GOT A SECRET CAN YOU KEEP IT? HOW THE HIPAA PRIVACY RULE BREACHES PLAN DEPENDENT CONFIDENTIALITY

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I. INTRODUCTION

Imagine a twenty-five-year-old man. He graduated from college, and though he has a full-time job, he decides to remain on his parents' health insurance plan. He begins to feel constantly anxious with the stressors that come with living independently, paying his own bills, and working a new job. A colleague at work recommends that he see a therapist. Initially hesitant because of his family's historic comments denouncing therapists, he agrees and begins visiting a therapist biweekly. The therapist prescribes medication that substantially helps his day-to-day functioning and bills both the biweekly therapist visits and prescriptions to his health insurance with no out-of-pocket costs to him. The insurer sends the medical bill to his parents because they are the policyholders of his health insurance. Though he is a legal adult and can consent to his own medical care, his parents receive his health insurance bills and see that he has been seeing a therapist and taking medication. They call him "weak, crazy, and unstable" and pressure him to stop seeing the therapist.

Imagine a thirty-five-year-old married woman. She lives with her physically and verbally abusive husband, and she is desperately trying to save enough money to leave him. He is a devout Catholic and vehemently opposes abortion, whereas his wife wholeheartedly rejects the idea of having a child with her husband. Meanwhile, she remains on her husband's health insurance. She realizes she is pregnant and goes to the doctor to get an abortion. Her health insurance covers the abortion, but because her husband is the policyholder, her husband receives a copy of the bill that details the abortion. He is furious.

Imagine a sixteen-year-old female who has her first boyfriend. After a few months of dating, she starts to feel a fever, fatigue, and headaches. She is on her parents' health insurance and goes to the

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doctor. She can fully consent to receive care without her parents' consent, and the doctor discovers she has syphilis and prescribes medication. Insurance covered both the doctor's visit and medication. Since her parents are the policyholders, they receive a bill and realize their daughter's private health information without her consent.

While the existing Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule (Privacy Rule) provides some protections surrounding the release of medical information, the Rule contains a critical exception, which allows health care plans to release private health information for insurance billing practices.[1] Third-party insurers can subsequently release health information to the policyholder.[2] As a result, the current laws in many states do little or nothing to prevent the problematic disclosures referenced above. This Comment analyzes the gaps in the Privacy Rule's confidentiality protection, evaluates efforts by various states to fill those gaps, and proposes an enhanced reformation of the Privacy Rule.

Congress enhanced patient privacy by signing into law HIPAA in 1996, initially aimed at improving the portability and renewability of health insurance coverage for employees between jobs.[3] This included "administrative simplification"[4] provisions to improve the "efficiency and effectiveness of the nation's health care system."[5] Congress seemed to recognize that people could not receive high-quality health care without ensuring the confidentiality of health information. Congress also recognized the shift from doctors' offices keeping medical records on hard copies in locked filing cabinets to keeping electronic records stored in health networks that are accessible by many providers.[6]

HIPAA directed the Department of Health and Human Services (HHS) to issue privacy regulations if Congress failed to do so within three years of HIPAA's enactment.[7] Potentially, HHS predicted scenarios

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1 45 C.F.R. § 164.506(c) (2021).

2 *See id.*

3 *See* Health Insurance Portability and Accountability Act of 1996 (HIPAA), Pub. L. No. 104–191, §§ 261–64, 110 Stat. 1936 (1996); *see also* James Cordone, *Health Care Reform in the 1990's from the Clinton Plan to Kassebaum-Kennedy*, 3 CONN. INS. L.J. 193, 206–10 (1996).

4 HIPAA §§ 261–64.

5 Diane Kutzko et al., *HIPAA in Real Time: Practical Implications of the Federal Privacy Rule*, 51 DRAKE L. REV. 403, 407 (2003) ("The Act required the establishment of unique health identifiers for employers, health plans, health care providers, and individuals.").

6 Peter A. Winn, *Confidentiality in Cyberspace: The HIPAA Privacy Rules and the Common Law*, 33 RUTGERS L.J. 617, 638 (2002).

7 Standards for Privacy of Individually Identifiable Health Information; Final Rule, 67 Fed. Reg. 53,182 (Aug. 14, 2002) (codified at 45 C.F.R. § 160.201).

like those mentioned above were too common and anticipated the need for strengthened privacy regulations. Congress failed to issue privacy regulations, and HHS responded in 1999 with the then proposed HIPAA Privacy Rule[8] and issued final modifications in 2002.[9] The Privacy Rule created national privacy standards to provide all patients with a basic level of confidentiality by minimizing the release of health information to essential people for health care operations—setting a federal floor for covered entities to follow.[10] States can increase privacy protections beyond the Privacy Rule.[11] The Privacy Rule's implementation sought to strike a balance between allowing the release of personal health information for health care operations and protecting the privacy rights of individuals.

The Privacy Rule tries to minimize the release of health information, but the idealized minimization does not extend to confidentiality for third-party billing operations.[12] As detailed in the examples above, even if patients can fully consent to their care, health care providers can still release patients' health information to policyholders for health insurance billing purposes without getting patients' consent.[13] Because of nonconsensual disclosures for billing purposes, this Comment argues that the Privacy Rule does not provide adequate privacy protection to health plan dependents. Part II of this Comment explains how the Privacy Rule protects patient information while identifying holes in the Privacy Rule that result in unauthorized disclosures of personally identifiable health information. Part III explains the dramatic ramifications of these holes, notably for vulnerable plan dependents. Part IV details states that have attempted to strengthen the Privacy Rule, noting that many state efforts have fallen short of what is necessary to fill the holes in the Privacy Rule while others offer potentially workable solutions. Part V introduces a proposal for Congress to amend the Privacy Rule to incorporate successful state efforts and identifies additional privacy measures that will increase patient confidentiality and autonomy. Part VI summarizes the problem, the current state modifications of the Privacy Rule, and an enhanced Privacy Rule proposal.

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[8] *See* Standards for Privacy of Individually Identifiable Health Information, 64 Fed. Reg. 59,921 (Nov. 3, 1999) (codified at 45 C.F.R. §§ 160, 164).

[9] *See* Standards for Privacy of Individually Identifiable Health Information, 67 Fed. Reg. 53,182.

[10] *See id.*

[11] 45 C.F.R. § 160.203(b) (2021).

[12] *See id.* § 164.506(c).

[13] *Id.*

II. THE HIPAA PRIVACY RULE AND MISSING PRIVACY PROTECTIONS

A. *The Privacy Rule*

As the 1990s saw a growing use of electronic medical records and an increasingly complicated health care system, Congress necessarily enacted the Privacy Rule.[14] The national trend saw a shift from patients seeing one doctor to patients seeing many doctors and having their medical records in more places than ever before.[15] One 2002 study indicated a typical individual's medical records may be handled by seventeen different health care providers.[16] Congress sought to respond with a system that would host all medical records in one electronic place to make it easier to send information between physicians.[17] The public also had growing concerns about the confidentiality of increasingly popular electronic mediums to store medical records.[18] One New York Congresswoman kept her medical records, which indicated depression and an attempted suicide, in an electronic format, and hackers faxed them to a New York newspaper and television station during her campaign; this prompted the Congresswoman's public statement asking

[14] Lawrence Gostin & James Hodge, Jr., *Personal Privacy and Common Goods: A Framework for Balancing Under the National Health Information Privacy Rule*, 86 MINN. L. REV. 1439, 1439–40 (2002).

[15] *See Proposed Rule on the Privacy of Individually Identifiable Health Information: Hearing Before the S. Comm. on Health, Educ., Labor, & Pensions*, 106th Cong. 2 (2002) (opening statement of Sen. Jeffords, Chairman, S. Comm. on Health, Educ., Labor, and Pensions) (explaining the "pathway of a typical medical record is no longer confined within the control of the patient's personal physician."); *Hearing on H.R. 1281, War Crimes Disclosure Act, Health Information Privacy Protection Act, and S. 1090, Electronic Freedom of Information Improvement Act of 1995 Before the Subcomm. on Gov't Mgmt., Info., and Tech. of the H. Comm. on Gov't Reform and Oversight*, 104th Cong. 114 (1996) (statement of Janlori Goldman, Deputy Director, Center for Democracy and Technology) ("The development of a national information infrastructure and information superhighway are changing the ways that we deal with each other. Traditional barriers of distance, time and location are disappearing as information and transactions become more computerized – few relationships in the health care field will remain unaffected . . . .").

[16] *Proposed Rule on the Privacy of Individually Identifiable Health Information: Hearing Before the S. Comm. on Health, Educ., Labor, and Pensions*, 106th Cong. 2 (2002).

[17] Kutzko et al., *supra* note 5, at 409.

[18] *Hearing on H.R. 1281, War Crimes Disclosure Act, Health Information Privacy Protection Act, and S. 1090, Electronic Freedom of Information Improvement Act of 1995 Before the Subcomm. on Gov't Mgmt., Info., and Tech. of the H. Comm. on Gov't Reform and Oversight*, 104th Cong. 113 (1996) (statement of Janlori Goldman, Deputy Director, Center for Democracy and Technology) (explaining that "[t]he public will not have trust and confidence in the emerging health information infrastructure if their sensitive health data is vulnerable to abuse and misuse").

for stronger, more private federal confidentiality policies.[19] The Privacy Rule sought to quell these concerns about the confidentiality of electronic medical records.[20]

The Privacy Rule aims to limit the release of health information to promote patient privacy and autonomy.[21] Covered entities must comply with the Privacy Rule.[22] Covered entities include (1) health plans; (2) healthcare clearinghouses; and (3) healthcare providers who transmit health information electronically in certain transactions.[23] Compliance with the Privacy Rule means a covered entity may not use or disclose protected health information (PHI) except as permitted under the Privacy Rule.[24] The Privacy Rule permits covered entities to use or disclose PHI for payment purposes, so health insurers receive PHI without prior patient consent.[25]

PHI refers to individually identifiable health information that is transmitted by electronic media, maintained in electronic media, or transmitted or maintained in any other form or medium.[26] Individually identifiable health information is information created by the covered entity that relates to "past, present, or future physical or mental health condition; the provision of health care to the individual; or past present or future payment of the provision of health care to the individual" that can reasonably be used to identify the individual.[27]

The Privacy Rule allows individuals to access their health information, request to amend certain health information, and obtain a record of when and how the insurer shared their PHI with others.[28] Nonetheless, covered entities still make disclosures of PHI for payment purposes without getting the patient's consent.[29]

The Privacy Rule is federal and establishes a floor for PHI privacy protections.[30] States can implement additional safeguards to provide

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19 *Id.* (noting another example of a misuse of health information when a journalist "disguised himself as a doctor, obtained the medical record of an actress, and published that she had been treated for a sexually transmitted disease").

