



CONFIDENTIALITY & EXPLANATION OF BENEFITS: Protecting Patient Information in Third Party Billing

EXECUTIVE SUMMARY

Patient confidentiality has been raised as a serious concern in the context of third party billing for screening and treatment of HIV, HCV, and STIs. While there are general privacy protections in place at the state and federal level, separate billing requirements and common practices may put the confidentiality of patient information at risk when sensitive services are billed to a private insurer or Medicaid. For example, the third party payer will often send an Explanation of Benefits, which details the medical services received, to the primary policyholder instead of the beneficiary receiving the care. By expanding insurance coverage, including requiring insurers to permit dependents to stay on their parent's coverage through age 26, the Affordable Care Act has largely expanded the group of patients that could potentially have their Explanation of Benefits accessed by another person.

Concerns regarding Explanation of Benefits could impact confidentiality and thus, public health, if individuals are averse to seeking testing and treatment for infectious diseases. This issue brief provides an overview of the potential privacy issues, an outline of the legal landscape (including an analysis of relevant pending legislation), and suggestions to address these concerns.

The Center for Health Law & Policy Innovation provides information and technical assistance on issues related to health reform, public health, and food law. This document should not be considered legal advice. For specific legal questions, consult with an attorney.

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ABOUT THE AUTHORS

The Center for Health Law and Policy Innovation of Harvard Law School (CHLPI) advocates for legal, regulatory, and policy reforms to improve the health of underserved populations, with a focus on the needs of low-income people living with chronic illnesses. CHLPI works with consumers, advocates, community-based organizations, health and social services professionals, government officials, and others to expand access to high-quality healthcare; to reduce health disparities; to develop community advocacy capacity; and to promote more equitable and effective healthcare systems. CHLPI is a clinical teaching program of Harvard Law School and mentors students to become skilled, innovative, and thoughtful practitioners as well as leaders in health and public health law and policy.

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I. OVERVIEW OF THE PROBLEM

An Explanation of Benefits (EOB) is a form of communication from a health insurer that sets out the medical services plan enrollees received, as well as associated costs. EOBs are typically detailed and may identify the individual who received care, the clinician who provided care, and information about the services provided.¹ EOBs are intended to verify services to curb health care fraud.²

EOBs are often sent to the primary policyholder when any beneficiary receives services. This practice can result in sensitive health information about beneficiaries being disclosed without their knowledge or consent. This problem particularly affects minors and young adults who are dependents on their parents' insurance coverage³ and spouses who may not want their partner to know they received a particular service.⁴ Women are disproportionately affected by this issue. Twenty-five percent of adult women are insured as a dependent compared to 13 percent of adult men.⁵

The practice of sending EOBs to the primary policyholder can have serious negative consequences for patient confidentiality and care. Concerned patients may instead seek uncompensated care, thereby threatening the health safety net that is already under pressure. Minors concerned that their parents will find out they are sexually active may delay or avoid testing or treatment for sexually transmitted infections (STIs), which can jeopardize the health of both patients and their sexual partners.⁶ Patients seeking treatment for behavioral health issues may have information about their illness disclosed without their consent. Patients in abusive environments may be subject to retaliatory violence when the abuser receives the EOB for certain services, which may cause some patients to not seek treatment at all.⁷ This is particularly concerning because of the cyclical relationship between HIV and domestic or sexual violence and abuse.⁸

Confidentiality with respect to EOBs has become a concern in Massachusetts.⁹ Women's advocacy groups have highlighted the potential for EOBs to breach confidentiality after providers informed these groups that EOBs sent to policyholders were causing confidentiality problems for their clients seeking reproductive health services. Health Care For All, a non-profit organization focusing on improving access to health care in Massachusetts, recognized that EOBs more broadly affect beneficiaries seeking sensitive services and created the "Protecting Access to Confidential Health Care" (PATCH) Alliance. The PATCH Alliance is a coalition of providers, as well as advocacy and community-based organizations, concerned with maintaining confidentiality in health insurer communications.¹⁰ The PATCH Alliance includes providers and at least 40 organizations operating in the fields of reproductive health, sexually transmitted infections, adolescent and young adult health, HIV, mental health and substance use disorders, and interpersonal and domestic violence.

