

# CONFIDENTIAL + COVERED



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

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Abigail English  
Julie Lewis  
Monique Morales  
Clare Coleman

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# Introduction

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

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

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

This report provides a profile of the current (as of January 2016) policy environment for confidentiality and insurance in California based on interviews in person and by telephone with a total of 16 informants conducted between September 2015 and January 2016 as well as a review of California laws. The informants included diverse stakeholders such as family planning providers and administrators, adolescent and young adult health care providers, policy researchers and advocates, lawyers, and health insurance carriers.<sup>3</sup>

The profile offers background on the legal and policy framework for confidentiality and insurance in California; explains Senate Bill (S.B.) 138, legislation enacted in 2013 to provide improved privacy protection for the health information of individuals insured as dependents;<sup>4</sup> highlights major themes that characterized the evolution of California health privacy policy; details implementation efforts for S.B. 138; and explores future policy challenges and next steps needed to further confidentiality protection for patients while enabling providers to receive revenues from health insurance payments. The report represents a composite picture drawn from the varied comments of the informants interviewed.

1 Abigail English, Robin Summers, Julie Lewis, and Clare Coleman, Confidentiality, Third-Party Billing, & the Health Insurance Claims Process: Implications for Title X (Washington, DC: National Family Planning & Reproductive Health Association, 2015). [http://www.confidentialandcovered.com/file/ConfidentialandCovered\\_WhitePaper.pdf](http://www.confidentialandcovered.com/file/ConfidentialandCovered_WhitePaper.pdf).

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

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

4 2013 Cal. S.B. 138, 2013 Cal. Stats. ch. 144 (Oct. 1, 2013).

## Background: Confidentiality & Insurance in California

Since the Affordable Care Act (ACA) was enacted in 2010, California has experienced an increase in the number of individuals with health insurance.<sup>5</sup> Largely driven by successful enrollment in marketplace plans through the state's health insurance exchange, Covered California;<sup>6</sup> via the state's expansion of Medi-Cal, its Medicaid program;<sup>7</sup> and as a result of the ACA provision allowing young adults (often referred to as adult children) to remain on a parent's health insurance up to age 26.<sup>8</sup> California also has several publicly funded state and local programs that have provided health insurance coverage or health care access to low-income individuals, such as Family PACT,<sup>9</sup> Healthy San Francisco,<sup>10</sup> and the Medi-Cal Minor Consent Program.<sup>11</sup>

Many of the newly insured individuals who gained health insurance coverage as a result of the ACA as well as those with coverage under employer-based plans are covered as dependents on a family member's plan.<sup>12</sup> These include young adults and adolescents, as well as spouses and domestic partners, some of whom are affected by intimate partner violence. When health insurance reimbursement is sought for dependents' care, these individuals may have their privacy infringed. This occurs due to legal and policy requirements for disclosure of information in the health insurance billing and claims process, or as a result of health plan contracts and practices, and in spite of existing legal protections for the confidentiality of health information.

### ***Federal Notice Requirements for "Denials"***

Federal law requires that insurers and health plans share information about denials of claims with policyholders, subscribers, and enrollees – as detailed in the Affordable Care Act (ACA), Employee Retirement Income Security Act (ERISA), and Medicaid Managed Care regulations.<sup>13</sup> These denial notices are commonly sent in a format that looks like an explanation of benefits (EOB). See *Confidentiality, Third-party Billing, & the Health Insurance Claims Process: Implications for Title X* for a robust discussion of federal insurance law and its impact on privacy.<sup>14</sup>

California has long been a leader in protecting patients' privacy, with a broad range of health privacy and medical confidentiality laws in place for several decades. Although health insurers and health plans in the state also have been bound by the federal privacy regulations under the Health Insurance Portability and Accountability Act—the HIPAA Privacy Rule—until recently California state law had not explicitly incorporated a mechanism to protect the privacy of individuals assured as dependents on a family member's plan; this gap was addressed in 2013 when the legislature enacted S.B. 138.

5 U.S. Dept. of Health & Human Services. 5 Years Later: How the Affordable Care Act is Working for California. <http://www.hhs.gov/healthcare/facts-and-features/state-by-state/how-aca-is-working-for-california/>.

6 Covered California. [www.coveredca.com](http://www.coveredca.com).

7 The California Department of Health Services provides information and links regarding the state's expansion of Medicaid under the Affordable Care Act. <http://www.dhcs.ca.gov/individuals/Pages/AffordableCareActLinks.aspx>.

8 U.S. Dept. of Health & Human Services, Young Adult Coverage. <http://www.hhs.gov/healthcare/about-the-law/young-adult-coverage/index.html>.

9 California Department of Health Services. Family PACT, [www.familypact.org](http://www.familypact.org).

10 Healthy San Francisco. [www.healthysanfrancisco.org](http://www.healthysanfrancisco.org).

11 22 Cal. Code Reg. § 51473.2.

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

13 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.

14 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](http://www.confidentialandcovered.com/file/ConfidentialandCovered_WhitePaper.pdf).

## **HIPAA Privacy Rule Protections**

In California, as in every state, the HIPAA Privacy Rule requires health care providers and health insurers to protect patients' privacy. Of particular importance, the rule includes two special protections that restrict disclosure of protected health information (PHI) and provide for confidential communications. The first allows patients to request restrictions on the disclosure of their PHI.<sup>15</sup> 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."<sup>16</sup> Health care providers must accommodate reasonable requests and may not require patients to claim they would be endangered by disclosure; health plans must accommodate reasonable requests when there is a claim of endangerment. It is noteworthy that with respect to requests for confidential communications the HIPAA rule for health care providers differs from the requirement for health plans: plans are only required to comply with requests if endangerment is claimed. The California legislature built on these HIPAA protections in crafting S.B. 138.

