Executive Summary: Health Impact Review of SSB 5889

Concerning insurance communications confidentiality (2019 Legislative Session)

Evidence indicates that SSB 5889 has the potential to improve confidentiality for protected individuals, which will improve access to and use of healthcare services and decrease inequities by age, gender identity and sexual orientation, and for victims/survivors of violence.

BILL INFORMATION

Sponsor: Dhingra

Summary of Bill:

- Requires health carriers to direct all communication regarding a protected individual's receipt of sensitive healthcare services directly to the protected individual receiving care.
- Prohibits health carriers from requiring protected individuals to obtain authorization from the primary policyholder to receive healthcare services if the individual has the right to consent to care.
- Allows protected individuals to request a health carrier limit disclosure of any information, including personal health information, to the protected individual or to an email address or telephone number specified by the protected individual regardless of whether the information relates to sensitive services.
- Prohibits health carriers and insurers from requiring a policyholder or primary subscriber to pay for charges for healthcare services if the policyholder has not authorized the receipt of healthcare services for a protected individual who has limited disclosure.
- Directs Office of the Insurance Commissioner to:
    - Develop a process to ensure compliance and to regularly collect information from carriers on requests for confidential communications in order to monitor the effectiveness of the process and education and outreach activities conducted by carriers to inform enrollees about their right to confidential communication.
    - Develop and make available a standardized form for protected individuals to request confidential communication.
    - Develop rules to implement this act.

HEALTH IMPACT REVIEW

Summary of Findings:

This Health Impact Review found the following evidence regarding the provisions in SSB 5889:

This review makes the **informed assumption** that some protected individuals will use the standardized process to limit disclosure of all personal health information, not just information related to sensitive healthcare services. This informed assumption is based on discussions with staff at the Oregon State Department of Consumer and Business Services.

- **A fair amount of evidence** that health carriers directing all communications regarding a protected individual's receipt of sensitive healthcare services directly to the protected individual receiving care; health carriers not requiring protected individuals to obtain

For more information:
Phone: (360) 628-7342
Email: hir@sboh.wa.gov
sboh.wa.gov/hir

authorization from the policyholder to receive healthcare services; and protected individuals using the standardized process to limit disclosure of all personal health information will improve access to and use of healthcare services for those protected individuals.

- **Very strong evidence** that increasing access to and use of healthcare services will improve health outcomes for protected individuals.
- **Strong evidence** that improved health outcomes will decrease inequities by age, gender identity and sexual orientation, and for victims/survivors of violence.

For more information:
Phone: (360) 628-7342
Email: hir@sboh.wa.gov
sboh.wa.gov/hir

Health Impact Review of *SSB* 5889

Concerning insurance communications confidentiality (2019 Legislative Session)

April 1, 2019

Staff contact:
Caitlin Lang-Perez
Phone: (360) 628-7342
Email: caitlin.lang@sboh.wa.gov

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Contents

Introduction and Methods

A Health Impact Review is an analysis of how a proposed legislative or budgetary change will likely impact health and health disparities in Washington State (RCW 43.20.285). For the purpose of this review 'health disparities' have been defined as the differences in disease, death, and other adverse health conditions that exist between populations (RCW 43.20.270). This document provides summaries of the evidence analyzed by State Board of Health staff during the Health Impact Review of Substitute Senate Bill 5889 (SSB 5889).

Staff analyzed the content of SSB 5889 and created a logic model depicting possible pathways leading from the provisions of the bill to health outcomes. We consulted with experts and contacted key informants about the provisions and potential impacts of the bill. We conducted an objective review of published literature for each pathway using databases including PubMed, Google Scholar, and University of Washington Libraries. More information about key informants and detailed methods are available upon request.

The following pages provide a detailed analysis of the bill including the logic model, summaries of evidence, and annotated references. The logic model is presented both in text and through a flowchart (Figure 1). The logic model includes information on the strength-of-evidence for each relationship. The strength-of-evidence has been defined using the following criteria:

- **Not well researched:** the review of literature yielded few if any studies or only yielded studies that were poorly designed or executed or had high risk of bias.
- **A fair amount of evidence:** the review of literature yielded several studies supporting the association, but a large body of evidence was not established; or the review yielded a large body of evidence but findings were inconsistent with only a slightly larger percentage of the studies supporting the association; or the research did not incorporate the most robust study designs or execution or had a higher than average risk of bias.
- **Strong evidence:** the review of literature yielded a large body of evidence on the relationship (a vast majority of which supported the association) but the body of evidence did contain some contradictory findings or studies that did not incorporate the most robust study designs or execution or had a higher than average risk of bias; or there were too few studies to reach the rigor of "very strong evidence;" or some combination of these.
- **Very strong evidence:** the review of literature yielded a very large body of robust evidence supporting the association with few if any contradictory findings. The evidence indicates that the scientific community largely accepts the existence of the association.

This review was subject to time constraints, which influenced the scope of work for this review. The annotated references are only a representation of the evidence and provide examples of current research. In some cases only a few review articles or meta-analyses are referenced. One article may cite or provide analysis of dozens of other articles. Therefore the number of references included in the bibliography does not necessarily reflect the strength-of-evidence. In addition, some articles provide evidence for more than one research question, so are referenced multiple times.

Analysis of SSB 5889 and the Scientific Evidence

Summary of relevant background information

- The Health Insurance Portability and Accountability Act of 1996 (HIPAA) established federal standards for use, disclosure, storage, and transfer of protected health information for healthcare providers, health plans, and healthcare clearinghouses.[1] These covered entities must receive patient authorization to use or disclose healthcare information.[1] Under HIPAA, covered entities must allow an individual to request restricted use and disclosure of protected health information.[1]
- As of March 1, 2019, 13 states have provisions to protect the confidentiality of individuals insured as dependents.[2] Five states (including Washington) allow "individuals insured as dependents to request confidential communications from their insurance provider via a written request."[2] Two states had confidentiality protections specific to EOBs. Six states explicitly protect the confidentiality of minors insured as dependents (i.e., 3 specific to STI treatment and 3 seeking any medical service). Three states, California,[3] Maryland,[4] and Oregon,[5] explicitly require insurers to provide confidential communications upon written request of insured dependents and each have adopted a common process and form, widely available online, by which patients may request confidential communication from insurers.
    - The Oregon Health Authority developed information for providers about the protections and outlined additional ways clinics/practices can support patients requesting confidential communication (e.g., have hard-copy versions of the standardized form available at the front desk, in exam rooms, and at check-out; ensure all staff are aware of and understand the new law).[6]
- In 2001, Washington State created the right for patients to submit a written request to limit disclosure by insurers of their health information (WAC 284-04-510).[7] The regulation contains "protections for individuals who would be jeopardized by disclosure, for individuals receiving a range of sensitive health services, and for minors who may obtain healthcare without parental consent."[7] The text specifically requires insurers to refrain from disclosing information regarding services for which a minor has consented without first obtaining authorization from the minor.[7,8] Young adult and adult dependents must submit a written request to limit disclosure. Patients are largely unaware of the protections and their right to request to limit disclosure.[7,9]
    - WAC 284-04-510 requires individuals requesting nondisclosure to contact their insurance company and provide: their name and address; description of the type of information that should not be disclosed; in the case of reproductive health information, the type of services subject to nondisclosure; the identity or description of the types of persons from whom information should be withheld; information as to how payment will be made for any benefit cost-sharing; and a phone number or email address where the individual may be reached if additional information or clarification is necessary to satisfy the request.[8]
    - The requirement that patients initiate the process by contacting their insurance company poses a unique burden for individuals, particularly minors and those experiencing abusive, coercive relationships.[9]

- In 2017, the Washington State Department of Health, in collaboration with the Departments of Corrections and Social & Health Services, Health Care Authority, and Office of Superintendent of Public Instruction released the Multi-Agency Unintended Pregnancy Prevention report. The multi-agency workgroup analyzed current programs, identified gaps, and recommended strategies to improve their overall impact on unintended pregnancy. The workgroup identified assurance of confidentiality for family planning and sexually transmitted infections (STI) and sexually transmitted diseases (STD) services as a gap and recommended two strategies for health plans to address confidentiality: 1) "have a universal form that clients can use to request that services be kept confidential and require that all health insurance carriers in Washington State use the standard form and have procedures in place to assure that the request is maintained"; and 2) "make it universally mandatory that all insurers always suppress [Explanation of Benefits (EOBs)] and other notices when it pertains to confidential services, regardless of cause. There would no longer be need to have 'good cause.'"[10]
- The Governor's Interagency Council on Health Disparities completed the Literature Review on Inequities in Reproductive Health Access as required by SSB 6219, Concerning health plan coverage of reproductive healthcare (Reproductive Parity Act, 2018 Legislative Session). The Council identified health insurance communication confidentiality as one barrier to accessing reproductive healthcare services. The Council recommended 14 actions the Washington State Legislature or state agencies could take to reduce or eliminate specific inequities in access to reproductive health services, including two recommendations related to insurance communication.[11]
- In 2018, the Dr. Robert Bree Collaborative (Bree Collaborative) adopted recommendations "to align care delivery with existing evidence-based, culturally sensitive standards of care for LGBTQ people in Washington State and, through that effort, decrease health disparities."12 The Bree Collaborative recommended health plans establish a simple process for dependents insured on another person's health plan to access confidential care using their insurance and to inform enrollees how to access this process.[12]

Summary of SSB 5889

- Requires health carriers to direct all communication regarding a protected individual's receipt of sensitive healthcare services directly to the protected individual receiving care.
    - A protected individual is defined as an adult covered as a dependent on the enrollee's health plan (e.g. spouse, registered domestic partner) or a minor who may obtain healthcare without the consent of a parent or legal guardian. It does not include individuals deemed not competent to provide informed consent for care.
    - Sensitive healthcare services include services related to reproductive health, sexually transmitted diseases, substance use disorders, gender dysphoria, gender affirming care, domestic violence, and mental health.
    - Communication includes written, verbal, or electronic communications, including bills and attempts to collect payment; notice of adverse benefits determinations; explanations of benefits notice; request for additional information regarding a

        claim; notice of a contested claim; the name and address of a provider; description of services provided; other visit information; any written, oral, or electronic communication from a carrier that contains protected health information.
- Prohibits health carriers from requiring protected individuals to obtain authorization from the primary policyholder to receive healthcare services if the individual has the right to consent to care.
- Allows protected individuals to request a health carrier limit disclosure of any information, including personal health information, to the protected individual or to an email address or telephone number specified by the protected individual regardless of whether the information relates to sensitive services.
- Prohibits health carriers and insurers from requiring a policyholder or primary subscriber to pay for charges for healthcare services if the policyholder has not authorized the receipt of healthcare services for a protected individual who has limited disclosure.
- Directs Office of the Insurance Commissioner to:
    - Develop a process to ensure compliance and to regularly collect information from carriers on requests for confidential communication in order to monitor the effectiveness of the process and education and outreach activities conducted by carriers to inform enrollees about their right to confidential communication.
    - Develop and make available a standardized form for protected individuals to request confidential communication.
    - Develop rules to implement this act.

Health impact of SSB 5889

Evidence indicates that SSB 5889 has the potential to improve confidentiality for protected individuals, which will improve access to and use of healthcare services and decrease inequities by age, gender identity and sexual orientation, and for victims/survivors of violence.

Pathway to health impacts

The potential pathways leading from the provisions of SSB 5889 to decreased health inequities are depicted in Figure 1. Based on discussions with staff at the Oregon State Department of Consumer and Business Services, we made the informed assumption that protected individuals will use the standardized process to limit disclosure of all personal health information, not just information related to sensitive healthcare services. There is a fair amount of evidence that health carriers directing all communications regarding a protected individual's receipt of sensitive healthcare services directly to the protected individual receiving care; health carriers not requiring protected individuals to obtain authorization from the policyholder to receive healthcare services; and protected individuals using the standardized process to limit disclosure of all personal health information will improve access to and use of healthcare services for those protected individuals.[13-18] There is very strong evidence that increasing access to and use of healthcare services will improve health outcomes for protected individuals.[15,19-21] In turn, there is strong evidence that improved health outcomes will decrease inequities by age,[14,22-32] gender identity and sexual orientation,[33-37] and for victims/survivors of violence.[11,38-42] Each of these factors is analyzed beginning on page 8.

Due to time limitations, we only researched the most direct connections between the provisions of the bill and decreased health inequities and did not explore the evidence for all possible pathways. The provisions outlined in SSB 5889 relate to private health carriers in the state, and do not apply to Medicaid plans (personal communication, Health Care Authority, March 2019). Therefore, this analysis is limited to the impacts on individuals who are privately-insured and not to individuals insured through Medicaid. There are already federal protections in place to ensure confidentiality for Medicaid clients, including HIPPA. In addition, Medicaid does not send EOBs for any service[43] and mechanisms are in place for clients to redirect communication or request limited disclosure. For example, adolescents who can consent to care may request that communication go to an address other than the head of household or primary policyholder, and individuals listed as dependents with Third Party Liability carriers may request to limit communications from their Third Party carrier (personal communication, Health Care Authority, March 2019). In addition, data from the 2013-2015 National Survey of Family Growth found that concerns about confidential reproductive healthcare were less common among those who were covered by Medicaid compared to those aged 15-17 years old covered under their parents' private insurance.[44]

Magnitude of impact

A national survey conducted in 2013 by Kaiser Family Foundation found that approximately 3% of women aged 18 to 25; 22% aged 26 to 44; and 24% aged 45 to 64 are covered as a dependent on a spouse/partner's employer-sponsored health insurance plan.[19] In Washington State, approximately 52% of individuals on a public employee plan (PEBB), school employee plan (SEBB), and political subdivision plan are enrolled as dependents (i.e. legal spouses, state-registered domestic partners, or children under the age of 26) (Table 1).

