CONFIDENTIAL + COVERED

Proactive Policies to Protect Patients in the Health Insurance Claims Process

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National
Family Planning
& Reproductive Health Association

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Contents

Introduction

Confidential & Covered, part of an ACA Collaborative funded by the Office of Population Affairs (OPA), is responding to the challenge of protecting patient confidentiality while billing health insurance. The project is looking at policy and health care delivery factors that impact the ability of Title X-funded health care providers to bill insurance when patients request confidential services. *Confidential & Covered* researched and analyzed laws and policies at the federal level and in eight states to better understand how insurance, commercial and public, can impact providers' capability to maximize revenue while protecting confidentiality. This guide is a companion to *Confidentiality, Third-Party Billing, & the Health Insurance Claims Process: Implications for Title X*, a white paper also created under this project. The paper provides an analysis of current federal law regarding confidentiality, Medicaid, and commercial insurance as well as examples of relevant state law, while this policy guide offers recommendations to Title X advocates and administrators about how to use or improve existing policy.

Based on the legal review in the white paper, it appears that while some potentially beneficial laws and policies exist, few are utilized to their fullest potential. Many health centers, advocates, and other interested parties do not know how public and commercial payers communicate and interact with patients. The guide offers a set of key questions to ask insurance commissioners, issuers, or Medicaid directors to gain more information about existing communication policies/protocol, followed by action items and then essential policy elements that could be used to influence consumer communication policy and practice in a state. This document is meant to serve as a guide to developing protective policies in states by highlighting examples in current law and policy, and is not intended to be a full portrait of all relevant questions or potential solutions.

How has your state implemented the federal Health Insurance Portability and Accountability Act's (HIPAA) Privacy Rule, including the special confidentiality protections? Is there a comprehensive statutory or regulatory scheme in state law that incorporates the HIPAA Privacy Rule requirements? If so, does it correspond to HIPAA or contain stronger requirements?

Impact:

The HIPAA Privacy Rule creates a floor of privacy protections, and some states have adopted more stringent policies.[1] The Rule protects and provides access to patients' health information and records—referred to as "protected health information" or PHI—but also makes allowances to release information for "treatment, payment, or health care operations" without patient authorization.[2] In practice, this means that confidential patient information, which the health care provider has ethical and legal obligations to protect, moves rapidly in the health care market. PHI is shared among insurers, health care providers, and others, with the potential of being included in a bill, an EOB, or other communication in ways that can unintentionally disclose private information to people other than the patient. The Privacy Rule has two additional provisions designed to protect patient privacy: the first relates to restrictions on disclosure of PHI;[3] the second focuses on confidential communications.[4]

First, health plans and health care providers must allow patients to request restrictions on the disclosure of their PHI. They are not generally required to comply with such requests, but they must comply if *either*: they agree to do so; *or* the disclosure is not otherwise required by law and the information pertains to health care that has been fully paid for by the patient or someone other than the health plan.

Second, health plans and health care providers must allow patients to request that communications such as EOBs be redirected to an alternative address or sent by an alternative means. Both plans and providers must accommodate reasonable requests, but health plans may require individuals to state that they would be endangered by disclosure.

State law and health plan documents may also include provisions for implementing these requirements of the HIPAA Privacy Rule and information about whether/when patient authorization is needed for disclosure of PHI and how it can be shared. Some states have requirements in addition to those in the HIPAA Privacy Rule that further protect patients. For example, some states require insurance issuers to grant requests that pertain to sensitive services or involve endangerment,[5] or requests from certain populations, such as adults insured as dependents.[6] Understanding how your state has implemented the law and how insurance issuers maintain HIPAA compliance will help you to assess how to best interact with or change the law.

