



Administrative Simplification

Covered Entity Guidance



Find out whether an organization or individual is a covered entity under the Administrative Simplification provisions of HIPAA



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 (referred to here as a “covered health care provider”),
- A health care clearinghouse, or
- A health plan

An organization or individual that is one or more of these types of entities is referred to as a “covered entity” in the Administrative Simplification regulations, and must comply with the requirements of those regulations.

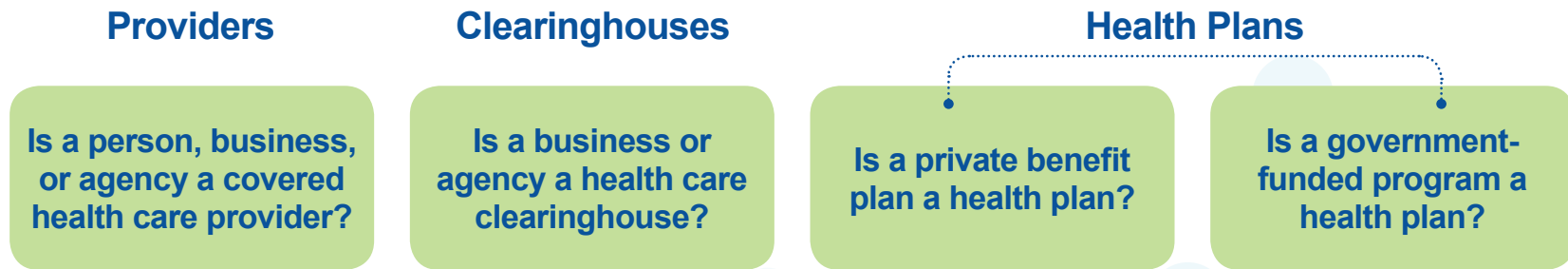
How to Use This Tool

To determine if a person, business, or government agency is a covered entity, go to the question(s) that apply to the person, business, or agency, and answer the questions.

If you are uncertain about which set of questions applies, answer all the questions.

Many terms used here 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.

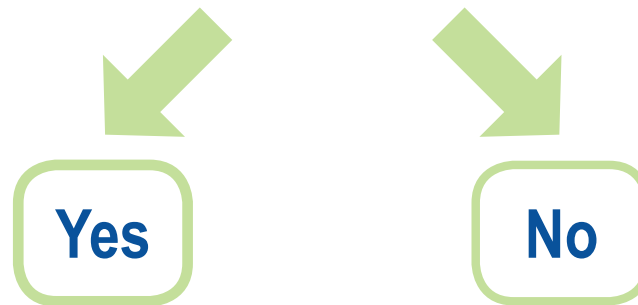
Covered Entity Guidance: Providers, Clearinghouses, Health Plans



Click on the box that reflects the question you want to answer

Covered Entity Guidance: Providers

Q: Does the person, business, or agency furnish, bill, or receive payment for, health care in the normal course of business? 1

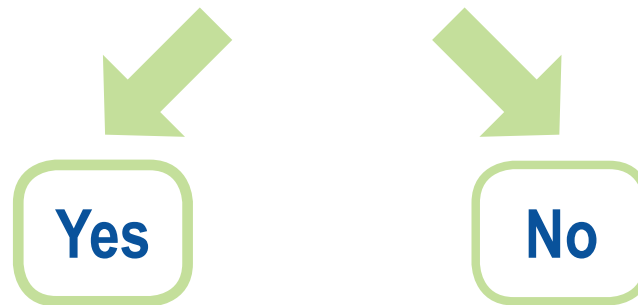


Covered Entity Guidance: Providers

Q: Does the person, business, or agency furnish, bill, or receive payment for health care in the normal course of business?

A: Yes

Q: Does the person, business, or agency transmit (send) any covered transactions electronically? 2



Covered Entity Guidance: Providers

Q: Does the person, business, or agency furnish, bill, or receive payment for health care in the normal course of business?

A: No

The person, business, or agency is NOT a covered health care provider and therefore not a covered entity.

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Covered Entity Guidance: Providers

Q: Does the person, business, or agency transmit (send) any covered transactions electronically? 2

A: Yes

The person, business, or agency is a covered health care provider and therefore a covered entity.

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Covered Entity Guidance: Providers

Q: Does the person, business, or agency transmit (send) any covered transactions electronically?

