Explanation of Benefits Policy Brief

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This brief will describe an explanation of benefits ("EOB") in relation to minor dependents' sexual and? reproductive health care. Part I will define an EOB and how it relates to a minor's right to health care privacy. Part II will explore EOB suppression as a means to protect the privacy of minors when seeking care. Part III will examine legal implications such as parental rights and contract law in relation to EOB suppression. Part IV will include a comparative landscape of other state EOB suppression laws and how they compare to House Bill 1654, the proposed Pennsylvania legislation regarding EOB suppression. Part V will conclude with next steps to further our goal of getting EOB suppression legislation passed.

I. What is an EOB and Why Do We Care About Them?

An EOB is a document sent by insurance companies that details the medical care received by all of the individuals on an insurance plan.[1] EOBs typically identify the individual who received care, the health care provider, the type of care obtained, and the cost breakdown of said care.[2] This document is usually sent to the primary insurance plan holder, but this procedure may differ based on state law or the specific insurance policy or contract that the insurance plan holder has agreed to.[3] For example, Pennsylvania law only mandates that insurers provide an EOB to the health care provider, such as a hospital or physician, not the insurance plan holder. Thus, any time an insurance

[1] *Understanding Your Explanation of Benefits (EOB)*, Cigna (July 2018), https://www.cigna.com/individuals-families/understanding-insurance/explanation-of-benefits.
[2] Abigail English et al., *Confidentiality for Individuals Insured as Dependents: A Review of State Laws and Policies*, Guttmacher Institute 1, 5 (2012).
[3] *Id.*

company chooses to send an EOB to an insurance plan holder in Pennsylvania, it is doing so based on general contract law, not state law.[4] For insured dependents, the primary insurance plan holder is typically their parent, guardian, or spouse. EOBs can pose barriers for minors who are seeking care that their parent or guardian would not approve of. Often stigmatized care includes reproductive care such as birth control, PrEP (HIV pre-exposure prophylaxis), PEP (HIV post-exposure prophylaxis), abortion services, and STI/STD testing and treatment. It can also involve substance abuse and mental health care.

While minors can legally consent to most reproductive health, mental health, and substance abuse care without a parent or guardian's permission, the primary insurance plan holder will still receive notice when their dependents seek out this type of care due to common practices surrounding distribution of the EOB. This can make minors, and individuals who are 18 or older but still dependents for insurance purposes, hesitant to seek out necessary care out of fear that their parent, guardian, or spouse will find out and will not approve or that their safety may be threatened.

The consequences of this hesitancy are harmful on both a personal and a public health level. Personally, individuals will not receive care that they want and need to live healthy and safe lifestyles. Putting off certain care out of hesitancy puts an individual's overall health at risk both in the short-term and in the long-term, as health needs can add up as time goes on. From a public health perspective, hesitancy to seek out pre- and post-exposure HIV treatment, STI/STD screening, and STI/STD treatment can pose a danger to at-risk members of our community. Additionally, restricted access to birth control and abortion services also poses a public health threat as adolescents who are unable or unprepared to become parents are forced to either have a baby or resort to unsafe and harmful methods for abortion.

[4] 34 PA. CODE § 127.209(a).

The requirement to send EOBs creates a rights conundrum for minors and dependents who are empowered to seek care but simultaneously have no privacy due to their dependent-insured status. Most teenagers in Pennsylvania have the power to consent to their own reproductive health care, mental health care, substance abuse treatment, and care for communicable diseases.[5] Unfortunately, this right to consent does not also grant them a right to privacy with respect to that care. This conundrum is developed further in Section III, Part D of this brief.

This brief has focused on the risks faced by dependents as a result of sending EOBs; however, there are competing interests which may justify or necessitate the practice of sending EOBs. It is important to the primary insurance plan holder to receive an accurate and complete EOB when there is a draw on their insurance so they are informed about what kind of care and treatment they and their family members are receiving and being asked to pay for. Disputes with insurance companies arise all too often. Thus, having transparent documentation of care and payment obligations is crucial for an insurance plan holder to be able to advocate against the insurance company. Additionally, it is impractical from a business perspective to expect insurance holders to pay for services without receiving notice of the payment obligation. There must be a means by which the insurance holder is notified of an expectation to pay in order for them to actually fulfil the payment.