## **California Privacy Laws**

California has strong laws protecting patients' privacy and the confidentiality of their health information. These laws include the state's Confidentiality of Medical Information Act,<sup>17</sup> and the Patient Access to Health Records Act,<sup>18</sup> along with other protections such as a right of privacy under the California Constitution,<sup>19</sup> evidentiary privileges,<sup>20</sup> professional licensing requirements, and laws requiring confidentiality in specific state-funded programs and for particular services<sup>21</sup>. The Confidentiality of Medical Information Act contains detailed requirements governing when a patient's confidential information can be released—with or without the patient's authorization—and applies to a broad range of health care professionals and providers including managed care plans.<sup>22</sup> California law also includes the Insurance Information and Privacy Protection Act<sup>23</sup> that applies to insurers generally and specifies the circumstances in which individuals' personal or privileged information, including medical information, can be disclosed—with and without authorization.<sup>24</sup> The Patient Access to Health Records Act grants patients and their authorized representatives a right to access their medical records and specifies procedures for doing so.

## **Minor Consent Laws**

In addition to the laws that provide confidentiality protection for individuals of all ages, California has detailed laws that allow minors to consent for their own care in a broad range of situations and provide confidentiality protection for the health information associated with that care. Several groups of minors are allowed to consent for most of their own health care: emancipated minors,<sup>25</sup> minors age 15 or older who are living apart from their parents and managing their own financial affairs,<sup>26</sup> and married minors.<sup>27</sup> Minors of any age are allowed to consent for pregnancy-related care, including family planning and contraception, prenatal and maternity care, and abortion.<sup>28</sup> Minors age 12 or older are allowed to consent for

15 45 C.F.R. § 164.522(a)(1).

16 45 C.F.R. §§ 164.502(h); 164.522(b)(1).

17 Cal. Civil Code §§ 56 – 56.37.

18 Cal. Health & Safety Code §§ 123100–123149.5.

19 Cal. Constitution, Art. 1, Sec 1.

20 Evidentiary privileges provide protection against disclosure of confidential information in court or other legal proceedings; they include, for example, the physician-patient privilege. Cal. Evidence Code §§ 990-1007.

21 For extensive summaries and citations to the California medical privacy and confidentiality laws, see HealthInformation&theLaw, [www.healthinfo.org](http://www.healthinfo.org).

22 Cal. Civ. Code § 56.10.

23 Cal. Insurance Code §§ 791–791.29.

24 Cal. Insurance code § 791.13; 10 Cal. Code Reg. § 2689.11.

25 Cal. Fam. Code § 7050.

26 Cal. Fam. Code § 6922.

27 Cal. Fam. Code §§ 7002, 7050.

28 Cal. Fam. Code § 6925. A law requiring parental consent for abortion was declared unconstitutional as violating the right of privacy in the California Constitution. *American Academy of Pediatrics v. Lungren*, 16 Cal. 4th 307 (1997).

prevention, diagnosis, and treatment of sexually transmitted disease (STDs);<sup>29</sup> diagnosis and treatment of other reportable communicable diseases;<sup>30</sup> diagnosis and treatment of drug and alcohol addiction;<sup>31</sup> and outpatient mental health treatment or counseling under specific circumstances.<sup>32</sup> Minors are also allowed to consent for medical care and collection of evidence related to sexual assault, at any age, or rape, beginning at age 12.<sup>33</sup> California relieves parents of financial responsibility for care in most situations when a minor has given consent.<sup>34</sup> Minors who have the authority to consent for their own care also generally have the right to control disclosure of their confidential medical information or to access their medical records to the same extent that an adult may do so.<sup>35</sup>

**“Minors who have the authority to consent for their own care also generally have the right to control disclosure of their confidential medical information or to access their medical records to the same extent that an adult may do so.”**

### **Insurance Disclosure Laws**

As in other states, the confidentiality protections for medical and health information in California law are not absolute. In particular, the insurance laws contain various requirements for the disclosure of otherwise confidential information, sometimes with the individual's authorization, sometimes without. For example, the Confidentiality of Medical Information Act was amended, in conformity with the HIPAA Privacy Rule, to provide that health care providers and certain managed care plans may disclose a patient's medical information without authorization of the patient "to an insurer, employer, health care service plan, hospital service plan, employee benefit plan, governmental authority, contractor, or other person or entity responsible for paying for health care services rendered to the patient, to the extent necessary to allow responsibility for payment to be determined and payment to be made."<sup>36</sup> A provision applicable to insurers generally, which governs disclosure of medical and other personal or privileged information, is included in the California Health Information and Privacy Protection Act.<sup>37</sup> California law also contains specific statutory and regulatory requirements for notices and explanations, which may be included on an EOB, when claims are granted or denied by either managed care plans<sup>38</sup> or other health insurers.<sup>39</sup> Prior to 2013, the laws pertaining to disclosures by health insurers and managed care plans did not include specific requirements for protecting confidential information for minors or adults insured as dependents; this was rectified in 2013.

