HIPAA Privacy Definitions

Purpose:
The purpose is to provide all) associates with the HIPAA Privacy Definitions for terms that may appear in the HIPAA Privacy Policies.

Scope:
This policy applies to all workforce members including, but not limited to full-time associates, part-time associates, trainees, volunteers, contractors, and temporary workers.

Definitions:
Affiliated Covered Entity:
Legally separate Covered Entities that are affiliated may be designated as a single Covered Entity for purposes of HIPAA Privacy, if the separate entities are under common ownership or control.

Business Associate:
A business associate includes an entity that ''creates, receives, maintains, or transmits'' protected health information on behalf of a covered entity. Entities that maintain or store protected health information on behalf of a covered entity are business associates, even if they do not actually view the protected health information.

Examples of business associates are:
- Patient Safety Organizations
- Health Information Organizations
- Vendors of Personal Health Records that require routine access to PHI
- Persons who facilitate data transmission
- Data storage company that has access to PHI (whether digital or hard copy), even if the entity does not view the information
- Subcontractors that create, receive, maintain, or transmit PHI on behalf of the business associate.

Examples of Persons and Organizations Who Are Not Considered Business Associates:
Oversight agencies (OIG, CMS); a person or organization that acts merely as a conduit (a conduit transports information but does not access it, ex: United States Postal Service); financial institutions; health care provider; and an employee of a covered entity.

"Certain" Health Care Operations:
"Certain" Health Care Operations means any of the following activities performed or undertaken by another Covered Entity which the Covered Entity is requesting a disclosure from OMG.
1. Quality assessment and improvement activities, including outcomes evaluation and development of clinical guidelines
2. Population-based activities relating to improving health or reducing health care costs, protocol development, case management and care coordination
3. Contacting patients regarding information about treatment alternatives
4. Reviewing the competence or qualifications of health care professionals
5. Evaluating provider performance
6. Evaluating health plan performance
7. Accreditation
8. Certification
9. Licensing
10. Credentialing

11. Health care fraud and abuse detection or compliance

Covered Entities:
Health plans, health care clearinghouses and health care providers.

De-identification (De-identified):
See company HIPAA PRIVACY De-Identification Policy.

Disclosure (Disclose):
Release, transfer, provide of access to, or divulge in any other manner of information outside of the company.

Electronic Media:
These media include any electronic storage material as defined by NIST. Thus "intranets" come within the definition. PHI stored, whether intentionally or not, in a photocopier, facsimile, and other devices is subject to the Privacy and Security Rules. **Exception**: If the information exchanged by facsimile did **not** exist in electronic form ***immediately*** before transmission, that information is **not** electronic media.

Employee:
For purposes of the Privacy policies, the definition of employee (associate) includes all members of the company workforce, including interns and temporary personnel. See also "Workforce Member" below.

Group Health Plan:
An employee welfare benefit plan defined in section 3(1) of ERISA, 29 U.S.C. 1002(1), including insured and self-insured plans to the extent that the plan provides medical coverage to employees or their dependents directly or through insurance, reimbursement or otherwise and that has 50 or more participants or is administered by an entity other than the employer that established and maintains the plan.

Health Care Operations:

1. Health Care Operations means any of the following activities performed or undertaken by the company:
   - A. Conducting quality assessment and improvement activities
   - B. Accreditation
   - C. Credentialing
   - D. Certification
   - E. Case management
   - F. Licensing
   - G. Evaluating health plan performance
   - H. Patient safety activities as defined in the PSQIA
   - I. Prohibition on using or disclosing genetic information for underwriting purposes
   - J. Insurance activities relating to the renewal of a contract for insurance:
     - i. Underwriting
     - ii. Premium rating
     - iii. Other activities relating to the creation, renewal or replacement of a contract for health insurance or health benefits, as well as ceding, securing or placing a contract for reinsurance of risk relating to claims for health care (including stop-loss and excess loss insurance)

Note: A group health plan that wants to replace its insurance carrier may disclose certain PHI to insurance issuers to obtain bids on new coverage, and an insurance carrier interested in bidding on new business may use PHI obtained from the potential new client to develop the product and price.

