

EOB POLICY BRIEF

JUNE 2014

PROTECTING ADOLESCENT CONFIDENTIALITY UNDER HEALTH CARE REFORM: THE SPECIAL CASE REGARDING EXPLANATION OF BENEFITS (EOBs)



We Understand . We Care . We're Here for You



Authors:

*Kathleen P. Tebb, PhD, Erica Sedlander, MPH,
Gingi Pica, MPH, Angela Diaz, MD, MPH,
Ken Peake, DSW, Claire D. Brindis, DrPH*

EOB POLICY BRIEF

JUNE 2014

PROTECTING ADOLESCENT CONFIDENTIALITY UNDER HEALTH CARE REFORM: THE SPECIAL CASE REGARDING EXPLANATION OF BENEFITS (EOBs)



We Understand • We Care • We're Here for You

Authors:

**Kathleen P. Tebb,¹ PhD, Erica Sedlander, MPH,²
Gingi Pica, MPH,³ Angela Diaz, MD, MPH,⁴
Ken Peake, DSW,⁴ Claire D. Brindis, DrPH,^{1,2}**

Suggested Citation:

Tebb, K.P., Sedlander, E., Pica, G., Diaz, A. Peake, K., Brindis, C.D. Protecting Adolescent Confidentiality Under Health Care Reform: The Special Case Regarding Explanation of Benefits (EOBs): Philip R. Lee Institute for Health Policy Studies and Division of Adolescent and Young Adult Medicine, Department of Pediatrics, University of California, San Francisco; June 2014.

For additional copies: <http://healthpolicy.ucsf.edu/>

¹ University of California, San Francisco, Department of Pediatrics, Division of Adolescent and Young Adult Medicine, UCSF Benioff Children's Hospital

² University of California, San Francisco, Philip R. Lee Institute for Health Policy Studies

³ ICF International

⁴ Mount Sinai Adolescent Health Center

Commissioned by Mount Sinai Adolescent Health Center with funding provided by Atlantic Philanthropies

CONTENTS

Background	1
Importance of Confidentiality	1
Methodology	7
Results	8
The Tension between Billing Transparency and Patient Confidentiality.....	8
Implications/Discussion	25
EOB Suppression (Opting In Versus Opting Out).....	25
Enforcement, Operations and Evaluation of Policy Changes	26
Engaging Multiple Stakeholders, Especially the Insurance Industry	28
Conclusion	30
Acknowledgements	32
References	34

BACKGROUND

Importance of Confidentiality

Patient confidentiality is widely accepted as a fundamental tenet of health care and is particularly important for sensitive health services, such as sexual and reproductive health, mental health, and substance use regardless of the patient's age. This report focuses on the additional confidentiality concerns for adolescents and young adults. When adolescents and young adults are assured of confidentiality, they are more likely to seek health services, disclose health risk behaviors to a clinician, and return for follow-up care.¹ Concerns about potential confidentiality breaches can result in delayed or forgone care, which can lead to serious consequences, including unprotected sex, unintended pregnancy, untreated STIs, and mental health issues.^{1,2,3,4} Adolescents most at risk (e.g., those who report engaging in health risk behaviors, experiencing psychological distress and/or having difficulty communicating with parents) are even more likely to forgo care because of confidentiality concerns than their lower-risk peers.⁵ As a result, major health organizations recommend that adolescents have access to comprehensive confidential health services.^{1,6,7,8} Despite these recommendations, few teens report having time alone with their clinician for confidential health discussions.^{9,10} Other teens and young adults turn to public health safety net funds or free clinics (e.g., Title X clinics, Planned Parenthood, and adolescent clinics, such as the Mount Sinai Adolescent Health Center) to receive confidential care.¹¹

Tension between patient confidentiality and disclosure of services, costs, and payments to inform policyholders and prevent insurance fraud

There is inherent tension between the importance of confidentiality (see Case Study 1) and the need for policyholders to be informed about the costs of health care services and benefits under their health plan (see Case Study 2).

Case Study 1: The Importance of Confidentiality: How a Teen's Confidentiality was Compromised when an EOB was Sent Home

Lila, 16, came from a strict home. She knew her parents would be devastated if they found out she was sexually active. She also knew consequences would be severe, were she to become pregnant. But she found herself needing a pregnancy test. She went to a local clinic, knowing that she could obtain confidential care on her own, given her awareness of her state's confidentiality protections. She could have signed up for a publicly funded insurance program to pay for the pregnancy counseling. However, she had private insurance through her parents and assumed it would be safe to use. About two weeks later, Lila's parents received a letter, at home, from their health insurance company. It was an EOB informing them that one of the persons enrolled on their health policy received pregnancy-related services. They confronted Lila. Several days later, Lila attempted suicide.¹²

Case Study 2: The Value of EOBs

"We had a policy that was a high-deductible plan, \$3,000 a year, and our insurer would send back an EOB every time someone on our plan went to the doctor. Every EOB would show what the doctor would normally charge and the negotiated rate between the insurer and the doctor, which showed us what we had to pay. The EOB told us how much we had left on the deductible. With a high-deductible plan, an EOB helps out a lot."¹³

The ultimate purpose of Explanation of Benefits (EOBs) is to hold insurance companies accountable and to reduce fraud. EOBs inform policyholders of insurance claims made and actions taken on their account by anyone covered under their policy (including dependents) so policyholders can verify receipt of services for which they were billed; how much the insurance company pays to various providers; and the remaining balance for which the policyholder is responsible. However, the practice of sending EOBs to the primary insurance policyholder is a major barrier to protecting confidentiality of dependents seeking services under the primary policyholder's plan. EOBs typically include a significant amount of personal health information.⁴ For instance, EOBs identify the individual who received care, the clinician who provided care, and information about the services provided. The ability to keep client information confidential is further complicated by plans with family deductibles, where joint costs among members of the same health plan are tracked and tallied for the primary policyholder to view, with the purpose of calculating the total amount applied to the family deductible amount before insurance coverage begins to take effect. Neither advocates nor insurers seem to have devised a strategy for ensuring that sensitive services are not disclosed in an EOB. This gap jeopardizes minors' access to confidential services, which they can legally consent to, but may be unable to access due to fear of exposing the reason for their visit through the insurer's communication to the policyholder (see Case Study 3).

Case Study 3: Mistakenly Billing Private Insurance instead of a Public Safety Net Program: The Consequences for One Family

Mei-ling, a 17-year-old peer health educator, decided she would be a good candidate for a more effective longer-acting reversible contraceptive method (in this case an implant, Implanon). Her mother was supportive of Mei-ling's use of hormonal birth control. Mei-ling made an appointment at a family planning clinic, which offered her a confidential health visit. Unfortunately, the clinic's administrative staff, who had collected her insurance information, mistakenly billed her implant insertion to her insurance, rather than to the confidential public safety net program. As a result, her mother received an EOB that stated her daughter had gone to a family planning clinic for "minor surgery." The mother was distraught and mistakenly believed her daughter had an abortion, without her knowledge. In this case, open communication between the mother and daughter resolved the misunderstanding. However, this case illustrates that even in a confidential safety net system, confidentiality breaches are possible when private insurance is used for billing for sensitive services.

The Federal and State Legal Context Regarding EOBs: On a *Federal* level, EOBs are considerably less of a problem for individuals enrolled in Medicaid, because most state Medicaid programs do not send EOBs at all, or withhold EOBs for sensitive services (although nationally, policyholders must be notified when claims are denied).^{14,15} The issue of EOBs breaching confidentiality is a particular challenge for dependents enrolled in private plans. Even in this context, EOBs are not legally mandated; however, claims reflecting services received in the doctor's office that are denied because they may not be part of the insurance benefits package should be reported to the policyholder.¹⁶ The only Federal policy that addresses the issue of confidential communications directly is the Endangerment Clause, which is embedded within the Health Insurance Portability and Accountability Act (HIPAA). This clause states that health plans must accommodate reasonable requests by patients for alternative communications, if disclosure would "endanger" the requestor.¹⁷ Despite this policy, the actual number of endangerment clause requests appears to be very low because patients often do not know their rights; do not feel empowered to exercise them; or do not understand how EOBs work, in general. Furthermore, Federal regulations allow health care providers to obtain consent from patients to use their protected health information to secure payment from insurers. Thus, patients frequently provide such consent without fully realizing the implications of doing so.⁴

On a *state level*, regulations pertaining to EOBs vary considerably.² Regulations in about half the states either require or contain language that assumes EOBs will be sent to policyholders. In some states, EOBs are sent only when a claim is denied. Yet, EOBs are ubiquitous in most states.² States also have different confidentiality laws that can conflict with established policies and practices for sending EOBs.² This complexity makes it extremely difficult for patients and clinicians to understand the parameters of confidentiality protections and the risk of confidentiality breaches through EOBs.

Impact of Expanded Coverage on EOBs: The challenge of protecting patient confidentiality in the context of EOBs is not new but is exacerbated by the dramatic expansion of health insurance (through increased coverage by private plans; Medicaid expansion; and expanded health insurance coverage for dependents up to age 26) under the Patient Protection and Affordable Care Act (ACA). As of March 2013, an estimated 15 million young adults ages 19 to 25 were on their parents' health plans. Of these, about 7.8 million would not have been able to enroll prior to the ACA.¹⁸ As coverage expands, initial reports indicate a pent-up demand for sensitive health services. For instance, one early study shows the ACA is contributing to a rise in mental health services among young adults, with 42% of all their insurance claims related to mental health and substance use service—a rate 50% higher than other age groups.¹⁹ As the need for sensitive services,

"There is nothing within our clinic, in our administration, or in our operations of providing care to adolescents, that is more important to us right now than how we maintain confidentiality."

