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The Cost of Implementing HIPAA in Private Physicians' Offices in South Carolina

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THE COST OF IMPLEMENTING HIPAA IN PRIVATE PHYSICIANS' OFFICES IN SOUTH CAROLINA

BY

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A doctoral project submitted to the faculty of the Medical University of South Carolina in partial fulfillment of the requirements for the degree
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Executive Doctoral Program in Health Administration & Leadership
Medical University of South Carolina
In Partial Fulfillment of the Requirements for the
Degree of Doctor of Health Administration

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HIPAA – the **H**ealth **I**nsurance **P**ortability and **A**ccountability **A**ct of 1996 is the largest government action in healthcare since Medicare. Since the passage of the HIPAA legislation, estimated cost of implementation has ranged from $3.8 billion to $45 billion for the implementation of the privacy rules. This study examines the cost on implementing HIPAA in private physicians' offices in South Carolina. The study selected the medical specialties of family practice, general practice, obstetrics & gynecology, and pediatrics.

The study compares and analyzes cost of rural vs. urban physician practices, by specialty, and by type of entity when implementing privacy rules.

THE COST OF IMPLEMENTING HIPAA IN PRIVATE PHYSICIANS' OFFICES IN SOUTH CAROLINA

INTRODUCTION

HIPAA – the Health Insurance Portability and Accountability Act of 1996 is the largest government action in healthcare since Medicare. HIPAA provides legislation to protect workers who leave their jobs from losing their ability to be covered by health insurance (Portability), and to protect the integrity, confidentiality and availability of electronic health information (Accountability) (HIPAA Complete, 2003). HIPAA requirements are intended to standardize public and private financial and administrative health transactions and set minimum regulations for the storage, use, and transfer of health information.

One portion of HIPAA, Title II, Subtitle F, Section 261-264 of the Act, contains the Administrative Simplification Provision. The Administrative Provision applies to health plans, healthcare clearinghouses, and those healthcare providers that transmit health information in electronic form. This legislation's intent is to reduce the administrative costs of providing and paying for healthcare by requiring standards to be adopted for electronic transactions, unique identifiers, code sets, security and privacy of electronic health information, and electronic signatures (HIPAA Complete, 2003).

Background and Need

On August 21, 1996, President William J. Clinton signed into law the Health Insurance Portability and Accountability Act of 1996 – commonly referred to as HIPAA (Keohane, 2002; Unknown, 1996). The HIPAA legislation was enacted in response to

national concern for the need for healthcare reform and in a direct response to the failure of the Clinton Health Care proposal of 1994 (*History and Overview of HIPAA*, 1996). HIPAA, also referred to as the Kassenbaum-Kennedy Act, named after the original sponsors of the bill – Senators Nancy Kassenbaum (R-KS) and Edward Kennedy (D-MA), is the most far-reaching legislation to affect the healthcare industry and has the largest impact on medical practices since Title XVIII of the Social Security Act of 1964, commonly known as Medicare (Keohane, 2002). The purpose of HIPAA is to enable employees and their families to transfer healthcare benefits when they change or lose their jobs (*History and Overview of HIPAA*, 1996; White, 2001), to improve the efficiency of the healthcare system and protect the security and privacy of transmitted information (Braithwaite, 2001).

The objectives of the act are to: (1) ensure the portability, access, and renewability of health insurance by consumers, (2) prevent healthcare fraud and abuse, (3) simplify the administration of health insurance (Administrative Simplification), (4) reform medical liability, and (5) promote the use of medical savings accounts (Leer, 2002; Tucker, 2002; White, 2001).

The act itself is intended to address a variety of healthcare related issues (White, 2001); however, the focus of this doctoral project is directed toward the third objective of HIPAA – Administrative Simplification. It was the intent of Congress, through the Administrative Simplification provision of the act, to reduce the cost and administrative burden of healthcare by standardizing the electronic transmission of administrative and financial transactions (White, 2001).

The Administrative Simplification concept was conceived in 1991 via the establishment of the Workgroup for Electronic Data Interchange (WEDI) by the Department of Health and Human Services. According to White (2001 p. 4), "The primary goal was to expedite the advent of electronic claims submission in order to improve the speed and efficiency of billing procedures between healthcare providers and payers." The work of WEDI by the American National Standards Institute (ASNI) to establish standards for the electronic transmission of health related billing data was a precursor to the HIPAA legislation passed by the 104th Congress in 1996 (White, 2001). The purposes of the Administrative Simplification Regulations are: (1) to protect the rights of consumers by providing them access to their protected health information and controlling the inappropriate use of that information; (2) to improve the quality of healthcare in the United States by restoring trust in the healthcare system among consumers, healthcare professionals and the multitude of organizations and individuals committed to the delivery of care; and (3) to improve the efficiency and effectiveness of healthcare delivery by creating a national framework for health privacy protection that builds on the efforts by states, health systems, and individual organizations and individuals. (Braithwaite, 2001; Keohane, 2002). The Administrative Simplification Regulations have four major components. They are: (1) standards for Electronic Transaction Code Sets, (2) national standards for providers, employers, health plans, and individual identifiers, (3) standards for privacy and confidentiality rules, and (4) standards for security rules (Leer, 2002; Vandiver, 2002).

Of the four major components of the Administrative Simplification regulations, only two provisions have had final rules published (see Table 1 below).

Table 1
Summary of HIPAA Standards Regulations

Standard	Date of Proposed Rule	Date of Final Rule	Compliance Date	HHS Estimated Industry Cost (Over 10 years)
Transactions and Code Sets Standards	5/7/1998	8/17/2000 Published	10/16/2002*	$7 billion
National Provider Identifiers Standards	5/7/1998	Not Finalized		
National Employer Identifiers Standards	6/16/1998	Not Finalized		
Security Standards	8/12/1998	Not Finalized		
Privacy and Confidentiality Standards	11/3/1999	12/28/2000 Published 8/14/2002 Modified	4/14/2003**	17.6 billion
Total costs				$24.6 billion
*Small Health Plans have until 10/16/2003 to comply with Transaction Code Set Standards; Automatic extension until 10/16/2003 given to all providers who applied for extension before 10/16/2002.				
**Small Health Plans have until 4/14/2004 to comply with Privacy and Confidentiality Standards.				
Source: Moody's Investors Service - Municipal Credit Research Report - Dated March 2001; http:/aspc.hhs.gov/admnsimp/pubsched.htm; Federal Register: February 28, 2001 (Volume 66, Number 40).				

The component of the Administrative Simplification provision that is the most difficult to implement is the privacy and confidentiality standards. This component impacts three entities within the healthcare industry (named covered entities) (Keohane, 2002). These three entities are: health plans, healthcare clearinghouses, and healthcare providers that transmit any healthcare information electronically in connection with covered transactions. (Keohane, 2002; Leer, 2002). The requirements of the privacy and confidentiality rules have been the most difficult to interpret. After the initial publication of the proposed rules in November 1999, the United State Department of Health and Human Services (HHS) received more than 52,000 comments from groups, providers and other interested parties (HHS, 2002; *Privacy Standards: Issues in HHS' Proposed Rule on Confidentiality of Personal Health Information, 2000*). The final privacy and confidentiality rules addressed the privacy of identifiable health information through

consent and authorizations (Hamby & McLaughlin, 2001). Many providers, physicians in particular, were worried that they would have to change the way they conducted business. As a result of the many comments and questions regarding the publication of the final Privacy Rules on December 28, 2000, HHS modified some of the provisions, which were published in the Federal Register on August 14, 2002.

Failure to comply with the Administrative Simplification provisions will result in stiff penalties and fines being imposed on the covered entity. Penalties for wrongful disclosure of protected health information can be as high as $50,000 and/or imprisonment for up to one (1) year. Penalties and fines for wrongful disclosure under false pretenses are $100,000 and/or imprisonment for up to five (5) years. Finally, if wrongful disclosure is done with the intent to sell protected health information for unauthorized or illegal purposes, the fine may be as high as $250,000 and/or imprisonment for up to ten (10) years (Hamby & McLaughlin, 2001).

The publication of the modified final regulations on August 14, 2002, has clarified some questions regarding the specific requirements of the privacy and confidentiality rules. Below are some of the administrative requirements of the final privacy and confidentiality rules which will impact all covered entities:

- Designation of a privacy officer;
- Provision for training to all employees who have potential contact with protected health information;
- Implementation of policies and procedures for handling patient data;
- Proper notification to patients and others of their rights regarding their personal health information;

- Establishment of a reporting and complaint processing mechanism;
- Identification of business associates relationships and contracting with business associates for the protection of health information.

The implementation of the privacy and confidentiality standards are new and comprehensive requirements for all covered entities. The cost and the degree of changes that have to be made by covered entities are still unknown and are a major concern of covered entities. According to a study sanctioned by the American Hospital Association, HHS's estimate of $3.8 billion (see Table 2) for the entire healthcare field to comply with HIPAA's privacy rules alone did not include several provisions, which understates the cost (Mitchell, 2000).

The purpose of this study is to determine the cost of implementing the new privacy and confidentiality standards in private physicians' offices in the state of South Carolina. There have not been any formal studies of the cost of implementing the privacy standards in private physicians' offices. Additionally, the studies that have been made regarding privacy standards have been from the hospitals' perspective. Several studies have attempted to include the physicians' perspective on the cost of implementing the privacy rules; however, the response has not been good.

Research Question

The research question is: What is the cost of implementing HIPAA in private primary care physicians' offices in the State of South Carolina?

Assumptions

The assumptions that will be made in this study are that all private physicians will have some knowledge of HIPAA's privacy rules before the effective date of April 14, 2003 and that there will be some effort to implement some, if not all, of the privacy rules provisions before the effective date. Another assumption is that many physicians will do the minimum necessary to implement the privacy rules and will not have full implementation until some time after the effective date of the regulations.

Limitations

One limitation of this research is that there are no benchmarks as to what exactly must be done in private physicians' practices in order to become compliant with HIPAA. Questions abound regarding the meanings of "reasonable effort" and "minimum necessary" to achieve HIPAA compliance. It is not the intent of the Federal government to put undue financial pressure on private physicians, leaving them in the untenable position of wondering if they have done enough to implement HIPAA or if they have not, what will be the penalties for non-compliance.

Another limitation is that physicians are just beginning to focus on the privacy standards and the entire implementation is a work-in-progress. The efforts to implement HIPAA will be on-going until the day the privacy standards become effective and beyond. Initial cost to implement HIPAA will be incurred after the effective date and that cost will get muddied with the ongoing cost and future costs of HIPAA implementation because of the time period over which the cost will be incurred.

The final limitation will be that covered entities have not attached a cost to all of the efforts in implementing HIPAA. Covered entities are only addressing the out-of-pocket expenses directly associated with HIPAA implementation and have not attached cost to research the regulations, typing and reproducing policies, and training staff.

LITERATURE REVIEW

Since its passage, one of the main topics of discussion regarding the implementation of the HIPAA standards has been the cost. Some healthcare providers have compared the implementation of HIPAA to Y2K in terms of complexity and cost. "Just when you thought you were finished hemorrhaging money from Y2K compliance along comes the Health Insurance Portability and Accountability Act of 1996 to burn through more of your cash resources" (Szabo, 2000). This is the reaction of many healthcare Chief Financial Officers, Chief Information Officers, and administrators when they talk about HIPAA implementation: "Listening to the various doomsayers, one might think that pending changes in the way the healthcare industry processes its financial and administrative data will result in a healthcare Armageddon" (Scott, 2000). It is interesting that some have painted such a dismal picture of how much it will cost to implement HIPAA when a recent study by the Gartner Group found that only 32% of healthcare organizations were able to estimate their anticipated cost of HIPAA implementation (Coate & MacDonald, 2002). Some have gone as far as to say that nobody knows what the cost is or will be (Amatayakul & Cohn, 2002).

The implementation touches on legal, regulatory, process, security, and technology issues that must be evaluated before an organization can implement its plan. As noted in Table 1, HHS has issued final rules on two components of HIPAA as of the end of 2002. The HIPAA component regarding privacy and confidentiality of patient health information and disclosure is the most challenging of the two components. Every private physician practice and clinic in the country will feel the impact of HIPAA's privacy and confidentiality regulations: "Estimates for converting to HIPAA standards range from

$300 to $5,000 for a solo practitioner and $75,000 to $250,000 for 50-physician, multi-specialty, or group practices" (*HIPAA will change all facets of information*, 2001). Many feel that these costs will be primarily related to computer software and hardware or information technology problems. This myth must be dispelled. Good business practices, training, education and attention to detail can and should eliminate some of the significant confidentiality breaches that are facing all providers today. Elimination of casual conversation regarding a patient's condition, shredded documents (i.e., laboratory test results), secure passwords on computers, secure modem lines, putting faxes in secure locations, and prompt elimination of terminated employees' security codes are just a few of the measures that can be taken to improve and enhance confidentiality within any healthcare operation. Mark Lisa, CEO of Thayer Health System noted that 80-85 percent of HIPAA compliance issues will depend on adjusting human behavior (Marietti, 2002). This attention to detail does not require a great outlay of cash and is a practice that should be implemented regardless of HIPAA requirements. HIPAA compliance requires an institutional effort that focuses on behavior modification and organization wide cooperation (Weber, Alcaro, & Ciotti, 2001).

Since the publication of the final rules in the Federal register in August 2000 on transaction and code sets and in December 2000 on the Privacy Rules, many healthcare providers have lobbied HHS, Congress, and the executive branch to extend the time for implementation. In December 2001, Congress passed, and President Bush signed, legislation allowing a one-year extension of the transaction and code sets until October 16, 2003 (Duncan, 2002). However, Gartner is already seeing anecdotal evidence of what many anti-extension advocates feared – a mind set among healthcare executives of

'Well, we have an extra year so we don't need to get busy for a while'(Duncan, 2002). Another indication of healthcare providers' complacency regarding HIPAA is that less than half (550,000) of the healthcare organizations filed for the automatic extension for complying with transaction code sets standards (Hawryluk, 2002), according to a spokesperson for the Centers for Medicare and Medicaid Services. The transaction code sets regulations are not as onerous and costly to implement as the privacy code sets, and the initial cost to implement are not as great as those predicted for privacy. With that in mind, one wonders how many physicians will be in compliance on April 14, 2003 when the standards become effective.

The cost estimate of implementing HIPAA continues to escalate. The first cost estimate was performed by the HHS, which is discussed in detail in the methodology section. Their initial cost estimate was $3.8 billion for implementing the privacy rules (see Table 7). This cost was for the entire healthcare industry but did not include all of the provisions of the regulation. Another study performed by the Robert Nolan Company, Inc. for Blue Cross Blue Shield Association estimated the cost of implementing the privacy standards at $43 billion over a five-year period. The study focused on common components of specific sectors of the healthcare industry: health plan, doctors, and hospitals. The Blue Cross Blue Shield study did not estimate all of the provisions included in HHS' November 3, 1999 proposed regulations; nor did it capture all information and the ability of patients/subscribers to inspect, copy, and amend protected health information (Robert E Nolan Company, 1999). The Blue Cross Blue Shield report is not without criticism. The reasons why some discount the report are:

1. It was performed using the proposed rules and not the final rules;

2. It did not focus on the entire healthcare industry; and,

3. It did not include all of the provisions of the proposed rules.

However, the report does support the fact that the original cost estimate performed by HHS is understated. The costs identified in the report are:

• New authorization forms	$1.94 billion
• Tracking and disclosure	9.10 billion
• Inspection copying and amendments	4.00 billion
• Infrastructure support (system, compliance & training)	23.40 billion
• Impact of medical management	4.40 billion

(Source: Cost and Impact Analysis; Common Components of Confidentiality Legislation prepared by The Robert E. Nolan Company. Inc., Fall 1999 for Blue Cross Blue Shield Association)

In a study prepared for the American Hospital Association, First Consulting Group (FCG), a multinational pharmaceutical/life sciences and health information technology services firm, estimated the cost of complying with the proposed privacy rule could reach $22.5 billion over a five-year period (First Consulting Group, 2000). This estimate is a compilation of the cost on three key provisions that were not included in the HHS estimate. They are:

• Minimum necessary use of information	$1.3 billion
• Contracting with business associates	2.3 billion
• Preemption of contrary and less stringent state laws	372 million

FCG estimates that the overall cost to achieve these three provisions could range from $4 billion to $22.5 billion.

Moody's Investors Services prepared a third hospital study in March 2001. Moody's report was based on a survey of public rated not-for-profit hospitals. The study was directed toward determining if the cost associated with the implementation of HIPAA privacy rules would have an adverse impact on the overall credit of not-for-profit hospitals. The report found that the cost of complying with HIPAA privacy rules would not have an adverse effect on the credit rating of not-for-profit hospitals. According to the report, compliance with the regulations would require providers to invest in new hardware and software technology, personnel and training. They estimated the cost to range between $2 billion and $5 billion in aggregate expenditures for hospital providers.

In a study prepared by Matthew Duncan, Research Director at Gartner, in March 2002, thirty-four (34) private physicians' group practices comprising thirty physicians or more were surveyed (physician practices were stratified by the amount of revenue). Only eleven (11) responses were received. The estimated cost of implementing HIPAA ranged from a low of $25,000 to a high of $1 million. According to Duncan there are far too many private physicians who do not understand HIPAA, what it will take to implement HIPAA, and when it must be implemented. Thus, any knowledge of cost is totally foreign to them and will become a greater issue as the effective date approaches. The study also estimated that hospitals' costs of complying with HIPAA range from $150,000 to $20,000,000 (hospitals were stratified by the amount of revenue). According to HHS the estimated cost of complying with HIPAA privacy rules by hospitals will be $1.5 billion.

Except for the estimates in the Federal Registers prepared by HHS, this researcher has not been able to locate any other study(ies) that estimates the cost of complying with HIPAA privacy rules by physicians. White (2001) and Duncan (2002) indicated that they do not believe that any study has been done by a third party on the physicians' cost of complying with the HIPAA privacy rules.

The modification of the final Privacy Rules in August 2002 did not answer all of the questions surrounding the costs of complying with the standards. Two physicians who were interviewed for this project revealed that they still have major concerns on how they will recoup the cost of consultation with patients who request changes are made in their medical records (see Appendix B and G).

While most providers are concerned about the cost of implementing HIPAA, one could ask the question, "Do the costs out way the benefits?" Much of the literature has focused on the cost and there are those who believe that HIPAA has some redeeming value and benefits to patients and the healthcare industry. Many in the industry believe that the standardization of transaction code sets will produce a cost saving in the healthcare industry, even if the amount cannot be quantified. In regard to the Privacy rules, (Zimmerman, 2000) states, "The security and privacy regulations are clearly "wins" for patients leading to the secure delivery of the right data, to the right place, at the right time. The privacy regulations themselves are directed at protecting patient's privacy. According to Hamby, "Congress recognized that as patient's personal health information is increasingly transmitted electronically, there is an increasing threat that the security and/or privacy of the information might be breached. Therefore, Congress

included in HIPAA provisions mandating that security and privacy standards be developed to ensure against such breaches" (Hamby & McLaughlin, 2001).

METHODLOGY

Introduction

This chapter describes the methodology used for conducting the research. The first section discusses the methodology of the study conducted by the HHS. This section is obtained from the November 3, 1999 (proposed regulations) and December 28, 2000 (final regulations) Federal Registers. The estimated cost of implementing HIPAA increased significantly between publishing the proposed and final regulations. The detailed discussion of the cost determination by HHS is taken directly from the December 28, 2000 Federal register, modified somewhat to address the estimated costs for implementing the privacy rules for private physicians. The second section discusses the method the researcher used to conduct this study.

Section I

The Privacy Rule describes the requirements that govern the circumstances under which protected health information must be used or disclosed with and without patient involvement and when a patient may have access to his or her protected health information.

While the vast majority of healthcare entities are privately owned and operated, HHS noted that federal, state, and local government providers are reflected in the total costs as well. Federal, state, and locally funded hospitals represent approximately 26 percent of hospitals in the United States. This is a significant portion of hospitals, but it represents a relatively small proportion of all provider entities. HHS estimated that the

number of government providers who are employed at locations other than government hospitals is significantly smaller (approximately two percent of all providers). Weighting the relative number of government hospital and non-hospital providers by the revenue these types of providers generate, HHS estimated that healthcare services provided directly by government entities represent 3.4 percent of total healthcare services. Indian Health Service and tribal facilities costs are included in the total, since the adjustments made to the original private provider data to reflect federal providers included them. In developing the rule, HHS consulted with states, representatives of the National Congress of American Indians, representatives of the National Indian Health Board, and a representative of the self-governance tribes. During the consultation HHS discussed issues regarding the application of Title II of HIPAA to the states and tribes.

The costs for each provision associated with this final rule involve consideration of both the degree to which covered entities must modify their existing records management systems and privacy policies under the final rule, and the extent to which there is a change in behavior by both patients and the covered entities as a result of the final rule. The following sections examine these provisions as they apply to the various covered entities under the final rule. The major costs that covered entities will incur are one-time costs associated with implementation of the final rules and ongoing costs that result in continuous requirements in the final rule.

HHS quantified the costs imposed by the final regulation to the extent possible. The cost of many provisions was estimated by first using data from the Census Bureau's Statistics of U.S. Business to identify the number of non-hospital healthcare

providers, hospitals and health plans. Then, using the Census Bureau's Current Population Survey (CPS) wage data for the classes of employees affected by the rule, HHS identified the hourly wage of the type of employee assumed to be mostly likely responsible for compliance with a given provision. Where HHS believed a number of different types of employees might be responsible for complying with a certain provision, as is often expected to be the case, HHS established a weighted-average wage based on the types of employees involved. Finally, the Department made assumptions regarding the number of person-hours per institution required to comply with the rule.

HHS could not determine precisely how many person-hours per institution would be required to comply with a given provision; however, HHS attempted to establish reasonable estimates based on fact-finding discussions with private sector healthcare providers, the advice of the HHS' consultants, and the HHS' own best judgment of the level of burden required to comply with a given provision. Moreover, HHS recognized that the number of hours required to comply with a given requirement of the rule will vary from provider to provider, particularly given the flexibility and scalability permitted under the rule. Therefore, HHS considered the estimates to be averages across the entire class of healthcare providers, hospitals, or health plans in question.

Underlying all annual cost estimates are growth projections. For growth in the number of patients, HHS used data from the National Ambulatory Medical Care Survey, the National Hospital Ambulatory Medical Care Survey, the National Home

and Hospice Survey, the National Nursing Home Survey, and information from the American Hospital Association. For growth in the number of healthcare workers, HHS used data from the Bureau of Health Professions in the Department's Health Resources Services Administration (HRSA). For insurance coverage growth (private and military coverage), HHS used a five-year average annual growth rate in employer-sponsored, individual, military, and overall coverage growth from the Census Bureau's CPS, 1995-1999. To estimate growth in the number of Medicare and Medicaid enrollees, HHS used the enrollment projections of the Healthcare Financing Administration's Office of the Actuary. For growth in the number of hospitals, healthcare providers, and health plans, trend rates were derived from the Census Bureau's Statistics of U.S. Businesses, using SIC code-specific five-year annual average growth rate from 1992-1997 (the most recent data available). For wage growth, HHS used the same assumptions made in the Medicare Trustees' Hospital Insurance Trust Fund report for 2000.

In some areas, HHS was able to obtain very reliable data, such as survey data from the Statistics of U.S. Businesses and the Medical Expenditures Panel Survey (MEPS). In numerous areas, however, there was too little information or data to support quantitative estimates. As a result, HHS relied on data provided in the public comments or subsequent fact-finding to provide a basis for making key assumptions. HHS was able to provide a reasonable cost estimate for virtually all aspects of the regulation, except law enforcement. In this latter area, HHS was unable to obtain sufficient data about current practices (e.g., the number of criminal and civil investigations that may involve requests for protected health information and the number of subpoenas for

protected health information) to determine the marginal effects of the regulation. HHS believes the effects of the final rule are marginal because the policies adopted in the final rule appear to largely reflect current practice.

The Notices of Proposed Rulemaking (NPRM) included an estimate of $3.8 billion for the privacy proposal. The estimate for the final rule is $18.0 billion (See Table 2). Much of the difference can be explained by two factors. First, the NPRM estimate was for five years; the final rule estimate is for ten years. HHS chose the longer period for the final rule because ten years was also the period of analysis in the Transactions Rule RIA, and HHS wanted to facilitate comparisons, given that the net benefits and costs of the Administrative Simplification rules should be considered together. Second, the final impact analysis includes cost estimates for a number of key provisions that were not estimated in the NPRM because HHS did not have adequate information at the time. Although HHS received little useable data in the public comments, HHS was able to undertake more extensive fact-finding and collect sufficient information to make informed assumptions about the level of effort and time various provisions of the final rule are likely to impose on different types of affected entities.

Table 2
The Cost of Complying with the Proposed Privacy Regulations
(Comparison of HHS Cost Estimates in November 3, 1999 (proposed regulations) and December 28, 2000 (final regulations))

	November 3, 1999			December 28, 2000		
Provision	Initial or First Year Cost (2000)	Annual Cost after the First Year	Five year Cost (2000-2004)	Initial or First Year Cost (2003, $ mil)	Average Annual Cost ($ mil, years 2-10)	Ten year Cost (2003-2012, $ mil)***
Policy Development	395.0	0	395.0	597.7	0	597.7
Systems Changes-All Entities	90.0	0	90.0			
Minimum Necessary				926.2	536.7	5,756.7
Privacy Officials				723.2	575.8	5,905.8
Disclosure Tracking/History				261.5	95.9	1,125.1
Business Associates				299.7	55.6	800.3
Notice Distribution				50.8	37.8	391.0
Notice Development - All Entities	20.0	0	30.0			
Notice Issuance-Providers	59.7	37.2	208.3			
Notice Issuance - Plans	46.2	46.2	231.0			
Consent				166.1	6.8	227.5
Written Authorization	54.3	54.3	271.5			
Inspection/Copying	81.0	81.0	405.0	1.3	1.7	16.8
Amendments	407.0	407.0	2,035.0	5.0	8.2	78.8
Requirements on Research				40.2	60.5	584.8
Training	22.0	22.0	110.0	287.1	50.0	737.2
De-Identification of Information				124.2	117.0	1,177.4
Employers with Insured Groups Health Plans				52.4	0	52.4
Internal Complaints				6.6	10.7	103.2
Other Cost*	N/E	N/E	N/E			
Total**	$1,165.2	$647.7	$3,775.8	$3,242.0	$1,556.9	$17,554.7

*Other Costs include: minimum necessary disclosure, monitoring business partners with whom entities share PHI, creation of de-identified information, internal complaint processes, sanctions, compliance and enforcement, the designation of a privacy official and creation of a privacy board, additional requirements on research/optimal disclosures that will be imposed by the regulation. (N/E = not estimated)

**Note: Numbers may not add due to rounding

Source: Federal Registers November 3, 1999 and December 28, 2000

The estimate of $18.0 billion represents a gross cost, not a net cost. As discussed more fully below in the benefits section, the benefits of enhanced privacy and confidentiality of personal health information are very significant. If people believe their information will be used properly and not disseminated beyond certain bounds without their knowledge and consent, they will be much more likely to seek proper healthcare, provide all relevant health information, and abide by their providers' recommendations. In addition, more confidence by individuals and covered entities that privacy will be maintained will lead to an increase in electronic transactions and the efficiencies and cost savings that stem from such action. HHS was not able to identify data sources or models that would permit us to measure benefits more broadly or accurately. The inability to quantify benefits, however, does not lessen the importance or value that is ultimately realized by having a national standard for health information privacy.