Table 1. Percentage enrolled as dependents on public employee, school employee, and participating political subdivision plans in Washington State, by insurance type[45]

	Total enrolled	Total dependents	Percentage dependents
Public employees (PEBB)	236,648	122,509	52%
School employees (SEBB)	8,389	4,784	57%
Participating county, municipal, or other political subdivisions employees (Political sub)	30,593	14,932	49%
TOTAL	**275,630**	**142,225**	**52%**

With the passage of the Patient Protection and Affordable Care Act (ACA) allowing adult children to stay on their parent's health insurance plan, the proportion of women aged 18 to 25 enrolled on their parent's healthcare plan increased fourfold from 2007 to 2014.[26] For example, the percentage of women aged 24 years old on their parent's insurance increased from 7% in 2007 to 60% in 2014.[26] A national survey conducted by the Kaiser Family Foundation found that nearly half of all women ages 18-25 years (45%) reported coverage through a parent's policy, "accounting for the single largest segment of coverage in this age group." Overall, among women aged 15-25 years, 79.3% were enrolled on their parent's plan; 16.3% were self-insured; and 4.4% were enrolled on their spouse's plan.[26]

Lastly, although individuals in Washington State may currently submit a written request to limit disclosure by insurers of their health information, data is not available about who is currently submitting requests or how many requests have been submitted. Therefore, we are unable to conclude how many additional individuals may submit requests as a result of SSB 5889. The Washington State Office of the Insurance Commissioner (OIC) currently receives inquiry/complaint calls regarding confidentiality and EOBs and does not anticipate the number of calls will change based on the provisions in SSB 5889.[46]

Logic Model

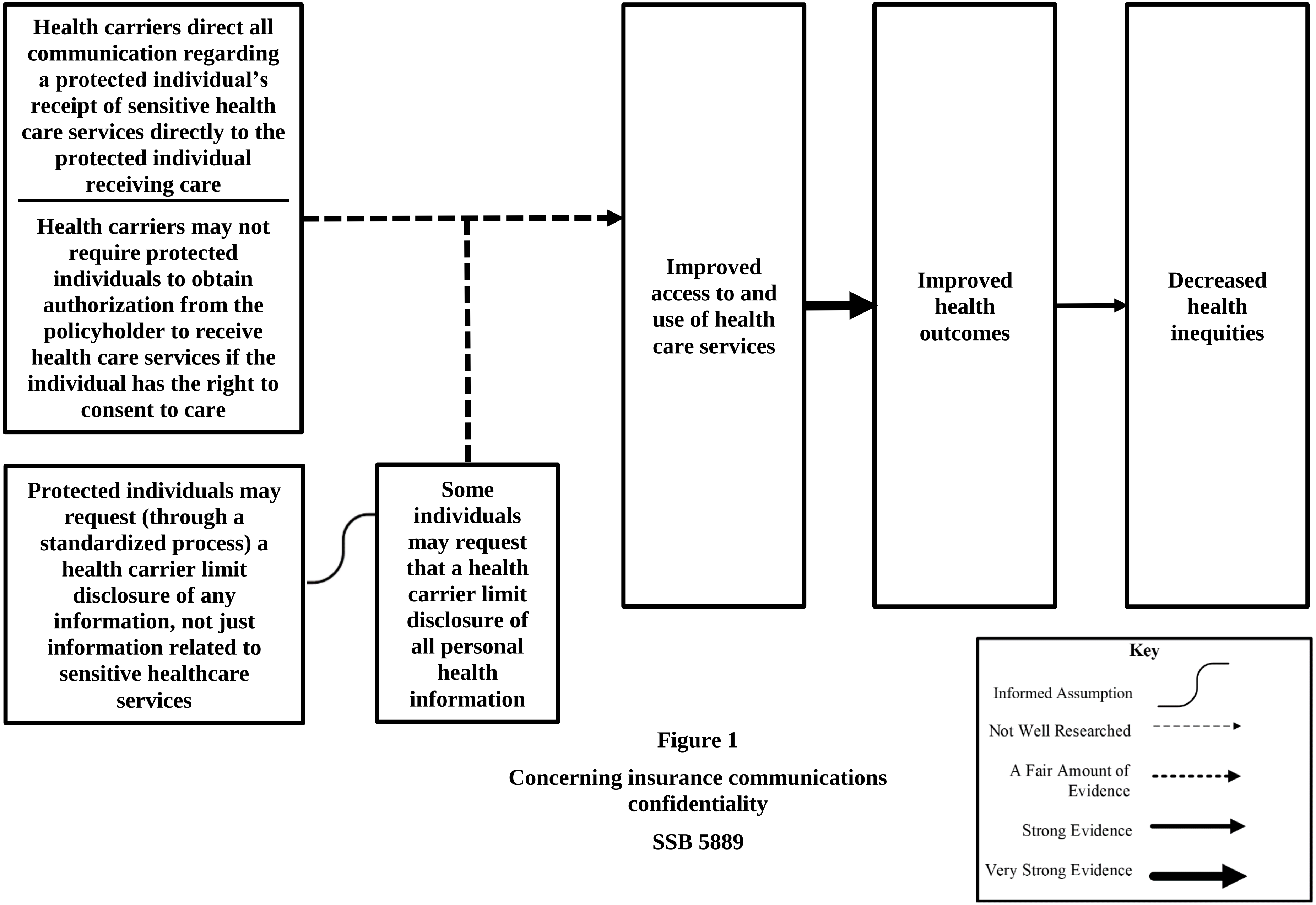

Figure 1

Concerning insurance communications confidentiality

SSB 5889

Summaries of Findings

Will having an option to use a standardized process to limit disclosure of all personal health information, not just information related to sensitive healthcare services, result in some individuals requesting to limit disclosure?

We made the informed assumption that some protected individuals will use the standardized process to limit disclosure of all personal health information, not just information related to sensitive healthcare services. This informed assumption is based on discussions with staff at the Oregon State Department of Consumer and Business Services.

In 2015, the Oregon Legislative Assembly passed House Bill 2758, which required a process be established for health insurance enrollees to redirect insurance communications containing protected health information.[47] The legislation required Oregon State Department of Consumer and Business Services (DCBS) to work with stakeholders to develop and make available to the public a standardized form for enrollees to use when making a confidential communications request.[47] Additionally, the bill required DCBS to report on: 1) the effectiveness of the process established to allow health insurance enrollees to redirect insurance communications containing protected health information; 2) the extent to which enrollees used the process; and 3) whether the process worked properly.[47]

DCBS reported that due to initial data collection issues (e.g., unable to identify reason for confidential communication request), "comparisons between the baseline data and the data for the first six months this law has been in effect can only give us a general idea of how well the law is working."[47] The report stated, "ninety requests for redirection of protected health information were made during the first six months of 2016, which is about 50% less than the number of requests made during the baseline period."[47] However, DCBS noted, "some reporting entities were unable to segregate these requests from other general requests for confidential communication limits our full understanding of the effectiveness of the new law."[47] During the first six months of 2016, entities reported 100% compliance with the processing requirements received by electronic or telephone and those made in hardcopy, up from 85% and 97% respectively during baseline.[47] DCBS learned of one complaint filed with insurers during the baseline period compared to 41 reported during the first six months after the law became effective.[47] Thirty-nine of the 41 complaints were made against one insurer. Meanwhile, DCBS did not receive any complaints regarding requests for confidential communications during the first six months of 2016.[47]

Board staff contacted DCBS to learn whether the department conducted a subsequent evaluation. A key informant shared that the legislation required an initial implementation assessment of the program, but it did not require ongoing monitoring of the program (Division of Financial Regulation [DFR], DCBS, personal communication, March 2019). Therefore, no subsequent evaluation has been conducted since the initial survey of insurance companies in 2016. The DCBS staff member who worked with stakeholders, including advocates and insurers, to establish the standardized request process has not received complaints from either group related to its implementation (DFR, DCBS, personal communication, March 2019). However, anecdotally, DCBS has heard that distrust of the insurance industry and its ability to follow through and maintain the level of privacy requested may still prevent some people from using the process (DFR, DCBS, personal communication, March 2019). Therefore, it is important that insurers clearly indicate on company webpages to whom enrollees should direct their forms. For example, DCBS worked with insurers to include links to the proper party (e.g., the responsible division, position, and title vary by company) on company websites (DFR, DCBS, personal communication, March 2019). The key informant recommended that the expectation be that insurers are responsible to properly address all requests for confidential communication. Thus, all staff members should be trained on what to do if they receive a misaddressed request for confidential services—who within the company to direct the request and how to do so (DFR, DCBS, personal communication, March 2019). This will help build trust in the system by ensuring requests are processed correctly and in a timely manner.

The DCBS staff member also recommended outreach with providers to inform patients of their right to request confidential communications. The Oregon Health Authority (OHA) developed information for providers about the protections and outlined additional ways clinics/practices can support patients requesting confidential communications.[6] Additionally, as department webpages change or are updated, OHA staff and DCBS staff coordinate to make sure appropriate links with information about confidential communication requests remain available and active for Oregon residents (DFR, DCBS, personal communication, March 2019).

Maryland Insurance Administration (MIA) staff reported it "does not collect data from health insurance providers related to [the use of the standard Request for Confidential Communications] form" (MIA, personal communication, March 2019). MIA does not know if patients use this form (MIA, personal communication, March 2019). Board staff also attempted to contact California regarding the effectiveness of the confidential communications request procedure/form. However, due to time limitations we were unable to speak with staff from California.

Based on discussions with staff in Oregon, we would expect that standardizing the process allowing protected individuals to request a health carrier limit disclosure of any information, not just information related to sensitive healthcare services would result in some number of individuals requesting confidential communications.

Will health carriers directing all communications regarding a protected individual's receipt of sensitive healthcare services directly to the protected individual receiving care; health carriers not requiring protected individuals to obtain authorization from the policyholder to receive healthcare services; and protected individuals using the standardized process to limit disclosure of all personal health information improve access to and use of healthcare services for protected individuals?

The provisions of SSB 5889 all aim to improve confidentiality for protected individuals. There is a fair amount of evidence that improved confidentiality for protected individuals will improve access to and use of healthcare services. The strength-of-evidence for this research question focused only on the literature for reproductive health services due to availability of published research. While some evidence looks at the impact of confidentiality concerns on access to mental health and behavioral health, there is less research in these areas and therefore this literature was not included in the strength-of-evidence analysis.

Reproductive health

Confidentiality of insurance communications has been documented as a barrier to accessing reproductive health services.[13-16] A nationally-representative survey of women (n=2,094) across 13 states receiving services at one of 22 family planning clinics, found that 32% of respondents reported they did not plan to use their insurance to pay for the visit.[14] Eighteen percent reported this was because they were worried someone might find out about the visit.[14] Similarly, a 2014 report from Kaiser Family Foundation stated that 61% of women aged 18-44 years and 71% of women aged 18-25 years reported it is vital that information about healthcare visits be kept confidential from a parent or spouse.[19] Among women aged 18-25 years, only 37% knew that private insurers typically send an EOB to primary policyholders. Moreover, "awareness is even lower among teens ages 15 to 18, where only 24% reported knowing that EOBs were typically sent to the home."[19]

Health plan communications sent to the primary policyholder (e.g., spouse, partner, parent, or guardian) for reproductive health services pose unique barriers for adolescents and young adults[48-50] and for individuals experiencing intimate partner violence (IPV).[9] Healthcare professionals have expressed concern about unintentionally exposing sensitive healthcare information about services received by a patient to their family members through parental viewing of a minor's electronic health record[50] or receipt of EOBs sent to the primary insurance policyholder for services sought by an adolescent, young adult, or adult dependent.[9,48-50]

In a 2016 position paper, the Society for Adolescent Health and Medicine, American Academy of Pediatrics, and American College of Obstetricians and Gynecologists recognized that "confidentiality is potentially violated by billing practices and in the processing of health insurance claims."[48] To address this problem, the organizations recommended "policies and procedures should be established so that healthcare billing and insurance claims processes do not impede the ability of providers to deliver essential healthcare services on a confidential basis to adolescents and young adults covered as dependents on a family's health insurance plan."[48]

Evidence indicates that confidentiality concerns are of particular importance to adolescents and young adults.[14,24-27,51] An analysis of 2013-2015 National Survey of Family Growth data showed that, overall, 7.4% of those aged 15-25 years covered as dependents on their parents/guardians' health insurance would not seek sexual or reproductive healthcare because of concern that their parents/guardians might find out about it.[25] However, when stratified by age, those aged 15-17 were more likely to report they would not seek care because of confidentiality concerns than those aged 23-25 (17.9% compared to 1.8%, respectively).[25] Additionally, female respondents aged 15-17 years and 18-25 years "who reported concerns about seeking sexual or reproductive healthcare because their parents might find [out] about it were less likely than those without these concerns to receive such services in the past year (19.9% [received services] compared with 34.0% for females aged 15-17, and 53.1% [received services] compared with 72.9% for females aged 18-25)."[25] There were no differences in the percentage of males aged 15-25, regardless of age, who received sexual or reproductive health services according to whether they had confidentiality concerns.[25]

Another survey of female patients accessing services at family planning clinics found that adolescent respondents were significantly more likely than those in their 30s to avoid using their insurance because of confidentiality concerns (31% versus 4%).[14] Similarly, a study conducted by the Centers for Disease Control and Prevention (CDC) found that women aged 18-25 years enrolled on their parent's plan were less likely to receive reproductive healthcare services and less likely to receive chlamydia testing compared to self-insured young women.[26] In contrast, young women enrolled on their parent's plan were more likely to receive the flu vaccine than self-insured women, suggesting that confidentiality may be more of a concern for sensitive health services and that concerns about confidentiality could result in young women foregoing reproductive healthcare services.[26]

Mental and behavioral health

Confidentiality of insurance communications has also been documented as a barrier to accessing mental health and behavioral healthcare services.[15,17,18] A national survey of college students conducted by the National Alliance on Mental Illness (NAMI) found that 50% of college students with a mental health concern stated that they did not disclose their mental health condition to their school.[17] Lack of trust that their medical information would remain confidential was among the top five reasons for not disclosing their mental health status.[17]

Overall, there is strong evidence that concerns about confidentiality serve as a barrier and limit access to healthcare services. However, since there is less research showing that removing confidentiality as a barrier would increase access to care, and because most research focuses on reproductive health services and adolescents and young adults, we have downgraded the strength-of-evidence for this pathway to a fair amount of evidence.

