COVERED ENTITY CHARTS

Guidance on how to determine whether an entity is a covered entity under the Administrative Simplification provisions of HIPAA

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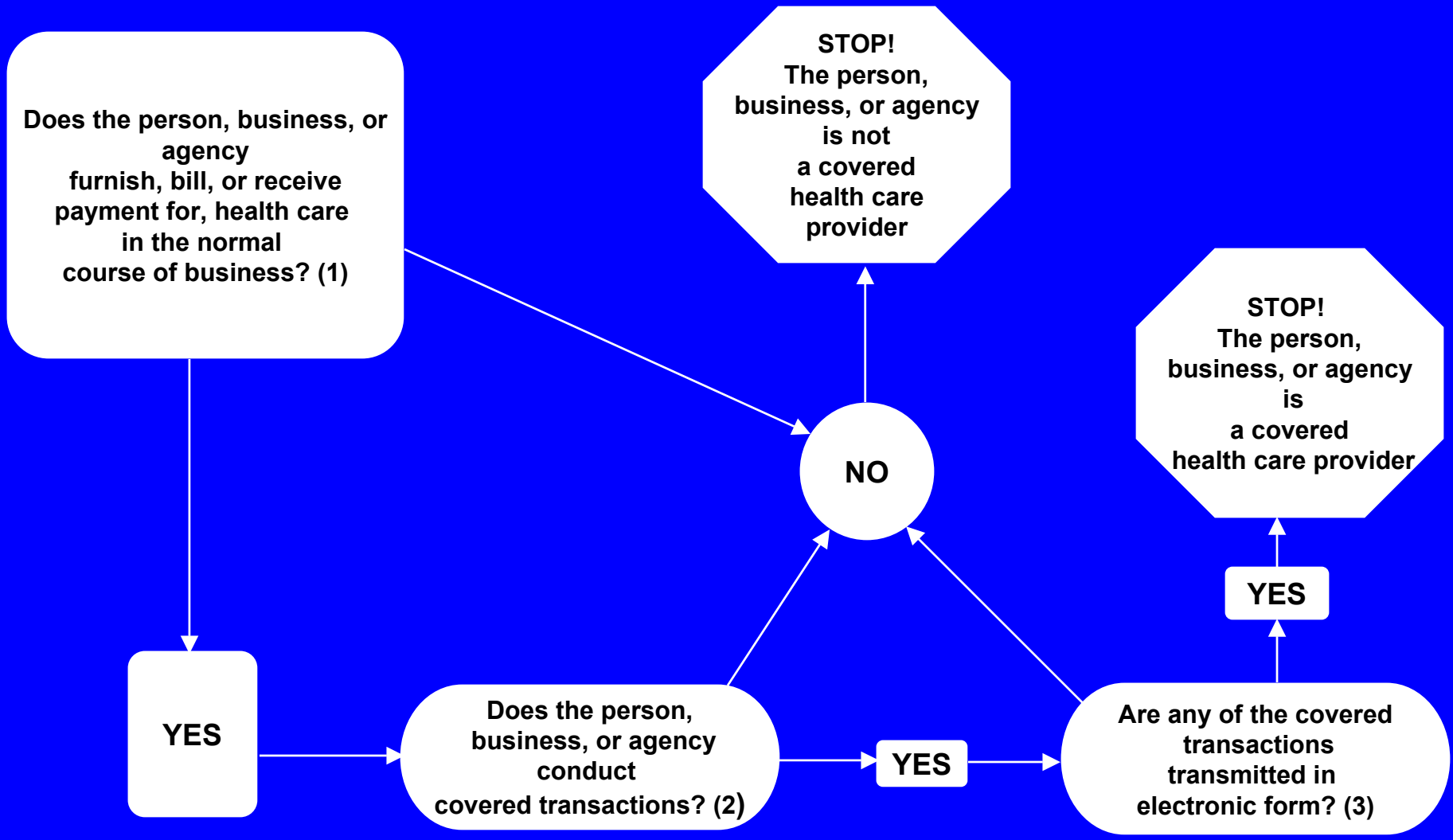
Background

- The Administrative Simplification standards adopted by HHS under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) apply to any entity that is -
  - a health care provider that conducts certain transactions in electronic form (called here a "covered health care provider"),
  - a health care clearinghouse, or
  - a health plan.
- An entity that is one or more of these types of entities is referred to as a "covered entity" in the Administrative Simplification regulations.