Actions:

- Determine where your state's laws and policies implementing the federal HIPAA Privacy Rule reside and if they need to be more robustly implemented or amended/changed through legislation or regulatory action.
- Determine whether your state has privacy and confidentiality protections that meet the requirements of HIPAA or are more protective than the federal Rule. Find out if it is common practice among health insurance issuers in your state to require an endangerment statement when patients are requesting EOBs to be redirected under the HIPAA Privacy Rule confidential communications clause.
- Ask your state insurance commissioner to create a common form for patients to use when they are requesting EOBs be redirected under the HIPAA confidential communications clause and to specify mechanisms for making sure patients are informed of the form's availability.

Essential Protective Policy Elements:

In this set of essential protective policy elements, elements are described that could enhance HIPAA protections through changing state statutes or regulations if they are not already included in your state's law. These are items that should be considered if an effort to use HIPAA to extend privacy protections in a state is underway.

- Include a broad definition of "endangerment" as a basis for requesting confidential communications (e.g. risk of harassment, danger of violence, or undermining of access to health care).
- Exclude requirements for individuals requesting confidential communications protection to explain why they would be "endangered" if their request is not honored.
- Avoid age restrictions to protect individuals of all ages who need confidentiality protection.
- Include a description of the confidential communications policy in plain language in all plan documents.

How are insurance consumer communications regulated in your state?

Impact:

Regulations implementing both the Employee Retirement Insurance Security Act (ERISA) and the Affordable Care Act (ACA) contain requirements for insurers to issue notices when claims are denied in full or in part.[7,8] The recipient of these notices might be the policyholder or patient. These requirements have been incorporated into state law in virtually all states. Although denial notification requirements are designed to foster transparency, nearly all health insurance claims will result in a denial of some sort and they can have unintended negative consequences. For example, health care providers almost always bill insurers at a higher charge than they will be paid under their contract. Thus, even when a service is a covered service and the claim has been paid by the insurer, there will likely be a technical denial in the form of payment in an amount less than the provider's full charge, even if the patient or the policyholder bears no residual financial responsibility.[9] If these denial notices reach policyholders rather than patients, they may cause harm. These federal and state policies appear to be responsible for EOBs being routinely sent.

Further, these policies make full suppression of EOBs nearly impossible, as the EOB serves to fulfill policies contained in federal and state law and is a tool to inform patients and policyholders of their appeal rights.[10] In addition, EOBs help policyholders keep track of coinsurance or reaching a deductible. Determining what the laws and policies are in your state concerning denial notification will help clarify the web of requirements under which plan issuers may be acting. Anecdotally, health insurance issuers often follow one scheme for sending notifications for all the plans they issue. As a result, even plans not covered by ERISA or ACA denial requirements may use uniform documents such as EOBs to send denials or other communications regarding their action on claims.

Action:

- Determine what laws and policies exist in your state to implement the requirements of ERISA and the ACA, or in addition to those requirements, for consumer communications, especially denials.

Essential Protective Policy Elements:

Below are essential protective policy elements that could be considered if an effort is underway to change how an insurer interacts with its members. Depending on the state, this element would need to be implemented using either regulatory or legislative action.

- Suppress EOBs if there is no residual financial obligation on the part of the policyholder.
  - Specify that EOBs are not required for services covered under the ACA's requirement of coverage without cost sharing for certain preventive services.
  - Make this suppression mandatory rather than optional to ensure it is implemented by insurance carriers.
  - Extend this suppression to cases when an individual other than the policyholder has consented to and received the care.

How do commercial health insurance or Medicaid plans in your state provide guidance or requirements related to consumer communications in plan documents such as health insurance policies, insurance contracts, or others?

Impact:

One finding from research and ongoing personal interactions with Title X-funded and other family planning providers in the field is that commercial health insurance and Medicaid plans often have protocols in contracts or policies that define how the plan communicates with policyholders.[11] The language and clauses in plan documents may state how the plan maintains compliance with HIPAA and uses PHI. It may also include specific information on how enrollees can access protections like requesting redirection of EOBs. This language may also appear on agency websites or be in practice throughout the insurer landscape in a state, but may not be formally stated in regulation or law. Identifying these practices is important because there may be opportunity to advocate for change. It is also important because they could be changed without notice or formal processes like legislation or regulations, making them vulnerable to changes in management or leadership at a health plan.

