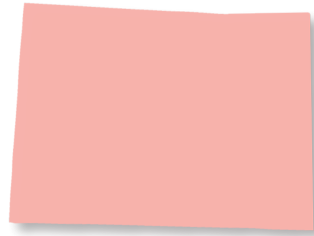
CONFIDENTIAL + COVERED



Protecting Patients' Privacy in Health Insurance Billing & Claims: **A Colorado Profile**

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Introduction

Confidential & Covered is a three-year research project led by the National Family Planning & Reproductive Health Association (NFPRHA) and funded by the US Department of Health & Human Services' Office of Population Affairs as part of its Affordable Care Act Collaborative. The project is designed to identify policies and practices to mitigate revenue loss at Title X-funded health centers due to the provision of confidential health services. The purpose is to improve service sites' sustainability while preserving one of Title X's core principles, namely the provision of confidential services for patients served by this essential program. *Confidential & Covered* partnered with the Center for Adolescent Health & the Law (CAHL), the George Washington University's Milken Institute School of Public Health, and the University of California, San Francisco's Bixby Center for Global Reproductive Health to conduct research on insurance use and confidentiality throughout the payment process--in other words, payment that does not breach privacy.

Protecting confidentiality is complex and has presented particular challenges in the health insurance arena. The insurance landscape is replete with opportunities for disclosure of private information, some of which are the result of explicit legal requirements or insurance carriers' policies and practices, such as the sending of explanations of benefits (EOBs) when insurance claims are filed and acted upon. These disclosures may result in patients' information reaching a family member, often the policyholder for the health insurance, even when the patient wants the information to remain private. In some cases, the information could pertain to family planning or other sensitive health services or the patient would be in jeopardy due to the disclosure. In this context, the *Confidential & Covered* project is working to identify ways to protect confidentiality without forfeiting the opportunity to secure health insurance payments for patients insured as dependents on a family member's policy.

In the first year of the project (2014-2015) the *Confidential & Covered* policy team at NFPRHA and CAHL undertook extensive research and detailed analysis of federal and state laws and policies relevant for publicly funded family planning that provide confidentiality protection or, on the other hand, that can lead to the disclosure of confidential information via billing and health insurance claims. The team published a white paper[1] and policy guide[2] based on that research and analysis. In the second year of the project (2015-2016) the team visited states that have laws in place designed to enable individuals to use their health insurance coverage without foregoing confidentiality protection or triggering privacy breaches. The three states visited in 2015 were California, Colorado, and Washington.

This report provides a profile of the current policy environment for confidentiality and insurance in Colorado based on a review of Colorado laws and in-person and telephone interviews with key informants conducted between September 2015 and January 2016. The informants included diverse stakeholders, such as family planning providers, adolescent and young adult health experts, policy advocates, public health officials, health insurance carriers, and health insurance regulators.[3]

The profile highlights major themes that characterized the development of Colorado policy, offers background on the legal and policy framework for confidentiality and insurance in the state, explains a state regulation adopted in 2013 designed to improve privacy protection, details the implementation efforts for the new regulation, and explores future policy challenges and next steps needed to strengthen confidentiality protection for patients while enabling providers to receive revenues from health insurance. The report represents a composite picture drawn from the varied comments of the informants interviewed.

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). http://www.confidentialandcovered.com/file/ConfidentialandCovered_WhitePaper.pdf.

2 Julie Lewis, Robin Summers, Abigail English, and Clare Coleman, Proactive Policies to Protect Patients in the Health Insurance Claims Process (Washington, DC: National Family Planning & Reproductive Health Association, 2015). http://www.confidentialandcovered.com/file/ConfidentialandCovered_PolicyGuide.pdf.

3 A list of individuals interviewed is included in Appendix A.

Background: Confidentiality & Insurance in Colorado

Since the Affordable Care Act (ACA) was enacted in 2010, Colorado has experienced an increase in its insured population[4] driven by enrollment in health plans available through the state's exchange, Connect for Health Colorado; expansion of Medicaid; and the ACA provision allowing young adults to remain on a parent's health insurance up to age 26. Many of the newly insured individuals who gained health insurance coverage as a result of the ACA as well as those with coverage under employer-based plans are covered as dependents on a family member's plan. These include young adults and adolescents, as well as spouses and domestic partners, some of whom are affected by intimate partner violence. When health insurance reimbursement is sought for dependents' care, these individuals may have their privacy infringed. This occurs due to legal and policy requirements for disclosure of information in the health insurance billing and claims process, or as a result of health plan contracts and practices, and in spite of existing legal protections for the confidentiality of health information.

