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Administrative Simplification: Adoption of Operating Rules for Health Care
Electronic Funds Transfers (EFT) and Remittance Advice Transactions;
Final Rule

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Office of the Secretary

45 CFR Part 162

RIN 0938-AR01

**Administrative Simplification:
Adoption of Operating Rules for Health
Care Electronic Funds Transfers (EFT)
and Remittance Advice Transactions**

AGENCY: Office of the Secretary, HHS.

ACTION: Interim final rule with comment period.

SUMMARY: This interim final rule with comment period implements parts of section 1104 of the Affordable Care Act which requires the adoption of operating rules for the health care electronic funds transfers (EFT) and remittance advice transaction.

DATES: *Effective Date:* These regulations are effective on August 10, 2012. The incorporation by reference of the publications listed in this interim final rule with comment period is approved by the Director of the Office of the Federal Register August 10, 2012.

Compliance Date: The compliance date for operating rules for the health care electronic funds transfers (EFT) and remittance advice transaction is January 1, 2014.

Comment Date: To be assured consideration, comments must be received at one of the addresses provided in the **ADDRESSES** section of this interim final rule with comment period on or before October 9, 2012.

ADDRESSES: In commenting, please refer to file code CMS-0028-IFC. Because of staff and resource limitations, we cannot accept comments by facsimile (FAX) transmission.

You may submit comments in one of four ways (please choose only one of the ways listed)

1. *Electronically.* You may submit electronic comments on this regulation to <http://www.regulations.gov>. Follow the "Submit a comment" instructions.

2. *By regular mail.* You may mail written comments to the following address ONLY: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS-0028-IFC, P.O. Box 8013, Baltimore, MD 21244-8013.

Please allow sufficient time for mailed comments to be received before the close of the comment period.

3. *By express or overnight mail.* You may send written comments to the following address ONLY: Centers for Medicare & Medicaid Services,

Department of Health and Human Services, Attention: CMS-0028-IFC, Mail Stop C4-26-05, 7500 Security Boulevard, Baltimore, MD 21244-1850.

4. *By hand or courier.* Alternatively, you may deliver (by hand or courier) your written comments ONLY to the following addresses prior to the close of the comment period:

a. For delivery in Washington, DC—Centers for Medicare & Medicaid Services, Department of Health and Human Services, Room 445-G, Hubert H. Humphrey Building, 200 Independence Avenue SW., Washington, DC 20201.

(Because access to the interior of the Hubert H. Humphrey Building is not readily available to persons without Federal government identification, commenters are encouraged to leave their comments in the CMS drop slots located in the main lobby of the building. A stamp-in clock is available for persons wishing to retain a proof of filing by stamping in and retaining an extra copy of the comments being filed.)

b. For delivery in Baltimore, MD—Centers for Medicare & Medicaid Services, Department of Health and Human Services, 7500 Security Boulevard, Baltimore, MD 21244-1850.

If you intend to deliver your comments to the Baltimore address, call telephone number (410) 786-1066 in advance to schedule your arrival with one of our staff members.

Comments erroneously mailed to the addresses indicated as appropriate for hand or courier delivery may be delayed and received after the comment period.

For information on viewing public comments, see the beginning of the **SUPPLEMENTARY INFORMATION** section.

FOR FURTHER INFORMATION CONTACT: Matthew Albright (410) 786-2546. Denise Buenning (410) 786-6711.

SUPPLEMENTARY INFORMATION:

Inspection of Public Comments: All comments received before the close of the comment period are available for viewing by the public, including any personally identifiable or confidential business information that is included in a comment. We post all comments received before the close of the comment period on the following Web site as soon as possible after they have been received: <http://regulations.gov>. Follow the search instructions on that Web site to view public comments.

Comments received timely will also be available for public inspection as they are received, generally beginning approximately 3 weeks after publication of a document, at the headquarters of the Centers for Medicare & Medicaid Services, 7500 Security Boulevard,

Baltimore, Maryland 21244, Monday through Friday of each week from 8:30 a.m. to 4 p.m. To schedule an appointment to view public comments, phone 1-800-743-3951.

I. Executive Summary

A. Purpose of the Regulatory Action

Health care spending in the United States constitutes nearly 18 percent of the U.S. Gross Domestic Product (GDP) and costs an average of \$9,000 per person annually.¹ Many factors contribute to the high cost of health care in the United States, but studies point to administrative costs as having a substantial impact on the growth of spending² and an area of costs that could likely be reduced.³

One area of administrative burden that can be lessened for health care providers is the time and labor spent interacting with multiple health insurance plans, called billing and insurance related (BIR) tasks. The average physician spends a cumulative total of 3 weeks a year on BIR tasks according to one study,⁴ and, in a physician's office, two-thirds of a full-time employee per physician is necessary to conduct BIR tasks.⁵

The tasks and costs of activities directly related to collecting payments is a category of BIR tasks. Nearly 40 percent of nonclinical staff time spent on BIR tasks in a physician practice is dedicated to activities directly related to collecting payments.⁶ According to estimates that are discussed more broadly in the Regulatory Impact Analysis (RIA), most health care providers collect and deposit paper

¹ Keehan, S.P.; Sisko, A.M.; Truffer, C.J.; Poisal, J.A.; Cuckler, G.A.; Madison, A.J.; Lizonitz, J.M.; & Smith, S.D.; "National Health Spending Projections Through 2020: Economic Recovery and Reform drive faster Spending Growth," *Health Affairs* 30(8): doi:10.1377/hlthaff.2011.0662, 2011.

² "Technological Change and the Growth of Health Care Spending," A CBO Paper, Congressional Budget Office, January 2008, pg.4, <http://www.cbo.gov/ftpdocs/89xx/doc8947/01-31-TechHealth.pdf>.

³ Morra, D., Nicholson, S., Levinson, W., Gans, D. N., Hammons, T., & Casalino, L.P. "U.S. Physician Practices versus Canadians: Spending Nearly Four Times as Much Money Interacting with Payers," *Health Affairs*: 30(8):1443-1450, 2011.

Blanchfield, Bonnie B., James L. Hefferman, Bradford Osgood, Rosemary R. Sheehan, and Gregg S. Meyer, "Saving Billions of Dollars—and Physician's Time—by Streamlining Billing Practices," *Health Affairs*: 29(6):1248-1254, 2010.

⁴ Casalino, L.P., Nicholson, S., Gans, D.N., Hammons, T., Morra, D., Karrison, T., & Levinson, W., "What does it cost physician practices to interact with health insurance plans?" *Health Affairs*: 28(4) (2009): w533-w543.

⁵ Sakowski, J.A., Kahn, J.G., Kronick, R.G., Newman, J.M., & Luft, H.S., "Peering into the black box: Billing and insurance activities in a medical group," *Health Affairs*: 28(4): w544-w554, 2009.

⁶ *Ibid.*, p. w547.

checks, and manually post and reconcile the health care claim payments in their accounting systems. By automating some of these tasks, time and labor spent on the collection of payments can be decreased. Automation can be achieved through the electronic transfer of information or electronic data interchange (EDI). Through the use of electronic funds transfers (EFT) for health care claim payments and the use of electronic remittance advice (ERA) that describes adjustments to the payments, BIR costs can be decreased.

The benefits of EFT have been realized in many other industries. The benefits include material cost savings, fraud control, and improved cash flow and cash forecasting. The benefits of ERA have also been demonstrated in terms of cost savings in paper and mailings. By receiving remittance advice electronically, providers can use electronic denial management tools that dramatically improve payment recovery and reconciliation. Despite these advantages, an estimated 70 percent of health care claim payments continue to be in paper check form and an estimated 75 percent of remittance advice is sent through the mail in paper form.⁷

There is evidence that the use of operating rules for specific electronic health care transactions results in higher use of EDI by health care providers.⁸ We expect usage of EFT and ERA by the health care industry will increase and administrative savings will be realized when industry implements the operating rules for those transactions.

B. Legal Authority for the Regulatory Action

The legal authority for the adoption of operating rules rests in section 1173(g) of the Social Security Act (the Act). Section 1173(g) of the Act was added by section 1104(b)(2) of the Patient Protection and Affordable Care Act (Pub. L. 111–148), enacted on March 23, 2010, as amended by the Health Care and

Education Reconciliation Act of 2010 (Pub. L. 111–152), enacted on March 30, 2010 (collectively known as and hereinafter referred to as the Affordable Care Act).

C. Summary of the Major Provisions of the Regulatory Action

In this interim final rule with comment period (IFC), we are adopting the Phase III Council for Affordable Quality Healthcare (CAQH) Committee on Operating Rules for Information Exchange (CORE) EFT & ERA Operating Rule Set, including the CORE v5010 Master Companion Guide Template, for the health care EFT and remittance advice transaction (hereinafter referred to as the EFT & ERA Operating Rule Set), with one exception: We are not adopting Requirement 4.2, titled “Health Care Claim Payment/Advice Batch Acknowledgement Requirements,” of the Phase III CORE 350 Health Care Claim Payment/Advice (835) Infrastructure Rule because that requirement requires the use of the Accredited Standards Committee (ASC) X12 999 acknowledgement standard, and the Secretary has not adopted standards for acknowledgements.

Covered entities must be in compliance with the EFT & ERA Operating Rule Set by January 1, 2014.

D. Costs and Benefits

Both costs and benefits are analyzed by examining the costs and cost savings of implementing and using the EFT & ERA Operating Rule Set adopted in this IFC in the following four areas of administrative tasks—

- Provider enrollment in EFT and ERA;
- Implementing infrastructure and communication networks between trading partners;
- Reassociation of the payment information with the remittance information; and
- Posting payment adjustments and claim denials.

To a large extent, the costs of implementing the EFT & ERA Operating Rule Set will be borne by the health plans, with much of the benefits accruing to providers. Many health plans actively participated in the development of these rules, and the requirements they put on themselves were carefully deliberated. In the RIA of this IFC, we estimate that the cost to implement the EFT & ERA Operating Rule Set is \$1.2 to \$2.7 billion for government and commercial health plans, including third party administrators (TPAs), hospitals, and physician offices. The savings from and cost benefit of using the EFT & ERA

Operating Rule Set is \$3 to \$4.5 billion for government and commercial health plans, hospitals, and physician offices. The net savings derived from using the EFT & ERA Operating Rule Set over 10 years ranges from approximately \$300 million to \$3.3 billion.

II. Background

A. Statutory and Regulatory Background

1. The Health Insurance Portability and Accountability Act of 1996 (HIPAA)

Congress addressed the need for a consistent framework for electronic health care transactions and other administrative simplification issues through the Health Insurance Portability and Accountability Act of 1996 (HIPAA), (Pub.L. 104–191), enacted on August 21, 1996. HIPAA amended the Act by adding Part C—Administrative Simplification—to Title XI of the Act, requiring the Secretary of the Department of Health and Human Services (HHS) (the Secretary) to adopt standards for certain transactions to enable health information to be exchanged more efficiently and to achieve greater uniformity in the transmission of health information.

In the August 17, 2000 **Federal Register** (65 FR 50312), we published a final rule titled “Health Insurance Reform: Standards for Electronic Transactions” (hereinafter referred to as the Transactions and Code Sets final rule). That rule implemented some of the HIPAA Administrative Simplification requirements by adopting standards for electronic health care transactions developed by standard setting organizations (SSOs) and medical data code sets to be used in those transactions. We adopted the ASC X12 Version 4010 standards and the National Council for Prescription Drug Programs (NCPDP) Telecommunication Version 5.1 standard.

Section 1172(a) of the Act states that—

Any standard adopted under [HIPAA] shall apply, in whole or in part, to * * *

- (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 [HIPAA transaction].

These entities are referred to as covered entities.

In the January 16, 2009 **Federal Register** (74 FR 3296), we published a final rule titled, “Health Insurance Reform; Modifications to the Health Insurance Portability and Accountability Act (HIPAA) Electronic Transaction Standards” (hereinafter referred to as the Modifications final rule). Among other things, the

⁷ Estimates for the percentage of EFT are taken from the interim final rule “Administrative Simplification: Adoption of Standards for the Health Care Electronic Funds Transfers (EFT) and Remittance Advice” published in the January 10, 2012 **Federal Register** (77 FR 1556). Estimates for the percentage of ERA are taken from the proposed rule “Administrative Simplification: Adoption of a Standard for a Unique Health Plan Identifier; Addition to the National Provider Identifier Requirements: And a Change to the Compliance Date for ICD–10–CM and ICD–10–PCS Medical Data Code Sets,” published in the April 17, 2012 **Federal Register** (77 FR 22950). The calculations from these two rules are explained in more detail in the Regulatory Impact Analysis of this rule.

⁸ “CAQH CORE Phase I Measures of Success Final Report, July 7, 2009,” PowerPoint presentation; and “CORE Certification and testing: A Step-by-Step Overview,” February 17, 2011, CAQH and Edifecs Webinar.

Modifications final rule adopted updated versions of the standards, ASC X12 Version 5010 (hereinafter referred to as Version 5010) and NCPDP Telecommunication Standard Implementation Guide Version D.0 (hereinafter referred to as Version D.0) and equivalent Batch Standard Implementation Guide, Version 1, Release 2 (hereinafter referred to as Version 1.2) for the electronic health care transactions, which are specified at 45 CFR part 162, Subparts I through R.

Covered entities were required to comply with Version 5010 and Version D.0 on January 1, 2012. We also adopted a standard for the Medicaid pharmacy subrogation standard, NCPDP Version 3.0, in the Modifications final rule, specified at 45 CFR part 162, Subpart S, with which covered entities were required to comply on January 1, 2012, except small health plans, which have until January 1, 2013.

As January 1, 2012 approached, we became aware that there were still a

number of outstanding issues and challenges impeding full implementation of Version 5010 and Version D.0. Therefore, we announced two consecutive 90-day periods during which we would not initiate enforcement action against any covered entity through June 30, 2012.

Table 1 summarizes the full set of transaction standards adopted in the Transactions and Code Sets final rule and as modified in the Modifications final rule.

TABLE 1—CURRENT ADOPTED STANDARDS FOR HIPAA TRANSACTIONS

Transaction	Standard
Health care claims or equivalent encounter information—Dental.	ASC X12 Standards for Electronic Data Interchange Technical Report Type 3—Health Care Claim: Dental (837), May 2006, ASC X12N/005010X224, and Type 1 Errata to Health Care Claim: Dental (837), ASC X12 Standards for Electronic Data Interchange Technical Report Type 3, October 2007, ASC X12N/005010X224A1.
Health care claims or equivalent encounter information—Professional.	ASC X12 Standards for Electronic Data Interchange Technical Report Type 3—Health Care Claim: Professional (837), May 2006, ASC X12N/005010X222.
Health care claims or equivalent encounter information—Institutional.	ASC X12 Standards for Electronic Data Interchange Technical Report Type 3—Health Care Claim: Institutional (837), May 2006, ASC X12/N005010X223, and Type 1 Errata to Health Care Claim: Institutional (837), ASC X12 Standards for Electronic Data Interchange Technical Report Type 3, October 2007, ASC X12N/005010X223A1.
Health care claims or equivalent encounter information—Retail pharmacy.	Telecommunication Standard Implementation Guide, Version D, Release 0 (Version D.0), August 2007 and equivalent Batch Standard Implementation Guide, Version 1, Release 2 (Version 1.2), National Council for Prescription Drug Programs.
Health care claims or equivalent encounter information—Retail pharmacy supplies and professional services.	Telecommunication Standard, Implementation Guide Version 5, Release 1, September 1999; The Telecommunication Standard Implementation Guide, Version D, Release 0 (Version D.0), August 2007, and equivalent Batch Standard Implementation Guide, Version 1, Release 2 (Version 1.2), National Council for Prescription Drug Programs; and ASC X12 Standards for Electronic Data Interchange Technical Report Type 3—Health Care Claim: Professional (837), May 2006, ASC X12N/005010X222.
Coordination of Benefits—Retail pharmacy drugs.	Telecommunication Standard Implementation Guide, Version D, Release 0 (Version D.0), August 2007, and equivalent Batch Standard Implementation Guide, Version 1, Release 2 (Version 1.2), National Council for Prescription Drug Programs.
Coordination of Benefits—Dental	ASC X12 Standards for Electronic Data Interchange Technical Report Type 3—Health Care Claim: Dental (837), May 2006, ASC X12N/005010X224, and Type 1 Errata to Health Care Claim: Dental (837), ASC X12 Standards for Electronic Data Interchange Technical Report Type 3, October 2007, ASC X12N/005010X224A1.
Coordination of Benefits—Professional ...	ASC X12 Standards for Electronic Data Interchange Technical Report Type 3—Health Care Claim: Professional (837), May 2006, ASC X12, 005010X222.
Coordination of Benefits—Institutional	ASC X12 Standards for Electronic Data Interchange Technical Report Type 3—Health Care Claim: Institutional (837), May 2006, ASC X12/N005010X223, and Type 1 Errata to Health Care Claim: Institutional (837), ASC X12 Standards for Electronic Data Interchange Technical Report Type 3, October 2007, ASC X12N/005010X223A1.
Eligibility for a health plan (request and response)—Dental, professional, and institutional.	ASC X12 Standards for Electronic Data Interchange Technical Report Type 3—Health Care Eligibility Benefit Inquiry and Response (270/271), April 2008, ASC X12N/005010X279.
Eligibility for a health plan (request and response)—Retail pharmacy drugs.	Telecommunication Standard Implementation Guide, Version D, Release 0 (Version D.0), August 2007, and equivalent Batch Standard Implementation Guide, Version 1, Release 2 (Version 1.2), National Council for Prescription Drug Programs.
Health care claim status (request and response).	ASC X12 Standards for Electronic Data Interchange Technical Report Type 3—Health Care Claim Status Request and Response (276/277), August 2006, ASC X12N/005010X212, and Errata to Health Care Claim Status Request and Response (276/277), ASC X12 Standards for Electronic Data Interchange Technical Report Type 3, April 2008, ASC X12N/005010X212E1.
Enrollment and disenrollment in a health plan.	ASC X12 Standards for Electronic Data Interchange Technical Report Type 3—Benefit Enrollment and Maintenance (834), August 2006, ASC X12N/005010X220.
Health care payment and remittance advice.	ASC X12 Standards for Electronic Data Interchange Technical Report Type 3—Health Care Claim Payment/Advice (835), April 2006, ASC X12N/005010X221.
Health plan premium payments	ASC X12 Standards for Electronic Data Interchange Technical Report Type 3—Payroll Deducted and Other Group Premium Payment for Insurance Products (820), February 2007, ASC X12N/005010X218.
Referral certification and authorization (request and response)—Dental, professional, and institutional.	ASC X12 Standards for Electronic Data Interchange Technical Report Type 3—Health Care Services Review—Request for Review and Response (278), May 2006, ASC X12N/005010X217, and Errata to Health Care Services Review—Request for Review and Response (278), ASC X12 Standards for Electronic Data Interchange Technical Report Type 3, April 2008, ASC X12N/005010X217E1.

TABLE 1—CURRENT ADOPTED STANDARDS FOR HIPAA TRANSACTIONS—Continued

Transaction	Standard
Referral certification and authorization (request and response)—Retail pharmacy drugs.	Telecommunication Standard Implementation Guide, Version D, Release 0 (Version D.0), August 2007, and equivalent Batch Standard Implementation Guide, Version 1, Release 2 (Version 1.2), National Council for Prescription Drug Programs.
Medicaid pharmacy subrogation	Batch Standard Medicaid Subrogation Implementation Guide, Version 3, Release 0 (Version 3.0), July 2007, National Council for Prescription Drug Programs.

In general, the HIPAA transaction standards enable electronic data interchange using a common interchange structure, thus minimizing the industry’s reliance on multiple data transmission formats. According to a recent report to Congress by the National Committee on Vital and Health Statistics (NCVHS), “[t]he HIPAA electronic data requirements for standardized formats and content were intended to move the health care industry from a manual to an electronic system to improve security, lower costs, and lower the error rate.”⁹

However, according to the NCVHS report, “the speed of adoption [of electronic transactions] across industry has been disappointing.”¹⁰ The NCVHS report continues, “The achievement of the vision of seamless electronic flow of information in a confidential and secure manner has been slow.”¹¹

2. The Introduction of Operating Rules in the Affordable Care Act

The use of operating rules is widespread and varied among other industries. For example, uniform operating rules for the exchange of Automated Clearing House (ACH) EFT payments among financial institutions are used in accordance with U.S. Federal Reserve regulations (12 CFR Part 370) and maintained by the Federal Reserve and NACHA—The Electronic Payments Association (known as NACHA). Additionally, credit card issuers employ detailed operating rules (for example, Cirrus Worldwide Operating Rules) describing things such as types of members, their responsibilities and obligations, and licensing and display of service marks.

⁹ “The Tenth Report to Congress on the Implementation of the Administrative Simplification Provisions of the Health Insurance Portability and Accountability Act (HIPAA) of 1996 (As Required by the Health Insurance Portability and Accountability Act, Public Law 104–191, Section 263),” submitted to the Senate Committee on Finance and Committee on Health, Education, Labor and Pensions, House Committee on Ways and Means, Committee on Education and Labor and Committee on Energy and Commerce by the National Committee on Vital and Health Statistics, December, 2011, p. 1.

¹⁰ Ibid, p. 1.

¹¹ Ibid, p. 2.

Before the passage of the Affordable Care Act, States enacted various laws that were analogous to operating rules, in that they established business rules directed toward more efficient and effective transmission of electronic health care transactions. Similarly, the CAQH Committee on Operating Rules for Information Exchange (CORE), a nonprofit alliance of health care stakeholders, developed voluntary operating rules for the health care industry. CAQH CORE’s operating rules include business rules that require common platform standards, establish companion guide formats, define the rights and responsibilities of all parties in a transaction, establish response times and error resolution, require specific acknowledgement standards and data content, remove optionality from specific data content, and establish business rules directed at efficient and effective business practices. Voluntary agreements among health care industry stakeholders to use operating rules were shown to reduce costs and administrative complexities.¹²

Through the Affordable Care Act, Congress sought to promote implementation of electronic transactions and achieve cost reduction and efficiency improvements by creating more uniformity in the implementation of standard transactions. This was done by mandating the adoption of a set of operating rules for each of the HIPAA transactions. Section 1173(g)(1) of the Act, as added by section 1104(b)(2)(C) of the Affordable Care Act, requires the Secretary to “adopt a single set of operating rules for each transaction * * * with the goal of creating as much uniformity in the implementation of the electronic standards as possible.” The Affordable Care Act defines operating rules and specifies the role of operating rules in relation to the standards. Operating rules are defined by section 1171(9) of the Act (as added by section 1104(b)(1) of the Affordable Care Act) as “the necessary business rules and guidelines for the electronic exchange of information that are not defined by a

¹² “CAQH CORE Phase I Measures of Success Final Report,” (presentation), July 7, 2009.

standard or its implementation specifications as adopted for purposes of this part.” Additionally, section 1173(a)(4)(A) of the Act (as added by section 1104(b)(2)(B) of the Affordable Care Act) requires that—

The standards and associated operating rules adopted by the Secretary shall—

- (i) To the extent feasible and appropriate, enable determination of an individual’s eligibility and financial responsibility for specific services prior to or at the point of care;
- (ii) Be comprehensive, requiring minimal augmentation by paper or other communications;
- (iii) Provide for timely acknowledgment, response, and status reporting that supports a transparent claims and denial management process (including adjudication and appeals); and

(iv) Describe all data elements (including reason and remark codes) in unambiguous terms, require that such data elements be required or conditioned upon set values in other fields, and prohibit additional conditions (except where necessary to implement State or Federal law, or to protect against fraud and abuse).