Actions:

- Form alliances with state insurance commissioners and consumer advocates to investigate and clarify common practices of insurers for communicating with consumers.
- Get involved with consumer groups advocating to health insurers and ask about differences among the major insurers or systems in your state in their practice of sending EOBs. Some states have groups specifically focused on engaging consumers in health insurance. Some of these may be connected with state marketplaces.
- Ask the plans your health center contracts with about their standard practices for sending EOBs and how your patients can access confidential communications.

Essential Protective Policy Element:

- Establish beneficial policies and include them in written guides or other broadly available material.

What is your state Medicaid program's practice for sending EOBs and other notices that may disclose confidential information? Are they sent? If so, under what circumstances and to whom?

Impact:

State Medicaid programs have discretion in how, when, and sometimes even whether they send communications to enrollees, as long as they fulfil the federal requirement to verify services.[12] Thus understanding that commercial insurance plans may have different requirements than Medicaid, and even that there may be differences in how claim communications are handled in Medicaid fee-for-service compared to Medicaid managed care plans, is essential.

Medicaid programs may vary in the frequency of the communications. For example, some may send EOBs for each service; others may only send an annual summary. Because they do not have to send an EOB for every service, some programs suppress EOBs for reproductive health services. Medicaid programs may already have practices in place that are more protective of patient confidentiality, like issuing EOBs to enrollees rather than to the head of household.[13]

It may also be important to consider family planning Medicaid expansion program practice for consumer communications. Family planning state plan amendment or waiver programs may not send EOBs at all. These programs are often clearly branded so they are easily contrasted with full-benefit Medicaid programs. Because the two programs may have different policies for sending EOBs, it is important to understand how patients could be affected depending on their specific Medicaid payer.

The use of EOBs in the context of Medicaid can be further complicated by the presence of Medicaid managed care in a state or region. Medicaid managed care organizations (MCOs) are required to send notices of denial, which often take the form of EOBs, when a service is denied in "amount, duration, or scope that is less than requested."[14] Similarly to the denials requirements laid out for commercial insurers, this requirement may have a far-reaching effect given that nearly all claims will result in a technical denial, as the payment will be less than the provider's full charge.

Actions:

- Assess state landscape in regards to Medicaid managed care enrollment versus full-benefit Medicaid versus family planning expansion program coverage.
- Ask the state Medicaid agency about their practice for sending EOBs
  - Under what circumstances, if any, are they sent?
  - To whom are EOBs or equivalent communications sent?
  - Does the state require managed care plans to follow the same requirements as fee-for-service Medicaid?
  - Does the state require or allow suppression or redirection of EOBs for family planning and/or other sensitive services?
  - If the state has a Medicaid family planning expansion program, are EOB requirements different than for fee-for-service Medicaid and/or Medicaid managed care?

Essential Protective Policy Elements:

The essential protective policy elements described in this section could be used to enhance privacy for Medicaid enrollees.

- Suppress or redirect EOBs in fee-for-service Medicaid and Medicaid managed care for family planning services. This may require different approaches depending on how your state Medicaid program works:
  - For fee-for-service Medicaid, talk to your Medicaid agency. Your agency may have the authority to make this change itself, or legislative action may be needed.
  - For Medicaid managed care, first consider asking your state Medicaid agency to require this of all Medicaid managed care plans in the state.
- Incorporate the essential protective policy elements outlined in the HIPAA section above to provide similar protections for Medicaid enrollees.

How does your state implement Medicaid's third-party liability requirement? How does your state operationalize the Medicaid good-cause exception?