The PATCH Alliance, state legislators, and other advocates have recognized the potential confidentiality concerns and have sought to address them. This issue brief provides an overview of the potential privacy issues and outlines the legal landscape (including an analysis of relevant pending legislation). We conclude with several potential strategies and workarounds to protect privacy in Massachusetts that policymakers can adopt and advocates can encourage.

II. LEGAL LANDSCAPE

A. FEDERAL LAW: PRIVATE INSURANCE

Federal law does not require EOBs to be sent home and for certain services, federal health reform has reduced the need and likelihood that EOBs will be sent home. One goal of the Affordable Care Act (ACA) was to increase access to health care and standardize the benefits covered. Under the ACA, preventive services the United States Preventive Services Task Force (USPSTF) recommends with an A or B rating, including STI screenings and certain women’s health services, are now covered without cost sharing.¹¹ This change has not only increased access to these services, but also has the potential to improve confidentiality in accessing them. EOBs are intended to confirm the enrollee received the services billed to the insurer and inform enrollees of any remaining payments due.¹² When more preventive services are covered without cost sharing, the financial disclosure reason for the communication is eliminated. National organizations, such as Partnership for Prevention, the American Academy of Pediatrics, the American College of Obstetricians and Gynecologists, and the Society for Adolescent Health and Medicine, have advocated for eliminating EOBs for any USPSTF recommended A or B preventive service.¹³

Federal law requires insurers of non-grandfathered group and individual health insurance plans to issue notices of adverse benefit determinations. These notices of adverse benefit determinations must include information sufficient to identify the claim involved, the claim amount, if applicable, and a statement describing the availability of the diagnosis and treatment code and its corresponding meaning upon request.¹⁴ To protect confidentiality, the final rule does not require that diagnostic and treatment codes *automatically* be listed on a notice of adverse benefit determination, but instead requires they be available *upon request*.¹⁵ The requirement that the issuer include information sufficient to identify the claim could potentially violate a patient’s confidentiality, depending on how this information is conveyed.

Similarly, under the Employee Retirement Income Security Act (ERISA), covered health plans must send notice to the participant or beneficiary of any adverse benefit determination.¹⁶ The participant is defined as the “employee” who is normally the policyholder. Under ERISA regulations, an adverse benefit determination encompasses situations where the participant is responsible for paying any part of the claim, including patient copayments. In other words, if the plan pays less than 100 percent of the claim, it is required to notify the participant, and plans use EOBs to meet that requirement.¹⁷ ERISA applies to health plans, funds, or programs that an employer establishes or maintains for the purpose of providing benefits ERISA covers to their beneficiaries.¹⁸ Therefore, when coverage for a service is denied under these plans, funds, or programs, or when there is any patient cost sharing as part of a claim, insurers could unintentionally disclose the insured dependent’s health information to the policyholder.

B. MEDICAID

Federal law does not specifically require state Medicaid agencies to send EOBs. However, state Medicaid agencies must have a method for verifying with beneficiaries that they received the services which the provider billed.¹⁹ The law does not specify a particular method; therefore, state agencies can adopt other methods of complying with this requirement, such as requiring providers to review records retrospectively to confirm the accuracy of the bill.²⁰

Federal law does not require that Medicaid managed care organizations (MCOs) send EOBs for the general provision of services. The Balanced Budget Act of 1997, however, does require Medicaid MCOs to notify enrollees in writing whenever a decision is made to deny a service authorization request or to authorize a service in amount, duration, or scope that is less than requested.²¹ The written notification must provide a description of the adverse

benefit determination, the reasons for the determination, and the enrollee’s right to request an appeal.²² While these notifications are an important tool for ensuring fair notice and opportunity to appeal, they can also put beneficiaries at risk of a confidentiality breach if sent to the policyholder.

Massachusetts does not require Medicaid MCOs to send EOBs, although there have been legislative efforts to implement such a requirement. For example, *An Act Requiring MassHealth to Provide an Explanation of Benefits to beneficiaries* was introduced during the 2013-2014 and 2011-2012 legislative sessions and was referred to the Senate Committee on Ways and Means and the Committee on Health Care Financing but did not advance any further.²³

C. FEDERAL CONFIDENTIALITY PROTECTIONS

Federal law provides some basic confidentiality protections in the context of EOBs. Health Insurance Portability and Accountability Act (HIPAA) regulations state that individuals may request to receive protected health information “by an alternative means or at alternative locations” if disclosure of the information “could endanger the individual.”²⁴ Under these regulations, insured dependents can request to have protected health information communicated directly to them in certain circumstances, thereby avoiding unwanted disclosure to primary policyholders.