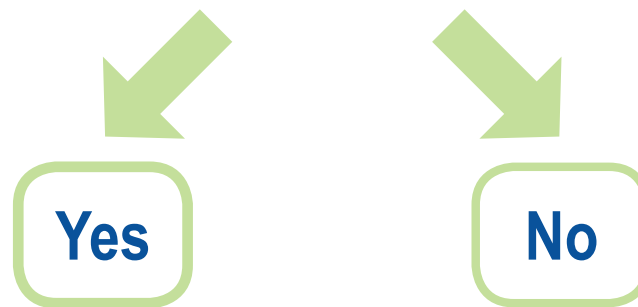
A: No

The person, business, or agency is NOT a covered health care provider and therefore not a covered entity.

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Covered Entity Guidance: Clearinghouses

Q: Does the business or agency process, or facilitate the processing of, health information from nonstandard format or content into standard format or content or from standard format or content into nonstandard format or content? 3

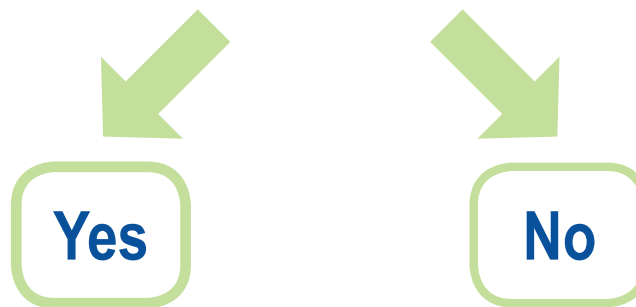


Covered Entity Guidance: Clearinghouses

Q: Does the business or agency process, or facilitate the processing of, health information from nonstandard format or content into standard format or content or from standard format or content into nonstandard format or content?

A: Yes

Q: Does the business or agency perform this function for another legal entity?



Covered Entity Guidance: Clearinghouses

Q: Does the business or agency process, or facilitate the processing of, health information from nonstandard format or content into standard format or content or from standard format or content into nonstandard format or content?

A: No

The business or agency is NOT a health care clearinghouse and therefore not a covered entity.

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Covered Entity Guidance: Clearinghouses

Q: Does the business or agency perform this function for another legal entity?

A: Yes

The business or agency is a health care clearinghouse and therefore a covered entity.

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Covered Entity Guidance: Clearinghouses

Q: Does the business or agency perform this function for another legal entity?

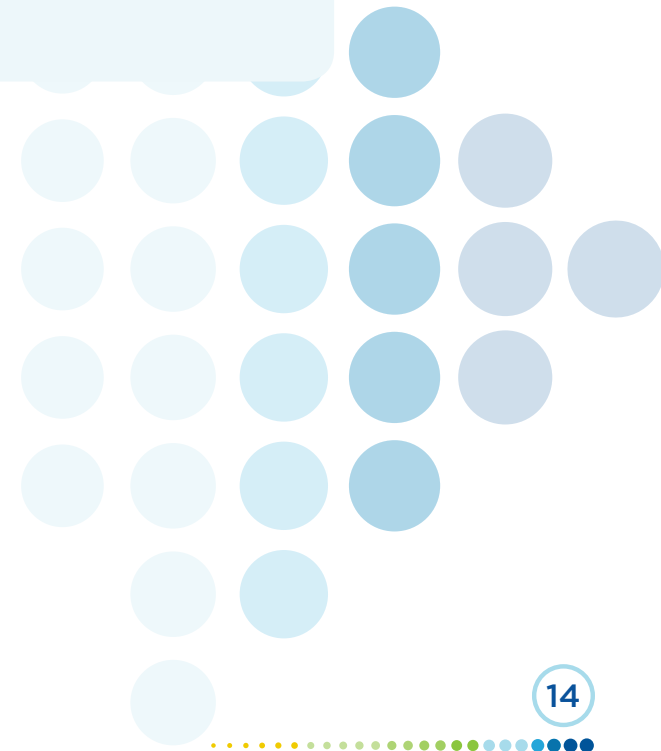
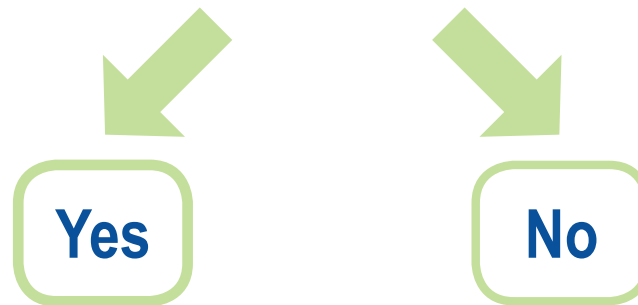
A: No

The business or agency is NOT a health care clearinghouse and therefore not a covered entity.

