making-a-difference/>; Benjamin D. Sommers, Office of the Assistant Secretary for Planning and Evaluation, U.S. Dept. of Health & Human Services, Number of Young Adults Gaining Insurance Due to the Affordable Care Act Now Tops 3 Million, June 2012. <http://aspe.hhs.gov/aspe/gaininginsurance/rb.cfm>.
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- 37 45 C.F.R. §§ 164.502(h); 164.522(b)(1).
- 38 Ibid.
- 39 Tex. Health & Safety Code §§ 181.001-181.250.
- 40 Cal. Civil Code §§ 56.10-56.16.
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- 42 Ala. Admin. Code § 27-21A-25; Colo.Rev.Stat. § 10-16-423
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- 46 E.g., Cal. Fam. Code § 6922; 410 Ill. Comp. Stat. §§ 210/4, 210/5; N.Y. Pub. Health Law §§ 18(2)(c), 18(3)(c); Tex. Fam. Code Ann. § 32.003.
- 47 English, et al., *State Minor Consent Laws*. [see note 44, above]
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- 50 42 C.F.R. § 59.5(a)(9).
- 51 42 C.F.R. § 59.11.
- 52 Program Requirements for Title X Funded Family Planning Projects, Sec. 10. [see note 8, above]
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- 59 42 U.S.C. § 300a(4)(c)(2); 42 C.F.R. § 59.5(a)(7).
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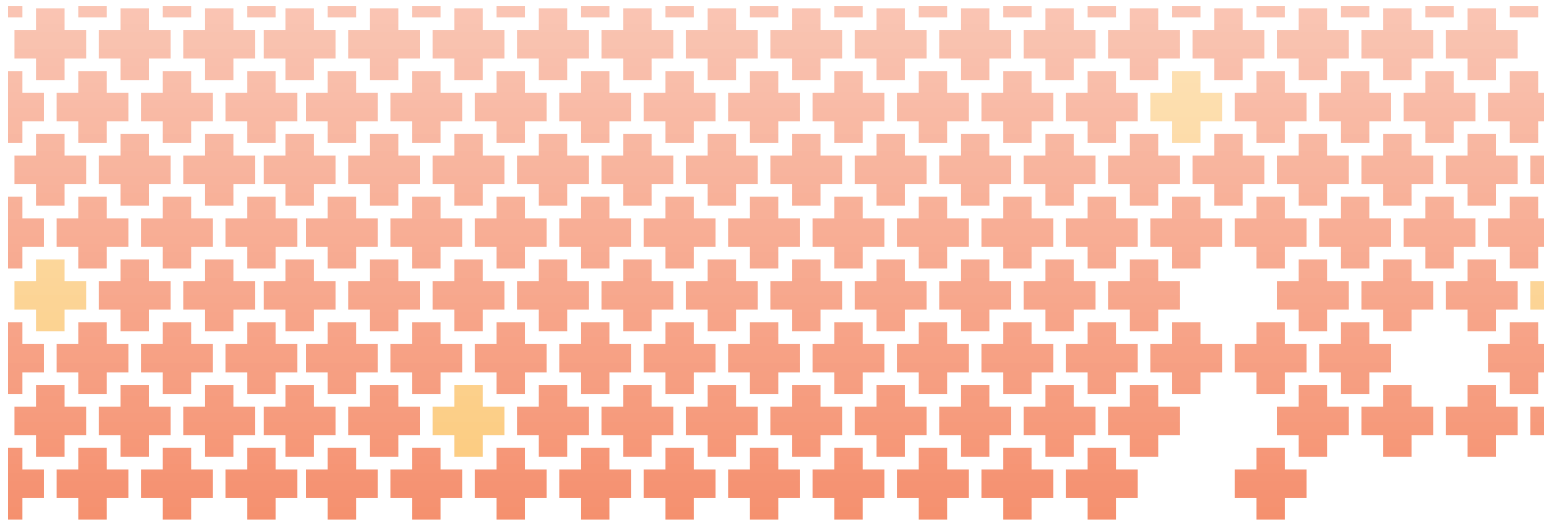
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Confidential & Covered is a multi-year research project designed to understand the factors that may make it difficult for Title X-funded family planning providers to seek reimbursement due to patient privacy concerns. Learn more at www.confidentialandcovered.com.

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NFPRHA represents the broad spectrum of family planning administrators and clinicians serving the nation's low-income and uninsured. NFPRHA serves its members by providing advocacy, education, and training to those in the family planning and reproductive health care fields. For over 40 years, NFPRHA members have shared a commitment to providing high-quality, federally funded family planning care - making them a critical component of the nation's public health safety net.



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