Subchapter KK. Health Care Reimbursement Rate Information
28 TAC §§21.4501 - 21.4507

1. INTRODUCTION. The Texas Department of Insurance (Department) proposes new Subchapter KK, §§21.4501 – 21.4507, concerning the collection and submission of aggregate health care reimbursement rate information by health benefit plan issuers. The Department proposes this new subchapter to implement SECTION 8 of Senate Bill (SB) 1731, enacted by the 80th Legislature, Regular Session, effective September 1, 2007. Senate Bill 1731 adds new Insurance Code Chapter 38, Subchapter H, which requires the Department to collect data concerning health benefit plan reimbursement rates by region. This bill requires the Department to create a new data collection program to collect certain information related to the reimbursement rates and to organize this information in a specific fashion. The proposed new subchapter applies to issuers of preferred provider benefit plans, health maintenance organization plans, and specified governmental employee plans under the Insurance Code Chapters 1551, 1575, 1579, and 1601. The Insurance Code §38.351 states that the purpose of the subchapter is to authorize the Department to collect data concerning health benefit plan reimbursement rates in a uniform format, and disseminate, on an aggregate basis for geographical regions in this state, information concerning health care reimbursement rates derived from the data. Section 38.354 gives the Commissioner the authority to adopt rules to implement the subchapter. Section 38.355 requires the Department to develop data

submission requirements in a manner that allows collection of reimbursement rates as a dollar amount and not by comparison to other standard reimbursement rates. Section 38.353(e) authorizes the exclusion by rule of a type of health benefit plan from the requirements of the Insurance Code Chapter 38, Subchapter H, if the Commissioner finds that data collected in relation to the health benefit plan would not be relevant to accomplishing the purposes of the subchapter. Section §38.353(e) is implemented in proposed §§21.4501 – 21.4507 by exempting health benefit plan issuers if the total number of covered lives in private market preferred provider benefit plans or health maintenance organizations offered by the issuer in Texas does not exceed 10,000 persons as of December 31 of the year preceding the report. The proposed rules prescribe the data submission requirements and form for submission of data related to health care reimbursement rates by health benefit plan issuers, specify definitions to implement the Insurance Code Chapter 38, Subchapter H, and facilitate the Department's provision of aggregate health care reimbursement rate information derived from the data collected under this subchapter to the Department of State Health Services (DSHS) for publication. Proposed new §§21.4501 – 21.4507 are necessary to implement the data collection requirements in the Insurance Code Chapter 38, Subchapter H, and SECTION 19 of SB 1731. Pursuant to the Insurance Code §38.355, health benefit plan issuers are required to submit data for the period specified by the Department at the time and in the form and manner required by the Department. Section 38.355 further mandates that the data be submitted in a standardized format to

permit comparison of health care reimbursement rates and that the submission requirements allow, to the extent feasible, for the collection of reimbursement rates as a dollar amount and not by comparison to other standard reimbursement rates, such as Medicare reimbursement rates. Definitions are specified for purposes of standardization. Further, the Insurance Code §38.357 requires the Department to provide aggregate health care reimbursement rate information derived from the data collected under the subchapter to DSHS for publication. The proposed new subchapter will facilitate the provision of this information.

The Department held a preliminary stakeholder meeting February 28, 2009, to discuss concepts for implementation of Subchapter H. The Department posted an informal draft of this proposal on its website August 4, 2009, and invited further public comment. Originally set to expire August 12, the informal comment period was extended until August 17, 2009, at the request of stakeholders. The informal draft was additionally discussed at a second stakeholder meeting September 24, 2009. Using stakeholder feedback, the Department has identified approximately 280 Current Procedural Terminology (CPT) codes, and 60 Medicare severity diagnosis related group (MS-DRG) codes for which data is proposed for collection in Form No. LHL616, entitled Health Care Claims Reimbursement Rate Report. The Department proposes Form No. LHL616 (Health Care Claims Reimbursement Rate Report) for adoption by reference in §21.4507. The codes represent commonly used or particularly expensive procedures for some categories of professional services, as well as outpatient and inpatient services by institutional providers. In selecting

procedures for purposes of the proposed data collection, the Department considered information and recommendations provided by members and representatives of the physician and institutional provider community and health insurers. The Department also considered: (i) reimbursement claims reports by the Centers for Medicare and Medicaid Services (CMS) under the Health Care Economics Program; (ii) inpatient and outpatient reports from the CMS National Claims History database; (iii) claims data reports from the Texas Department of State Health Services Inpatient Hospital Discharge Database; and (iv) claims experience data reports provided by the Texas Health Insurance Risk Pool.

The following provides an overview of and explains additional reasoned justification for the proposed new rules.

Proposed §21.4501 states the purpose of the proposed new subchapter, which includes the collection of data concerning health benefit plan reimbursement rates in a uniform format.

Proposed §21.4502 identifies the types of health benefit plans to which the new subchapter does and does not apply. Proposed §21.4502 addresses and reiterates the Insurance Code §38.353.

Proposed §21.4503 provides definitions for terms used in the proposed new rules, including *group health benefit plan, institutional provider, physician, provider,* and *reporting period*. *Group health benefit plan* is defined in proposed §21.4503(1) as specified in the Insurance Code §38.352 to mean a *preferred provider benefit plan* as defined by the Insurance Code §1301.001, or an *evidence of coverage* for a health care plan that provides basic health care

services as defined by the Insurance Code §843.002. The Insurance Code §1301.001(9) defines *preferred provider benefit plan* as a benefit plan in which an insurer provides, through its *health insurance policy*, for the payment of a level of coverage that is different from the basic level of coverage provided by the health insurance policy if the insured person uses a preferred provider. Section 1301.001(2) defines *health insurance policy* as a group or individual insurance policy, certificate, or contract providing benefits for medical or surgical expenses incurred as a result of an accident or sickness. The Insurance Code §843.002, in turn, defines *evidence of coverage* to mean any certificate, agreement, or contract, including a blended contract, that: (i) is issued to an enrollee; and (ii) states the coverage to which the enrollee is entitled. The term *group health benefit plan*, therefore, includes both group and individual coverage. The Department has further clarified in proposed §21.4503(1) that the term does not include a health maintenance organization plan providing routine dental or vision services as a single health care service plan or a preferred provider benefit plan providing routine vision services as a single health care service plan. As previously discussed, the Insurance Code §38.353(e) authorizes the exclusion by rule of a type of health benefit plan from the requirements of the Insurance Code Chapter 38, Subchapter H, if the Commissioner finds that data collected in relation to the health benefit plan would not be relevant to accomplishing the purposes of the subchapter. The routine dental or vision services provided under single health care service plans are not consistent with the general reimbursement data that will be collected under proposed new Subchapter KK at

this time. *Institutional provider* is defined in proposed §21.4503(2) as an institution providing health care services, including but not limited to hospitals, other licensed inpatient centers, ambulatory surgical centers, skilled nursing centers and residential treatment centers. *Physician* is defined in proposed §21.4503(3) as any individual licensed to practice medicine in this state and, with regard to a health maintenance organization, as defined in the Insurance Code §843.002(22). *Provider* is defined in proposed §21.4503(4) as any practitioner, institutional provider, or other person or organization that furnishes health care services and that is licensed or otherwise authorized to practice in this state, other than a physician. *Reporting period* is defined in proposed §21.4503(5) as the six-month interval of time for which a plan or health benefit plan issuer must submit data, beginning each January 1 and ending the following June 30.

Proposed §21.4504 designates geographic regions by ZIP Code for purposes of data collection. This designation is in accordance with the Insurance Code §38.351 and §38.355, which authorize the Department to collect and disseminate aggregated data for geographical regions in this state. The geographic regions in proposed §21.4504 generally approximate the 11 Health Service Regions established by the Department of State Health Services for purposes not related to enactment of SB 1731 and are already familiar to most issuers. These regions include: (1) Region 1 – Panhandle, including Amarillo and Lubbock; (2) Region 2 – Northwest Texas, including Wichita Falls and Abilene; (3) Region 3 – Metroplex, including Fort Worth and Dallas; (4) Region 4 – Northeast Texas, including Tyler; (5) Region 5 – Southeast Texas, including

Beaumont; (6) Region 6 – Gulf Coast, including Houston and Huntsville; (7) Region 7 – Central Texas, including Austin and Waco; (8) Region 8 – South Central Texas, including San Antonio; (9) Region 9 – West Texas, including Midland, Odessa, and San Angelo; (10) Region 10 – Far West Texas, including El Paso; and (11) Region 11 – Rio Grande Valley, including Brownsville, Corpus Christi, and Laredo.

Proposed §21.4505 addresses the requirements in §38.355 of the Insurance Code to collect the requested data and to specify the time periods for which the submission is to be provided. Proposed §21.4505(a) requires health benefit plan issuers and plans to collect the underlying data necessary for submission of all information specified in Form No. LHL616, proposed for adoption by reference in §21.4507. Proposed §21.4505(b) addresses the time periods for which the information and data is to be provided. It provides that: (i) the six-month reporting period for the information and data requested in Form No. LHL616 is January 1 to June 30 of the applicable calendar year; and (ii) the enrollment data required in Form No. LHL616 is for the total number of lives covered under the plans for both December 31 of the year prior to the applicable reporting period and June 30 of the applicable reporting year. Proposed §21.4505(c) allows a health benefit plan issuer that is exempt pursuant to proposed §21.4506(e) to collect and report information required in Form No. LHL616, Section B to support an exemption rather than the full data indicated in Form No. LHL616.

Proposed §21.4506 addresses the requirements and deadlines for the submission of the requested data. Proposed §21.4506(a) proposes the deadlines for the submission of the required data in annual reporting subsequent to the initial filing. Proposed §21.4506(b) specifies that the initial reporting date for the submission of the required data is 60 days from the effective date of the proposed rule. Proposed §21.4506(c) specifies the procedures for electronic filing of the required information and data. Proposed §21.4506(d) identifies the procedure for accessing the report form, including acceptance of the End User Agreement concerning use of CPT codes. Proposed §21.4506(e) requires a health benefit plan issuer asserting an exemption to the reporting requirement specified in proposed §21.4506(a) to submit an exemption statement and the data specified in Form No. LHL616 to support an exemption. Assertion of an exemption for either private market preferred provider benefit plans or health maintenance organization plans requires certification by the health benefit plan issuer that the number of covered lives in Texas in the type of plan for which an exemption is sought does not exceed 10,000 persons as of December 31 of the year preceding the report. As previously discussed, the Insurance Code §38.353(e) permits the exclusion by rule of a type of health benefit plan from the requirements of Chapter 38, Subchapter H, if the Commissioner finds that the data collected in relation to the health benefit plan would not be relevant to accomplishing the purposes of the subchapter. The Department anticipates that the inclusion of reimbursement data from health benefit plan issuers with enrollment that does not exceed 10,000 persons will not markedly affect the

aggregate data that the Department is required to furnish to DSHS for publication as provided in the Insurance Code §38.357. For this reason, the Department proposes to permit the exemption of such plans as specified in proposed §21.4506(e). A representation of the End User Agreement included with Form No. LHL616 is provided in proposed Figure: 28 TAC §21.4506(f). The End User Agreement facilitates the Department's use of procedural codes and descriptions to which the American Medical Association asserts copyright rights.

