

HIPAA GLOSSARY

A

Adequate Separation: The concept that requires the recognition of separate plan and employer functions and requires that physical and technological firewalls be established between those functions.

Administrative Simplification: The provisions of HIPAA relating to standards for electronic health care transactions and the privacy and security of health information.

Authorization: A written authorization by an individual authorizing the use or disclosure of his or her protected health information.

B

Business Associate: A person or organization that assists a covered entity with treatment or operations, and generates, receives or has access to protected health information. Covered entities are required to obtain confidentiality agreements (called business associate agreements) with their business associates.

Business Associate Agreement: An agreement between a covered entity and its business associate in which the business associate agrees to restrict its use and disclosure of the covered entity's protected health information.

C

Covered Entity: A health plan, a health care clearinghouse, or a health care provider that transmits electronic transactions.

D

Data Aggregation: The combining of such protected health information by a business associate on behalf of more covered entities than one, to permit data analysis relating to the health care operations of the participating covered entities.

Data Use Agreement: A confidentiality agreement between a covered entity and the recipient of health information in a limited data set.

De-identified Health Information: Health information from which individual identifiers have been removed, so that it cannot be used to identify an individual. De-identified health information is not protected by HIPAA.

Designated Record Set: A health care provider's medical records and billing records about individuals, a health plan's enrollment, payment, claims adjudication, and case or medical management records, and any other records used by a covered entity to make decisions about individuals.

Disclosure: The release, transfer, provision of access to, or divulging in any other manner of information outside the covered entity holding the information.

E

Electronic Data Interchange: The computer-to-computer exchange of business data in standard formats.

Employee Welfare Benefit Plan: A plan, fund or program maintained by an employer or an employee organization that provides medical, surgical or hospital care.

ERISA: The Employee Retirement Income and Security Act of 1975. Most group health plans covered by ERISA are also health plans under HIPAA.

F

G

Group Health Plan: An employee welfare benefit plan (as defined in ERISA) that provides health benefits. A group health plan is a health plan under HIPAA unless it has fewer than 50 participants, and it is administered by the sponsoring employer.

H

HHS: The U.S. Department of Health and Human Services. The Office of Civil Rights is a department within HHS.

Health Care: Care, services, or supplies related to the health of an individual.

Health Care Clearinghouse: An organization that processes health information received from another entity in a nonstandard format or containing nonstandard data content into standard data elements or a standard transaction, or vice versa.

Health Care Operations: Business management and operations, including quality assessment and improvement, peer review, underwriting, medical review and audits, and business planning, management and development.
Health Care Provider: A person or organization that furnishes, bills, or is paid for health care in the normal course of business.

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 or university, or health care clearinghouse; and (2) relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual.

HIPAA: The Health Insurance Portability and Accountability Act.

Health Insurance Issuer: A company that is licensed to engage in the business of insurance in a State and is subject to State law that regulates insurance.

Health Maintenance Organization (HMO): A federally qualified HMO, or an organization regulated by State law as a health maintenance organization.

Health Plan: An organization that provides, or pays the cost of, medical care. Employee health benefit plans are health plans, unless they are self-administered, and have fewer than 50 participants. Government-funded programs whose principal function is providing direct health care services are not health plans.

Hybrid Entity: A single entity that has both covered (health plan, health care provider or health care clearinghouse) functions, and non-covered functions. A county that provides health services and non-health services

is an example.

I

Individually Identifiable Health Information: Information that relates to an individual's physical or mental health; the provision of health care to an individual; or the payment for health care provided to an individual, that identifies the individual or could be used to identify the individual.

J

K

L

Law Enforcement Official: An officer or employee of any governmental agency who is empowered by law to investigate or prosecute violations of law.

Limited Data Set: Health information from which specified identifiers have been removed. Information in a limited data set is protected, but may be used for research, health care operations and public health activities without the individual's authorization.

M

Marketing: A communication that encourages the purchase or use of a product or service. Marketing does not include a covered entity's communications about its own products, services or benefits, or communications for treatment, case management, care coordination or referral for care.

Minimum Necessary: The minimum amount of protected health information necessary to accomplish a permitted use or disclosure for payment or health care operations.

N

Notice of Privacy Practices: A notice that a covered entity is required to make available to patients or enrollees describing how the entity uses and disclosures of protected health information, and the individual's rights with respect to protected health information.

O

Office of Civil Rights: The department within HHS that enforces the HIPAA privacy requirements.

Organized Health Care Arrangement: 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 utilization review, quality assurance or financial risk for health care services.

P

Payment: The activities of a health care provider to obtain payment for health care services, or of a health plan to obtain premiums, or to adjudicate and pay claims.

Plan Sponsor: The sponsor of an employee welfare benefit plan (typically an employer or union).

Privacy Officer: The official appointed by a covered entity to be responsible for developing and implementing policies and procedures for complying with the health information privacy requirements of HIPAA.

Protected Health Information: Individually identifiable health information in any form.

Public Health Activities: The activities of public health authorities to collect information for the purpose of preventing or controlling disease, illness or injury.

Public Health Authority: A government that is responsible for public health matters.

Public Interest Disclosures: Disclosures for a variety of public interest-related purposes, which HIPAA permits without the individual's authorization.

Q

R

Research: A systematic investigation, including research development, testing, and evaluation, designed to develop or contribute to generalized knowledge.

S

Secretary: The Secretary of Health and Human Services.

Small Health Plan: A health plan with annual receipts of \$5 million or less. Small health plans have an extra year, until April 14, 2004, to comply with HIPAA.

T

Trading Partner Agreement: An agreement related to the exchange of information in electronic transactions. Trading partner agreements specify the communications protocols and transaction standards to be used.

Transaction: The transmission of information between two parties to carry out financial or administrative activities related to health care. HIPAA sets standards for the following electronic transactions:

Health care claims or equivalent encounter information.

Health care payment and remittance advice.

Coordination of benefits.

Health care claim status.

Enrollment and disenrollment in a health plan.

Eligibility for a health plan.

Health plan premium payments.

Referral certification and authorization.

Treatment: The provision, coordination, or management of health care and related services by a health care provider.

U

Use: The sharing, employment, application, utilization, examination, or analysis of information within the entity that maintains such information.

V

W

X

Y

Z