20 *See* Kutzko et al., *supra* note 5, at 407.

21 *See* 45 C.F.R. § 164.512 (2021).

22 *Id.*

23 *Id.* § 160.103(4)(iv).

24 *Id.* § 164.506(a).

25 *Id.* § 164.506(c).

26 *Id.* § 160.103.

27 45 C.F.R. § 160.103 (2021).

28 *Id.* § 164.526(a)(1).

29 *Id.* § 164.506(c).

30 *See id.* §§ 160.202, 160.203. "This final rule establishes, for the first time, a set of basic national privacy standards . . . [and] sets a floor of ground rules for health care

patients greater protections beyond those identified in the Privacy Rule.[31] The Privacy Rule preempts state law if the state law is contrary to the Privacy Rule or if the Privacy Rule is stricter than state law.[32] State laws are important for claims arguing a breach of PHI because HIPAA, and consequently the Privacy Rule, does not provide a private cause of action.[33] Rather, the Privacy Rule can serve to inform a state law claim by informing the standard of care.[34]

A breach of PHI is an impermissible "disclosure[] of PHI that compromise[s] the privacy or security of the information."[35] A covered entity that impermissibly discloses PHI is presumed to have committed a breach unless the covered entity shows that

> there is a *low probability* that PHI has been compromised based upon a four-part risk assessment that considers: (1) the nature and extent of the PHI involved . . . ; (2) the unauthorized person who used the PHI or to whom the disclosure was made; (3) whether the PHI was actually . . . viewed; and (4) the extent to which the risk to PHI has been mitigated.[36]

The Office of Civil Rights (OCR) of HHS, which "is responsible for investigating and enforcing the HIPAA Privacy and Security Rules," and

providers, health plans, and health care clearinghouses to follow." BARRY R. FURROW ET AL., HEALTH LAW CASES, MATERIALS AND PROBLEMS 174 (8th ed. 2018).

[31] *See id.* §§ 160.202, 160.203. These additional safeguards can provide greater protections for PHI, reporting of diseases, child abuse, or public health surveillance. *Id.* § 164.512.

[32] *See* 45 C.F.R. §§ 160.202, 160.203 (2021). A state law provision is contrary to the Privacy Rule if (1) a covered entity cannot comply with both state and federal requirements; or (2) the state law is an obstacle to comply with HIPAA. *Id.* § 160.202; *see also* Byrne v. Avery Ctr. for Obstetrics and Gynecology, 102 A.3d 32, 49 (Conn. 2014) (holding HIPAA does not preempt state claims that would be a HIPAA violation).

[33] *See Byrne*, 102 A.3d at 49; Acara v. Banks, 470 F.3d 569, 571 (5th Cir. 2006) (holding "HIPAA does not contain any express language conferring private rights upon a specific class of individuals").

[34] *See, e.g.*, *Byrne*, 102 A.3d at 49; Bonney v. Stephens Mem'l Hosp., 17 A.3d 123, 128 (Me. 2011); Fanean v. Rite Aid Corp. of Del. Inc., 984 A.2d 812, 823 (Del. Super. Ct. 2009). Though HIPAA can inform the standard of care, some courts allow HIPAA to amount to negligence per se. I.S. v. Wash. Univ., No. 4:11CV235SNLJ, 2011 WL 2433585, at *3 (E.D. Mo. June 14, 2011). Other courts have declined to allow HIPAA standards to establish negligence per se. Sheldon v. Kettering Health Network, 40 N.E.3d 661, 672 (Ohio Ct. App. 2015).

[35] BARRY R. FURROW ET AL., *supra* note 30, at 189.

[36] *Id.* at 189–90. If there is not a low probability that the covered entity has compromised the confidentiality of the PHI, covered entities and business associates must notify affected individuals about breaches of their PHI. *Id.* at 190.

the Privacy Rule do not deem the disclosure of confidential information for payment purposes a breach of PHI.[37]

B. *Problems with the Privacy Rule*

Although Congress enacted the Privacy Rule to provide greater privacy protections—and it did provide greater privacy protections than HIPAA did initially—the Privacy Rule does not provide for the utmost level of confidentiality that patients need. The twenty-five-year-old patient from the introduction can fully consent to treatment with a therapist, the thirty-five-year-old married woman can fully consent to an abortion, and the sixteen-year-old minor can consent to sexually transmitted disease treatment. These three facially different examples show two striking underlying commonalities: first, they are all plan dependents on someone else's insurance policy; and second, the Privacy Rule exposes PHI through insurance billing practices. Plan dependents lose under the Privacy Rule because the Privacy Rule allows a covered entity to disclose PHI for its payment purposes, regardless of that individual's ability to self-consent to care.[38] This means health care providers can send PHI to insurers without getting patients' consent.[39]

The problem for these plan dependents is the consistent revelation of PHI—despite recognition about the importance of confidentiality—that occurs when insurers communicate services rendered under the health insurance policy to policyholders through an explanation of benefits (EOB). [40] An EOB is a comprehensive "document members receive after they see a physician or other health care professional" that shows "patient payment information for members and their covered family in a single statement."[41] A policyholder with a private insurer

[37] *Id.* at 189; 45 C.F.R. § 164.506 (2021). OCR punishes breaches of PHI both civilly, when the breacher unknowingly discloses PHI, and criminally, when the breacher knowingly obtains or discloses PHI. BARRY R. FURROW ET AL., *supra* note 30, at 189.

[38] 45 C.F.R. § 164.506(c)(1) ("A covered entity may use or disclose protected health information for its own treatment, payment, or health care operations.").

[39] *See id.*

[40] ABIGAIL ENGLISH ET AL., GUTTMACHER INST., CONFIDENTIALITY FOR INDIVIDUALS INSURED AS DEPENDENTS: A REVIEW OF STATE LAWS AND POLICIES 9–10 (2012) [hereinafter CONFIDENTIALITY FOR INDIVIDUALS] (finding current insurance billing practices includes sending EOBs whenever a health care provider bills for care under the policy).

[41] JAMILLE FIELDS ET AL., CTR. FOR HEALTH L. & POL'Y INNOVATION, CONFIDENTIALITY & EXPLANATION OF BENEFITS: PROTECTING PATIENT INFORMATION IN THIRD PARTY BILLING 2 (2016). An EOB is not a bill, but rather an informational document "members receive after they see a physician or other health care professional" which shows the costs associated with the services the insured received. *Explanation of Benefits*, HORIZON BLUE CROSS BLUE SHIELD OF N.J. [hereinafter *Horizon's Explanation of Benefits*], https://www.horizonblue.com/employers/resource-center/understanding-your-coverage/explanation-of-benefits (last visited Oct. 18, 2021).

gets an EOB any time a plan dependent receives health care and uses insurance to pay for that care.[42] Plan dependents, therefore, can seek and consent to their own medical care, but, no matter a plan dependent's age or relation to the policyholder, insurers will nonetheless reveal plan dependents' PHI to policyholders through EOBs.[43]

Insurers use EOBs to help reduce fraud by informing policyholders of claims and actions made on their account.[44] EOBs seek to promote transparency in billing practices by allowing policyholders to verify receipt of services and to see remaining balances from all dependents on their policy, including plan dependents who can consent to services without the policyholder.[45] Insurers know that EOBs sent to policyholders reveal the PHI of all persons covered under the policy, including "information for members and their covered family in a single statement."[46] Since the Privacy Rule does not extend to the arena of EOB transmissions,[47] any confidences the plan dependent reveals to a physician[48] also does not extend to EOBs. Simply because the patient used insurance, the twenty-five-year-old's parents, the thirty-five-year-old's spouse, and the sixteen-year-old's parents will all receive an EOB detailing care to which the patient had full capacity to consent. These hypothetical plan dependents in the introduction show how current insurance practices create tension between the right of the policyholder to know about the claims and charges on the policyholder's health insurance policy and the plan dependent's right to receive completely confidential medical services.

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[42] CONFIDENTIALITY FOR INDIVIDUALS, *supra* note 40, at 9–10; *see Understanding Your Explanation of Benefits (EOB*), CIGNA (July 2018), https://www.cigna.com/individuals-families/understanding-insurance/explanation-of-benefits ("The EOB is generated when your provider submits a claim for the services . . . received.").

[43] *See* CONFIDENTIALITY FOR INDIVIDUALS, *supra* note 40, at 9–10.

[44] KATHLEEN P. TEBB ET AL., PROTECTING ADOLESCENT CONFIDENTIALITY UNDER HEALTH CARE REFORM: THE SPECIAL CASE REGARDING EXPLANATION OF BENEFITS (EOBS) 2 (2014).

[45] *Id.*; FIELDS ET AL., *supra* note 41, at 2. Insurers use EOBs to provide "a straightforward way to [see] claims information . . . [and] use [it] in tracking health care services or expenditures." *Horizon's Explanation of Benefits*, *supra* note 41.

[46] *Horizon's Explanation of Benefits*, *supra* note 41; *see also Understanding Your Explanation of Benefits (EOB*), CIGNA (July 2018), https://www.cigna.com/individuals-families/understanding-insurance/explanation-of-benefits; *Understanding your Explanation of Benefits*, AETNA (Nov. 2016), https://member.aetna.com/memberSecure/assets/pdfs/CS01125_final.pdf.

[47] *See* 45 C.F.R. § 164.506(c)(1) (2021) ("A covered entity may use or disclose protected health information for its own treatment, payment or health care operations.").