**—Director of Family Planning Program,
Children's Hospital Colorado**

including mental health care, increases due to expanded coverage, more adolescents and young adults will need confidentiality protections to ensure that they can fully access and use the care they need. Research continues to show that if confidentiality is not ensured, adolescents and young adults report foregoing health care altogether.^{20,21,22}

The role of safety net clinics that have traditionally served those in need of confidential health services, especially those without health insurance, is unclear in this shifting health care reform landscape. Adolescents and young adults have historically qualified more easily, than older populations, for free safety net services on the basis of their individual income. As more adolescents and young adults become insured, they will likely continue to seek health care services where they have long accessed them confidentially (e.g. family planning and other public safety net clinics) especially if privacy protections are not guaranteed, widely advertised, or made accessible to them by private insurers. Early data suggests that the number of insured clients who are turning to safety net clinics, where their confidentiality can be assured, is on the rise.²³ This utilization pattern increases the costs and burden on the public health safety net system when care could otherwise be paid for by private plans.²⁴ It also represents a financial inequality for safety-net clinicians and public safety net systems because health plans are being compensated for providing health coverage; yet, they are not responsible for paying for services provided through public funding of safety-net systems.

Clinicians, especially those concerned about their ability to protect their patient's confidentiality, will either bill public safety systems that can provide such assurances or will forgo billing and payment for services they provided (see Case Study 4). Thus, the cost burden falls on the taxpayer or clinician rather than what would otherwise be rightfully paid for by the private insurer. Given the large numbers of young adults who are enrolling in the ACA, addressing their confidentiality needs is essential to ensure both optimal utilization of health services and private and public sector cost containment (public sector savings by reduced cost-shifting; private sector savings by promoting access to preventive services for its insured members that save money) and to improve health in the long term (through preventive, sensitive health services e.g. STI screening, contraception, contraceptive care, violence screening, etc.).^{25,26}

Case Study 4: Health Care Delivery Model for Adolescents and Young Adults (MSAHC) New York City, New York, Established in 1968

MSAHC is the largest adolescent-specific outpatient health center in the country, providing physical, sexual/reproductive, behavioral and mental health, dental and vision services to approximately 12,000 youth (ages 10–24) in 2013. MSAHC has provided these comprehensive services, regardless of an individual's ability to pay. It has a long history of protecting the confidentiality of its adolescent & young adult clients; 1/3 of patients are covered by Medicaid, for which EOBs are not generated. For private insurance patients, MSAHC does not generate an EOB to ensure that it is not inadvertently sent home. MSAHC does not receive any reimbursements for care provided to these clients. To compensate for revenue loss, MSAHC raises funds, through a variety of philanthropic efforts, to continue to meet the comprehensive health needs of adolescent and young adults confidentially.

A new emphasis on expanding access to preventive services presents both opportunities and challenges to protect patient confidentiality in the context of EOBs. The ACA requires preventive services, including many deemed sensitive, to be provided without cost-sharing for patients (i.e., there will be no balance due, or payment collected).²⁷ Since it is common practice for EOBs to be sent when payment is due, this suite of prevention services could potentially reduce the need for EOBs, and thereby, minimize the risk of confidentiality breaches for these services.

Having a readily defined, consistent core set of preventive services that would never be subject to EOBs would allow providers to deliver many commonly requested confidential services such as pregnancy and STI tests. Yet currently, there are complexities in deciphering which sensitive services are “preventive,” which services will actually be covered, and whether the visit in question is purely for preventive care. For instance, in some circumstances, the patient may be responsible for co-pays associated with the visit in which a preventive service was provided as part of a visit in which they received additional services.²⁸ Also, co-pays are charged for visits that occur, “out-of-the-plan” provider network, even if the services are covered without cost-sharing.²⁸ In other cases, some diagnoses and procedures associated with preventive counseling (e.g., pregnancy test, partner treatment for a teen with a positive STI result, among others) might *not* be covered.²⁸ If the office visit and the preventive service are billed separately, the insurer may still require cost-sharing for the office visit itself.^{29,30} Thus, even though many preventive services do not require patient reimbursement, confidentiality can still be compromised through EOBs that pertain to other parts of the visit, unless there are changes to practice and policy.³

The transition period for ACA implementation presents a unique opportunity to reconsider policies and practices of sending EOBs. However, this issue is not on the radar of most policymakers, as they have been consumed with enrollment and other critical issues associated with the rollout of the ACA. Yet, the issue of protecting patient confidentiality within the context of EOBs remains critical for many dependents in need of confidential health services. There is no single solution to this complex problem; rather, there are a number of different approaches that attempt to balance the need to communicate information with the primary policyholder, with the need for the confidentiality of insured dependents who seek sensitive health services.

There is a great deal of tension between the need for patient confidentiality and the rights of policyholders to understand their health care benefits, services provided under their plan, and costs to hold insurance companies accountable for assuring that costs are tracked and services delivered. This is exacerbated by family deductible plans.

The purpose of this brief is to explore a number of these strategies and to share insights gathered through interviews with key experts (clinicians, health care administrators, health plan representatives, adolescent health advocates, researchers and policy experts). The goal is to begin to unravel some of the complexities within each of the

various approaches and to identify the benefits, challenges and implementation implications to inform future directions. Given the emphasis on enrolling young people within the ACA, it is important to consider the provision of confidential services, including preventive health care, and its impact on motivating this population to navigate the new health care landscape successfully.

METHODOLOGY

The research team invited 37 health care administrators, health policy experts, adolescent health clinicians, advocates, and representatives from health plans to participate in individual semi-structured telephone interviews. Potential participants were selected on the basis of their contributions to the literature on EOBs, and expertise in the field. Additional candidates were identified via a snowball sampling approach in which each interviewee was asked to recommend additional key informants. Up to four attempts were made to follow up with those who did not respond to the invitation letter. Of those invited, 30 completed the interview. Each interview lasted approximately one hour. Reasons for nonparticipation included not responding after four attempts (n=4); not feeling sufficiently versed in the topic (n=2); and not having enough time to complete the interview (n=1).

Participants were asked several open-ended questions about the extent to which EOBs have the potential to threaten confidentiality for adolescents and young adults. They were then presented with a range of strategies and asked to comment on the benefits and limitations of each approach, as well as any other potential policy or programmatic solutions. These questions were developed through a literature review and prior research in the area of patient confidentiality.³¹ The initial interview was pilot tested with two participants, well versed on this topic, to make sure the questions captured the most relevant issues, were understandable, and could be addressed within a 60-minute time frame. After obtaining informed verbal consent, each interview was audio recorded and transcribed. Each transcript was analyzed to capture the key themes that emerged using preset categories, as well as to identify new themes. Data were further analyzed to identify the range of responses within each theme; the relative importance of different themes; and divergent/convergent responses within each theme. Data were stored in a secure, password-protected file. This study received approval from the Institutional Review Board (IRB) at the University of California, San Francisco.

RESULTS

The Tension between Billing Transparency and Patient Confidentiality

All participants acknowledged the tension between two competing interests. On one side of this issue is the right of the policyholder to make insurance companies accountable for requested payment. This requires transparency about billing practices and all services rendered under that plan, generally captured and communicated through EOBs. On the other side are patients' rights/needs for confidentiality, especially for sensitive health services. While not all adolescents and young adults want or need confidential health services, for many, disclosure to the policyholder (typically the parent) represents a potential risk. Achieving a balance between protecting patient confidentiality and informing policyholders via EOBs is complex and difficult to achieve. As one clinician reported:

"The consumer protection piece and the confidentiality piece are completely in conflict. And we have to decide which is more ethically important."

-Director of Policy & Advocacy, American Academy of Pediatrics, New York

"There's going to be the time, even in ideal settings, where, the patient is not willing to take the risk [of using insurance in case their parents will find out], and you understand why. So you have to get them to a system (safety net health center) that can provide that service confidentially."

-Professor of Pediatrics, The Children's Hospital of Philadelphia, University of Pennsylvania

The following sections present different approaches that are either being considered or implemented across different regions of the United States, to address the complexities of protecting the confidentiality of adolescents and young adults in need of sensitive health services. **Table 1** presents an overview of these different approaches; a brief description of the advantages and limitations of each (as noted by our interviewees); and examples of where the approach is being implemented. We provide additional detail related to each strategy in the following section. While the focus of this report is on the special population of adolescents and young adults, it was frequently mentioned that these issues are relevant to any adult dependent who would like their health services to remain confidential especially those who are at risk of emotional or physical abuse, including reproductive or other types of health care decision-making coercion, simply exposing the fact that they have developed a relationship with a health care provider can be problematic. Since EOBs can be used to track someone's address and preferred health care provider/location, they are a potential safety threat particularly in cases of domestic violence.