However, current HIPAA regulations are not, on their own, sufficient to fully protect patient confidentiality. The HIPAA regulations do not guarantee that a request for confidentiality will be granted. The regulations also set a high bar for the protection of health information—endangerment. This standard may not cover all scenarios in which a patient would want to protect their health information from disclosure. Furthermore, what rises to the level of endangerment may be open to interpretation. Finally, insurers may vary in how they implement the endangerment clause (e.g., in the format that they require requests to be submitted or in their timelines for addressing requests).²⁵ Patients may therefore struggle to properly submit a request or to have their request approved quickly enough to meet their needs. States must therefore build upon the “floor” set by HIPAA regulations in order to fully protect patient confidentiality.²⁶

D. MASSACHUSETTS LAW: PRIVATE INSURANCE

Massachusetts state law does include protections for patients’ rights to confidentiality of medical records and medical information. For example, Massachusetts law provides additional protections to prevent disclosure of HIV testing.²⁷ However, these privacy laws provide no explicit protections for patients regarding the sending of sensitive information in EOBs.

A 2012 Massachusetts law currently requires the Division of Insurance (DOI) to develop a common summary of payments form (i.e., EOB) for provider claims submitted to health care payers; the form must be written in an easily readable format and show the patient’s responsibility, if any, for payment of any portion of a health care provider claim.²⁸ While DOI has not yet issued guidance or regulations pertaining to the common summary of payments form, a bill was introduced in 2015 that would specify elements of the form that would better protect patient confidentiality. This bill is discussed further below.

E. AN ACT TO PROTECT ACCESS TO CONFIDENTIAL HEALTHCARE

An Act to Protect Access to Confidential Healthcare was filed on January 15, 2015. Senator Karen Spilka and Representative Kate Hogan sponsored the legislation.²⁹ This bill seeks to ensure confidentiality regarding insurers sending EOBs. The bill contains several strong protections for patient confidentiality.³⁰

- Preferred Method of Receipt*

The bill would allow insured members who are legally authorized to consent to care (or a party legally authorized to consent to care for the insured member) to choose his or her preferred method of receiving the summary of payment form, including sending the form to the address of the subscriber, the address of the insured member, or an alternate address upon request (including a post office box or domestic violence agency), or allowing only the insured member to access the form through electronic means. The method selected is valid until a new method is listed as preferred.
- No Descriptions of Sensitive Services*

The bill restricts insurers from sending EOBs with descriptions of services for sensitive health care services. The Massachusetts Division of Insurance (DOI) is charged with defining sensitive health care services. DOI must consider the recommendations of the National Committee on Vital Health Statistics and consult with experts on infectious disease, reproductive and sexual health, domestic violence and sexual assault, mental health, and substance abuse when defining sensitive health services.
- Consumer Option to Suppress EOBs When No Remaining Balance*

The bill would allow insured members who are legally authorized to consent to care (or a party legally authorized to consent to care for the insured member) to suppress the issuance of an EOB for a specific service or procedure if the insured has no outstanding liability for payment. This includes services the USPSTF recommends with an A or B rating. The insured must make an oral or written request, and insurers generally cannot require an explanation as to why the insured wishes to suppress the EOB.
- Education*

The bill requires implementation of a plan to educate providers and consumers regarding the rights of beneficiaries. The bill requires the DOI, in collaboration with the Massachusetts Department of Public Health (DPH), and in consultation with stakeholder groups, to develop and implement a plan to educate providers and consumers of their rights and to promote compliance with the other requirements of the bill. The education plan must include: staff training and other education for hospitals, community health centers, school-based health centers, physicians, nurses, and other licensed health care professionals, as well as administrative staff involved in patient registration, confidentiality education, and processing of insurance claims. Insurance carriers must conspicuously display information about EOB confidentiality protections on their member websites and online portals. The public education campaign must begin no later than six months after the effective date of the law.
- Implementation*

DOI would be required to produce implementing regulations within three months from the date the act is effective. Plans would have 12 months from the law's effective date to come into compliance; for provisions regarding electronic access, the deadline is 24 months, unless the carrier has the capacity to comply earlier.

