



Analysis of the Proposed Rule, August 22, 2008, Health Insurance Reform; Modifications to the Health Insurance Portability and Accountability Act (HIPAA) Electronic Transaction Standards

On Friday, August 22, 2008, the Department of Health and Human Services (HHS) published a proposed rule for modifications to the HIPAA electronic transaction standards under rules, 45 CFR Part 162, of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

An electronic copy of this Proposed Rule can be found on the electronic Web pages of the *Federal Register* at www.access.gpo.gov/su_docs/fedreg/a080822c.html . Look for the Health and Human Services Department Proposed Rule. HHS also published a Proposed Rule to Modify the Medical Data Code Set by adopting ICD-10-CM and ICD-10-PCS.

Key Highlights of the Proposed Rule

- ASC X12 and NCPDP HIPAA standards are proposed to update the current standards in use, with a compliance date of April 1, 2010 (except for Medicaid Pharmacy Subrogation).
- Comments on the August 22, 2008 Proposed Rule are due to HHS no later than October 21, 2008.
- ASC X12 and NCPDP standards versions will affect all HIPAA-covered entities. There will be no staggered implementation dates (for example, for large versus small entities) except for Medicaid Pharmacy Subrogation.
- HHS expects the upgraded HIPAA standards to be implemented with much less impact than the original HIPAA standards, since they will essentially build on the original standards.
- These HIPAA standards among other improvements will facilitate the implementation and use of ICD-10 classification codes proposed by HHS in a companion proposed rule.
- Adoption and implementation of the HIPAA transaction standards upgrade provide:
 - Clearer instructions in the standards and guidance,
 - Elimination of ambiguous language and redundant and unnecessary data content requirements,
 - Clearly defined rules for required and situational data elements,
 - Consistent data representation,
 - Increased functionality and consistency, and
 - Accommodation for business needs sought by the industry since inception in 2000.
- Costs and benefits for the industry and government were reviewed by Gartner. Net benefits to those covered range from \$7,378,000 to \$42,123,000.

This HHS proposal for adoption of the updated transaction sets CMS-0009-P (RIN 0538-AN50) would upgrade the HIPAA transaction standards using Accredited Standards Committee X12 (X12) from standards version 4010 to version 5010 technical reports type 3 and National Council for Prescription Drug Programs (NCPDP) telecommunication Standard version 5.0 to telecommunication standard

implementation guide version D Release 0 (D.0). HHS also introduces Medicaid Pharmacy Subrogation into the mix of standards.

Comments on this proposal are due by 5 p.m. eastern on October 21, 2008. On page 73FR49742 instructions are given for submitting comments and what information must be conveyed with the comments. Comments must have the file code CMS-0009-P.

Questions for HHS regarding this proposed rule can be directed to:

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AHIMA has initiated a Web page dedicated to the adoption of the ICD-10-based code sets at www.ahima.org/icd10. This Web page also addresses, to some extent, the adoption and implementation of the X12 and NCPDP standards.

NOTICE: This review of the Proposed Rule for Health Insurance Reform; Modifications to the HIPAA Electronic Transaction Standards is intended for as overview of the proposed rule and not as a complete analysis of the rule. Readers seeking to comment on the proposed rule to the Department of Health and Human Services are encouraged to read the entire rule and not rely on this or any other summary of the rule.

I. Background (73FR49743)

Legislative

HHS provides this initial section to summarize the statutory and regulatory background for adoption of and modification of the electronic transaction standards covered by HIPAA. HIPAA, otherwise known as Public Law 104-191, was enacted on August 21, 1996.

