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HIPAA

The Health Insurance Portability and Accountability Act

The Health Insurance Portability and Accountability Act (HIPAA) was enacted by Congress in 1996. The purpose behind this **landmark law** was to:

- provide consumers with greater access to health care
- promote more standardization and efficiency within the health care industry
- protect the privacy of health care information.

The world of health care, as we once knew it, has drastically changed. The days of "one physician," who kept our medical records in a locked cabinet have given way to HMOs, Health Partnerships and electronic storage and transfers of our medical information. Prior to the HIPAA ruling, there were only a patchwork of State laws in place to protect the storing and transmittal of our health information. Not only did the HIPAA ruling provide clear standards for the protection of our personal health information, it put into place a method of standardization for the health care industry.

Who needs to comply?

Health Plans: Individual and group plans that provide or pay the cost of medical care (i.e. health, dental, prescription insurers, HMOs, Medicare, Medicaid, employer or government sponsored health plans, etc).

Health Care Clearinghouses: Entities that process nonstandard information that they receive from one format into a standard format (i.e. billing services).

Health Care Providers: Health care providers of medical or other health services, who *electronically transfer* health information in connection with a transaction for which standard requirements have been adopted must comply. (Typically includes health plans, hospitals, pharmacies, doctors, nurses, social workers, drug counselors, etc).

What does HIPAA cover? HIPPA covers a number of important health care issues, amongst them

- **Portability of Health Insurance**
- **Administrative Simplification**
- **HIPAA Privacy Rule**

A Closer Look:

I. Portability of Health Insurance: This provision of HIPAA protects health insurance coverage for workers and their families when they change or lose their jobs. "Portability of health insurance" ensures that a person can take their health insurance with them from one place to another, thus minimizing dilemmas such as waiting periods or non-coverage of pre-existing conditions.

II. Administrative Simplification: The purpose of this provision of HIPAA was to streamline the administration of health care and promote uniformity by adopting standards for several types of electronic health care transactions. Transactions are activities involving the transfer of health care information for specific purposes. These transactions (under HIPAA) include claims or info related to claims, specifically: *payment and remittance, *benefit eligibility inquiries, *referral authorization requests *enrollment or disenrollment in a health plan, *health plan premium payments, *coordination of benefits, *claims attachments (pending). Under the Administrative Simplification regulations of HIPAA, all covered entities who do business electronically, must provide the same information in a standard format, using specific code sets and identifiers.

Other HIPAA Administrative Simplification Requirements:

- **Privacy Requirements**: to govern disclosure of patient protected health information while protecting patient rights
- **Security Requirements:** to adopt safeguards to prevent unauthorized access to protected health information.
- **National Identifier Requirements:** Providers, plans and employers must have standard national numbers to identify themselves on standard transactions.

III. HIPAA Privacy Rule: In enacting the HIPAA Privacy Rule, Congress mandated the establishment of Federal standards for the privacy of **"**individually identifiable health information". The regulations **protect medical records and other individually identifiable health information, whether it be on paper, in computers or communicated orally.** Prior to this rule, personal health information could be shared or released basically to anyone, without either notice or authorization, for reasons that had nothing to do with a person's medical treatment or health care reimbursement. The Privacy Rule establishes a Federal floor of safeguards to protect the confidentiality of medical records. It gives patients specific protections while requiring covered entities to establish policies and procedures that will protect the confidentiality of protected health information about their patients!!

Patient Protections:

- **Access to Medical Records:** Patients can generally see and obtain copies of their medical records.
- **Guarantees Notice of Privacy Practices**: Covered entities must provide a notice to their patients how they may use their personal medical information and their rights under the new privacy regulations
- **Limits the use of Personal Medical Information**: Sets limits on how health care providers may use personal health information. **However, to promote the best quality of care, the rule does not restrict the ability of providers to share information needed to treat their patients.** Personal health information many not be used for purposes not related to health care unless the patient signs a specific authorization allowing the release of information.
- **Puts Restrictions on the use Patient Information for Marketing Purposes**
- **Does not affect State Laws that offer Additional Privacy Protections for Patients**
- **Confidential Communications:** Health care professionals must take reasonable steps to ensure that communications with the patient are confidential
- **Complaints**: Allows consumers to file complaints regarding privacy practices.

Health Plans and Providers Requirements: (In addition to the protections listed above)

- **Written Privacy Procedures:** Covered entities must have written privacy procedures, including who has access to protected information, how it will be used and how and when it will be disclosed.
- **Employee Training and Privacy Officer:** Covered entities must train their employees in their privacy practices and designate an individual who is responsible for ensuring the procedures are followed.
- **Public Responsibilities:** Under limited circumstances, the final rule *permits* but does not *require* covered entities to continue certain existing disclosure of health information for public responsibilities.

PERMITTED USES AND DISCLOSURES

There **ARE** permitted uses and disclosures allowed without an individual's authorization!

- **To the individual**: Health care providers can disclose protected health information to the individual who is the subject of the information.
- **Treatment. Payment and Health Care Operations:** Treatment is the provision or management of health care and related services for an individual by one or more health care providers including consultation between providers and referral by one provider to another. **Obtaining "consent"** (written permission from individuals to use and disclose their protected health information for treatment, payment or health care operations) **is optional under the Privacy Rule.** The content of the consent forms and the process for obtaining consent is up to the provider. (**One exception**: The use and disclosure of **Psychotherapy notes** for treatment, payment and health care operations purposes require an authorization (see below).
- **Use and Disclosure with opportunity to object**: In certain circumstances informal permission is acceptable. (Example: listing a patient in a hospital directory, or notification to family members regarding a patient's location, general condition or death.
- **Public Interest and Benefit Activities:** As are required by law, public health activities, law enforcement, judicial proceedings, cadaver organ donations, essential government functions, etc.

AUTHORIZATION

A covered entity must obtain the individual's **written authorization for any use or disclosure of protected health information that is not for treatment, payment or health care operations or otherwise permitted or required by the Privacy Rule.**

Authorization must be written in specific terms:

- Written in Plain language
- Specific information regarding the information to be disclosed,
- The person disclosing and receiving the information
- Expiration
- Right to revoke in writing
- Other applicable data

Psychotherapy notes: A covered entity must obtain an individuals authorization to use or disclose psychotherapy notes with the following exceptions: *the covered entity that generated the notes can use them for treatment and *the covered entity may use with an authorization, the psychotherapy notes for its own training, to defend itself in legal proceedings, to avert a serious or imminent threat to public safety, and/or lawful activities of a coroner.

Minimum Necessary;

Central to the Privacy Rule is the principle of minimum necessary when it comes to disclosures. Covered entities must make reasonable efforts to disclose only what is necessary to accomplish the intended purpose.

Minimum necessary doesn't apply to: disclosure to or request by a health care provider for treatment, disclosure to the individual who is subject of the information, use or disclosure made prior to an authorization, disclosure for complaint purposes, and several others.

Outreach and Enforcement :

Health and Human Services Office for Civil Rights (OCR) is responsible for overseeing the new federal privacy regulation. OCR offers the following services to ensure patients receive HIPAA protections as well as assist health care providers in meeting HIPAA requirements and regulations.

- Guidance and technical assistance: http://www.hhs.gov/ocr/hipaa/assist.html.
- Information line, toll free # 866-627-7748
- Complaint investigation
- Civil and Criminal Penalties for non compliance