The largest initial costs resulting from the final Privacy Rule stem primarily from the requirement that covered entities use and disclose only the minimum necessary protected health information, that covered entities develop policies and codify their privacy procedures, and that covered entities designate a privacy official and train all personnel with access to individually identifiable health information. The largest ongoing costs will result from the minimum necessary provisions pertaining to internal uses of individually identifiable health information and the cost of privacy official. In addition, covered entities will have recurring costs for training, disclosure tracking, and notice requirements. A smaller number of large entities may have

significant costs for de-identification of protected health information and additional requirements for research.

The privacy costs are in addition to the Transactions Rule estimates. The cost of complying with the regulation represents approximately 0.23 percent of projected national health expenditures the first year the regulation is enacted. The costs for the first eight years of the final regulation represents 0.07 percent of the increase in national healthcare costs experienced over the same period.

Minimum Necessary

The minimum necessary policy in the final rule has essentially three components: first, it does not pertain to certain uses and disclosures including treatment-related exchange of information among healthcare providers; second, for disclosures that are made on a routine and recurring basis, such as insurance claims, a covered entity is required to have policies and procedures for governing such exchanges (but the rule does not require a case-by-case determination); and third, providers must have a process for reviewing non-routine requests on a case-by-case basis to assure that only the minimum necessary information is disclosed.

Based on public comments and subsequent fact-finding, HHS has concluded that the requirements of the final rule are generally similar to the current practice of most providers. For standard disclosure requests, for example, providers generally have established procedures for determining how much health information is released. For non-routine disclosures, providers have indicated that they currently ask questions to

discern how much health information is necessary for such disclosure. Under the final rule, HHS anticipates providers will have to be more thorough in their policies and procedures and more vigilant in their oversight of them; hence, the costs of this provision are significant.

To make the final estimates for this provision, HHS considered the minimum necessary requirement in two parts. First, providers, hospitals, and health plans will need to establish policies and procedures, which govern uses and disclosures of protected health information. Next, these entities will need to adjust current practices that do not comply with the rule, such as updating passwords and making revisions to software.

To determine the policies and procedures for the minimum necessary requirement, HHS assumed that each hospital would spend 160 hours, health plans would spend 107 hours, and non-hospital providers would spend 8 hours. The time estimates for this and other provisions of the rule are considered an average number of person-hours for the institutions involved. An underlying assumption is that some hospitals, and to a lesser extent health plans, are part of chains or larger entities that will be able to prepare the basic materials at a corporate level for a number of covered entities.

Once the policies and procedures are established, HHS estimated there would be costs resulting from implementing the new policies and procedures to restrict internal uses of protected health information to the minimum necessary. Initially, this would require 560 hours for hospitals, 160 hours for health plans, and 12 hours for non-

hospital providers. The wage for healthcare providers and hospitals is estimated at $47.28 per hour, a weighted average of various healthcare professionals based on CPS data; the wage for health plans is estimated to be $33.82 per hour, based on average wages in the insurance industry (note that all wage assumptions in this impact analysis assume a 39% load for benefits, the standard Bureau of Labor Statistics assumption). In addition, there will be time required on an annual basis to ensure that the implemented practices continue to meet the requirements of the rule. Therefore, HHS estimated that on an annual ongoing basis (after the first year), hospitals will require 320 hours; health plans 100 hours, and non-hospital providers 8 hours to comply with this provision.

The initial cost attributable to the minimum necessary provision is $926 million. The total cost of the provision is $5.757 billion.

Privacy Official

The final rule requires entities to designate a privacy official who will be responsible for the development and implementation of privacy policies and procedures. In this cost analysis, HHS estimated each of the primary administrative requirements of the rule (e.g., training, policy and procedure development, etc), including the development and implementation costs associated with each specific requirement. These activities would certainly involve the privacy official to some degree; thus, some costs for the privacy official, particularly in the initial years, are subsumed in other cost requirements. HHS anticipates that there will be additional ongoing responsibilities that the privacy official will have to address, such as

coordinating between departments, evaluating procedures and assuring compliance. To avoid double counting, the cost calculated in this section is only for the ongoing, operational functions of privacy official (e.g., clarifying procedures for staff) that are in addition to items discussed in other sections of this impact analysis.

HHS assumes the privacy official role will be an additional responsibility given to an existing employee in the covered entity, such as an office manager in a small entity or a compliance official in a larger institution. Moreover, today any covered entity that handles individually identifiable health information has one or more people with responsibility for handling and protecting the confidentiality of such information. As a result of the specific requirement for a privacy official HHS assumed covered entities will centralize this function, but the overall effort is not likely to increase significantly. Specifically, HHS assumed non-hospital providers would need to devote, on average, an additional 30 minutes per week of an official's time (i.e., 26 hours per year) to compliance with the final regulation for the first two years and 15 minutes per week for the remaining eight years (i.e., 13 hours per year). For hospitals and health plans, which are more likely to have a greater diversity of activities involving privacy issues, HHS has assumed three hours per week for the first two years (i.e., 156 hours per year), and 1.5 hours per week for the remaining eight years (i.e., 78 hours per year).

For non-hospital providers, the time was calculated at a wage of $34.13 per hour, which is the average wage for managers of medicine and health according to the CPS. For hospitals, HHS used a wage of $79.44 per hour, which is the rate for senior planning officers. For health plans HHS assumed a wage of $88.42 per hour based on

the wage for top claims executives. Although individual hospitals and health plans may not necessarily select their planning officers or claims executives to be their privacy officials, HHS believes they will be of comparable responsibility, and, therefore, comparable pay, in larger institutions.

The initial year cost for privacy officials will be $723 million; the ten-year cost will be $5.9 billion.

Internal Complaints

The final rule requires each covered entity to have an internal process to allow an individual to file a complaint concerning the covered entity's compliance with its privacy policies and procedures. The requirement includes designating a contact person or office responsible for receiving complaints and documenting the disposition of them, if any. The privacy official may perform this function, but because it is a distinct right under the final rule and may be performed by someone else, HHS cost it separately.

The covered entity only is required to receive and document a complaint, which HHS assumed would take, on average, ten minutes. HHS believes that such complaints will be uncommon. HHS has assumed that one in every thousand patients will file a complaint, which are approximately 10.6 million complaints over ten years. Based on a weighted-average hourly wage of $47.28 at ten minutes per complaint, the cost of this policy is $6.6 million in the first year. Using wage growth and patient growth assumptions, the cost of this policy is $103 million over ten years.

Disclosure Tracking and History

The final rule requires providers to be able to produce a record of all disclosures of protected health information, except in certain circumstances. The exceptions include disclosures for treatment, payment, healthcare operations, or disclosures to an individual. This requirement will require a notation in the record (electronic or paper) of when, to whom, and what information was disclosed, as well as the purpose of such disclosure or a copy of an individual's written authorization or request for a disclosure.

Based on information from several hospital sources, HHS assumed that all hospitals already track disclosures of individually identifiable health information and that 15 percent of all patient records held by a hospital will have an annual disclosure that will have to be recorded in an individual's record. It was more difficult to obtain a reliable estimate for non-hospital providers, though it appears that they receive many fewer requests HHS assumed a 10% rate for ambulatory care patients and 5%, for nursing homes, home health, dental and pharmacy providers. (It was difficult to obtain any reliable data for these latter groups, but those HHS talked to said that they had very few, and some indicated that they currently keep track of them in the records.) These estimated percentages represent about 63 million disclosures that will have to be recorded in the first year, with each recording estimated to require two minutes. At the average nurse's salary of $30.39 per hour, the cost in the first year is $25.7 million. For health plans HHS assumed that disclosures of protected health information are rarer than for healthcare providers. Therefore, HHS assumed that there would be disclosures of protected health information for five percent of covered lives. At the average wage

for the insurance industry of $33.82 per hour, the initial cost for health plans is $6.8 million. Using HHS' standard growth rates for wages, patients, and covered entities, the ten-year cost for providers and health plans is $519 million.

In addition, although hospitals generally track patient disclosures today, HHS assumed that hospitals would seek to update software systems to assure full compliance. Based on software upgrade costs provided by HHS' private sector consultants with expertise in the area (the Gartner Group), HHS assumed that each upgrade would cost $35,000 initially and $6,300 annually thereafter, for a total cost of $572 million over ten-years.

The final rule also requires covered entities to provide individuals with an accounting of disclosures upon request. HHS assumed that few patients will request a history of disclosures of their protected medical information. Therefore, HHS estimated that one in a thousand patients will request such an accounting each year, which is approximately 850,000 requests. If it takes an average of five minutes to copy any disclosures and a nurse does the work, the cost for the first year will be $2.1 million. The total ten-year cost is $33.8 million.

De-Identification of Information

The Privacy Rule allows covered entities to determine that health information is de-identified (for example, that it is not individually identifiable health information) if certain conditions are met. Currently, some entities release de-identified information for research purposes. De-identified information may originate from automated systems

(such as records maintained by pharmacy benefit managers) and non-automated systems (such as individual medical records maintained by providers). As compared with current practice, the rule requires that an expanded list of identifiers be removed for the data (such as driver's license numbers, detailed geographic and certain age information). For example, as noted in a number of public comments, currently complete birth dates (day, month, and year) and zip codes are often included in de-identified information. The final rule requires that only the year of birth (except in certain circumstances) and the first three digits of the zip code can be included in de-identified information.

These changes will not require extensive change from the current practice. Providers generally remove most of the 19 identifiers listed in the final rule. HHS relied on Gartner Group estimates that some additional programmer time would be required by covered entities that produce de-identified information to make revisions in their procedures to eliminate additional identifiers. Entities that de-identify information will have to review existing and future data flows to assure compliance with the final rule. For example, an automated system may need to be re-programmed to remove additional identifiers from otherwise protected health information. (The costs of educating staff about the de-identification requirements are included in the cost estimate for training staff on privacy policies.)

HHS was not able to obtain any reliable information on the volume of medical data that is currently de-identified. To provide some measure of the potential magnitude, HHS assumed that health plans and hospitals would have an average of two

existing agreements that would need to be reviewed and modified. Based on information provided by HHS consultants, HHS estimate that these agreements would require an average of 152 hours by hospitals and 116 hours by health plans to review and revise existing agreements to conform to the final rule. Using the weighted average wage of $47.28, the initial costs will be $124 million. Using HHS standard growth rates for wages, patients, and covered entities, the total cost of the provision will be $1.1 billion over ten years.

HHS expects that the final rule and the increasing trend toward computerization of large record sets will result over time in de-identification being performed by relatively few firms or associations. Whether the covered entity is a small provider with relatively few files or a hospital or health plan with large record files, it will be more efficient to contract with specialists in these firms or associations (as business associates of the covered entity) to de-identify files. The process will be different, but the ultimate cost is likely to be the same or only slightly higher than the costs for de-identification today. The estimate is for the costs required to conform existing and future agreements to the provisions of the rule. HHS has not quantified the benefits that might arise from changes in the market for de-identified information because the centralization and efficiency that will come from it will not be fully realized for several years, and HHS does not have a reliable means of estimating such changes.

Policy and Procedures Development

The final regulation imposes a variety of requirements, which collectively will necessitate entities to develop policies and procedures (hereafter referred to as policies) to establish and maintain compliance with the regulation. These include policies such as those for inspection and copying, amending records, and receiving complaints. In developing the final regulations, simplifying the administrative burden was a significant consideration. To the extent practical, consistent with maintaining adequate protection of protected health information, the final rule is designed to encourage the development of policies by professional associations and others that will reduce costs and facilitate greater consistency across providers and other covered entities.

The development of policies will occur at two levels: first, at the association or other large-scale levels; and second, at the entity level. Because of the generic nature of many of the final rule's provisions, HHS anticipates that trade, professional associations, and other groups serving large numbers of members or clients will develop materials that can be used broadly. These will likely include the model privacy practice notice that all covered entities will have to provide patients; general descriptions of the regulation's requirements appropriate for various types of healthcare providers; checklists of steps entities will have to take to comply; training materials; and recommended procedures or guidelines. HHS spoke with a number of professional associations who confirmed that they would expect to provide such materials for their members at either the federal or state level.

Using Faulkner and Gray's Health Data Directory 2000, HHS identified 216 associations that would be likely to provide guidance to members. In addition, HHS assumed three organizations (one for hospitals, one for health plans, and one for other healthcare providers) in each state would also provide some additional services to help covered entities coordinate the requirements of this rule with state laws and requirements. HHS assumed that these associations would each provide 320 hours of legal analysis at $150 per hour, and 640 hours of senior analyst's time at $50 per hour. This equals $17.3 million. Hourly rates for legal council are the average billing rate for a staff attorney. The senior analysts rates are based on a salary of $75,000 per year, plus benefits, which was provided by a major professional association.

For larger healthcare entities such as hospitals and health plans HHS assumed that the complexity of their operations would require them to seek more customized assistance from outside council or consultants. Therefore, HHS concluded that each hospital and health plan (including self-administered, self-insured health plans) would, on average, require 40 hours of outside assistance. The resulting cost for external policy development is estimated to be $112 million.

All covered entities are expected to require some time for internal policy development beyond what is provided by associations or outside consultants. For most non-hospital providers, the external assistance will provide most of the necessary information. Therefore, HHS expect these healthcare providers will need only eight hours to adapt these policies for their specific use (training cost is estimated separately in the impact analysis). Hospitals and health plans, which employ more individuals and

are involved in a wider array of endeavors, are likely to require more specific policies tailored to their operations to comply with the final rule. For these entities, HHS assumed an average of 320 hours of policy development per institution. The total cost for internal policy development is estimated to be $468 million.

The total cost for policy, plan, and procedures development for the final regulation is estimated to be $598 million. All of these costs are initial costs.

Training

The final regulations' requirements provide covered entities with considerable flexibility in how to best fulfill the necessary training of their workforce. As a result, the actual practices may vary substantially based on such factors as the number of members of the workforce, the types of operations, worker turnover, and experience of the workforce. Training is estimated to cost $737 million over ten years. HHS estimated that at the time of the effective date, approximately 6.7 million healthcare workers will have to be trained, and in the subsequent ten years, 7 million more will have to be trained because of worker turnover. The estimate of employee numbers are based on 2000 CPS data regarding the number of healthcare workers who indicated they worked for a healthcare institution. To estimate a workforce turnover rate, HHS relied on a study submitted in the public comments, which used a turnover rate of ten percent or less, depending on the labor category. To be conservative, HHS assumed ten percent for all categories.

Covered entities will need to provide members of the workforce with varying amounts of training depending on their responsibilities, but on average, HHS estimated that each member of the workforce who is likely to have access to protected health information will require one hour of training in the policies and procedures of the covered entity. The initial training cost estimate is based on teacher training with an average class size of ten. After the initial training, HHS expects some training will be done by videotape, videoconference, or computer, all of which are likely to be less expensive. Training materials were assumed to cost an average of $2 per worker. The opportunity cost for the training time is based on the average wage for each healthcare labor category listed in the CPS, plus a 39% load for benefits.

Wages were increased based on the wage inflation factor utilized for the short-term assumptions (which cover 10 years) in the Medicare Trustees' Annual Report for 1999.

Notice

Covered healthcare providers with direct treatment relationships are required to provide a notice of privacy practices no later than the date of the first service delivery to individuals after the compliance date for the covered healthcare provider. HHS assumed that for most types of healthcare providers (such as physicians, dentists, and pharmacists) one notice would be distributed to each patient during his or her first visit following the compliance date for the covered provider, but not for subsequent visits. For hospitals, however, HHS assumed that a notice would be provided at each

admission, regardless of how many visits an individual has in a given year. In subsequent years, HHS assumed that non-hospital providers would only provide notices to their new patients, because it is assumed that providers can distinguish between new and old patients, although hospitals will continue to provide a notice for each admission. The total number of notices provided in the initial year is estimated to be 816 million.

Under the final rule only providers that have direct treatment relationships with individuals are required to provide notices to them. To estimate the number of visits that trigger a notice in the initial year and in subsequent years HHS relied on the Medical Expenditure Panel Survey (MEPS, 1996 data) conducted by the HHS' Agency for Healthcare Quality and Research. This data set provides estimates for the number of total visits to a variety of healthcare providers in a given year and estimates of the number of patients with at least one visit to each type of each care provider. To estimate the number of new patients in a given year, HHS used the National Ambulatory Medical Care Survey and the National Hospital Ambulatory Medical Care Survey, which indicate that for ambulatory care visits to physician offices and hospital ambulatory care departments, 13 percent of all patients are new. This data was used as a proxy for other types of providers, such as dentists and nursing homes, because HHS did not have estimates for new patients for other types of providers. The number of new patients was increased over time to account for growth in the patient population. Therefore, the number of notices provided in years 2004 through 2012 is estimated to be 5.3 billion.

The printing cost of the policy is estimated to be $0.05, based on data obtained from the Social Security Administration, which does a significant number of printings for distribution. Some large bulk users, such as health plans, can probably reproduce the document for less, and small providers simply may copy the notice, which would also be less than $0.05. Nonetheless, at $0.05, the total cost of the initial notice is $50.8 million. Using HHS standard growth rate for patients, the total cost for notices is estimated to be $391 million for the ten-year period.

Requirements on Use and Disclosure for Research

The final regulation places certain requirements on covered entities that supply individually identifiable health information to researchers. As a result of these requirements, researchers who seek such health information and the Institutional Review Boards (IRBs) that review research projects will have additional responsibilities. Moreover, a covered entity doing research, or another entity requesting disclosure of protected health information for research that is not currently subject to IRB review (research that is 100 percent privately funded and which takes place in institutions which do not have multiple project assurances) may need to seek IRB or privacy board approval if they want to avoid the requirement to obtain authorization for use or disclosure of protected health information for research, thereby creating the need for additional IRBs and privacy boards that do not currently exist.

To estimate the additional requirements placed on existing IRBs, HHS relied on a survey of IRBs conducted by James Bell Associates on behalf of the National

Institute of Health (NIH) and on estimates of the total number of existing IRBs provided by NIH staff. Based on this information HHS concluded that of the estimated 4,000 IRBs in existence, the median number of initial current research project reviews is 133 per IRB, of which only ten percent do not receive direct consent for the use of protected health information. Therefore, in the first year of implementation, there will be 76,609 initial reviews affected by the regulation, and HHS assumes that the requirement to consider the privacy protections in the research protocols under review will add an average of 1 hour to each review. The cost to researchers for having to develop protocols which will protect protected health information is difficult to estimate, but HHS assumed that each of the affected 76,609 studies will require an average of an additional eight hours of time for protocol development and implementation.

At the average medical scientist hourly wage of $46.61, the initial cost is $32.1 million; the total ten-year cost of these requirements is $468 million over ten years.

As stated above, some privately funded research currently not subject to any IRB review may need to obtain IRB or privacy board approval under the final rule. Estimating how much research exists which does not currently go through any IRB review is highly speculative, because the experts consulted by HHS all agree that there is no data on the volume of privately funded research. Public comments on this subject provided no useful data. However, HHS assumed that most research that takes place today is subject to IRB review, given that so much research has some government funding and many large research institutions have multiple project assurances. As a

result, HHS assumed that the total volume of non-IRB reviewed research is equal to 25 percent of all IRB-reviewed research, leading to 19,152 new IRB or privacy board reviews in the first year of the regulation. Using the same assumptions mentioned previously for wages, time spent developing privacy protection protocols for researchers, and time spent by IRB and privacy board members, the total one-year cost for new IRB and privacy board reviews is $8 million.

For estimating total ten-year costs, HHS used the Bell study, which showed an average annual growth rate of 3.7 percent in the number of studies reviewed by IRBs. Using this growth rate, the total ten-year cost for the new research requirements is $117 million.

Consent

Under the final rule, a covered healthcare provider with direct treatment relationships must obtain an individual's consent for use or disclosure of protected health information for treatment, payment, or healthcare operations. Covered providers with indirect treatment relationships and health plans may obtain such consent if they so choose. Providers and health plans that seek consent under this rule can condition treatment or enrollment upon provision of such consent. Based on public comments and discussions with a wide array of healthcare providers, it is apparent that most currently obtain written consent for use and disclosure of individually identifiable health information for payment. Under the final rule, they will have to obtain consent for treatment and healthcare operations as well, but this may entail only minor changes in

the language of the consent to incorporate these other categories and to conform to the rule.

Although HHS was unable to obtain any systematic data, the anecdotal evidence suggests that most non-hospital providers and virtually all hospitals follow this practice. For the cost analysis HHS assumed that 90 percent of the non-hospital providers and all hospitals currently obtain some consent for use and disclosure of individually identifiable health information. For providers that currently obtain written consent, there is only a nominal cost for changing the language on the document to conform to the rule. For this activity, HHS assumed $0.05 cost per document for revising existing consent documents.

For the ten percent of treating providers who currently do not obtain consent, there is the cost of creating consent documents (which will be standardized), which is also assumed to be $0.05 per document. It is assumed that all providers required to obtain consent under the rule will do so upon the first visit, so there will be no mailing cost. For non-hospital providers, HHS assumed the consent will be maintained in paper form, which is what most providers currently do (electronic form, if available, is cheaper to maintain). There is no new cost for records maintenance because the consent will be kept in active files.

The initial cost of the consent requirement is estimated to be $166 million. Using HHS standard assumptions for patient growth, the total costs for the ten years are estimated to be $227 million.

Authorizations

Patient authorizations are required for uses or disclosures of protected health information that are not otherwise explicitly permitted under the final rule with or without consent. In addition to uses and disclosures of protected health information for treatment, payment, and healthcare operations with or without consent, the rule also permits certain uses of protected health information, such as fund-raising for the covered entity and certain types of marketing activity, without prior consent or authorization. Authorizations are generally required if a covered entity wants to provide protected health information to third party for use by the third party for marketing or for research that is not approved by an IRB or privacy board.

The requirement for obtaining authorizations for use or disclosure of protected health information for most marketing activity will make direct third-party marketing more difficult because covered entities may not want to obtain and track such authorizations, or they may obtain too few to make the effort economically worthwhile. However, the final rule permits an alternative arrangement: the covered entity can engage in health-related marketing on behalf of a third party, presumably for a fee. Moreover, the covered entity could retain another party, through a business associate relationship, to conduct the actual health-related marketing, such as mailings or telemarketing, under the covered entity's name. HHS was unable to estimate the cost of these changes because there is no credible data on the extent of current third party marketing practices or the price that third party marketers currently pay for information from covered entities. The effect of the final rule is a change in the arrangement of

practices to enhance accountability of protected health information by the covered entity and its business associates; however, there is nothing inherently costly in these changes.

To use or disclose psychotherapy notes for most purposes (including for treatment, payment, or healthcare operations), a covered entity must obtain specific authorization by the individual that is distinct from any authorization for use and disclosure of other protected health information. This is current practice, so there is no new cost associated with this provision.

Confidential Communications

The final rule permits individuals to receive communications of protected health information from a covered healthcare provider or a health plan by an alternative means or at an alternative address. A covered provider and a health plan must accommodate reasonable requests; however, a health plan may require the individual to state that disclosure of such information may endanger the individual. A number of providers and health plans indicated that they currently provide this service for patients who request it. For providers and health plans with electronic records systems, maintaining separate addresses for certain information is simple and inexpensive, requiring little or no change in the system. For providers with paper records, the cost may be higher because they will have to manually check records to determine which information must be treated in accordance with such requests. Although some providers currently provide this service, HHS was unable to obtain any reliable estimate of the number of such

requests today or the number of providers who perform this service. The cost attributable to this requirement to send materials to alternate addresses does not appear to be significant.

Employers with Insured Group Health Plans

Some group health plans will use or maintain protected health information, particularly group health plans that are self-insured. Also, some plan sponsors that perform administrative functions on behalf of their group health plans, may need protected health information. The final rule permits a group health plan, or a health insurance issuer or HMO that provides benefits on behalf of the group health plan, to disclose protected health information to a plan sponsor who performs administrative functions on its behalf for certain purposes and if certain requirements are met. The plan documents must be amended to describe the permitted uses and disclosures of protected health information by the plan sponsor; to specify that disclosure is permitted only upon receipt of a certification by the plan sponsor that the plan documents have been amended and the plan sponsor agrees to certain restrictions on the use of protected health information; and to provide for adequate firewalls to assure unauthorized personnel do not have access to individually identifiable health information.

HHS assumes that most plan sponsors who are small employers (those with 50 or fewer employees) will elect not to receive protected health information because they will have little, if any, need for such data. Any needs that plan sponsors of small group health plans may have for this type of information can be accomplished by receiving

the information in summary form. HHS has assumed that only 5 percent of plan sponsors of small group health plans that provide coverage through a contract with an issuer will actually take the steps necessary to receive protected health information. This is approximately 96,900 firms. For these firms, HHS assumed it will take one hour to determine procedural and organization issues and an additional 1/3 hour of an attorney's time to make plan document changes, which will be simple and essentially standardized. This will cost $7.1 million.

