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**Human Resources Operating Procedure No. 125**

**HIPAA Privacy and Security**

**Trinity Health Corporation Welfare Benefit Plan**

**Trinity Health Corporation Retiree Benefit Plan (Grandfathered)**

**Integrity & Compliance Policy No. 01 Integrity & Compliance Program**

EFFECTIVE DATE*:* January, 12017

Original Effective Date: April 14, 2003

PROCEDURE TITLE:

***Restrictions on the Use or Disclosure of***

***Protected Health Information for Marketing***

***Activities***

***To be reviewed every three years by:***

***Trinity Health Corporation Welfare Benefit Plan Privacy Official***

**REVIEW BY January, 1 2020**

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This Procedure is in furtherance of the Trinity Health Corporation Integrity & Compliance Program as set forth in Trinity Health Corporation Integrity & Compliance Policy No. 01.

**PURPOSE**

The purpose of this Procedure is to outline when the Plan and its Business Associates may Use and Disclose PHI for Marketing activities. If the regulations under HIPAA are changed by HHS the Plan will follow the revised regulations.

**PROCEDURES**

***1. Uses and Disclosure of PHI for Marketing Activities***

* 1. In General. The Plan (or the Plan’s Business Associate if it will be making the communication) is responsible for determining if a communication is Marketing and, if it is Marketing, whether an Authorization is required before making the communication.
  2. Remuneration is Received but Written Authorization is Not Required. If a communication is to provide refill reminders or otherwise communicate about a drug or biologic that is currently being prescribed for the Individual, an Authorization from the Individual is not required if any financial remuneration received by the Plan in exchange for making the communication is reasonably related to the Plan’s cost of making the communication.
  3. Treatment and Health Care Operations. Using and Disclosing PHI for Marketing for Treatment and/or Health Care Operations to the Individual whose PHI is Used or Disclosed, does not require an Authorization unless direct or indirect financial remuneration is received by the Plan in exchange for the communication. Accordingly, the following communications are permitted without an Authorization unless the Plan receives financial remuneration in exchange for making the communication:

i. For Treatment of an Individual by a health care provider, including case management or care coordination for the Individual, or to direct or recommend alternative treatments, therapies, health care providers, or settings of care to the individual;

ii. To describe a health-related product or service (or payment for such product or service) that is provided by, or included in a plan of benefits of, the Covered Entity making the communication, including communications about: the entities participating in a health care provider network or health plan network; replacement of, or enhancements to, a health plan; and health-related products or services available only to a health plan enrollee that add value to, but are not part of, a plan of benefits; and

iii. For case management or care coordination, contacting of Individuals with information about treatment alternatives, and related functions to the extent these activities do not fall within the definition of Treatment.

***2. Marketing – Written Authorization is Required.***

a. If a communication is Marketing, except as provided in Section 1. of this Procedure, the Plan (or its Business Associate, if applicable) must obtain the Individual’s Authorization in order to Use or Disclose his or her PHI for the Marketing purpose unless the communication is in the form of a face-to-face communication made by the Plan to the Individual or a promotional gift of nominal value provided by the Plan. For example, Using an Individual’s PHI for Marketing other than to the Individual requires the Individual’s Authorization (e.g., Using an Individual’s PHI as a testimonial).

i. The Plan (or its Business Associate, if applicable) will take steps to help ensure that, for those Marketing communications requiring an Authorization, it obtains such Authorization prior to making the communication. The Plan will follow the requirements set forth in Human Resources Operating Procedure No. 120 (Use and Disclose of Protected Health Information).

ii. The Plan (or its Business Associate, if applicable) is responsible for taking steps to ensure that PHI Used or Disclosed pursuant to an Authorization for a Marketing communication is not Used or Disclosed outside the permissible parameters of the Authorization.

b. If Marketing involves financial remuneration to the Plan from a third party, an Authorization must state that such remuneration is involved.

c. If a communication is not Marketing, is described in Section 1.b. or c., is a face-to-face communication made by the Plan (or its Business Associate, if applicable) to an Individual or is a promotional gift of nominal value provided by the Plan (or its Business Associate, if applicable), the Plan (or its Business Associate, if applicable) does not need to obtain the Individual’s Authorization in order to Use or Disclose his or her PHI for the Marketing purpose but must comply with any other applicable requirements under the Privacy Rule.

# DEFINITIONS

The following are definitions of key terms used in this Procedure. Any terms used in this Procedure, but not otherwise defined herein, shall have the meaning set forth in the HIPAA regulations, 45 CFR §§ 160.103, 164.103, 164.304, 164.402 and 164.501.

**Authorization means** the written permission from an Individual that permits the Plan to Use or Disclose PHI for purposes beyond the scope of Treatment, Payment or Healthcare Operations.