II. EOB Suppression

EOB suppression is a means by which the law can help to protect confidentiality for individuals insured as dependents. From a policy standpoint, there are several ways to "suppress" an EOB statement. For example, in Pennsylvania, new legislation is being proposed that would

[5] *Reference Card: Minors' Access to Confidential Health Care in Pennsylvania*, ACLU Pennsylvania (March 2014), https://www.aclupa.org/en/reference-card-minors-access-confidential-health-care-pennsylvania.

allow dependents to choose how and where they receive their EOB, which means they could keep the health care services they receive private if they so choose.[6] This proposed legislation, along with similar laws that have already passed in other states, will be described in more detail in Section IV of this brief.

The issue of EOBs raising privacy concerns arguably surfaced in the public consciousness in 2011 and 2012, which is when most states that have EOB suppression legislation decided to enact laws that make certain dependent care confidential.[7] It appears that while minors and dependents are the primary groups being negatively affected by the practice of sending EOBs, they are not the ones raising the issue of EOB suppression. This may be a result of an information barrier—the fact that these groups may not even know that EOB suppression is an option. Rather, it seems as though EOB suppression has gained traction solely through the efforts of state legislators and organizations who are lobbying these state legislators. For example, local organizations such as the Center for Women's Health Research and Innovation at the University of Pittsburgh and the Women's Law Project have been working alongside state legislators like Pennsylvania State Representative Leanne Krueger and Pennsylvania Senator Judy Schwank to get EOB suppression legislation in front of other members of the General Assembly and raise awareness of the issue.

There are several key stakeholders worth noting when discussing the issue of EOB suppression. These include insurance providers, primary insurance plan holders, minors and dependents on a parent or guardian's insurance plan, organizations advocating for the implementation of EOB suppression policy, and state legislators. Insurance providers and state legislators are the parties with the most power and capability to change the existing EOB

[6] H.R. 1654, 117th Cong. (2021).
[7] Abigail English et al. *supra* note 2 at Appendix.

landscape. State legislators can pass law that addresses the privacy concerns raised by the practice of sending EOBs, such as HB 1654. Insurance providers can amend their insurance contracts to include carve outs from sending EOBS in certain circumstances.

While minors and dependents, along with insurance plan holders, likely have the least amount of power to bring change to EOB practices, they do have crucial rights and interests with respect to the issue. Under the Privacy Rule of the Health Insurance Portability and Accountability Act ("HIPAA"), minors and dependents have a right to privacy with respect to treatment that they are allowed to consent for by way of state law.[8] The HIPAA Privacy Rule is discussed in more detail in Part C, Section 3 of this brief. Minors and dependents also have an interest in receiving desired and necessary health care in order to promote their well-being and a healthy and safe lifestyle. On the other hand, primary insurance plan holders have a contractual right to know and understand what they are obligated to pay for. They have an interest in receiving an explanation of the care that their insurance is being billed for, along with the amount that they must pay out of pocket, in a transparent manner.

III. Legal Implications of EOB Suppression

A. General Contract Law

Many procedures and communications resulting from health insurance claims are determined by the provisions of insurance contracts and policy documents themselves.[9] Thus, it is possible that the sending of EOBs may be required in insurance contracts and policies rather than

[8] *A Matter of Law: Privacy Rights of Minor Patients*, American Psychological Association Services, Inc. (2005), https://www.apaservices.org/practice/business/legal/professional/minor-privacy.
[9] Abigail English et al. *supra* note 2 at 9

in state statutes and regulations.[10] When services are provided to a covered individual, like a dependent on an insurance policy for example, it is inconsistent with contract law to expect the policyholder to pay for the care rendered unless the policyholder is made aware of it.[11] Rather, general contract law requires that terms of a contract are reasonably certain in order for the contract to be valid.[12] Thus, without an EOB, terms of the payment obligation would not be reasonably certain to the policyholder, making the insurance policy unenforceable.

Since the passage of the Affordable Care Act ("ACA"), insurance plans are required to cover specified reproductive care without any cost to the patient.[13] Section 1302 of the ACA mandates coverage of ten essential health benefits without any out-of-pocket payment.[14] One of these essential health benefits is preventive and wellness services.[15] Birth control, STI/STD screening, and PrEP are all covered under this category of benefits.[16] As a result, the financial motivation for sending EOBs on the part of the insurance provider, which is described above as sending an EOB in order to make payment obligations transparent and reasonably certain, and notices to policyholders is eliminated.[17] The financial motivation is eliminated because there is no longer an expectation that the primary insurance plan holder pay for the specified care. This allows proposals like EOB suppression to be more viable solutions for protecting dependents'