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Covered Entity Guidance: Private Benefit Plans

Q: Is the plan an individual or group plan, or combination thereof, that provides, or pays for the cost of, medical care? 4



Covered Entity Guidance: Private Benefit Plans

Q: Is the plan an individual or group plan, or combination thereof, that provides, or pays for the cost of, medical care?

A: No

The plan is NOT a health plan and therefore not a covered entity.

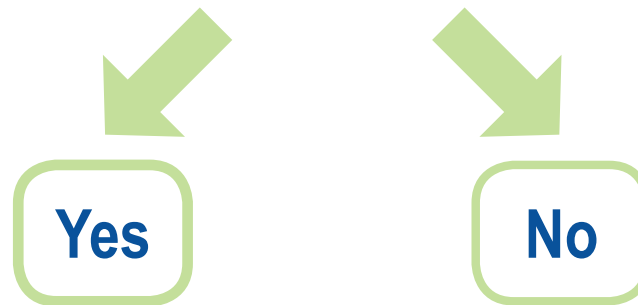
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Covered Entity Guidance: Private Benefit Plans

Q: Is the plan an individual or group plan, or combination thereof, that provides, or pays for the cost of, medical care?

A: Yes

Q: Is the plan a group health plan? 5

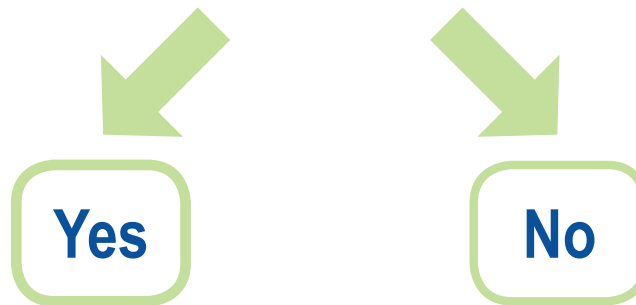


Covered Entity Guidance: Private Benefit Plans

Q: Is the plan a group health plan?

A: Yes

Q: Does the plan have both of the following characteristics: (a) it has fewer than 50 participants and (b) it is self-administered? 6



Covered Entity Guidance: Private Benefit Plans

Q: Is the plan a group health plan?

A: No

Q: Is the plan a health insurance issuer? 7



Yes



No

Covered Entity Guidance: Private Benefit Plans

Q: Does the plan have both of the following characteristics: (a) it has fewer than 50 participants and (b) it is self-administered?

A: Yes

The plan is NOT a health plan and therefore not a covered entity.

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Covered Entity Guidance: Private Benefit Plans

Q: Does the plan have both of the following characteristics: (a) it has fewer than 50 participants and (b) it is self-administered?

A: No

The plan is a health plan and therefore a covered entity.

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Covered Entity Guidance: Private Benefit Plans

Q: Is the plan a health insurance issuer?

A: Yes

The plan is a health plan and therefore a covered entity.