[48] Humphers v. First Interstate Bank of Or., 696 P.2d 527, 535 (Or. 1985) ("A physician's duty to keep medical and related information about a patient in confidence is beyond question.").

Plan dependents, who choose to use insurance and are legally authorized to consent to their own care, can request insurers keep their PHI confidential on their health insurance bills.[49] The Privacy Rule, however, does not *require* health care providers to honor this request unless the patient pays for the full cost of treatment in cash, thereby bypassing the provider's submission to the health insurer altogether.[50] Maybe the sixteen-year-old minor does not have enough money to pay for health care without insurance. Or maybe the thirty-five-year-old woman does not have access to money independent of her spouse. By erecting financial barriers to confidential health care, the Privacy Rule effectively erects barriers to health care altogether. If a plan dependent does not or cannot completely pay for treatment with cash and instead uses health insurance to pay the medical bill, the Privacy Rule's confidentiality provisions fail to protect the plan dependent, and the insurer will reveal the PHI included in an EOB to the policyholder.[51]

Patients may request that the health plan communicate directly with the patient, not the policyholder.[52] But the Privacy Rule only mandates health plans comply with *reasonable* requests to do so if a patient states the disclosure of any or all of the patient's PHI could *endanger* the individual.[53] The Privacy Rule does not define "reasonable" or "endanger" in this context,[54] meaning these terms are open to interpretation—interpretation by plan dependents, health care providers, insurers, or policyholders. Without proper definitions, patients may struggle to submit properly a "reasonable" request explaining they feel "endangered" that passes muster under varying subjective definitions. A failure to meet ambiguous definitions under the Privacy Rule can hinder the ability of plan dependents to keep their PHI confidential.

Like private health insurers, Medicaid has similar confidentiality breaches. Unlike private health insurers, Medicaid does not have the same practices of sending the policyholders an EOB for every service

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49 45 C.F.R. § 164.522(a)(1)(i).

50 *Id.* § 164.522(a)(1)(vi)(B).

51 *Id.*; Abigail English & Julie Lewis, *Privacy Protection in Billing and Health Insurance Communications*, 18 AMA J. ETHICS 279, 280 (2016) [hereinafter *Privacy Protection in Billing and Health Insurance Communications*], (explaining if insurers agree to a request to keep plan dependent PHI confidential, the insurer only must comply "when the health care has been fully paid for").

52 45 C.F.R. § 164.522(b) (2020).

53 *Id.* (emphasis added).

54 *Id.*

rendered.[55] Instead, Medicaid plans send policyholders periodic EOBs to comply with federal regulations, and, usually, Medicaid sends EOBs once per month.[56] These federal regulations, similar to private health insurers, aim to prevent health care fraud and verify services received.[57] Still, even the periodic disclosure of EOBs sent to policyholders as part of federally regulated Medicaid do not provide greater protections to plan dependents like the twenty-five-year-old man, the thirty-five-year-old married woman, or to the sixteen-year-old minor.

Additionally, the federal government requires Medicaid to be a payer of last resort, meaning states must collect money from third-party payers before collecting from Medicaid.[58] Since states must determine if those receiving Medicaid simultaneously have other types of insurance, states may incidentally notify private insurance policyholders of plan dependents' healthcare even before the annual EOB—thereby disallowing Medicaid to give plan dependents more privacy than private insurance.[59] Medicaid does have a "good-cause exception," similar to the "reasonably endangered" requirement for private insurers, where policyholders will not get medical information about plan dependents if "it is anticipated that cooperation will result in reprisal against, and cause physical or emotional harm to, the individual or other person."[60] Patients must prove that they anticipate harm from the disclosure of PHI instead of simply requesting insurers keep their PHI confidential like private insurers. Moreover, because Medicaid is a payer of last resort, other payers may release EOBs to policyholders outside of Medicaid's "good cause exception."[61]

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55 ASS'N OF STATE & TERRITORIAL HEALTH OFFS., STATE EFFORTS TO PROTECT CONFIDENTIALITY FOR INSURED INDIVIDUALS ACCESSING CONTRACEPTION AND OTHER SENSITIVE HEALTHCARE SERVICES 3 (2018) ("Unlike commercial insurance, Medicaid does not have the same requirements to send out EOBs.").

56 *Id.*; *Check the Status of a Claim*, MEDICARE.GOV, https://www.medicare.gov/claims-appeals/check-the-status-of-a-claim (last visited Feb. 14, 2021); *Explanation of Benefits (EOB)*, MEDICARE INTERACTIVE, https://www.medicareinteractive.org/get-answers/medicare-denials-and-appeals/medicare-advantage-appeals/explanation-of-benefits-eob (last visited Feb. 14, 2021).

57 ASS'N OF STATE AND TERRITORIAL HEALTH OFFS., *supra* note 55, at 3.

58 *Id.*

59 *Id.*

60 ABIGAIL ENGLISH ET AL., NAT'L FAM. PLANNING & REPROD. HEALTH ASS'N, CONFIDENTIALITY, THIRD-PARTY BILLING, & THE HEALTH INS. CLAIMS PROCESS: IMPLICATIONS FOR TITLE X 12 (2015) [hereinafter CONFIDENTIALITY, THIRD-PARTY BILLING, & THE HEALTH INS. CLAIMS PROCESS]; 42 U.S.C. § 1396(k)(a)(1)(C); 42 C.F.R. § 433.147 (2021).

61 CONFIDENTIALITY, THIRD-PARTY BILLING, & THE HEALTH INS. CLAIMS PROCESS, *supra* note 60, at 13 ("[I]n today's age of electronic records and databases, and with the expansion of commercial health insurance coverage through the ACA marketplaces, many states now have alternate ways to identify and bill potential third-party payers" that may disclose PHI to the policyholder.).

Patients must understand that insurers get patients' PHI from both private medical insurance and Medicaid in the course of normal billing practices. By doing so, the Privacy Rule does not absolutely protect a plan dependent's PHI even though the patient can consent fully to health services.

III. RAMIFICATIONS OF THE PRIVACY RULE HOLES

The gaps in the Privacy Rule's confidentiality will impact plan dependents because policyholders receive insurance EOBs revealing plan dependents' PHI.[62] Normal billing practices will expose plan dependents' PHI to policyholders without the plan dependents' explicit consent.[63] The inability to receive completely confidential health care services will disproportionately impact how adolescents,[64] young adults,[65] and adult spouses[66] seek health care. The lack of confidential health care also impacts the type of care plan dependents seek, most notably impacting family planning and sensitive services.[67]

A. *The Impact of the Privacy Rule on Minors*

Though minors cannot consent to all health care without a parent or guardian, minors have decision-making capacity to consent to certain types of care while being legally incompetent.[68] State law varies with regard to minor consent laws, but all states allow minors to consent to

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[62] 45 C.F.R. § 164.506(c)(1) (2021) ("A covered entity may use or disclose protected health information for its own treatment, payment, or health care operations.").

[63] *Id.*

[64] MADLYN C. MORREALE ET AL., CTR. FOR ADOLESCENT HEALTH & THE L., POLICY COMPENDIUM ON CONFIDENTIAL HEALTH SERVICES FOR ADOLESCENTS 7 (2005) [hereinafter POLICY COMPENDIUM ON CONFIDENTIAL HEALTH SERVICES FOR ADOLESCENTS].

[65] Gale R. Burnstein et al., *Confidentiality Protections for Adolescents and Young Adults in the Health Care Billing and Insurance Claims Process*, 58 J. ADOLESCENT HEALTH 374, 376 (2016).

[66] Jessica Arons & Lindsay Rosenthal, *The Health Insurance Compensation Gap*, CTR. FOR AM. PROGRESS (Apr. 16, 2012, 9:00AM), https://www.americanprogress.org/issues/women/reports/2012/04/16/11429/the-health-insurance-compensation-gap/.

[67] Madlyn Morreale et al., *Access to Health Care for Adolescents and Young Adults*, 35 J. ADOLESCENT HEALTH 342, 343 (2004) [hereinafter *Access to Health Care for Adolescents and Young Adults*], https://www.adolescenthealth.org/SAHM_Main/media/Advocacy/Positions/Oct-04-Access_to_Health_Care_for_Adolescents.pdf.

[68] HEATHER BOONSTRA & ELIZABETH NASH, MINORS AND THE RIGHT TO CONSENT TO HEALTH CARE, GUTTMACHER REP. ON PUB. POL'Y 5 (2000) (finding "[a]ll 50 states and the District of Columbia specifically allow minors to consent to testing and treatment for STDs" and "[t]wenty-five states and the District of Columbia" allow minors to consent to contraceptive services). *But see* Newmark v. Williams, 588 A.2d 1108, 1110 (Del. 1990) (announcing a legal presumption that parents can make important health care decisions for their children).

some health services without the consent of a parent or guardian.[69] All fifty states "allow minors to consent to testing and treatment for STDs."[70] Twenty-five states allow minors to consent to contraceptive services.[71] Twenty states allow minors "to consent to outpatient mental health services."[72] A small minority of states even allow minors to consent to certain vaccines.[73] Research suggests adolescents, especially those ages fourteen and older, "may have well developed decisional skills," and often, a sufficiently mature minor's refusal of care may be legally and ethically binding.[74] This data supports the hypothetical at the beginning of this Comment detailing a sixteen-year-old minor who consented to sexually transmitted disease treatment without the consent or notification of her parents.