Table 1: Overview of Strategies to Protect Patient Confidentiality Breaches for Adolescents and Young Adults Seeking Sensitive Services

Current Strategies to Address EOBs and Confidentiality	Pros	Cons	Examples of Where Strategy Is Implemented
<p>Strategy #1: Does not require health plans to send an EOB when no balance is due for services provided</p>	<p>Protects patient confidentiality for covered services, as long as EOBs are not sent when no payment is due</p>	<ul style="list-style-type: none"> • Insurance companies can <i>choose</i> whether to send the EOB or not • Only a limited number of sensitive services are universally covered • Reprogramming of billing mechanisms is necessary 	<p>New York, Wisconsin and Massachusetts</p>
<p>Strategy #2: Applies a generic current procedural terminology (CPT) code to sensitive services</p>	<p>Would not specify the exact service provided</p>	<ul style="list-style-type: none"> • Policyholders are still informed that someone on their plan went to see a clinician • This could put the dependent in the position of having to lie about services received 	<p>Implemented across the country by insurance companies, for example in Erie County, New York and Massachusetts</p>
<p>Strategy #3: Requires plans to honor requests for confidential communications from all individuals obtaining sensitive services</p>	<p>EOBs go directly to the individual seeking care or wherever they request the EOB to be sent</p>	<ul style="list-style-type: none"> • The patient may have to take the initiative to make the request • It could be difficult for the patient to come up with an alternative private address • This requires education on the part of the patient and the clinician • May require systems changes to make this option easier to utilize 	<p>California SB 138 to take effect in 2015³² and Maryland SB 790, passed April 2014.³³</p>
<p>Strategy #4: Creates a CPT code to suppress EOBs for confidential services</p>	<p>Clinicians are familiar with using CPT codes in their practice and the onus would be on the clinician and the insurance carrier, not the patient</p>	<ul style="list-style-type: none"> • Feasibility is limited, due to a legal review provided by the American Medical Association 	<p>Kaiser Permanente, Northern California</p>

Table 1: Overview of Strategies to Protect Patient Confidentiality Breaches for Adolescents and Young Adults Seeking Sensitive Services (continued)

Current Strategies to Address EOBs and Confidentiality	Pros	Cons	Examples of Where Strategy Is Implemented
Strategy #5: Requires health plans to communicate directly with adult patients (up to age 26), who are covered as dependents on their parents' plan	Dependents have to consent before any communication can be released to the policyholder	<ul style="list-style-type: none"> Process to obtain consent is unclear and needs to be developed 	Colorado Division of Insurance
Strategy #6: Educate parents so they can understand the importance of the provision of confidential care. Parents are then informed that they will not know the specific services that may show up on their insurance plan or bill, but they can feel assured that their offspring will receive care.	<p>Provides a way to protect confidentiality without relying on legislative changes</p> <p>It is important to educate parents about confidentiality, regardless of the strategy</p>	<ul style="list-style-type: none"> Some parents will disagree with confidential care or specific services for their child if they are unable to be fully informed of the service This requires continuous effort by the health center and provider 	Currently a part of the Erie County Health Department in New York and Kaiser Permanente, Northern California
Strategy #7: Engage and educate adolescents about their rights to confidential health services.	<p>Provides a way to protect confidentiality without relying on legislative changes.</p> <p>It is important to educate adolescents about confidentiality so they know their rights and to support their transition to adulthood</p>	<ul style="list-style-type: none"> Providers do not get reimbursed for patient education and are concerned about the amount of time it may take to address this issue along with other patient education responsibilities Insurance, billing and EOBs are complex topics for the average adolescent to comprehend 	Currently used in several states, including but not limited to New York's Erie County Health Department and Northern California's Kaiser Permanente
Strategy #8: Adopt overlapping strategies, using a combination of several different approaches at the same time	More strategies reduce risk of confidentiality breaches	<ul style="list-style-type: none"> Same cons/drawbacks discussed in each of the individual strategies 	Massachusetts Women's Health Care Reform Coalition is proposing overlapping five different strategies

Strategy #1: Does not require health plans to send an EOB when no balance is due for services provided

Many interviewees thought the strategy of sending EOBs to the policyholder only when a balance is due was a potential solution because preventive services will be covered under the ACA without any cost-sharing (including many sensitive health services). Some interviewees thought this strategy had the potential to protect confidentiality. However, many stated that this was *only a step* in the right direction because it does not require EOBs to be withheld and insurance companies would still have the option of sending them, regardless of whether or not balance is due. Also, if these EOBs are sent for some survivors of domestic violence or sexual assault, simply exposing that they had received health care services, or where they or their provider was located would be problematic. Most of the interviewees, particularly those from New York, where this policy is in place, expressed that this strategy has, thus far, been ineffective because insurance companies are still sending out EOBs, and no formal checks and balances are in place to ensure that this subset of EOBs is not sent to the policyholder. Furthermore, young people may or may not be aware of the specific policy held by the insurance company that provides health coverage for their families. In all likelihood, adolescent and young adult awareness about the possibility of an EOB being sent is likely to be low (unless they have been adequately educated regarding these policies).

"It basically leaves it up to the insurance company to decide whether it should be sent. I think that's the problem. It's much too wishy-washy."

-MD, Chairman, Department of Pediatrics, Director of Adolescent Medicine,
Coney Island Hospital, New York

"The one thing is what is on the books, and the one thing is what is reality? And the reality is the EOBs are sent out."

-RN, MPH, Vice President of Health Care Planning at Planned Parenthood, New
York City

Participants further stated there is no incentive for insurance companies to withhold EOBs. Some felt it was logistically easier for them, and therefore, economically advantageous, to send an EOB to every policyholder. In addition, insurance companies prefer to send EOBs to all policyholders, regardless of whether there is a liability for payment because of the push toward increased transparency in billing³⁴; and regulations in about half the states either require that EOBs be sent or assume that EOBs will be sent.² However, others, notably those in Massachusetts, found that large insurance companies are already not sending EOBs when there is no cost sharing because it saves them the time and cost associated with such distribution.

“Finding a format that can be consistently used by insurers without having to modify it in response to individual cases and individual diagnosis is probably going to be key in this situation.”

-JD, Director, Center for Adolescent Health & the Law

Participants also felt this approach was limited because it is often difficult to completely differentiate between *preventive* services, in which there is no liability for payment, and *treatment* services which require cost sharing. As mentioned previously, the ACA requires no patient/policyholder cost-sharing for a number of preventive health services. However, a range of services and procedures included in a comprehensive preventive health visit are not included, thus, leaving patients or policyholders liable for payment. For example, the STI screening test may not require any co-payment as part of a preventive health visit, but if treatment is needed, health care costs could be incurred, potentially generating a need for an EOB.

“One of the issues that is not clear is what really counts as preventive service. For instance, chlamydia screening is a preventive service, but if somebody comes in with symptoms and they are getting treated for chlamydia, that may not necessarily be considered prevention. So, I think there are a lot of gray areas.”

-MD, Adolescent Medicine, Kaiser Permanente, Northern California

“I think there are limitations to this approach because there are many situations in which the initial visit may be one which can take place without a residual financial obligation, but then some subsequent visit does involve a financial obligation. Alternatively, a single visit may combine services that have no cost-sharing with services that do, with both being of a sensitive nature.”

-JD, Director, Center for Adolescent Health & the Law

The consensus among interviewees was that the main advantage to this strategy is protecting an array of preventive health services (including a number deemed sensitive) because they are to be provided without a co-pay or cost-sharing on the part of the policyholder. However, several limitations include the gray area between preventive and treatment services, and the lack of requirements for insurance companies to withhold EOBs, even if no outstanding payment is due. As evidenced in New York, insurance companies still choose to send out EOBs, despite the policy that permits plans to bypass an EOB for a sensitive visit or a service that does not require a co-payment.³⁵ Limits to EOB distribution would require a new or modified computer billing system; currently, health plans have no incentives to develop this structural scaffolding. Even if such a system were to be set up, clinicians and patients would need to understand the limitations of this policy on protecting the confidentiality of sensitive services that would potentially still be disclosed on an EOB.

Strategy #2: Applies a generic current procedural terminology (CPT) code to sensitive services

"If a parent of a 16-year-old receives an EOB and it doesn't have any of the CPT codes listed or what the service is, and it says [service received at] 'Planned Parenthood of New York City,' it's not helping at all."

-RN, MPH, Vice President of Health Care Planning at Planned Parenthood, New York City

Another strategy requires insurance carriers to assign a generic code or description (in the electronic medical record system) for sensitive services that need confidentiality protections.³⁶ In this approach, if a patient was screened for an STI, the EOB would state "lab work," instead of the name of the STI test conducted. Most participants felt this approach only provided limited confidentiality protections because the EOB may still include information that could compromise confidentiality (i.e., the location where the service was received, such as an obstetrician/gynecologists' office). They also stated this strategy is only effective if parents are already aware that their adolescent or young adult is seeking health services.

"The limitation is if you go to a safety-net clinic and the explanation of benefits doesn't say anything about the diagnosis, but it says something about the site at which services are provided, or even if it just says that services were provided, it essentially begins to crack the cover of confidentiality."

-Professor of Clinical Population and Family Health and Department Chair, Population and Family Health, Columbia University School of Public Health, New York

Furthermore, key informants stated that any information associated with the visit could lead parents to question their child about the reason for the visit or contacting their health plan to get additional information about any potential co-payments or deductibles associated with the visit.

"There are going to be parents that are going to look at their kid at the dinner table and say, 'What's going on? Why were you going to the doctor?' I think that puts the kid in a tough position."

-Acting Vice President for Public Policy, Guttmacher Institute

"They see that they have this huge co-payment and they can call the health plan and get that information, at least for a minor. So it's only partially protected. I mean it makes the parents jump through a couple of hoops, but they still can have access to that information."

-Commissioner, Erie County Department of Health and Clinical Professor of Pediatrics, University at Buffalo School of Medicine and Biomedical Sciences, New York

As one participant noted, to fully protect confidentiality, everything associated with the visit should remain confidential, including follow-up care resulting from the initial visit. Without such assurance, the participant expressed fear that many young people would forgo needed care.

“If it’s going to be confidential, it shouldn’t just be the reason for the visit that should be confidential. I think the whole thing should be confidential.”

