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General Overview of Standards for Privacy of Individually Identifiable Health Information

{45 CFR Part 160 & Subparts A & E of Part 164}

To improve the efficiency and effectiveness of the health care system, the Health Insurance Portability and Accountability Act (HIPAA) of 1996, Public Law 104-191, included "Administrative Simplification" provisions that required the Department of Health and Human Services (HHS) to adopt national standards for electronic health care transactions. At the same time, Congress recognized that advances in electronic technology could erode the privacy of health information. Consequently, Congress incorporated into HIPAA provisions that mandated the adoption of Federal privacy protections for individually identifiable health information.

In enacting HIPAA, Congress mandated the establishment of Federal standards for the privacy of individually identifiable health information. When it comes to personal information that moves across hospitals, doctors' offices, insurers or third party payers, the patchwork of laws existing prior to adoption of HIPAA and the Privacy Rule, personal health information could be distributed – without either notice or authorization – for reasons that had nothing to do with a patient's medical treatment or health care reimbursement. For example, unless otherwise forbidden by State or local law, without the Privacy Rule, patient information held by a health plan could, without the patient's permission, be passed on to a lender who could then deny the patient's application for a home mortgage or a credit card, or to an employer who could use it in personnel decisions. The Privacy Rule establishes a Federal floor of safeguards to protect the confidentiality of medical information. State laws which provide stronger privacy protections will continue to apply over and above the new Federal privacy standards.

The HIPAA Privacy Rule for the first time creates national standards to protect individuals' medical records and other personal health information.

• It gives patients more control over their health information.

• It sets boundaries on the use and release of health records.

• It establishes appropriate safeguards that health care providers and others must achieve to protect the privacy of health information.

• It holds violators accountable with civil and criminal penalties that can be imposed if they violate patients' privacy rights.

• It strikes a balance when public responsibility supports disclosure of some forms of data – for example, to protect public health.

For patients – it means being able to make informed choices when seeking care and reimbursement for care based on how personal health information may be used.

• It enables patients to find out how their information may be used and about certain disclosures of their information that have been made.

• It generally limits release of information to the minimum reasonably needed for the purpose of the disclosure.

• It generally gives patients the right to examine and obtain a copy of their own health records and request corrections.

• It empowers individuals to control certain uses and disclosures of their health information.

Health care providers have a strong tradition of safeguarding private health information. However, in today's world, the old system of paper records in locked filing cabinets is not enough. With information broadly held and transmitted electronically, the Rule provides clear standards for the protection of personal health information.

For the average health care provider or health plan - the Privacy Rule requires activities such as

• Notifying patients about their privacy rights and how their information can be used.

• Adopting and implementing privacy procedures for its practice, hospital, or plan.

• Training employees so that they understand the privacy procedures.

• Designating an individual to be responsible for seeing that the privacy procedures are adopted and followed.

• Securing patient records containing individually identifiable health information so that they are not readily available to those who do not need them.

Covered entities of all types and sizes are required to comply with the Privacy Rule. To ease the burden of complying with the new requirements, the Privacy Rule gives needed flexibility for providers and plans to create their own privacy procedures, tailored to fit their size and needs. The scalability of the Rule provides a more efficient and appropriate means of safeguarding protected health information than would any single standard. For example,

• The “Privacy Official” at a small physician practice may be the Office Manager, who will have other non-privacy related duties; the Privacy Official at a large health plan may be a full-time position and may have the regular support and advice of a privacy staff or board.

• The training requirement may be satisfied by a small physician practice providing each new member of the workforce with a copy of its privacy policies and documenting that new members have reviewed the policies; whereas a large health plan may provide training through live instruction, video presentations, or interactive software programs.

• The policies and procedures of small providers may be more limited under the Rule than those of a large hospital or health plan, based on the volume of health information maintained and the number of interactions with those within and outside of the health care system.

As required by Congress in HIPAA, the Privacy Rule covers:

• Health Plans

• Health care clearinghouses

• Health care providers who conduct certain financial and administrative transactions electronically. These electronic transactions are those for which standards have been adopted by the Secretary under HIPAA, such as electronic billing and fund transfers.

