

## § 160.103

### § 160.103 Definitions.

Except as otherwise provided, the following definitions apply to this subchapter:

*Act* means the Social Security Act.

*ANSI* stands for the American National Standards Institute.

*Business associate*: (1) Except as provided in paragraph (2) of this definition, *business associate* means, with respect to a covered entity, a person who:

(i) On behalf of such covered entity or of an organized health care arrangement (as defined in § 164.501 of this subchapter) in which the covered entity participates, but other than in the capacity of a member of the workforce of such covered entity or arrangement, performs, or assists in the performance of:

(A) A function or activity involving the use or disclosure of individually identifiable health information, including claims processing or administration, data analysis, processing or administration, utilization review, quality assurance, billing, benefit management, practice management, and re-pricing; or

(B) Any other function or activity regulated by this subchapter; or

(ii) Provides, other than in the capacity of a member of the workforce of such covered entity, legal, actuarial, accounting, consulting, data aggregation (as defined in § 164.501 of this subchapter), management, administrative, accreditation, or financial services to or for such covered entity, or to or for an organized health care arrangement in which the covered entity participates, where the provision of the service involves the disclosure of individually identifiable health information from such covered entity or arrangement, or from another business associate of such covered entity or arrangement, to the person.

(2) A covered entity participating in an organized health care arrangement that performs a function or activity as described by paragraph (1)(i) of this definition for or on behalf of such organized health care arrangement, or that provides a service as described in paragraph (1)(ii) of this definition to or for such organized health care arrangement, does not, simply through the performance of such function or activ-

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ity or the provision of such service, become a business associate of other covered entities participating in such organized health care arrangement.

(3) A covered entity may be a business associate of another covered entity.

*CMS* stands for Centers for Medicare & Medicaid Services within the Department of Health and Human Services.

*Compliance date* means the date by which a covered entity must comply with a standard, implementation specification, requirement, or modification adopted under this subchapter.

*Covered entity* means:

(1) A health plan.

(2) A health care clearinghouse.

(3) A health care provider who transmits any health information in electronic form in connection with a transaction covered by this subchapter.

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

*EIN* stands for the employer identification number assigned by the Internal Revenue Service, U.S. Department of the Treasury. The EIN is the taxpayer identifying number of an individual or other entity (whether or not an employer) assigned under one of the following:

(1) 26 U.S.C. 6011(b), which is the portion of the Internal Revenue Code dealing with identifying the taxpayer in tax returns and statements, or corresponding provisions of prior law.

(2) 26 U.S.C. 6109, which is the portion of the Internal Revenue Code dealing with identifying numbers in tax returns, statements, and other required documents.

*Electronic media* means:

(1) Electronic storage media including memory devices in computers (hard drives) and any removable/transportable digital memory medium, such as magnetic tape or disk, optical disk, or digital memory card; or

(2) Transmission media used to exchange information already in electronic storage media. Transmission media include, for example, the internet (wide-open), extranet (using internet technology to link a business with

information accessible only to collaborating parties), leased lines, dial-up lines, private networks, and the physical movement of removable/transportable electronic storage media. Certain transmissions, including of paper, via facsimile, and of voice, via telephone, are not considered to be transmissions via electronic media, because the information being exchanged did not exist in electronic form before the transmission.

*Electronic protected health information* means information that comes within paragraphs (1)(i) or (1)(ii) of the definition of *protected health information* as specified in this section.

*Employer* is defined as it is in 26 U.S.C. 3401(d).

*Group health plan* (also see definition of *health plan* in this section) means 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 (as defined in section 2791(a)(2) of the Public Health Service Act (PHS Act), 42 U.S.C. 300gg-91(a)(2)), including items and services paid for as medical care, to employees or their dependents directly or through insurance, reimbursement, or otherwise, that:

(1) Has 50 or more participants (as defined in section 3(7) of ERISA, 29 U.S.C. 1002(7)); or

(2) Is administered by an entity other than the employer that established and maintains the plan.

*HHS* stands for the Department of Health and Human Services.

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

(1) Preventive, diagnostic, therapeutic, 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.

*Health care clearinghouse* means a public or private entity, including a billing service, repricing company, community health management information system or community health information system, and “value-added” networks and switches, that does either of the following functions:

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

(2) Receives a standard transaction from another entity and processes or facilitates the processing of health information into nonstandard format or nonstandard data content for the receiving entity.