Impact:

The Medicaid statute requires that, as a part of their medical assistance programs, states must "take reasonable measures to determine the legal liability of the third parties who are liable to pay for services furnished under the plan."[15] However, states seeking reimbursement from third-party payers may inadvertently trigger disclosures of confidential patient information, putting patients at risk of harm. This can happen when a state requires providers to bill or receive a denial from third-party payers before Medicaid will pay a provider claim, or when the state itself seeks reimbursement from a third-party payer. Medicaid programs may require that individuals disclose other sources of payment for medical services in the application process, and it is important to note that there may be implications for patients who do not divulge their insurance status. In some states, the Medicaid agency may directly seek reimbursement from the identified third party payer, while in other states, the Medicaid agency will deny the claim and return it to the provider, leaving the decision about how to pursue up to the provider.

Federal Medicaid law provides 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 when the patient would be at risk of physical or emotional harm.[16] This exception has long been used by family planning providers to protect patient confidentiality, enabling providers to obtain Medicaid reimbursement for provided services while not putting patients at risk of disclosure from third-party payers. However, states increasingly use technology, such as electronic databases, to identify third-party payers, better enabling states to seek out and obtain payments from third parties and increasing the risk to Medicaid patients of EOB disclosures. Further, with the ACA's expansion of insurance coverage to millions of low-income individuals, more people now have the potential to have both Medicaid coverage (either through full-benefit Medicaid or a Medicaid family planning expansion program) and commercial insurance (such as subsidized coverage through a state insurance exchange, or employer-sponsored coverage). This increases the risk of third-party disclosures for Medicaid-enrolled individuals as well as the need for strengthened implementation of Medicaid's good-cause exception.

Action:

- Ask the state Medicaid office how the good-cause exception is implemented in the state.
- Determine how third-party payer databases are used to establish liability.
- Work with the state and/or your legislature (as necessary) to properly implement the good-cause exception if needed. This may include improvement of state databases and systems to properly track good-cause exception requests; clarifying for providers the process by which they should notify the state of good-cause exception requests; establishing new guidance or legislation clarifying how the good-cause exception works in the context of third-party liability; etc.

Essential Protective Policy Elements:

In this set of essential protective policy elements, elements are described that would implement policy to clarify access to the good-cause exception by working with the state Medicaid agency. These elements could be implemented in all states.

- Implement an inclusive good-cause exception policy that does not specify age or limit the use of the good-cause exception to certain populations, such as victims of intimate partner violence.
  - ▸ Consider if good cause can be initiated by the provider at the health center or the patient, or both.
- Implement systems to denote individuals who have requested a good-cause exception, so the third-party payer is not billed by the state.

Conclusion

The questions, action items, and essential policy elements offer a set of guiding principles to use or improve existing consumer communications policy. While the guide is not intended to be an assessment of all the potential solutions, it is designed to serve as a starting point for improving consumer communications policy.

Endnotes

1 Abigail English, Robin Summers, Julie Lewis, and Clare Coleman, Confidentiality, Third-Party Billing, & the Health Insurance Claims Process: Implications for Title X (Washington, DC: National Family Planning & Reproductive Health Association, 2015).

2 45 C.F.R. § 164.502(a)(1)(ii).

3 45 C.F.R. §164.522(a).

4 45 C.F.R. §164.522(b).

5 S.B. 138, Sec. 4(a)(1).

6 3 Colo. Code Reg. § 702-4, Sec. 6.

7 Interim Final Rules for Group Health Plans and Health Insurance Issuers Relating to Internal Claims and Appeals and External Review Processes Under the Patient Protection and Affordable Care Act. 75 Fed. Reg. 43330, Jul. 23, 2010.

8 29 C.F.R. § 2560.503-1(b).

9 Coleman et al., Confidentiality, Third Party Billing, & the Health Insurance Claims Process: Implications for Title X (Washington, DC: National Family Planning & Reproductive Health Association, 2015).

10 29 C.F.R. § 2560.503-1(b).

