“Ask Abigail”: Protecting Adolescent Confidentiality in Health Care

By Abigail English, JD

Between December 2014 and January 2017, Abigail English, JD, of the Center for Adolescent Health & the Law, presented a series of webinars on confidentiality in collaboration with the School-Based Health Alliance. The topics of the five webinars included a basic introduction to adolescent consent and confidentiality under state and federal law as well as confidentiality issues related to billing and insurance claims, electronic health records and web portals, and services for LGBTQ youth. In January 2017, SBHA provided an additional opportunity to listen to the webinars and pose questions related to their subject matter. Questions selected for response have been revised to make the responses relevant for a broad audience located in different states.

Each of the questions raises complex issues; resolving them ultimately depends on the application of both federal and state law to the facts of a specific situation. State laws vary, so the responses provided here are designed to highlight general considerations relevant to each question rather than to provide a specific response based on one state’s law. Each response also includes a listing of relevant resources. The responses are not legal advice and do not replace consultation with an attorney familiar with the laws in a particular state.

For each question it is essential to consider, at minimum:
- Which federal or state laws are relevant?
- Do other governmental or institutional policies, standards, or opinions address the question?
- Do ethical standards or practice guidelines provide specific guidance?

When minors receive a prescription – such as for birth control or anti-depressant medications – are they able to fill the prescription on a confidential basis?

Whether a minor is able to fill a prescription confidentially would depend initially on an important threshold question: can the minor legally receive the treatment represented by the prescription on a confidential basis? This in turn depends on whether the minor is allowed to consent for that treatment without parental consent being required.

State law generally determines whether a minor is legally allowed to consent for specific care. These laws vary from state to state. In all states some minors are allowed to consent for their own care based on their status (e.g., living apart from parents or being of a certain age); also in all states minors are allowed to consent for some specific services without parental consent (e.g., diagnosis and treatment for STDs). In about two thirds of states minors are explicitly allowed to consent for contraception by state law; in all states minors are also able to consent for contraception when the services are funded by Medicaid or the federal Title X Family Planning Program. Two thirds of states authorize minors to consent for outpatient mental health services; some of these laws exclude psychotropic medication and others only provide for consent to counseling.

When minors are able to consent for their own care, both federal and state laws may provide confidentiality protection. The federal HIPAA Privacy Rule treats minors who consent for their own care as “individuals” with rights to control their own protected health information (PHI); HIPAA also defers to state and other applicable law (such as Title X or Medicaid).
on whether parents have access to that information. Many state laws that allow minors to consent for care also provide confidentiality protection for information about the care; some allow health care providers to inform parents to protect the minor’s health. Title X and Medicaid both provide confidentiality protection when minors receive family planning services funded by those programs.

In addition to the laws that directly address consent and confidentiality requirements for minors, other laws govern pharmacies and the filling of prescriptions. For example, state pharmacy boards are responsible for overseeing compliance with state pharmacy practice acts. The National Association of Boards of Pharmacy has published the Model State Pharmacy Act and Model Rules. The Model Act and accompanying rules include numerous provisions that address the necessity for pharmacies to protect the confidentiality of patients’ health information; specifically, the Model Act incorporates by reference many of the requirements of the HIPAA Privacy Rule for handling PHI. Also some state pharmacy practice acts explicitly recognize that minors sometimes have the right to consent for their own care and that certain confidentiality protections may apply in those situations.

In addition to the pharmacy practice acts, some states have laws that specifically allow pharmacists to refuse to dispense contraception. Specific rules also apply to emergency contraception (EC). Plan B One-Step and its generic forms are available without a prescription (“over the counter” or OTC) to individuals of any age in all states. Other versions of EC may require a prescription depending on specific provisions of state law. Some states explicitly require pharmacies to fill valid prescriptions for EC.

Ultimately whether a minor is able fill a prescription confidentially would depend at minimum on the purpose of the prescription, whether the minor can consent to the treatment associated with that prescription, what general confidentiality protections are required by state or federal law, and the specifics of state laws governing pharmacies, as well as the HIPAA Privacy Rule.

Resources

- Center for Adolescent Health & the Law. [www.cahl.org](http://www.cahl.org).
- National Center for Youth Law. [www.youthlaw.org](http://www.youthlaw.org).

Does a positive pregnancy test trigger an obligation to make a report under child abuse reporting laws?