Based on negotiations between the bill champions and Massachusetts health plans, the bill was revised from the version originally filed.³¹ The redrafted version allows health plan enrollees to request that insurers fully suppress EOBs only when there is no cost sharing, in order to comply with federal Department of Labor regulations.³² In addition, a provision to automatically suppress EOBs for services with no cost sharing was removed due to concerns that EOBs serve as a tool for promoting health care cost transparency, even when a claim has been paid in full.³³

Other amendments to the bill were also proposed during the Senate debate, but were ultimately rejected. These amendments included only sending a summary of payment form upon request, requiring coordination of care between medical and behavioral health providers, sending an annual notice of standards for written consent to release information, and requiring parental notification of a minor's opioid overdose.³⁴

Potential Remaining Confidentiality Issues

The existing legislation does leave some potential gaps in protecting confidentiality, and thus, an opportunity for further action to protect confidentiality. The bill if passed would only allow insured individuals who are legally authorized to consent to care or a party legally authorized to consent to care for the insured to choose the preferred method of receiving EOBs.³⁵ The requirement regarding only those able to consent to care will leave some minors unable to suppress or redirect EOBs. Massachusetts law provides for a number of circumstances in which minors may consent to their own health care (e.g., most pregnancy related care, family planning services offered through DPH, substance abuse treatment, and STI treatment) without consent of a parent or guardian, including when a physician believes that a minor can give informed consent and it is in the minor's best interest not to notify the parents/guardians.³⁶ This ability to consent does not extend to abortion, except if the minor is married, divorced, or widowed. A minor who does not fall within the exceptions must have one parent or guardian's consent or petition the court.³⁷ Thus, a minor without parent, guardian, or court's permission to consent to an abortion will not be able to suppress or redirect EOBs. Likewise, a minor who does not meet one of the designated categories under Massachusetts law and who has a physician who does not believe he or she is able to provide informed consent to care will also not be able to suppress or redirect EOBs.³⁸

Further, the extent to which the bill will improve confidentiality largely depends on the education of providers and patients. For instance, patients will be able to suppress EOBs when there is no patient liability for payment; however, they will only exercise this right if they know it exists. The most ideal method to protect confidentiality would be to automatically suppress EOBs for confidential services to the extent allowed by federal regulations, as discussed below. The bill does contemplate DOI working with DPH to educate providers and patients regarding their rights; the success of this education will depend on how it is implemented.

III. PROPOSED WORKAROUNDS

A. STRONGEST PROTECTIONS

Passage of the proposed legislation is currently the most comprehensive option for addressing patient confidentiality concerns in the Commonwealth. However, if the legislature fails to pass the comprehensive bill, legislators could pursue more incremental change by introducing legislation on individual provisions of the legislation in the next legislative session. This section provides an overview of the legislative solutions that might offer the strongest protections.

1. *Passage of An Act to Protect Access to Confidential Healthcare*

As outlined above, *An Act to Protect Access to Confidential Healthcare* (S. 2138) would provide many protections for patient confidentiality. The ability of patients to request an alternative method to receive EOBs provides a solid base for confidentiality. This is bolstered by the option for consumers to request that EOBs be suppressed for services when there is no payment due from the patient.

As expected, the bill has been met with praise and criticism. Private health plans opposed the original version of the bill, as many of the bill's provisions would require plans to make administrative changes, but became supporters of the revised bill. A committee hearing on the bill took place on July 21, 2015, at which Attorney General Maura Healy testified. Attorney General Healy stated that EOBs are "routinely sent to the primary policy holder without any screening as to whether that information reveals something about the patient's care that should be private."³⁹ She also noted that this creates "a real risk for certain patients," including survivors of sexual and domestic violence, young people seeking to access reproductive health care services

and mental health services, and those receiving treatment for other potentially sensitive conditions. After the public hearing, support from the Attorney General, and positive media coverage,⁴⁰ the outlook for the bill looked promising.