Further, section 1104(b)(2) of the Affordable Care Act amended section 1173 of the Act by adding new subsection (a)(4)(B), which states that “[i]n adopting standards and operating rules for the transactions * * *, the Secretary shall seek to reduce the number and complexity of forms (including paper and electronic forms) and data entry required by patients and providers.”

Section 1104(b)(2) of the Affordable Care Act added section 1173(g)(1) to the Act, which states that “[s]uch operating rules shall be consensus-based and reflect the necessary business rules affecting health plans and health care providers and the manner in which they operate pursuant to standards issued under Health Insurance Portability and Accountability Act of 1996.”

New sections 1173(g)(2)(D), (g)(3)(C), and (g)(3)(D) of the Act also clarify the scope of operating rules. They provide that—

- (2) Operating Rules Development.— In adopting operating rules under this subsection, the Secretary shall consider recommendations for operating rules developed by a qualified nonprofit entity that meets the following requirements * * *

(D) The entity builds on the transactions standards issued under Health Insurance Portability and Accountability Act of 1996. * * *

(3) Review and recommendations.— The National Committee on Vital and Health Statistics shall * * *

(C) Determine whether such operating rules represent a consensus view of the health care stakeholders and are consistent with and do not conflict with other existing standards;

(D) Evaluate whether such operating rules are consistent with electronic standards adopted for health information technology.

3. Adoption of Operating Rules for Eligibility for a Health Plan and Health Care Claim Status Transactions

In the July 8, 2011 **Federal Register** (76 FR 40458), we published an IFC titled, “Administrative Simplification: Adoption of Operating Rules for Eligibility for a Health Plan and Health Care Claim Status Transactions” (hereinafter referred to as the Eligibility and Claim Status Operating Rules IFC). That rule adopted operating rules for two HIPAA transactions: (1) Eligibility for a health plan; and (2) health care claim status. The Eligibility and Claim Status Operating Rules IFC also added the definition of operating rules to 45 CFR 162.103 and describes their relationship to standards. For details on operating rules and their relationship to standards, please see the Eligibility and Claim Status Operating Rules IFC (76 FR 40458).

4. Affordable Care Act: Standards and Operating Rules for Electronic Funds Transfers (EFT) and Remittance Advice Transactions

Section 1104(b)(2)(A) of the Affordable Care Act amended section 1173(a)(2) of the Act by adding the EFT transaction to the list of electronic health care transactions for which the Secretary must adopt a standard under HIPAA. Section 1104(c)(2) of the Affordable Care Act required the Secretary to promulgate a final rule to establish an EFT standard, and authorized the Secretary to do so by an interim final rule. That section further required the standard to be adopted by January 1, 2012, in a manner ensuring that it is effective by January 1, 2014.

Section 1104(b)(2)(C) of the Affordable Care Act also added a requirement, at section 1173(g)(4)(B)(ii) of the Act, for the Secretary to adopt a set of operating rules for electronic funds transfers (EFT) transactions and health care payment and remittance advice transactions that shall “(I) allow for automated reconciliation of the electronic payment with the remittance advice; and (II) be adopted not later than

July 1, 2012, in a manner ensuring that such operating rules are effective not later than January 1, 2014.”

Section 1104(b)(2)(C) of the Affordable Care Act also amended section 1173(g)(4)(C) of the Act, which provides that “[t]he Secretary shall promulgate an interim final rule applying any standard or operating rule recommended by the [NCVHS] pursuant to paragraph (3). The Secretary shall accept and consider public comments on any interim final rule published under this subparagraph for 60 days after the date of such publication.”

To better explain the context in which a standard for EFT was adopted, we review below how the health care electronic funds transfers (EFT) and remittance advice transaction is used to transmit health care claim payments.

5. Payment of Health Care Claims via EFT and ERA

In the January 10, 2012 **Federal Register** (77 FR 1556), we published an IFC titled, “Administrative Simplification: Adoption of Standards for the Health Care Electronic Funds Transfers (EFT) and Remittance Advice” (hereinafter referred to as the Health Care EFT Standards IFC). In the Health Care EFT Standards IFC, we defined the health care electronic funds transfers (EFT) and remittance advice transaction, found in 45 CFR 162.1601, as the transmission of either of the following for health care:

- The transmission of any of the following from a health plan to a health care provider:
 - ++ Payment.
 - ++ Information about the transfer of funds.
 - ++ Payment processing information.
- The transmission of either of the following from a health plan to a health care provider:
 - ++ Explanation of benefits.
 - ++ Remittance advice.

The transmission described in § 162.1601(a), hereinafter referred to as a health care EFT, is primarily a financial transmission, and the data content is payment information. Traditionally, health care payments were in the form of paper checks sent through the mail, and use of EFT for health care claim payments remains low. When an EFT is used, the payment is generally transmitted through the ACH Network, the same network that transmits salary payments via Direct Deposit, though there are instances when other networks are used, such as Fedwire.

The transmission described in § 162.1601(b) is the ERA. A health plan

rarely pays a provider the exact amount a provider bills the health plan for health care claims. A health plan adjusts the claim charges based on contract agreements, secondary payers, benefit coverage, expected copays and co-insurance, and other factors. These adjustments are described in the ERA through the use of four codes: Claim Adjustment Reason Codes (CARCs), Remittance Advice Remark Codes (RARCs), Claim Adjustment Group Codes (CAGCs), and NCPDP External Code List Reject Codes (NCPDP Reject Codes).

CARCs identify reasons why the claim or services are not being paid as charged. For instance, “163” means “attached references on the claim was not received.” RARCs provide additional information about the adjustment. For instance, “M30” means “missing pathology report.” CAGCs categorize CARCs by financial liability. For instance, “PR” means “patient responsibility.” NCPDP Reject Codes identify reasons why a retail pharmacy claim was rejected. For instance, “73” means “refills are not covered.”

With few exceptions, the ERA and the health care EFT are sent in different electronic formats through different networks, contain different data that have different business uses, and are often received by the health care provider at different times. The health care EFT is transmitted from the health plan’s treasury system. It is then processed by financial institutions, and ultimately entered into the health care provider’s treasury system. The path of the health care EFT through the ACH Network from health plan to provider is represented in Illustration A by the solid arrow.

In contrast, the ERA is traditionally sent from the health plan’s claims processing system and processed through the provider’s billing and collections system. The path of the ERA from health plan to provider is represented in Illustration A by the arrow with dashes.

When both the health care EFT and the ERA to which it corresponds arrive at the health care provider (often at different times), the two transmissions must be matched back together or “reassociated” by the provider; that is, the provider must associate the ERA with the payment that it describes. This process is referred to as “reassociation.”

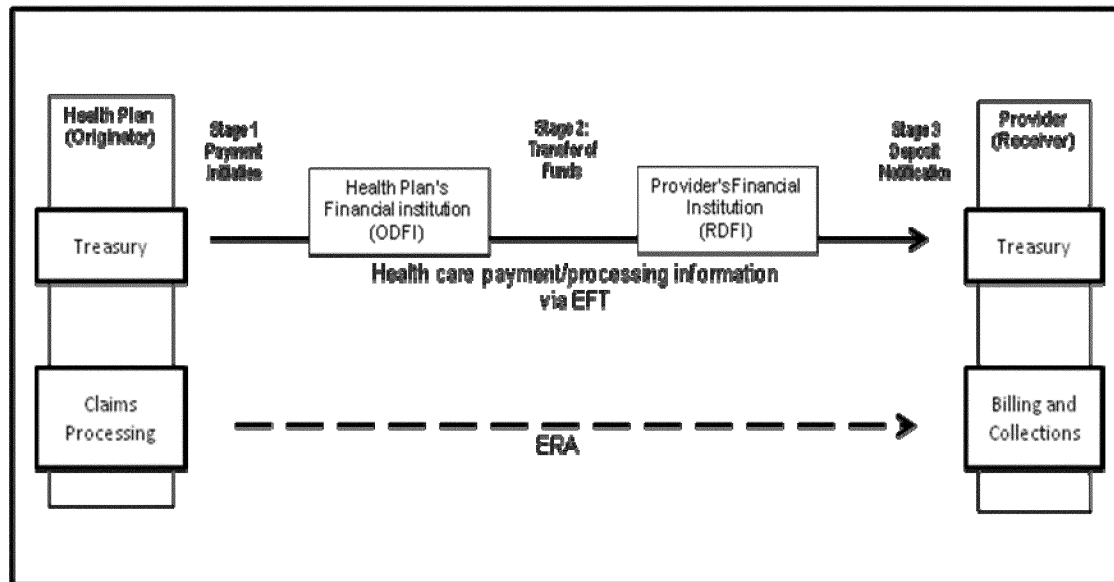
Providers receive many payments from different health plans, often separated from the ERA or paper remittance advice by days or even weeks. This makes reassociation of the payment with the remittance advice a slow burdensome task, especially when

the two cannot be associated by matching identical data elements. In order to realize the greatest level of time- and cost-savings, reassociation of

the ERA with the health care EFT should be automated through the provider's practice management system. Reassociation can only be automated if

there are data elements in the ERA that can be matched with data elements in the EFT.

ILLUSTRATION A: PATH OF HEALTH CARE EFT and ERA



6. Adoption of Standards for the Health Care Electronic Funds Transfers (EFT) and Remittance Advice Transaction

The Health Care EFT Standards IFC adopted standards for the format and the data content for the electronic transmission that a health plan sends to its financial institution in order to initiate a health care claim payment to a health care provider via the ACH Network.

One of the goals of the Health Care EFT Standards IFC was to adopt standards for the format and data content of the health care EFT that would ensure that the provider could reassociate the health care EFT with the ERA by matching identical data elements between the two. The Health Care EFT Standards IFC requires that a specific ACH file format be used with specific data content when health plans originate a health care EFT with their financial institutions to transmit through the ACH Network.

Specifically, the Health Care EFT Standards IFC adopts the ACH Network format known as the Corporate Credit or Deposit Entry (CCD) with Addenda Record (CCD+Addenda) as the standard that health plans must use to originate an EFT for health care payments made through the ACH Network. The data content of the Addenda Record is also standardized by the Health Care EFT Standards IFC: Health plans must

include the TRN Segment, an ASC X12 data segment the implementation specifications of which are found in the ASC X12 835 TR3 (hereinafter referred to as the X12 835 TR3) in the Addenda Record of the CCD+Addenda. No protected health information (PHI) is to be included in the health care EFT transaction according to the standards adopted in the Health Care EFT Standards IFC. For a comprehensive description of the EFT transmission through the ACH Network, please see the Health Care EFT Standards IFC (77 FR 1556).

The standard for the ERA is the X12 835 TR3, adopted in the Transactions and Code Sets final rule. An updated version of the X12 835 TR3, Version 5010, was adopted in the Modifications final rule.

By requiring health plans to use the same format to originate a health care EFT as that used by financial institutions to transmit an EFT through the ACH Network, there will be one less step in formatting/translating the data in the overall transaction and, therefore, a decrease in the risk that an error or omission will be made in that translation. Consistent format and data elements in the file format used by health plans to originate an EFT through the ACH Network will make it more likely that the provider will be able to reassociate the health care EFT with the

ERA because of identical data elements contained in both.

B. The National Committee on Vital and Health Statistics (NCVHS) December 2010 Hearings on EFT

The NCVHS was established by Congress to serve as an advisory body to the Secretary on health data, statistics, and national health information policy, and has been assigned a significant role in the Secretary's adoption of standards, code sets, and operating rules under HIPAA.

Per the Affordable Care Act, the Health Care EFT Standards IFC was based on recommendations from the NCVHS after a hearing the NCVHS Subcommittee on Standards held on December 3, 2010 on standards and operating rules for the health care payment and remittance advice transaction. During the December 2010 hearing titled "Administrative Simplification under the Patient Protection and Affordable Care Act Standards and Operating Rules for Electronic Funds Transfer (EFT) and Remittance Advice (RA)," ¹³ the NCVHS subcommittee conducted a comprehensive review of potential standards and operating rules for the health care electronic funds transfers (EFT) and remittance advice transaction.

¹³ For agenda and testimony, see <http://www.ncvhs.hhs.gov>.

The December 2010 hearing also included a review of standard setting organizations and operating rule authoring entities, for purposes of making a recommendation to the Secretary as to whether such standards and operating rules should be adopted. The NCVHS hearing consisted of a full day of public testimony with participation by stakeholders representing a cross-section of the health care industry, including health plans, health care provider organizations, health care clearinghouses, retail pharmacy industry representatives, standards developers, professional associations, representatives of Federal and State health plans, the Workgroup for Electronic Data Interchange (WEDI), the banking industry, and potential standard setting organizations (also known as standards development organizations or SDOs) for EFT standards and authoring entities for operating rules, including CAQH CORE, ASC X12, the NACHA, and the NCPDP.

The testimony, both written and verbal, described many aspects and issues of the health care electronic funds transfers (EFT) and remittance advice transaction. Testifiers described the advantages to using EFT to pay health care claims. The savings in time and money for health plans and health care providers that EFT affords was paramount amongst these advantages. Testifiers presented a number of case studies to illustrate these benefits as well as a number of obstacles to greater EFT use in health care. We refer the reader to the testimonies posted to the NCVHS Web site at <http://www.ncvhs.hhs.gov> for a more comprehensive discussion of the issues.

During the December 2010 NCVHS hearing, it became evident that no operating rules for the health care electronic funds transfers (EFT) and remittance advice transaction had yet been written by any entity. On February 17, 2011, following the December 2010 NCVHS Subcommittee on Standards hearing, the NCVHS sent a letter to the Secretary stating that "NCVHS has formally requested potential operating rules authoring entities to develop and present their applications to be authoring entities for operating rules for the health care EFT standard and ERA standard. These will be reviewed by NCVHS after they are received, and further recommendations will be considered."¹⁴

¹⁴ February 17, 2011 Letter to Kathleen Sebelius, Secretary, Department of Health and Human Services, from the National Committee on Vital and Health Statistics (NCVHS), p. 6.

After the February 17, 2011 letter was sent, three entities applied to be the authoring entity for the EFT and ERA operating rules: ASC X12 (for nonpharmacy ERA transactions); NCPDP (for pharmacy ERA transactions); and CAQH CORE (for all EFT and ERA transactions). The NCVHS evaluated the applications from the three potential authoring entities. Each application was evaluated based on the statutory requirements including: (1) Focus on administrative simplification; (2) having a multistakeholder and consensus-based process for development of operating rules; (3) building on the transaction standards issued under HIPAA; and (4) plans to develop operating rules that meet the functional requirements defined in the statute.

On March 23, 2011 the NCVHS sent a letter to the Secretary recommending that CAQH CORE, in collaboration with NACHA—The Electronic Payments Association, be named as the "candidate authoring entity for operating rules for all health care EFT and ERA transactions, with the provision that this entity submit to NCVHS fully vetted operating rules for consideration by the committee, by August 1, 2011."¹⁵ The letter noted that the proposed operating rules would be reviewed by NCVHS and further recommendations would be considered, including that the operating rules submitted may or may not be deemed acceptable for a recommendation for adoption.

C. CAQH CORE Operating Rules for the Health Care Electronic Funds Transfers (EFT) and Remittance Advice Transaction

Between March and August 2011, CAQH CORE held more than 30 open calls and over 15 straw polls with industry and government representatives to discuss, debate, and develop operating rules for EFT and ERA. Over 80 health care entities, including health plans, clearinghouses, providers, and financial institutions, were represented at weekly meetings and spent hundreds of hours of analyzing, reviewing, and consensus-building on the operating rules.¹⁶

¹⁵ March 23, 2011 letter to Kathleen Sebelius, Secretary of the Department of Health and Human Services, from Justine M. Carr, Chairperson, National Committee on Vital and Health Statistics, Affordable Care Act (ACA), Administrative Simplification: Recommendation for entity to submit proposed operating rules to support the Standards for Health Care Electronic Funds Transfers and Health Care Payment and Remittance Advice, pp. 4–5, <http://www.ncvhs.hhs.gov/110323lt.pdf>.

¹⁶ August 1, 2011 letter to Walter Suarez and Judith Warren, Co-Chairs of the National Committee

CAQH CORE collaborated with the medical, pharmacy, and financial services industries in the following ways in order to draft the operating rules:

- Conducted research, for example, reviewed over 100 EFT and ERA enrollment forms to identify gaps in data collection.
- Held open calls and shared draft documentation with a wide range of constituents, many of which in turn forwarded copies of the drafts to their affiliates.
- Vetted the complete draft CAQH CORE operating rules through the weekly call process, open update calls, surveys, and straw polls, and shared updates on the CAQH CORE and NACHA Web sites.

On August 1, 2011 CAQH CORE and NACHA—The Electronic Payments Association, submitted five separate draft EFT and ERA operating rules to the NCVHS for consideration¹⁷:

- Draft Phase III CORE ERA Infrastructure (835) Rule
- Draft Phase III CORE EFT Enrollment Data Rule
- Draft Phase III CORE ERA Enrollment Data Rule
- Draft Phase III CORE EFT & ERA Reassociation (CCD+/835) Rule
- Draft Phase III CORE Uniform Use of CARCs and RARCs (835) Rule; includes Draft CORE-required Code Combinations for CORE-defined Business Scenarios.

In its August 1, 2011 letter to the NCVHS, CAQH CORE urged the NCVHS to consider the rules as draft: "Further vetting is underway to finalize the rules per the CAQH CORE process or to identify further dialogue that should occur within the industry."¹⁸

On October 10, 2011, CORE produced another draft of the EFT & ERA Operating Rule Set in which the five rules were packaged as a set, titled: "Draft Phase III CORE EFT & ERA Operating Rule Set." Hereinafter, we will refer to the complete set of Draft Phase III CORE EFT & ERA Operating Rules as of October 10, 2011 as the EFT & ERA Draft Operating Rule Set.

on Vital Health Statistics (NCVHS) Subcommittee on Standards from Gwendolyn Lohse, Deputy Director CAQH and Managing Director of CORE and Janet Estep, President and CEO, NACHA (p. 2).

¹⁷ August 1, 2011 letter to Walter Suarez and Judith Warren, Co-Chairs of the National Committee on Vital Health Statistics (NCVHS) Subcommittee on Standards from Gwendolyn Lohse, Deputy Director CAQH and Managing Director of CORE and Janet Estep, President and CEO, NACHA (pg. 1).

¹⁸ August 1, 2011 letter to Walter Suarez and Judith Warren, Co-Chairs of the National Committee on Vital Health Statistics (NCVHS) Subcommittee on Standards from Gwendolyn Lohse, Deputy Director CAQH and Managing Director of CORE and Janet Estep, President and CEO, NACHA (p. 1).

D. The December 2011 NCVHS Recommendation to the Secretary

On December 7, 2011, the NCVHS sent a letter to the Secretary recommending that the EFT & ERA Draft Operating Rule Set be adopted, conditional on the authoring entities making certain revisions to the proposed operating rules (recommendations 1.1 and 1.2), including the following:

- All references to the CORE certification requirement are removed from any documents that are adopted as mandatory by HHS, and that the CAQH CORE Web site be similarly updated and amended. The NCVHS noted that one of the items specifically excluded in the Eligibility and Claim Status Operating Rules IFC is the requirement that all entities (providers, health plans and clearinghouses) using the operating rules be CORE certified, and stated that the “language in the operating rules that requires CORE certification specifically can be misleading.”¹⁹

- “The Secretary worked with CAQH CORE to develop a naming convention that consistently and easily identifies the transaction to which the rule applies.”²⁰ CORE currently names its operating rules using the term “Phase” in each one. The NCVHS letter observed that certain operating rules were common to all operating rules (“technical rules”) while other operating rules applied only to the specific transactions (“business rules”). The NCVHS suggested that the technical rules could be more appropriately maintained in a separate set of “base infrastructure” operating rules. Industry users could apply the technical rules across all transactions and use separate

documents for individual transactions to implement the business rules for that specific transaction.

Subsequent to the December 7, 2011 NCVHS letter, CORE edited the Draft EFT & ERA Operating Rule Set per the NCVHS recommendation that references to the CORE certification be removed. The final version, published by CAQH CORE on June 27, 2012, is titled the Phase III CORE EFT & ERA Operating Rule Set (June 27, 2012).

Discussions are underway between the Secretary and CORE as to NCVHS’ second recommendation that a different naming convention be developed for operating rules. However, it was not possible to develop a new naming convention in the period between the December, 2011 recommendation from NCVHS and the publication of this IFC.

III. Provisions of the Interim Final Rule with Comment Period

A. Adoption of Phase III CORE EFT & ERA Operating Rule Set (§ 162.1603)

In 45 CFR 162.1603, we adopt CAQH CORE Phase III CORE EFT & ERA Operating Rule Set (Approved June 2012), hereinafter referred to as the EFT & ERA Operating Rule Set, for the health care EFT and remittance advice transaction, with one exception noted later in this section of the IFC. In § 162.920, we list the EFT & ERA Operating Rule Set as being incorporated by reference.

The EFT & ERA Operating Rule Set includes the following rules: (1) Phase III CORE 380 EFT Enrollment Data Rule; (2) Phase III CORE 382 ERA Enrollment Data Rule; (3) Phase III Core 360 Uniform Use of Claim Adjustment Reason Codes and Remittance Advice

Remark Codes (835) Rule; (4) CORE-required Code Combinations for CORE-defined Business Scenarios for the Phase III Core Uniform Use of Claim Adjustment Reason Codes and Remittance Advice Remark Codes (835) Rule; (5) Phase III CORE 370 EFT & ERA Reassociation (CCD+/835) Rule; and (6) Phase III CORE 350 Health Care Claim Payment/Advice (835) Infrastructure Rule.

The Phase III CORE 350 Health Care Claim Payment/Advice (835) Infrastructure Rule includes a requirement, at 4.4.1, that entities’ companion guides must follow the format/flow as defined in the CORE v 5010 Master Companion Guide Template, so we are also adopting the CORE v 5010 Master Companion Guide Template.

We exclude the Phase III CORE 350 Health Care Claim Payment/Advice (835) Infrastructure Rule Requirement 4.2 in § 162.1603(a)(6). We are not adopting the Phase III CORE 350 Health Care Claim Payment/Advice (835) Infrastructure Rule Requirement 4.2, titled “Health Care Claim Payment/Advice Batch Acknowledgement Requirements” because that requirement requires the use of the ASC X12 999 acknowledgement standard, and the Secretary has not adopted standards for acknowledgement transactions.

Table 2 summarizes the high level requirements of the EFT & ERA Operating Rule Set. Table 2 does not include all aspects of the EFT & ERA Operating Rule Set, and readers are advised to refer to the EFT & ERA Operating Rule Set itself.