The HIPAA Privacy Rule applies to:

• **Practices that transmit electronic transactions through a vendor or clearinghouse**

• **Practices that transmit paper claims to a billing service for conversion to electronic transactions**

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

The Health Insurance Portability & Accountability Act of 1996 (HIPAA) is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information.

As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

Our Rights:

We may use and disclose your medical records only for each of the following purposes: treatment, payment, and health care operations.

• **Treatment** means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include teeth cleaning services.

• **Payment** means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.

• **Health care operations** include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

We may mail *you* reminder cards which is permissible under 45 CFR 164.502 (a) (1) (ii).

We may use a sign in sheet as long as pertinent health information is not included.

We may be required to disclose to Federal officials or military authorities health information necessary to complete an investigation related to public health or national security. Health information could be important when the government believes that the public safety could benefit when the information could lead to the control or prevention of an epidemic or the understanding of new side effects of a drug treatment or medical device.

We will notify government authorities if we believe a patient is the victim of abuse, neglect or domestic violence. We will make this disclosure only when we are compelled by our ethical judgment, when we believe we are specifically required or authorized by law or with the patient's agreement.

We may include your health information with an invoice used to collect payment for treatment you receive in our office. We may do this with insurance forms filed for you in the mail or sent electronically. We will be sure to only work with companies with a similar commitment to the security of your health information.

Your health information may be used during performance evaluations of our staff. Some of our best teaching opportunities use clinical situations experienced by patients receiving care at our office. As a result, health information may be included in training programs for students, interns, associates, and business and clinical employees. It is also possible that health information will be disclosed during audits by insurance companies or government appointed agencies as part of their quality assurance and compliance reviews. Your health information may be reviewed during the routine processes of certification, licensing or credentialing activities.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

Please ask if you have any questions regarding our HIPAA Privacy Policy. We will be happy to answer any and all questions.

Your Rights:

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

• The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.

• The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.

• The right to inspect and copy your protected health information.

• The right to amend your protected health information.

• The right to receive an accounting of disclosures of protected health information.

• The right to obtain a paper copy of this notice from us upon request.

You have the right to request restrictions on certain uses and disclosures of your health information. Our office will make every effort to honor reasonable restriction preferences from our patients.

You have the right to request that we communicate with you in a certain way. You may request that we only communicate your health information privately with no other family members present or through mailed communications that are sealed. We will make every effort to honor your reasonable requests for confidential communications.

You have the right to read, review, and copy your health information, including your complete chart, x-rays and billing records. If you would like a copy of your health information please let us know. We may need to charge you a reasonable fee to duplicate and assemble your copy.

You have the right to ask us to update or modify your records if you believe your health information records are incorrect or incomplete. We will be happy to accommodate you as long as our office maintains this information. In order to standardize our process, please provide us with your request in writing and describe your reason for the change. Your request may be denied if the health information record in question was not created by our office, is not part of our records or if the records containing your health information are determined to be accurate and complete.

You have the right to ask us for a description of how and where your health information was used by our office for any reason other than for treatment, payment or health operations. Our documentation

procedures will enable us to provide information on health information usage from April 14, 2003 and forward. Please let us know in writing the time period for which you are interested. Thank you for limiting your request to no more than six years at a time. We may need to charge you a reasonable fee for your request.

You have the right to obtain a copy of this Notice of Privacy Practices directly from our office at any time. Stop by or give us a call and we will mail, or email a copy to you. We are required by law to maintain the privacy of your health information and to provide to you and your representative this Notice of our Privacy Practices. We are require to practice the policies and procedures described in this notice but we do reserve the right to change the terms of our Notice. If we change our privacy practices we will be sure all of our patients receive a copy of the revised Notice.

You have the right to express complaints to us or to the Secretary of Health and Human Services if you believe your privacy rights have been compromised. We encourage you to express any concerns you may have regarding the privacy of your information. Please let us know your concerns or complaints in writing.