## **The California Legislation: S.B. 138**

### **Amendment of Multiple Sections of California Law**

S.B. 138 created in California law a set of protections for the confidential health information of individuals with health insurance, which are particularly important for those who are insured as dependents on a family member's plan. Due to the way California health insurance law is structured, S.B. 138 is a complex piece of legislation that amended several different parts of California law including the Confidentiality of

<sup>29</sup> Cal. Fam. Code § 6926.

<sup>30</sup> Cal. Fam. Code § 6926.

<sup>31</sup> Cal. Fam. Code § 6929.

<sup>32</sup> Cal. Fam. Code § 6924; Cal Health & Safety Code § 124260.

<sup>33</sup> Cal. Fam. Code §§ 6927, 6928.

<sup>34</sup> Cal. Welf. & Inst. Code § 14010; Cal. Fam. Code §§ 6922, 6924, 6926, 6929; Cal. Health & Safety Code § 124260. The laws relieving parents of financial liability in situations where their minor children are authorized to consent for their own care provides a foundation for the Medi-Cal Minor Consent program. 22 Cal. Code Reg. § 51473.2.

<sup>35</sup> Cal. Civ. Code §§ 56.10, 56.11; Cal. Health & Safety Code §§ 123110, 123115.

<sup>36</sup> Cal. Civ. Code § 56.10(c)(2).

<sup>37</sup> Cal. Insurance Code § 791.13.

<sup>38</sup> E.g., Cal. Health & Safety Code § 1371; Cal. Admin. Code tit. 28, § 1300.71(d).

<sup>39</sup> E.g., Cal. Insurance Code § 10123.13; Cal. Admin. Code tit. 10, §§ 2695.2(f), 2695.7(b)(1).

Medical Information Act,<sup>40</sup> which also applies to managed care plans governed by the Knox-Keene Health Care Service Plan Act,<sup>41</sup> and the Insurance Information and Privacy Protection Act.<sup>42</sup> These laws have been in place for many years and amended numerous times.<sup>43</sup>

| <b>California Law</b>                                   | <b>Governs</b>  |
|---|---|
| Confidentiality of Medical Information Act (1981)       | Protection and disclosure of medical information by health care providers and managed care plans                    |
| Knox-Keene Health Care Service Plan Act (1975)          | Administration and management of managed care plans   |
| Insurance Information and Privacy Protection Act (1980) | Collection, use, and disclosure by insurers of information, including health information, in insurance transactions |

### **Rationale and Mechanism**

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. The law was prefaced by a set of legislative findings and included several definitions that are key to the law’s implementation.

### **Legislative Findings in S.B. 138**

*The legislature finds and declares all of the following:*

(a) Privacy is a fundamental right of all Californians, protected by the California Constitution, the federal Health Insurance Portability and Accountability Act (HIPAA; Public Law 104-191), and the Confidentiality of Medical Information Act, Part 2.6 (commencing with *Section 56*) of *Division 1 of the Civil Code*.

(b) Implementation of the recently enacted federal Patient Protection and Affordable Care Act (Public Law 111-148) will expand the number of individuals insured as dependents on a health insurance policy held in another person’s name, including adult children under 26 years of age insured on a parent’s insurance policy.

(c) HIPAA explicitly protects the confidentiality of medical care obtained by dependents insured under a health insurance policy held by another person.

(d) Therefore, it is the intent of the Legislature in enacting this act to incorporate HIPAA standards into state law and to clarify the standards for protecting the confidentiality of medical information in insurance transactions.<sup>44</sup>

### **Key Elements**

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.

40 Cal. Civ. Code §§ 56-56.37.

41 Cal. Health & Safety Code §§ 1340-1399.864.

42 Cal. Ins. Code §§ 791-791.29.

43 The specific provisions added by S.B. 138 are set forth in Appendix B.

44 2013 Cal. S.B. 138, 2013 Cal. Stats. ch. 144, Sec. 1 (Oct. 1, 2013).

## Definitions

### Confidential Communications Request

Request by an insured to a health insurer or by a subscriber or enrollee to a health care service plan that communications containing medical information be communicated to him or her at a specific mail or e-mail address or specific telephone number, as designated by the insured or by the subscriber or enrollee.<sup>i</sup>

### Endanger

The insured or the subscriber or enrollee fears that disclosure of his or her medical information could subject the insured or the subscriber or enrollee to harassment or abuse.<sup>ii</sup>

### Sensitive Services

Health services specified by reference to the California statutes that allow minors to consent for health care services,<sup>iii</sup> received by a patient of any age above the minimum age for consent specified in the statute, including services related to:

- Pregnancy
- Family planning
- Abortion
- STDs
- Other reportable diseases
- HIV
- Sexual assault and rape
- Outpatient mental health
- Drug and alcohol problems.<sup>iv</sup>

### Protected Individuals

Adult and minor individuals who are insured under a health insurance policy or who are subscribers or enrollees in a health care service plan, including individuals insured as dependents.<sup>v</sup>

## Legislative Elements

### Individual Rights

Request by an insured to a health insurer or by a subscriber or enrollee to a health care service plan that communications containing medical information be communicated to him or her at a specific mail or e-mail address or specific telephone number, as designated by the insured or by the subscriber or enrollee.<sup>vi</sup>