Regulatory (73FR49743)

The HIPAA Health Insurance Reform: Standards for Electronic Transactions final regulatory rule was published on August 17, 2000 (65FR50312) and adopted standards for eight electronic transactions for use by covered entities. These transactions included: healthcare claims or equivalent encounter information; healthcare payment and remittance advice; coordination of benefits; eligibility for a health plan; healthcare claim status; enrollment and disenrollment in a health plan; referral certification and authorization; and health plan premium payments. These transactions were specified at 45 CFR part 162, subparts I and K through R. NCPDP Telecommunication standard version 5.1 and its equivalent batch standard was adopted for retail pharmacy drug claims under the healthcare claims or equivalent encounter transaction, as well as the eligibility for health plan transaction for retail pharmacy drugs, the retail pharmacy drug claims remittance advice transaction, and the coordination of benefits information transaction for retail pharmacy drug claims. The 2000 final rule also provided a procedure for maintaining existing standards, and for adopting modifications to existing standards, and for the adoption of new standards. On February 20, 2003, HHS published a final rule titled *Health Insurance Reform: Modifications to Electronic Data Transaction Standards and Code Sets* (68FR8381). In that rule certain modifications to some of the eight electronic standards transactions were made.

HHS suggests that for information about the ballots and construction of the standards, readers should visit the Web sites of the standards organizations.

- ASC X12: www.x12.org/ and www.disa.org/
- NCPDP: www.ncpdp.org/

Information on the HIPAA standards can also be found at www.wpc-edi.com/.

Standards Adoption and Modification (73FR49744)

HHS goes on to describe Standards Development Organizations (SDO), noting all are accredited by the American National Standards Institute (ANSI); and the **designated standards maintenance organizations (DSMO)**. In 2000 the Secretary designated six organizations (65FR50373) to maintain the healthcare transaction standards adopted by the Secretary and to process requests for modifying an adopted standard or for adopting a new standard. The six included the X12 and NCPDP along with Health Level Seven (HL7), the National Uniform Billing Committee (NUBC), the National Uniform Claim Committee (NUCC), and the Dental Content Committee (DCC). More information on the DSMO process can be found at www.hipaa-dsmo.org/Main.asp.

HHS also describes the process and steps necessary to **adopt modifications to a standard(s)**, including the roles of the SDOs, DSMO, and the National Committee on Vital and Health Committee (NCVHS) which serves as the principal advisor to the Secretary for HIPAA transactions. The proposed rule also describes recent hearings that the NCVHS held relevant to the proposal now being made and the September 26, 2007 recommendations of the Committee that can be found at www.ncvhs.hhs.gov/070926lt.pdf.

Finally, this section covers the operating rules for the standards noting that each adopted standard has operating rules documented in an **implementation specification or guide**. These implementation specifications or guides comprise the specific instruction for implementing a standard. Technical Reports Type 3 for the X12 standards was initiated in 2003 and is part of what is being proposed in the new rule. NCPDP has not updated its terminology and NCPDP standards continue to be referred to as implementation guides or specifications.

Highlights of this section:

- Congress adopted the use of electronic transaction set standards for various healthcare claims-related functions as part of the HIPAA.
- HHS proposed the initial transaction standards to be used for healthcare transactions in a final rule published on August 17, 2000, and slightly modified on February 20, 2003.
- ASC X12 and NCPDP standards were chosen to be used for eight transactions: healthcare claims or equivalent encounter information; healthcare payment and remittance advice; coordination of benefits; eligibility for a health plan; healthcare claim status; enrollment and disenrollment in a health plan; referral certification and authorization; and health plan premium payments.
- HHS is proposing to upgrade the X12 and NCPDP standards by adopting X12 Technical Reports Type 3 Version 5010, NCPDP Telecommunication Version D.0 and Medicaid Pharmacy Subrogation: NCPDP Medicaid Subrogation Implementation Guide, Version 3.0
- NCVHS provided final recommendations on the upgrading of the X12 and NCPDP Telecommunication Standards in September 2007. These recommendations came from not only

the upgraded versions of the standards by the SDOs, but also the recommendations of the DSMO.

II. Provisions of the Proposed Rules (73FR49745)

This section describes the proposed changes to the standards.

Proposed Adoption of X12 Version 5010 Technical Reports Type 3 for HIPAA Transactions (73FR49745)

HIPAA the wording of §162 that will be changes to facilitate the adoption of X12 Technical Reports Type 3 Version 5010 (referred to as Version 5010), and is a modification of X12 Version 4010 and 4010A. HHS is also adopting the errata connected with 5010 Type 1. The affected transactions (see below) are listed as well, and HHS notes that the upgraded transactions will, with implementation:

- Provide clearer instructions,
- Eliminate ambiguous language,
- Clearly defined the rules for required and situational data element,
- Consistent data representation, and
- Other technical improvements.

