

A New Frontier in the Era of Health Reform: Protecting Confidentiality for Individuals Insured as Dependents

By Rachel Benson Gold

Billing and claims processing procedures widely used in private health insurance routinely, albeit inadvertently, make it impossible for anyone insured as a dependent on someone else's policy to obtain sensitive services confidentially. One of the most frequent ways in which disclosure occurs is through explanation of benefits (EOB) forms sent by insurers to policyholders after anyone covered under their policy obtains care. An EOB typically identifies the individual who received care, the health care provider and the type of care obtained. It also includes information on the amount charged for the care, the amount reimbursed by the insurer and any remaining financial obligation on the part of the policyholder or patient. The long-standing practice of sending EOBs essentially makes it impossible for dependents—often minors and young adults—to obtain the confidential access to sexual and reproductive health care they need.

Millions of Americans are expected to obtain health insurance coverage as a result of the Affordable Care Act (ACA), including large numbers of young adults who can now remain covered as dependents under a parent's policy until age 26.¹ This means that addressing the long-standing challenge of how to protect dependents' confidentiality about sensitive health services is becoming increasingly important.

Historically, states have had the lead role in regulating health insurance, including whether and to whom insurers must send EOBs. Accordingly, some creative ideas already are starting to bubble up from states. These approaches may lead

the way to simple, workable solutions that satisfy the needs of insurers, protect policyholders from unexpected financial exposure and, most importantly, facilitate access to confidential sexual and reproductive health care for all covered individuals, including dependents.

Long-Standing Problem, New Openings

Although a long-standing feature of health insurance in the United States, the practice of sending EOBs to policyholders has enormous and extremely concerning consequences.² Privacy concerns can be important for individuals of both genders; however, women are more likely than men to be insured as dependents. According to the Kaiser Family Foundation, 27% of women of reproductive age are insured as a dependent, compared with 20% of men of the same age.³ Moreover, concerns can arise for individuals in a wide range of marital circumstances, such as when married individuals seek care under a spouse's policy, when a couple is separated or estranged, or when children of divorced or separated couples obtain services. Issues may arise when coverage is held by a domestic partner. And, of course, confidentiality issues frequently come into play when minors or young adults seek care.

Confidentiality may be a factor when individuals are seeking a wide range of care. For example, those seeking substance abuse or mental health services may not want their parents or spouses to know that they need such care. This may be especially true for people who have experienced violence perpetrated by a parent or partner. Individuals who have experienced such violence

may forego needed care for fear that their abuser may be alerted.

Privacy concerns among individuals seeking sexual and reproductive health care may be particularly acute—and the potential for harm, considerable. For example, someone who foregoes or even delays testing and treatment for STIs and HIV puts not only himself or herself at risk, but his or her partners as well. Or a pregnant woman who is worried about telling her husband that she is pregnant may delay entry into prenatal care, potentially leading to adverse maternal and child health outcomes. Indeed, fear of disclosure is likely an important factor explaining why many women decline to use their insurance coverage to pay for an abortion.

Privacy is certainly important when it comes to contraceptive services. In fact, national data show that many insured teens and young adults aged 20–24 appear unwilling to use their insurance coverage to pay for their contraceptive care. According to a Guttmacher Institute analysis of National Survey of Family Growth data, among privately insured females who obtained contraceptive services, 82% of teens and 79% of young adults used their coverage to pay for their care, compared with 93% of women 30 or older.⁴

Because they feel unable to use their coverage, teens and other dependents seeking contraceptive services often turn to publicly funded family planning centers to obtain affordable, confidential care. Nearly one in five insured women obtaining care at a family planning center who indicated that they were not planning on using their insurance coverage to pay for their care said that they were doing so because of confidentiality concerns.⁵ Not surprisingly, teens—who are almost always insured as dependents—were the age-group most likely to say confidentiality was the reason for not using their coverage: Almost one-third of insured teens who were not using their coverage cited confidentiality concerns (see chart). Relying on publicly supported family planning centers to offer care with no reimbursement from insurers puts additional burdens on already-stretched programs such as Title X, as well as on the safety-net providers themselves. Moreover, it leaves insurers in the enviable position of collecting premiums to cover services for which they are not asked to pay.

Confidentiality concerns about insurance processing procedures are not new.⁶ The enactment of the ACA, however, has upped the ante in two significant ways. First, by allowing young adults to remain on their parents' policies until age 26,

PRIVACY PROBLEMS

Teens are far more likely than older women to cite confidentiality as the reason they are not planning to use their insurance coverage to pay for the care they receive at reproductive health-focused health centers.



Source: reference 5.

the ACA has already brought new coverage to more than three million young adults.⁷ By definition, all of these newly insured young adults are covered as dependents and, therefore, subject to these confidentiality barriers. Beyond that, the ACA's broader coverage expansions will grow the ranks of Americans who have insurance coverage. Many of these newly insured individuals will be covered as dependents through a parent, spouse or domestic partner and, thus, potentially unable to obtain services confidentially.