Will improved access to and use of healthcare services lead to improved health outcomes for protected individuals?

There is very strong evidence that increasing access to and use of healthcare services will improve health outcomes. Healthy People 2020 states that access to healthcare must be improved by increasing access to health insurance coverage, health services, and timeliness of care to promote and maintain health, prevent and manage disease, reduce unnecessary disability and premature death, and achieve health equity.[21] There is a large body of evidence supporting the positive association between use of health services for the early detection and treatment of physical and mental health disorders[20] and improved health outcomes. A report from the Kaiser Family Foundation stated, "clinical preventive care helps identify health problems earlier, allowing conditions to be treated or managed more effectively before they become more serious."[19] Specific to adolescents and young adults, the American Academy of Pediatrics has noted that "provider-initiated screening for physical and mental health conditions, early disease identification and prevention, health promotion, and anticipatory guidance are critical components of routine care for [adolescents and young adults]" and can change the health trajectory of youth into adulthood.[15]

Since there is strong consensus in the scientific literature supporting this association, we are providing only a few examples here. For example, the U.S. Preventive Services Task Force (USPSTF) found evidence to support that screening tests for HIV are accurate and that antiretroviral therapy (ART) reduces the risk of death and sexual transmission of HIV.[52] Another study from USPSTF found that behavioral therapy and pharmacotherapy in combination demonstrated an 82% increase in tobacco cessation when compared to minimal intervention or usual standard of care.[53] While these examples do not indicate that all treatments are effective, they illustrate that evidence-based treatments are available.

Will improved health outcomes for protected individuals decrease health inequities experienced by these groups?

There is strong evidence that SSB 5889 has the potential to decrease inequities by age, gender identity and sexual orientation, and for victims/survivors of violence.

Inequities by age (adolescents/young adults)

Evidence indicates that confidentiality concerns pose a particular barrier for adolescents and young adults.[14,22-27] One study found that adolescents would forgo care due to confidentiality concerns and that “adolescents who forgo care due in whole or in part to confidentiality concerns are a particularly high-risk population in need of healthcare services” because of higher rates of mental health difficulties, sexual/reproductive health risks, and substance use.[51] Another study found confidentiality was the top reason for adolescents to use publicly-funded family planning clinics (90%).[14] Results of a 1999 survey of sexually active girls, aged 12 to 17 years, seeking care at 33 Planned Parenthood clinics in Wisconsin showed parental notification upon seeking prescribed birth control would present a barrier to care.[22] Overall, 59% of girls indicated they would do one of the following: stop using all sexual healthcare services (48%), delay testing or treatment for HIV or other STIs, or discontinue use of some specific sexual healthcare services if their parents were informed that they were seeking prescribed contraceptives.[22] Of the 48% who said they would stop using all services if their parents were notified, girls reported they would resort to using condoms (57%), using withdrawal method (29%), or having unprotected sex (29%).[22]

Another survey of 156 adolescents and young adults aged 18-25 years found that concerns about parent-patient confidentiality were associated with lower willingness to start pre-exposure prophylaxis (PrEP) prescriptions as HIV prevention medication, suggesting a potential barrier to PrEP uptake.[24] The analysis found “individuals who indicated that they would not want their parents to know that they are taking PrEP had a 59% lower odds of using PrEP than those who would, after adjusting for covariates.”[24] A CDC analysis of 2013-2015 National Survey of Family Growth data found that “females [aged 15-25] with confidentiality concerns regarding seeking sexual and reproductive healthcare reported a lower prevalence of receipt of chlamydia screening (17.1%) than did females who did not cite such concerns (38.7%).”[27]

Adolescents and young adults have the highest rates of sexually transmitted diseases and infections (STDs/STIs) in the U.S.[28-32] According to 2017 Washington State data, adolescents and young adults accounted for 67.8% of the state’s chlamydia cases (9.0% and 58.8%, respectively).[11] Similarly, those ages 15-24 account for the highest rates of chlamydia and gonorrhea in the U.S.[54] In 2008, approximately 18% of all new HIV diagnoses nationally were among young people aged 13-24 years.[29] Therefore, avoiding care could impact the incidence of STIs among adolescent and young adult cohorts.[28] Additionally, national data from 2011 indicate that young adults aged 18-19 years and aged 20-24 years have the highest unintended pregnancy rates among any age group.[55] While unintended teen pregnancy has declined, U.S. rates are still higher than many other high-income countries, and barriers to accessing care necessary to improve a variety of reproductive health outcomes remain.[30,31,56]

Inequities by gender identity and sexual orientation

Evidence indicates that some gender and sexual minorities express concerns related to medical confidentiality, particularly adolescents and young adults (e.g., fear that information will be shared with their family).[33]

Gender minorities face inequities in reproductive health access in the form of economic, structural, and social oppression. For example, the transgender population is more likely to live in poverty and less likely to have health insurance than the general population.[34,35] Transgender people's access to health services is further limited by high levels of mistreatment and stigma encountered when seeking health services.[34,35] These barriers can contribute to worse health outcomes and unmet healthcare needs. One study found that transgender women, particularly transgender women of color, are at high risk of HIV.[34] In addition, individuals identifying as lesbian had lower odds of having a Pap test and lower rates of routine physical exams than heterosexual females.[36] The CDC recognizes that "while many [lesbian, gay, or bisexual (LGB)] youth thrive during adolescence, stigma, discrimination, and other factors may put them at increased risk for negative health and life outcomes."[37] CDC reported that about one-third of LGB youth are bullied at school or online, 16% experience sexual dating violence, and more than 47% have seriously considered suicide.[37]

Inequities experienced by victims/survivors of violence

Victims and survivors of violence face both unique and exacerbated barriers to accessing reproductive healthcare related to their experiences of violence and exploitation.[11] Published literature identified human trafficking (i.e., labor and sex trafficking), intimate partner violence (IPV), and sexual violence as detrimental to reproductive health service access. In addition, "while most of the literature related to violence focuses on cisgender women and girls and/or trans women, cisgender men and boys and trans men are also at risk for violence, particularly trafficking."[11] Due to the underground nature of human trafficking, it is difficult to estimate the prevalence of victims and survivors.[11]

Intimate partner behaviors that prevent individuals from accessing health services (e.g., limiting access to transportation or finances, physical violence, reproductive coercion) interfere with the individual's ability to prevent, screen, and address IPV and adequately fulfill sexual and reproductive health needs.[38-42] Data spanning from 1994 to 2010 from the Bureau of Justice Statistics show that females in their reproductive years experienced higher rates of IPV, particularly those aged 18-24 years and aged 25-34.[19,57] National data indicate that while men and women experience IPV at similar rates, women experience negative health impacts at higher rates than men do (27% compared to 11%).[58] Transgender people experience IPV at particularly high rates and 24% of respondents to the U.S. Transgender Survey reported severe physical violence by an intimate partner, compared to 18% of the U.S. population.[35] According to FUTURES, the federally-designated National Health Resource Center on Domestic Violence, "in addition to the immediate trauma caused by abuse, domestic violence contributes to a number of chronic health problems, including depression, alcohol and substance abuse, [and] sexually transmitted diseases such as HIV/AIDS."[59] Such violence may also result in pregnancy complications, including "low weight gain, anemia, infections, and first and second trimester bleeding are significantly higher for abused women, as are maternal rates of depression, suicide attempts, tobacco, alcohol, and illicit drug use."[59] Evidence also indicates that STIs, unintended pregnancy, substance use, and traumatic injury are among the most common physical effects of sex trafficking and commercial sexual exploitation.[60]

Since SSB 5889 has potential to improve reproductive health outcomes for adolescents and young adults, LGBTQIA people, and victims/survivors of violence, groups which already experience reproductive health inequities, SSB 5889 the has potential to decrease inequities.

Other considerations

We also explored whether limited disclosure in payment and billing communications could have unintended consequences, especially for minors enrolled on their parent's plan or dependents unable to pay a bill. For example, during public hearings on SSB 5889, concerns were raised about how to protect confidentiality of treatment if the parent is still responsible for payment and the EOB does not include description of services. We ultimately did not include this pathway in the logic model on page 7 because this pathway has not been well researched.

SSB 5889 (as amended in the House) includes a provision that would prohibit health carriers and insurers from requiring a policyholder or primary subscriber to pay for charges for healthcare services if the policyholder has not authorized the receipt of healthcare services for a protected individual who has limited disclosure. The bill also intends to use the rulemaking process to establish how health plans can collect payments (personal communication, Planned Parenthood Votes Northwest and Hawaii, March 2019). This provision is in line with recommendations offered in one study, noting that privacy protections best apply when there is no liability for payment, as parents should not be expected to pay for services if they receive no explanation of the services given.[28] In another model, key informants shared that Maryland defined a specific list of protected services that require no financial obligation for protected individuals so that protected individuals who cannot pay do not face negative financial ramifications for seeking care (Planned Parenthood Votes Northwest and Hawaii, personal communication, March 2019).

However, it is important to note that health carriers would not typically contact the policyholder for payment for a service (personal communication, Association of Washington Healthcare Plans, March 2019). Rather, providers collect copayment or coinsurance at the point of service, bill patients for services, and attempt to collect payment (personal communication, Association of Washington Healthcare Plans, March 2019). Carriers pay in-network providers directly for services after receiving a claim from the provider. Although a protected individual may direct their provider to send billing and payment communications to a specific address and phone number, SSB 5889 relates to insurance communications and does not address provider communications. Therefore, there is the potential that the confidentiality of protected individuals may be breached during provider communications and attempts to collect payment.

Providers may seek to collect payment for certain services that fall into the sensitive health service categories outlined in SSB 5889 (personal communication, Association of Washington Healthcare Plans, March 2019). For example, the ACA requires health plans cover 10 Essential Health Benefits, including ambulatory services, emergency services, hospitalization, maternity and newborn care, mental health and substance use disorder services (including behavioral health treatment), prescription drugs, rehabilitative and habilitative services and devices, laboratory services, preventive and wellness services and chronic disease management, and pediatric services.[15,19] Kaiser Family Foundation reports, “the ACA’s requirement for preventive services coverage without cost sharing includes a number of counseling services, screening tests, and supplies that could affect women’s access to reproductive and sexual health services, such as contraceptives, screening tests for [STIs] and HIV, and the Human Papilloma Virus (HPV) vaccine.”[19] While most “sensitive services” are preventive services and covered under the ACA with no cost-sharing,[28] coverage for some services (i.e. services that may not be preventive services) varies between plans.[15,19]

In addition, although some of the sensitive health service categories are clearly defined in statute (e.g., reproductive health services), other categories like domestic violence are intentionally broader to allow more general coverage. Key informants shared that this distinction is important because it provides guidance while allowing flexibility in rulemaking so that the policy can be implemented as intended.

Overall, since it has not been well-researched whether payment and billing communications may have unintentional consequences for confidentiality and since it is unclear whether provisions in SSB 5889 fully address these concerns, we did not include this pathway in the logic model.

Annotated References

Uncategorized References

1. **Research Office of Program. Bill Analysis: SSB 5889. Washington State House of Representatives; 2019.**
This Bill Analysis for SSB 5889 was prepared by the Washington State House of Representatives, Office of Program Research for the House Health Care & Wellness Committee. It includes background information related to the bill provisions and summary of the bill.

2. **Protecting Confidentiality for Individuals Insured as Dependents. Guttmacher Center for Population Research Innovation and Dissemination; March 1, 2019 2019.**
Guttmacher Institute provides an overview of state laws and policies protecting confidentiality for individuals insured as dependents. The page identified explanation of benefits forms (EOBs) sent by insurers to policy holders as one of the most frequent ways in which disclosures of receipt of sensitive services. As of March 1, 2019, 13 states had provisions to protect the confidentiality of individuals insured as dependents. Five states allowed "individuals insured as dependents to request confidential communications from their insurance provider via a written request." Two states had confidentiality protections specific to EOBs. Six states explicitly protect the confidentiality of minors insured as dependents (i.e., 3 specific to STI treatment and 3 seeking any medical service). California, Maryland, and Oregon explicitly require insurers to provide confidential communications upon written request of insured dependent and each provides a standardized form that clients can use when making their request. Colorado and Illinois limit confidential communication requests and protections to specific requesters. Additionally, two states have protections specific to EOBs; three states include confidentiality protections for minors specific to STI treatment. Maine allows minors to refuse parents' request for EOB or claim denial. In Hawaii, health care providers must inform the insurer when "minors without support" request confidentiality.

