CONFIDENTIAL COVERED

Protecting Patients' Privacy in Health Insurance Billing & Claims: A Perspective from Six States

JUNE 2017

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Introduction

Confidential & Covered was 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 was 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 was 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.[1]

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 has worked 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[2] and policy guide[3] based on that research and analysis.

In the second and third years of the project (2015-2017), the team visited six states that have statutes or regulations in place specifically designed to enable individuals to use their health insurance coverage without foregoing confidentiality protection or triggering privacy breaches. In these states, the policy team interviewed numerous key informants that included family planning and other health care providers, adolescent health experts, advocates, insurance regulators, and public health officials. Profiles of California, Colorado, and Washington were published in 2016; profiles of Illinois, Maryland, and Oregon were released in 2017.

These states were selected because they have specific policies in place to protect the privacy of individuals insured as dependents on a family member's health insurance. The project team was interested in identifying policies and strategies that might inform work in other states to increase privacy protection for insured dependents.

This report provides an overview of what was learned in the six states profiled by the *Confidential & Covered* policy team. It briefly reviews the framework of federal and state laws that protect confidentiality and control disclosures in the health insurance billing and claims process, describes the broad policy approaches adopted in the states, outlines the key elements of each state's laws, highlights favorable aspects of state policy environments, and identifies salient themes and lessons learned across the six states.

1 Publications and other resources developed as part of the Confidential & Covered project are available at www.confidentialandcovered.com.

2 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.

3 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.

Federal and State Law Framework

Federal and state laws contain numerous confidentiality protections that vary in terms of what information they protect, who can access the information, when the patient's permission is required for disclosure, and other factors. Federal confidentiality laws of paramount importance include the Title X regulations and the federal privacy regulations under the Health Insurance Portability and Accountability Act—the HIPAA Privacy Rule. Also important, many requirements of state and federal law can lead to the disclosure of confidential health information, particularly in the course of health insurance billing and claims. The white paper published in the first year of the *Confidential & Covered* project contained detailed analysis of the disclosure requirements and confidentiality protections in numerous federal and state laws: the HIPAA Privacy Rule, state medical privacy laws, Title X, the Ryan White HIV/AIDS Program, the Section 330 Federally Qualified Health Centers (FQHCs) program, Medicaid, and laws related to commercial health insurance.[4]

It is against this backdrop that California, Colorado, Illinois, Maryland, Oregon, and Washington enacted statutes or adopted regulations designed to improved privacy protection for individuals insured as dependents. Two key elements of federal law were of particular importance to the design of these laws and their implementation: the HIPAA Privacy Rule and the federal requirements for notices to be sent regarding the denial of claims.

HIPAA Privacy Rule Protections

In every state, the federal HIPAA Privacy Rule requires health care providers and health insurers to protect patients' privacy. The rule includes two special protections that restrict disclosure of protected health information (PHI) and provide for confidential communications. These two HIPAA Privacy Rule protections are clearly reflected in the policy approaches adopted by the states.

The first special protection 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] 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. 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. Thus, plans are only required to comply with requests if endangerment is claimed.

Federal Notice Requirements for Denials of Claims

Federal law contains important requirements for notice to be given when claims are denied; these requirements also risk disclosure of an insured dependent's confidential health information. The federal requirements for notice of denials apply in Medicaid managed care as well as in the commercial insurance arena.

4 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).

5 45 C.F.R. § 164.522(a)(1).

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

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.[7] These denial notices are commonly sent in a format that looks like an explanation of benefits (EOB). The requirements apply when claims are denied completely or not paid in full and therefore help to contribute to the ubiquitous prevalence of EOBs, especially in the commercial insurance arena.