HHS also notes that **structural changes** to the physical components of the transactions have been made. New segments and new data elements were added and data elements were modified or removed to make the data elements longer, shorter, or of a different data type to add functionality and improve consistency.

Data content has also been modified so that redundant and unnecessary data content requirements have been removed to eliminate confusion for implementers. Additional requirements have been added where necessary to clarify existing data content requirements, and HHS notes the companion proposed rule to adopt ICD-10-CM and ICD-10-PCS which must be recognized in the upgraded X12 and NCPDP transaction standards.

Each of the **HIPAA transactions are reviewed** with the proposed rule's text identifying the major changes that impact the specific transaction:

- **Health Care Claims or Equivalent Encounter Information Transaction (X12 837).** HHS reviews each of the three versions of the 837 – Institutional (837I) Professional (837P), and Dental (837D). HHS notes the changes related to the introduction of ICD-10-CM and ICD-10-PCS. In addition to these changes the 837I will have to be modified to permit separate diagnosis code reporting by principal diagnosis, admitting diagnosis, external cause of injury and reason for visit. Other changes will permit the use of “Present on Admission” (POA) indicators, something the current 4010 has not permitted. 5010 also includes clear and precise rules and definitions that clarify how and when the NPI is to be reported and other provider information. Version 5010 will only allow the reporting of minutes for anesthesia time ensuring consistency and clarity across transactions. Other changes are being made to accommodate ambulance bill and data has been added to better facilitate dental billing including situations where the dental service is considered a medical service.

- **Health Care Payment and Remittance Advice Transaction (X12-835).** The 835 is addressed for all claim types. The X12 changes will impact all claim types including retail pharmacy claims. Instructions and other technical changes have been made to clarify previous problems. Some codes related to value options have been tightened. Version 5010 includes a new Medical Policy segment that provides more up-to-date information on payer policies that should help in detail management, appeals, and follow-up according to HHS. Version 5010 also eliminates codes marked “Not Advised,” but leaves the code representing “debit” as situational, with instructions on how and when to use the code. The new version also provides “clear instruction for use of the claims status indicator codes.
- **Enrollment and Disenrollment in a Health Plan (X12-834).** HHS proposes modifications that will affect health plans and their sponsors (employers, unions, etc.). HHS indicates that additional functionality including the use of ICD-10 codes. Version 5010 also adds the ability to designate certain information as confidential and restrict access to member information. Additional codes have been added to for maintenance of coverage changes. Other changes are expected to improve the overall management of policies and communications between the plan and sponsors.
- **Health Plan Premium Payments (X12-820).** This section covers a transaction generally between health plans and sponsors; although the 820 is used in many industries. Improvements brought about by the introduction of 5010 will impact payments and premium remittance.
- **Eligibility for a Health Plan (X12-270/271).** This is also a transaction generally between health plans and providers. While version 4010 does not require health plans to report relevant coverage information, version 5010 will require the payer to report specific coverage information. 5010 also provides for nine categories of benefits that must be reported if they are available to the patient. Additional patient service type codes are also expanded for use in the submission of an eligibility inquiry. X12-270/271 is just beginning to be used in electronic communication of eligibility information in various segments of the industry, and the 5010 change may increase its use once they are available to providers.
- **Referral Certification and Authorization (X12-278).** The Health Care Services Request for Review and Response transaction has seen limited use, in part due to constraints in version 4010. Version 5010 is seen as improving the situation along with expanding support for a variety of business cases that have been sought by the industry. Like the changes to the 270/271, the 5010 changes should expand the use of these transactions which in turn should allow improvements in the administrative simplification goals originally targeted by HIPAA.
- **Health care Claim Status (X12-276/277)** – the Health Care Claims Status Request and Response is also deemed to be improved by Version 5010 according to HHS. The proposed rule notes improvements in inquiries related to prescriptions as well as improved confidentiality since it eliminates a number of requirements to report certain data elements which are considered sensitive personal information specific to a patient but not necessary for the transaction purpose. 5010 also clarifies a number of situational rules and implements consistent rules across the transactions, as well as providing clear instructions not provided in version 4010.
- **Coordination of Benefits (COB – X12-837)** – again version 5010 is seen – as not only improving the COB transaction but in turn also increasing the use of this transaction.