Plan sponsors who are employers of medium (51-199 employees) and large (over 200 employees) firms that provide health benefits through contracts with issuers are more likely to want access to protected health information for plan administration, for example to use it to audit claims or perform quality assurance functions on behalf of the group health plan. HHS assumes that 25 percent of plan sponsors of medium sized firms and 75 percent of larger firms will want to receive protected health information. This amounts to approximately 38,000 medium size firms and 27,000 larger firms. To provide access to protected health information by the group health plan, a plan sponsor will have to assess the current flow of protected health information from their issuer and determine what information is necessary and appropriate. The plan sponsors may then have to make internal organizational changes to assure adequate protection of protected health information so that the relevant requirements are met for the group health plan. HHS assume that medium size firms will take sixteen work hours to complete organizational changes, plus one hour of legal time to make changes to plan documents and certify to the insurance carrier that the firm is eligible to receive

protected health information. HHS assumed that larger firms would require 32 hours of internal organizational work and one hour of legal time. This will cost $52.4 million and is a one-time expense.

Business Associates

The final rule requires a covered entity to have a written contract or other arrangement that documents satisfactory assurance that business associate will appropriately safeguard protected health information in order to disclose it to a business associate based on such an arrangement. HHS expects business associate contracts to be fairly standardized, except for language that will have to be tailored to the specific arrangement between the parties, such as the allowable uses and disclosures of information. HHS assumed the standard language initially will be developed by trade and professional associations for their members. Small providers are likely to simply adopt the language or make minor modifications, while health plans and hospitals may start with the prototype language but may make more specific changes to meet their institutional needs. The regulation includes a requirement that the covered entity take steps to correct and in some cases terminate a contract if necessary, or if they know of violations by a business associate. This oversight requirement is consistent with standard oversight of a contract.

HHS could not derive a per-entity cost for this work directly. In lieu of this, HHS assumed that the trade and professional associations' work plus any minor tailoring of it by a covered entity would amount to one hour per non-hospital provider

and two hours for hospitals and health plans. The larger figure for hospitals and health plans reflects the fact that they are likely to have a more extensive array of relationships with business associates.

The cost for the changes in business associate contracts is estimated to be $103 million. This will be an initial year cost only because HHS assumed that this contract language would become standard in future contracts.

In addition, HHS has estimated the cost for business associates to comply with the minimum necessary provisions. As part of the minimum necessary provisions, covered entities will have to establish policies to ensure that only the minimum necessary protected health information is shared with business associates. To the extent that data are exchanged, covered entities will have to review the data and systems programs to assure compliance.

For non-hospital providers, HHS estimates that the first year will require an average of three hours to review existing agreements, and thereafter, they will require an additional hour to assure business associate compliance. HHS estimate that hospitals will require an additional 200 hours the first year and 16 hours in subsequent years; health plans will require an additional 112 hours the first year and 8 hours in subsequent years. As in other areas, HHS has assumed a weighted average wage for the respective sectors.

The cost of the covered entities assuring business associates' complying with the minimum necessary is $197 million in the first year, and a total of $697 million over

ten years. (These estimates include the both the cost for the covered entity and the business associates.)

Inspection and Copying

In the NPRM estimate, inspection and copying were a major cost. Based on data and information from the public comments and further fact-finding, however, HHS has re-estimated these policies and found them to be much less expensive. The public comments demonstrate that copying of records is widespread today. Records are routinely copied, in whole or in part, as part of treatment or when patients change providers. In addition, copying occurs as part of legal proceedings. The amount of inspection and copying of medical records that occurs for these purposes is not expected to change measurably as a result of the final regulation.

The final regulation establishes the right of individuals to access, that is to inspect and obtain a copy of, protected health information about them in designated record sets. Although this is an important right, HHS does not expect it to result in dramatic increases in requests from individuals. The Georgetown report on state privacy laws indicates that 33 states currently give patients some right to access medical information. The most common right of access granted by state law is the right to inspect personal information held by physicians and hospitals. In the process of developing estimates for the cost of providing access, HHS assumed that most providers currently have procedures for allowing patients to inspect and obtain a copy of individually identifiable health information about them. The economic impact of

requiring entities to allow individuals to access their records should be relatively small. One public commenter addressed this issue and provided specific data, which supports this conclusion.

Few studies address the cost of providing medical records to patients. The most recent was a study in 1998 by the Tennessee Comptroller of the Treasury. It found an average cost of $9.96 per request, with an average of 31 pages per request. The cost per page of providing copies was $0.32 per page. This study was performed on hospitals only. The cost per request may be lower for other types of providers, since those seeking hospital records are more likely to have more complicated records than those in a primary care or other types of offices. An earlier report showed much higher costs than the Tennessee study. In 1992, Rose Dunn published a report based on her experience as a manager of medical records. She estimated a 10-page request would cost $5.32 in labor costs only, equaling labor cost per page of $0.53. However, this estimate appears to reflect costs before computerization. The expected time spent per search was 30.6 minutes; 85 percent of this time could be significantly reduced with computerization (this includes time taken for file retrieval, photocopying, and re-filing; file retrieval is the only time cost that would remain under computerization).

In estimating the cost of copying records, HHS relied on the public comment from a medical records outsourcing industry representative, which submitted specific volume and cost data from a major firm that provides extensive medical record copying services. According to these data, 900 million pages of medical records are copied each year in the U.S., the average medical record is 31 pages, and copying costs are $0.50

per page. In addition, the commenter noted that only 10 percent of all requests are made directly from patients, and of those, the majority is for purposes of continuing care (transfer to another provider), not for purposes of individual inspection. HHS assumed that 25 percent of direct patient requests to copy medical records are for purposes of inspecting their accuracy (i.e., 2.5 percent of all copy requests) or 850,000 in 2003 if the current practice remains unchanged.

To estimate the marginal increase in copying that might result from the regulation, HHS assumed that as patients gained more awareness of their right to inspect and copy their records, more requests will occur. As a result HHS assumed a ten percent increase in the number of requests to inspect and copy medical records over the current baseline, which would amount to a little over 85,000 additional requests in 2003 at a cost of $1.3 million. Allowing for a 5.3 percent increase in records based on the increase in ambulatory care visits, the highest growth rate among health service sectors (the National Ambulatory Medical Care Survey, 1998), the total cost for the ten-year period would be $16.8 million.

The final rule allows a provider to deny an individual the right to inspect or obtain a copy of protected health information in a designated record set under certain circumstances, and it provides, in certain circumstances, that the patient can request the denial to be reviewed by another licensed healthcare professional. The initial provider can choose a licensed healthcare professional to render the second review.

HHS assumed denials and subsequent requests for reviews would be extremely rare. HHS estimated there are about 932,000 annual requests for inspections, or

approximately 11 million over the ten-year period. If one-tenth of one percent of these requests were to result in a denial in accordance with the rule, the result would be 11,890 cases. Not all these cases would be appealed. If 25 percent were appealed, the result would be 2,972 cases. If a second provider were to spend 15 minutes reviewing the case, the cost would be $6,000 in the first year and $86,360 over ten years.

Amendments to Protected Health Information

Many providers and health plans currently allow patients to amend the information in their medical record, where appropriate. If an error exists, both the patient and the provider or health plan benefit from the correction. However, as with inspection and copying, many states do not provide individuals with the right to request amendment to protected health information about themselves. Based on these assumptions, HHS concluded that the principal economic effect of the final rule would be to expand the right to request amendments to protected health information held by a health plan or provider to those who are not currently covered by amendment requirements under state laws or codes of conduct. In addition, the rule may draw additional attention to the issue of inaccuracies in information and may stimulate patient demand for amendment of medical records, including in those states that currently provide a right to amend medical records.

Under the final regulation, if a patient requests an amendment to his or her medical record, the provider must either accept the amendment or provide the

individual with the opportunity to submit a statement disagreeing with the denial. The provider must acknowledge the request and inform the patient of his action.

The cost calculations assume that individuals who request an opportunity to amend their medical record have already obtained a copy of it. Therefore, the administrative cost of amending the patient's record is completely separate from inspection and copying costs.

Based on fact-finding discussions with a variety of providers, HHS assumed that 25 percent of the projected 850,000 people who request to inspect their records would seek to amend them. This number is the existing demand plus the additional requests resulting from the rule. Over ten years, the number of expected amendment requests would be 2.7 million. Unlike inspections, which currently occur in a small percentage of cases, HHS fact-finding suggests that patients very rarely seek to amend their records, but that the establishment of this right in the rule will spur more requests. The 25 percent appears to be high based on HHS discussions with providers but it is being used to avoid an underestimation of the cost.

As noted, the provider or health plan is not required to evaluate any amendment requests, only to append or otherwise link to the request in the record. HHS expect the responses will vary: sometimes an assistant will only make the appropriate notation in the record, requiring only a few minutes; other times a provider or manager will review the request and make changes if appropriate, which may require as much as an hour. To be conservative in its estimate, HHS assumed, on average, 30 minutes for each amendment request at a cost of $47.28 per hour (2000 CPS).

The first-year cost for the amendment policy is estimated to be $5 million. The ten-year cost of this provision is $78.8 million.

Law Enforcement, Judicial, and Administrative Proceedings

The law enforcement provisions of the final rule allow disclosure of protected health information without patient authorization under four circumstances: (1) Pursuant to legal process or as otherwise required by law; (2) to locate or identify a suspect, fugitive, material witness, or missing person; (3) under specified conditions regarding a victim of crime; and (4) when a covered entity believes the protected health information constitutes evidence of a crime committed on its premises. As under current law and practice, a covered entity may disclose protected health information to a law enforcement official if such official.

Based on HHS fact finding, HHS was not able to estimate any additional costs from the final rule regarding disclosures to law enforcement officials. The final rule makes clear that current court orders and grand jury subpoenas will continue to provide a basis for covered entities to disclose protected health information to law enforcement officials. The three-part test, which covered entities, must use to decide whether to disclose information in response to an administrative request such as an administrative subpoena, represents a change from current practice. There will be only minimal costs to draft the standard language for such subpoenas. HHS is unable to estimate other costs attributable to the use of administrative subpoenas. HHS have not been able to discover any specific information about the costs to law enforcement of establishing the

predicates for issuing the administrative subpoena, nor has HHS been able to estimate the number of such subpoenas that will likely be issued once the final rule is implemented.

A covered entity may disclose protected health information in response to an order in the course of a judicial or administrative proceeding if reasonable efforts have been made to give the individual, who is the subject of the protected health information, notice of opportunity to object to the disclosure or to secure a qualified protective order.

HHS was unable to estimate any additional costs due to compliance with the final rule's provisions regarding judicial and administrative proceedings. The provision requiring a covered entity to make efforts to notify an individual that his or her records will be used in proceedings is similar to current practice; attorneys for plaintiffs and defendants agreed that medical records are ordinarily produced after the relevant party has been notified. With regard to protective orders, HHS believes that standard language for such orders can be created at minimal cost. The cost of complying with such protective orders will also likely be minimal, because attorney's client files are ordinarily already treated under safeguards comparable to those contemplated under the qualified protective orders. HHS was unable to make an estimate of how many such protective orders might be created annually.

HHS thus does not make any estimate of the initial or ongoing costs for judicial, administrative, or law enforcement proceedings.

Costs to the Federal Government

The rule will have a cost impact on various federal agencies that administer programs that require the use of individual health information. The federal costs of complying with the regulation and the costs when federal government entities are serving as providers are included in the regulation's total cost estimate outlined in the impact analysis. Federal agencies or programs clearly affected by the rule are those that meet the definition of a covered entity. However, non-covered agencies or programs that handle medical information, either under permissible exceptions to the disclosure rules or through an individual's expressed authorization, will likely incur some costs complying with provisions of this rule. A sample of federal agencies encompassed by the broad scope of this rule include the: Department of Health and Human Services, Department of Defense, Department of Veterans Affairs, Department of State, and the Social Security Administration.

The greatest cost and administrative burden on the federal government will fall to agencies and programs that act as covered entities, by virtue of being either a health plan or provider. Examples include the Medicare, Medicaid, Children's Health Insurance and Indian Health Service programs at the Department of Health and Human Services; the CHAMPVA health program at the Department of Veterans Affairs and the TRICARE health program at the Department of Defense. These and other health insurance or provider programs operated by the federal government are subject to requirements placed on covered entities under this rule, including, but not limited to, those outlined in the impact analysis. While many of these federal programs already

afford privacy protections for individual health information through the Privacy Act and standards set by HHS and implemented through their contracts with providers, this rule is nonetheless expected to create additional requirements. Further, HHS anticipated that most federal health programs would, to some extent, need to modify their existing practices to comply fully with this rule. The cost to federal programs that function as health plans will be generally the same as those for the private sector.

A unique cost to the federal government will be in the area of enforcement. The Office for Civil Rights (OCR), located at the Department of Health and Human Services, has the primary responsibility to monitor and audit covered entities. OCR will monitor and audit covered entities in both the private and government sectors, will ensure compliance with requirements of this rule, and will investigate complaints from individuals alleging violations of their privacy rights. In addition, OCR will be required to recommend penalties and other remedies as part of their enforcement activities. These responsibilities represent an expanded role for OCR. Beyond OCR, the enforcement provisions of this rule may have additional costs to the federal government through increased litigation, appeals, and inspector general oversight.

Examples of other unique costs to the federal government may include such activities as public health surveillance at the Centers for Disease Control and Prevention, health research projects at the Agency for Healthcare Research and Quality, clinical trials at the National Institutes of Health, and law enforcement investigations and prosecutions by the Federal Bureau of Investigations. For these and other activities,

federal agencies will incur some costs to ensure that protected health information is handled and tracked in ways that comply with the requirements of this title.

HHS estimates that federal costs under this rule will be approximately $196 million in 2003 and $1.8 billion over ten years. The ten-year federal cost estimate represents about 10.2 percent of the privacy regulation's total cost. This estimate was derived in two steps.

First, HHS assumed that the proportion of the privacy regulation's total cost accruing to the federal government in a given year will be equivalent to the proportion of projected federal costs as a percentage of national health expenditures for that year. To estimate these proportions, HHS used the Healthcare Financing Administration's November 1998 National Health Expenditure projections (the most recent data available) of federal health expenditures as a percent of national health expenditures from 2003 through 2008, trended forward to 2012. HHS then adjusted these proportions to exclude Medicare and Medicaid spending, reflecting the fact that the vast majority of participating Medicare and Medicaid providers will not be able to pass through the costs of complying with this rule to the federal government because they are not reimbursed under cost-based payment systems. This calculation yields a partial federal cost of $166 million in 2003 and $770 million over ten years.

Cost to Private Physicians

HHS employed the two basic functions of the regulatory impact analysis (RIA) model in determining the cost to small businesses that are covered entities. The

regulatory flexibility analysis (RFA) determines the cost to small businesses by apportioning the total costs in the RIA using SIC code data. In places where the cost of a given provision of the final rule is a function of the number of covered entities, HHS determined the proportion of entities in each SIC code that have less than $5 million in revenues. They then multiplied this proportion by the per-entity cost estimate of a given provision as determined in the RIA. For example, the cost of the privacy official provision is based on the fact that each covered entity will need to have privacy official. Therefore, HHS multiplied the total cost of the privacy official, as determined in the RIA, by the proportion of small businesses in each SIC code to determine the small business cost.

HHS used a second similar method when the cost of a given provision in the RIA did not depend on the number of covered entities. For example, the requirement to provide notice of the privacy policy is a direct function of the number of patients in the health care system because the actual number of notices distributed depends on how many patients are seen. Therefore, for provisions like the notice requirement, HHS used SIC code revenue data in a two-step process. First, they apportioned the cost of each provision among sectors of the healthcare industry by SIC code. For example, because hospital revenue accounts for 27 percent of all health care revenue, HHS multiplied the total cost of each such provision by 27 percent to determine the cost for the hospital sector in total. Then, to determine the cost for small hospitals specifically, HHS calculated the proportion by the overall cost. For example, 45.1 percent of all hospitals

revenue is generated by small hospitals, therefore, the cost to small hospitals was assumed to account for 45.1 percent of all hospital costs.

Based on the methodology described above, the total cost of complying with the final rule in the initial year of 2003 is $1.9 billion. The ongoing costs to small business from 2004 to 2012 are $9.3 billion. Table 3 presents the initial and ongoing costs to small businesses by each SIC code. According to this table, small doctor's offices, small dentist's offices and small hospitals will face the highest cost of complying with the final rule. However, much of the reason for the higher costs faced by these three groups of small health care providers is explained by the fact that there are a significant number of health care providers in these categories.

Table 3
Annual Cost to Small Businesses of Implementing Provisions of the Proposed Privacy Regulation (1)

SIC	Industry	Number of entities that meet health care standards	Initial Year Cost (Year 1) (2)	Ongoing Cost (year 2-10)	Total Cost
5910	Drugstores & Proprietary Stores	23,923	$153,976,159	$780,573,862	$934,550,021
6320	Accident & Health Insurance & Medical Service Plans (3)	665	41,348,527	169,540,638	210,889,164
8010	Offices & Clinics of Doctors of Medicine	170,962	633,033,192	3,209,127,747	3,842,160,938
8020	Offices and Clinics of Dentists	113,864	283,774,344	1,438,578,786	1,722,252,130
8030	Offices & Clinics Doctors of	8,850	24,278,673	123,079,430	147,358,103

	Osteopathy				
8040	Office & Clinics of Other Health Practitioners	86596	139,251,750	705,929,263	845,181,013
8050	Nursing and Personal Care Facilities	17,727	147,143,775	745,937,461	893,081,236
8060	Hospitals	3,485	355,459,094	1,199,498,063	1,554,957,157
8070	Medical & Dental Laboratories	13,015	41,242,809	209,078,203	250,321,012
8080	Home Healthcare Services	12,841	72,632,601	368,207,067	440,839,668
8090	Miscellaneous Health & Allied Services	11,219	40,938,582	207,535,943	248,474,525
7353	Medical Equipment Rental & Leasing		7,171,728	36,356,688	43,528,416
N/A	Fully Insured/ERISA		7,137,028	0	7,137,028
N/A	IRBs		88,813	84,162,446	84,251,259
	Total Cost for Small Business		$1,947,477,073	$9,277,605,598	$11,225,082,671
	Total Cost for entire healthcare industry		$3,242,000,000	$14,012,100,000	$17,554,700,000
(1) Source: Office of Advocacy, U.S. Small Business Administration, from data provided by the Bureau of the Census, Statistics U.S. Business, 1997. Entities that have less than $5,000,000 in annual revenue are considered small business here, as are non-profit entities (regardless of revenue). We have non-profit data for the following SIC: 8050, 8080, and 8060 and have included the number of non-profits in each category in the table.					
(2) The initial cost includes all costs in the first year, including costs that recur in subsequent years.					
(3) We have included self-insured/self-administered health plans and third party administrators in the total number of health plans even though neither have individual SIC codes because we have the ability to impute revenue to them.					
Source: Federal Register December 28, 2000; Moody's Investors Service, March 2001					

Section II

Purpose and Location

The purpose of this study is to determine the cost of implementing HIPAA in private physicians' offices in the state of South Carolina. The preceding chapter and sections presented a literature review and other cost computations that have been used to compute the cost of implementing HIPAA in hospitals and in private physicians' practices nationally. This section will identify the study's location and population and discuss the research design including the questionnaire, data collection procedures, statistical measures that will be used to analyze the data, and the potential study limitations.

Population and Sample

The study consists of two phases: Phase One involves structured interviews with six physicians or the office/practice managers within the state of South Carolina. The questions used in the interviews are shown on Appendix A. The questions were unstructured or "open-ended" questions because only the question is expressed and no alternative answers are listed for the respondents (Alreck & Settles, 1995). Responses from the questions will be used to prepare the structured survey to be administered to the total population selected to survey. The physicians' offices in Phase One were selected based on convenience without regard to specialty, size of practice, geographical region, number of employees, or patient populations. According to Alreck & Settles, "Personal interviewing is often able to win respondent cooperation

and hold it for a long time. Non-response bias is minimal, and this method is quicker than mail surveys for small, geographically concentrated samples"(Alreck & Settles, 1995). Phase Two will involve sending written survey instruments (constructed from information collected in Phase One) to family practice, general practice, obstetrics and gynecology, and pediatrics physicians in South Carolina.

The physicians selected for surveys were primary care physicians in family practice, general practice, pediatrics, and obstetrics & gynecology. These primary care physicians have a heavier patient load than other specialties and the HIPAA standards will have a greater impact on their practices than on those of other specialty physicians. The primary care physicians are generally the first line of medical care received by the patients before they are referred to a specialist. The family practice, general practice, pediatrics, and obstetrics and gynecology physicians in South Carolina were obtained from the South Carolina Department of Research (SCDR) in August 2002. The SCDR is the governmental entity that maintains the most complete record of licensed physicians who practice within the state of South Carolina.

The list obtained from the SCDR was organized in alphabetical (physician's name) order by specialty, by county, with the mailing address for each physician. The lists were sorted by mailing addresses to group all members of the same physician practice together. The surveys developed in Phase Two will be mailed to the solo practitioners and to physician groups. Physicians at the same address will receive one survey. Physicians in the selected specialties who are employed by hospitals and

clinics and are not in private practice were not included in the physicians surveyed. These physicians were excluded from the population of physicians by the SCDR.

The questions in Phase One are `trigger` questions, designed to draw out various opinions and stimulate conversation about plans to implement the HIPAA privacy standards (Alreck & Settles, 1995). The interviewer asked specific questions regarding the cost of implementing HIPAA when appropriate during the interview. Some questions were directed toward the transaction code sets and the yet to be published security standards in order to get an indication of whether the practices were going to expend any other funds specifically to implement theses components of HIPAA, which are separate from the privacy and confidentiality standards.

The interviews conducted in Phase One have been transcribed and are shown in Appendices B through G. The transcription contains only the words of the interviewees but not necessarily the manner in which they were spoken (Alreck & Settles, 1995). The transcriptions have been edited for grammar, sentence structure, and have omitted all superfluous comments. The interviewees have been designated Subject I, II, III, IV, V, and VI to maintain their anonymity.

The survey developed in Phase Two will be administered, tested, modified and refined by administering the survey to the physicians' offices interviewed in Phase One. Attention will be given to the wording of the questions in a way that gathers cost data, and that does not generate bias in the responses and eliminates redundancies in the questions. The questions will be geared toward gathering data to compute the cost of implementing the HIPAA privacy standards. The survey questions are also directed at

determining the pre and post-implementation date cost of implementing HIPAA privacy standards.

The HIPAA cost data collected in previous studies for hospitals was conducted via email and via the Internet (surveys were completed online and submitted electronically). No previous studies have been done or HIPAA cost data collected for the cost of implementing HIPAA in private physicians' offices.

The surveys mailed to physicians will not have any identifying information that could be linked to the physicians' practice, and no identifying information will be recorded on the survey. A stamped return envelope will be provided with each survey (to return the survey instrument.) After a reasonable time has elapsed, post cards will be mailed to all the physicians thanking them if they completed and returned the survey, asking that they return the survey if they have not already done so, and to disregard if the survey has been completed and returned. The second request will be mailed to all physicians sent surveys on the first request, except for physicians for whom the addresses were incorrect and an up-to-date address cannot be obtained and physicians no longer in practice due to retirement or death.

The number of physicians surveyed is shown in Figure 1 below:

Figure 1
Survey Results

Type Practice	Number	% of Total	Responses	% of Total
Family Practice	653	59%	53	60%
Pediatrics	218	20%	16	18%
Obstetrics & Gynecology	230	21%	19	22%
Total	1,101	100%	88	100%

The percentage of the total for the specialties responses received almost mirrors the specialty's ratio to the total population.

Analysis

The surveys received will be entered into an Excel spread sheet to analyze the results. (See the Data Dictionary for how the information will be entered.) In instances where the research participant gave ranges of cost, the highest numbers will always be used. In cases where the research participant indicated that the cost was less than or greater than a certain number, the amount used will be one dollar less or greater than the amount shown. Where the amount of training was given in days instead of hours, one day will be converted to eight (8) hours.

As noted in Section I, HHS categorized the Privacy and Confidentiality rules into specific areas with which the covered entities must comply to implement HIPAA. Conversations with physicians' offices during Phase I revealed that many the covered entities were not familiar with the provisions of the Privacy rules in enough detail to respond to questions regarding specific provisions of the regulation. Much of the cost

of implementing HIPAA's privacy and confidentiality standards will be in staff and physician time expended in training, understanding, and addressing HIPAA issues. Thus the survey was designed to gather information regarding training, seminars and other costs that could be readily attached to HIPAA. Much of the cost will be in staff time. The staff and physicians' time will be converted to dollars by multiplying the hours devoted to HIPAA training by the physicians' and staffs' hourly rates. The hourly rates for each staff position identified by the research participant were obtained from the Occupational Employment Statistics (OES) Program of the U.S. Department of Labor, Bureau of Labor Statistics. According to the U.S. Department of Labor, "The OES program produces employment and wage estimates for over 700 occupations. These are estimates of the number of people employed in certain occupations and estimates of the wages paid to them." (Labor, 2003). The wage data is the 2001 State Occupational Employment and Wage estimates for the state of South Carolina. No distinction will be made for the wage rate differences, which may exist between regions of the state or urban and rural areas. The mean wage hourly wage computed by the OES will be used as the occupational wage rates for the staff identified in the research participant.

The non-medical staff wage rate was determined by dividing the aggregate wage rates of the office manager, practice manager, receptionist, medical secretary, office assistant, accounting clerk and billing clerk by seven. These wages are classified as office and administrative support occupations. The OES did not specifically identify X-ray technician and phlebotomist. Their wage rates were obtained from the medical

and clinical laboratory technicians' occupational code. Staff identified in the "other" category such as ultrasound techs and surgical techs were assigned the wage rates of the medical and clinical technologists wage rates. The researcher could not locate a wage rate in the OES for a Nurse Practitioner. The wage rate was determined from the average urban, suburban and rural salary for nurse practitioners provided by Allied Physicians.

The OES identified the wage rates of each physician specialist surveyed (family practice, general practice, pediatrics, and obstetrics & gynecology). No distinction was made in the OES of the owner/partner vs. employee physicians; therefore the same wage rate will be used for the physician regardless of whether he/she is an owner or an employee of the physician practice.

Fringe benefits are applied to wages at a conservative rate of 30%, which includes the employer's share of FICA and Medicare, Federal and state unemployment, two weeks vacation, and the employers' portion of healthcare insurance.

The wage rates were further adjusted by the increase in the Employment Cost Index for the South Region of 2.2%.

Question #14 of the survey asks for the quantity and cost of certain categories expenditures prior to December 31, 2002, between January 1, 2003 and April 14, 2003, and between April 14, 2003 and April 14, 2004. The average cost of the equipment was applied uniformly throughout the survey to obtain the total cost of the equipment purchased.