   - I. Conducting or arranging for medical review

J. Auditing functions, including fraud and abuse detection and compliance programs
K. Conducting or arranging for legal services
L. Business planning and development, such as conducting cost-management and planning-related analyses related to managing and operating the entity, including formulary development and administration, development or improvement of methods of payment or coverage policies.
M. Business management activities and general administrative functions, such as:
    i. Management activities relating to implementation of and compliance with the requirements for Health Care Operations
    ii. Customer Service, including the provisions of data analyses for policyholders, Plan Sponsors or other customers, provided that PHI is not disclosed to such policyholder, Plan Sponsor or customer
    iii. Resolution of internal grievances (includes quality of care and internal employee complaints)
    iv. Due diligence in connection with the sale or transfer of assets to a potential successor in interest, if the potential successor in interest is a Covered Entity or, following completion of the sale or transfer, will become a Covered Entity

2. Activities that would not be considered Health Care Operations:

    A. Marketing of health and non-health items and services
    B. Disclosure of PHI for sale, rent or barter
    C. Use of PHI by a non-health related division of an entity
    D. Disclosure to an employer for employment determinations

Health Information:
Any information, whether oral or recorded in any form or medium, that:

1. Is created or received by a health care provider, health plan, public health authority, employer, life insurer, school, university or health care clearinghouse.

Relates to the past, present or future physical or mental health or condition of a patient; the provision of health care to a patient; or past, present or future payment for the provision of health care to a patient. "Health Information" includes genetic information.

Health Plan:
A Health plan is an individual or group plan that provides or pays the cost of medical care, including church plans and government plans. (any plan to which creditable coverage applies.)

Individually Identifiable Health Information:
Information that is a subset of health information, including demographic information, collected from a patient and that:

1. Is created by or received by a Covered Entity.
2. Relates to the past, present or future physical or mental health or condition of a patient, the provision of health care to a patient or past, present or future payment for the provision of health care to a patient:

    A. Which identifies the patient.
    B. With respect to which there is a reasonable basis to believe the information can be used to identify the patient.

Marketing:

See company HIPAA PRIVACY Use or Disclosure of PHI for Marketing Purposes Policy.

Organized Health Care Arrangement:

1. A clinically integrated care setting in which patients typically receive health care from more than one health care provider.
2. An organized system of health care in which more than one Covered Entity participates, and in which the participating Covered Entities hold themselves out to the public as participating in a joint arrangement and participate in joint activities that include at least one of the following:
   A. Utilization review, in which health care decisions by participating Covered Entities are reviewed by other participating Covered Entities or by a third party on their behalf.
   B. Quality assessment and improvement activities, in which treatment provided by participating Covered Entities is assessed by other participating Covered Entities or by a third party on their behalf.
   C. Payment activities, if the financial risk for delivering health care is shared, in part or in whole, by participating Covered Entities through the joint arrangement and if PHI created or received by a Covered Entity is reviewed by other participating Covered Entities or by a third party on their behalf for the purpose of administering the sharing of financial risk.
3. A Group Health Plan and a health insurance issuer or HMO with respect to such Group Health Plan, but only with respect to PHI created or received by such health insurance issuer or HMO that relates to patients who are or who have been participants or beneficiaries in such Group Health Plan.
4. A Group Health Plan and one or more other Group Health Plans each of which are maintained by the same Plan Sponsor.
5. The Group Health Plans described in number 4 directly above and health insurance issuers or HMOs with respect to such Group Health Plans, but only with respect to PHI created or received by such health insurance issuers or HMOs that relates to patients who are or have been participants or beneficiaries in any of such Group Health Plans.

Payment:

1. The activities undertaken:

   A. To obtain premiums or determine or fulfill our responsibilities for coverage and provision of benefits.
   B. To obtain or provide reimbursement for the provision of health care.

2. The activities that relate to the patient receiving the health care, include but are not limited to:

   A. Determinations of eligibility or coverage (including coordination of benefits) and adjudication or subrogation of health benefit claims
   B. Adjusting premium amounts due based on enrollee health status and demographic characteristics (this is aggregate data used to rate an entire group)
   C. Billing, claims management, collection activities, obtaining payment under a contract for reinsurance (including stop-loss)
   D. Medical necessity review
   E. Utilization review activities (preauthorization)
3. The company may disclose to consumer reporting agencies any of the following PHI relating to collection of premiums or reimbursement: a patient’s name, address, date of birth, social security number and payment history, account number, as well as the name and address of the patient’s health care provider and/or health plan.