The Four Policy Approaches

Each of the states profiled incorporated different policy approaches to reducing privacy breaches and unwanted disclosures during the insurance claims process. Advocates in the states chose particular approaches for strategic reasons related to the policy landscape in the state as well as the receptiveness of state legislatures and insurance regulators. The approaches were modified to adapt to specific conditions in each state. The four broad approaches are:

1. Allowing requests for confidential communications
2. Allowing requests for restrictions on disclosure of information
3. Restricting disclosure of information based on service or population
4. Requiring specific confidentiality protections for adult dependents

Allowing Requests for Confidential Communications

One of the primary policy approaches considered and adopted by the states is establishing a right for insured individuals to make requests for "confidential communications" and have those requests honored by their insurers. This approach can be limited to "sensitive services" or to situations in which the insured individual would be endangered by disclosure or it can be made available more broadly to any insured individuals including insured dependents. This approach is grounded in the HIPAA Privacy Rule protection allowing individuals to request that communications be sent to them by alternate means or at alternate locations, often referred to as "redirection" of communications. California, Maryland, Oregon, and Washington have all adopted variants of this approach.

Allowing Requests for Restrictions on Disclosure

A second policy approach that is grounded in the other special HIPAA Privacy Rule protection is allowing individuals to request that insurers restrict disclosure of their private health information and requiring insurers to honor those requests. The restriction might include an insured dependent asking that information not be disclosed to the policyholder. Washington adopted this approach for adults.

Restricting Disclosure of Information Based on Service or Population

A third policy approach is to impose an affirmative obligation on insurers to restrict the disclosure of individuals' private health information. This requirement can be applied to specific populations or particular services. Washington adopted this approach for minors who are allowed to consent for their own care and Illinois did so for its population enrolled in Medicaid managed care.

Requiring Specific Confidentiality Protections for Adult Dependents

A fourth policy approach is to require that insurers affirmatively implement specific confidentiality protections for a group of insured dependents—adults who are insured on a parent or other family member's plan. This approach can include requiring communication directly with the adult dependents,

7 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.

not the policyholder, or establishing separate communications with adult dependents. This is the approach taken in Colorado within its existing rules governing explanation of benefits that insurers establish a "confidential" method of communication with adult dependents.

Key Elements in the Six State Laws

The laws in each of the profiled states that were designed to increase confidentiality protection and decrease unwanted disclosures by insurers incorporated one or more of the broad policy approaches discussed above. Each state's law represented an attempt to address unique concerns in the advocacy community and policy landscape in the state.

California

The California legislature enacted a statute, still referred to as S.B. 138, creating a set of confidentiality protections for the health information of insured individuals.[8] The protections are particularly important for—but not limited to—those who are insured as dependents on a family member's plan. Specifically, S.B. 138 creates a right for individuals with health insurance to make a request to their health insurers or managed care plans for what the law referred to as "confidential communications." This new right was grounded in both the HIPAA Privacy Rule and in the intricate web of California confidentiality and insurance laws. S.B. 138 required health insurers—beginning January 1, 2015—to accept "confidential communications" requests. The law is comprised of multiple elements and definitions that are applicable to insurers, providers, and enrollees. For the insurers, the law created an obligation to comply—within a specified timeframe—with requests from insureds, subscribers, or enrollees to redirect insurance or health plan communications. For enrollees, it established a right to make a request and have the request honored. Finally, it allows providers to work directly with their patients to arrange for the payment of cost-sharing under the policy or plan if the patient has asked for redirection.

Colorado

In 2013, the Colorado Division of Insurance amended an 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.[9] The new provision requires insurers to take "reasonable steps" to ensure that the protected health information (PHI) of any adult child or adult dependent is protected. This protection includes ensuring that any communications between the carrier and covered adult child remain confidential and private. The regulation explicitly references the HIPAA Privacy Rule. The regulation also specifies that 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.[10] 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.

Illinois

In 2015, Illinois added a section to its Medicaid statute that requires managed care entities to take spe-

8 2013 Cal. S.B. 138, 2013 Cal. Stats. ch. 144 (Oct. 1, 2013).
9 3 Colo. Code Reg. § 702-4: 4-2-35, Sec.6.
10 3 Colo. Code Reg. § 702-4: 4-2-35, Sec.6.

cific steps to avoid breaching enrollees' privacy.[11] The law is designed to make sure that Medicaid managed care plans disclose information about sensitive services only to enrollees, to their providers and care coordinators, and to plan employees and business associates for specific permissible purposes.[12] The law requires Medicaid managed care entities to refrain from sending EOBs or otherwise disclosing information about sensitive services received by Medicaid managed care enrollees without their authorization, except as required or permitted by state and federal law, including the HIPAA Privacy Rule.[13]