Question #14 also asked if the physician installed an electronic medical records (EMR) system. Some respondents answered positively to the question without supplying a cost while others supplied the cost. The cost of the researcher use will be the average cost of the EMR and for all EMRs reported as being installed.

Finally, Question #14 asked if the physicians performed any renovation at their site for HIPAA implementation. Any renovation will be considered as one; and the average cost of renovation will be applied to all renovations for this study.

The consultant cost was determined from survey Question #15 where physicians responded positively regarding hiring a consultant and provided the consultant's fees. The average cost computed from this question was used throughout this research.

Equipment, EMR system, and building renovations were considered capital assets that benefit more than one accounting period. Normally, the historical costs of these items would systematically be allocated over their estimated useful life to properly reflect the benefit they have to future periods via a method called depreciation. The researcher recognizes the fact that this is the preferred way of addressing these items; however, the researcher has elected not to consider any depreciation of these capital assets during this study. The researcher's greatest concern is the cash flow rather than generally accepted accounting principles. It should be noted that if the cost of the equipment were allocated to the number of years they benefit the physicians' practices (i.e. depreciated); the estimated cost to implement HIPAA in the initial year would be reduced.

In preparing the survey, the researcher recognized the fact that all physicians would not implement HIPAA in the same manner and that all questions may not be applicable to all respondents. Some respondents would hire a consultant, others would not; while some would hire a privacy director, others would assign the duty to current staff members; some would purchase new equipment, others would not; and some may choose to renovate while others may elect not to. In addition, the instructions to the survey asked the respondents to complete only questions 1 through 7 if they did not want to complete the entire survey. Therefore, for the reasons stated above, there is no minimum rate of responses for the use of data in this study. The researcher would note however, that all questions had better than a fifty percent response rate.

The data will be analyzed to answer the following questions regarding the cost of implementing HIPAA in private physicians' practices in South Carolina:

1. What is the average cost of physicians' practices by specialty category and by number of employees?
2. How does the cost of HIPAA implementation vary by the amount of cash receipts of a physician's practice?
3. How does the cost of HIPAA implementation vary by the number of patients seen in a week?
4. Is there a significant difference in the cost of implementing HIPAA by rural and urban physicians' practices?
5. Compare the pre and post-implementation date cost of HIPAA.

6. What are the characteristics of physicians' practices that hire a privacy officer compared to the characteristics of physicians' practices where the duties of a privacy officer are assumed by current staff?

RESULTS

Introduction

This chapter contains the findings derived from applying cost to the data private physicians in South Carolina provided in the survey. The analysis is primarily financial and addresses the cost private physicians anticipated incurring in the implementation of the privacy and confidentiality standards of HIPAA.

The first section provides a demographic data analysis of the responses received. The second section analyzes the financial impact of HIPAA implementation from the data provided in the surveys. No Personal Services Corporation (PSC) responded to the survey and thus will not be reflected in any of the charts in the results section. Also, as mentioned in the methodology section, family practice and general practice data are combined because they are closely aligned and are very similar specialties. Hereafter, these specialties will be referred to collectively as family practice.

Demographic Data

As noted in Table 4, fifty-three (60%) of the respondents were family practice, sixteen (18%) were pediatrics, and nineteen (22%) were obstetrics and gynecology. In addition, the types of entities responding to the surveys were: sole proprietors twenty-four (27%), partnerships fourteen (16%), corporations forty-five (51%), and not for profit five (6%). (See Table 4).

Table 4
Response Rate to Surveys

	Sole Proprietor	Partnership	Corporation	Not for Profit	Total	% Response
Family Practice	15	8	26	4	53	60%
Pediatrics	5	2	8	1	16	18%
Obstetrics & Gynecology	4	4	11	0	19	22%
Total	24	14	45	5	88	100%
% Response	27%	16%	51%	6%	1,005	

The numbers of rural and urban physician practices are identical. Most of the rural and urban physicians are in the family practice specialty and are of a corporate entity.

Table 5
Rural and Urban Physicians

Specialty	Rural	Urban	Total
Family Practice	30	23	53
Pediatrics	9	7	16
Obstetrics & Gynecology	4	13	17
Total	43	43	86*
Entity			
Sole Proprietor	14	10	24
Partnerships	5	9	14
Corporation	22	21	43
Not for Profit	2	3	5
Total	43	43	86*
*Two respondents did not indicate rural or urban.			

Sixty-five (74%) of the respondents indicated that they operate from one office location. The number of rural and urban physicians operating from one location was

almost identical with thirty-two. More family practice physicians operate from one location than any of the other specialties; however, this is not surprising because over 55% of the respondents were family practice physicians. More corporations have only one location than any other entity (See Table 6).

Table 6
Number of Locations

Locations	Rural	Urban	FP	PED	OBGYN	SP	PRTNR	CORP	NFP	Overall
1	32	32	39	11	15	23	9	31	2	65
2	7	5	8	3	2	1	1	10	1	13
3	1	1	0	0	2	0	1	1	0	2
4	1	3	3	1	0	0	2	2	0	4
5	0	1	1	0	0	0	1	0	0	1
7	0	1	0	1	0	0	0	0	1	1
9	1	0	1	0	0	0	0	0	1	1
Total	42*	43	52*	16	19	24	14	44*	5	87*

FP = Family Practice
PED = Pediatrics
OBGYN = Obstetrics and Gynecology

SP = Sole Proprietor
PRTNR = Partnership
CORP = Corporation
NFP = Not for Profit

* One respondent did not indicate the number of locations.

There was not any apparent difference between the numbers of weeks physicians' practices were open by specialty or type entity (See Table 7). Eighty-five (97%) of the respondents indicated that they are open 50 or more weeks per year.

Table 7
Number of Weeks Open Per Year

	Minimum	Maximum	Mean	Median
SPECIALTY				
Family Practice	44.0	52.0	51.4	52.0
Pediatrics	40.0	52.0	50.8	52.0
Obstetrics & Gynecology	51.0	52.0	51.9	52.0
TYPE ENTITY				
Sole Proprietor	44.0	52.0	50.8	52.0
Partnership	52.0	52.0	52.0	52.0
Corporation	40.0	52.0	51.6	52.0
Not For Profit	50.0	52.0	52.0	52.0
Overall	40.0	52.0	51.4	52.0

The variation in the number of patients per week indicates a wide range of practice sizes. The overall *average* number of patients visiting private practices per week is 392. With the exception of pediatrics, the average numbers for the other specialties do not vary by more than 50 patients per week (See Table 8).

Table 8
Number of Patients per Week

	Minimum	Maximum	Mean	Median
SPECIALTY				
Family Practice	25	2,000	368	210
Pediatrics	80	2,400	531	240
Obstetrics & Gynecology	50	1,375	341	150
TYPE ENTITY				
Sole Proprietor	50	300	135	130
Partnership	85	2,000	496	450
Corporation	25	2,400	470	314
Not For Profit	150	1,400	720	665
Overall	25	2,400	392	205

Question #7 of the survey requested of the respondents their best estimate of the cost of implementing the privacy and confidentiality rules before the effective date (April 14, 2003) and after the effective date. A comparison of the cost estimated by the respondents and the cost computed by the researcher is shown in Tables 9, cost prior to April 14, 2003 and cost after the effective date, respectively. Not all respondents replied to both parts of the question. Their answers are not considered in the analysis where there were no responses. The costs that are being compared are the training costs computed from Questions #11 and #12, cost of seminars, conferences, and workshops, and costs computed from Question #14 regarding the cost of additional equipment, facilities renovations, installation of electronic medical records and

consultants. Seventy-two respondents estimated their pre-April 14, 2003 cost of implementing HIPAA at $507,631 vs. $685,426 actual cost. Thirty-seven of the seventy-two respondents incurred costs greater than what they had estimated. The aggregate amount greater than the estimate was $223,392. Thirty-four of the seventy-two respondents incurred cost less than their estimated cost. The aggregate amount less than the estimated amount was $401,187.

Fifty-two respondents estimated a post April 14, 2003 cost of HIPAA implementation of $184,432 vs. the computed cost based on their data of $298,409. Eighteen of the respondents exceeded the estimate by $215,141. Thirty-two respondents computed costs were less than the projected by $101,268.

The computed cost of implementing HIPAA prior to the effective date is 35% higher or $177,795 more than the costs that were estimated by the respondents. The average cost per physician's practice computed by the researcher is $9,520 compared to the average cost of $7,050 estimated by the respondents for cost incurred before April 14, 2003. The average cost in the subsequent year computed by the researcher is $5,739 versus an average cost per the respondents of $3,547. The difference in the average computed cost over the average estimated cost is attributable to the respondents not including all costs associated with the training, underestimating the number of training hours employees receive, and the cost of equipment acquired. The respondents failed to include the salaries, travel and lodging costs of employees attending seminars and training sessions.

Table 9
Comparison of Estimated vs. Actual Cost

	Cost Before April 14, 2003		Cost After April 14, 2003	
	Per respondents	Per calculations	Per respondents	Per calculations
Total Cost	$507,631	$685,426	$184,432	$298,409
Minimum	0	0	0	0
Maximum	$150,001	$87,718	$50,000	$81,173
Average	$7,050	$9,520	$3,547	$5,739
Median	$2,500	$2,235	$1,750	$357

Sixteen respondents answered only Questions #1 through # 7 of the survey. The total estimated costs of implementing HIPAA are shown in Table 9A below.

Table 9A

Estimated Implementation Cost

Minimum Cost	$99
Maximum Cost	$15,000
Average Cost	$3,569
Median Cost	$2,750

Question #15 of the survey asked the physicians if they anticipated hiring a consultant in implementing the HIPAA privacy and confidentiality rules. This question was asked because, during Phase One, there appeared to be some concern as to what physicians practices must do to implement the HIPAA privacy rules. HHS was concerned, before and after the April 14, 2003 implementation date, that physicians' practices may be going overboard in implementing the federal standards. Supposedly, consultants would have helped the physicians streamline their efforts and only do the things that are necessary to comply with the federal regulation. Sixty-nine (78%) of the eighty-eight respondents answered this question. Fourteen (20%) of the sixty-nine

respondents answered positively to utilizing a consultant in implementing the HIPAA privacy standards. The average, minimum, maximum, and median costs of the consultants were $2,415, $500, $10,000, and $1,325, respectively. Sole proprietors and family practice had the highest average cost per entity and specialty, respectively (See Table 10).

Table 10
Cost of Consultants

	Average	Minimum	Maximum	Median	No. of Respondents
Family Practice	$ 3,420	$ 1,000	$10,000	$ 2,500	9
Pediatrics	800	800	800	800	1
Obstetrics & Gynecology	1,563	500	3,000	1,375	4
Sole Proprietor	$ 4,033	$ 1,000	$10,000	$ 1,100	4
Partnership	2,500	2,500	2,500	2,500	2
Corporation	1,410	500	3,000	1,250	7
Not for Profit	0	0	0	0	1
Rural	$ 1,800	$1,100	$2,500	$1,800	4*
Urban	2,717	500	10,000	1,250	8*
Overall	$2,415	$500	$10,000	$1,375	14
* Two respondents did not indicate rural or urban					

One provision of the HIPAA privacy rules requires the physician practice to assign a specific person with the responsibility as the privacy officer. Questions 16, 17, 18, 19, and 20 were asked if the practices would be hiring a specific person to take care of the HIPAA responsibilities, if the responsibilities were assumed by someone currently in the practice, if additional compensation were given to the person assuming the additional responsibilities, how much time the practice estimated the privacy officer

would devote to HIPAA responsibilities and if additional staff would be hired as a result of a shift in responsibilities. Seventy-one respondents answered question 16 regarding the hiring of a privacy director. Of the seventy-one responses, sixty-eight (96%), indicated they were not hiring a privacy director. Of the sixty-eight, sixty-four (94%) indicated that staff currently employed in the practice would assume the duties of the privacy director. Sixty-six physicians responded to question 17 regarding additional compensation for staff assuming the additional duties of the privacy director. Of the sixty-six, eight (12%) indicated the staff would receive additional compensation. The majority, fifty-eight (88%) said that no additional compensation would be given to the privacy director. Seventy physicians responded to question 20 regarding hiring of additional staff. Sixty-seven (96%) of the respondents to this question said they were not hiring additional staff. Finally, fifty-five physicians responded to question 19 regarding their estimate of the number of hours per week they anticipate devoting to HIPAA privacy rules. The average estimated hours anticipated per week are 5.1 hours per week.

Sixty-seven physicians responded to the question as to whether they thought more changes would be made to the HIPAA privacy and confidentiality standards. The results were almost evenly split, 34 (yes) to 33 (no), between those who thought that more changes would and would not be made to the standards.

Fifty-eight physicians indicated that they were not making any facility changes in their offices as a result of HIPAA privacy and confidentiality standards. This represented 85% of the sixty-eight physicians answering this question. It is not the

intent of HIPAA rules to require major renovations of facilities by physicians. Some of the renovations performed in physicians' offices were:

a. Built separate room for the nurses to obtain appointments, consultations and assessment of information.
b. Installed glass partitions in windows.
c. Installed clinical areas and check out window.
d. Blocked access to records room.
e. Installed new doors and locks in medical records room.
f. Installed screensavers on computer, with passwords.

Private physicians are not enthusiastic about the new privacy and confidentiality standards and think they are disruptive to office flow. Below is a recent event reported by one respondent of the complexities and disruption that the HIPAA privacy and confidentiality standards imposed on his staff.

1. A patient was seen last night in the emergency room (ER) and was told to visit his physician the next morning.
2. Patient visited his personal physician as instructed.
3. ER was called regarding patient's condition and ER indicated they would fax the information in 10 minutes.
4. ER called and said they needed a signed release.
5. Staff gets form, explains it to patient, patient signs form.
6. Form faxed to ER. Staff waits 10 minutes.
7. Staff calls ER again.

8. Information faxed to physician by ER.

9. Patient visit completed.

The physician lamented, "Steps 4–7 should not be necessary and took up an additional 30 minutes, disrupted office flow and tied up an exam room." This example reflects the same frustration that was noted during the interview of the family practice physicians and/or practice managers during interviews in Phase One.

Financial Costs

In order to curtail the cost of HIPAA privacy standard implementation, some physicians turned to their professional association. Thirty-three physicians' practices utilized the services of professional associations with twenty-one of these practices utilizing the services free of charge. Of the twelve that paid for professional association services, the cost ranged from $30 to $1,450.

Thirty-three physicians' practices utilized on-line websites to help with their HIPAA implementation. Thirty-one of the physicians indicated that the website on-line assistance was free of charge.

HHS created a website to answer HIPAA implementation questions concerning HIPAA, provided teleconferences, and held seminars on the privacy rules to assist covered entities in the implementation of the HIPAA. Only twenty-one of the respondents indicated that they received assistance from HHS; and of those that did, nineteen received the assistance at no cost to their practices.

Overall, training seminars and training manuals provided most of the assistance for the implementation of the HIPAA privacy standards. One physician expended $12,000 for training seminars while the other thirty spent in the range of $150 - $3,000.

Below is a summary of the cost of implementing HIPAA by specialty and entity. Family practices had the largest amount of employee training for the first year and estimate for the subsequent year, at $97,706 and $73,950, respectively (see Tables 11 and 13). On an entity type expenditure, corporations had the largest employee training expenses for the first year and estimate for the subsequent year at $120,005 and $77,742, respectively (see Tables 12 and 14). It is not surprising that family practices and corporations were the leaders in employee training expenses since family practice had the largest survey return rate. Likewise, corporations represented more than 50% of the respondents and it would seem natural for them to have the largest employee training cost.

Table 11
Training Costs by Specialty Prior to April 14, 2003

	Family Practice	Pediatrics	Obstetrics & Gynecology	Total**
Physicians	$41,698	$14,373	$15,872	$71,943
Physician Assistants	876	484	114	1,475
Nurse Practitioners	3,883	279	716	4,878
Registered Nurse	1,290	1,470	4,080	6,840
Licensed Practical Nurse	3,883	3,188	1,020	8,091
Medical Office Assistant	5,382	1,218	1,406	8,006
X-Ray Tech	2,092	0	733	2,825
Phlebotomist	664	385	789	1,837
Non-Medical Staff	33,569	13,944	11,796	59,310
Other*	369	0	1,139	1,508
Total**	$93,706	$35,342	$37,666	$166,713
Average training cost per physician practice	$1,768	$2,209	$1,982	$1,894
*Other includes custodians, surgical technicians, lab technicians and ultra sound technicians.				
**Totals may not agree due to rounding.				

Table 12
Training Costs by Type Entity Prior to April 14, 2003

	Sole Proprietor	Partnerships	Corporations	Not for Profit	Total**
Physicians	$6,168	$13,611	$51,954	210	$71,943
Physician Assistants	456	0	1,019	0	1,475
Nurse Practitioners	186	698	3,994	0	4,878
Registered Nurse	210	3,360	2,970	300	6,840
Licensed Practical Nurse	74	1,324	6,506	185	8,091
Medical Office Assistant	665	1,274	5,929	138	8,006
X-Ray Tech	77	858	1,794	96	2,825
Phlebotomist	77	750	914	96	1837
Non-Medical Staff	3,322	10,714	4470	503	59,310
Other*	0	1353	155	0	1,508
Total**	$11,235	$33,943	$120,005	$1,530	$166,713
Average training cost per physician practice	$468	$2,464	$2,667	$306	$1,894
*Other includes custodians, surgical technicians, lab technicians and ultra sound technicians					
**Totals may not agree due to rounding.					

Table 13
Estimated Training Costs by Specialty During 1st Year

	Family Practice	Pediatrics	Obstetrics & Gynecology	Total**
Physicians	$31,339	$15,469	$9,909	$56,717
Physician Assistants	869	0	57	926
Nurse Practitioners	2,000	233	0	2,232
Registered Nurse	990	1,290	3,900	6,180
Licensed Practical Nurse	3,577	3,058	704	7,339
Medical Office Assistant	3,593	1,191	1,260	6,043
X-Ray Tech	2,068	0	664	2,732
Phlebotomist	750	0	904	1,654
Non-Medical Staff	28,745	7,786	8,256	44,786
Other*	19	0	1,301	1,320
Total**	$73,950	$29,026	$26,954	$129,930
Average training cost per physician practice	$1,395	$1,814	$1,419	$1,476
*Other includes custodians, surgical technicians, lab technicians and ultra sound technicians				
**Totals may not agree due to rounding.				

Table 14
Estimated Training Costs by Entity During 1st Year

	Sole Proprietor	Partnerships	Corporations	Not for Profit	Total**
Physicians	$1,936	$24,690	$29,881	$210	$56,717
Physician Assistants	0	0	926	0	926
Nurse Practitioners	93	326	1,814	0	2,232
Registered Nurse	150	3,960	1,770	300	6,180
Licensed Practical Nurse	0	778	6,376	185	7,339
Medical Office Assistant	360	1,689	3,856	138	6,043
X-Ray Tech	38	1,529	1,068	96	2,732
Phlebotomist	38	866	654	96	1,654
Non-Medical Staff	973	11,964	31,345	503	44,786
Other*	0	1,267	53	0	1,320
Total**	$3,590	$47,069	$77,742	$1,530	$129,930
Average training cost per physician practice	**$150**	**$3,362**	**$1,728**	**$306**	**$1,476**
*Other includes custodians, surgical technicians, lab technicians and ultra sound technicians					
**Totals may not agree due to rounding.					

Prior to the implementation of HIPAA privacy standards, physicians had an opportunity to attend seminars, conferences, workshops, in-service, etc. The personnel, seminar, and equipment/renovation costs by specialty and entity types are shown below in Table 15, which reflect the total costs of HIPAA implementation for all physicians responding to the surveys. The equipment cost is the accounting historical cost (in accordance with generally accepted accounting principles). No provision has been made to amortize the cost of the equipment over the estimated useful life. Assuming all equipment had a useful life of five years, the $810,525 would be spread over the five years the equipment would benefit the practice. The total two-year costs of implementation would be reduced to $678,693 and the overall average cost would be $7,712.

Table 15

Total Physicians' Costs for HIPAA Implementation

	Personnel Cost	Cost of Seminars, Workshops, Conferences, etc.	Equipment and Renovations	Total	Average Cost
Specialty					
Family Practice	$167,655	$38,552	$555,277	$761,484	$14,368
Pediatrics	64,368	9,718	161,107	235,193	14,700
Obstetrics & Gynecology	64,620	9,570	94,142	168,332	8,860
Entity					
Sole Proprietorship	$14,825	$5,878	$142,835	$163,537	$6,814
Partnerships	81,012	9,074	133,238	223,324	15,952
Corporations	197,747	37,288	508,092	743,127	16,514
Not For Profit	3,060	5,600	26,360	35,020	7,004
Overall	$296,643	$57,840	$810,525	$1,165,009	$13,239

Seventy-two respondents estimated their pre-April 14, 2003 costs of implementing HIPAA at $507,631 vs. $685,426 actual cost. Thirty-seven of the seventy-two respondents incurred costs greater than what they had estimated. The aggregate amount greater than the estimate was $223,392. Thirty-four of the seventy-two respondents incurred cost less than their estimated cost. The aggregate amount less than the estimated amount was $401,187.

Fifty-two respondents estimated a post April 14, 2003 cost of HIPAA implementation of $184,432 vs. the computed cost based on their data of $298,409. Eighteen of the respondents exceeded the estimate by $215,141. Thirty-two respondents computed costs were less than the projected by $101,268.

DISCUSSION

Introduction

This chapter discusses the findings and interpretations of the surveys. Due to the percentage of responses received, no generalizations are made concerning the cost of implementing HIPAA throughout the entire population of physicians' offices in the state of South Carolina. The chapter concludes with some recommendations for further research.

Application of Literature to Findings

As mentioned in the literature review, the most comprehensive studies done on the cost of implementing HIPAA have been done on hospitals and were focused on transaction code sets. HHS performed a detailed study on the cost of implementing the privacy standards by estimating the cost of each provision of the privacy standards (See Table 2). These costs were then assigned to the industry by their Standard Industrial Classification (SIC) code. It would have been impractical and unrealistic for HHS to define the cost at a lower level than the SIC codes for the entire healthcare industry. The average estimated costs in the initial year and over a ten-year period of the offices and clinics of doctors of medicine per HHS were $3,703 and $22,474, respectively. When compared to this study, the average cost computed for the respondents was $13,239 for a two-year period.

In 2002 Duncan surveyed thirty-four physicians' group practices comprising thirty or more physicians. The results of the eleven responses are shown in Table 16.

Table 16
Estimated Compliance Costs for Large Group Medical Practices

Organization Type	Revenue Category	Average Total Estimated Costs	Lowest Estimate	Highest Estimate	Number Responding
Group MD Practice	<$100M	$204,286	$30,000	$1,000,000	7
Group MD Practice	$100M - $249M	$116,667	$25,000	$200,000	3
Group MD Practice	$250M - $500M	$500,000	N/A	N/A	1
M=Million; N/A = Not Applicable					
Source: November 2001 HIPAA Panel Results: Estimated Costs by M. Duncan					

Question #8 of the survey requested income gross cash receipts for the physicians. An analysis of the cash receipts ranges and costs within each range are shown in Table 17 (see page 91). The average cost of HIPAA implementation of the fifty-three respondents was $19,854. These associations are made for comparison purposes only and no inferences are intended or implied. However, employee training comprises a significant portion of the cost of implementing HIPAA. Larger and wealthier practices would be more aggressive regarding HIPAA implementation due to the number of employees that require knowledge, awareness, and training and on HIPAA privacy standards.

Discussion of Results

A t-test was performed to determine if there was a significant difference in the training cost of family practice, pediatrics, and obstetrics and gynecology physicians

during the first and second year. The results of the t-test ranged from p-value =.07 to p-value = .78, which revealed that there is not a significant difference between the training costs of the three specialties. A t-test was also performed to determine if a significant difference existed between the training costs of physicians in different types of entities. The results of the test revealed that there is a significant difference between the training costs of sole proprietors/partnerships (p=.027), sole proprietors/corporations (p=.047), and partnerships/not-for-profit corporations (p=.049) during the first year. In the second year, there is a significant difference between all entities except partnerships/corporations.

As noted previously, there were equal numbers of rural and urban physicians (See Table 5). The average costs of implementing HIPAA for rural and urban physicians are $7,721 and $10,092, respectively, for costs incurred prior to April 14, 2003. Also, Table 5 reveals that the differences in the numbers of rural and urban specialties varied by no more than six, except for obstetrics and gynecology, which varied by nine. The variance per type entity was not more than four for any entity.

Physicians are attempting to minimize the cost of HIPAA by assigning the responsibility of the HIPAA privacy officer to current staff. This finding supports HHS' conclusion that covered entities will assign the duties of privacy officers to existing staff. Also, note that fifty-eight of the sixty-six physicians responding to this inquiry indicated that the existing staff would not receive compensation for the additional duties of the privacy officer.

Only a small number of the respondents (fourteen) indicated that they would hire a consultant to help with HIPAA implementation. Many think they can implement the privacy standards by utilizing the Internet online sources available to them by HHS and others. The surveys revealed that the cost of the consultants ranged from a minimum of $800 to a maximum of $10,000. There were no indications as to the scope of work the consultants performed; therefore, no conclusions can be drawn from the range of cost. One respondent indicated that in his opinion, consultants are what they called "HIPAA Terrorists" (experts that erroneously interpreted HIPAA as one huge privacy "cone of silence"). They further suggested that a follow-up study be done on what they call "HIPAA Extortionist" (attorneys, over zealous privacy patients, and insurance companies that will develop new insurance product lines for health professionals to purchase to pay for unauthorized privacy disclosures.)

On February 20, 2003, HHS published the final rules for HIPAA Security Standards in the Federal Register. The effective date is sixty days after publication in the register and the compliance date is twenty-four months after the effective date. The publication comes on the heels of the privacy standards, when the respondents are almost evenly split on whether there will be more changes to the HIPAA privacy rules.

Appendix K compares the total costs of HIPAA implementation for each respondent to the costs the physicians estimated. A t-test was performed on the computed costs and the estimated costs at a value of .01 indicating a significant difference between the computed costs and the estimated costs.

Areas for Future Studies

There was a significant amount of misunderstanding on what physicians considered necessary to implement HIPAA in their offices. Physicians could estimate the training staff would need for HIPAA implementation, but there was uncertainty about the actual time staff would devote to HIPAA related issues and what training was actually needed for the physicians' offices to be compliant with HIPAA. A study could be performed after the first year to determine the exact amount of time staff devoted to HIPAA related issues, how HIPAA has affected the flow of information between other covered entities, and if HIPAA has had any affect on the quality of care patients receive. At some time in the future, the overall costs of HIPAA must be calculated for implementing all of the components of HIPAA, transaction code sets, privacy standards, security standards, and the provider/patient identifiers.