TABLE 2—SUMMARY OF THE PHASE III CORE EFT & ERA OPERATING RULE SET ADOPTED IN THIS IFC

Rule	High level requirements
Phase III CORE 380 EFT Enrollment Data Rule.	<ol style="list-style-type: none"> Requirement 4.2: Identifies a maximum set of standard data elements that health plans can request from providers for enrollment to receive EFT. Requirement 4.2: Applies a “controlled vocabulary”—predefined and authorized terms—for health plans to use when referring to the same data element. For instance, “Financial Institution Routing Number” is to be used instead of, for example, “Routing Number” or “Bank Routing Number.” Requirements 4.3.1 and 4.3.2: Require standard data elements to appear on paper enrollment forms in a standard format and flow, using Master Templates for paper-based and electronic enrollment. Requirement 4.3.1: Requires health plans to give specific information or instruction to providers to assist in manual paper-based EFT enrollment. For instance, for paper-based enrollment, health plans are required to inform the provider that it must contact its financial institution to arrange for the delivery of the data elements in the EFT required for reassociation of the payment and the ERA. Requirement 4.4: Requires that a health plan offer electronic EFT enrollment. (It does not require health plans to discontinue manual or paper-based methods of enrollment, but that electronic EFT enrollment be made available by a health plan if requested by a trading partner.) Requirement 4.5: Requires health plans to convert all their paper-based enrollment forms to comply with this rule no later than six months after the compliance date specified in this IFC.

¹⁹December 7, 2011 letter to Kathleen Sebelius, Secretary, Department of Health and Human Services, “Re: Affordable Care Act (ACA), Administrative Simplification: Recommendation to

adopt operating rules to support the Standards for Health Care Electronic Funds Transfers and Health Care Payment and Remittance Advice,” from

Justine M. Carr, Chairperson, National Committee on Vital and Health Statistics, pp. 5.

²⁰Ibid, pp. 5–6.

TABLE 2—SUMMARY OF THE PHASE III CORE EFT & ERA OPERATING RULE SET ADOPTED IN THIS IFC—Continued

Rule	High level requirements
Phase III CORE 382 ERA Enrollment Data Rule.	<ol style="list-style-type: none"> 1. Requirement 4.2: Identifies a maximum set of standard data elements that health plans can request from providers for enrollment to receive ERA. 2. Requirement 4.2: Applies a “controlled vocabulary”—predefined and authorized terms—for health plans to use when referring to the same data element. For instance, “Provider Name” is to be used instead of “Provider” or “Name.” 3. Requirements 4.3.1 and 4.3.2: Require standard data elements to appear on paper enrollment forms in a standard format and flow, using Master Templates for paper-based and electronic enrollment. 4. Requirement 4.3.1: Requires health plans to give specific information or instruction to providers to assist in manual paper-based ERA enrollment. For instance, for paper-based enrollment, health plans are required to provide specific information regarding the enrollment form, a fax number and/or address to send it to, and contact information for provider questions. 5. Requirement 4.4: Requires that a health plan offer electronic ERA enrollment. (It does not require health plans to discontinue manual or paper-based methods of enrollment, but that electronic ERA enrollment be made available by a health plan if requested by a trading partner.) 6. Requirement 4.5: Requires health plans to convert all their paper-based enrollment forms to comply with this rule no later than six months after the compliance date specified in this IFC.
Phase III CORE 360 Uniform Use of CARCs and RARCs (835) Rule, including CORE-required Code Combinations for CORE-defined Business Scenarios.	<p>Requirements 4.1.1 and 4.1.3: Identify four business scenarios with a maximum set of CARCs/RARCs/CAGCs/NCPDP Reject Codes combinations that can be applied to convey details of the claim denial or payment adjustment to the provider. Health plans can only use the CARC/RARC/CAGC/NCPDP Reject Code combinations specified in the “CORE-required Code Combinations for CORE-defined Business Scenarios” document except that new or adjusted combinations can be used if the code committees responsible for maintaining the codes create a new code or adjust an existing code. The four business scenarios are the minimum set of business scenarios; health plans may develop additional ones. The four business scenarios include:</p> <ol style="list-style-type: none"> 1. Additional Information Required—Missing/Invalid/Incomplete Documentation. 2. Additional Information Required—Missing/Invalid/Incomplete Data from Submitted Claim. 3. Billed Service Not Covered by Health Plan. 4. Benefit for Billed Service Not Separately Payable.
Phase III CORE 370 EFT& ERA Re-association (CCD+/835) Rule.	<ol style="list-style-type: none"> 1. Requirement 4.1: Requires that providers must proactively contact their financial institutions to arrange for the delivery of the CORE-required Minimum CCD+ Data Elements necessary for successful reassociation of the EFT with the ERA. The five (plus one situational) CORE-required Minimum CCD+ Data Elements are: <ol style="list-style-type: none"> a. Effective Entry Date. b. Amount. c. Trace Type Code. d. Reference Identification (EFT Trace Number). e. Originating Company Identifier (Payer Identifier). f. Reference Identification (Originating Company Supplemental Code), which is only required in some situations. 2. Requirements 4.2: Requires health plans to transmit the EFT within three days of the transmission of the ERA. 3. Requirement 4.2.1 For retail pharmacy, the health plan may release the ERA anytime before the EFT is released, but must release the ERA within three days after the EFT is released. 4. Requirement 4.3: Outlines requirements for resolving late or missing EFT and ERA transmissions.
Phase III CORE 350 Health Care Claim Payment/Advice (835) Infrastructure Rule.	<ol style="list-style-type: none"> 1. Requirement 4.1: Requires covered entities to implement HTTP/S Version 1.1 over the public Internet as a transport method for the health care electronic funds transfers (EFT) and remittance advice transaction. The requirements are designed to provide a “safe harbor” that application vendors, providers, and health plans (or other information sources) can be assured will be supported by all covered entities. The rule does not require that all CORE trading partners remove existing connections that do not match the rule, nor is it intended to require that covered entities must use this method for all new connections. The connectivity safe harbor also includes requirements for a minimum set of metadata outside the ASC x12 payload and aspects of connectivity/security such as response times, acknowledgements and errors. As part of this, two envelope standards are to be used. 2. Requirement 4.3: Requires health plans that issue proprietary paper claim remittance advices to continue to offer paper remittance advice for a minimum of 31 days from the implementation of ERA. 3. Requirement 4.4.1: Requires the use of the CORE Master Companion Guide Template for the flow and format of companion guides. This is the same CORE Master Companion Guide Template that was adopted in the Eligibility and Claim Status Operating Rules IFC.

B. Summary of Reasons for Adopting the EFT & ERA Operating Rule Set

As is demonstrated in the RIA of this IFC, the EFT & ERA Operating Rule Set will bring efficiencies to four areas of administrative tasks and, in so doing, will incentivize more health care entities to utilize electronic transactions. The four areas of administrative tasks that EFT & ERA

Operating Rule Set will streamline include:

- Provider enrollment in EFT and ERA: As detailed in Table 2, the EFT & ERA Operating Rule Set includes requirements for health plans to use common format, flow, and vocabulary in their enrollment forms for EFT and ERA, as well as a maximum set of data elements that can be used in the enrollment forms and shared between

the EFT and ERA enrollment forms. These requirements make EFT and ERA enrollment easier from the perspective of providers because all health plan enrollment forms will be similar, and a provider will be able to identify and collect all the required data for the multiple health plan forms simultaneously.

- Setting up initial trading partner connectivity and processes between

providers, clearinghouses and health plans: The connectivity or “safe harbor” requirements of the Phase III CORE 350 Health Care Claim Payment/Advice (835) Infrastructure Rule allow for quick initial connectivity between new trading partners. The connectivity requirements set up “ground rules” between trading partners with regard to connectivity over the public Internet. Although trading partners are not required to remove existing connections, providers and other trading partners can be assured that this connectivity can be used for transactions, that is, providers and other trading partners will find that this connectivity over the public Internet is always available to them, should they want to use it (safe harbor). The Phase III CORE 350 Health Care Claim Payment/Advice (835) Infrastructure Rule also requires health plans to format their ERA companion guides according to a CORE Master Companion Guide Template. These requirements could save days and perhaps weeks in terms of setting up with new trading partners.

- Reassociation of the EFT data with the ERA data. The maximum set of standard data elements required by the Phase III CORE 380 EFT Enrollment Data Rule and Phase III CORE 382 ERA Enrollment Data Rule ensures that the health plan will have the proper data necessary for the required data content—the data elements of the X12 TRN Segment—for the health care EFT so that automated reassociation is supported. The Phase III CORE 370 EFT & ERA Reassociation (CCD+/835) Rule has further data content requirements for the CCD+ and a requirement of plus or minus three days between transmission of the EFT and ERA, both of which facilitate automated reassociation by the provider. The Phase III CORE 370 EFT & ERA Reassociation (CCD+/835) Rule also requires a transition period between paper and electronic remittance advice, allowing a provider a test period before implementing ERA exclusively.

- Posting payment adjustments and claim denials. The Phase III CORE 360 Uniform Use of CARCs and RARCs (835) Rule, including CORE-required Code Combinations for CORE-defined Business Scenarios, puts limits on the number of code combinations used for four common rejection scenarios. This rule makes it easier for providers to understand the reasons for a health plan’s rejection or adjustment of a claim payment, and will decrease time spent on the manual follow-up (telephone calls, emails, etc.) on rejections and adjustments.

C. Operating Rules on Acknowledgements

The CORE EFT & ERA Operating Rule Set requires the use of the Version 5010 999 acknowledgements standard in the Phase III CORE 350 Health Care Claim Payment/Advice (835) Infrastructure Rule Requirement 4.2, titled “Health Care Claim Payment/Advice Batch Acknowledgement Requirements.” As noted previously, we are not adopting that particular requirement within the EFT & ERA Operating Rule Set.

Acknowledgements are responses transmitted by electronic data interchange (EDI) that inform transaction senders whether or not their transaction has been received or if there are problems with the transaction. The use of acknowledgements adds value to the underlying transactions for which they are sent by informing the sender that a transaction has been received or has been rejected. Without acknowledgements, it is difficult for the sender to know whether the intended recipient received the transmission, which often results in the sender repeatedly querying the intended receiver as to the status of the transmission.

In its September 22, 2011 letter to the Secretary, the NCVHS forwarded some observations and recommendations on the adoption of a standard for electronic acknowledgment transactions based on a hearing of the NCVHS Subcommittee on Standards on April 27, 2011.²¹ In the letter, the NCVHS noted that “[d]uring the April 2011 hearing, virtually all testifiers were supportive of a mandate for acknowledgment standards because of the time and costs savings benefits.”²² The NCVHS recommended that ASC X12 Acknowledgment standards be adopted for three different Acknowledgments transactions.²³

Section 1173(a)(4)(A)(iii) of the Act, as added by section 1104(b) of the Affordable Care Act, provides that standards and associated operating rules shall “provide for timely acknowledgement, response, and status reporting that supports a transparent claims and denial management process (including adjudication and appeals).” This provision is an indication of Congress’ recognition of the important role acknowledgements play in EDI.

²¹ September 22, 2011 letter to the Honorable Kathleen Sebelius, Secretary, Department of Health and Human Services, from the National Committee on Vital and Health Statistics, “Re: Observations and Recommendations on the Adoption of a Standard for Electronic Acknowledgment Transactions.”

²² *Ibid.*, pp 3.

²³ *Ibid.*, pp. 4

Although we are not requiring compliance with Phase III CORE 350 Health Care Claim Payment/Advice (835) Infrastructure Rule requirement 4.2, we are addressing the important role acknowledgements play in EDI by strongly encouraging the industry to implement the acknowledgements requirements in the CAQH CORE rules we are adopting herein. We reflect the exclusion of the requirement to use acknowledgments in § 162.1603(a)(6).

Until such time as the Secretary adopts a standard for acknowledgments, we support the industry’s ongoing voluntary use of acknowledgments and encourage even more widespread use.

D. Applicability (§ 162.100)

Per 45 CFR 162.100, the health care electronic funds transfers (EFT) and remittance advice transaction operating rules adopted in this interim final rule with comment period apply to all covered entities: Health plans, health care clearinghouses, and health care providers who transmit any health information in electronic form in connection with a transaction for which a standard has been adopted under HIPAA.

E. Technical Changes (§ 162.1601)

In the Health Care EFT Standards IFC, we named the new transaction the “Health Care Electronic Funds Transfers (EFT) and Remittance Advice” Transaction. In this IFC, we are making a conforming change to the title and introductory language of § 162.1601 to reference the transaction by the new name.

Specifically, we are changing the heading of § 162.1601 from “health care payment and remittance advice transaction” to “health care electronic funds transfers (EFT) and remittance advice transaction.” In the introductory text, we are revising the statement “The health care payment and remittance advice transaction is the transmission of either of the following for health care” to read “The health care electronic funds transfers (EFT) and remittance advice transaction is the transmission of either of the following for health care.”

F. Effective and Compliance Dates

Section 1173(g)(4)(B)(ii) of the Act, as added by section 1104(b)(2)(C) of the Affordable Care Act, states that “[t]he set of operating rules for electronic funds transfers and health care payment and remittance advice transactions shall * * * be adopted not later than July 1, 2012, in a manner ensuring that such operating rules are effective not later than January 1, 2014.” In each of our previous HIPAA rules, the date on

which the rule was effective was the date on which the rule was considered to be established or adopted or, in other words, the date on which adoption took effect and the CFR was accordingly amended. Typically, the effective date of a rule is 30 or 60 days after publication in the **Federal Register**. Under certain circumstances, the delay in the effective date can be waived, in which case the effective date of the rule may be the date of filing for public inspection or the date of publication in the **Federal Register**.

The effective date of standards, implementation specifications, modifications, or operating rules that are adopted in a rule, however, is different than the effective date of the rule. The effective date of standards, implementation specifications, modifications, or operating rules is the date on which covered entities must be in compliance with the standards, implementation specifications, modifications, or operating rules. The Act requires that the operating rules for the health care electronic funds transfers (EFT) and remittance advice transaction be effective not later than January 1, 2014. This means that covered entities must be in compliance with the operating rules by January 1, 2014. New § 162.1603 reflects this compliance date for the EFT & ERA Operating Rule Set.

If we change any of the policies we are finalizing in this interim final rule with comment period as a result of comments received, we will seek to finalize any such changes to allow sufficient time for industry preparation for compliance.

IV. Other Considerations: Process for Maintaining and Revising the EFT & ERA Operating Rule Set

The CORE EFT & ERA Operating Rule Set includes a number of statements about how the operating rules will be reviewed and updated. According to the Phase III CORE 382 ERA Enrollment Data Rule and the Phase III CORE 380 EFT Enrollment Data Rule, CORE will review the enrollment data sets on an annual or semi-annual basis. The Phase III CORE 382 ERA Enrollment Data Rule and the Phase III CORE 380 EFT Enrollment Data Rule state: “The first review shall commence one year after the [adoption] of a federal regulation requiring” implementation of the two CORE enrollment rules.²⁴ “Substantive

changes necessary to the data set will be reviewed and approved by CORE as necessary to ensure accurate and timely revision to the data set.”²⁵

The Phase III CORE 360 Uniform Use of CARCs and RARCs (835) Rule states that—

CAQH CORE will establish an open process for soliciting feedback and input from the industry on a periodic basis, no less than 3 times per year, on the CARC/RARC/CAGC and CARC/NCPDP Reject Codes/CAGC combinations in the *CORE-required Code Combinations for CORE-defined Business Scenarios.doc* and convene a Subgroup to agree on appropriate revisions. As part of this process, it will be expected that health plans/providers/vendors will report to CORE additional business Scenarios that health plans may be using on a frequent basis that are not covered by this CORE rule for consideration for additional Business Scenarios.²⁶

Note that these processes will be applied by CORE to update and revise those particular rules in the EFT & ERA Operating Rule Set. However, any modified versions of the EFT & ERA Operating Rule Set would be vetted through the rulemaking process before covered entities would be required to comply with them under HIPAA.

The CORE process for updating the operating rules is separate and distinct from the HHS process for updating standards and operating rules. Section 1104(b)(2)(C) of the Affordable Care Act added new section 1773(i) to the Act, which requires the establishment of a “review committee” to evaluate and review the adopted standards and operating rules and to report recommendations for updating and improving standards and operating rules to the Secretary. We will establish the review committee at a later date and a description of the review, evaluation, and update process will be presented at that time.

V. Waiver of Proposed Rulemaking and Delay in Effective Date

Under 5 U.S.C. 553(b) of the Administrative Procedure Act (APA), we are required to publish a notice of proposed rulemaking in the **Federal Register**. In addition, the APA mandates a 30-day delay in the effective date. Sections 553(b) and (d) of the APA provide for an exception from these APA requirements. Section 553(b)(B) of the APA authorizes the Department to waive normal rulemaking requirements if the Department for good cause finds

that notice and comment procedures are impracticable, unnecessary, or contrary to the public interest. Section 553(d)(3) of the APA allows the Department to waive the 30-day delay in effective date where the Department finds good cause to do so and includes a statement of support.

Subsection (C) of section 1173(g)(4) of the Act is titled “Expedited Rulemaking” and provides that “[t]he Secretary shall promulgate an interim final rule applying any standard or operating rule recommended by the [NCVHS] pursuant to paragraph (3). The Secretary shall accept and consider public comments on any interim final rule published under this subparagraph for 60 days after the date of such publication.” As discussed previously, this interim final rule applies the recommendations made by the NCVHS to adopt the EFT & ERA Operating Rule Set.

Because the statute requires us to publish an interim final rule with comment period for the adoption of these operating rules, we conclude that it is unnecessary to undertake ordinary notice and comment procedures. On this basis, we waive the ordinary notice and comment provisions of the APA. In accordance with the requirements of section 1173(g)(4)(C) of the Act, we are providing a 60-day public comment period.

We also find that it is unnecessary to undertake ordinary notice and comment procedures to revise the name in the title and introductory language of the transaction in § 162.1601. In the Health Care EFT Standards IFC, we named the new transaction the “Health Care Electronic Funds Transfers (EFT) and Remittance Advice,” and we are simply making a conforming change to the title and introductory language of that regulatory section to call the transaction by the new name.

We also find good cause for waiving the 30-day delay in the effective date of this interim final rule with comment period. The 30-day delay is intended to give affected parties time to adjust their behavior and make preparations before a final rule takes effect. Sometimes a waiver of the 30-day delay in the effective date of a rule directly impacts the entities required to comply with the rule by minimizing or even eliminating the time during which they can prepare to comply with the rule. In this case, covered entities are not required to comply with the adopted operating rules until January 1, 2014, approximately one-and-one-half years after the publication of this interim final rule with comment period; a waiver of the 30-day delay in the effective date of

²⁴ CAQH Committee on Operating Rules for Information Exchange (CORE), Phase III CORE EFT & ERA Operating Rules Set (As of May XX, 2012), Phase III CORE 382 ERA Enrollment Data Rule, Section 3.4. and Phase III CORE 380 EFT Enrollment Data Rule, Section 3.4.

²⁵ *Ibid.*

²⁶ CAQH Committee on Operating Rules for Information Exchange (CORE), Phase III CORE EFT & ERA Operating Rules Set (As of May XX, 2012), Phase III CORE 360 Uniform Use of CARCs and RARCs (835) Rule, Section 3.5.

the rule does not change that fact. A waiver is in fact inconsequential here to covered entities; their statutorily prescribed date of compliance remains January 1, 2014. Because we believe the 30-day delay is unnecessary, we find good cause to waive it.

VI. Collection of Information Requirements

Under the Paperwork Reduction Act of 1995, we are required to provide 60-day notice in the **Federal Register** and solicit public comment before a collection of information is submitted to the Office of Management and Budget (OMB) for review and approval. In order to fairly evaluate whether an information collection should be approved by OMB, section 3506(c)(2)(A) of the Paperwork Reduction Act of 1995 requires that we solicit comment on the following issues:

- The need for the information collection and its usefulness in carrying out the proper functions of our agency.
- The accuracy of our estimate of the information collection burden.
- The quality, utility, and clarity of the information to be collected.
- Recommendations to minimize the information collection burden on the affected public, including automated collection techniques.

We are soliciting public comment on the information collection requirements (ICRs) on each of these issues that contains information collection requirements (ICRs): Specifications: Companion Guides Template, CORE-Required Maximum ERA Enrollment Data Elements, and CORE-Required Maximum EFT Enrollment Data Elements.

A. Health Plans Are Required To Format Companion Guides According to Companion Guide Template

In current practice, companion guides are developed by individual health plans and require providers to adhere to different transaction implementation rules for each health plan. Health plans have created these companion guides to describe the specifics of how they implement the HIPAA transactions and how they will work with their trading partners.

Health plans' companion guides vary not only in format and structure, but also in size, being anywhere from a few to 60 pages or more. Such variance can be confusing to trading partners and providers who must implement them along with the standard implementation guides, and who must refer to different companion guides for different health plans. There are more than 1,200 such companion guides in use today.

The Phase III CORE 350 Health Care Claim Payment/Advice (835) Infrastructure Rule, Requirement 4.4, adopted in this interim final rule with comment period, requires a standard template/common structure that health plans must use that is more efficient for providers to reference, given the multiple industry companion guides they must consult today.

OMB has determined that this regulatory requirement (which mandates that the private sector disclose information and do so in a particular format) constitutes an agency-sponsored third-party disclosure as defined under the PRA. The burden associated with the requirements of this interim final rule with comment period, which is subject to the PRA, includes the initial one-time burden on health plans to use a standardized template for companion guides.

Common practice in the industry is for companion guides to be published as electronic documents and updated periodically in the routine course of business. Companion guides are posted to and made available on health plan Web sites for trading partners, including providers, to access; therefore, printing and shipping costs are not considered.

The burden associated with the routine or ongoing maintenance of the information reported in the standard template format for companion guides is exempt from the PRA as defined in 5 CFR 1320.3(b)(2).

Based on the assumption that the burden associated with systems modifications that need to be made to implement the standard template for companion guides may overlap with the systems modifications needed to implement other HIPAA standards, and the fact that the standard template for companion guides will replace the use of multiple companion guides, resulting in an overall reduction of burden for providers, commenters should take into consideration when drafting comments that: (1) One or more of these current companion guides may not be used; (2) companion guide modifications may be performed in an aggregate manner during the course of routine business; and/or (3) systems modifications may be made by contractors such as practice management vendors, in a single effort for a multitude of affected entities.

Health plans that issue companion guides do so, in part, to direct providers on how to implement the ASC X12 standards and, in the case of the NCPDP standards, issue payer sheets specific to their requirements, and often provide other plan-specific information, such as contact information, address, etc. It is expected that even with the advent of

operating rules, companion guides will never be completely eliminated, but the companion guides themselves may be greatly reduced in size and complexity as a result of the use of operating rules.

The CORE Master Companion Guide Template serves the purpose of providing a uniform structure for health plans to use when preparing companion guides. The use of this template by health plans currently issuing companion guides is considered to be a one-time action and is considered a permanent standard template for a health plan companion guide.

As the transition to the CORE Master Companion Guide Template is a one-time requirement, we do not estimate any ongoing labor costs associated with the use of CORE Master Companion Guide Template beyond the initial first year conversion.

In the Eligibility and Claim Status Operating Rules IFC, we estimated the one-time conversion to the template will cost health plans across the industry \$3,028,000. The calculations in the Eligibility and Claim Status Operating Rules IFC Collection of Information section were as follows: The current length of health plan companion guides related to the eligibility for a health plan and health care claim status transactions is anecdotally estimated as ranging from just a few to 60 or more pages. We estimate it will take a health plan staff person, most likely a technical writer, from 1 to 4 hours per page to reformat companion guides into the standard template for companion guides. This burden would involve re-entering information, reconfiguring the sequence in which information appears, adding information, and other word processing and related tasks. Also, it would require specific technical knowledge, such as expertise in the Version 5010 standard transactions.