3. **Confidential Communications Request (CCR). Sacramento, California: California Department of Insurance; 2015.**
As of January 2015, California law obligates health insurers to honor a Confidential Communications Request (CCR) when the CCR requests that "sensitive services" information, as defined in the law, be kept from the policyholder, or when the CCR requests confidentiality of all health service information because disclosure of the information to the main policy holder could lead to harm or harassment. Under California law, when a CCR is submitted, health insurers must send communications directly to the insured individual noted above and NOT the holder of the policy. To comply with California law, health insurers must implement CCRs within 7 days of their receipt by electronic transmission or 14 days of receipt by first class mail. See Cal. Civ. Codes 56.05 and 56.107 and Cal. Insurance Codes 791.02 and 791.29.

4. **Request for Confidential Communications Form. Baltimore, Maryland: Maryland Insurance Administration; 2014.**
This Maryland Insurance Administration Request for Confidential Communications Form allows patients to determine where their health information gets sent after a healthcare visit. The common form is available on the agency's website as well as through multiple carriers' pages. According to the Code of Maryland (Insurance § 15-141), carriers are required to accept the

common form but are not limited from accepting any other form of written request from an enrollee.

5. **Oregon Request for Confidential Communication. Salem, Oregon: Department of Consumer and Business Services; 2016.**
The Department of Consumer and Business Services worked with stakeholders to develop and make available to the public a standardized form that an enrollee may submit to make a confidential services request. The form is available online as well as on-hand in provider offices. The form includes a disclaimer that it may take up tot 30 days from the date of receipt for a carrier or third party administrator to process the form.

6. **Protecting Patient Privacy: The Oregon Confidential Communication Request What Providers Need to Know. In: Authority OH, ed. Salem, Oregon: Oregon Health Authority; 2016:1-6.**
This Oregon Health Authority document aimed at medical providers describes House Bill 2758 (2015) and what it does and does not do in regards to protecting patient privacy in Oregon. The law "allows patients enrolled in private health insurance policy the right to request that protected health information be sent directly to them instead of the person who pays for their health insurance." Confidential communication requests cover: (1) an explanation of benefits (EOB); (2) Name and address of provider, description of services provided, or other visit information; (3) A claim denial; (4) A request for additional information about a claim; (5) A notice of a contested claim; (6) Any written, oral, or electronic communication described on this list that contains protected health information. The document details the common process by which requests are made, the timeline by which insurance companies are required to complete requests, and other ways that medical clinics/practices can support patients requesting confidential communication.

7. **English Abigail, Lewis Julie, Morales Monique, et al. Association NFPRH. Protecting Patients' Privacy in Health Insurance Billing & Claims: A Washington Profile. Confidential & Covered. Washington, DC: National Family Planning & Reproductive Health Association; September 2016 2016.**
This report was part of *Confidential & Covered*, a three-year research project led by the National Family Planning & Reproductive Health Association (NFPRHA) and funded by the U.S. Department of Health & Human Services' Office of Population Affairs as part of its Affordable Care Act Collaborative. This document provided a provide of the policy environment (as of January 2016) for confidentiality and insurance in Washington State based on interviews (in person and by phone) with key informants between October 2015 and December 2015, as well as a review of Washington State laws.

8. **Washington Administrative Code. In: Commissioner WSOotI, ed. *284.* Vol WAC 284-04-510. Olympia, Washington: Washington State Office of the Code Reviser; 2001.**
This Office of the Insurance Commissioner (OIC) Washington Administrative Code outlines patient rights to limit disclosure of health information. OIC's statutory authority is established in RCW 48.43.505.

9. **Gold Rachel Benson. A New Frontier in the Era of Health Reform: Protecting Confidentiality for Individuals Insured as Dependents. 2013.**
Gold reviewed current policies in various US states aimed at improving confidentiality with EOBs, particularly for minors and young adult dependents. The author notes that EOB suppression is also particularly important for individuals who experience intimate partner violence. Gold found some success of these policies with an additional need for improved education of patients rights to confidentiality and a national response to the issue. Looking to California, Colorado, Massachusetts, New York, Wisconsin, and Washington as examples revealed successful efforts to protect confidentiality with some significant limitations. Policies suppressing EOBs without a balance rely on the ACA ban on cost-sharing for certain sensitive services, and without the ACA or similar protection would provide little to no benefit to patients. Out-of-network providers (such as many safety-net providers) and non-preventative follow-up services such as STI treatment would carry a balance and thus this practice doesn't provide a full protection from EOB confidentiality breaches to patients seeking sensitive services. Limitations in other policies include the lack of patient and provider education on patient rights to confidentiality, and differing procedures between insurance providers to request confidentiality with EOBs. Policies in Colorado and Wisconsin requiring insurance providers to communicate directly with adult dependents would offer protections to spouses, domestic partners, and adult children, but would not provide protection to minors. Washington patients have long had the ability to suppress an EOB upon request for sensitive services, but few patients use this service due to lack of knowledge and requiring patient action. Gold recommends further patient education, improved protection from cost-sharing with safety-net providers, and a standardized national response to the issue of EOB confidentiality in the spirit of HIPAA.

10. **Multi Agency Unintended Pregnancy Prevention. Tumwater, Washington: Washington State Department of Health; March 2017 2017.**
The Washington State Department of Health (DOH) led a multi-agency effort to review current programs that work to address obstacles preventing family from having the necessary information to make informed family planning decisions. DOH, Health Care Authority (HCA), the Department of Social and Health Services (DSHS), Office of Superintendent of Public Instruction (OSPI), and Department of Corrections (DOC) "attended and actively participated in a workgroup to analyze their approach and develop new strategies for future efforts to improve their overall impact on unintended pregnancy." Among the gaps and strategies discussed, the report included confidentiality for family planning and STI/STD services and recommended creating a standard form clients can use to request confidential communication from their health plans. Additionally, it recommended making it "universally mandatory that all insurers always suppress EOBs and other notices when it pertains to confidential services, regardless of cause. There would no longer be need to have 'good cause.'" It provided examples from other states that have implemented universal policies and procedures (CA, OR, MD, MA).

11. **Disparities Governor's Interagency Council on Health. Report to the Legislature: Literature Review on Inequities in Reproductive Health Access. 2019.**
The Governor's Interagency Council on Health Disparities completed the Literature Review on Inequities in Reproductive Health Access as required by SSB 6219, Concerning health plan coverage of reproductive health care (Reproductive Parity Act, 2018 Legislative Session). The Council identified health insurance communications confidentiality as one barrier to accessing

reproductive health care services. The Council recommended 14 actions the Washington State Legislature or state agencies could take to reduce or eliminate specific inequities in access to reproductive health services, including two recommendations related to insurance communications.

12. **Collaborative Dr. Robert Bree. LGBTQ Health Care Report and Recommendations. Dr. Robert Bree Collaborative; 2018.**
In September 2018, the Dr. Robert Bree Collaborative (Bree Collaborative) adopted its LGBTQ Health Care Report and Recommendations in which it provided recommendations "to align care delivery with existing evidence-based, culturally sensitive standards of care for LGBTQ people in Washington State and, through that effort, decrease health disparities." The report cites evidence that LGBTQ persons experience elevated rates of depression, sexual abuse, smoking, and other substance use among other health disparities. The report includes recommendations regarding the importance of confidentiality for LGBTQ patients. For example, it recommends health plans "establish a simple process for individuals insured as dependents on another person's health plan (e.g., a minor using their parent's insurance) to access care confidentially using their insurance, and provide enrollees with clear and accessible information about how to access this process."

13. **Washburn K., Goodwin C., Pathela P., et al. Insurance and billing concerns among patients seeking free and confidential sexually transmitted disease care: New York City sexually transmitted disease clinics 2012. *Sex Transm Dis.* 2014;41(7):463-466.**
Washburn et al. surveyed New York City (NYC) Department of Health and Mental Hygiene (DOHMH) sexually transmitted disease (STD) clinic patients to examine the response to the prospect of billing insurance and charging sliding-scale fees for services. A total of 5,017 patients were surveyed from all those accessing clinic services between September and December 2012 across 8 NYC DOHMH STD clinics. The anonymous survey was provided to all patients, in English and Spanish. Nearly half of insured patients (48.4%) said that they would not be willing to share insurance information with the STD clinics. Moreover, 34.3% of men and 38.3% of women surveyed reported being concerned about receiving an EOB. The statistical analysis women were statistically significantly more likely than men to report confidentiality concerns. Additionally, the potential loss of billing confidentiality was "particularly problematic among younger respondents and those who were unemployed and worked part-time. In the comment sections of the survey, respondents expressed worry primarily about their insurance company or families knowing about an STD clinic visit."Authors concluded, "confidentiality concerns and income are potential obstacles to billing insurance or charging a direct fee for STD services. New York City DOHMH plans to take the concerns raised in the survey findings into account when designing our billing system and carefully evaluate its impact to ensure that the need for accessible, confidential STD services continues to be met."

14. **Frost J. J., Gold R. B., Bucek A. Specialized family planning clinics in the United States: why women choose them and their role in meeting women's health care needs. *Womens Health Issues.* 2012;22(6):e519-525.**
Publicly-funded family planning clinics provide contraceptive services to more than seven million women in the US every year. They tend to offer a broader range of contraceptive options, and often serve to refer patients to other primary care clinics in their communities. The authors

of this study sought to understand why patients choose to visit family planning clinics specializing in reproductive health, especially when they have access to other publicly-funded clinics that offer similar services. They conducted a survey to reach patients accessing care from specialized clinics located in communities that also had primary care centers. The survey asked the reasons for choosing the specialized clinic. The survey reached 2,094 women in 13 states, in a nationally representative sample of clinics. In the survey, nearly one-third (32%) of women reported that they did not plan to use their insurance to pay for the visit. Eighteen percent of them said that this was because they were worried someone might find out about the visit. When that subgroup was stratified by age, "teenagers were significantly more likely than women in their 30s to avoid using their insurance because of confidentiality concerns (31% versus 4%)." Confidentiality was the top reason for teens to use publicly-funded family planning clinics (90%). This study demonstrates that access to confidential family planning services is important to teenagers, and may even cause them to pay out of pocket rather than using family health insurance.

15. **Marcell A.V., Breuner C.C., Hammer L., et al. Policy statement: Targeted Reforms in Health Care Financing to Improve the Care of Adolescents and Young Adults. *Pediatrics.* 2018;142(6):1-9.**

This policy statement from the American Academy of Pediatrics (AAP) summarizes barriers that adolescents and young adults face in accessing timely and appropriate health care as well as barriers providers face providing care to adolescents and young adults. AAP finds that lack of insurance, limitations of coverage, variability of insurance plans, cost-sharing, inadequate provider reimbursement, and insufficient confidentiality in billing and insurance impact access to care for adolescents and young adults, especially for reproductive health, mental health, and behavioral health services. The authors state, "during the transition into adulthood, [adolescents and young adults] develop autonomy and may adopt high-risk behaviors that can cause serious and preventable morbidity and even mortality. Timely prevention and treatment of these problems during this transition can change the trajectory of health into adulthood…Provider-initiated screening for physical and mental health conditions, early disease identification and prevention, health promotion, and anticipatory guidance are critical components of routine care for [adolescents and young adults]." The authors discuss two pieces of federal legislation, the Patient Protection and Affordable Care Act of 2010 (ACA) and the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008. The ACA required health plans cover 10 Essential Health Benefits, including ambulatory services, emergency services, hospitalization, maternity and newborn care, mental health and substance use disorder services (including behavioral health treatment), prescription drugs, rehabilitative and habilitative services and devices, laboratory services, preventive and wellness services and chronic disease management, and pediatric services. Specific to confidentiality, the AAP found that, "few insurers have adjusted their administrative and billing systems to protect adolescent confidentiality." They state that confidentiality concerns for adolescents and young adults pertain to patient portals, electronic medical records, EOBs, requests for additional information about a claim, actual payment of claims, and claims made in divorce and child custody disputes. The AAP provided 8 recommendations to improve financing health care for adolescents and young adults, including a recommendation that, "private and government insurance plans develop and implement unique billing and claims strategies that ensure [adolescents and young adults] can obtain care with full protection of their confidentiality for appropriate services."

16. **Bender S. S., Fulbright Y. K. Content analysis: a review of perceived barriers to sexual and reproductive health services by young people.** ***Eur J Contracept Reprod Health Care.*** **2013;18(3):159-167.**
This systematic review of empirical studies by Bender & Fulbright reveals significant perceived barriers to access and utilization of sexual and reproductive care by 10-25-year-olds. Of the 17 studies, 2 were conducted in the US, and the rest in other high-income countries. Barriers to care are present in all aspects of care throughout the entire process, beginning with initiating the process of seeking care. Although some barriers are difficult to remove (e.g. place of living), most barriers identified can be changed to some degree to improve accessibility. 1) Service access barriers include lack of knowledge about availability of services (such as age limits, or males uncertain if a clinic would provide care to them), inconvenience (travel distance, availability of transport, hours conflicting with work and school), and anonymity (accessing a clinic without being seen by peers). 2) Service entry barriers involved various anxieties related to being in the clinic (being seen by peers, not wanting to discuss care with receptionists, long wait times, and uncomfortable atmosphere). 3) Quality of services affecting utilization of care included feeling ridiculed or judged, providers not listening to concerns, and concern about lack of confidentiality, with the majority of these felt more strongly by females than males across various studies. 3) Personal factors include aspects of the aforementioned barriers, with an emphasis on reputation and embarrassment in social circles, as well as confidentiality. Fear of breaches in confidentiality were repeatedly found to be the largest reported barriers to care for youth access and use of sexual and reproductive healthcare. Although many of these concerns could easily be addressed to improve access and utilization, none of the studies examined the potential magnitude of the effect, and thus there is a lack of understanding about which factors are most effective to address.