Section 21.4507 proposes the adoption by reference of the form to be used in reporting the data required in the new subchapter (Form No. LHL616, entitled Health Care Claims Reimbursement Rate Report). Plans and health benefit plan issuers must utilize this form to submit summary company identification and contact information and to provide data on reimbursement rates for certain CPT and MS-DRG codes for each of the 11 geographic regions specified in proposed §21.4504. Qualifying health benefit plan issuers must also use this form to certify that the health benefit plan issuer is exempt from certain of the reporting requirements. Proposed §21.4507 also provides a link for accessing the form on the Department's Internet website.

Form No. LHL616, proposed to be adopted by reference in §21.4507, is comprised of Sections A - J. Section A of the form includes detailed instructions and definitions necessary for completion of each section of the form. Section B of the form includes space to report company information, contact information for an individual representative of the health benefit plan, and data certification. The remaining sections of the form include spaces for the reporting of reimbursement

rate data for: (i) professional services – general, in Section C; (ii) professional services – pathology, in Section D; (iii) professional services – anesthesiology, in Section E; (iv) professional services – radiology, in Section F; (v) professional services – neonatology critical care/newborn care, in Section G; (vi) professional services – outpatient health care claims, in Section H; (vii) institutional provider – outpatient health care claims, in Section I; and (viii) institutional provider – inpatient health care claims, in Section J. For each of these respective categories of claim, the form instructs health benefit plan issuers and plans to provide aggregate reimbursement data for designated procedural and diagnostic codes for both in-network and out-of-network claims.

2. FISCAL NOTE. Dianne Longley, Director of Research and Analysis, Life, Health & Licensing Program, has determined that for each year of the first five years the proposed new sections will be in effect, there will be no fiscal impact to state and local governments as a result of the enforcement or administration of the proposal. There will be no measurable effect on local employment or the local economy as a result of enforcing or administering the proposal.

3. PUBLIC BENEFIT/COST NOTE.

Anticipated Public Benefit.

Ms. Longley has determined that for each year of the first five years the proposed new sections are in effect, there are public benefits anticipated as a result of the enforcement and administration of the rule, and there will also be

potential costs for persons required to comply with the proposal. The Department, however, drafted the proposed rules to maximize public benefits consistent with the intent of Chapter 38, Subchapter H of the Insurance Code while mitigating costs. The anticipated public benefits will be: (i) implementation of a new program to collect data in a uniform format concerning group health benefit plan reimbursement rates for certain in-network and out-of-network health services, including general professional services, pathology services, anesthesiology services, radiology services, neonatology services, outpatient professional and institutional provider services, and inpatient institutional provider services; (ii) dissemination on an aggregate basis for designated geographical regions in Texas the health care reimbursement rate information derived from the new data collection program; and (iii) improved transparency concerning health care reimbursement rate information that will be available to consumers. Specifically, the Insurance Code §38.357 requires the Department to provide, for identified geographical regions, aggregate health care reimbursement rate information derived from the data collected under the Insurance Code Chapter 38, Subchapter H, to the DSHS for publication. This proposal will facilitate the Department's provision of such information to the DSHS. The publication of the reimbursement rate information by the DSHS will be available to consumers. Similarly, §38.357 permits the Department to make the aggregate health care reimbursement rate information available through the Department's Internet website. If the Department also publishes the reimbursement rate information on its website, this will be another source for consumers to access the information.

Although the Insurance Code §38.357 provides that the published information may not reveal the name of any health care provider or health benefit plan issuer, the Department nevertheless anticipates that the publication of the information for identified geographical regions will permit consumer comparison of health care reimbursement rate information between such regions.

Potential Costs for Persons Required to Comply with the Proposal

Overview of proposed requirements resulting in potential costs. The cost to persons required to comply with the proposed new rules results from requirements concerning: (i) the collection and preparation of health care reimbursement data as specified in proposed §21.4505; and (ii) the submission of the report as specified in proposed §21.4505 and §21.4506. The cost components associated with these compliance requirements include: (i) the cost of any additional technology or software necessary to comply with the data collection, preparation, and submission requirements in proposed §21.4505 and §21.4506, including the enrollment information and claims data specified in Form No. LHL616; (ii) personnel costs associated with programming information systems for compliance with the requirements in proposed §21.4505 and §21.4506; and (iii) personnel costs associated with completing and reviewing Form No. LHL616 in compliance with the requirements in proposed §21.4505 and §21.4506.

Persons required to comply with the proposal. In accordance with the Insurance Code §38.353(a), the persons required to comply with the proposal are issuers of a group health benefit plan, including: (i) an insurance company;

(ii) a group hospital service corporation; (iii) a fraternal benefit society; (iv) a stipulated premium company; (v) a reciprocal or interinsurance exchange; and (vi) a health maintenance organization. Additionally, in accordance with the Insurance Code §38.353(b), several governmental employee plans must comply with the data submission requirements. These plans are: (i) a basic coverage plan under the Insurance Code Chapter 1551; (ii) a basic plan under the Insurance Code Chapter 1575; (iii) a primary care coverage plan under the Insurance Code Chapter 1579; and, (iv) basic coverage under the Insurance Code Chapter 1601. Further, pursuant to the Insurance Code §38.353(c), small employer health benefit plans under the Insurance Code Chapter 1501 are required to comply with the data submission requirements except as provided in subsection (d) of §38.353. Under the Insurance Code §38.353(d), the data submission requirements do not apply to: (i) standard health benefit plans provided under the Insurance Code Chapter 1507; (ii) children's health benefit plans provided under the Insurance Code Chapter 1502; (iii) health care benefits provided under a workers' compensation insurance policy; (iv) Medicaid managed care programs operated under the Government Code Chapter 533; (v) Medicaid programs operated under the Human Resources Code Chapter 32; or (vi) the state child health plan operated under the Health and Safety Code Chapters 62 or 63.

Additionally, some health benefit plan issuers may report information and data on behalf of certain government employee plans. As provided in proposed Form No. LHL616, each designated governmental employee plan shall either

independently submit the report required pursuant to this proposal or shall authorize and require the entity administering the governmental employee plan to submit the information and data on its behalf. A governmental employee plan may determine that the entity with which it contracts is more appropriately situated to provide the requested information. Based upon reporting on behalf of governmental employee plans in other data collections unrelated to this proposal, the Department anticipates that such delegation is more probable than not. The proposal therefore affords some flexibility to health benefit plan issuers that administer governmental employee plans. The estimated cost for reporting for a governmental employee plan should be comparable to the cost incurred by a health benefit plan issuer. To the extent that a health benefit plan issuer submits information on behalf of a governmental employee plan in addition to the issuer's own data, the cost to a governmental employee plan may be reduced. Health benefit plan issuers submitting the requested information and data on behalf of other entities in addition to submitting the information and data for themselves may incur some additional costs. Such costs may be mitigated, however, to the extent that the issuer maintains aggregate claims data for the governmental employee plans and data for the issuer's own group health benefit plans.

Potential costs resulting from certain proposed requirements. The Insurance Code §38.355(a) provides that each health benefit plan issuer shall submit to the Department, at the time and in the form and manner required by the Department, aggregate reimbursement rates by region paid by the health benefit plan issuer for health care services identified by the Department. To implement

this requirement, proposed §21.4505 requires each group health benefit plan issuer and plan identified in proposed §21.4502(a) and (b) to collect the data specified in Form No. LHL616. Proposed §21.4505 further requires that the report data be prepared and filed in accordance with the requirements of proposed §21.4506. Proposed §21.4506(a) requires each plan and health benefit plan issuer to submit the completed Form No. LHL616 not later than September 1 of each year. Consistent with SB 1731, SECTION 19, proposed §21.4505(b) further provides that the initial submission of data shall be 60 days from the effective date of the rule. Proposed §21.4506(c) requires the filed data to be submitted electronically in Excel format by: (i) accessing a link on the Department's website to obtain the report form; (ii) completing the report in accordance with the form's instructions; and (iii) emailing the completed report to the Department's email address. Proposed §21.4506(d) requires the user to indicate acceptance of the End User Agreement concerning the use of Current Procedural Terminology in order to access the report form. The content of this End User Agreement is provided at proposed §21.4506(f). Proposed §21.4506(e) permits preferred provider group health benefit plan issuers to submit to the Department an exemption statement and the required supporting data in Part B of Form No. LHL616 if the issuer meets the criteria in proposed paragraphs (1) or (2) of §21.4506(e), as applicable. Under these paragraphs, a health benefit plan issuer qualifies for an exemption if the total number of covered lives in private market plans offered by the health benefit plan issuer in Texas does not exceed 10,000 persons as of December 31 of the year preceding

the report. The exemption applies to plans operating under the Insurance Code Chapters 843 or 1301, as applicable. The Department proposes to adopt Form No. LHL616 by reference in proposed §21.4507.

Cost components. The probable cost to health benefit plan issuers required to comply with this proposal will result from the following cost components: (i) the cost of any additional technology or software necessary to comply with the data collection, preparation, and submission requirements in proposed §21.4505 and §21.4506, including the enrollment information and the claims data information specified in Form No. LHL616; (ii) personnel costs associated with programming information systems for compliance with the requirements in proposed §21.4505 and §21.4506; and (iii) personnel costs associated with completing and reviewing Form No. LHL616 in compliance with the requirements in proposed §21.4505 and §21.4506.

(i) Cost of technology or software. The Department anticipates that some group health benefit plan issuers may initially incur costs related to the purchase of technology or software necessary to enable the issuer to collect, prepare, and submit health care reimbursement data in compliance with proposed §21.4505 and §21.4506. The need for such technology and software largely will be determined by the specific information technology platforms currently used by the issuer. The Department, therefore, anticipates that such need will vary among group health benefit plan issuers and that potential associated costs will vary accordingly. In addition to basic data collection requirements, proposed §21.4506(c) requires that data filed with the Department pursuant to that section

be filed in Excel format. Feedback from representatives of various issuers at stakeholder meetings indicates that Excel software is commonly used in the industry and will not likely require additional expenditure by group health benefit plan issuers. Should the purchase of the software be necessary, the program may be purchased for approximately $229.99 retail based on information the Department obtained online from various sellers.