Using the high estimate obtained in testimony to the NCHVS by the American Medical Association of 1,200 companion guides currently in use, we calculated in the Eligibility and Claim Status Operating Rules IFC an estimated average of 40 pages, (48,000 responses) at an average rate of 2 hours per page (1,200 guides × 40 pages × 2 hours per page), for a one-time burden of approximately 96,000 hours across the industry to implement the CORE Master Companion Guide Template.

The total burden calculated in the Eligibility and Claim Status Operating Rules IFC applied to the transition to the template for two transactions, while we are only considering one here: the health care electronic funds transfers (EFT) and remittance advice transaction. Therefore, for purposes of this IFC, in

order to calculate the burden to transition companion guides to the CORE Master Companion Guide Template, we have taken the total burden as estimated in the COI section of the Eligibility and Claim Status Operating Rules IFC and divided it in two, to result in approximately 48,000 hours (Table 3).

As existing word processing capabilities would be used for this task, we do not anticipate any software, hardware or other specialized equipment to be purchased and/or maintained for this specific purpose.

B. Health Plans Are Required To Use CORE-Required Maximum ERA Enrollment Data Elements and CORE-Required Maximum EFT Enrollment Data Elements in ERA and EFT Enrollment Forms

Requirements 4.2 and 4.3 of both the Phase III CORE 380 EFT Enrollment Data Rule and the Phase III CORE 382 ERA Enrollment Data Rule require health plans to change the forms they currently use for enrolling providers in EFT and ERA, as these rules require a

maximum set of standard data elements, a controlled vocabulary, and a standard format and flow to the forms. We assume that most, if not all, health plans will have to alter their current enrollment forms for EFT and ERA in order to comply with these requirements.

Health plans make alterations to their forms on a fairly routine basis in order to comply with internal business needs and State and Federal mandates. Changing or altering an existing form will often include a technical writer to make the actual changes, and an approval process that guarantees that the changes do not alter business processes in the organization. The burden associated with the requirements of this interim final rule with comment period is the initial one-time burden on health plans to use the CORE-required Maximum ERA Enrollment Data Elements and CORE-required Maximum EFT Enrollment Data Elements.

The burden associated with the routine or ongoing maintenance of the

enrollment forms is exempt from the PRA as defined in 5 CFR 1320.3(b)(2).

We assume that, for each of the two forms, it will take a technical writer 16 hours to reformat and alter the form according to the requirements in the Phase III CORE EFT 380 Enrollment Data Rule and Phase III CORE ERA 382 Enrollment Data Rule (2 forms * 16 hours = 32 hours). This includes the time it takes to incorporate revisions that may result from the approval process.

We assume that the two forms will have to get a number of levels of approval before they can be used, so we have added 4 hours of time being reviewed by general and operations managers. We multiply these hours (36) by the number of health plans and third party administrators (2,577) for a total burden to the industry of approximately 92,772 hours (Table 3).

As existing word processing capabilities would be used for this task, we do not anticipate any software, hardware or other specialized equipment to be purchased and/or maintained for this specific purpose.

TABLE 3—THE ONE-TIME BURDEN TO HEALTH PLANS OF REFORMATTING EXISTING COMPANION GUIDES AND ALTERING EFT AND ERA ENROLLMENT FORMS

One-time burden of reformatting companion guides (in hours)	Burden of reformatting EFT and ERA enrollment forms (in hours)	Total burden (in hours)
48,000	92,772	140,772

C. Cost of Provider Enrollment

The EFT & ERA Operating Rule Set adopted herein does not require providers to accept payments via EFT or remittance advice via ERA, so there is no requirement that providers must enroll in EFT to receive these transactions.

However, we do assume that, in part due to this regulation, physician practices, and hospitals will increase their usage of EFT, or, in some cases, will begin accepting EFT for health care claim payments for the first time. As we relay in the RIA of this interim final rule with comment period, for the savings for health plans, the high range of estimated increase in EFT usage attributable to implementation of the EFT and ERA standards makes up a percentage of the total increase.

Therefore, we have included the cost of enrollment in EFT to both physician practices and hospitals (Table 3), as we did in the Health Care EFT Standards IFC. This cost will also be reflected in the summary included in the RIA of the

cost and benefits of implementing the EFT & ERA Operating Rule Set.

We have not included the cost of enrollment in ERA to providers in this COI or RIA. The standard for the ERA was adopted in the Transaction and Code Sets final rule and the costs for implementing EDI were considered in that rule. A provider's enrollment in ERA with a health plan is a cost that would be included in initial implementation of EDI.

Data have demonstrated that hospitals have a much higher usage of EDI than physician practices and, by extension, we assume that hospitals have a higher usage of EFT than physician practices. However, there is no valid data on EFT usage among hospitals and so we will include them with physician practices, knowing that cost estimates are likely conservative.

Many physician practices and hospitals already accept EFT for health care claim payments from the health plans that pay them the most (as a percentage of total payments to the

provider), pay them most often, or transmit payment/processing information that works most successfully with the particular provider's practice management system.

The burden associated with this requirement of the EFT & ERA Operating rules is the completion of the health care EFT enrollment which is accomplished by filling out and submitting what is generally a 3- to 18-page form, obtaining signatures, and transmitting the completed document. The burden associated with the providers' routine or ongoing enrollment in order to receive payments from health plans is exempt from the PRA as defined in 5 CFR 1320.3(b)(2).

In order to quantify the average cost per physician practice or hospital, we have applied the following assumptions:

- In the Health Care EFT Standards IFC, we assumed that, for the typical physician practice, the time burden of an EFT enrollment with a single health plan is 2 hours. We base this time burden on the estimated length of time

it would take an average consumer to complete and submit a 3 to 18 page form, including obtaining bank account, bank routing, and necessary signatures to allow an employer to Direct Deposit an employee's salary into the employee's account (a common consumer EFT enrollment). However, Phase III CORE 380 EFT Enrollment Data Rule Requirement 4.4 requires health plans to offer electronic EFT enrollment. The rule does not require health plans to discontinue manual or paper-based methods of enrollment, but that electronic EFT enrollment be made available by a health plan if requested by a trading partner. We assume that providers that take advantage of the electronic EFT enrollment will find the time it takes to enroll cut significantly. If we assume that up to 50 percent of physician practices may opt to use the electronic enrollment in EFT, then the time it takes for a physicians practice to

enroll will be decreased to between 1 to 2 hours. For simplicity, we are using the average enrollment time of 1.5 hours.

- The majority of the enrollment will be done by a billing and posting clerk, at that position's average salary rate of approximately \$17.50 per hour. This rate is based on Bureau of Labor Statistics adjusted to 2014 by factoring an increase in labor costs at the rate of 3 percent per year.

- The model physician practice receives the vast majority of its payments from 25 or less plans.²⁷ From the beginning of 2014 through 2018, we assume that the number of health plans with whom the model physician practice does business will remain constant because industry trends indicate that the number of health plans will remain constant, or even decrease.

- According to our projections, the typical physician practice will receive 34 percent of its health care claim

payments via EFT at the beginning of 2014, and this will increase to 56 percent by the end of 2018 (reflecting our calculation in the RIA of this interim final rule with comment period for the whole industry). Using these factors, we can calculate that the typical physician practice is already enrolled in an EFT program with approximately eight of the twenty five health plans with which it does business (34 percent) at the beginning of 2014. We predict that the model physician practice would be expected to add six new EFT enrollments from 2014 through 2018, 18 percent of which are due to the positive consequences of the EFT & ERA Operating Rule Set. The 18 percent attribution is the percentage of total EFT usage that is attributable to the EFT & ERA Operating Rule Set as calculated in the RIA of this IFC. Any updates to the enrollments would be in the normal course of business.

TABLE 4—COSTS AND NUMBER OF ENROLLMENTS IN EFT BY PHYSICIANS AND HOSPITALS FOR 2014 THROUGH 2018

Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6
Time (in hours) per enrollment form (column 1)	Base hourly rate (in dollars) for billing and posting clerks* (column 2)	Number of physician practices/hospitals (column 3)	Total number of increased EFT enrollments (column 3 * 6 enrollments) (column 4)	Total number of EFT enrollments attributable to adoption of EFT & ERA operating rules set at 18% of total (column 5)	Number of annual enrollments in EFT attributable to adoption of operating rules set (column 6)
1.5	\$17.5	240,727	1,444,362	259,985	52,000

The total burden to providers that move to EFT due to the EFT & ERA Operating Rule Set from 2014 through

2018 is \$7.27 million. Table 5 illustrates the annualized burden.

TABLE 5—ESTIMATED ANNUALIZED BURDEN

	Year					Total
	2014	2015	2016	2017	2018	
Cost (Burden Hours for total hospitals & providers) (in millions)	\$1.4	\$1.4	\$1.5	\$1.5	\$1.5	\$7.3

If you comment on these information collection and recordkeeping requirements, please do either of the following:

1. Submit your comments electronically as specified in the **ADDRESSES** section of this proposed rule; or
2. Submit your comments to the Office of Information and Regulatory Affairs, Office of Management and

Budget, Attention: CMS Desk Officer, CMS-0028-IFC
 Fax: (202) 395-6974; or
 Email: OIRA_submission@omb.eop.gov.

VII. Regulatory Impact Analysis

We have examined the impacts of this interim final rule with comment period as required by Executive Order 12866 on Regulatory Planning and Review (September 30, 1993, as further amended), Executive Order 13563 on

Improving Regulation and Regulatory Review (January 18, 2011), the Regulatory Flexibility Act (RFA) (September 19, 1980, Pub. L. 96-354) (as amended by the Small Business Regulatory Enforcement Fairness Act of 1996, Pub. L. 104-121), section 1102(b) of the Social Security Act, section 202 of the Unfunded Mandates Reform Act of 1995 (March 22, 1995; Pub. L. 104-4), Executive Order 13132 on Federalism (August 4, 1999), and the

²⁷ American Medical Association, "Competition in Health Insurance: A Comprehensive Study of U.S. Markets," 2008 and 2009.

Robinson, James C., "Consolidation and the Transformation of Competition in Health Insurance," Health Affairs, 23, no.6 (2004):11-24.

"Private Health insurance: Research on Competition in the Insurance Industry," United States Government Accountability Office (GAO), July 31, 2009 (GAO-09-864R).

Congressional Review Act (5 U.S.C. 804(2)).

Executive Orders 12866 and 13563 direct agencies to assess all costs and benefits of available regulatory alternatives and, if regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects, distributive impacts, and equity). Executive Order 13563 emphasizes the importance of quantifying both costs and benefits, of reducing costs, of harmonizing rules, and of promoting flexibility. Executive Order 13563 also directs agencies to not only engage public comment on all regulations, but also calls for greater communication across all agencies to eliminate redundancy, inconsistency and overlapping, as well as outlines processes for improving regulation and regulatory review.

A Regulatory Impact Analysis (RIA) must be prepared for major rules with economically significant effects (\$100 million in 1995 dollars or more in any 1 year). We estimate that this rulemaking is “economically significant,” under section 3(f)(1) of Executive Order 12866 as it will have an impact of over \$100 million on the economy in any 1 year. Accordingly, we have prepared an RIA that, to the best of our ability, presents the costs and benefits of this interim final rule with comment period, and the rule has been reviewed by the Office of Management and Budget. We anticipate that the adoption of the EFT & ERA Operating Rule Set would result in benefits that outweigh the costs to health care providers and health plans.

The Regulatory Flexibility Act (RFA) requires agencies to analyze options for regulatory relief of small businesses if a rule has a significant impact on a substantial number of small entities. For purposes of the RFA, small entities include small businesses, nonprofit organizations, and small government jurisdictions. Small businesses are those with sizes below thresholds established by the Small Business Administration (SBA).

We have determined, and certify, that this rule will not have a significant economic impact on a substantial number of small entities, and that a regulatory flexibility analysis is not required. Our reasoning is as follows:

- Most physician practices, hospitals and other health care providers are small entities, either by nonprofit status or by having revenues of \$7 to \$34.5 million in any 1 year. However, the costs to individual providers will be minimal.

- The health insurance industry was examined in depth in the RIA prepared for the August 3, 2004 proposed rule on establishment of the Medicare Advantage program (69 FR 46866). In that analysis, it was determined that there were few if any “insurance firms,” including health maintenance organizations (HMOs), that fell below the size thresholds for “small” business established by the SBA. Then, and even more so now, the market for health insurance is dominated by a relatively small number of firms with substantial market shares. We assume that the “insurance firms” are synonymous, for the most part, with health plans that make health care claims payments to health care providers and are, therefore, the entities that will have costs associated with implementing health care EFT standards. However, there are a number of HMOs that are small entities by virtue of their nonprofit status even though few, if any, of them are small by SBA size standards. There are approximately 100 such HMOs. These HMOs and health plans that are nonprofit organizations, like the other firms affected by this interim final rule, will be required to implement the EFT & ERA Operating Rule Set.

Accordingly, this IFC will affect a “substantial number” of small entities; that is, nonprofit health plans. However, as illustrated in the RIA, we estimate that the costs for implementation of this IFC are, at most, approximately \$460,000 to \$1 million per health plan (regardless of size or non-profit status). We assume that the nonprofit HMOs that are considered “small” by virtue of their nonprofit status are not small in terms of revenue. Therefore, we do not consider the cost of implementation to be substantial for these nonprofit health plans.

In addition, section 1102(b) of the Act requires us to prepare a regulatory impact analysis if a rule may have a significant economic impact on the operations of a substantial number of small rural hospitals. This analysis must conform to the provisions of section 604 of the RFA. This IFC would not affect small rural hospitals, under the same reasoning previously given with regard to health care providers. Therefore, the Secretary has determined that this rule would not have a significant impact on the operations of a substantial number of small rural hospitals.

Section 202 of the Unfunded Mandates Reform Act of 1995 (UMRA) also requires that agencies assess anticipated costs and benefits before issuing any rule whose mandates require spending in any 1 year of \$100 million in 1995 dollars, updated

annually for inflation. In 2012, that threshold is approximately \$139 million. This IFC will impose unfunded mandates in excess of \$139 million on the private sector.

Executive Order 13132 establishes certain requirements that an agency must meet when it promulgates a proposed rule (and subsequent final rule) that imposes substantial direct requirement costs on State and local governments, preempts State law, or otherwise has Federalism implications. This IFC does not have a substantial direct effect on State or local governments, preempt State law, or otherwise have a Federalism implication.

A. Current State, Need for the EFT & ERA Operating Rule Set, and General Impact of Implementation

1. EFT and Remittance Advice Usage a. Billing and Insurance Related (BIR) Costs

As noted in the preamble, a significant portion of administrative costs for physician practices and hospitals are billing and insurance-related (BIR) costs. It is estimated that half of administrative costs for physician practices are BIR costs²⁸—or between 10 to 12 percent of a physician practice’s annual revenue.²⁹ In contrast, the U.S. retail sector spends about 2 percent of annual revenue on payment processing.³⁰

Along with estimated increases in all health care administrative costs, we can expect BIR costs to grow as well: In a study by the Washington State Office of the Insurance Commissioner, BIR costs grew between 1997 and 2005 at an average pace of 20 percent per year for hospitals in Washington State and 10 percent per year for physicians.³¹ In some cases, the increasing administrative cost of processing claims threatens the survival of small and mid-size physicians’ offices.³²

²⁸ Kahn, J. G., Kronick, R., Kreger, M., & Gans, D.N. “The Cost of Health Insurance Administration in California: Estimates for Insurers, Physicians, and Hospitals.” *Health Affairs*: 24(6):1629–1639, 2005.

²⁹ Sakowski, J.A., Kahn, J.G., Kronick, R.G., Newman, J.M., & Luft, H.S., “Peering Into the Black Box: Billing and Insurance Activities in a Medical Group.” *Health Affairs*: 28(4):w544–w554, 2009.

³⁰ “Overhauling the U.S. Healthcare Payment System,” conducted by McKinsey & Company, published in *The McKinsey Quarterly*, June 2007.

³¹ “Health Care Administrative Expense Analysis, Blue Ribbon Commission Recommendation #6: Final Report 11/26/07;” Washington State Office of the Insurance Commissioner.

³² Akscin J., Barr T., & Towle E.; “Key Practice Indicators in Office-Based Oncology Practices: 2007 Report on 2006 Data.” *J Oncol Pract* 3:200–203, 2007, and Mulvey, T.: “The Time Has Come for

BIR tasks include: Patient billing, insurance verification, responding to patients' cost questions, contracting with health plans, health care provider credentialing, processing payer requests for additional information, authorizations (procedures, referrals), payment for services provided outside the group, coding support, entering charges, claims review and edits, filing claims, creating and mailing patient statements, data entry and payment processing managements, collecting payments and posting to patient accounts, depositing checks and payments, account reconciliation, discrepancy research, follow-up, write-offs, posting refunds, filing for shared risk-pool payments, filing for contractual payments, and follow-up on denials, underpaid and nonresponsive claims.³³

BIR tasks are costly, in part, because physician practice staff must often manually customize transactions depending on the separate requirements of multiple health plans, insurance companies, clearinghouses, and TPAs with which the physician practice contracts. Because of the manual nature of BIR tasks, the majority of BIR costs are associated with staffing costs. Hospitals, physician offices and other health care providers employ more billing and posting staff than any other industry, according to the U.S. Bureau of Labor Statistics.³⁴

These costs include not just the labor costs of employing staff, but also the opportunity cost of providers whose time would otherwise be spent caring for patients. A 2009 study found that the average physician spent three hours a week interacting with health plans—nearly 3 weeks a year—while physicians' nursing and clerical staff spent much more time.³⁵ Even beyond the financial costs of manual BIR tasks, interruptions in the work of physician practices to deal with BIR tasks may interfere with patient care.

Twenty-eight percent of administrative staff time on BIR tasks in a physician practice is spent simply receiving and posting payments, follow-up, and payment reconciliation in accounts receivable.³⁶ The operating rules adopted in this IFC are designed

specifically to streamline the receipt of and the posting of payments, follow-up, and payment reconciliation in accounts receivable in the provider office.

b. The Benefits of ERA and EFT

As described in the preamble, three standards have been adopted for the health care electronic funds transfers (EFT) and remittance advice transaction. In August 2000, the Secretary adopted the ASC X12 835 TR3 in the Transaction and Code Sets final rule as the standard for what was then the health care payment and remittance advice transaction. The Modifications final rule adopted a new version of the ASC X12 835 TR3. In January 2012, the Secretary adopted two standards for the health care EFT transmission in the Health Care EFT Standards IFC: The CCD + Addenda for the Stage One payment initiation and the TRN Segment from the ASC X12 835 TR3 as the standard data elements that are inputted into the Addenda of the CCD. In the Health Care EFT Standards IFC, the Secretary maintained the ASC X12 835 TR3 as the standard for the ERA transmission.

There is some evidence that adoption of a standard for the ERA in August 2000 returned benefits for the health care industry. The Medical Group Management Association (MGMA) suggests that, for many physician practices, when the EFT and ERA are sent instead of paper checks and paper remittance advice, payment posting time has gone from six to seven hours per day to 3 to 4 hours.³⁷

As an anecdote, a large health system, with 20 hospitals, 400 clinical locations, and a 1.6 million member health plan, found that the adoption of the X12 835 standard required its staff to spend less time programming individual file formats, significantly reduced staffing expenses incurred in applying payments to billing systems, and provided a better understanding of the root causes of denied payments. For this health system, over 85 percent of payment data was applied electronically to the health system's patient accounts as of early 2012.³⁸

Similarly, the Veterans Health Administration (VHA) conducted a study of cost avoidance after implementing an "E-payment system" in 2003 with the 1,675 health care "payers" from which it collect health care claim payments. The new E-

payment system implemented a number of changes to how payers paid VHA claims, including: (1) Enabling the VHA to accept ERA (X12 835 TR3) and health care EFT, and urging health plans to transmit remittance advice and payment electronically; (2) routing the payment to a single lockbox bank; and (3) routing the health care EFT and ERA together for accounts receivable posting.³⁹

In cases where health plans transmitted both the health care EFT and the ERA electronically, the VHA found two substantial consequences resulted from the new system. There was a: (1) 71 percent reduction in the time between when a claim was submitted and when the payment was received by the VHA, from 49 days down to 14 days; and (2) 64 percent time savings for accounts receivable management and related tasks by 2010. The first result is especially important when applied to small physician practices for which cash-on-hand is crucial for continuity of operations. The second consequence resulted in \$9.3 million in annual cost avoidance for the VHA. In a clear example of how cost avoidance can be of benefit, the 64 percent time saving resulted in the VHA being able to handle 2.5 times the number of claims that were processed before the E-payment system was implemented in 2003 without adding additional staff.

However, in both examples, simply developing the capability to transmit or receive EDI in the standard format was not enough to realize the efficiencies of EFT and ERA. Both entities needed to create new processes, assure there were specific data elements in the transactions, coordinate with trading partners, and apply best practices to transmitting and receiving the transactions.

2. Current and Projected EFT and ERA Usage

For this impact analysis, we make a base assumption that the usage of EFT and ERA will increase over the next 10 years for a number of reasons. We base this projection on many of the same reasons we gave for projecting an increased usage of EFT in the RIA of the Health Care EFT Standards IFC.

First, the number of total health care claim payments are expected to increase

National Insurance Cards," *J. Oncol Pract*, 4:161, 2008.

³³ Casalino, L.P., Nicholson, S., Gans, D.N., Hammons, T., Morra, D., Karrison, T., & Levinson, W., "What Does It Cost Physician Practices to Interact With Health Insurance Plans?" *Health Affairs*, 28(4) (2009):w533-w543.

³⁴ <http://data.bls.gov/cgi-bin/print.pl/oes/current/oes433021.htm>.

³⁵ Casalino, et al., 2009.

³⁶ Sakowski et al., 2009.

³⁷ March 12, 2012 letter from the Medical Group Management Association (MGMA) to Secretary Sebelius as public comment on the health care EFT standards IFC.

³⁸ March 9, 2012 letter from UPMC, submitted to HHS as public comment on the health care EFT standards IFC.

³⁹ "E-Payment Cures for Healthcare," presentation, Barbara C. Mayerick, Department of Veterans Affairs, April 26, 2010, <https://admin.nacha.org/userfiles/File/Healthcare%20Resource/Epayers%20Cures%20for%20Healthcare.pdf> and "Comments from VHA Health Care as Health Care Provider," testimony by Barbara Mayerick for NCVHS December 3, 2010 hearing: http://hhs.granicus.com/MediaPlayer.php?publish_id=11.

considerably due to the anticipated increase in the number of claims, and usage of EFT is expected to rise with it. Health care claims are expected to increase due to an aging population that will require an increasing number of health care services. For instance, aging baby boomers will double Medicare's enrollment between 2011 and 2031.⁴⁰ Moreover, the Affordable Care Act is expected to increase the number of insured adults by 32 million in 2014,⁴¹ though this anticipated rise in the number of health care claims may be countered somewhat by the Affordable Care Act's initiatives to encourage the bundling of payments.⁴² Not only will more health care claims mean more payments, but the expected increase in claims will drive health care providers to seek more automated BIR processes in order to handle them all.