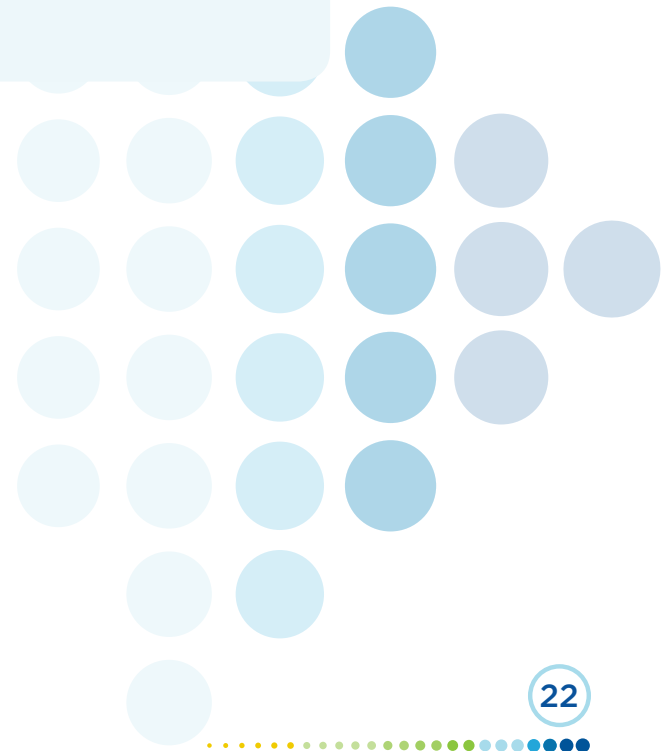
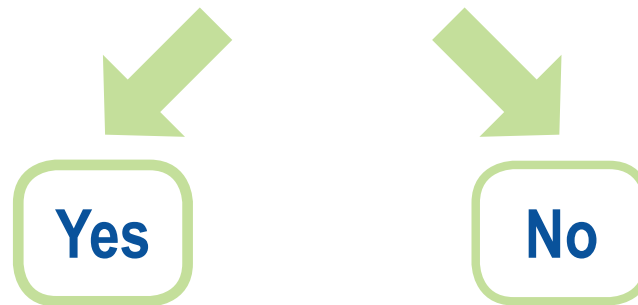
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Covered Entity Guidance: Private Benefit Plans

Q: Is the plan a health insurance issuer?

A: No

Q: Is the plan an issuer of a Medicare supplemental policy? 8



Covered Entity Guidance: Private Benefit Plans

Q: Is the plan an issuer of a Medicare supplemental policy?

A: Yes

The plan is a health plan and therefore a covered entity.

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Covered Entity Guidance: Private Benefit Plans

Q: Is the plan an issuer of a Medicare supplemental policy?

A: No

Q: Is the plan a health maintenance organization (HMO)? 9

Yes

No

Covered Entity Guidance: Private Benefit Plans

Q: Is the plan a health maintenance organization (HMO)?

A: Yes

The plan is a health plan and therefore a covered entity.

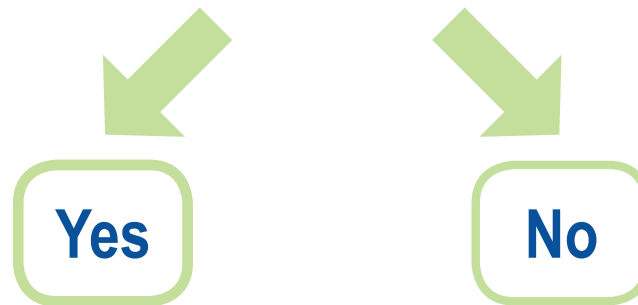
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Covered Entity Guidance: Private Benefit Plans

Q: Is the plan a health maintenance organization (HMO)?

A: No

Is the plan a multi-employer welfare benefit plan? 10



Covered Entity Guidance: Private Benefit Plans

Q: Is the plan a multi-employer welfare benefit plan?

A: Yes

The plan is a health plan and therefore a covered entity.

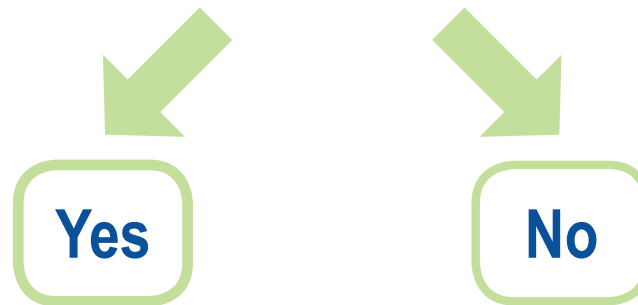
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Covered Entity Guidance: Private Benefit Plans

Q: Is the plan a multi-employer welfare benefit plan?

A: No

Q: Is the plan an issuer of long-term care policies?



Covered Entity Guidance: Private Benefit Plans

Q: Is the plan an issuer of long-term care policies?

A: Yes

Q: Does the plan provide only nursing home fixed-indemnity policies?



Yes



No

Covered Entity Guidance: Private Benefit Plans

Q: Is the plan an issuer of long-term care policies?