Proposed §21.4506(c)(1) requires group health benefit plan issuers to access a link on the Department's website to obtain Form No. LHL616. The Department anticipates that access to Internet services is standard in the group health benefit plan issuer industry and therefore unlikely to cause additional costs to those issuers. Actual cost to purchase such access, should it be required, will likely vary depending upon the service provider used by the group health benefit plan issuer. Any issuers needing to purchase Internet services may contact one or more providers in their area to obtain costs. Based on information the Department obtained online from various Internet service provider websites, such services range from $99 to $600 per month for commercial accounts.

Proposed §21.4506(c)(3) requires group health benefit plan issuers to email the completed report to the Department at the Department's designated email address. The Department anticipates that access to email service is standard in the group health benefit plan issuer industry and is therefore not likely to impose additional costs to those issuers. As with access to Internet services, the cost of email services, should an additional email account be required, will likely vary depending upon the service provider used by the group

health benefit plan issuer. Based on information the Department obtained online from various email providers, such services range from free or inclusive with Internet service to $4.50 per user per month for commercial accounts.

Additionally, proposed §21.4506(c)(2) requires group health benefit plan issuers to complete Form No. LHL616 in accordance with the form's instructions. Section B, Part II of the form defines the term "MS-DRG" as the most current Medicare-severity diagnosis related group code as maintained and released by the CMS Due to variations in reporting by institutional providers and lag times between claim submissions and processing, the Department anticipates that group health benefit plan issuers will require grouper software in order to provide accurate and uniform reporting of health care reimbursement data in Section J of Form No. LHL616. According to description for CMS MS-DRG software hosted by the National Technical Information Service, grouper software classifies hospital case types into groups based on diagnoses, procedures, other demographic information, and the presence of complications or co-morbidities. These groups are expected to have similar hospital resource use. The Department further anticipates that such purchase will be a recurring expense as and when the MS-DRG Codes are updated by CMS. Use of the most current grouper software is standard practice for many group health benefit plan issuers and will therefore not impose additional costs for those issuers. The actual cost of the grouper software will depend upon the vendor used by the group health benefit plan issuer. Retail grouper software can be purchased from several vendors, with prices beginning at $500. Although the Department anticipates

that the cost of technology and software as necessary to comply with proposed §21.4505 and §21.4506 will vary, as described herein, for group health benefit plan issuers, each group health benefit plan issuer may use the Department's cost analysis to calculate its total costs for compliance with proposed §21.4505 and §21.4506 based on its estimated costs for the various individual cost components.

(ii) Cost of personnel associated with programming information systems. The Department anticipates that group health benefit plan issuers will undertake information system programming in order to collect information as required by proposed §21.4505(a) and as specified in Form No. LHL616. Proposed §21.4505(a) requires that issuers submit group health benefit plan issuer identification and enrollment information and data for in-network and out-of-network claim information for each of 11 geographic regions for several categories of medical and health care services. These services include: (i) general professional services; (ii) professional pathology services; (iii) professional anesthesiology services; (iv) professional radiology services; (v) professional neonatology critical care/newborn care; (vi) outpatient professional services; (vii) outpatient institutional provider services; and (viii) inpatient institutional provider services. For each category of service, group health benefit plan issuers are required to provide health care reimbursement rate information for designated Common Procedural Terminology (CPT) or Medicare severity diagnosis related group (MS-DRG) codes, as applicable. In addition to programming as necessary to collect the required data and information, the

Department anticipates that health benefit plan issuers will perform programming necessary to automate population of the Health Care Claims Reimbursement Rate Report with the collected data to the extent possible. Total programming costs will vary depending upon the number of hours required, the skill level of the programmer or programmers, the complexity of the group health benefit plan issuer's information systems, and whether outside contract programmers will be involved. Each issuer has the information needed to estimate its individual costs for such programming. However, based on the latest Texas Workforce Commission (TWC) wage information data, the mean hourly wage for a computer programmer working for an insurer in Texas is $37.54. Based upon information that the Department has previously obtained from insurers, hourly wage rates for outside contract programmers are estimated to range to as much as $200 and over per hour. The actual number, types, and cost of personnel will be determined by the group health benefit plan issuer's existing information systems and staffing. Further, issuers with larger networks operating across multiple or in all of the 11 geographical areas may incur greater costs in Form No. LHL616 than those issuers operating in fewer areas.

(iii) Cost of personnel associated with completion and review of report. The Department further estimates that to the extent that such population is not automated, group health benefit plan issuers will incur personnel costs associated with the completion of Form No. LHL616, proposed for adoption by reference at §21.4507 and required pursuant to proposed §21.4506, as well as costs associated with review of the final report. The actual number, types, and

cost of personnel will be determined by the group health benefit plan issuer's existing staffing and the extent to which form completion is automated. The Department anticipates that these personnel costs will typically range from approximately $200 to $400. This estimate is based upon a member of a health benefit plan issuer's administrative staff preparing the necessary application in four to eight hours. The salary for this employee is estimated at the mean salary rate of $24.06 per hour, as set forth for similar office and administrative support positions in the latest State Occupational Employment and Wage Estimates for Texas published by the Department of Labor (DOL, May 2009) at http//www.bls.gov/oes/current/oes_tx.htm. Additionally, the Department estimates that a member of the health benefit plan issuer's management staff can review and approve the prepared information in two to four hours to complete the data certification portion of Form No. LHL616. The salary for this employee is estimated at the mean salary rate of $53.32 per hour, as set forth for similar management positions in the latest State Occupational Employment and Wage Estimates for Texas published by the DOL (May 2009).

The Department requested cost information by public comment during the posting of the informal draft of this proposal. The Department received a total cost estimate of $4,400 from one large, statewide health benefit plan issuer. The Department has made repeated requests for additional information relating to any cost components or any other basis for this estimate, but has been unable to obtain the additional information.

Exempt issuers and optional additional data inclusion. Pursuant to the Insurance Code §38.353(e), the Commissioner by rule may exclude a type of health benefit plan from the requirements of Chapter 38, Subchapter H, if the Commissioner finds that data collected in relation to the health benefit plan would not be relevant to accomplishing the purposes of Subchapter H. Additionally, the Insurance Code §38.353(d)(1) specifies that standard health benefit plans provided under the Insurance Code Chapter 1507 are not subject to the data submission requirements of Chapter 38. Two types of health benefit plan issuers are exempt in whole or in part from compliance with this proposal, and a third type of issuer can opt to exclude data relating to Chapter 1507 plans. The Department considered these proposed exemptions and optional data exclusion as a means of mitigating compliance costs.

First, pursuant to the Insurance Code §38.353(e), the Department has included a limited exemption in proposed §21.4505(c) and §21.4506(e) for private market preferred provider benefit plans operating under the Insurance Code Chapter 1301 and private market health maintenance organizations operating under the Insurance Code Chapter 843 that do not exceed 10,000 covered lives as of December 31 for the year preceding the submission of the report. A private market plan with exactly 10,000 covered lives as of December 31 for the year preceding the submission of the report would be eligible for the exemption. Health benefit plan issuers asserting this exemption are permitted to collect enrollment data and submit to the Department an exemption statement and the data required in Form No. LHL616 to support the exemption rather than

the full data required in Form No. LHL616. As a result, such issuers may have reduced costs of compliance in comparison to those issuers that do not qualify for the exemption. Specifically, such issuers are unlikely to incur costs associated with additional technology or software necessary for compliance with data collection and preparation, and the Department anticipates that the cost of personnel associated with programming information systems will be minimal because data collection, preparation, and submission will primarily consist of enrollment information. Such issuers, however, will still incur costs of personnel associated with completion and review of the final report. However, because the information submission necessary to support an exemption consists of company identification information and enrollment data, such review will require much fewer staff hours than will a submission on behalf of an issuer not qualifying for the limited exemption. The Department anticipates that the total probable cost of preparing and submitting the information for the limited exemption under proposed new §21.4505(c) and §21.4506(e) will vary but will typically be less than $100. This estimate is based upon a member of a health benefit plan issuer's staff preparing the necessary information in one to four hours. The salary for this employee is estimated at the mean salary rate of $24.06 per hour, as set forth for similar office and administrative support positions in the latest State Occupational Employment and Wage Estimates for Texas published by the DOL (May 2009). Additionally, the Department estimates that a member of the health benefit plan issuer's staff can review and approve the prepared information in less than one hour to complete the data certification portion of

Form No. LHL616. The salary for this employee is estimated at the mean salary rate of $53.32 per hour, as set forth for similar management positions in the latest State Occupational Employment and Wage Estimates for Texas published by the DOL (May 2009).

Second, proposed §21.4503(1) specifies that the term “group health benefit plan” includes neither a health maintenance organization providing routine dental or vision services as a single health care service plan nor a preferred provider benefit plan providing routine vision services as a routine single health care service plan. As such, neither type of single health care service plan is currently subject to the data collection, preparation, filing, and submission requirements in this proposal, nor will these types of plans incur costs as a result of the enforcement or administration of this proposal.

Third, the Insurance Code §38.353(d)(1) specifies that standard health benefit plans provided under the Insurance Code Chapter 1507 are not subject to the data submission requirements of Chapter 38. Proposed §21.4502(c)(1) incorporates this provision. Proposed §21.4502(d), however, permits a group health benefit plan issuer to electively include data concerning reimbursement rates for standard health benefit plans in its submission of Form No. LHL616. This proposed provision enables health benefit plan issuers who offer standard health benefit plans to avoid the possible expense of separating out claims data for those types of plans if such claims data is otherwise aggregated with the data that is required to be submitted.

4. ECONOMIC IMPACT STATEMENT AND REGULATORY FLEXIBILITY ANALYSIS FOR SMALL AND MICRO BUSINESSES. The Government Code §2006.002(c) requires that if a proposed rule may have an economic impact on small businesses, state agencies must prepare as part of the rulemaking process an economic impact statement that assesses the potential impact of the proposed rule on small businesses and a regulatory flexibility analysis that considers alternative methods of achieving the purpose of the rule. The Government Code §2006.001(2) defines "small business" as a legal entity, including a corporation, partnership, or sole proprietorship, that is formed for the purpose of making a profit, is independently owned and operated, and has fewer than 100 employees or less than $6 million in annual gross receipts. The Government Code §2006.001(1) defines "micro business" similarly to "small business" but specifies that such a business may not have more than 20 employees. The Government Code §2006.002(f) requires a state agency to adopt provisions concerning micro businesses that are uniform with those provisions outlined in the Government Code §2006.002(b) - (d) for small businesses.