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[10] Abigail English et al., *Confidentiality, Third-Party Billing, & the Health Insurance Claims Process: Implications for Title X*, National Family Planning & Reproductive Health Association (2015), https://health.maryland.gov/pophealth/Documents/Local%20Health%20Department%20Billing%20Manual/PDF%20Manual/Section%20IV/Natl%20FP%20Title%20X%20Confidential%20and%20Covered.pdf.
[11] *Id.*
[12] Restatement (Second) of Contracts § 33 (Am. Law. Inst. 1981).
[13] Abigail English et al. *supra* note 2 at 6.
[14] Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 § 1302 (2010).
[15] *Id.*
[16] *Preventive Care Benefits for Adults*, HealthCare.gov, https://www.healthcare.gov/preventive-care-adults/ (last visited Nov. 13, 2021).
[17] Abigail English et al. *supra* note 2 at 6.

confidentiality, since there will no longer be a fear of violating general contract law by failing to send an EOB.[18]

Protections for minors may also be included in the contract language for health insurance policies.[19] For example, a New York Medicaid MCO contract includes a clause that reads, "The Contractor must ensure that any Enrollee's, including a minor's, use of Family Planning and Reproductive Health services remains confidential and is not disclosed to family members or other unauthorized parties, without the Enrollee's consent to the disclosure."[20] This is significant because it indicates that there could be flexibility to address confidentiality through negotiation with insurance providers about the terms of insurance contracts and policies, as opposed to, or side by side with, seeking legislative or regulatory change.[21] For example, UPMC is one insurance provider who has decided on its own to protect minor and dependent confidentiality through UPMC portals for adolescents and electronic distribution of EOBs.

B. State Law

Most states have several laws that directly or indirectly result in disclosure of confidential health information as a result of the billing and health insurance claims processes.[22] For example, in California, the "Confidentiality of Medical Information Act" provides:

> A provider of health care or a health care service plan may disclose [without authorization of the patient] medical information as follows:…to an insurer, employer, health care service plan, hospital service plan, employee benefit plan,

[18] *Id.*
[19] Abigail English et al. *supra* note 10 at 9.
[20] *N.Y. Medicaid Managed Care/Family Health Plus/HIV Special Needs Plan Model Contract*, New York State Department of Health (March 2014), https://www.health.ny.gov/health_care/managed_care/docs/medicaid_managed_care_fhp_hiv-snp_model_contract.pdf.

[21] Abigail English et al. *supra* note 2 at 17.
[22] Abigail English et al. *supra* note 10 at 14.

> governmental authority, contractor, or other person or entity responsible for paying for health care services rendered to the patient, to the extent necessary to allow responsibility for payment to be determined and payment to be made.[23]

The most common types of communications that result in disclosures are EOBs and denials of claims.[24] While not every state has law explicitly requiring the sending of an EOB for all insurance claims, the use of EOBs is almost universal in the health system. EOBs are often required by state law to make insurance holders aware of actions taken and charges incurred under their insurance policies.[25]

In terms of confidentiality for minors, some states explicitly bar disclosure of information or records regarding services for which minors may legally consent unless the minor gives permission for disclosure.[26] Other states give discretion to health care professionals to disclose certain information to parents or guardians in specific situations, regardless of whether the minor gives permission for such disclosure. When state or federal law does not address whether or when a minor's confidential information can be disclosed to parents or guardians, the HIPAA Privacy Rule gives discretion to health care providers to exercise medical judgment and make the disclosure determination.[27] Part IV of this brief explores different states and federal approaches to minor and dependent confidentiality in detail.

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[23] CAL. CIV. CODE § 56.10(c)(2).
[24] Abigail English et al. *supra* note 10 at 14.
[25] Abigail English et al. *supra* note 2 at 4.
[26] Abigail English et al. *supra* note 10 at 9.
[27] 45 C.F.R. § 164.502(g)(3)(ii)(C) (1996).

C. Federal Law

i. Title X

The Title X Family Planning Program is a federal grant program created to provide comprehensive and confidential family planning services and preventive health services.[28] The program prioritizes serving low-income individuals and is implemented through grants to clinical sites, including public health departments and non-profit health centers.[29] The law consists of "strong confidentiality requirements and a requirement that reimbursement be sought from potentially liable third parties, such as Medicaid and commercial health insurers."[30] Title X-funded health centers are required to hold "all information concerning the personal facts and circumstances of a patient" confidentially.[31] These confidentiality regulations apply to both adolescents and adults.[32]

Title X health centers are starting to encounter more patients with commercial health insurance, such as dependents who remain on their parents' policies.[33] Thus, these centers now face the challenge of complying with relevant federal and state law, along with the communication requirements imposed by insurance policies and related contracts, while attempting to maintain confidentiality of dependent patients.