Second, it is anticipated that the use of electronic payments is expected to become more widespread and acceptable for U.S. businesses and society at large. ACH payments increased 9.4 percent every year between 2006 and 2009.⁴³ Business-to-business transactions have increasingly moved to EFT. E-commerce is expected to have a compound average growth rate of 11 percent each year from 2009 to 2014.⁴⁴ Growth of ACH payments is expected in sectors of the economy that have remained largely untapped by electronic payments; for instance, business-to-consumer transactions and person-to-person EFT transactions.⁴⁵

Third, statutory and regulatory initiatives at the State and Federal levels will drive or attract health care entities to increased usage of EFT and ERA. On the Federal level, regulatory initiatives include EFT requirements for Federal payments issued by the Department of

the Treasury, and implementation of provisions in the Affordable Care Act, including the required use of EFT for health care claim payments for Medicare mandated in section 1104(d) of the Affordable Care Act, the health care EFT standards adopted in the Health Care EFT Standards IFC, and the EFT & ERA Operating Rule Set adopted herein.

Other nonregulatory initiatives promote adoption of the EFT and ERA over paper and manual-based transactions as well. For instance, Medicare offers a free application to providers, Medicare Remit Easy Print (MREP), that allows providers to view and print remittance advice and special reports from the ERA.⁴⁶

In order to calculate our assumed increase in ERA and EFT, we start with an estimate of the current usage of EFT and ERA to establish a baseline.

a. ERA Usage: 2013 Baseline

For the RIA of the April 17, 2012 proposed rule (77 FR 22950), titled "Administrative Simplification: Adoption of a Standard for a Unique Health Plan Identifier; Addition to the National Provider Identifier Requirements; and a Change to the Compliance Date for the International Classification of Diseases, 10th Edition (ICD-10-CM and ICD-10-PCS) Medical Code Sets," (hereinafter referred to as the HPID/NPI/ICD-10 Delay Proposed Rule), we calculated the baseline usage of ERA in 2013. In that proposed rule, we used the baseline and projected an increase in the use of ERA across the industry from 2014 to 2022 in order to arrive at a savings for health plans and providers attributable to the implementation of a standard health plan identifier (HPID). We apply the same calculation here to arrive at a baseline ERA usage in 2013 and projected increase in use.

In the HPID/NPI/ICD-10 Delay Proposed Rule and in this IFC, we calculate the 2013 estimates of ERA usage (illustrated in Table 6) based on a number of sources and calculations:

- We use national health expenditures⁴⁷ and Medicare data to arrive at the average dollar amount of a single batch payment for health care

claims, projected from 2013 through 2023.⁴⁸

- We used the ratio of remittance advice to single batch payment according to Medicare data and applied that to industry payments and remittance advice at large.⁴⁹

- The percentage estimate of electronic remittance advice as a proportion of total remittance advice (electronic and paper) industry wide was calculated using a weighted average of Medicare data (electronic remittance advice as a percentage of total remittance advice), VA data,⁵⁰ and industry studies⁵¹ on ERA usage.

b. EFT Usage: 2013 Baseline

We calculate the baseline 2013 estimates of EFT usage with the same calculations we used in the Health Care EFT Standards IFC. We summarize the assumptions in calculating 2013 usage of EFT by industry and government payers as follows:

- We considered numerous health care and other industry studies, but all report that EFT is generally used for less than 40 percent of all health care claim payments to providers. According to the "2010 AFP Electronic Payments: Report of Survey Results," produced by the Association for Financial Professionals and underwritten by J.P. Morgan,⁵² the typical U.S. business makes 43 percent of its business-to-business payments by EFT. There was general agreement among industry representatives who testified at the December 2010 NCVHS hearing that EFT usage in the health care industry was considerably less than other industries (that is, less than 43 percent). Based on data supplied by Emdeon, a national health care clearinghouse, the National Progress Report on Healthcare Efficiency, 2010 (sponsored by Emdeon) reports that

⁴⁸ CMS Electronic Data Interchange (EDI) Performance Statistics (<http://www.cms.gov/EDIPerformanceStatistics/>) and CMS CROWD data.

⁴⁹ There are 6 percent more remittance advice sent than payments (some remittance advice adjusts to no payment). CMS Electronic Data Interchange (EDI) Performance Statistics (<http://www.cms.gov/EDIPerformanceStatistics/>) and CMS CROWD data.

⁵⁰ Financial Management Service, U.S. Department of Treasury, Payment Volume Charts Treasury-Disbursed Agencies, (www.fms.treas.gov/eft/reports.html).

"Comments from VHA Health Care as Health Care Provider," testimony by Barbara Mayerick for NCVHS December 3, 2010 hearing.

"FY10 Geographic Distribution of VA Expenditures (GDX)," Veterans Health Administration Chief Business Office.

⁵¹ The National Progress Report on Healthcare Efficiency, 2010, Produced by the U.S. Healthcare Efficiency Index.

⁵² "2010 AFP Electronic Payments: Report of Survey Results," Association for Financial Professionals, underwritten by J.P. Morgan, November, 2011.

⁴⁰ "The 2011 Medicare Trustees Report: The Baby Boomer Tsunami," presentation by the American Enterprise Institute for public Policy Research, May 2011: <http://www.aei.org/event/100407>.

⁴¹ <http://www.whitehouse.gov/healthreform/relief-for-americans-and-businesses>.

⁴² <http://www.whitehouse.gov/healthreform/timeline>.

⁴³ "The 2010 Federal Reserve Payments Study: Noncash Payment Trends in the United States: 2006-2009," Research Sponsored by the Federal Reserve System, April 2011, http://www.frb-services.org/files/communications/pdf/press/2010_payments_study.pdf.

⁴⁴ Sucharita Mulpuru, P. Hult, "U.S. Online Retail Forecast, 2009 to 2014: Online Retail Hangs Tough for 11% Growth in a Challenging Economy," March, 2010, Forrester Research, http://www.forrester.com/ib/Research/us_online_retail_forecast_2009_to_2014/q/id/56551/t/2.

⁴⁵ Shy, Oz, "Person-to-Person Electronic Funds Transfers: Recent Developments and Policy Issues," Public Policy Discussion Paper No. 10-1, Federal Reserve Bank of Boston, <http://www.bostonfed.org/economic/ppdp/2010/ppdp1001.pdf>.

⁴⁶ More information on the MREP: <https://www.cms.gov/Research-Statistics-Data-and-Systems/CMS-Information-Technology/AccessToDataApplication/MedicareRemitEasyPrint.html>.

⁴⁷ National Health Expenditure Projections 2009-2019 (CMS), http://www.cms.gov/NationalHealthExpendData/25_NHE_Fact_Sheet.asp.

only 10 percent of all health care claim payments are conducted electronically,⁵³ though other anecdotal evidence suggests that estimate may be low. PNC Bank representatives testified at the December 3, 2010 NCVHS hearing that 30 percent of health care claim payments it initiated on behalf of health industry clients in September 2010 were EFT payments.⁵⁴

Based on this data and research, we estimate that approximately 10 to 20 percent of commercial health plan payments are made via EFT. This range reflects our uncertainty. For simplicity sake, we will use the average, 15 percent, as the EFT usage rate for commercial health plans.

- Seventy percent of Medicare payments to health care providers are made via EFT, and Medicare EFT payments to health care providers account for 20 percent of all industry health care claim payments.⁵⁵

- Knowing the percentage of payments made by EFT for Medicare, we calculated a weighted average of

usage by the entire health care industry as making up approximately 32 percent of all health care claim payments in 2010.

The baseline estimates on EFT and ERA usage are not precise, and we welcome comments on our assumptions and calculations.

We have noted previously in this IFC the reasons why we predict that electronic transactions, overall, will increase. These reasons include a substantial increase in the number of claims, a broader acceptance of the use of electronic transactions by U.S. businesses and society at large, and State and Federal mandates and initiatives requiring or promoting electronic transactions of health information. Due to these reasons, we foresee a 20 percent increase in ERA usage year over year from 2013 through 2018, and a 12 percent increase year over year from 2019 through 2023. Again, despite the year over year increases, the number of total remittance advice transactions will

increase substantially over that same period, so the percentage of ERA as a proportion of all remittance advice increases at a slower rate, averaging less than 5 percentage points a year over 11 years.

Based on the reasons given previously, we assume that EFT usage will increase by 52 percentage points, as a percentage of total payments, across the whole industry, from 33 percent in 2013 to 84 percent in 2023 (Table 6).

Table 6 illustrates the predicted increase in usage of EFT and ERA by health plan category, driven by the increased number of health care claims, business acceptance, and regulatory initiatives. We believe these estimates to be conservative: The increase in patients and patient visits in the next decade alone may drive a greater number of health care entities to adopt EDI. However, we recognize the uncertainties inherent in this projection, and we are specifically soliciting comments on these assumptions.

TABLE 6—EFT AND ERA USAGE FOR MEDICARE, MEDICAID AND OTHER GOVERNMENT HEALTH PLANS, AND COMMERCIAL HEALTH PLANS BETWEEN 2013 AND 2023

Payment source	EFT Usage as a percentage of payments per payment source in 2013	ERA Usage as a percentage of all remittance advice per payment source in 2013	EFT Usage as a percentage of payments per payment source in 2023	ERA Usage as a percentage of all remittance advice per payment source in 2023
Medicare	76%	65%	98%	90%
Medicaid, CHIP, VHA, and Other Federal, State, and Local Governmental Payers	18	37	79	80
Commercial Health Plans	15	27	79	75
Entire Industry	33*	35*	84*	82*

* Weighted average, based on proportion of payments per category.

c. Overall Assumption for Industry Savings in RIA: A Projected Increase in EFT and ERA Attributable to the EFT & ERA Operating Rule Set

We have assumed that, in addition to the causes listed previously, some of the anticipated increase in EFT and ERA will be attributable to the implementation of the EFT & ERA Operating Rule Set adopted herein because these operating rules will make health care claim payments via EFT and the transmission of ERA more cost effective, thus incentivizing increased use of EFT and ERA.

We have applied the same basic assumption—that improvements to the standards and transactions will

incentivize more providers and health plans to use EDI—in the RIA of other Administrative Simplification regulations. For instance, the Modifications Proposed Rule, the Eligibility and Claim Status Operating Rules IFC, the HPID/NPI/ICD-10 Delay Proposed Rule, and the Health Care EFT Standards IFC all suggested that, with improved standards and transactions, more providers and health plans will move from manual and paper-based transactions to EDI.

Anecdotally, representatives of the health care industry agree with this assumption. For instance, during public comment for the Health Care EFT Standards IFC, a large provider association suggested that the adopted

standard “should increase the number of providers willing to take EFT as the preferred method of receiving payments.”⁵⁶

The RIA in this interim final rule with comment period illustrates that savings to physician practices, hospitals and commercial and government health plans will be derived through two avenues: (1) Time/staff savings realized by the adoption of operating rules that streamline provider payment processes; and (2) material savings (paper, printing, postage) derived from an overall increased use in EFT and ERA over paper and manual remittance advice. The time/staff savings incentivizes the increase usage in EFT

⁵³ The National Progress Report on Healthcare Efficiency, 2010, Produced by the U.S. Healthcare Efficiency Index.

⁵⁴ <http://www.ncvhs.hhs.gov>.

⁵⁵ “Medicare Contractor Transaction Report, MAC Part A Electronic Funds Transfer (EFT) Data by Year (2007–2011).”

⁵⁶ March 7, 2012 Letter to Marilyn Taverner for Public Comment from American Hospital

Association, “RE: CMS Administrative Simplification: Adoption of Standards for Health Care Electronic Funds Transfers (EFTs) and Remittance Advice; File Code CMS-0024-IFC.”

and ERA by industry and thus results in the material savings.

B. Alternatives Considered

1. Do Not Adopt the EFT & ERA Operating Rule Set at This Time

We considered delaying the adoption of the EFT & ERA Operating Rule Set. There are a number of advantages to delaying the EFT & ERA Operating Rule Set, including the following:

- A delay would give the industry more time to develop more comprehensive EFT and ERA operating rules. The EFT & ERA Operating Rule Set adopted herein were developed and vetted over a 6-month period in 2011. Given a longer period to develop operating rules, we might expect more comprehensive rules. A longer period to develop operating rules might also allow time for a more comprehensive analysis by industry of the costs and benefits of specific operating rules.

- A delay would give the industry more time to implement the EFT & ERA Operating Rule Set. Over the next few years, the health care industry as a whole is working to comply with a number of different Federal and State laws and regulations. Delaying implementation of operating rules would allow more time for the health care industry to prepare for the compliance dates of these Federal and State laws and regulations.

However, a delay in adopting operating rules would not be an appropriate approach for a number of reasons:

- The adoption and compliance dates for the health care EFT and remittance advice transaction operating rules is mandated by the Affordable Care Act.

- By implementing these operating rules, we believe the health care industry will make large strides toward automating reassociation, yielding a fairly immediate return on investment.

- The EFT & ERA Operating Rule Set is not dependent on or directly impacted by other Federal regulations or their adoption and compliance dates.

- The expected positive return on investment represents more benefit than burden to the industry.

2. Adopt a Different Set of EFT and ERA Operating Rules

We considered adopting a different set of EFT and ERA operating rules. Other organizations have worked on some of the problem areas of the health care EFT and remittance advice

transaction, although they are not labeled as operating rules. For instance, the state of Minnesota has developed and implemented the “Minnesota Uniform Companion Guide for the Implementation of the Health Care Claim Payment and Remittance Advice.”⁵⁷ The Minnesota Uniform Companion Guide includes requirements that are analogous in scope to operating rules; for instance, it includes data content requirements that further clarify the implementation specifications in the X12 835 TR3 and a crosswalk of CARCs, CAGCs, and RARCs that establishes limits to the combinations of those codes that can be used.

Nevertheless, we have adopted the operating rules as developed by CAQH CORE for a number of reasons:

- The NCVHS recommended CAQH CORE as the authoring entity of the EFT and ERA operating rules and the Draft EFT & ERA Operating Rule Set that CORE developed for adoption by the Secretary. The NCVHS based both of these recommendations on requirements established in section 1104 (b)(2)(C) of the Affordable Care Act that they believed the authoring entity CAQH CORE met, including—

(A) The entity focuses its mission on administrative simplification.

(B) The entity demonstrates a multi-stakeholder and consensus-based process for development of operating rules * * *;

(C) The entity has a public set of guiding principles that ensure the operating rules and process are open and transparent, and support nondiscrimination and conflict of interest policies that demonstrate a commitment to open, fair, and nondiscriminatory practices.

(D) The entity builds on the transaction standards issued under Health Insurance Portability and Accountability Act of 1996.

(E) The entity allows for public review and updates of the operating rules.

- The CAQH CORE had robust participation by health care entities in the development of its operating rules in terms of types of health care entities, geographic location of the entities, and numbers of entities represented.

- The CAQH CORE considered the work done by many organizations on

⁵⁷ “Minnesota Uniform Companion Guide for the Implementation of the Health Care Claim Payment and Remittance Advice Electronic Transaction (ANSI ASC X12 835),” Minnesota Department of Health, Division of Health Policy, Center for Health Care Purchasing Improvement, Prepared in Consultation with Minnesota Administrative Uniformity Committee, October, 2009, Version 4.0.

the health care electronic funds transfer (EFT) and remittance advice transaction that fit the scope of operating rules, including work by WEDI, ASC X12, and Minnesota.⁵⁸ In some cases, the operating rules reflect some of this work.

3. Adopt Certain EFT & ERA Operating Rules of Those Recommended by NCVHS

While there was some consideration given to adopting some but not all of the EFT & ERA Operating Rule Set developed by CAQH CORE, this idea was abandoned (with the exception of the decision not to adopt operating rules related to acknowledgements). First, as reflected in our RIA, all of the rules in the EFT & ERA Operating Rule Set result in net savings. Second, as noted in the preamble, the EFT & ERA Operating Rule Set was developed with representation from over 80 health care entities. These representatives developed the operating rules with the understanding that the rules would likely become required law on January 1, 2014. That is, as industry developed these rules, their decision making process was guided by what they believed was most likely to be ultimately implemented by the industry. Many votes, both formal and straw votes, were taken at every step in the development of the rules in order to gauge industry’s acceptance of the operating rules as they were written. Given the net savings and the prudence of the entities represented, we think it is appropriate to adopt the EFT & ERA Operating Rule Set nearly in its entirety.

C. Impacted Entities

All HIPAA covered entities may be affected by the EFT & ERA Operating Rules adopted in this IFC. HIPAA covered entities include all health plans, health care clearinghouses, and health care providers that transmit health information in electronic form in connection with a transaction for which the Secretary has adopted a standard.

Table 7 outlines the number of entities that may be impacted by the EFT & ERA Operating Rules, along with the sources for that data:

⁵⁸ “Committee on Operating Rules for Information Exchange (CORE) ACA Operating Rules Status for AMA Federation Staff: EFT and ERA,” presentation April, 2011 (<http://www.caqh.org/Audiocast/AMA/April2011/ERA-1slide.pdf>).

TABLE 7—TYPE AND NUMBER OF AFFECTED ENTITIES

Type	Number	Source
Health Care Providers—Offices of Physicians (includes offices of mental health specialists).	234,222	Health Insurance Reform; Modifications to the Health Insurance Portability and Accountability Act (HIPAA) Electronic Transaction Standards; Proposed Rule http://edocket.access.gpo.gov/2008/pdf/E8-19296.pdf (based on the AMA statistics).
Health Care Providers—Hospitals	5,764	Health Insurance Reform; Modifications to the Health Insurance Portability and Accountability Act (HIPAA) Electronic Transaction Standards; Proposed Rule http://edocket.access.gpo.gov/2008/pdf/E8-19296.pdf .
Health Care Providers—Nursing and Residential Care Facilities not associated with a hospital.	66,464	The number of providers was obtained from the 2007 Economic Census Data—Health Care and Social Assistance (sector 62) using the number of establishments: http://factfinder.census.gov/servlet/IBQTable?_bm=y&-ds_name=EC0762A1&-geo_id=01000US&-dataitem=* and http://factfinder.census.gov/servlet/IBQTable?_bm=y&-fds_name=EC0700A1&-skip=100&-ds_name=EC0762SLLS1&-NAICS2007=62&-lang=en . ~NAICS code 623: Nursing Homes & Residential Care Facilities n = 76,395 × 87 percent (percent of nursing and residential care facilities not associated with a hospital) = 66,464.
Other Health Care Providers—Offices of dentists, chiropractors, optometrists, mental health practitioners, speech and physical therapists, podiatrists, outpatient care centers, medical and diagnostic laboratories, home health care services, and other ambulatory health care services, resale of health care and social assistance merchandise (durable medical equipment).	384,192	The number of providers was obtained from the 2007 Economic Census Data—Health Care and Social Assistance (sector 62) using the number of establishments: http://factfinder.census.gov/servlet/IBQTable?_bm=y&-ds_name=EC0762A1&-geo_id=01000US&-dataitem=* and http://factfinder.census.gov/servlet/IBQTable?_bm=y&-fds_name=EC0700A1&-skip=100&-ds_name=EC0762SLLS1&-NAICS2007=62&-lang=en . ~NAICS code 621: All ambulatory health care services (excluding offices of physicians) = 313,339 (547,561 total—234,222 offices of physicians). ~NAICS code 62–39600 (product code): Durable medical equipment = 70,853.
Health Care Providers—Independent Pharmacies	18,000	Health Insurance Reform; Modifications to the Health Insurance Portability and Accountability Act (HIPAA) Electronic Transaction Standards; Proposed Rule http://edocket.access.gpo.gov/2008/pdf/E8-19296.pdf .
Health Care Providers—Pharmacy chains	200	Health Insurance Reform; Modifications to the Health Insurance Portability and Accountability Act (HIPAA) Electronic Transaction Standards; Proposed Rule http://edocket.access.gpo.gov/2008/pdf/E8-19296.pdf .
Health Plans—Commercial: Impacted commercial health plans considered in this RIA are health insurance issuers; that is, insurance companies, services, or organizations, including HMOs, that are required to be licensed to engage in the business of insurance in a State.	1,827	This number represents the most recent number as referenced in “Patient Protection and Affordable Care Act; Standards Related to Reinsurance, Risk Corridors, and Risk Adjustment, 2011 Federal Register (Vol. 76), July, 2011,” from www.healthcare.gov .
Health Plans—Government	60	Represents the 56 Medicaid programs, Medicare, the Veteran’s Administration (VHA), Indian Health Service (IHS), and TRICARE.
Health Plans—All	1,887	Insurance issuers (n = 1,827) + Government agencies (N = 60).
Clearinghouses and Vendors	162	Health Insurance Reform; Modifications to the Health Insurance Portability and Accountability Act (HIPAA) Electronic Transaction Standards; Proposed Rule http://edocket.access.gpo.gov/2008/pdf/E8-19296.pdf , based on a study by Gartner.
Third Party Administrators	750	Summary of Benefits and Coverage and the Uniform Glossary; Notice of Proposed Rulemaking http://www.gpo.gov/fdsys/pkg/FR-2011-08-22/pdf/2011-21193.pdf .

D. Scope and Methodology of the Regulatory Impact Analysis

This impact analysis analyzes the costs and benefits to be realized by implementation of the EFT & ERA Operating Rule Set.

While we assume that adoption of the EFT & ERA Operating Rule Set may impact a broad range of health care providers, as illustrated in Table 7, we will only be examining the costs and benefits of the operating rules on two types of providers: hospitals and

physician practices. There are two reasons for narrowing the scope of this analysis to only two categories of health care providers: (1) We have very little data on the adoption rate or usage of the health care electronic funds transfers (EFT) and remittance advice transaction among pharmacies, dentists, suppliers of durable medical equipment, nursing homes, and residential care facilities. The lack of data for these types of health care providers has been noted in other studies on administrative

simplification;⁵⁹ and (2) we assume that hospitals and physician practices, which receive the majority of health care claim payments, stand to gain the greatest benefits.

We do not analyze the impact on nursing and residential care facilities,

⁵⁹ Kahn, James, “Excess Billing and Insurance-Related Administrative Costs,” in *The Healthcare Imperative: Lowering Costs and Improving Outcomes: Workshop Series Summary*, edited by Yong, P.L., Saunders, R.S., & Olsen, L.A., The National Academies Press: 2010.

dentists or suppliers of durable medical equipment. Also, based on the information we have regarding EFT and ERA usage for pharmacies, we do not anticipate that there will be a significant benefit, though there may be some costs.

We welcome comments from industry and the public as to our assumptions.

We include health care clearinghouses and vendors as impacted entities in Table 7. However, we did not calculate costs and benefits in our impact analysis for these entities because we assume that any associated costs and benefits will be passed on, and included in the costs and benefits we apply, to health plans.