As required by the Government Code §2006.002(c), the Department has determined that proposed new §21.4505 and §21.4506 may have an adverse economic effect on two to five health maintenance organizations (HMOs) and four to seven preferred provider benefit plan issuers (hereafter referred to collectively as group health benefit plan issuers, when appropriate) that qualify as small or micro businesses under the Government Code §2006.001(1) and (2)

and that are required to comply with these proposed rules. This estimated number of small and micro businesses is based on an analysis of the financial data collected by the Department, such as the annual gross premiums of licensed HMOs and insurance companies, and on self-reporting by preferred provider benefit plan issuers regarding whether they qualify as small businesses. The adverse economic impact will result from the necessary costs to comply with this proposal that are discussed in the Public Benefit/Cost Note part of this proposal for group health benefit plan issuers that are: (i) collecting and preparing health care reimbursement data as specified in proposed §21.4505; and (ii) submitting the data as specified in proposed §21.4505 and proposed §21.4506. As also discussed in the Public Benefit/Cost Note part of this proposal, the cost components associated with these compliance requirements include: (i) the cost of any additional technology or software necessary to comply with the data collection, preparation, and submission requirements in proposed §21.4505 and §21.4506, including the enrollment information and claims data specified in the proposed Health Care Claims Reimbursement Rate Report form; (ii) personnel costs associated with programming information systems for compliance with the requirements in proposed §21.4505 and §21.4506; and (iii) personnel costs associated with completing and reviewing Form No. LHL616 (Health Care Claims Reimbursement Rate Report) in compliance with the requirements in proposed §21.4505 and §21.4506.

The proposed rules incorporate regulatory provisions designed to reduce potential economic impact for all group health benefit plan issuers, including

small and micro businesses. These proposed measures are: (i) a reduced data collection and reporting requirement for those issuers whose plans do not cover more than 10,000 persons pursuant to proposed §21.4505 and §21.4506; (ii) permissive reporting of claim data for standard plans for purposes of administrative convenience pursuant to proposed §21.4502(d); and (iii) inclusion of a shorter reporting period in proposed §21.4505(b).

In developing the data collection and reporting requirements included in proposed §21.4505 and §21.4506, the Department initially considered requiring all group health benefit plan issuers to collect and report data as specified in those proposed sections. However, the Department anticipates that the exclusion of reimbursement data from health benefit plan issuers with enrollment that does not exceed 10,000 persons will not markedly affect the aggregate data. Accordingly, proposed §21.4505 and §21.4506 include a limited exemption based upon enrollment that the Department anticipates may reduce the economic impact of this proposal for small and micro businesses. Proposed §21.4505(c) provides that a health benefit plan issuer that is exempt from filing a full reimbursement report pursuant to §21.4506(e) of the subchapter is not required to collect the full data specified in Form No. LHL616. Instead, such issuer shall collect enrollment data as necessary to comply with the applicable instructions in Part B of Form No. LHL616 to support an exemption. Proposed §21.4506(e) permits group health benefit plan issuers operating under the Insurance Code Chapters 843 or 1301 to submit to the Department an exemption statement and the data required in Form No. LHL616 to support an exemption if

the issuer meets the criteria in proposed paragraphs (1) or (2) of proposed §21.4506(e), as applicable. Under these paragraphs, a health benefit plan issuer qualifies for an exemption if the total number of covered lives in private market plans offered by the health benefit plan issuer in Texas does not exceed 10,000 persons as of December 31 of the year preceding the report. The limited exemption in proposed §21.4505(c) and §21.4506(e) applies to private market preferred provider benefit plans operating under the Insurance Code Chapter 1301 and private market health maintenance organizations operating under the Insurance Code Chapter 843, as applicable for each line of business. This limited exemption from specified data collection and reporting requirements in proposed §21.4505 and §21.4506 is available to all group health benefit plan issuers that qualify, including qualifying issuers that are small or micro businesses. While the limited exemption is not directly contingent upon the qualification of the group health benefit plan issuer as a small or micro business pursuant to the Government Code §2006.001, the Department anticipates that small and micro business issuers are more likely to qualify for the exemption than are larger issuers. A comparison of enrollment data to the data used to estimate the number of insurers and HMOs that qualify as small or micro businesses supports the conclusion that those qualifying small or micro businesses are also likely to qualify for the reduced data collection and reporting requirements permitted under proposed §21.4505 and §21.4506.

As originally considered by the Department, proposed §21.4502(c)(1), concerning applicability, provided that these proposed rules did not apply to

standard health benefit plans provided under the Insurance Code Chapter 1507 (standard plans). This provision incorporated the statutory exception in the Insurance Code §38.353(d)(1). However, informal comment from stakeholders at stakeholder meetings indicated that some group health benefit plan issuers maintain aggregated claim data. As a result, it would be costlier for these issuers to segregate claim data for standard plans than to include it. The Department anticipates that inclusion of reimbursement rate data for standard plans will not markedly affect the aggregate data. Accordingly, proposed §21.4502(d) permits a group health benefit plan issuer to electively include the data concerning reimbursement rates for standard plans in its submission of data for purposes of administrative convenience. The Department anticipates that proposed §21.4502(d) may reduce the economic impact of this proposal for all group health benefit plan issuers that issue standard plans, including small and micro businesses.

The Department similarly considered cost implications in determining the period of time for which reimbursement rate data must be collected and submitted, as authorized in the Insurance Code §38.355. The Department has determined that a sample of half of all claims in an applicable calendar year is likely to provide an adequate representation of all reimbursement rates. Accordingly, the Department has also determined that requiring the annual collection and submission of reimbursement rate data for six months per applicable calendar year, January 1 to June 30, will be sufficient to permit comparison of health care reimbursement rates as required in the Insurance

Code §38.355(b). The Department anticipates that inclusion of this reduced data collection and submission requirement in proposed §21.4505(b) will lessen the costs of compliance for all group health benefit plan issuers, including small and micro businesses.

The Government Code §2006.002(c)(2) requires a state agency, before adopting a rule that may have an adverse economic effect on small businesses, to prepare a regulatory flexibility analysis that includes the agency's consideration of alternative methods of achieving the purpose of the proposed rule. The Government Code §2006.002(c-1) requires that the regulatory analysis "consider, if consistent with the health, safety, and environmental and economic welfare of the state, using regulatory methods that will accomplish the objectives of applicable rules while minimizing adverse impacts on small businesses."

The August 21, 2007, bill analysis for SB 1731, as enacted by the 80th Legislature, Regular Session, states that health care costs have risen steadily in recent years. (TEXAS STATE SENATE STATE AFFAIRS COMMITTEE, BILL ANALYSIS (ENROLLED), SB 79, 80TH Leg., R.S. (Aug. 21, 2007)). According to the analysis, these increases have resulted in much discussion and debate among employers, providers, health plans and patients. The bill analysis points out that a “major point of this discussion is the potential for inaccurate information and the absence of transparency in the costs of health care services.” The bill analysis concludes that, "The disclosure of this information may help patients to make appropriate and cost effective health care choices." As part of the transparency requirements mandated pursuant to SB 1731, the Insurance Code §38.355

requires each health benefit plan issuer to submit to the Department, at the time and in the form and manner required by the Department, aggregate reimbursement rates by region paid by the health benefit plan issuer for health care services identified by the Department. Section 38.357 requires the Department to provide the aggregated data to the DSHS for publication on the DSHS website. As previously discussed in this Economic Impact Statement, the Department has considered and incorporated into this proposal regulatory provisions that will minimize adverse economic impact upon all group health benefit plan issuers, including small and micro businesses. Nevertheless, the Department considered additional regulatory alternatives as required by the Government Code §2006.002(c)(2). These alternatives include: (i) total exemption of small or micro business group health benefit plan issuers from data collection and reporting requirements in lieu of the reduced data collection and reporting requirement on the basis of reduced enrollment in the proposal; (ii) limited exemption of small or micro business group health benefit plan issuers solely on the basis of their meeting the criteria of a small or micro business pursuant to the Government Code §2006.001; and (iii) reduced frequency requirement for the provision of collection and submission of health care reimbursement data by small or micro business group health benefit plan issuers such as every other year. For the following reasons, the Department rejected each of these alternatives as not being sufficiently consistent with the purpose of the statute or sufficiently protective of the economic welfare of the state, including small and micro businesses.

Total exemption of small or micro businesses from data collection and reporting requirements. The Department has determined that if small and micro business group health benefit plan issuers are exempted from all data collection and reporting requirements, it is possible that the accuracy and reliability of the claims data submitted by the Department to the DSHS and published by that agency would be compromised. Health care rate reimbursement data from an issuer with a large number of covered lives, and therefore likely a more significant quantity of claims, has a greater potential to affect the overall aggregation of data that will be published for purposes of comparison. This is particularly true considering that the data is collected and reported on the basis of eleven specific geographic regions. As previously explained in this Economic Impact Statement, the Department has instead elected in proposed §21.4505 and §21.4506 to permit reduced data collection and reporting on the basis of reduced enrollment. Although the reduced data collection and reporting under this proposal is permitted on the basis of reduced enrollment rather than the group health benefit plan issuer meeting the criteria to qualify as a small or micro business pursuant to the Government Code §2006.001, the Department anticipates that small and micro business issuers will likely qualify for the proposed limited exemption. However, under the proposal, should the qualifying small or micro business issuer provide coverage to a greater number of persons than 10,000 as provided in proposed §21.4506, and thus have a greater likelihood of affecting the aggregated data, the small or micro business issuer will not qualify for the limited exemption. The Department has determined that a total

or an unqualified exemption for all small or micro business issuers would not be sufficiently protective of the quality and reliability of the data. As a result, the impaired data would not be consistent with the intent of the statute to improve the ability of patients to make appropriate and cost effective health care decisions. Further, impaired data would reduce the ability of employers, including small and micro businesses, to accurately compare health care reimbursement data in selecting health benefit plans. As such, the Department has determined that this total exemption regulatory alternative is not sufficiently protective of the economic welfare of the state or sufficiently consistent with the purpose of Chapter 38 Subchapter H of the Insurance Code as enacted in SB 1731 to provide greater accuracy and transparency of health care costs for consumers.