**Business Associate means**, with respect to a Covered Entity, a person or organization that:

1. Creates, receives, maintains, or transmits PHI for a function or activity on behalf of a Covered Entity other than in the capacity of a member of the Covered Entity’s Workforce; or

2. Provides, other than in the capacity of a member of the Covered Entity’s Workforce, legal, actuarial, accounting, consulting, data aggregation, management, administrative, accreditation, or financial services to or for the Covered Entity, where the provision of the service involves the Disclosure of PHI from the Covered Entity, or from another Business Associate of the Covered Entity, to the person.

However, a person or organization is not a Business Associate if it is:

3. A health care provider (e.g., hospital medical staff), with respect to Disclosures by a Covered Entity to the health care providing concerning the treatment of an individual; or

4.. A plan sponsor with respect to Disclosures by a group health plan (or by a health insurance issuer or HMO with respect to a group health plan) to the plan sponsor, to the extent the requirements of 45 CFR § 164.504(f) of HIPAA apply and are met.

**Covered Entity means** (a) a health plan, (b) a healthcare clearinghouse, or (c) a health care provider who transmits any health information in an electronic form in connection with a transaction covered under 45 CFR Subtitle A, Subchapter C, Parts, 160, 162 and 164.

**Disclosure (or Disclose) means**, with respect to PHI, the release, transfer, provision of access to, or divulging in any other manner of information outside the entity holding the information.

**HHS means** the U.S. Department of Health and Human Services.

**Healthcare Operations means** any of the following activities of the Covered Entity to the extent that the activities are related to covered functions:

1. Conducting quality assessment and improvement activities, including outcomes evaluation and development of clinical guidelines, provided that the obtaining of generalizable knowledge is not the primary purpose of any studies resulting from such activities; patient safety activities (as defined in 42 CFR § 3.20), population-based activities relating to improving health or reducing health care costs, protocol development, case management and care coordination, contacting of health care providers and patients with information about treatment alternatives; and related functions that do not include treatment;

2. Reviewing the competence or qualifications of health care professionals, evaluating practitioner and provider performance, health plan performance, conducting training programs in which students, trainees or practitioners in areas of health care learn under supervision to practice or improve their skills as health care providers, training of non-health care professionals, accreditation, certification, licensing or credentialing activities;

3. Except as prohibited under 45 CFR §164.502(a)(5)(i) (prohibited use of genetic information for underwriting), underwriting, enrollment, premium rating and other activities relating to the creation, renewal or replacement of a contract of health insurance or health benefits, and ceding, securing or placing a contract for reinsurance of risk relating to claims for health care (including stop-loss insurance and excess of loss insurance);

4. Conducting or arranging for medical review, legal services and auditing functions, including fraud and abuse detection and compliance programs;

5. Business planning and development, such as conducting cost-management and planning-related analyses related to managing and operating the entity, including formulary development and administration, development or improvement of methods of payment or coverage policies; and

6. Business management and general administrative activities of the entity, including, but not limited to:

a. Management activities relating to implementation of and compliance with the requirements of HIPAA;

b. Customer service, including the provision of data analyses for policy holders, plan sponsors, or other customers, provided that PHI is not disclosed to such policy holder, plan sponsor, or customer;

c. Resolution of internal grievances;

d. The sale, transfer, merger or consolidation of all or part of the Covered Entity with another Covered Entity, or an entity that, following such activity, will become a Covered Entity, and due diligence related to such activity; and

e. Consistent with the applicable requirements of HIPAA, creating de-identified health information or a limited data set, and fund raising for the benefit of the Covered Entity.

**HIPAA means** the Privacy Standards of the Health Insurance Portability and Accountability Act of 1996 (P.L. 104-191), 42 U.S.C. § 1320d, et. seq., and the regulations issued thereunder, 45 CFR Parts 160 and 164, as amended from time to time.

**Individual** **means** the person who is the subject of PHI and who is also a participant or former participant in the Plan or a covered spouse, dependent or beneficiary under the Plan.

**Individually Identifiable Health Information means** information that is a subset of health information, including demographic information collected from an Individual, and that:

1. Is created or received by a health care provider, health plan, employer, or health care clearing house; 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

3. Identifies the Individual or with respect to which there is a reasonable basis to believe the information can be used to identify the Individual.

**Marketing** **means** a communication about a product or service that encourages recipients of the communication to purchase or use the product or service. Marketing does not include communications made:

1. To provide refill reminders or otherwise communicate about a drug or biologic that is currently being prescribed for the Individual, only if any financial remuneration received by the Covered Entity in exchange for making the communication is reasonably related to the Covered Entity’s cost of making the communication;

2. For the following Treatment and Healthcare Operations purposes, except where the Covered Entity receives financial remuneration in exchange for making the communication:

a. For Treatment of an Individual by a health care provider, including case management or care coordination for the Individual, or to direct or recommend alternative treatments, therapies, health care providers, or settings of care to the individual;

b. To describe a health-related product or service (or payment for such product or service) that is provided by, or included in a plan of benefits of, the Covered Entity making the communication, including communications about: the entities participating in a health care provider network or health plan network; replacement of, or enhancements to, a health plan; and health-related products or services available only to a health plan enrollee that add value to, but are not part of, a plan of benefits; or

c. For case management or care coordination, contacting of Individuals with information about treatment alternatives, and related functions to the extent these activities do not fall within the definition of Treatment.