### Health Insurer/ Health Care Service Plan Obligations

- Allow individuals to submit confidential communications requests.<sup>vii</sup>
- Accommodate confidential communications requests if the individual states that the communication relates to sensitive services or that disclosure would endanger the individual.<sup>viii</sup>
- Implement a request within seven days of receipt of an electronic or telephone request and within 14 days of receipt of a request sent by mail.<sup>ix</sup>

### Health Insurer/ Health Care Service Plan Rights

- Require that the request be made in writing or electronically.<sup>x</sup>
- Require a statement that the request pertains to sensitive services or that disclosure could endanger the individual but may not require an explanation of the basis for the claim of endangerment.<sup>xi</sup>

### Health Care Provider Rights

- Make arrangements directly with their patients for cost sharing and communicate that arrangement with a health plan or insurer.<sup>xii</sup>

## **Lessons for State Advocates**

A number of important themes related to the adoption and implementation of S.B. 138 emerged from interviews with key informants in California and may offer useful lessons for advocates in other states.

### **Actions by Advocates**

#### **Importance of a committed group of advocates**

A small group of key advocates came together to secure foundation funding for the initial legal research before the bill was introduced and for implementation efforts once the bill passed. The group had extensive expertise related to the legal, policy, and health service delivery environment in California.

#### **Identification of and potential for an effective legislative strategy**

The strategy grounded the bill in existing California laws that were already protective of the privacy rights of minors and adults, built on a foundation of federal protections contained in the HIPAA Privacy Rule that were already binding on California insurers and health plans, and enlisted the support of an influential legislative sponsor.

### **California Policy Landscape**

#### **Comprehensive protection of both adults and minors**

S.B. 138 protects both adults and minors, a goal that other states have aspired to but not all have succeeded in reaching. This was possible in California both because the state's minor consent laws are extensive and because those laws are linked to important confidentiality protections. Specifically, when minors are authorized to consent for their own care, the confidentiality of information about that care is protected, and control over access to and disclosure of information is vested in the minors, under the Confidentiality of Medical Information Act and the Patient Access to Health Records Act. This provided an existing infrastructure in which to place the protection of minors along with adults with regard to insurance communications.

#### **Unique state policy environment**

A state constitutional right of privacy, a detailed set of health privacy protections in state law, comprehensive minor consent laws, and a history of relatively generous state and local funding programs supporting access to confidential care are all key characteristics that made the California policy environment receptive to S.B. 138. Although other states have some of these elements, few other states have such a robust policy environment.

### **Implementation Terrain**

#### **Capacity for implementation efforts by advocates**

The core group of advocates created a website that contained background information and forms for both providers and patients to use in making communications requests to health plans and insurers. They conducted statewide trainings with diverse stakeholders including health care providers, youth-serving professionals, and educators. They also engaged in direct communication with health plans and insurers via letters and phone calls to educate them about the law's requirements and to learn about their implementation efforts.

#### **Identification of remaining challenges and barriers to implementation**

In spite of the intensive efforts undertaken to implement S.B. 138, challenges remain. Many of these challenges involve training of key actors at all levels of the health care delivery system and the insurance sector. Due to staff turnover in many environments, this needs to be an ongoing process rather than a one-time event. Public education efforts for patients are also essential but potentially costly. One overarching challenge that is present in California and in every state is to find a way to protect the confidentiality of individuals insured as dependents while providing policyholders with the transparency necessary to keep them informed of the financial status of their obligations with respect to deductibles, cost-sharing, and coinsurance.

## Origins & Evolution of S.B. 138

S.B. 138 evolved in response to a widespread recognition in California among health care providers and policy advocates that disclosure of confidential information via EOBs and other insurance communications was hindering the ability of adolescents and young adults to obtain needed care and limiting health care providers' ability to bill insurance for services for which coverage existed. The urgency of addressing this problem increased after the ACA enabled young adults to remain on their parents' plans.

Beginning in 2012, the California Family Health Council (CFHC), the American Civil Liberties Union (ACLU), and the National Center for Youth Law (NCYL) held a meeting attended by a broad range of California stakeholders including some health insurers. Although the insurers and health plans expressed sympathy for the situation of patients affected by the problem, generally they were concerned about the logistical complexity and potential cost of implementing a solution and were also preoccupied with ACA implementation issues.

The advocates' work was aided initially by a foundation grant. Those funds could not be used for legislative work, but did support research on federal and state laws to look for possible solutions. The advocates reviewed models that had been put in place by other states,<sup>45</sup> such as Washington's regulation that created a right to restrict disclosure<sup>46</sup> and New York's statute that provided insurers an option not to send an EOB when there was no balance due on the part of the patient or policyholder.<sup>47</sup> No ideal approach or "golden ticket" emerged from the review of other states' laws, however, so the advocates pursued a different approach in California, one grounded in the HIPAA Privacy Rule's protection for confidential communications.

The final version of the bill contained many of the features sought by the advocates but also represented some compromises. For example, the advocates had preferred that confidential communications would occur automatically for sensitive services (an "opt-out" approach) but the health plans and insurers insisted on an "opt-in" approach, which places a greater burden on patients and providers. According to the advocates, agreeing to an "opt-in" approach led to a breakthrough in negotiations.