Limited exemption of small or micro businesses solely on the basis of their meeting the criteria of a small or micro business. Reducing the data collection and reporting requirements for group health benefit plan issuers solely on the basis of their meeting the criteria of a small or micro business pursuant to the Government Code §2006.001 could adversely affect the accuracy and reliability of the claims data submitted by the Department to the DSHS for publication. For example, it is possible that a small or micro business issuer could provide coverage to a sufficient number of persons -- greater than the 10,000-person requirement in the proposed §21.4505 and §21.4506 limited exemption -- that a significant quantity of claims are generated. Absent such data, the data available for purposes of comparison by both employers and patients could be less accurate and therefore less reliable. Therefore, the Department has instead

proposed §21.4505 and §21.4506 to permit reduced data collection and reporting on the basis of reduced enrollment, regardless of whether the issuer meets the criteria to qualify as a small or micro business. Although under this proposal the reduced data collection and reporting is permitted on the basis of reduced enrollment rather than whether the issuer meets the criteria to qualify as a small or micro business, the Department anticipates that issuers that meet the criteria as a small or micro business will likely qualify for the limited exemption in proposed §21.4505 and §21.4506. However, under the proposal, should the qualifying small or micro business issuer provide coverage to a number of persons in excess of 10,000 covered lives requirement in proposed §21.4506, and thus have a greater likelihood of affecting the aggregated data, the small or micro business issuer will not qualify for the limited exemption. As a result, such small and micro business issuers claims data will be included in the collected data along with those issuers that do not meet the criteria as a small or micro business pursuant to the Government Code §2006.001. Therefore, the Department has determined that this regulatory alternative is not sufficiently protective of the economic welfare of the state or sufficiently consistent with the purpose of Chapter 38 Subchapter H of the Insurance Code as enacted in SB 1731 to provide greater accuracy and transparency of health care costs for consumers.

Reduced frequency requirement for small or micro businesses to collect and submit data. Permitting small or micro business group health benefit plan issuers to submit health care reimbursement data on a reduced frequency basis

could similarly impair the quality and reliability of the data submitted by the Department to the DSHS for publication. As previously discussed, the bill analysis for SB 1731 notes that health care costs have been consistently rising in recent years. This trend increases the importance of collecting data on an annual basis. This is particularly true because this proposal in §21.4505(b) includes a reduced reporting period of six months per year for all group health benefit plan issuers required to comply with the proposal, including small and micro businesses. This proposed reduced reporting requirement provides that the six-month reporting period for data is January 1 to June 30 of the applicable reporting year. Further, because small or micro businesses are likely to be subject to the proposed §21.4505 and §21.4506 limited exemption based upon not exceeding the 10,000 covered lives requirement, the small or micro businesses that would be subject to the reduced frequency reporting requirement would likely have a significant quantity of claims data sufficient to affect the aggregate data for the region or regions in which the small or micro business operates. The Department has determined that absent such data, the quality of data available for purposes of comparison by both employers and patients would be less reliable during the periods of time for which the reduced frequency reporting precluded submission of data. As a result, this regulatory alternative would not be consistent with the intent of the statute to improve the ability of patients to make appropriate and cost effective health care decisions. Therefore, the Department has determined that this regulatory alternative is not sufficiently protective of the economic welfare of the state or sufficiently consistent with the

purpose of Chapter 38 Subchapter H of the Insurance Code as enacted in SB 1731 to provide greater accuracy and transparency of health care costs for consumers.

For these reasons, the Department has determined, in accordance with the Government Code §2006.002(c-1), that there are no regulatory alternatives to the proposed requirements in §§21.4501 – 21.4506 that will sufficiently protect the health, safety, environmental, and economic welfare of the state in a manner consistent with the objective and intent of Chapter 38 Subchapter H of the Insurance Code as enacted by SB 1731 and the proposed rule.

5. TAKINGS IMPACT ASSESSMENT. The Department has determined that no private real property interests are affected by this proposal and that this proposal does not restrict or limit an owner's right to property that would otherwise exist in the absence of government action and, therefore, does not constitute a taking or require a takings impact assessment under the Government Code §2007.043.

6. REQUEST FOR PUBLIC COMMENT. To be considered, written comments on the proposal must be submitted no later than 5:00 p.m. on October 11, 2010, to Gene C. Jarmon, General Counsel and Chief Clerk, Mail Code 113-2A, Texas Department of Insurance, P. O. Box 149104, Austin, Texas 78714-9104. An additional copy of the comment must be simultaneously submitted to Dianne Longley, Director of Research and Analysis, Life/Health Division, Mail Code 107-2A, Texas Department of Insurance, P.O. Box 149104, Austin, Texas 78714-

9104. Any request for a public hearing should be submitted separately to the Office of the Chief Clerk before the close of the public comment period. If a hearing is held, written and oral comments presented at the hearing will be considered.

7. STATUTORY AUTHORITY. The new sections are proposed under SECTION 19 of SB 1731, as enacted by the 80th Legislature, Regular Session, effective September 1, 2007, and the Insurance Code §§38.351, 38.352, 1301.001, 843.002, 38.353, 38.354, 38.355, 38.357, 38.358, and 36.001. SECTION 19 of SB 1731 mandates that the rules adopted to implement the Insurance Code Chapter 38, Subchapter H (hereafter Subchapter H) must require that each health benefit plan issuer subject to that subchapter make the initial submission of data under that subchapter not later than the 60th day after the effective date of the rules. Section 38.351 provides that the purpose of Subchapter H, to authorize the Department to: (i) collect data concerning health benefit plan reimbursement rates in a uniform format; and (ii) disseminate, on an aggregate basis for geographical regions in the state, information concerning health care reimbursement rates derived from the data. Section 38.352 provides that in Subchapter H, *group health benefit plan* means a preferred provider benefit plan as defined by §1301.001 or an evidence of coverage for a health care plan that provides basic health care services as defined by §843.002. Section 1301.001 provides at paragraph (9) that *preferred provider benefit plan* means a benefit plan in which an insurer provides, through its health insurance policy, for the

payment of a level of coverage that is different from the basic level of coverage provided by the health insurance policy if the insured person uses a preferred provider. Section 1301.001 provides at paragraph (2) that *health insurance policy* means a group or individual insurance policy, certificate, or contract providing benefits for medical or surgical expenses incurred as a result of an accident or sickness. Section 843.002(9) provides that *evidence of coverage* means any certificate, agreement, or contract, including a blended contract, that: (i) is issued to an enrollee; and (ii) states the coverage to which the enrollee is entitled. Section 38.353(e) permits the Commissioner to exclude a type of health benefit plan from the requirements of Subchapter H if the Commissioner finds that data collected in relation to the health benefit plan would not be relevant to accomplishing the purposes of the subchapter. Section 38.354 grants the Commissioner authority to adopt rules as provided by the Insurance Code Chapter 36, Subchapter A, to implement Subchapter H. Section 38.355(a) requires each health benefit plan issuer to submit aggregate reimbursement rates by region paid by the health benefit plan issuer for health care services identified by the Department, in the form and manner and at the time required by the Department. Section 38.355(b) requires that the Department by rule establish a standardized format for the submission of the data submitted under the section to permit comparison of health care reimbursement rates. The subsection also requires the Department, to the extent feasible, to develop the data submission requirements in a manner that allows collection of reimbursement rates as a dollar amount and not by comparison to other standard

reimbursement rates. Section 38.355(c) requires the Department to specify the period for which reimbursement rates must be filed. Section 38.357 requires the Department to provide to the Department of State Health Services for publication, for identified regions, aggregate health care reimbursement rate information derived from the data collected under Subchapter H. Section 38.357 also provides that the published information may not reveal the name of any health care provider or health benefit plan issuer and authorizes the Department to make the aggregate health care reimbursement rate information available through the Department's Internet website. Section 38.358 provides that a health benefit plan issuer that fails to submit data as required is subject to an administrative penalty under the Insurance Code Chapter 84. Further, each day the issuer fails to submit the data as required is a separate violation for purposes of penalty assessment. Section 36.001 authorizes the Commissioner to adopt any rules necessary and appropriate to implement the powers and duties of the Department under the Insurance Code and other laws of this state.

8. CROSS REFERENCE TO STATUTE. The following statutes are affected by this proposal:

Rule	Statute
§§21.4501 – 21.4507	Insurance Code Chapter 38, Subchapter H; and Chapters 843, 1301, 1501, 1507, 1551, 1575, 1579, and 1601

9. TEXT.

§21.4501. Purpose. The purpose of this subchapter is to:

(1) prescribe the data collection and submission requirements and form for the submission of data related to health care reimbursement rates by health benefit plan issuers;

(2) specify the definitions necessary to implement the Insurance Code Chapter 38, Subchapter H; and

(3) facilitate the department's provision of aggregate health care reimbursement rate information derived from the data collected under this subchapter to the Department of State Health Services for publication.

§21.4502. Applicability.

(a) This subchapter applies to the issuer of a group health benefit plan as defined in §21.4503 of this subchapter (relating to Definitions), including, as provided by the Insurance Code §38.353(a):

(1) an insurance company;

(2) a group hospital service corporation;

(3) a fraternal benefit society;

(4) a stipulated premium company;

(5) a reciprocal or interinsurance exchange; and

(6) a health maintenance organization.

(b) In accordance with the Insurance Code §38.353(b), and notwithstanding any provision in the Insurance Code Chapter 1551, 1575, 1579, or 1601 or any other law, this subchapter applies to:

(1) a basic coverage plan under the Insurance Code Chapter 1551;

(2) a basic plan under the Insurance Code Chapter 1575;

(3) a primary care coverage plan under the Insurance Code Chapter 1579; and

(4) basic coverage under the Insurance Code Chapter 1601.

(c) Pursuant to the Insurance Code §38.353(d), this subchapter does not apply to:

(1) standard health benefit plans provided under the Insurance Code Chapter 1507;

(2) children's health benefit plans provided under the Insurance Code Chapter 1502;

(3) health care benefits provided under a workers' compensation insurance policy;

(4) Medicaid managed care programs operated under the Government Code Chapter 533;

(5) Medicaid programs operated under the Human Resources Code Chapter 32; or

(6) the state child health plan operated under the Health and Safety Code Chapter 62 or 63.

(d) Notwithstanding subsection (c)(1) of this section, a group health benefit plan issuer is not prohibited from electively including data concerning reimbursement rates for standard health benefit plans provided under the Insurance Code Chapter 1507 in its submission of the report required in §21.4506 of this subchapter (relating to Submission of Report) for purposes of administrative convenience. Data from all other plans identified in subsection (c) of this section shall be excluded from the report.

§21.4503. Definitions. The following words and terms when used in this subchapter shall have the following meanings unless the context clearly indicates otherwise.

(1) Group health benefit plan--As specified in the Insurance Code §38.352, a preferred provider benefit plan as defined by the Insurance Code §1301.001 or an evidence of coverage for a health care plan that provides basic health care services as defined by the Insurance Code §843.002. The term does not include a health maintenance organization plan providing routine dental or vision services as a single health care service plan or a preferred provider benefit plan providing routine vision services as a single health care service plan.

(2) Institutional provider--An institution providing health care services, including but not limited to hospitals, other licensed inpatient centers, ambulatory surgical centers, skilled nursing centers, and residential treatment centers.

(3) Physician--Any individual licensed to practice medicine in this state and, with regard to a health maintenance organization, as defined in the Insurance Code §843.002(22).