Although we acknowledge the impact to self-funded health plans and non-Federal government plans, we did not include the costs or benefits of such “health plans” or other employers who might be defined as “health plans” in our analysis due to the lack of data with regard to these types of health plans. Only a very small percentage of employers with self-insured health plans conduct their own health care transactions. The majority employ TPAs. For our analysis, we use the number of TPAs (~750) estimated in the August 22, 2011 proposed rule (76 FR 52455) titled “Summary of Benefits and Coverage and the Uniform Glossary.” Self-funded and non-Federal government health plans meet the definition of covered entities under HIPAA, while TPAs, in general, do not. However, TPAs employed by self-funded and non-federal government health plans will ultimately be the party that implements the health care EFT standards. Ostensibly, these TPAs will pass on their costs and benefits to the self-funded and non-Federal government health plans that they serve. In order to reflect the costs to self-insured plans, we will estimate the costs and benefits to TPAs in this analysis, and assume that TPAs will be impacted similarly to the 1,827 commercial health insurance issuers indicated in Table 7.

In this RIA, we do not separate the analysis of the costs and benefits of TPAs and commercial health insurers, and, hereinafter, we refer to both collectively as “commercial health plans” for purposes of this analysis.

We use the total number of health insurance issuers as the number of commercial health plans that will be affected by this IFC, and will use this number, plus the number of TPAs in our impact analysis. A health insurance issuer is an insurance company, insurance service, or insurance organization, including an HMO, that is required to be licensed to engage in the business of insurance in a State, and

that is subject to State law that regulates insurance. Although this number is specific to the individual and small group markets, we assume that many health insurance issuers in the large group market are included in this number because they are likely to market to individuals and small groups as well. While the category of “health insurance issuers” represents a larger number of health plans than those included in the NAICS codes for “Direct Health and Medical Insurance Carriers” (897 firms) we believe the category of health insurance issuers is a more accurate representation of companies conducting HIPAA transactions.

We estimate that, because of the time savings that will be quantified in the analysis of benefits, patients will benefit downstream from a health care delivery system that spends less time on administrative tasks. However, we do not quantify the benefits to patients.

Table 8 summarizes the sectors that will be analyzed in the impact analysis.

TABLE 8—ENTITIES ANALYZED IN THE REGULATORY IMPACT ANALYSIS

Entities	Number of entities
Physician Practices (includes offices of mental health specialists)	234,222
Hospitals	5,764
Commercial Health Plans (includes TPAs and health insurance issuers)	2,577
Medicare	1
Other Government Health Plans (Medicaid, VHA, TRICARE, IHS)	60

In general, the high and low range approach used in this impact analysis illustrates both the range of probable outcomes, based on our analysis, as well as the uncertainty germane to a mandated application of a operating rules on an industry with highly complex business needs and processes.

E. Costs

We assume that the costs of implementing the EFT & ERA Operating Rule Set will fall mostly on health plans, and that providers as a whole will garner most of the benefits.

The EFT & ERA Operating Rule Set requires health plans to implement best business practices that will make it less difficult for providers to: enroll in EFT and ERA, connect with health plans, and reassociate and reconcile the EFT and the ERA data.

A provider is not required to accept EFT under this IFC for health care claim payments, nor is a provider required to

accept ERA. If a provider decides or has decided to accept EFT or ERA, there are no requirements within the EFT & ERA Operating Rule Set that would result in substantial costs for providers.

However, in our COI and in the summary tables of the RIA, we have calculated a provider cost associated with the initial enrollment in EFT and ERA because our projection of savings for the health care industry is dependent upon this enrollment.

There is a requirement that a provider “must proactively contact its financial institution to arrange for the delivery of the CORE-required Minimum CCD+ Data Elements necessary for successful reassociation of the EFT payment with the ERA remittance advice * * *” (Phase III CORE 370 EFT & ERA Reassociation (CCD+835) Rule, Requirement 4.1) We have not attributed a provider cost to this requirement, as it is dependent on the relationship a provider has with its bank, the bank’s policies and customer service, and other variable factors. The specific requirement can be met by simply sending an email, but the intent of the rule, we assume, is for a provider to work with its bank to assure that the data elements are delivered, and meeting that intent may take more time. We assume that most providers maintain routine communication with their banks, and that this discussion can take place within one of those routine communications.

Aside from specific requirements of the EFT & ERA Operating Rule Set, the efficiencies that are possible through a provider’s use of EFT and ERA are dependent upon the sophistication of a provider’s practice management software (PMS) system used for the day-to-day management of a provider’s office. There is a wide range of sophistication among providers’ PMS systems and accounts receivable processes. An underlying assumption in this RIA is that even providers with the most elementary PMS systems will garner savings when these operating rules are implemented because the sophistication of PMS systems is not a factor in the cost and savings calculations.

For example, these operating rules will produce time savings for providers in the EFT & ERA enrollment process, and the sophistication of a provider’s PMS system is not a factor in the enrollment process. These operating rules also include data content requirements that will make it easier for a provider to reassociate the EFT with the ERA data and reconcile accounts through the use of RARCs and CARCs. We have assumed that these savings

will occur even if the reassociation and reconciliation processes remain manual processes because the operating rule requirements address data necessary for streamlining both automated and manual processes. Finally, these operating rules include connectivity requirements for health plans that will give providers a choice on how to connect to their health plan. The sophistication of the PMS system may be a factor in a provider's decision on which network to choose; however, the connectivity requirements allow more flexibility with regard to choosing a network that works well with PMS system, not less.

We believe the implementation of the EFT & ERA Operating Rule Set provides an opportunity for substantial savings beyond what is estimated in this RIA if a provider has a sophisticated PMS that is able to automate many of the payment and reconciliation processes. The amount of investment in PMS systems and the amount of time and resources spent on business processes is dependent upon the size and complexity of the provider and the provider's priorities with regard to resources and budget. Because there are no substantive requirements for providers in this IFC, and because the cost savings for providers are not dependent on the level of sophistication of the provider PMS system, an analysis of such factors is not calculated in this RIA.

We have divided the costs of implementation of the EFT & ERA Operating Rule Set into four areas. The majority of these costs are one-time costs. The four areas of costs parallel the four areas of administrative tasks in which the cost savings will be found when the EFT & ERA Operating Rule Set is implemented. The four areas of costs are associated with:

- Implementing the operating rules regarding provider enrollment in EFT and ERA.
- Implementing connectivity requirements.
- The data requirements for health plans for providers to successfully reassociate the EFT data with the ERA data.
- The data requirements for health plans associated with posting payment adjustments and claim denials.

We present each of the areas of costs by detailing the operating rules that apply to them and the assumptions we use for each cost.

1. The Cost of Implementing the Operating Rules With Regard to Provider Enrollment in EFT and ERA

Requirements 4.2 and 4.3 of both the Phase III CORE 380 EFT Enrollment Data Rule and the Phase III CORE 382 ERA Enrollment Data Rule require health plans to change the forms they currently use for enrolling providers in EFT and ERA, as these rules require a maximum set of standard data elements, a controlled vocabulary, and a standard format and flow respectively. We assume that most, if not all, health plans will have to alter their current enrollment forms for EFT and ERA in order to comply with these requirements.

We estimate that a technical writer, at an estimated hourly salary rate of approximately \$32,⁶⁰ would make these revisions. As noted in the Collection of Information section of this IFC, we assume that, for each of the two forms, it will take a technical writer 16 hours to reformat and alter the form according to the requirements in the Phase III CORE EFT 380 Enrollment Data Rule and Phase III CORE ERA 382 Enrollment Data Rule (2 forms * 16 hours = 32 hours) resulting in a cost of approximately \$1,024. This includes the time it takes to incorporate revisions that may result from the approval process.

We assume that the two forms will have to get a number of levels of approval before they can be used, so we have added 4 hours of time priced at the hourly salary rate of approximately \$55,⁶¹ the mean hourly wage of general and operations managers, for a total cost of \$1,244. We multiply this cost to health plans by the number of health plans and third party administrators (2,577) for a total cost to the industry of approximately \$3.2 million.

We will include that cost in our summary of costs in Table 13. Please refer to the Collection of Information section for more details on our assumptions with regard to that calculation.

Requirement 4.4 of both the Phase III CORE 380 EFT Enrollment Data Rule and the Phase III CORE 382 ERA Enrollment Data Rule requires health

⁶⁰ Mean hourly wage for Technical Writers (27–3042), “May 2011 National Occupational Employment and Wage Estimates, United States,” Bureau of Labor Statistics, United States Department of Labor, http://www.bls.gov/oes/current/oes_nat.htm#43-0000.

⁶¹ Mean hourly wage for General and Operations Managers (11–1021), “May 2011 National Occupational Employment and Wage Estimates, United States,” Bureau of Labor Statistics, United States Department of Labor, http://www.bls.gov/oes/current/oes_nat.htm#43-0000.

plans to offer electronic enrollment for EFT and ERA. (It does not require health plans to discontinue manual or paper-based methods of enrollment, but that electronic EFT enrollment be made available by a health plan if requested by a trading partner.) We have made a number of assumptions in order to calculate the cost of setting up an electronic enrollment form for both the EFT and ERA:

- We assume that 60 to 80 percent of health plans do not currently have electronic enrollment for both EFT and ERA and will be required to offer it to providers. This assumption is based on an informal review of payers, including Medicare, a Medicaid health plan, four commercial health plans, and one vendor that found that only two of the seven offered electronic forms (or 30 percent).⁶² As the survey has little statistical validity, the range of 60 to 80 percent reflects the uncertainty in this estimate.

- For all IT infrastructure estimates in this RIA, which includes software updates, we have based the costs on a wide range of projected “person-months” required at each phase of the implementation. It is important to view these estimates as an attempt to furnish a realistic context rather than as precise budgetary predictions. In this estimate and in the other IT infrastructure estimates, we have tried to detail specific steps, periods of time, and personnel that we assume would be necessary for IT infrastructure alterations. We welcome comments that might speak to specific assumptions in our calculations.

- We assume that creating on-line forms is a comparatively simple technological upgrade. Based on cost estimates for large institutions such as universities and financial institutions, the software cost for developing an online form that can interact with existing databases and systems is approximately \$4,500 a year.⁶³ This cost is for infrastructure, and not for the more complex task of actually integrating an online form with existing systems so that enrollment is truly automated. For the task of integrating an online form with existing systems, we estimate a cost of \$10,000 to \$50,000, reflecting a range of costs dependent on the complexity of a health plans' systems. The \$10,000 represents 2 weeks full time work by two computer

⁶² “Healthcare EFT Enrollment: Stakeholder Meeting: Pre-read material, March 25, 2011,” Research sponsored by CAQH, NACHA—The Electronic Payments Association, The Clearinghouse, pg 14.

⁶³ Based on case studies from PerfectForms, www.perfectforms.com.

programmers and one computer systems analyst. The \$50,000 represents 2 months full time work by two computer programmers, one computer system analyst, and one administrative services manager.⁶⁴

However, we believe this range to be high, because an electronic enrollment will not be any more expensive to

integrate into systems than the paper forms that are currently being used. We welcome comments on these estimates.

- As the range of costs could encompass both large and small health plans, we have combined the government health plans, including Medicare, with the commercial health plans for the total number of health

plans. The low and high totals illustrated in Table 9 reflect the cost for all health plans, government, and commercial.

With these assumptions, the cost of creating on-line forms for EFT and ERA enrollment are calculated in Table 9.

TABLE 9—THE COST OF CREATING ON-LINE ENROLLMENT FORMS FOR EFT AND ERA ENROLLMENT

	Ongoing cost of on-line enrollment forms	LOW one-time cost for business process changes	HIGH one-time cost for business process changes	LOW number of health plans without electronic forms (60%)	HIGH number of health plans without electronic forms (80%)	LOW total cost (in millions)	HIGH total cost (in millions)
2014	\$4,500	\$10,000	\$50,000	1,582	2,110	\$22.9	\$115
2015	4,500	.....	.....	1,582	2,110	7.1	9.5
2016	4,500	.....	.....	1,582	2,110	7.1	9.5
2017	4,500	.....	.....	1,582	2,110	7.1	9.5
2018	4,500	.....	.....	1,582	2,110	7.1	9.5
2019	4,500	.....	.....	1,582	2,110	7.1	9.5
2020	4,500	.....	.....	1,582	2,110	7.1	9.5
2021	4,500	.....	.....	1,582	2,110	7.1	9.5
2022	4,500	.....	.....	1,582	2,110	7.1	9.5
2023	4,500	.....	.....	1,582	2,110	7.1	9.5
Total .....	.....	.....	.....	.....	.....	87	200

2. The Cost of Implementing Infrastructure Rule Requirements

Requirement 4.1 of the Phase III CORE 350 Health Care Claim Payment/Advice (835) Infrastructure Rule requires health plans to offer connectivity over the internet, with specific rules regarding usage patterns for batch transactions, the exchange of security identifiers, and communications-level errors and acknowledgements. There will be costs associated with developing this connectivity in order to have the ability to offer it to trading partners, though we assume that much of the development of this connectivity will have already occurred in order to comply with the Eligibility and Claim Status Operating Rules IFC.

The Eligibility and Claim Status Operating Rules IFC adopted Phase I and Phase II Operating Rules (with the exception of operating rules from those

phases that refer to acknowledgments or CORE certification). Requirement 4.1 of the Phase III CORE 350 Health Care Claim Payment/Advice (835) Infrastructure Rule requires health plans to offer the same infrastructure, with accompanying security, usage patterns, and errors and acknowledgments that are required under Phase I and Phase II CORE Operating Rules.

Therefore, though there will be some costs associated with offering the same connectivity as is used for the eligibility for a health plan transaction and the claim status transaction, the costs will be minimal in comparison to the costs associated with developing this infrastructure from the ground up.

We have no concrete costs associated with offering this connectivity for transmission of the ERA. Therefore, we have made the assumption that it will be 10 to 20 percent of the cost to

establish the connectivity for Phase I and Phase II Operating Rules as estimated in the Eligibility and Claim Status Operating Rules IFC (Table 10, Columns IV and V). We adjusted the costs to account for the smaller number of health plans that we have estimated in this IFC in contrast to the number that was used in the Eligibility and Claim Status Operating Rules IFC (Table 10, Column VI). We have calculated these costs in Table 10. The low cost is calculated by multiplying the low cost from the Eligibility and Claim Status Operating Rules IFC times the low adjustment, 10 percent (Table 10, Column IV), times the percent adjustment to account for a lower number of health plans than was used in the Eligibility and Claim Status Operating Rules IFC. The high cost is calculated using the same factors. We welcome comments on this assumption.

⁶⁴ Mean hourly wages, "May 2011 National Occupational Employment and Wage Estimates,

United States," Bureau of Labor Statistics, United

States Department of Labor, http://www.bls.gov/oes/current/oes_nat.htm#43-0000.

TABLE 10—COSTS TO HEALTH PLANS TO IMPLEMENT CONNECTIVITY REQUIREMENTS OF THE EFT AND ERA OPERATING RULES IN MILLIONS

I	II	III	IV	V	VI	VII	VIII
	Low costs from eligibility and claim status operating rules (implementation + transition costs)	High cost from eligibility and claim status operating rules (implementation + transition costs)	Low percent adjustment	High percent adjustment	Percent adjustment to account for smaller number of health plan than operating rules estimate	Low cost	High cost
2014	\$1742	\$3484	10%	20%	58%	\$100.34	\$401.36
2015	410	820	10	20	58	23.62	94.41
2016	410	820	10	20	58	23.62	94.41
Total .....	.....	.....	.....	.....	.....	147.57	590.17

Requirement 4.4 requires health plans to conform to form and format standards for their companion guides for the ERA. In the Collection of Information section of this IFC, we have estimated the burden in hours for health plans to change their current companion guides so that they meet the flow and format requirements of the operating rules. We stated in that section that we used the same calculation that was used in the Eligibility and Claim Status Operating Rules IFC to arrive at an estimate of the time that was required. As we noted in that section, the total cost calculated in the Eligibility and Claim Status Operating Rules IFC applied to the transition to the template for two transactions, while we are only considering one here: The health care electronic funds transfers (EFT) and remittance advice transaction. Therefore, for purposes of this IFC, in order to calculate the cost to transition companion guides to the CORE Master Companion Guide Template, we have taken the total cost as estimated in the COI section of the Eligibility and Claim Status Operating Rules IFC and divided it in two, to result in approximately \$1.5 million. We have adjusted for a slight rise in the salary of a technical writer that has occurred since the calculations for the Eligibility and Claim Status Operating Rules IFC were made (2011 mean hourly wage: \$32).⁶⁵

We will include that cost in our summary of costs in Table 13. Please refer to the Collection of Information section of this IFC for details on our assumptions with regard to that calculation.

⁶⁵ Mean hourly wage for Technical Writers (27-3042), "May 2011 National Occupational Employment and Wage Estimates, United States," Bureau of Labor Statistics, United States Department of Labor, http://www.bls.gov/oes/current/oes_nat.htm#43-0000.

3. The Cost of Meeting Data Requirements for Successful Reassociation of the EFT Data With the ERA Data

Although Phase III CORE 370 EFT & ERA Reassociation (CCD+/835) Rule, Requirement 4.1, does not explicitly require health plans to include five (plus one situational) defined data elements in the CCD+, it does define CORE-required Minimum Data Elements from the CCD+ that a provider must access. This rule builds on the standards adopted in the Health Care EFT Standards IFC which included the standard for the data content of the addenda record for the CCD+, the TRN Segment from the X12 835 TR3. The standard for the data content of the addenda record for the CCD+ includes three of the data elements required in this operating rule, plus the situational data element.

The Health Care EFT Standards IFC (77 FR 1581) accounted for the costs of including these 3 data elements, plus the situational data element, noting that "[t]he high range of costs takes into consideration the possible difficulties associated with coordinating the health plan's payment or treasury systems so that the TRN Segment is duplicated in both the ERA and the health care EFT."

Requirement 4.1 of the Phase III CORE 370 EFT & ERA Reassociation (CCD+/835) Rule requires two data elements in addition to the three data elements required by the Health Care EFT Standards IFC that must be inputted in the CCD+. We assume the cost of inputting these two data elements is insignificant: These data elements include the "Effective Entry Date" and the "Amount" of the payment, both of which, we assume, are relatively easy to establish and input, regardless of the system. We have not included any costs

associated with inputting these two data elements.

Both Requirements 4.2 and 4.2.1 place time restrictions on health plans with regard to synchronizing EFT with the corresponding ERA and will likely require health plans to incur costs by making sure their systems and process can meet these requirements.

Phase III CORE 370 EFT & ERA Reassociation (CCD+/835) Rule, Requirement 4.2, requires health plans to transmit the ERA corresponding to the CCD+ within 3 days before or after the CCD+ Effective Entry Date. The CCD+ Effective Entry Date is defined as "the date the payer intends to provide good funds to the payee via EFT as specified in the ACH CCD+ Standard in Field #9 of the Company Batch Header Record 5."⁶⁶

Phase III CORE 370 EFT & ERA Reassociation (CCD+/835) Rule, Requirement 4.2.1 applies to health care claim payments to retail pharmacy and allows a health plan to transmit the ERA any time prior to the CCD+ Effective Entry Date of the corresponding EFT, but no later than 3 days after the CCD+ Effective Entry Date.

In order to meet the requirements of these rules, health plans will have to make alterations in their IT infrastructures and business processes in order to coordinate the treasury system—that often is the source of the EFT transmission—and the claims processing system—that often is the source of the ERA transmission. In addition, health plans may have to coordinate with their trading partners

⁶⁶ "CAQH Committee on Operating Rules for Information Exchange (CORE), CORE Steering Committee, Draft Phase III EFT & ERA Reassociation (CCD+/835) Rule For Steering Committee Review—as of 10/10/11," p. 19, referencing *NACHA Operating Rules and Guidelines 2011*.

that process the EFT or ERA in order to meet this requirement.

For purposes of this RIA, we are defining IT infrastructure as the equipment, systems, software, and services used in common across an organization, regardless of mission, program, or project. IT infrastructure also serves as the foundation on which mission, program, or project-specific systems and capabilities are built.⁶⁷ However, we assume that the majority of costs will be in altering software.

In terms of software alterations, this is a difficult estimate to make and we welcome comments from health plans as to our assumptions and estimates. As noted in a Department of Defense cost estimating handbook, “[o]ne of the first steps in any estimate is to understand and define the system to be estimated. Software, however, is intangible, invisible, and intractable * * *. Software grows and changes as it is written.”⁶⁸ This is especially true with regard to the legacy software and IT systems of health plans and TPAs that are altered according to a swiftly changing world of business needs and State and Federal regulations.

Estimating an overall average cost to health plans and TPAs is further complicated because the systems for each entity will have a range of differences with regard to the complexity and reliability of their software, the analyst and programmer capabilities, the experience of the team that will apply the changes, schedule overlaps, number of locations, management and executive oversight and the use of tools and software engineering practices.⁶⁹ Because of these variables, it would be difficult to

apply a parametric or “bottoms up” analysis that could be applied to calculate an industry-wide estimate.

The major cost associated with system changes is the staff time required to develop and carry out the business requirements. We assume that there will be no hardware costs to meeting the requirements of this rule. The software costs will be a one-time cost, with a few years of transitional costs. The costs associated with altering business processes—that is, the organizational processes that feed the input to the systems and process the output—will also be a one-time cost with a few years of transitional costs.

For all IT infrastructure estimates in this RIA, we have based the costs on a wide range of projected “person-months” required at each phase of the implementation. It is important to view these estimates as an attempt to furnish a realistic context rather than as precise budgetary predictions. In our estimates, we detailed specific steps, periods of time, and personnel that we assume would be necessary for IT infrastructure alterations. We welcome comments that might speak to specific assumptions in our calculations.

In Table 11, we have broken down the major tasks required to implement any software implementation project, based on the Government Accountability Office’s “work breakdown structure” for software projects as referenced in the “GAO Cost Estimating and Assessment Guide.”⁷⁰

For each task, we have assigned a group of employees, calculated their total annual salaries and monthly salaries based on Bureau of Labor statistics,⁷¹ then estimated a low and high range of time that the team would spend on a particular task. The group of employees is to be understood to likely include more than just the specific employees listed; that is, the group of

employees represents a cumulative effort that a health plan would expend on a task. For example, project management includes four employees—one Computer and Info Systems manager, one operations manager, one computer Systems analyst, and one computer programmer—that together spend 2 weeks (0.5 to 1 month) full time defining the project and assigning roles to employees and team. We expect that more than four employees will be involved at different levels in this task; however, the total anticipated time spent in the task is expected not to exceed four full time employees working at these organizational levels full time for 2 weeks.

Although we expect that some health plans already transmit ERA and its associated EFT within 3 days of each other, we have no basis for that expectation. We have multiplied the cost per health plan, as calculated in Table 11, times the number of commercial health plans and TPAs in order to arrive at the range of total cost for all commercial health plans and TPAs: \$474 million to \$931 million.

We assume that government health plans, including the VHA, Indian Health Plans, Medicaid, and Medicare, will have more difficulty altering systems. In many cases, government health plans will have to work across agencies—for example, with the Department of Treasury—to meet the requirements of the EFT & ERA Operating Rule Set while also ensuring that their own Federal requirements and business needs are met. In addition, agencies such as Medicare may have more complex implementation solutions because multiple systems will be affected. We have doubled the average cost to arrive at a total for all government health plans: \$22 to \$43 million.

We assume that the majority of health plan costs with regard to meeting data content requirements will occur in 2013, with some transition costs occurring in 2014. For simplicity’s sake, we include the costs as occurring in 2013.

We welcome comments addressing our assumptions and calculations.