–MD Chairman, Department of Pediatrics, Director of Adolescent Medicine,
Coney Island Hospital, New York

Thus, a small number of interviewees expressed confidence that a generic visit on an EOB provided some confidentiality protection. However, the overwhelming majority were not confident in this as an effective strategy because the EOB could still contain information that places the dependent in a position of having to either disclose information to a parent or lie about sensitive services received.

Strategy #3: Require plans to honor requests for confidential communications from all individuals obtaining sensitive services

Thus far, three states have enacted formal policies that require insurance companies to honor patients’ requests for confidential communications about sensitive health care services. (1) California passed *the Confidential Health Information Act*, Senate Bill (SB) 138, which takes effect January 1, 2015. This legislation builds on a number of existing confidentiality provisions under California law (e.g., adolescents age 12 and above can consent for a number of sensitive services, such as sexual/reproductive, mental health, and substance use counseling without parental knowledge or consent). In brief, this strategy requires health plans to honor individual or clinician requests not to send EOBs to policyholders for sensitive services, when disclosure of this information could lead to patient endangerment. “Endangerment” is defined as fear that disclosure of medical information could subject the subscriber or enrollee to harassment or abuse.³⁷

According to this law, once a confidential communication request is submitted, the individual is required to provide the health plan with a way to communicate information directly to the patient. In other words, dependents need to provide a physical or electronic address where it is safe to receive communications about services rendered. This way, the EOBs are sent directly to the patient instead of the policyholder. (2) Maryland passed legislation (April, 2014) which requires the Maryland Insurance Administration to create a standard form for individuals in danger to request insurance communications to be redirected to an alternate address. SB 790, *An Act Concerning Health Insurance – Communications Between Carriers and Enrollees – Conformity with HIPAA*. The policies in California and Maryland are so recent it is too soon to be able to tell if/how they will actually be implemented in practice. (3) Hawaii also has a state statute that requires providers to inform the insurer when minors request that their visit

remain confidential.³⁸ While this statute has been in effect since 2007, there is no evidence about how this component of the law is being implemented in practice.

Several participants believe that prohibiting an EOB from being sent directly to the policyholder could be an effective way to protect confidentiality for adolescents and young adults. Yet, at the same time, they expressed major concerns about how this particular strategy would be implemented:

Concern #1 How will patients know they have a right to withhold an EOB from being sent and how will they be able to exercise this right? Most participants felt that many of the individuals who would benefit most from this strategy are young and may not understand EOBs, in general, and would need to be educated about their rights to request that no EOBs be sent directly to the primary policy holder, but to an alternative address.

“For something like this, where the patient has to ask for the EOB to be issued by alternative means, the educational piece is a really key component.”

-JD, MPH, Senior Health Policy Manager, Health Care For All

“So this [approach] does require education and outreach, and it requires some effort, knowledge, and savviness on the part of clinicians and patients.”

-Senior Attorney, National Center for Youth Law

Some mentioned that educating patients about their right each time they book an appointment and at every “point of service” should be the default practice for this legislation to improve its efficacy.

“I’d like to see more education because I believe that anything that happens has to happen at the point of access. It would be effective if practitioners informed young people that they had this right. “

-Pediatrician, Adolescent and Preventive Medicine Specialist, Health Plan
Medical Director and Attorney at Law, California

However, others raised questions about who would be responsible for this education and how it would be integrated into the visit. Most participants were concerned about the policy’s reliance on the patient or clinician to “actively” request that an EOB not be sent. They stated that adolescents and young adults are unlikely to understand EOBs and insurance in general, and even if they were informed, they may not take the initiative to exercise their rights provided in this law.

"If it [the way the law is implemented] puts the onus on the patient that means that the patient has to know that they have this right. And not only know that it's their right, but be comfortable to exercise their right – confident enough to say, 'I don't want anything mailed home.'"

-Assistant Commissioner, Department of Health and Mental Hygiene,
New York City

"We're talking about the people who are most vulnerable here, those that have the greatest confidentiality concerns. To expect them to be able to do that [request that the EOB is sent to an alternative address] is pretty unrealistic."

-Family Planning Unit Manager, Department of Public Health & Environment,
Colorado

Participants also stated that it may be particularly difficult for clinicians to make this request when they have limited time with each patient to discuss the range of recommended health topics for preventive health visits, as well as in the time-constrained acute care setting.

"From a realistic standpoint, the clinicians don't have the time or the capacity to do that level of education either, and I don't think it's fair for us to put that on them and expect that they can do that."

-Family Planning Supervisor, Colorado Department of Public Health &
Environment

"Each year we have more and more things we want to try and teach people about when they come into the practitioner's office and we're going to have to figure out how to do that efficiently."

-Pediatrician, Adolescent and Preventive Medicine Specialist, Health Plan
Medical Director and Attorney at Law, California

Concern #2 How will adolescents know where to have an EOB sent (an alternative address) other than their own home? Interviewees raised a lot of questions and concerns about where the patient would request the EOB be sent (another house, e-mail address) if it did not go to the policyholder's home address.

"Where would you have it sent to? A house? Or, you know, where would it go? I mean, I can't imagine what kind of choices young people would make for another place. Even if it's your partner's house, your boyfriend or girlfriend's house, still it's what, do you do, hang around the mailbox 'til it gets there and then grab it?"

-Director of Policy & Advocacy, American Academy of Pediatrics, New York

“What would a 15-year-old say? You know, how would she come up with an answer to, ‘Where do you want this EOB sent?’ Would it prompt them to give a fictitious address?”

-Director of Family Planning Program, Children's Hospital Colorado

A few participants acknowledged that with the transition to technology over paper-based communications, sending an EOB electronically to the patient, via a password-protected Web site, confidential/secure e-mail address, or as a private text message may address this problem. How or whether this could be operationalized is still unknown, but it is important for those responsible for implementation to consider this option in the early planning stages of California's *Confidential Health Information Act*.

“If the insurance company has the capacity to send you an EOB by e-mail or by text, you can really be assured that it's going to be sent to you and that you are the only one that will have access to it. And I think as we move more into electronic records and electronic communication, this will become easier for both the insurers and for the consumers.”

-Senior Attorney, National Center for Youth Law

While many questions and concerns about this strategy were expressed, several interviewees recognized that it is too soon to tell how it will be fully operationalized in the field once the law takes effect. Advocates have been able to secure funding to support an educational campaign to raise awareness about California's new law and to strategize various approaches to facilitate its implementation.³⁹

“In California, they have some funding from a foundation to do a big educational campaign after passage of this law, which will be critically important in the law's implementation.”

-JD, MPH, Senior Health Policy Manager, Health Care For All

The ultimate success of this policy will likely be driven by how well it is implemented. Evaluating this policy throughout implementation is an important step in further understanding the efficacy of this approach.

Strategy #4: Creates a Current Procedural Terminology (CPT) code to suppress EOBs for confidential services

CPT codes, operated by the American Medical Association (AMA), are used to describe medical services and procedures provided to patients and to communicate that information to a variety of stakeholders, such as clinicians, patients, accreditation organizations, and payers for administrative, financial, and analytic purposes. The objective of this strategy is to create a code for any service or procedure that should be confidential. Currently, no state or national policies require use of CPT codes to

suppress EOBs for confidential services. However, Kaiser Permanente of Northern California is using a computerized coding approach to protect the confidentiality of their adolescent patients between the ages of 12 through 17 years (see Case Study 5).

Case Study 5: Kaiser Permanente, Northern California's Internal Electronic Coding System

Kaiser Permanente, Northern California, has developed a system to balance the needs of parents to support their children's health with adolescents' needs for confidential care. Kaiser's Adolescent Medicine champions worked to ensure their system is legally compliant with State regulations and that it promotes adolescents' access to and assurance of confidentiality for sensitive services. Protocols are in place to protect confidentiality in all aspects of the Kaiser health care system for adolescents, including the call center, online communications, appointments, actual visits, diagnoses, laboratory, pharmacy, injection, Electronic Medical Record (EMR), and billing. Specifically, Kaiser implemented a computerized coding system (using a unique electronic code) for all adolescent confidential health services. Under Kaiser's policy, an appointment, visit or procedure classified and/or coded as "confidential" for an adolescent will not count toward the policyholder's deductible; EOBs will not be sent out; and even follow-up patient satisfaction surveys (clinician survey) are not sent to the home. Additionally, if a co-payment is required for a sensitive service, but the patient cannot pay it, the fee is waived. Furthermore, if the provider fails to check the appropriate box, the programming for billing prevents any EOB billing from being sent for certain codes used by the provider. While Kaiser is a "closed" health care system, in contrast to a "fee for service" system with multiple insurance companies, Northern California's Kaiser has demonstrated its commitment to assuring adolescent confidentiality for sensitive services. It has truly prioritized this issue by creating a system that successfully suppresses all communications for adolescent sensitive services covered by law.

"We have a special code—'adolescent confidential visit'—to make sure that a member clinician survey is not sent to the home and to make sure that the information of that visit is not shared with people who should not see it."

—MD, Adolescent Medicine, Kaiser Permanente, Northern California

Many participants expressed that this was the only strategy worth pursuing because it would automatically suppress the EOB instead of relying on patient/clinician education and action.

"There's no simple or elegant way to do this, other than use the technology to help you, as opposed to try to fight the technology because you won't win. So, if we can use the technology by saying this age and these CPT codes equal suppression, I think we can get something done."

—Director of Policy & Advocacy, American Academy of Pediatrics, New York

"It would be a good strategy because clinicians are used to doing CPT coding and insurers are used to dealing with CPT codes, so probably both clinicians' billings and claims systems and insurers' computer systems are already pretty much set up to deal with variations in CPT codes."