Still, policymakers experience tensions regarding minors' ability to consent to health care. "[I]t seems reasonable that parents should have the right and responsibility to make health care decisions for their minor child."[75] Some people assume parents are more apt to make health care decisions on behalf of their children "on the presumption that before reaching the age of majority . . . young people lack the experience and judgment to make fully informed decisions."[76] Current legislation indicates that modern policymakers have reached a general

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[69] ALA. CODE §§ 22-8-6 (2012) (stating minors can consent to health care for "pregnancy, venereal diseases, [and] drug dependency" without a parent or guardian); CAL. FAM. CODE § 6922 (2012) (stating a minor can consent to the minor's medical or dental care so long as the minor is fifteen years old or older); 410 ILL. COMP. STAT. ANN. 210/4 (2012) (explaining that so long as the minor is twelve years old or older, the minor can consent to treatment for sexually transmitted diseases and drug or alcohol abuse); N.C. GEN. STAT. § 90-21.5(a) (2012) (stating any minor can give consent to treatment for "(i) venereal diseases . . . (iii) abuse of controlled substances or alcohol, and (iv) emotional disturbance"); MONT. CODE ANN. § 41-1-402(c) (2012) (stating "a minor who professes or is found to be pregnant or afflicted with any reportable communicable disease . . . or drug and substance abuse" can consent to health care without a parent or guardian). For an overview of minor consent laws as of January 2013, see NAT'L DIST. ATT'YS ASS'N, MINOR CONSENT TO MED. TREATMENT LAWS 1–164 (2013), https://ndaa.org/wp-content/uploads/Minor-Consent-to-Medical-Treatment-2.pdf.

[70] BOONSTRA & NASH, *supra* note 68, at 5.

[71] *Id.*

[72] *Id.*

[73] *See* UTAH CODE ANN. § 26-10-9 (2012) (explaining a minor can consent to "vaccinations against epidemic infections and communicable diseases"). *But see* S.B. 3835, 218th Leg. (N.J. 2019), https://www.njleg.state.nj.us/2018/Bills/S4000/3835_I1.HTM (denying a proposed New Jersey law that would allow minors fourteen years old and older to consent to certain vaccines or boosters like the human papillomavirus (HPV), mumps, measles, diphtheria).

[74] POLICY COMPENDIUM ON CONFIDENTIAL HEALTH SERVICES FOR ADOLESCENTS, *supra* note 64, at 49.

[75] BOONSTRA & NASH, *supra* note 68, at 4.

[76] *Id.*

consensus that minors can consent to reproductive care and those health services deemed sensitive without a parent.[77] Since the trend is moving towards allowing minors to consent to more services without a parent, allowing minors to consent to services without also allowing them to receive confidential services seems problematic.

Even if minors can legally consent to certain services without informing their parents, insurers will still send EOBs to policyholders, who are likely parents.[78] Minors can request that insurers keep these services confidential from policyholders, but the Privacy Rule does not require insurers to honor these requests unless a minor shows that the request is reasonable under the circumstances or that notifying the policyholder will endanger the minor.[79] The Privacy Rule does not define "reasonable" or "endanger."[80] Additional protections defer to state-specific law.[81] Minors must understand and inform themselves about the distinction between the ability to consent to treatment through a confidential physician-patient relationship and when the provider will abrogate this confidentiality for payment purposes.[82]

A minor's fear of lack of confidential health services and policyholders learning about the minor's diagnosis and treatment may intimidate minors and cause them to avoid seeking needed health care.[83] "[S]ituations exist in which parental notification could place an adolescent at risk of verbal and/or physical abuse or conflict."[84] When minors "do seek health care, privacy concerns likely affect the quality of health care received" because minors do not disclose all of their questions and relevant information to the health care providers.[85] The

[77] *Id.* at 5 (explaining "over the last 30 years, states have passed laws explicitly authorizing minors to consent to health care").

[78] *See infra* Section II.B.

[79] 45 C.F.R. § 164.522(b)(1)(ii) (2020).

[80] *Id.*

[81] Abigail English & Carol A. Ford, *The HIPAA Privacy Rule and Adolescents: Legal Questions and Clinical Challenges*, 36 PERSPS. ON SEXUAL & REPROD. HEALTH 80, 82 (2004), https://www.jstor.org/stable/3181198?seq=1.

[82] *Id.* at 80.

[83] Comm. on Adolescence, *Achieving Quality Health Services for Adolescents*, 121 AM. ACAD. OF PEDIATRICS 1263, 1265 (2008)

> Confidentiality is the key for addressing many types of preventable problems, because fear of disclosure, diagnosis, and treatment may cause adolescents to delay or avoid needed care. . . several studies have shown that adolescents are both interested in and willing to talk with clinicians about recommended preventative counseling and screening topics, especially during private, confidential health care visits.

[84] Burstein, *supra* note 65, at 376.

[85] Carol Ford et al., *Confidential Health Care for Adolescents: Position Paper for the Society of Adolescent Medicine*, 35 J. ADOLESCENT HEALTH 160, 162 (2004), https://

Policy Compendium on Confidential Health Services for Adolescents interviewed health care providers who work with adolescents and explained that minors "tend to underutilize health care services" because of confidentiality.[86] One study indicated that 35 percent of middle school and high school students cited the reason for not seeking health care as "not wanting to tell their parents," who are likely the policyholder.[87]

Even if minors are already using health care services, seventy percent of minors at a family planning clinic said they would stop getting care if the clinic told their parents.[88] The Acting Vice President for Public Policy at the Guttmacher Institute explained that minors want to avoid having those awkward conversations with parents.[89] He noted that "[t]here are going to be parents that are going to look at their kid at the dinner table and say, 'What's going on? Why were you going to the doctor?' I think that puts the kid in a tough position."[90] Professional medical institutions like the American Academy of Pediatrics, the American Academy of Family Physicians, the American College of Obstetricians and Gynecologists, and the Society for Adolescent Medicine oppose legislation that will undermine federal guarantees of confidentiality for adolescents receiving health care services.[91] The Privacy Rule, however, already undermines confidentiality by not guaranteeing confidential payment opportunities. With lacking federal legislation, the burden may then shift to health care plans and providers to inform minor patients about the scope and limitations of confidentiality.[92]

www.jahonline.org/action/showPdf?pii=S1054-139X%2804%2900086-2 (noting adolescents who are concerned about privacy are less likely to communicate openly with health care providers "about issues related to substance use, mental health, and sexual behaviors").

86 POLICY COMPENDIUM ON CONFIDENTIAL HEALTH SERVS. FOR ADOLESCENTS, *supra* note 64, at 7.

87 Ford et al., *supra* note 85, at 162.

88 CONFIDENTIALITY FOR INDIVIDUALS, *supra* note 40, at 3.

89 TEBB ET AL., *supra* note 44, at 13.

90 *Id.*

91 POLICY COMPENDIUM ON CONFIDENTIAL HEALTH SERVICES FOR ADOLESCENTS, *supra* note 64, at 46.

92 Morreale et al., *supra* note 67, at 343.

B. *The Impact of the Privacy Rule on Young Adults*

In 2010, Congress enacted the Patient Protection and Affordable Care Act (ACA),[93] which permits adults ages eighteen to twenty-five to remain on their parents' health insurance plans and increased the number of adults in this age group that have health insurance.[94] In 2009, one year before Congress enacted the ACA, fifteen million adults aged eighteen to twenty-five were insured—one-third of the people in this age group.[95] As a result of the ACA, the Department of Health and Human Services estimates that by 2016, 6.1 million adults under twenty-six gained health insurance.[96]

Before Congress enacted the ACA, thirty-seven states allowed young adults to remain on their parents' health plans with varying age limitations and qualifications.[97] The ACA, like the Privacy Rule, sets a floor that states must follow.[98] States can expand upon these qualifications, like increasing age qualifications to exceed twenty-six, and some states have done so.[99] But the ACA will preempt state law if states directly contradict the ACA.[100]

The ACA requires insurers to cover preventative services without cost-sharing, meaning the patient will not have to pay out-of-pocket

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93 Patient Protection and Affordable Care Act, 111 Pub. L. No. 148, 124 Stat. 119 (2010).

94 42 U.S.C. § 300gg-14; CONFIDENTIALITY FOR INDIVIDUALS, *supra* note 40, at 5.

95 ABIGAIL ENGLISH & M. JANE PARK, CTR. FOR ADOLESCENT HEALTH & THE LAW, NAT'L ADOLESCENT & YOUNG ADULT HEALTH INFO. CTR., ACCESS TO HEALTH CARE FOR YOUNG ADULTS: THE AFFORDABLE CARE ACT IS MAKING A DIFFERENCE 1 (2012) [hereinafter ACCESS TO HEALTH CARE].

96 NAMRATA UBEROI ET AL., U.S. DEP'T OF HEALTH & HUM. SERVS., HEALTH INSURANCE COVERAGE AND THE AFFORDABLE CARE ACT, 2010-2016, at 2 (2016).

97 ACCESS TO HEALTH CARE, *supra* note 95, at 2 (finding states had upper limits of 23–31 for dependents' ability to remain on their parents' health insurance plans); *see also* WEST'S F.S.A. § 627.6562 (2021); N.J. REV. STAT. § 17B:27-30.5 (2013); N.Y. INS. LAW § 3216 (McKinney 2020); S.D. CODIFIED LAWS § 58-17-2.3 (2021); WIS. STAT. § 632.885 (2009); 40 PA. CONS. STAT. §617.1 (2009); 215 ILL. COMP. STAT. 5/356z.12 (2014).

98 45 C.F.R. § 164.512 (2020).

99 *Id.* For state regulations that have laws requiring insurance coverage for adults exceeding the age of twenty-six under certain circumstances, see FLA. STAT. § 627.6562 (2021); NJ. REV. STAT. § 17B:27-30.5 (2013); N.Y. INS. LAW § 3216 (McKinney 2020); S.D. CODIFIED LAWS § 58-17-2.3 (2021); WIS. STAT. § 632.885 (2009); 40 PA. CONS. STAT. §617.1 (2009); 215 ILL. COMP. STAT. 5/356z.12 (2014). For example, Wisconsin allows full-time students to stay on their parents' health insurance regardless of age. WIS. STAT. § 632.885 (2009). Florida allows individuals to remain a plan dependent on their parents' plan until age of thirty so long as they are not married and have no dependents. FLA. STAT. § 627.6562 (2021).

100 45 C.F.R. § 164.512 (2020); Ashley Noble, *Dependent Health Coverage and Age for Healthcare Benefits*, NAT'L CONF. OF STATE LEGS. (Nov. 1, 2016), https://www.ncsl.org/research/health/dependent-health-coverage-state-implementation.aspx.

costs.[101] Still, insurers commonly send EOBs to policyholders when the patient does not have a balance due if the patient uses health insurance to receive medical services.[102] Even if the plan dependent is an adult who can fully consent to health care, communications from health insurers, nonetheless, go through the policyholder.[103] This breaches the confidentiality of adults who are plan dependents rather than policyholders of their own plan.