*Health care provider* means a provider of services (as defined in section 1861(u) of the Act, 42 U.S.C. 1395x(u)), a provider of medical or health services (as defined in section 1861(s) of the Act, 42 U.S.C. 1395x(s)), and any other person or organization who furnishes, bills, or is paid for health care in the normal course of business.

*Health information* means 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.

*Health insurance issuer* (as defined in section 2791(b)(2) of the PHS Act, 42 U.S.C. 300gg-91(b)(2) and used in the definition of *health plan* in this section) means 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. Such term does not include a group health plan.

*Health maintenance organization (HMO)* (as defined in section 2791(b)(3) of the PHS Act, 42 U.S.C. 300gg-91(b)(3) and used in the definition of *health plan*

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in this section) means a federally qualified HMO, an organization recognized as an HMO under State law, or a similar organization regulated for solvency under State law in the same manner and to the same extent as such an HMO.

*Health plan* means an individual or group plan that provides, or pays the cost of, medical care (as defined in section 2791(a)(2) of the PHS Act, 42 U.S.C. 300gg-91(a)(2)).

(1) *Health plan* includes the following, singly or in combination:

(i) A group health plan, as defined in this section.

(ii) A health insurance issuer, as defined in this section.

(iii) An HMO, as defined in this section.

(iv) Part A or Part B of the Medicare program under title XVIII of the Act.

(v) The Medicaid program under title XIX of the Act, 42 U.S.C. 1396, *et seq.*

(vi) An issuer of a Medicare supplemental policy (as defined in section 1882(g)(1) of the Act, 42 U.S.C. 1395ss(g)(1)).

(vii) An issuer of a long-term care policy, excluding a nursing home fixed-indemnity policy.

(viii) An employee welfare benefit plan or any other arrangement that is established or maintained for the purpose of offering or providing health benefits to the employees of two or more employers.

(ix) The health care program for active military personnel under title 10 of the United States Code.

(x) The veterans health care program under 38 U.S.C. chapter 17.

(xi) The Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) (as defined in 10 U.S.C. 1072(4)).

(xii) The Indian Health Service program under the Indian Health Care Improvement Act, 25 U.S.C. 1601, *et seq.*

(xiii) The Federal Employees Health Benefits Program under 5 U.S.C. 8902, *et seq.*

(xiv) An approved State child health plan under title XXI of the Act, providing benefits for child health assistance that meet the requirements of section 2103 of the Act, 42 U.S.C. 1397, *et seq.*

(xv) The Medicare+Choice program under Part C of title XVIII of the Act, 42 U.S.C. 1395w-21 through 1395w-28.

(xvi) A high risk pool that is a mechanism established under State law to provide health insurance coverage or comparable coverage to eligible individuals.

(xvii) Any other individual or group plan, or combination of individual or group plans, that provides or pays for the cost of medical care (as defined in section 2791(a)(2) of the PHS Act, 42 U.S.C. 300gg-91(a)(2)).

(2) *Health plan* excludes:

(i) Any policy, plan, or program to the extent that it provides, or pays for the cost of, excepted benefits that are listed in section 2791(c)(1) of the PHS Act, 42 U.S.C. 300gg-91(c)(1); and

(ii) A government-funded program (other than one listed in paragraph (1)(i)-(xvi) of this definition):

(A) Whose principal purpose is other than providing, or paying the cost of, health care; or

(B) Whose principal activity is:

(1) The direct provision of health care to persons; or

(2) The making of grants to fund the direct provision of health care to persons.

*Implementation specification* means specific requirements or instructions for implementing a standard.

*Individual* means the person who is the subject of protected health information.

*Individually identifiable health information* is information that is a subset of health information, including demographic information collected from an individual, and:

(1) Is created or received by a health care provider, health plan, employer, 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; and

(i) That identifies the individual; or

(ii) With respect to which there is a reasonable basis to believe the information can be used to identify the individual.

*Modify* or *modification* refers to a change adopted by the Secretary, through regulation, to a standard or an implementation specification.

*Organized health care arrangement* means:

(1) A clinically integrated care setting in which individuals 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:

(i) Hold themselves out to the public as participating in a joint arrangement; and

(ii) 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; or

(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 protected health information 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 protected health information created or received by such health insurance issuer or HMO that relates to individuals 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; or

(5) The group health plans described in paragraph (4) of this definition and health insurance issuers or HMOs with respect to such group health plans, but

only with respect to protected health information created or received by such health insurance issuers or HMOs that relates to individuals who are or have been participants or beneficiaries in any of such group health plans.