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[28] 42 U.S.C. § 300 (1970); *What is Title X? An Explainer*, Physicians for Reproductive Health, https://prh.org/what-is-title-x-an-explainer/ (last visited Nov. 13, 2021).
[29] *What is Title X? An Explainer*, Physicians for Reproductive Health, https://prh.org/what-is-title-x-an-explainer/ (last visited Nov. 13, 2021).
[30] Abigail English et al. *supra* note 10 at 1.
[31] *Id.* at 4.
[32] *Id.* at 10.
[33] *Id.* at 2.

ii. HIPAA and Parental Rights Under the HIPAA Privacy Rule

HIPAA is a "federal law that mandated the creation of national standards to protect sensitive patient health information from being disclosed without the patient's consent or knowledge."[34] The U.S. Department of Health and Human Services (HHS) issued the HIPAA Privacy Rule to implement the requirements of HIPAA.[35]

The HIPAA Privacy Rule has both strengthened confidentiality protections and created opportunities for Protected Health Information ("PHI") to be disclosed.[36] It confers special confidentiality protections that limit disclosures, particularly when disclosures would place patients in danger.[37] However, it also allows for disclosures connected to billing and payment, which potentially undermine these confidentiality protections.[38] Under the Rule, health care providers, health plans, and insurers are permitted to disclose, without consent from the patient, confidential PHI for "treatment, payment, or health care operations."[39]

On the other hand, the Rule also provides protections specifically for minors. Generally speaking, a parent of an unemancipated minor is considered the authorized representative of the minor.[40] Nevertheless, there are certain situations in which the Rule considers minors as having

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[34] *Health Insurance Portability and Accountability Act of 1996 (HIPAA)*, Centers for Disease Control and Prevention, https://www.cdc.gov/phlp/publications/topic/hipaa.html (last updated Sept. 14, 2018); Health Insurance Portability and Accountability Act of 1996 (HIPAA), Pub. L. No. 104-191, 110 Stat. 1936 (codified as amended in scattered sections of 18, 26, 29, and 42 U.S.C.).
[35] *Health Insurance Portability and Accountability Act of 1996 (HIPAA)*, Centers for Disease Control and Prevention, https://www.cdc.gov/phlp/publications/topic/hipaa.html (last updated Sept. 14, 2018); 45 C.F.R. § 164 (2003).
[36] Abigail English et al. *supra* note 10 at 4.
[37] 45 C.F.R. § 164.522(b)(2)(iv) (2003).
[38] *Id.*
[39] 45 C.F.R. § 164.502(a)(1)(ii) (2003).
[40] *Does the HIPAA Privacy Rule Allow Parents the Right to See Their Children's Medical Records?*, HHS.gov (Dec. 2002), https://www.hhs.gov/hipaa/for-professionals/faq/227/can-i-access-medical-record-if-i-have-power-of-attorney/index.html.

the legal capacity to consent for their own health care.[41] In these situations, the parent would not be considered the minor's personal representative. Thus, the parent would not have access to PHI related to the care.[42] Protection under the Privacy Rule is not bulletproof. Even in these exceptional situations, the parent may still have access to the medical records and the EOB when State or other applicable law requires or permits.[43] Thus, it is imperative to push for the passage of state laws like House Bill 1654 to prevent the holes in the HIPAA Privacy Rule from permitting disclosure.

iii. The Employee Retirement Insurance Security Act ("ERISA")

ERISA is a "federal law that sets minimum standards for most voluntarily established retirement and health plans in private industry to provide protection for individuals in these plans."[44] It applies to "health plans, funds, or programs that an employer establishes or maintains for the purpose of providing benefits ERISA covers to their beneficiaries."[45] An important provision of ERISA requires commercial health plans to send notice to the participant or beneficiary of any adverse benefit determination.[46] Under the law, adverse benefit determinations can include situations where the participant is financially responsible for paying any part of the claim, such as copayments and coinsurance.[47] Additionally, ERISA requires health plans to "provide adequate notice in writing to any participant or beneficiary whose claim for benefits under