Like the twenty-five-year-old man who was an adult and could fully consent to treatment from any doctor and to use prescribed medication without consent from his policyholder, "the issue of protecting patient confidentiality within the context of EOBs remains critical for many dependents in need of confidential health services."[104] These young adults exceed the age of majority and as such can give full consent to their health care. The Privacy Rule should then entitle them to the same level of confidentiality as adults who are not plan dependents. "The breaches of confidentiality that occur through the billing and insurance claims process have potentially serious consequences because protecting confidentiality for . . . young adults is critical to encouraging those individuals to access health care needed to prevent negative health outcomes."[105] To encourage quality health care, young adults who are plan dependents need the same level of confidentiality as those young adults who are policyholders.

C. *The Impact of the Privacy Rule on Spouses*

Much like the Privacy Rule leaves a wanting gap in confidentiality for minors and young adults who are plan dependents, spouses experience a similar hole in confidentiality protection. This gap in spousal confidentiality disproportionately affects women.[106] The Kaiser Family Foundation conducted a study that indicates 24 percent of adult women are insured as a dependent on their spouse's insurance plan compared to 13 percent of men.[107] The thirty-five-year-old married woman from the introduction was a plan dependent on her husband's insurance policy. This situation detailed the marked moral differences about abortion between spouses and illustrates why one spouse would

101 29 C.F.R. § 2590.715-2713 (2021).

102 TEBB ET AL., *supra* note 44, at 5.

103 *Id.*

104 *Id.*

105 Burstein, *supra* note 65, at 376 (emphasizing the impact a lack of confidential services will have on family planning and sexually transmitted disease treatment).

106 Arons & Rosenthal, *supra* note 66.

107 *Id.*

want to receive medical care completely confidential from the other spouse.

An adult spouse, similar to young adults and minors with certain services, can fully consent to medical treatment simply by virtue of exceeding the age of majority. Yet, the health insurer will still send EOBs to the policyholder, leaving the spouse plan dependent with lacking confidentiality.[108] The inability for a woman to receive confidential health services when on her spouse's insurance policy poses a threat to women's safety, notably if an abusive spouse discovers that the other spouse disclosed intimate partner violence (IPV) to a health care provider.[109] Women who have experienced IPV "often pay out of pocket [instead of using insurance] out of fear that their abuser will find out they have sought medical attention."[110] In fact, self-pay for IPV emergency department visits "was almost two times higher compared with [using] private insurance."[111] Because of the lacking Privacy Rule protections that allow health care providers to disclose PHI for payment purposes, "women and IPV survivors will have to disproportionately shoulder the cost of their victimization" instead of using their health insurance.[112]

The argument exists for the notion that "[m]arriage is the union of two people" and "a union of [their] minds and wills" merging them into one person.[113] In the landmark *Obergefell v. Hodges* decision in 2015, the U.S. Supreme Court even said, "[n]o union is more profound than marriage . . . ."[114] Since society seems to hold marriage as a sacred union between two people "who make a permanent and exclusive commitment to each other,"[115] people may also see marriage as an inherent waiver of medical confidentiality. But to equate marriage with a waiver of confidentiality between spouses poses a dramatic, unwarranted, and problematic release of privacy. The failure to have confidential medical services amongst spouses illustrates a dichotomy

108 *See* CONFIDENTIALITY FOR INDIVIDUALS, *supra* note 40, at 10; *see* sources cited *supra* note 46.

109 Rachel Benson Gold, *Unintended Consequences: How Insurance Processes Inadvertently Abrogate Patient Confidentiality*, 12 GUTTMACHER POL'Y REV. 12, 14 (2009), https://www.guttmacher.org/sites/default/files/article_files/gpr120412.pdf.

110 Tatiana L. Mariscal et al., *Changes in Incidents and Payment Methods for Intimate Partner Violence Related Injuries in Women Residing in the United States*, 30 WOMEN'S HEALTH ISSUES J. 338, 339 (2020).

111 *Id.* at 341.

112 *Id.* at 342.

113 Sherif Girgis et al., *What is Marriage?*, 34 HARV. J. L. & PUB. POL'Y 245, 246, 253 (2011).

114 Obergefell v. Hodges, 576 U.S. 644, 681 (2015).

115 Girgis et al., *supra* note 113, at 246.

between the policyholder's desire, and maybe internalized right, to see the charges on the policy, and the plan dependent's right to receive completely confidential services.[116]

D. *The Impact of the Privacy Rule on Health*

The Privacy Rule's gaps in confidentiality coverage do not allow plan dependents to secure completely confidential health services, notably for minors, young adults, and spouses, but the Privacy Rule's gaps also seem disproportionately to impact specific types of health care. This section discusses the Privacy Rule's impact on two notable health care treatments: reproductive care and sexually transmitted disease care.

1. Lacking Privacy for Reproductive Health

First, minors and adults delay or forgo reproductive health services because of confidentiality concerns.[117] Statistics and trends reveal that of women who use contraceptive services, older women are more likely to use their insurance to pay for such services.[118] 90 percent of women over thirty who used contraceptive services in 2002 used their insurance to pay for those services, while 76 percent of privately insured women in their early twenties and 68 percent of privately insured teens used their insurance to pay for contraceptive services.[119] Likely, this correlation between the use of insurance and age exists because women over thirty have their own health insurance policies, are their own policyholders, and thus receive their own EOBs.[120] The same breach of confidentiality through EOBs that exists for women in their teens and early twenties does not exist for women who have their own insurance.

Congress recognized the special need for confidentiality with regard to family planning services and enacted Title X of the Public Health Service Act in 1970 to provide federal grant money to family planning services.[121] The HHS Office of Population Affairs administers

116 TEBB ET AL., *supra* note 44, at 2; FIELDS ET AL., *supra* note 41, at 2; *Explanation of Benefits*, HORIZON BLUE CROSS BLUE SHIELD, https://www.horizonblue.com/shbp/understanding-your-plan/explanation-benefits (last visited October 24, 2021) (explaining insurers use EOBs to provide "a straightforward way to capture . . . information in one place for use in tracking . . . health care services or expenditures").

117 TEBB ET AL., *supra* note 44, at 1.

118 CONFIDENTIALITY FOR INDIVIDUALS, *supra* note 40, at 3–4.

119 *Id.*

120 *Id.*

121 42 U.S.C. §§ 300–300a-6.

Title X grants to more than 4,000 clinics across the country.[122] These grants solely fund "comprehensive family planning services" and were intended as a "safety net" for low-income people who do not have another source of health care coverage like private health insurance or Medicaid to afford family planning services.[123] Title X can also assist women who are reluctant to use their insurance for fear the policyholder will view the services through an EOB.[124] Some women who have an established doctor may opt to visit a strange, new doctor through Title X services to avoid a provider sending an EOB altogether. "In 2012, Title X-funded clinics served 4.8 million clients" and helped alleviate the stress about confidentiality.[125]

By enacting Title X and providing grant funding to family planning clinics, Congress acknowledged and acted to ensure confidential health services. The confidentiality regulations in Title X are "among the strongest in federal or state law," though they only apply to family planning services.[126] "[T]he ethical commitment to protecting patient privacy is firmly embedded in the policies and practices of providers of Title X-funded family planning services."[127] In fact, Congress went beyond the Privacy Rule's confidentiality provisions when enacting Title X; Title X clinics do not send EOBs to policyholders like providers do under the Privacy Rule.[128]

Still, Title X clinics have a finite amount of federal funds.[129] Title X requires providers to make "all reasonable efforts" to bill a third-party if the third-party "is authorized or legally obligated to pay for services."[130] Therefore, Title X providers face pressure to bill third parties, not only because Title X statutorily requires them to do so when feasible but also because of limited federal grant funding.[131]

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122 JULIA STRASSER ET AL., JACOBS INST. OF WOMEN'S HEALTH, LONG-ACTING REVERSIBLE CONTRACEPTION 1, 27 (2016).

123 *Id.*

124 *Id.* (noting "[c]osts can be especially problematic for adolescents who lack independent access to the funds needed to pay for services or who use their parents' insurance").

125 ANGELA NAPILI, CONG. RSCH. SERV., TITLE X (PUBLIC HEALTH SERVICE ACT) FAMILY PLANNING PROGRAM (2017).

126 *Privacy Protection in Billing and Health Insurance Communications*, *supra* note 51, at 280.

127 *Id.* at 282.

128 42 C.F.R. § 59.11 (2020).

129 NAPILI, *supra* note 125 (noting the 2014 Title X budget was $286 million and the 2013 Title X budget was $278 million).

130 42 C.F.R. § 59.5(a)(9) (2021).

131 NAPILI, *supra* note 125 (noting the 2014 Title X budget was $286 million and the 2013 Title X budget was $278 million).

Nonetheless, providers acknowledge the privileges and benefits that come with Title X confidentiality. In one survey, 62 percent of Title X funded providers said they "do not send bills at all for patients who request confidentiality."[132] Instead, providers reject Title X's statutory guidelines, try to use grant funds first, and, when necessary, charge based on a sliding scale fee.[133]

That statistic shows the demand for confidential services and the inadequacy of federal law, even if Title X provides more protection than the Privacy Rule. The statistic also shows Title X clinics and providers acknowledge the need and benefit of keeping these reproductive services confidential but still feel the obligation to use a patient's insurance for needed funds. The National Prevention, Health Promotion, and Public Health Council called on health systems, insurers, and clinicians to ensure confidential reproductive and sexual health services outside of the realm of Title X clinics.[134] The Privacy Rule has not answered the call to amend insurance billing practices.