17. **Gruttandaro D., Crudo D. College Students Speak: A survey report on mental health. National Alliance on Mental Illness; 2012.**
In this report, the National Alliance on Mental Illness (NAMI) summarized findings from a national survey of 765 college students with mental health concerns. Specifically, the evaluated whether college campuses are meeting their needs and how campuses could better support students' academic experiences. They note that, "these issues are vitally important because colleges across the county are reporting large increases in the prevalence and severity of mental health conditions experienced by students." Overall, 27% of college students reported experiencing depression, 24% reported bipolar disorder, and 11% reported anxiety. Students also reported schizophrenia, post-traumatic stress disorder, ADHD, substance use, borderline personality disorder, dysthymia, eating disorders, obsessive-compulsive disorder, schizoaffective disorder, and autism spectrum disorder. Approximately 64% of survey respondents stated that they were no longer attending college because of a mental health related reason. Of these respondents, half also reported not accessing mental health services and supports. In addition, 50% of college students with a mental health concern stated that they did not disclose their mental health condition to their school. The top five reasons for not disclosing their health status included fear or concern about how others would perceive them, lack of opportunity to disclose, limited impact on academic performance, lack of knowledge that disclosure could help secure accommodations, and lack of trust that their medical information would remain confidential.

18. **Bonnie Richard J., Datta VIvek, Fisher Carl, et al. Resource Document on College Mental Health and Confidentiality. In: Law CoPa, ed: American Psychiatric Association; 2016.**
This American Psychiatric Association (APA) Resource Document, approved by the Joint Reference Committee, was prepared to "give practitioners working with young adults on college campuses a guide to providing good clinical care within the framework of relevant law." Authors discuss the transitional needs of young adults and relevant legal issues related to medical privacy. Additionally, they provide guidance regarding disclosure of students' mental health status. For example, "Parental notification should not be mandated, even when students' health or safety may be at risk. The nature of the student's relationship with his or her parents needs to be explored and assessed prior to a decision about disclosure." Moreover, authors warn that weakening confidentiality requirements or mandating parental notification could have serious unintentional, deleterious impacts on the care of college students. " If students believe that discussing troubling thoughts, feelings, fantasies or impulses will result in unwanted parental or administrative involvement, they will be significantly less likely to seek assistance from college counseling services."

19. **Salganicoff A., Ranji U., Beamesderfer A., et al. Women and Health Care in the Early Years of the Affordable Care Act: Key findings from the 2013 Kaiser Women's Health Survey. The Henry J. Kaiser Family Foundation; 2014.**
This report from the Kaiser Family Foundation evaluated the impact of the early implementation (2010-2013) of the Affordable Care Act (ACA) on women's insurance coverage, access to care, affordability of care, connections to health providers, and use of preventive care. Broadly, the ACA prioritizes and promotes access to clinical preventive services in ten Essential Health Benefits, including services related to counseling and screening tests related to cancer, chronic conditions, mental health, health behaviors, and certain sexual and reproductive health services. The report states, "clinical preventive care helps identify health problems earlier, allowing conditions to be treated or managed more effectively before they become more serious." In 2013, Kaiser Family Foundation conducted a nationally representative survey with 2,907 women aged 18 to 64. The survey was also administered with 700 men aged 18 to 64 as a comparison group. While the survey found that early implementation of the ACA expanded access to health insurance, the majority of women (57%) were covered by employer-sponsored insurance and half of that group (45%) were covered as a dependent through a spouse or parent. Specifically, the report finds that "coverage under a parent's plan is now the leading way that women under age 26 get their coverage, but few are aware that parents may get information about their care." Approximately 45% of women aged 18 to 25 are covered as a dependent on a parent's plan and "extension of coverage has raised concerns about their ability to maintain privacy regarding the use of sensitive health services such as reproductive and sexual health care and mental health." Although 60% of women aged 18 to 44 stated that it was important that information from health care visits be kept confidential from a parent or spouse, "it is a higher priority among young women" and 71% of women aged 18-25 stated that it was important that their use of health services be confidential. However, only 37% of women aged 18 to 25 and 24% of young women aged 15-18 were aware that health carriers send an Explanation of Benefits (EOB) to the primary policyholder (i.e., their parent). Mental health services are included as one of 10 Essential Health Benefits, but coverage for specific services varies between plans. The report cites evidence that, "21% of adult women are affected by some form of mental illness, such as depression, anxiety,

trauma, eating disorders, or dementia." However, only 41% of women have talked with their provider about mental health issues. In addition, the report provides an overview of demographic and health characteristics of women in the U.S. and summarizes major themes from the survey related to coverage, access, and affordability; impact of medical bills; connections to care; usual sources of care; health care settings; preventive services; knowledge and understanding of ACA coverage for preventive care; general wellness visits and provider-patient counseling; screening tests; reproductive and sexual health services, counseling, and screening; use of contraceptives; contraceptive coverage; and insurance and confidentiality. They also provide conclusions and implications for insurance coverage, costs and access, connections to care, preventive services, and sexual and reproductive health.

20. **American Psychological Association. Evidence-Based Practice in Psychology: APA Presidential Task Force on Evidence-Based Practice. 2006;61(4):271-285.**
The American Psychological Association (APA) created a policy indicating that the evidence-base for a psychological intervention should be evaluated using both efficacy and clinical utility as criteria. The Association President appointed the APA Presidential Task Force on Evidence-Based Practice and the task force published this document with the primary intent of describing psychology"s commitment to evidence-based psychological practices. This document, though, also references many research articles providing evidence for the efficacy of a number of psychological treatments and interventions. The reference list for this document highlights the growing body of evidence of treatment efficacy from the 1970s through 2006. Note that this does not indicate that all treatments are effective, but rather than there is a very large body of evidence supporting that evidence-based treatments are available.

21. **Healthy People 2020: Access to Health Services. 2018; Available at: https://www.healthypeople.gov/2020/topics-objectives/topic/Access-to-Health-Services. Accessed October 2018, 2018.**
Although the Affordable Care Act of 2010 increased opportunities to access health insurance, many individuals still lack coverage. Access to health insurance and healthcare varies by race/ethnicity, socioeconomic status, age, sex, disability status, sexual orientation, gender identity, and geography. As a result, one goal of the Healthy People 2020 initiative is to improve access to healthcare by improving access to health insurance coverage, health services, and timeliness of care. Healthy People 2020 found that "access to comprehensive, quality health care services is important for promoting and maintaining health, preventing and managing disease, reducing unnecessary disability and premature death, and achieving health equity for all Americans." Barriers to accessing healthcare "lead to unmet health needs, delays in receiving appropriate care, inability to get preventive services, financial burdens, [and] preventable hospitalizations." Access to health insurance is the first step to improving access to health services generally as it provides entry into the healthcare system. Individuals who are uninsured are, "more likely to have poor health status, less likely to receive medical care, more likely to be diagnosed later, and more likely to die prematurely" than individuals with insurance. Improving access to health services includes ensuring people have a "usual and ongoing source of care (that is, a provider or facility where one regularly receives care." Patients with a usual source of care experience better health outcomes, fewer health inequities, lower health costs, and better use of preventive health services. Lastly, delay in healthcare can negatively impact health outcomes and also result in, "increased emotional distress, increased complications, higher treatment costs, and

increased hospitalizations." Healthy People 2020 noted that "future efforts [to improve access to care] will need to focus on the deployment of a primary care workforce that is better geographically distributed and trained to provide culturally competent care to diverse populations."

22. **Reddy Diane M. Effect of Mandatory Parental Notification on Adolescent Girls' Use of Sexual Health Care Services. *Jama.* 2002;288(6).**
Reddy et al. conducted a survey girls aged 12-17 years seeking care at 33 Planned Parenthood (PP) clinics in Wisconsin. All single sexually active girls (n = 1118) seeking care at all PP clinics in Wisconsin (n = 33) in the spring of 1999 were asked to complete the survey with an 85% response rate (n = 950). Findings showed parental notification upon seeking prescribed birth control would present a barrier to care including unrelated STI and HIV testing and treatment, and would instead encourage the use of less effective birth control methods without a meaningful increase in abstinence. Overall, 59% of girls indicated they would do one of the following: stop using all sexual health care services (48%), delay testing or treatment for HIV or other STIs, or discontinue use of some specific sexual health care services, if their parents were informed that they were seeking prescribed contraceptives. This included services unrelated to prescribed birth control. Disparities in race and age were present; African American girls were significantly less likely than white girls (χ21, 7.7; P = .008) and other girls of color (χ21, 7.1; P = .008) to stop seeking all services. Seventeen-year-olds were significantly less likely than 16-year-olds (χ21, 7.0; P = .008) and those 15 years or younger (χ21, 10.0; P = .002) to stop seeking all services. No difference was found between urban and rural clinics. Of the 48% who said they would stop using all services if their parents were notified, girls reported they would resort to using condoms (57%), withdrawal method (29%), or have unprotected sex (29%). None indicated they would use spermicidal products or use the rhythm method, and only 1% indicated they would abstain from intercourse and instead have oral sex. Fourteen percent of the girls who indicated they would use condoms said they would not use them consistently and would at times use withdrawal method or have unprotected sex. The statistical analyses clearly show that parental notification upon seeking prescribed birth control services at PP clinics would present a significant barrier to adolescents seeking all types of sexual health care at the clinics.

23. **Jones Rachel K., Purcell Alison, Singh Shusheela, et al. Adolescents' Reports of Parental Knowledge of Adolescents' Use of Sexual Health Services and Their Reactions to Mandated Parental Notification for Prescription Contraception. *JAMA.* 2005.**
Jones et al surveyed adolescent girls seeking reproductive healthcare on their response to mandatory parental notification of prescribed contraception, finding a slight majority would continue use of these services, while others would resort to less effective methods or none at all. Surveys were coducted between May 2003 and February 2004 with female participants younger than age 18 (n = 1526), sampled from 79 family planning clinics across the nation. The majority (60%) indicated that their parents were already aware of their clinic visit. In the event of mandatory parental notification, 59% of participants would continue use of the clinic for prescribed contraception, although participants with this response were about 3 times as likely to have parents who already knew about their visit. Many adolescents provided more than one response to mandated parental involvement: 46% would use an over-the-counter method, 18% would go to a private physician, 18% reported they would use no contraception or the withdrawal method , and 7% said they would stop having sex. However, only 1% reported

abstinence as their only response to mandated parental involvement for prescription contraception. This study indicates that parental notification is a barrier to care for a large percentage of adolescent girls. In the face of parental notification, a significant portion of girls would resort to less-effective contraception or none at all, potentially leading to increases in unintended pregnancy and STIs.

24. **Moore K., Dell S., Oliva M., et al. Does Parental Insurance Impact Willingness to Take PrEP in Adolescents & Young Adults? *Journal of Adolescent Health.* 2018;Poster Symposia Abstracts(62):S23-S24.**
While adolescents and young adults account for a disproportionately high number of new HIV infections, they account for a disproportionately low number of pre-exposure prophylaxis (PrEP) prescriptions. This study consisted of a survey administered in an urban adult Emergency Department to adolescents and young adults ages 18-25 years. The survey assessed how participants felt about their parents possibly knowing they took PrEP, and whether parental knowledge would discourage them from using PrEP. Analysis showed that individuals who expressed not wanting their parents to know they took PrEP had a lower odds of using PrEP than their peers; "concerns about parent-patient confidentiality were associated with lower willingness to start PrEP, suggesting a potential barrier to PrEP uptake."

25. **Copen Casey E., Dittus Patricia J., Leichliter Jami S. Statistics NCfH. Confidentiality Concerns and Sexual and Reproductive Health Care Among Adolescents and Young Adults Aged 15–25. NCHS Data Brief. Atlanta, Georgia: U.S. Department of Health and Human Services; December 2016- 2016.**
This National Center for Health Statistics data brief presents data from the National Survey of Family Growth, 2013-2015. Among those aged 15-25 years covered under their parents/guardians' insurance, 7.4% would not seek sexual or reproductive health care because of concern that their parents might find out about it. When stratified by age, 17.9% of those aged 15-17, 6.6% of those aged 18-19, 3.9% of those 20-22, and 1.8% of those 23-25 reported they would not seek sexual or reproductive health services due confidentiality concerns. "Females aged 15-17 and 18-25 who reported concerns about seeking sexual or reproductive health care because their parents might find [out] about it were [statistically significantly, p<0.05] less likely than those without these concerns to receive such services in the past year (19.9% compared with 34.0% for females aged 15-17 and 53.1% compared with 72.9% for females aged 18-25)." Meanwhile, there were no differences in the percentage of males aged 15-25, regardless of age, who received sexual or reproductive health services according to whether they had confidentiality concerns.