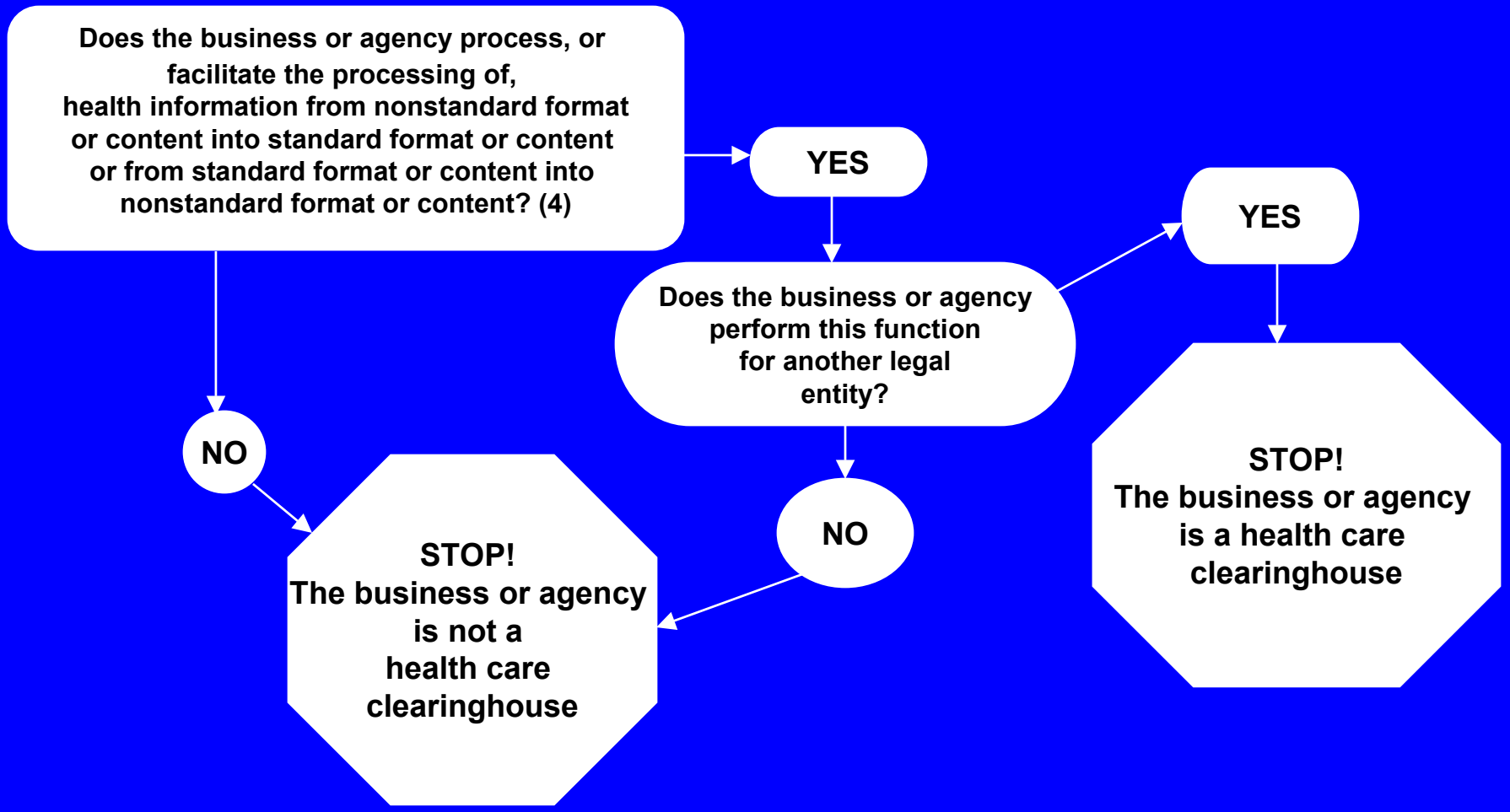
How to Use These Charts

- To determine if a natural person, business, or government agency is a covered entity, go to the chart(s) that apply to the person, business, or agency, and answer the questions, starting at the upper left-hand side of the chart(s).
- If you are uncertain about which chart(s) applies, answer the questions on all of the charts.
- Many terms used in the charts are defined terms or have a special meaning. The definitions or special meanings are set out in the endnotes. The number for the appropriate endnote appears at the end of the question, if the defined term or special meaning is used in, or is relevant to, the question.