*Protected health information* means individually identifiable health information:

(1) Except as provided in paragraph (2) of this definition, that is:

(i) Transmitted by electronic media;

(ii) Maintained in electronic media;

or

(iii) Transmitted or maintained in any other form or medium.

(2) *Protected health information* excludes individually identifiable health information in:

(i) Education records covered by the Family Educational Rights and Privacy Act, as amended, 20 U.S.C. 1232g;

(ii) Records described at 20 U.S.C. 1232g(a)(4)(B)(iv); and

(iii) Employment records held by a covered entity in its role as employer.

*Secretary* means the Secretary of Health and Human Services or any other officer or employee of HHS to whom the authority involved has been delegated.

*Small health plan* means a health plan with annual receipts of \$5 million or less.

*Standard* means a rule, condition, or requirement:

(1) Describing the following information for products, systems, services or practices:

(i) Classification of components.

(ii) Specification of materials, performance, or operations; or

(iii) Delineation of procedures; or

(2) With respect to the privacy of individually identifiable health information.

*Standard setting organization* (SSO) means an organization accredited by the American National Standards Institute that develops and maintains standards for information transactions or data elements, or any other standard that is necessary for, or will facilitate the implementation of, this part.

*State* refers to one of the following:

(1) For a health plan established or regulated by Federal law, State has the

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meaning set forth in the applicable section of the United States Code for such health plan.

(2) For all other purposes, *State* means any of the several States, the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, and Guam.

*Trading partner agreement* means an agreement related to the exchange of information in electronic transactions, whether the agreement is distinct or part of a larger agreement, between each party to the agreement. (For example, a trading partner agreement may specify, among other things, the duties and responsibilities of each party to the agreement in conducting a standard transaction.)

*Transaction* means the transmission of information between two parties to carry out financial or administrative activities related to health care. It includes the following types of information transmissions:

- (1) Health care claims or equivalent encounter information.
- (2) Health care payment and remittance advice.
- (3) Coordination of benefits.
- (4) Health care claim status.
- (5) Enrollment and disenrollment in a health plan.
- (6) Eligibility for a health plan.
- (7) Health plan premium payments.
- (8) Referral certification and authorization.
- (9) First report of injury.
- (10) Health claims attachments.
- (11) Other transactions that the Secretary may prescribe by regulation.

*Use* means, with respect to individually identifiable health information, the sharing, employment, application, utilization, examination, or analysis of such information within an entity that maintains such information.

*Workforce* means employees, volunteers, trainees, and other persons whose conduct, in the performance of work for a covered entity, is under the direct control of such entity, whether or not they are paid by the covered entity.

[65 FR 82798, Dec. 28, 2000, as amended at 67 FR 38019, May 31, 2002; 67 FR 53266, Aug. 14, 2002; 68 FR 8374, Feb. 20, 2003]

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**§ 160.104 Modifications.**

(a) Except as provided in paragraph (b) of this section, the Secretary may adopt a modification to a standard or implementation specification adopted under this subchapter no more frequently than once every 12 months.

(b) The Secretary may adopt a modification at any time during the first year after the standard or implementation specification is initially adopted, if the Secretary determines that the modification is necessary to permit compliance with the standard or implementation specification.

(c) The Secretary will establish the compliance date for any standard or implementation specification modified under this section.

(1) The compliance date for a modification is no earlier than 180 days after the effective date of the final rule in which the Secretary adopts the modification.

(2) The Secretary may consider the extent of the modification and the time needed to comply with the modification in determining the compliance date for the modification.

(3) The Secretary may extend the compliance date for small health plans, as the Secretary determines is appropriate.

[65 FR 82798, Dec. 28, 2000, as amended at 67 FR 38019, May 31, 2002]

**Subpart B—Preemption of State Law**

**§ 160.201 Applicability.**

The provisions of this subpart implement section 1178 of the Act, as added by section 262 of Public Law 104-191.

**§ 160.202 Definitions.**

For purposes of this subpart, the following terms have the following meanings:

*Contrary*, when used to compare a provision of State law to a standard, requirement, or implementation specification adopted under this subchapter, means:

- (1) A covered entity would find it impossible to comply with both the State and federal requirements; or
- (2) The provision of State law stands as an obstacle to the accomplishment