Personal Representatives:
See company HIPAA PRIVACY Policy, Personal Representative Policy.

Plan Sponsor:
Plan Sponsor is defined in section 3(16) (B) of ERISA, 29 U.S.C. 1002(16) (B). The Plan Sponsor is the employer or employee organization in the case of an employer benefit plan established or maintained by an employer (includes church and government plans). The Plan Sponsor is responsible for setting up the plan, regulatory reports, retains the right to amend the plan and signs official documents of the plan. The Plan Sponsor is limited to assigned responsibilities.

Protected Health Information (PHI):
All individually identifiable health information transmitted or maintained by a Covered Entity, regardless of form.

The HIPAA Privacy and Security Rules do not protect the individually identifiable health information of persons who have been deceased for more than 50 years.

Subcontractor:
A person who acts on behalf of a business associate, other than in the capacity of a member of the workforce of such business associate. The covered entity is not required to have a contract with the subcontractor. The business associate is required to obtain satisfactory assurances from the subcontractor in the form of a written contract or other arrangement that a subcontractor will appropriately safeguard PHI.

Treatment:
The provision, coordination or management of health care and related services by one or more health care providers, including the coordination or management of health care by a health care provider with a third party; consultation between health care providers relating to a patient; or the referral of a patient for health care from one health care provider to another.

Underwriting Purposes:
In this context, “underwriting” refers to a group health plan, health insurance coverage, or Medicare supplemental policy. Examples of “underwriting purposes” are:

1. Rules for, or determination of, eligibility (including enrollment and continued eligibility) for, or determination of, benefits under the plan, coverage, or policy. This includes changes in deductibles or other cost-sharing mechanisms in return for activities such as completing a health risk assessment or participating in a wellness program.
2. The computation of premium or contribution amounts under the plan, coverage, or policy.
3. Includes discounts, rebates, payments in kind, or other premium differential mechanisms in return for activities such as completing a health risk assessment or participating in a wellness program.
4. The application of any pre-existing condition exclusion under the plan, coverage, or policy.
5. Other activities related to the creation, renewal, or replacement of a contract of health insurance or health benefits.

“Underwriting Purposes” does not include determinations of medical appropriateness where an individual seeks a benefit under the plan, coverage, or policy.

Use:
It is the employment, application, utilization, examination or analysis of individually identifiable health information within an entity that maintains the information.

Workforce Member:
The term includes the associates, volunteers, trainees, and other persons whose conduct, in the performance of work for a covered entity or a business associate and is under the direct control of the covered entity or business associate.

Responsibilities:
All individuals identified in the scope of this policy are responsible for meeting the requirements of this policy.

The Compliance Officer is responsible for maintaining this policy and communicating this policy to members of the workforce.

Retention:
Every policy and procedure revision/replacement will be maintained for a minimum of six years from the date of its creation or when it was last in effect, whichever is later. Other company requirements may stipulate a longer retention. Log-in audit information and logs relevant to security incidents must be retained for six years.

Compliance:
Failure to comply with this or any other privacy policy will result in disciplinary actions as per the Sanction Policy. Legal actions also may be taken for violations of applicable regulations and standards such as the HIPAA Privacy Rule and others.

Form(s): None

References:

- Omnibus HIPAA Final Rulemaking, http://www.hhs.gov/ocr/privacy/hipaa/administrative/omnibus/index.html
- HIPAA Final Privacy Rule, 45 CFR Part 164.514(h), Department of Health and Human Services, http://www.hhs.gov/ocr/privacy/hipaa/administrative/privacyrule/ August 14, 2002.
- American Reinvestment and Recovery Act of 2009 (ARRA) / (HITECH). http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=111_cong_bills&docid=f:h1enr.pdf. *(The HITECH Act begins at H.R. 1-112 through 1-165 (pp. 112 through 165 in the document). The security and privacy provisions are found at Subtitle D Privacy, beginning H.R. 1-144 (p. 144)).*

Policy History:
Initial effective date: December, 2015