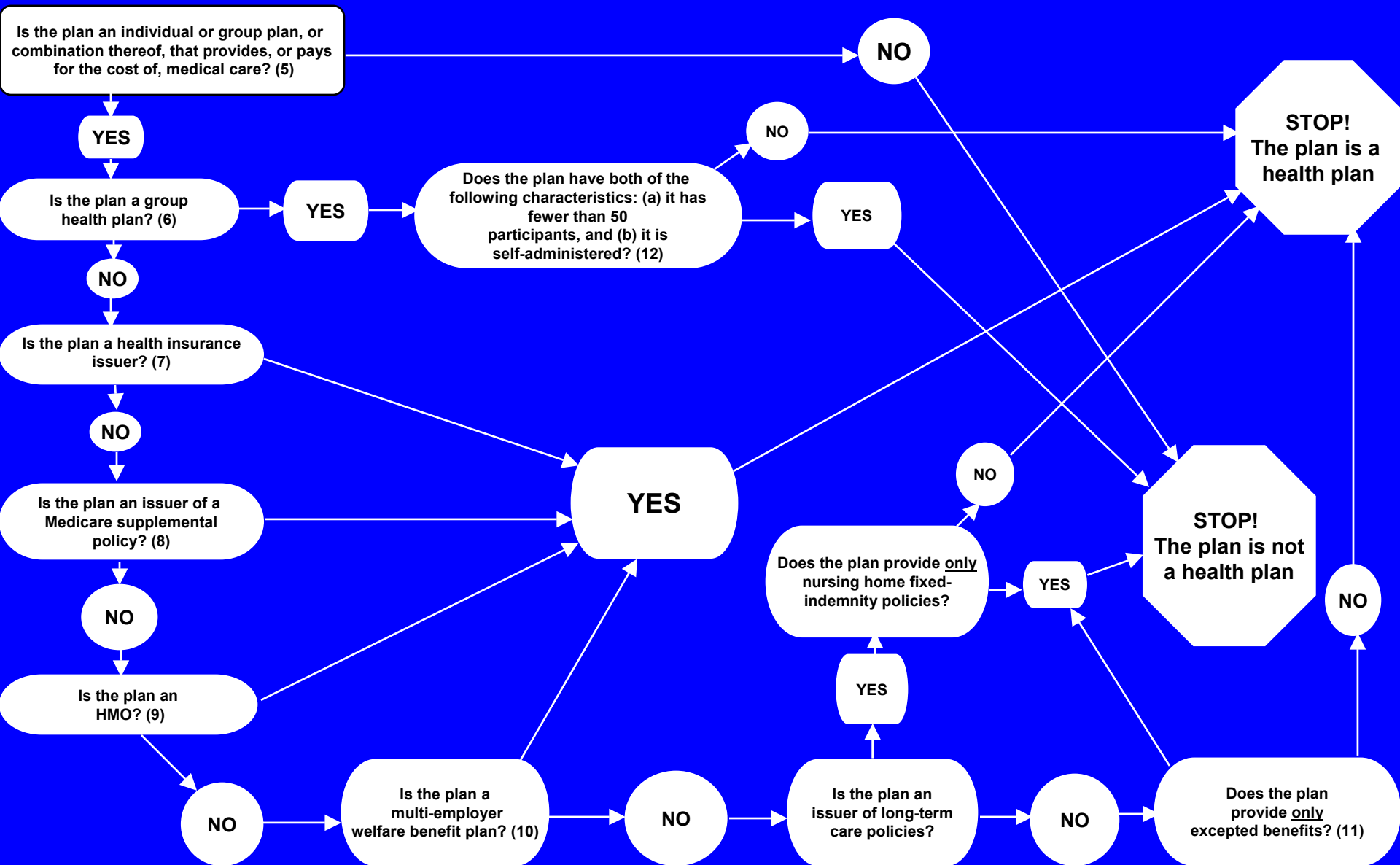
Is a person, business, or agency a covered health care provider?