### ***Opt-in vs. Opt-out for Insurer Communications***

An "opt-out" approach may be desirable to family planning advocates because it would seem to allow information about sensitive services to be automatically redirected or suppressed without patient or provider engagement with the insurer or health plan. From the perspective of insurers and health plans this approach has several limitations. If information is to be redirected, they may not have alternative addresses or confidential contact information for the affected patients and may not know how to identify those individuals in their system. If information is to be suppressed, there still may be situations in which federal law requires the sending of a denial, EOB, or other communication, and even if those communications were sent directly to the patient, the insurer or health plan would need a confidential way to do that. Either way, automatic redirection or suppression may have an impact on other required disclosures to policyholders to document cost-sharing.

<sup>45</sup> For a discussion of some models that have been used in other states, see 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](http://www.confidentialandcovered.com/file/ConfidentialandCovered_PolicyGuide.pdf)

<sup>46</sup> Wash. Admin. Code § 284-04-510.

<sup>47</sup> N.Y. Ins. Code § 3234(c).

Regardless of the limitations of an opt-in approach, the bill contains many positive features. It specified clearly defined time limits for implementing a confidential communications request. If a request includes a statement that it relates to sensitive services or that disclosure would lead to endangerment, the individual submitting the request should be able to assume that the insurer or health plan will accommodate it. Nevertheless, a mechanism was included for patients to verify that a request had been implemented by requesting information on the status of the request; if a patient does make such a request, the insurer or health plan must respond. A cross-reference of California's minor consent laws in the definition of sensitive services avoided the need for extensive negotiations over that definition. Also, California law already includes accountability mechanisms in its confidentiality laws—such as civil suits for damages and even criminal penalties—so positioning S.B. 138 requirements in the Confidentiality of Medical Information Act as well as in the laws governing managed care plans and other health insurers avoided the necessity of including a specific enforcement mechanism in the bill itself.

The HIPAA Privacy Rule obligates providers and health plans to honor confidential communications requests if they are “reasonable.” One particularly important goal of the advocates in crafting the California bill was to avoid inclusion of the term “reasonable” as the criterion for which communications insurers were obligated to honor—the advocates viewed the term as too vague and overly susceptible to restrictive determinations by insurers; this effort was successful. Under S.B. 138, health plans and insurers may not differentiate among requests based on their perceived reasonableness: if a request states that it relates to information about sensitive services or if a patient states that disclosure would endanger them,<sup>48</sup> the request must be granted. One of the key advantages of S.B. 138 compared with the HIPAA Privacy Rule is that it obligates insurers and health plans to implement confidential communications not only when an individual claims endangerment but also when the request relates to sensitive services, regardless of whether there is any risk of endangerment.

The ultimate success in enacting S.B. 138 was due to several factors. Using the HIPAA Privacy Rule protections as a foundation for S.B. 138 made it more acceptable to health plans and insurers who were already bound to comply with HIPAA. Legislators were receptive because the bill held out the potential for care to be paid for by commercial insurance coverage rather than Family PACT or Minor Consent Medi-Cal, thereby alleviating burdens on the state's budget. The bill received little organized opposition and garnered support, to varying degrees, from the family planning, intimate partner violence, mental health, and substance abuse provider communities. Stories from health care professionals about the impact on patients of confidentiality breaches were influential with legislators and created a helpful sense of urgency. The bill's progress also was aided by having a strong legislative sponsor, the chair of the Senate Health Committee, who brought the insurers to the table and who worked to promote the bill's final passage. The advocates described S.B. 138 as “the little bill that could,” which kept passing one hurdle after another.

## **Implementation Efforts**

Once S.B. 138 had been signed into law on October 1, 2013, there was a period of 15 months before it took effect on January 1, 2015. The group of advocates who had spearheaded its passage used this time to initiate intense implementation efforts. These included work supported by a “phase 2” foundation grant, which funded staff time and a public awareness effort as well as focus groups to find out what the target audience needed, development of a website, extensive training, interaction with health plans and insurers, and support for targeted efforts by health care providers.

The advocates engaged in broad outreach about S.B. 138, particularly through the creation of a website: *My Health My Info*.<sup>49</sup> The site has two distinct sections, one for providers and one for individuals who are

<sup>48</sup> The term “endanger” is defined in the statute to mean that a patient would be subjected to harassment or abuse. Cal. Civ. Code § 56.05(e); Cal. Ins. Code § 791.02(ab).

<sup>49</sup> *My Health My Info*. [www.myhealthmyinfo.org](http://www.myhealthmyinfo.org).

covered on someone else's health insurance. The website contains a "Need Help?" button that people can use to request help: if they want help completing and submitting a confidential communications request; if their request was rejected by their insurer; if their insurer violated their request and sent information to the policyholder without their permission; or if they are a provider whose patient needs help submitting a confidential communications request and they have questions about the process. As of late 2015, the website had received 10,000 hits. In addition to creating the website, the advocates and their respective organizations —ACLU, CFHC, and NCYL— have served as a clearinghouse for information for patients, policyholders, and providers; created FAQs for patients; and used social media for outreach. They also asked individuals with a desire for additional confidentiality to submit confidential communications requests and report on the outcome to test the process. They are deferring widespread public marketing until they are assured that the process is working effectively.

The advocates engaged in extensive training that reached health care providers, medical directors at the University of California campuses, community colleges, and school districts. They have offered trainings in staff meetings at Title X-funded health centers, for health educators, and for Planned Parenthood health center directors. They have also partnered with domestic violence advocates for webinars and live presentations. The training efforts are ongoing and serve as a complement to the website and future marketing efforts to the general public.

