

all Medicare providers, and 753,853 (66.1 percent) of all Medicare physicians, practitioners and suppliers could qualify for an exception of the electronic claim filing requirement based on provider size, leaving approximately 24,126 providers and 386,692 physicians, practitioners, and suppliers (a total of 410,818 potentially affected by the ASCA Medicare requirement nationally).

Approximately 98 percent of providers, and 83 percent of physicians, practitioners, and suppliers already submit claims to Medicare electronically though, and are expected to continue doing so, so the total impacted must be further reduced to determine the approximate number of current paper claim submitters that would likely be affected. It is reasonable to assume that the majority of the paper claims received by Medicare are submitted by smaller providers, physicians, practitioners, and suppliers. As a result, it would not be accurate to reduce the number of affected providers by the full 98 percent of 83 percent. In the absence of reliable statistics to project the current source of all paper claims however, the number of providers potentially affected by the mandatory Medicare electronic claim requirement will be conservatively estimated at a maximum of 50 percent of the entities that would not qualify for a waiver. This leaves 12,063 providers and 193,346 physicians, practitioners, and suppliers (a total of 205,409) that would need to begin submitting claims to Medicare electronically.

Statistics collected for PRA clearance of the Medicare paper claim forms and referenced in the "Collection of Information Requirements" section of this preamble indicate that in the absence of a mandatory electronic claim requirement effective for FY 2004, 2.5 million paper claims are expected to be sent to Medicare intermediaries and 133.7 million paper claims are to be sent to Medicare carriers.

Today, many Medicare providers use billing agents or clearinghouses to bill the Medicare program. Many providers, physicians, practitioners, and suppliers that currently submit paper claims have indicated anecdotally that they use paper as they would rather avoid the "hassle" of dealing with the multiple electronic claim formats currently required by payers, and the need to have staff keep abreast of the updates to those formats. HIPAA will largely eliminate format differences among payers, but there will continue to be differences concerning use of certain "situational" segments and data elements in the formats. It is reasonable to assume that

up to half ( $205,409 \times 50$  percent = 102,704) of those entities that do not submit claims to Medicare electronically today would prefer to contract with third party to deal with such differences on their behalf.

A small sampling of Medicare contractors indicated an average cost of \$0.30 per claim for billing agent and clearinghouse services. The total cost to physicians, practitioners, facilities, suppliers, and other health care providers to use a billing agent or clearinghouse should not be more than \$7,055,895 (that is,  $\$0.30 \times \{\text{the sum of 2.5 million paper claims sent to intermediaries as estimated previously for FY 2004 multiplied by the 68.6 percent of providers that would not meet the exception criteria plus 133.7 million paper claims estimated to be sent to carriers multiplied by the 33.9 percent of physicians, practitioners, and suppliers that would not meet the exception criteria}\}$ , reduced by 50 percent to account for the assumption that 50 percent of the firms will contract with the third party claims processors).

Finally, in regard to the balance of 102,704 ( $205,409 \times 50$  percent) providers, physicians, practitioners, and suppliers that would not be expected to meet the criteria to submit paper claims, we conservatively estimate that approximately 75 percent of these already own personal computers that are used to prepare the paper claim forms they currently submitted to Medicare. Very few hand-written or manually typed claims are submitted to Medicare. Although many paper claim submitters have not used personal computers for electronic billing, they have used them for claim preparation, patient scheduling and other aspects of their practice.

We estimate that at a maximum, the remaining total of 25,676 (25 percent of 102,704) providers, physicians, practitioners, and suppliers will obtain personal computers to allow them to submit their claims directly to Medicare electronically. A recent review of ads in Sunday newspapers indicated that personal computers sufficient to meet the mandatory electronic claim requirement could be obtained for between \$500 to \$1,000 for hardware (personal computer, monitor, printer, and modem). Billing software is available free or at low cost (less than \$25 for shipping and handling) from Medicare. At the average rate of \$750, it would cost \$19.3 million to purchase 25,676 personal computer systems. More expensive equipment and peripherals could be used, but would not be necessary for basic compliance. Therefore, the total maximum cost

should be no higher than \$26.4 million (\$7.1 million for users of clearinghouses or billing services, and \$19.3 million for those that obtain personal computers).

Following the HIPAA savings calculation used in the Transaction Rule, but projected to FY 2004 to account for inflation, a savings of \$615 per provider could result in a total provider savings of approximately \$15.8 million (that is, 25,676 times \$615).

We note that pages 50353 through 50359 of the August 17, 2000 transaction final rule for HIPAA used a 10-year time frame to capture the full extent of costs and savings that could be attributed to the use of the transactions adopted under HIPAA. Data from the 2000 edition of Faulkner and Gray's "Health Data Directory," from a Workgroup for Electronic Data Interchange study report, and from the Department of Labor was used in those calculations to determine total claims in the health care industry, costs to use the transactions electronically, savings expected to be realized, the historical growth rate for claims overall as well as electronic claims, the percentage of electronic health care claims nationally in 2000, and the anticipated inflation rate for the 10-year period.

The RFA requires agencies to analyze options for regulatory relief of small businesses. For purposes of the RFA, small entities include small businesses, nonprofit organizations, and government agencies. According to the Small Business Administration's (SBA's) data, approximately 95 percent of offices of physicians are considered small businesses (see the Small Business Administration's final rule titled "Small Business Size Standards, Health Care," published in the **Federal Register** on November 17, 2000, 65 FR 69432). Most practitioners, facilities, suppliers, and other providers are small entities either because of nonprofit status or because of having revenues of \$6 million to \$29 million or less in any 1 year. For purposes of the RFA, all physicians, practitioners, facilities, suppliers, and other health care providers that serve Medicare beneficiaries are considered to be small entities. However, as stated earlier, this rule in and of itself does not impose a regulatory burden. The ASCA mandates most aspects of this rule, in particular, the ASCA requires Medicare providers to submit claims electronically and stipulates exceptions that will and may be granted. We did have discretion; however, in setting conditions for exceptions, and believe these exceptions reduce the burden relative to the burden that may have been imposed by ASCA without this enabling regulation.