The bill, however, has not thus far passed into law during the 2015-2016 legislative session. The bill made substantial progress, receiving favorable reports from both the Joint Committee on Financial Services and Joint Committee on Health Care Financing.⁴¹ In March 2016, the Senate passed the bill with 30 yes votes and 5 no votes, and the bill was then referred to the House Committee on Ways and Means.⁴² The formal legislative session ended on July 31, 2016, and the legislature continues to meet in informal sessions – where bills can pass by unanimous consent – for the remainder of the calendar year. If the bill is not enacted by the end of the session, policymakers will need to reintroduce it in the next session.

If the bill is passed this session, there will be a delay before the new protections take effect. Once the law goes into effect, DOI would then have three months to promulgate regulations. Additionally, patients would need to become aware of the changes in the law in order to realize its benefits. Therefore, the effects of the law may not be realized for many months after its passage.

2. *Allow those accessing care to request an alternative method to receive EOBs to the extent permitted by federal law*

If the *Act to Protect Access to Confidential Healthcare* does not become law, legislative efforts that are less comprehensive could provide some improvements and might be more likely to pass in the legislature. For example, the legislature could pass a portion of the *Act to Protect Access to Confidential Healthcare*, such as the requirement that health plans allow enrollees who are legally authorized to consent to care to request an alternative method to receive EOBs (e.g., that EOBs be sent to an alternative mailing address or be made electronically available only to the enrollee). California passed a similar law, the *Confidential Health Information Act*, which took effect on January 1, 2015. To the extent permitted by federal law, the Act requires health plans to allow individuals or clinicians to request EOBs not be sent to policyholders for sensitive services when disclosure of this information could lead to patient endangerment. Under the law, the individual is required to provide the health plan with a way to communicate information directly to the patient (i.e., physical or electronic address).⁴³ Further, to implement the legislation if passed, the Massachusetts DOI could create a standard form that allows individuals to request insurance information be sent to an alternative address.⁴⁴

This proposal alone also has limitations. Many adolescents may face difficulties finding an alternative address if they live with the primary policyholder or may not meet state requirements to consent to care. There also may be administrative barriers as this workaround may require IT systems to be updated and require coordination of many different business units, including member services, utilization management, appeals, and mail vendors.

3. *Require insurers to communicate directly with and send “member-level” EOBs to individual members, including insured dependents, to the extent permitted by federal law*

Policymakers could pursue legislation to require that health plans send “member-level” EOBs and communicate individually with beneficiaries to the extent permitted by federal law. Implementing this workaround would allow more beneficiaries control over access to private information without sacrificing the fraud-fighting component, as EOBs would still be issued and communication about services would continue. The Colorado Division of Insurance implemented a similar requirement for health plans: the regulation requires health plans to ensure confidential communications between the carrier and a covered adult child by communicating exclusively with the covered dependent regarding protected health information. This information is not permitted to be

sent to the policyholder without prior consent of the covered adult child or adult dependent.⁴⁵ Enacting such a law would strongly protect confidentiality because the confidential communications are by default directed to the insured accessing the services.

This workaround is not without limitations. For many patients, the member-level address may be the same as the primary policyholder, so it does not completely eliminate the possibility of a confidentiality breach. The implementation may also require the insurer to make some technological changes to redirect communications.⁴⁶

4. Prohibit insurers from sending EOBs in certain circumstances to the extent permitted by federal law

A law that prohibits EOBs from being sent in certain instances, including when no remaining payment is due or the service is deemed “sensitive,” would protect the confidentiality of many people accessing sensitive health services. If insurers were only permitted to send EOBs when a balance was due, then many sensitive services covered without cost sharing under the ACA would remain confidential. Massachusetts could pass legislation that prohibits the use of EOBs when the insurer has already covered the entire cost of services provided.

However, this workaround also suffers from certain limitations. Prohibiting EOBs from being sent when no balance is due may provide only limited improvement given that many large insurers in Massachusetts reportedly already do not send EOBs when no remaining balance is due, yet confidentiality concerns persist. Also, this option obviously does not protect patient confidentiality for services that require a payment. Similarly, prohibiting EOBs for sensitive services only protects patient confidentiality with respect to certain services that generally are deemed sensitive and not for other services that an individual patient might not want to disclose that they are accessing, such as treatment related to domestic violence, and would also be subject to the federal ERISA regulation limitations discussed above.