Although the ACA's expansion of contraceptive and other reproductive health coverage means that the confidentiality problem is about to affect more people than ever before, the law's prohibition against cost-sharing for certain preventive care services seems to offer a major opening to address the problem, at least in some critical respects. One function of EOBs is to alert policyholders when they may have some financial liability for costs relating to care obtained by dependents. But the ACA's preventive services requirement provides for coverage of a package of key sexual and reproductive health services—including contraception, STI and HIV testing, and prenatal care—with no out-of-pocket costs (see table).⁸ As a result, the policyholder will have no financial exposure in many circumstances, thereby making moot an important underlying rationale for the practice of sending EOBs.

Although this provision offers critical protection, it alone is not sufficient to protect individuals in all cases where confidentiality may be needed. For example, it only applies when services are obtained from a provider that has a contract with the individual's health plan; services obtained from out-of-network providers may be subject to cost-sharing. In addition, insurers still have some, albeit more limited, opportunities to require cost-sharing for some formulations of some contraceptive methods (related article, page 8). Finally, cost-sharing may be required when follow-up care—such as treatment for an STI—is obtained. In those instances, not only may cost-sharing be required, but the amount paid out-of-pocket would be credited toward any deductible required under the policy.

Innovation in the States

Because EOBs are an important tool in preventing fraud and abuse in health insurance coverage, about half the states either require or presume that these documents will be sent whenever care is obtained.⁹ Although virtually all states require notices when claims are denied, these requirements differ in the extent to which they specify to whom these denials must be sent—with some, for example, specifying that the insured be notified and with others indicating that either the enrollee or the claimant be informed instead.

COVERAGE WITHOUT COST-SHARING

WOMEN'S SEXUAL AND REPRODUCTIVE HEALTH	ADDITIONAL WOMEN'S HEALTH CARE	MEN'S SEXUAL HEALTH
<ul style="list-style-type: none"> • Contraceptive counseling, services and methods (as prescribed for women) • Numerous perinatal health services • HIV and STI counseling • STI testing (HIV, chlamydia, gonorrhea, syphilis) • Cervical cancer screening (Pap testing and HPV testing) • HPV vaccination • Hepatitis A and B vaccination 	<ul style="list-style-type: none"> • Well-women visits • Domestic and interpersonal violence screening and counseling • Breast cancer prevention (mammography, genetic screening and counseling, and chemoprevention counseling) 	<ul style="list-style-type: none"> • HIV and STI counseling • STI testing (HIV, chlamydia, gonorrhea, syphilis) • Hepatitis A and B vaccination

Notes: This table lists sexual and reproductive health–related preventive care services that must be covered by most private health plans without patient cost-sharing. The requirement to cover some of these services is limited by patient characteristics and risk factors, in accordance with expert recommendations. *Source:* reference 8.

Spurred by both the challenges and opportunities created by the ACA, advocates in several states have been working to devise innovative solutions. In California, a state in which the ACA had already brought dependent coverage to more than 400,000 young adults by August 2013,¹⁰ advocates initiated consultations with a broad range of stakeholders—including health care providers, health plans and policymakers—more than a year ago. According to organizers, the plans made it clear from the beginning that they were sympathetic to issues around confidentiality. After working with the organizers on amendments to ensure workability and the ability of health plans to comply with existing federal law, the critically important Association of California Life and Health Insurance Companies declared itself as neutral on the legislation.¹¹ Gov. Jerry Brown (D) signed a measure, known as the Confidential Health Information Act, into law in early October.

The California approach builds on long-standing federal protections in the Health Insurance Portability and Accountability Act (HIPAA) and the subsequent regulations, known as the Privacy Rule, which allow individuals to submit confidential communications requests when disclosure could endanger the person obtaining care. The new California law requires plans to honor those requests from individuals obtaining sensitive services such as contraception, abortion, pregnancy-related care, STI services and mental health services or when the request states that disclosure could lead to harm. The law prohibits plans from conditioning acceptance on an explanation for the reasons behind the request.

With the legislation signed into law, the three groups that cosponsored the effort—the California Family Health Council (CFHC, the Title X grantee for the state of California), the American Civil Liberties Union of Northern California and the National Center for Youth Law—are embarking on a major consumer and provider education drive. The campaign seeks to ensure that health care providers are aware of the new protections, so they can alert their patients. The coalition will also be taking steps to educate consumers directly about their rights

under the law. For their part, the state's health plans have indicated that they want to work with the coalition to make implementation as smooth as possible.

Even more recently, the Colorado Division of Insurance issued rules requiring health plans to protect health information for adults (whether children, spouses or domestic partners) who are covered as dependents. The rule requires plans to develop a way to communicate directly with the dependent so that information would not be sent to the policyholder without the dependent's consent.