Alongside their outreach to patients and training of providers, the advocates reached out directly to health plans and insurers. They sent a letter to the privacy officers of the largest plans operating in the state, describing what compliance would look like and offering examples of noncompliance; the letter included the history of the law, an explanation of the need for it, the plans' responsibilities, and best practices for compliance. The advocates also communicated with the Association of Health Plans regarding S.B. 138 implementation. At meetings between the advocates and a few of the largest plans, the privacy officers described their implementation efforts and the advocates shared the experiences of patients.

S.B. 138 has been positively received by health care providers in California, and family planning providers are excited about its potential. Some providers are issuing internal communications about the law and others are beginning to get the word out to their patients and the general community. However, some providers are reserving judgment about their ultimate willingness to recommend that patients rely on the new policy.

One hospital-based adolescent health center has been working to build infrastructure necessary to assist their patients in filing confidential communications requests. They are creating tools to make it easier for providers to determine who would be eligible; putting copies of confidential communication request forms in all exam rooms; and providing a fax cover sheet listing health plans with fax numbers and including check boxes for required information. They have begun by focusing on sexual and reproductive health services even though confidential communications requests can be made for other services such as mental health and substance abuse services. They are training their providers and working to spread the word to other primary care centers within the hospital system. They are also working to use the implementation of confidential communications requests in their service site as the basis for a quality improvement project. Implementation of confidential communications requests is viewed as potentially related to other goals such as increasing chlamydia screening rates or uptake of long acting reversible contraceptives. Their service site operations personnel are interested in being able to bill insurance for services that are supposed to be covered—rather than referring patients out to other sites for confidential care—so there is a financial as well as a quality improvement incentive for implementing S.B. 138.

## Challenges Remaining

Although the initial efforts at implementing S.B. 138 represent significant progress, numerous challenges remain. A few of the important challenges include the following:

### **Ensuring that health plans and insurers understand their responsibilities**

This includes making sure that they understand the differences between the requirements of the HIPAA Privacy Rule and S.B. 138 and that communications include those that take place on web portals. It also involves the insurers and plans themselves implementing continuous, system-wide training for their personnel and sending repeat messages throughout the year.

### **Ensuring that patients have the information they need to use the confidential communications request option effectively**

This includes updating the My Health My Info website and printed materials to indicate that patients need to know their health plan information, submit their confidential communications request, and confirm with their plan that it has been honored and encouraging patients to file their requests in advance of an appointment for a medical service.

### **Finding ways to alleviate the burden on patients and providers**

Because S.B. 138 is structured as an "opt-in" approach, and the health plans and insurers have no affirmative duty to get the word out to patients and policyholders, the burden falls on providers to inform their patients and on patients to take the initiative in making confidential communications requests. This creates the necessity for training staff at every level of a health care delivery site, and for retraining them on a continuous basis, to account for turnover. It also creates the necessity for a patient to take steps to learn whether they are enrolled in an ERISA plan, which is not governed by S.B. 138, or in a plan where they are entitled to protection.

### **Addressing the issue of transparency and documentation**

The question of how to provide policyholders with the transparency they need while protecting the confidentiality of insured dependents remains an overarching challenge in California as in other states. Although the definition of communications that are covered by S.B. 138 is broad, the law does not appear to close the door entirely on health plans and insurers finding a way to inform policyholders of their residual financial liabilities and their status in relation to deductibles, cost sharing, and coinsurance under their policies. One advocate referred to this as the "Achilles heel" of S.B. 138. The implications of this challenge are that some providers will continue to refer their patients with a heightened or absolute need for confidentiality to other sites or find ways to serve them without charge or enroll them in publicly funded programs for which they may be eligible.

## **The California Environment: Implications for Confidentiality**

In many ways and in spite of the numerous challenges remaining for fully effective implementation of S.B. 138, California is an excellent model for other states interested in attempting this type of protection. At the same time, the characteristics that make addressing the privacy needs of individuals insured as dependents possible in California may make it a less than ideal model for other states that do not operate with a similar policy environment.

California has longstanding public policy that is supportive of privacy rights, in general and in the health arena. The tradition is supported by an explicit right of privacy in the state constitution and expressed in numerous state statutes and regulations. A comprehensive set of minor consent laws and medical privacy laws have been in place for decades. The state has been progressive in adopting policies to increase access to family planning, including confidential services, with bipartisan support. It has a sophisticated network of advocacy for family planning with strong leadership in statewide organizations. The state has also been strongly committed to health care reform and access, including ACA implementation.

One of the key elements characterizing the California health policy environment to date has been the existence of a strong social safety net. A number of publicly funded programs exist that can and do provide care for vulnerable populations, including confidential care. These include statewide programs such as Medi-Cal, Minor Consent Medi-Cal, and Family PACT, as well as local programs such as Healthy San Francisco. The possibility of referring a patient who needs confidentiality protection to a site where they can receive care funded in one of these ways has alleviated some of the pressure on providers and patients that would exist without such a safety net. The presence of the safety net continues to allow gradual implementation of S.B. 138 with individuals for whom it is safe to do so and who are enrolled in protective health plans or insurance policies, knowing that other patients will still have options for ways to seek and receive confidential care.

## **Conclusion**

The legislative approach taken in California creates an expanded right to request confidential insurance communications. Because it is grounded in extensive existing state and federal law, S.B. 138 is one of the most sweeping insurance communications confidentiality laws in the nation. Many states do not have a similar foundation of state law to build upon, making emulation potentially difficult. California has several advantages as it implements S.B. 138, including a broad array of safety-net funding for individuals in need of confidentiality and dedicated implementation efforts through coalition and the California Family Health Council. Nevertheless, as other states pursue improvement in confidentiality policies, California is an important model with its success owed to a strong coalition and a conducive policy environment.