Proposed Adoption of NCPDP Telecommunication Standard Implementation Guide Version D Release 0 (D.0) and Equivalent Batch Standard Batch Implement Guide Version 1, Release 2 (1.2) for Retail Pharmacy Transactions (73FR49751)

This section covers the adoption of the NCPDP standard D.0 and the equivalent batch standard. HHS provides a brief history of the upgrade, that was requested by the industry, and notes some of the business needs addressed by the increase functionality of version D.0, including:

- Enhanced guidance for Coordination of Benefits (COB) including for Medicare Part D;
- Improvement in processing Medicare Part D claims;
- Enhanced eligibility checking; and,
- Streamlined claims processing for compounded drugs.

Proposed Adoption of a Standard for Medicaid Pharmacy Subrogation: NCPDP Medicaid Subrogation Implementation Guide, Version 3.0 for Pharmacy Claims (73FR49751)

HHS provides a detailed review of the Medicaid subrogation process that allows a state Medicaid program to be the payer of last resort for pharmacy claims. The review provides a description of the subrogation program as well as a history of the program, HHS' option for standards, and HHS' rationale for making the proposal to use the NCPDP Medicaid Subrogation Implement guide, Version 3.0 under the subrogation pharmacy claims process. This standard would only apply to Medicaid and is not intended for other healthcare providers or health plans.

Modification to the Descriptions of Standards (73FR49754)

In this section HHS notes that in identifying and adopting the eight healthcare transaction standards the specification of "to whom" and "from whom" the transaction is transmitted was not always easy to determine. This lack of specificity creates confusion and uncertainty in the industry about when a particular electronic transmission meets the definition of a transaction. HHS is therefore revising descriptions for three of the standards to ensure that "to" and "from" requirements are specified. The three transactions in question are: Enrollment and Disenrollment in a Health Plan Transaction, Referral Certification and Authorization Transaction, and Health Care Claim Status Transactions.

Proposed Compliance and Effective Dates (73FR49754)

HHS first describes the compliance dates associated with **Medicaid pharmacy subrogation** transactions, calling for compliance within 24 months after the effective date of the final rule. Small health plans (as defined under HIPAA) would be required to be compliant within 36 months. HHS notes the **problem of having two different compliance dates** and accordingly plans to revise §162.923 as follows: "(a) *General rule.* Except as otherwise provided in this part, if a covered entity conducts with another covered entity that is required to comply with a transaction standard adopted under this part (or within the same covered entity), using electronic media, a transaction for which the Secretary has adopted a standard under this part, the covered entity must conduct the transaction as a standard transaction." HHS believes this change will allow smaller health plans to have the breathing room for implementation called for originally by HIPAA.

HHS notes that implementation of NCPDP version D.0 is not expected to be difficult, but since most entities need to implement X12 version 5010, HHS will keep the compliance dates consistent between the NCPDP and X12 projects.

HHS, therefore, proposes that for Version 5010 and D.0 health plans, including small health plans, healthcare clearing houses and covered healthcare providers to be compliant on and after April 1, 2010. HHS notes that it does not propose a two-year time frame for compliance, as recommended by NCVHS due to its belief that the “industry has sufficient experience with implementation issues associated with the HIPAA standards to enable them to conduct their design/build activities, and schedule and perform testing within a 12-month period.” HHS further states, **“the ability to implement and use the ICD–10 code set is contingent upon implementation of Version 5010. Since we anticipate a timely publication of regulations to adopt the ICD–10 code set, we wish to give the industry sufficient time in which to effectively plan and implement the Version 5010 transaction standards. We anticipate the compliance date for ICD–10 to be in 2011.”**

HHS suggests, given the anticipated schedule (see above), the industry will have 18 months experience with 5010 before the compliance date for ICD-10. HHS goes on to state, “We believe that the benefits of the new versions, the potential for mitigating existing inefficient work-a-rounds, and streamlining business process will outweigh any benefits to be derived from a two-year compliance time frame recommended by the NCVHS.” HHS specifically asks for comments on this assumption and time compliance dates. HHS also does not propose an additional year for small health plans to comply and provides its rationale for making such a recommendation.