2. Lack of Privacy for Sexually Transmitted Disease Care

Second, minors and adults delay or forgo testing and treatment for sexually transmitted diseases, though members of all genders who delay or forgo treatment put themselves at risk for severe health complications.[135] Numerous health organizations like the American Academy of Pediatrics, American Academy of Family Physicians, American Academy of Child & Adolescent Psychiatry, the Society for Adolescent Health and Medicine, the American College of Obstetricians and Gynecologists, and the American Medical Association, have adopted formal policy statements supporting confidentiality protections for minors and adults seeking these types of sensitive services.[136]

In response to current billing practices where an EOB will reveal these sensitive services, plan dependents "sometimes still choose to act as though they [are] uninsured."[137] Acting uninsured means plan

132 *Privacy Protection in Billing and Health Insurance Communications*, *supra* note 51, at 283.

133 *Id.*

134 CONFIDENTIALITY FOR INDIVIDUALS, *supra* note 40, at 4.

135 *Id.* (finding untreated chlamydia and gonorrhea can lead to infertility in women, and both men and women with some sexually transmitted diseases like chlamydia, syphilis, herpes, and gonorrhea may be more likely to acquire an HIV infection).

136 *Id.*

137 *Privacy Protection in Billing and Health Insurance Communications*, *supra* note 51, at 282; *see* Nat'l Fed'n of Indep. Bus. v. Sebelius, 567 U.S. 519, 548 (2012) (explaining the goal of the individual mandate was to prevent providing an incentive for individuals to delay purchasing health insurance until they become sick and lowering the cost of health insurance for all people).

dependents are not using their health insurance when seeking health care, "thus undermining the personal and social benefit of insurance."[138] Instead, plan dependents would rather pay with cash. Patients further exacerbate the problem of acting uninsured when they cannot afford to pay with cash, especially when clinics and providers do not have adequate grant funds to cover these services.[139]

IV. STATE SOLUTIONS

When HHS amended the Privacy Rule in 2013, the amendments failed to address third-party billing practices which still allow a covered entity to reveal PHI for payment purposes.[140] But the Privacy Rule is the federal floor, and states can establish their own ceilings.[141] States have developed their own laws, including constitutional privacy rights, minor consent laws, medical record laws, and health privacy laws, but states are careful to avoid adopting laws the Privacy Rule will preempt—the supreme law of the land.[142]

Even with the apparent liberty states have to create new protections, a majority of states still require health care providers to bill insurance companies and to detail the treatment the plan dependent received, the provider, and the co-payment, which the insurer will ultimately reveal to the policyholder.[143] A minority of states have used this liberty to implement additional safeguards, though states have created fragmented, varied, and inconsistent safeguards.[144] This section will analyze those increased protections and propose which protections the federal Privacy Rule should adopt.

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138 *Privacy Protection in Billing and Health Insurance Communications*, *supra* note 51, at 282.

139 *Id.*

140 Health Information Technology for Economic and Clinical Health, 78 Fed. Reg. 5566, 5568 (Jan. 25, 2013) (codified at 45 C.F.R. §§ 160, 164), https://www.govinfo.gov/content/pkg/FR-2013-01-25/pdf/2013-01073.pdf.

141 45 C.F.R. § 160.202 (2021).

142 CONFIDENTIALITY FOR INDIVIDUALS, *supra* note 40, at 9–16; 45 C.F.R. § 160.202 (2021) (Federal law preempts state law when: "(1) A covered entity or business associate would find it impossible to comply with both State and Federal requirements; or (2) The provision of State law stands as an obstacle to the accomplishment of the [Privacy Rule]").

143 CONFIDENTIALITY FOR INDIVIDUALS, *supra* note 40, at 6 ("[E]ach state has a department of insurance that is charged, in part, with protecting consumers and regulating the business of insurance within its borders.").

144 *Id.* at 9–16 ("Significant variations occur among the states in terms of the topics addressed in statutes and regulations, the level of detail and the consistency of definitions and use of terms.").

A. *State Regulations for Third-Party Billing Practices*

In an article from the Guttmacher Institute entitled *Confidentiality for Individuals Insured as Dependents: A Review of State Laws and Policies*, the authors indicated EOBs are the most "ubiquitous" elements of insurance claims processing since "[v]irtually anyone who has a health insurance policy under which care has been received and a claim has been submitted has received an EOB."[145] EOBs generally include a description of the care provided, the charges submitted to the insurer, the amount covered by insurance, the amount not covered, and the policyholder's outstanding financial responsibility.[146] States have taken strides to depart from the practice of sending EOBs for every service rendered.

For example, New York law does not require health insurers to send an EOB to the policyholder if the patient has no balance, meaning the patient has no financial liability to the health care provider.[147] Under New York law, insurers still must send an EOB when a balance is due on the policyholder's account and when the insurer denies the claim.[148] Still, the New York law provides more protection for plan dependents who have the means to pay for their health care without the help of a health insurer.[149] But the law only does not *require* insurers to send EOBs.[150] Insurers still have the discretion to send EOBs to the policyholder and policyholders can request the insurer send the policyholder an EOB.[151] The New York law, therefore, only provides greater confidentiality to patients who can pay for their own health care and whose insurer decides not to send an EOB.[152]

Much as policyholders can request the insurer send an EOB in New York, Washington and New Jersey similarly specify that "if a policyholder or enrollee requests . . . an 'explanation,'" meaning an EOB, the insurer must send it.[153] States seem to experience a push and pull

145 *Id.* at 9–10.

146 *Id.*; *see* sources cited *supra* note 46.

147 N.Y. Ins. Law § 3234*3 (2014); *see* CONFIDENTIALITY FOR INDIVIDUALS, *supra* note 40, at 15.

148 N.Y. Ins. Law § 3234*3 (2014). In New York, every insurer is required to send an EOB to the policyholder when a balance is due on their policy that *at least* includes the name of the provider, the date of service, the service, the provider's charge, the amount payable after co-payments and deductibles, explanation of denial, policyholder address or telephone number. *Id*.

149 *Id.*

150 *Id.* (emphasis added).

151 *Id.*

152 *Id.*

153 CONFIDENTIALITY FOR INDIVIDUALS, *supra* note 40, at 11.

between aiming to achieve the very reasons insurers send EOBs to policyholders—to prevent fraud and promote transparency—with enhancing plan dependent confidentiality.[154] New York law acknowledged an interest in patient confidentiality by refraining from sending EOBs when the patient has no balance.[155] Yet, since New York, New Jersey, and Washington explicitly allow policyholders to request EOBs regardless of whether the patient has a balance due,[156] the scales seem to weigh in favor of the policyholder's interest in transparent policy usage. This eliminates plan dependents' ability to receive confidential health services.

A proposed law in Massachusetts follows New York's suit and indicates insurers should not send EOBs when the policyholder has no balance due.[157] Unlike New York, Massachusetts' proposed law does not have a provision that explicitly allows the policyholder to request an EOB when the plan dependent has no outstanding financial liability.[158] While it is possible the absence of an explicit provision preventing insurers from sending EOBs implicitly allows insurers to send them, the absence of such provision seems more likely to indicate that the Massachusetts proposal tips the scales to favor plan dependent confidentiality rather than policyholder transparency. Still, Rhode Island law tips the scales in the other direction to favor transparency.[159] Rhode Island law specifically says an insurer must send an EOB with any claim payment whether or not the plan dependent has an outstanding balance.[160] Rhode Island strongly weighs in favor of promoting transparency for the policyholder while eliminating the opportunity for a plan dependent to use health insurance and receive completely confidential care.

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154 TEBB ET AL., *supra* note 44, at 2. "The ultimate purpose of Explanation of Benefits (EOBs) is to hold insurance companies accountable and to reduce fraud." *Id.* "EOBs inform policyholders of insurance claims made and actions taken on their account by anyone covered under their policy (including dependents) so policyholders can verify receipt of services for which they were billed . . . ." *Id.*

155 N.Y. Ins. Law § 3234*3 (2014).

156 *Id.*; CONFIDENTIALITY FOR INDIVIDUALS, *supra* note 40, at 11.

157 H.R. 871, 189th Gen. Ct., H.D. 595 (Mass. 2015) at 20.

158 *Id.* The Massachusetts proposal says, "[u]nless specifically requested by the insured, a carrier shall not provide a common summary of payments [an EOB] form if the insured has no liability for payment . . . ." *Id.*

159 *See* R.I. GEN. LAWS § 20-40-1; § 19-205(a)(1).

160 R.I. GEN. LAWS § 20-40-1. Rhode Island law mandates insurers send an EOB with each claim detailing "the name of the provider or services covered, dates of service, and a reasonable explanation of the computation of benefits." *Id.*

B. *State Regulations for Plan Dependents' Requests for Confidentiality*

The laws discussed in the previous section mandate aspects of insurance billing practices, meaning the insurer does not have to notify the policyholder or plan dependent before sending EOBs that include PHI. Plan dependents do have a level of autonomy outside of these mandates because they can affirmatively request that the health care provider and insurer not disclose information to the policyholder. Confidential communications requests are requests by an insured to a health insurer or health plan that "communications containing medical information be communicated to him or her at a specified mail or e-mail address or specific telephone number, as designated by the insured or by the subscriber or enrollee."[161] States have made strides toward allowing patients to request confidential communications, and in those strides, states seem to account and weigh the interests of plan dependents wanting confidentiality and policyholders wanting transparency.[162]

California implemented laws to strengthen the Privacy Rule by allowing minors and adults to request confidential communications from their health plan.[163] The California law gives health insurers the option to require the plan dependent make the request in writing or electronically.[164] Additionally, the law only requires insurers comply with the plan dependents' request when the patient is receiving sensitive services or the patient's claim revealing such services will endanger the patient.[165] California defines "sensitive services" as pregnancy, family planning, abortion, STDs, HIV, reportable disease, sexual assault, outpatient mental health, and drug and alcohol problems.[166] California defines "endanger" to mean the subscriber or enrollee fears that disclosure of his or her medical information could subject the subscriber or enrollee to harassment or abuse.[167] By allowing plan dependents to make confidential communications requests, California acknowledges the need for plan dependent privacy, but by limiting these requests to services that the California legislature

161 ABIGAIL ENGLISH ET AL., NAT'L FAMILY PLANNING & REPRODUCTIVE HEALTH ASS'N, PROTECTING PATIENTS' PRIVACY IN HEALTH INSURANCE BILLING & CLAIMS: A CALIFORNIA PROFILE 6 (2016) [hereinafter PROTECTING PATIENTS' PRIVACY].