—JD, Director, Center for Adolescent Health & the Law

However, others reported that creating a CPT code to automatically suppress an EOB was not feasible for a number of reasons. A few reported that EOBs are required by some states when there is a liability for payment. Thus, this approach would require changing state mandates, which many viewed as unrealistic.

Key informants also expressed concern that even if such a code existed, clinicians would have to take the initiative to use it and they would need to have a common understanding of when to deem it appropriate to use. Some were concerned that such reliance on clinicians could lead to mistakes about which EOBs to suppress and which not to suppress. Thus, additional build-in programming to suppress the subset of CPT codes would be warranted to maximize success of this strategy.

"I would worry about that [onus on clinicians]. I think I might feel a little better if there were some trigger for clinicians, that some kind of prompt pops up in the electronic health record."

-Acting Vice President for Public Policy, Guttmacher Institute

"It depends on the clinician actually knowing what services were legally protected in terms of confidentiality. Clinician knowledge of the adolescent confidentiality laws are rather erratic or inconsistent or variable."

-JD, Director, Center for Adolescent Health & the Law

Importantly, several interviewees were proponents of this strategy at a national level, but were unsuccessful in getting it adopted. Since CPT codes are a registered trademark of the AMA, the AMA has to approve the development of any new code. In 2009, key stakeholders (from the American Academy of Pediatrics, American Congress of Obstetricians and Gynecologists, Center for Adolescent Health and the Law, Society for Adolescent Health and Medicine, National Institute for Health Care Management, and the Guttmacher Institute), many of whom were interviewed for this study, discussed strategies for preventing the disclosure of confidential health services and requested that the AMA create a new CPT code to suppress EOBs. However, the AMA's legal review stated other laws would have to be altered to develop this code because EOBs are legally mandatory in many states when there is a financial obligation. As a result, AMA did not pursue EOB confidentiality strategies further at that time.⁴⁰

Participants also discussed potential resistance from insurance companies as a barrier to this strategy. Some received feedback from insurers who stated a need for practices and policies to be logistically simple to implement "across the board" and would not invest money and time in developing a new reporting system, re-programming, staff training, or accommodating for CPT codes that are subject to change over time.

"We thought it was a great idea. The [insurance] carriers said it was an impossible mission."

-MPH, Health Access and Promotion Coordinator, Department of Public Health, Massachusetts

“Insurance companies strongly prefer and maybe insist on not having to modify forms in individual situations. In other words, they want a standard form that they can use for everything.”

-JD, Director, Center for Adolescent Health & the Law

While almost all interviewees viewed this approach as the most difficult to accomplish, several still saw it as the best approach for protecting confidentiality. Opinions as to whether the CPT strategy should be pursued further, particularly after the implementation of the ACA and new advances in EMRs, fell into two divergent categories: (1) efforts should continue because this is the only viable option to adequately and automatically address this issue; and (2) because of the barriers faced in previous efforts, it is not feasible to pursue further.

Strategy #5: Requires health plans to communicate directly with adult patients (up to age 26), who are covered as dependents on their parents' plan

During this study, the Colorado Division of Insurance passed a requirement for health plans to protect the health information of adults covered as dependents (children, spouses, or domestic partners).⁴¹ The rule requires plans to develop their own way to communicate directly with the dependent so that they give consent to release any communication to the policyholder. We interviewed three representatives from the Colorado Department of Public Health and Environment (CO DPHE) team responsible for this policy change. They reported that a key to their success was working closely with other sensitive service advocates, such as mental health advocates and domestic violence organizations, to galvanize support for this policy, since the provision of other “sensitive services” may be less “divisive” than reproductive and sexual health services, and because the issue affects not only adolescents and young adults but adult dependents as well. Thus, all of these related services require a great deal of commitment to the provision of services in a highly confidential manner if they are to effectively reach the populations in need.

“We also have a huge issue with mental health and depression and a lot more advocacy towards that, a lot more normalizing of that conversation here. Our governor champions those issues. It’s actually a winnable battle in our state. So the time was ripe in fact for us to expand the discussion to all sensitive services.”

-Family Planning Unit Manager, Department of Public Health & Environment, Colorado

CO DPHE educated multiple stakeholders, such as the Division of Insurance, local health centers, and some of the biggest insurance plans, about this issue in order to

garner interest in and support for this issue. After this educational strategy, implementing a rule change was relatively quick.

“We actually went straight to the Department of Regulatory Agencies, another sister agency. So rather than doing it legislative[ly] through a bill, we were able to do it through a rule change, and it was just perfect timing, quite frankly. They were working on revising all of their rules and regulations. And again, we didn’t necessarily influence the decision, but we helped to educate folks about the issue. And then about 3 weeks after our meeting, the language was revised.”

–Family Planning Unit Manager, Department of Public Health & Environment, Colorado

This rule change is in its infancy, and like most of the strategies discussed, its success will likely hinge on how a wide variety of health plans, clinicians, and settings operationalize and enforce it in the field, including informing and educating consumers regarding this protection.

Strategy #6: Educate parents about the importance of adolescent confidentiality

In addition to the policy-related strategies previously presented, participants were asked to comment on an approach to educate parents about the importance of confidentiality in the provision of health care for their adolescent. Under this strategy, parents receive information/handouts that explain that providers are required to deliver confidential health services as a standard of quality care and that certain

“We also want to be sure that we don’t leave parents behind. I mean, part of what we’re trying to do with these young people is help guide them as they transition into adulthood, when they’re going to be consumers themselves.”

–Vice President, Health and Reproductive Rights, National Women’s Law Center

sensitive services, such as STI screening tests, are a normal part of wellness visits for adolescents and young adults. Parents are informed that the clinician encourages patients to discuss their health issues with their parents and to prepare parents for the types of information that might appear on an EOB. It can also help parents understand

that as adolescents assume a greater role in their health care, a confidential visit can support their transition to adulthood.⁴² The idea behind this approach is that through increased knowledge, parents will be more accepting of their children having access to confidential services as a normative part of their child’s health care experience and as an opportunity for them to developmentally gain skills for using the health care system effectively now and into the future.

Many respondents viewed parental education as a critical piece to normalize confidentiality and certain preventive services as part of most wellness visits for adolescents and young adults. However, several interviewees felt that, overall, this was an ineffective approach because education is insufficient to change the attitudes of those

parents who adamantly disagree with the provision of specific sensitive health services provided in a confidential manner to their children without their involvement.

“I think that parental education is important, but I don’t think this is a solution to the confidentiality problem.”

-Director of Family Planning Program, Children's Hospital Colorado

Overall, participants saw parental education as an important piece to this complex puzzle. However, they expressed that other strategies that do not solely rely on parental acceptance are necessary too.

Strategy #7: Need for patient education

Interviewees were asked about the importance of adolescent and young adult education and all participants agreed that educating adolescents and young adults about their rights to confidential health services is important, especially because every state requires some confidentiality protections for adolescents (e.g., STI screening and treatment). However, the specifics of what services are considered confidential and the age range in which those protections begin vary from state to state.⁴³ Participants said it is particularly important for this education to be done at the “point of service,” as well as part of community outreach and education efforts. At the same time, they also acknowledged that insurance and billing are complex and difficult for clinicians, let alone adolescents and young adults, to fully comprehend.

“So it’s also about the timely delivery of that information, which is why we want to really work with health care providers to make sure that they have information available in their offices and you know, ideally that they mention it any time that a youth seeks sensitive services.”

-Senior Attorney, National Center for Youth Law

“Frankly, education at a whole bunch of levels is going to be key to all of this.”

-Acting Vice President for Public Policy, Guttmacher Institute

At the same time, participants also acknowledged the challenge of communicating complex issues of confidentiality and EOBs to adolescents and even young adults.

“Most adolescents don’t know what an EOB is and many of them are not even aware which insurance they are covered under with their parents’ policy. For the ones that do know, they are fearful of disclosing or wanting to use it.”

-RN, MPH, Vice President of Health Care Planning at Planned Parenthood, New York City

“So when that teen comes in for the pregnancy test, they [the office or clinic staff] ask, ‘Do you know you can use your parent’s insurance, but did you know if you

fill this out, then that means you can ensure that your parents won't get an EOB about that?' "

-Senior Attorney, National Center for Youth Law

Some interviewees also stated it would be too difficult and an additional un-reimbursable responsibility for clinicians to educate patients at this intense level.

"From a realistic standpoint, the providers don't have the time or the capacity to do that level of patient education either, and I don't think it's fair for us to put that on them and expect that they can do that."

-Family Planning Supervisor, Colorado Department of Public Health & Environment

Thus educating adolescents and young adults about their confidentiality protections is important but not always feasible during all clinical encounters nor is it sufficient in ensuring adequate confidentiality protections are in place.

Strategy #8: Adopt overlapping strategies

Some interviewees thought implementing multiple and different types of strategies would address the complexities of this issue in a synergistic manner and would be more feasible to implement than a comprehensive Federal solution. Case Study 6 highlights this approach, which is being implemented in Massachusetts.

Case Study 6: Massachusetts Implements an Approach with Multiple Strategies

The Massachusetts Women's Health Reform Coalition is a group of advocates, lawyers, providers, public policy and governmental agency staff who are actively pursuing an approach that incorporates multiple strategies. Amendments to the statutory language regarding EOBs have been proposed formally, authorizing the Massachusetts' Division of Insurance to implement these recommendations and other regulations necessary to assure patient confidentiality. The Massachusetts Women's Health Reform Coalition recommends implementing five strategies concurrently.⁴⁴ In September 2013, they submitted the following recommendations to the Division of Insurance:

- Recommendation 1: Send EOBs directly to the member, not necessarily the policyholder.
- Recommendation 2: Limit when EOBs are issued (only when a balance is due on the claim).
- Recommendation 3: Suppress diagnostic descriptions (use general service descriptions).
- Recommendation 4: Allow patients the right to request that no EOB be sent for sensitive services, or when safety or continuance of services are at issue.
- Recommendation 5: Allow members the option of accessing EOBs by alternative means (EOBs mailed to an alternate address or issued via secure electronic communication).