B. ALTERNATIVE STRATEGIES

While the legislative workarounds provide the strongest protections for confidentiality, they may not be the most feasible and offer no protections for patients until their passage. Therefore, Massachusetts policymakers may want to consider workarounds that do not require legislative action and could be implemented prior to passage of any new laws.

1. Summary of Payment form could restrict descriptions for sensitive health services

The DOI could issue regulations restricting information about sensitive health services on the summary of payment form sent to primary enrollees. As mentioned above, a bill was passed in 2012 authorizing DOI to issue regulations around the summary of payment form that insurers use. To date, no such regulations have been issued. The DOI form could require insurers to use generic language for sensitive services.⁴⁷ As in the pending legislation, DOI could reference the National Committee on Vital Health Statistics and consult with experts on infectious disease, reproductive health, domestic violence and sexual assault, mental health, and substance abuse when defining sensitive health services.

This workaround would help prevent overtly breaching the confidentiality of the insured dependent if the form is inadvertently shared with the primary policyholder. This workaround is especially helpful because it is a viable option as the DOI already has statutory authority. Potential limitations are that even a description with generic terminology will still alert a primary policyholder to services that were allegedly received by another member on the plan. The implementing regulations would also have to appropriately define sensitive health services to ensure the needed services are protected.⁴⁸

2. *Work with individual insurers to protect confidentiality*

As noted, Massachusetts law does not require health plans, in general, to send EOBs. EOBs are a common insurance practice, which allows individual insurers to alter their own methods of communication about claims paid. For instance, Cigna, a national insurer, does not send home EOBs, unless payment is due. Other issuers have reported improved STI screenings by listing these services as “general lab services.”⁴⁹ Policymakers could encourage issuers to adopt policies that protect confidentiality. The most feasible approach for insurers would be a policy change in how services are listed on EOBs. Policymakers could also encourage issuers to only send EOBs when a payment balance is due and ask the insured individual consenting to services to note where they would want their EOB sent.

3. *Use CPT codes to automatically suppress EOBs for sensitive information*

Health plans could work with providers to recommend a Current Procedural Terminology (CPT) code for certain confidential services that would automatically suppress EOB creation when applied.⁵⁰ CPT codes are five-character, alphanumeric codes with standardized descriptions used to report health services and procedures to payers for reimbursement.⁵¹ Because of federal ERISA regulations, as previously described, this option could only be applied to services that are mandated to have no patient cost sharing, such as preventive services rated A or B by the USPSTF. This option completely eliminates the possibility of sensitive information being received by anyone other than the patient receiving the health service. It would also eliminate the responsibility for the patient in requesting the suppression.

Limitations of this option are that CPT codes are a product of American Medical Association (AMA) and that for plans under ERISA jurisdiction, the new CPT codes could apply only to services where patient cost sharing is prohibited. In order to create new CPT codes, policymakers would have to negotiate with both health plans and providers. The AMA would also have to endorse the codes, which is unlikely according to a 2012 AMA review of this option.⁵² Additionally, this strategy eliminates the fraud-fighting function of EOBs with respect to these services.⁵³

4. *Education*

Education is necessary to supplement any proposal. Policymakers can take a leadership role in educating providers on the ways that they can work to protect sensitive health care information. In New York, the Erie County Department of Public Health sought to increase Chlamydia screening rates in the county so they worked with local providers and health plans to improve confidentiality and adolescents’ confidence in confidentiality when accessing sexual health care services. To this end, the County Department of Public Health created a toolkit for providers that included guidelines for screening and treating STIs. Insurers were permitted to send EOBs but the toolkit provides advice on discussing insurance with adolescents to avoid involuntary disclosure, choosing CPT codes that protect confidentiality, offering alternative forms of payment for those concerned about insurance disclosure of confidentiality, and providing a list of Title X clinics that offer reproductive health care services without cost or with little cost. The three major local health plans all endorsed the toolkit.⁵⁴ Providers can also be provided materials to give to parents and youth about the importance of confidential health services.⁵⁵

Another essential step is to educate all insured dependents—including youth and young adults—about their rights to confidential care. This step is particularly important when the patients must proactively take steps to protect their confidentiality. For example, all insured dependents should be educated on their right under HIPAA regulations to request confidential communication of protected health information when disclosure could be dangerous to them. Educating patients will allow them to feel confident about the confidentiality of their medical care and will give them the knowledge and resources to request measures when necessary.⁵⁶

Parents or guardians also need to be educated so they can understand the importance of confidential care for their children. Parents should be assured that their children are receiving adequate care but know that they may not receive specific information regarding that care.