In Colorado, as in every state, the privacy regulations under the Health Insurance Portability and Accountability Act—the HIPAA Privacy Rule—require health care providers and health insurers to protect patients' privacy. Of particular importance, the HIPAA Privacy Rule includes two special protections that provide for restrictions on disclosure of protected health information (PHI) and confidential communications. The first allows patients to request restrictions on the disclosure of their PHI.[5] Health care providers and health plans are not generally required to comply with such requests unless they agree to do so, but they must agree if the care has been fully paid for by the patient or someone other than the health plan. The second special protection allows patients to request that they "receive communications of protected health information … by alternative means or at alternative locations."[6] Health care providers must accommodate reasonable requests and may not require patients to claim they would be endangered by disclosure. Health plans must accommodate reasonable requests when there is a claim of endangerment. It is noteworthy that with respect to requests for confidential communications the HIPAA rule for health care providers differs from the requirement for health plans: plans are only required to comply with requests if endangerment is claimed.

Although Colorado has not enacted a comprehensive state statute implementing the HIPAA Privacy Rule, Colorado law includes several statutory and regulatory protections for medical confidentiality and health privacy. For example, certain health insurers (e.g. health care maintenance organizations and health care cooperatives) are specifically required to protect confidentiality.[7] The privacy notices of multiple health insurance carriers in Colorado and the state's Medicaid program also include protection for confidential communications consistent with the HIPAA Privacy Rule.[8]

Colorado has a significant set of state laws that allow minors to consent for their own care in varied circumstances and provide some confidentiality protection when they do so. Minors under age 18 generally may consent for a broad range of sensitive services, including: family planning and contraception;[9] pregnancy-related care, including prenatal, delivery, and post-natal care;[10] STD services, and HIV screening and treatment;[11] examination and treatment for substance use and addiction;[12] mental health services,

4 The U.S. Department of Health & Human Services' Assistant Secretary for Planning Evaluation tracks and disseminates insurance enrollment. Up to date enrollment numbers can be found at https://aspe.hhs.gov/affordable-care-act-research.

5 45 C.F.R. § 164.522(a)(1).

6 45 C.F.R. §§ 164.502(h); 164.522(b)(1).

7 Colo. Rev. Stat. § 10-16-423.

8 E.g., Cigna Health and Life Insurance Company, Notice of Privacy Practices, http://www.cigna.com/assets/docs/privacy-notices-and-forms/855489_a_Cigna_Global_Health_Benefits_NPP.pdf; Colorado Choice Health Plans, Privacy Policy, http://cochoice.com/privacy-policy/; Colorado Medical Assistance Program, Notice of Privacy Practices, https://www.colorado.gov/pacific/sites/default/files/Colorado%20Medicaid%20Notice%20of%20Privacy%20Practices.pdf; Kaiser Permanente – Colorado Region, Notice of Privacy Practices, https://healthy.kaiserpermanente.org/static/health/en-us/pdfs/col/Colorado_Notice_of_Privacy_Practices_2013.pdf.

9 Colo. Rev. Stat. § 13-22-105 and § 25-6-102.

10 Colo. Rev. Stat. § 13-22-103.5.

11 Colo. Rev. Stat. § 25-4-1405(6).

12 Colo. Rev. Stat. § 13-22-102.

if the minor is age 15 or older;[13] and examination and treatment for sexual assault.[14] Married minors, as well as those who are age 15 and older and living apart from their parents and managing their own finances, are also allowed to consent for their own care.[15] Colorado law generally does not require health care providers to disclose information to parents about the services to which minors give their own consent; exceptions include mandatory child abuse reports.

In addition to the federal laws that are applicable in all states, Colorado has laws that require disclosure of confidential information during the health insurance claims process as well as laws that protect confidentiality in health care.[16] For example, a Colorado regulation details the information that must be included on an explanation of benefits (EOB) that is sent to "covered persons or providers."[17] That information includes multiple items, some of which could result in disclosure of sensitive information about a patient if it is sent to a family member, such as the name of the provider with a notice that diagnosis and treatment codes and their meaning are available on request.[18] The EOB also must include information about how the claim was calculated; the subscriber or member's financial liability; and the status of deductibles, out-of-pocket amounts, and policy maximums.[19] Consistent with federal law, Colorado also has statutory and regulatory requirements for informing policyholders about denials of claims.[20]

Federal Notice Requirements for "Denials"

Federal law requires that insurers and health plans share information about denials of claims with policyholders, subscribers, and enrollees – as detailed in the Affordable Care Act (ACA), Employee Retirement Income Security Act (ERISA), and Medicaid Managed Care regulations.[21] These denial notices are commonly sent in a format that looks like an explanation of benefits (EOB). See *Confidentiality, Third-party Billing, and the Health Insurance Claims Process: Implications for Title X for a robust discussion of federal insurance law and its impact on privacy.*[22]

The Colorado Regulation

Against this background, in 2013, the Colorado Division of Insurance amended the existing regulation that required insurers to include detailed information on EOBs by adding a new provision to ensure the confidentiality of protected health information pertaining to adults covered on a family member's health insurance.[23] The new provision states:

> *Carriers[24] must take reasonable steps to ensure that the protected health information (PHI) of any adult child or adult dependent who is covered under the policy is protected. This protection includes ensuring that any communications between the carrier and covered adult child remain confidential and private, as required under the Health Insurance Portability and Accountability Act (HIPAA). This*

