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Authors

Sedlander, Erica
Brindis, Claire D
Bausch, Sara H
et al.

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Commentary

Options for Assuring Access to Confidential Care for Adolescents and Young Adults in an Explanation of Benefits Environment

Erica Sedlander, M.P.H.^{a,*}, Claire D. Brindis, Dr.P.H.^{b,c}, Sara H. Bausch, M.S.^d,
and Kathleen P. Tebb, Ph.D.^b

^a Department of Population Health, New York University School of Medicine, New York, New York

^b Division of Adolescent and Young Adult Medicine, Department of Pediatrics, UCSF Benioff Children's Hospital, University of California San Francisco, San Francisco, California

^c Philip R. Lee Institute for Health Policy Studies, University of California San Francisco, San Francisco, California

^d ICF International, New York, New York

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A B S T R A C T

The Affordable Care Act (ACA) has expanded the enrollment of young people in insurance plans and aims to increase access to preventive health services. For adolescents and young adults to fully utilize these services, access to confidential care is critical, especially for sensitive services, like sexual and reproductive health care. With this expansion, the ACA inadvertently exposes more individuals (especially those with private insurance) to confidentiality breaches through routine communications in the form of Explanation of Benefits (EOBs) sent to policyholders (typically the parent). This commentary is based on a qualitative study of individual, semi-structured telephone interviews with 31 health care administrators, policy experts, clinicians, and health plan representatives. The study identified and examined five main policy options aimed at reconciling confidentiality protections and EOBs. While no one solution emerged, approaches that incorporate automatic system changes that do not require action from the patient or provider for protections to take effect were considered most effective for protecting confidentiality. The review of these policy options are designed to inform states and health care advocates confronting this issue. In addition, since many of these approaches are new, a better understanding of how they are operationalized and enforced is necessary to truly evaluate their effectiveness.

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This commentary is a summary of our policy brief that examined strategies for addressing potential confidentiality breaches through the practice of sending explanation of benefits (EOBs). The full report can be accessed at: <http://nahic.ucsf.edu/wp-content/uploads/2014/06/639265-0-000-00-020EOB-Policy-Brief-Final-June-2014.pdf>.

The practice of sending EOBs creates a sharp conflict between patient confidentiality and the need for policy holders to be

informed about actions taken on their health insurance plan (e.g., to prevent fraud and to monitor outstanding balances) [1]. Although EOBs provide important information for policy holders, they frequently violate confidentiality protections for dependents—especially around sensitive health services such as reproductive health, mental health, and substance use [2–4]. Fears of potential confidentiality breaches can cause adolescents to delay or forego needed care and decrease their willingness to disclose sensitive health information to their provider [5–7]. Protecting adolescent and young adult confidentiality is critical to ensure their full access to care.

Ironically, risks of confidentiality breaches through EOBs are exacerbated under the Affordable Care Act (ACA), as more

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* Address correspondence to: Erica Sedlander, M.P.H., Department of Population Health, New York University School of Medicine, New York, NY 10016.

E-mail address: Erica.sedlander@gmail.com (E. Sedlander).

individuals are becoming insured, including young adults up to age 26 years as part of their parent's private plans [8]. Although EOBs are not federally mandated, about half of the states either require or contain language stating that EOBs will be sent to the primary policy holders [3,9,10], potentially jeopardizing dependents' confidentiality. If this issue is not addressed, the burden to find confidential services outside the dependent's insurance plan falls on the provider and/or the young person. Some patients will turn to safety net providers (e.g., Title X clinics and Planned Parenthood) that have historically assured confidentiality [11]. The use of safety net clinics by those with insurance coverage however strains the already limited resources intended for uninsured or underinsured populations [12]. Others may pay for care "out-of-pocket" to avoid confidentiality breaches that may otherwise occur through the insurance billing process, which can create a further financial burden for the insured dependent [13].

