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State Policies Affecting the Assurance of Confidential Care for Adolescents

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Developing independence is one of the central tasks of adolescence. As such, adolescents should be assured confidentiality in their interactions with health care professionals. Time alone with providers not only facilitates open communication but also encourages adolescents to assume more personal responsibility for their own health care. Yet, not all adolescents need or want confidential access to health care services. They may be comfortable with their parents knowing that they are receiving health care services or even willing to involve their parents in obtaining care. But for some adolescents, seeking parental consent is difficult, and, in some cases, impossible because of family dysfunction or the adolescents' fear of embarrassment, disapproval, or even punishment. For these adolescents, a guarantee of confidentiality can be the deciding factor in whether they seek necessary health care services. This is particularly true for services generally considered to be sensitive -- family planning, sexually transmitted disease (STD) screening and treatment, mental health treatment, and substance abuse treatment.

Adolescents themselves have reported that privacy concerns play a significant role in their reluctance to seek health care and that requiring parental consent and notification may cause them to forego essential health care, especially reproductive and sexual health care.[1,2,3,4,5,6,7] National data, for example, show that requiring parental consent for birth control discourages adolescents from seeking family planning services, but not from engaging in sexual activity.[8,9] In addition, anecdotal reports from providers underscore that requiring consent for mental health and substance abuse services, particularly if an adolescent has a troubled relationship with a parent, can be an impediment to receiving services. For these adolescents, it is widely recognized by professional medical organizations that getting them needed health care services should take precedence over parental consent or notification. The Society for Adolescent Medicine, the American Academy of Pediatrics, the American College of Obstetricians and Gynecologists, the American Academy of Family Physicians, and the American Academy of Child and Adolescent Psychiatry all have formal policy statements espousing the importance of confidentiality protections for adolescents.[10] All states, therefore, have granted at least some adolescents the right to consent independently for the receipt of one or more types of health care services.

This fact sheet provides an overview of states' minor consent laws and new

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information on the use of explanation of benefit (EOB) statements by state Medicaid agencies and their contracting managed care organizations. It explains how and why EOBs are used and addresses the implications of these policies for adolescents and for providers.[11]

Minor Consent Laws Vary Widely by State

Individual states establish the age at which adolescents reach majority, becoming adults who are able to make their own legal decisions, including those about health care. While four states have established 19 or 21 as this age, all others have established 18 as the age of majority. Adolescents under age 18, therefore, are generally considered minors who require parental consent before receiving any health care services.

Both federal and state laws, however, make exceptions, authorizing minors to consent to one or more types of health care services. Federal law allows minors to receive family planning services without parental consent at Title X-funded family planning clinics[12,13] and also from participating Medicaid providers.[14] In addition, laws in all states explicitly give certain minors the right to consent to specific services that might include general medical care and sensitive services.

Our analysis of minor consent statutes in 2008 shows that 27 states allow some minors the right to consent independently for general medical care, an important factor for adolescents who need to access all health care services on their own. There is only one state in which all adolescents may consent on their own for general medical care, although there are three in which adolescents over a certain age -- 14, 15, or 16 -- may consent.[15] The other 23 states permit minor consent only for adolescents who meet specific criteria, which, depending on the state, might include adolescents who are high school graduates, serving in the military, pregnant, married, or legally emancipated from their parents. Minor consent protections for general medical care are absent in the remaining 24 states, but adolescents who are legally emancipated, married, or serving in the military are usually able to consent for general medical care, irrespective of explicit authority granted under minor consent statutes.[16]

With respect to sensitive services, all states allow minor consent for at least one service, typically for adolescents who are 12 or older. Research conducted by the Guttmacher Institute in 2008 shows that, only 15 states, including the four mentioned above, grant minors the right to consent for four key sensitive services -- family planning, STD screening and treatment, outpatient mental health treatment, and substance abuse treatment. Minor consent for STD services is permitted in all states, although the age of consent is 14 in five states and 16 in one. Minor consent for substance abuse treatment is authorized in the vast majority of states, but for family planning services and also for outpatient mental health services, is permitted in only about half of the states.[17] Also, about two-thirds of the states that allow minors to consent for mental health care allow minors to consent for psychotropic medications.[18] Although we found that minor consent laws in a small number of states require parental notification, it is usually limited to particular circumstances -- an HIV diagnosis, receipt of a prescribed psychotropic medication, or at a specified point in the course of mental health or substance abuse treatment.[19] A few other states require only that providers make reasonable efforts to engage parents in the adolescent's treatment.[20]

Private and Public Insurance Practices Often Negate Confidentiality Protections

Importantly, however, even where parental notification is not required, the right to consent independently for services is not sufficient to guarantee confidentiality. Administrative and billing practices used by Medicaid and private insurers may eviscerate the confidentiality protections made possible by minor consent laws. The major problem is the practice of mailing home EOB statements to publicly insured individuals or privately insured policy holders. These statements can violate adolescents' confidentiality even where the right of minors to consent for certain services is afforded by federal or state law. Because EOBs generally list the recipient's name, services provided, a description of the services, dates of service, and providers' information, parents reading these statements would then have knowledge of services an adolescent received, regardless of whether the adolescent consented independently.