13 Colo. Rev. Stat. § 27-65-103(2).
14 Colo. Rev. Stat. § 13-22-106.
15 Colo. Rev. Stat. § 13-22-103.
16 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). http://www.confidentialandcovered.com/file/ConfidentialandCovered_WhitePaper.pdf.
17 3 Colo. Code Regs. § 702-4:4-2-35, Sec. 2.
18 3 Colo. Code Regs. § 702-4:4-2-35, Sec. 5.
19 3 Colo. Code Regs. § 702-4:4-2-35, Sec. 5. The regulatory language is included in Appendix B.
20 Colo. Rev. Stat. § 10-3-1104(1)(h)(XIV); Colo. Rev. Stat. §§10-16-113(2) and (3); 3 Colo. Code Regs. § 702-4:4-2-17; 3 Colo. Code Regs. § 702-4:4-2-35, Sec. 5(H).
21 45 C.F.R § 147.136; 26 C.F.R § 54.9815-2719; 29 C.F.R. § 2590.715-2719; 42 C.F.R. § 438.404.
22 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). http://www.confidentialandcovered.com/file/ConfidentialandCovered_WhitePaper.pdf.
23 3 Colo. Code Regs. § 702-4:4-2-35, Sec.6. The regulatory language is included in Appendix B.
24 "Carrier" means any entity that provides health coverage in this state, including a franchise insurance plan, a fraternal benefit society, a health maintenance organization, a nonprofit hospital and health service corporation, a sickness and accident insurance company, and any other entity providing a plan of health insurance or health benefits subject to the insurance laws and rules of Colorado. Colo. Rev. Stat. § 10-16-102(8).

> *protection of personal health information would include, but is not limited to, developing a means of communicating exclusively with the covered adult child or adult dependent such that PHI would not be sent to the policyholder without prior consent of the covered adult child or adult dependent.*[25]

This regulatory provision does not contain detailed definitions of each of its terms, but several key elements are important to highlight for understanding its scope.

Elements of the Regulation

Protected Health Information

- "[H]ealth information: 1. That identifies an individual who is the subject of the information; or 2. With respect to which there is a reasonable basis to believe that the information could be used to identify an individual."[26]

Protected Individuals

- Adults—including any adult child or adult dependent—insured as dependents

Adult child

- Any adult such as an adult age 18 up to 26 who is insured on a parents' policy as allowed by the ACA

Adult dependent

- Any adult such as a spouse or domestic partner who is insured on a family member's policy

Insurer obligation

- Take "reasonable steps" to ensure that protected health information of adult children and adult dependents remains confidential
- At minimum, establish a way to communicate exclusively with the covered adult child or dependent
- Obtain consent of covered adult child or dependent prior to sending their protected health information to the policyholder

Reference to HIPAA

- Suggests the regulation is intended to provide at least as much protection as the HIPAA Privacy Rule

Although the new provision is a relatively short addition to existing regulatory language governing insurance communications to consumers, the language does make it clear that health insurers are obligated to maintain the confidentiality of the protected health information of adult individuals insured as dependents. This requirement recognizes that adult children and dependents may have a privacy interest in not disclosing their information to the family member who is the policyholder.

25 3 Colo. Code Regs. § 702-4:4-2-35, Sec. 6.

26 3 Colo. Code Regs. § 702-4:4-2-21, Sec. 4(V).

Positive Features in the Policy Landscape

Regulatory vs. Legislative Approach

Although some states, such as California[27] and Oregon,[28] have pursued a legislative strategy for improving confidentiality protection in the context of billing and health insurance claims, Colorado's choice of a regulatory approach was driven by two main factors: a receptive insurance commissioner and a less receptive legislature, particularly in the state senate. The regulatory strategy was reinforced by the absence of any active opposition from insurance carriers and by the fact that the regulation was grounded in important elements of Colorado and federal law: the expansion of coverage under the ACA for young adults and the HIPAA Privacy Rule.

Broad Coalition of Allies

A coalition spearheaded by a nonprofit, nonpartisan consumer health advocacy organization, with support from foundation funding, provided the impetus for a focused effort to develop proactive policy in Colorado and played a crucial role in advocating for effective implementation of the new regulation. The coalition comprised both reproductive health groups and a broader array of allies and advocates including family planning providers (both Title X-funded and non-Title X funded); public health agencies; hospitals and community health centers; LGBTQ advocacy organizations; and domestic violence, sexual assault, school health, and mental health providers. These groups were active at varying points in the effort and the intensity of their participation varied as well, but the diversity of views was important in shaping the overall strategies of the group.

Alternative Confidentiality Strategies

The health care delivery environment in Colorado is characterized by the presence of a mix of public and private providers, including Title X-funded entities and other family planning providers, who have successfully adopted a range of alternative strategies for protecting the confidential health information of their patients, particularly their adolescent patients. Many of these strategies have involved forgoing the revenue from patients' health insurance coverage, which has imposed a financial burden on those providers.