IV. CONCLUSION

The practice of sending EOBs to primary policyholders, instead of individual enrollees, may place patient privacy at risk. This practice, especially when applied to sensitive services, can result in negative consequences for individual patients and for broader public health. Legislative efforts, either comprehensive or piecemeal, would provide the strongest protections, though implementation of the protections could take time. In the absence of such legislation, policymakers should consider working with health plans to implement feasible solutions and educate providers, patients, and parents/guardians on their current rights and options to best protect their sensitive health information.

ENDNOTES

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21 See 42 CFR § 438.210(c).
22 42 CFR § 438.404(a) - (b).
23 S.B. 539, 188th Gen. Assemb., Reg. Sess. (2014).
24 42 CFR § 164.522(b)(1)(ii).
25 Communications with Alyssa Vangeli, Senior Health Policy Manager, Health Care for All.
26 See 45 CFR § 160.203 (allowing states to adopt more stringent policies).
27 MGL c. 111, § 70F (prohibits disclosure of HIV test results to any person other than the subject without
written consent or identification of the subject of HIV testing to any person without written consent).
28 MGL c. 176O, § 27.
29 See S.B. 557, H.B. 871 189th Gen. Assemb., Reg. Sess. (2015).
30 S.B. 2138, 189th Gen. Assemb., Reg. Sess., <https://malegislature.gov/Bills/189/Senate/S2138>; Corrective
Amendment, S.B. 2138, 189th Gen. Assemb., Reg. Sess., [https://malegislature.gov/Bills/189/Senate/S2138/
Amendment/Senate/6/Text](https://malegislature.gov/Bills/189/Senate/S2138/Amendment/Senate/6/Text); Communications with Alyssa Vangeli, Senior Health Policy Manager, Health
Care for All.
31 Communications with Alyssa Vangeli, Senior Health Policy Manager, Health Care for All.
32 29 C.F.R. § 2560.503-1; Department of Labor FAQs About The Benefit Claims Procedure Regulation, C-12,
https://www.dol.gov/ebsa/faqs/faq_claims_proc_reg.html.
33 For all other changes, see redrafted version of the bill, S.B. 2138, [https://malegislature.gov/Bills/189/
Senate/S2138](https://malegislature.gov/Bills/189/Senate/S2138).
34 The 189th General Court of the Commonwealth of Massachusetts, Bill S. 2138, An Act to Protect Access
to Confidential Healthcare, Senate Amendments (last visited June 20, 2016), [https://malegislature.gov/
Bills/189/Senate/S2138/History](https://malegislature.gov/Bills/189/Senate/S2138/History).
35 The bill only allows insured individuals who are legally authorized to consent to care (or a party legally
authorized to consent to care for the insured) to choose a preferred method of receiving EOBs due to
regulatory requirements associated with the federal Health Insurance Portability and Accountability Act
(HIPAA). HIPAA regulations generally allow parents to access information about their minor child's health
care except when state law permits the minor to consent to his or her own care and the minor seeks
that care independently. See 45 C.F.R. § 164.502(g)(3)(i); see also U.S. Department of Health and Human
Services guidance, available at [http://www.hhs.gov/hipaa/for-professionals/privacy/guidance/personal-
representatives/index.html](http://www.hhs.gov/hipaa/for-professionals/privacy/guidance/personal-representatives/index.html).
36 See, e.g., M.G.L. c.112, § 12F; M.G.L. c.111, §§ 6, 117; M.G.L. c.111, § 24E; M.G.L. c.112, § 12E; M.G.L.
c.123, § 10; M.G.L. c.112, § 12S; *Baird v. Attorney Gen.*, 37` Mass. 741 (1977); 104 C.M.R. § 25.04.
37 M.G.L. c.112, § 12S.
38 It is important to note that An Act to Protect Access to Confidential Healthcare does not change any of
the Massachusetts minor consent to care laws, nor parents' ability to access minor children's health care
information. Under the federal Health Insurance Portability and Accountability Act (HIPAA) regulations,
if a minor receives care under a state's minor consent to care laws, health plans may not disclose that
information to parents. See 45 CFR § 164.502(g)(3)(i); see also U.S. Department of Health & Human Service
guidance regarding health information privacy and personal representatives, available at: [http://www.hhs.
gov/hipaa/for-professionals/privacy/guidance/personal-representatives/index.html](http://www.hhs.gov/hipaa/for-professionals/privacy/guidance/personal-representatives/index.html).
39 Testimony of Attorney General Maura Healey, Joint Committee on Financial Services at 1-2 (July 21, 2015),
[http://www.mass.gov/ago/docs/testimonies/2015/testimony-on-explanation-of-benefits-aca-as-prepared-
for-delivery.pdf](http://www.mass.gov/ago/docs/testimonies/2015/testimony-on-explanation-of-benefits-aca-as-prepared-for-delivery.pdf).
40 See, e.g., Felice J. Freyer, *State bill pushes for more medical privacy*, The Boston Globe (Aug. 14, 2015),
[https://www.bostonglobe.com/metro/2015/08/13/legislation-aims-protect-privacy-health-insurance-
forms/HGvYA5Xip9SLXOK9IGRhZH/story.html](https://www.bostonglobe.com/metro/2015/08/13/legislation-aims-protect-privacy-health-insurance-forms/HGvYA5Xip9SLXOK9IGRhZH/story.html); The Editorial Board, *Medical privacy plan offers sensible
remedy*, The Boston Globe (Aug. 18, 2015), [https://www.bostonglobe.com/opinion/editorials/2015/08/18/
medical-privacy-plan-offers-sensible-remedy/sM46MniG09arIRxcP5Z9pl/story.html](https://www.bostonglobe.com/opinion/editorials/2015/08/18/medical-privacy-plan-offers-sensible-remedy/sM46MniG09arIRxcP5Z9pl/story.html).