Commercial and public insurers have different EOB policies. Commercial insurers routinely send EOBs to the policy holder, as required by insurance regulations in almost all states. State Medicaid programs are not required by state or federal law to send EOBs, but our survey of state Medicaid agency staff found that states do send them for fee-for-service recipients, although their contracting managed care organizations (MCOs) generally do not.[21] With respect to the State Children's Health Insurance Program (SCHIP), we found that policies appear to vary depending on the type of program (Medicaid or non-Medicaid) and whether Medicaid or another agency, such as the state department of insurance or a private insurer, administers the program. For adolescents enrolled in Medicaid SCHIP expansions (32 states), the EOB policies followed by state Medicaid agencies and their MCOs would apply. For those in separate SCHIP programs (37 states),[22] EOBs would not be sent by Medicaid or any other administering agency.[23] They would only be sent by participating MCOs in programs administered by agencies other than Medicaid; in these programs, SCHIP enrollees are essentially incorp-orated into commercial MCOs.

EOBs for Medicaid Services Are Not Mailed Routinely

In nearly all states, the confidentiality of Medicaid-insured adolescents would be compromised if either the MCOs in which they were enrolled or the Medicaid agencies themselves mailed EOBs home. Perhaps contrary to expectations, we found that adolescents enrolled in MCOs are not likely to have their confidentiality protections violated. Medicaid MCOs typically have broad discretion in determining their EOB policies. States, as federally mandated, require MCOs to send EOBs whenever a claim for service has been denied,[24] but only three of the 42 states responding to our survey reported requiring their participating MCOs to send EOBs routinely for all covered services, while only one state (Minnesota) reported prohibiting MCOs from mailing EOBs for sensitive services. The other states provide no directives to MCOs regarding the use of EOBs. Yet, based on our interviews with six large national commercial health plans serving the Medicaid population and six nonprofit plans with predominantly public enrollment, it appears that Medicaid MCOs do not send EOBs to Medicaid enrollees except as required by the state.[25]

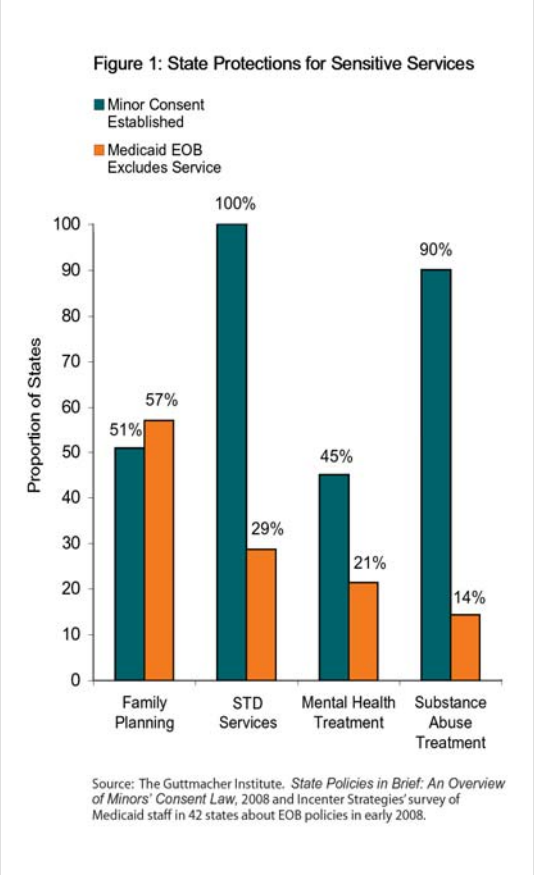
In the vast majority of states, Medicaid-insured adolescents who are not enrolled in MCOs but are enrolled in primary care case management systems (PCCMs) or are otherwise receiving services on a fee-for-

service basis have less assurance of confidentiality protections. State Medicaid agencies have sole discretion in determining whether to mail EOBs, and the vast majority have chosen to do so. Among the 42 states responding to our survey, we found 37 states, 88%, in which EOBs are mailed home by the state Medicaid agency. The other five states include three (Arizona, Georgia, and Texas) that do not send EOBs or similar documents but two others that have a mandatory MCO enrollment policy and are among the three states requiring their MCOs to send EOBs routinely.