Erie County Department of Health (ECDOH) in New York State is another example of pioneering a multifaceted approach to address patient confidentiality needs on a local level. It involves direct negotiation with health plans and educating clinicians, adolescents, young adults, and their parents about confidentiality rights and the potential limits to confidentiality. Community health care provider offices post signs, give informational handouts, and clinicians have follow-up conversations with parents to discuss how confidentiality is helpful for adolescent and young adult development. Providers also have conversations with the adolescents and young adults to explain their confidentiality protections. In addition, ECDOH contacted insurance companies in the county directly to ensure that they comply with New York State EOB laws already in place, as well as to educate insurers about how EOBs can breach confidentiality if used inappropriately.

“The system that is set up right now is far too complex for a single fix to work.”

-Senior Policy Director, National Family Planning & Reproductive Health

IMPLICATIONS/DISCUSSION

Addressing the existing and perceived tension between the need for patient confidentiality and the rights of policyholders is extremely complex. As a result, no single strategy emerged as an answer to resolve this issue. This policy brief provides an overview of a number of strategies, along with their pros and cons, which are currently being implemented in a relatively small number of communities across the country. The following section describes a number of cross-cutting implications for operationalizing any particular strategy that emerged during the interviews.

EOB Suppression (Opting In Versus Opting Out)

Many participants stressed the importance of having a systematic, automatic approach that does not require the patient or provider to take action. Specifically, participants felt that such an approach was critical for over-burdened clinicians, as well as young or vulnerable patients who are unlikely to know how they could even take individual action to prevent the insurance companies from sending an EOB.

“That is the problem with placing the onus on the covered member, and I am much more a proponent of really trying to get the system to be fixed as opposed to yet again placing the onus on the patient.”

-RN, MPH, Vice President of Health Care Planning at Planned Parenthood,
New York City

“Anything that doesn't automatically suppress EOBs is problematic because it's not error proof. It's so easy for something to slip through the cracks. ... I think you have to have something that makes the easy option, you know, automatic. I think it's like taking trans fats out of food or putting chlorine in the water.”

-Assistant Commissioner, Department of Health and Mental Hygiene,
New York City

Several interviewees stated it is easier for patients that are proactive about understanding their billing and payments to request an EOB than for an adolescent or young adult to have to request that no EOB be sent. Stressing this point further, several participants recommended an “opt in” approach to receive an EOB. In other words, the *default* would be for no EOB to be sent (for sensitive services).

"I think that if we can get the legislature to agree to this, when patients access services, especially under ACA, EOBs should be suppressed. If there's no financial liability and the parent doesn't owe the doctor anything, the insurance company is taking care of it, the EOB should be suppressed, based on age."

-MD Chairman, Department of Pediatrics, Director of Adolescent Medicine, Coney Island Hospital, New York

"The standard of practice would be there is no EOB if the person is between this age and this age for sensitive services."

-Director of Policy & Advocacy, American Academy of Pediatrics, New York

The rationale for this "opt in" approach was based on participants' concerns about negative consequences of breaching confidentiality for a teenager or young adult. Yet, maintaining confidentiality for all dependents, regardless of age, through EOB suppression remains a challenge. This "opt in" recommendation would be applicable to adult dependents as well as adolescents. While a default strategy would be difficult to implement, some participants felt this was the only effective way of suppressing EOBs to truly ensure confidentiality.

Enforcement, Operations and Evaluation of Policy Changes

Written rules and state laws are important in addressing this issue, but ensuring that written legislation is actually operationalized and enforced (or as a few interviewees put it, "have teeth") is an equally important element to consider. In the case of Hawaii's statute³⁸; EOB policy experts/advocates who are aware of this law do not know how it is being implemented. Most were either unaware of this particular legislation or stated that, "while it is on the books, it [is] not actually being implemented."⁴⁵ Therefore, considering how each policy will be operationalized (e.g., patient education, provider education, or holding the insurance plans accountable) may be as critical as signing the rule or passing the law itself.

"Whatever we say we want to do (pass EOB and confidentiality-related legislation), understanding how to monitor fidelity so that people are doing what they are supposed to be doing is a really big part of this issue."

-Professor of Pediatrics, The Children's Hospital of Philadelphia, University of Pennsylvania

The California SB 138 advocates are particularly concerned with how this legislation will be operationalized and implemented. As a result they are working on a detailed implementation plan (See Case Study 7).

Case Study 7: California's Confidential Health Information Act (SB 138) Implementation Plan [Strategy #3. Require plans to honor requests for confidential communications from all individuals obtaining sensitive services]

With financial support from a private foundation, the cosponsors of the Confidential Health Information Act, California Family Health Council, the American Civil Liberties Union of Northern California, and the National Center for Youth Law, considered various approaches to address potential confidentiality breaches that arise from EOBs. Their work led to the introduction of SB 138 (which takes effect on January 1, 2015). It allows adolescents, as well as all adults, to request confidential communications around sensitive health services and requires health plans to honor such requests. Aware that the effectiveness of this legislation hinges upon how it is implemented, the authors of this legislation are working on a detailed implementation plan that includes the following key components:

1. Outreach to insurance plans (through an industry collaborative and the state-wide insurance plan association) to potentially establish a standardized confidential communication request form (both electronic and paper-based) and a consistent process across the plans for receiving confidential communications requests. The goal is for information about enhanced confidentiality protections under SB 138 and the process for submitting a confidential communications request to be made available to patients through a variety of patient touch points (insurance Web sites, health center Web sites, on clipboards when patients check-in at clinics).
2. Trainings and patient education tools provided to all health center staff, including call center staff, billing staff, front desk staff, and clinicians, to increase knowledge of the law and to support the use of tools to facilitate implementation (e.g., a hard copy of the confidential communication request form, frequently asked questions and answers (FAQs) for front desk staff, online education tool kit for staff).
3. Development of a state-wide plan to educate patients about their new right and how to exercise it (e.g., through online content, social media, and dissemination of information by organizations that serve targeted patient populations).

Engaging Multiple Stakeholders, Especially the Insurance Industry

Several interviewees discussed the importance of galvanizing support from insurance plans to ensure effective implementation of changes to the way EOBs are issued. Specifically, they suggested working directly with insurance plans to include them in the conversation and to verify that they are complying with current state laws pertaining to EOBs. Approaches in New York, Colorado, and California are examples in which communication and negotiation with the insurance industry led to industry buy-in and support for implementation of changes to EOB distribution.

“And what we really learned is the value of partnering or at least trying to partner with the actual communicators, which would be the insurance companies. I think all of a sudden we were like, ‘Oh, yeah, the insurance companies should probably be involved with this.’ ”

-Family Planning Unit Manager, Department of Public Health & Environment, Colorado

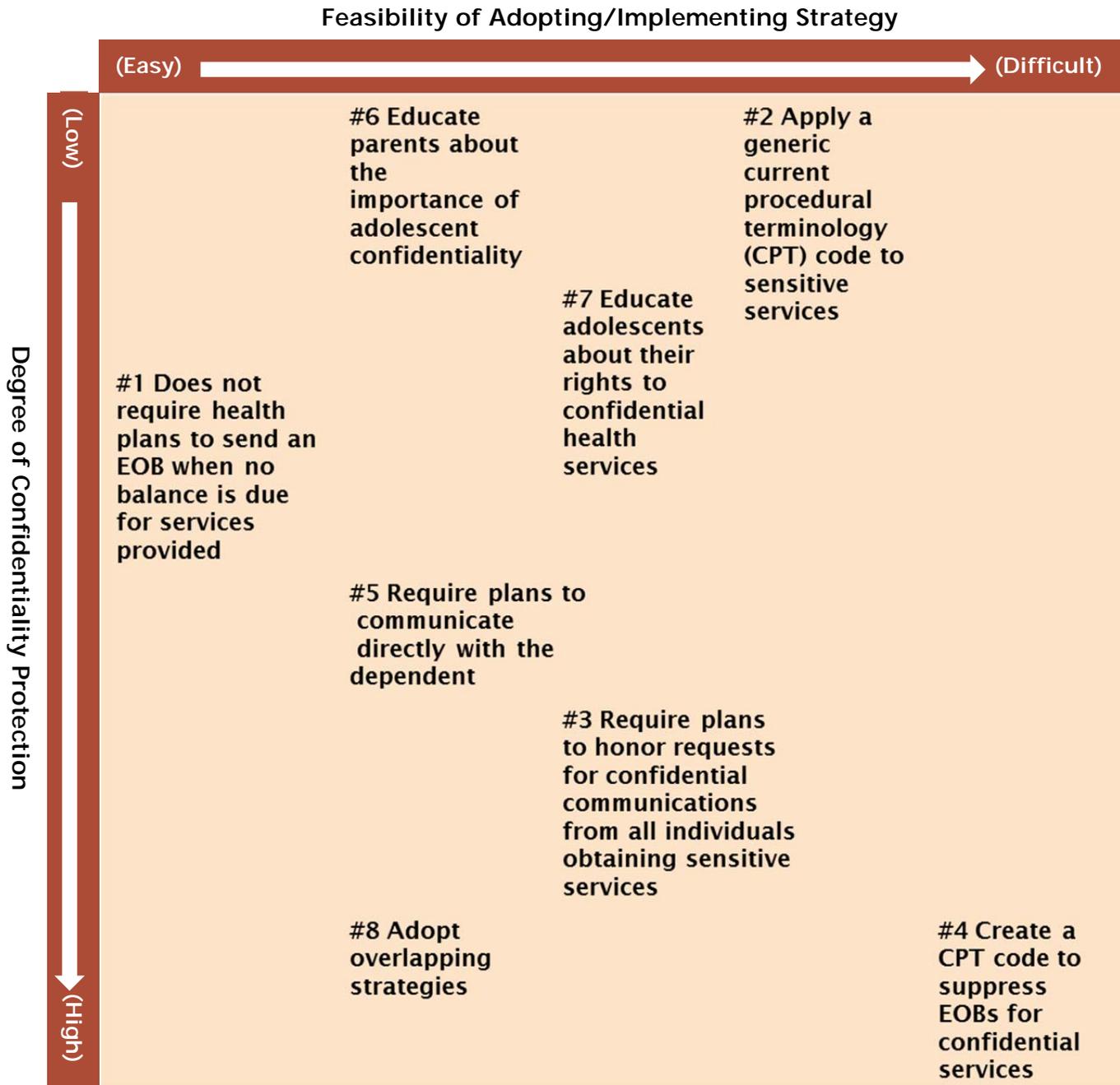
“And now I’m the Erie County Health Commissioner and I can say that, as far as our commercial health plans, most of the market is covered by three big health plans. So I asked them what they are doing about this experience with confidential services.”