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[41] Abigail English et al. *supra* note 10 at 8; 45 C.F.R. § 164.502(g)(3)(iii) (2003).
[42] 45 C.F.R. § 164.502(g)(3)(iii) (2003).
[43] *Does the HIPAA Privacy Rule Allow Parents the Right to See Their Children's Medical Records?*, HHS.gov (Dec. 2002), https://www.hhs.gov/hipaa/for-professionals/faq/227/can-i-access-medical-record-if-i-have-power-of-attorney/index.html.
[44] *ERISA*, U.S. Department of Labor, https://www.dol.gov/general/topic/health-plans/erisa (last visited Nov. 13, 2021); Employee Retirement Income Security Act of 1974 (ERISA), Pub. L. No. 93-406, 88 Stat. 829 (codified as amended at 29 U.S.C. §§ 1001-1461 and in scattered sections of 5, 18, and 26 U.S.C.).
[45] Jamille Fields et al., *Confidentiality & Explanation of Benefits: Protecting Patient Information in Third Party Billing*, HARV. L. SCH. CTR. HEALTH L. & POL'Y INNOVATION, 1, 3 (Aug. 2016).
[46] Pub. L. No. 93-406 § 716(f).
[47] Jamille Fields et al., *supra* note 45.

the plan has been denied."[48] According to the definitions of "participant" and "beneficiary" provided in the law, these denial notices could be sent either to the insurance holder or to the dependent.[49]

As a federal law, ERISA supersedes state or local law when it conflicts with the federal law.[50] This is known as preemption and is a result of the Supremacy Clause of the U.S. Constitution, which declares that federal law is "the supreme law of the land."[51] At first glance, it may seem like ERISA's requirement to send notice of adverse benefit determinations would preempt state legislation such as House Bill 1654 since the bill's mandate to hold certain information confidential directly conflicts with ERISA's requirements. However, ERISA provides for a safe harbor, known as the savings clause, which allows laws regulating insurance to avoid preemption.[52] Courts have interpreted the savings clause to "allow states to regulate traditional insurance carriers conducting traditional insurance business."[53] Here, sending EOBs tends to involve traditional insurance carriers conducting traditional insurance business. Thus, House Bill 1654 would not be preempted by ERISA.

D. Parental Rights

The territory of adolescent medical autonomy is quite complex. This is a result of the fact that generally, parents are legally entitled to make medical decisions for their minor children, unless there is an exception. Two categories of teen consent exceptions exist. These are mature

[48] Pub. L. No. 93-406 § 716(f).
[49] Abigail English et al. *supra* note 10 at 13.
[50] U.S. CONST. art. VI.
[51] *Id.*
[52] Pub. L. No. 93-406 § 514(b)(2)(A).
[53] *ERISA Preemption Primer*, National Academy for State Health Policy (March. 2009), https://www.nashp.org/wp-content/uploads/sites/default/files/ERISA_Primer.pdf.

minor exceptions—when a minor has capacity, which is the legal ability to consent to care—and subject matter exceptions—when public health aims supersede parental control rights.[54]

Additionally, children have a constitutional right to bodily integrity.[55] At the same time, parents have a constitutional right under the 14th Amendment to control their children.[56] It quickly becomes clear how these rights can begin to conflict with each other. There is often no single right answer when it comes to balancing these rights; however, case law such as *Parents United for Better Schools, Inc. v. School District of Philadelphia Board of Education* may provide guidance. In this case, the Eastern District Court of Pennsylvania held that a voluntary school program for condom distribution did not offend parental rights regarding the custody and care of their children.[57] The court also held that a parental consent requirement would infringe students' privacy rights.[58] The court in this case was explicit about its process in balancing both the rights of children and parents and, in the end, came to the conclusion that children's privacy rights outweighed the rights of parents to control their children in this situation.[59]

In terms of parental rights under the HIPAA Privacy Rule, this answer is also not crystal clear. As described above, there are certain situations, such as minors seeking reproductive health care, where parents would not necessarily be considered personal representatives of their child, and thus would not have a right to the relevant health information; however, this is a rebuttable presumption.[60] State law may rebut this presumption and allow for disclosure.[61] If state law is

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[54] *See generally*, Hill, Beatrice Jessie, Medical Decision Making by and on Behalf of Adolescents: Reconsidering First Principles (April 10, 2012). Journal of Health Care Law & Policy, Vol. 15, 2012, Case Legal Studies Research Paper No. 2012-10, Available at SSRN: https://ssrn.com/abstract=2038091
[55] *Doe v. Taylor I.S.D.*, 15 F.3d 443 (5th Cir. 1994) (en banc), *cert. denied, Lankford v. Doe*, 513 U.S. 816 (1994).
[56] *Troxel v. Granville*, 530 U.S. 57 (2000).
[57] *Parents United for Better Schools, Inc. v. School Dist. of Philadelphia Bd. of Ed.*, 978 F. Supp. 197, 211 (E.D. Pa. 1997).
[58] *Id.* at 199.
[59] *Id.* at 212.
[60] 45 C.F.R. § 164.502(g)(3)(iii) (2003).
[61] 45 C.F.R. § 164.502(g)(3)(ii)(C) (1996).