Maryland

In April 2014, the Maryland legislature passed and the governor signed S.B. 790, a bill designed to bring communications between health insurance carriers and enrollees into conformity with specific requirements of HIPAA.[14] S.B. 790 added a new section to the Maryland Insurance Code entitled "Communications between carriers and enrollees – Confidentiality."[15] The legislation required the Maryland Insurance Commissioner to develop a form for enrollees to use when they rely on one of the special protections of the HIPAA Privacy Rule to request confidential communications from health insurance carriers.[16] S.B. 790 also requires an insurance carrier to accept the form if it requires confidential communication requests to be submitted in writing but allows carriers to accept other forms of written communication as well.[17] In addition, the legislation specifies that the notices of denials of claims and explanations of benefits required by Maryland law are both subject to the HIPAA Privacy Rule provision allowing individuals to request confidential communications.[18]

Oregon

The Oregon statute enacted in 2015[19]—often still referred to by its legislative bill number, H.B. 2758—created new requirements related to protected health information, building on the protections already in existence under Oregon law and the HIPAA Privacy Rule. The new statute requires health insurers to allow health plan enrollees to request that communications be sent directly to them and not to the policyholder. H.B. 2758 has several noteworthy and important features that make it comprehensive in its reach. First, it applies to all enrollees in commercial health insurance plans regulated by the state, including minors as well as adults. Second, it applies to a broad range of communications. Third, requests that communications be confidential may be made with respect to any services, not just sensitive services such as family planning or mental health services.

Washington

In 2001, Washington promulgated a regulation creating a right for patients to limit disclosure by insurers of their health information.[20] The Washington regulation contains protections for individuals who would be jeopardized by disclosure, for individuals receiving a range of sensitive health services, and for minors who may obtain health care without parental consent. Notably, the language in the Washington regulation is broader than the language in other states' laws in at least two ways: first, it encompasses not only requests for confidential communications (as in California) but also restrictions on disclosure of information; and second, it grants protection to minors as well as adults (in contrast to Colorado).

11 305 Ill. Comp. Stat 5/5-30(i).
12 305 Comp. Stat 5/5-30(i).
13 S.B. 1253 and H.B. 2812, 99th Gen. Assem., Reg. Sess. (Il. 2015), 2015 Ill. Laws 181.
14 S.B 790, 434th Gen. Assem. Reg. Sess. (Md. 2014), 2014 Md. Laws 72, amending Md. Code Ann. Insurance §§ 15-1006 and 15-1007 and adding Md. Code Ann. Insurance § 15-141.
15 Md. Code Ann. Insurance § 15-141.
16 Md. Code Ann., Insurance § 15-141(b); 45 C.F.R. § 164.522(b).
17 Md. Code Ann., Insurance § 15-141(c) and (d).
18 Md. Code Ann., Insurance §§ 15-1006(c) and 15-1007(d).
19 H.B. 2758, 78th Leg. Assem., Reg. Sess. (Or. 2015); 2015 Or. Laws ch. 470, adding a new section to the insurance code, Or. Rev. Stat. § 743B.555.
20 Wash. Admin. Code § 284-04-510.

The Washington regulation comprises a number of key elements. First, the regulation provides that insurers must limit disclosure of an individual's health information if the individual clearly states in writing that disclosure could jeopardize the individual's safety. Second, insurers must honor written requests by individuals not to disclose their health information pertaining to reproductive health, sexually transmitted diseases (STDs), chemical dependency, and mental health. Third, the regulation makes clear that minors who may obtain health care under state or federal law without parental consent are able to exercise the right to limit disclosure under the regulation and that insurers must recognize this right on the part of minors. Notably, the protection for minors does not require them to make a written request, but rather requires insurers to refrain from disclosing the information whether or not such a request is made. Finally, the regulation specifies the information that must be included when a request for nondisclosure is made, either based on endangerment or in connection with the enumerated sensitive services. Significantly, the Washington regulation explicitly states that its provisions apply *"[n]otwithstanding any insurance law requiring the disclosure of information."*[21]

Favorable Policy Environments

A few specific aspects of the policy environments in the six profiled states made them more or less hospitable to addressing the thorny problem of confidentiality in insurance. These include the characteristics of confidentiality protections in state law and of state laws related to insurance disclosures, receptiveness of state legislatures, and attitudes of state agency officials.