Challenges in the Policy Landscape

Implementation Barriers

The collective discussions among stakeholders and with the insurance commissioner also highlighted a number of barriers to effective implementation. The primary impediment appeared to be carrier concerns about transparency and their obligations to policyholders to document deductibles, coinsurance, and residual financial liability. An additional concern of carriers focused on the technological challenges (such as inflexible software systems). Also, the insurers often only have contact information for the policyholders, another challenge for implementing the regulation. Other implementation barriers included a lack of knowledge or understanding of the regulation, due to a lack of education–both of carriers by the Division of Insurance and of providers, policyholders, and patients by carriers. This is in part due to a lack of resources and capacity on the part of organizations and agencies for public education and advocacy.

Adults vs. Minors

The 2013 Colorado regulation afforded protection to adult dependents but did not extend protection to minors. This approach facilitated adoption of the regulation in an environment in which both insurance carriers and regulators had greater comfort with protecting adult individuals age 18 and older; but it also highlighted the discrepancy between the protections available to minors under Colorado's minor consent laws and their exclusion from the new regulation.

27 Cal. S.B. 138, Ch. 444 (Oct. 1, 2013).
28 Or. H.B. 2758, 78th Leg., Reg. Sess. (Or. 2015).

Discerning the Meaning of the New Regulation

The Colorado regulation was issued by the Division of Insurance with input from a wide array of stakeholders. Both before it was finalized and after it took effect in January 2014, the regulation has given rise to strong interest in the protections it potentially offered, some confusion, and numerous questions.

Questions about what the regulation means and how it should be interpreted include:

- What "reasonable steps" are carriers required to take?
- Which communications are covered by the regulation?
- What action is needed to trigger the protections and by whom?
- How does the regulation relate to the requirements of the HIPAA Privacy Rule?
- What is the relationship between the regulation and other state insurance laws?
- How does the regulation affect insurance carriers' obligations to policyholders?

Throughout 2015, the Colorado Consumer Health Initiative (CCHI), working closely with other stakeholders, embarked on a multi-step process in an effort to clarify the meaning of the regulation and the measures by which it would be most effectively implemented. With foundation funding, CCHI formalized earlier coalition work by creating a Women's Health Coalition that included a smaller working group focused on the issue of confidentiality and insurance. The Coalition took the lead in approaching the Division of Insurance (DOI) to ask for clarification of "reasonable steps" and seek improvements in the scope of the regulation, namely to extend its protection to minors as well as adults.

Outreach to DOI resulted in a series of meetings between DOI and stakeholders from the health care provider and consumer advocacy community as well as among DOI, those stakeholders, and insurance carriers. The responsiveness of DOI and its influence with insurance carriers meant that most of the relevant players were at the table for these discussions. The meetings were instrumental in illustrating the differing perspectives of each group about the regulation and providing an opportunity to address the differences. These different perspectives emerged both in the process of specifying the problems the regulation was intended to solve and in identifying the best ways of using the regulation to address the problems.

For example, DOI initially viewed the regulation as addressing confidentiality concerns related primarily to reproductive health; health care providers and consumer advocates, on the other hand, saw it as important in the context of mental health, substance abuse, domestic violence, and LGBTQ issues as well as reproductive health. At least some health insurance carriers were uncertain about the relationship of the new regulation to the HIPAA Privacy Rule and seemed concerned that their compliance with HIPAA was being questioned, while patient advocates interpreted the regulation as grounded in HIPAA but broader in scope because it went beyond protecting the confidentiality of communications for patients who claimed endangerment and protected those needing privacy for other reasons. Each group also viewed its primary obligations and loyalties as distinct and different: health care providers and advocates were concerned primarily about the impact on insured patients' access to care; health insurance carriers were also concerned about access but were even more focused on their obligations to purchasers and policyholders. These competing priorities led to varied ideas about what was necessary to implement the regulation effectively and the limitations on what would be possible.

Defining "Reasonable Steps"

A key element of the regulation is the requirement that health insurance carriers take "reasonable steps" to protect the confidentiality of the health information and privacy of adult children and adult dependents covered under a family member's policy. The regulation itself mentions only two specific measures required to ensure such protection: developing a way of communicating exclusively with the adult child or dependent

and not sending their protected health information to the policyholder without the adult child or dependent's consent. The regulation also makes clear that these are not the only means of protection required. Delineating the full range of measures that would constitute reasonable steps has been the subject of extensive ongoing discussion and debate among the DOI, insurance carriers, and other stakeholders in Colorado.

The DOI did not articulate a reasonable steps standard; rather, DOI facilitated discussion among the various stakeholders, prompting them to describe past actions and articulate future goals and plans. One outcome of the stakeholder meetings hosted by DOI with the insurance carriers was that DOI instructed the carriers to report back on the systems they had in place to comply with the regulation, including any capabilities they had for flagging patients or claims requiring protection, and any steps they require patients to take. The DOI urged carriers to offer "out of the box" ideas. The Women's Health Coalition hoped that one carrier might have developed a straightforward procedure for implementing the regulation's confidentiality protections that would be minimally burdensome for patients to use. At time of the informant interviews, carriers had not yet provided this information to DOI.