A study could be performed on the number of practices that engaged a consultant to help implement HIPAA privacy standards and whether they benefited more than those practices that did not hire a consultant.

Limitations of the study

One limitation of this study was that physicians do not have a clear understanding of the HIPAA privacy rules. This misunderstanding has lead to many "myths" about what personal health information may or may not be disclosed. Many physicians have taken the attitude that HIPAA may impede their efforts to provide quality care to physician. It has been reported that over 500,000 private physicians did

not meet and did not file for an extension for compliance with transaction code sets. This researcher knows that some physicians were not fully compliant with HIPAA privacy rules on the April 14, 2003 compliance date.

Physicians do not know how to begin estimating the costs of implementing the privacy rules. They can identify the large dollar items such as equipment, but they fail to factor in printing costs, staff time away from work attending in-house training sessions, workshops, and seminars. They do, however, include the costs of the seminars and workshops but do not factor in the travel costs.

The return rate for this study was less than what the researcher desired. However, the researcher thinks the results would have been worst if the survey had been mailed earlier than March 7, 2003

Some physicians delay to the last minute any efforts to become compliant with HIPAA with the expectation that the implementation date would be extended or waived. Some physicians have taken the attitude that the Office of Civil Rights, who will audit HIPAA compliance, will not punish them too severely if they are not in compliance on the effected date.

This study, nor the survey, cannot and does not predict the physicians' practices compliance to the privacy standards mandated by HIPAA. As previously stated, the privacy standards are implemented to protect the heath information of patients. Key to the protection of the protected health information is the human element. Regardless of the costs of implementing HIPAA, the human element cannot be eliminated and no costs incurred can guarantee or identify a practice's actual and successful compliance.

Finally, a limitation in the study results from the small number of not-for-profit physicians practices that are included in the study. As noted in Tables 4 and 5, only one pediatric not-for-profit and four family practice not-for-profit physician practices surveys were received and included in the study, which tend to skew the results of t-tests and other analysis.

CONCLUSION

This study has determined that physicians do not know how much it will cost them to implement the HIPAA privacy rules. HHS thinks that the cost outlay for new equipment and facility renovations are not necessary to properly implement and become compliant with HIPAA. This researcher agrees with that premise and also thinks that compliance begins with proper training of staff, a working knowledge of the rules, and good professional judgment. The rules are mainly intended for patients and how their Personal Health Information (PHI) can be used and disclosed. To a certain extent the rules give them the tools to monitor their PHI with physicians and, within certain guidelines, determine who can receive their PHI. The major costs to physicians should be all costs associated with training staff, which may be in the form of in-house training, seminars, workshops, and on-line websites. This researcher thinks that privacy costs in the years after HIPAA can be directly related to employee training.

The investment of dollars in equipment for the implementation of HIPAA is an indirect cost and most likely will not have a direct impact on HIPAA privacy. Physicians must take reasonable steps to protect patients' PHI. With minor revisions those steps will be the same with an automated system or a manual system. It will be interesting to see how physicians view the implementation of the security standards which appears to fit well with the privacy rules.

As for determining the cost of implementing HIPAA in private physicians' offices in South Carolina, outside of training, copying, consultation, and responses to

patients' requests for copies of their medical records or to request changes in medical documentation which the physician may or may not agree.

Finally, when attempting to determine the average costs of implementing HIPAA, there are a number of analyses that can be performed depending on what factors are considered. For example, one may look at the cost by patient population, rural or urban, cash receipts, number of employees, and number of office locations. However, the bottom line is that personnel training will be the key ingredient that will filter through all of the analyses and will continuously be the recurring cost to physicians in their practice.

Table 17
HIPAA Cost by Cash Receipts Range
(000 omitted in Cash Receipts Range column)

				Specialty			Entity			
Cash Receipt Range	# of Entities	Total Cost	Average Cost	FP	PED	OB	SP	PRTR	CORP	NFP
<= 250	8	$146,891	$18,361	5	2	1	7	0	1	0
> 250 <= 500	13	257,406	19,800	6	3	4	2	0	11	0
> 500 <= 750	4	21,684	5,421	3	1	0	1	1	1	1
>750 <= 1,000	8	43,834	5,479	6	1	1	2	3	3	0
> 1,000 <= 1,250	4	119,351	29,838	3	0	1	0	0	3	1
> 1,250 <= 1,500	4	52,210	13,053	2	1	1	0	2	2	0
> 1,500 <= 1,750	1	9,223	9,223	0	0	1	0	0	1	0
> 1,750 <= 2,000	2	64,393	32,196	2	0	0	0	0	2	0
> 2,250 <= 2,500	2	149,449	74,724	2	0	0	0	0	2	0
> 2,750 <= 3,000	1	3,842	3,842	1	0	0	0	1	0	0
> 3,500 <= 3,750	1	28,253	28,253	0	1	0	0	0	1	0
> 4,250 <= 4,500	2	85,111	42,555	1	0	1	0	1	1	0
> 5,000 <= 5,250	1	13,020	13,020	0	0	1	0	0	1	0
> 5,750 <= 6,000	1	11,899	11,899	0	1	0	0	0	1	0
> 6,250 <= 6,500	1	45,682	45,682	0	0	1	0	1	0	0
Totals	53	$1,052,245	$19,854	31	10	12	12	9	30	2

FP = Family Practice
PED = Pediatrics
OB - Obstetrics and Gynecology
SP = Sole Proprietor
PRTR = Partnership
CORP = Corporation
NFP = Not for Profit Corporation

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APPENDICES

Questionnaire

1. The Health Insurance Portability and Accountability Act of 1996 (HIPAA) was signed into law on August 21, 1996. What is your interpretation of the HIPAA act?
2. The HIPAA Privacy rules were published on August 14, 2002. How does your practice plan on implementing the HIPAA privacy standards?
3. What changes are you anticipating making in your practice that are a result of the new privacy rules?
4. The new HIPAA privacy rules cover patients' privacy and confidentiality of personal health information. How will you ensure that privacy and confidentiality standards are met?
5. In order for HIPAA to be effective in your practice, employees must be aware of the HIPAA requirements. What will you do to ensure that employees are informed of HIPAA requirements?
6. Transaction code sets are another component of the HIPAA Act. What has your practice done to comply with the standards for transaction code sets?
7. Finally, another component of the HIPAA Act is the security standard component, for which proposed rules have not been published but about which much has been written. What has your practice done to prepare for the unofficial published security standards?

Interview with Subject 1, Practice Manager
November 6, 2002

Bell: The Health Insurance Portability and Accountability Act of 1996 (HIPAA) was signed into law on August 21, 1996. What is your interpretation of the HIPAA act?

Subject 1: Basically, I feel it's a lot of rules that the offices have to adhere to, to streamline processing, so that we look more alike. Like in banking, for example, they went in and made all the transactions the same so that they were able to go over them and be able to quantify them and look over them with the same information. So it's hard for us because doctors have always had autonomy. But it's something that we're all striving to do so that it will look alike across the board, you'll be able to see us and analyze us using the same set of rules.

Bell: Do you think it's something to evaluate you?

Subject I: I think that in a sense as far as the transactions codes go that is uniformity. And with that uniformity, everybody using the same coding and modifiers, and things like that, you're able to track better. Yes.

Bell: Have you had a chance to read the Act?

Subject I: I've read a little bit of it, and frankly, I couldn't get through the legalese. I'm looking at some other things that were given to me, that make it a little bit more palatable. But I have a copy of the regulations.

Bell: The modified HIPAA Privacy Rules were published on August 14, 2002. How does your practice plan on implementing the Privacy Standards?

Subject I: Well, our practice is in a particular place in its existence. We've been in practice probably about 20 years and we have actually outgrown our physical plant. So we are in the midst of renovating to combine two suites and our practice filing procedures. Our current filing system is antiquated, so we have to get a new filing system. A new filing room is in the plan for our renovation. So it's something that we have to do because we've outgrown our space. It will have a secondary affect of helping us comply with HIPAA.

Bell: So, you think that the renovation is going to help you with HIPAA compliance?

Subject I: Absolutely, because we are using the information that we have gotten so far on HIPAA, on what they expect, what we need and what they want, to help us in our plan. In our architectural design we are going to put into place those things that will help us in HIPAA compliance.

Bell: What about the actual implementation of HIPAA as it relates to other things like patients' privacy and providing patients with information?

Subject I: Well, a lot of the HIPAA mandates per se we are already doing in our practice. Of course, we're going to take a look at the ones we are already using and see if we can spruce them up or make them more compliant. A lot of these things we're already doing. We're already asking for consents, we already have agreements with different vendors that we use in our practice. But we're going to enhance the measures that we have taken. Paying particular attention to the HIPAA rules.

Bell: The agreements that you mentioned, are you talking about business associate agreements?

Subject I: Yes.

Bell: How many business associates agreements do you anticipate having?

Subject I: Well, I see at least four, a minimum of four. They would be our software and hardware vendor, our transcriptionist, our billing service and I think on a very limited basis our accountant, because he really doesn't see patient information. He just gets figures. I would like to have a confidentiality agreement with the accountant and our cleaning service.

Bell: Do you have any idea on (a) how much time it's going to take and (b) who is going to be doing it?

Subject I: Well I've been given the title of Privacy Officer, Security Officer and I guess Compliance Officer. It is a lot of work. I am in the process now of training my staff to do the things that I used to do, so that I can take on these functions. And that's taking time, and it's taking money, because I had to hire staff.

Bell: The staff that you hired, was that a direct result of HIPAA?

Subject I: Well in a sense, you could say yes. Because I have to be available to do the HIPAA work, which means that the things I used to do, I can't do them anymore because of my focus on HIPAA. So yes, I think there is a causal relationship there. Now, of course, I can't say all of that is HIPAA because in a practice you have to get things done, and you have to get people to work in the practice. But the level, the caliber of employees that I had to hire were hired because I had to have people that I knew could handle what I use to do. So that is kind of like a causal relationship there.

Bell: How much are you paying this new person?

Subject I: Normally, we pay in the range of $8 - $9 an hour. We had to go up to $12 to get the caliber of person to do the job that was needed.

Bell: Twelve dollars per hour?

Subject I: Yes.

Bell: On a regular 40 hour work week.

Subject I: Yes.

Bell: And that's 2080 hours a year?

Subject I: Right.

Bell: When you consider FICA and Medicare taxes and other fringe benefits, what is the fringe benefits percent that the company pays?

Subject I: Well, we pay 100% of the health insurance for the employees and the employees pay for their family if they need that coverage. And we also pay for long-term disability and short-term disability, as well as dental.

Bell: If you had to give a percent, would you say that's 5%, 10%, or 20% of the annual salary?

Subject I: It's a big percentage. It's more than 10%.

Bell: Getting back to this new person that you are hiring. What percent of the time, did you say they are going to devote to HIPAA?

Subject I: I'm doing HIPAA.

Bell: Okay, you're doing HIPAA, but they're doing what you use to do?

Subject I: Yes.

Bell: If all of your time is going to be spent on HIPAA, then what percent of your time will be spent on HIPAA as opposed to your practice management duties that you also have?

Subject I: Well, I'm thinking, because HIPAA impacts on every aspect of practice management, I really can't separate that. When I review my personnel manual that is a HIPAA function. And that's covered under the HIPAA rules. So I'm actually working for HIPAA. Basically most things that I do in the office are covered under HIPAA rules.

Bell: What changes are you anticipating making to your practice, that are a result of the new HIPAA regulations in addition to what you've already told me about the new plant, physical plant and the hiring of the new employee? What other changes do you anticipate?

Subject I: Well, the computer systems. I'm pretty sure that there's going to be some type of new version or something that's going to cost us more money. So I know that's going to happen. I know that the files that we buy are going to be HIPAA compliant. We are now seriously considering a locked file room to be HIPAA compliant.

Bell: When you say computer system, are you talking about a computer system for the entire office, or just for you or are you talking about upgrading your current system?

Subject I: I have gone to one meeting about our computer system. I have been told there is a version 10 and that it will cost $10,000 plus. I have also been told that everything would be going to an Internet based system and I kind of have to analyze if we want to go out on our own or do we still want to be under the arm of Companion Technologies which is our vendor for our software and our hardware. That's a decision that we will have to make as we get closer to the implementation date. As I see the product that Companion is going to offer us, I'll be better able to make a more informed decision on how to proceed.

Bell: Then the computer system is basically for . . .

Subject I: Transmission and billing.

Bell: Would the computer system also enhance the privacy portion of the regulations?

Subject I: It will overlap on privacy because there are certain aspects of our system where privacy will come into effect. Absolutely.

Bell: How many people will be getting computers?

Subject I: Basically we need a CRT and we need to be able to look up patient information. We will need at least 6 or 7 CRT's. There is only one unit in the office right now where you can transmit. And that's a security measure. You know, you can't do it from every computer, one computer to transmit and that's it. But we do need to have access to the information on the computer for various tasks that we do during the day, referrals, and appointments. Does that answer your question?

Bell: Yes. Let's talk about training for a second. All of your employees are going to have to be trained. Are you going to do the training since you are the privacy officer?

Subject I: Correct.

Bell: How much training are you going to give your employees?

Subject I: Well as I hire employees I start the training right then. In a way it's hard to distinguish what is HIPAA related as opposed to what we would normally do. When you're in a medical office each employee must sign a confidentiality statement that they will not discuss outside of the office, patient's medical information. That's a common sense thing, but it is covered under HIPAA rules. So it's kind of hard sometimes in the course of doing your practice management to say well this is HIPAA and this is ordinary business training, because they really do overlap.

Bell: Do you anticipate having a concentrated training just on HIPAA?

Subject I: Yes. I will say this is HIPAA, but it will also be a review of procedures and policies that they have in place.

Bell: Would you have normally done this training if HIPAA had not come along?

Subject I: See that's what I'm getting at. We would have done some of it. We would have done confidentiality. But it will be more intensive because of HIPAA.

Bell: Do you anticipate hiring a consultant to help you implement HIPAA?

Subject I: That's a good possibility. I don't know right now if it's necessary because all the rules aren't in. But you know, certainly it's a big effort and yes you might need some help. We might need some professional help.

Bell: The new HIPAA policy rules affect patients' privacy and confidentiality of personal health information, how would you ensure that the patient's privacy and confidentiality standards are implemented?

Subject I: The training of the staff. We are doing an office brochure for the patients so that they know exactly when they walk through our doors what to expect. Our office hours, the providers, their backgrounds, the financial agreement between us and the patient are items that we are reviewing to ensure compliance. If their insurance company doesn't pay, we expect them to pay, in a reasonable amount of time. We expect them to know their insurance and keep us abreast of changes. There's a brochure being developed now that when they come in they know what to expect from us. And then also HIPAA related, we're designing new consent forms and release of information forms and things like that. We will design a new fax form for fax transmittals. We're taking a look at what HIPAA is telling us and then integrating it into what we already have. If we need to do something totally different we will do that, to be in compliance.

Bell: These new forms that you spoke about. Are they being printed outside or inside the office?

Subject I: I would think right now it would depend on cost. That's a cost factor that has to be kind of weighed. But if it's cheaper to have them done out then I guess that would be the way to go. But we have capacity right here inside the office to print our own forms.

Bell: In order for HIPAA to be effective in this process, employees must be aware of the HIPAA requirements. You have already said that you plan to have employees trained. Do you plan on sending any of them out for additional training or as a back up to you?

Subject I: We're such a small office that although it may be a good idea, it's very difficult for someone else to be out of the office day to day. That really would cause us a problem. I would have to hire someone to take their place and then they wouldn't know what to do. It seems to work a little better if I go and translate the information to my staff. Of course, there are some things that the nurses need to go to and they go to school, go to class. Each staff member is given money in this office to pursue a course. If the receptionist wants to take something that will enhance her ability, that's fine. Everyone is allowed something each year for improvement.

Bell: How many employees do you have?

Subject I: Eleven.

Bell: What is the average hourly wage?

Subject I: You have to divide them up, because we have the owner doctor, a doctor employee, and a nurse practitioner. Their salaries are going to be totally different and not in line with the clerical staff.

Bell: Let's look at the professionals, which include the doctors and nurse practitioner. I just want their averages. I don't want to know what their salaries are.

Subject I: Let's just put it this way. Salaries are the largest expenses of the practice.

Bell: We spoke about transaction codes briefly a minute ago. You talked about the new computer system. What else do you foresee you may have to do to implement these transaction codes?

Subject I: Well, I'm certain if we remain with our vendor, Companion Technologies we will have to go to classes with them. And to my knowledge, whomever we use as vendor will include training.

Bell: Do you have any idea as to how much training they're going to provide?

Subject I: Well, we're talking money now. Because they want $10,000 and they'll give you eight hours of training. So it depends on what they offer as their package and they haven't offered anything yet.

Bell: And you will see that your employees attend that training?

Subject I: Oh, absolutely. But see now, every employee doesn't have to be a part of that.

Bell: I understand, but whichever employee goes, that day that they are gone, is that a cost you can almost directly associate with HIPAA?

Subject I: Absolutely.

Bell: I just want to make sure I understand what you're saying. Even when you go, that is a cost you can automatically associate directly to HIPAA?

Subject I: Exactly.

Bell: Another component of HIPAA is security standards. I know the security standards have not been published by HHS. However, there have been a lot of articles in different periodicals regarding security. You seem to have read a lot about HIPAA. What is your opinion about the proposed security standards and how do you become HIPAA compliant regarding the security standards?

Subject I: Well, again because security and privacy overlap, it is so hard to say this is security when basically if you think about it, it is almost a privacy thing too. So they are overlapping and basically we're taking a look. We are doing an assessment of how you come in our front door and how you walk out, and everything in between. We will be looking to see if there are any gaps and if we are abusing people's privacy in any manner. We will be assessing our procedures phase-by-phase and step-by-step from when you come in the door and sign in. Do we need to get rid of our sign in sheet and devise another plan? Do we need to have our nurse call you just ma'am or sir and not use a name at all or let them go over to you and take your hands. We are going step-by-step analyzing areas where breeches in privacy and security could occur. So the best way that I think to do it is to actually become a patient. Walk through the door, sit in the waiting room, sign in, follow the procedure, and just look at everything I possible can see to analyze what is happening; where we maybe falling down in compliance; where our strong points are on compliance. I think that is the only way to try to get this thing done.

Bell: Do you have any idea on what cost you have already incurred as a result of HIPAA? What cost you plan on incurring during the next year and what the future cost would be on an annual basis?

Subject I: That is kind of hard, because I know I have incurred additional personnel cost by hiring additional staff. This staff I would have normally paid $8 or something like that per hour, but now I have to have people who have a degree that they can handle more and I have to pay them more, because more is expected of them.

Bell: I would suspect that you have a number on the cost of what you have sunk into HIPAA, outside of personnel cost?

Subject I: Well, I purchased the two computers and scanner because we are going to be Internet based now. I'm investigating how much it's going to cost for a DS outline. So I would think I have spent about $1,500 so far. I went to Atlanta to a seminar to learn more about HIPAA. The seminar was free, but of course I had to pay to get there and to get back. I spent maybe $100 on that. This gathering information as part of the office managers for the African-American doctors we kind of get together and try to share information and we have been meeting and we went to an online HIPAA seminar. That of course was time away from the office. So that was money as well. We're trying. It's going to cost money. There's no way to get around that.

Bell: Is there anything else that's related to HIPAA about the Privacy Act and what you're going to be doing that we haven't discussed that you can tell me?

Subject I: Well, again, I'm sure there are many things that I cannot really tell you, until I get into it. Again I have studied the assessment, looking and ordering things and looking in catalogs. How would this fit in? Again, we're in the midst of renovation. So we're dealing with that, we can't just put clear things on the side of doors because that's a HIPAA violation. Only the number to be exposed but never the name. We do not need to leave charts on our desk. So I have locked rolling carts where we can put charts in.

Bell: The rolling carts are another type of equipment that you have been considering purchasing?

Subject I: Rolling carts that lock.

Bell: That lock?

Subject I: So that the doctors may need ten or twelve charts to work on, but we still need them to be secure. We are thinking of all kinds of things so that our flow is not interrupted and we are able to get the job of taking care of patients done, which is our number one concern. But also we know we want to be in compliance because we cannot, as a practice, absorb any kind of massive fine. It will shut us down.

Bell: This Internet base. Is it special for doctors?

Subject I: Well, what's happening is there won't be anymore. It seems that if we were doing it the way we are doing it now, we would need to have agreements with every insurance company that we billed to. Okay, so that is impossible. So now what they are saying is we are going to get the identifier and some of these other things and we are going to be able to transmit all claims over the Internet. What was happening before, we were going through Companion or clearing houses. We don't want to do that. We can go directly over the Internet and file our claims.

Bell: Then you won't need your billing system any more?

Subject I: Well, with our billing service, we don't send anything to them. They come in house and put our claims in.

Bell: So really you do your own claim filing except that you just use somebody outside to input?

Subject I: That's it. Because of the way we use our billing service system we would keep them. Again as we travel down this road we will get a better idea of what's myth or what's fact. And right now there's so much myth out there that you really need to be cautious, because you could spend a lot of money unnecessarily. And for Dr. X or Dr. Y, both African American doctors who treat poor people, we can't afford that. We can't afford to lose money. So I have to be very cautious. I went to the meeting in Atlanta and I heard people telling me, well we got this, we got that. I got phone calls this week; the Total Medical Compliance was the name of the organization. Do you need a consultant? We just want to come over and do an evaluation or your HIPAA compliance. Have you started? You know people see an opportunity to make money. They ask, 'Are you HIPAA compliant now?' I liken it to Y2K. There was so much hype. The computers are going to crash and basically it was a money thing. It was pay some more money. Upgrade equipment that didn't need to be upgraded, but you didn't know that, because you were caught in the big lie. So you pay the money because you're

thinking, oh my God, what if? You pay the money. Y2K happens. It's a great night. I had a great night Y2K. I went to Church. But people spent a lot of money. People made a lot of money and it was really quite unnecessary.

Bell: There was a study done by Blue Cross/Blue Shield that said that privacy was cost about 43 billion dollars over a ten-year period, for physicians and offices implementing the privacy standards. Give me your reaction to that.

Subject I: God help us. God help us. Because it seems that the insurance companies are getting richer. They're charging more money for premiums. They are not paying us any more money for the services we provide and they are giving us a whole lot of paper work that no matter how efficient you get it's too much; too much to have to do a referral to another doctor's office before a patient can be seen. We called and made the appointment. It's too much. I don't know the answer to that. But I know that the health system in the United States is headed for a deadly fall. We are just on the brink and that's the truth. We can't accept Medicaid. We can't accept any more Medicare patients because of the reimbursement. So where are those people going? We have to send them to government funded agencies that are going to clog that system up.

Bell: Didn't Medicaid go up? And didn't they come back down in reimbursements?

Subject I: What happened is that Medicaid stops paying if you have a secondary insurance and the secondary pays more than they pay. For example, if you have Medicare and Medicaid, Medicare paid $43 for a 99213, which is a regular office visit, Medicaid paid $21.51. Medicare said okay we allow this much and you have Medicare deductible of $100 okay we'll send that over the Medicaid. Medicaid is saying, well you know that they allowed $46.51 and that's more than we allow, so we're not going to pay anything as the secondary. And you can't bill the patient for that $46.51.

Bell: So you're seeing the patient for free.

Subject I: For free.

Bell: And if that happens twice, you've seen them twice or 2 ½ times almost and you can't get any money out of them.

Subject I: Exactly. And when we get paid, we're only going to get paid 80% of what Medicare allows. The other 20% we have to eat. That's the problem.

Bell: Thank you again for you time and patience.

Interview with Subject II
November 15, 2002

Bell: The Health Insurance Portability and Accountability Act of 1996 was signed into law on August 21, 1996. What is your interpretation of the Act?

Subject II: General interpretation is that it is to provide a better-organized healthcare system. To provide insurance healthcare in whatever form for anybody that leaves their job and goes somewhere else. Those are streamlined things. Right now every insurance company can have whatever rules and regulations they want. Identification numbers. HIPAA will require everybody to get a different set of identification numbers. Currently, there are no specific rules on what you can and cannot say in the office or what can and cannot be seen. From the classes that I have been too, most of the people are concentrating on those types of issues as far as the Privacy part. And that is our focus. That's the part that goes into effect in April and that's where we're focusing on right now. We did the extension on the transaction code sets, mainly because our computer company doesn't know yet. We have an extension until October of next year. The general thing is, it's going to be a real shake up in how you do everything in your office to ensure privacy, more than anything for the patient and continuity of care. It's supposed to simplify things, but everything the government says is that it is supposed to be simple. I'm not sure this is what HIPAA is going to do, but we have to give it a shot because that is what they say.

Bell: You mentioned the HIPAA Privacy. It was published on August 14th 2002, how does your practice plan on implementing the HIPAA Privacy Standards?

Subject II: My understanding is that we have to have a Privacy Officer, who probably is going to be me. Hopefully I will have someone to help me out to relieve the volume of my every day workload. We have already started small things in our offices such as making sure there' is no list posted anywhere that has patient's names on them. Sign in sheets are going to have to change. How we handle general trash will have to change. We will either hire a shredding company or get some kind of shredders in all the offices. It is going to be an expense, either way. Training the staff is the biggest part. We don't have a formal training program yet and I think Dr. X will have me or hire someone who will

give us a training program. There are forms that are required. We will have to post the privacy notice on patients' rights. We will have them sign forms. You don't have to use the consent form in September but there's another form in my mind.

Bell: Authorization?

Subject II: Yes, authorization. We have to have all those signs. We have to get the forms printed up. My initial goal was to have everything in place by January 1st, so we could start with the New Year. But we're also building a new office, which seems to be taking a lot of my time. At the last meeting I went to everybody was laughing and saying they were putting it into effect April 15th, it's due April 16th, and they are waiting until then. We're getting it in as quickly as we can, but we're relegated to a point where I have to sit down and get something formal going. I got lots of general information, I just haven't had time to sit down and put it together.

Bell: Privacy Officers. The rules state that you have got to have a Privacy Officer. You have said that you are probably going to be the Privacy Officer and your duties are going to change. Are your duties going to be assigned to somebody else or are you going to hire somebody to take up the slack? If you take over the Privacy Officer and have to hire somebody that will be an additional cost that is a result of HIPAA.