Advocates in Massachusetts are also working to address the issue, looking to a regulatory approach that would provide automatic protections in some cases by, for example, narrowing the scope of services for which EOBs are sent; it would also provide enrollees with options in other cases, such as requesting that EOBs not be sent, or that they be sent to the individual who obtained the care rather than to the policyholder. The Massachusetts advocates are looking to leverage an opportunity created when the legislature recently directed the state Division of Insurance to develop a standard "summary of payments" form that will essentially replace EOBs in the state. A group that includes the Massachusetts Women's Health Coalition and the Massachusetts Family Planning Association has petitioned the agency to ensure that any guidance or regulations include confidentiality protections. In part, they are seeking to build on the current practices of Blue Cross Blue Shield of Massachusetts, the largest insurance carrier in the state. The insurer is transitioning to providing all EOBs directly to members rather than policyholders. In the meantime, it only sends EOBs when there is a balance due on the claim beyond whatever copayment was paid at the time of service. (This is not an entirely new approach: Two other states, New York and Wisconsin, offer at least some protection in cases where there is no balance due from the policyholder after the patient has paid any applicable copayments.⁹)

This approach has particular salience because of the ACA's bar on cost-sharing for key preven-

tive care. Suppressing EOBs when there is no financial exposure for the policyholder would effectively mean that EOBs would not be sent when an individual obtains any of the services covered under that provision. For services such as treatment of STIs not under the purview of the preventive services requirement or for services obtained from an out-of-network provider, EOBs would still be suppressed as long as the patient had paid any required cost-sharing in full, again leaving the policyholder with no financial liability.

Although such an approach would have a wide reach and provide protection for many accessing key reproductive health services, it would not prevent all confidentiality breaches. When care is outside the purview of the requirement and cost-sharing is necessary, an additional hurdle is posed by plans that require enrollees to satisfy a deductible before benefits kick in. In that case, the issue would be how to credit the cost of the care toward the deductible without resulting in the policyholder's de facto notification. The coalition in the state is working hard to find creative approaches to providing protection in these additional circumstances.

Paths to Future Progress

Experiences in California, Colorado and Massachusetts have important lessons for advocates, policymakers and reproductive health providers in other states seeking to establish policies to protect the privacy of individuals insured as dependents. This would include building broad-based coalitions of support and, most importantly, addressing the concerns of health plans up front. At the same time, cautionary tales are also emerging as more states contemplate proceeding down this path.

One lesson learned from the experience in the state of Washington points to the importance of raising awareness and knowledge among health care providers and within the general public in a state where dependents do have options to protect their confidentiality even now. In Washington, individuals have long been able to ask that EOBs be suppressed in some cases.⁹ But the combination of each insurer having its own procedures for making the request and a lack of

public knowledge that the protections even exist has meant that very few individuals have availed themselves of their rights. As a result, insurance regulators in the state are now discussing potential additional safeguards with advocates and health care providers. And this experience has spurred the extensive patient and provider education effort planned in California.

The second lesson for supporters of access to sensitive services is to examine carefully the opportunities, and limitations, presented by the ACA's preventive services requirement. The steps being proposed in Massachusetts to suppress EOBs when there is no financial exposure for the policyholder demonstrate the potential importance of that provision in protecting confidentiality, at least for that limited package of services. By taking cost-sharing off the table for a critical package of care, that provision effectively removes one of the rationales frequently given for EOBs while at the same time allowing safety-net providers to more confidently bill for the sensitive services they provide.

The fact that the ACA provides for a set of preventive services to be covered without co-pays does not, by itself, clear the path forward, however. The legal protections apply only to a limited set of services received from in-network providers. Furthermore, cost-sharing imposed when services are provided outside the purview of that protection could raise the additional issue of being counted against any deductible that is required under an individual's policy. Because of the heightened salience of being in-network, safety-net providers need to redouble their efforts to secure plan contracts; doing so will give their clients the legal protections from cost-sharing and ensure that the family planning centers are reimbursed for the care they offer. Family planning providers—and especially those operated by health departments—have a long way to go in this regard.¹²

Finally, although states such as California are important laboratories for innovation, this is a national problem requiring a national response. All individuals insured as dependents deserve the right to receive sensitive health care—and cover-

age for it—confidentially. Although it is certainly true that insurance regulation has traditionally been within the purview of the states, rather than the federal government, the notion that disclosure could lead to endangerment is at the heart of privacy protections provided by the federal HIPAA law and regulations.

The new California law rests on the presumption that disclosing receipt of sensitive services could endanger a patient. In 2011, a group of national organizations, including the American Academy of Pediatrics, the American Congress of Obstetricians and Gynecologists, the Center for Adolescent Health & the Law and the Society for Adolescent Health and Medicine, along with the Guttmacher Institute, wrote to Department of Health and Human Services (DHHS) Secretary Kathleen Sebelius asking that the administration issue a broader interpretation of the existing protections. Specifically, they asked DHHS to explicitly recognize that the inability to obtain sensitive services could by itself endanger an individual, a move that would trigger legal protections that could allow individuals to request that EOBs be sent to the patient and not the policyholder in such cases. Hopefully, the fact that California has acted will trigger federal protections to enable individuals insured as dependents to access the confidential care they need regardless of where they live. www.guttmacher.org

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