In the course of the meetings, the carriers themselves did not offer a unified view of what they thought would constitute reasonable steps, but outlined various approaches that they either were already taking or could put in place. These ranged from including information about the regulation's protections in member booklets, with or without a colored "pull-out" to highlight it, to steps the carrier might itself take to ensure confidentiality such as automatically sending EOBs to adult dependents, to specified procedures for insured dependents to use in actively requesting confidentiality. Carriers suggested they could send EOBs and other communications to a separate address specified by an insured dependent, but no consistent mechanism for initiating this was apparent. A dependent might have to call the insurer, or go online; and the alternate address might have to be a physical address rather than an electronic one. DOI suggested that whether carriers had taken "reasonable steps" might ultimately be determined on a case-by-case basis, while the Women's Health Coalition advocated for a clearly articulated standard to guide carriers and inform patients and policyholders.

Health care providers and patient advocates also had varied ideas about what should go into a standard for "reasonable steps" to protect confidentiality. One major suggestion of what might constitute "reasonable steps" was that EOBs be suppressed—either for preventive services, such as those covered without cost sharing under the ACA, or for all sensitive services. Another was that carriers contribute to a common pool of funds to pay for sensitive services so that insurance claims would not be processed and communications would not take place in the otherwise routine manner. The latter idea did not generate enthusiasm from carriers and, in any case, would likely have required legislative action, which made it essentially non-negotiable. The suppression of EOBs for preventive services generated more interest, and possibly more support, but also presented potential problems for patients and their advocates as well as for carriers. The advantage of this approach is that under the ACA, specific preventive health services must be paid for by health plans without cost sharing. These include services recommended by the US Preventive Services Task Force (USPSTF), the Advisory Committee on Immunization Practices (ACIP), the Health Resources and Services Administration's (HRSA's) Bright Futures Project, and the Institute of Medicine (IOM) committee on women's clinical preventive services. Thus, for those services at least, the rationale most frequently offered by carriers for the necessity of EOBs or other communications going to policyholders—documentation of deductibles, copayments, and residual financial liability—is less compelling. However, even when there is no cost sharing or residual financial liability on the part of the policyholder, carriers seemed reluctant to give up on transparency and the opportunity to demonstrate value to purchasers and policyholders by informing them of the services that have been provided under the policies that are paying for.

Preventive Services vs. Sensitive Services

The ACA requires most health insurance plans to cover, without cost sharing, a wide range of preventive services specified by the USPSTF, ACIP, and Bright Futures and women's preventive services specified by the IOM. These include family planning services and supplies as well as screening and counseling for STDs, HIV, and domestic violence. Neither diagnosis for symptomatic STDs nor treatment for STDS, mental health problems, or substance abuse are included.

Sensitive services are generally considered to encompass a full range of reproductive health care, as well as STD and HIV, mental health, and substance abuse services and to include diagnosis and treatment as well as screening.

In addition, from the perspective of patients and health care providers, the suppression of EOBs solely for preventive services has at least two significant limitations. First, the scope of preventive services as defined in the ACA does not include all sensitive services—leaving out, for example, mental health counseling and substance abuse care, and various family planning and reproductive health services such as STD diagnosis and treatment as well as other diagnostic procedures such as colposcopy. Second, a visit might begin with a service that is covered as a preventive service with no cost sharing—such as STD screening—but lead to the necessity for further laboratory tests or treatment that go beyond the scope of preventive services, making it difficult for patients and providers to know when the line has been crossed and increasing the likelihood that an EOB will be required.

These limitations led to a suggestion that EOBs be suppressed not just for the preventive services with no cost sharing under the ACA but for all sensitive services. Although the idea expanded the services for which EOBs would be suppressed, there may still be other services for which certain groups, such as those experiencing intimate partner violence, would need suppression. Additionally, it raised the question of how to communicate essential financial information to the policyholder or, if that were not to occur, how to pay for the services.

Achieving Early Progress

In the two years following the effective date of the new Colorado regulation, important early progress took place. Neither the DOI, the carriers, nor any of the stakeholders had mechanisms available for assessing implementation in a systematic way. Nevertheless, informants could point to a few instances of ongoing efforts to implement the regulation, in spite of the lack of clarity about the regulation's meaning and some significant implementation challenges. Examples were of carrier efforts to communicate directly with covered adult dependents and provider efforts to educate staff and patients.

Although no consistent pattern was identified, and the variations were significant, some carriers had put in place procedures to comply with the regulation. For example, it was reported that some carriers were sending EOBs directly to addresses for individuals age 18 and older, rather than sending it addressed to their name but at the policyholder's address with the goal of avoiding the EOB being viewed by the policyholder rather than the covered adult dependent; at least one carrier did so automatically, whereas others required action by the covered adult, in a telephone call or online, to trigger this. Some carriers indicated they could send electronic EOBs, while others insisted on a physical address. Overall, according to informants, the carriers mostly appeared comfortable communicating directly with individuals age 18 and older, with only a small number indicating willingness to allow both adults and minors to call or go online to provide an alternate address. One possibility mentioned was that carriers might be able to send more "neutral" or "scrubbed" EOBs with fewer details about the more sensitive aspects of the services.