Subject II: Right.

Bell: Can you respond to that?

Subject II: I would imagine Dr. X's response would be that I would be getting paid to do what I do and that too. I haven't talked to him yet. I had one employee interested in being involved in it [HIPAA] and I think that I would probably pull from staff that we have. But, that may mean an additional part-time person to take up that person's place. We have not gotten to a point where we can visualize how much time we are talking about. I think once the initial thing is set-up, once training takes place it won't take that much time. As the Privacy Officer, I will go through and observe to make sure we're following all the rules. It won't be a major thing past the initial set up.

Bell: The other thing you mentioned was shredding general trash. You mentioned that you're going to have to buy some shredders or hire a

shredding company. Have you'll really considered hiring a shredding company?

Subject II: Yes, I got a firm. Someone left some information awhile back and I really sort of put it on the back burner because of having four locations; basically five locations with this office. All of our trash is sensitive. To be able to have trash put in bins and have the shredder company come around to shred the trash maybe just as cost effective as buying shredders. The size of the shredders we have to get is going to be very large and I'm going to have a person day to day to be a shredder, when are they going to shred, how are they going to do it? How big of a shredder is it going to take? Right now we got a little one over the trashcan that if you put four pieces of paper in it, it jams up. Well that's totally impractical. To get someone to do the volume that we have will be costly, but paying an employee to be a shredder is sort of against my grain of common sense. It's not too cost effective. That is why I am interested in checking into the shredding company. I have no idea what their cost is running. But I would be interested, because that would simplify it and we would have one big bin pretty much, where everybody can put everything in. My understanding is that they are sealed. Just like a mailbox. You put it in and you can't take it out. They come pick it up and shred it on site or take it away to shred it. But it's their responsibility once they get the bin, which release us. That's an ideal thing.

Bell: You mentioned something about additional expense as a result of HIPAA, can you expand on that a little more?

Subject II: Our Y Office for instance, is completely open. The waiting rooms, the check-in area where patients checked in, is all one open area. There is no separation whatsoever. That whole office really is an open area in a circular pattern. The lab is right behind the check-in area, so anything that is said can be heard; the medical records are open. There's just an opening, not a door or gate. It is a cabinet top height that divides the two. We're going to have to look into something for that. The new building that we just built, we are going to have to make an adjustment for that. We will install more privacy type cubicles that we did not initially need to have. Every office will have a designated spot where we can talk to people about their accounts. We have not looked into the dollar value yet. When I filed the extension I think one of the categories was maybe 0 - $50,000 and we checked $50,000. I mean I would think that when it is all over, with printing, training, what we have spent going to schools to learn what we need to do $50,000 would be close.

Bell: How many employees do you have?

Subject II: I have 87, I think. Not counting doctors.

Bell: Not counting doctors you have about let's say 90 employees? Counting doctors that would be . . . you have about 16 doctors?

Subject II: Right.

Bell: You're talking about 105 people. If I understand the HIPAA regulations correctly everybody has to be trained.

Subject II: Correct.

Bell: How much training do you anticipate for all employees, excluding doctors? When I say how much, I mean in total of number of hours?

Subject II: Our offices have what we call team leaders, our head nurse and head receptionist. I would probably spend a large amount of time with them. I've already started introducing them to HIPAA policy. They didn't know anything about it, what it meant or anything. So we started introducing that to them. And some offices have already started making little baby steps from something as simple as no chart racks on the door, turning the name on the chart to the wall rather than how we usually just pop them in there. Doctor's schedules are now in a folder. So those are little things, they will not cost anything. I get emails every day from different places that have training programs. I think Dr. X has some training information that we use in our offices. I don't know what all is involved yet. I would hope that in a lunch hour kind of time, we could do the meetings. It may take a couple in each office, it just depends on what kind of program I put together. The more they know and understand the better the chances of them following the rules. If you gloss over it and they don't understand the real need for it, we're mandated to do this, it's not something on which we have an option; they have to do it and that basically their reviews will be based on their willingness to comply with the rules. It's an ongoing re-enforcement thing more than anything else. We get busy in the day to day operations of trying to take care of our patients; you lose track of all the little details that you have to watch out for.

Bell: What I'm hearing you say is that training is important and the amount of training may be determined by the job classifications.

Subject II: Right. I think so.

Bell: The doctors also have to be trained and sometimes they are some of the worse ones to train, because they think that all they are there for is to practice medicine.

Subject II: Right.

Bell: Do you have any idea of how much training you're going to give them? The number of hours . . . half a day or full day?

Subject II: We have a monthly meeting, which is about an hour or close to two hours if we can get everybody there on time. Our doctors are very progressive, most of them know about HIPAA already. Most of them have read articles and are very aware. There are only a few who bury their heads in the sand and don't want to know, just want to see patients like you said. But I think when they understand the importance of it they will tend to be reading more and Dr. X will probably take on the role of training the physicians so that they understand the importance of it. Or at least, if I did the training he would be there to re-enforce it and to make sure they understood that this is not just a fly by night thing. He would make sure that they stay and take the training. We have a Compliance Committee because we are so large we have different committees that manage the practice. HIPAA is part of the Compliance Committee's responsibility. But there's so much going with just compliance that we're really going to get a sub-committee for HIPAA. So the committee would probably be the one that I will get to help me out. I think they will be receptive to it. Everybody is concerned about the privacy part of HIPAA. They don't really have a clue about the codes sets and the electronic part of it. They don't necessary need to be concerned with codes sets because that is really the billing department.

Bell: How many patients do you have?

Subject II: Twenty-five thousand.

Bell: Twenty-five thousand patients?

Subject II: Yes.

Bell: So if you talk to 25,000 patients, a consent form for each patient, you're talking at least 25,000 consent forms?

Subject II: Yes, that is an expense. We were talking about the class that I went to last week. Dr. X and I both went. It was not the best I've been to but one of the things we talked about was that exact thing. Are you going to have a printed copy of the Privacy Notice and all that kind of stuff? And the consensus there was that most people are going to have something big framed on the wall. People will be given the consent thing that they have to sign, they will be notified that if they want copies of the privacy notice it will be available to them; but please read what is on the wall. We will probably put them [privacy notices] in the exam rooms so that we don't make 100,000 copies of them. That was one of the things we talked about.

Bell: It is my understanding that these privacy notices are to be placed in the waiting area and a copy given to the patient.

Subject II: I think if you want one, here it is on the wall, please read it. And if you want one I'll provide it to you. So we won't necessarily make 25,000 copies. How much mail did you get from your bank that you looked at? You know, and that's what we're assuming people will do. But there will be cost to get them put on the wall; they have to be big enough to see.

Bell: You are building a new facility. You mentioned that because of HIPAA you had to make some modifications. What changes did you make because of HIPAA, how much do the changes cost?

Subject II: We caught it early enough. This was one of the first things that I reminded Dr. X about. The patient check out was my biggest concern in that area. The Z office; we're going to have to do something there. Rather than structural changes we may rope off areas like the banks to control patients at the entrance window. We may have music overhead coming down at that spot, to muffle sounds. So we could do things like that which are fairly cost effective. But the Y office and the W Street office really are very open. We are going to have to figure out something there. And we both know if you do anything structural, no matter how extensive, it's going to be some dollars.

Bell: What changes are you anticipating making in your practice that are the results of the new HIPAA privacy rules?

Subject II: One thing we have to look at is that records have to be locked up or in a locked area. That interpretation is so wide, people that I've talked to have gone out and bought these things that come down over their chart

records. From my understanding we don't have to do that if they are in an area that can be locked. My understanding is patients should not have access to open records. If the maintenance is in there vacuuming you have your agreement with them. However, in the Y office there are no separations for locked records.

Bell: The way I read the rules is that you must make a reasonable effort to secure your records. You are absolutely right. If files are not in a locked file cabinet, they should be in a secure area.

Subject II: Yes, that's what we have. But we have doors close enough everywhere that make that separation. I talked to one lady who said they have real problems because their charts are down the hallway. They have grown so much they have a rack down an open hallway. That's where all of their medical records are. They have a problem in my estimation. All of our charts are within an area that is designated as check in. There are doors, it might not be a locked door, but there is separation that patients could not just wander through and have any access to them. Something we're pretty well comfortable with.

Bell: The new HIPAA privacy rules cover patients' privacy and confidentiality and personal health information, how would you ensure that patient's privacy and confidentiality standards are met?

Subject II: When you say from the privacy officer and all of that stuff you have to make every reasonable effort. Most people have not gotten into reasonable efforts. And we will certainly make reasonable efforts. We've already made changes as I said. Our schedules that are given to doctors everyday are now in folders. Things that we had up on the wall, lists of children that needed immunizations and things like that is down off the wall. Chart racks were turned in against the wall rather than out against the wall. Check-in where we used to have them sign their names, the time they arrive, the doctor they were going to see, and why the reason they are there, is now their name and the doctor. We've heard things as far as giving people numbers when they check in because you couldn't call their name or you can call the first name but you couldn't call the last name. You can call the last name but you can't call the first name and all that kind of stuff, so again reasonable. What we say now is, "Susie, you can come back now," or whatever. Those kinds of things I think we have control of anyway. Other things we talked about are the right to access their records and the right to make changes, but the changes have to be approved. Patients just can't come in and mark out what they don't want and all of that kind of stuff. But

they have to be made aware that they do have that right. And that has to go through the privacy officer. Those things aren't that big of a deal to me. We must be careful discussing patient health information because our offices are so open. It's a sad fact if a mom calls on the phone and is a bear to the receptionist she's liable to hang that phone up and say, 'that stupid Mrs. S, I'm so sick of her calling about that brat of hers.' Well that's inappropriate anyway, but those of the kind of things we have to be very careful about. Even the physicians walking up front with a chart and saying, 'Mary Nurse, I need you to call whatever specialist and get Susie Smith an appointment.' You can't do that because there could be heard by someone else. So those are the judgments that are going to be very, very critical to the doctors. Again it is reasonable, but I think if we are going to make changes and we're going to be compliant then you need to do the best you can do to ensure that you do it in as much detail as possible.

Bell: One thing that you talked about was the sign in sheet. Somewhere I read that if you have a sign in sheet, you can put down the name and check in time. You are saying you need to put the doctor's name also. Someone said it is a good idea to rotate the sheets periodically, so that an afternoon check in will not see a morning check in. Any comments on that?

Subject II: In our offices the sign-in sheet has maybe 25 names on it. When you got five doctors in the office and they're seeing about 30 patients a day, those sheets rotate very quickly. Just in general, they're filling up. When it's finished we put it under the counter; it does not stay there. You would be amazed at what patients will do. If they're standing there and a chart is on the counter, we've seen them just flip it open, somebody else's chart, and look through it. I have saw a patient looking at the sign in sheet to see who else is there. Now we mark through the names, after we see them. You never know.

Bell: What about the fax machine? I have been in doctors' offices where fax machines are in the open receptionist area where anyone can read the fax.

Subject II: In most offices again, they're all in a close area away from people, except for the Y office. I'm glad you asked that because I had not thought about the fax machine and where it sits. It's not in a good place right there. So we can move that. But most of them are in a separate enclosed area. So there wouldn't be a problem there. I think XX office actually is not faxing any more. We've heard extremes from one thing

to the other. Can you call a person on the telephone? Can you leave a message on the voice mail, to confirm an appointment? Every time I go to a meeting I hear something different. So I'm waiting until the final thing comes out. It will probably be April 15th.

Bell: You know it may not be until April 15th of the following year that it all settles down.

Subject II: That's true. Our take right now is that we must have a confidentiality statement on our faxes. Generally we don't fax a lot of stuff anyway, because it just gets out of control. People want you to fax everything. We don't do that normally. So most of what we're faxing is really more interoffice stuff than outgoing that would be patient records.

Bell: In order for HIPAA to be affective in your practice, employees must be aware of the HIPAA requirements. What would you do to ensure that employees are informed of HIPAA requirements? I know you talked about training.

Subject II: Right.

Bell: You talked about a training program. Is that a specific program that you have in place now?

Subject II: We do not have it now. But I want to have one and I will go to every office and have meetings where I will go over how important this is. I will inform them that this is not just a fly by night thing that we are talking about and you can forget about it, like employees like to do when you tell them they have to do something different. Nobody likes changes. And we are very set in our ways here. So it's not something that's going to be an option. It's a requirement and it's going to be part of your annual review. This year we have actually added a HIPAA category for employees to be compliant with for their annual review. So we sort of slipped it in there because we don't really have HIPAA in place yet. But we do have confidentiality agreements that everyone signed and common sense statements that people should do.

Bell: Do you anticipate buying/investing in more computers because of the privacy rules? This is kind of a two-part question - the transaction codes might necessitate more computers; but did privacy also play a part in it?

Subject II: I don't think we would probably have to get many more because we have pretty much one everywhere. We need them now. We have so

many computers now because just about every clerical has to have a computer. Nurses have to have computers to look up patients', names and phone numbers and that type of stuff. So it's just that we won't have many more. What we are looking at is the electronic transmission part of it. We do electronic claims now, but I've been talking with the phone company, on the new phone system for our new facility and we're talking about firewalls and that kind of stuff that I didn't know anything about. But it's a given that we need something like that for privacy or protection. And we'll probably go to an on-line type of transmission where we can access a lot of information on line. You can now go to the insurance companies and find eligibility, dates of eligibility, if a patient is covered. Part of that is something that we need to be doing.

Bell: It is a part of it, because ...

Subject II: You're talking about the privacy part of it.

Bell: Yes, privacy, and you said that basically all receptionists have computers on their desks, have you thought about maybe some type of passwords?

Subject II: Yes, they have simple passwords now, because we never thought about any of this. But one of the things I would like to be able to do is sit down with our Billing Department Manager who assigns people their passwords as they come on and reclassify everybody. Because right now everybody pretty much has access to anything. And part of this is to reclassify and those that only need to be able to look up a patient do just that. So we really have it too open now, and I've known that since way before HIPAA came into effect. So we'll reclassify that and then probably change the password on a regular basis. When you have 87 people though you sort of run out of passwords.

Bell: Transaction Codes are really not privacy but I have a question on it. What is the practice policy to comply with transaction codes? I know you have already filed for the extension.

Subject II: Right.

Bell: What were the reasons you needed to apply for the extension?

Subject II: Well, the main one is our Medical Office Manager Program (billing program) is not ready. So we're investigating that. We did get a quote from them for what they said it would cost to upgrade our system to be

HIPAA compliance. Which was I think, they told me $7,000 or $9,000. We're not happy with the program that we have right now, so we're actually looking at completely new systems. That would be a very big cost, to do something like that.

Bell: You are looking at changing because of your dissatisfaction with the program; HIPAA just helps support your dissatisfaction?

Subject II: Right. So we know that it's a $7,000 - $9,000 base figure right now. I am sure by the time they finish it would be more than that. We have a billing system that is very organized. The program is in place and the system is ready for it, we will be able to relatively easily convert to the new program upgrade. One of the classes that I went to suggested having 90-days worth of operating cash in the bank. Their thoughts were that the Y2K was nothing compared to what this would be. I am not sure that I agree with that because that's a little extreme.

Bell: I found in my research that when HIPAA first came out the cost became a major issue. HHS initially said it would cost $3.8 billion. Blue Cross Blue Shield did a study and estimated the cost at $43 billion over a ten-year period. There were quotes that HIPAA was going to make Y2K expenditures look like pennies. Those types of quotes got me interested in this project. Is it really going to get that bad? I really don't know yet. Everything that I've read thus far has been focused on hospitals. Nobody has really focused on physicians' practices. HHS came up with an annual cost of HIPAA after the first year of $342 per physician practice. I think that is low but I don't think it is as high as everybody else says.

Subject II: I don't either but then you know that's not looking at the small things. The thing that is going to hurt is the one person or two-person group practice like your brother. They are going to have somebody trained in their office. I think they are going to have to make a lot of changes in their office setup.

Bell: His office set up is OK as far as the physical layout. They have a window; you have to be buzzed in; all files are in a secure area. It's good in that respect. You're talking about open like open in your Y office. If he were open like that he would really be having a problem. But it's going to cost him some money that he doesn't even know about yet.

Subject II: We are not going to be able to track every dollar we spend on HIPAA. I don't think it is going to be tremendous for us. Everybody's going to have to make some changes.

Bell: Are you going to have all of your privacy forms printed outside of the practice?

Subject II: Yes.

Bell: Another part HIPAA is the Security Standards, for which proposed rules have not been published. What has your practice done to prepare for the security standards?

Subject II: At this point I have ignored security. I figure that I am covered under privacy I am probably covered on Security and that was one of the things that we have talked about. I think if you are working on your privacy, a lot of the security is going to be in that anyway. I am not familiar with the security part of HIPAA. I am not even worried about the security part. I am more worried about the codes and being able to transmit claims and get paid. That's a big concern. Is it going to work when somebody flips the switch?

Bell: Have you considered hiring a consultant?

Subject II: No. Dr. X works independently. You know, he thinks he can figure it all out and he's not going to give his money to somebody else. He thinks we can figure it out. He is so smart and involved in everything. I think as long as you are making every effort to be in compliance as you go down the road, you will learn more and more and you will make the changes you need. But if you're showing the effort to do what needs to be done I think everything will be okay. I hope, knock on wood.

Bell: I was reading an article Wednesday that estimated that 550,000 physicians had not filed for the extension on transaction code sets.

Subject II: Dr. X told me something about that the other day. I think it was the same thing he read; the same number. They are not ready. Those are the people that don't have a clue.

Bell: HHS doesn't know what they're going to do with those physicians. There is no mechanism in place for wavering or penalizing the physicians. They are not going to come out and put the hammer to

them. I think they are going to try to get them in compliance if something comes up.

Subject II: I met people at these classes from smaller practices that have said they are not ready. They may file claims electronically and they're saying, "Well, can we just stop filing claims electronically?" I said, "No sorry. You're there already and it was my understanding that if you have already you can't change your mind." There are a lot of them that just aren't ready. It's such varying degrees when I go to these meetings of people who are way ahead of us in larger organizations, hospital base physicians who seem to be ahead of us and there are others who are not. This is the first they even heard about HIPAA. So they're completely lost and completely frustrated in trying to figure out what they have to do. The last class we went to, there was a property management lady there whose company rents spaces to physicians. She was there trying to see what they were going to have to do to upgrade physicians' offices. She was saying "Oh, my God. You know, I can't believe this is happening, this is for real."

Bell: Have you gone through and identified all your business associates?

Subject II: Sort of. It is just a small focus group that we deal with. I don't think there's a lot. They are relatively easy to identify. One class that I went to gave examples of business associates agreements and all those kinds of things. We have that. You know you can find those pretty much anywhere. It's an inconvenience, I guess. I just think it is a horrible overwhelming thing to deal with. But the fact of the matter is you got to do it. So you might as well do the best.

Bell: It's going to be an initial cost in the first year and then there's going to be ongoing cost. Some of the ongoing costs would be continuously training. Every year you're going to have to probably do some type of refresher as the HIPAA standards are finalized or become more definitive.

Subject II: Right, specific things.

Bell: Are you going to become the Security Officer also?

Subject II: I hope not. The recommendations are we've only got two sets of people for privacy and security officer. That was early on and I have not really read anything about it lately. What are you seeing or hearing?

Bell: Well, I'm hearing that the privacy and security officer are going to be the same person. Now you are a larger practice that I have talked with. The other practices are maybe 10 or 12 folks and two doctors. So going out and hiring a security officer will be a major cost. The person I was talking to was the Practice Manager. She said the same thing that you said. "Yes, I'm going to become the Privacy Officer and someone else will absorb a lot of my duties." They did hire somebody else to take over some of her duties. She said they just had to do that. They hired a highly skilled person, so therefore they were just paying up $3 to $4 per hour more than they ordinarily would have.

Subject II: If we got somebody to help me, you can take someone who already exists and say here are some additional duties and it won't necessarily be an upgrade. I'm not really seeing that this is such a huge time consuming thing, it can be either one. Once you get set up and then after that you monitor what you've done and you got to have an on-site person, which basically I am anyway. I just don't see it being a big thing. I can't imagine hiring another person just to do that... unless you are a really big entity, but then again I'm cheap. I have to worry about the money too.

Bell: Thank you for your time. I am talking to a lot of physicians about HIPAA implementation. If I can help you with anything give me a call.

Subject II: Well, thank you.

Interview with Subject III
November 15, 2002

Bell: Today is November 15, 2002 and I'm talking with Subject III, who is the Practice Manager, The Family Healthcare Center, PA

Bell: The Health Insurance Portability and Accountability Act of 1996 (HIPAA) was signed into law on August 21, 1996. What is your interpretation of the HIPAA act?

Subject III: My interpretation of the act was that the federal government wanted to assure patient privacy and security when it comes to their healthcare issues. I initially thought the act was mainly focused at clearinghouses for prescriptions refills, organic supply companies where they somehow get the information and then target market to the individuals. One day I was sitting in a room with a drug representative eating lunch. She said, "When the doctor and Al come in, I have never met him, would you make sure I know which one he is?" I said, yes I will. I asked why? She responded that he was her number one prescriber of a certain medication. What was happening is the insurance companies will buy the list of how the doctors write prescriptions, and they knew what doctor to target and which ones not to target. I thought HIPAA was mainly aimed at protecting us from healthcare marketing and things like that. I have learned since then it's more almost directed towards me and I have to do a better job protecting the patient information. I did not understand at the time all the code set issues and things like that. So as time has gone along I've learned more that the initial focus was just patient privacy. I just didn't realize it was more in the office. I thought it was stuff going outside the office.

Bell: So now you're aware that it covers pharmacists, clinics, health plans and physicians?

Subject III:: Yes.

Bell: The HIPAA Privacy Rules were published on August 14, 2002. How does your practice plan on implementing the HIPAA Privacy Standard?

Subject III: Well we're not exactly sure yet. That's a great question. Prior to the publishing date, everybody was saying this is what you got to do. As a matter of fact, I really didn't pay any attention to them until after they were published. To be honest with you, I have yet to read through the whole document. Some of the thought processes have changed over time, when we talk about the reasonableness of implementing it. So really we have just started within the last month sort of thinking of what we need to do. Our environment is a little different, because we have electronic medical records. We don't have charts so we do not have to deal with issues regarding charts that other practices have. We are starting to handle some of the privacy and security issues of electronics medical records. Our hope is in January to do a strategic review of everything we do. At that time we will determine where our issues are and where we need to go.

Bell: You understand some of the things that have to be done for HIPAA, but you are really not going to do any concentrated implementation until January?

Subject III: Yes. Since August, things have become a little bit clearer on how we should do things. So as they're doing them, we started implementing some changes already, just subtle things. Things like making sure that the encounter forms are turned over backwards. We use to have chair appointments where a patient would be put in a chair outside of the nurse station and a doctor would come and talk with him. Well those do not exist anymore. Every patient gets put in a room. In January we're going to have a full review of everything we do. We will trace our operation from the time a patient walks in the door and go through everything. Also we are waiting on our electronic medical record company to implement some stuff for us that we think will be effective for HIPAA. We are hoping that these changes will give us some extra time for HIPAA implementation. Is our deadline for implementing the security privacy issues the 16th of April?

Bell: It's April 14th.

Subject III: Okay, I thought somewhere at that time. We are thinking of gradually doing everything. We will meet with our staff on a monthly basis, in small groups. We will inform them of changes we want to make and go ahead and start implementing some stuff as we get close to that April 14th date. In January we would have already done a lot of stuff, but

we're not going to really say where we are deficient until January. Then have January through April to finish everything up.

Bell: What it sounds like is that you're going to be doing something starting in January that some practices call a gap analysis. A gap analysis identifies what is required for HIPAA and determines where the practice is in meeting those requirements. So basically what you're saying, you're not going to do that until January?

Subject III: Yes, I'm not going to do it until January, because I don't want to waste a lot of time and effort to go through a lot of stuff and then have HHS come out with different interpretations of those rules. I'll give you an example. MICES, which is the parent company of the company that runs our patient management system, said doctors need to get the Tax ID numbers and UPIN numbers on all the physicians that refer patients to you. Well, fortunately in family medicine we don't have a lot of people who refer to us. I started getting all these letters, from our specialist, saying we need these numbers and we need you to send to us soon to comply with HIPAA. Well, we just put a fact sheet together and we just tacked it to theirs and sent it back to them. Well, they were just going by what information MICES had sent out. MICES sent a letter out last week saying we really don't think you need to collect this information. We went by the strictest interpretation of the rules. HHS is now saying maybe we're not going to do that. All these people have spent all this time gathering all this data that they may in fact not use. I'd like just a little time to see how things will shake out. What if they changed their mind and you've done all of this work. It's sort of like these consultants who went out before the regulations were published saying this is what you have to do to be HIPAA compliant, and they weren't sure it was. So that's really my thought process.

Bell: Yes, but there are some things that I know they're probably not going to change their mind on. One is the privacy notice that has to be displayed in your waiting rooms or in a prominent place for patients to see. Most people say well we're going to display it in the waiting room. Other folks will display it in the waiting room and some in the exam rooms. Other things are the consent forms and the authorization forms. Are you going to wait until January to do those things?

Subject III: We have several avenues to educate our patients on. What we want to do is just make a concerted effort through all our different avenues and educate them on the multitude of things that are going on. To do that just takes a little bit longer than we want and so probably January is

when we will start the process. We want to come in and use it to do some other stuff. You're probably aware, there are some changes with advance beneficiary notices dealing with Medicare waivers and that type of stuff and that's going to take an educational process. So if we're going to have a big education process with our patients, we must capture several things in the process. We understand we got to do it. But we would just rather wait until the first of the year before we get started on it.

Bell: Were the electronic medical records implemented or installed because of HIPAA or were you going to install it anyway?

Subject III: We were going to install that anyway.

Bell: And it just so happens that it coincided with HIPAA?

Subject III: Yes. Really HIPAA was out there, but it wasn't on of our radar screen. We talked to the doctors and felt that there were some financial benefits to have the electronic medical records. We really did not think of the HIPAA benefits. I didn't think about it until eight or nine months ago. And they hit me, we can really protect patient information a whole lot better now than we ever could. Now we still have charts, but we could easily scan all the charts into the MR System if we wanted to.
If the regulation becomes where I'll have to spend a lot of money to protect my charts; I'd just scan them into the system and destroy them all and then you got to have a password and everything to get into my system. Our system now, is developing the methodology where you don't have a password or anything but you do a finger scan. So even if you know the password that's not going to get you in the system. So we see a lot of benefits. I'll give you two examples. If you're walking through our practice, you'll probably see fewer than 20 charts throughout the building. So the likelihood now of you just walking by and picking up somebody's chart is real little. We do have some concerns about physicians who print out prescriptions and things like that to get to the system and often they don't get put in the shred bin like they should. But really the EMR was not purchased to deal with HIPAA.