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⁶⁷ “GAO Cost Estimating and Assessment Guide: Best Practices for Developing and Managing Capital Program Costs,” March 2009, United States Government Accountability Office, Applied Research and Methods (GAO-09-3SP), p. 138.

⁶⁸ *Parametric Cost Estimating Handbook*, “Chapter 5—Software Parametric Cost Estimating,” Joint Government/Industry Initiative, Fall 1995, Department of Defense, p. 114.

⁶⁹ Some of these elements are taken from “Table 17: Common Software Risks That Affect Cost and Schedule,” GAO Cost Estimating and Assessment Guide: Best Practices for Developing and Managing Capital Program Costs,” March 2009, United States Government Accountability Office, Applied Research and Methods (GAO-09-3SP), p. 138.

⁷⁰ “GAO Cost Estimating and Assessment Guide: Best Practices for Developing and Managing Capital Program Costs,” March 2009, United States Government Accountability Office, Applied Research and Methods (GAO-09-3SP).

⁷¹ Mean hourly wages, “May 2011 National Occupational Employment and Wage Estimates, United States,” Bureau of Labor Statistics, United States Department of Labor, http://www.bls.gov/oes/current/oes_nat.htm#43-0000.

TABLE 11: COST FOR HEALTH PLAN OF IMPLEMENTING PHASE III CORE 370 EFT & ERA REASSOCIATION (CCD+/835) RULE REQUIREMENT 4.2: TRANSMIT ERA WITHIN 3 DAYS BEFORE/AFTER EFT

	Cost based on Mean Wages		Assumed Time Required in Person-Months		LOW COST	HIGH COST
	Annual Salary	Monthly	LOW	HIGH		
IT Infrastructure (Software) Changes						
Project Management (define project objectives, assign roles)	347,450	28,954	0.5	1.0	\$14,477	\$28,954
	1 Computer and Info Systems managers 1 Operations manager 1 Computer Systems analysis 1 Computer programmer					
Product Requirements (analyze and define business requirements)	314,720	26,227	1	2	\$26,227	\$52,453
	2 Computer programmers 1 Computer systems analyst 1 Administrative Services manager					
Detail software design/plan to implement business requirements	228,030	19,003	1	2	\$19,003	\$38,005
	2 Computer programmers 1 Computer systems analyst					
System construction and integration(code, configure software)	228,030	19,003	1	3	\$19,003	\$57,008
	2 Computer programmers 1 Computer systems analyst					
Test (verification)	314,720	26,227	1	2	\$26,227	\$52,453
	2 Computer programmers 1 Computer systems analyst 1 Administrative Services manager					
Support and Training	314,720	26,227	1	2	\$26,227	\$52,453
	1 Training and Development manager 1 Administrative Services manager 1 Training and Development specialists 1 Computer systems analyst					
Go live (deployment)	320,550	26,713	0.1	0.5	\$2,671	\$13,356
	2 Computer programmers 1 Computer systems analyst					
Transition	76,010	6,334	1	3	\$6,334	\$19,003
	1 Computer programmer					
Business Processes						
Analysis	196,720	16,393	0.5	0.5	\$8,197	\$8,197
	1 Operations manager 1 Computer Systems analysts					
Plan	196,720	16,393	0.5	0.5	\$8,197	\$8,197
	1 Operations manager, 1 Computer Systems analyst					
Support and Training	314,720	26,227	1	1	\$26,227	\$26,227
	1 Training and Development manager 1 Administrative Services manager Training and Development specialists Computer systems analyst					
Go live (implement)	114,490	9,541	0.1	0.5	\$954	\$4,770
	1 Operations manager					
ESTIMATED COST FOR SINGLE HEALTH PLAN/TPA					\$183,742	\$361,076
COST FOR ALL COMMERCIAL HEALTH PLANS (in millions)					\$473.5	\$930.5
COST OF GOVERNMENT HEALTH PLANS (in millions)					\$22	\$43

4. The Data Requirements Associated With Posting Payment Adjustments and Claim Denials

Phase III CORE 360 Uniform Use of CARCs and RARs (835) Rule, 4.1.1 defines four business scenarios with a maximum set of CARC/RARC/CAGC combinations that can be applied to convey details of the claim denial or payment adjustment to the provider. Health plans can only use the CARC/RARC/CAGC combinations specified in

the “CORE-required Code Combinations for Core-defined Business Scenarios” document except that new or adjusted combinations can be used if the code committees responsible for maintaining the codes create a new code or adjust an existing code. The four business scenarios are the minimum set of business scenarios; health plans may develop additional scenarios.

In order to meet the requirements of this rule, health plans will likely have

to make alterations to their business processes, and, in some instances, to their IT infrastructures. It is likely that health plans will have to remove certain coding combinations from their business processes. IT infrastructure changes are only required if the health plan needs to alter its payment system with regard to certain code combinations that will no longer be allowed. We assume that this is a minimum IT infrastructure cost, though

it may be a more extensive cost to business processes, as reflected in Table 12.

We have adopted the same categories of IT infrastructure and business process changes that we applied for Table 11, with many of the same factors. A major distinction between the two estimates is the higher cost to business processes

and training in order to meet the requirements of this rule compared to the IT infrastructure changes necessary under the Phase III CORE 370 EFT & ERA Reassociation (CCD+/835) Rule.

We assume that the majority of health plan costs with regard to meeting data content requirements will occur in 2013, with some transition costs

occurring in 2014. For simplicity's sake, we include the costs as occurring in 2013. Again, it is important to view these estimates as an attempt to furnish a realistic context rather than as precise budgetary predictions. We welcome comments that might speak to specific assumptions in our calculations.

TABLE 12: COST OF IT INFRASTRUCTURE AND BUSINESS PROCESSES FOR PHASE III CORE 360 EFT & ERA UNIFORM USE OF CARCS AND RARCS (835) RULE

	Cost based on Mean Wages*		Assumed Time Required in Person Months		LOW COST	HIGH COST
	Annual	Monthly	LOW	HIGH		
Software Changes						
	\$347,450	\$28,954				
Project Management (define project objectives, assign roles)	1 Computer and Info Systems managers 1 Operations manager 1 Computer Systems analysis 1 Computer programmer		0.5	0.5	\$14,477	\$14,477
	\$314,720	\$26,227	0.5	1	\$13,113	\$26,227
Product Requirements (analyze and define business requirements)	2 Computer programmers, 1 Computer systems analyst, 1 Administrative Services manager					
	\$228,030	\$19,003	0.5	0.1	\$9,501	\$1,900
Detail software design/plan to implement business requirements	2 Computer programmers, 1 Computer systems analyst					
	\$228,030	\$19,003	2	4	\$38,005	\$76,010
System construction and integration(code, configure software)	2 Computer programmers, 1 Computer systems analyst					
	\$314,720	\$26,227	1	2	\$26,227	\$52,453
Test (verification)	2 Computer programmers 1 Computer systems analyst, 1 Administrative Services manager					
	\$314,720	\$26,227	0.5	1	\$13,113	\$26,227
Support and Training	1 Training and Development manager, 1 Administrative Services manager, 1 Training and Development Specialists 1 Computer systems analyst					
	\$320,550	\$26,713	0.1	0.5	\$2,671	\$13,356
Go live (deployment)	2 Computer programmers, 1 Computer systems analyst					
	\$76010	\$6,334	3	6	\$19,003	\$38,005
Transition	1 Computer programmer					
Business Processes						
	\$196,720	\$16,393	0.5	1	\$8,197	\$16,393
Analysis	1 Operations manager 1 Computer Systems analysts					
	\$196,720	\$16,393	0.5	1	\$8,197	\$16,393
Plan	1 Operations manager, 1 Computer Systems analyst		1	2	\$26,227	\$52,453
	\$314,720	\$26,227				
Support and Training	2 Training and Development manager 2 Administrative Services manager 2 Training and Development specialists 2 Computer systems analyst 1 Technical writer					
	\$296,260	\$24,688	0.1	0.5	\$2,469	\$12,344
Go live (implement)	1 Operations manager					
ESTIMATED COST FOR SINGLE HEALTH PLAN/TPA					\$181,199	\$346,239
COST FOR ALL COMMERCIAL HEALTH PLANS (in millions)					\$467	\$892
COST OF GOVERNMENT HEALTH PLANS (in millions)					\$22	\$42

* Mean hourly wages, "May 2011 National Occupational Employment and Wage Estimates, United States," Bureau of Labor Statistics, United States Department of Labor, http://www.bls.gov/oes/current/oes_nat.htm#43-0000

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Table 13 summarizes all the estimated costs to commercial and government health plans and providers for

implementing the EFT & ERA Operating Rule Set. It includes figures from Table 5 with regard to providers and Tables 3, 9, 10, 11, and 12 for costs to health

plans. The costs are from 2013 through 2023, but the majority of the costs are incurred from 2013 through 2016.

TABLE 13—SUMMARY OF COSTS TO IMPLEMENT THE EFT & ERA OPERATING RULE SET FOR PROVIDERS, AND COMMERCIAL AND GOVERNMENT HEALTH PLANS

	Low (in millions)	High (in millions)
Health Plan EFT and ERA Electronic Enrollment Costs for Health Plans	\$87	\$200
Health Plan Infrastructure Costs (SAFE HARBOR/HTTPS) Costs for Health Plans.	\$148	\$590
EFT & ERA Reassociation rule 4.2: Transmit ERA within 3 days before/after EFT —Cost to Health Plans.	\$474 for commercial plans	\$931 for commercial plans
	\$22 for government plans	\$43 for government plans
EFT & ERA Uniform Use of CARCs and RARs (835 Rule) Cost to Health Plans.	\$467 for commercial plans	\$892 for commercial plans
	\$22 for government plans	\$42 for government plans
One-Time Cost to Health Plans of Reformatting Companion Guides	\$1.5	\$1.5
Cost to Health Plans of Reformatting EFT and ERA Enrollment Forms	\$3.2	\$3.2
Cost to providers to enroll in EFT	\$15.7	\$15.7
TOTAL COSTS	\$1,239	\$2,719

F. Savings

The quantifiable savings estimated in this RIA are derived from two means: (1) time savings will be realized by the adoption of operating rules that streamline provider payment processes; and (2) material savings will be derived from an overall increased use in EFT and ERA over paper and manual remittance advice and payment processes and the decrease in printing, paper, and mailing costs as a consequence of this increase. The time savings of the former incentivizes the increase usage in EFT and ERA and thus results in material savings.

We have based our time savings on the assumption that four areas of administrative tasks will be streamlined by the implementation of the EFT & ERA Operating Rule Set adopted in this IFC. The four areas of administrative tasks include the following:

- Provider enrollment in EFT and ERA.
- Setting up connectivity between trading partners.
- Reassociation of the EFT data with the ERA data.
- Posting payment adjustments and claim denials.

We will consider the time and material savings for commercial and government health plans and then analyze the time and material savings for physician practices and hospitals.

1. Commercial Health Plans, Government Health Plans, and Third Party Administrators: Time Savings From Implementation of the EFT & ERA Operating Rule Set

We estimate that commercial and government health plans will achieve savings in two of the four areas of tasks that implementation of EFT & ERA Operating Rule Set adopted in this IFC will streamline: Setting up connectivity between trading partners and the processing of rejection and denial codes

by provider practice management systems.

However, these time savings cannot be easily quantified for health plans and TPAs. We will give narrative description below about how health plans and TPAs can achieve time savings through streamlining these tasks, but we are unable to quantify the savings on these two particular tasks.

a. Setting Up Connectivity Between Trading Partners

The requirements in the Phase III CORE 350 Health Care Claim Payment/Advice (835) Infrastructure Rule will streamline the process for setting up new trading partner arrangements. The Phase III CORE 350 Health Care Claim Payment/Advice (835) Infrastructure Rule broadens the infrastructure requirements contained in the Phase I and Phase II CORE Operating Rules, adopted in July, 2011, to include the health care electronic funds transfers (EFT) and remittance advice transaction.

The Phase III CORE 350 Health Care Claim Payment/Advice (835) Infrastructure Rule requires health plans to use the CORE V5010 Master Companion Guide Template for their companion guides that describe implementation of the X12 835 to their trading partners. Requiring health plans to use a common flow and format for their companion guides will enable providers to more efficiently and effectively configure their accounting systems to automatically process the ERA successfully.

The Phase III CORE 350 Health Care Claim Payment/Advice (835) Infrastructure Rule also requires that health plans have the capability to use the public Internet for connectivity. Currently, multiple connectivity methods are in use for electronic transaction between trading partners. Health care providers and health plans support multiple connectivity methods

to connect to different health plans, clearinghouses, provider organizations and others. Supporting multiple connectivity methods for different entities adds costs for health plans and providers. When new trading partners set up connectivity parameters, knowing that all entities are capable of using the public Internet for connectivity saves time.

b. Posting Payment Adjustments and Claim Denials

The requirements in the Phase III CORE 360 Uniform Use of CARCs and RARCs (835) Rule will reduce the time needed by health plans and TPAs spent interacting with providers who have questions concerning a payment denial and adjustment codes used on the ERA. We expect that phone calls to the health plan help desk by providers with questions about denied claims will decrease considerably.

c. Commercial Health Plans, Government Health Plans, and TPAs: Material Cost Savings in Increase in Use of EFT and ERA

The implementation of all administrative simplification initiatives mandated by the Affordable Care Act are expected to streamline HIPAA electronic transactions, make them more consistent, and decrease the dependence on manual intervention in the transmission of health care and payment information. This, in turn, will drive more health care providers and health plans to utilize electronic transactions in their operations. Each transaction that moves from a nonelectronic, manual transmission of information to an electronic transaction, brings with it material and time cost savings by virtue of reducing or eliminating the paper, postage, and equipment and the additional staff time required to conduct paper-based transactions.

Table 14 lists our estimates of the savings for health plans and TPAs per transaction when they move from a nonelectronic transaction for payment and remittance to usage of ERA and EFT. We have used the following assumptions to arrive at these per transaction savings for health plans:

- The estimated savings associated with the ERA is taken from Medicare data. Medicare found that the average estimated cost avoidance in terms of printing and mailing charges was \$4.24 per ERA transaction when it was sent electronically as opposed to through the mail in paper form.⁷² We have assumed that an equivalent savings can be realized for commercial and other government health plans.

- Table 14 reflects the same dollar savings per EFT transaction that we used in the Health Care EFT Standards IFC. There are a number of different analyses and case studies with regard to the possible savings realized when a health plan switches from paper checks to EFT for health care claim payments. We considered a 2007 analysis by McKinsey and Company that concluded that the “system wide cost” of using paper checks for health care claim payments was \$8.00 per check.⁷³ We did not use the McKinsey’s conclusion because we do not know what methodology was used and wanted to be specific about the difference between health care provider savings and health plan savings. A United Healthcare report found that it costs the company \$30.7 million to pay 145 million health care claims with paper checks compared with the cost of \$2.7 million to pay the same amount of claims using EFT.⁷⁴ We did not use United Healthcare’s savings estimate since, apparently, it is based on single claims, and the metric we used is

based on health care claim payments. A single health care claim payment from a health plan often includes payments for multiple claims submitted by a provider.

For our calculations, we use data from the Financial Management Service (FMS), a bureau of the United States Department of the Treasury. We use FMS data because they are the lowest estimates, and because we consider them the most valid. According to FMS, it costs the U.S. government \$0.11 to issue an EFT payment compared to \$1.03 to issue a check payment—a difference of \$0.92 per payment.⁷⁵ This estimate includes the cost of material such as postage, envelopes, and checks, but does not include labor costs. FMS processes millions of transactions so it enjoys economies of scale that health plans may not experience, thus the \$0.92 estimate is probably less than the amount plans will experience. Table 14 summarizes the estimated increase and savings based on the Department of the Treasury’s numbers.

TABLE 14—BASELINE COST SAVINGS FOR EFT AND ERA FOR COMMERCIAL AND GOVERNMENTAL HEALTH PLANS (DIFFERENCE BETWEEN NONELECTRONIC TRANSACTION AND ELECTRONIC TRANSACTION)

Transaction	Savings per transaction for commercial and government health plans
Health care electronic funds transfer (EFT)	\$0.92
Electronic remittance advice (ERA)	\$4.24

* Based on 2012 dollars.

In Table 15, we illustrate a projected annual increase of 6 (LOW) to 8 (HIGH) percent in the use of the ERA attributable to the implementation of the EFT & ERA Operating Rule Set over the next 10 years. We estimate an annual increase of 6 (LOW) to 8 (HIGH) percent in the use of the EFT resulting from the adoption of the EFT & ERA Operating Rule Set. These are not annual increases in percentage points, but rather percent increases in the use of electronic transactions from the year before attributable to implementation of the EFT & ERA Operating Rules Set. The total annual increases in EFT and ERA implementation will be greater, attributable to implementation of the EFT & ERA Operating Rule Set, the health care EFT standards, and other factors as discussed in section VII.A.2. of this IFC and illustrated in Table 15.

Based on these assumptions, we estimate that the savings to health plans because of increased usage in the EFT and ERA will be at least \$50 million within 10 years of implementation of the EFT & ERA Operating Rule Set. This represents total quantified savings for all government and commercial health plans attributable to EFT & ERA Operating Rule Set.

TABLE 15—ANNUAL COST SAVINGS FOR GOVERNMENT AND COMMERCIAL HEALTH PLANS FROM INCREASE IN EFT AND ERA ATTRIBUTABLE TO THE EFT & ERA OPERATING RULE SET *

I	II		IV		V
Year	Savings from Increase in ERA attributable to the EFT & ERA Operating Rule Set		Savings from Increase in EFT attributable to the EFT & ERA Operating Rule Set		
	LOW Annual Cost Savings Attributable to Operating Rules (in millions)	HIGH Annual Cost Savings Attributable to Operating Rules (in millions)	LOW Annual Cost Savings Attributable to Operating Rules (in millions)	HIGH Annual Cost Savings Attributable to Operating Rules (in millions)	
2014	\$26.6	\$35.5	\$1.82	\$2.42	
2015	31.9	42.6	2.36	3.15	

⁷² “Trend in Remittance Advice (Abstract),” October 26, 2011, Center for Medicare and Medicaid Services.

⁷³ “Overhauling the U.S. Healthcare Payment System,” conducted by McKinsey & Company, published in *The McKinsey Quarterly*, June 2007.

(http://www.mckinseyquarterly.com/Overhauling_the_US_health_care_payment_system_2012).

⁷⁴ “E-Payment Cures for Healthcare,” presentation by J.W. Troutman (PNC Healthcare), D. Lisi (United Healthcare), B.C. Mayerick (Department of Veterans Affairs), April 26, 2010,

<https://admin.nacha.org/userfiles/File/Healthcare%20Resource/Epayments%20Cures%20for%20Healthcare.pdf>.

⁷⁵ www.fms.treas.gov/eft/index.html.

TABLE 15—ANNUAL COST SAVINGS FOR GOVERNMENT AND COMMERCIAL HEALTH PLANS FROM INCREASE IN EFT AND ERA ATTRIBUTABLE TO THE EFT & ERA OPERATING RULE SET *—Continued

Year				
2016	38.3	51.1	3.07	4.09
2017	46.0	61.3	3.99	5.32
2018	55.2	73.6	5.18	6.91
2019	44.2	66.2	4.49	6.74
2020	49.5	74.2	5.39	8.09
2021	55.4	83.1	6.47	9.71
2022	62.0	93.1	7.76	11.65
2023	69.5	104.2	9.32	13.98
Total	478.7	685.0	49.86	72.04

* Based on 2012 dollars.

2. Physician Practices and Hospitals: Time Savings in BIR Tasks

According to a 2009 study published in Health Affairs,⁷⁶ the cumulative time, on a per physician basis, that a physician and his or her staff and administration spend interacting with health plans is approximately 60 hours per week. (Staff includes office managers, receiving and posting clerks etc. Administration includes attorneys, accountants, physician practice directors, and administrators, etc.) Of that time, 88 percent is spent on authorizations and claims/billing issues.

We believe the implementation of the EFT & ERA Operating Rule Set will eliminate some of the manual intervention that is required when providers re-associate the EFT with the ERA and reconcile the adjustments on the ERA in their systems. We estimate that 3 percent to 5 percent of the time spent on reconciling and following-up on payments and posting can be trimmed on account of implementation of the EFT & ERA Operating Rule Set. This is equivalent to 7 to 11 minutes a week for every health plan from which a provider receives EFT payments.

We estimate that the 3 percent to 5 percent of time on follow-up and reconciliation can be saved because the EFT & ERA Operating Rule Set will streamline the following four areas of administrative tasks:

a. Provider Enrollment in EFT and ERA: Standardizing the Flow, Format, and Data Content of Enrollment Forms

Both the Phase III CORE 380 EFT Enrollment Data Rule and the Phase III

CORE 382 ERA Enrollment Data Rule require that health plans request specific data elements on the EFT enrollment form when first setting providers up for health care claim payments through EFT. This addresses a key barrier to the use of EFT by providers and further enables automated processing of healthcare payments.

Currently, providers face significant challenges when enrolling to receive EFT payments from a health plan. These challenges include health plans requesting a diverse set of data elements, health plans using a variety of terms to refer to the same data elements (“Routing number” vs. “Bank Routing number”), differences in enrollment processes and approvals that each health plan requires, and, in some cases, an absence of critical data elements providers need health plans to know in order for health plans to correctly route the payments to providers.

Due to these variations across health plans in the data elements requested, providers manually process enrollment forms for each plan to which they bill claims and from which they wish to receive an EFT payment. This results in unnecessary manual processing of multiple forms requesting a range of information.

Both the Phase III EFT and ERA Enrollment Data Rules require that health plans offer an electronic way for providers to complete and submit ERA and EFT enrollment. Once the EFT & ERA Operating Rule Set is implemented, we assume that there will be time savings for providers when they first enroll with EFT or ERA, due to the fact that now the flow, format, and data requirements of different health plan enrollment forms will be similar and enrollment can be done electronically. The enrollment process for EFT, it has

been noted, is considered burdensome for providers and has been characterized as an obstacle to providers making the switch from receiving paper checks to receiving EFT.

However, we have not quantified the cost savings associated with a more standardized enrollment form in terms of the staff time saved. Instead, we will attribute some staff time saved in the reassociation process, previously defined, because the EFT & ERA Operating Rule Set will require data elements in the enrollment process that will make it easier for reassociation to occur.

b. Reassociation of the EFT Data With the ERA Data in the Provider’s Practice Management System

The main intent of the health care EFT standards, adopted in the Health Care EFT Standards IFC on January 10, 2012 (77FR 1565), is to provide some assurance that providers could automate the reassociation of the ERA with the EFT that it describes. The Health Care EFT Standards IFC did this by requiring a specific NACHA format be used, the CCD+Addenda, and specific data content, the X12 TRN Segment, be placed in the addenda. The Health Care EFT Standards IFC did not require that the X12 TRN Segment in a particular EFT be the same X12 TRN Segment that is included in the associated ERA because “[w]e believe that the details of any such requirement are best addressed through operating rules for the health care EFT and remittance advice transaction.”

The EFT & ERA Operating Rule Set includes a number of requirements that will facilitate reassociation, including the following:

- Phase III, CORE 370 EFT & ERA Reassociation (CCD+/835) Rule,

⁷⁶ Lawrence P. Casalino, S. Nicholson, D.N. Gans, T. Hammons, D. Morra, T. Karrison and W. Levinson, “What does it cost physician practices to interact with health insurance plans?” Health Affairs, 28(4)(2009): w533–w543.