silent, the minor's health care provider must exercise professional judgment to grant or deny parental access to the medical information.[62] This is exactly why legislation like House Bill 1654 is crucial for protection of minors' privacy. House Bill 1654 would eliminate the gray area of an individual health care professional's professional judgment and would obligate the health care provider not to disclose the information.

Overall, parents do have significant rights when it comes to the health care information of their minor children. This makes sense as parents have interests in the care, custody, and control of their children.[63] Additionally, minors do not have the right to consent to any and all treatment, only those specified by state law.[64] Parents need to have the ability to access records regarding the care for which minors cannot consent to, since childen themselves cannot access them. However, this does give rise to tension between a parents right to accessing their child's medical records and the child's right to confidentiality with respect to certain care allowed by the state. Disclosure becomes a matter of whether the care sought by the minor fits within a given exemption and whether any state law or health care provider permits disclosure of the information to parents. When it comes to the care we have discussed throughout this brief—care that is often stigmatized—a lack of confidentiality for the minor can result in danger and shame to the minor. Thus, EOB suppression is necessary to protect the health and safety of minor and dependent individuals seeking stigmatized care, notwithstanding the valid concerns of the parents' rights position.

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[62] *Id.*
[63] 530 U.S. at 57.
[64] 35 PA. CONST. STAT. § 10101; 35 PA. CONST. STAT. § 10103.

IV. Comparative Survey of EOB Suppression Laws

When a law is introduced by a politician, that law rarely passes out of the chamber without extensive modification by other members. One common consideration in evaluating the desirability of laws, including HB 1654, is by comparing the provisions of this bill to similar laws in other states. Fourteen states; California, Colorado, Connecticut, Delaware, Florida, Hawaii, Illinois, Maine, Maryland, Massachusetts, New York, Oregon, Washington, and Wisconsin, currently have some form of confidentiality protection similar to that called for in HB 1654[65]. The Pennsylvania bill accords with seven of these other states in directly requiring insurance providers to provide confidentiality when affirmatively requested by the dependent beneficiary.[66] Specifically this method is used by California, Colorado, Oregon, Maryland, Illinois, New York, and Washington. Before exploring the details and differences between the Pennsylvania provision and the seven similar provisions, it is worth reiterating that these statutes apply only to the degree allowed by federal statute, including those discussed previously.

A. Eligibility and Requesting Confidentiality

The proposed Pennsylvania House Bill specifically provides that health insurers must provide a readable and standardized form for qualified dependents to request that confidential information be communicated in an alternative method.[67] The dependent could then request information be sent to a different address, sent to a specific email address, or be withheld until an alternative method is requested at a later date.[68] The California law is more permissive, allowing

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[65] Protecting Confidentiality for Individuals Insured as Dependents, https://www.guttmacher.org/state-policy/explore/protecting-confidentiality-individuals-insured-dependents (last visited Nov. 14, 21).
[66] H. R. 1654, 2021-2022 Gen. Assemb., Reg. Sess. (Pa. 2021).
[67] Id.
[68] Id.

dependents to request communications in "the form and format requested by the individual, if it is readily producible" and allows insurers the option to require such requests be made either in paper or electronically.[69] Maryland, Massachusetts, and Oregon follow California's more permissive lead.

For example, Oregon allows any beneficiary of any age to request confidential communications, requires insurers to provide a standardized request but other methods are permissible, and requires insurers to then send the requested information directly to the dependent rather than the policyholder.[70] Massachusetts requires only a clear request in writing and an affirmation that disclosure would lead to danger or limited access to future services before allowing changes in physical or electronic addresses confidential information is to be sent to.[71] Finally, Maryland's Senate Bill 790 which was signed into law in 2014 requires a standard form be developed, but that insurers still accept alternative written methods.[72] These four states and the proposed bill in the Pennsylvania House of Representatives ensure a relatively consistent scheme that protects both minor and adult dependents who are able to consent to medical treatment.