3. Financial remunerationmeans direct or indirect payment from or on behalf of a third party whose product or service is being described. Direct or indirect payment does not include any Payment for Treatment of an Individual.

**Payment** **means**:

1. The activities undertaken by:

a. Except as prohibited under 45 CFR §164.502(a)(5)(i) (prohibited use of genetic information for underwriting), a health plan to obtain premiums or to determine or fulfill its responsibility for coverage and provision of benefits under the health plan; or

b. A health care provider or health plan to obtain or provide reimbursement for the provision of health care; and

2. The activities in paragraph 1. of this definition relate to the Individual to whom health care is provided and include, but are not limited to:

a. Determinations of eligibility or coverage (including coordination of benefits or the determination of cost sharing amounts) and adjudication or subrogation of health benefit claims;

b. Risk adjusting amounts due based on enrollee health status and demographic characteristics;

c. Billing, claims management, collection activities, obtaining payment under a contract for reinsurance (including stop-loss insurance and excess of loss insurance) and related healthcare data processing;

d. Review of healthcare services with respect to medical necessity, coverage under a health plan, appropriateness of care or justification of charges;

e. Utilization review activities, including precertification and preauthorization of services, concurrent and retrospective review of services; and

f. Disclosure to consumer reporting agencies of any of the following PHI relating to collection of premiums or reimbursement:

i. Name and address;

ii. Date of birth;

iii. Social security number;

iv. Payment history;

v. Account number; and

vi. Name and address of the healthcare provider and/or health plan.

**Plan means** the Trinity Health Corporation Welfare Benefit Plan (“Welfare Plan”) and the Trinity Health Corporation Retiree Benefit Plan (Grandfathered) (“Retiree Plan”), with respect to the benefit programs thereunder that constitute “health plans,” as defined in 45 CFR § 160.103. For the Welfare Plan, the benefit programs that constitute health plans are the medical/prescription drug, dental, vision, employee assistance, flexible healthcare spending account and healthcare reimbursement account program components of the Plan. For the Retiree Plan, the benefit programs that constitute health plans are the medical/prescription drug, dental, vision and healthcare reimbursement account program components of the Plan. The Welfare Plan and the Retiree Plan are each a Covered Entity. Whenever reference is made to the Plan’s action, the activities of the Plan Sponsor on behalf of the Plan shall be treated as the action of the Plan.

**Plan Sponsor** **means** the “plan sponsor” as defined in section 3(16)(B) of ERISA, 29 U.S.C. § 1002(16)(B) and means Trinity Health Corporation and, except where context indicates otherwise, employees and agents of Trinity Health Corporation and the other participating employers in the Plan who are responsible for Plan administration functions.

**Privacy Official means** the person designated by the Plan or Plan Sponsor to oversee and administer the Plan’s compliance with these Procedures and HIPAA.

**Protected Health Information or PHI means** Individually Identifiable Health Information that is transmitted by electronic media, maintained in electronic media, or transmitted or maintained in any other form or medium. PHI excludes Individually Identifiable Health Information: (a) in education records covered by the Family Educational Rights and Privacy Act, as amended, 20 U.S.C. 1232g; (b) in records described at 20 U.S.C. 1232g(a)(4)(B)(iv); (c) in employment records held by a the Plan Sponsor or a Covered Entity in its role as employer; and (d) regarding a person who has been deceased for more than 50 years.

**Treatment means** the provision, coordination, or management of healthcare and related services by one or more healthcare providers, including the coordination or management of healthcare by a healthcare provider with a third party; consultation between healthcare providers relating to a patient; or the referral of a patient for health care from one health care provider to another.

**Use (or Uses) means**, with respect to PHI, the sharing, employment, application, utilization, examination, or analysis of such information within an entity that maintains such information.

**Workforce or Workforce Member** **means** employees and other persons whose conduct, in the performance of work for the Plan, is under the direct control of the Plan or Plan Sponsor or one of its affiliated entities on behalf of the Plan, whether or not they are paid by the Plan or Plan Sponsor or one of its affiliated entities. The Workforce Members are described in Section 2.a.i. of Human Resources Operating Procedure No. 122 (Minimum Necessary Use or Disclosure of

Protected Health Information).

**RELATED PROCEDURES AND OTHER MATERIALS**

* Human Resources Operating Procedure No. 120 (Use or Disclosure of Protected Health Information)
* Human Resources Operating Procedure No. 122 (Minimum Necessary Use or Disclosure of Protected Health Information)
* Human Resources Operating Procedure No. 123 (Business Associate Agreements)
* Enterprise Information Security Procedures

**APPROVALS**

**Initial Approval: 04/14/2003**

**Subsequent Review/Revisions: December 20, 2016**