A: No

Q: Does the plan provide only excepted benefits? 11



Yes



No

Covered Entity Guidance: Private Benefit Plans

Q: Does the plan provide only excepted benefits?

A: Yes

The plan is NOT a health plan and therefore not a covered entity.

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Covered Entity Guidance: Private Benefit Plans

Q: Does the plan provide only excepted benefits?

A: No

The plan is a health plan and therefore a covered entity.

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Covered Entity Guidance: Private Benefit Plans

Q: Does the plan provide only nursing home fixed-indemnity policies?

A: Yes

The plan is NOT a health plan and therefore not a covered entity.

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Covered Entity Guidance: Private Benefit Plans

Q: Does the plan provide only nursing home fixed-indemnity policies?

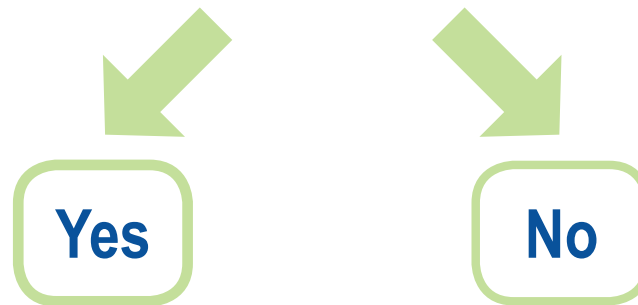
A: No

The plan is a health plan and therefore a covered entity.

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Covered Entity Guidance: Government-Funded Programs

Q: Is the program one of the listed government health plans? 12



Covered Entity Guidance: Government-Funded Programs

Q: Is the program one of the listed government health plans?

A: Yes

The plan is a health plan and therefore a covered entity.

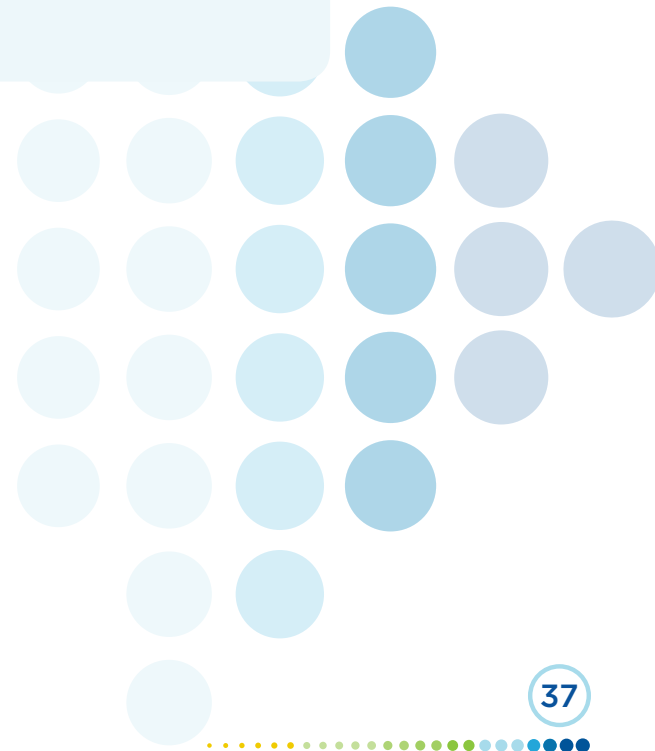
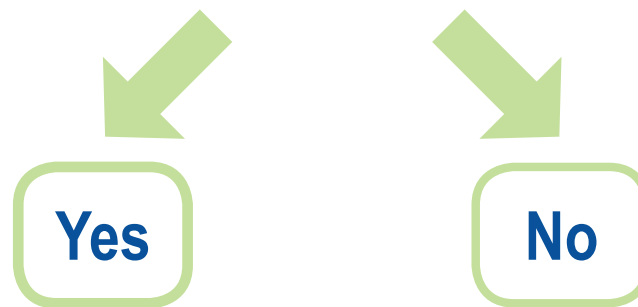
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Covered Entity Guidance: Government-Funded Programs

Q: Is the program one of the listed government health plans?