## Appendix A: List of Key Informants

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

| <b>Organization</b>  | <b>Name</b>                     | <b>Title</b>   |
|--|---------------------------------|--|
| American Civil Liberties Union of Northern California            | Maggie Crosby                   | Senior Staff Attorney  |
| American Civil Liberties Union of Southern California            | Ruth Dawson                     | Staff Attorney   |
| Association of Reproductive Health Professionals, Washington, DC | Rivka Gordon, PA, MHS           | Policy Chair   |
| California Family Health Council                                 | Amy Moy                         | Vice President, Public Affairs   |
| Futures Without Violence   | Lisa James                      | Director of Health   |
| Kaiser Permanente, Northern California                           | Merula Franzgrote, MD           | Adolescent Medicine Chief, The Teen Health Center Kaiser Permanente Hayward<br><br>Chair, Adolescent Medicine Subspecialists   |
| National Center for Youth Law                                    | Rebecca Gudeman, JD, MPA        | Senior Attorney, Adolescent Health   |
| Planned Parenthood Mar Monte                                     | Stephanie Rivera Merrell, MPH   | Chief Operating Officer  |
| San Francisco General Hospital                                   | Tonya Chaffee, MD, MPH          | Director, The Teen and Young Adult Health Center<br><br>Medical Director, Child and Adolescent Support Advocacy and Resource Center Zuckerberg San Francisco General Hospital<br><br>Clinical Professor, Department of Pediatrics UCSF |
| UCSF Bixby Center for Global Reproductive Health                 | Claire Brindis, Dr. P.H.        | Director, Bixby Center for Global Reproductive Health<br><br>Director, Philip R. Lee Institute for Health Policy Studies UCSF  |
| UCSF Bixby Center for Global Reproductive Health                 | Jennifer Yarger, Ph.D.          | Project Director, Bixby Center for Global Reproductive Health<br><br>Project Director, Philip R. Lee Institute for Health Policy Studies UCSF  |
| UCSF Medical Center, Adolescent & Young Adult Clinic             | Josephine S. Lau, MD, MPH       | Adolescent Medicine Specialist, Kaiser Permanente San Leandro Medical Center   |
| UCSF Medical Center, Adolescent & Young Adult Clinic             | Veronika Mesheriakova, MD, FAAP | Clinical Fellow, Adolescent and Young Adult Medicine UCSF  |
| Women's Community Clinic   | Lisa K Mihaly, RN, FNP          | Assistant Clinical Professor, UCSF School of Nursing   |

## Appendix B: The California Statute

### **S.B. 138, SEC. 2. Section 56.05 of the Civil Code is amended to read:**

56.05. For purposes of this part:

...

(c) "Confidential communications request" means a request by a subscriber or enrollee that health care service plan communications containing medical information be communicated to him or her at a specific mail or email address or specific telephone number, as designated by the subscriber or enrollee.

...

(e) "Endanger" means that the subscriber or enrollee fears that disclosure of his or her medical information could subject the subscriber or enrollee to harassment or abuse.

...

(j) "Medical information" means any individually identifiable information, in electronic or physical form, in possession of or derived from a provider of health care, health care service plan, pharmaceutical company, or contractor regarding a patient's medical history, mental or physical condition, or treatment. "Individually identifiable" means that the medical information includes or contains any element of personal identifying information sufficient to allow identification of the individual, such as the patient's name, address, electronic mail address, telephone number, or social security number, or other information that, alone or in combination with other publicly available information, reveals the individual's identity.

...

(n) "Sensitive services" means all health care services described in Sections 6924, 6925, 6926, 6927, 6928, and 6929 of the Family Code, and Sections 121020 and 124260 of the Health and Safety Code, obtained by a patient at or above the minimum age specified for consenting to the service specified in the section.

...

### **S.B. 138, SEC. 4. Section 56.107 is added to the Civil Code, to read:**

56.107. (a) Notwithstanding any other law, and to the extent permitted by federal law, a health care service plan shall take the following steps to protect the confidentiality of a subscriber's or enrollee's medical information on and after January 1, 2015:

(1) A health care service plan shall permit subscribers and enrollees to request, and shall accommodate requests for, communication in the form and format requested by the individual, if it is readily producible in the requested form and format, or at alternative locations, if the subscriber or enrollee clearly states either that the communication discloses medical information or provider name and address relating to receipt of sensitive services or that disclosure of all or part of the medical information or provider name and address could endanger the subscriber or enrollee.

(2) A health care service plan may require the subscriber or enrollee to make a request for a confidential communication described in paragraph (1), in writing or by electronic transmission.

(3) A health care service plan may require that a confidential communications request contain a statement that the request pertains to either medical information related to the receipt of sensitive services or that disclosure of all or part of the medical information could endanger the subscriber or enrollee. The health care service plan shall not require an explanation as to the basis for a subscriber's or enrollee's statement that disclosure could endanger the subscriber or enrollee.

(4) The confidential communication request shall be valid until the subscriber or enrollee submits a revocation of the request or a new confidential communication request is submitted.