To date, this issue has received little attention, but as the ACA rolls out, a number of states are beginning to respond. We interviewed 31 stakeholders, including health care administrators, policy experts, clinicians, advocates, and health plan representatives, to discuss policy options, their advantages and limitations, and examples of where they are implemented. The following options were identified through a literature review of current state policies and during the course of the interviews. Although this report presents a number of different options for protecting confidentiality in the context of EOBs, no single approach was selected as a solution.

Option 1: Do not require health plans to send an EOB when no balance is due for services provided: This approach is currently implemented in New York, Wisconsin, and Massachusetts and could provide some confidentiality protections nationally because under the ACA, all preventive services are covered without cost sharing. However, eliminating the requirement does not guarantee that insurance companies would actually withhold sending EOBs. It can be logistically easier and therefore economically advantageous for insurance companies to send EOBs to every policy holder rather than specific subsets. In addition, "preventive" and "treatment" services are often closely linked and can occur within the same visit. For example, a screening test for a sexually transmitted infection would be "preventive" with no copayment, but if medication is provided for *treatment*, the patient or policy holder may be liable for payment, potentially generating an EOB.

Option #2: Apply a generic current procedural terminology (CPT) code to sensitive services: In this approach, which has been negotiated by some private insurance companies, EOBs would still be sent, but sensitive services would not be disclosed; rather, they would be classified using a generic code. However, this approach is limited as the EOB may still compromise confidentiality through disclosing the location where the service was received, type of clinic (e.g., family planning), or type of provider (e.g., obstetrician).

Option #3: Require plans to honor patients' requests for confidential communications from all individuals obtaining sensitive services: This approach could potentially protect confidentiality if there was a consumer-friendly, automatic, opt-in process. However, if the onus of initiating such a request were the responsibility of the young person or provider, it may not be effective. Providers face a number of time constraints and competing priorities in any given visit, and the young person may not be aware of the threat EOBs pose to their confidentiality,

their rights to request confidential communications, or how to exercise those rights. This strategy is relatively new; Maryland's policy, senate bill 790, went into effect April 2014 and California's policy, senate bill 138, goes into effect January 2015. The recent implementation of these policies provides an opportunity to evaluate real-time outcomes which will have implications for the next wave of states seeking a solution to this issue.

Option #4: Create a current procedural terminology (CPT) code to suppress EOBs for confidential/sensitive services: CPT codes are operated by and a registered trademark of the American Medical Association. In 2009, advocates from a number of health organizations requested that a new CPT code be created to suppress EOBs for sensitive health services. On the American Medical Association's legal review, this approach was rejected because EOBs are legally mandatory in many states. However, this option was considered the most effective because it was both automatic and comprehensive. Although this was not deemed feasible at the national level, Kaiser Permanente, Northern California has been able to implement this type of approach with its internal network of both insurance and providers.

Option #5: Require health plans to communicate directly with adult patients (18–26 years old), who are covered as dependents on their parents' plan: This rule, which was passed in Colorado in fall 2013, requires health plans to protect health information of all adults covered as dependents (offspring, spouses, or domestic partners). Although the specifics have not been worked out, health plans will need to develop a strategy to communicate directly with the dependent. The success of this approach largely depends on how it is implemented, whether insurance companies adhere to the policy, and patients are educated about it and able to easily exercise their right.

Although no one solution emerged as "the answer," it is likely that a combination of approaches will be necessary to protect confidentiality. Some approaches may be relatively easy to implement (such as using generic terms on EOBs) but offer limited confidentiality protections. Others (such as creating a CPT code) are more difficult to implement but could yield greater protections. Options that allow patients to request an EOB not to be sent (option 3) or require direct communications with patients (option 5) will require patient and provider education and system modifications. Most adolescents and young adults may not know about EOBs, the details of their insurance plan, or their rights to confidentiality. Although education is important, it is critical to have systematic, automatic approaches that do not require the patient or provider to take action. Creating automatic processes, as opposed to relying on individual action, is essential because clinicians have limited time and patients, especially the young and vulnerable, are unlikely to know how to take action to prevent insurance companies from sending an EOB. As states adopt various approaches, evaluation studies are needed to fully document implementation efforts and measure whether these policies actually improve access to care and in turn improve health outcomes.

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