11 Coleman et al., Confidentiality, Third Party Billing, & the Health Insurance Claims Process: Implications for Title X (Washington, DC: National Family Planning & Reproductive Health Association, 2015).

12 Harriette B. Fox and Stephanie J. Limb, *State Policies Affecting the Assurance of Confidential Care for Adolescents*, The National Alliance to Advance Adolescent Health, April 2009.

13 Ibid.

14 42 C.F.R. 438.210.

15 "Medicaid Third Party Liability & Coordination of Benefits," Medicaid.gov, accessed April 2, 2014, http://www.medicaid.gov/medicaid-chip-program-information/by-topics/eligibility/tpl-cob-page.html.

16 See good cause exception when "it is anticipated that cooperation will result in reprisal against, and cause physical or emotional harm to, the individual or other person." (42 U.S.C. 1396k; 42 C.F.R. 433.147).

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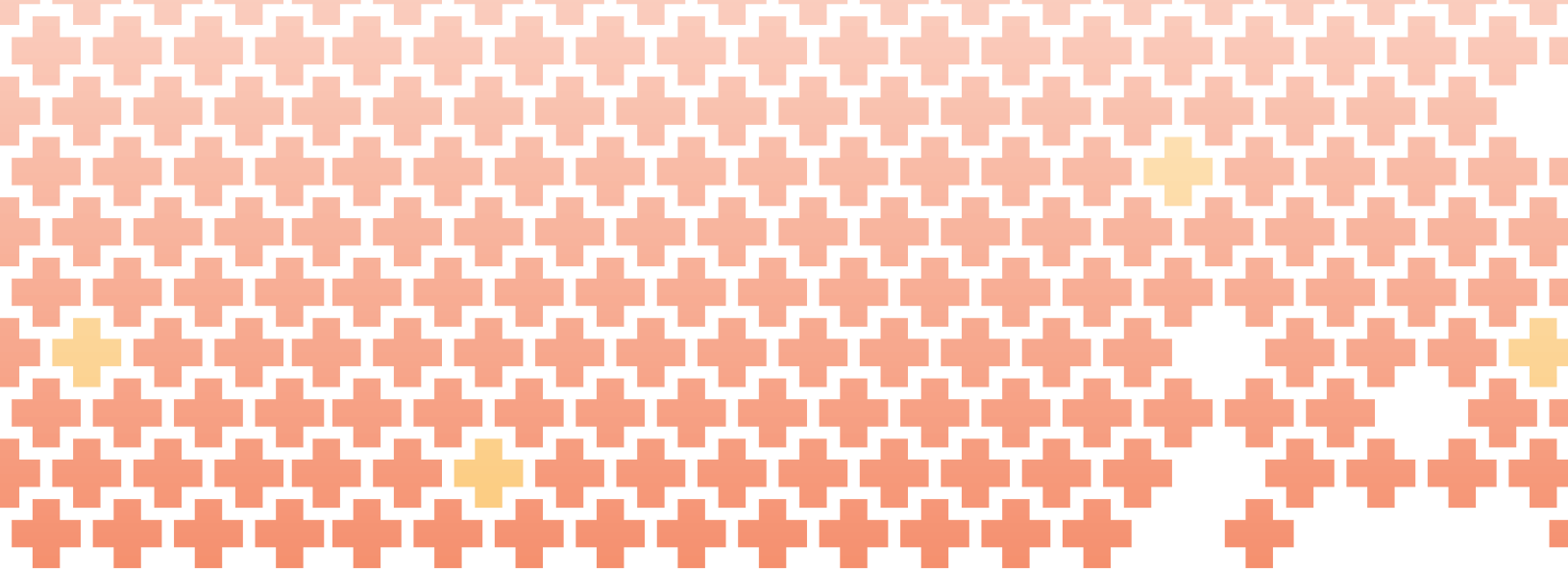
About *Confidential & Covered*

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.

About NFPRHA

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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