EOBs are used by state Medicaid agencies in an effort to comply with the federal verification regulation enacted to combat fraud. According to CMS, EOBs *per se* are not federally required but are viewed by states as a simple and inexpensive method of verifying services. The regulation requires only that states "have a method to verify whether services reimbursed by Medicaid were actually furnished to recipients."[26] The actual method to be used is not specified. There are other means of complying with the regulation -- including retrospective provider record reviews and site visits -- that do not compromise patient confidentiality.

Importantly, we found that state agencies do not send EOBs every time a provider files a claim. Rather, each month or quarter, a small sample of recipients -- 400 to 500 -- are sent an EOB, or a similar document like the Recipient Explanation of Medical Benefits (REOMB) or a Medical Service Verification letter. These statements list the services provided and request that the recipient confirm receipt of the services. Our analysis shows that, while about half of the 42 states reported sending the statements directly to the adolescent, the other half reported sending them to the parent or head of the household.

Recognizing that EOBs can violate recipients' confidentiality, many states have policies in effect to exclude certain services. Unlike minor consent laws, however, these policies are not designed specifically with minors' health care needs in mind; rather, they apply to all Medicaid enrollees. Family planning services are the most commonly excluded, while many fewer states exclude STD services, mental health services, and substance abuse treatment services,[27] as shown in Figure 1. Interestingly, no state excludes from EOB mailings all four sensitive services important for adolescents.



Aligning Medicaid Policies to Ensure Confidentiality

To maintain confidentiality protections afforded under federal and state law, the services for which minors are able to consent would need to be excluded from EOB mailings by states and participating MCOs. We found, however, that only one state (Florida) has fully aligned its minor consent laws with its EOB policies, excluding from EOBs all of the services for which adolescents can consent independently under state law. In the majority of states, there appears to be little consistency between state minor consent laws and the exclusion of particular services from EOBs. Moreover, most states' EOB policies fail to account for the federal confidentiality protections established for adolescents receiving family planning services from Medicaid providers, including Title X providers.

Yet, where policies are aligned for specific services, confidentiality for family planning is most likely to be protected. In 11 states, adolescents are assured confidential access to family planning services. These 11 states allow minor consent for family planning services and also exclude them from EOB mailings. The assurance of confidential access to the other sensitive services is less common -- only nine states align their consent laws and EOB policies for STD services, only four states align them for mental health services, and only three states align them for substance abuse treatment services.

As a result of these policy inconsistencies, even in the states with broad minor consent laws, an adolescent's confidentiality would be compromised if he or she were selected for an EOB mailing. In fact, among the 15 states that allow minor consent for the four sensitive services important for adolescents, none have structured their EOB policies so as to assure adolescents' confidentiality for all four services, with three states having no EOB confidentiality protections at all.

Adolescents are not the only ones who are negatively affected by these practices. Providers also are affected when health insurance practices interfere with the delivery of confidential care. Providers concerned about their adolescent patients' confidentiality are likely to be reluctant to bill for sensitive services, knowing that the Information could be disclosed to an adolescent's parent if the adolescent were included in the EOB sample. As a result, some providers either modify the billing code used[28] or forego reimbursement entirely.[29] They may also refer adolescents to family planning clinics or public health department STD clinics that can guarantee confidentiality, but this can undermine the delivery of integrated care and lead to fragmentation of services.

Conclusions

Minor consent laws are imperative if adolescents are to be able to seek sensitive health care services independently. These laws exist to ensure that adolescents receive services that are vital to their health. Without such laws in place, adolescents might feel compelled to forego services. All states have recognized the importance of minor consent for sensitive services and allow it for at least one service -- STD screening and treatment. Many more states might consider expanding minor consent to mental health and family planning services, particularly in light of data showing high rates of mental, behavioral, and emotional problems among adolescents and a teenage pregnancy rate that is consistently higher than that of most other industrialized countries.[30]

Equally important to preserving adolescent confidentiality is ensuring that Medicaid administrative practices do not inadvertently divulge adolescents' service use. The U.S. General Accountability Office (GAO) has put Medicaid on its list of government programs that are at "high risk" of fraud, waste, and abuse, and state Medicaid agencies commonly use EOBs or similar documents in an effort to combat fraud. Yet, for a variety of reasons, the effectiveness of the EOB and similar documents as fraud detection tools is questionable. States process millions of Medicaid claims each month, but EOBs are sent to a very small sample of recipients. In addition, some states have reported that most EOBs do not get returned and those that do are often in error. Further, many EOB recipients call their providers with questions about the statements, thus alerting the provider and undermining efforts to detect possible fraud.