Bell: So you don't see any changes in your facility then for HIPAA compliance?

Subject III: No.

Bell: Okay.

Subject III: Well mainly because, from a chart standpoint, I would almost say we would scan the documents into the system rather than make changes to the system.

Bell: The EMR system was not a result of HIPAA coming into play?

Subject III: Yes. There are a couple of things that we need to do that we're working on right now, such as: password protective screensavers. The staff member would step away from the computer and the screensaver would come up; then you need a password to get back in. We haven't got it yet because we want to customize a screensaver. Another thing is a password protected individual chart. If we have patients who may have psychiatric problems or HIV problems, then we can password protect those charts from individuals who are not allowed to see them.

Bell: You mean a password getting into the system and getting into a specific chart?

Subject III: Yes. Right now the system has only two levels of security. And they're supposed to add multiple levels for us. One of the things that we would like it to do is not necessarily password protect the whole chart, but password protect parts of the chart. And so if we need to get into certain information like insurance cards, to file the insurance claim for the individual, we want to be able to get into that, but not necessarily get into the office visits or see what the diagnosis were. So there's still some work to be done. But we're educating the staff and I think in the next six – eight months those things will hopefully be taken care of.

Bell: How many staff members do you have?

Subject III: Twenty-four – twenty-five. They're seven docs and two nurse practitioners, two locations.

Bell: You have two locations?

Subject III: Yes.

Bell: So, two locations are going to have to be trained?

Subject III: Yes. We've already started the process. Like I said earlier we're working along at it. Just to really get down and dirty and say okay this

is where we need to be, we've started the process. I know how it is. You know, if committing to a lot of stuff at one time, it can be a bear. So I've decided to piece meal it and so we've started the educational process.

Bell: How much time do you think it's going to take for each individual to receive HIPAA and the privacy rules? Let's say between now and April 14th.

Subject III: The concept or the rules ...

Bell: The concept and the rules, because that has a cost. So if you're talking about eight hours and a person make $8 an hour that's $64. Do you plan on making sure everybody's trained on this?

Subject III: Yes, to some extent.

Bell: Then how much time do you think it's going to take?

Subject III: Some of the training is just that we're going to change operating procedures. I would suspect that between now and April we'll spend somewhere between 5 and 8 hours per person training. I would suspect that we will spend another 8 hours after April, probably 12 or 13 hours all of next year dealing with these issues, with 5 – 6 of them coming in the first four months. For us, suppose you said ten dollars is our average cost per staff members including benefits and everything, in what they call rated and un-rated cost, is that what it's called?

Bell: I don't know.

Subject III: Somebody asked me, "What is your rated cost?" I'm like, "What do you mean by rated cost?" Rated meaning benefits and everything, probably runs $13 - $15 an hour. So we're working at a minimum of $150 per person. So $150 x 20.

Bell: And what about the doctors? They have to be trained, also.

Subject III: We would probably not spend as much time on their training just because theirs is more common sense stuff. They would probably spend 10 – 12 hours, because you want to make sure they understand the whole process. And their time is a little more expensive too.

Bell: How many patients do you have?

Subject III: We probably have somewhere around 24,000.

Bell: Twenty-four thousand?

Subject III: Yes. Our active patients are between 12,000 and 15,000. And this year we'll have in the neighborhood of 50,000 encounters. That includes hospital encounters.

Bell: Patients are going to have a consent form.

Subject III: Getting back to the consent forms and things like that. There are a lot of things that we want to address from an operational standpoint. You know when we turn people over to collection agencies, trying to collect the money. I got to pay thirty cents on a dollar just to get the money. Well, we won't change our forms. When they sign our forms, part of the consent form, or another sheet, they're saying, "We're going to pay." If I got to go to collections I'll pay the 30 cents on the dollar to get back in to see a doctor. We want to make sure that when we go through this process we cover every thing in one fell swoop. And you know part of that delay is making sure we get everything.

Bell: Is that legal?

Subject III: Sure is. It's just like a contract. The patient has to know this sort of thing. We've implemented this for people who have turned over to a collection agency. We tell them we will see them again but you have to pay 33 cents on a dollar to come back. Because if you don't pay me $100, I will have to pay somebody else 33 cents on the dollar to collect the debt, which gives me under 70 cents. And you know, we usually will cancel all of it. But if I'm going to do it, I want one fell swoop to get it all done.

Bell: You're the first person I ever heard that says that they will kick patients out.

Subject III: It's bad when you send somebody off to collections and you only get 70 cents on a dollar.

Bell: What changes are you anticipating making in your practice as a result of the new HIPAA rules?

Subject III: One of the things we've already implemented four or five months ago is anything that is trashed with the patient's name goes in the shredder. So regardless of what it is it goes in the shredder. That's a simple change that we've made.

Bell: Are you going to use a shredder company?

Subject III: Use a shredder company? They bring in like one of these 55-gallon things on wheels and we fill it up probably every three weeks.

Bell: Is this a result of HIPAA?

Subject III: Yes. Probably should have done it a long time ago. But now the staff shred everything. There are things you don't think about that I haven't come up with solutions to yet. When we call lab results back to patients. And we say, "Can I speak with Ms. Jones?" How do you know it's Ms. Jones? You don't know. But when you mail back the stuff to the patients, how do you know, even if it's normal mail, how do you know that, that person opens his mail? Those are things that I haven't come up with a solution to yet. Maybe you could tell me?

Bell: I don't know whether you need to come up with a solution on that. This is why. The last time that patient came in you may have asked them is this still your current address? "Yes it's my current address. If you move you need to inform us." You've taken reasonable steps to ensure that patient is at that address. If that patient moves or if somebody else opens that patient's mail, that's not your responsibility. Just like mail coming to your house. To answer your question, you need to make a reasonable effort to ensure accuracy and that's all you are going to be held accountable for. So is there anything else? What other changes are you making in the practice?

Subject III: We're doing some stuff with paperwork that's going through the office and so that people who are sitting around will not have wandering eyes. Then we got to decide how we want to handle the chart situation. But those are the sort of things we're going through right now.

Bell: What about fax machine?

Subject III: The fax machine is located in a central office area that the patient don't go through. In the future our electronic medical records will now accept faxes coming into it. So one of the things that we have going on now is that all the faxes will come through our electronic medical records. Then

we will index them to the patient and send it to the doctor. We are hoping this will be in the new update coming out this fall or next winter. The only thing we have to worry about now is outgoing faxes. But with the incoming faxes we've pretty much got all that handled with the changes. Also with lab work coming in; all our lab work comes to us through our EMR. So there is no lab work floating around the office where patients might see them.

Bell: The EMR system, although not installed for HIPAA, is very beneficial and will help tremendously with HIPAA compliance.

Subject III: Yes. I do not have some of the problems other practices have regarding files because of EMR.

Bell: How much did this EMR cost?

Subject III: You buy the licenses, and the licenses are concurrent. If we brought just one license, you or I could use it but we couldn't use it at the same time. It was $1,500 - $2,000 a license, which is a one-time fee. Which is not bad for a one-time cost. Our cost for our licenses and everything like that was $75,000 - $80,000. Then you got the hardware and we made some changes with our network and upgraded our patient management system so it really came in right around $300,000 - $350,000. So yes, the EMR was not pertinent to HIPAA. HIPAA had nothing to do with the purchase of EMR but it sure is going to help us out a bunch.

Bell: The new HIPAA rules cover patient privacy and confidentiality of personal health information. How would you ensure that these patients' privacy and confidentiality standards are implemented?

Subject III: We have told our staff we need to educate them. They have easier access to records now than they have had before. We use numerical charting versus alpha charting. You had to look a person's name up, find out what number it is and then flip through the charts to find a patient. Now you just pull it up on your computer, at your desk, and you're working. So from an employee standpoint you have more access and more information than you ever had. But that access is only on a need to know basis. Our system will track whoever accesses that chart, for whatever reason. If you are a patient of ours and you say somebody in your practice is talking about my pay problems or everybody knows I got four toes versus five - somebody's talking about it. Well, our system will tell who and when the charts were accessed. So we can actually go back and say, "Why were you in this chart? You don't work in this

office. You have nothing to do with the claims. Why were you in it?" Now we have the ability to take action against an employee for getting information that they have no need to know.

The staff was told this several months ago or so. With this HIPAA stuff it's a need to know basis and I can track it. So guess what? Don't do it. The staff has learned this very quickly. We had a situation in which a patient came to us and said one of your staff members is talking about my health condition. The physician printed out the chart to the patient. It showed there was nothing in this chart about that health condition on the patient and provided information on everybody that had access to the chart. It revealed that the accused person never touched that chart. They understand stuff real quick so we made sure they were aware of the complaint and what we showed. And you know what? The patient said, "Well, the person who told me this stuff must be wrong." It was reinforcement to our staff because we had just talked to them about it.

Bell: I have read that you need to have in your policies and procedures the disciplinary action that will be taken if somebody violates one of these rules. You need to be able to demonstrate what you've done to discipline those employees.

Subject III: Yes, that's what I've heard too. It's almost like a Medicare compliance plan. You have to have it built into the system what your disciplinary strategy is going to be. Now one of the things that I've always been told in the disciplinary procedures area, and you might have heard the same thing, is you want it gray; you don't want it black and white, because you want to have flexibility.

Bell: Flexibility to do what you want to do. You want the flexibility, but you also want to be fair. You want to treat everybody the same and without favoritism, because that's something else.

Subject III: That is another employment law issue. That's the thing that we have not really thought about, that could become an issue, whether employment law come into play in this. If we go to disciplining somebody in regards to this, are we being consistent? Is there an employment issue that we don't even realize we may have? We may end up bringing employment attorneys in here. That could become some of the employment laws issues as to how we deal with sanctions and disciplinary actions.

Bell: Another thing that you might want to think about in regard to HIPAA is the employee's evaluation. Some people are saying that if a person

violates HIPAA, especially after they have been trained, it could have an effect on their performance evaluation.

Subject III: That's a good idea.

Bell: That's just something for you to think about.

Subject III: It's a great idea.

Bell: In order for HIPAA to be effective in your practice your employees must be aware of the HIPAA requirements. What would you do to ensure that employees are informed of specific requirements?

Subject III: Well, we'll have employee training.

Bell: Transaction codes are another component of the HIPAA Act. My first question is: (1) what has your practice done to comply with the standard of transaction codes?

Subject III: We haven't done anything. We have been relying on our software company. One thing that has been good for us is that our software company has kept us informed on their status on handling transactions codes and information. We already have business agreements with them. And they are supposedly coming out with their HIPAA compliant version the first of the year. Other than that we have not done anything.

Bell: (2) When you filed for the extension what were the reasons you put down of why you needed an extension?

Subject III: The reasons we put down were: (1) we were still waiting on software; (2) we were really unsure of how the code sets actually involved us. From our standpoint it was not a financial issue. Some physicians' reasons were strictly financial. But that was our main thing. One, we're waiting on upgrades in software, and two, just not knowing how it all affected us.

We can get things done with the company that we're dealing with. They have kept us more than up to date on where they stand and how it is going to affect us. One of the last upgrades that we had, in August or September, they told us this upgrade is critical because it is part of our HIPAA compliance. They've done an excellent job of keeping us updated on where we stand.

Bell: Do you plan on hiring a consultant?

Subject III: Well, yes and no. Miller Ham (not his real name) is our Healthcare Attorney, whose office is in Greenville. She told us that she would tell us when we need to start worrying about HIPAA. She has held several seminars on where we should be at this time. Our implementation process has been based on those seminars. We are going to run everything by her in February and March and get her approval on what we are doing. Yes, we're using one, but we're using one for legal reasons more than anything else.

Bell: HIPAA requires that a practice have a Privacy Officer. Who will it be?

Subject III: You're looking at him.

Bell: That's three for three. The practice or office manager is the privacy officer in every interview thus far.

Subject III: You're looking at the Compliance Officer too.

Bell: What about the Security Officer?

Subject III: You're looking at him too.

Bell: If you assume all of those duties, your current duties may have to be assigned to other staff. True or false?

Subject III: False. It may add a couple of hours to the day.

Bell: Are you going to incur any more cost?

Subject III: Yes. It's going to be gray hair cost.

Bell: Something that you don't get paid for.

Subject III: That's right.

Bell: Did you have to buy any additional computers for the transaction codes?

Subject III: All of that is being handled by the software company.

Bell: Another component of HIPAA is the security standard components, which have not been published. What has your practice done to prepare for the unofficial published security standard?

Subject III: We haven't done anything. My approach has always been as long as it is not in front of us I am not worried about it. But I think some of the stuff that we've done in our EMR system really protects us. From a security standpoint our server is at another office where you can't get to it. You can try to hack into it if you wanted to, but it will be very difficult to get into it.

Bell: When HIPAA was first published I think the HHS terminology had a cost impact. They estimated the cost at $3.8 billion. Blue Cross Blue Shield did a study and it came out with a $43 billion dollar cost over a ten-year period. Do you feel these costs are high?

Subject III: I would think $43 billion would be high. But I've heard that it will be mostly costly to operate some stuff. I think the $3.8 is a little low, $43 is a little high but it's going to cost a bunch. The thing is you just don't know. I don't see how you can put a number on it. When you look at our practice you can almost say that for us to meet HIPAA guidelines we brought an EMR system. That's a $400,000 investment. I would suspect that it would cost us maybe $10,000 - $15,000. You know I don't think it's actual cost outright. But I think it's tying up people's time. Right now you pay me anyway, but there are other things that I need to be doing that it's going to cost you because I have to spend my time on it.

Bell: Thanks for allowing me to interview you. I appreciate your time and candid answers.

Subject III: You are welcome.

Interview with Subject IV
November 16, 2002

Bell: The Health Insurance Portability and Accountability Act of 1996, commonly referred to as HIPAA, was signed into law on August 21, 1996. What is your interpretation of the HIPAA Act?

Subject IV: When you say my interpretation, I presume you mean, what do I know about it?

Bell: What do you know about it and how do you think it is going to affect your practice?

Subject IV: When I first heard about it I was under the impression that it was another piece of governmental regulation that would cost me more money as a practicing physician and that I got very little from. As time has progressed I recognized that it does have its place. However, I can tell you that the act caused me to make a significant change in my practice. I no longer do a lot of lab work that would be beneficial to my patient from the standpoint of convenience, because the regulations that were imposed ended up costing me more money. It was not cost effective for me to continue doing that for my patients. I don't have a bad feeling about it. I know that medicine changes. I understand there are going to be some changes that are going to be coming up. I just hope that the changes are not so great that it causes the private practitioner, like myself, so much money as to encourage us to get out of private practice.

Bell: You talk about cost. What cost are you referring to?

Subject IV: For an example, when we were doing lab work in my office there were certain guidelines that we did not have to adhere to. Some of those guidelines were we had to have in place certain documents present and we always had to have certain pieces of equipment in order to do certain laboratory values, and the list just kind of goes on and on. When the law came about saying that not only do you have to have certain documents in your office but also the laboratory equipment that you use has got to reach certain standards. The people that do the lab work have to attend school. The list just went on and on and on. And I just thought it made it somewhat difficult for a person like myself to try to do. I recognize

that you got to have certain quality assurance in order to practice good medicine. But I also felt that it went too far to the left. I thought the guidelines that they put in place could have been less strenuous.

Bell: The HIPAA Privacy Rules were published on August 14th 2002. How does your practice plan on implementing the HIPAA Privacy Rules?

Subject IV: I have not read enough about it to really know. I know as a result of talking to you that there are going to be some changes that I am going to have to make in regards to my record storage, make sure that those records are not accessible to the folks who come in and clean up the office, that they are going to have to be under lock and key, informing patients of their rights, and the staff will have to be more conscious of the privacy and confidentiality rules when it comes to patient information. Here again that's going to be an additional output of money to make that happen. We can't very well pass that cost on to the patient. We will end up doing it ourselves. So I'm probably going to have to spend money that I had not anticipated nor budgeted for. I recognize there will be changes, I am not looking forward to it.

Bell: What's your total patient population?

Subject IV: I have probably about 1,500 patients.

Bell: You talked about the records. Do you anticipate making any other changes in your practice as a result of the new privacy rule?

Subject IV: Well, yes. I know I'm going to have to make some other changes. I do not know what they are. The only changes that I'm aware of thus far are the ones that you made me aware of.

Bell: Are you familiar with the Patient's Privacy and Confidentiality rules? How would you ensure that the patient's privacy and confidentiality rules are implemented?

Subject IV: To be perfectly honest with you I have only become aware of it today, in an earlier conversation with you. And I had kind of superficially thought about them. I don't have a problem with that. I do have some questions about it. And one of the questions I have about it is that if a patient decides that he wants to review his medical records and he wants to talk to me about it... there is something in the chart that he doesn't understand. Am I going to be in a position to bill that patient for the time that I am going to use explaining to him what his medical chart

says? I think that since they have not found an answer to that question, it's just another indication that they are asking us (private physicians) to bear a lot of the financial burden of all the changes. I think that it is another swipe at probably forcing private doctors out of practice, because you cannot continue taking these kinds of hits.

Bell: The HIPAA standards require that each practice have a Privacy Officer. This may be the first time for you hearing about this. Some physicians I have talked with say, they have already assigned that duty to their Practice Manager or Office Manager, or they have assumed that duty themselves. Do you anticipate hiring another person to be a Privacy Officer?

Subject IV: No.

Bell: Will the responsibility of the Privacy Officer then fall on you or your Office Manager?

Subject IV: It will probably fall on my Office Manager.

Bell: As a result of your Office Manager having these additional responsibilities, do you anticipate that you may increase the salary of your Office Manager?

Subject IV: I don't know what that privacy person is going to be doing. But in the spirit of HIPAA, we probably have already been doing what HIPAA is going to demand that we do. We probably don't have some of the hardware that HIPAA will require of us, like the lock down of the files. So the answer to your question is I'm probably not going to increase her salary based on that but here again I do not know all that it is going to be required.

Bell: You recently purchased a new computer system. What were the things that went through your mind in you making a decision to buy the computer system?

Subject IV: Well, it was largely driven by my Office Manager. Our current computer system was about fourteen years old. The Office Manager was beginning to tell me that the computer could not produce a lot of the productivity and financial reports I was asking for. A billing consultant also recommended we get a new system to enhance our electronic billing which would in turn increase our cash flow, and it would comply

with the new HIPAA standards.

Bell: So, it was time.

Subject IV: My computer system was out molded. My Office Manager would attend conferences and would tell me things that other systems were doing that we needed to be doing. And so with a lot of reluctance, I did. To be perfectly honest with you I was thinking it was another financial hit that we had to take already in tough times.

Bell: It's interesting that I didn't hear you say that one of the motivating factors was HIPAA.

Subject IV: No. The motivating factor were billing and increased cash flow; HIPAA was insignificant in the decision-making. I was not aware that HIPAA would require us to do this.

Bell: There are several parts to HIPAA. There's Transaction Code Sets, which is the billing part. Then there are the Privacy Standards, which the final regulation came out on August 14th of this year. And then there's going to be the Security Rule, which we expect to be published late this year or the first part of 2003. Then there are the Health Care Identifiers. Do you know anything about the Transaction Codes Sets?

Subject IV: No.

Bell: The Security Standards are another component of HIPAA. Those rules have not been published yet. Practices are going to be required to have a security officer. Do you anticipate hiring a separate person to be a Security Officer?

Subject IV: No.

Bell: Who then will probably assume those duties in the practice?

Subject IV: The Security Officer will probably be between my Office Manager and me.

Bell: Are there any other things that you know about HIPAA that you'd like to pass on?

Subject IV: It is really going to be interesting to see how these new regulations are going to be received by physicians in private practices. I continue to

wonder who is going to pay far all of this. We're already in an atmosphere where the private doctors are taking a significant hit in reimbursement. Cuts that are coming from insurance companies and we have no control over. I wonder how we are going to survive with all of the guidelines, which have major dollar signs attached to them.

Bell: HIPAA requires that all staff be trained on the HIPAA standards. Have you thought about training for your employees? How much time are you going to devote to training?

Subject IV: Well, as much time as it takes for them to be competent. I'm certainly not going to fight it. But whatever amount of time it is going to take for them to become competent, I'll give them that.

Bell: And the other thing is that you as a physician need to be aware of all the HIPAA standards. The same question. How much time are you going to allow yourself for training?

Subject IV: Well, I plan on continuing practicing private practice and I've always prided myself in being on top of what's going on. So I'll do whatever is necessary to make myself knowledgeable on what's going on.

Bell: Thank you for your time and candid responses.

Interview with Subject V
November 20, 2002

Bell: The Health Insurance Portability Act (HIPAA) was signed in the law on August 21, 1996. What is your interpretation of this HIPAA act?

Subject V: As it relates to me, my interpretation is two fold. First of all, that I must take certain steps to safeguard patients' privacy. And the second part is that I must make my records accessible to patients.

Bell: Could you expand on that a little bit?

Subject V: I pretty much think it's almost self-explanatory. For the size of my office, there are some things that I need to do in terms of ensuring patient's privacy, protecting their records and other vital information including financial information. And at the same time allow them an opportunity to review their records upon request.

Bell: The HIPAA covers a little more than privacy. It covers privacy, transaction codes, and security. How is that going to impact your office?

Subject V: Well, that has to do with the privacy. And with my level of operation in terms of computer sets, program sets, I really don't anticipate any major changes. That primarily impacts people who are considering getting a new information system so that they can interface with a standardized program that is also being mandated. But what my understanding is the final implementation of this act is not complete until April 2003. And probably some other changes are anticipated at that time. So really there's still a gray area in terms of implementation of this act in this point and time.

Bell: The part that is going to become effective on April 14, 2003 is the privacy rules. There are four parts to the Act. Transaction Codes were supposed to become effective on October 16th of this year and has been extended until October 16, 2003; the Privacy Rule, which becomes effective on April 14th 2003.; the Security part has not been published yet; and the provider identifiers which also have not been published. The Privacy Rules modifications were published on August 14th 2002. How does your practice plan on implementing the Privacy Rules?

Subject V: I have a wonderful Office Manager who is currently doing a gap analysis to see what we need to do to become HIPAA compliant. I think for the most part we've always taken extra steps to maintain a place of privacy. So there are a few additional things we need to do to secure patients records such as lock file cabinets, rearranging some patient seating so that conversations cannot be overheard. I use an outside billing agency so we would have to institute a business associate's contract with this particular company in order to make sure that we come into compliance. We will also institute new or different consent and authorization forms as it relates to privacy and release of records and those types of things.

Bell: How many patients do you have?

Subject V: Actively about 5,000 patients.

Bell: Do you plan on producing the consent and authorization forms outside or inside of your practice?

Subject V: Most probably get a template and produce them inside.

Bell: You talked about locks. Are you talking about locks for the file cabinets?

Subject V: Doors and file cabinets.

Bell: What changes are you anticipating in making your practice as a result of the new Privacy Rules?

Subject V: In terms of the way I practice medicine?

Bell: Yes.

Subject V: I don't intend to change the way I practice medicine, very little.

Bell: Can you expand a little on how you are going to ensure that the confidentiality of patient's health information is adhered to?

Subject V: That is still being thought out. The major portion is these authorization forms and not releasing any information. Then just making sure those people who have access to records are those people that need to have those records and are authorized to have them.

Bell: One of the provisions of the Privacy Rules states that a practice must have a Privacy Officer. Have you given any consideration to who will be your Privacy Officer?

Subject V: That was not interpretation. What I'm reading is this law is liberal in some sense of latitude and different requirements would be based on the size of the practice. There are a lot of practices that really would not have a Privacy Officer. My personal view is that that is for multi-site offices, very large offices, and offices with different departments where records go through. I'm a single site practice, a single physician practice with a very small staff. My charts aren't going any place and are under my control. They don't leave the office, except in the case of testimony in court. So frankly I don't really need to have someone to be designated as a privacy officer or security officer. If they require it, it would be shared among the office staff.

Bell: I understand you filed for an extension for transaction code sets. What were reasons the extension was filed?

Subject V: Mainly the time element. And to specifically study what needs to be done. I have read that those codes are still not in concrete, they're still being negotiated and changed. Everybody recognizes that there needs to be some change and the AMA is the leader in efforts to make some changes to those codes.

Bell: Another provision of the Act is that all employees must be trained on HIPAA. How many employees do you have?

Subject V: Two full timers.

Bell: Are you willing to give your employees time off to get trained on HIPAA?

Subject V: You mean time at my expense? Absolutely.

Bell: And do you plan on getting trained on this?

Subject V: Absolutely.

Bell: Do you know how much time the training is going to take? How many hours? Let's say between now and April 14th and then within the first year after implementation?

Subject V: I don't think anybody knows what the time would be because nobody's ever been there before. But at this point in time I anticipate no more than about 8 hours initially. After that we will train as much as we need to stay competent on HIPAA.

Bell: Another provision of HIPAA rules is security, and they're talking about security of computer systems and the information systems. Is your office networked to the extent that you have an integrated computer system?

Subject V: Only internally. My network is in-house.

Bell: Do these employees have access codes and passwords to get into the system?

Subject V: Yes.

Bell: Some practices will engage a shredding company to shred all of their documents that may have patient information on it, like lab reports. Are you considering doing the same thing?

Subject V: I wouldn't do a shredding company. I'd use a shredder. I'd probably get an extra shredder.

Bell: Are there any other things about HIPAA that you would like to tell me that I might be able to use in this research?

Subject V: Right now HIPAA is still nebulous. From what I'm reading there is still a lot of latitude. I think there needs to be some more guidance for smaller offices in terms of providing guidance for patients to review their records. And I understand there's one time every twelve months that's free. I would like to know frankly whether records could be written in code that cannot be deciphered by the patient. I'll give you an example: you may have a patient who is on the brink of homicide or suicide and you may in fact not want to have that blazingly written on the chart. It may produce some irrational or emotional response for the patient. Is that patient entitled to review his records, if he wants to? Another example would be a patient that may have a disease, which you tell them about anyway, but at the time that he reviewed his records maybe under some other stress and may commit suicide. The liability, is it your liability or is it the patient's liability? Again what happens if the patient decides he wants to review his chart every three months. Can we

charge that patient for subsequent visits? Must someone be available to discuss this information with that patient? My understanding is, there's an information amendment sheet that the patient may disagree or feel the need to explain information. Must that be maintained in the chart? If that patient disagrees with the information, what are my requirements in terms of rebuttal? Or what are my legal constraints and responsibilities if in fact I have to go to court and testify? My feeling is that it will affect the recording of information and obviously at some point and time it has to affect the actual practice of medicines in terms of what is done to a patient.