Requirement 4.1: Requires five (plus one situational) defined data elements in the CCD+Addenda.

- Phase III, CORE 370 EFT & ERA Reassociation (CCD+/835) Rule, Requirement 4.2: Requires health plans to transmit the EFT within three days of the transmission of the ERA.

- Phase III, CORE 370 EFT & ERA Reassociation (CCD+/835) Rule, Requirement 4.3: Outlines requirements for the resolving late or missing EFT and ERA transmissions.

- Phase III, CORE 370 EFT & ERA Reassociation (CCD+/835) Rule, Requirement 4.1: Requires that providers proactively contact their financial institutions to arrange for the delivery of minimum data elements necessary for successful reassociation of the EFT with the ERA.

- Phase III CORE 382 ERA Enrollment Data Rule and Phase III CORE 380 EFT Enrollment Data Rule, Requirement 4.2: Identifies a maximum set of standard data elements that health plans can request from providers for enrollment to receive ERA.

- Phase III CORE 382 ERA Enrollment Data Rule and Phase III CORE 380 EFT Enrollment Data Rule, Requirement 4.2: Applies a “controlled vocabulary”—predefined and authorized terms—for health plans to use when referring to the same data element. For instance, “Provider Name” is to be used instead of “Provider” or “Name.”

- Phase III CORE 382 ERA Enrollment Data Rule and Phase III CORE 380 EFT Enrollment Data Rule, Requirements 4.3.1 and 4.3.2: Requires standard data elements to appear on paper enrollment forms in a standard format and flow, using Master Templates for paper-based and electronic enrollment, respectively.

We assume that, given all the rules and how their implementation will facilitate reassociation, a physician practice or hospital can expect a decrease in the time spent on receiving and posting claim payments. For instance, in our calculation for physician practices, we assume that, for every health plan with which a provider enrolls to receive payment via EFT, 7 to 11 minutes a week will be saved.

The EFT & ERA Operating Rule Set, complementing the Health Care EFT Standards IFC, will allow for automation of the reassociation process. However, complete automation of reassociation rests with the provider and the capability of the provider’s practice management system, so the requirements in the EFT & ERA Operating Rule Set facilitate manual reassociation as well.

c. Posting Payment Adjustments and Claim Denials

Consistent and uniform rules enabling providers to reassociate the EFT with the ERA will help to decrease manual provider follow-up, faulty electronic secondary billing, inappropriate write-offs of billable charges, incorrect billing of patients for co-pays and deductibles, and posting delays. This allows for less staff time spent on phone calls and Web sites, increased ability to conduct targeted follow-up with health plans and/or patients, and more accurate and efficient payment of claims.

We assume that implementation of the Phase III CORE 360 Uniform Use of CARCs and RARCs (835) Rule, including CORE-required Code Combinations for CORE-defined Business Scenarios will lead to a decrease in “follow up and payment reconciliation” BIR tasks.

d. Time Savings Calculation

In order to estimate the cost avoidance of a 3 to 5 percent decrease in the time (cost) spent on following up and reconciling payments, we used the following assumptions and calculations:

- A study of BIR tasks by Sarkowski, et al. (2009) categorized BIR tasks within a physician practice office, specifying a dollar cost per single physician to specific tasks.⁷⁷ The study found that 28 percent of the equivalent of a full-time staff was dedicated to “follow-up and payment reconciliation” and “receiving and posting payments.” Sarkowski, et. al. assigned a dollar amount to these tasks, which included collecting payments and posting to patients’ accounts; depositing checks and payments; account reconciliation; discrepancy research, follow up, and write-offs; receiving and allocating capitated payments; posting refunds; follow-up on denials, underpaid, or nonresponsive claims; filing for stop-loss and other contractual payments; filing for shared risk-pool payments, and follow-up supervision. This is a category of tasks that will be most affected by the streamlining of the four areas of administrative tasks that we detailed previously.

- The total cost per physician for these tasks is reflected in Table 16, Column II, adjusted for 2013 dollars and increased annually by 3 percent to reflect cost of living increases, because the majority of this cost is for salaries and benefits (70 percent). A smaller

percentage of the cost is for operating expenses, purchased services, and allocation of overhead, and for the purchase and operation of IT systems.

- We have projected the increase in the number of physicians in physician practices between 2014 and 2023 (Table 16, Column I) based on the average between the projected supply and demand of physicians according to the Association of American Medical Colleges.⁷⁸

- Table 16, Column III illustrates the total cost of receiving and posting payments, follow up and payment reconciliation for all physicians in physician practices.

- We have previously assumed, in the Health Care EFT Standards IFC, that the average provider will newly enroll to receive payments in EFT from 12 health plans from 2014 through 2023, reflected in Table 16, Column VI. We make an identical projection here—the average provider will newly enroll to receive payments in EFT from 12 health plans from 2014 through 2023. Therefore, a factor in the calculation will be a multiplier of 1.2 every year that represents the number of health plans with which typical provider has newly to receive EFT.

- We assume that there will be a reduction of 3 to 5 percent in time costs for each of the 12 new EFT enrollments that the typical physician practice will enroll between 2014 and 2023, compounded yearly (Table 16, Columns IV and VII). By 2023, this will result in a cost savings of as much as 50 percent (high estimate) in tasks related to follow up and payment reconciliation and receiving and posting payments.

- The number of billing and posting clerks in physician practices is approximately double the number of billing and posting clerks in hospitals.⁷⁹ We used this ratio as representative of the physician practice to hospital administrative burden of receiving and posting payments, follow-up and payment reconciliation. To arrive at the cost to hospitals, therefore, we halved the costs that physician practices experienced carrying out these tasks (Table 16, Columns V and VIII). Although 55 percent of physicians are employed in hospitals, BIR tasks in

⁷⁸ Summary of “The Complexities of Physician Supply and Demand: Projections Through 2025,” Center for Workforce Studies, AAMC,” 2008, by the Association of American Medical Colleges, and “The Impact of Health Care Reform on the Future Supply and Demand for Physicians Updated Projections Through 2025,” Association of American Medical Colleges.

⁷⁹ Occupational Employment and Wages, May 2011, 43–3021 Billing and Posting Clerks, Bureau of Labor Statistics, <http://www.bls.gov/oes/current/oes433021.htm>.

⁷⁷ Sakowski, Julie Ann, James G. Kahn, Richard G. Kronick, Jeffrey M. Newman and Harold S. Luft, “Peering into The Black Box: Billing and Insurance Activities in a Medical Group,” *Health Affairs*, 28, No. 4 (2009): w544–w554.

hospitals would likely be significantly less on a per physician basis due to economies of scale that are found in hospital billing and payment processes.

TABLE 16—EFT & ERA OPERATING RULE SET: 3 PERCENT TO 5 PERCENT DECREASE IN COST SPENT IN PHYSICIAN PRACTICES AND HOSPITALS ON RECEIVING AND POSTING, FOLLOW-UP AND RECONCILIATION OF PAYMENTS 2013–2023

	I	II	III	IV	V	VI	VII	VIII
	Total number of physicians in physician practices *	Total cost per practice of receiving and posting payments, follow-up and payment reconciliation (28%)**	Total reduction in cost of receiving and posting payments, follow-up and payment reconciliation [col.I * col.II] (in millions)	Physician practice low 3% reduction in cost of receiving and posting payments, follow-up and payment reconciliation attributable to EFT & ERA operating rule set—compounded yearly (in millions)	Hospital low 3% reduction in cost of receiving and posting payments, follow-up and payment reconciliation attributable to EFT & ERA operating rule set—compounded yearly (in millions)	Average number of new EFT enrollment per provider	Physician practice high 5% reduction in BIR time (number of minutes per week per EFT enrollment) attributable to EFT & ERA operating rule set—compounded yearly (in millions)	Hospital high 5% reduction in BIR time (number of minutes per week per EFT enrollment) attributable to EFT & ERA operating rule set—compounded yearly (in millions)
2013	335,120	\$15,028	\$5036	\$0.0	\$0	0	\$0.0	\$0.0
2014	340,146	15,479	5265	181	91	1.2	302	151
2015	345,173	15,943	5503	175	87	1.2	284	142
2016	348,638	16,421	5725	168	84	1.2	267	133
2017	352,103	16,914	5955	162	81	1.2	251	125
2018	355,568	17,421	6194	157	78	1.2	236	118
2019	359,033	17,944	6442	151	75	1.2	222	111
2020	362,498	18,482	6700	145	73	1.2	208	104
2021	366,561	19,037	6978	140	70	1.2	196	98
2022	370,625	19,608	7267	135	68	1.2	184	92
2023	374,688	20,196	7567	130	65	1.2	173	87
Total .....	.....	.....	.....	1,545.79	772.90	12	2,324	1,162

* Occupational Employment and Wages, May 2011, 43–3021 Billing and Posting Clerks, Bureau of Labor Statistics, <http://www.bls.gov/oes/current/oes433021.htm>.
 ** Based on Sakowski, et. al. 2009, adjusted to 2012 dollars.

3. Physician Practices and Hospitals: Material Cost Savings in Increase in Use of EFT and ERA

As noted previously, the more efficient and streamlined EDI becomes, the more providers and health plans will be incentivized to use EDI for their billing and insurance related tasks. Our assumption is that implementation of the EFT & ERA Operating Rule Set will result in time and staff savings for both providers and health plans. Therefore, more providers and health plans will decide to switch their payment and remittance advice to electronic transactions.

Table 17 illustrates estimates on the material costs that can be avoided for every EFT or ERA that is transmitted electronically instead of produced on paper and sent through the post. For Table 17, we used the following assumptions.

- The estimated savings associated with the ERA are taken from the “The National Progress Report on Healthcare

Efficiency, 2010,”⁸⁰ which calculates its data based on available studies of cost from a variety of sources, and which is sponsored by Emdeon, a national health care clearinghouse. We found no other resources for this estimate, though other reports, such as the Oregon survey,⁸¹ used the same Emdeon report for its projections.

- The estimated savings for using EFT over paper checks is taken from a 2009 American Medical Association white paper on Administrative Simplification.⁸² As noted in our

⁸⁰ “The National Progress Report on Healthcare Efficiency, 2010,” Produced by the U.S. Healthcare Efficiency Index.

⁸¹ “Oregon Administrative Simplification Strategy and Recommendations: Final Report of the Administrative Simplification Work Group, June 2010,” Oregon Health Authority, Office for Oregon Health Policy and Research.

⁸² “Standardization of the Claims Process: Administrative Simplification White Paper,” Prepared by the American Medical Association, Practice Management Center, June 22, 2009, adjusted for 2012 dollars.

⁸³ “Standardization of the Claims Process: Administrative Simplification White Paper,”

discussion of estimated savings of EFT over paper checks for health plans, we found a number of estimates with regard to EFT that estimate the combined cost avoided for both health plan and provider. However, we found no other resources for the more specific cost avoidance for providers.

Prepared by the American Medical Association, Practice Management Center, June 22, 2009, adjusted for 2012 dollars.

TABLE 17—SUMMARY OF SAVINGS ATTRIBUTABLE TO THE EFT & ERA OPERATING RULE SET: BASELINE COST SAVINGS FOR EFT AND ERA FOR PROVIDERS (DIFFERENCE BETWEEN NON-ELECTRONIC TRANSACTION AND ELECTRONIC TRANSACTION)

Transaction	Savings per transaction for health care providers
Health care electronic funds transfers (EFT)	\$1.63 ⁸³
Electronic remittance advice (ERA)	1.55

Based on 2012 dollars.

In Table 18 we illustrate a projected annual increase of 6 (LOW) to 8 (HIGH) percent in the use of the ERA attributable to the implementation of the EFT & ERA Operating Rule Set over the next 10 years. We estimate an annual increase of 6 (LOW) to 8 (HIGH) percent in the use of the EFT resulting from the implementation of the EFT & ERA Operating Rule Set. These are not annual increases in percentage points, but rather annual percent increases in the use of ERA and EFT compounded yearly.

Based on these assumptions, we estimate that the savings to providers because of increased usage in three transactions will be at \$172 million to \$249 million over the 10 years after

implementation of the EFT & ERA Operating Rule Set.

TABLE 18—ANNUAL COST SAVINGS IN REDUCED USE OF MATERIALS FOR PROVIDERS FROM INCREASE IN EFT AND ERA ATTRIBUTABLE TO THE EFT & ERA OPERATING RULE SET *

I Year	II		III		IV		V	
	Savings from Increase in EFT attributable to the EFT & ERA Operating Rule Set		Savings from Increase in ERA attributable to the EFT & ERA Operating Rule Set		LOW Annual Cost Savings Attributable to Operating Rules (in millions)	HIGH Annual Cost Savings Attributable to Operating Rules (in millions)	LOW Annual Cost Savings Attributable to Operating Rules (in millions)	HIGH Annual Cost Savings Attributable to Operating Rules (in millions)
2014	\$3.22	\$4.29	\$3.06	\$4.08				
2015	4.18	5.57	3.98	5.30				
2016	5.44	7.25	5.17	6.89				
2017	7.07	9.42	6.72	8.96				
2018	9.19	12.25	8.73	11.65				
2019	7.96	11.94	7.57	11.36				
2020	9.55	14.33	9.08	13.63				
2021	11.46	17.20	10.90	16.35				
2022	13.76	20.63	13.08	19.62				
2023	16.51	24.76	15.70	23.55				
Total	88.33	127.64	83.99	121.38				

* Based on 2012 dollars.

TABLE 19—SUMMARY OF SAVINGS FOR PROVIDERS ATTRIBUTABLE TO THE EFT & ERA OPERATING RULE SET

Year	LOW Time savings for physician practices and hospitals (Table 16) (in millions)	HIGH Time savings for physician practices and hospitals (Table 16) (in millions)	LOW Increase in EFT & ERA transactions attributable to EFT & ERA operating rule set for physician practices and hospitals (Table 18) (in millions)	HIGH Increase in EFT & ERA transactions attributable to EFT & ERA operating rule set for physician practices and hospitals (Table 18) (in millions)	LOW Total provider savings/cost avoidance	HIGH Total provider savings/cost avoidance
2014	\$272	\$453	\$6	\$8	\$278	\$462
2015	262	426	8	11	270	437
2016	253	400	11	14	263	415
2017	244	376	14	18	257	395
2018	235	354	18	24	253	378
2019	226	333	16	23	242	356
2020	218	313	19	28	237	341
2021	210	294	22	34	233	327
2022	203	276	27	40	230	317

TABLE 19—SUMMARY OF SAVINGS FOR PROVIDERS ATTRIBUTABLE TO THE EFT & ERA OPERATING RULE SET—
Continued

Year	LOW Time savings for physician prac- tices and hospitals (Table 16) (in millions)	HIGH Time savings for physician prac- tices and hospitals (Table 16) (in millions)	LOW Increase in EFT & ERA transactions attributable to EFT & ERA operating rule set for physi- cian practices and hospitals (Table 18) (in millions)	HIGH Increase in EFT & ERA transactions attributable to EFT & ERA operating rule set for physi- cian practices and hospitals (Table 18) (in millions)	LOW Total provider savings/cost avoidance	HIGH Total provider savings/cost avoidance
2023	196	260	32	48	228	308
Cumulative total over 10 years	2,319	3,485	172	249	2491	3734

Table 20 reflects the total costs and benefits for the years 2013 through 2023 detailed in this RIA according to sector. The net savings for the health care industry as a whole (savings minus costs) ranges from approximately \$300 million (low savings minus high costs) to \$3.3 billion (high savings minus low cost) over ten years, or an expected net savings of \$1.8 billion.

TABLE 20—SUMMARY OF TOTAL COSTS AND BENEFITS FOR COMMERCIAL AND GOVERNMENTAL HEALTH PLANS, TPAS, PHYSICIAN PRACTICES, AND HOSPITALS ATTRIBUTABLE TO THE EFT & ERA OPERATING RULE SET
[In millions]

	Savings: Commercial and govern- ment health plans/TPAs	Savings: Physician practices & hospitals	Total savings	Costs: Commercial and govern- ment health plans/TPAs	Costs: Physician practices & hospitals	Total costs	Net savings
Low	\$529	\$2,491	\$3,020	\$1,224	\$16	\$1,239	\$301
High	757	3,734	4,491	2,703	16	2,719	3,252
Mean	643	3,113	3,755	1,963	16	1,979	1,777

Table 21 is a summary of the costs and benefits annualized and discounted.

TABLE 21—SUMMARY OF TOTAL COSTS AND BENEFITS FOR COMMERCIAL AND GOVERNMENTAL HEALTH PLANS, TPAS, PHYSICIAN PRACTICES, AND HOSPITALS ATTRIBUTABLE TO THE EFT & ERA OPERATING RULES SET
[In millions]

	Present values	
	7%	3%
BENEFITS Monetized (\$millions):		
Low	\$1,986	\$2,503
High	2,982	3,738
COSTS Monetized (\$millions):		
Low	1,133	1,190
High	2,497	2,618

G. Accounting Statement

As required by OMB Circular A-4 (available at link [http://www.](http://www.whitehouse.gov/sites/default/files/omb/assets/regulatory_matters_pdf/a-4.pdf)

[whitehouse.gov/sites/default/files/omb/assets/regulatory_matters_pdf/a-4.pdf](http://www.whitehouse.gov/sites/default/files/omb/assets/regulatory_matters_pdf/a-4.pdf)), we have prepared an accounting statement.

TABLE 22—ACCOUNTING STATEMENT 2013–2023
[In millions, 2012 dollars]

Category	Primary estimate (millions)	Minimum estimate (millions)	Maximum estimate (millions)	Source citation (RIA, preamble, etc.)
BENEFITS				
Annualized Monetized benefits:				
7% Discount	Not estimated	\$265	\$398	RIA
3% Discount	Not estimated	\$270	\$404	RIA
Qualitative (un-quantified) benefits				
Benefits generated from health plans to health care providers, and health care providers to health plans.				
COSTS				
Annualized Monetized costs:				
7% Discount	Not Estimated	\$151	\$333	RIA and Collection of Information.
3% Discount	Not Estimated	\$129	\$283	RIA and Collection of Information.
Qualitative (unquantified) costs				
Health plans and health care providers will pay costs to software vendors, programming and IT staff/contractors, transaction vendors, and health care clearinghouses.				
TRANSFERS				
Annualized monetized transfers: “On budget”.	N/A	N/A	N/A.	
From whom to whom?	N/A	N/A	N/A.	
Annualized monetized transfers: “Off-budget”.	N/A	N/A	N/A.	

In accordance with the provisions of Executive Order 12866, this regulation was reviewed by the Office of Management and Budget.

List of Subjects in 45 CFR Part 162

Administrative practice and procedures, Electronic transactions, health facilities, health insurance, hospitals, Incorporation by reference, Medicaid, Medicare, Reporting and recordkeeping requirements.

For the reasons set forth in this preamble, the Department of Health and Human Services amends 45 CFR part 162 to read as follows:

PART 162—ADMINISTRATIVE REQUIREMENTS

■ 1. The authority citation for part 162 continues to read as follows:

Authority: Secs. 1171 through 1180 of the Social Security Act (42 U.S.C. 1320d–9), as added by sec. 262 of Pub. L. 104–191, 110 Stat. 2021–2031, sec. 105 of Pub. L. 110–233, 122 Stat. 881–922, and sec. 264 of Pub. L. 104–191, 110 Stat. 2033–2034 (42 U.S.C. 1320d–2 (note)), and secs. 1104 and 10109 of Pub. L. 111–148, 124 Stat. 146–154 and 915–917.

■ 2. Section 162.920 is amended as follows:

■ A. In paragraph (c)(2), the references “§§ 162.1203 and 162.1403” are removed and the references

“§§ 162.1203, 162.1403, and 162.1603” are added in their place.

■ B. Adding a new paragraph (c)(4). The addition reads as follows:

§ 162.920 Availability of implementation specifications and operating rules.

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(c) * * *
(4) Council for Affordable Quality Healthcare (CAQH) Phase III Committee on Operating Rules for Information Exchange (CORE) EFT & ERA Operating Rule Set, Approved June 2012, as specified in this paragraph and referenced in § 162.1603.

(i) Phase III CORE 380 EFT Enrollment Data Rule, version 3.0.0, June 2012.

(ii) Phase III CORE 382 ERA Enrollment Data Rule, version 3.0.0, June 2012.

(iii) Phase III 360 CORE Uniform Use of CARCs and RARCs (835) Rule, version 3.0.0, June 2012.

(iv) CORE-required Code Combinations for CORE-defined Business Scenarios for the Phase III CORE 360 Uniform Use of Claim Adjustment Reason Codes and Remittance Advice Remark Codes (835) Rule, version 3.0.0, June 2012.

(v) Phase III CORE 370 EFT & ERA Reassociation (CCD+/835) Rule, version 3.0.0, June 2012.

(vi) Phase III CORE 350 Health Care Claim Payment/Advice (835) Infrastructure Rule, version 3.0.0, June

2012, except Requirement 4.2 titled “Health Care Claim Payment/Advice Batch Acknowledgement Requirements”.

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■ 3. Section 162.1601 is amended by revising the section heading and introductory text to read as follows:

§ 162.1601 Health care electronic funds transfers (EFT) and remittance advice transaction.

The health care electronic funds transfers (EFT) and remittance advice transaction is the transmission of either of the following for health care:

* * * * *

■ 4. Section 162.1603 is added to Subpart P to read as follows:

§ 162.1603 Operating rules for health care electronic funds transfers (EFT) and remittance advice transaction.

On and after January 1, 2014, the Secretary adopts the following for the health care electronic funds transfers (EFT) and remittance advice transaction:

(a) The Phase III CORE EFT & ERA Operating Rule Set, Approved June 2012 (Incorporated by reference in § 162.920) which includes the following rules:

(1) Phase III CORE 380 EFT Enrollment Data Rule, version 3.0.0, June 2012.

(2) Phase III CORE 382 ERA Enrollment Data Rule, version 3.0.0, June 2012.

(3) Phase III 360 CORE Uniform Use of CARCs and RARCs (835) Rule, version 3.0.0, June 2012.

(4) CORE-required Code Combinations for CORE-defined Business Scenarios for the Phase III CORE 360 Uniform Use of Claim Adjustment Reason Codes and Remittance Advice Remark Codes (835) Rule, version 3.0.0, June 2012.

(5) Phase III CORE 370 EFT & ERA Reassociation (CCD+/835) Rule, version 3.0.0, June 2012.

(6) Phase III CORE 350 Health Care Claim Payment/Advice (835) Infrastructure Rule, version 3.0.0, June 2012, except Requirement 4.2 titled "Health Care Claim Payment/Advice Batch Acknowledgement Requirements".

(b) ACME Health Plan, CORE v5010 Master Companion Guide Template, 005010, 1.2, March 2011 (incorporated by reference in § 162.920), as required by the Phase III CORE 350 Health Care Claim Payment/Advice (835)

Infrastructure Rule, version 3.0.0, June 2012.

Dated: June 26, 2012.

Marilyn Tavenner,

Acting Administrator, Centers for Medicare & Medicaid Services.

Approved: August 1, 2012.

Kathleen Sebelius,

Secretary, Department of Health and Human Services.

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