Confidentiality Protections in State Law

Some of the states had strong confidentiality protections for health information in state law, in addition to the HIPAA Privacy Rule protections that apply in all states. Some of these protections are contained in detailed medical privacy laws that specify the types of information protected, the circumstances in which the information may be disclosed, and who controls disclosure. In a few, the protections in state law include specific confidentiality requirements for insurers that preceded the adoption of the new law. The presence of strong confidentiality protections in state law provided a strong foundation for creating new and more specific protections for insured dependents.

State Laws Related to Insurance Disclosures

In a few states, the laws contained specific detailed requirements related to insurance communications and disclosures, in addition to the requirements of federal law related to notices of denials of claims that apply in all states. For example, some states detail the specific information that must be included in EOBs, denials of claims, or other communications from health insurers to policyholders. The presence of these detailed requirements provided an appropriate place in state law for locating a new statute or regulation.

Receptiveness of State Legislatures

In some states, the role of the legislature was critical. A receptive state legislature that was prepared to expand confidentiality protections for insured individuals, including insured dependents, made it possible to address the problem in statute rather by regulation. Doing so by regulation required that there be a statutory basis for the authority of the insurance regulator to act in this manner, whereas a legislative approach provided the opportunity for considering a wider range of policy approaches. The existence of a strong legislative champion with a leadership role was also instrumental in moving forward. The receptiveness of state legislatures often depended on the influence of insurance carriers and whether they were opposed or neutral.

21 Wash. Admin. Code § 284-04-510(2).

Attitudes of State Agency Officials

The attitudes of government officials in the state—insurance commissioners and regulators and public health officials at the state and county level—were critical elements in several states to the progress of policy efforts to address confidentiality protections in the insurance arena. This was true with respect to the creation of new protections and to their implementation. An insurance commissioner would be in a position to promulgate a regulation, which was especially important when a legislative strategy was not feasible. Insurance regulators were less able to play a role in implementation due to limits on their enforcement authority. However, state and county public health officials were able to provide significant assistance with implementation efforts.

Themes and Lessons Across the Six States

Numerous themes and lessons emerged from the review of the six states' laws and the interviews with key informants in each state. These themes and lessons exhibited strong similarities across states. Several of the most important themes and lessons related to the role of coalitions of allies, the coverage of adults and minors, implementation barriers, and continuing confidentiality and financial sustainability concerns.

Coalitions of Allies

In each of the states a coalition of allies played important roles in the crafting, adoption, and implementation of the policies. Some of the coalitions were formal, others informal. Although the coalitions varied in size and composition, all included representation from diverse sectors including family planning providers, other health care providers, adolescent health experts, domestic violence organizations, and other advocates. These coalitions conducted research about laws in other states; developed strategies; and worked with insurers, state officials, and legislators to enlist support for adoption of a new policy. They also often played a key role in the implementation of the policy once it was adopted. These implementation efforts included working with state officials to develop forms for individuals and insurers to use; dissemination of information via webinars, staff trainings, and social media; and development of websites to inform and support providers and patients. An important factor in the intensity and success of the coalitions and of advocates' implementation efforts was the availability of resources—such as from foundation funding—to support staff time. The trainings and information dissemination efforts required for successful implementation were extensive.

Coverage of Adults and Minors

A key strategic issue in each of the states was whether the law should provide protection for both adults and minors or only for adults. Concern for adolescents was paramount for many of the coalition partners and allies in the states. Most, but not all, of the state laws do include protection for minors who are able to consent for their own health care. This addressed a pressing concern of the health care provider and advocacy community but also raised concerns for some insurers who were uncertain about when minors can legally consent for care and uneasy about communicating directly with minors rather than their parents. In at least one state minors were not included because the office of the insurance commissioner did not think it had authority to include them in the regulation's scope. In part because of relatively comprehensive and longstanding laws allowing minors to consent for their own care, most of the states did include protections for both minors and adults.