In this section, HHS also highlights the need for testing of the upgraded standards. Testing is described in three types (identified by the NCVHS): testing of the standards for workability, conformance testing of products and applications that send or receive the transactions, and end-to-end testing to ensure interoperability among trading partners. HHS discusses the impact of testing on the compliance dates chosen and the alternative of staggered compliance dates. Again HHS seeks comments on these assumptions.

Finally, HHS notes the impact on the ICD-10 implementation and testing as well as the need for the industry to begin the process of planning and implementation, now! HHS indicates that it will provide education and outreach, and engage industry leaders and other stakeholder organizations, but it is up to the industry to work together for a smooth transition.

HHS provides a draft of the proposed timeline for the two conversions.

DRAFT PROPOSED TIMELINE FOR ICD-10 AND VERSIONS 5010/D.0 IMPLEMENTATION

ICD-10	Version 5010/D.0
8/08: Publish proposed rule	8/08: Publish proposed rule.
	9/08: Industry begins requirements documentation for systems changes; CMS and industry initiate education and outreach.
12/08: CMS and industry begin ongoing education and outreach.	
	4/09: Industry builds and tests systems changes (internal and external testing).
06/09: Industry begins design documentation.	
12/09: Industry builds and internally tests systems changes.	
	4/10: Compliance date for all covered entities.
07/10-10/11: Conduct testing with trading partners.	
10/11: ICD-10 compliance date for all covered entities.	

Highlights of this Section

- HHS provides a detailed description of the changes impacting each of the eight HIPAA transactions, noting that the implementation of the new versions will provide clearer instructions, eliminate ambiguous language, define the rule for required versus situational data, consistently represent data, and other technical improvements.
- NCPDP changes will enhance guidance for COB, improved the processing of Medicare Part D claims, enhance eligibility checking, and streamline claims processing for compounded drugs.
- “To” and “from” requirements of key transactions will be more clearly defined in the upgraded versions.
- With the exception of the standards associated with the Medicaid pharmacy subrogation, HHS calls for a single compliance date of April 1, 2010, and describes why it believes that the industry can accommodate and succeed with its 18-month implementation period as opposed to the NCVHS recommendation for two years.
- HHS highlights the need for testing as part of the HIPAA transaction standards updating.
- HHS solicits comments on the timelines given for implementation and the specific timelines given to different sized organization as defined under HIPAA.

III. Collection of Information Required (73FR49757)

HHS lists the sections of the HIPAA requirements in section 162 that are subject to the Paperwork Reduction Act of 1995. HHS merely notes that the sections are approved under OMB control number 0938-0866 will be kept updated as required.

IV. Response to Comments (73FR49757)

This section notes that individual comments will not be acknowledged or responded to. All comments received within the specified comment period will be considered. The final rule document will contain responses to the comments in the preamble.

V. Regulatory Impact Analysis (RIA) (73FR49757)

Overall Impact (73FR49808)

This section outlines requirements that HHS must follow in proposing a rule and determining its impact including:

- Executive Order (EO) 12866 on Regulatory Planning and Review
- Regulatory Flexibility Act
- Business Regulatory Enforcement Fairness Act of the SSA
- Unfunded Mandates Reform Act
- EO 13132 on Federalism
- Congressional Review Act

The RIA explains calculations for costs and benefits and impact analysis focusing on savings projections and cost estimates. An RIA must be completed on major rules with economically significant effects - \$100 million in any one year (\$130 million adjusted for inflation.). HHS notes that it believes that covered entities have already largely invested in the hardware, software and connectivity necessary to conduct the new version of the standards, and the new standard proposed. “We anticipate that the adoption of these new versions and the new standard would result in costs that would be outweighed by the benefits. Accordingly, we have prepared a Regulatory Impact Analysis that to the best of our ability presents the costs and benefits of the proposed rulemaking.”