(4) Provider--Any practitioner, institutional provider, or other person or organization that furnishes health care services and that is licensed or otherwise authorized to practice in this state, other than a physician.

(5) Reporting period--The six-month interval of time for which a plan or health benefit plan issuer must submit data, beginning each January 1 and ending the following June 30.

§21.4504. Geographic Regions. For purposes of data submission pursuant to this subchapter, geographic regions for the reporting of claims are designated as follows:

(1) Region 1--Panhandle, including Amarillo and Lubbock, comprised of the following ZIP Coded areas: 79001, 79002, 79003, 79005, 79007, 79008, 79009, 79010, 79011, 79012, 79013, 79014, 79015, 79016, 79018, 79019, 79021, 79022, 79024, 79025, 79027, 79029, 79031, 79032, 79033, 79034, 79035, 79036, 79039, 79040, 79041, 79042, 79043, 79044, 79045, 79046, 79051, 79052, 79053, 79054, 79056, 79057, 79058, 79059, 79061, 79062, 79063, 79064, 79065, 79066, 79068, 79070, 79072, 79073, 79077, 79078, 79079, 79080, 79081, 79082, 79083, 79084, 79085, 79086, 79087, 79088, 79091, 79092, 79093, 79094, 79095, 79096, 79097, 79098, 79101, 79102, 79103, 79104, 79105, 79106, 79107, 79108, 79109, 79110,

79111, 79114, 79116, 79117, 79118, 79119, 79120, 79121, 79124, 79159, 79166, 79168, 79172, 79174, 79178, 79185, 79187, 79189, 79201, 79220, 79221, 79226, 79229, 79230, 79231, 79233, 79234, 79235, 79236, 79237, 79239, 79240, 79241, 79243, 79244, 79245, 79250, 79251, 79255, 79256, 79257, 79258, 79259, 79261, 79311, 79312, 79313, 79314, 79316, 79320, 79322, 79323, 79324, 79325, 79326, 79329, 79330, 79336, 79338, 79339, 79343, 79344, 79345, 79346, 79347, 79350, 79351, 79353, 79355, 79356, 79357, 79358, 79363, 79364, 79366, 79367, 79369, 79370, 79371, 79372, 79373, 79376, 79378, 79379, 79380, 79381, 79382, 79383, 79401, 79402, 79403, 79404, 79405, 79406, 79407, 79408, 79409, 79410, 79411, 79412, 79413, 79414, 79415, 79416, 79423, 79424, 79430, 79452, 79453, 79457, 79464, 79490, 79491, 79493, and 79499;

(2) Region 2--Northwest Texas, including Wichita Falls and Abilene, comprised of the following ZIP Coded areas: 76228, 76230, 76239, 76251, 76255, 76261, 76265, 76270, 76301, 76302, 76305, 76306, 76307, 76308, 76309, 76310, 76311, 76351, 76352, 76354, 76357, 76360, 76363, 76364, 76365, 76366, 76367, 76369, 76370, 76371, 76372, 76373, 76374, 76377, 76379, 76380, 76384, 76385, 76388, 76389, 76424, 76427, 76429, 76430, 76432, 76435, 76437, 76442, 76443, 76444, 76445, 76448, 76450, 76452, 76454, 76455, 76458, 76459, 76460, 76464, 76466, 76468, 76469, 76470, 76471, 76474, 76481, 76483, 76486, 76491, 76801, 76802, 76803, 76804, 76821, 76823, 76827, 76828, 76834, 76845, 76857, 76861, 76865, 76873, 76875, 76878, 76882, 76884, 76888, 76890, 79223, 79225, 79227,

79247, 79248, 79252, 79501, 79502, 79503, 79504, 79505, 79506, 79508, 79510, 79512, 79516, 79517, 79518, 79519, 79520, 79521, 79525, 79526, 79527, 79528, 79529, 79530, 79532, 79533, 79534, 79535, 79536, 79537, 79538, 79539, 79540, 79541, 79543, 79544, 79545, 79546, 79547, 79548, 79549, 79550, 79553, 79556, 79560, 79561, 79562, 79563, 79565, 79566, 79567, 79601, 79602, 79603, 79604, 79605, 79606, 79607, 79608, 79697, 79698, and 79699;

(3) Region 3--Metroplex, including Fort Worth and Dallas, comprised of the following ZIP Coded areas: 75001, 75002, 75006, 75007, 75009, 75010, 75011, 75013, 75014, 75015, 75016, 75017, 75019, 75020, 75021, 75022, 75023, 75024, 75025, 75026, 75027, 75028, 75029, 75030, 75032, 75034, 75035, 75037, 75038, 75039, 75040, 75041, 75042, 75043, 75044, 75045, 75046, 75047, 75048, 75049, 75050, 75051, 75052, 75053, 75054, 75056, 75057, 75058, 75060, 75061, 75062, 75063, 75065, 75067, 75068, 75069, 75070, 75071, 75074, 75075, 75076, 75077, 75078, 75080, 75081, 75082, 75083, 75085, 75086, 75087, 75088, 75089, 75090, 75091, 75092, 75093, 75094, 75097, 75098, 75099, 75101, 75102, 75104, 75105, 75106, 75109, 75110, 75114, 75115, 75116, 75118, 75119, 75120, 75121, 75123, 75125, 75126, 75132, 75134, 75135, 75137, 75138, 75141, 75142, 75143, 75144, 75146, 75147, 75149, 75150, 75151, 75152, 75153, 75154, 75155, 75157, 75158, 75159, 75160, 75161, 75164, 75165, 75166, 75167, 75168, 75172, 75173, 75180, 75181, 75182, 75185, 75187, 75189, 75201, 75202, 75203, 75204, 75205, 75206, 75207, 75208, 75209, 75210, 75211,

75212, 75214, 75215, 75216, 75217, 75218, 75219, 75220, 75221, 75222, 75223, 75224, 75225, 75226, 75227, 75228, 75229, 75230, 75231, 75232, 75233, 75234, 75235, 75236, 75237, 75238, 75240, 75241, 75242, 75243, 75244, 75245, 75246, 75247, 75248, 75249, 75250, 75251, 75252, 75253, 75254, 75258, 75260, 75261, 75262, 75263, 75264, 75265, 75266, 75267, 75270, 75275, 75277, 75283, 75284, 75285, 75286, 75287, 75301, 75303, 75310, 75312, 75313, 75315, 75320, 75323, 75326, 75334, 75336, 75339, 75340, 75342, 75343, 75344, 75353, 75354, 75355, 75356, 75357, 75358, 75359, 75360, 75363, 75364, 75367, 75368, 75370, 75371, 75372, 75373, 75374, 75376, 75378, 75379, 75380, 75381, 75382, 75386, 75387, 75388, 75389, 75390, 75391, 75392, 75393, 75394, 75395, 75396, 75397, 75398, 75401, 75402, 75403, 75404, 75407, 75409, 75413, 75414, 75418, 75422, 75423, 75424, 75428, 75429, 75438, 75439, 75442, 75443, 75446, 75447, 75449, 75452, 75453, 75454, 75458, 75459, 75474, 75475, 75476, 75479, 75485, 75488, 75489, 75490, 75491, 75492, 75495, 75496, 76001, 76002, 76003, 76004, 76005, 76006, 76007, 76008, 76009, 76010, 76011, 76012, 76013, 76014, 76015, 76016, 76017, 76018, 76019, 76020, 76021, 76022, 76023, 76028, 76031, 76033, 76034, 76035, 76036, 76039, 76040, 76041, 76043, 76044, 76048, 76049, 76050, 76051, 76052, 76053, 76054, 76058, 76059, 76060, 76061, 76063, 76064, 76065, 76066, 76067, 76068, 76070, 76071, 76073, 76077, 76078, 76082, 76084, 76085, 76086, 76087, 76088, 76092, 76093, 76094, 76095, 76096, 76097, 76098, 76099, 76101, 76102, 76103, 76104, 76105, 76106, 76107, 76108, 76109, 76110, 76111, 76112,

76113, 76114, 76115, 76116, 76117, 76118, 76119, 76120, 76121, 76122, 76123, 76124, 76126, 76127, 76129, 76130, 76131, 76132, 76133, 76134, 76135, 76136, 76137, 76140, 76147, 76148, 76150, 76155, 76161, 76162, 76163, 76164, 76166, 76177, 76179, 76180, 76181, 76182, 76185, 76191, 76192, 76193, 76195, 76196, 76197, 76198, 76199, 76201, 76202, 76203, 76204, 76205, 76206, 76207, 76208, 76209, 76210, 76225, 76226, 76227, 76233, 76234, 76238, 76240, 76241, 76244, 76245, 76246, 76247, 76248, 76249, 76250, 76252, 76253, 76258, 76259, 76262, 76263, 76264, 76266, 76267, 76268, 76271, 76272, 76273, 76299, 76401, 76402, 76426, 76431, 76433, 76439, 76446, 76449, 76453, 76461, 76462, 76463, 76465, 76467, 76472, 76475, 76476, 76484, 76485, 76487, 76490, 76623, 76626, 76639, 76641, 76651, 76670, 76679, and 76681;

(4) Region 4--Northeast Texas, including Tyler, comprised of the following ZIP Coded areas: 75103, 75117, 75124, 75127, 75140, 75148, 75156, 75163, 75169, 75410, 75411, 75412, 75415, 75416, 75417, 75420, 75421, 75425, 75426, 75431, 75432, 75433, 75434, 75435, 75436, 75437, 75440, 75441, 75444, 75448, 75450, 75451, 75455, 75456, 75457, 75460, 75461, 75462, 75468, 75469, 75470, 75471, 75472, 75473, 75477, 75478, 75480, 75481, 75482, 75483, 75486, 75487, 75493, 75494, 75497, 75501, 75503, 75504, 75505, 75507, 75550, 75551, 75554, 75555, 75556, 75558, 75559, 75560, 75561, 75562, 75563, 75564, 75565, 75566, 75567, 75568, 75569, 75570, 75571, 75572, 75573, 75574, 75599, 75601, 75602, 75603, 75604, 75605, 75606, 75607, 75608, 75615, 75630, 75631, 75633, 75636, 75637,

75638, 75639, 75640, 75641, 75642, 75643, 75644, 75645, 75647, 75650, 75651, 75652, 75653, 75654, 75656, 75657, 75658, 75659, 75660, 75661, 75662, 75663, 75666, 75667, 75668, 75669, 75670, 75671, 75672, 75680, 75681, 75682, 75683, 75684, 75685, 75686, 75687, 75688, 75689, 75691, 75692, 75693, 75694, 75701, 75702, 75703, 75704, 75705, 75706, 75707, 75708, 75709, 75710, 75711, 75712, 75713, 75750, 75751, 75752, 75754, 75755, 75756, 75757, 75758, 75759, 75762, 75763, 75764, 75765, 75766, 75770, 75771, 75772, 75773, 75778, 75779, 75780, 75782, 75783, 75784, 75785, 75789, 75790, 75791, 75792, 75797, 75798, 75799, 75801, 75802, 75803, 75832, 75839, 75853, 75861, 75880, 75882, 75884, 75886, 75925, and 75976;