The HIPAA Law: Your rights to health insurance portability

If you're worried about keeping your health benefits when you change jobs, you should know about a federal law called HIPAA. It's the Kassebaum-Kennedy Act, also known as the Health Insurance Portability and Accountability Act of 1996, or HIPAA for short. While HIPAA offers little protection if you're switching from a group health plan to an individual health plan, and nothing if you don't have insurance at all, it can help you from losing coverage when you have a gap in ***group*** health insurance.

The law was designed to ease what was then a growing problem known as "job lock" – the reluctance to move from one company to another for fear of losing health coverage. (Another federal law called COBRA helps you buy benefits when you're between jobs.)

Pre-existing Conditions

The driving force behind HIPAA is that health insurance companies have traditionally tried to hold down their costs by invoking a "pre-existing condition" clause – refusing to cover a condition you had before you bought the health plan.

The concept of pre-existing conditions makes sense when you're talking about auto insurance: For example, if your windshield was cracked ***before*** you bought your coverage, you can't expect your new auto insurer to replace if ***after*** you buy a policy. That would be like asking your insurer to replace the windshield for free when you haven't paid premiums for that problem.

But when it comes to someone's health, the issue might seem less clear-cut or even downright unfair.

Got diabetes? Your current group health plan might pay for insulin and visits to the doctor. But before HIPAA was enacted, if you switched to a new group health plan, it would have been allowed to consider your diabetes a pre-existing condition and refuse to cover treatment for it. You'd then be stuck paying for all of your diabetes treatment yourself, on top of the regular out-of-pocket expenses you'd pay for other medical care. The frightening prospect of having to pay hundreds or thousands of dollars for medical care created "job lock" and helped fuel the push for legislation banning such practices.

HIPAA imposes limits on the extent to which some group health plans can exclude coverage for pre-existing conditions. For instance, *if you've had "creditable" health insurance for 12 straight months, with no lapse in coverage of 63 days or more, and you switch to a new group health plan, it cannot invoke the pre-existing condition exclusion at all.* ***It must cover your medical problems as soon as you enroll in the plan***. (Newborns and adopted children who are covered within 30 days are not subject to the 12-month waiting period.)

Most United States health coverage is creditable. It includes prior coverage you had under a group health plan (including a governmental or church plan), health insurance coverage (either group or individual), Medicare, Medicaid, a military-sponsored health care program such as TriCare, a program of the Indian Health Service, a state high-risk pool, the Federal Employees Health Benefit Program, a public health plan established or maintained by a state or local government, and a health benefit plan provided for Peace Corps member.

On the other hand, ***if you don't have that creditable coverage behind you when you enroll in a new group plan*** – or had coverage from an overseas health insurer – *your new health insurer can refuse to pay for any of your existing medical problems* (*except pregnancy, if the plan has maternity coverage),* ***but only for a maximum of 12 months.*** Late enrollees in group health plans may have to wait up to 18 months for coverage of pre-existing conditions.

HIPAA says that ***group*** health plans cannot deny your application for coverage based solely on your health status. It also limits exclusions for pre-existing conditions.

In addition, HIPAA says you can't be denied group health insurance because of mental illness, genetic information, disability, or the claims you have filed in the past.

Group health plans that offer maternity coverage cannot consider pregnancy a pre-existing condition and cannot exclude coverage for prenatal care or your baby's delivery, regardless of your employment or health insurance history. This holds true whether you are the primary insured or listed as a dependent.

Note that there is no *federal* law that requires health plans to actually provide maternity coverage, although some ***states*** have such laws.

Pre-existing conditions

A **pre-existing condition** is generally considered a physical or mental condition for which ***medical advice, diagnosis, care or treatment was recommended or received before you enroll in a health insurance plan.***

You might be surprised, however, to learn that ***it can also be considered a problem that you were aware of but never sought treatment for.***

And worse, ***under some definitions***, says a spokesperson for the Arizona Department of Insurance, a ***medical problem can be considered pre-existing even if you didn't know you had the problem before you bought your health plan.***

HIPAA's rules apply to every employer group health plan that has at least two participants who are current employees, including companies that are self-insured. States have the option of applying the

rules to "groups" of one, which some have opted to do – a big bonus for the self-employed. Some states also have enacted their own laws protecting health insurance consumers, and in many cases they afford more rights than federal law.