162 *Id.* at 6–7; *see* S.B. 138 at § (4)(b) 2013 Legis. Counsel's Digest (Cal. 2013).

163 S.B. 138, 2013 Legis. Counsel's Digest § (3)(a-b)) (Cal. 2013).

164 *Id.* at § (4)(b).

165 *Id.* at § 4.

166 *Id.*; CAL. FAM. CODE §§ 6924–29; CAL. HEALTH & SAFETY CODE §§ 121020, 124260.

167 *Id.* at § (1)(e).

deems sensitive, California also seems to give weight to policyholder transparency.

Maryland, like California, requires insurers to honor requests for confidential communications from all individuals obtaining sensitive services.[168] Maryland passed this Senate bill to expand confidentiality requirements beyond the Privacy Rule in response to the implementation of the ACA and the expected 52,000 Maryland adults who would gain coverage through their parents' policies.[169] Evidently, Maryland noticed a looming confidentiality problem with the expected surge of adults as plan dependents but stopped short of allowing completely confidential services without an affirmative request for confidential sensitive services.[170]

An Oregon law goes further to "permit any enrollee to submit confidential communications request" without limiting these requests to "sensitive services" or to feeling "endanger[ed]" like California and Maryland.[171] This law requires insurers send communications to the plan dependent upon *any* request, effectively eliminating the insurer's discretion to send EOBs when requested.[172] The plan dependent still must fill out a form and make this request, but the Oregon law helps overcome the barrier of formulating a reason to make that request.[173] Oregon's law further requires the Department of Consumer and Business Services to create a clear and easy to understand form to submit to a carrier or third-party administrator to make the requests for confidentiality.[174]

Colorado takes the efforts of Maryland, California, and Oregon a step further by requiring health plans to get the adult plan dependent's consent before releasing any information to the policyholder.[175] The insurer does not have to deem these services "sensitive," rather the law provides that insurers cannot send information to the policyholder without the consent of the adult plan dependent.[176] This Colorado law

168 S.B. 790, 2014 Md. St. Leg. Sess. (Md. 2014); TEBB ET AL., *supra* note 44, at 9.

169 Jenny Black, *Closing a Confidentiality Gap*, BALT. SUN (Apr. 14, 2014), https://www.baltimoresun.com/opinion/bs-xpm-2014-04-14-bs-ed-planned-parenthood-20140414-story.html.

170 S.B. 790, 2014 Md. St. Leg. Sess. (Md. 2014).

171 H.R. 2758 at § 2, 78th Leg., Reg. Sess. (Or. 2015); *see* S.B. 790, 2014 Md. St. Leg. Sess. (Md. 2014) and S.B. 138, 2013 Legis. Counsel's Digest (Cal. 2013).

172 H.R. 2758, 78 Leg., Reg. Sess. (Or. 2015) (emphasis added).

173 *Id.*

174 *Id.* The form, at minimum, must inform the plan dependent of the option to request confidential billing practices, and the department can encourage health care providers to display this form. *Id.*

175 3 COLO. CODE REGULS. § 702-4-6 (2018).

176 *Id.*

tips the scale heavily to favor plan dependent autonomy over policyholder transparency.

C. *State Regulation for Minors' Requests for Confidentiality*

States have also created legislation that directly affects minors' ability to request confidential health services.[177] Hawaii tried to preserve the confidentiality of minors by passing a law that requires providers to inform the insurer when minors request their visit remain confidential.[178] The insurer then may require the minor to make the request in writing and contain a statement that "the information to which the request pertains could endanger the minor."[179] The minor must feel endangered, though the Hawaiian law did not define 'endanger,' and the insurer *may* choose to "accommodate requests by the minor . . . to receive communications . . . by alternative means or at alternative locations."[180] Hawaii, like other states, faces this balancing issue about the minor's autonomy as a plan dependent and the policyholder's interest in seeing the full extent of claims under the policy. Hawaii achieves a balance by allowing the minor to make a request while limiting those requests to the ill-defined term—"endanger." Though Hawaii makes efforts to include minors in the enhancement of the Privacy Rule, a better standard would allow any consenting minor to request health services remain confidential and require the insurer to comply with any such request.

Washington addresses minors directly by limiting insurers from disclosing PHI if the minor states in writing that the disclosure could "jeopardize" their safety.[181] For minors, this includes not disclosing PHI relating to care "to which the minor has lawfully consented, including mailing appointment notices, calling the home to confirm appointments, or mailing" an EOB.[182] Like Hawaii failed to define "endanger," Washington similarly fails to define "jeopardize."[183] The minor is left to navigate the potentially convoluted definitions determined by insurers or policyholders. Washington's recognition of the right of a minor who

177 *See* HAW. CODE R. 31, § 577D-2(i) (2009), *and* WASH. ADMIN. CODE § 284-04-510(1) (2001).

178 HAW. CODE R. 31, § 577D-2-(3)(i) (2009).

179 *Id.*

180 *Id.*

181 WASH. ADMIN. CODE § 284-04-510(1)(a) (2001) ("A licensee shall limit disclosure of any information, including health information, about an individual who is the subject of the information if the individual clearly states in writing that the disclosure . . . could jeopardize the safety of the individual.").

182 WASH. ADMIN. CODE § 284-04-510(3)(b) (2001).

183 *Id.* at (1)(a).

has the ability to consent to medical care to exercise rights beyond the Privacy Rule weighs in favor of patient autonomy, but Washington's legislation also balances policyholder transparency by making plan dependents climb the ambiguous barrier of showing their safety is jeopardized.

D. *Alternatives to Current Third-Party Billing Practices*

Colorado spearheads the state reform effort by requiring an insurer to obtain consent from the plan dependent before releasing any PHI to a policyholder, including through EOBs.[184] This extremely confidential approach prevents insurers from communicating with the policyholder about a plan dependent's care without consent.[185] The concern with this approach is plan dependents, most notably minors, spouses, and young adults, will not have different addresses from the policyholder. For example, if an insurer addresses an EOB to the plan dependent who shares a mailing address with the policyholder, the plan dependent will not receive the desired increased level of confidentiality. A modern solution is the use of increasing electronic communications,[186] potentially in the form of emails and text messages. A Senior Attorney for the National Center for Youth Law explains, "I think as we move more into electronic records and electronic communication, . . . [confidential communications] will become easier for both the insurers and for the consumers" by allowing the plan dependent to receive electronic EOB information independent of the policyholder and to ultimately receive completely confidential health care.[187]

Though communicating solely with the plan dependent may increase confidentiality, this practice may not achieve the level of billing transparency policyholders want.[188] A policyholder who pays for the policy may feel entitled to view all services billed to the policy.[189] The

184 3 COLO. CODE REGULS. § 702-4:4-2-35 (2013).

185 *Id.*

186 TEBB ET AL., *supra* note 44, at 17.

187 *Id.*

188 *See Understanding Your Explanation of Benefits (EOB)*, CIGNA (July 2018), https://www.cigna.com/individuals-families/understanding-insurance/explanation-of-benefits ("EOBs are a tool for showing you the value of your health insurance plan. You see the cost of services you received and the savings your plan helped you achieve. EOBs also help you gauge how much money you have left in accounts related to your plan.").

189 *Id.*

governmental interest in preventing fraud may also weigh in favor of the policyholder viewing all services billed on the policy.[190]

Three states, New York, Massachusetts, and California, tried de-identifying information on EOBs as a compromise between providing greater plan dependent confidentiality and allowing policyholders to view claims on the policy.[191] The Privacy Rule says health information is not individually identifiable if it does not identify an individual, and the covered entity has no reasonable basis to believe someone could use the information to identify an individual.[192] To achieve de-identified information, the expert determination method uses someone with appropriate knowledge and experience to render the information not individually identifiable.[193] The safe harbor method eliminates all identifiable information like names, zip codes, dates, telephone numbers, and social security numbers.[194] Insurers could use either method to de-identify EOBs regarding the treating physicians, the type of care received, and the date the plan dependent received the care to improve patient confidentiality.

Current Procedural Technology (CPT) numerically or alphanumerically codes medical services to help healthcare professionals offer a uniform method by "streamlin[ing] reporting . . . [and] increase[ing] accuracy and efficiency."[195] CPT codes aim to create uniform standards "so that a diverse set of users can have common understanding across the clinical health care paradigm."[196] Though health care professionals use CPT terminology as the "most widely accepted medical nomenclature,"[197] insurers often do not use CPT codes for billing purposes. Instead, insurers explicitly detail the provider and services for the policyholder to view.[198]

190 TEBB ET AL., *supra* note 44, at 2.

191 *Id*. at 9.

192 45 C.F.R. § 164.514(a) (2021).

193 § 164.514(b).

194 *Id*.

195 *CPT Overview and Code Approval*, AM. MED. ASS'N, https://www.ama-assn.org/practice-management/cpt/cpt-overview-and-code-approval (last visited Feb. 14, 2021) ("All CPT codes are five-digits and can be either numeric or alphanumeric, depending on the category." Category I numerally codes a procedure or service, Category II alphanumerically codes performance measurements, Category III alphanumerically codes new and developing technology, and procedures, and services.).

196 *Id.* (explaining the CPT Editorial Panel, a group of independent expert volunteers appointed by the American Medical Association Board of Trustee, meets three times a year to revise CPT codes and create new ones).

197 *Id.*

198 *See* sources cited *supra* note 46.

Erie County, New York, and Massachusetts apply CPT codes to sensitive services when sending EOBs to policyholders.[199] This means the policyholder can view the CPT codes for billing purposes rather than view the EOB explicitly detailing the provider and services rendered.[200] Only applying these codes to sensitive services still leaves room for interpretation and subjectivity about what treatments insurers will reveal on the EOB versus which services will remain confidential, but the CPT codes promote greater plan dependent confidentiality than current EOB communications.