The three remaining states that require affirmative requests for confidentiality take a more complicated approach than those described above. For example, Washington state has different rules for adult versus minor dependents. For adult dependents, protection is granted, "if the individual clearly states in writing that disclosure to specified individuals of all or part of that information could jeopardize the safety of the individual."[73] Alternatively, minor information must be protected unless the minor affirmatively consents to disclosure.[74] While the Washington system

[69] Id.
[70] Or. Rev. Stat. § 743B.555 (2015).
[71] Mass. Gen. Laws ch. 1760, § 27 (2018).
[72] S. 790, 2014 Gen. Assemb., Reg. Sess. (MD. 2014).
[73] Wash. Admin. Code § 284-04-510 (2001).
[74] Id.

has two separate requirements and obligations depending on if the dependent is a minor or an adult, the Colorado statute only protects information for adult dependents. This is not to say that minors are unprotected. Instead, privacy protections derive from a patchwork of several statutes and state regulations.[75] In contrast to the permissive, California-style statute, Illinois provides protection but only to Medicaid enrollees. Those covered under private insurance are instead subject to state regulations that indeed require disclosures and do not allow for dependents to request a more private alternative.[76]

B. Sensitive and Protected Information Subject to Suppression

Returning to the proposed Pennsylvania bill, once a confidentiality request is submitted, only certain information is eligible for protection under HB 1654. Specifically, the bill protects explanations of benefits; information related to an appointment for health care services; a claim denial; a request for additional information related to a claim; a notice of a contested claim; the name and address of a provider, a description of services provided and other visit information; and any written, oral or electronic communication from a carrier that contains protected health information.[77] While other states provide general grants to protect "sensitive", "substance use", "mental health", or "reproductive health" services, some are more like Pennsylvania and have a specific list of information that cannot be adjusted via state regulations.[78]

Massachusetts, New York, Washington, and Wisconsin specifically provide protections related to Explanations of Benefits. Taking two specific examples from this group, both

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[75] Abigail English et. al., Protecting Patients' Privacy in Health Insurance Billing & Claims: A Colorado Profile, https://www.nationalfamilyplanning.org/file/confidential--covered/A_Colorado_Profile.pdf.
[76] Abigail English et. al., Protecting Patients' Privacy in Health Insurance Billing & Claims: An Illinois Profile, https://www.nationalfamilyplanning.org/file/confidential--covered/Illinois_StateProfile_CC.pdf.
[77] H. R. 1654, 2021-2022 Gen. Assemb., Reg. Sess. (Pa. 2021).
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Massachusetts and Washington decide what services should be private. Beyond that specific protection, Massachusetts entrusts the State's Division of Insurance to develop guidelines that "define sensitive health care service" for the purposes of the privacy legislation.[79] This allows for a more flexible approach that quickly responds to complaints, public pressure, and judicial decisions without the arduous process of amending the original legislation.

In contrast to the broad grant of authority to a state agency taken in the Massachusetts statute, Washington takes the enumeration approach and specifically lays out that:

> Notwithstanding any insurance law requiring the disclosure of information, a licensee shall not disclose nonpublic personal health information concerning health services related to reproductive health, sexually transmitted diseases, chemical dependency and mental health, including mailing appointment notices, calling the home to confirm appointments, or mailing a bill or explanation of benefits to a policyholder or certificate holder, if the individual who is the subject of the information makes a written request. In addition, a licensee shall not require an adult individual to obtain the policyholder's or other covered person's authorization to receive health care services or to submit a claim.[80]

The Washington statute also creates an interesting concern with enumeration. When a statute takes the care to outline exactly what is and is not protected, it may be more stable, as mentioned above, but it also poses the risk of courts declining to protect similar information that is not explicitly included. For example, the Washington statute protects adult individuals from needing to obtain the policyholder's permission for certain procedures; however, the explicit and specific language could mean that minors, otherwise able to consent to certain sensitive medical treatments will still need approval of the policyholder. This drastically limits the practical benefit of the statute unless a court steps in and saves it. This is especially awkward since Washington elsewhere holds that insurers cannot disclose private health information, including through an EOB, without the minor's

[79] Mass. Gen. Laws ch. 1760, § 27 (2018).

[80] Wash. Admin. Code § 284-04-510(2)(a) (2001).

authorization.[81] How the courts may decide to reconcile those two sections is always uncertain, and without knowing in advance how Pennsylvania courts would resolve it, it is uncertain exactly how many people would, in fact, be protected by H.B. 1654.