Some key providers and patient advocates took steps to promote implementation of the regulation. For example, the Title X grantee in Colorado, Colorado Department of Public Health and Environment (CDPHE), shared information about the regulation with the Title X-funded health centers. A Title X registration form was adapted to include information indicating that adults can contact their insurance carriers to request confidentiality.

CCHI hosted a webinar for consumers and advocates on greater awareness of preventive services, during which the new regulation was highlighted; and CDPHE held a training on intimate partner violence which also highlighted the new rule. Overall, aggressive implementation efforts by providers and patient advocates, including more widespread public education, seemed to be awaiting further DOI clarification of the rule and carrier specification of their compliance procedures.

Confronting Ongoing Challenges

Ongoing challenges to full implementation of the regulation:

- Transparency and documentation
- Technology issues
- State-regulated vs. ERISA plans
- Resource limitations
- Lack of confidence

Transparency and Documentation

An omnipresent concern expressed by carriers and acknowledged by providers and patient advocates was the tension between confidentiality and transparency. Everyone, including carriers, seemed aware of the importance of protecting the privacy of patients. At the same time, carriers have both a strong interest in making sure purchasers and policyholders can see the "value" of what they are paying for and a legal and contractual obligation to communicate essential financial information—about copayments, deductibles, coinsurance, residual financial liability, and policy maximums—to policyholders. The extent to which this obligation can be met by communicating the information solely to the covered adult dependent, or by sending the policyholder a "scrubbed" EOB with limited information, remains unclear. Some of the specific issues raised in this context were that: even a scrubbed EOB might spark a conversation; at least a provider's name is needed to match an EOB about a claim with a bill; and the policyholder needs enough information to know whether a claim was calculated correctly and whether there is a residual financial liability if they are ultimately the financially responsible party.

Technology Issues

Carriers' software systems may present difficulties in fine-tuning procedures for maintaining confidentiality. Some carriers have older "legacy" computer systems with minimal flexibility that may make it difficult or expensive to modify their systems in customized ways for specific categories of patients, services, or claims. Also, addressing the specific privacy concerns of individual patients, or subgroups of patients, requires building judgment into electronic systems that used to be exercised by humans processing paper claims. Significant updating and customization may be required for carriers' technology to enable compliance with the new regulation. In addition, there are limitations in the extent to which carriers can implement certain customizations. For example, individual carriers cannot create a "check box" to suppress certain information or a whole claim because the electronic claim form—which is created at the federal level by CMS—has no check boxes and modifying it would require federal action.

State-regulated vs. ERISA Plans

There are three main categories of health insurance plans in Colorado, as in other states: state-regulated plans; self-funded plans; and Medicare/Medicaid plans. The Colorado DOI only has authority over "state-regulated" insurance plans, which represent about one-third of the market in Colorado. Medicaid plans are regulated by the Colorado Department of Health Care Policy & Financing, and self-funded plans, known as "ERISA" plans, are regulated by the federal Department of Labor. This means that the new regulation applies to carriers that offer state-regulated plans subject to DOI authority. This creates a number of dilemmas for carriers, providers, and patients. Carriers may be offering or administering plans that fall into each of the three categories but only the state-regulated plans are technically subject to the regulation. Carriers might choose to adopt similar procedures for both state-regulated plans and ERISA plans in the interest of administrative simplicity but it is not known whether they would do so. Providers operate in an environment of multiple plans offered by numerous carriers and it is not easy to differentiate which ones are state-regulated. Patients also frequently are not aware of the type of plan in which they are enrolled.

> **"This means that the new regulation applies to carriers that offer state-regulated plans subject to DOI authority."**

Resource Limitations

Ultimately, fully effective implementation of the regulation will depend not only on action by DOI and carriers but also on efforts by providers and patient advocates. The DOI emphasized the importance of the agency receiving complaints and stories from individuals to which they could respond. In particular, it will be necessary for providers to educate both their patients and their staff—front desk, billing and finance, medical records, technicians, and providers. Patient and consumer advocacy groups will need to engage in broad public education efforts, which might include information on a website, public service messages in various venues, webinars, and other mechanisms. Thus the burden on providers could be considerable and, at present, sufficient resources for these educational undertakings are not available.

Lack of Confidence

Finally, the regulation's effectiveness in increasing privacy protection for adults in Colorado who are insured as dependents will depend on the willingness of those individuals to rely on it and of their providers to encourage them to do so. In other words, providers and patients must have trust in the protection offered by the regulation. Many informants reported that at this point they had not developed this confidence, due in part to the lack of specific guidance from DOI and lack of clarity on the part of carriers, but some indicated that, with clarification by DOI, they believed carriers could implement the rule and provide the required protection. An important element in determining the level of confidence in the regulation is determining the level of risk for each patient if their privacy were breached through the payment process and the policyholder received their confidential information. Some patients might have a preference for maintaining privacy but acknowledge minimal risk if confidential information were revealed; others might be willing to incur some risk of disclosure to be able to use their insurance and avoid significant out-of-pocket costs; some might not be able to take any risk that their information would be communicated to a family member who is the policyholder. Having a way of identifying which group a patient falls into would potentially increase providers' confidence in relying on the regulation.