Bell: Okay, I can't answer all of your concerns, but I can answer a few of them. The first one is that before you would allow a patient to review his records, typically you would go through the records and extract from the records anything that is written in there which may be referring to him as being homicidal or suicidal. That's my understanding. Secondly, just because a patient asks you to remove something from his records, does not mean that you have to remove it from his records. You can inform the patient that you're not going to remove it from his records. At this time I don't know what recourse the patient has, but you are not obligated to remove something from his record that you think is factual and based on your medical expertise.

Subject V: Suppose it affects the patient's insurability?

Bell: Now you're getting into something legal and I'm not qualified to answer. But those are just some of the things that I have come across in my reading that address some of your concerns. Obviously they don't address all of your concerns and you are not the first doctor that I have talked with that has the same concerns. These are some things that are going to have to be ironed out with HIPAA in the years to come.

Thank you very much for allowing me to interview you.

Subject V: Thank you, Mr. Bell.

Interview with Subject VI
December 12, 2002

Bell: The Health Insurance Portability and Accountability Act of 1996 was signed into Law August 21, 1996. What is your interpretation of the HIPAA Act?

Subject VI: My interpretation is primarily two things: Confidentiality of the patient records and cost reduction in terms of electronically transmitting claims.

Bell: You say cost reduction; do you really think there's going to be a cost reduction in the transmitting of claims?

Subject VI: I think if you look at it from just the cost reduction of transmitting claims, yes. Because it's a faster turn around and a lot less likely less error, I feel. Now in terms of entire HIPAA regulation or Act, is it going to be costly? I really don't have the answer to that. I am not sure of other offices but we have incurred additional costs in order to implement HIPAA.

Bell: Can you be a little bit more specific on what additional costs have you incurred?

Subject VI: Well one is from the patient privacy standpoint. We had to implement new procedures in order to maintain that confidentiality to a higher degree. We've had to purchase a new filing system and relocate it. The different notices and notifications that we have to provide to the patients or vendors and everybody else have cost us money. The ongoing training of staff is going to cost. All of that impact the bottom line for our doctor's office.

Bell: The new filing system that you installed, was that something done just because of the HIPAA Privacy Act?

Subject VI: It was purchased primarily because of the HIPAA Privacy Standards. We were running out of space and could have done it a little bit differently, but we chose to do it this way so that we wouldn't have to incur additional cost once this Act was supposed to be fully implemented.

Bell: Was this an electronic filing system?

Subject VI: No. It's still a manual filing system.

Bell: So the filing systems, basically what does it consist of, new equipment, moving, etc.?

Subject VI: At that time we had over 13,000 charts and five staff members. We not only had to move it, but we wanted to change our system of filing; we were filing alphabetically and we decided that we would start to filing numerically because of HIPAA. When we did that we had to number each chart with their account number and then come back and change our filing from alphabetical to numerical. It took us about eight months, because it wasn't anything that we do and shut the office down in order to do. So as the charts would come up the patients would come in and we would try to number it at that point. On Fridays since we schedule no patients, we try to take the entire staff to systematically go and number them. But that's not the end of it. After you numbered them all you can't just switch them over to the new medical system. You have to go through the whole system. Print out a home copy and methodically verify that every one of those accounts was numbered properly before putting it into the file. This was a very tedious and expensive process. The file cabinets cost over $6,000.

Bell: Over $6,000 just for the file cabinets?

Subject VI: Yes.

Bell: And that's not even including the . . .

Subject VI: It doesn't include any staff time. It's the file cabinets and the additional charts, the new numbering and all of that. That was actually the equipment and supply cost. It rounded out to about $6,000. It took seven staff members. We did it over an eight months period. If I had to try to confine it to say how many hours we had to spend on it, it would have been in excess of 100 hours. We actually had to take a whole week just to shutdown to convert over from alphabetical to numerical because we do have a lot of charts.

Bell: HIPAA published a modification to the regulations on August 14, 2002. Now how does your practice plan on implementing the additional

standards of HIPAA of the Privacy Standards that you haven't already covered with your filing system?

Subject VI: To be honest we are looking for an outside consultant, primarily because this being a small office and we don't have anybody to pay attention to that. So we need an outside source to be able to come in and we'll give them all the resources they need. This is what needs to be done in order to meet the HIPAA Act by April of 2003. We are okay filing electronic from a billing standpoint. The other administrative type task, we don't have anybody who is designated that can spend that kind of time to truly understand the language of the Act and make sure that we will not get in trouble down the road, because somebody misinterpreted it.

Bell: That an interesting comment that you made. The act says that each office must assign a Privacy Officer.

Subject VI: I understand and don't have a problem with that.

Bell: Have you decided who will be the Privacy Officer or are you going to hire somebody as the Privacy Officer? Or are you going to assign that responsibility within?

Subject VI: Initially we're going to rely on the consultant to give us appropriate directions. Down the road if it were too much for us to handle we would look to out source. But right now we will handle it internally.

Bell: You can out source to help you implement, but the Privacy Officer must be directly in the business. What other changes have been anticipated making as a result of the new HIPAA Act?

Subject VI: Changes that we haven't done that I know we need to do are: posting of the privacy policy in the waiting room and notifying all of our patients about the privacy. Also making sure all of our vendors have the privacy statements as well.

Bell: How many patients do you have?

Subject VI: Over 14,000.

Bell: Do you have the means to communicate the patient by way of the Internet?

Subject VI: No we don't.

Bell: Do you have a Web Site?

Subject VI: No we don't.

Bell: The vendors that you mentioned, are you referring to business associates?

Subject VI: Exactly.

Bell: Have you identified all the business associates?

Subject VI: We've identified the majority of them.

Bell: Are they truly business associates or are they just folks that may need a confidentiality agreement?

Subject VI: Well, the ones that are business associates like our billing company have been identified. Actually what's the difference between the two?

Bell: The business associates would be the person that you give personal health information to like a billing company or a transcriber. A confidentially agreement would be given to someone like a cleaning service who comes in and cleans up your office. You really don't give them any health information about the patient but they may happen to see a file on the desk and may recognize the name. Or they may just happen to pick up something when emptying the trash and recognize somebody's name. So that's why you need to identify business associates and distinguish them from someone you would give the confidentiality agreement too.

Subject VI: We have all of the business associates. We need to identify all of the vendors to receive confidentiality agreements.

Bell: In another interview the practice manager said she was thinking about hiring a shredding firm. They are going to throw all paper in a bin and hire a shredding company to come in once a week. Have you thought of anything like that?

Subject VI: No because I don't think our volume warrants it at this point. Everybody who needs to shred, will shred his or her own paper. We use Fridays as our clean up day, so I don't think we have the volume to worry about that.

Bell: The new HIPAA Privacy Rules cover patients privacy and confidentiality of personal health information. How do you insure that patient's private and confidentiality standards are implemented?

Subject VI: Actually one of the things that we're looking at is renovating our lobby so that we have a check in and a check out area. Right now we only have one window. We do more talking to the patient at the time of check out than we do at the time of check in. So we're looking to use another window off to the side for the patient to check out so that if there are any questions about their bill or anything else they can do it away from where other patients can hear.

Bell: This renovation, is it actually directly toward HIPAA?

Subject VI: Part of it is. The renovation needs to be redone because as you can see the office is kind of dated. You know it's been like this well before I came and it's time to up fit it. The new HIPAA guidelines just accelerated our actions.

Bell: How many employees do you have?

Subject VI: We have two offices. Including the physicians we have a total of 15.

Bell: How many physicians do you have?

Subject VI: We have two physicians and two nurse practitioners.

Bell: Where's your other office?

Subject VI: In Sumter.

Bell: The 14,000 patients that you're talking about, is that 14,000 for both doctors?

Subject VI: Correct. The office in Sumter opened up in 1998. So it's safe to say that about 9,000 - 10,000 are from this office.

Bell: Will there be any particular thing that you will do at the Sumter office for HIPAA?

Subject VI: We went ahead and moved their files to one room as well. Kind of did the same thing.

Bell: Were their hours also included in the 100 hours that you mentioned previously?

Subject VI: No because actually they're in the process.

Bell: Oh, they're still in the process?

Subject VI: They're still in the process of doing theirs. I couldn't do them both at the same time.

Bell: Now how long has that been going on?

Subject VI: They've been doing it for about two months. And they have one-third of the charts that we have, so their task won't be as large. Every chart that they have in Sumter we have here, because all the nuclear stress tests we do are done in this office. Whatever we do here we will mirror it there. They have one check out and we've talked about putting another one in. The patients aren't right up to the window like they are here; thus we have a little bit more room to work with.

Bell: Do you have any idea what the cost of that renovation is going to be?

Subject VI: Actually, I have a couple of quotes on the renovation but it's more than just renovating the front office, so I couldn't give you a figure as to what it would take to break that out.

Bell: All of the employees must be trained on HIPAA. How much training will each employee receive and who will train your employees?

Subject VI: I'm looking for the consultant to come in and tell us exactly where we need the training. We know that everybody needs to be trained. And depending on their position they're going to be trained at different levels. You know you're not going to give the same information to the doctors that you're going to give to the rest of the staff.

Bell: The doctors are agreeable to being trained also?

Subject VI: Absolutely.

Bell: And the nurses?

Subject VI: Oh definitely. So there will be some cost depending on whatever they're doing.

Bell: The transaction codes are another component of the HIPAA Act. What has your practice done to comply with those standards of the Transaction Code Sets?

Subject VI: Since we do our billing through a third party in conjunction with Companion, they have the sole responsibility of making sure all that we are compliant with transaction code sets. We are in constant communication with them to make sure that they're meeting the deadlines that are required. And so far they have.

Bell: What about security? They have not been published, but there have been articles in periodicals about the security standards. Have you been aware of them? Have you given any consideration of what needs to be done?

Subject VI: To be honest no I am not aware of them; therefore I haven't given a lot of consideration to what needs to be done. The system that we have now has nine different security levels. So I feel that whenever they are published we'll adjust accordingly. I don't see any problems with that. The only thing that we need to take into consideration now is transcription information because those are done on a regular word document or a regular pc so we do need to put in place some passwords.

Bell: Does your transcriber e-mail the transcription? If they do, that presents additional problems.

Subject VI: We have an in-house transcriber. So we don't run across that problem. I do know though when they use an outside source, that even if they dictate over the phone lines, they have to have a secure line.

Bell: Yes, that is part of the security.

Subject VI: But we don't have that problem. We're in-house.

Bell: Do you intend to purchase any additional computers or upgrade your computer?

Subject VI: We'll be upgrading our Companion Computer to the newest version.

Bell: You mentioned that you are going to hire an outside consultant. Is that definite or is it under consideration?

Subject VI: We are about 98 % positive that we are going to go with a consultant.

Bell: Those are all of the questions that I have. Thank you for your time.

Subject VI: You are welcome.

Gary E. Bell
P. O. Box 23103
Columbia, SC 29224-3103
March 1, 2003

Dear Research Participant:

My name is Gary E. Bell. I am a doctoral student at the Medical University of South Carolina. I am conducting a research project on the cost of implementing the Health Insurance Portability and Accountability (HIPAA) privacy and confidentiality standards in private primary care physicians' offices in South Carolina. This survey is being sent to the following medical specialties: family practice, general practice, pediatrics, and obstetrics and gynecology. The purpose of the survey is to identify all costs that have been and will be incurred in complying with HIPAA privacy and confidentiality standards.

When the study is complete, this information may be published, but you will not be identified. No individual identifying information will be collected. **The final report will analyze cost for physician practices, which will help determine if your costs are in line with industry norms.**

Please ask your office manager, practice manager, or the person serving in that position to complete this survey. If they are not able to complete the entire survey, ask them to complete questions 1 through 7 and as much of the remaining questions as possible, and return the survey to me in the enclosed self addressed envelope right away.

Of course, your participation in this study is voluntary. If you complete the survey and wish to receive a copy of the survey results, please let me know in a separate letter or e-mail, and I will be very happy to send you a summary of the final report.

If you have questions regarding this survey, please contact Gary E. Bell @ 803-865-4156, email garyeb6@juno.com, or fax 803-462-6032.

Private Practice Statement

We (I) have been given a chance to ask questions about this research study. These questions have been answered to my satisfaction. If we (I) have any more questions about my participation in this study, we (I) may contact Gary E. Bell @ 803-865-4156, e-mail address garyeb6@juno.com, or fax 803-462-6032.

If we (I) have any question about my rights as a research subject in this study, we (I) may contact the Medical University of South Carolina Intuitional Review Board for Human Research at (843-792-4148).

We (I) agree to participate in this study. We (I) have been given a copy of this form for our (my) own records.

If you are willing to participate please sign below.

_____

Signature of Participant Date

SURVEY
HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA) PRIVACY AND CONFIDENTIALITY STANDARDS

1. Please mark your practice specialty.
   a. Family Practice _____
   b. General Practice _____
   c. Pediatrics _____
   d. Obstetrics & Gynecology _____

2. Please indicate the type of entity that represents your practice. (Check one)
   a. Sole Proprietorship _____ b. Partnership _____
   c. Corporation _____ d. Personal Service Corp. _____
   e. Not for Profit Organization _____

3. How would you classify your practice? (Please check one)
   a. Rural _____
   b. Urban _____

4. How many weeks out of the year is the practice open? _____

5. How many office locations does the practice have? _____

6. On average, how many patient visits does your practice provide per week (for all locations)? _____

7. What is your best estimate of the cost of implementing HIPAA privacy and confidentiality standards in your practice?
   a. Before the effective date of April 14, 2003 $_____
   b. Expected annual recurring costs after the effective date of April 14, 2003 $_____

8. What is the annual **gross** revenue (cash receipts) of the practice? (Please give your best estimate) $_____

9. What are the annual **direct** (operational) expenses of the practice? (Please give your best estimate) $_____

10. Please identify below the percent of practice revenue (cash receipts) received from the following sources:
    a. Private pay or self-pay_____
    b. Private Insurance_____
    c. HMO_____
    d. Capitation agreements_____

e. Arrangements with hospitals_____
f. Medicaid_____
g. Medicare_____
h. Other (specify)_____

11. How many of the following types of personnel are in your office? (Please convert to full-time equivalent personnel)
    a. Physician(s) (owner/partner)_____
    b. Physician(s) (employee) _____
    c. Physician Assistant(s) _____
    d. Nurse Practitioner(s) _____
    e. Registered Nurse(s) _____
    f. Licensed Practical Nurse _____
    g. Medical Office Assistant _____
    h. X-Ray Technician _____
    i. Phlebotomists _____
    j. Non-Medical Staff _____
    (Office/Practice Manager, receptionists, case managers, office assistants, accountants, billing clerks, etc.)
    k. Others (Specify) _____

12. How many (actual or estimated) training hours for HIPAA privacy and confidentiality standards will the personnel identified above receive between **August 14, 2002 and April 14, 2003** and **during the first year of HIPAA (April 15, 2003 – April 14, 2004)?** (Please give the average number of training hours per FTE.)

FTE	8/14/02 – 4/14/03	4/15/03 - 4/14/04
a. Physician(s) (owner/partner)	_____	_____
b. Physician(s) (employee)	_____	_____
c. Physician Assistant(s)	_____	_____
d. Nurse Practitioner(s)	_____	_____
e. Registered Nurse(s)	_____	_____
f. Licensed Practical Nurse	_____	_____
g. Medical Office Assistant	_____	_____
h. X-Ray Technician	_____	_____
i. Phlebotomists	_____	_____
j. Non-Medical Staff (Office/Practice Manager, Receptionists, case managers, office assistants, accountants, billing clerks, etc.)	_____	_____
k. Others (Specify)	_____	_____

13. Identify the number of employees, per person cost, and length of training that employees in your practice have attended for HIPAA privacy and confidentiality standards training (Check all that apply)

Type	# of Employees	Per person Cost	Duration of Training
a. Seminars	_____	_____	_____
b. Conferences	_____	_____	_____
c. Workshops	_____	_____	_____
d. Schools	_____	_____	_____
e. In-service	_____	_____	_____
f. Others (specify)	_____	_____	_____

14. We are interested in the categories of expenditures your practice has incurred, or expects to incur, for HIPAA compliance. Please provide your best estimates for spending (or expected spending) in the following categories and time periods (round to the nearest hundred dollars).

	Quantity	Prior to 12/31/02	1/1/03 - 4/14/03	4/15/03- 4/14/04
a. Computers	_____	_____	_____	_____
b. Shredders	_____	_____	_____	_____
c. Facility renovations	_____	_____	_____	_____
d. Partitions	_____	_____	_____	_____
e. File cabinets	_____	_____	_____	_____
f. Electronic Medical Record Systems	_____	_____	_____	_____
g. Desks	_____	_____	_____	_____
h. Chairs	_____	_____	_____	_____
i. Rolling Carts	_____	_____	_____	_____
j. Consultants	_____	_____	_____	_____
k. Other (Specify)	_____	_____	_____	_____

15. Does your practice anticipate hiring a consultant to assist in implementing the HIPAA privacy and confidentiality standards? (Please check one)
    a. Yes _____
    b. No _____
    c. If yes, how much do you expect the consultant to cost?
    $_____

16. HIPAA standards require that the practice **designate** a Privacy Officer. Does the practice anticipate **hiring** a Privacy Officer? (Please check one)
    a. Yes _____ (if yes, go to question 22)
    b. No _____ (if no, go to question 17)

17. Will someone on the current staff assume the duties of the Privacy Officer? (Please check one)

a. Yes _____ (if yes, go to question 18)
b. No _____ (if no, go to question 21)

18. Will that staff member be compensated for the additional duties as Privacy Officer? (Please check one)
    a. Yes _____ (go to question 20)
    b. No _____ (go to question 19)

19. a) How many hours per week are expected to be dedicated to privacy issues by the Privacy Officer? _____ (your best estimate)

    b) What is the annual compensation of the Privacy Officer? $_____ (go to 20)

20. Will additional staff be hired as a result in the shift of responsibilities? (Please check one)
    a. Yes _____ (go to question 22)
    b. No _____ (go to question 22)

21. Explain how your practice will comply with the requirement of having a Privacy Officer.

_____

_____

_____

_____

_____

22. Do you think there will be additional changes/interpretations of the HIPAA privacy and confidentiality rules before the April 14, 2003 implementation date? (Please check one)

    a. Yes_____
    b. No _____

23. Identify any assistance your practice has received in implementing the HIPAA privacy and confidentiality standards, and your best estimate for how much that assistance cost (if the assistance was free, please enter $0).

Assistance Received From:	Cost
a. Professional Associations	_____
b. On-line web sites	_____
c. Consultants	_____
d. Dept. of Health & Human Services	_____
e. Training seminars	_____
f. Others (specify)	_____

24. Do you plan to do any major renovation in your practice as a result of HIPAA?
    a. No: ____
    b. Yes: ____ (explain how)

_____
_____
_____
_____
_____

Thank you very much for completing this survey. You may e-mail (garyeb6@juno.com), fax (803-462-6032), call (803-865-4156), or write (Gary E. Bell, P. O. Box 23103, Columbia, SC 29224-3103) if you would like a copy of the survey results.

Please return the completed survey right away in the self-addressed envelope.

Data Dictionary

Question #	
1	Family Practice = 1; General Practice = 2; Pediatrics = 3; Obstetrics & gynecology = 4
2	Sole = 1; Partnership = 2; Corporation = 3; Public Service Corporation= 4; Non-profit = 5
3	Rural = 0; Urban = 1
4	# value
5	# value
6	# value
7	A = $ value b = $ value
8	$Value
9	$Value
10	a through h = %
11	a through k: column 1 = # value (hours); column 2 = # value (hours)
12	a through k = # value
13	a through f: column 1 = # value; column 2 = $ value; column 3= # value (hours)
14	a through k: column 1 = # value; column 2 = $ value column 3= $ value; column 4 = $ value
15	a = 0; b = 1; c = # value
16	a = 0; b = 1
17	a = 0; b = 1
18	a = 0; b = 1
19	a = # value; b = $ value
20	a = 0; b = 1
21	Verbal response
22	a = 0; b = 1
23	a through f = $ value
24	a = 0; b = 1

Survey Results by Respondent

	Costs							
	Training	Seminars	Equipment	Total	Projected Cost	Specialty	Entity	R/U
1	0	0	0	0	1,250	FP	NFP	R
2	0	0	0	0	0	FP	NFP	R
3	0	0	0	0	20,000	FP	CORP	U
4	2,159	2,550	19,241	23,950	33,000	FP	PRTR	R
5	326	0	0	326	0	FP	CORP	U
6	0	0	367	367	3,500	PED	CORP	R
7	2,046	0	0	2,046	5,000	OBGYN	SP	R
8	470	140	245	855	0	FP	SP	R
9	1,291	150	794	2235	600	FP	CORP	R
10	618	50	0	668	1,500	OBGYN	CORP	U
11	3,433	800	41,341	45574	8,000	OBGYN	CORP	R
12	0	0	0	0	0	PED	PRTR	R
13	1,921	0	2,415	4,336	6,400	FP	PRTR	U
14	306	800	33,053	34,160	1,000	FP	SP	R
15	3,060	5,600	26,360	35,020	5,000	FP	NFP	U
16	14,276	0	28,248	45,524	28,000	FP	CORP	R
17	1,465	0	0	1465	1,000	FP	CORP	U
18	0	0	0	0	99	FP	SP	U
19	3,716	550	10,049	14315	13,000	FP	SP	R
20	0	998	0	998	2,700	FP	SP	U
21	0	0	0	0	10,000	FP	CORP	R
22	0	0	0	0	500	FP	SP	U
23	3,665	5,584	520	9769	4,000	FP	CORP	U
24	0	0	0	0	5,000	OBGYN	CORP	R
25	0	0	0	0	0	OBGYN	SP	R
26	318	0	21,964	22,283	0	OBGYN	CORP	R
27	0	0	0	0	3,000	PED	CORP	R
28	1,030	403	15,193	16,626	10,000	FP	CORP	U
29	0	0	0	0	2,000	FP	SP	U
30	0	0	0	0	10,000	FP	CORP	R
31	0	0	18,826	18,826	6,000	FP	CORP	R
32	0	0	0	0	500	OBGYN	SP	R
33	0	650	0	650	6,200	FP	CORP	U
34	341	400	0	3,741	12,500	OBGYN	CORP	R
35	2,315	250	5,252	7,817	0	FP	SP	U
36	1,871	105	0	1,976	540	OBGYN	CORP	R
37	22,818	5,068	367	25,253	10,000	PED	CORP	U
38	0	0	0	0	4,000	FP	CORP	R
39	0	0	0	0	6,000	PED	NFP	R
40	0	0	0	0	0	FP	PRTR	R
41	0	0	0	0	0	FP	PRTR	R
42	3,788	526	4,909	9,223	4,475	OBGYN	CORP	U
43	972	1,000	46,184	48,156	8,000	FP	CORP	R
44	4,771	900	35,648	41,319	17,000	FP	CORP	R
45	0	0	0	0	0	FP	SP	U
46	468	0	0	468	2,000	PED	CORP	U
47	14,436	500	22,912	37,848	11,998	FP	CORP	U
48	1,386	2,200	6,662	10,247	12,500	OBGYN	CORP	R
49	0	0	0	0	0	FP	NFP	U
50	0	0	0	0	1,000	FP	PRTR	U

51	2,197	260	0	2,457	5,000	OBGYN	PRTR	R
52	1,985	75	2,000	4,060	3,500	FP	CORP	U
53	657	75	2,000	2,732	3,000	FP	CORP	U
54	14,701	0	87,621	102,321	200,001	FP	CORP	R
55	677	240	22,912	23,829	5,500	PED	SP	R
56	10,509	900	490	11,899	50,000	PED	CORP	R
57	0	0	0	0	8,500	FP	CORP	U
58	448	0	0	448	1,000	FP	SP	R
59	2,853	270	0	533	6,000	FP	CORP	U
60	13,897	800	25,288	39,986	4,000	FP	CORP	U
61	0	600	122	722	1,001	PED	SP	U
62	40,653	5,029	0	45,682	17,100	OBGYN	PRTR	R
63	0	0	0	0	3,500	OBGYN	CORP	R
64	0	0	0	0	0	OBGYN	SP	U
65	0	0	0	0	7,500	FP	SP	U
66	1,056	200	9,326	10,582	0	OBGYN	PRTR	U
67	0	0	0	0	0	PED	SP	U
68	1,342	700	0	2,042	2,002	PED	SP	U
69	31,535	2,002	2,192	35,729	3,002	FP	CORP	U
70	4,465	1,200	37,921	43,587	1,500	PED	CORP	R
71	3,807	35	0	3,842	1,500	FP	PRTR	U
72	0	0	0	0	1,000	FP	CORP	U
73	0	0	0	0	1,500	OBGYN	PRTR	R
74	67	250	3,869	4,186	3,300	FP	SP	U
75	3,081	0	43,754	46,835	0	PED	PRTR	U
76	10,855	0	25,349	36,204	5,000	PED	CORP	U
77	2,029	0	400	2,429	2,700	FP	CORP	U
78	1,208	1,100	245	2,553	1,500	FP	SP	R
79	9,237	2,300	35,590	47,127	0	FP	CORP	U
80	25,609	1,000	58,502	8,511	25,000	FP	PRTR	R
81	8,779	760	0	9,539	5,000	PED	CORP	U
82	833	0	0	833	1,595	OBGYN	CORP	U
83	1,375	250	28,824	31,448	500	PED	SP	U
84	3,080	0	9,939	13,020	16,200	OBGYN	CORP	U
85	0	0	4,830	4,830	2,000	FP	SP	U
86	529	0	0	529	7,000	FP	PRTR	R
87	2,060	8,40	35,366	45,566	2,500	FP	CORP	U
88	854	0	32,434	33,288	16,400	FP	SP	R
Total	296,643	57,840	810,525	1,165,009	692,063			

FP - Family Practice
PED - Pediatricians
OBGYN - Obstetrics and Gynecology
SP - Sole Proprietor
PRTR - Partnership
CORP - Corporation
NFP - Not for Profit