26. **Loosier P. S., Hsieh H., Cramer R., et al. Young Adults' Access to Insurance Through Parents: Relationship to Receipt of Reproductive Health Services and Chlamydia Testing, 2007-2014. *Journal of Adolescent Health.* 2018;63(5):575-581.**
Loosier et al. conducted an analysis of data from the 2017-2014 Truven Health MarketScan commercial claims and encounters database to determine whether young women aged 18-25 enrolled on their parent's plan accessed reproductive health services or chlamydia testing. The authors note that Truven Health MarketScan includes information from multiple health insurance plans, but that data are primarily contributed by large employers and commercial plans. The study was approved by the Centers for Disease Control and Prevention (CDC). The authors

included measures related to age; enrollment ratios; proportion with parental insurance, spousal insurance, or self insurance; receipt of reproductive health services (i.e., Pap test, pelvic examination, pregnancy-related service, contraceptive service, infertility-related service, or STI-related service); receipt of chlamydia testing; and receipt of influenza vaccine. . From 2007 to 2014, the majority of women aged 18-25 were enrolled on their parent's plan (range= 55.5% to 79.3%). For example, in 2014, 79.3% of women aged 18-25 were enrolled on their parent's plan; 16.3% were self-insured; and 4.4% were enrolled on their spouse's plan. The authors found that the proportion of young women enrolled on their parent's plan increased fourfold from 2010 to 2014 (Adjusted Odds Ratio (AOR)= 4.32; CI= 4.29-4.33). For example, the percentage of women aged 24 on their parent's insurance increased from 7% in 2007 to 11.1% in 2010 to 60% in 2014. Compared to self-insured young women, young women enrolled on their parent's plan were less likely to receive reproductive health care (AOR= 0.66, CI= 0.66-0.67) and less likely to receive chlamydia testing (AOR= 0.75, CI- 0.75-0.76). The authors concluded, "young women who are insured through a parent are less likely to receive reproductive health services or chlamydia testing using their parent's insurance, which could suggest that concerns about confidential receipt of health services may result in missed care." In contrast, young women enrolled on their parent's plan were more likely to receive the flu vaccine than self-insured women (AOR= 1.13, CI 1.12-1.14), suggesting that confidentiality may be more of a concern for sensitive health services.

27. **Leichliter Jami S., Copen Casey, Dittus Patricia J. Services USDoHaH. Confidentiality Issues and Use of Sexually Transmitted Disease Services Among Sexually Experienced Persons Aged 15–25 Years —**
United States, 2013–2015. Morbidity and Mortality Weekly Report. Atlanta, Georgia: Centers for Disease Control and Prevention; 10 March 2017 2017.
This CDC Morbidity and Mortality Weekly Report (MMWR) examined the influence of confidentiality concerns and use of sexually transmitted disease services among sexually experienced persons aged 15-25 years. Although the Patient Protection and Affordability Act (ACA) allows dependent children to remain on a parent's health insurance plan until the child's 26th birthday to facilitate access to the health care system, "adolescents and young adults might not seek care or might delay seeking care for certain services because of concerns about confidentiality, including fears that their parents might find out." This analysis of 2013-2015 National Survey of Family Growth data found that overall "12.7% of sexually experienced youths [13.5% of females and 12.0% of males] (adolescents aged 15-17 years and those young adults aged 18-25 years who were on a parent's insurance plan) would not seek sexual and reproductive healthcare because of concerns that their parents might find out." Concerns were highest among youth aged 15-17 years (22.6%). Additionally, "females with confidentiality concerns regarding seeking sexual and reproductive health care reported a lower prevalence of receipt of chlamydia screening (17.1%) than did females who did not cite such concerns (38.7%)." Confidentiality-related concerns were associated with less reported use of some STD services, particularly among younger people and females.

28. **Slive L., Cramer R. Health Reform and the Preservation of Confidential Health Care for Young Adults.** ***Journal of Law, Medicine & Ethics.*** **2012:383-390.**
Slive and Cramer assess issues around confidentiality related to the ACA's provision allowing adult children to remain on their parents' health insurance plans until age 26. This article

describes the importance of confidentiality in health care; analyzes the impact of the ACA on health care for young adults; gives an overview of existing confidentiality laws around the country; and reviews potential solutions and ethical challenges relating to ensuring confidentiality for young adults. The authors review research that shows that lack of confidentiality around sensitive services may cause young adults to forgo those services. For example, young adults are the age group most at risk for STIs; therefore, avoiding care could have a serious impact on incidence of STIs. The ACA allowed young adult children to remain on their parents' insurance plans until age 26. The authors estimate that 2.5 million young adults gained access to private health insurance due to this provision in the ACA. This is the group potentially most vulnerable to breaches in confidentiality. The existing legal landscape provides some protections at the state and federal level. Historically, minors have been the group most at risk for exposure. Some states already prohibit breaches of confidentiality for certain services for minors who have the right to consent. These risks now apply to young adults, and as of the writing of this article, no states had yet implemented laws to specifically protect this group. HIPAA does provide protections of confidentiality, and the authors argue that these protections should be expanded to cover EOBs and other insurance communications when there is no remaining liability for payment. However the authors note that other communications such as "policyholder access to electronic medical records, reporting of lab results, prescription purchasing, and the ability of parents to open mail sent to their own address" all represent potential situations for a breach of confidentiality. The authors recognize that privacy protections best apply when there is no liability for payment; as parents should not be expected to pay for services if they receive no explanation of the services given. However when no payment is needed, some insurance companies already do not provide EOBs. Additionally, most "sensitive services" are USPSTF Grade A or B preventative services and so under the ACA are provided with no cost-sharing. EOBs are most necessary in cases of cost-sharing—when the policy holder has to pay for part or all of the service received. For young people who have the means to pay out of pocket, the above policies could increase their access to confidential services, as there is then no need for an EOB. However this creates an equity issue, as young adults who have less means to pay for services are also at greater risk for a breach of confidentiality. The authors note that "the expansion of preventive services being covered without cost-sharing by insurance… would both eliminate the practical issues and ethical implications of paying for confidentiality."

29. **Bringing High-Quality HIV and STD Prevention to Youth in Schools: CDC's Division of Adolescent and School Health. Atlanta, Georgia: Centers for Disease Control and Prevention; October 1, 2010 2010.**
This CDC fact sheef from the Division of Adolescent and School Health provided an overview of HIV and STD prevention for young people in schools. According to the factsheet, "nearly 40 percent of sexually active students did not use a condom the last time they had sex, and one in five drank alcohol or took drugs before their last sexual intercourse." In 2008, approximately 18% of all new HIV diagnoses (in 37 states with confidential, name-based reporting systems) were among young people aged 13-24 years. Additionally, teens and young adults have the highest rates of sexually transmitted diseases of any age group.

30. **Thaxton L., Espey E. Family Planning American Style Redux: Unintended Pregnancy Improves, Barriers Remain.** ***Obstet Gynecol Clin North Am.*** **2017;44(1):41-56.**

Thaxton and Espey examine factors affecting unintended pregnancy in the U.S., particularly teen pregnancy, and the barriers that remain to seeking contraceptive services. The review focuses on teens and young adults with regards to education, young parenting, and health insurance coverage. Authors considered multiple sources of research and literature to determine barriers to reducing unintended pregnancy in the U.S. While rates of unintended pregnancy have declined among all races/ethnicities, disparities persist despite decreasing. "Black and Hispanic teenagers had higher pregnancy rates (83 and 74 per 1,000 teenagers) than non-Hispanic white teenagers (35 per 1,000 teenagers)." Authors focus on societal obstacles to sexual health as barriers to reducing unintended pregnancy (i.e., inadequate sex education, confusing media messages, cultural attitudes, lack of accurate knowledge of abortion and birth control, inadequate availability of medical care, unnecessarily burdensome contraceptive dispensing practices, and hospital limitations on services provided). Authors cite evidence from a 2003 to 2004 survey that found one in five adolescents surveyed stated that if faced with mandatory parental notification laws, they would not use contraception at all or rely on withdrawal. Additionally, authors noted that "teenagers entrolled in their parents' health plans may nevertheless fear loss of confidentiality via explanation of benefits or copays."

31. **Ralph L. J., Brindis C. D. Access to reproductive healthcare for adolescents: establishing healthy behaviors at a critical juncture in the lifecourse. *Curr Opin Obstet Gynecol.* 2010;22(5):369-374.**
In this opinion, Ralph and Brindis present recent research on adolescent's access to reproductive healthcare, identifying a number of structural and perceived barriers: insurance status, primary care providers, adolescent's knowledge, and provider perceptions. Authors note confidentiality protections regardless of patient age, have particularly benefited adolescents, who often fear disclosure of confidential infomration to family and friends. Specifically, "confidentiality is critical to ensuring adolescents' willingness to access health services, disclose sensitive heatlh information, and return for necessary follow-up care." In particular, confidentiality is important for adolescent use of reproductive and other sensitive healthcare services.

32. **Instruction Office of Superintendent of Public. Youth Sexual Health; Education, Youth Behaviors, & School Safety Fact Sheet. 2017.**
Both the Healthy Youth Survey (HYS) and the School Health Profiles Survey (SHPS) were administered in 2016 to both students and school principals and health educators, respectively, to examine the scope and quality of sexual health education in Washington State. The HYS was administered by the Washington State Office of Superintendent of Public Instruction (OSPI) and other state agencies to students in grades 6, 8, 10, and 12 in schools that chose to participate. Information on participation rates is not readily available. The SHPS was designed by the CDC with an added WA supplemental survey, and is administered every two years. Students in Washington are still engaging in risky sexual behavior; only 53-57% reported using condoms during last sexual intercourse. Students receiving low grades are more likely to engage in risky sexual behavior than those receiving high grades. Similarly, additional health risks for students are correlated with lower academic achievement. Although WA State Law makes reproductive health services available to adolescents without parental consent or notification or an age requirement, 29% of schools require parental consent for sexual and reproductive health (SRH) services and 29% for SRH referrals. Recommendations are as follows: WA State should improve

professional development, utilization of evidence-based curricula, and provide resources for marginalized and at-risk youth.

33. **Klein D. A., Berry-Bibee E. N., Keglovitz Baker K., et al. Providing quality family planning services to LGBTQIA individuals: a systematic review. *Contraception.* 2018.**
Klein et al. conducted a systematic review to synthesize findings from peer-reviewed literature examining the provision of family planning services, specifically services to prevent or achieve pregnancy, to lesbian, gay, bisexual, transgender, queer/questioning, intersex and asexual (LGBTQIA) clients to inform clinical and research strategies. Of the 7193 abstracts published from January 1985 through April 2016 that met search parameters; 19 descriptive studies met inclusion criteria. Two included studies focused on the perspectives of health care providers towards LGBTQIA clients. While 17 studies that documented client perspectives; of those 12 elucidated factors facilitating a client's ability to enter into care, and 13 examined client experience during care. Two studies specifically discussed confidentiality as a barrier to LGBTQ youth accessing services. In 1998, Allen et al. conducted a client-level study in Colorado and Wyoming with gay, lesbian, and bisexual youth (n=102) ages 18-23 years. Barriers included concerns about confidentiality. Results showed, "participants who reported being informed about their right to medical confidentiality were three times more likely to have discussed sexual orientation with their provider." A 2002 study by Ginsburg et al. included self-described LGBTQ youth ages 14 to 23 years (n=94). Participants expressed privacy concerns including fear about information related to their sexuality getting back to their parents.

34. **Kates Jen, Ranji Usha, Beamesderfer Adara, et al. Health and Access to Care and Coverage for Lesbian, Gay, Bisexual, and Transgender Individuals in the U.S.: The Henry J. Kaiser Family Foundation; 2015:1-27.**
This Kaiser Family Foundation issue brief provides an overview of the challenges sexual and gender minorities experience in accessing health care. The analysis categorizes barriers as structural, economic, or social and examples include gaps in insurance coverage, cost-related hurdles, and poor treatment from health care providers, respectively. Authors also discuss the intersection of sexual orientation and gender identity with other factors (e.g., sex, race/ethnicity, and class) that shape an individual's health, access to care, and experience with the health care system. Authors also discuss barriers to care experienced by the transgender population, which is much more likely to live in poverty and less likely to have health insurance than the general population. One survey found that 48% of transgender respondents had postponed or went without care when they were sick because they could not afford it. Additionally, authors found evidence that "many health plans include transgender-specific exclusions that deny transgender individuals coverage of services provided to non-transgender individuals, such a surgical treatment related to gender transition, mental health services, and hormone therapy." Moreover, studies show that up to 39% of transgender people have faced some type of harrassment or discrimination in health care settings. This is further complicated by the general lack of competent training provided in medical schools and public health school curricula regarding LGBT health issues. Additionally, "three times as many LGB youth report ever being raped compared to their heterosexual peers (16% vs. 5%)." They are also four times more likely to attempt suicide than heterosexual youth. The report presents additional information indicating groups within the LGBTQIA population are at greater risk of sexual assault and other negative reproductive health related outcomes.

35. **James Sandy E., Herman Jody L., Rankin Susan, et al. The Report of the 2015 U.S. Transgender Survey Washington, DC: National Center for Transgender Equality; 2016.**
This report summarizes the results of the 2015 U.S. Transgender Survey (USTS) and provides insights into the impact of stigma and discrimination on the health of many transgender people. Respondents encountered high levels of mistreatment when seeking health care. For example, in the year prior to completing the survey, one-third (33%) of those who saw a health care provider had at least one negative experience related to being transgender (e.g., being verbally harassed or refused treatment due to their gender identity). "Nearly one-quarter (23%) of respondents reported that they did not seek the health care they needed in the year prior to completing the survey due to fear of being mistreated as a transgender person, and 33% did not go to a health care provider when needed because they could not afford it." Fifty-four percent of respondents to the U.S. Transgender Survey experienced some form of IPV and 24% reported severe physical violence by an intimate partner, compared to 18% of the U.S. population. The report also provides insight into the compounding impact of other forms of discrimination.