Regulatory Flexibility Analysis (73FR49757)

HHS notes that most hospitals and other providers and suppliers are small entities either by nonprofit status or by qualifying under the SBA’s size standards of revenues between \$6.5 million and \$31.5 million in any one year. HHS states: “We believe that the conversion to Versions 5010 and D.0 would have an impact on virtually every healthcare entity, since at least some personnel in every covered entity would have to adjust to certain new business rules and procedures to accommodate the improvements in the data available from the transactions.” HHS further notes that it does not believe that there are many pharmacy benefit managers (PBMs) and clearinghouses that would be considered small entities because of the consolidation that has occurred in the marketplace over the past five years.

This section addresses the initial flexibility analysis covering small entities, the estimated costs for small entities, policy alternatives, and HHS conclusions. HHS notes there were few alternatives to adopting versions 5010, D.0, and 3.0. HHS also discusses its alternatives for compliance dates and how this affects costs.

Anticipated Effects (73FR49761)

This section lays out the objectives HHS used for looking at the costs and benefits of the rule: with includes:

- Migrating from Version 4010/4010A to Version 5010 in the context of the current healthcare environment;
- Migrating from Version 5.1 to Version D.0; and
- Adopting a new standard for the Medicaid subrogation transaction

Adoption of Version 5010 will impact the following entities directly:

- Providers
 - Hospital
 - Physicians
 - Dentists
 - Pharmacies
- Health Plans
 - Commercial Health Plans and Blue Cross/Blue Shield Plans
 - Government Plans: Medicare and Medicaid
- Clearinghouses and Vendors
 - Clearinghouses
 - Vendors

These affected entities were surveyed for a cost benefit analysis by Gartner Incorporated for HHS. It should be noted that Gartner did not interview any “nonhospital” institutions, but made the assumption that skilled nursing facilities (SNFs) and other types of organizations may be affiliated with some of the larger hospital systems, which were included in the analysis. It was presumed that all HIPAA-covered entities affected by the proposed rule would incur several one-time costs related to:

- Analysis of business flow changes
- Software procurement or customized development
- Integration of new software
- Staff training
- Collection of new data
- Testing
- Transition processes

It is suggested that transitioning to version 5010 is assumed to be a less complex move than was the transition to 4010 (the initial adoption of the HIPAA standards). 5010 will enable low transaction costs resulting from movement from paper to electronic transactions. 5010 will enable a reduction in staff resource time resulting from a decrease in phone calls to check eligibility and claims status and obtain referral authorizations via electronic transactions that provide the same information.

Gartner identified three specific categories of savings:

- Savings due to better standards for electronic claims transactions;
- Cost savings due to an increase in use of the electronic claims transactions by more covered entities; and
- Operational savings due to electronic auxiliary transactions by more covered entities.

Other general assumptions for the cost benefit analysis for providers and health plans:

- All providers using 835/837 messages would accrue benefits in the way of savings (ex. Reduced phone calls);
- Physicians that have not yet implemented 835/837 would accrue future savings through lower transaction costs for these electronic exchanges;
- An expected uptake of between 2 to 5 percent the first five years following implementation for all providers implementing 837 transactions;

- An expected uptake of between 5 to 10 percent over 10 years for all providers for 835 transactions;
- Costs and benefits for the COB transaction are included in the estimates for the 837 claim standard transaction and are not broken out separately;
- Providers would benefit from fewer phone calls to health plans to check eligibility for claims status for auxiliary transactions;
- An expected increase in the usage of auxiliary transactions across the entire provider community and new adopters would see net benefits that would compound the aforementioned benefits as adopters utilize EHI more often;
- Operational savings would result from reductions in manual efforts as phone calls:
 - 835—a reduction in phone calls between 1.45% and 2.9% as a percentage of pended claims,
 - 837—A reduction in phone calls between .28 percent and .percent as a percentage of pended claims, and
 - For all other transactions, the current call volume would be reduced proportional to their total transaction volume.
- Health Plans could expect corresponding benefits including:
 - For 835/837 messages, plans would receive benefits in the way of savings through reduced phone calls related to ambiguity in the current messages,
 - As uptake of the 835/837 transactions increase between trading partners, there would be savings through lower transaction costs (unit costs would decrease),
 - For auxiliary transactions (270/271, 276/277, 278), plans would receive benefit in the way of operational savings through reduced phone calls.