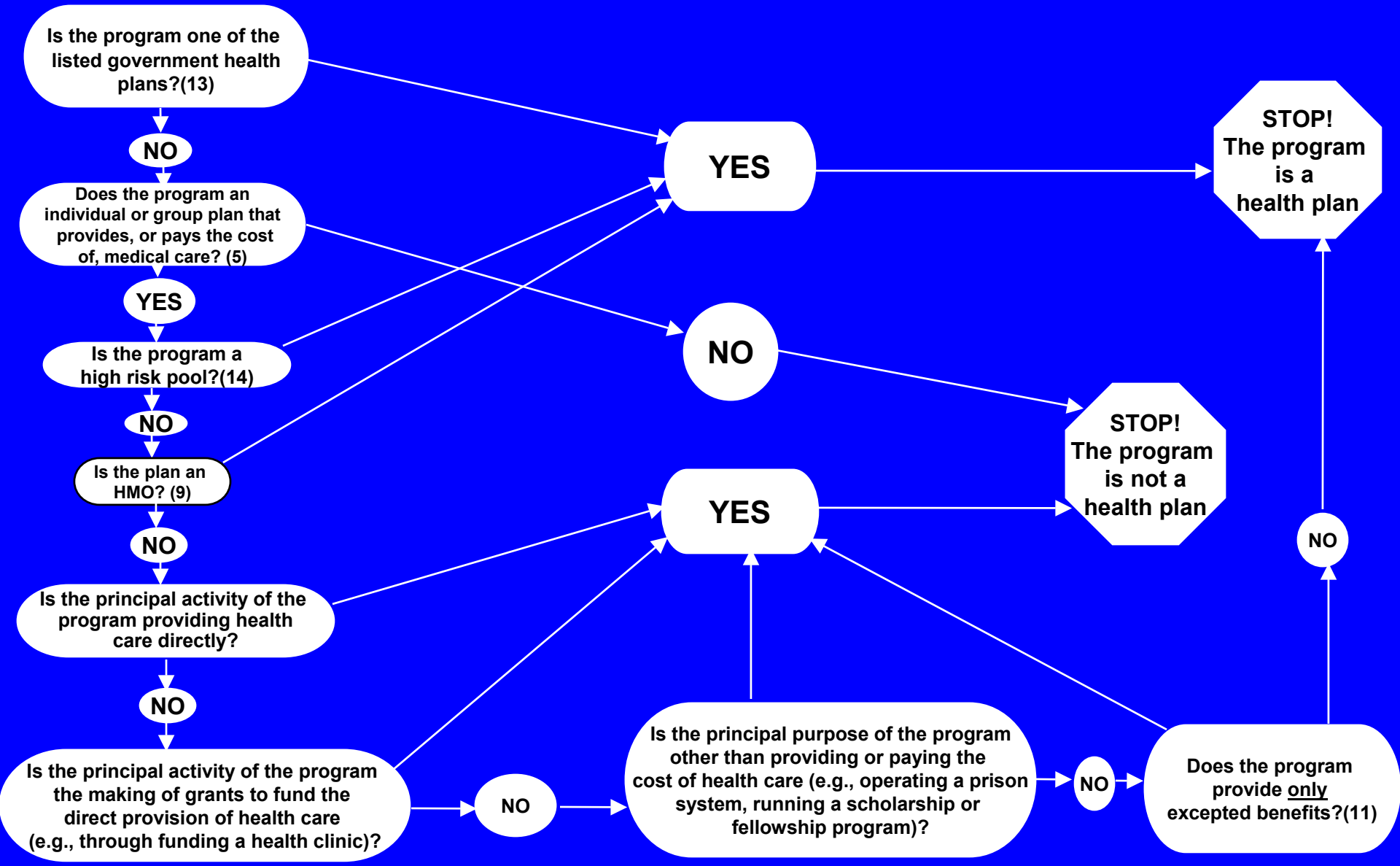
Is a business or agency a health care clearinghouse?