- 41 Bill History for S.B. 2081, 189th Gen. Assemb., Reg. Sess., <https://malegislature.gov/Bills/189/Senate/S2081/History>.
- 42 Bill History for S.B. 2138, 189th Gen. Assemb., Reg. Sess., <https://malegislature.gov/Bills/189/Senate/S2138/History>.
- 43 S.B. 138, Confidentiality of Medical Information (2013-2014 Session).
- 44 Tebb, *supra* note 2 at 14-16.
- 45 3 CCR 702-4 Amended Regulation 4-2-35, Colorado Division of Insurance, <http://www.sos.state.co.us/CCR/Upload/AGORequest/AdoptedRules02013-01057.DOC>.
- 46 Tebb, *supra* note 2 at 16, 20-21.
- 47 *Id.* at 13-14.
- 48 Abigail English et al., *Confidentiality, Third-Party Billing, & the Health Insurance Claims Process: Implications for Title X*, National Family Planning and Reproductive Health Association 19 <http://www.hivlawandpolicy.org/sites/www.hivlawandpolicy.org/files/A%20English-confidentiality,%203rd%20party%20billing%20and%20HIPAA-june2015.pdf>.
- 49 *Id.* at 8.
- 50 Tebb, *supra* note 2 at 17-19.
- 51 See *What is CPT?* AAPC, <https://www.aapc.com/resources/medical-coding/cpt.aspx>.
- 52 See *Understanding Adolescent Confidentiality as it Relates to Billing*, Position Paper: American Academy of Pediatrics Committee on Coding and Nomenclature, American Academy of Pediatrics (Sept. 2012), <https://www.aap.org/en-us/professional-resources/practice-support/Coding-at-the-AAP/Documents/COCN-Adolescent-Confidentiality-White-Paper-Aug-12.doc>.
- 53 Tebb, *supra* note 2 at 17-19.
- 54 Nat'l Inst. For Health Care Management Found., *Protecting Confidential Health Services for Adolescents & Young Adults: Strategies & Considerations for Health Plans* 57 (May 2011).
- 55 Tebb, *supra* note 2 at 21.
- 56 See Nat'l Inst. for Health Care Management, *Protecting Confidential Health Services for Adolescents & Young Adults: Strategies & Considerations for Health Plans* (May 2011), <http://www.cicatelli.org/ipp/downloadable/NIHCM-Confidentiality-Final.pdf>; Tebb, *supra* note 2 at 22.