Gartner took its costs from estimates of the original cost of implementing HIPAA, and then applying a percentage since implementation of 5010 is based on a platform already established by 4010. The outcomes of Gartner’s efforts are best illustrated by looking at the tables published in the rule.

Table 9 – Version 5010 Cost Benefit Summary for Hospitals (73FR49767)
 [In millions]

	Minimum	Maximum	
Costs:			
System Implementation	\$792	\$1,584	
Transition	140	280	
Total costs	932	1,864	
Benefits:			
Operational Savings—better standards.	403	1,096	Formula: Number of estimated transactions (835/837) requiring a phone call × number of minutes per call × \$ average cost per minute. Number of transactions converted from paper to EDI × estimated cost savings per transaction (\$.55). Number of estimated transactions (270/271, 276/277, 278) requiring a phone call × number of minutes per call x \$ average cost per minute.
Cost Savings—increase in electronic claims transactions.	66	219	
Operational Savings—increase in use of auxiliary transactions.	1,314	3,414	
Total benefits	1,783	4,729	
Net Benefits	851	2,865	

Table 11 – Version 5010 Cost Benefit Summary for Physicians (73FR49768)
[In Millions]

	Minimum	Maximum
Costs:		
System Implementation	\$370	\$740
Transition	65	131
Total Costs	435	870
Benefits:		
Operational Savings—better standards	1,612	4,378
Cost Savings—increase in electronic claims transactions	270	874
Operational Savings—increase in use of auxiliary transactions	5,251	13,562
Total Benefits	7,133	18,814
Net Benefits	6,698	17,944

Table 11 – Version 5010 Cost Benefit Summary for Dentists (73FR49769)
[In Millions]

	Minimum	Maximum
Costs:		
System Implementation	\$254	\$508
Transition	45	90
Total Costs	299	598
Benefits:		
Operational Savings—better standards	274	699
Cost Savings—increase in electronic claims transactions	45	56
Operational Savings—increase in use of auxiliary transactions	889	2,173
Total Benefits	1,208	2,928
Net Benefits	909	2,330

Table 14 – Version 5010 Cost Benefit Summary for Private Health Plans (73FR49769)
[In Millions]

	Minimum	Maximum
Costs:		
System Implementation	\$3,064	\$6,128
Transition	541	1,081
Total Costs	3,604	7,209
Benefits:		
Operational Savings—better standards	1,283	3,430
Cost Savings—increase in electronic claims transactions	111	276
Operational Savings—increase in use of auxiliary transactions	4,386	11,406
Total Benefits	5,780	15,112
Net Benefits	2,175	7,903

Table 15 – Version 5010 Cost Benefit Summary for Government Health Plans (73FR49770)
[In Millions]

	Minimum	Maximum
Costs:		
System Implementation	\$214	\$409
Transition	38	72
Total Costs	252	481
Benefits:		
Operational Savings—better standards	279	746
Cost Savings—increase in electronic claims transactions	24	60
Operational Savings—increase in use of auxiliary transactions	953	2,480
Total Benefits	1,256	3,286
Net Benefits	1,004	2,805

Table 15 – Version 5010 Cost Benefit Summary for Clearinghouses (73FR49770)
[In Millions]

Costs	Maximum	Minimum
System Implementation	\$33	\$41
Transition	3	4
Total Costs	\$37	\$45

HHS notes that with few exceptions, the study sources expressed their belief that the advancement of the HIPAA standards was the right thing to do across the industry. Among the qualitative benefits that were consistently mentioned by interviewees were the following:

- Improved accuracy resulting from simplified messaging;
- A new field specifically to capture certain hospital acquired condition indicators that are critical to the industry;
- A new field to capture “Present on Admissions” indicators as directed by the Deficit Reduction Act;
- Resultant quality through greater reliability of clean message exchange;
- Collaborative benefits stemming from the ability to share more information; and
- (as noted by HHS) the dependency of implementing ICD-10, which requires 5010 implementation, and has itself several benefits.