Is a private benefit plan a health plan?



Is a government-funded program a health plan?



1. ***Health care*** means: care, services, or supplies related to the health of an individual. It includes, but is not limited to, the following:

(1) Preventive, diagnostic, rehabilitative, maintenance, or palliative care, and counseling, service, assessment, or procedure with respect to the physical or mental condition, or functional status, of an individual or that affects the structure or function of the body; and (2) Sale or dispensing of a drug, device, equipment, or other item in accordance with a prescription. See 45 C.F.R.160.103.

2. ***Covered transactions*** are transactions for which the Secretary has adopted standards; the standards are at 45 C.F.R. Part 162. If a health care provider uses another entity (such as a clearinghouse) to conduct covered transactions in electronic form on its behalf, the health care provider is considered to be conducting the transaction in electronic form.

A transaction is a covered transaction if it meets the regulatory definition for the type of transaction. The regulatory definition for each type of covered transaction is as follows:

45 C.F.R.162.1101: Health care claims or equivalent encounter information transaction is either of the following:

(a) A request to obtain payment, and necessary accompanying information, from a health care provider to a health plan, for health care.

(b) If there is no direct claim, because the reimbursement contract is based on a mechanism other than charges or reimbursement rates for specific services, the transaction is the transmission of encounter information for the purpose of reporting health care.

45 C.F.R.162.1201: The eligibility for a health plan transaction is the transmission of either of the following:

(a) An inquiry from a health care provider to a health plan, or from one health plan to another health plan, to obtain any of the following information about a benefit plan for an enrollee:

(1) Eligibility to receive health care under the health plan.

(2) Coverage of health care under the health plan.

(3) Benefits associated with the benefit plan.

(b) A response from a health plan to a health care provider's (or another health plan's) inquiry described in paragraph (a) of this section.

45 C.F.R.162.1301: The referral certification and authorization transaction is any of the following transmissions:

(a) A request for the review of health care to obtain an authorization for the health care.

(b) A request to obtain authorization for referring an individual to another health care provider.

(c) A response to a request described in paragraph (a) or paragraph (b) of this section.

45 C.F.R.162.1401: A health care claim status transaction is the transmission of either of the following:

(a) An inquiry to determine the status of a health care claim.

(b) A response about the status of a health care claim.

45 C.F.R.162.1501: The enrollment and disenrollment in a health plan transaction is the transmission of subscriber enrollment information to a health plan to establish or terminate insurance coverage.

45 C.F.R.162.1601: The health care payment and remittance advice transaction is the transmission of either of the following for health care:

(a) The transmission of any of the following from a health plan to a health care provider's financial institution:

(1) Payment.

(2) Information about the transfer of funds.

(3) Payment processing information.

(b) The transmission of either of the following from a health plan to a health care provider:

(1) Explanation of benefits.

(2) Remittance advice.

45 C.F.R.162.1701: The health plan premium payment transaction is the transmission of any of the following from the entity that is arranging for the provision of health care or is providing health care coverage payments for an individual to a health plan:

(a) Payment.

(b) Information about the transfer of funds.

(c) Detailed remittance information about individuals for whom premiums are being paid.

(d) Payment processing information to transmit health care premium payments including any of the following:

(1) Payroll deductions.

(2) Other group premium payments.

(3) Associated group premium payment information.

45 C.F.R.162.1801: The coordination of benefits transaction is the transmission from any entity to a health plan for the purpose of determining the relative payment responsibilities of the health plan, of either of the following for health care:

(a) Claims.

(b) Payment information.

3. ***In electronic form*** means: using electronic media, as that term is defined at 45 C.F.R. 162.103. It includes transmissions over the Internet (wide-open), Extranet (using Internet technology to link a business with information only accessible to collaborating parties), leased lines, dial-up lines, and private networks, and those transmissions that are physically moved from one location to another using magnetic tape, disk, or CD media.

4. As pertinent here, a ***health care clearinghouse*** is a "public or private entity ... that does either of the following functions:

(1) Processes or facilitates the processing of health information ... in a nonstandard format or containing nonstandard data content into standard data elements or a standard transaction.