> **"An important element in determining the level of confidence in the regulation is determining the level of risk for each patient if their privacy were breached through the payment process and the policyholder received their confidential information."**

Extending Protection to Minors

Many informants expressed frustration that the regulation does not provide protection for minors. In particular, they highlighted the discrepancy between the Colorado laws that allow minors to consent for their own health care, for the most part on a confidential basis, and the absence of protection for them in the insurance communications arena.

Colorado is home to a number of important health care provider sites that recognize the right of minors to consent to a range of sensitive services for themselves and provide minors with confidential care when they do so. These providers, many of whom receive Title X funds to provide services including Planned Parenthood health centers, Denver Health, Children's Hospital, Kaiser Permanente, and others—have developed detailed and careful methodologies for protecting the privacy of their adolescent patients. They have, however, forgone significant revenue in doing so, finding ways to pay for the care without billing insurance. Adding minors to the scope of the new regulation would better enable adolescents' care to be paid for by their insurance, as it should be, while supporting the long tradition of confidential care for minors that has been established by Colorado law and providers.

"Colorado is home to a number of important health care provider sites that recognize the right of minors to consent to a range of sensitive services for themselves and provide minors with confidential care when they do so."

Prior to the adoption of the regulation, DOI was asked to include minors but declined to do so. The coalition of providers and patient advocacy groups continues to urge the expansion of the regulation to include minors, but several factors remain stumbling blocks. The political climate seems inhospitable to expansion of minors' rights, with a parents' rights bill having been recently introduced in the state legislature, leading to some sensitivity on the part of both DOI and carriers about including minors in the regulation. Carriers also have concerns about the pushback they would get from parents if they were to communicate exclusively with a minor dependent, even those authorized to consent for their own care under state law.

Although both carriers and DOI seemed aware of the importance of making sure that minors receive necessary care for sensitive issues, so far they have not used that as a basis for including minors in the regulation. Providers and patient advocates have turned their attention to making the regulation work for adults, putting the effort to include minors temporarily on the back burner. In the meantime, minors who have pressing confidentiality concerns will have to rely on the confidential services currently offered by some providers without insurance reimbursement.

Using the Current Regulation to Protect Adults

The Colorado regulation is narrow, but it nevertheless represents the potential for significant progress in protecting privacy in the insurance arena for adult dependents covered on a family member's policy: young adults on a parent's plan and other adults on a spouse or domestic partner's plan. If properly implemented, the regulation could assure these adults that the insurer would communicate exclusively with them about their PHI and that their PHI would not be disclosed to a family member who is the policyholder without their prior consent. This would be a major step forward compared to past practice in which EOBs and other communications have routinely been sent to the policyholder even for adults covered on a policy.

In order for the regulation to work well for adults, further progress is needed on implementing the rule to achieve its intended results. Some of the ways to bring this about include:

- Articulating a "reasonable steps" standard that would apply across carriers in a consistent and predictable manner
- Ensuring that the regulation's protections could be easily accessed, either by treating them as automatic ones that an adult insured dependent could opt out of but would otherwise receive, or establishing easy procedures for an insured to use to "opt in"
- Identifying which communications from insurers would go exclusively to the adult dependent and which ones, if any, would go to the policyholder instead of or in addition to the adult dependent, so that insured adults are able to evaluate the risks of disclosure of their sensitive information
- Developing a means for limiting the level of detail on communications policyholders receive so that sensitive PHI is not disclosed without the consent for the insured adult
- Informing insured adults and health care providers of the regulation's protections and the procedures available to access them

Next Steps

The Women's Health Coalition's intensive work with DOI and carriers to clarify the regulation and move its implementation forward led to a recognition that there was not going to be a "Cadillac solution" but that further progress could result in benefits at least for adult dependents. The agenda of next steps to be pursued by provider and patient advocates will involve both working to maximize the effectiveness of the regulation in its current form and ultimately expanding it to minors when possible. The path forward seems likely to involve:

- Focus on regulatory rather than legislative approaches
- Emphasis on consistent implementation of reasonable steps to protect confidentiality that place more of the burden on carriers and less on patients
- Serious exploration of ways to address the challenge of communicating essential financial information to policyholders while breaching privacy as little as possible
- Identification of accountability mechanisms for noncompliance by carriers
- Eventual expansion of the regulation to include minors

The presence in Colorado of a receptive insurance regulator, carriers that are sympathetic to the importance of privacy protection, and an active broad coalition of health care providers and patient advocates enhances the likelihood that this agenda will move forward.