(5) Region 5--Southeast Texas, including Beaumont, comprised of the following ZIP Coded areas: 75760, 75788, 75834, 75835, 75844, 75845, 75847, 75849, 75851, 75856, 75858, 75862, 75865, 75901, 75902, 75903, 75904, 75915, 75926, 75928, 75929, 75930, 75931, 75932, 75933, 75934, 75935, 75936, 75937, 75938, 75939, 75941, 75942, 75943, 75944, 75946, 75948, 75949, 75951, 75954, 75956, 75958, 75959, 75960, 75961, 75962, 75963, 75964, 75965, 75966, 75968, 75969, 75972, 75973, 75974, 75975, 75977, 75978, 75979, 75980, 75990, 77326, 77331, 77332, 77335, 77350, 77351, 77359, 77360, 77364, 77371, 77374, 77376, 77399, 77519, 77585, 77611, 77612, 77613, 77614, 77615, 77616, 77619, 77622, 77624, 77625, 77626, 77627, 77629, 77630, 77631, 77632, 77639, 77640, 77641, 77642, 77643, 77651, 77655, 77656, 77657, 77659, 77660, 77662, 77663, 77664,

77670, 77701, 77702, 77703, 77704, 77705, 77706, 77707, 77708, 77709, 77710, 77713, 77720, 77725, and 77726;

(6) Region 6--Gulf Coast, including Houston and Huntsville, comprised of the following ZIP Coded areas: 77001, 77002, 77003, 77004, 77005, 77006, 77007, 77008, 77009, 77010, 77011, 77012, 77013, 77014, 77015, 77016, 77017, 77018, 77019, 77020, 77021, 77022, 77023, 77024, 77025, 77026, 77027, 77028, 77029, 77030, 77031, 77032, 77033, 77034, 77035, 77036, 77037, 77038, 77039, 77040, 77041, 77042, 77043, 77044, 77045, 77046, 77047, 77048, 77049, 77050, 77051, 77052, 77053, 77054, 77055, 77056, 77057, 77058, 77059, 77060, 77061, 77062, 77063, 77064, 77065, 77066, 77067, 77068, 77069, 77070, 77071, 77072, 77073, 77074, 77075, 77076, 77077, 77078, 77079, 77080, 77081, 77082, 77083, 77084, 77085, 77086, 77087, 77088, 77089, 77090, 77091, 77092, 77093, 77094, 77095, 77096, 77097, 77098, 77099, 77201, 77202, 77203, 77204, 77205, 77206, 77207, 77208, 77209, 77210, 77212, 77213, 77215, 77216, 77217, 77218, 77219, 77220, 77221, 77222, 77223, 77224, 77225, 77226, 77227, 77228, 77229, 77230, 77231, 77233, 77234, 77235, 77236, 77237, 77238, 77240, 77241, 77242, 77243, 77244, 77245, 77246, 77247, 77248, 77249, 77250, 77251, 77252, 77253, 77254, 77255, 77256, 77257, 77258, 77259, 77260, 77261, 77262, 77263, 77265, 77266, 77267, 77268, 77269, 77270, 77271, 77272, 77273, 77274, 77275, 77276, 77277, 77278, 77279, 77280, 77282, 77284, 77285, 77286, 77287, 77288, 77289, 77290, 77291, 77292, 77293, 77294, 77296, 77297, 77298, 77299, 77301, 77302, 77303, 77304,

77305, 77306, 77315, 77316, 77318, 77320, 77325, 77327, 77328, 77333, 77334, 77336, 77337, 77338, 77339, 77340, 77341, 77342, 77343, 77344, 77345, 77346, 77347, 77348, 77349, 77353, 77354, 77355, 77356, 77357, 77358, 77362, 77365, 77367, 77368, 77369, 77372, 77373, 77375, 77377, 77378, 77379, 77380, 77381, 77382, 77383, 77384, 77385, 77386, 77387, 77388, 77389, 77391, 77393, 77396, 77401, 77402, 77404, 77406, 77410, 77411, 77412, 77413, 77414, 77415, 77417, 77418, 77419, 77420, 77422, 77423, 77428, 77429, 77430, 77431, 77432, 77433, 77434, 77435, 77436, 77437, 77440, 77441, 77442, 77443, 77444, 77445, 77446, 77447, 77448, 77449, 77450, 77451, 77452, 77453, 77454, 77455, 77456, 77457, 77458, 77459, 77460, 77461, 77463, 77464, 77465, 77466, 77467, 77468, 77469, 77470, 77471, 77473, 77474, 77475, 77476, 77477, 77478, 77479, 77480, 77481, 77482, 77483, 77484, 77485, 77486, 77487, 77488, 77489, 77491, 77492, 77493, 77494, 77496, 77497, 77501, 77502, 77503, 77504, 77505, 77506, 77507, 77508, 77510, 77511, 77512, 77514, 77515, 77516, 77517, 77518, 77520, 77521, 77522, 77530, 77531, 77532, 77533, 77534, 77535, 77536, 77538, 77539, 77541, 77542, 77545, 77546, 77547, 77549, 77550, 77551, 77552, 77553, 77554, 77555, 77560, 77561, 77562, 77563, 77564, 77565, 77566, 77568, 77571, 77572, 77573, 77574, 77575, 77577, 77578, 77580, 77581, 77582, 77583, 77584, 77586, 77587, 77588, 77590, 77591, 77592, 77597, 77598, 77617, 77623, 77650, 77661, 77665, 78931, 78933, 78934, 78935, 78943, 78944, 78950, 78951, and 78962;

(7) Region 7--Central Texas, including Austin and Waco, comprised of the following ZIP Coded areas: 73301, 73344, 75831, 75833, 75838, 75840, 75846, 75848, 75850, 75852, 75855, 75859, 75860, 76055, 76436, 76457, 76501, 76502, 76503, 76504, 76505, 76508, 76511, 76513, 76518, 76519, 76520, 76522, 76523, 76524, 76525, 76526, 76527, 76528, 76530, 76531, 76533, 76534, 76537, 76538, 76539, 76540, 76541, 76542, 76543, 76544, 76545, 76546, 76547, 76548, 76549, 76550, 76554, 76556, 76557, 76558, 76559, 76561, 76564, 76565, 76566, 76567, 76569, 76570, 76571, 76573, 76574, 76577, 76578, 76579, 76596, 76597, 76598, 76599, 76621, 76622, 76624, 76627, 76628, 76629, 76630, 76631, 76632, 76633, 76634, 76635, 76636, 76637, 76638, 76640, 76642, 76643, 76644, 76645, 76648, 76649, 76650, 76652, 76653, 76654, 76655, 76656, 76657, 76660, 76661, 76664, 76665, 76666, 76667, 76671, 76673, 76676, 76678, 76680, 76682, 76684, 76685, 76686, 76687, 76689, 76690, 76691, 76692, 76693, 76701, 76702, 76703, 76704, 76705, 76706, 76707, 76708, 76710, 76711, 76712, 76714, 76715, 76716, 76795, 76797, 76798, 76799, 76824, 76831, 76832, 76844, 76853, 76864, 76870, 76871, 76877, 76880, 76885, 77363, 77426, 77801, 77802, 77803, 77805, 77806, 77807, 77808, 77830, 77831, 77833, 77834, 77835, 77836, 77837, 77838, 77840, 77841, 77842, 77843, 77844, 77845, 77850, 77852, 77853, 77855, 77856, 77857, 77859, 77861, 77862, 77863, 77864, 77865, 77866, 77867, 77868, 77869, 77870, 77871, 77872, 77873, 77875, 77876, 77878, 77879, 77880, 77881, 77882, 78602, 78605, 78606, 78607, 78608, 78609, 78610, 78611, 78612, 78613, 78615,

78616, 78617, 78619, 78620, 78621, 78622, 78626, 78627, 78628, 78630, 78633, 78634, 78635, 78636, 78639, 78640, 78641, 78642, 78643, 78644, 78645, 78646, 78648, 78650, 78651, 78652, 78653, 78654, 78655, 78656, 78657, 78659, 78660, 78661, 78662, 78663, 78664, 78665, 78666, 78667, 78669, 78672, 78673, 78674, 78676, 78680, 78681, 78682, 78683, 78691, 78701, 78702, 78703, 78704, 78705, 78708, 78709, 78710, 78711, 78712, 78713, 78714, 78715, 78716, 78717, 78718, 78719, 78720, 78721, 78722, 78723, 78724, 78725, 78726, 78727, 78728, 78729, 78730, 78731, 78732, 78733, 78734, 78735, 78736, 78737, 78738, 78739, 78741, 78742, 78744, 78745, 78746, 78747, 78748, 78749, 78750, 78751, 78752, 78753, 78754, 78755, 78756, 78757, 78758, 78759, 78760, 78761, 78762, 78763, 78764, 78765, 78766, 78767, 78768, 78769, 78772, 78773, 78774, 78778, 78779, 78780, 78781, 78783, 78785, 78786, 78788, 78789, 78798, 78799, 78932, 78938, 78940, 78941, 78942, 78945, 78946, 78947, 78948, 78949, 78952, 78953, 78954, 78956, 78957, 78960, 78961, and 78963;

(8) Region 8--South Central Texas, including San Antonio, comprised of the following ZIP Coded areas: 76883, 77901, 77902, 77903, 77904, 77905, 77951, 77954, 77957, 77960, 77961, 77962, 77963, 77964, 77967, 77968, 77969, 77970, 77971, 77973, 77974, 77975, 77976, 77977, 77978, 77979, 77982, 77983, 77984, 77986, 77987, 77988, 77989, 77991, 77993, 77994, 77995, 78001, 78002, 78003, 78004, 78005, 78006, 78008, 78009, 78010, 78011, 78012, 78013, 78014, 78015, 78016, 78017, 78019, 78021, 78023, 78024, 78025, 78026, 78027, 78028, 78029, 78039, 78050,