The Northern California branch of Kaiser Permanente has a CPT code for all adolescent confidential health visits.[201] By using this code, the adolescent's visit will "not count towards the policyholder's deductible;" the insurer will not send the policyholder an EOB; and if the plan dependent cannot pay the co-payment, the insurer will waive the co-payment.[202] A solution that suppresses EOBs makes an adolescent's health care services confidential, and by waiving any co-payments, makes the health care accessible. The policyholder can still request an EOB which may include a term like "adolescent confidential visit,"[203] but like New York and Massachusetts, this CPT coding system makes great strides to protect adolescent confidentiality.

A strengthened Privacy Rule would encourage these CPT codes for all services, not just those services deemed sensitive or confidential. CPT codes allow policyholders to see all claims billed to their policy without revealing confidential plan dependent information.[204] Even with CPT codes, de-identified information will still put the policyholder on notice that the insurer billed a service to the policy and general information about where the plan dependent sought the care, but it will not reveal the exact type of treatment. Depending on when the insurer sends the EOB, the policyholder can still estimate when, where, and what treatment the plan dependent received. Nonetheless, CPT codes provide exponentially more confidentiality than current third-party billing practices.

199 TEBB ET AL., *supra* note 44, at 9.

200 *Id.*

201 *Id.* at 18.

202 *Id.*

203 *Id.*

204 TEBB ET AL., *supra* note 44, at 13.

E. *Education and Notice to Encourage Patients to Request Confidentiality*

Even with the opportunity to request confidential communications or confidential CPT codes, covered entities still need to educate patients about their rights to request confidential health services.[205] The acting Vice President for Public Policy at the Guttmacher Institute said, "[f]rankly, education at a whole bunch of levels is going to be the key to all of this."[206] Many people "don't know what an EOB is" nevertheless understand that it releases PHI.[207] States and communities have already begun education efforts.

In California, a group of advocates, namely the California Family Health Council, the American Civil Liberties Union, and the National Center for Youth Law, created a website, "My Health My Info," that has a section for individuals covered on someone else's health insurance.[208] This helps those individuals submit a confidential communications request.[209] Within one year, the website received 10,000 hits.[210] The advocates in California have also made outreach efforts through social media and offered training at University of California campuses, community colleges, school districts, Title X funded health centers, and Planned Parenthood Centers.[211]

In 2015, Massachusetts Senator Karen Spilka and Representative Kate Hogan sponsored "An Act to Protect Access to Confidential Healthcare."[212] Among other elements, it has provisions educating providers, consumers, hospitals, community health centers, physicians, and other licensed health care professionals.[213] Again, the emphasis is on educating individuals about their rights to request confidential health communications.

In New York, the Erie County Department of Public Health wanted to increase chlamydia screenings, so they developed "tool kits" that included information for providers about discussing insurance procedures with adolescents, "choosing CPT codes that protect confidentiality," and "providing a list of Title X clinics that offer

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205 *Id.* at 15.

206 *Id.* at 22.

207 *Id.*

208 PROTECTING PATIENTS' PRIVACY, *supra* note 161, at 8–10.

209 *Id.* at 10.

210 *Id.*

211 *Id.*

212 S.B. 557, 189th Gen. Assemb., Reg. Sess. (Mass. 2015); *see* FIELDS ET AL., *supra* note 41, at 4.

213 FIELDS ET AL., *supra* note 41, at 5.

reproductive health care services" with little to no cost.[214] Similar to the Erie County Department of Public Health, the Colorado Department of Public Health and Environment (CO DPHE) worked with other sensitive service advocates to "galvanize support" for a policy that promotes confidential billing practices.[215]

V. PROPOSAL

While states have made strides to enhance the Privacy Rule's confidentiality protections, Congress can utilize these efforts to deliver national scale privacy reforms. State efforts provide Congress with a menu of possibilities and practical examples of strategies that proved effective and those that failed. Taking successful elements from different states' enhancement of the Privacy Rule can suggest a practical and compelling national enhancement.

To avoid insurers revealing even the slightest plan dependent PHI to policyholders, California and Maryland allow plan dependents to make confidential communications requests when plan dependents receive sensitive services.[216] Even better, Colorado requires insurers to get plan dependent consent before releasing any plan dependent PHI.[217] If a plan dependent can fully consent to receive healthcare, the Privacy Rule should also require insurers to seek the plan dependent's consent before releasing PHI to the policyholder.

Though minors can consent to an increasing number of health care services, requiring insurers to seek minors' consent before releasing PHI may still seem odd. Hawaii and Washington account for that peculiarity by requiring insurers to obey a minor's confidential communications requests with a proclamation that such revelation will endanger[218] or jeopardize[219] the minor. Congress should properly define these terms when revising the Privacy Rule, but the conditional nature of a confidential communications request for minors may quell policyholders' concerns about minor plan dependent transparency.

Still, insurers have no incentive to stop sending EOBs to policyholders because policyholders pay the bills, and insurers want to

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214 *Id.* at 9; *see also id.* at 4. The bill also allows members who are legally authorized to consent to care to choose the preferred method of receiving the "summary of payment form," to suppress the sending of an EOB when there's no outstanding balance and to restrict sending EOBs with the description of sensitive information. *Id.*

215 TEBB ET AL., *supra* note 44, at 20.

216 S.B. 790, 2014 Md. St. Leg. Sess. (Md. 2014); S.B. 138, 2013 Legis. Counsel's Digest (Cal. 2013).

217 3 COLO. CODE. REGULS. § 702-4:4-2-35 (2013).

218 HAW. REV. STAT. § 577D-2(i) (2009).

219 WASH. ADMIN. CODE § 284-04-510(1)(a)–(3)(b) (2001).

appease the people who pay for insurance rather than plan dependents who simply receive care. Reforms like those in New York or Massachusetts, where the insurer will not send an EOB when the plan dependent has an outstanding balance,[220] fail to account for the policyholder's want for transparency. Apt solutions to bolster the Privacy Rule's confidentiality would not cease sending EOBs altogether, but would, like states have begun to implement, frame and formulate insurance billing practices to protect the confidentiality of plan dependents.

Increasing technological innovations present some modern solutions. A Senior Attorney for the National Center for Youth Law highlighted that plan dependents may not have a separate mailing address than that of their policyholder,[221] but electronic communications, such as emailing and text messaging, may overcome that barrier. The problem rests with policyholders' self-determined right to view claims billed to the policy for which they pay.

Congress could amend the Privacy Rule in an increasingly technology-savvy world to create CPT codes to de-identify PHI. Health care providers are already using these CPT codes when billing the insurer,[222] so the insurer would simply need to transfer these codes to EOBs. Northern California Kaiser Permanente has implemented this solution for confidential adolescent visits.[223] CPT codes would de-identify plan dependent PHI and provide a greater level of plan dependent confidentiality.

The hypothetical plan dependents, taking the form of a twenty-five-year-old man, a married woman, and a minor, may benefit from de-identified EOBs because the policyholder will not see the exact care the plan dependent sought. The twenty-five-year-old man may avoid ridicule from his family for seeing a therapist. The married woman may avoid the wrath of her husband for getting an abortion. The minor may avoid feeling uncomfortable and nervous to seek the care she needs without getting in trouble with her parents. But the EOBs will still show the plan dependents received some type of care. The health care information may be de-identified, but the revelation that a plan dependent sought health care remains.

Though CPT codes neglect to protect fully the plan dependent's confidentiality, they seem to strike the right balance between patient confidentiality and policyholder transparency. The services that plan

220 H.R. 871, 189th Gen. Ct., H.D. 595 (Mass. 2015); ISC § 3234*3.

221 TEBB ET AL., *supra* note 44, at 16–17.

222 *CPT Overview and Code Approval*, *supra* note 195.

223 TEBB ET AL., *supra* note 44, at 18.

dependents receive from a provider pose the biggest opportunity to avoid the adverse consequences that the hypothetical plan dependents experienced. Deidentifying PHI eliminates this risk and still allows the policyholder to view a form of EOBs.

The other barrier that remains is the willingness of insurers to transition to using CPT codes. Implementing these changes will pose challenges for insurers to make the technological changes needed to redirect communications. The insurance companies would need to invest money and time developing a new reporting system, re-programming their systems, and training their staff.[224] The Health Access and Promotion Coordinator from the Department of Public Health in Massachusetts said, "[w]e thought it was a great idea" to develop CPT codes to anonymize confidential services, but "the [insurance] carriers said it was an impossible mission."[225] Insurers seem unwilling to voluntarily transition to a CPT coding system and would seemingly only comply with a law—a law that strengthens the Privacy Rule.

In the meantime, it all comes down to education.[226] The key is to take what advocates from California, Massachusetts, and New York have done to educate people about their level of confidentiality and expand that to a national campaign.[227] State efforts have shown that education is the key to successfully implementing confidential health communications. Nonetheless, states have different and everchanging laws that make widespread education outreaches difficult. If Congress amended the Privacy Rule to communicate health information solely with the plan dependent or to implement confidential CPT codes, a national education campaign using community health organizations, as proven successful at the state level, would garner greater and more consistent results.

VI. CONCLUSION

Confidential health services are essential for adolescents and minors to seek and receive adequate health care. The Privacy Rule served to promulgate confidential health services, but plan dependents are hesitant to have their PHI revealed to policyholders. Without guaranteeing confidential health services, patients will continue to receive inadequate health care. Some states have taken strides to

224 *Id.* at 19.

225 *Id.* at 20.

226 TEBB ET AL., *supra* note 44, at 15.

227 *See* PROTECTING PATIENTS' PRIVACY, *supra* note 161, at 8–10; S.B. 557, 189th Gen. Assemb., Reg. Sess. (Mass. 2015); FIELDS ET AL., *supra* note 41, at 4–5.

increase privacy protections beyond the Privacy Rule, though many of these efforts have fallen short of what is necessary to protect adequately patient confidentiality. Still, the efforts of various states can serve as examples of successful implementation strategies that Congress can mold to create a Privacy Rule with increased confidentiality protections. Changes such as communicating solely with the plan dependent and creating CPT codes to anonymously bill for health services will create the confidentiality that plan dependents so desperately need. With a national amendment to the Privacy Rule, national education campaigns about these confidential services will encourage patients to utilize them.