Conclusion

The regulatory approach taken in Colorado is an important and feasible policy step that state insurance agencies can take without legislative involvement. The experience of advocates and providers in Colorado can also be used as an example for advocates in states currently pursuing policies to protect the privacy of individuals insured as dependents. The coalition work played a crucial role both in improving the regulatory language and in subsequently encouraging implementation that other states could fruitfully emulate.

While the Colorado regulation has several key elements, its overarching goal is to protect adults insured as dependents (either through a parent's, spouse's, or domestic partner's health insurance policy). The regulation proposed to do this by requiring that carriers take reasonable steps to keep information already protected by HIPAA private from policyholders. The DOI, carriers, and advocates have encountered a number of challenges to implementating the existing regulation satisfactorily. As the challenges of implementation and limitations of the rule were identified, a coalition of advocacy organizations in the state convened to identify and worked together to discern potential policy solutions.

Appendix A: List of Key Informants

The *Confidential & Covered* project staff would like to thank the many key informants that contributed to this work. All comments are a composite of interviews conducted, and comments should not be construed to represent the views of the organizations listed below.

Organization	Name	Title
Children's Hospital Colorado	Kelly Galloway, MS, RN, CPN	Ambulatory Practice Director, Primary Care and Community Health Programs
Children's Hospital Colorado	Liz Gonzales-Salazar	Ambulatory Operations Manager, Primary Care Clinics
Children's Hospital Colorado	David W. Kaplan, MD, MPH	Head, Adolescent Medicine University of Colorado – School of Medicine
Children's Hospital Colorado	Ryan Larson	Executive Director, Revenue Cycle
Children's Hospital Colorado – Adolescent Clinic	Liz Romer, RN, MSN, FNP	Director of Family Planning Program, Adolescent Medicine
Children's Hospital Colorado	Zach Zaslow	Government Affairs Manager
Colorado Association of Health Plans	Sara Orrange	Associate Director
Colorado Coalition Against Domestic Violence	Lydia Waligorski	Public Policy Director
Colorado Consumer Health Initiative	Amber Burkhart	Former Policy Analyst
Colorado Consumer Health Initiative	Debra Judy	Policy Director
Colorado Department of Health, Family Planning	Karen Artell	Family Planning Program Nurse Consultant, Colorado Department of Public Health and Environment
Colorado Department of Health, Family Planning	Jody Camp	Colorado Family Planning Section Manager Colorado Department of Public Health and Environment
Colorado Department of Health, Family Planning	Greta Klingler	(Former) Family Planning Supervisor Colorado Department of Public Health and Environment
Denver Health Medical Center	Steve Federico, MD	Director of General Pediatrics, School and Community Programs Associate Professor of Pediatrics
Denver Health Medical Center	Tara Thomas-Gale, MPH	Family Planning Administrator
Denver Health Medical Center	Jackie Zheleznyak, MA	Manager Government Relations Government and Community Relations
Common Good Consulting	Cody Belzley	President
Kaiser Permanente	Mark Groshek, MD	Medical Director, Kaiser Permanente Digital Experience Center Colorado Permanente Medical Group
Planned Parenthood of the Rocky Mountains	Ashley Wheeland, JD	Legislative and Political Director Planned Parenthood of the Rocky Mountains Planned Parenthood Votes Colorado

Appendix B: The Colorado Regulation

3 Colo. Code Regs. § 702-4:4-2-35, Sec. 5.

A regulation issued by the Colorado Division of Insurance specifies the minimum required information for health carriers to provide on an explanation of benefits form sent to covered persons or providers. 3 Colo. Code Regs. 702-4:4-2-35, Sec. 5 provides that an EOB must contain the following information:

A. Name of member.
B. Relationship of member to subscriber.
C. Subscriber/member's claim number.
D. Name of subscriber.
E. Provider name and whether the provider is in or out of network.
F. Date of service.
G. Type of service (emergency, inpatient, outpatient, etc.).
H. Denial information (with enough specificity to enable the member/subscriber to determine the reason for the denial). Additionally, a notice will need to go out with the denial: "Notice: The diagnosis and treatment codes (and their meaning) related to the service that is the subject of this Explanation of Benefits (EOB) are available upon request made to the carrier."
I. Carrier contact information.
J. Explanation of appeal rights (Can be an attachment to EOB).
K. Notice "THIS IS NOT A BILL."
L. Claim payment calculation.
M. Subscriber/member's financial liability.
N. Status of policy deductible, out-of pocket amount, and policy maximums.

3 Colo. Code Regs. § 702-4:4-2-35, Sec. 6.

The Colorado Division of Insurance amended the state's EOB regulation to include a new section 6 that provides:

> *Carriers must take reasonable steps to ensure that the protected health information (PHI) of any adult child or adult dependent who is covered under the policy is protected. This protection includes ensuring that any communications between the carrier and covered adult child remain confidential and private, as required under the Health Insurance Portability and Accountability Act (HIPAA). This protection of personal health information would include, but is not limited to, developing a means of communicating exclusively with the covered adult child or adult dependent such that PHI would not be sent to the policyholder without prior consent of the covered adult child or adult dependent.*

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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.