(5) For the purposes of this section, a confidential communications request shall be implemented by the health care service plan within seven calendar days of receipt of an electronic transmission or telephonic request or within 14 calendar days of receipt by first-class mail. The health care service plan shall acknowledge receipt of the confidential communications request and advise the subscriber or enrollee of the status of implementation of the request if a subscriber or enrollee contacts the health care service plan.

(b) Notwithstanding subdivision (a), the provider of health care may make arrangements with the subscriber or enrollee for the payment of benefit cost sharing and communicate that arrangement with the health care service plan.

(c) A health care service plan shall not condition enrollment or coverage on the waiver of rights provided in this section.

**S.B. 138, SEC. 17. Section 791.02 of the Insurance Code is amended to read:**

(aa) "Confidential communications request" means a request by an insured covered under a health insurance policy that insurance communications containing medical information be communicated to him or her at a specific mail or email address or specific telephone number, as designated by the insured.

(ab) "Endanger" means that the insured covered under a health insurance policy fears that the disclosure of his or her medical information could subject the insured covered under a health insurance policy to harassment or abuse.

(ac) "Sensitive services" means all health care services described in Sections 6924, 6925, 6926, 6927, 6928, and 6929 of the Family Code, and Sections 121020 and 124260 of the Health and Safety Code, obtained by a patient of any age at or above the minimum age specified for consenting to the service specified in the section.

(ad) "Medical information" means any individually identifiable information, in electronic or physical form, in possession of or derived from a provider of health care, health insurer, pharmaceutical company, or contractor regarding a patient's medical history, mental or physical condition, or treatment. "Individually identifiable" means that the medical information includes or contains any element of personal identifying information sufficient to allow identification of the individual, such as the patient's name, address, electronic mail address, telephone number, or social security number, or other information that, alone or in combination with other publicly available information, reveals the individual's identity.

**S.B. 138, SEC. 18. Section 791.29 is added to the Insurance Code, to read:**

791.29. (a) Notwithstanding any other law, and to the extent permitted by federal law, a health insurer shall take the following steps to protect the confidentiality of an insured's medical information on and after January 1, 2015:

(1) A health insurer shall permit an insured to request, and shall accommodate requests for, communication in the form and format requested by the individual, if it is readily producible in the requested form and format, or at alternative locations, if the insured clearly states either that the communication discloses medical information or provider name and address relating to receipt of sensitive services or that disclosure of all or part of the medical information or provider name and address could endanger him or her.

(2) A health insurer may require the insured to make a request for a confidential communication described in paragraph (1) in writing or by electronic transmission.

(3) A health insurer may require that a confidential communications request contain a statement that the request pertains to either medical information related to the receipt of sensitive services or that disclosure of all or part of the medical information could endanger the insured. The health insurer shall not require an explanation as to the basis for a insured's statement that disclosure could endanger the insured.

(4) The confidential communication request shall be valid until the insured submits a revocation of the request, or a new confidential communication request is submitted.

(5) For the purposes of this section, a confidential communications request must be implemented by the health insurer within seven calendar days of the receipt of an electronic transmission or telephonic request or within 14 calendar days of receipt by first-class mail. The health insurer shall acknowledge receipt of the confidential communications request and advise the insured of the status of implementation of the request if an insured contacts the insurer.

(b) Notwithstanding subdivision (a), a provider of health care may make arrangements with the insured for the payment of benefit cost sharing and communicate that arrangement with the insurer.

(c) A health insurer shall not condition coverage on the waiver of rights provided in this section.

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- i Cal. Civ. Code § 56.05(c); Cal. Ins. Code § 791.02(aa).
- ii Cal. Civ. Code § 56.05(e); Cal. Ins. Code § 791.02(ab).
- iii Cal. Fam. Code §§ 6924, 6925, 6926, 6927, 6928, and 6929; Health & Safety Code §§ 121020, 124260.
- iv Cal. Civ. Code § 56.05(n); Cal. Ins. Code § 791.02(ac).
- v Cal. Civ. Code § 56.107(a)(1); Cal. Ins. Code § 791.29(a)(1).
- vi Cal. Civ. Code § 56.107(a)(1); Cal. Ins. Code § 791.29(a)(1).
- vii Cal. Civ. Code § 56.107(a)(1); Cal. Ins. Code § 791.29(a)(1).
- viii Cal. Civ. Code § 56.107(a)(1); Cal. Ins. Code § 791.29(a)(1).
- ix Cal. Civ. Code § 56.107(a)(5); Cal. Ins. Code § 791.29(a)(5).
- x Cal. Civ. Code § 56.107(a)(2); Cal. Ins. Code § 791.29(a)(2).
- xi Cal. Civ. Code § 56.107(a)(3); Cal. Ins. Code § 791.29(a)(3).
- xii Cal. Civ. Code § 56.107(b); Cal. Ins. Code § 791.29(b).

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### **About *Confidential & Covered***

*Confidential & Covered* is a multi-year research project designed to understand the factors that may make it difficult for Title X-funded family planning providers to seek reimbursement due to patient privacy concerns. Learn more at [www.confidentialandcovered.com](http://www.confidentialandcovered.com).

### **About NFPRHA**

NFPRHA represents the broad spectrum of family planning administrators and clinicians serving the nation's low-income and uninsured. NFPRHA serves its members by providing advocacy, education, and training to those in the family planning and reproductive health care fields. For over 40 years, NFPRHA members have shared a commitment to providing high-quality, federally funded family planning care - making them a critical component of the nation's public health safety net.