HHS took a similar approach to the implementation and use of **Version D.0 and Version 5010** for pharmacies and extensively reports on this in the proposed plan. This table represents the summation of HHS analysis on pharmacies.

Table 24– Cost Benefit Summary for Pharmacies for Version D.0 and Version 5010 (73FR49778)
 [In Millions]

	Minimum	Maximum
Costs (Chains and independents):		
D.0 Pharmacy Chains Systems Implementation	\$18	\$38
D.0 Independent Pharmacies Maintenance Fees	540	1,080
D.0 PBM Programming	8.6	10.6
5010 System Implementation	58	114
5010 Transition	10	20
Total Costs	95.14	183.6
Benefits:		
D.0 Pharmacist Productivity Savings	1,134	2,268
D.0 Pharmacy Technician Productivity Savings	98	196
D.0 Avoided Audits and Accurate Payments	190	380
5010 Operational Savings—better standards	20	27
Total Benefits	1,442	2,871
Net Benefits	1,346	2,870

Additional work was also done related to the impact of Version D.0 on Medicaid programs which includes the subrogation program. Given its narrow impact on the industry we are not reporting on this analysis here, but refer the reader to pages 73FR49779 through 49783.

TABLE 10—SUMMARY OF TOTAL ESTIMATED COSTS
 [In millions]

	Minimum	Maximum	Primary estimate
Training:			
Full-time Coders (Inpatient)	\$110	\$165	\$137.51
Part-time Coders (Outpatient)	\$55	\$165	\$98.50
Code Users	\$27	\$55	\$37.50
Physicians	\$0	\$165	\$82.20
Productivity Losses:			
Coders (Inpatient)	\$0	\$55	\$8.90
Coders (Outpatient)	\$0	\$55	\$8.56
Physician Practices	\$5.5	\$27	\$10.98
Improper and Returned Claims	\$274	\$1,100	\$543.29
Systems Changes:			
Providers	\$55	\$220	\$137.20
Software Vendors	\$55	\$137	\$96.05
Payers	\$110	\$274	\$164.64
Government Systems	\$157.5	\$630	\$315.00

Alternatives Considered (73FR49783)

HHS notes that it looked at alternatives related to each of the three upgrades – 5010 , D.0, and 3.0 (for Medicaid subrogation) – and failed to find any viable alternatives

Summary of Cost and Benefits for This Proposed Rule (73FR49783)

HHS summarizes the total of costs and benefits on several tables. The numbers cover 10 years from 2010 through 2019.

Estimated Minimum and Maximum Aggregate Costs and Benefits (in Millions) for Years 2010 through 2019		
	Minimum	Maximum
Cost	\$5,656	\$11,257
Benefit	\$18,635	\$47,779

[Numbers taken from tables 27a & 27b (73FR49786 – 49789)]

Highlights of this section:

- HHS notes that every HIPAA entity will be affected by this proposed rule.
- All healthcare providers are considered small entities for this review (not the same as a small entity as defined by HIPAA).
- Gartner' review addresses the anticipated effects (costs and benefits) for all covered entities.
- Transitioning to the new versions appears to be less complex than the original implementation to the HIPAA standards, and the costing out of the expense was made in part on that estimate.
- Savings were looked at over 10 years and included savings due to better standards for electronic claims transactions, cost savings due to an increase in the use of the electronic claims transactions by more covered entities, and operational savings due to electronic auxiliary transaction by more covered entities.
- Net benefits over 10 years appear to be a minimum of \$7,378 in millions (maximum cost minus minimum benefit) and at a maximum \$42,123 in millions (maximum benefit minus minimum cost). Minimum cost is estimated at \$5,656 in millions and maximum \$11,257 in millions.

List of Subjects in 45 CFR Part 162 Administrative Requirements (73FR49790)

Finally, HHS notes the language changes that will be made to Part 162 if the proposed rule is accepted as stated.

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