Implementation Barriers

Barriers to implementation of the laws in the six states arose from policy and legal considerations as well as from the capacity and commitment of all of the parties whose active participation is necessary. Several of the laws require action on the part of individual insured patients to request specific action by their insurers; this opt-in approach imposes a significant burden that is difficult for most patients to be aware of and initiate without support. This approach therefore also requires health care providers to assume significant responsibilities to educate patients and help them avail themselves of protections. All of the laws require insurers to adhere to their obligations of honoring requests for confidential communication, restricting certain disclosures, and communicating directly with insured dependents rather than policyholders. Some insurers were willing to do these things but found ongoing training of all of the relevant staff to be a challenge. Other insurers were reluctant to limit their communications with the policyholders to whom they feel contractually bound to provide certain kinds of information. Ultimately, one of the major barriers to full implementation of the laws in each state has been the issue of transparency and documentation: policyholders have a right to know what is happening with respect to copayment, coinsurance, and deductibles; insurers have an obligation to inform policyholders of their residual financial liabilities. This remains an unresolved issue in all of the states.

Continuing Confidentiality and Financial Sustainability Concerns

Safety-net providers are keenly aware of the need to improve their financial sustainability. One of the key potential ways of doing so is to increase revenues by billing commercial insurance or Medicaid. With the increased number of individuals covered by either Medicaid or commercial insurance since the Affordable Care Act became effective, the potential to increase revenues from these third-party sources has increased for safety-net providers. At the same time, protecting the confidentiality of their patients continues to be a legal obligation and a paramount clinical and ethical concern. Ensuring protection for the patients for whom confidentiality protection is an issue of urgency or safety is a priority for family planning and other safety-net providers. Being able to rely on other sources of funding has enabled many providers to avoid billing insurance whenever confidentiality might be a concern. The advent of laws designed to address confidentiality concerns while allowing health insurance to be billed has prompted many providers to evaluate the potential effectiveness of this approach and to consider helping their patients to make use of the newly available protections. Nevertheless, many providers continue to mistrust insurers and to have doubts about the timely and effective implementation of the protections by insurers.

Conclusion

The challenge of protecting confidentiality without forfeiting insurance coverage has a long history. Some steps were taken to address the issue in special protections that are part of the HIPAA Privacy Rule. More recently several states have enacted statutes or adopted regulations to increase privacy protection in the insurance billing and claims process. The general policy approaches and mechanisms chosen for doing this varied among these states. The likelihood of success in each state depended in part on the presence of a favorable policy environment. Advocates and other stakeholders in the states experienced some successes and encountered important challenges in their efforts to implement the laws. Extensive efforts have already been devoted to the creation and implementation of these state laws. These efforts are ongoing.

Acknowledgments

This overview was prepared by Abigail English of the Center for Adolescent Health & the Law, and Clare Coleman and Amanda Mulligan of the National Family Planning & Reproductive Health Association (NFPRHA).

The authors wish to thank Audrey Sandusky and Nikida Levy of NFPRHA. The authors also wish to thank Ana Carolina Loyola Briceno of the Office of Population Affairs.

Funding for this project was provided by the Office of Population Affairs (Grant Number 1 FPRPA006059). The views expressed by this project do not necessarily reflect the official policies of the US Department of Health and Human Services; nor does mention of trade names, commercial practices, or organizations imply official endorsement by the US Government.

About Confidential & Covered

Confidential & Covered was 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. To learn more about the project and to access all six state-profiles referenced in this document, please visit www.confidentialandcovered.com.

About NFPRHA

Founded in 1971 and located in Washington, DC, the National Family Planning & Reproductive Health Association (NFPRHA) is a 501(c)3 non-profit membership organization representing the broad spectrum of family planning administrators and providers who serve the nation's low-income, under-insured, and uninsured women and men.