78052, 78054, 78055, 78056, 78057, 78058, 78059, 78061, 78062, 78063, 78064, 78065, 78066, 78069, 78070, 78073, 78074, 78101, 78107, 78108, 78109, 78111, 78112, 78113, 78114, 78115, 78116, 78117, 78118, 78119, 78121, 78122, 78123, 78124, 78130, 78131, 78132, 78133, 78135, 78140, 78141, 78143, 78144, 78147, 78148, 78150, 78151, 78152, 78154, 78155, 78156, 78159, 78160, 78161, 78163, 78164, 78201, 78202, 78203, 78204, 78205, 78206, 78207, 78208, 78209, 78210, 78211, 78212, 78213, 78214, 78215, 78216, 78217, 78218, 78219, 78220, 78221, 78222, 78223, 78224, 78225, 78226, 78227, 78228, 78229, 78230, 78231, 78232, 78233, 78234, 78235, 78236, 78237, 78238, 78239, 78240, 78241, 78242, 78243, 78244, 78245, 78246, 78247, 78248, 78249, 78250, 78251, 78252, 78253, 78254, 78255, 78256, 78257, 78258, 78259, 78260, 78261, 78262, 78263, 78264, 78265, 78266, 78268, 78269, 78270, 78275, 78278, 78279, 78280, 78283, 78284, 78285, 78286, 78287, 78288, 78289, 78291, 78292, 78293, 78294, 78295, 78296, 78297, 78298, 78299, 78604, 78614, 78618, 78623, 78624, 78629, 78631, 78632, 78638, 78658, 78670, 78671, 78675, 78677, 78801, 78802, 78827, 78828, 78829, 78830, 78832, 78833, 78834, 78836, 78837, 78838, 78839, 78840, 78841, 78842, 78843, 78847, 78850, 78852, 78853, 78860, 78861, 78870, 78871, 78872, 78873, 78877, 78879, 78880, 78881, 78883, 78884, 78885, 78886, and 78959;

(9) Region 9--West Texas, including Midland, Odessa, and San Angelo comprised of the following ZIP Coded areas: 76820, 76825, 76836, 76837, 76841, 76842, 76848, 76849, 76852, 76854, 76855, 76856, 76858,

76859, 76862, 76866, 76869, 76872, 76874, 76886, 76887, 76901, 76902, 76903, 76904, 76905, 76906, 76908, 76909, 76930, 76932, 76933, 76934, 76935, 76936, 76937, 76939, 76940, 76941, 76943, 76945, 76949, 76950, 76951, 76953, 76955, 76957, 76958, 78851, 79331, 79342, 79359, 79360, 79377, 79511, 79701, 79702, 79703, 79704, 79705, 79706, 79707, 79708, 79710, 79711, 79712, 79713, 79714, 79718, 79719, 79720, 79721, 79730, 79731, 79733, 79735, 79738, 79739, 79740, 79741, 79742, 79743, 79744, 79745, 79748, 79749, 79752, 79754, 79755, 79756, 79758, 79759, 79760, 79761, 79762, 79763, 79764, 79765, 79766, 79768, 79769, 79770, 79772, 79776, 79777, 79778, 79780, 79781, 79782, 79783, 79785, 79786, 79788, 79789, and 79848;

(10) Region 10--Far West Texas, including El Paso, comprised of the following ZIP Coded areas: 79734, 79821, 79830, 79831, 79832, 79834, 79835, 79836, 79837, 79838, 79839, 79842, 79843, 79845, 79846, 79847, 79849, 79851, 79852, 79853, 79854, 79855, 79901, 79902, 79903, 79904, 79905, 79906, 79907, 79908, 79910, 79911, 79912, 79913, 79914, 79915, 79916, 79917, 79918, 79920, 79922, 79923, 79924, 79925, 79926, 79927, 79928, 79929, 79930, 79931, 79932, 79934, 79935, 79936, 79937, 79938, 79940, 79941, 79942, 79943, 79944, 79945, 79946, 79947, 79948, 79949, 79950, 79951, 79952, 79953, 79954, 79955, 79958, 79960, 79961, 79968, 79976, 79978, 79980, 79990, 79995, 79996, 79997, 79998, 79999, 88510, 88511, 88512, 88513, 88514, 88515, 88516, 88517, 88518, 88519, 88520, 88521, 88523, 88524, 88525, 88526, 88527, 88528, 88529, 88530, 88531,

88532, 88533, 88534, 88535, 88536, 88538, 88539, 88540, 88541, 88542, 88543, 88544, 88545, 88546, 88547, 88548, 88549, 88550, 88553, 88554, 88555, 88556, 88557, 88558, 88559, 88560, 88561, 88562, 88563, 88565, 88566, 88567, 88568, 88569, 88570, 88571, 88572, 88573, 88574, 88575, 88576, 88577, 88578, 88579, 88580, 88581, 88582, 88583, 88584, 88585, 88586, 88587, 88588, 88589, 88590, and 88595; and

(11) Region 11--Rio Grande Valley, including Brownsville, Corpus Christi, and Laredo, comprised of the following ZIP Coded areas: 77950, 77990, 78007, 78022, 78040, 78041, 78042, 78043, 78044, 78045, 78046, 78049, 78060, 78067, 78071, 78072, 78075, 78076, 78102, 78104, 78125, 78142, 78145, 78146, 78162, 78330, 78332, 78333, 78335, 78336, 78338, 78339, 78340, 78341, 78342, 78343, 78344, 78347, 78349, 78350, 78351, 78352, 78353, 78355, 78357, 78358, 78359, 78360, 78361, 78362, 78363, 78364, 78368, 78369, 78370, 78371, 78372, 78373, 78374, 78375, 78376, 78377, 78379, 78380, 78381, 78382, 78383, 78384, 78385, 78387, 78389, 78390, 78391, 78393, 78401, 78402, 78403, 78404, 78405, 78406, 78407, 78408, 78409, 78410, 78411, 78412, 78413, 78414, 78415, 78416, 78417, 78418, 78419, 78426, 78427, 78460, 78461, 78463, 78465, 78466, 78467, 78468, 78469, 78470, 78471, 78472, 78473, 78474, 78475, 78476, 78477, 78478, 78480, 78501, 78502, 78503, 78504, 78505, 78516, 78520, 78521, 78522, 78523, 78526, 78535, 78536, 78537, 78538, 78539, 78540, 78541, 78543, 78545, 78547, 78548, 78549, 78550, 78551, 78552, 78553, 78557, 78558, 78559, 78560, 78561, 78562, 78563, 78564, 78565, 78566, 78567, 78568,

78569, 78570, 78572, 78573, 78574, 78575, 78576, 78577, 78578, 78579, 78580, 78582, 78583, 78584, 78585, 78586, 78588, 78589, 78590, 78591, 78592, 78593, 78594, 78595, 78596, 78597, 78598, and 78599.

§21.4505. Requirement to Collect Data.

(a) Each group health benefit plan issuer and plan specified in §21.4502(a) and (b) of this subchapter (relating to Applicability) is required to collect the data specified in Form No. LHL616 (Health Care Claims Reimbursement Rate Report) that is adopted by reference in §21.4507 of this subchapter (relating to Report Form) and is required to prepare and file data in accordance with the requirements in §21.4506 of this subchapter (relating to Submission of Report).

(b) The six-month reporting period for the data requested in Form No. LHL616 (Health Care Claims Reimbursement Rate Report), including the claims and reimbursement rate data, is January 1 to June 30 of the applicable reporting year. The enrollment data required in Form No. LHL616 (Health Care Claims Reimbursement Rate Report) for private market plans and governmental employee plans is for the total number of lives covered under the plans as of both December 31 of the year prior to the applicable reporting period and June 30 of the applicable reporting year.

(c) Notwithstanding subsection (a) of this section, a health benefit plan issuer that is exempt from filing a full reimbursement report pursuant to §21.4506(e) of this subchapter is not required to collect the full data indicated in

Form No. LHL616 (Health Care Claims Reimbursement Rate Report) and is required to instead collect enrollment data as necessary to comply with the applicable instructions specified in Form No. LHL616 (Health Care Claims Reimbursement Rate Report) to support an exemption.

§21.4506. Submission of Report.

(a) Not later than September 1 of each year, each plan and health benefit plan issuer identified in §21.4502(a) and (b) of this subchapter (relating to Applicability) is required to submit to the department the data required in Form No. LHL616 (Health Care Claims Reimbursement Rate Report) that is adopted by reference in §21.4507 of this subchapter (relating to Report Form).

(b) Notwithstanding the requirements of subsection (a) of this section, the first reporting date for the submission of data required by this subchapter is 60 days from effective date of this rule for data regarding claims payments from January 1, 2010, to June 30, 2010.

(c) The data filed pursuant to this section is required to be filed electronically in Excel format by:

(1) accessing a link designated on the department's website, http://www.tdi.state.tx.us/forms/form10accident.html, to obtain Form No. LHL616 (Health Care Claims Reimbursement Rate Report);

(2) completing the report in accordance with the form's instructions; and

(3) emailing the completed report to the department at ReimbursementRates@tdi.state.tx.us.

(d) To access the report form, the user must indicate acceptance of the End User Agreement concerning use of Current Procedural Terminology. Acceptance is indicated by clicking the button labeled "Accept." The content of the End User Agreement is provided in Figure: 28 TAC §21.4506(f) of this section.

(e) Notwithstanding subsections (a) – (d) of this section, a group health benefit plan issuer as specified in §21.4502(a) of this subchapter may submit to the department an exemption statement and the data required in Section B of Form No. LHL616 (Health Care Claims Reimbursement Rate Report) to support an exemption in place of the full report described in subsections (a) – (d) of this section. The group health benefit plan issuer asserting an exemption shall certify that the group health benefit plan issuer is exempt from the reporting requirement applicable to its health benefit plans for one of the following reasons:

(1) the total number of all covered lives in private market preferred provider benefit plans operating under the Insurance Code Chapter 1301 and offered by the health benefit plan issuer in Texas does not exceed 10,000 persons as of December 31 of the year preceding the report; or

(2) the total number of all covered lives in the private market health maintenance organization plans operating under the Insurance Code Chapter 843 and offered by the health benefit plan issuer does not exceed 10,000 persons as of December 31 of the year preceding the report.

(f) The content of the End User Agreement is as follows:

Figure: 28 TAC §21.4506(f):

End User Agreement:

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Should the foregoing terms and conditions be acceptable to you, please indicate your agreement and acceptance by clicking below on the button labeled "accept."

ACCEPT DO NOT ACCEPT

§21.4507. Report Form. Form No. LHL616 (Health Care Claims Reimbursement Rate Report) is adopted by reference. The form:

(1) contains instructions for completion of the report and requires submission of information and data concerning group health benefit plan issuer identification and enrollment information;

(2) requires the submission of both contracted and out-of-network claim information for general professional services; pathology services; anesthesiology services; radiology services; neonatology services; outpatient professional and institutional provider services; and inpatient institutional provider services; and

(3) is available at http://www.tdi.state.tx.us/forms/form10accident.html.