36. **Charlton B. M., Corliss H. L., Missmer S. A., et al. Reproductive health screening disparities and sexual orientation in a cohort study of U.S. adolescent and young adult females. *J Adolesc Health.* 2011;49(5):505-510.**
Charlton et al investigate disparities in uptake of reproductive health services including Pap test, STI tests, and annual exams, finding strong associations with sexual orientation. The authors used data from the Growing Up Today Study (GUTS), which surveyed children of nurses in the Nurses' Health Study II. Participants selected for the authors' multivariable regression analysis were aged 17-25 (n = 4,224). The analysis focused on associations between sexual orientation and reproductive health care utilization and abnormal results, using completely heterosexual females as a referent group. The analysis controlled for age, race/ethnicity, geographic region, sexual history. Compared to completely heterosexual females, mostly heterosexual and bisexual females had 30% lower odds of having a Pap test within the last year, yet almost 40% higher odds of being diagnosed with an STI. Lesbians had very low odds of having had a Pap test in the last year or in life. Lesbians also had lower rates (47%) of routine physical exams within the last year compared to bisexual (54%), mostly heterosexual (53%), and completely heterosexual (59%) females. Despite contact with a male partner being a large risk factor for HPV infection, lesbians are still at risk. Of those tested, abnormal Pap tests were consistent amongst all groups (20%), and HPV consistently accounted for 66% of all STI diagnoses across all groups. The authors also cite other studies noting high rates (76% to 98%) of sexual contact with males in female youth across all sexual orientations. Regardless, current guidelines require all women above the age of 21 have regular Pap tests regardless of orientation and sexual history, yet the authors found disparities still existed when looking just at participants over age 21. Access to reproductive healthcare in this case is likely due to perceptions of risk by both providers and patients associated with sexual orientation. The authors also note possible barriers among sexual minority youth including perceived insensitivity of providers to their concerns, and forgoing preventative care due to lack of need for birth control.

37. **How CDC Prepares Healthy Youth for Successful Futures. Atlanta, Georgia: Centers for Disease Control and Prevention; July 2018 2018.**

This CDC fact sheet from the Division of Adolescent and School Health (DASH) noted that while sexual risk behaviors among adolescents are declining (2007-2017), the prevalence of some behaviors remains high and puts youth at risk. Data from the National Youth Risk Behavior Survey (2017) and HIV Surveillance Report (2016) show that half of all new sexuall transmitted diseases reported each year are among young people aged 15 to 24. Additionally, the document reported that "while many LGB youth thrive during adolesence, stigma, discrimination, and other factors may put them at increased risk for negative health and life outcomes." For example, 16% LGB youth experience sexual dating violence, they are nearly twice as likely as other student sto use illegal drugs, and more than 47% have seriously considered suicide.

38. **Moya E. M., Chavez-Baray S., Martinez O. Intimate partner violence and sexual health: voices and images of Latina immigrant survivors in southwestern United States. *Health Promot Pract.* 2014;15(6):881-893.**
Moya et al. assessed the relationships between IPV and sexual health among Latina immigrants in southwestern United States. Researchers used photo-voice methodology and a community-based participatory research approach to gather and assess data from a convenience sample of 22 Latina survivors of IPV and 20 community stakeholders in El Paso, Texas. Participants reported "feelings of hopelessness, humiliation, loneliness, fear, and isolation from resources and services due to physical, sexual, and verbal abuse." Similarly, the majority of participants reported STIs from their partners and shared they were afraid to seek medical treatment because of their status (e.g., HIV/AIDS) for fear of being stigmatized or discriminated against. Study participants also described limited/no access to health services, fear of deportation and separation from children, limited English proficiency, and lack of health insurance as barriers to sexual and reproductive health. They explained that stigma, discrimination, humiliation, oppression, economic control, and fear act as barriers to sharing struggles and health concerns with health providers, family members, employers, and policy officers. Authors note, "[t]he inability to access physical and mental health services interfered with their ability to prevent, screen, and address IPV and adequately fulfill sexual and reproductive health needs." Participants came to a consensus and recommended the use of promotoras (community health worker) "to better reach and address IPV and sexual and reproductive health concerns in the U.S.-Mexico border region and beyond." Promotoras can disseminate information on IPV and connect affected women to resources. Participants expressed the need for community engagement and community-based organizations to moderate structural and social barriers and promote access to IPV, sexual, and reproductive health services.

39. **Holliday C. N., Miller E., Decker M. R., et al. Racial Differences in Pregnancy Intention, Reproductive Coercion, and Partner Violence among Family Planning Clients: A Qualitative Exploration. *Womens Health Issues.* 2018;28(3):205-211.**
Holliday et al. conducted a qualitative study of low-income Black and White women with histories of intimate partner violence (IPV) and reproductive coercion (RC) to qualitatively describe and compare contexts for unintended pregnancy (UIP) risk. Researchers conducted semistructured interviews with 10 non-Hispanic Black women and 34 non-Hispanic White women with histories of IPV or RC, ages 18-29 years, recruited from family planning clinics in Pittsburgh, Pennsylvania. Analysis of interviews found that both Black and White participants described instances of reproductive coercion in which their partner sabotaged their birth control

method. Examples include removing condom during sex, destroying contraceptives, and preventing her from attending appointments to receive a Depo-Provera shots. Participating Black women commonly cited male-dominated contraceptive decision making, condom refusal, and intentional impregnation as barriers to reproductive decision making. Historical mistrust of medical professionals was also identified as a barrier among Black participants, and authors cited evidence that lack of knowledge about contraception among Black men may also influence RC. White participants also cited birth control sabotage and condom refusal as forms of RC. Additionally, White participants described threats of femicide as an additional barrier impacting unintended pregnancy. Authors conclude that "clinicians offering contraceptive counseling should consider exploring women's pregnancy intentions and the role of male partners, IPV, and RC in their reproductive decision making."

40. **Miller E., Decker M. R., McCauley H. L., et al. Pregnancy coercion, intimate partner violence and unintended pregnancy. *Contraception.* 2010;81(4):316-322.**
Miller et al. conducted a cross-sectional survey of English- and Spanish-speaking females ages 16-29 years seeking services in five family planning clinics in Northern California (N=1278). Researchers assessed participants' histories of intimate partner violence (IPV), pregnancy coercion, and birth control sabotage. Survey results found 53% percent of respondents reported physical or sexual partner violence, 19% reported experiencing pregnancy coercion, and 15% reported birth control sabotage. Additionally, 35% of those reporting partner violence also reported reproductive coercion. Authors interpreted results as suggesting "pregnancy coercion and birth control sabotage may be an aspect of partner violence that should be identified by providers in clinical settings," as both relate to reproductive health. Authors recommend clinicians ask specifically about pregnancy coercion and birth control sabotage so that they can assist clients in identifying strategies to reduce their risk of unintended pregnancy (e.g., "invisible" forms such as injectable and intrauterine contraceptives, and accessible emergency contraception). Providers should also connect individuals experiencing pregnancy coercion and birth control sabotage with violence-related support services.

41. **Miller E., Jordan B., Levenson R., et al. Reproductive coercion: connecting the dots between partner violence and unintended pregnancy. *Contraception.* 2010;81(6):457-459.**
Miller et al. discuss evidence of the association between partner violence and unintended pregnancy and how it relates to the need for providers to consider reproductive coercion when counseling women regarding pregnancy prevention options (e.g., form of contraception). For example, teens may benefit from education and harm reduction strategies that focus on healthy relationships as they may not recognize controlling behaviors as abusive or coercive. Therefore, when working with teens who inconsistently use contraception (i.e., non-adherent), providers should consider assessment for partner violence and reproductive coercion rather than assuming the patient lacks motivation and education. The author also recommends comprehensive sexuality education curricula that discusses partner violence, reproductive coercion, and the contrast with healthy relationships as a strategy. This may support girls and women negotiate contraception and seek help for an unhealthy relationship. Similarly, prevention program directed at boys and men are necessary to promote healthy, respectful, gender-equitable relationships.

42. **Peek-Asa C., Wallis A., Harland K., et al. Rural disparity in domestic violence prevalence and access to resources.** ***J Womens Health (Larchmt).*** **2011;20(11):1743-1749.**
Peek-Asa et al. conducted a cross-sectional clinic-based survey to determine of prevalence, frequency, and severity of IPV differ by rurality and to identify variance in geographic access to IPV resources. Participants (N= 1470) were opting for an elective abortion, proficient in English or Spanish, and were Iowa state residents. Survey results indicated that among the study sample, the prevalence, frequency, and severity of physical and sexual IPV was higher among women living in small or isolated rural areas than in urban or large rural towns. Psychological abuse did not vary by rurality. Researchers cited evidence that geographic distance and isolation are barriers to accessing reproductive health services. Additionally, rural areas have significantly fewer primary care physicians and obstetrics/gynecology specialists, and residents have less access to acute care hospitals than urban residents. For example, one study found that travel distances greater than 20 miles negatively affected patient use of free mammogram services. Long travel distances represent a significant barrier to those experiencing more frequent and severe IPV. Lack of public transportation in rural areas as a barrier for rural women is further exacerbated for IPV victims whose partner may control access to a vehicle or track when they leave or where they go.

43. **Masselink L. E., Lewis J., Coleman C., et al. Title X-Funded Health Center Staff Members' Perspectives on Barriers to Insurance Use For Confidential Family Planning Services.** ***Perspectives on Sexual and Reproductive Health.*** **2018;50(2):51-57.**
The ACA expanded health coverage, including for individuals who receive family planning and reproductive health services at Title X-funded health centers; however, those health centers face difficulties billing insurance for services due to confidentiality protections. This study convened focus groups with Title X-funded health center staff and administrators to identify barriers to billing insurance. These barriers mean that many clinics will continue to use Title X funds even to cover services for insured patients. Title X is a federal grant program that provides funding to family planning providers. Title X has very strict patient confidentiality rules that allow patients to restrict sensitive information from family members; “evidence suggests that patients who rely on these centers highly value their confidentiality protections,” and might even choose to access these centers because of those same confidentiality protections. Federal regulations require Title X-funded health centers to make “all reasonable efforts” to bill insurance companies for services, while still maintaining patient confidentiality. Title X-funded clinics will often prioritize confidentiality over reimbursement, using grants to cover costs for patients who don’t have the means to pay out of pocket, rather than taking the risk that the insurance company may breach confidentiality. As the ACA increased insurance coverage, the proportion of patients using Title X-funded health centers who are covered by private or public insurance has increased. While public insurance such as Medicaid does not send communications such as EOBs to policy holders, many states are contracting with private insurance companies, who might have such policies. Additionally, while the increase of insurance coverage means in theory that Title X-funded clinics have more opportunity to bill insurance companies for services, in practice the questionable confidentiality practices and other changes to state insurance plans may make it harder to Title X-funded clinics to bill insurance, threatening their financial solvency. The focus group discussions in this study revealed that despite the increase in health insurance coverage under the ACA, Title X-funded health centers “still face significant barriers to billing health insurance for services they provide to patients with confidentiality concerns.” The authors note

that Medicaid expansions under managed-care plans are a significant part of that barrier, as managed care plans are typically run by private insurance companies, and so use conventional communication practices such as EOBs. The barriers that Title X-funded clinics face in billing insurance means that they are more and more reliant on grant funding for their services; any political changes in support could represent serious challenges to their ability to provide services to vulnerable populations.

44. **Fuentes L., Ingerick M., Jones R., et al. Adolescents' and Young Adults' Reports of Barriers to Confidential Health Care and Receipt of Contraceptive Services. *J Adolesc Health.* 2018;62(1):36-43.**
Fuentes et al. examined adolescents' and young adults' concerns about confidential reproductive health care and time spent alone with providers. Authors used data from the 2013-2015 National Survey of Family Growth to analyze responses from those aged 15 to 25 years (n = 1,032) who met study inclusion criteria and gave valid responses. Analysis was conducted by: age, sex, race, insurance status, current living arrangement, mother's education level, whether mother was teen at first birth, sexual experience, and sexual education. Results show a greater number of factors influenced confidentiality concern among adolescents (15-17 years old) than for young adults (18-25 years old). Only age of mother at first birth had an affect on the concerns of young adults (18-25). Among 15- to 17-year-olds, concerns about confidential reproductive health care were less common among those who were covered by Medicaid compared to those aged 15-17 years covered under their parents' private insurance (adjusted risk ratio [ARR] = .61, confidence interval [CI] .41–.91). Additionally, 15- to 17-years-olds who lived with neither parent were more likely to cite confidentiality concerns compared to those living with both parents (ARR = 2.0, CI 1.27–3.16). Notably, race, sexual experience, and sexual education did not have an effect on confidentiality concerns of either age group.

45. **Authority Washington State Health Care. PEBB Total Member Enrollment for March 2019 Coverage. 2019.**
In this report, the Washington State Health Care Authority (HCA) provides total member enrollment as of March 24, 2019 for individiduals enrolled in the state Public Employee Benefits Board (PEBB) plans, school employees plans, and political sub active plans. They provide total number of subscribers, spouses, and dependents for each plan category.

46. **Weeks-Green Mandy. Individual State Agency Fiscal Note | 5889 S SB In: Commissioner OotI, ed. Olympia, Washington2019:1-4.**
This multiple agency fiscal note includes information regarding estimated operating expenditures from the Office of the Insurance Commissioner. It noted, "the OIC already receives inquiry/complaint calls regarding confidentiality and EOBs and does not anticipate that the number of call will change based on the changes in this bill. However, it is assumed there will be more cases referred for enforcement and compliance."

47. **Report of the Department of Consumer and Business Services on the Effectiveness of the Confidential Communications Process. Salem, Oregon: Oregon State Department of Consumer and Business Services; 2016.**
This report from the Oregon State Department of Consumer and Business Services (DCBS) Division of Financial Regulation to the Legislative Assembly examines the effectiveness of the

state's new Confidential Communications Process, as passed in HB 2758. It discussed challenges with data collection, which limited the department's full understanding of the effectiveness of the new law. Additionally, it presented data on timeliness of requests, consumer complaints, and methods of outreach.