Every state has a child abuse reporting law that obligates most professionals who work with children and adolescents to report known or suspected instances of child abuse to child welfare and/or law enforcement agencies. Health care providers are included among the mandated reporters. The federal Child Abuse Prevention and Treatment Act (CAPTA)
also includes requirements for what states must include in their child abuse reporting laws to qualify for certain federal funds. The specific provisions of the child abuse reporting laws vary from state to state. Multiple types of harm are included: physical abuse, sexual abuse, emotional abuse, and neglect. Most states also include sexual exploitation as reportable abuse. The definition of sexual abuse varies from state to state and may include different types of sexual assault. All states require reports when the abuser is the parent, guardian, or person responsible for the child; more than half of states also require reports of abuse by third parties. The federal Child Welfare Information Gateway contains a searchable database of state child abuse reporting laws.

Most of the information health care professionals have about their adolescent patients is protected by confidentiality requirements under state and federal law. Such requirements include those contained in the HIPAA Privacy Rule and in state medical privacy laws. Child abuse reporting laws sometimes override these confidentiality requirements.

In addition to child abuse reporting laws, states also have laws that impose criminal penalties when specific sexual acts occur with minors. These laws vary from state to state based on the ages of the “victim” and “perpetrator,” or the ages of the sexual partners. The relationship among child abuse reporting laws, laws criminalizing sex with minors, and confidentiality laws is often a source of confusion for health care professionals. Acts that violate state criminal laws – such as, for example, sexual intercourse with a minor under a certain age – do not always fall within the requirements of the state’s child abuse reporting law. This is because the definitions of reportable abuse and the definitions of sexual crimes involving minors do not necessarily match although they often overlap. Sexual activity that violates a state’s criminal law does not have to be reported simply because it is a crime; it is reportable if it fits the reporting law’s definition of reportable abuse or neglect.

A positive pregnancy test for an adolescent who is a minor may trigger an obligation to make a child abuse report but does not necessarily do so. If the pregnancy resulted from actions or behavior that fall within the state’s definition of sexual abuse, sexual assault, or sexual exploitation, a report would be required. Thus coercive or involuntary sexual activity would almost certainly require a child abuse report. When pregnancy results from voluntary sexual activity, particularly between partners of similar age, a report may or may not be required. The answer depends on a very specific analysis of the facts of the situation – such as the age of the partners – and the particular requirements of the state’s child abuse reporting law.

Resources

Is it permissible to prescribe antibiotics for the partner of a patient who is being treated for a sexually transmitted disease (STD) such as chlamydia or gonorrhea?

Health care professionals usually only prescribe medications, including antibiotics, for individuals who are their patients, whom they have examined, and for whom they have a health history. This is consistent with legal requirements, ethical guidelines, and best practice standards. Historically, treatment of patients’ partners for STDs has relied on notification of the partners by patients, their health care providers, or public health officials.

In recent years, recognizing the significant health risks posed by certain sexually transmitted diseases (STDs), such as chlamydia and gonorrhea, public health officials have developed a new approach known as expedited partner therapy (EPT). EPT is designed to reduce reinfection of individuals who have been treated for an STD as well as continued spread of infection by partners who have not been treated.

According to the Centers for Disease Control and Prevention (CDC), EPT is “the clinical practice of treating the sex partners of patients diagnosed with chlamydia or gonorrhea by providing prescriptions or medications to the patient to take to his/her partner without the health care provider first examining the partner.” (https://www.cdc.gov/std/ept/) Since 2006, the CDC has recommended EPT as an alternative strategy for certain populations and specific conditions.

Information provided by the CDC indicates that, as of December 2016, EPT is permissible in 38 states and the District of Columbia, potentially allowable in 8 states, and prohibited in 4 states. (https://www.cdc.gov/std/ept/legal/default.htm) The relevant legal authority may be found in diverse sources including state statutes, regulations, and court decisions that explicitly address EPT, attorney general or pharmacy board opinions, specific STD and infectious disease guidelines that are incorporated into law by reference, and laws specifying prescription requirements. The CDC online resource, “Legal Status of Expedited Partner Therapy (EPT),” includes an assessment of each of these factors for each state and the District of Columbia, with citations of the relevant authorities, and provides an indication of whether EPT in the state is permissible, potentially allowable, or prohibited.

Resources
- CDC. Expedited Partner Therapy. https://www.cdc.gov/std/ept/

When is a minor able to request that an explanation of benefits (EOB) be sent somewhere other than their home address?