The final approach to what medical information should be covered is one taken by Oregon and other states like Colorado. While Oregon primarily relies on statutory protection and Colorado focuses on regulatory protections, both incorporate HIPAA protections on the state level. Both states incorporate some of the same standards as those in HIPAA. These include defining protected information as all individually identifiable health information, including demographic data, medical histories, test results, insurance information, and other information used to identify a patient or provide healthcare services or health care coverage. It also means that the states make various provisions for when disclosure would place a dependent in danger. As mentioned above, some states require a statement of potential harm to be part of the confidentiality request whereas others omit that particular factor.

Illinois is an example of the most overt borrowing from HIPAA for their state schema. The Medical Patient Rights Act directly points to federal regulations promulgated in accordance with HIPAA.[82] While convenient, even more so than handing the issue to state regulators, this leaves the state law in the uncomfortable position of being subject to the whims of federal agencies. Overall, the Pennsylvania bill is an early draft and will certainly develop as it moves through committee and a senate counterpart is proposed. Some of the examples here will be useful when it comes to filling out the skeleton of the bill in its current form.

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[81] Id at § 284-04-510(3)(b)

[82] 410 Ill. Comp. Stat. 50/3(d) (2020).

V: Looking Ahead

Pennsylvania House Bill 1654 currently has twenty sponsors and co-sponsors in the 203-member lower house of the General Assembly. Every single one of those Members is a Democrat, despite the fact that both houses of the legislature are controlled by Republicans. Clearly any chance for this bill to pass for the foreseeable future requires bipartisan support which will certainly involve significant tinkering. A simple example is found in HB 1654 Section 635.8(f), which prescribes that health insurers acknowledge receipt of a protected enrolled dependent's confidential communications request form by providing notice to the protected enrolled dependent through the alternative method of communication as requested by the protected enrolled dependent. Nevertheless, the bill does not clearly provide protections for communications approving, denying, or requesting additional information from a protected defendant regarding their confidential communications request.

Beyond such peripheral concerns the Pennsylvania bill could avoid some of the issues of general protection vs enumerated protections illustrated above by explicitly listing a series of statutorily protected information and granting a general privacy protection who' specifics shall be promulgated by the Pennsylvania Department of Health or other appropriate agency. This allows for legislatures to fix certain central privacy rights in the relatively stable medium of statute while preserving the ability of the state government to respond to changing circumstances. This would not only mean that the state government was able to respond to novel problems but changes in state laws.

For example, when Pennsylvania legalized medical cannabis, protection of the controversial substances use is unlikely to be specifically authorized in statute, especially statutes that predate such legalization. While the legislature weights the appropriateness of adding newly

approved treatments to the statutory scheme, regulators could provide a stop-gap under their delegated authority, providing guidance to insurers and some protection in any subsequent litigation. Since the legislation is broadly drafted, this may be less of a concern but considering the critical nature of health information privacy, certainly it is better to provide a multi-pronged system of protection so that even if courts later limit the reach of either the statute or later regulations, petitioners still have the ability to avail themselves of the other protection.

Another possible change that may improve H.B. 1654, would be adopting an exception for dependent's regardless of age, who would be in danger if certain information were not suppressed. Some states only require an affirmative averment that disclosing the contested information would place the dependent in danger, without further investigation or justification. Alternatively, the state could require that an Administrative or magisterial authority review such petitions with specific claims describing the danger the dependent claims to be in. In either case, this also adds increased flexibility because it allows petitioners to request confidentiality based on their unique situation without requiring a general statutory or regulatory principal to justify their request.

Continuing along the mention of a dependent's age, HB 1654 could be amended to explicitly provide that all the protections contained therein apply to dependent over the age of 18 and minors otherwise legally able to consent to the procedure related to the information they are asking be suppressed. This seems like the widest demographic the bill could apply to without risking a clash with other laws. If the legislature were to otherwise set a firm age, say 16 years old, it would likely fall to the courts to decide if the policyholder was entitled to information about procedures that the dependent could not consent to on their own.

This would almost invariably involve a conflict between one parent or guardian who consents to the procedure and another parent or guardian who is the policyholder but remains

ignorant about the procedure. Any such conflict would implicate the parental and contract rights discussed above and certainly risk alienating some parents and legislators who worry the state is interfering with an intimate familial relationship. In multiple areas, activists may reasonably hope H.B. 1654 will provide the greatest amount of protection allowed under the law and with the least possible burden to policy dependents. Exactly how expansive any bill can be while securing passage would require detailed and care conversations with state leadership in both parties of the legislature and an existing lobbying plan by activists including which provisions are non-negotiable.