A: No

Q: Is the program an individual or group plan that provides, or pays the cost of, medical care? 4

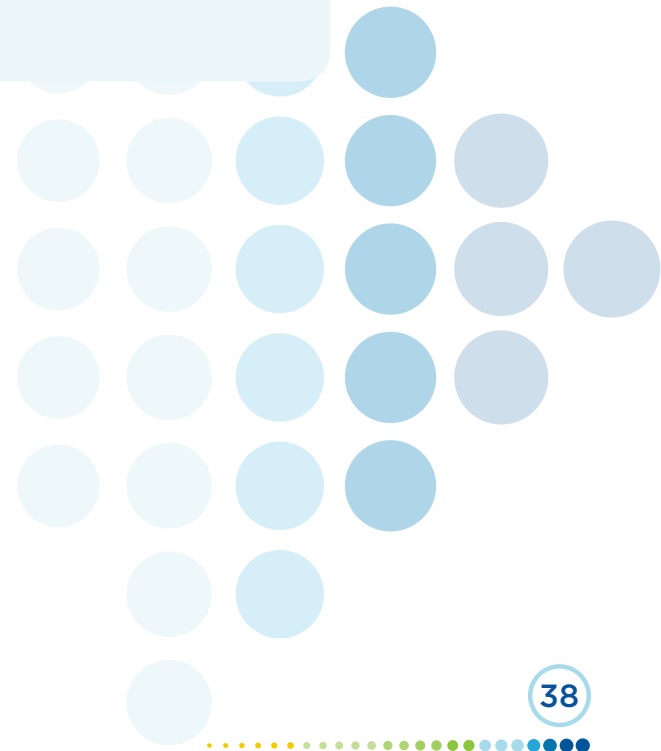
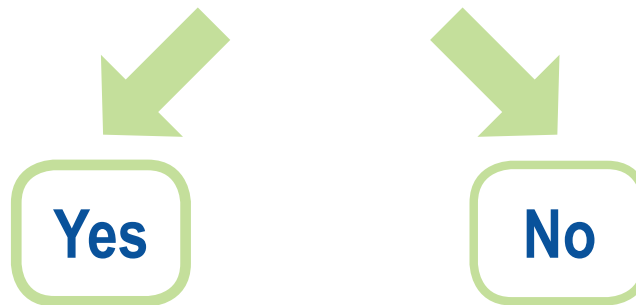


Covered Entity Guidance: Government-Funded Programs

Q: Is the program an individual or group plan that provides, or pays the cost of, medical care?

A: Yes

Q: Is the program a high risk pool? 13



Covered Entity Guidance: Government-Funded Programs

Q: Is the program an individual or group plan that provides, or pays the cost of, medical care?

A: No

The plan is NOT a health plan and therefore not a covered entity.

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Covered Entity Guidance: Government-Funded Programs

Q: Is the program a high risk pool?

A: Yes

The plan is a health plan and therefore a covered entity.

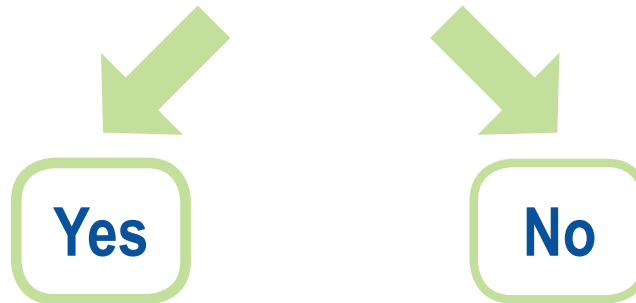
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Covered Entity Guidance: Government-Funded Programs

Q: Is the program a high risk pool?

A: No

Q: Is the plan a health maintenance organization (HMO)? 9



Covered Entity Guidance: Government-Funded Programs

Q: Is the plan a health maintenance organization (HMO)?

A: Yes

The plan is a health plan and therefore a covered entity.

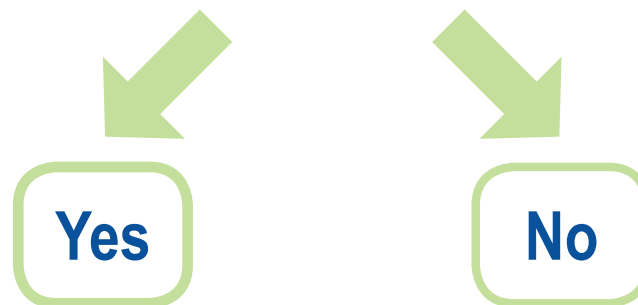
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Covered Entity Guidance: Government-Funded Programs

Q: Is the plan a health maintenance organization (HMO)?