Unfortunately, there is one huge exception to HIPAA: **It provides no protection if you switch from one individual health plan to another individual plan.** That's what makes buying individual plans especially difficult for people who have chronic medical problems – the insurers can simply turn them away time after time.

The ifs, ands, or buts of HIPAA

In an effort to balance the interests of consumers and the interests of insurers, HIPAA also contains plenty of other exceptions, conditions, and loopholes that limit your rights. Thus, it's important to understand HIPAA *before* you change health plans.

First, understand some fundamental tenets of the American health care system. Employers are **not** required by most states or federal law to offer or pay for health insurance for employees (Hawaii is an exception.) And unless mandated by state law, employers do not have to offer specific types of benefits, such as mental health or maternity coverage. Further, just because HIPAA grants you insurance "portability" does not mean that you will have the same benefits, premiums, co-payments, or deductibles when you move from one health plan to another.

Your group health coverage can be canceled if you or your employer fail to pay the premiums, commit fraud, violate health plan rules, or move outside of your insurer's service area. HIPAA also does not eliminate the common practice of requiring a waiting period, generally one to three months, before you become eligible to join a new group health plan when you switch jobs. (Note, however, that waiting periods do not count as a lapse in health coverage and thus you would not be penalized under HIPAA.)

HIPAA requirements **do not apply** to certain types of benefit plans known as "*excepted benefits*." *Those benefits are:*

• *Coverage only for accident (such as accidental death or dismemberment) or disability income insurance.*

• *Liability insurance.*

• *Supplements to liability insurance.*

• *Workers Compensation or similar insurance.*

• *Automobile medical payment insurance (known as "MedPay".)*

• *Credit-only insurance (for example, mortgage insurance.)*

• *Coverage for on-site medical clinics.*

Creditable Coverage

Under HIPAA, if you've already been in a group health plan, chances are you won't have to sit out the full 12-month exclusion period. Your new health plan must give you "credit for time served" – the amount of time you were enrolled in your previous plan – and deduct it from the exclusion period. Thus, if you've had 12 or more months of *continuous* coverage, you'll have no pre-existing condition waiting period. And if you had prior coverage for eight months, you can be subject to only a 4-month exclusion period when you switch jobs.

But let's say you're a recent college graduate and you haven't had health insurance for the last six months because you'd rather spend your money elsewhere. But then you land a job that offers you group health coverage. Because you've had such a long lapse in coverage, you'll likely face the 12-month exclusion period for any existing medical problems you have. (Keep in mind that insurers are not required to impose these pre-existing exclusions, but it is their standard practice.)

In order to keep your coverage continuous, you cannot let it lapse for more than 63 days That's where COBRA can help. If you leave one company before starting with another, consider buying COBRA coverage to keep your coverage continuous. Otherwise, you'll be back at square one and faced with another 12-month exclusion period.

Whenever you leave any health plan, either group or individual, make sure that you get a "certificate of creditable coverage" in writing. Among other things, your certificate should say:

• Your coverage dates.

• Your policy ID number.

• The insurer's name and address.

• Any family members included under your coverage.

This is the easiest way to ensure your rights under HIPAA. However, you can use other evidence to prove creditable coverage. These include:

• Pay stubs that reflect a health insurance premium deduction.

• Explanation-of-benefit forms.

• A benefit-termination notice from Medicare or Medicaid.

• Verification letter from your doctor or your former health insurance provider that you had prior health coverage.

Remember to review the evidence for accuracy. When applying for a new group health plan, you'll give the evidence to the plan administrator at your company.

As an alternative method of determining your creditable coverage, insurers can look at your coverage for five specific benefits:

- Prescription medications
- Vision
- Dental
- Mental health
- Substance abuse treatment

If you had a group health plan for 12 continuous months but had coverage for, say dental benefits, for just six of those months, you would only be credited for six months of dental coverage. Thus, your new group health plan could impose a pre-existing condition exclusion for dental benefits only – not the entire health plan – for up to six months.

In regards to the HIPAA policy, ***this office will not release any information to anyone without the patient's explicit permission in writing.***

Signature:_____.

Date:_____.