48. **Medicine Society for Adolescent Health and, Pediatrics American Academy of. Confidentiality Protections for Adolescents and Young Adults in the Health Care Billing and Insurance Claims Process. *Journal of Adolescent Health.* 2016;58(3):374-377.**
The Society for Adolescent Health and Medicine, American Academy of Pediatrics, and American College of Obstetricians and Gynecologists released this position piece arguing that "policies and procedures should be established so that [healthcare] billing and insurance claims processes do not impede the ability of providers to deliver essential health care services on a confidential basis to adolescents and young adults covered as dependents on a family's health insurance plan." To this point, they note that insurance communications regarding billing and claims can have unintended consequences of sharing information about confidential health services accessed by a dependent to the primary insured individual. They note that expansion of ACA to cover young adults increases the risk that this group will be vulnerable to breaches of confidentiality through insurance billing and Explanations of Benefits (EOBs). Ample research suggests that confidentiality is important for adolescents and young adults seeking sensitive health care services. State laws and policies vary on details regarding confidentiality, such as age of consent for certain sensitive health care services. Breaches of confidentiality could result in verbal and/or physical abuse of the individual or underutilization of services.

49. **Sedlander E., Brindis C. D., Bausch S. H., et al. Options for assuring access to confidential care for adolescents and young adults in an explanation of benefits environment. *J Adolesc Health.* 2015;56(1):7-9.**
Sedlander et al. conducted a qualitative study to identify 5 potential policy options aimed at reconciling confidentiality protections and EOBs (explanation of benefits). Authors conducted semi-structure telephone interviews with 31 stakeholders including healthcare administrators, policy experts, clinicians, advocates, and health plan representatives, to discussion policy options, limitations, and examples of implementation. The identified options are as follows: 1) not requiring health plans to send an EOB when no balance is due, 2) applying a generic CPT code to sensitive services, 3) requiring plans to honor patient requests for confidential communications, 4) creating a CPT code to suppress EOBs for sensitive services, and 5) to require health plans to communicate directly with adult dependents (18-26 years old) rather than the policyholder. The authors highlight that no one policy is the answer, but a combination of approaches will give the greatest success, with a particular emphasis on systematic approaches that enact automatically without requiring action from the patient or provider. Education of patients on their rights to confidentiality would also contribute to greater success of these policies.

50. **Tebb K. P., Sedlander E., Bausch S., et al. Opportunities and Challenges for Adolescent Health Under the Affordable Care Act. *Matern Child Health J.* 2015;19(10):2089-2093.**
Tebb et al. examine barriers to care for adolescents under the Patient Protection & Affordable Care Act (ACA) through both a literature review and interviews. Authors found confidentiality

to be a significant factor affecting adolescents use of health care services. Through in-depth semi-structured telephone interviews with healthcare administrators, health policy researchers, and adolescent medicine specialists (n = 45 total), authors learned that increased use of explanations of benefits (EOBs) and electronic health records (EHRs) has the unintended potential for serious breaches in confidentiality of sensitive services, particularly for adolescents. Adolescents' use of comprehensive care hinges on the assurance of true confidentiality, particularly for substance use, mental health, and reproductive/sexual health services. Additionally, adolescents would benefit from greater awareness of the benefits they do have under the ACA to improve utilization.

51. **Lehrer J. A., Pantell R., Tebb K., et al. Forgone health care among U.S. adolescents: associations between risk characteristics and confidentiality concern. *Journal of Adolescent Health.* 2007;40(3):218-226.**
Studies have shown that high numbers of adolescents do not receive routine preventive care, and that adolescents are concerned about the confidentiality of their care visits. However there is little evidence showing how much of foregone care is due to confidentiality concern; and what the specific risk characteristics are of youth who forgo primary preventive care due to concerns about confidentiality. This study assessed data from the National Longitudinal Study of Adolescent Health (Add Health) to identify risk factors associated with forgoing care. Factors identified included risky health behaviors, psychological distress and unsatisfactory communication with parents, implying that youth who forgo care because of lack of confidentiality are those who stand to benefit most from increased access to care. The data used for this study came from WAVE I of the Add Health study. Interview data was collected in 1995 from youth from grades 7 through 12 and their parents. The sample for this study consisted of 2,435 youth who reported having forgone health care in the past year. Researchers then analyzed the reasons given for not accessing care and participation in risky behavior. The results show that "adolescents who forgo care due in whole or in part to confidentiality concern are a particularly high-risk population in need of health care services" because of higher rates of mental health difficulties, sexual/reproductive health risks, and substance use. Girls were more likely than boys in this study to list confidentiality as a reason for not receiving needed care. There are some important limitations of the study. The study did not link specific risk characteristics to type of care foregone. The cross-sectional nature of the study limited ability to infer causality. Finally, definitions of risky behavior on the survey use heteronormative wording (for example, sexual activity was specifically defined as heterosexual sex). However, the results do suggest that concerns about confidentiality are a barrier to accessing preventive care, especially for adolescents engaged in risky behavior who might most benefit from access to preventive health services.

52. **R Chou, S Selph, T Dana, et al. Screening for HIV: systematic review to update the U.S. Preventive Services Task Force recommendation. Evidence synthesis No. 95. *Agency for Healthcare Research and Quality.* 2012.**
The U.S. Preventive Services Task Force (USPSTF) is an independent panel of experts who systematically reviews the evidence and provides recommendations that are intended to help clinicians, employers, policymakers, and others make informed decisions about health care services. This review, which focused benefits and harms of screening for Human Immunodeficiency Virus (HIV) in adolescents and adults, included randomized clinical trials and

observational studies. Findings indicate that screening for HIV is accurate, screening only targeted groups misses a large number of cases, and that antiretroviral therapy (ART) reduces the risk death and sexual transmission of HIV.

53. **CP Patnode, JT Henderson, JH Thompson, et al. Behavioral counseling and pharmacotherapy interventions for tobacco cessation in adults, including pregnant women: a review of reviews for the U.S. Preventive Services Task Force. Evidence synthesis No. 134. *Agency for Healthcare Research and Quality.* 2015.**
The U.S. Preventive Services Task Force (USPSTF) is an independent panel of experts who systematically reviews the evidence and provides recommendations that are intended to help clinicians, employers, policymakers, and others make informed decisions about health care services. This summary focused on the effectiveness and safety of pharmacotherapy and behavioral interventions for tobacco cessation and included a total of 54 systematic reviews. The findings indicate that behavioral interventions had a significant impact on increasing smoking cessation at 6 months (risk ratio= 1.76 [95% CI, 1.58 to 1.96]), and that various pharmacotherapy interventions also demonstrated effectiveness. In combination, behavioral therapy and pharmacotherapy demonstrated an 82% increase in tobacco cessation when compared to minimal intervention or usual standard of care. The authors conclude that behavioral and pharmacotherapy interventions are effective interventions to improve rates of smoking cessation both individually and in combination.

54. **Schapiro N. A., Mejia J. Adolescent Confidentiality and Women's Health: History, Rationale, and Current Threats. *Nurs Clin North Am.* 2018;53(2):145-156.**
In this article, Schapiro and Mejia present information that shows consent and confidentiality are core components of adolescent health care. Specifically, "adolescent access to reproductive health services, mental health services, and treatment of drug and alcohol use depends on teens' rights to consent and confidentiality in the state in which they live." The article reviews "the history, current practices, and potential challenges to confidentiality, including Title X funding, questions about brain development and ability to make autonomous choices, and meaningful use practices in electronic records."

55. **Finer Lawrence B., Zolna Mia R. Declines in Unintended Pregnancy in the United States, 2008-2011. *The New England Journal of Medicine.* 2016;374(9):843-852.**
Authors calculated the rates of pregnancy for the years 2008-2011 according to women's and girls' pregnancy intentions and the outcomes of those pregnancies. Authors used a variety of national datasets and surveys to conduct their analysis. Results show that 45% of pregnancies in 2011 were unintended, compared to 51% of pregnancies in 2008. Overall, the rate of unintended pregnancy declined substantially between 2008 and 2011. However, disparities exist. For example, the unintended pregnancy rate declined in every age group. "However, the highest rate of unintended pregnancy in 2011 was seen among women 20 to 24 years of age, followed by women 18 to 19 and women 25 to 29 years of age." Additionally, "the rate of unintended pregnancy declined between 2008 and 2011 in every income and education group, with the largest declines occurring among poor females and those who did not have a high school education." While the rate of unintended pregnancy declined between 2008 and 2011 in all racial and ethnic groups, with the largest decline among Hispanics, "substantial disparities in the rates

of unintended pregnancy in 2011 according to race and ethnic group," even after accounting for income.

56. **Gynecologists American College of Obstetricians and. Committee Opinion: Committee on Adolescent Health Care - Adolescent Pregnancy, Contraception, and Sexual Activity. 2017;129(5).**
The American College of Obstetricians and Gynecologists ("ACOG" or "the College") Committee on Adolescent Health Care has published a committee opinion on adolescent pregnancy, contraception, and sexual activity, outlining recommendations for improved access to reproductive health care. Teen birth rates in the US are hitting historic lows largely due to more effective contraceptive use. Many barriers still remain, including concerns about confidentiality and cost, fear of pelvic exam, misconceptions about LARC and long wait time for LARC initiation, and abstinence-only education. ACOG ("the College") recommends and supports: a reproductive justice framework for contraceptive counseling and access to provide equitable health care; access for adolescents and young adults to all contraceptive methods approved by the FDA; LARC (IUDs and implants) recommended to adolescents and discussed with pregnant adolescents; immediate initiation of LARC when appropriate; patient-provider discussion without parents/guardians present where allowed; evidence-based, medically accurate, age-appropriate sexuality education; dual method use – pairing condoms with more effective contraception to protect against STIs and pregnancy. In general, the College regards patient choice as the principal factor in choosing contraception methods in the absence of any contraindications.

57. **Catalano Shannan. Intimate Partner Violence, 1993-2010. Special Report. Washington, DC: Bureau of Justice Statistics; November 2012 2015. NCJ239203.**
This Special Report from the Bureau of Justice Statistics examines declining trends in the rate of intimate partner violence (IPV) in the U.S. From 1994 to 2010, the overall IPV rate declined by 64%, from 9.8 victimizations per 1,000 persons ages 12 or older to 3.6 per 1,000. The overall number of victimizations also declined from approximately 2.1 million in 1994 to roughly 907,000 in 2010. The report states that during the this time period about 4 in 5 victims of IPV were female. Moreover, females ages 18 to 24 and 25 to 34 generally experienced the highest rates of IPV.

58. **Health Washington State Department of. Intimate Partner Violence has Serious Health Impacts in Washington State. Tumwater, WA: Washington State Department of Health.**
This factsheet provides and overview of the health impacts of intimate partner violence (IPV).

59. **The Facts on Health Care and Domestic Violence. Futures Without Violence.**
This fact sheet from FUTURES, the federally-designated National Health Resource Center on Domestic Violence, provides an overview of domestic violence and its impact on health. For example, "In addition to the immediate trauma caused by abuse, domestic violence contributes to a number of chronic health problems, including depression, alcohol and substance abuse, sexually transmitted diseases such as HIV/AIDS." Domestic violence may also result in pregnancy complications, including "low weight gain, anemia, infections, and first and second trimester bleeding are significantly higher for abused women, as are maternal rates of depression,

suicide attempts, tobacco, alcohol, and illicit drug use." Authors also cite evidence that "homicide is the leading cause of traumatic death for pregnant and postpartum women in the United States, accounting for 31 percent of maternal injury deaths."

60. **Greenbaum Jordan. Child Sex Trafficking and Commercial Sexual Exploitation. *Advances in Pediatrics.* 2018;65(2018):55-70.**
"Accurately estimating the incidence and prevalence of a public health problem is important but these statistics are elusive for [Child Sex Trafficking/Commercial Sexual Exploitation] CST/CSEC because of the criminal nature of the activity, lack of a centralized database, differences in interpretation of definitions, underrecognition of exploited persons by authorities, and underreporting by victimsa themselves." As boys and transgender youth are likely underrecognized, total global estimates and proportions of victims based on gender may be distorted. Some of the most common physical effects are sexually transmitted infections (STIs), pregnancy, substance use/misuse, and traumatic injury. Studies document that visits to health facilities are fairly common among victims. One study found 43% of CST/CSEC victims had visited a health provider in the last 2 months. Similarly, 80% of suspected/confirmed victims had sought medical care in the last 12 months, with an average of 3.46 visits. Potential presenting reproductive health complaints for CST/CSEC Youth include: 1) traumatic injury (often with inconsistent history of event); 2) reported sexual assault; 3) genital-urinary complaint (discharge, pelvic/abdominal pain, abnormal bleeding); 4) HIV/STI or pregnancy test request; and 5) pregnancy-related issues (e.g., abortion or abortion complications). Authors provided a list of possible indicators of CST/CSEC. Authors recommend providers use a trauma-informed, rights-based, culturally and gender sensitive approach when they suspect a patient may be a CST/CSEC victim. For example, trauma informed care requires demonstrating respect (e.g., explain reasons for questions and every component of the medical visit, obtain patient's consent/assent for each step and respect their decision to refuse elements of the evaluation/treatment) and facility safety (e.g., interview patient alone, outside presence of companion, ask patient about basic needs [Warm enough? Hungry? Thirsty?]). The article details how the trauma-informed, rights-based approach may be implemented during the physical examination and diagnostic testing phases of the evaluation.