A: No

Q: Is the principal activity of the program providing health care directly?



Covered Entity Guidance: Government-Funded Programs

Q: Is the principal activity of the program providing health care directly?

A: Yes

The plan is NOT a health plan and therefore not a covered entity.

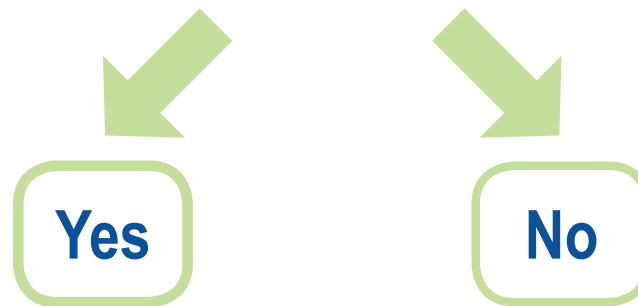
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Covered Entity Guidance: Government-Funded Programs

Q: Is the principal activity of the program providing health care directly?

A: No

Q: Is the principal activity of the program the making of grants to fund the direct provision of health care (e.g., through funding a health clinic)?



Covered Entity Guidance: Government-Funded Programs

Q: Is the principal activity of the program the making of grants to fund the direct provision of health care (e.g., through funding a health clinic)?

A: Yes

The plan is NOT a health plan and therefore not a covered entity.

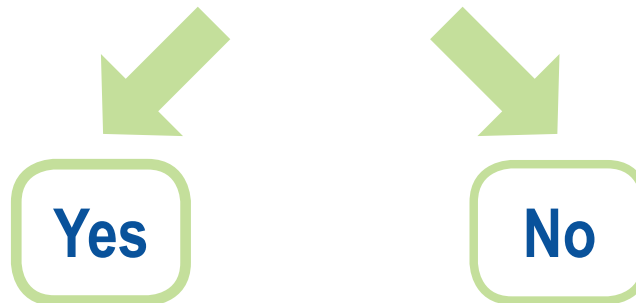
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Covered Entity Guidance: Government-Funded Programs

Q: Is the principal activity of the program the making of grants to fund the direct provision of health care (e.g., through funding a health clinic)?

A: No

Q: Is the principal purpose of the program other than providing or paying the cost of health care (e.g., operating a prison system, running a scholarship or fellowship program)?



Covered Entity Guidance: Government-Funded Programs

Q: Is the principal purpose of the program other than providing or paying the cost of health care (e.g., operating a prison system, running a scholarship or fellowship program)?

A: Yes

The plan is NOT a health plan and therefore not a covered entity.

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Covered Entity Guidance: Government-Funded Programs

Q: Is the principal purpose of the program other than providing or paying the cost of health care (e.g., operating a prison system, running a scholarship or fellowship program)?

A: No

Q: Does the program provide only excepted benefits? 11



Covered Entity Guidance: Government-Funded Programs

Q: Does the program provide only excepted benefits?

A: Yes

The plan is NOT a health plan and therefore not a covered entity.

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Covered Entity Guidance: Government-Funded Programs

Q: Does the program provide only excepted benefits?

A: No

The plan is a health plan and therefore a covered entity.

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Covered Entity Guidance: Definitions

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 healthcare 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.

These definitions for each type of covered transaction are provided below:

[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.

Covered Entity Guidance: Definitions

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:

Covered Entity Guidance: Definitions

(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:

Covered Entity Guidance: Definitions

- (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. As pertinent here, a **health care clearing house** is a “public or private entity... that performs 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.

Covered Entity Guidance: Definitions

(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](#).

4. 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 [45 CFR Part 140](#).

5. 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, 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 (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](#).

6. 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

Covered Entity Guidance: Definitions

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.

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](#).

Covered Entity Guidance: Definitions

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. 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 (45 CFR Parts [1002](#), [1003](#)); the health care program for active military personnel ([32 CFR Part 108](#)); the veterans health care program ([38 U.S.C. Ch. 17](#)); the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) ([32 CFR Part 199.2](#)); the Indian Health Service program under the Indian Health Care Improvement Act ([42 CFR Part 136](#)); 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).

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