-Commissioner, Erie County Department of Health and Clinical Professor of Pediatrics, University at Buffalo School of Medicine and Biomedical Sciences, New York

In summary, the various strategies reflect the complexity and the challenges of balancing patient confidentiality with the needs and requirements for EOBs and billing transparency. This brief discusses how each of these strategies can balance the tension between the need for EOBs with the need to protect patient confidentiality. In doing so, it is also important to consider the feasibility in adopting and implementing a particular strategy with the extent to which it protects patient confidentiality.

Figure 1 illustrates the nature of this complex relationship between feasibility and ultimate impact.

Figure 1. Relationship between the Feasibility to Implement and Potential Impact of Strategies that Respond to both Confidentiality and EOB Requirements



CONCLUSION

Assuring and maintaining confidentiality of sensitive health services is a basic tenet of health care and is particularly important for many adolescents and young adults (as well as other dependents on a policyholder's plan). A number of state and Federal laws protect patient confidentiality^{2,46}; however, these protections vary considerably from state to state and often come in conflict with policies and practices of sending EOBs to policyholders. The practice of sending EOBs also varies across states, public and private insurance plans, and clinic settings. This complexity and variability makes it extremely difficult for patients and providers to understand the parameters of confidentiality protections, as well as the potential risk of confidentiality breaches through EOBs. Additionally, this complexity is heightened with constantly evolving state-level legislation and health care changes as a result of the ACA.

As the ACA increases the number of adolescents and young adults who have health insurance (through increased coverage for dependents, and expansion of public and private insurance coverage), it also potentially exposes more individuals to confidentiality breaches. The ACA's inclusion of key preventive health services without cost-sharing could potentially reduce the risk of EOBs—if EOBs are limited to services in which payment is due. However, many routine sensitive services are not among the recommended preventive services, for example, the provision of mental health services. If adolescents or young adults forego care or seek care through safety-net providers, who would bear the potential burden of providing care to populations already covered under other health insurance programs for which premiums are paid by the policyholder and/or through Federal subsidies, the overall reach and effectiveness of the ACA could be limited.

The early phases of ACA implementation present a unique opportunity to address this issue now. Although policymakers are understandably consumed with enrollment and the overall roll out of the ACA, it is imperative to consider how the policy for EOBs could affect confidentiality for adolescents, young adults, and other dependents on an insurance policy who wish to receive confidential services, without the primary policyholder knowing about service provision. Many current strategies are relatively new (e.g., the California Confidential Health Information Act and the Colorado Division of Insurance's regulatory claim), and little is known about how successful these approaches will be as they are operationalized and implemented "on the ground." Future studies of each of these strategies, as well as other potential multipronged strategies described in this brief, are critical to inform both policy and practice from the perspectives of consumers, policyholders, health care providers, and insurers.

The snapshot of strategies described in this brief represent current attempts to achieve a better balance between health care transparency and patient confidentiality. Given the complexity of this issue, it is not surprising that no single strategy emerged from this

study as a solution. However, the key informants interviewed provided a great deal of insight about the pros and cons of each approach. Ideally, we can learn from past advocacy efforts to pass additional legislation or implement other regulatory strategies that will maximize patient confidentiality protections. Until then, it is up to clinicians, administrators, and health plans to consider the various strategies and implement available approaches that maximize their ability to protect patient confidentiality, while providing the highest quality health care, particularly for our most vulnerable populations.

ACKNOWLEDGEMENTS

We are grateful to Atlantic Philanthropies for its support of this research. This study is part of a larger study commissioned by the leadership of Mount Sinai Adolescent Health Center (MSAHC) to explore how Federal and state policy issues affect service delivery and the financing of care for young people. This study is also aligned with the Institute of Medicine's (IOM) report, *Adolescent Health Services: Missing Opportunities*, which called for more research on how health care settings, systems, and policies help to promote high quality health services for adolescents, as well as barriers they encounter in the provision of such services. ICF International (hereafter ICF) was selected to conduct the independent evaluation of the MSAHC, and ICF partnered with the Philip R. Lee Institute for Health Policy Studies, the Department of Pediatrics, Division of Adolescent and Young Adult Medicine and the UCSF Benioff Children's Hospital at the University of California, San Francisco, to conduct this EOB policy study.

The authors wish to acknowledge the following study participants for their time and their sharing of their valuable insights: Abigail English, JD, Director, Center for Adolescent Health & the Law; Alice Berger, RN, MPH, Vice President of Health Care Planning at Planned Parenthood New York City; Alyssa Vangeli, JD, MPH, Senior Health Policy Manager, Health Care For All; Carol Ford, MD, Professor of Pediatrics, The Children's Hospital of Philadelphia, University of Pennsylvania; Charles E. Irwin Jr, MD, Professor, Pediatrics Department UCSF School of Medicine; Charles Wubblesman, MD, Adolescent Medicine, Kaiser Permanente, Northern California; Deborah Kaplan, DrPH, MPH, R-PA, Assistant Commissioner, Department of Health and Mental Hygiene, New York City; Elie Ward, MSW, Director of Policy & Advocacy, American Academy of Pediatrics, New York; Gale Burstein, MD, MPH, Commissioner, Erie County Department of Health and Clinical Professor of Pediatrics, University at Buffalo School of Medicine and Biomedical Sciences, Buffalo, NY; Jeffrey Lindenbaum, MD, Pediatrics, Group Health Cooperative; Jody Camp, MPH Family Planning Unit Manager, Department of Public Health & Environment, Colorado; Greta Klingler, MPH, CHES, Family Planning Supervisor, Colorado Department of Public Health & Environment; Karen Artell, CNM, JD, Nurse Consultant, Colorado Department of Public Health and Environment, Title X Family Planning Program; John Goldenring, MD, MPH, JD Pediatrician, Adolescent and Preventive Medicine Specialist, Health Plan Medical Director and Attorney at Law; John Santelli, MD, MPH, Professor of Clinical Population and Family Health and Department Chair, Population and Family Health, Columbia University School of Public Health; Judy Waxman, JD Vice President, Health and Reproductive Rights, National Women's Law Center; Kathryn Santoro, MA, Director of Policy & Development, National Institute for Health Care Management (NIHCM) Foundation; Kathy Kneer, President and CEO of Planned Parenthood Affiliates of California; Lenore Tsikitas, MPH, Health Access and Promotion Coordinator, Massachusetts' Women's Health Reform Coalition, Massachusetts; Margaret J. Blythe, MD, Professor of Pediatrics & Clinical Gynecology,

Medical Director, Wishard Teen Care & Wellness Program, Indiana University; Liz Romer, RN, MSN, FNP, Director of Family Planning Program Children's Hospital Colorado; Amy Moy, Vice President of Public Affairs, California Family Health Council; Margaret McManus, MHS, President, The National Alliance to Advance Adolescent Health; Rachel Gold, MPA, Acting Vice President for Public Policy, Guttmacher Institute; Rebecca Gudeman, JD, MPA, Senior Attorney, National Center for Youth Law; Robin Summers, JD, Senior Policy Director, National Family Planning & Reproductive Health; Sarah Ross, Director of Public Policy, California Family Health Council; Teri Salus, MPA, CPC, Senior Health Policy Analyst, American Academy of Pediatrics; Lou A. Terranova, MHA, Senior Health Policy Analyst, Department of Practice, American Academy of Pediatrics; Warren Seigel, MD, MBA, Chairman, Department of Pediatrics, Director of Adolescent Medicine, Coney Island Hospital, New York, Associate Professor of Clinical Pediatrics, SUNY-Health Science Center at Brooklyn.

The views expressed in the interviews and presented in this report are those of the individual participants and do not necessarily reflect those of their affiliated institutions.