In every state, the federal HIPAA Privacy Rule requires health care providers and health insurers to protect patients’ privacy. The rule includes a special protection that provides for confidential communications in specific situations. This special protection allows patients to request that they “receive communications of protected health information … by alternative means or at alternative locations.” (45 C.F.R. §164.522(b)(1)) Health care providers must accommodate reasonable requests and may not require patients to claim they would be endangered by disclosure; health plans must accommodate reasonable requests when there is a claim of endangerment. The HIPAA requirement regarding
confidential communications for health care providers differs from the requirement for health plans: plans are only required to comply with requests if endangerment is claimed.

Under the HIPAA Privacy Rule a minor would be able to exercise this right to request confidential communications, including a request to send an EOB somewhere other than their home address, if the minor qualifies as “an individual” under the rule and is able to claim endangerment if the request were not honored. Minors qualify as individuals under the HIPAA Privacy Rule if they are legally allowed to consent for their own care, and do so, or if their parents have acceded to a confidentiality agreement between the minor and the health care provider.

A few states have enacted statutes or adopted regulations to increase privacy protections for individuals who are insured as dependents on a family member’s plan. Some of these state laws specifically allow individuals to request redirection of their EOBs; others could be interpreted to do so. Some of these state laws build on the HIPAA Privacy Rule protection for confidential communications but are broader in scope than HIPAA: they provide protection in cases that do not involve a claim of endangerment or apply to all communications related to sensitive services. Some of the state laws protect minors as well as adults.

A minor in any state would be able to request that an EOB be sent somewhere other than their home address if they are legally allowed to consent to their own care and have done so – and thus qualify as an individual under the HIPAA Privacy Rule – and claim that they would be endangered if the EOB were sent to their home address. In a few states a minor would be able to request redirection of EOBs in other circumstances – such as for communications related to sensitive services – even without a claim of endangerment. There may be logistical challenges for minors in doing so, but most health insurers have some information on their website, often as part of their Notice of Privacy Practices, for how individuals can request confidential communications.

Resources

- Rights to Request Privacy Protection for Protected Health Information. 45 C.F.R. § 164.522.

Are there any model systems for protecting the confidentiality of adolescents’ health information in electronic health records (EHRs) and patient portals?

Protecting the confidentiality of adolescents’ health information in electronic health records (EHRs) and patient portals is an emerging issue of widespread interest and rapid development. Numerous health care sites and institutions have adopted different approaches to handling this issue. Various models are in use. There is no single or universal system that is ideal or appropriate in all situations; each model currently in use has both advantages and disadvantages.
EHRs and patient portals offer the potential for important benefits to patients and their health care providers. These electronic systems also involve risks of inadvertent disclosure of confidential information, such as through automated appointment reminders, problem and medication lists generated after visits, posting and notification of lab test results, and patient notes.

Several federal laws address various aspects of EHRs and patient portals: the Health Information Technology for Economic and Clinical Health Act of 2009 (HITECH), the Health Insurance Portability and Accountability Act of 1996 (HIPAA), and the Affordable Care Act of 2010 (ACA). None of these laws specifically address the issue of adolescent confidentiality in EHRs and patient portals. However, health care sites that provide care to adolescents are affected by some of the requirements of these laws that may have indirect implications for adolescent confidentiality. For example, the HITECH Act contains requirements related to EHRs, health information exchanges, and “meaningful use” that can affect the ability of health care providers and sites to protect the confidentiality of adolescents’ health information; the HIPAA Privacy Rule also includes many requirements relevant to health IT and privacy protection.

In order to comply with the legal requirements applicable to EHRs and patient portals while also adhering to the confidentiality protections mandated by state and federal law for adolescents who are both minors and young adults, health care institutions and sites have adopted varied approaches. Within electronic medical records (EMRs) and EHRs, some sites have negotiated with their vendors or their own IT staffs to customize the EMR or EHR to provide methods for recording different types of confidential information in ways that protect it from widespread access. With respect to patient portals, some systems are being structured in different ways during the adolescent years (e.g., ages 12 to 18): turn off access for both parents and adolescents; provide access for adolescents but not for parents unless adolescents give permission; or provide full access for adolescents and limited access for parents (e.g. for immunization records or other data not considered confidential). Each of these approaches is effective for some but not all purposes.

The American Academy of Pediatrics and the Society for Adolescent Health and Medicine have both issued detailed policy statements on adolescent privacy in the context of health information technology and electronic health records. Many sites are working with their vendors and IT staffs to modify EHR systems and patient portals in ways that are consistent with these recommendations and consistent with existing legal requirements and confidentiality protections.

**Resources**