States seeking to safeguard adolescents' confidentiality can comply with the federal verification regulation through other means, including retrospective provider record reviews and site visits. In states that perceive these techniques to be too costly or complex and prefer to rely on the EOB, every effort should be made to exclude the services for which minor consent is allowed under federal and state law.

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Endnotes

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[9] Reddy, Fleming, and Swain, 2002.
[10] Morreale MC, Stinnett AJ, and Dowling EC, eds. *Policy Compendium on Confidential Health Services for Adolescents, 2nd Edition*. Chapel Hill, NC: Center for Adolescent Health and the Law, 2005.
[11] More extensive analyses of state minor consent laws and judicial interpretations are available from the Guttmacher Institute (www.agi.org), the Center for Adolescent Health and the Law (www.cahl.org), and the National Center for Youth Law (www.youthlaw.org).
[12] 42 CFR 59.11.
[13] Title X does not expressly grant minors the right to consent for family planning services; rather, it requires confidentiality. As a result, minors may effectively give their own consent for services.
[14] 42 U.S.C. 1396d(a)(4)(c).
[15] Findings based on Incenter Strategies' review of state minor consent statutes in February 2008.
[16] In the vast majority of states legally emancipated adolescents are explicitly or implicitly given the right to consent for their own medical care. In five states, the courts may determine the scope of the emancipated adolescent's rights, which may or may not include the right to consent independently for medical care. Julianelle P, Mabe M, Reeg B, and Wolf K. *Alone Without a Home: A State-by-State Review of Laws Affecting Unaccompanied Youth.* Washington, DC: National Network for Youth, 2003.
[17] The Guttmacher Institute. *State Policies in Brief: An Overview of Minors' Consent Law*. New York: Guttmacher Institute, 2008.
[18] Of the nine states that allow minor consent for mental health services but not psychotropic medication, five explicitly prohibit minors from consenting independently for medication, and four allow minor consent for counseling services only, with an implied exclusion of medication. Incenter Strategies' review of state minor consent statutes in February 2008.
[19] Parental notification is required in one state for an HIV diagnosis, in two states for psychotropic medications, in four states after a specified number of mental health visits, in one state after completion of substance abuse treatment, and in one state as soon as practicable in the course of substance abuse treatment. Incenter Strategies' review of state minor consent statutes in February 2008.
[20] In states where parental notification is not required, providers still have discretion in deciding whether to notify parents about the receipt of services for which minors can consent independently. In some states, this discretion is explicit in the statute.
[21] Incenter Strategies surveyed state Medicaid agencies about their EOB practices in January and February 2008. Forty-two states (82%) responded to the survey.
[22] Eighteen states operate combination SCHIP programs.
[23] This is explained by the fact that separate SCHIP programs are not operated as fee-for-service programs and, in addition, are subject to fewer federal requirements.
[24] The Balanced Budget Act of 1997 requires Medicaid MCOs to notify enrollees in writing whenever a decision is made to deny a service authorization request or to authorize a service in amount, duration, or scope that is less than requested. 42 CFR 438.210 – Coverage and Authorization of Services.
[25] Incenter Strategies interviewed 12 of the largest MCOs serving the Medicaid population about their EOB practices in March 2008.
[26] 42 CFR 455.20 – Recipient Verification Procedures.
[27] Federal law establishes strong confidentiality protections with respect to a provider's disclosure of substance abuse treatment records and any information that could identify a patient as a drug or alcohol abuser. It does not authorize minors to consent independently for substance abuse treatment services. The law pertains to all providers of alcohol or drug abuse diagnostic, treatment, or referral services who receive any form of federal financial assistance, including Medicaid. In order for information to be submitted to a third-party payer, the minor must provide written consent. However, providers are not prohibited from refusing to provide treatment without such consent. See 42 §USC 290dd-2 and 42 CFR Part 2. See also Substance Abuse and Mental Health Services Administration. *Welfare Reform and Substance Abuse Treatment Confidentiality: General Guidance for Reconciling Need to Know and Privacy. Technical Assistance Publication (TAP) Series 24*. Rockville, MD: SAMHSA, U.S. Department of Health and Human Services, 1999. Available at http://kap.samhsa.gov/products/manuals/taps/24.htm. Accessed April 21, 2008. Substance Abuse and Mental Health Services Administration. *Confidentiality of Patient Records for Alcohol and Other Drug Treatment. Technical Assistance Publication (TAP) Series 13*. Rockville, MD: SAMHSA, U.S. Department of Health and Human Services, 1994. Available at http://kap.samhsa.gov/products/manuals/taps/13.htm. Accessed April 21, 2008.

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