REFERENCES

- ¹ Ford C., English A., & Sigman G. (2004). Confidential Health Care for Adolescents: Position Paper for the Society for Adolescent Medicine. *Journal of Adolescent Health*; 35(2):160-167.
- ² English A., Benson Gold R., Nash E., and Levine J. *Confidentiality for Individuals Insured as Dependents: A Review of State Laws and Policies*, New York: Guttmacher Institute and Public Health Solutions, 2012. Retrieved from <http://www.guttmacher.org/pubs/confidentiality-review.pdf>
- ³ Slive L. & Cramer R. Health Reform and the Preservation of Confidential Health Care for Young Adults. *Independent Journal of Law, Medicine and Ethics*, 2012.
- ⁴ Benson Gold R. Unintended Consequences: How Insurance Processes Inadvertently Abrogate Patient Confidentiality. *Guttmacher Policy Review*, 2009, 12(4).
- ⁵ Lehrer J.A., Pantell R., Tebb K., et al.(2007). Forgone Health Care Among US Adolescents: Associations Between Risk Characteristics and Confidentiality Concern. *Journal of Adolescent Health*; 40:218e26.
- ⁶ Department of Adolescent Health, American Medical Association. *Guidelines for Adolescent Preventive Services*, 1992. Chicago, IL: American Medical Association.
- ⁷ Hagan J.F., Shaw J.S., & Duncan P.M., Eds. *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents*. 3rd edition. Elk Grove Village, IL: American Academy of Pediatrics, 2008.
- ⁸ The Society for Adolescent Health and Medicine. Sexual and Reproductive Health Care: A Position Statement of the Society for Adolescent Health and Medicine. *Journal of Adolescent Health*, 2014, March.
- ⁹ Irwin Jr C.E., Adams S.H., Park M.J., & Newacheck P.W. Preventive Care for Adolescents: Few Get Visits and Fewer Get Services. *Pediatrics*, 2009; 123:e565-572.
- ¹⁰ Edman J.C., Adams S.H., Park M.J., & Irwin Jr C.E. Who Gets Confidential Care? Disparities in a National Sample of Adolescents. *Journal of Adolescent Health*, 2010; 46:393-395.
- ¹¹ Hasstedt, Kinsey. Title X: An Essential Investment Now, More than Ever. *Guttmacher Policy Review*, 2013, Summer; 16(3). Retrieved from <http://www.guttmacher.org/pubs/gpr/16/3/gpr160314.html>

¹² Gudeman R. Closing Confidentiality Loopholes So That Adolescents Nationwide Can Benefit Fully from Newly Available Health Benefits and Insurance. *Youth Law News*, 2013; 32(3).

¹³ Anonymous EOB Advocate, San Francisco, California. Semi-structured interview. March 11, 2014.

¹⁴ Fox HB & Limb SJ. *State Policies Affecting the Assurance of Confidential Care for Adolescents*, Fact Sheet No. 5. 2008. Washington, DC: National Alliance to Advance Adolescent Health.

¹⁵ 29 USC 1002.

¹⁶ 29 USC 1133.

¹⁷ HHS.gov. Health Information Privacy. Personal Representatives. 45 CFR 164.502(g). Retrieved April 9, 2014, from <http://www.hhs.gov/ocr/privacy/hipaa/understanding/coveredentities/personalreps.html>

¹⁸ The Commonwealth Fund. *Covering Young Adults Under the Affordable Care Act*, 2013, August. Retrieved from http://www.commonwealthfund.org/~media/Files/Publications/Issue%20Brief/2013/Aug/1701_Collins_covering_young_adults_tracking_brief_final_v4.pdf

¹⁹ Fact Sheet. Young Invincibles: Young Adults Get Needed Mental Health Services Under Obamacare, 2013, July. Retrieved April 2013, from <http://younginvincibles.org/2013/07/young-adults-get-needed-mental-health-services-under-obamacare/>

²⁰ Klein J., Wilson K., McNulty M., Kapphahn C., & Collins K. Access to Medical Care for Adolescents: Results from the 1997 Commonwealth Fund Survey of the Health of Adolescent Girls. *Journal of Adolescent Health*, 2013, July; 25:120-130.

²¹ Ford C., Bearman P., & Moody J. Foregone Healthcare Among Adolescents. *Journal of the American Medical Association*, 1999; 282:2227-2234.

²² The Society for Adolescent Health and Medicine. Sexual and Reproductive Health Care: A Position Statement of the Society for Adolescent Health and Medicine. *Journal of Adolescent Health*, 2014, March.

²³ Kneer K. President and CEO of Planned Parenthood Affiliates of California. Semi-structured interview. 2014, March 4.

-
- ²⁴ Frerich, E.A., Garcia C.M., Long S.K., Lechner K.E., Lust K. and Eisenberg M.E.. Health Care Reform and Young Adults' Access to Sexual Health Care: An Exploration of Potential Confidentiality Implications of the Affordable Care Act. *American Journal of Public Health*, 2012, October; 102(10).
- ²⁵ Maciosek M.V., Coffield A.B., Edwards N.M., Flottemesch T.J., Goodman M.J., Solberg L.I. Priorities among effective clinical preventive services: results of a systematic review and analysis. *American Journal of Preventative Medicine*, 2006;31:52-61
- ²⁶ Trussell J., Lalla A.M., Doan Q.V., Reyes E., Pinto L., Gricar J. Cost Effectiveness of Contraceptives in the United States. *Contraception*. 2009. 79(1):5-14. [Update. *Contraception*. 2010;82:391. Update and correction, *Contraception*. 2012;85:218]
- ²⁷ Healthcare.gov. *What Are My Preventive Care Benefits?* Retrieved March 12, 2014, from <https://www.healthcare.gov/what-are-my-preventive-care-benefits/>
- ²⁸ U.S. Department of Health and Human Services. *Preventive Services Covered Under the Affordable Care Act*. Retrieved April 9, 2014, from <http://www.hhs.gov/healthcare/facts/factsheets/2010/07/preventive-services-list.html#CoveredPreventiveServicesforAdults>
- ²⁹ English A. *The Patient Protection and Affordable Care Act of 2010: How Does It Help Adolescents and Young Adults?* Chapel Hill, NC: Center for Adolescent Health and the Law; San Francisco, CA: National Adolescent Health Information and Innovation Center, 2010.
- ³⁰ The Henry J. Kaiser Foundation. *Preventive Services Covered by Private Health Plans Under the Affordable Care Act*, 2011, September. Retrieved from <http://kaiserfamilyfoundation.files.wordpress.com/2013/01/8219.pdf>
- ³¹ Tebb K., Brindis C.D., Giordano A., Combelick S., Bausch S. and Diaz A. *A Shifting Health Landscape for Adolescents and Young Adults: Planning for the Implementation for Federal Healthcare Reform in New York*. San Francisco, CA: Philip R. Lee Institute for Health Policy Studies and Division of Adolescent Medicine, Department of Pediatrics, University of California San Francisco; December 2012. Retrieved from http://nahic.ucsf.edu/wp-content/uploads/2012/12/Health_Reform_In_New_York.pdf
- ³² California State law. Confidentiality of Medical Information. 2013. http://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201320140SB138. Accessed May 9, 2014.

-
- ³³ Maryland State law. Health Insurance Communications Between Carriers and Enrollees - Conformity With the Health Insurance Portability and Accountability Act (HIPPA). 2014. <http://www.fda.gov/orphan/oda.htm>. Accessed May 9, 2014.
- ³⁴ Munro D. Healthcare Pricing Transparency Gains Momentum. *Forbes*, 2013, June 9. Retrieved March 12, 2014, from <http://www.forbes.com/sites/danmunro/2013/06/09/healthcare-pricing-transparency-gains-momentum/>
- ³⁵ Berger A. Planned Parenthood New York City. Semi-structured interview. October 24, 2013.
- ³⁶ Anoshiravani A., Gaskin G., Groshek M., Kuelbs C., and Longhurst C. Special Requirements for Electronic Medical Records in Adolescent Medicine. Position paper for the Society for Adolescent Health and Medicine. *Journal of Adolescent Health*, 2014.
- ³⁷ SB 138. Confidentiality of Medical Information, Chapter 444, 2013–2014. Retrieved April 9, 2014, <http://leginfo.legislature.ca.gov/faces/billAnalysisClient.xhtml>
- ³⁸ Hawaii Legislation: Haw. Rev. Stat. § 577D-2: Hawaii Statutes, Section 577D-2. Consent to Primary Medical Care and Services. Retrieved November 2013 from <http://codes.lp.findlaw.com/histatutes/3/31/577D/577D-2#sthash.IRs9Kd7z.dpuf>
- ³⁹ Moy A. & Ross S. California Family Health Council. Semi-structured interview. 2014, March 3.
- ⁴⁰ American Academy of Pediatrics Committee on Coding and Nomenclature. *Position Paper: Understanding Adolescent Confidentiality as it Relates to Billing*. American Academy of Pediatrics, 2012, September.
- ⁴¹ Department of Regulatory Agencies Division of Insurance. Colorado, Section 6. Protected Health Information: Amended Regulation Effective January 1, 2014.
- ⁴² American Academy of Pediatrics. Bright Futures. Retrieved April 9, 2014, from <http://brightfutures.aap.org/about.html>
- ⁴³ English A & Kenney K. *State Minor Consent Laws: A Summary*. 2nd Ed. Chapel Hill, NC: Center for Adolescent Health and the Law, 2003.
- ⁴⁴ Recommendations for Division of Insurance Regulations Governing Common Summary of Payments Forms Pursuant to M.G.L. c. 176O, § 27, Section 207A of Chapter 224 of the Acts of 2012. 2013, September.
- ⁴⁵ Anonymous semi-structured interviews. 2013, September 15–December 8.

⁴⁶ U.S. Department of Health and Human Services. The Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy, Security and Breach Notification Rules. Retrieved from <http://www.hhs.gov/ocr/privacy/>