(2) Receives a standard transaction ... and processes or facilitates the processing of health information [in the standard transaction] into nonstandard format or nonstandard data content for the receiving entity". See 45 C.F.R. 160.103

A "standard transaction," for the purpose of this definition, is a transaction that complies with the standard for that transaction that the Secretary adopted in 45 CFR Part 162. See 45 C.F.R. 162.103. See the list of covered transactions in endnote 2.

5. ***Medical care*** means: amounts paid for: (A) diagnosis, cure, mitigation, treatment or prevention of disease, or amounts paid for the purpose of affecting any structure or function of the body; (B) amounts paid for transportation primarily for and essential to medical care referred to in (A); and (C) amounts paid for insurance covering medical care referred to in (A) and (B). See 42 U.S.C. 300gg-91(a)(2).

6. A ***group health plan*** is: an employee welfare benefit plan (as defined in section 3(1) of the Employee Retirement Income and Security Act of 1974 (ERISA), 29 U.S.C. 1002(1)), including insured and self-insured plans, to the extent that the plan provides medical care (see endnote 5), including items and services paid for as medical care, to employees or their dependants directly or through insurance, reimbursement, or otherwise, that: (1) has 50 or more participants (see endnote 12); or (2) is administered by an entity other than the employer that established and maintains the plan. See 45 C.F.R. 160.103.

7. A ***health insurance insurer*** is: an insurance company, insurance service or insurance organization (including an HMO) that is licensed to engage in the business of insurance in a state and is subject to state law that regulates insurance. (This term does not include a group health plan). See 45 C.F.R. 160.103.

8. An ***issuer of a Medicare supplemental policy*** is: a private entity that offers a health insurance policy or other health benefit plan, to individuals who are entitled to have payments made under Medicare, which provides reimbursement for expenses incurred for services and items for which payment may be made under Medicare, but which are not reimbursable by reason of the applicability of deductibles, coinsurance amounts, or other limitations imposed pursuant to or other limitations imposed by Medicare. A Medicare supplemental policy does not include policies or plans excluded under section 1882(g)(1) of the Social Security Act. See 42 U.S.C. 1395ss (g)(1).

9. A ***health maintenance organization*** is: a federally qualified health maintenance organization, an organization recognized as a health maintenance organization under state law, or a similar organization regulated for solvency under state law in the same manner and to the same extent as a health maintenance organization as previously described. See 45 C.F.R. 160.103.

10. A ***multi-employer welfare program*** is: an employee welfare benefit plan or any other arrangement that is established or maintained for the purpose of offering and providing health benefits to the employees of two or more employers. See 45 C.F.R. 160.103.

11. ***Excepted benefits*** are: coverage for accident, or disability income insurance, or any combination thereof; coverage issued as a supplement to liability insurance; liability insurance, including general liability insurance and automotive liability insurance; workers' compensation or similar insurance; automobile medical payment insurance; credit only insurance; coverage for on-site medical clinics; other similar insurance coverage, specified in regulations, under which benefits for medical care are secondary or incidental to other insurance benefits. See 42 U.S.C. 300gg-91(c)(1).

12. A ***participant*** means: any employee or former employee of an employer, or any member or former member of an employee organization, who is or may become eligible to receive a benefit of any type from an employee benefit plan which covers employees of such employer or member of such organization, or whose beneficiaries may be eligible to receive any such benefit.

13. The listed ***government-funded health plans*** are: the Medicare program under Title XVIII of the Social Security Act (Parts A, B and C) (42 U.S.C. 1395, et seq.); the Medicaid program under Title XIX of the Social Security Act (42 U.S.C. 1396, et seq.); the health care program for active military personnel (10 U.S.C. 1074, et seq.); the veterans health care program (38 U.S.C. Ch.17); the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) (10 U.S.C. 1061, et seq.); the Indian Health Service program under the Indian Health Care Improvement Act (25 U.S.C. 1601); the Federal Employees Health Benefit Program (5 U.S.C. Ch. 89); and approved state child health programs under Title XXI of the Social Security Act (42 U.S.C. 1397, et seq.) (SCHIP).

14. *A* ***high risk pool*** is a mechanism established under State law to provide health insurance coverage or comparable coverage to eligible individuals.